Trust Board Meeting

Date and Time: **Thursday 26th July: 10:00 – 13:00**

Venue: **H2.8, 2nd Floor Hunter 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 on 28 June 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**	**Corporate Objectives 2018-19: Quarterly update**	**Suzanne Marsello** Director of Strategy	Inform	Report
QUALITY & PERFORMANCE					
11:10	**3.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
	3.2	**Integrated Quality & Performance report**	**Executive Team**	Inform	Report
	3.3	**Elective Care Recovery Programme**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
	3.4	**Emergency Care Performance**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
	3.5	**Transformation update: Quarterly report**	**James Friend** Director of Delivery, Efficiency & Transformation	Inform	Report
	3.6	**MCA/DOLs Annual report**	**Avey Bhatia** Chief Nurse & DIPC	Approve	Report
FINANCE					
12:05	**4.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
	4.2	**Month 3 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
GOVERNANCE					
12:10	**5.1**	**Audit Committee Report**	**Sarah Wilton** Committee Chair	Assure	Report
	5.2	**Board Assurance Framework**	**Avey Bhatia** Chief Nurse & DIPC	Assure	Report
CLOSING ADMINISTRATION					
13:00	**6.1**	**Questions from the public**	-	-	Oral
	6.2	**Any new risks or issues identified**	**All**	-	-

Time	Item	Subject	Lead	Action	Format
	6.3	**Any Other Business**	**All**	-	-
	6.4	**Reflection on meeting**	**All**	-	Oral
13:10	**STAFF/PATIENT STORY**				
13:30	**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 30th August 2018, 10.00 – 13.00 Hyde Park Room, St George's Hospital

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
Mike Murphy	Quality Improvement Director – NHS Improvement	QID
Ellis Pullinger	Chief Operating Officer	COO
Secretariat	**Designation**	**Abbreviation**
Terri Burns	Interim Assistant Trust Secretary	ATS

Minutes of Trust Board Meeting

Thursday 28 June 2018, 10:00 – 13:00, Barnes, Richmond & Sheen Rooms, Queen Mary's Hospital

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Mike Murphy	Quality Improvement Director, NHS Improvement	QID
Ellis Pullinger	Chief Operating Officer	COO
APOLOGIES		
Stephen Collier	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
SECRETARIAT		
Terri Burns	Interim Assistant Trust Secretary	ATS
Sal Maughan	Head of Corporate Governance	HCG

Feedback from Walkabout

Members of the Board gave feedback on the departments they had visited ahead of the meeting. These included: Douglas Bader Rehabilitation Centre, Gwynne Holford Ward, Wolfson Rehab unit, Bryson Whyte Rehab Unit, Mary Seacole Ward, Gait Lab/Wheelchair Service, Special Seating, Day Case and Endoscopy, Dermatology, Outpatient Physiotherapy and Rehab and Bader Gym.

The MD reported that staff in the Douglas Bader Rehabilitation Centre were enthusiastic and knowledgeable. The facilities were impressive, particularly the outpatient and prosthetic rooms. It was noted that there were very few patients at the time of the visit, and this potentially gave rise to questions around productivity. There was also a concern that there was only one practitioner for nursing, as this could lead to sustainability issues. The CN agreed to pick this up. The CFO noted the need to explore commissioning arrangements, as well as looking at prevention options.

The COO reported on the visit to the Gwynne Holford Ward and Wolfson Rehabilitation Unit, and

commented that the group had been able to see the whole patient pathway during their visit. The links with the amputee service were also evident. The clinicians were keen to learn and the ward sister was enthusiastic about increasing the ward accreditation from silver to gold. The group were particularly impressed at the attention to detail, with the outside space designed to be a part of the rehabilitation process. There was opportunity to utilise the outpatient service for more activity. The COO would be meeting with the team again soon.

The DEF reported that the Bryson White Rehab Unit and Mary Seacole Ward were very spacious and bright. The reception staff were welcoming. The staff were pleased that their ward accreditation had increased. The matron was keen to ensure the system was well bedded in. Agency costs remained too high, however there was a plan in place to address this. There were some barriers in place from social care, although these were not significant.

The DS reported that the services that she visited covered south west London and the south of England. They were small specialised teams, where staff retention was high. However due to the nature of the services it was difficult to recruit when staff did move on. This could have a significant impact on waiting lists. Staff were happy generally and well motivated, although there was some uncertainty as to how to access corporate services. She would ensure this was addressed.

The DDET reported that the group had seen good patient flow through the services visited, with a calm atmosphere. There were some environmental issues, as well as concern around mixed sex accommodation. However the nurse leadership in place was an exemplar of modern working. Ann Beasley noted the stark positive difference when compared with the endoscopy unit she had recently attended at another hospital.

The DCA reported that the services visited had been quiet, clean and freshly painted. The friends and family test score was very good at 97%. There were some issues with working areas for staff. Desk space was a challenge. In addition, cupboards in the staff kitchen were being used for storage of clinical equipment as this was the only lockable cupboard. The CN and DEF agreed that alternative arrangements for storage would be found. Staff were keen to start using ERS for referrals. The COO would be following up with the team in relation to the switch over. The Bader Gym was an impressive facility and while there were only a few patients during the time of the visit, the gym was used by both patients and staff.

The Chairman commented that it was important for the Board to be at Queen Mary's Hospital. She also noted that there had been general messages of under-utilisation. The CEO responded that it was clear there was not enough leadership on the site. Arrangements would be made to have regular Board meetings there. Plans were in place to strengthen the leadership, including Executive Directors being on site more often. Using the site more would help to ensure the local population did not have to travel to access services.

The DCA reported that actions arising for Board visits would be brought quarterly for follow up, to ensure Board members were kept updated on progress.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed members of the public and a number of the Trust's Governors. Apologies had been received from Stephen Collier and Sarah Wilton, Non-Executive Directors. The Chairman also welcomed Penny Lock to the meeting, who would be observing on behalf of Integrated Development, who were working with the Board on its development.
Declarations of Interest	

1.2	No declarations of interest were made.
Minutes of previous meetings	
1.3	The minutes of the meetings held on 24 May 2018, 31 May 2018 and 14 June 2018 were agreed as true and accurate records.
Action log and matters arising	
1.4	The Board reviewed the action log and agreed to close the action related to the Board Assurance Framework (TB.31.05.18/80). It also noted the following updates: • TB. 29.03.18/ 76 and TB. 29.03.18/ 77 - The DHROD stated that he would cover actions relating to the Freedom to Speak Up Guardian and the Staff Survey under the Workforce and Education Committee Report. • TB. 31.05.18/ 78 - The CEO reported that she had met with staff affected by the Trust's decision to withdraw from a number of community services contracts. A programme lead had been appointed, who would be working closely with the communications team, to ensure ongoing communications with affected staff. • TB. 31.05.18/ 79 - Non-Executive Director opinions had been sought at the Finance and Investment Committee in relation to the new style of Integrated Performance & Quality Report. The updated report format was a work in progress.
1.5	**CEO's update**
	The CEO reported that a number of staff and stakeholder workshops were scheduled to take place throughout July to help inform the development of the Trust's new clinical strategy. The early indications were that these would be well attended and would help ensure those who work at the Trust and use its services have an opportunity to shape the strategy, particularly in its formative phases of development. The CEO acknowledged that the Trust's ICT infrastructure remained fragile but reported that additional funding had been secured for the Trust's critical care service. The Trust's ICT Strategy was in development, and the Board would consider this in Part 2. Securing further investment in the ICT infrastructure remained crucially important to staff and patients. NHS70 events would be taking place the following week. The CEO commented that it was great to see staff and the values and achievements of the NHS being celebrated. The CEO congratulated a number of staff who had been nominated for awards. The Urology team had been chosen as hosts for a European training centre. Staff had also been hosted at the Houses of Parliament in May by Siobhain McDonagh MP to thank them for their hard work and dedication during the winter months. An afternoon tea had been held earlier in the month for long serving members of staff and volunteers. The CEO reflected that it was very enjoyable spending time with such passionate people and it was important that their dedication to the Trust was acknowledged and celebrated. In relation to staff, the DDET noted that although the vacancy rate was improving, it should

	not be overlooked that there were still some areas causing operational issues. This had been discussed at the Workforce and Education Committee, which agreed that it should be kept under review and revisited if the Trust was unable to put in place robust plans to fill junior doctor rota gaps. The risk rating may also need to be reviewed. This was particularly relevant in relation to the medical staffing issues as a result of breaches in agreed caps by other trusts.
STRATEGY	
2.1	**Corporate Objectives 2018-19**
	The DS reported that feedback from Non-Executive Directors had been received and included in the updates made to the objectives. The process remained developmental, with the aim of using the learning for the following year's objectives. A great deal of thought had been put into how to measure progress in the future. The quarter one report would be presented to the Board in July 2018 and this would include more detail around the delivery milestones and mitigations. The Chairman commented that there had been a significant improvement to the document since the objectives were first brought to the Board in May 2018, though there was still room for further development and next year's objectives would reflect this. Ann Beasley noted that further proof reading was required. Some of the objective measures of success also needed further work, as some of the objectives were not as 'SMART' as others. This would be key in ensuring that progress and impact could be measured effectively. The Chairman agreed, and noted that she had provided detailed feedback to the DS ahead of the meeting. As such, she would not go through all of these points at Board. However, there were some significant gaps to highlight, including a lack of reference to funding for medicines management, patient partnership work and detail on equalities work. The CN agreed that the metrics around patient partnership and stakeholder engagement needed further refinement and input from the DCA and communications team would be sought on the latter. The DS noted that all feedback would be included in the final version at the next Board meeting. The Board approved the revised corporate objectives and agreed to delegate authority to the Chairman and CEO to finalise the further refinements required. The Chairman also asked that the agreed objectives be circulated to the Board within a fortnight. **TB. 28.06.18/ 81: Objectives to be recirculated to Board members following further update, within two weeks**
QUALITY & PERFORMANCE	
3.1	**Quality & Safety Committee Report**
	Sir Norman Williams presented the Committee's report and noted that the draft CQC report had been reviewed for factual accuracy and that the Trust expected to receive the final report expected in July. There had been improvements in the QIP dashboard, with the four hour accident and emergency performance gradually increasing, and improvements to outpatient follow ups, never events, and avoidable grade 3 and 4 pressure ulcers. The Committee had also noted an improvement in meeting complaint response times, with 84% of complaints now dealt with within 25 days. However, the Committee had seen a deterioration in performance in on the day cancellations for theatre and percentage utilisation of pre-operative appointments. The Committee also requested that additional focus be given to improving performance in discharging patients before 11 am. The

	importance of learning from legal claims was noted, with one significant settlement having been reported to the Committee. The Committee had also received an informative report about learning from deaths and had also received a report on Clinical Negligence Scheme for Trusts in relation to maternity, both of which were on the Trust Board agenda. Sir Norman Williams observed that the GIRFT programme was an important driver of quality and productivity improvements and it would be important to understand more about the Trust's approach on this. The CEO responded that visits were in place, but the Board needed to be better sighted on GIRFT. The MD noted that GIRFT and Model Hospital were both very good models that had been shown to have a positive effect elsewhere. He also noted that the lead Emergency Department Consultant would be taking a deep dive to the Committee on sepsis following a drop in performance. Sir Norman Williams suggested that the Quality and Safety Committee and the Finance and Investment Committee should receive reports on the Trust's work on GIRFT so that the Board could have greater assurance on this. **TB. 28.06.18/ 82: Updates on progress and impact of GIRFT reviews to Board via QSC and FIC.** The DDET noted that 11am discharges were slightly better than had been reported due to recording issues that had since been addressed, but there was further work to do to improve performance. The improved response rate to complaints was noted. The Board queried whether this meant that there was a drop in the quality of responses. The CN assured the Board that responses were monitored by the appropriate Executive who signed off each one. The Trust also reviewed how many complaints where upheld by the Ombudsman and this was considered when looking at quality control. The COO noted that the Trust did not have an internal target for on the day cancellations, which were currently at less than two per cent. Over 90% were rebooked within 28 days. The aim was to make this 100%. Ann Beasley noted the importance of understanding the reasons behind cancellations, and suggested that it would not be suitable to set a target where cancellations were for valid clinical reasons. The Board noted the report.
3.2	**Integrated Quality & Performance Report**
	The DDET introduced the report and observed that there had been a good level of outpatient activity, although elective and day surgery numbers remained a challenge. Outpatient clinic outcome recording was being revisited and the previous target set had been met, which was positive. The CN reported that May had been better in relation to quality. There had been no Never Events and both falls and pressure ulcer numbers were reducing. The reasons behind this were being reviewed and it appeared to be linked to a reduction in the number of unfilled duty hours. C.Difficile had fallen in May 2018 following a peak in cases the previous month; whereas there had been six cases of C.Difficile in April, there had been a single case in May. The friends and family test results for the Emergency Department were red and below the national and London averages, and the team were looking at whether there were any recurring themes which could be addressed to improve the scores. The Chairman queried how the Emergency Department got their feedback, as she had been unable to give any formally following a recent visit. The CN stated that all patients should be invited to do so by text message. The COO reported that the Trust had delivered six out of seven national cancer standards in

	April. Tim Wright welcomed the intention to move the format of the report towards a balanced scorecard approach, and asked that this be further developed ahead of the July Board meeting. He also observed that it would be helpful for the summary slide ('how are we doing?') to set out the previous month's scores in addition to the results from the current reporting period so that the Board could see at a glance the direction of travel of the key metrics. The DDET noted that the balanced scorecard approach was a work in progress and a further development of the pack would be introduced in July. The QID commented that he had challenged the format of the report on several occasions and further refinements would be welcome. In particular, he noted that, in places, the briefing and commentary which provided context to the detailed performance metrics needed more detail and explanation. In the absence of this, it would be hard for the Board or its Committees to take assurance. In relation to maternity and mortality performance, for example, the QID observed that these appeared to have been declining in recent months, but the commentary in the report did not provide sufficient explanation for this. On maternity, the C-Section rate indicator had turned red in May, and the commentary stated only that the indicators would continue to be monitored and reviewed by the divisional governance process. More information to explain this movement was needed. The MD acknowledged this, and agreed that further information should be included in future reports to explain significant movements in performance. A forecast would also help to promote discussion. The CFO stated that the Finance and Investment Committee had agreed to show forecasting following month three. The CEO stated that the Trust wanted to get to the position where the position could be seen on a daily basis, to enable issues to be identified and addressed as quickly as possible. There also needed to be a culture of setting mitigations at the same time as the data they related to for assurance. **TB. 28.06.18/ 83: Next report to give further detail on reasons for changes in Maternity, Mortality and Readmissions performance figures.** The DHROD reported that the downwards trend in vacancies and sickness continued. Appraisals were also increasingly taking place. The new pay deal allowed the Trust to stop increments if appraisals were not completed. Agency performance remained below target for the year. The Trust had committed to break glass rates for junior doctors, however some trusts locally were not abiding by this agreement, and this posed a real challenge in holding the position at the Trust. The Agenda for Change pay deal had been ratified, so would begin from July and be backdated to April. The Chairman noted that although the funding was in place for the first one per cent, how the remainder would be funded had not been clarified. Sir Norman Williams questioned whether there was a national process in place to stop others breaking the rates agreed upon between trusts. The DHROD stated that there was not. However, trusts would have to start reporting overpayments shortly. The MD noted the pressure this had put on junior doctor recruitment and the operational impact felt. The Board noted the report.
3.3	**Elective Care Recovery Programme**
	The COO reported that there was a significant amount of work to be done, but the timeline discussion for a return to reporting had taken place. The forward planner would be brought to the July Board meeting for feedback. RTT staff training was taking place and a review of cancer services had also been undertaken.

	The Board noted the report.
3.4	**Emergency Care Performance**
	The COO reported that the report format had been standardised. The performance against the four hour standard was expected to be 93-94% overall for year to date. There had been a difficult two week period which had affected the result. Inpatient modelling work had taken longer than expected and would be scrutinised further at the Trust Executive Committee and Board Committee level. Ann Beasley asked what a reasonable assumption would be to reduce the length of stay. The COO noted that this was one of the areas which required further discussion. Clarity was also needed as to what constituted length of stay. The CFO noted that this was a first cut of the data and no assumptions had been made as to what improvements would be required as yet. Engagement would take place with NHS Improvement and all clinical divisions. The Board noted the report.
3.5	**Safeguarding Adults Annual Report**
	The CN reported that separate reports would come to the Board at future meetings in relation to the Mental Capacity Act, Deprivation of Liberty and children's safeguarding. There were a number of interdependencies. A Head of Safeguarding had been appointed, who had a background in social work, and brought invaluable experience and a new approach. There were no section 42 investigations to report. The main risks to note related to training. The outcome of the ongoing consultation would determine decisions around resourcing for training. PREVENT training required improvement, with a target of 85% agreed with commissioners by the end of August 2018. The Board noted the report.
3.6	**Learning from Deaths – Quarterly Report**
	The MD reported that the report had been reviewed by the Quality and Safety Committee and was required quarterly. The process centred around learning and doing things better in the future. The Trust had often been held out as an exemplar nationally. Some procedural changes were under consideration but required more work. The CN noted that any avoidable death went through the serious incident process. Sir Norman Williams noted that there had recently been a report published on gross negligence manslaughter in healthcare. It was important to review reports such as this and ensure national guidance was followed to ensure standards were maintained. Family involvement was also important to ensure they did not feel resentment, which could lead to legal action. Ann Beasley stated that the prison service had begun investigating near deaths as a way of learning. The MD noted that the Trust did this in certain cases, with a group of clinicians reviewing through the risk process. The Board noted the report.
3.7	**CNST Incentive Scheme for Maternity**
	The MD introduced the report. The Department of Health had set out a strategy which aimed to reward organisations which had taken action to improve maternity safety. One aspect of

	this was that Trusts which could demonstrate compliance against 10 nationally set criteria could qualify for a 10% reduction on their Clinical Negligence Scheme for Trusts premium, which was an insurance scheme for medical errors. The MD explained that assurance had been reviewed at divisional level and by the Trust Executive Committee and the Quality and Safety Committee. All 10 metrics were being achieved, and the Quality and Safety Committee had commended the self-reporting compliance statement to the Board. The DDET noted that a great deal of work had gone into the process, with multi-disciplinary training being an area of particular challenge. A 10% CNST reduction was a significant saving for the Trust and one which could contribute significantly to achieving the forecast deficit for the year. The Board approved the submission to NHS Resolution.
FINANCE	
4.1	**Finance & Investment Committee Report**
	The Chairman noted that she had chaired the Committee meeting on 25th June, in the absence of the Committee Chair. The Committee had discussed the current assessment of the key financial risks and how these related to the strategic risks on the Board Assurance Framework. It had also noted that work was ongoing to address the estates risks discussed during a recent Board workshop. The ICT Strategy progress was reported on, with the Committee welcoming the appointment of a new Chief Information Officer and the grip she had brought to the ICT function. It had been agreed to recommend the iClip business case to the Board for approval. The Committee had considered month 2 financial performance and had noted that this was broadly within plan, but also noted that elective activity was below plan and was adversely affecting income. There were some areas of overspend which needed to be addressed, particularly as CIP delivery was scheduled to increase sharply in the coming months. The Committee also discussed the business plan for 2018/19 which had been resubmitted to NHSI on 20 June 2018. The final control total had been confirmed as £29m, and receipt of an additional sum of £12.6m Provider Sustainability Funding would be contingent on delivering the agreed control total. The Committee also approved two finance policies, the first on private patients, the second in relation to overseas visitors. The Board noted the report.
4.2	**Month 2 Finance Report**
	The CFO reported that the Trust had a deficit of £10.7m at the end of May 2018, which was £200k adverse to plan. The key issue was shortfall against income targets. This was, in part, offset by an underspend in expenditure, particularly in relation to non-pay. CIP delivery in the first quarter of 2018/19 was in line with plan, though the CFO noted that months three to five required material increases in the CIP delivery targets. Control of expenditure was a key area of focus, as some parts of the organisation were continuing to overspend. The CFO also reported that actions were being picked up to ensure that speciality teams were including them in weekly planning. Workforce planning was also included to manage capacity issues. The activity target had been met, but not on a consistent basis. In response, the COO noted that a new general manager for Outpatients was in place who had been tracking the daily booking lists to ensure robust control and progress delivery against

	targets. The Board noted the report.
WORKFORCE	
5.1	**Workforce & Education Committee Report**
	The DHROD presented the report in the absence of the Committee Chair. The DHROD explained that the Committee had received a report from the Freedom to Speak Up Guardian. Communications relating to how the Guardian could be contacted were extensive and she also attended every Trust induction session, as well as holding webinars for staff. The Guardian also carried out ward visits and was involved in policy development. Five referrals had been received this year, with three of them live. The DHROD had met with Sir Norman Williams as the Non-Executive lead for whistleblowing. There remained work to be done in relation to bullying and harassment and patient safety. The DHROD reported that the majority of the actions taken from the 2016 staff survey had now been implemented. The two year engagement plan that was in place was under review, with a great deal of work ongoing. Staff engagement sessions would take place as part of the review. The DHROD thanked the Trust Quality Improvement Director for her hard work in facilitating this. Sir Norman Williams noted that there could be a fear of reprisals related to whistleblowing and queried what the Trust did to counteract this. The DHROD stated that the Trust ensured individuals felt supported, and this was embedded within the policy. They had access to a Non-Executive Director as well as the DHROD meeting with them personally. However there was no standard approach that would suit all whistle blowers. The CEO noted the importance of strong leadership to manage conflicts and assure staff. The Chairman noted that she looked forward to seeing a diversity and inclusion report at the Board. The DHROD questioned whether a Board seminar would be more appropriate, which was welcomed by Board members. **TB. 28.06.18/ 84: Diversity and inclusion Board seminar to be arranged.** The Board noted the report.
5.2	**Fit & Proper Persons Regulation – Quarterly Update**
	The DHROD reported that all Board members met the Fit and Proper Person requirements. All appropriate checks had now been received for Stephen Jones, Director of Corporate Affairs. The Board noted the report.
CLOSING ADMINISTRATION	
6.1	**Questions from the public**

	Khaled Simmons, public Governor from Merton, asked how the corporate objectives could be approved when there was still work outstanding and how they could be owned by one Executive. The Chairman stated that they had been developed and owned by all Executives, with each of them agreeing milestones for their particular areas of responsibility. The role of the DS was to coordinate the objectives across the Executive team, rather than to own this herself. The Chairman added that that the objectives were in a much better position than the version shared with the Board the previous month, never the less it was a work in progress and emphasised that the Board had agreed to delegate final authority to the Chairman and Chief Executive to approve the further refinements that were necessary. Performance against the objectives would be reviewed quarterly by the Board. In relation to whistleblowing, Khaled Simmons commented that the financial sector had shown enthusiasm for ensuring that speaking up in relation to whistleblowing would not adversely affect career prospects.
6.2	**Any new risks identified**
	The CFO noted the medical staffing issues as a result of breaches in agreed caps by other trusts. The DHROD noted that this should be reviewed under the risk register. **TB. 28.06.18/ 85: Review risk register to ensure medical staffing risk is adequately expressed and mitigations explained.**
6.3	**Any Other Business**
	The Chairman reported that she had collected the Armed Forces Covenant Employment Recognition Scheme award on behalf of the Trust, which had been nominated by a member of staff. The Human Resources team had worked hard and the staff member had recognised this. The positive impact made was very apparent. Tim Wright noted the thanks from St George's Charity for the input into their Chief Executive recruitment process by the DHROD.
6.4	**Reflection on the meeting**
	The DDET noted the benefits of meeting at Queen Mary's Hospital and the importance of the Board being visible to staff outside of St George's Hospital. The CEO stated that, in future, at the point at where the Trust was taken out of special measures, consideration would need to be given to attendance at Board sub-Committees and how the Committees gave assurance to the Board.
	PATIENT STORY
	Sara Smith, amputee therapy team lead at Queen Mary's, accompanied Mr William Dickel who spoke to the Board about his experience as a patient at Queen Mary's Hospital. Sarah had been working at the hospital since 1987. She explained that Queen Mary's was one of 35 prosthetic centres across the country, with both in- and outpatient facilities. Patients remained with the Trust for life. Referrals were of both vascular and trauma patients. There

	were 10 inpatient beds, where stays tended to be for six to seven weeks. Once discharged, patients would be reviewed regularly. She also noted that inpatients were seen daily by the team, which was shown to give good outcomes and reduce length of stay when compared with other facilities. Mr Dickel told the Board that he had stayed as an inpatient for 12 weeks, due to complications. He had suffered a blood clot which resulted in amputation six years previously. He said that the staff had been fantastic and were very dedicated. He was able to come back to the hospital whenever he needed to and found it easy to access the services. When asked if there was anything he thought could be improved, Mr Dickel said that there was not. He would have preferred to have had a shorter inpatient stay, but that could not have been avoided. The DS asked what, if any, psychological help had been offered to him. Mr Dickel said that, while he had not made use of it himself, there was support available. Sara Smith noted that there was a clinical psychologist available two days a week within the team. The Chairman thanked both Sara and Mr Dickel for attending and sharing their experiences with the Board.

Date and time of next meeting: Thursday 26 July 2018, 10:00 – 13:00
Hyde Park Room, St George's Hospital

Trust Board Action Log - June 2018

Action Ref	Theme	Action	Due	Lead	Commentary	Status
TB. 29.03.18/ 76	**Freedom to Speak Up**	Board to receive report after the next Workforce & Education Committee (WEC) meeting and subsequent regular reports	28.06.2018	DHROD	DHROD gave update under Workforce & Education Committee Report at 28 June 2018 Board meeting	PROPOSE FOR CLOSURE
TB. 29.03.18/ 77	**NHS Staff Survey 2017**	Staff Survey action plan to be considered by the Board after the discussion at next meeting of the Workforce and Education Committee	28.06.2018	DHROD	DHROD gave update under Workforce & Education Committee Report at 28 June 2018 Board meeting. WEC to consider fuller update at next meeting, with WEC Board report addressing this.	OPEN
TB. 31.05.18/ 78	**CEO Update**	Ensure clear messages communicated to staff regarding the Trust's withdrawal from provision of certain community services	28.06.18	DS & DCA	CEO met with staff from some services. COO reported programe lead appointed - working closely with Communications team.	PROPOSE FOR CLOSURE
TB. 31.05.18/ 79	**Integrated Quality & Performance Report**	NED opinions to be sought regarding new style of report before returning to FIC	28.06.18	DDET	Discussed at Finance & Investment Committee and members feedback incorporated.	PROPOSE FOR CLOSURE
TB. 28.06.18/ 81	**Corporate Objectives 2018-19**	Objectives to be recirculated to Board members following further update, within two weeks	13.07.18	DS	Board agreed to delegate responsibility for signing off the updated corporate objectives to the Chairman, with the final version of the objectives being circulated by the corporate governance team to the Board within two weeks of the June 2018 meeting	OPEN
TB. 28.06.18/ 82	**Quality & Safety Committee Report**	Updates on progress and impact of GIRFT reviews to Board via QSC	26.07.18	MD & DDET	GIRFT to be added to July Quality and Safety Committee agenda, and reported to the Board via the QSC Board report	OPEN
TB. 28.06.18/ 83	**Integrated Quality & Performance Report**	Next report to give further detail on reasons for changes in Maternity, Mortality and Readmissions performance figures	26.07.18	MD	Commentary included in IQPR for July 2018	PROPOSE FOR CLOSURE
TB. 28.06.18/ 84	**Integrated Quality & Performance Report**	Develop IQPR pack towards balanced scorecard approach and add to the "how are we doing?" slide, the previous month's performance figure to highlight movement between months	26.07.18	DDET	Balanced scorecard included in report to Board - July 2018	PROPOSE FOR CLOSURE
TB. 28.06.18/ 85	**Workforce & Education Committee Report**	Diversity and inclusion Board seminar to be arranged	26.07.18	DHROD & DCA	Upcoming Board development dates being sought for the rest of 2018.	OPEN
TB. 28.06.18/ 86	**Any new risks/issues identified**	Review risk register to ensure medical staffing risk is adequately expressed and mitigations explained	26.07.18	DHROD & MD	To be reviewed at next Workforce & Education Committee meeting - August 2018	OPEN

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 July 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 Trust 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's report to the Trust Board – July 2018

I want to begin my report by talking about our Care Quality Commission (CQC) inspection report, which was published on Thursday, 19 July.

The headline results are now well known, but I want to reiterate here how pleased I am that the Trust has moved from an overall Inadequate rating to Requires Improvement.

This is a big step forward for our hospital and community services – and one that wouldn't have been possible without the commitment of our 9,000 staff. Indeed, in my message to staff last week, I stressed the psychological significance of moving from Inadequate to Requires Improvement.

We know we are still a long way from providing Outstanding Care, Every Time for our patients – and remain in special measures for the time being. However, what last week's news tells me – and which I related to staff – is that we *can* get better, and that we *are* capable of great things.

I mention this because some of the very real challenges staff face – particularly in terms of our IT infrastructure and hospital estate at St George's – can sometimes make the potential for improvement feel a very distant ambition.

We are investing in our IT and hospital estate, but what the CQC's improved rating tells me is that, regardless of this, we have been able to improve and can do more if we stick to the task – which I know we will.

Visit by Dr Kathy McLean, Executive Medical Director at NHS Improvement:

On this same topic of improvement, I was pleased to welcome Dr Kathy McLean, Executive Medical Director at NHS Improvement, to St George's on Friday 6 July. During her visit, Kathy spent some time on the wards, meeting and talking with staff.

Kathy visited Trevor Howell ward, and spoke to one of our Heads of Nursing about her work, including our ward accreditation scheme. Kathy was extremely impressed by the scheme – and followed up her visit with a letter praising what she'd seen, and the positive impact it has having, which I was delighted to share with the staff who have made it possible.

The ward accreditation scheme gives us, for the first time, a consistent view of how wards are performing across a set of quality metrics. This is important because, like many NHS organisations, we demonstrate excellent practice in some parts of the hospital (such as management of pressure ulcers), but inconsistent and sometimes poor practice in others.

The key is to be consistent, and ensure best practice is being followed across all of our services – this is what the CQC expect but, more importantly, it is the right thing for our patients, and the communities we serve.

The ward accreditation scheme is only part of the solution, but it's a fantastic platform to build from – and I am glad that someone with Kathy's knowledge and experience found it worthy of praise.

Staff achievements:

I am delighted that seven members of Trust (as well as university) staff were recognised in the annual academic promotions made by St George's, University of London, earlier this month.

This is a significant achievement for the individuals involved, and the end result of a lot of hard work. Indeed, it is to their immense credit that they've been able to expand their clinical and academic portfolios whilst also carrying out their day to day roles.

The Trust staff recognised are:

- Asma Khalil - Professor of Obstetrics and Maternal Medicine
- Caroline Hing - Honorary Reader in Orthopaedics
- Duncan Tennent - Professor of Practice
- James Spratt - Honorary Reader in Interventional Cardiology
- Julene Carvalho - Professor of Practice
- Kate Tatton-Brown - Professor of Clinical Genetics and Genomic Education
- Nicholas Watkin - Professor of Practice

Our relationship with the university is so important, and closer links between clinical practice and academic research will only benefit the patients we treat.

So this is good news – as is the news, published last week, that our 1,022 participants in life science research studies during 2017-18 puts us amongst the very best recruiting centres nationally.

Clinical success and innovation:

I am also pleased that the Trust rated top of the table in a recent peer review of transplant centres across the UK.

The NHS England Quality Surveillance team visited all visited 23 renal and pancreas transplant sites within the UK before publishing their recent results, so the fact our centre rated the highest of all is a significant achievement.

The review evaluated every aspect of the transplant patient's pathway – including an individual's assessment, preparation for surgery, the transplantation, and the long term follow-up service provided.

Our transplant service was found to have a compliance rate of 96% across the different quality indicators, which is absolutely fantastic, and a real credit to the staff who run, and work in, this special service at St George's.

We are also leading the way in the opening of our Energy Centre at St George's, which was officially opened at the end of June.

This major revamp of our energy facilities is helping to reduce our annual carbon emissions by 6,000 tonnes, the same amount produced by 3,000 cars.

The project is also guaranteed to save £1 million per year in energy bills, and replaces the previous facility which had been powering our Tooting site for over 40 years. A big step forward, and an important – if largely unseen – development for the organisation.

NHS 70:

Finally, I would like to say a huge thank you to the many staff and volunteers who supported the NHS 70 celebrations on 5 July across the Trust.

It was a fantastic day at St George's, Queen Mary's, and for NHS organisations across the country. Our celebrations had pretty much everything; sponsored walks, tea parties, celebratory films, media coverage, staff visits to Westminster Abbey and Downing Street, bake-offs – all of which created a wonderful celebration of life here at St George's over the past 70 years.

The events earlier this month would not have been possible without the support of so many staff, volunteers and partner organisations; and the support we had from external organisations and charities was also second to none. It's important we mark events such as this, and I think we did a great job!

Jacqueline Totterdell,
Chief Executive

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	26th July 2018	**Agenda No**	**2.1**
Report Title:	2018/19 Corporate Objectives – Quarter 1 report		
Lead Director	Suzanne Marsello, Director of Strategy		
Report Author:	Tom Ellis, Head of Business Planning		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	In December 2017, the Trust Board agreed a new set of Strategic Objectives: *Outstanding Care, Every Time.* These built on the Quality Improvement Plan, published by the organisation in September 2017. The Trust Board approved the set of corporate objectives which reflect the key priorities for the organisation in 2018-19 in the June Board meeting. This is the Quarter 1 report of progress with delivery against those agreed milestones. The Quarter 1 report has 7 objectives where delivery has not been as expected at Quarter 1. The mitigation to ensure these actions are delivered and do not impact on planned delivery at year end is provided to the Trust Board.		
Recommendation:	The Trust Board is asked to asked to note the Corporate Objectives Quarter 1 position and: 1. Confirm the RAG ratings awarded for each action/milestone, and the overall RAG rating awarded against each of the Corporate Objectives and for the Trust. 2. Identify any additional assurance required in relation to the objectives where Q1 delivery is delayed		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	▪ Any risks associated with the corporate objectives are covered within the BAF, Trust Risk Register or local risk registers		
Legal/Regulatory:	As legal/regulatory issues associated with the Corporate Objectives are		

	covered by the governance underpinning that particular area of delivery of the trusts work programme		
Resources:	Delivery core business as usual of the trust, and supported by trust leadership cohort		
Previously Considered by:	Trust Executive Committee	**Date:**	18th July 2018
Appendices:	2018-19 Corporate Objectives		

2018/19 Corporate Objectives: Quarter 1 Report

1.0 Purpose

1.1 In December 2017, the trust agreed a new set of Strategic Objectives: *Outstanding Care, Every Time.* These built on the Quality Improvement Plan, published by the organisation in September 2017, and included key priorities for 2018/19. These form the basis of the corporate objectives (priorities) for 2018/19.

1.2 The June Trust Board approved the Corporate Objectives for 2018/19, subject to some final revisions / clarifications which have been approved by the Chair and CEO. The final approved set of objectives is provided with this report.

1.3 There is a director lead for each objective who is responsible for reporting on delivery and any necessary mitigations. The Director of Strategy is responsible for coordinating the reporting to Trust Board.

2.0 Quarter 1 Delivery

2.1 In line with the Trust Board's agreed reporting timetable, delivery in Quarter 1 (April – June 2018), is required to be reported to the July Trust Board.

2.2 The position at Quarter 1 is positive, with 36 'Green' Actions, 3 'Amber', 2 'Red', with 6 actions having no milestones in Q1, and 10 responses outstanding. The overall RAG rating for Quarter 1 for the Trust is 'Green'

Organisational Objective	Green	Amber	Red	N/a (for quarter)	Update outstanding	Quarterly Position
Treat the patient, treat the person	**7**	**0**	**0**	**2**	**0**	
Right care, right place, right time	**7**	**2**	**2**	**1**	**0**	
Balance the books, invest in our future	**3**	**0**	**0**	**1**	**0**	
Build a better St. George's	**10**	**3**	**0**	**2**	**0**	
Champion Team St. George's	**6**	**0**	**0**	**0**	**0**	
Develop tomorrow's treatments today	**4**	**0**	**0**	**0**	**1**	
OVERALL	**37**	**5**	**2**	**6**	**1**	

2.3 A summary of the objectives where delivery is delayed is provided in the table below, with the reasons for delay and the mitigation to ensure delivery is achieved and does not adversely impact on delivery of the subsequent milestones.

2.4 The full reporting of all corporate objectives (including those where progress is rated as green) was provided to the Trust Executive Committee, and can be provided to the Trust Board if required for assurance.

2.5 If all mitigations are delivered as outlined below, there are no anticipated additional risks to impact on the key strategic risks identified on the BAF.

2.6 Trust Board should note that for the objective 8.1 Increase Theatre Productivity there has been a decision made regarding the theatre refurbishment programme which means the milestones identified will need to be completely revised, and this will be reported to Board with the Quarter 2 report.

Corporate Objective	Action	Milestone and Progress	Mitigation	Risk	RAG Rating at Q1
Objective: Right care, right place, right time **7. Unplanned and admitted care**	**7.1 – Admit patients to the right ward, discharge them efficiently and ensure a positive patient experience**	▪ AMU bed occupancy at Midday =<80% - **Not delivered** AMU bed occupancy at Midday = 85.3% Although the AAA model has been stabilised, only one in seven AMU beds have been empty at Midday on average in Q1. This is an improvement from 1 in 19 seen in Q4. Opportunity exists to ensure consistent early morning discharge from / admission to the downstream wards ▪ Model Hospital and Get it Right First Time (GIRFT) benchmarked Length of stay and Daycase rate performance to be identified – **Delivered** The Beddays Opportunity analysis tracker has been created	From 24th July extended opening hours for AAA means there will be a reduction in admissions late in the day which is expected to lead to a reduction in bed occupancy at 12pm. Exemplar patient initiative will increase morning discharges.	**Overall risk associated with Q1 position:** Delays in delivery impact on bed occupancy linked to ability to deliver 95% A&E standard.	
Objective: Right care, right place, right time **7. Unplanned and admitted care**	**7.3 – Achieve SAFER compliance on wards**	▪ UAPC Steering Group agree minimum expectations of ward teams – **Partially Delivered** Minimum Standards have been drafted and sent to the UAPC Steering Group	To be completed by end of July	**Overall risk associated with Q1 position:** Not a material risk at this stage.	
Objective: Right care, right place, right time **8. Theatres**	**8.1 – Increase theatre productivity**	▪ Develop and implement new theatre service template – **Not Delivered** Decision taken at TRIG to keep Theatre 7 open and revised theatre template to be introduced from September 2018 (linked to activity and income recovery plan)	Milestones for the remaining quarters of the year will need to be revisited as the decision to keep Theatre 7 open impacts on the milestones.	**Overall risk associated with Q1 position:** The impact of the change on ability to increase theatre productivity will need to be considered by the COO as part of the resetting of milestones in line with the change	
Objective: Right care, right place,	**10.1 – Return Tooting campus to national**	▪ Robust strategy for delivery of RTT training across the organisation for BAU – **Not Delivered** BAU RTT training requires a Trust wide approach. This strategy	Strategy for delivery of RTT training to be agreed by TEC in Q2	**Overall risk associated with Q1 position:** Return to RTT reporting is	

right time **10. Waiting lists and RTT**	**reporting of the 18 week RTT standard and work to reduce waiting times against all national standards**	will need to be agreed in Q2 ▪ E-Learning RTT modules 1 & 2 complete by 85% of all identified staff – **Not delivered** Training completed at 53%. Focus on improvement in July 2018. ▪ Cancer improvement: RMP Recommendations to be presented back and agreed by the Trust – **Not delivered in Q1** Update delivered to TEC 18th July ▪ E-Triage - backlog reduction of 25% of all referrals waiting longer that 5 days from April baseline – *Backlog position being confirmed*		a significant objective for the organisation in terms of assurance re patient safety and reputation; links to CQC rating and Quality Special Measures.	
Objective: Build a Better St. George's **13. Governance**	**13.3 – Use the CQC Well-Led Framework to ensure we are meeting our regulatory requirements**	▪ Receive CQC report which will detail new ratings across all domains for the 6 core services inspected in March / April 2018 – **Partially Delivered in Q1** Draft CQC report provided to Trust June 2018. Final CQC report published 19th July 2018. ▪ Refresh QIP priorities accordingly whilst maintaining focus on the basics – **Partially delivered** Final CQC report published 19th July 2018. – delay outside control of organisation Draft action plan and priorities completed with Improvement Director in preparation for report publication and this will now be finalised.	Action plan to be approved by QSC in Q2	**Overall risk associated with Q1 position:** Ability to exit Quality Special Measures by March 2019 is a high priority objective.	
Objective: Build a Better St. George's **13. Governance**	**13.4 – Ensure the appropriate governance measures are in place to learn from incidents and complaints**	▪ Evidence of learning from complaints to be captured on DATIX and reported to Patient Safety and Quality Board (PSQB) and QSC – **Partially Delivered** Learning from complaints published on the intranet and achieving a high 'hit' rate. Complaints report (including learning) on August PSQB agenda. ▪ Evidence of organisational learning by testing in practice implementation of agreed actions – **Not delivered** Audit of actions that have been implemented for incidents and complaints not currently in place. QIP work stream is in place to scope what is required to do this. Although this is a Q1 milestone, full delivery is not planned until Q3 where this is the key milestone for delivery.	Learning from complaints report to be delivered to PSCB in Q2.	**Overall risk associated with Q1 position:** Links to CQC and quality requirements regarding patient safety.	
Objective: Build a Better	**14.2 – Renew local area**	▪ Implementation plan developed – **Partially delivered** Plan developed for IGG in August. Plan for IGG will need to	To be delivered in August 2018	**Overall risk associated with Q1 position:**	

St. George's 14. Information Technology	**network on Tooting site**	outline mitigations and how SMART measures of success (and associated timelines) can be met.		Delays have potential to impact on future milestones and delivery of this objective. This is a material risk for the trust, given acknowledged IT risks.	

3.0 Recommendation

The Trust Board is asked to asked to note the Corporate Objectives Quarter 1 position and:

1. Confirm the RAG ratings awarded for each action/milestone, and the overall RAG rating awarded against each of the Corporate Objectives and for the Trust.
2. Identify any additional assurance required in relation to the objectives where Q1 delivery is delayed

Author: **Suzanne Marsello, Director of Strategy**
Tom Ellis, Head of Business Planning
Date: **20th July 2018**

St George's University Hospitals NHS
NHS Foundation Trust

Outstanding Care, Every Time

Organisational Objectives 2018/19

Annual Delivery Plan and Monitoring

St George's University Hospitals NHS
NHS Foundation Trust

Delivery of our 18/19 Corporate Objectives

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 strategic objectives – all of which are designed to improve care for patients, and the working lives of our staff. These are:

- 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

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.

The Quality Improvement Plan was agreed by Trust Board in 2017, with key objectives to be delivered by March 2019 that support the strategic objectives. These are the key organisational priorities for 2018-19. The Trust Board will oversee delivery of these objectives, with quarterly reporting of progress. There are further objectives that need to be delivered in 2018/19, that will be monitored by the relevant Board Sub-Committees, in line with the governance arrangements detailed on the following slide



Governance: Reviewing progress

We will use a number of different mechanisms to ensure that we are able to track progress against the trust's objectives. These are:

- Reporting to the Trust Board quarterly on the agreed 2018/19 objectives
- Detailed review of key plans through the relevant Board sub -committees:
  - Trust Executive Committee – day to day management of the trust, delivery of trust strategy and monitoring all aspects of performance
  - Quality Committee – clinical safety and experience, patient experience, and clinical governance
  - Finance & Investment Committee – financial planning and performance, governance and business case oversight
  - Workforce & Education Committee – Workforce planning and development, staff training and development
  - Audit Committee – Monitor and review the trust's systems of internal control
- Quarterly reviews with the clinical divisions
- Clinical Divisions monitoring their own plans at Division and Care Group levels via their Divisional Management Board and the Divisional Governance Board

Objective: Treat the patient, treat the person

1. Fundamentals of Care

Aim	To consistently deliver the fundamentals of patient care to ensure our patients are kept safe and free of avoidable harm.				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
1.1 – Ensure patients receive safe care and are not put at risk of avoidable harm, including pressure ulcers, falls, hospital acquired infection and Venous Thromboembolism	▪ Detailed milestones as part of QIP in Safe and Effective workstreams and delivery monitored monthly at Quality and Safety Committee and will be reported to Trust Board ▪ Performance data in Integrated Performance Report	▪ Review delivery against targets set in Quality Accounts for Falls and Pressure Ulcers and report to QSC ▪ Infection Prevention and Control (IPC) targets monitored monthly at Board ▪ QIP update to Trust Board	▪ Review delivery against targets set in Quality Accounts for Falls and Pressure Ulcers and report to QSC ▪ IPC targets monitored monthly at Board ▪ QIP update to Trust Board	▪ Review deliver against targets set in Quality Accounts for Falls and Pressure Ulcers ▪ IPC targets monitored monthly at Board ▪ QIP update to Trust Board	▪ 95% minimal compliance with safety thermometer (Harm Free Care) ▪ Delivery of IPC thresholds ▪ Delivery against targets / thresholds set out in QIP dashboard
1.2 – Prepare substantive and definitive report to be shared with the CQC Inspectors on return visit and review. **Ensure that the environment is safe and appropriate for the treatment of our patients, with plans to achieve relevant standards as our baseline**	▪ Undertake a review of the PAM regulations with the external assessors and produce a report on PAM itself, for a Board development session presentation.	▪ Produce first draft of assured report from our external assessors to another pre-determined Board Assessment in September with relevant documents being available for CQC Inspectors in the predicted review date of September	▪ Quarterly review to be undertaken of all PAM matters in December Board	▪ Quarterly Review to be undertaken of all PAM matters in March	▪ Minutes of Board ▪ Notes of Presentation to Board Development Session ▪ PAM Report ▪ Improvement of external assurance

Objective: Treat the patient, treat the person

2. End of Life Care

Aim	We will continue to improve the experience for patients and their loved ones at the end of their life				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
2.1 – Improve End of Life Care (EoLC) for patients and their families across the Trust	▪ Milestones detailed in EoLC strategy ▪ Delivery monitored via the QIP programme dashboard and at EoLC meeting	▪ Identified resource to support development and delivery of educational programme	▪ Development and implementation of EoLC training programme	▪ Focus of training identified staff and measure performance against agreed trajectory	▪ 0 complaints relating to EoLC themes for patients in our care ▪ 100% of relatives / carers who respond to the bereavement survey who rated overall care as good or excellent ▪ Evidence to support delivery of strategy milestones ▪ Training compliance against agreed trajectory

Objective: Treat the patient, treat the person

3. Patient involvement in decision making

Aim	We will ensure there is no decision without the patients or carers involvement and that the patient's wishes are at the centre of their care				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
3.1 – Improve our compliance with Mental Capacity Act Assessment (MCAA)	▪ Develop Level 1 training ▪ Undertake quarterly MCA audits	▪ Implement L2 MCA / Deprivation of Liberty Standards (DoLS) training	▪ Develop L3 training	▪ Implement L3 training	▪ 100% Compliance with L1 training by September 2018 ▪ 95% compliance with MCA Audits
3.2 – Improve the safe, effective and appropriate use of restraints (e.g. bed rails) throughout the Trust	▪ Monthly audits on all wards / units ▪ Ensure staff are trained as detailed in objective above	▪ Monthly audits on all wards / units ▪ Ensure staff are trained as detailed in objective above	▪ Monthly audits on all wards / units ▪ Ensure staff are trained as detailed in objective above	▪ Monthly audits on all wards / units ▪ Ensure staff are trained as detailed in objective above	▪ 100% compliance with bed rail assessments

3.3 – Improve carer access for patients with dementia and be recognised as a dementia friendly hospital	▪ Monitored and delivered through the QIP programme ▪ Undertake 5 dementia carer surveys per quarter ▪ Improve compliance with dementia carer's survey to obtain better feedback from this important group of service users ▪ Issue 45 dementia passports ▪ Increase use of Butterfly Scheme ▪ 85% of staff with up to date dementia training awareness	▪ Undertake 5 dementia carer surveys per quarter ▪ Improve compliance with dementia carer's survey to obtain better feedback from this important group of service users ▪ Issue 45 dementia passports ▪ Increase use of Butterfly Scheme ▪ 85% of staff with up to date dementia training awareness ▪ Develop dementia/ delirium scorecard to monitor divisional performance	▪ Undertake 5 dementia carer surveys per quarter ▪ Improve compliance with dementia carer's survey to obtain better feedback from this important group of service users ▪ Issue 45 dementia passports ▪ Increase use of Butterfly Scheme ▪ 85% of staff with up to date dementia training awareness ▪ Implement dementia / delirium scorecard	▪ Undertake 5 dementia carer surveys per quarter ▪ Improve compliance with dementia carer's survey to obtain better feedback from this important group of service users ▪ Issue 45 dementia passports ▪ Increase use of Butterfly Scheme ▪ 85% of staff with up to date dementia training awareness ▪ Monitor dementia / delirium scorecard and implement remedial actions	▪ 20 Dementia carers surveys completed ▪ 180 Dementia Carers Passports issued per year ▪ 85% of staff completed dementia awareness training ▪ 100% of carers who would like to stay overnight with patient, who actually stayed at the bedside (measure being developed)

Objective: Treat the patient, treat the person

4. Deteriorating Patients

Aim	Recognise and manage deteriorating patients, and ensure staff support patients and their carers to make choices regarding their treatment				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
4.1 – Put in robust process to effectively identify patients who are at risk of deteriorating	▪ Increase awareness and local ownership of the associated risks with a deteriorating patient in every ward (this is on-going throughout the year)	▪ Set individual treatment escalation and EoLC plans for appropriate patients ▪ Review and make decision on requirements for Critical Care Outreach Team and our compliance against the relevant standards	▪ Set individual treatment escalation and EoLC plans for appropriate patients	▪ Set individual treatment escalation and EoLC plans for appropriate patients	▪ 50% reduction by April '18 from baseline of 14 In hospital (All) cardiac arrest rate / 1000 admissions ▪ Blue light sepsis assessment and antibiotics in ED within one hour – 85% ▪ Deteriorating patient audit results by ward ▪ Number of Sis related to delay in recognition of deteriorating patient.

Objective: Treat the patient, treat the person

5. Medicine Management

Aim	Ensure the safe and efficient storage and use of medicine and to continue to reduce the time a patient waits for their medicine				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
5.1 – Ensure safe and secure handling of medicines focusing on room and fridge temperature monitoring solution for medicines	▪ N/a	▪ Scoping exercise with Estates for automated temperature monitoring solutions for medicines storage	▪ Seek IDG approval for required investments, contingent on funding allocation from prioritised capital programme ▪ If funding not approved continue with current system of recording fridge temperatures and compliance monitoring	▪ Rollout of solution	▪ Installation of automated temperature monitoring solutions for medicines storage
5.2 – Continue to improve discharge medication turnaround times for patients to improve the patient experience and patient flow through the Trust	▪ N/a	▪ Add LW satellite dispensing unit to data tracker	▪ Tender to external partners for monitored dosage systems	▪ Increase the use of an external partner to provide monitored dosage systems to prevent delayed discharge ▪ Increase the number of prescribing and transcribing pharmacists	▪ 90% of medication to take out (TTOs) dispensed in satellite dispensing units ▪ 80% of pharmacists actively prescribing ▪ 90% of Monitored Dosage System dispensed by external partners ▪ 90% of TTO's completed in less than 60 minutes in satellite dispensing units

Objective: Right care, right place, right time

6. Emergency Care

Aim	We will improve the timeliness of emergency care for patients, and consistently meet the four hour operating standard				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
6.1 – Enhance processes within ED to improve emergency care performance and patient care and experience	▪ Meet NHSI agreed ED performance of 91% ▪ Fully embed best practice ambulatory care model and extend opening hours in line with business case ▪ 7.5% patients streamed to primary care	▪ Meet NHSI agreed ED performance of 95% ▪ 7.5% patients streamed to primary care ▪ Implement ED paper-lite	▪ Meet NHSI agreed ED performance of 92% ▪ 7.5% patients streamed to primary care	▪ Meet NHSI agreed ED performance of 92% ▪ 7.5% patients streamed to primary care	▪ Meet NHSI agreed 4 hour target performance

Objective: Right care, right place, right time

7. Unplanned and admitted care

Aim	▪ 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 patient are taken to the most appropriate environment for their assessment, treatment and care				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
7.1 – Admit patients to the right ward, discharge them efficiently and ensure a positive patient experience	▪ AMU bed occupancy at Midday =<80% ▪ Model Hospital and Get it Right First Time (GIRFT) benchmarked Length of stay and Daycase rate performance to be identified	▪ AMU bed occupancy at Midday =<85% ▪ Implementation plan agreed with given GIRFT specialties	▪ AMU bed occupancy at Midday =<90% ▪ Implementation underway	▪ AMU bed occupancy at Midday =<90 ▪ Demonstrable reduction in length of stay	▪ AMU bed occupancy at Midday =<85% ▪ Reduced variation to GIRFT opportunity benchmarks

7.2 – Develop boundary-less flow to minimise LOS for patient requiring on-going treatment or care, and create the flexibility with hospital to maintain a steady state during periods of increased demand	▪ Partnership working at and in support of Wandsworth & Merton Urgent & Emergency Care Transformation and Delivery Board (UECTB) ▪ Agreement of repatriation protocol at SWL UECTDB	▪ Partnership working at and in support of Wandsworth & Merton UECTB	▪ Launch of Smartboard in AMU ▪ Launch of auto-populated Repatriation Communications with partner hospitals ▪ Partnership working at and in support of Wandsworth & Merton UECTB	▪ Launch of Smartboard in Cavell, Nye Bevan and AAA ▪ Partnership working at and in support of Wandsworth & Merton UECTB	▪ All areas of virtual emergency floor to be simultaneously visible to clinical and patient flow decision makers ▪ % of beds occupied by patients identified as delayed transfer of care to be <3%
7.3 – Achieve SAFER compliance on wards	▪ UAPC Steering Group agree minimum expectations of ward teams	▪ 30% compliance	▪ 60% compliance	▪ 90% compliance	▪ 90% of wards using SAFER ▪ Achieved in line with quarterly milestones
7.4 – Estates will draw up and assist with physical plans/options to support emerging operations plans/strategy	▪ Review current plans with Local Health Economy and partake in bidding for transitional / sustainable projects with the STB	▪ Undertake Space Utilisation Review to be completed by end September. This review to inform first draft St. George's Estate Strategy (timing contingent on emergence of clinical strategy for South West London)	▪ First draft of Estates Strategy to Board in December dependent on the production of the Clinical Strategy.	▪ Approval and ratification of Estates Strategy to be undertaken at Board in March dependent on clinical strategy production. Including a timescale and final requests.	▪ Award of funding from central capital ▪ Board paper on Estate Strategy Assurance

Objective: Right care, right place, right time

8. Theatres

Aim	We will reduce cancellations of operations and make efficient use our operating theatres				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
8.1 – Increase theatre productivity	▪ Develop and implement new theatre service template	▪ One theatre to be mothballed, following introduction of new service template delivering improved productivity	▪ Theatre refurbishment programme starts*	▪ Completion and opening of refurbished theatre/s ▪ Improved access to robotic theatre and creation of spinal theatre in AMW	▪ 15% increase in elective and day case activity in targeted specialties ▪ 100% WHO Checklist Compliance
8.2 – Reduce cancellations on the day of surgery	▪ Cancellation Standard Operating Procedure (SOP) approved and implemented	▪ Review performance of 48 hour reminder calls for surgery, in line with agreed targets, and remedial action if required	▪ Review impact of cancellation SOP and take any required remedial measures	▪ 100% cancellations rebooked within 28 days	▪ 20% increase pre-admission appointment attendees

* Subject to securing of external capital funding

Objective: Right care, right place, right time

9. Patient choice

Aim	To offer patients greater choice in how they access our service and ensure we match our capacity to patient demand				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
9.1 – Ensure patients have access to high quality outpatient care, including by standardising outpatient pathways, supported by ICT, ensuring all activity is captured and reported.	▪ Complete roll-out of electronic advice and guidance for all specialties ▪ Complete roll-out of one-way text reminder service	▪ Complete successful paper switch off for GP referrals for consultant outpatient led services	▪ Hybrid Mail implemented ▪ Complete roll out of two way text reminders	▪ Automatic interface between ERS and Cerner ▪ Auto upload of key documents into Cerner functionality achieved	▪ 100% E-referral usage per month (CQUIN) ▪ 8% patients who DNA their appointment ▪ 73% Clinic appointment with eDM record
9.2 – Offer patients greater choice in how they access acute specialties with alterative to face-to-face appointments	▪ Roll out of virtual notes review clinics and open access follow up appts (initial tranche of services) ▪ Commence work on Clinical Assessment Service ▪ Dermatology primary care pathways launched	▪ Roll out of virtual notes review clinics and open access follow up appts (2nd tranche of services) ▪ Gastroenterology primary care pathway launched ▪ Virtual fracture clinic commences ▪ Tele-dermatology service commences	▪ Roll out of virtual notes review clinics and open access follow up appts (3rd tranche of services)	▪ Roll out of virtual notes review clinics and open access follow up appts (4th tranche of services)	▪ 100% advice and guidance activity per month (CQUIN)
9.3 – Ensure that patients have easy access to the hospital to check appointment enquires through phone and e-mail system	▪ N/a	▪ N/a	▪ Fully scoped project plan	▪ N/a	▪ Inclusion in 2019/20 capital and IMT implementation plans

Objective: Right care, right place, right time

10. Waiting lists and RTT

Aim	We will tackle our data quality and waiting list challenges, so ensuring patients are effectively tacked on our systems				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
10.1 – Return Tooting campus to national reporting of the 18 week RTT standard and work to reduce waiting times against all national standards	▪ Robust strategy for delivery of RTT training across the organisation for BAU ▪ E-Learning RTT modules 1 & 2 complete by 85% of all identified staff ▪ Cancer improvement - RMP Recommendations to be presented back and agreed by the Trust ▪ E-Triage - backlog reduction of 25% of all referrals waiting longer that 5 days from April baseline	▪ No patients waiting >52 weeks for all specialties apart from ENT & General Surgery ▪ DQ Metrics reported to Trust Board for assurance including Unknown Clock Starts (UCS), duplicates, Past TCI's, Past DNA's and cancellations with open pathways, No RTT status code. ▪ Service, AGM and General Manager cohort - 90% complete RTT e-learning modules 1-10 ▪ Implement cancer dashboard ▪ RTT incomplete aggregate performance achievement - 79%	▪ Reduction of outpatient caps at SGH to ensure booking does not extend out beyond max 14 weeks ▪ E-Triage - backlog reduction of 50% of all referrals waiting longer that 5 days from April baseline ▪ 2nd Return to Reporting gateway for SGUH Trust Board if No Go decision at September Board ▪ Recovery plan in place and achievement of 62 day target of 88.9% ▪ RTT incomplete aggregate performance achievement - 82%	▪ Returned Trust to RTT reporting for Tooting Campus ▪ Cerner roll-out at QMH to facilitate return to reporting at QMH campus in 19/20 ▪ Zero 52 week waiters ▪ E-Triage - backlog reduction of 75% of all referrals waiting longer that 5 days from April baseline ▪ RTT incomplete aggregate performance achievement - 82%	▪ Return Tooting campus to RTT reporting ▪ 9% improvement in RTT performance in year ▪ Meet and sustain all Cancer targets
10.2 – To lead clinical harm process relating to waiting delays	▪ To complete phase 1 of RTT programme	▪ To complete phase 2 of RTT programme ▪ Any harm identified and close down report presented to the Trust's Harm Review Team	▪ To return the clinical harm review process back to BAU	▪ N/a	▪ In line with delivery of quarterly milestones

11. Objective: Balance the books, invest in our future

We will	Quarter 1 milestones	Quarter 2 milestones	Quarter 3 milestones	Quarter 4 milestones	SMART Measures of Success
11.1 – We will continue to reduce our deficit and aim to break even in 2019	▪ Submit an annual financial plan with an internally agreed deficit of £29m ▪ Develop a £50m CIP programme	▪ Meet target monthly deficit ▪ Deliver CIP targets ▪ Manage to budget	▪ Meet target monthly deficit ▪ Deliver CIP targets ▪ Manage to budget	▪ Meet target monthly deficit ▪ Produce an affordable 5 year Workforce strategy fully aligned to Clinical Strategy ▪ Deliver CIP targets ▪ Manage to budget	▪ Deliver deficit of £29m ▪ Deliver exit run rate of circa £2m per month
11.2 – We will deliver organisational efficiencies – from the way we buy drugs to how we use our clinical IT systems	▪ Develop a robust £7m procurement CIP programme	▪ Develop a clinical IT strategy	▪ N/a	▪ N/a	▪ Delivery of £7m procurement CIP programme ▪ IT strategy agreed
11.3 – We will develop a financial model to help us identify and prioritise future investment requirements	▪ N/a	▪ Develop and begin to implement a 5 year capital programme	▪ Completion of draft long term financial model	▪ Deliver triangulated BP round with NHSI submissions completed to timetable ▪ Ensure Corporate and Divisional plans are triangulated	▪ Delivery of long term financial model, approved by Board ▪ Refreshed business planning process that delivers integrated activity, finance, pay and non-pay budgets.
11.4 – Estates will produce a timely and accurate delivery of CIPs including service contract negotiations and agreement of possible land sales	▪ Review and agree magnitude of savings. ▪ Commence negotiation with Legal Teams / possible investors and agree targets with FIC / CFO	▪ Prepare business case for sale of land and submit initial proposals to Executive Team and then onto Board in September ▪ Appoint legal teams to challenge outstanding historical PFI Issues and appoint to new Business Management Team which is being set up and should be functional by September	▪ Identify the Estates negotiations on the sale and agree the magnitude of the sale to the Executive Team, through to Board in December. First report to Board on PFI overview and potential contract saving to Board in December/January	▪ Land sales agreed for Doddington and possible Maybury Street Car Park land dependent on car park and land redevelopment scheme. ▪ Initial review of sales and outcome of negotiations with PFI provider by February	▪ Appointment of Advisor Consultants ▪ Board agreement for land sales ▪ Submission of claim following ratification of Board to PFI contractor.

Objective: Build a Better St. George's

12. Strategy and engagement

We will	Quarter 1 milestones	Quarter 2 milestones	Quarter 3 milestones	Quarter 4 milestones	SMART Measures of Success
12.1 – We will develop an organisational and clinical strategy that asserts St. George's position as a provider of local and world –leading specialist services	▪ Agree project plan ▪ Complete baseline data collection ▪ Benchmark against peers ▪ Begin internal / external stakeholder engagement	▪ Generate strategic options based on Q1 work ▪ Board seminar to explore strategic options for first tranche of clinical services ▪ Further engagement with internal / external stakeholders including public/patient and staff open events	▪ Refine strategic options ▪ Link options to STP developments ▪ Further Board seminar re strategy and clinical services	▪ Finalisation and approval of strategic options by Board ▪ Further round of intense internal and external engagement to test emerging strategy ▪ Trust Board approval	▪ New strategy approved
12.2 – We will work with our partners and stakeholders to seek their views, so we address the challenges we face together	▪ Build relationships with key external partners e.g. GP Federations, Commissioners, SWL Providers, Public Health ▪ Demonstrable input into SWL HCP ▪ Monthly SWL HCP report to Trust Board in place	▪ On-going development of relationships with external stakeholders ▪ Delivery of Executive to Executive meetings with key partner organisations	▪ N/a	▪ Undertake the annual stakeholder engagement survey to establish baseline perceptions	▪ Stakeholders feel listened to ▪ Stakeholders have a clear understanding of our priorities ▪ Stakeholders perceptions of the trust improve over time
12.3 – 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	▪ N/a	▪ N/a	▪ Work with the CEO of the Charity to identify where processes could be streamlined within the organisation to ensure that bids received by the Charity are ready to be considered by the Trustees when	▪ N/a	▪ When the new CEO of the Charity is appointed (expected in Q3) further milestones will be jointly agreed and measures of

			submitted		success

Objective: Build a Better St. George's

13. Governance

Aim	We will improve our governance arrangements, as well as our everyday management systems (such as Agresso and ESR)				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
13.1 – Undertaken an independent review of our corporate governance function	▪ Agree new corporate governance team structure and roles ▪	▪ Complete review of corporate governance structures below Board Committees and agree future structural design and reporting lines ▪ Develop clear Board forward work programme for 2018/19 ▪ Agree new Terms of Reference for Trust Executive Committee	▪ N/a	▪ N/a	▪ New corporate governance team structure in place ▪ New corporate governance structure fully implemented
13.2 – More engagement and involvement of patients, front line staff and partner organisations	▪ Agree action plan based on results of the annual communications survey ▪ Approve ToR for new Patient Partnership and Experience Group	▪ Agree action plan based on results of the annual communications survey ▪ For Patient Partnership and Experience Group to formally start meeting and commence the development of the Patient Engagement Strategy	▪ Launch of new Trust corporate branding for use across all communications and reporting channels ▪ Patient Experience Strategy to be presented and agreed at Trust Board ▪ Strategy to include milestones for delivery and dashboard to be incorporated into QIP dashboard	▪ Launch of new intranet and website, subject to finance approval ▪ Performance against delivery of milestones	▪ Improved NHS staff survey engagement scores ▪ Clear corporate brand established and used consistently ▪ Patient Partnership and Experience Group meeting regularly ▪ Patient Partnership Strategy approved by Trust Board ▪ Delivery against milestones agreed within the strategy

13.3 – Use the CQC Well-Led Framework to ensure we are meeting our regulatory requirements	▪ Receive CQC report which will detail new ratings across all domains for the 6 core services inspected in March / April 2018 ▪ Refresh QIP priorities accordingly whilst maintaining focus on the basics	▪ Self-assess our services against CQC domains ▪ Assess ourselves against well-led framework	▪ Mock quality review in September / October 2018	▪ N/a	▪ For CQC to recommend exit from Quality Special Measure by March 2019 at the latest
13.4 – Ensure the appropriate governance measures are in place to learn from incidents and complaints	▪ Evidence of learning from complaints to be captured on DATIX and reported to Patient Safety and Quality Board (PSQB) and QSC ▪ Evidence of organisational learning by testing in practice implementation of agreed actions	▪ Priorities for focus due to prevalence and limited assurance on barriers for the following never events – wrong site surgery, wrong implant / prosthesis and retained foreign object ▪ Consider each of the above never events and agree leadership, MDT approach using principles of Quality Improvement Methodology and Human Factors training ▪ Regularly monitor compliance with CAS alerts at PSQB	▪ Quarterly audit of actions agreed within SI reports / complaints responses ▪ Regularly monitor compliance with CAS alerts at PSQB	▪ Quarterly audit of actions agreed within SI reports / complaints responses ▪ Regularly monitor compliance with CAS alerts at PSQB	▪ Quarterly audits of agreed SI / complaints actions for ascertain assurance of delivery and changes in practice.
13.5 – Continue to monitor compliance with the risk management policy and improve risk registers at every level	▪ Continue to review risk registers at Risk Management Committee and challenge ratings, mitigation and progress to inform the BAF ▪ Ensure Divisional Governance Boards are reviewing and challenging their risks prior to presentation at RMC ▪ Ensure all risks that should	▪ N/a	▪ N/a	▪ Sufficient progress to show that extreme risks have reduced	▪ 0 Moderate/ high /extreme risks with overdue actions ▪ 0 Moderate/high /extreme risks with no mitigating actions

	be captured are captured accurately				

Objective: Build a Better St. George's

14. Information Technology

Aim	We will continue to stabilise and improve our IT infrastructure				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
14.1 – Develop an ICT Strategy including priorities and covering the work plan for 2 – 3 years	▪ ICT Strategy developed and agreed	N/A	N/A	N/A	▪ ICT Strategy presented to June Trust Board
14.2 – Renew local area network on Tooting site	▪ Implementation plan developed	▪ Network architecture agreed	▪ Wiring installed	▪ Work commenced on cabinets	▪ Network architecture plan developed by end of September ▪ Wiring installed by end of December
14.3 – Deploy iClip clinical documentation and e-prescribing across most remaining wards on Tooting site	N/A	▪ Deployment commenced	▪ Deployment in all planned wards	N/A	▪ Deployed in a further 25% of wards by end of September 2017 ▪ Deployed in a further 25% of wards by end of December 2017
14.4 – Roll out iClip to Queen Mary's Hospital Roehampton	▪ Outline business case developed and approved	▪ Plan, work streams and project governance in place ▪ Changes and processes agreed and documented	▪ Training commenced ▪ Equipment installed	▪ Go live in outpatients and inpatients at QMH	▪ Outline business case approved by June Trust Board ▪ Achieve planned project progress at end of September 2018 ▪ Achieve planned project progress at end of December 2018 ▪ QMH live with iClip by end of March 2019

Objective: Build a Better St. George's

15. Estates

We will	Quarter 1 milestones	Quarter 2 milestones	Quarter 3 milestones	Quarter 4 milestones	SMART Measures of Success
15.1 – We will undertake substantial reviews and surveys of the overall Estate and Environment. This will clearly identify the back-log maintenance position and allow for investment in such areas as Ward Refurbishment, Theatre Refurbishment and replacement of large Diagnostics dependent on Trust's priorities	▪ By June contracts will be in place to undertake surveys both physical and desk top including the Fixed Facet Survey and Engineering Asset Review. This will be linked to the population and production of PAM and the overview of our statutory regulatory items	▪ In line with the PAM documentation and the outcome of the surveys, publish the revised back-log maintenance list and identify high risk projects. ▪ Those projects such as Theatres and Ward Refurbishment will include within any bids made for upgrade of general infrastructure as part of the bidding process for emergency funding. Surveys will be underway with the majority reported by end of September.	▪ Reviews will be undertaken of progress and action plan/project plan and 5/10 year BM investment plan will be created with revised backlog maintenance number. ▪ Create a review of any emerging risk appetite issues to share with Risk management Executive.	▪ A full report on backlog maintenance and any increased levels of risk will be reported to the Board by March 2019 with a look forward to potential expenditure/investment in the new financial year	▪ Results of detailed surveys ▪ Publication of PAM results ▪ Programme requests via Committee to Board ▪ Result of emergency capital loan funding published
15.2 – We will ensure a safe environment with plans to achieve relevant statutory standards as our baseline	▪ Introduce and commence population of the PAM documentation and review the Risk Register set for the Estates and Facilities Directorate.	▪ In conjunction with the Risk Management Group, Infection Control and the Safety and Quality Committee, review all high level risks and identify what the risk appetite for the Trust which will then be presented for ratification to the Board	▪ Monitor and report via PAM quarterly report to Board performance against all domains.	▪ Prepare the Annual Report for the coming year and give state of the Estate address in March to Board ▪	▪ Board review of PAM at development days ▪ Quarterly review of PAM results commencing December 2018.

15.3 – Undertake a market review of substantive contracts including the FM contract. Instigate the implementation of a potential measured equipment service governing in the first instance Medical Equipment and large Diagnostic equipment	▪ From the framework identify and appoint an advisory company for the creation of a brief to go to Market	▪ Undertake market review and tendering process of Phase One of MES Contract with bolt on allowances for the expansion of the MES Contract of other service provision contracts not only within Estates and Facilities but within the Trust generally	▪ Undertake substantial review of Contracts and equipment within the hospital to find existing baseline. Update contact information in the first instance to negate any historical non-productive contracts and remove for savings plan linked to CIP. ▪ Present to the Board findings of the overall Risk Strategy, the need for Risk appetite and identify investment portfolio from the emerging issues	▪ Appoint and commence overall management contract with preferred supplier.	▪ Appointment of Consultants ▪ Tender returns adjudicated ▪ Finally secured ▪ MES Contract awarded

Objective: Champion Team St. George's

16. Leadership and Engagement

We will	Quarter 1 milestones	Quarter 2 milestones	Quarter 3 milestones	Quarter 4 milestones	SMART Measures of Success
16.1 - Improve staff engagement	▪ Refresh our two year Staff Engagement Plan ▪ Long Service Awards - Afternoon Tea ▪ Friends and Family Scores	▪ Pulse Survey ▪ Friends and Family Scores	▪ Friends and Family Scores	▪ 2018 NHS Staff Survey ▪ Staff Appreciation Awards ▪ Friends and Family Scores	▪ 70% recommend Trust on Friends and Family Scores – as a place to work ▪ Staff Engagement Score 3.9%
16.2 – Tackle bulling and harassment	▪ Raise profile of FSUG ▪ Promote helpline numbers ▪ Implement values based recruitment	▪ Charter of behaviour – bid to develop.	▪ N/a	▪ N/a	▪ Reduction in B&H evidenced via the Staff Survey
16.3 – Improve equality and diversity	▪ Appoint a new D&I Manager ▪ Refresh Equality and Diversity Strategy and Plan ▪ D&I Week	▪ Establish Staff networks	▪ N/a	▪ N/a	▪ 10% improvement on previous years Improved NHS National Staff Survey scores, across all areas.
16.4 – We will develop our leadership capacity and up skill our managers	▪ Commence the Leadership Development programmes ▪ Deliver effective people management courses	▪ Develop and deliver an effective Leadership strategy, working with the Quality Academy, SGUL and IHI – focusing on coaching	▪ Working with London HRDs on a Pan-London Talent Maps	▪ N/a	▪ 200 identified staff participating in formal leadership development programme ▪ Delivery of effective people management programme (200 staff per year)
16.5 – We will develop a behaviour charter based on our values of Excellent; Kind; Responsible; Respectful	▪ Transform Culture through the values programme – bid in with charity	▪ N/a	▪ N/a	▪ N/a	▪ Implementation of leading with values programme ▪ On-going roll out of Values based recruitment

16.6 – We will enhance communication for Estates and Facilities. We will be represented at relevant meetings and Divisional Joint meetings where we will publish a newsletters and action points linked to the PAM production. We will also performance dashboard for small works and reactive maintenance.	▪ Identify "buddies" from the Estates and Facilities Team for all Clinical / Non Clinical Areas ▪ Quarterly Divisional team meetings to be set up from September. ▪ We will ensure response times to breakdown and small works are in line with appropriate KPI's linked to Charter published in June.	▪ Produce the initial draft for the newsletter for the Estates and Facilities Team and submit to Communications ▪ Undertaken overall report to Division in quarterly meeting held in September of progress on PAM and current positions. ▪ Produce first draft of performance dashboard tracking work against small works and reactive maintenance.	▪ Newsletter published October / November ▪ Quarterly Divisional meeting held in December	▪ Quarterly Divisional Meeting held in March 2019. ▪ KPI performance report in March 2019.	▪ Minutes of Divisional team meeting ▪ Copies of Newsletter ▪ PAM presentation and feedback session

Objective: Develop Tomorrow's Treatments Today

17. Education & Training

We will	Quarter 1 milestones	Quarter 2 milestones	Quarter 3 milestones	Quarter 4 milestones	SMART Measures of Success
17.1 – We will work closely with St. George's University of London to train the healthcare professionals of tomorrow	▪ Develop the relationship and ID new roles/develop opportunities	▪ Implement and iterate Corporate Objectives	▪ N/a	▪ N/a	▪ To be agreed

Develop Tomorrow's Treatments Today

18. Research & Innovation

We will	Quarter 1 milestones	Quarter 2 milestones	Quarter 3 milestones	Quarter 4 milestones	SMART Measures of Success
18.1 – We will embed research into clinical practice, to further foster a 'bench to bedside' culture within our organisation	▪ Agree the ToR for the medical advisory committee (MAC) constitution for the joint research funding stream with the Trustees	▪ Have the first meeting of the MAC	▪ Agree the funding from the Trustees for Trust research	▪ Allocate internal research funding PAs for consultants	▪ To be agreed
18.2 – We will innovate and ensure our patients have access to the latest treatments and surgical procedures	▪ Review opportunities within NHSE Innovation and Technology Tariff through Health Innovation Network ▪ Work with digital accelerator to interview companies that can be supported through start-up phase	▪ Develop case for implementing opportunities identified from NHSE Innovation and Technology tariff	▪ Procure preferred technology identified	▪ Implement technology into practice	▪ Successful completion of procurement and implementation ▪ No. of technologies implemented at St. George's

18.3 – We will use the latest technology to improve outcomes for patients and make it easier for staff to provide care safely and effectively	▪ Implement paper switch off and electronic referral management solutions for St. George's ▪ Develop FBC for Cerner roll-out at QMH ▪ Ensure Business Case for additional MRI scanner is complete	▪ Embed PSO's and ER's at St. George's ▪ Approval of QMH Cerner business case ▪ Approval for additional MRI at St. George's*	▪ N/a	▪ Implement Cerner at QMH ▪ Install new MRI scanner at St. George's	▪ Delivery of quarterly milestones and completion of QMH Cerner and MRI installations
18.4 – We will plan to work with our existing Stakeholders to ensure that the Trust achieves better value for money and sustainability out of any investment available from central funds	▪ Through negotiations with our local partners and the SWL Project Board, submit the identified and agreed bids through the national process in June ▪ Agree and negotiate with our partner the sustainability and transformation projects we propose linked into on-going high level Healthcare economy plans and our Trust's emerging strategic objectives.	▪ Dependent on the outcome from the bidding process and the potential production of a clinical strategy from South West London in September (the initial timetable stated) we will undertake capital work in line with the projected timetables submitted	▪ Dependent on the outcome from the bidding process and the potential production of a clinical strategy from South West London.	▪ Dependent on the outcome from the bidding process and the potential production of a clinical strategy from South West London.	▪ Acceptance of Bids from SWL ▪ Publications of SWL Clinical Strategy ▪ Compliance with project timetables and Project Board meeting notes with regular updates via FIC or Capital Investment/ Disinvestment Group

* Subject to securing of external capital funding

Appendix 1 - Corporate Objective Link to Board Assurance Framework

The following table takes the April Board Assurance Framework (BAF), and seeks to identify where the Corporate Objectives outlined above will directly link to, and address, issues on the BAF.

Strategic Objective	Risk Appetite	Strategic Risk	Current Risk Score	Linked Corporate Objective (No.)
Treat the patient, treat the person	Moderate	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.	**16**	**6**
	Low	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.	**16**	**1, 4, 5, 6, 7, 8, 9, 10**
	Low	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.	**12**	**2, 3, 13**
Right care, right time, right place	Low	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.	**8**	**4, 7**
Balance the books, invest in our future	Low	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	**16**	**11**
	Low	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities	**20**	**11**
	Low	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.	**15**	**11, 12**
	Low	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.	**10**	**13, 16**

Champion Team St. George's	Moderate	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.	**12**	**13, 16**
	Low	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.	**9**	**2, 17**
	Moderate	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	**9**	**16**
Build a better St. George's	Low	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.	**20**	**10, 14**
	Low	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.	**15**	**15**
	Low	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.	**16**	**13**
	Moderate	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 clinical service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.	**12**	**12**
	Moderate	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.	**12**	**12**
Develop tomorrow's treatments today	High	We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.	**12**	**18**

Appendix 2 – Progress Tracker – Position at Q1

The following template will be inserted at the start of each quarterly return, summarising progress against the various objectives. It is shown here for information only.

Organisational Objective	Green	Amber	Red	Consolidated Quarterly Position	Comments
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					

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 July 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 17 July 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 – July 2018

Matters for the Board's attention

The Quality and Safety Committee met on Tuesday 17 July 2018 and agreed to bring the following matters to the Board's attention:

1. **CQC Inspection Update**
   The Committee heard from the Chief Nurse that the final CQC inspection report will be published on Thursday 19 July; the content is embargoed until this time. The action plan in response to the inspection report will be brought to the August meeting of the Board. Staff briefing sessions will take place on the day the report is published.

2. **Quality Improvement Plan Dashboard**
   The QIP dashboard was received by the Committee. The Committee noted improvements in the RAG rated performance in 5/78 KPIs and a deterioration in RAG rated performance in 4/78 KPIs.

   Improved performance in delivery of mandatory training (MAST) for infection prevention and control saw the target of 85% exceeded (86%) for the first time. The estates and facilities indicator for resolving emergency estates and facilities issues within 6 hours of notification has shown sustained improvement since January 2018 and a significant positive shift since last month moving from 54% to 82%.

   The Committee noted that the percentage of patients in the emergency department with sepsis receiving antibiotics within an hour has improved from 81% last month to 86% in June. This moved the RAG rating from red to amber.

   The committee heard that the QIP dashboard will be reviewed to ensure it captures the outcome measures for actions to meet the requirements of the CQC inspection report (July 18) and where possible actions will be integrated into existing programmes and work streams.

3. **Integrated Quality & Performance Report**
   The Committee received the report and noted that the three C.diff cases in June brought the year to date total to ten, against a target of no more than 30 cases in 2018/19. The year to date position is above that for the same period in 2017/18. The Chief Nurse gave the Committee assurance, based on the root cause investigations that have been carried out for each case, that there is no evidence of failures in care.

   The Committee noted that while the HSMR data remains significantly 'lower than expected' it has moved in a negative direction, from 83.4 in May to 85.6 in June. The Associate Medical Director commented that there has been a small but steady increase in the HSMR in recent months. He provided the Committee with assurance that the mortality group is monitoring this indicator and that neither excess mortality nor an increase in mortality for a specific diagnosis has been identified.

The committee asked for assurance on the process being followed following the recent declaration of three maternity serious incidents (SIs). The Chief Nurse told the Committee that the investigation of each of these incidents is in progress, she also told the Committee that she had asked for a review of all maternity serious incidents over the past four years to see if any themes are apparent. The Chief Nurse was able to assure the Committee that staff involved in the recent incidents are being provided with support. The final investigation report will be brought to the September meeting of the Committee.

The Committee heard about actions being taken to improve response rates for both the inpatient and outpatient friends and family test, these include the provision of more tablets and using volunteers to support and encourage patients to complete the FFT.

The Chief Operating Officer brought to the Committee's attention that in June one patient had waited over 12 hours in the Emergency Department following a decision to admit. A root cause analysis is being carried out, initial review has found that the patient had mental health needs and was waiting for a mental health bed.

4. QIP Deep Dive: Outpatients

The Committee received a detailed presentation that provided an overview of the joint work being carried out between the operational and transformation teams to improve both the patient experience of outpatient services and to transform the quality of the service. The programme is designed to address the CQC concerns and move the CQC rating for outpatient services from 'inadequate' to 'outstanding'. The presentation made it clear that the programme is looking at all areas where outpatient services are delivered within and outside our hospitals.

The Committee heard that there is a focus on introducing standardisation of working practices and processes across all clinics, this is expected to facilitate the use of appointments that may be available earlier at the Nelson Clinic or at Queen Mary's Hospital. The Committee welcomed the news that the environment in Clinic A is being improved to develop zones and make it clearer to patients where they need to be, ways to increase utilisation of 'check in' kiosks are also being explored.

5. Patient Safety & Quality Group (PSQG) Report

The Committee noted that PSQG had approved the implementation of the new Treatment and Escalation plan (TEP): a tool which documents an overall plan of care for a patient. It gives guidance on which treatments should or should not be considered in the event of acute deterioration. They are completed by the clinician, following a discussion with the patient and/or relative when a patient is at risk of suddenly becoming more unwell during an admission.

The Committee heard that there is a detailed communication and implementation plan supported by patient information and staff training and that the tools to evaluate the effectiveness of the TEP, and to audit its use, are all in place.

6. National Inpatient Survey

The Committee received a report on the results of the 2017 Inpatient survey and noted that a significant amount of time had passed between the survey taking place and the results being published. The Committee heard that the Trust performed worse than other

trusts in relation to three questions and disappointingly did not perform better than other trusts for any questions in the survey. The three questions where we performed worse than others are:

- Expectations after a procedure – were you told how you could expect to feel after the operation or procedure? (7/10) (new question)
- Being well looked after – did you feel well looked after by the non-clinical hospital staff? (8.7/10) (new question)
- Equipment and adaptations in the home – did hospital staff discuss if any equipment or home adaptations were needed when leaving hospital? (7/10) (This question was in the 2016 survey and our performance has improved, however we continue to perform worse than other trusts.)

Although results were broadly similar with the 2016 survey direct comparison with previous years is difficult as the questions used vary from year to year. The committee noted the areas of focus that have been identified across the full survey and the action underway to address each of these points (appendix 1).

7. Patient Experience and Partnership

The committee received the draft terms of reference for the newly formed Patient Experience and Partnership Group and heard that twelve patient partners had been recruited to the group and that they have worked together with the Trust to develop the terms of reference. The Committee heard that groups of patient partners already in existence had welcomed the formation of an overarching group through which to feedback and coordinate activity. The Committee noted the group's position in the Trust's governance framework, reporting to the Patient Safety and Quality Group and to the Trust Executive.

The Committee approved the terms of reference and noted that the Patient Experience and Partnership Strategy will come to the Committee in September.

8. MCA and DoLS Annual Report

The Committee received this report and noted the considerable progress made with staff training, level 1 training is being delivered across the Trust with level 2 launching in September and level 3 to be launched by year end. The Committee noted that as demand grows maintaining the pace of change, alongside providing direct support with complex cases is likely to have resource implications for the team.

9. Board Assurance Framework

The Committee discussed the risk scores and assurance ratings for the strategic risks allocated to the Committee. The Committee noted that the risk score for strategic risk 2, concerning processes for progressing patients through emergency and elective pathways, has reduced from 16 to 15. The risk remains extreme; the reduction was agreed based on the consistent improvement in performance against the 2 week cancer standard. The Committee discussed the improved performance against the emergency care 4 hour operating standard and agreed that this needed to be sustained for a longer period of time before it would reduce the risk score or improve the assurance rating.

The risk scores, assurance ratings and statements for the strategic risks allocated to the Committee were approved for inclusion in the board assurance framework Q1 report to this meeting of the Board.

Appendix 1

Extract from National Inpatient Survey 2017 report to QSC

Areas of focus and next steps

Areas of focus

The specific questions that the Trust needs to focus on are shown in the table below.

Survey Section	Question	Trust Score
The Accident & Emergency Department	Whilst you were in ED, how much information about your condition or treatment were you given?	8.5/10 Previous 8.8/10
The Hospital and the Ward	Did you feel well locked after by the **NON-Clinical** hospital staff (e.g. cleaners, porters, catering staff?	8.7/10* new question Worse than most Trusts
Care & Treatment	Did you find someone on the hospital staff to talk to about your worries and fears?	4.9/10 Previous 5.4/10
	Do you feel you got enough emotional support from hospital staff during your stay?	6.5/10 Previous 7.0/10
Operations & procedures	Beforehand were you told how you would expect to feel after your operation or procedure?	7.0/10* new question Worse than most Trusts
Leaving Hospital	Did a member of staff tell you about medication side effects to watch for when you went home?	4.6/10 Previous 5.1/10
	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptions made to your home after leaving?	7.0/10 Previous 6.9/10 Worse than most Trusts
	Did hospital staff take your family or home situation into account when planning discharge?	6.7/10 Previous 7.0/10
Overall	During your stay were you ever asked your views on the quality of your care?	2.2/10 Previous 2.0/10
	Did you see or were given, any information explaining how to complain to the hospital about the care you received?	1.8/10 Previous 2.0/10

Next steps

The inpatient survey results to be shared with Divisional teams in July/August, further analysis of the questions by division and speciality provided by Picker. The facilities team will be represented to so that the results and actions are also shared with non-clinical and support staff.

The SAFER discharge project focuses on preparing for discharge from admission using a multi-disciplinary team approach. This is part of the UAPC transformation programme and addresses the discharge process in current operation.

Matron quality checks include questions for patients that focus on the patient experience of communication with the medical and nursing teams, specifically did the patient get enough information before, during and after treatment. This initiative enables Matrons to address issues immediately.

Patient experience questions relating to the findings of the Inpatient Survey have been incorporated into the matron's monthly quality inspections and the ward accreditation assessments. Posters for display in clinical areas detailing how to raise concerns to Matrons, PALS and the Complaints and Compliments Team have been created.

The Trust has established a Patient Partnership Experience Group. This group have established terms of reference and a draft Patient Partnership and Engagement Strategy that are currently being approved by Trust Board. This group and strategy will priorities its work based on the findings of national patient experience audits and the Trust objectives.

The current system of sharing Friends and Family Test and Discharge Survey (a set of questions based on the national survey) will be reviewed to deliver a good response rate and a “you said we did” poster campaign which also tracks the improvements made.

The outpatient and theatres improvement programmes will review the patient information available for patients pre-operatively. This information will be provided to patients at the point of pre-operative assessment to strengthen explanations to the patient about what to expect and how they may feel after a procedure.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 26 July 2018
Reporting period – June 2018

Outstanding care, every time

St George's University Hospitals NHS
NHS Foundation Trust

OUTSTANDING CARE, EVERY TIME

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE & PRODUCTIVITY** PERSPECTIVE	Activity Summary	Bed productivity (length of stay)	Outpatient productivity (Attendances per day)	Theatre productivity (cases per session)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations		
OUR **PEOPLE** PERSPECTIVE	Workforce		Agency use			

Executive Summary – June 2018

St George's University Hospitals NHS
NHS Foundation Trust

Our Outcomes

- The area of greatest delivery challenge to the trust is around Elective activity through Theatres. Workforce planning, including annual leave planning, and operational processes bottlenecks, including booking capacity, combine to mean that the Trust is underutilising main theatre capacity. An activity Recovery Plan, initially focused on Urology and ENT, has been created to provide assurance over the aspects of the delivery control framework and to set out eleven key improvements required.

Finance and Productivity

- Elective and Daycase activity is 4.5% below plan. Cases per session are below previous highs in ENT and Cardiac Surgery. A recent improvement has been seen in Urology. Overall theatre touchtime utilisation is tracked weekly and is close to the 85% threshold targeted.
- Outpatient activity is better than planned and Emergency and Non-Elective activity is within a small number of patients compared to the planned levels. These positions have come about through the work of the operational teams involved and are a strong foundation for the rest of the year.

Our Patients

- The Trust reported three patients with attributable Clostridium Difficile infection in June, against an annual target set at 30 cases in 2018/19. The Trust is reporting ten cases year to date and is above trajectory for quarter one.
- The Trust's mortality rates are significantly better than expected in all measures and analysis shows that we are 17% lower than expected from typical hospitals and practices in this country

Process

- Performance against the Four Hour Operating Standard in June was 93.6%, which was below the monthly improvement trajectory of 95% but meant that across Quarter One the overall agreed trajectory was delivered. The improvement trajectory requires the delivery of 95% performance in July 2018 and relies upon continued improvement in the experience for patients not requiring admission.
- The Trust achieved six of the seven national mandated cancer standards in the month of May, continuing to achieve 14 day standard and achieving 62 day compliance, however the 14 day standard for breast symptomatic patients was not met delivering 79.4% against a target of 93%.
- The target for the number of elective patients cancelled for non-clinical reasons was reduced in June to fewer than two per day. Focus remains on reducing this further and on ensuring that all patients are always rebooked within 28 days.

Our People

- Staff sickness remains above the trust target of 3% for the month of June.
- Non Medical appraisal rates remain below expectation although there was a small increase this month.
- For June, the trust achieved both the overall pay cost budget and the total agency cost plan level.

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

June 2018

Daycase and Elective Surgery operations

Actual
4,562

Target 4,890

Discharges before 11am

Actual 17.37%

Target 30%

Four Hour Emergency Standard

Actual
93.59%

Target 95%

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
89%

Target
88%

Whole Trust Inpatient Friends and Family Test

Actual
97%

Target
95%

Outpatient First Appointment

Actual 17,154

Target 16,732

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	
		Jun-17	Jun-18	Variance	Plan Jun-18	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	13,869	14,148	2.01%	13,933	1.54%	42,236	42,171	-0.15%	42,264	-0.22%
Inpatient	Elective & Daycase	4,915	4,562	-7.18%	4,887	-6.65%	13,864	13,777	-0.63%	14,429	-4.52%
	Non Elective	3,973	3,995	0.55%	4,000	-0.12%	11,849	12,250	3.38%	12,073	1.47%
Outpatient	OP Attendances	55,874	55,063	-1.45%	54,022	1.93%	156,505	164,049	4.82%	159,573	2.81%

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

Source: SLAM

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

														Average length of Stay			
Directorate	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Discharges in the last month	2017-18	2018-19	Variance	Trend
Acute Medicine	3.0	2.8	3.1	2.8	2.9	3.0	3.2	3.4	3.5	2.8	2.9	2.7	2.7	2,304	3.0	2.8	-0.23	
Cardiothoracic	8.0	8.7	8.6	8.5	8.2	9.2	8.8	9.4	8.3	9.0	9.0	8.7	7.6	296	8.8	8.4	-0.36	
Childrens & Women	2.5	2.5	2.5	2.4	2.5	2.6	2.3	2.7	2.7	2.5	2.5	2.5	2.4	443	2.6	2.5	-0.08	
Neurosciences	7.4	10.4	8.0	10.7	10.1	9.5	10.6	9.4	8.7	10.6	8.9	9.7	12.0	287	9.4	10.2	0.78	
Senior Health	11.2	12.2	13.6	19.3	19.2	8.9	9.5	9.9	9.3	8.4	11.3	10.2	11.9	81	12.9	11.1	-1.81	
Specialist Medicine	8.3	7.9	6.2	8.4	7.0	6.8	9.7	7.7	9.7	7.6	6.1	9.1	6.9	256	7.8	7.3	-0.42	
Surgery & Trauma	3.9	4.5	4.0	4.1	4.6	4.4	4.1	4.5	4.7	4.0	4.3	3.8	4.1	1,011	4.3	4.1	-0.18	
Grand Total	**6.5**	**7.2**	**6.8**	**8.2**	**8.0**	**6.5**	**7.1**	**6.9**	**6.8**	**6.5**	**6.7**	**6.9**	**6.8**	**4,678**	**7.1**	**6.8**	-0.26	

Briefing

- Over the last twelve months patients admitted to the hospital via an emergency pathway spend on average 7 days in a hospital bed. This is in line with national benchmarking data.
- This has decreased in recent months within Acute medicine, this has been due to the implantation of a fully embedded ambulatory care unit operating in line with the best practice model, enabling rapid access to same day assessment, diagnostics and treatment and increased usage of the discharge lounge.
- Patients waiting in the Emergency Department for a bed to become available has decreased significantly due to improved workflow and from optimising discharge planning.

Actions
The Unplanned and Admitted Patient Care Programme is working to roll-out the SAFER and Red 2 Green initiatives to ensure that patients do not stay in hospital longer then necessary and that every patient moves towards discharge everyday

Length of Stay

Elective Length of Stay (Excluding Daycase)

															Average length of Stay			
Directorate	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Discharges in the last month	2017-18	2018-19	Variance	Trend
Cardiothoracic	3.7	4.3	3.9	3.8	4.5	3.8	3.7	3.9	3.8	4.2	3.6	3.7	3.8	257	4.1	3.7	-0.34	
Childrens & Women	2.2	3.4	2.9	2.3	2.5	2.3	3.0	3.1	1.6	3.0	2.6	3.0	2.7	140	2.7	2.8	0.07	
Neurosciences	10.0	8.8	8.2	10.7	7.0	8.7	10.9	10.3	7.3	11.8	7.7	6.4	12.0	173	9.3	8.7	-0.55	
Surgery & Trauma	4.1	3.4	4.9	3.7	4.4	4.5	4.0	4.4	3.1	3.2	3.8	4.1	3.8	667	3.9	3.9	-0.04	
Grand Total	4.0	3.8	3.9	3.8	3.6	3.9	3.9	4.1	3.2	4.2	3.4	3.4	4.1	**1,316**	**4.0**	**3.7**	-0.39	

Briefing

- Patients who are admitted to a hospital bed for a planned elective procedure on average spend four days in hospital.
- The Trust has observed significant improvement in this area with length of stay reducing by 0.4 days compared to last year.

Outpatient Productivity

First Outpatient Attendances (average per working day)

Directorate	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	First Outpatient Attendances 2017-18	2018-19	Variance	Variance	Trend
Other	80	80	74	67	31	35	31	33	35	33	38	35	29	54	34	-21	-37.9%	
Cardiothoracic & Vascular Services	76	69	63	70	62	72	53	65	59	63	65	62	57	66	61	-5	-7.2%	
Childrens Services	48	49	40	54	49	51	44	50	47	42	46	50	46	47	47	1	1.4%	
Neuro	76	75	65	78	89	98	81	91	85	90	97	83	75	83	85	2	2.9%	
Renal & Oncology	23	23	23	22	26	25	21	23	24	23	27	27	27	23	27	4	16.3%	
Specialist Medicine	138	147	134	141	142	156	129	151	152	155	158	156	140	145	151	7	4.6%	
Surgery	258	246	250	259	283	279	240	249	248	257	294	271	266	257	277	20	7.7%	
Womens Services	86	78	80	79	82	79	76	81	74	73	91	85	82	80	86	6	7.8%	
T&O	56	55	44	51	44	54	40	51	47	57	61	57	57	50	59	8	15.9%	
Total	**841**	**823**	**773**	**821**	**808**	**849**	**715**	**794**	**771**	**794**	**877**	**827**	**780**	**806**	**828**	**22**	**2.7%**	

Follow Up Outpatient Attendances (average per working day)

Directorate	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	FollowUp Outpatient Attendances 2017-18	2018-19	Variance	Variance	Trend
Other	98	95	91	91	89	84	76	89	88	81	103	90	83	89	92	2	2.7%	
Cardiothoracic & Vascular Services	116	112	103	110	113	119	96	119	107	103	135	116	102	111	117	7	6.1%	
Childrens Services	76	74	72	87	82	88	73	82	81	73	80	81	68	79	76	-2	-3.0%	
Neuro	104	90	82	102	96	116	98	112	104	112	127	113	108	102	116	13	13.1%	
Renal & Oncology	208	209	218	218	209	204	193	206	197	200	228	217	213	210	219	10	4.7%	
Specialist Medicine	494	475	456	467	461	494	442	500	489	524	562	525	492	484	526	43	8.8%	
Surgery	364	325	334	350	361	367	327	361	346	349	394	374	354	353	374	21	6.0%	
Womens Services	49	48	45	46	50	64	55	65	61	49	55	55	44	53	52	-1	-2.5%	
T&O	80	86	71	80	83	87	75	79	73	80	93	80	78	80	84	3	4.1%	
Total	**1,588**	**1,515**	**1,473**	**1,551**	**1,541**	**1,623**	**1,437**	**1,612**	**1,545**	**1,571**	**1,776**	**1,651**	**1,541**	**1,560**	**1,656**	**96**	**6.1%**	

Briefing

- Across the Directorates, First Outpatient attendances averaged 780 per working day, this is a decrease compared to previous months and below the same month the previous year. The RAG rating applied compares to the SLA plan per working day.
- Follow-up attendances on average also saw a reduction compared to May, with the decreases seen across all three divisions.

Actions

- Switch off for paper referrals from Primary Care took place from July 2nd 2018 with eRS (electronic Referral Services) being the only commissioned access method.

Outpatient Productivity

First and Follow Up Ratio

Directorate	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	First to FollowUp Ratio 2017-18	2018-19	Variance	Variance	Trend
Other	1.22	1.19	1.24	1.35	2.87	2.37	2.51	2.68	2.49	2.44	2.69	2.59	2.89	3.1	2.72	-0.38	-12.1%	
Cardiothoracic & Vascular Services	1.52	1.61	1.63	1.58	1.81	1.66	1.80	1.84	1.80	1.63	2.06	1.86	1.78	1.4	1.90	0.50	35.8%	
Childrens Services	1.58	1.52	1.78	1.61	1.68	1.74	1.68	1.65	1.74	1.76	1.75	1.60	1.48	1.4	1.61	0.21	15.1%	
Neuro	1.37	1.20	1.27	1.31	1.07	1.19	1.20	1.24	1.23	1.24	1.31	1.36	1.43	1	1.37	0.37	36.6%	
Renal & Oncology	9.15	8.95	9.53	9.79	7.94	8.28	9.39	8.77	8.07	8.67	8.38	8.07	7.83	8.7	8.10	-0.60	-7.0%	
Specialist Medicine	3.57	3.24	3.40	3.32	3.25	3.17	3.44	3.30	3.22	3.38	3.57	3.36	3.51	3	3.48	0.48	15.9%	
Surgery	1.41	1.32	1.34	1.35	1.27	1.31	1.36	1.45	1.40	1.35	1.34	1.38	1.33	1.3	1.35	0.05	3.8%	
Womens Services	0.57	0.62	0.56	0.58	0.61	0.81	0.73	0.80	0.82	0.67	0.61	0.65	0.54	0.6	0.60	0.00	-0.2%	
T&O	1.44	1.55	1.61	1.56	1.86	1.59	1.86	1.56	1.56	1.40	1.51	1.41	1.36	1.1	1.43	0.33	29.7%	
Total	1.89	1.84	1.91	1.89	1.91	1.91	2.01	2.03	2.01	1.98	2.02	2.00	1.98	1.8	2.00	0.20	11.1%	

First and Follow Up DNA Rates (by month)

Directorate	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	DNA patients in the last month	Patients not attending rate 2017-18	2018-19	Variance	Trend
Cardiothoracic & Vascular Services	8.5%	8.4%	8.8%	8.7%	9.4%	9.6%	9.6%	9.9%	9.3%	10.3%	10.8%	10.2%	9.4%	300	8.8%	10.1%	1.3%	
Childrens Services	10.3%	11.5%	13.0%	10.9%	11.5%	12.1%	13.3%	11.5%	12.4%	13.3%	16.0%	14.1%	12.9%	422	10.4%	14.3%	3.9%	
Neuro	8.5%	7.7%	7.1%	8.0%	8.3%	7.3%	8.0%	9.3%	9.7%	9.2%	10.8%	10.9%	8.5%	342	8.4%	10.1%	1.7%	
Other	10.9%	12.0%	10.5%	11.5%	10.6%	12.7%	12.0%	10.6%	11.5%	14.0%	10.0%	9.5%	11.6%	1,349	10.8%	10.4%	-0.4%	
Renal & Oncology	11.9%	10.4%	10.0%	9.2%	10.4%	10.1%	10.9%	11.8%	11.2%	10.6%	10.6%	11.0%	8.1%	428	13.0%	9.9%	-3.1%	
Specialist Medicine	11.1%	10.6%	11.0%	11.4%	11.9%	10.5%	12.2%	12.3%	12.7%	11.7%	14.3%	13.1%	11.3%	1,323	10.9%	12.9%	2.0%	
Surgery	10.3%	10.2%	10.1%	9.8%	9.6%	10.0%	10.1%	10.3%	10.1%	10.7%	12.1%	11.7%	9.0%	1,279	9.9%	10.9%	1.0%	
Womens Services	8.3%	8.3%	9.6%	8.0%	7.5%	7.4%	9.6%	7.9%	7.2%	8.4%	8.6%	8.7%	7.3%	518	9.3%	8.2%	-1.1%	
T&O	10.1%	9.1%	11.2%	10.8%	10.7%	11.0%	11.4%	12.0%	12.6%	12.0%	11.8%	13.7%	8.4%	308	10.0%	11.3%	1.3%	
Grand Total	10.3%	10.2%	10.5%	10.1%	10.4%	10.3%	11.0%	11.1%	11.2%	11.5%	12.6%	12.0%	10.0%	6,269	10.2%	11.5%	1.3%	

Briefing

- The Netcall text reminder service has been bedded in during June and a reduction in DNA rate seen
- Did Not Attend rates have fluctuated over the last twelve months with a decrease seen in June, however when comparing Quarter one with previous year a 1.3% increase is observed. The greatest increase seen is within Children's services

Actions

- Continue to roll out Netcall and develop two way text interaction to enable patients to rebook
- The migration to electronic Referral Services should enable patients to select the appointment date and time best suited to them

Theatre – Touch Time Utilisation

Utilisation	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Grand Total	Number of Patients in the last month
Cardiothoracic	89%	88%	89%	87%	91%	83%	83%	82%	83%	76%	83%	85%	85%	85%	[illegible]
ENT	83%	82%	87%	82%	86%	79%	77%	79%	80%	84%	88%	91%	84%	83%	202
General Surgery	85%	87%	85%	86%	84%	88%	87%	85%	83%	81%	80%	79%	85%	84%	283
Obstetrics And Gynaecology	82%	83%	84%	86%	84%	82%	81%	86%	82%	86%	82%	83%	82%	83%	244
Oral and Maxillofacial	88%	81%	88%	77%	86%	89%	87%	90%	90%	89%	87%	87%	94%	87%	121
Neurosurgery	81%	84%	83%	81%	88%	88%	79%	82%	83%	85%	82%	90%	83%	84%	210
Paediatric Dentistry	71%	70%	75%	65%	72%	78%	76%	71%	68%	77%	81%	70%	69%	73%	41
Paediatric Surgery	95%	92%	97%	97%	94%	91%	95%	94%	93%	92%	93%	94%	92%	94%	100
Plastic Surgery	81%	81%	81%	83%	87%	84%	82%	79%	79%	80%	83%	83%	81%	81%	267
Renal Medicine & Surgery	78%	84%	80%	86%	81%	83%	86%	84%	93%	88%	87%	83%	83%	84%	34
Trauma & Orthopaedics	90%	86%	90%	83%	84%	88%	81%	80%	88%	82%	88%	79%	85%	85%	211
Urology	81%	91%	84%	88%	88%	87%	83%	80%	85%	85%	86%	90%	86%	86%	259
Vascular Surgery	74%	84%	75%	82%	84%	80%	70%	67%	81%	79%	81%	83%	80%	78%	82
Grand Total	**84%**	**85%**	**85%**	**84%**	**86%**	**84%**	**82%**	**82%**	**83%**	**83%**	**84%**	**84%**	**84%**	**84%**	**2279**

Average Cases Per Session	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Cardiac Surgery	0.82	0.80	0.74	0.73	0.76	0.66	0.65	0.68	0.70	0.66	0.77	0.77	0.82
Cardiothoracic	1.61	1.69	1.65	1.61	1.48	1.54	1.34	1.56	1.48	1.46	1.61	1.59	1.75
ENT	1.88	1.91	1.97	1.87	1.80	1.59	1.52	1.63	1.43	1.59	1.81	1.92	1.78
General Surgery	1.95	1.69	2.12	2.00	2.01	1.88	1.94	1.72	1.82	1.89	1.86	1.87	1.84
Obstetrics and Gynaecology	2.13	2.47	2.29	2.48	2.51	2.48	2.30	2.35	2.00	2.58	2.35	2.27	2.25
Oral and Maxillofacial	1.50	1.45	1.79	1.55	1.61	1.73	1.42	1.74	1.99	1.92	1.95	1.82	1.63
Neurosurgery	1.20	1.16	1.16	1.13	1.32	1.25	1.05	1.16	1.18	1.18	1.20	1.23	1.13
Paediatric Dentistry	4.93	4.54	4.37	4.13	3.74	4.65	4.16	3.63	4.00	4.27	4.33	3.73	4.15
Paediatric Surgery	2.40	2.48	2.61	2.34	2.50	2.54	2.45	2.51	2.63	2.65	2.41	2.62	2.29
Plastic Surgery	1.90	2.06	2.11	2.13	2.24	2.07	1.87	2.01	1.91	2.17	2.16	1.97	2.03
Renal Medicine & Surgery	1.33	1.52	2.06	1.52	1.52	1.32	1.66	1.33	1.86	1.40	1.76	1.45	1.76
Trauma & Orthopaedics	1.70	1.53	1.69	1.86	1.71	1.79	1.98	1.66	1.75	1.53	1.58	1.47	1.57
Urology	1.94	1.91	1.84	1.74	1.82	1.76	2.08	1.78	1.83	2.00	2.13	2.06	2.03
Vascular Surgery	1.05	1.22	0.98	1.09	1.17	1.03	0.99	0.95	1.09	1.13	1.15	1.26	1.01
Grand Total	**1.62**	**1.62**	**1.71**	**1.69**	**1.73**	**1.63**	**1.62**	**1.58**	**1.59**	**1.66**	**1.69**	**1.67**	**1.64**

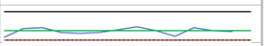
Briefing

Touchtime Utilisation has remained static at 84 % across all specialities and work is on going to support an increase in utilisation and increase in theatre case bookings

Actions

- Focused actions and additional support to the centralised Patient Pathway Coordinators (PPC) team from operational management across theatres and anaesthetics and speciality services.
- Clinicians are being sent screenshots of their lists to verify list order and appropriate case mix this is linked to theatre team review identifying theatre tray requirements, skill mix and specialist equipment to be ordered as required.
- Lists are locked down after review.
- Actions form the weekly list planning are reviewed and discussed which is further reviewed and supported by General Managers and services. All actions are reviewed in list planning the following week.
- There is a specific action plan to support utilisation in Paediatric dentistry.
- Increase to baseline PPC numbers has been agreed for financial year 18/19 to provide additional bank support to the teams to streamline processes particularly around the pre-assessment pathway and build a pool of pre assessed patients.
- The booking teams (PPC) will commence using the FEI scheduling tool this will provide accurate activity planning information along with the ability to schedule lists at 95-105 %.

Patient Safety

Indicator Description	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend (12 months)
Number of Never Events in Month	0	1	1	0	0	1	0	0	1	0	2	1	0	0	
Number of SIs where Medication is a significant factor	0	0	1	1	1	0	0	0	0	0	1	0	0	0	
Number of Serious Incidents	8 / mth	7	10	9	11	4	6	2	1	4	5	4	6	3	
Serious Incidents - per 1000 bed days	N/A	0.29	0.40	0.38	0.45	0.16	0.24	0.08	0.04	0.18	0.19	0.17	0.26	0.13	
Safety Thermometer - % of patients with harm free care (all harm)	95%	94.7%	93.8%	93.8%	95.7%	94.9%	95.0%	95.1%	94.9%	94.8%	94.3%	93.1%	95.3%	96.5%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.9%	97.5%	97.8%	98.3%	98.7%	98.1%	98.5%	98.9%	97.9%	98.5%	97.8%	98.0%	98.7%	
Percentage of patients who have a VTE risk assessment	95%	96.3%	95.8%	95.7%	95.4%	96.1%	96.4%	96.0%	95.4%	96.3%	96.0%	95.9%			
Number of Patient Falls	N/A	131	143	127	125	122	157	127	189	140	157	138	117	155	
Falls (Moderate and Above Severity)	N/A	3	5	2	0	2	1	3	1	2	2	3	1	1	
Number of patient falls- per 1000 bed days	N/A	5.43	5.71	5.29	5.15	4.89	6.23	5.17	7.49	6.15	6.05	5.78	5.02	6.71	
Number of Grade 2 Pressure Ulcers	N/A	28	23	15	18	7	16	13	16	13	12	2	6	6	
Acquired Grade 2 Pressure Ulcers per 1000 bed days	N/A	1.16	0.92	0.63	0.74	0.28	0.64	0.53	0.63	0.57	0.46	0.08	0.26	0.26	
Avoidable Grade 3 & 4 Pressure Ulcers	0	0	1	1	2	0	0	0	0	0	0	5	0	0	
Avoidable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0	0	0.04	0.04	0.08	0	0	0	0	0	0	0.21	0	0	
Acquired Grade 3 Pressure Ulcers							15	6	9	6	6	11	4	5	
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- No Never Event's were reported in June.
- The Trust declared three Serious Incidents in June, with a total of thirteen year to date.
- The number of falls reported in June increased from 117 in May to 155 in June. Of the falls reported, 132 resulted in No Harm. A significant number of patients sustained multiple falls during June- some related to complex premorbid medical conditions, alcohol withdrawal, confusion and agitation.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had an Rapid Response Report completed. These are now reviewed by a panel chaired by the Chief Nurse to establish their avoidability. From April 2018 all grade 3 and 4 pressure ulcers are reported to the Board that have been acquired at St Georges. Historically only grade 3 or 4 pressure ulcers that met the threshold for Serious Incident declaration were reported. In June no avoidable Grade 3 and 4 Pressure Ulcers were recorded and five patients with Acquired Grade 3 Pressure Ulcers.

Actions: All falls are looked at individually to identify themes. The Falls co-ordinator is working with divisions in terms of hot spot wards and pilot wards to improve falls practice and is continuing to carry out bespoke falls education and training.

The Trust is participating in NHSI Pressure Ulcer Collaborative and focusing work on the 4 wards with the highest instance of pressure ulcers

Infection Control

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD Actual	YTD Theshold	Trend (12 months)
MRSA Incidences (in month)	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Cdiff Incidences (in month)	30	1	2	3	1	4	0	0	0	1	2	6	1	3	10	7.5	
MSSA	25	4	4	4	1	1	2	3	0	3	1	2	2	1	5	6.25	
E-Coli	60.3	5	9	6	8	6	2	5	5	5	5	1	9	6	16	15	

Briefing

- C Diff threshold for 2018/19 reduces by one case with an annual threshold of 30 cases. For 2019-2020 the time limit for apportioning healthcare onset versus community onset is 48 hours rather than 72 hours. The data collected in 2018-19 for each Trust will be used to set the new targets for these categories. In the month of June the Trust reported three cases, totalling ten cases year to date.
- The Trust annual threshold for E coli is 60.3 for 2018-19 and year to date the Trust has reported sixteen cases, six of which occurred in June.
- There are no National thresholds for MSSA bacteraemia at present however the Trust has set itself an internal target of a 10% reduction on last years position setting the threshold at 25 incidents for 2018/19 . The Trust is reporting five cases since April 2018.
- There are no reported cases of MRSA Bacteraemia in June.

Actions

All June Cdiff cases have undergone a Root Cause Analysis (RCA) the ward has been placed on a period of increased surveillance and audit. No immediate learning has been identified

Mortality and Readmissions

Indicator Description	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	81.3	82.9	79.7	81.1	80.6	81.3	81.4	82.2	80.8	81.1	81.9	83.4	85.6	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	78.2	78.9	76.4	77.4	77.2	77.5	76.6	77	77.1	76.8	77.8	78.5	79.7	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	83.5	85.4	81.3	81.8	81.2	82	83.8	84.1	83.7	86.7	89.7	91.8	94.4	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.83	0.83	0.83	0.83	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	TBC	9.7%	8.9%	9.0%	9.7%	10.2%	9.20%	9.38%	8.85%	9.0%	9.20%	8.70%	8.80%		

Briefing

- The Trust's mortality rates are significantly better than expected in all measures and analysis shows that the Trust are 17% lower than expected from typical hospitals and practice in this country.
- Readmission rates following a non-elective spell observed a slight decrease in the month of May, reporting 8.8% of patients that were re-admitted to hospital within 30 days of discharge.
- The Associate Medical Director is reviewing the impact of the June heatwave on recent mortality trends which do not appear to be a factor of resourcing (the weekend and weekday trend is similar). This is to ensure that the underlying trend, which has been generally upward since last summer, is effectively identified compared to any extreme seasonal spike.

Maternity

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
C Section Rate - Emergency and Non Elective	28%	24.6%	29.5%	24.9%	30.2%	29.7%	31.9%	25.4%	23.6%	23.1%	26.9%	25.4%	29.7%	25.9%	
Admission of full term babies to neo-natal care		16	21	20	15	10	16	6	11	7	4	10	13	9	

- Maternity indicators continue to be monitored and reviewed by the Divisional Governance process.
- The Maternity Safety Champions are re-establishing the local Maternity Dashboard to track underlying trends in safety indicators and their root causes."
- The Maternity Transformation Group, in line with the monitoring required to sustain evidence for the NHS Resolution CNST premium reduction scheme, is working with HR to enable MDT training to be recorded through the Trust level systems so that assurance can be provided that all staff are effectively trained to deliver outstanding maternity care every time.

Patient Experience

St George's University Hospitals NHS
NHS Foundation Trust

Patient Voice

Indicator Description	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
Emergency Department FFT - % positive responses	90%	85.2%	83.9%	85.9%	83.5%	86.4%	84.1%	86.5%	82.2%	81.0%	81.4%	84.0%	85.0%	85.5%	
Inpatient FFT - % positive responses	95%	96.0%	96.6%	96.8%	96.5%	96.5%	95.7%	95.6%	94.7%	96.0%	96.3%	97.2%	97.3%	97.1%	
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	97.2%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	95.4%	87.1%	96.4%	100.0%	92.6%	96.0%	100.0%	99.0%	90.4%	100.0%	100.0%	98.4%	100.0%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	100%	98%	100%	100%	91.6%		100.0%	100.0%	100.0%		100.0%	100.0%	
Community FFT - % positive responses	90%	96.3%	94.5%	98.3%	94.1%	98.9%	95.7%	96.5%	99.2%	93.3%	98.3%	97.1%	98.5%	98.3%	
Outpatient FFT - % positive responses	90%	96.6%	94.2%	96.2%	94.4%	96.3%	94.3%	98.2%	97.6%	96.1%	98.4%	97.3%	97.3%	97.4%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		75	61	99	80	96	78	69	85	82	97	97	85	79	
PALS Received		234	268	170	203	185	298	262	283	234	257	193	230	290	

Briefing

- ED Friends and Family Test (FFT) – The score has seen a continued improvement in June reporting 85.5% in the recommended rate, this is observed in line with a decrease in waiting times.
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 97.1% in June providing reasonable assurance on the quality of patient experience
- Maternity FFT – The score for maternity care remain above local threshold with work continuing to improve the number of patients responding.
- The number of complaints received in the month of June was 79. All complaints are assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days. For 25 day complaints received in May 66% were responded to within 25 working days, this is on plan with the trajectory to achieve 85% by September 2018. For 40 day complaints received in April 78% were responded to within 40 working days, this is ahead of plan for the trajectory to meet 95% by September 2018.

Actions

FFT action being taken to improve response rates includes: weekly feedback to all areas on their response rate, this is published on the Quality Posters at the entrance to the area; improving the accessibility of the FFT by increasing the number of tablets and using volunteers to assist patients with the survey; scoping other opportunities to improve accessibility for example putting FFT and other patient surveys on our public website.

Complaints and PALS: The weekly CommCell is being used to maintain organisational focus on meeting both timeliness and quality standards for complaint responses. There has been a significant improvement with responding to complaints in the time given in the majority of directorates. The surgery directorate is a significant outlier, at the time of report 38% of all open complaints belong to the surgery directorate and 14 of the 20 overdue complaints. Additional resource to respond to complaints has been made available and the Director of Quality Governance is meeting with the directorate to put a recovery plan in place.

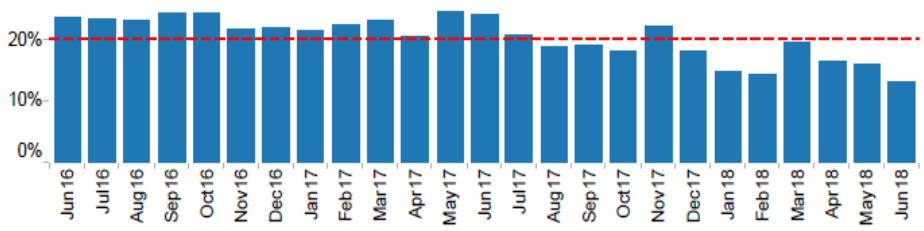
Patient Voice

CARING – Friends and Family Test

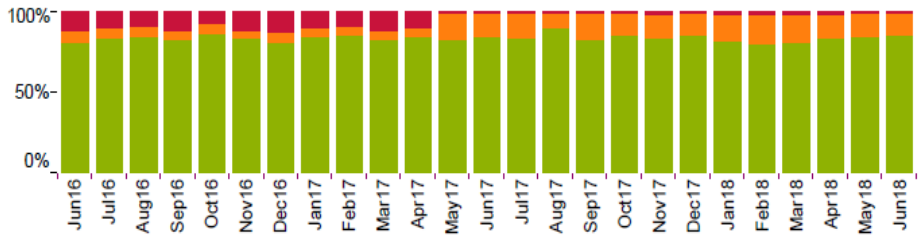
--- Target ¢ MetricMeasure Numerator Neutral Denominator

A&E Friends & Family Response Rate

Target 20% May 18: 15.99% Jun 18: 13.05% Movement: ▼-2.94%

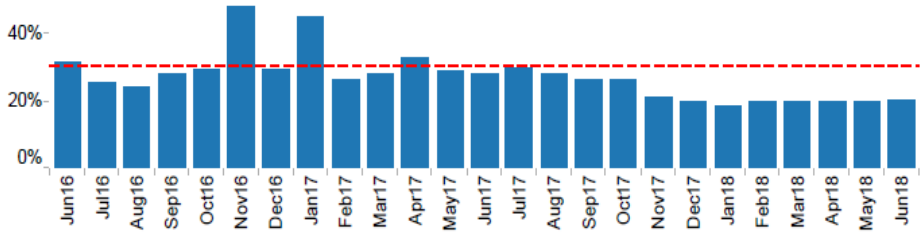


A&E Friends & Family Recommend Rate
The expected target is 90%

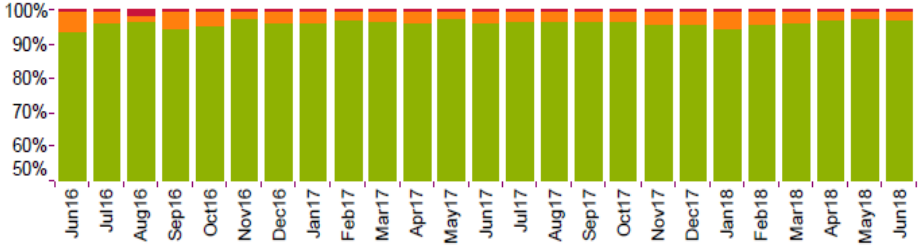


IP Friends & Family Response Rate

Target 20% May 18: 19.95% Jun 18: 20.07% Movement: ▲0.12%

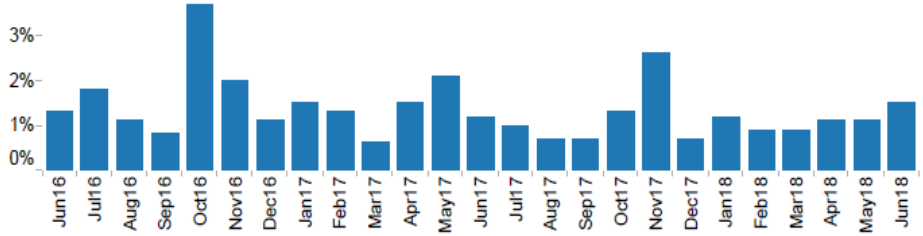


IP Friends & Family Recommend Rate
The expected target is 95%



OP Friends & Family Response Rate

Target 20% May 18: 1.10% Jun 18: 1.50% Movement: ▲0.40%



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

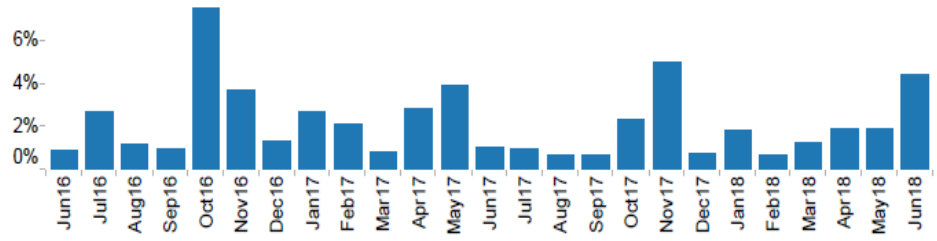
Patient Voice

CARING – Friends and Family Test

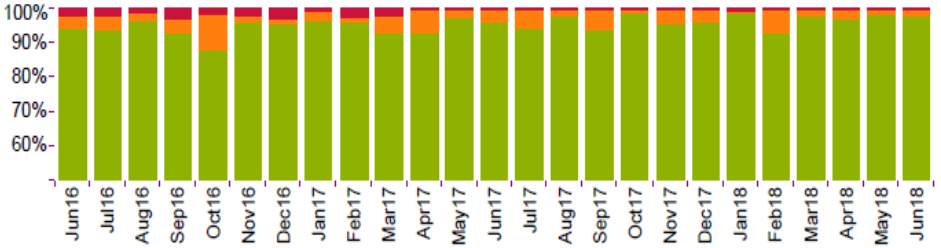
--- Target ¢ MetricMeasure Numerator Neutral Denominator

Community Friends & Family Response Rate

Target 20% May 18: 1.83% Jun 18: 4.44% Movement: ▲2.61%

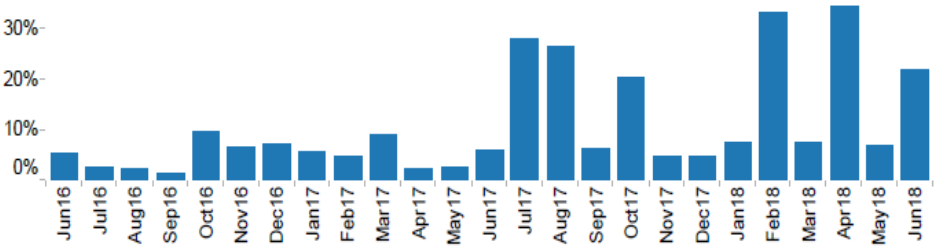


Community Friends & Family Recommend Rate
The expected target is 90%

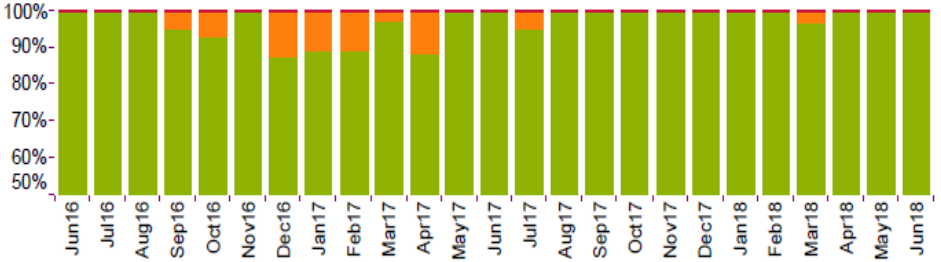


Maternity (Birth) Friends & Family Response Rate

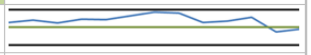
Target 20% May 18: 6.80% Jun 18: 21.70% Movement: ▲14.90%



Maternity (Birth) Friends & Family Recommend Rate
The expected target is 90%



Emergency Flow

Indicator Description	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
4 Hour Operating Standard	95%	92.1%	89.8%	90.1%	90.0%	88.0%	87.2%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	0	0	0	1	0	0	0	2	0	1	1	
Time to Treatment (number of patients seen within 60 minutes)	60%	58.8%	56.0%	56.2%	54.1%	54.2%	54.2%	54.1%	51.7%	52.2%	52.6%	61.5%	63.5%	65.5%	
Admitted patients with a length of stay 7 Days or Greater		338	346	336	349	348	362	376	373	337	343	356	301	313	
Ambulance Turnaround - % under 15 minutes	100%	51.9%	48.9%	51.8%	50.9%	49.9%	49.0%	44.3%	41.0%	42.2%	41.0%	45.0%	45.7%		
Ambulance Turnaround - % under 15 minutes (London Average)	100%	47.5%	46.4%	47.0%	46.5%	45.1%	46.1%	42.1%	41.4%	42.2%	41.1%	45.2%	45.7%		
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	71	53	84	71	57	82	112	180	135	105	92	65		
Ambulance Turnaround - % under 30 minutes	100%	96.5%	97.4%	96.0%	96.6%	97.4%	96.2%	94.8%	91.3%	93.2%	94.5%	95.3%	96.8%		
Ambulance Turnaround - % under 30 minutes (London Average)	100%	93.3%	93.2%	93.1%	92.2%	91.9%	91.7%	91.6%	86.7%	87.4%	87.5%	88.8%	91.9%		
Ambulance Turnaround - number over 60 minutes	0	0	1	1	0	0	0	2	3	3	10	1	0		

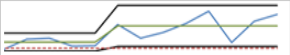
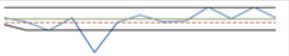
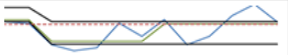
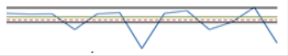
Briefing

- The Trust has delivered the aggregate position for Quarter 1 against the four hour standard however June's reportable position at 93.6% was below the monthly trajectory target of 95%.
- Key issues included delays in the Emergency Department assessment process, treatment to decision waiting times and specialty breaches which remain a key factor in the overall breach numbers.
- Enhanced adult's and children's ambulatory services launched in March 2018, with improvements noted against the core KPIs including a reduction in Four Hour breaches attributable to bed management reducing by 13% compared to the same period last year, reduced admissions to AMU and reduced bed occupancy on AMU.
- Ambulance Turnaround performance has seen a significant improvement in April and May reporting above London average against 30 minute turnaround target.
- One patient waiting over 12 hours following a decision to admit was reported in June.

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. As recommended by the National Emergency Care Improvement Programme, four key metrics 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.
- An internal 10 point plan has been formulated to reduce Emergency Department assessment breaches by 20% and treatment to decision breaches by 15%
- Minors Breach Reduction Programme Action Plan currently being developed in response to the National initiative to target a reduction in the number of minors breaches of the Four Hour Operating Standard.

Cancer

Indicator Description	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	76.6%	67.4%	80.3%	89.7%	93.98%	96.05%	97.25%	98.51%	94.76%	96.70%	96.80%	93.10%	93.34%	1,247	
Cancer 14 Day Standard Breast Symptomatic	93%	84.1%	62.9%	86.9%	90.3%	98.2%	99.6%	98.0%	97.3%	95.9%	96.5%	96.8%	94.4%	79.4%	256	
Cancer 31 Day Diagnosis to Treatment	96%	96.4%	96.8%	96.9%	96.2%	96.2%	98.1%	96.9%	97.4%	98.2%	99.3%	96.5%	98.4%	99.0%	202	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	95.9%	94.2%	90.9%	95.8%	82.4%	94.1%	96.9%	94.3%	94.6%	100.0%	95.5%	100.0%	95.7%	23	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94	
Cancer 62 Day Referral to Treatment Standard	85%	87.3%	85.4%	77.8%	75.6%	76.7%	85.5%	80.8%	86.8%	77.8%	80.8%	88.1%	92.3%	85.9%	74.5	
Cancer 62 Day Referral to Treatment Screening	90%	92.4%	92.5%	86.1%	92.5%	93.0%	78.4%	92.7%	93.9%	86.1%	89.1%	95.2%	80.8%	92.7%	21.5	

Briefing

- The Trust achieved six of the seven Cancer standards in the month of May, continuing to achieve 14 day standard reporting 93.34% and 62 day Standard reporting 85.9%.
- Performance against the 14 day Standard for Breast Symptomatic patients was not compliant in the month of May reporting 79.4% with a total of 53 patients waiting beyond the target of 14 days from referral.
- Cancer 62 day Standard Referral to Treatment performance continued to be achieved. A total of 11.5 patients were treated beyond target this included reasons of late ITT referrals received from other providers, patient choice and complex pathways.

62 Day wait for First Treatment- GP referral to treatment (actual and internal performance)

Month	Target	Actual Performance	Internal Performance
Dec-17	85%	86.8%	97.0%
Jan-18	85%	77.8%	79.0%
Feb-18	85%	80.8%	84.6%
Mar-18	85%	88.1%	87.5%
Apr-18	85%	92.3%	96.7%
May-18	85%	85.9%	87.1%

Actions

- There is a continued focus on improving internal processes as well as working with local providers to improve 38 day performance
- The Trust are looking at a number of patient pathways to improve waiting times and quicker access to diagnostics and treatment.
- The introduction of the 31 Day PTL will help drive further improvements and further visibility of the patient pathway.
- Surgical and diagnostic capacity constraints within the breast service impacting on performance, outsourcing to another provider commenced on 9th July and additional ultrasound equipment provided to increase internal capacity.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	No of Patients
Brain	93%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6
Breast	93%	84.7%	69.5%	76.4%	93.4%	94.1%	97.4%	98.4%	98.2%	96.0%	96.5%	93.9%	94.8%	91.9%	86
Children's	93%	80.0%	66.7%	80.0%	100.0%	100.0%	100.0%	71.4%	100.0%	87.5%	100.0%	100.0%	80.0%	100.0%	15
Gynaecology	93%	66.7%	75.6%	93.4%	90.4%	91.1%	90.8%	95.0%	97.6%	98.0%	96.8%	94.3%	94.9%	91.9%	99
Haematology	93%	96.9%	76.9%	95.7%	100.0%	100.0%	96.8%	100.0%	94.7%	91.7%	100.0%	100.0%	100.0%	100.0%	22
Head & Neck	93%	84.9%	82.4%	88.0%	82.4%	90.6%	99.1%	99.4%	98.4%	100.0%	97.6%	100.0%	100.0%	97.5%	161
Lower Gastrointestinal	93%	90.7%	44.4%	60.0%	73.9%	94.6%	97.4%	97.7%	99.3%	95.2%	100.0%	97.8%	94.1%	90.3%	185
Lung	93%	91.1%	91.2%	95.6%	100.0%	94.1%	97.7%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	96.3%	54
Skin	93%	48.1%	26.9%	74.3%	96.6%	93.4%	95.0%	95.5%	97.9%	92.7%	94.8%	95.9%	94.1%	93.8%	418
Upper Gastrointestinal	93%	96.1%	93.8%	97.6%	98.8%	98.8%	98.5%	99.0%	100.0%	89.0%	97.3%	95.3%	85.2%	88.1%	84
Urology	93%	90.1%	82.3%	93.8%	97.0%	96.4%	93.3%	97.1%	98.9%	95.0%	95.1%	98.2%	81.3%	92.9%	117

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	No of Patients
Brain	85%	-	0.0%	100.0%	0.0%	100.0%	-	100.0%	-	-	-	-	-	-	0
Breast	85%	100.0%	100.0%	87.5%	100.0%	91.7%	100.0%	95.2%	100.0%	71.4%	100.0%	88.9%	94.1%	84.6%	13
Children's	85%	-	-	-	0.0%	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	90.9%	100.0%	61.5%	100.0%	50.0%	83.3%	75.0%	67.0%	80.0%	77.8%	0.0%	100.0%	80.0%	5
Haematology	85%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	-	100.0%	88.9%	83.3%	81.8%	100.0%	63.6%	5.5
Head & Neck	85%	85.7%	46.2%	66.7%	71.4%	87.5%	78.6%	81.8%	71.0%	100.0%	83.3%	80.0%	100.0%	90.0%	5.0
Lower Gastrointestinal	85%	62.5%	100.0%	60.0%	100.0%	66.7%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	6
Lung	85%	85.7%	64.3%	41.7%	47.4%	72.2%	72.7%	41.2%	33.0%	90.9%	57.1%	100.0%	100.0%	87.5%	8
Skin	85%	96.4%	95.7%	100.0%	76.5%	93.8%	90.9%	91.7%	93.0%	86.7%	100.0%	100.0%	100.0%	90.9%	11
Sarcoma	85%	-	-	-	-	-	-	-	-	-	100.0%	-	-	-	0
Upper Gastrointestinal	85%	100.0%	100.0%	100.0%	77.8%	0.0%	100.0%	84.0%	100.0%	33.3%	57.1%	66.7%	87.5%	33.3%	1.5
Urology	85%	67.9%	81.8%	63.0%	64.3%	77.4%	100.0%	72.7%	91.0%	60.7%	70.0%	96.7%	80.5%	84.6%	19.5

Diagnostics

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
6 Week Diagnostic Performance	1%	2.2%	2.7%	2.0%	1.4%	0.3%	1.9%	0.1%	0.1%	0.0%	0.2%	0.2%	0.2%	0.3%	
6 Week Diagnostic Breaches	N/A	173	190	154	98	22	143	6	10	3	17	15	14	25	
6 Week Diagnostic Waiting List Size	N/A	7,843	6,988	7,751	7,184	7,072	7,534	6,440	6,884	7,232	7,075	7,956	7,735	7,809	

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
MRI	1%	0.6%	0.8%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.4%	
CT	1%	0.2%	0.2%	0.3%	1.2%	0.3%	0.1%	0.0%	0.1%	0.0%	0.3%	0.1%	0.0%	0.3%	
Non Obstetric Ultrasound	1%	0.3%	1.1%	0.9%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	
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%	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%	0.0%	
Audiology Assessments	1%	11.3%	4.6%	5.7%	4.5%	0.0%	17.4%	0.0%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	
Echocardiography	1%	2.0%	3.0%	0.3%	0.3%	0.3%	0.8%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	
Electrophysiology	1%	75.0%	75.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.3%	0.9%	0.0%	0.4%	0.2%	0.0%	0.0%	
Sleep Studies	1%						26.8%	0.0%	0.0%	0.4%	0.6%	0.0%	0.0%	0.0%	
Urodynamics	1%	64.4%	64.2%	50.6%	37.0%	16.7%	6.7%	0.0%	0.0%	0.0%	9.1%	5.0%	23.9%	6.3%	
Colonoscopy	1%	0.5%	1.8%	0.0%	0.4%	1.1%	0.0%	0.0%	0.0%	0.6%	0.7%	0.6%	0.4%	0.0%	
Flexi Sigmoidoscopy	1%	1.1%	4.9%	0.7%	1.5%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	
Cystoscopy	1%	24.4%	14.0%	12.3%	14.7%	4.0%	1.8%	1.5%	2.8%	0.7%	0.0%	1.0%	0.8%	3.0%	
Gastroscopy	1%	9.2%	11.2%	6.7%	0.8%	0.0%	0.8%	0.4%	0.0%	0.0%	1.8%	1.0%	0.0%	0.0%	

Briefing

- The Trust has continued to achieve performance in June reporting a total of twenty-five patients waiting longer than 6 weeks, 0.3% of the total waiting list.
- Compliance has been achieved in all modalities with the exception of Urodynamics with one patient waiting beyond six weeks out of sixteen patients on the waiting list, this is due to capacity following equipment failure. Additional capacity has been provided, resulting in a 54% reduction on the previous months waiting list size. In addition four Gastroenterology breaches were reported due to staffing issues within Paediatrics.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
Number of on the Day Cancellations		64	84	54	49	52	86	100	94	55	86	64	87	42	
Number of on the Day cancellations re-booked within 28 Days		54	70	43	43	34	76	67	76	48	76	60	80	33	
% of Patients re-booked within 28 Days	100%	84.4%	83.3%	79.6%	87.8%	65.4%	88.4%	67.0%	80.9%	87.3%	88.4%	93.8%	92.0%	78.6%	

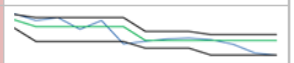
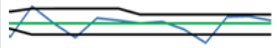
Briefing

- In June 78.6% of our on the day cancelled patients were-rebooked within 28 days.
- The number of patients cancelled on the day for non clinical reasons have decreased in month, reporting 42 cancellations compared to 87 last month.
- Of the 42 cancellations reported, 30% were due to emergency cases taking priority.

Actions

- Continue to improve the Pre Operative Assessment (POA) Process and the availability of more high risk capacity for POA
- Text reminder service to be implemented within pre-assessment.
- Introduce a call to every patient before surgery to check that they are Ready, Fit and Able to attend 72 hours prior.
- At times of high non-elective activity, ensure that elective patients are reviewed, including their bed requirements, in advance of the day of surgery
- Standard operating procedures have been signed off and implemented.

Workforce

Indicator Description	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
Trust Level Sickness Rate	3%	3.4%	3.6%	3.7%	3.6%	3.4%	3.8%	3.6%	4.1%	4.0%	3.6%	3.2%	3.2%	3.6%	
Trust Vacancy Rate	10%	17.1%	16.1%	16.5%	14.8%	16.1%	12.7%	13.0%	13.4%	13.5%	13.3%	12.6%	11.3%	11.0%	
Trust Turnover Rate* Excludes Junior Doctors	10%	18.8%	18.4%	19.6%	18.5%	18.5%	18.3%	18.4%	17.9%	17.6%	17.2%	16.9%	17.0%	17.3%	
Total Funded Establishment		9,948	9,879	9,855	9,794	9,808	9,470	9,474	9,515	9,540	9,497	9,469	9,318	9,242	
IPR Appraisal Rate - Medical Staff	90%	74.2%	84.8%	79.0%	74.0%	80.7%	80.0%	78.9%	79.6%	76.9%	72.2%	81.1%	81.3%	79.9%	
IPR Appraisal Rate - Non Medical Staff	90%	76.1%	76.1%	75.1%	79.4%	73.5%	70.2%	70.2%	67.2%	65.9%	61.6%	61.2%	63.4%	64.6%	
% of Staff who have completed MAST training (in the last 12 months)		87%	86%	86%	85%	86%	87%	86%	87%	87%	87%	87%	87%	87%	
Ward Staffing Unfilled Duty Hours	10%	5.8%	5.9%	6.5%	5.9%	6.1%	6.6%	7.8%	7.7%	7.9%	8.9%	6.5%	5.1%	4.9%	
Safe Staffing Alerts	0	1	2	1	0	1	2	2	4	1	1	1	1	2	

* Excludes Junior doctors

Briefing

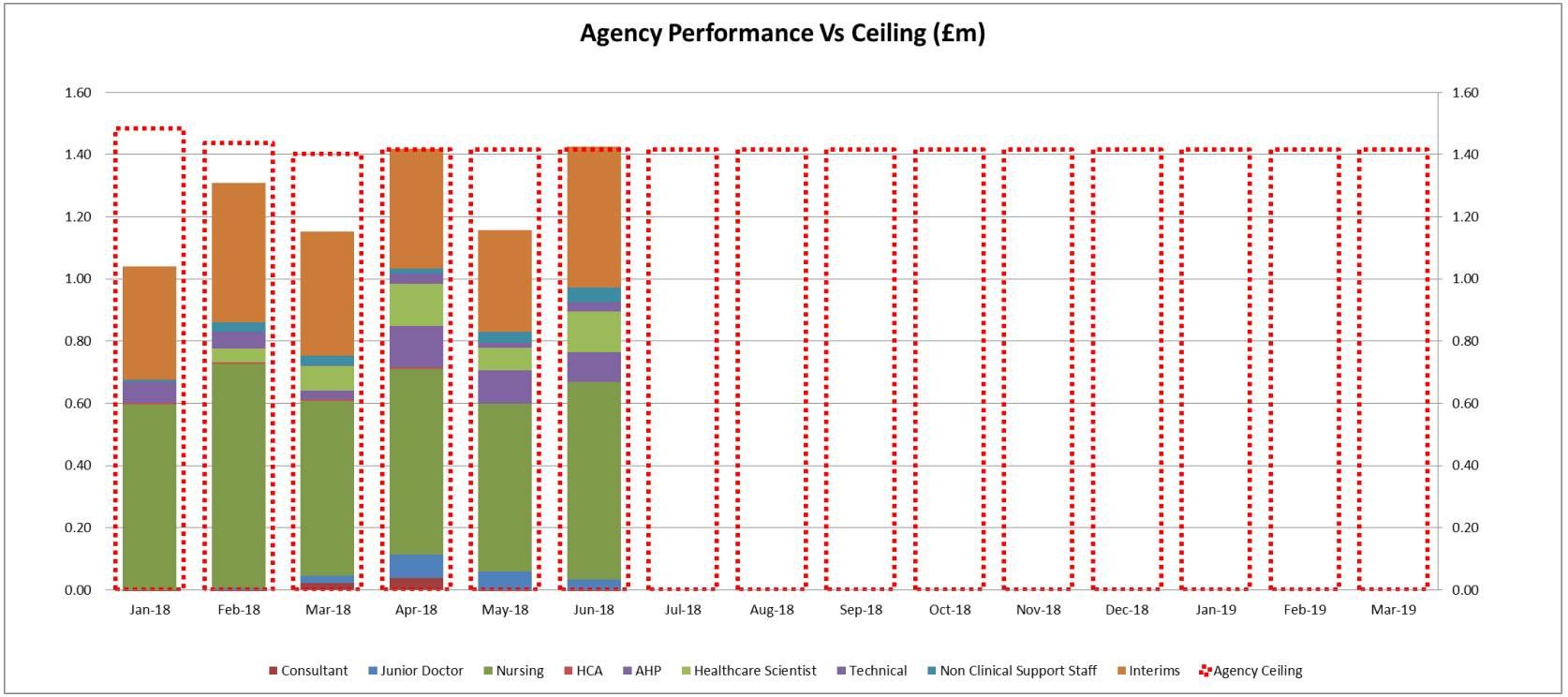
- Funded Establishment has continued to fall compared to the previous month reporting 9,242 WTE in June, a reduction of 7% reduction from 2017 as a result of the changes to the Community Division.
- The Trust Vacancy Rate continues to decrease in June reporting 11% in month.
- After a decrease in sickness absence in April and May, June has seen a slight increase reporting 3.6%.
- Mandatory and Statutory Training figures for June were recorded at 87%
- Medical Appraisal rates in June at 80% showing non compliance against a target of 90%
- Non-medical appraisal rates have seen a 1% improvement. Performance in June was 64.6% against a 90% target.

Actions

- The Trust is establishing a working group to look at how it can improve on its current appraisal rates.
- In parallel, the Trust is looking at how it can bring on stream an electronic appraisal solution via TOTARA

Workforce

Agency Use



- The Trust's total pay for June was £48.42m. This is £0.49m favourable to a plan of £48.91m.
- The Trust's 2018/19 annual agency spend target set by NHSI is £21.30m. There is an internal annual agency target of £17.00m.
- Total agency cost in June was £1.42m or 2.9% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For June, the monthly target set was £1.42m. The total agency cost is on plan with this target.
- Agency cost increased by £0.27m compared to May. There has been increases across most staff groups: Interims (£0.13m), Nursing (£0.10m), Healthcare Scientist (£0.06m), Non Clinical Staff (£0.01m) and Technical (£0.02m). This is offset by decreases in Junior Doctor (£0.03m) and AHP (£0.01m).
- The biggest area of overspend was in Interims, which breached the target by £0.15m.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board (Part 1)		
Date:	26 July 2018	**Agenda No**	**3.3**
Report Title:	Elective Care Recovery Programme (ECRP) update		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Ellis Pullinger Chief Operating Officer		
Presented for:	Update		
Executive Summary:	**This is the monthly update on ECRP to the public Trust Board. This report will provide an update on the following items:** 1) Treating patients against the referral to treatment (RTT) standard; 2) Training our staff to record patient activity accurately on the trust's IT system; 3) Outcome of the Trust's historical validation of patient records on its IT system – phases 1 and 2; 4) Return to reporting of the RTT standard as a Trust in 2018/19 **In addition, it is important to summarise that the ECRP has three key objectives in 2018/19:** 1) To deliver the plan to allow the Trust Board to make the decision, in partnership with our main Commissioner, to return to reporting at the end of the 2018/19 financial year. Please note that the Trust will only be able to report the waiting times for patients publically for the St George's (Tooting) site. 2) Linked to objective 1, the ECRP to continue to support the waiting time improvements on the Queen Mary's Hospital (Roehampton site) while the IT system is updated in order for it to return to reporting for RTT as well in 2019/20. 3) To continue to reduce the RTT waiting times for patients referred and treated at this trust. The Trust is not expecting to meet the national 92% standard in this financial year but is prioritising getting the actual Trust performance reported in public.		
Recommendation:	The Trust Board is asked to receive this report		
Trust Strategic Objective:	Treat the patient, treat the person Right Care, Right Place, Right Time		
CQC Theme:	Well-led, Safe, Caring and Responsive		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Risk:	The programme risks for ECRP continue to be reviewed and will be shared in part 1 of the next Trust Board to reflect the additional work required to return to reporting for RTT in 2018/19		

Legal/Regulatory:	Referral to treatment standard is a regulatory target		
Resources:	As part of the Elective Care Recovery Programme		
Previously Considered by:	Monthly update received by the Trust Executive Committee and Quality and Safety sub- Committee	June 2018	
Equality Impact Assessment:	N/A		
Appendices:	N/A		

Elective Care Recovery Programme Update

Trust Board (Part 1)

26 July 2018

1) Treating Patients

- The Trust continues to use and develop its five patient tracking lists (PTL's). They are as follows:

1) Active (the live PTL)
2) Planned
3) Active Monitoring
4) Diagnostics
5) Cancer

- A daily update on the size of the live PTL is available for all staff to view. This daily update tells the teams' how long each patient has been waiting. The focus on getting patients treated who have been waiting the longest for their next episode of care continues to be the priority. The number of patients waiting too long for their treatment continues to reduce.
- All patients from the phase one historical validation, that required an appointment, have now been seen. There is a further piece of validation work for those patients who did not respond to the Trust letter in the phase 1 validation process that the referring GP's are now checking that they definitely do not need any further clinical input from the Trust. Please see section 3 in this report for more detail.
- An update of progress for completing phase two of the historical validation is also in section 3 of this report.

2) Training

- Targeted training for the teams who use the Trust's IT system most to track patients on a RTT pathway continues.
- Wider RTT training strategy developed and submitted for both the St George's and Queen Mary Hospital sites. This work has now started.
- The completion of the RTT e-learning modules has been mandated by each of the Divisional management teams and is being tracked through the new weekly ECRP Access Meeting, chaired by the Divisional Director of Operations for Surgery, Cancer, Neurosciences and Theatres.
- The uptake for our staff completing the RTT e-learning modules remains a concern and is too low at 57% (as of w/c 16 July 2018) against a target of 85% (non-management groups) by the end of June 2018, and 90% of the management group by the end of August 2018.

3) Outcome of the Trust's historical validation of patient records on its IT system – phases 1 and 2

Phase 1 Historical Validation – Potential Lost to Follow Up Patients

- By way of context to this section in the paper, the Trust Board is reminded that in 2010 Cerner was deployed at the St George's Hospital site as part of the National Programme for IT. The Queen Mary Roehampton (QMH) site did not undergo any upgrade and remains on a CSC Clinicom Patient Administration System (PAS).

- In February 2014 the Trust upgraded this system to include, amongst other things additional RTT functionality. Following identification of a number of performance and data quality issues by the national RTT Intensive Support Team (IST), the Trust commissioned a comprehensive review of their systems and processes that manage patients on the elective care pathway.

- The external review conducted by a third party, MBI Health Group, identified multiple operational process and technology issues at every stage of the elective care pathway that posed significant risks to the quality of care and safety of patients.

- Part of this review identified concerns about the Trust's ability to accurately track all its patients who were showing on its waiting list. As a result, the Trust agreed to a phased validation approach with the 'high risk' patients being reviewed first to see if they required any further clinical care, or not, (Phase 1) and the 'lower risk' patients second (Phase 2.)

- In 2017 the Trust reviewed two million records and identified 129,000 "high risk" patients for validation. The Trust commissioned Cymbio to validate the 'high risk' patients and identify any potential patients at risk of clinical harm.

- The Trust established a Clinical Harm Review Team (CHRT) comprising of GPs to independently review the patient cases identified by the appropriate Clinical Service as potential risk of clinical harm.

- CHRT independently reviewed 646 cases across both sites that resulted in the following outcomes and these have been declared to our Commissioners and Regulators:
    - No Harm – 553
    - Low Harm – 74
    - Moderate Harm – 4
    - Severe Harm – 15

  From the 15 severe harm cases – ten (10) have been associated with RTT issues and one (1) is directly associated with the ECRP programme.

- In December 2017 a further cohort of patients were identified as being lost to follow up and considered potential high risk to clinical harm. The Trust sent 18,922 letters to patients to confirm if they felt a further appointment or advice from the Trust was still required. 4,830 patients responded across both the St George's and Queen Mary Hospital sites and have either been discharged or had an outpatient appointment. No patient was identified as being at risk to clinical harm from this process.

- 13,416 patients did not respond to the above process of sending out letters asking them for a proactive response. Following a pilot with Brocklebank GP Practice, the Merton & Wandsworth Local Delivery Unit requested to review their cohort of 7,462 patient cases who did not respond. In addition the South West London Alliance has also requested to review

their patient cases of circa 1,500. The Trust has agreed a process with the Commissioners so that each GP practice will effectively double check if each patient does/does not require any further clinical input from the Trust. A review of the issues, and any emerging themes from each GP practice reviewing this group of patients, will take place in August 2018.

- In March 2018 the CHRT reviewed the Serious Incident (SI) reports that relate to the ten (10) RTT related severe harm cases to identify themes and capture the learning. The three (3) main overarching themes identified were:

    - Operational & Process
    - Communication
    - Training

- Crucially the Trust has now implemented a 'live' Patient Tracking List (PTL) from February 2018 that tracks and manages all patients that are referred to the Trust for diagnosis and treatment and has introduced appropriate RTT training for staff.

Phase 2 Current and Historical Validations – Lost to Follow Up Patients

- By definition this cohort of patients is significantly lower risk than the cohort within Phase 1. It is expected that Phase 2 will be completed 31st August 2018.

- The initial validation work undertaken by Cymbio identified 10,000 patients who appeared to have an 'inconclusive' pathway – i.e. no definitive outcome from their last contact with the Trust in order to confirm that their episode of care could be closed. Of the 10,000 patients, 4,000 appeared to be on the St George's site, 6,000 at Queen Mary's.

- Following further internal validation to remove patients with an appointment after October 2017 and patients on 'active monitoring' the total number of inconclusive records across both sites from the original 10,000 is 4,189 (2,347 at St George's and 1,842 at Queen Mary's.)

- Good progress is being made to complete the phase 2 validation by August 2018.

4) Return to Reporting

The Trust Board took the decision to stop reporting its referral to treatment waiting times in 2016. Every non-reporting Trust is expected to agree and deliver a 'return to reporting' plan so it is able to assure itself that it can report RTT waiting times accurately to the public once the decision has been taken to do so. In part 2 of the June Trust Board, the five key principal themes (and underpinning evidence required) to start the return to reporting process formally was approved. The Trust aim is to return to reporting in late 2018/19.

5) Forward Look for the ECRP update to the July 2018 trust Board

- The Trust Executive Committee received a report in July 2018 from RM Partners with their recommendations on how the Trust could further strengthen its cancer services at the Trust, in particular the tracking of patients on its IT systems. No immediate concerns were raised from this report and good progress was noted. The Trust will now publish this report, with RM Partners permission, at the next public Board meeting. The original intention was to publish the report in July 2018.

- The Trust continues to work with its main Commissioner, the Intensive Support Team and NHS Improvement on finalising its return to reporting work plan. As referenced in the June

Trust report, the programme risks for ECRP need to reflect the return to reporting work stream once finalised. The updated risks will be available for the next public Board meeting.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	26 July 2018	**Agenda No.**	3.4
Report Title:	Emergency Care Performance Update – July 2018		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Gemma Phillips, General Manager for Emergency Department and Acute Medicine		
Presented for:	• This paper presents an updated position on the Trust's performance against the 95% Emergency Care Operating Standard and agreed improvement trajectories including the position for the end of Quarter 1 2018/19. • This paper also presents the actions being taken to improve performance in line with the agreed trajectory.		
Executive Summary:	• In June 2018, the Trust delivered performance of 93.59% against the improvement trajectory target of 95%. • The Trust achieved the target for the quarter, achieving 91.84% against the improvement trajectory target of 91% for the period April to June 2018. • The Trust is currently performing at 93% for July, 2% behind the agreed trajectory of 95% performance for the month, driven by deterioration in admitted pathway performance. • Year to date, Emergency Care Performance is 91.98% as at 12 July 2018 against the trajectory of 92% for 2018/19. • The inpatient demand and capacity model is being reviewed by specialties. The model has been updated to reflect Quarter 1.		
Recommendation:	• It is recommended that the Trust Board note the update on progress against the 4 hour Emergency Care Operating Standard, including Quarter 1 performance, and delivery of the 15 Point Plan. • The Trust Board is also asked to note the update on progress with the inpatient demand and capacity model which will inform the Trust's winter plan.		
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:	Emergency Care Performance is on the Divisional risk register. Risks to delivery remain unchanged from June 2018 update.		
Legal/Regulatory:	NHS Operating Standard.		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date:**	18.07.18
Appendices:	2		

1.0 Purpose

1.1 This paper is being presented to provide update on Emergency Care Performance and delivery of the 15 Point Plan for the month of July 2018. The paper outlines current performance against the improvement trajectory for the 4 hour Emergency Care Operating standard in 2018/19 and the position for the end of Quarter 1 (Q1, April – June 2018). An update is also presented on performance against the trajectories for admitted and non-admitted pathway performance and the actions being taken to improve performance sustainably. These actions are being driven across all Divisions, overseen by the weekly Emergency Care Performance Improvement Group chaired by the Chief Operating Officer.

1.2 The paper also provides an update on progress with the inpatient demand and capacity model which has been updated to reflect actual activity and length of stay for Q1.

2.0 Background

2.1 The Trust's performance against the 4 hour Emergency Care standard deteriorated between September 2017 and February 2018 across admitted and non-admitted pathways. The Trust reported an overall performance of 87.56% for 2017/18 with significant variability in daily performance.

2.2 In April 2018, The Trust Board approved a trajectory for Emergency Care Performance which would deliver 92% against the 4 hour Emergency Care Operating Standard across the year with the caveat that the Trust should strive to deliver further improvement towards achieving the 95% target sustainably. In May 2018, the Trust Board approved trajectories for admitted and non-admitted pathway performance.

3.0 Current Emergency Care Performance

3.1 Performance against the 4 hour Emergency Care Operating Standard continued to improve in June. The Trust delivered 93.59% performance in June 2018, a slight improvement compared to May 2018 performance of 93.31% but below the trajectory target of 95% for June. This represents a 1.5% improvement compared to performance in June 2017 of 92.12%. Emergency Care Performance for July 2018 is currently at 93% as at 12 July 2018, 2% below the 95% trajectory target for July and the national standard; however a 3% improvement compared to performance in July 2017 of 89.76%. Year to date for 2018/19, Emergency Care Performance is 91.98% as at 12 July 2018 against the trajectory to deliver 92% across the year ending in March 2019. The performance trajectory target for Q2, linked to Sustainability and Transformation Fund (STF) achievement, is 94.67%. The targets for Q3 and Q4 are 92% and 91.67% respectively.

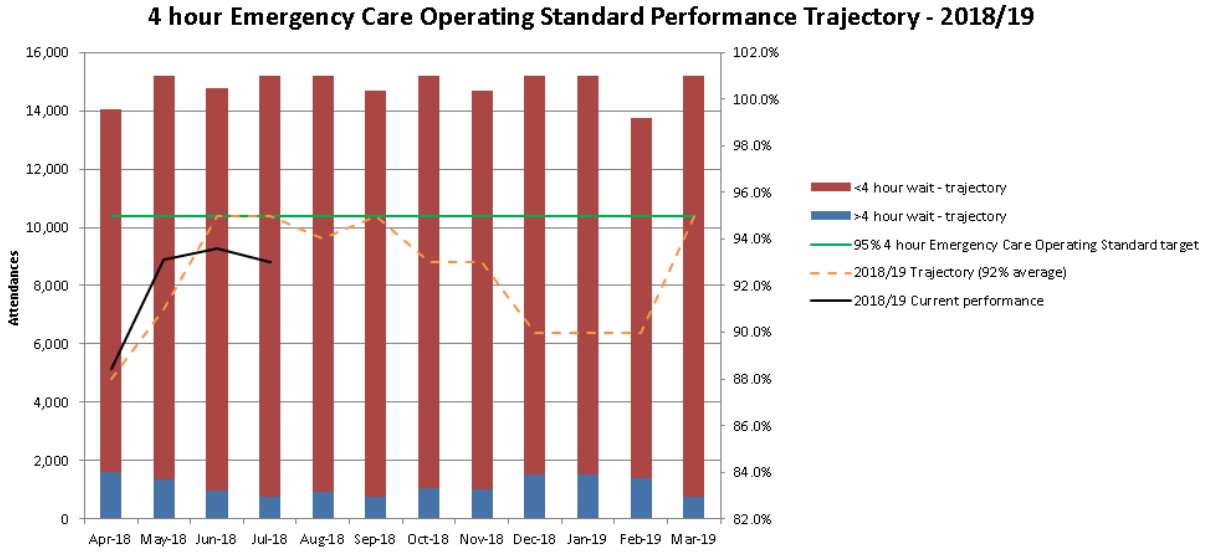
3.2 In June, bed occupancy increased affecting admitted pathway performance. The Trust has seen an increase in ambulance conveyances and overall attendances, including for mental health patients, in addition to experiencing challenges due to

medical staffing shortages in the Emergency Department (ED). The admitted patient pathway is a key area of focus. Pathway changes have been made in trauma and orthopaedics and the stroke pathway is currently being reviewed jointly between the ED and Neurology teams. A steering group has been established to review and improve the discharge model of care Trust-wide.

3.3 In June 2018, the Trust is expected to achieve 96.8% of ambulance handovers within 30 minutes, maintaining the improvements made in the previous month. This figure is still subject to final confirmation from the ambulance service. There were no 60 minute ambulance breaches in June 2018. The Trust incurred one 12 hour trolley breach in June 2018 and has incurred a further breach in July, both of which related to mental health patients. The Trust is continuing to work with mental health partner organisations to improve the care of patients with primary mental health needs attending the Emergency Department in addition to strengthening the support for patients within the ED. A second Registered Mental Nurse (RMN) commenced in post at the end of June 2018, an initiative that is recognised as best-practice and has been positively acknowledged by visitors from NHS Improvement (NHSI). There have been 251 breaches of the 4 hour standard for mental health reasons (5.89% of total breaches) since April 2018.

3.4 The chart (Fig 1) below outlines current performance against trajectory as at 12 July 2018 and 2017/18 performance. The latest Urgent and Emergency Care Dashboard published by NHSI is included in Appendix 2.

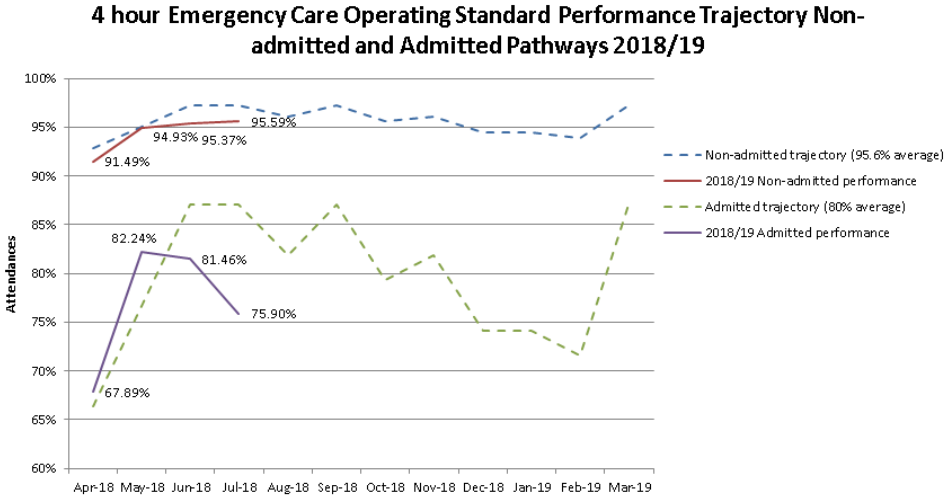
Fig 1. Emergency Care Performance against Trajectory



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2017/18 Performance	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	87.17%	84.99%	83.02%	83.52%	81.50%
2018/19 Trajectory	88%	91%	95%	95%	94%	95%	93%	93%	90%	90%	90%	95%
2018/19 Current performance	88.41%	93.31%	93.59%	93.00%								

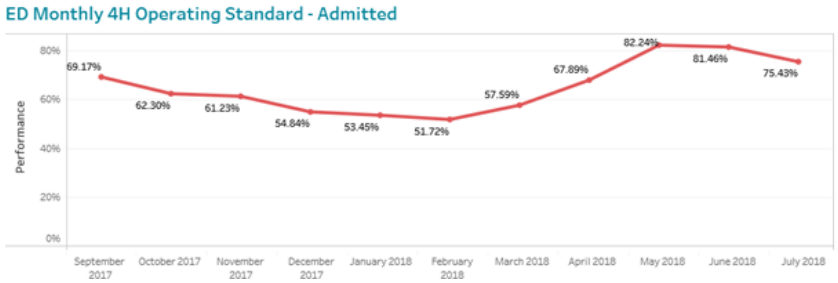
3.5 Performance across the non-admitted pathway continues to improve, achieving 95.37% for June 2018 and has improved further in July to 95.59% as at 12 July 2018. There has been a corresponding improvement in the time to treatment metric, with 65.5% of patients attending the ED being seen within 60 minutes in June 2018, compared to 63.5% in May and 61.5% in April 2018. Admitted pathway performance deteriorated in June to 81.46% down from 82.24% in May 2018 and has seen a further deterioration in July to 75.90%. The chart below (Fig 2) demonstrates current performance against the agreed trajectories for non-admitted and admitted pathways agreed by the Trust Board in May 2018. Figure 3 shows the admitted and non-admitted performance trend since September 2017.

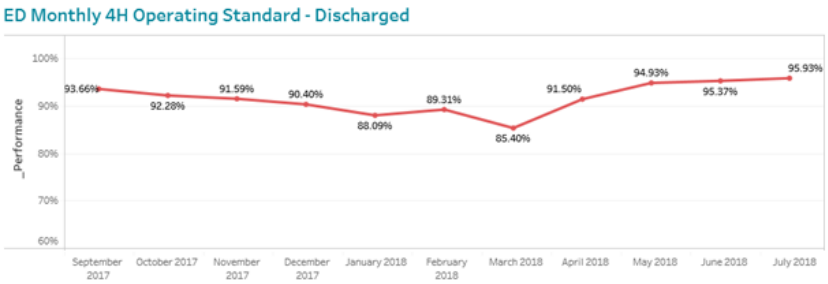
Fig 2. Admitted and Non-admitted Performance against Trajectory



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Non-admitted trajectory (95.6% average)	93.4%	95.0%	97.2%	97.2%	96.1%	97.2%	95.6%	96.1%	94.5%	94.5%	93.9%	97.2%
Non-admitted Current performance	91.50%	94.93%	95.37%	95.6%								
Admitted trajectory (80% average)	69.0%	76.7%	87.1%	87.1%	81.9%	87.1%	79.3%	81.9%	74.1%	74.1%	71.6%	87.1%
Admitted Current performance	67.89%	82.24%	81.46%	75.90%								

Fig 3. Admitted and Non-admitted Performance Trend

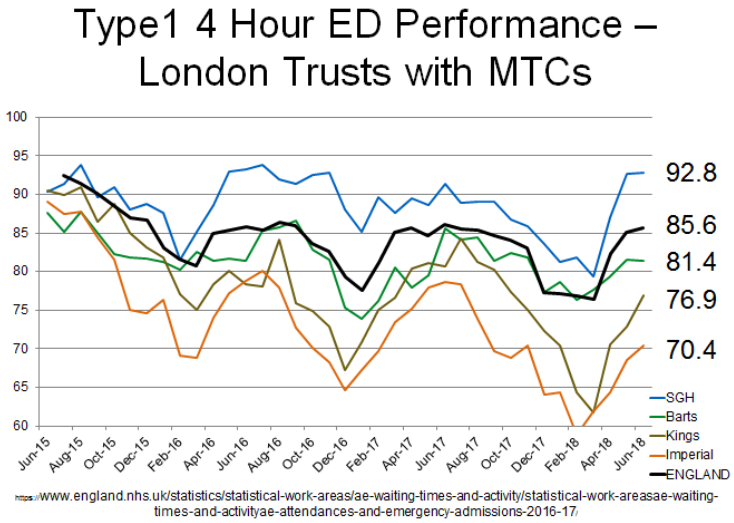




3.6 The admitted patient pathway performance is a key area of focus as this is a significant factor contributing to current performance below the agreed trajectory and has the highest correlation with overall Emergency Care Performance. Admitted performance has been impacted by an increase in bed occupancy in June 2018 as demonstrated by an increase in AMU occupancy and an increase in the proportion of breaches due to bed management and ED capacity compared to May (see 4.5 and Appendix 1). As part of the inpatient demand and capacity model and winter planning, the Trust is identifying the support required from system partners in order to further reduce LOS and improve flow. A Multi-Disciplinary Accelerated Discharge (MADE) Event is planned to take place on 16 October 2018 but a further smaller event may be organised before this time. The overall plan to improve admitted pathway performance will be overseen by the Emergency Care Performance Improvement Group.

3.7 The Trust continues to perform well compared to major trauma centre peer organisations. The chart (Fig 4.) below shows the Trust's Type 1 emergency care performance compared to London Trusts with major trauma centres updated for June 2018.

Fig 4. Emergency Care Performance – London Major Trauma Centre Comparison



3.8 Overall, the Trust continues to perform well against London peer organisations and benchmarks well nationally. For the week ending 11 July 2018 the latest urgent and emergency care dashboard published by the Emergency Care Improvement Programme (ECIP) ranks St George's 3/18 Trusts for Type 1 performance in London

and 28/137 Trusts nationally. The Trust was ranked 4/18 Trusts in London and 28/137 Trust nationally for all overall performance for the same period and 2/4 Trusts in South West London (see Appendix 2).

4.0 Progress against 15 Point Plan

4.1 The 15 Point Plan Dashboard is included in Appendix 1. This has been updated to include statistical process control (SPC) charts for improved accuracy and monitoring of trends. The dashboard continues to be reviewed on a weekly basis at the Emergency Care Performance Improvement Group (ECPIG) Meeting.

4.2 Specialty response time to the Emergency Department remains variable and a large number of specialties are not meeting the requirement to attend the ED within 30 minutes of a referral consistently. Improvement plans are being driven by Divisional Chairs and the Emergency Care Performance Improvement Group (ECPIG). A pilot is underway to improve the pathway for patients admitted with fractured next of femur to improve the quality of care and avoid unnecessary waiting in the ED and the stroke pathway is currently being reviewed by ED and Neurology teams.

4.3 The proportion of breaches since April 2018 due to waiting for specialist opinion is currently 12.75% up from 11.61% in 2017/18. The reduction of speciality breach times to below 10% is being targeted for the remainder of July and August. In June, the proportion of specialty breaches reduced to 12% of the total but has seen an increase to 15% in July so far.

4.4 23.41% of the breaches of the 4 hour standard since 1 April 2018 are due to ED assessment, a slight improvement from 23.54% last month, and a further 17.91% are due to treatment decisions, reduced from 18.35% last month. These areas are being addressed by the ED and an action plan overseen by ECPIG is in place to reduce this further. The ED aims to reduce ED assessment breaches to no more than 20% of the total breaches and treatment decisions to no more than 15% of the total sustainably from September 2018. As at 15 July 2018, this was being achieved for ED assessment breaches, with 16% as a proportion of total breaches compared to 24% in June. The proportion of breaches due to treatment decision breaches has also reduced, 16% of total in July so far compared to 21% in June. There continues to be a focus on strengthening the shift leadership within the ED.

4.5 The table below summarises the proportion of breaches under each category for each month since April 2018, with a RAG rating to denote trend compared to the previous month for June and July.

Primary Breach reason	Apr-18	May-18	Jun-18	Jul-18
Bed Management	16%	6%	7%	13%
Clinical Exception	5%	8%	7%	8%
Delay Social Services	0%	0%	0%	0%
ED Assessment	23%	26%	24%	16%
ED Capacity	9%	8%	9%	9%
ED Referral	7%	4%	7%	10%
Mental Health	4%	7%	7%	6%
Other	1%	2%	1%	1%
Patient Factors	1%	1%	1%	1%
Patient Transport	0%	0%	0%	1%
Treatment Decision	17%	19%	21%	16%
Waiting for diagnostic	4%	5%	4%	4%
Waiting for specialist opinion	12%	14%	12%	15%

4.6 The extended opening for the adult Ambulatory Assessment Area (AAA) from 8am to 12am 7 days a week is on track for implementation from 23 July 2018. The proportion of breaches attributable to bed management and ED capacity remain significantly lower than in 2017/18. Bed management breaches account for 11.16% since April and ED capacity breaches 8.87%. The proportion of breaches due to bed management in June increased to 7% of the total, compared to 6% in May. This has seen an increase to 13% in July, linked to deterioration in admitted performance.

4.7 The proportion of stranded patients (>7 day LOS) for the week ending 11 July 2018 was 32.43%, a reduction compared to the Trust's 6 week average of 35.84%. The proportion of super stranded (>21 day LOS) patients is 13.20%, compared to a 6 week average of 13.61%. Improvements will be required to reduce this number sustainably and in line with Trust and national expectations through improved discharge processes and collaborative working with system partners.

5.0 Risks and Mitigation

5.1 The key risks to delivery of Emergency Care Performance in line with the trajectory and mitigating actions remain unchanged from the June 2018 update. The risks associated with not delivering the 95% Emergency Care standard remain on the Directorate risk register and are reviewed and updated regularly.

6.0 Inpatient Demand and Capacity Model Update

6.1 The first iteration of the inpatient demand and capacity model which has been developed by the Trust's Information Team has been shared with the Divisional and Directorate Management Teams for the adult and paediatric bed base.

6.2 The model is based on the 2018/19 SLA plan for activity and length of stay for each month of 2017/18. The model assumes bed occupancy of 92.5% for inpatient wards and 85% for assessment and acute speciality areas, including the Acute Medical Unit, Nye Bevan Surgical Assessment Unit, Hyper Acute Stroke Unit and the Coronary Care Units. Bed occupancy of 92.5% is recognised by the Emergency Care Improvement Programme as the occupancy at which quality and safety can be maintained on general wards. 85% occupancy for the assessment and acute care

units is recognised by the Trust as the optimal occupancy that is required to maintain flow and accommodate patients requiring specialist care and treatment in emergency to these units providing specialist acute care.

6.3 Figure 5 below outlines the outputs of the model at specialty group level updated to reflect actual activity and length of stay data for Q1. In April 2018, the Trust-wide bed capacity gap of 0 was 10 beds better than the forecast. In May 2018, the actuals depict an overall bed capacity surplus of 4 beds for the month, mainly driven by a reduction in occupied bed days across medicine and senior health which has continued in June 2018. For general medicine non-elective average (mean) length of stay (LOS) was 5.25 days in April, 4.45 days in May and 4.44 in June 2018. This includes the benefits of the ambulatory care process model. For senior health, average LOS was 15.85 days in April and 12.99 days in May with a slight increase to 13.93 days in June 2018.

Fig 5. Inpatient Demand and Capacity Model (92.5% occupancy) – Updated with Q1 actual activity and length of stay

Specialty	Apr-18			May-18			Jun-18		
	Forecast	Actual	Variance	Forecast	Actual	Variance	Forecast	Actual	Variance
Cardiac & Thoracic Surgery & Cardiology	-2	-2	0	-2	-2	0	-2	-2	0
Clinical Infection	-6	-1	5	-6	-1	5	-3	-5	-2
Gynaecology	-1	-2	-1	-1	-3	-2	-1	-2	-1
Haematology & Oncology	-8	-13	-5	-10	-4	6	-9	-7	2
Medicine & Senior Health	23	34	11	37	6	-31	36	-2	-38
Neurosciences (all)	3	-4	-7	-1	2	3	-4	39	43
Renal	-2	-4	-2	-4	-4	0	-3	3	6
Surgery	0	0	0	-2	17	19	0	13	13
Trauma & Orthopaedics	-3	-6	-3	5	-14	-19	-2	-11	-9
Vascular	7	-2	-9	7	-1	-8	7	-1	-8
Trust Total	**11**	**0**	-11	**23**	**-4**	-27	**19**	**25**	6

NB. Red denotes a deficit and green denotes a surplus of beds.

6.4 Conversely, Neurosciences is showing a significant capacity deficit in June 2018 compared to previous months. This is due to the number of neuro-rehabilitation patients discharged in June, influencing average length of stay (21 patients compared to 5 patients in each of May and June 2018).

6.5 Surgery has seen an increase in both elective and non-elective activity in May and June 2018 compared to April (11% increase in surgical elective activity in May and June compared to April) leading to an overall bed deficit in May and June compared to the model which forecasted a balanced position. The revised model (Fig 5) requires further detailed review and validation by services.

6.6 The model including Q1 actuals is being shared with Directorates and will be updated ahead of a final iteration, to adjust the forecast taking into account the actuals for Q1 and any other changes anticipated by specialties for the remainder of the year. This should include any length of stay improvements in line with best practice and benchmarking, activity and elective care recovery plans and expected benefits from the Urgency and Admitted Patient Care Programme supported by the Transformation team.

6.7 For paediatrics, the model is being worked through by the Information and Directorate team. The model is currently showing paediatrics as having a significant surplus of beds which is not recognised by the service or operationally to be accurate and requires further validation.

7.0 Actions Required to Deliver Performance Trajectory across Quarters 2 to 4

7.1 The key initiatives and additional actions being taken to drive improvements in performance across Q2-4 in line with the trajectory are summarised in the table below.

Month	Initiative/action	Impact	Estimated daily breach reduction
July 2018	Extension of ambulatory care opening hours Transfer of DVT pathway from ED to AAA 7.75% patients streamed to primary care across Q2 Launch exemplar patient pilot across surgery and neurosciences Fully embed use of electronic PDD (predicted date of discharge)	Avoidance of additional 2 admissions per day to AMU Reduce UCC patients by approx. 6 per day Non-admitted performance of 98%. Minimum 8 discharges before 10am	-5 (admitted) -9 (non-admitted)
August 2018	Launch exemplar patient pilot across medicine and senior health wards Agree implementation date for red to green rollout	Minimum 7 discharges before 10am (15 total including surgery and neurosciences)	-5 (admitted) -9 (non-admitted)
September 2018	Implement minimum standards for enabling patient flow Launch SAFER patient flow bundle 30% of wards to be live by end Q2 Launch Older Person's Advice and Liaison (OPAL) pilot in ED	Bed occupancy maintained at 92.5% Admitted pathway performance minimum 80% Increase proportion of pre-12pm discharges by minimum 5% (22% currently)	-5 (admitted) -9 (non-admitted)
October 2018	Implementation of new discharge model of care Hold system-wide MADE event 8% patients streamed to primary care across Q3	Bed occupancy maintained at 92.5% Admitted pathway performance minimum 80% Non-admitted performance of 98%.	
November 2018 December 2018	Opening of additional bed capacity winter ward (23 beds) 60% of wards to be live with SAFER by end Q3	Maintain bed occupancy at 92.5% Admitted pathway performance minimum 80%	
January – March	90% of wards to be live	Maintain bed occupancy	

2019	with SAFER by end Q4 8.25% patients streamed to primary care across Q4	at 92.5% Admitted pathway performance minimum 80% Non-admitted performance of 98%.	

7.2 In order to recover admitted pathway performance to a minimum of 80% across the remaining months of the year, overall bed occupancy would be required to be no higher than 92.5% consistently. The Inpatient Processes and Discharge Processes work streams of the Unplanned and Admitted Patient Care Programme including the initiatives outlined above will need significant focus and engagement with the Divisions, clinical and multi-disciplinary teams in order to deliver this. The introduction of an electronic bed management process with some urgency is required in order to ensure that flow is optimised across the organisation.

7.3 As part of Inpatient Processes work stream 4, the roll out of the SAFER patient flow bundle and implementation of 'red to green' is a key priority. This recognised best practice has not yet been implemented across the Trust. An implementation plan is being developed, with the expectation that 30% of wards will be working in line with this best practice by the end of September 2018.

7.4 The Discharge Processes work stream is focused on a rapid review of the discharge model of care, Trust-wide and the implementation of a new discharge model by the end of September 2018, based on best practice and engagement with the clinical teams and system partners. This includes aligning clinical capacity to pathway demand and the introduction of an Integrated Discharge Team. This work is being supported by the Deputy Chief Nurse. The Transformation team are liaising with commissioners regarding impact of extensive use of discharge to assess between November 2018 and February 2019 on bed occupancy.

7.5 Services are identifying further opportunities to reduce length of stay across the Trust, including through reducing the proportion of stranded (>7 day LOS) and super stranded (>21 day LOS) patients and numbers of delayed transfers of care and repatriations, in addition identifying the support that will be required from system partners to achieve this, as part of the Trust's winter plan.

7.6 A steering group has been established to oversee the transition of Mary Seacole Ward and Brysson Whyte Unit at Queen Mary's Hospital and St John's Day Hospital from the Community Directorate under the Children's, Women's, Therapeutics, Diagnostics and Community (CWTDC) Division to the Senior Health Care Group under the Acute Medicine Directorate and Medicine and Cardiovascular Division. This move is expected to identify further improvements to reduce length of stay and improve patient pathways, patient experience and continuity of care between St George's and Queen Mary's Hospitals. It is expected that the transfer of services will be complete by the end of September 2018.

7.7 An internal winter planning forum is being established, with clinical representation across the Divisions to agree how the model will inform the internal bed configuration as part of the Trust's winter plan. The first meeting will be held in July 2018. The Trust is also engaging with system partners in planning for winter, supported by the Commissioning Support Unit and with the oversight of the Emergency Care Delivery Board. The Trust is identifying where there are opportunities to reduce the number of acute beds required through the provision of additional resources in the community and social care in winter months, including packages of care and additional beds for patients requiring placement. This is in line with the Trust's objective to ensure patients receive the 'right care in the right place at the right time and are supported to progress to the next step of their pathway without unnecessary delay.

7.8 The implementation of extended opening for the adult Ambulatory Assessment Area (AAA) service from 23 July 2018 is expected to further improve flow and avoid unnecessary admissions to the Acute Medical Unit. It is expected that at least 2 further admissions will be avoided each day, contributing to reduced bed occupancy on AMU as a key factor in improving flow and performance.

7.9 From a non-admitted pathway perspective, the transfer of the DVT pathway in conjunction with the extension of AAA opening hours is expected to support further improvements in non-admitted pathway performance with the aspiration to deliver 98% performance consistently. In addition, the ED is developing plans to reduce time to diagnostics through the upskilling of triage nurses. This is acknowledged as contributing to improved flow in other organisations delivering the 95% four hour standard.

7.10 Further focus on streaming is required to continue to deliver the front door CQUIN, requiring 7.75% of patients to be streamed to GPs in Q2 and ensuring that the ED workforce is able to focus on supporting patients who require treatment within the ED. Across Q1, the Trust streamed 7.74% of attendances to on and off-site primary care services against a 7.5% target.

7.11 Within the ED, there is continued focus on improving performance against the 60 minute time to treatment metric. Waiting times in assessment, paediatrics and the Urgent Care Centre need to be managed consistently at under an hour with escalation and the deployment of additional resources whenever 90 minutes is breached.

8.0 Recommendations

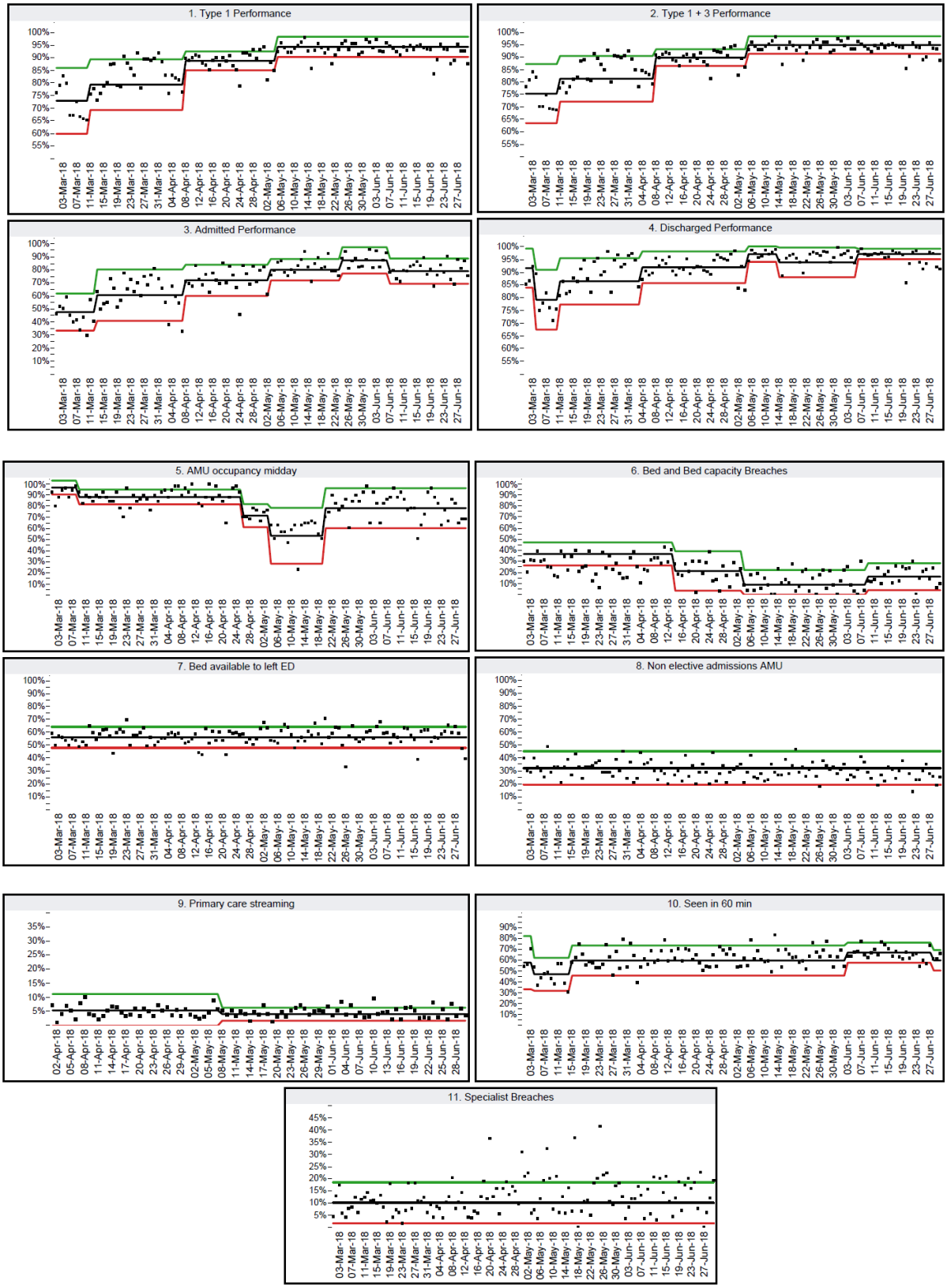
8.1 It is recommended that the Trust Board note the update on progress against the 4 hour Emergency Care Operating Standard, including the position for Q1.

8.2 The Trust Board is asked to note the update on progress with the adult inpatient demand and capacity model. A final version of the inpatient demand and capacity model and forecast will be presented through the Trust Executive Committee and Finance and Improvement Committee and Trust Board in August 2018.

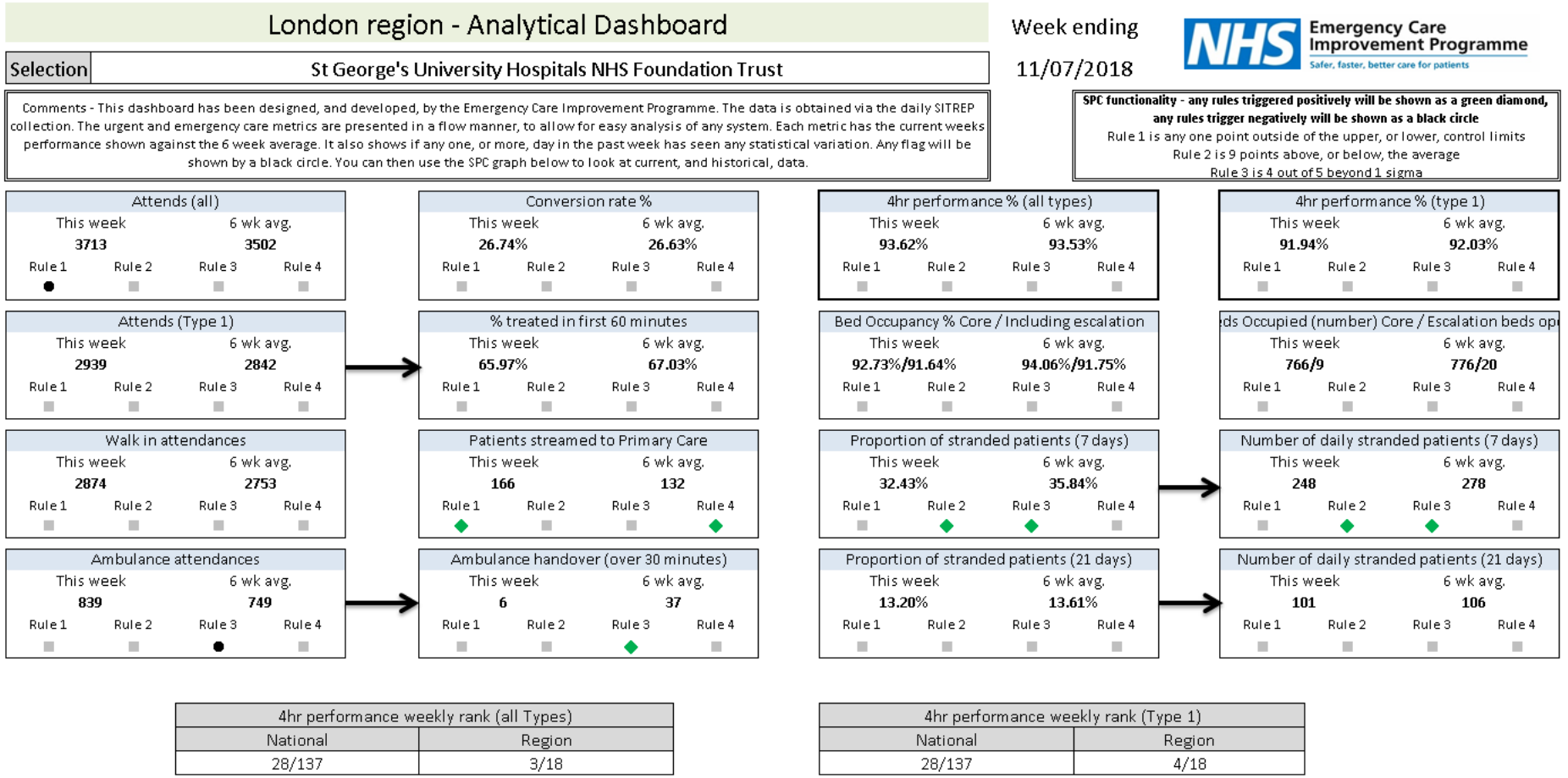
Appendix 1 15 Point Plan Dashboard (SPC format) - June 2018

Four Hour Operating Standard Performance

St George's University Hospitals NHS
NHS Foundation Trust



Appendix 2 Urgent and Emergency Care Dashboard



4hr performance weekly rank (all Types)	
National	Region
28/137	3/18

4hr performance weekly rank (Type 1)	
National	Region
28/137	4/18

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 July 2018	**Agenda No.**	**3.5**
Report Title:	**Transformation Quarter One Report**		
Lead Director/ Manager:	James Friend. Director of Delivery, Efficiency & Transformation		
Report Author:	James Friend. Director of Delivery, Efficiency & Transformation, with the programme team		
Presented for:	Information		
Executive Summary:	This is the first quarterly report setting out to the Trust Board the approach, progress and impact of the Transformation work underway. It is largely taken from monthly reports provided to internal stakeholders throughout the Trust. Overall, progress remains on track with the key change objectives. Interdependencies on IT change capacity and operational management capacity remain the most significant factors setting the pace of deliverable change and improvement.		
Recommendation:	The Trust Board is asked to note the report.		
Supports			
Trust Strategic Objectives:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Themes:	• **Effective*:*** your care, treatment and support achieve good outcomes, help you to maintain quality of life and are based on the best available evidence. • **Responsive*:*** services are organised so that they meet your needs. • **Well-led*:*** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	• Strategic Change		
Implications			
Risk:	No additional risks are identified in this report		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Through circulation to Trust Executive Committee members monthly	**Date:**	Monthly throughout Q1.
Appendices:	Appendix One – Key Performance Indicators Appendix Two - Key Deliverables for Next Quarter		

1. Transformation Programme 2018-19

1.1. The Trust's programmes of transformation for 2018-19 are embedded alongside operational improvement both for quality and performance and for use of resources. Transformation opportunities have been prioritised for resourcing based on their quality and financial impact and their alignment to the three Principles of Transformation:

- Getting our patients to the most appropriate environment for their Assessment, for their Treatment and for their Care
- Aligning our Clinical Capacity to Pathway Demand
- Making the right thing to do for our patients be the easiest thing to be done by our clinicians

1.2. Operational programmes of work are sponsored by lead clinicians and functional programmes are sponsored by Executive Directors. Each workstream within the programme is governed by an agreed Terms of Reference document that the Steering Group uses to set out their objectives and implementation plan.

1.3. Throughout Quarter One, members of the Transformation Team has also supported operational colleagues by being formally and informally seconded into business as usual roles to create the environments ready for Transformation. This has been particularly the case in Unplanned and Admitted Patient Care.

1.4. The Transformation team has also slimmed down from 2017-18 with around a third fewer members and a further cost saving delivered of £550,000 beyond the £1m saving delivered in the previous year through the migration away from interim staff members. Around a third of the team have direct operational experience at St George's.

1.5. The team focuses on being exemplars of the Trust's improvement methodology and dedicates time each week to learning and reviewing specific parts of the curriculum, with more detailed sessions monthly.

1.6. Each week, the workstreams are held to account for delivery through the review of Weekly Workstream Monitoring Forms that set out the key operational, financial and workforce impacts of initiatives implemented to date and the plans for the delivery of immediately upcoming milestones.

2. Unplanned & Admitted Patient Care ("UAPC")

2.1. A Multi-Agency Discharge Event (MADE) was held at the main St George's Tooting site in May and saw 36% of patients with a length of stay of over 7 days at the time of the event discharged within the next three days, compared to our background performance of 21%. That represented around an additional 50 beds available for timely admission.

2.2. MADE was then held for QMH in June, focused on the Rehabilitation pathways. The plan for these events over the next 18 months has been confirmed.

2.3. Through the SAFER initiative, there has been a gradual sustained increase month on month in patients transferred from assessment areas into the specialist inpatient wards (2% increase from May to June) and patients discharged pre 11am and pre 1pm (1% increase from May to June). In May 49.1% of radiology diagnostic tests were ordered before Noon in May, up from 47.8% in April. Minimum Standards have been drafted and sent to the UAPC Steering Group for approval.

2.4. The Inpatient Demand & Capacity model has been shared with the CCGs as part of the Transformation CQUIN and support for the Wandsworth and Merton Urgent and Emergency Care Delivery Board.

2.5. Partnership working has started with South West London St George's Mental Health Trust to both improve the identification of patients with mental health concerns and to reduce the number of Four Hour Operating Standard Breaches for these patients. Performance was 59% in May and June, up from 49% in April.

2.6. The Acute Ambulatory Assessment ("AAA") programme has now successfully delivered its objectives of developing a new expanded AAA service and a Paediatric ambulatory care service called Blue Sky Centre. These went live in March 2018 and the programme manager has completed the handover and integration to business as usual. The focus for Ambulatory Care now will be on the continuation of the development of the Cerner solution and scoping of all AAA information reporting needs.

2.7. Although the AAA model has been stabilised, only one in seven AMU beds have been empty at Midday on average in Q1. This is however a significant improvement from the 1 in 19 seen in Q4 2017-18. Opportunity exists to ensure consistent early morning discharge from / admission to the downstream wards and the Bed-days Opportunity analysis tracker has been created.

2.8. At the front door, direct booking of patients into GP slots has gone live for Merton practices, with Wandsworth to follow shortly. The estates work has continued and a staff survey to identify the next processes for continuous improvement has been undertaken. Throughout the quarter there were preparations for the launch of ED Paperlight at the end of July, and work completed on confirming the ED Front Door streaming models in use, with a map created to ensure clarity for commissioners and the trust as a whole.

2.9. The monthly Four Hour Operating Standard trajectory was achieved for April and May and the Quarterly performance achieved the level required for the STF Funding

3. Planned Care

3.1. The electronic Referral Service ("eRS") care group reviews were successfully completed for all services in June across all of the proposed exclusions and Referral Assessment Service ("RAS") clinics which were mutually agreed with the GPs and CCGs. This process reduced the number of RAS clinics ensuring that the vast majority of appointments are directly bookable for GPs where clinically appropriate.

3.2. Through working hand in hand with the operational team, considerable progress was made in May and June with eRS and the paper switch-off went live at the start of July.

3.3. One-way text reminders for outpatient appointments are now in place and since going live on 4 May we have sent 148,246 reminders to patients. This is having a positive effect on the Did Not Attend rate which is now around 10%.

3.4. A number of technical issues have now been resolved with the Self Check in Booths available within a cohort of outpatient clinic areas increasing the utilisation from 10% to 16% by June.

3.5. The standards around establishing Virtual Consultation Clinics and a new tariff have all been agreed both internally and externally and shared across the Divisions. The Paediatric service have been proactive on establishing their Virtual service converting a face to face follow up clinic per month for eight of the Consultant group into Virtual Consultation clinics. This will increase the number of Virtual Consultations undertaken by 80 appointments per month.

3.6. The initial tranche of Virtual clinics has rolled out with 4,278 patients benefitting in Q1 and Gastroenterology Clinical Assessment Service ("CAS") phase one is live as at the end of June.

3.7. The CAS model has enabled 61% of patients to have their investigations ahead of an outpatient appointment and 12% of patients to have their pathway managed completely virtually.

4. Maternity

4.1. The clinical team have completed their assessment and evidence base for the submission to NHS Resolution for the incentive scheme to reduce CNST premium payments. This was submitted at the end of June when the Trust declared compliance with all 10 Standards, with supporting evidence collated. A small number of actions have been identified to sustain performance.

4.2. Work has continued on progress towards launching a Continuity of Carer team in September 2018 with seven midwives confirming their personal commitment. Over the next two months they will have placements and training to refresh their skills across antenatal, intrapartum and postnatal care.

4.3. A long term strategy for digital maternity is evolving, within the wider context of South West London's business case for IT development.

4.4. There has been slower than anticipated progress in moving women's antenatal care from the hospital to the community due to staffing issues and a change of emphasis regarding changed boundaries and the anticipation of the next community team to offer Continuity. The midwifery management team is working with Estates to secure community venues for clinics; and with IT to ensure that connectivity and hardware issues are addressed.

5. Clinical Records

5.1. Sponsored by the Chief Finance Officer, work continues with IT to prioritise the overall work programme for clinical records transformation.

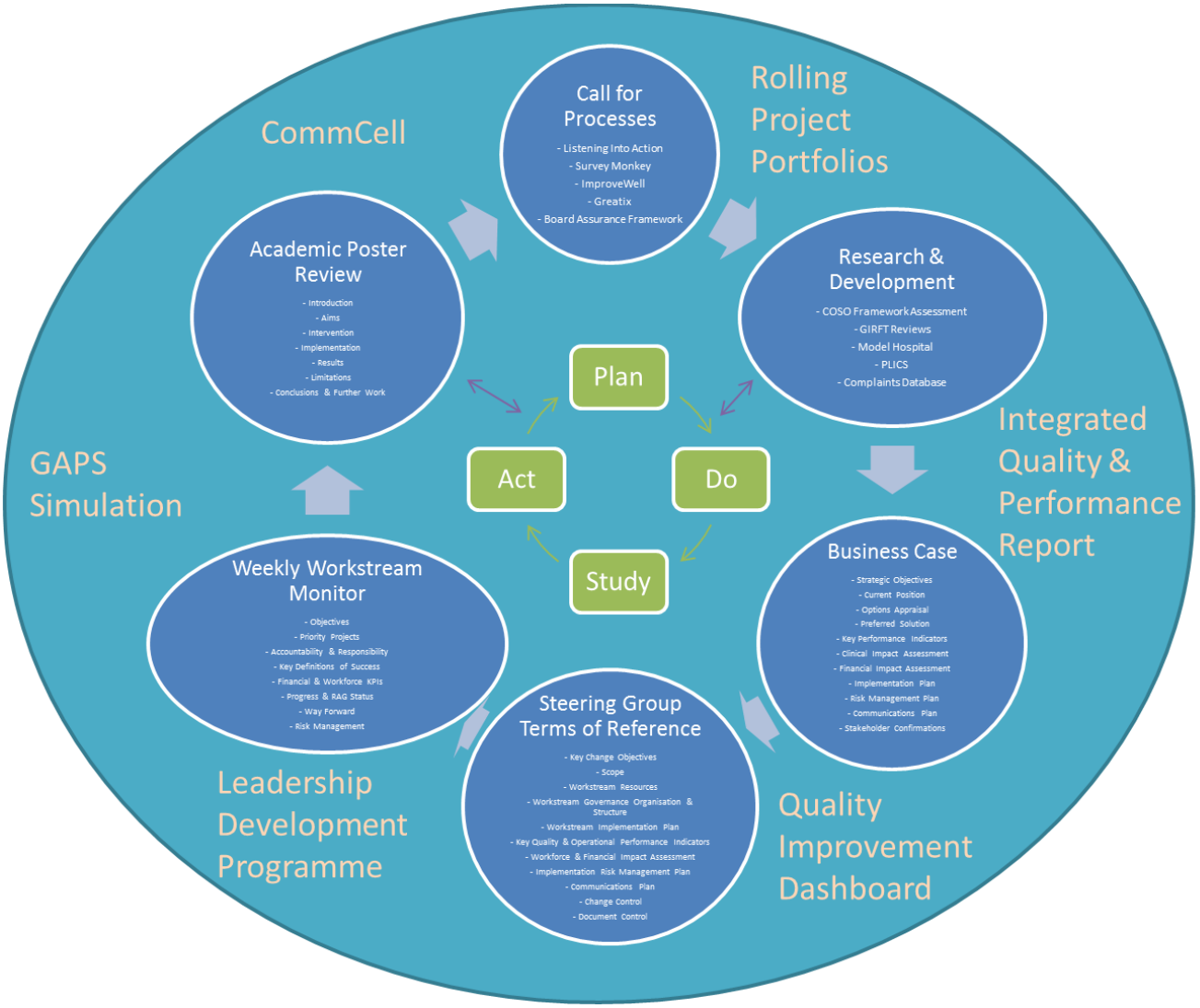
5.2. We have commenced the road map to implement a new shared health records library storage model, which involves all QMH Health Records currently at Trident being relocated to Iron Mountain.

5.3. The integrated health records library model will support the vision to deliver a high quality Health Records service across sites, aligning steps for requesting health records and delivering storage savings of approximately £32,000 through lower usage.

5.4. A records management workshop was held at QMH to focus on getting agreement on the activities to be taken forward and Health Records requesting workflow changes required to enable the change to happen this financial year.

6. Quality Improvement Academy

6.1. The Trust has developed an Improvement Methodology which is being used by a number of operational and transformation team to improve quality, performance and use of resources. It centres on the Institute for Health Improvement ("IHI") approach of 'Plan Do Study Act' cycles set within a range of locally appropriate tools:



6.2. In partnership with the IHI, a patient safety improvement week was held in May bringing together colleagues from across the trust to identify and work on a series of PDSA improvement projects. This initial cohort of ten project teams is being supported by the Improvement Methodology Director and each has two executive sponsors to enable them to overcome any challenges that may arise.

6.3. The key points of learning so far, which align to feedback from other Trusts, are that specific time needs to be set aside for the project team members and that the teams need to be clear that their objective is not already being pursued by a separate group.

6.4. The Quality Academy will maintain a trustwide portfolio of improvement projects underway so that learning can be shared and overall progress and themes identified. Post Implementation Review posters will be displayed across the trust to build momentum for and awareness of improvement.

7. Model Hospital & Get It Right First Time

7.1. During the quarter a significant proportion of leadership time has been directed at Operational Productivity, centred on a review meeting with NHS Improvement. A number of initiatives followed the meeting including:

- The opportunity to prepare to bid for capital to support the completion of ePrescribing Rollout. This is being taken forward in partnership between IT and Pharmacy.
- A review of imaging reporting medical productivity.
- Surgical Length of Stay and Day Case migration
- Obstetrics & Gynaecology – looking both at the surplus or deficit for individual obstetric procedures as well as cross charging other providers when Mum's to be switch hospital. Some of the aspects have now been implemented directly improving the Trust's overall run rate in Month 3.

7.2. The internally refreshed GIRFT Opportunity Dashboard is now available and will be maintained on a rolling four quarters basis at HRG level. If all Bed Day savings were achieved, it indicates that a further six beds might be released for additional capacity. It should be noted that a third of these relate to Orthopaedics where the SWLEOC impact may reduce the overall opportunity.

7.3. The focus at Care Group level centres on a number of quality improvement opportunities and, through the Quality Improvement Academy, the teams will be supported to apply PDSA style improvements.

7.4. Updated Model Hospital trust level target savings figures have been produced by NHS Improvement for Pharmacy and Medicines Management which across the Top Ten Drugs indicates an additional opportunity of £460k for this year with further switches. This is being taken forward by the Pharmacy team.

8. Recommendation

8.1. The Trust Board is asked to note the report.

Author: James Friend, Director of Delivery, Efficiency and Transformation

Date: 17 July 2018

Appendix One – Key Performance Indicators

No	Metric	Baseline	Baseline time period	Target	Actual		
					April	May	June
1	Proportion of Outpatient Attendances that are Non-Face to Face	<2% overall	FY 2017/18	By year end: 1st Attendances – 20% Follow-up Attendances – 50%	1st 0.4% FU 4.1% Total 2.8%	1st 0.6% FU 4.8% Total 3.3%	1st 0.4 % FU 4.2% Total 2.8%
2	Outpatient Did Not Attend Rate	10.6%	FY 2017/18	8.0%	12.7%	12.0%	10.0%
3	Admitted Pathway Four Hour Operating	64.3%	FY 2017/18	April – 69.0% May – 76.7% June & July – 87.1%	67.7%	82.2%	81.5%
4	SAFER – Downstream Ward Admissions before Noon	28.9%	FY 2017/18	30% (23.9% of Patients Admitted through ED Attend between 6am and 11am; 31.2% between 6am and Noon)	25.4%	25.8%	25.0%

Appendix Two - Key Deliverables for Next Quarter

PROGRAMME	DELIVERABLE	MONTH
Unplanned & Admitted Patient Care	Complete Care Navigator Room upgrade in ED	July
	Complete Post Implementation Reviews for AAA and Blue Sky capital investments and pathway changes delivered in March 2018	July
	Introduce and pilot the "Golden Patient" initiative to the surgical and medical wards	July
	Set up system learning case review for x3 complex patients with 100+ day length of stay	July
	Introduce criteria led discharge pathways in selective surgical wards	September
	Senior Review - Ensure all patients will have a senior review before midday by a clinician able to make management and discharge decisions	September
	Finish Service Specification for converting QMH Minor Injuries Unit to an Urgent Treatment Centre	September
	Launch of ED Paperlight	September
Planned Care	Rollout Virtual Consultations	Ongoing
	Launch Netcall Text Reminders for Pre-Operative Assessment and Day Surgery Unit	July
	Launch Netcall reminders for MRI and ultrasound appointments	July
	Electronic Advice & Guidance – go live with ENT and Rheumatology	July
	Launch Netcall two way text reminders for majority of appointment types	August
	Launch Netcall voice reminders for the majority of appointment types	August
	Launch Phase 1 Virtual Fracture Clinic	August
	Launch Netcall clinic cancellation module to communicate more effectively with our patients	September
	Launch Netcall clinic utilisation module to offer patients short notice appointment slots	September
	Launch Phase 2 Clinical Assessment Service model in Gastroenterology	September
Maternity	Feedback from NHS Resolution on CNST Assessment	August
	First Continuity of Care Team to be established	September
	Transfer for first cohort of women from Ivory to community teams	September
Clinical Records	Clinical paper - waste reduction project plan	July
	Complete scope for changing grade and volume of paper ordered	July
	Admin review financial opportunity scoping (clinical staff) completed	July
	Complete printing options discussion with Suppliers	July
	New Doctors Induction training – clinical records awareness	August
Model Hospital & Get It Right First Time	NHS Improvement Review meeting with Obstetrics & Gynaecology	July
	Quality Improvement Academy supported reporting back on GIRFT initiatives to Trust Board	August
Quality Improvement Academy	Deliver further IHI improvement workshops	September
	Attend Patient Safety Executive Development Programme	September
	Train and coach current QI project teams to use QI Life	September
	Work with senior leaders to prioritise Kings Fund projects which will benefit from QIA support	September

Meeting Title:	Trust Board		
Date:	26th July 2018	**Agenda No**	3.6
Report Title:	Annual Mental Capacity Act and Deprivation of Liberty Safeguards Report		
Lead Director/ Manager:	Avey Bhatia – Chief Nurse and Director of Infection Prevention and Control Robert Bleasdale – Deputy Chief Nurse		
Report Author:	James Godber, MCA and DoLs practitioner David Flood, Named Nurse for Safeguarding Adults,		
Presented for:	Assurance and Discussion		
Executive Summary:	The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect people who may not be able to make their own decisions, and support those who are to be the primary decision maker about their own treatment and care. It makes it clear who can take decisions on behalf of others, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. The report provides details of the key developments within the organisation following the CQC inspection in 2016 which highlighted areas of concern regarding knowledge and application of the MCA. It provides a detailed account of the improvements made within the 3 areas of : • Training; Audit; Resource Development and Awareness Raising The report also provides detail of the number of referrals received to the MCA and DoLs practitioner since July 2017. There has been an increase in number with the number of referrals in the first month of the current financial year being more than double the mean monthly referral rate seen over the previous two years. The MCA and DoLs activity, training progress and Quality Improvement plan is monitored through the Adult Safeguarding Steering Group and the Quality Delivery Meeting. The MCA and DoLs practitioner has completed a training needs analysis (TNA) for all staff groups and mapped this to a recognised syllabus for MCA. Working with an external provider level 1 e-learning has been launched in April 2018 with 58% of staff currently completing this. The level 2 module will be launched on the e-learning platform in September 2018 and includes filmed clinical scenarios, with level 3 face to face training planned to launch at the end of the year. In addition to the improved education and training package a programme of clinical audit has been initiated, consisting of notes/case reviews and staff knowledge through back to the floor and ward accreditation. It is recognised that whilst a significant amount of work has been completed the change required will take time to embed in practice and is evolving as more staff become confident in the principles of MCA and DoLs.		
Recommendation:	That the board discuss the report, and provide any feedback, challenge or scrutiny regarding MCA and DoLs at the Trust.		
Supports			
Trust Strategic Objective:	- Treat the patient – treat the person - Right care, right place, right time		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:			

Implications			
Risk:			
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duty in this area		
Resources:	The Annual Report references the currently available resources.		
Previously Considered by:	Quality and Safety Committee	**Date:**	17th June 2018
Appendices:	Nil		

MCA and DoLS Annual Report 2017-18

1.0 Introduction:

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may not be able to make their own decisions, and support those who are to be the primary decision maker about their own treatment and care. It makes it clear who can take decisions on behalf of others, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

The CQC's findings of poor implementation of the Mental Capacity Act (MCA) at St George's University Hospitals NHS Foundation Trust, in their 2016 assessment highlighted and implied:

- Poor staff knowledge and confidence in relation to the MCA.
- Reduced application of the MCA in relation to the use of restrictions and restraints.
- Reduced availability and effectiveness of training in relation to the MCA.
- Reduced quality assurance, via monitoring and audit, relating to application of the MCA.
- Pockets of good practice did not appear to have been widely shared or disseminated, limiting carry over.

In response to this, the following key actions were initiated:

- A full time substantive employee was recruited to The MCA Practitioner Post commencing October 2018.
- Key aims and objectives were developed to improve practice at St George's in relation to the MCA.
- These aims and objectives formed part of the Trust's Quality Improvement plan under the Dementia, MCA and DoLS workstream.

As the Mental Capacity Act applies to anyone working with patients of 16 years or over, and against a backdrop of nationwide poor implementation, improving practice at St George's was recognised as a broad scope, long term programme of behavioural change requiring support from multiple stakeholders.

The key areas for development targeted were:

- Training
- Audit,
- Awareness raising and resource development.

2.0 Governance and Structure:

The MCA/DoLs practitioner reports to the Lead Nurse for Adult Safeguarding and is a key member of the Safeguarding Team .

Progress against the actions in the Quality Improvement Plan are monitored through the Quality Delivery Meeting chaired by the Medical Director and reported to the Quality and Safety Committee.

In addition MCA/DoLs activity and training is monitored through the Adult Safeguarding steering group which meets every other month, with a dedicated report detailing activity and progress on the Quality Improvement Plan reporting to PSQB annually and every 6 months. The Adult Safeguarding lead for the CCG is an invited member of the Adult Safeguarding Steering group and annual and 6 monthly reports are presented to CQRG.

3.0 MCA and DoLS referrals/contacts

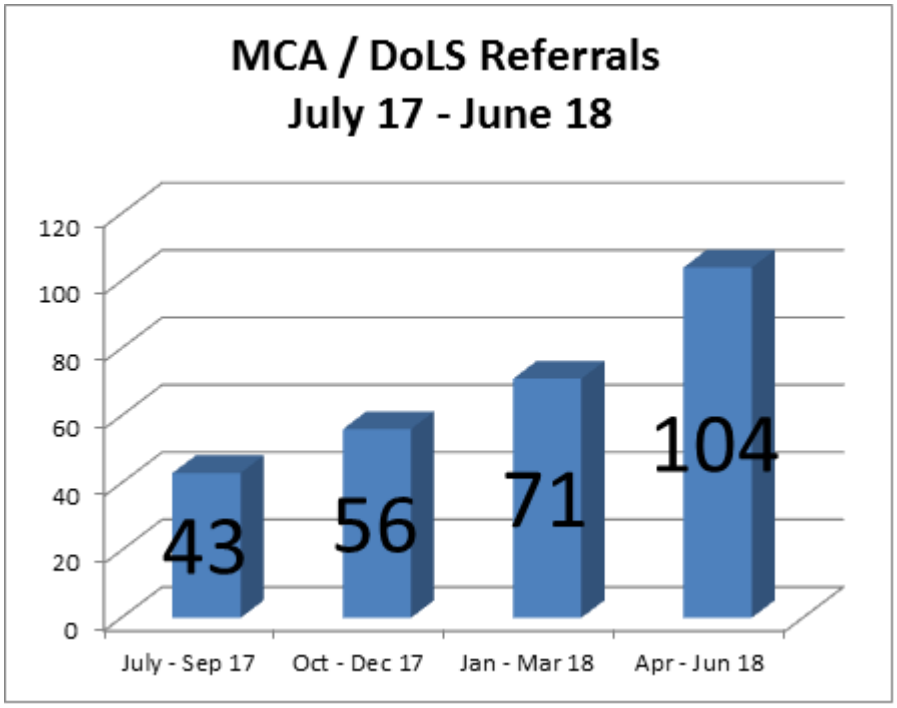
There are clear duties under the Mental Capacity Act (2005) that staff have to all patients. When a patient lacks capacity, decisions made for them, must have regard for the principles laid out in The MCA. Not doing so carries the risk of litigation, loss of reputation and infringement of human rights. In addition, the hospital, as a 'managing authority' has a responsibility to ensure that all those patients who could potentially meet the criteria of deprivation have the appropriate safeguards triggered (Deprivation of Liberty Safeguards) are referred to the 'supervisory authority' (the appropriate local authority) for independent assessments and that any such assessment or authorisation is reported to the Care Quality Commission.

In the past year there have been 232 contacts for advice on MCA and assessment of a DoLS, of these 112 resulted in an urgent DoLs being submitted. These often complex cases can include decisions relating to possible movements from a person's home to a nursing home, potentially lifesaving surgical and medical procedures and cases where restrictions or restraints are being used to deliver treatment.

Referrals/Contacts include:

- Direct and indirect support about the use of the MCA in complex and non-complex cases.

- Direct and indirect support relating to the appropriate use of Deprivation of Liberty safeguards.



Date range	Total Referrals/Contacts	Urgent DoLs submitted by Hospital	Standard DoLs granted
2017-18 Financial year	232	112	23
Last four quarters (July 2017-end June 2018)	274	134	20

Of note, the number of contacts in the first month of the current financial year is more than double the mean monthly contact rate seen over the previous two years. Whilst too early to draw robust conclusions, this may be the result of increased awareness amongst staff about their responsibilities under the MCA and the increased visibility of available support.

Operationally, the MCA Practitioner, with the support of the Safeguarding Lead Nurse, continues to provide day to day support to the wards in respect of MCA / DoLs. Support includes tailored and patient specific guidance on the use of the MCA with complex patients, ensuring we adhere to a risk based approach in regard to DOLS authorisations, and directly supporting capacity assessments and best interest decision making meetings and discussions.

The hospital is required to complete urgent DoLs applications when it is identified that a Deprivation of Liberty may be occurring. As the figures above illustrate though, these applications often results in limited action from local authorities who have been increasingly overwhelmed by the number of applications they are receiving in recent years.

Once the trust has submitted a formal DoLs application the responsibility for the legality of the process rests with the local authority from the point the trust submits the application and the local authority confirm they have received this. Whilst the local authority review the application the trust continues to monitor patients during this time using the principles of the MCA to ensure that any interventions, restrictions are least restrictive and in the best interests of the patient.

The support and time spent on non-DoLs cases can vary from brief phone conversation and keeping of a local record, to several hours of direct and indirect with patient, MDT and family members and extensive and detailed MDT notes and tasks can vary from re-assuring clinicians about their approach to using the MCA in practice. Actions may include directly supporting capacity assessment and chairing professionals meetings or best interests meetings, to supporting teams to use the law appropriately when a patient with unclear capacity to consent to admission and discharge is keen to leave against the team's advice.

The time spent supporting DoLs cases can involve liaison with local authorities, the MDT, social services and the Trust's legal team, the completion of legal documentation relating to deprivations of liberty or supporting others to do so, negotiating transfer of information between ward teams and local authorities when communication breaks down and completion of statutory notifications to the CQC about the outcome of each application.
All cases involve the accurate completion of detailed records providing qualitative and quantitative information about each case opened, reviewed and completed, in order to meet the Trust's statutory obligations under the law.

4.0 MCA Training:

4.1 Face to Face Training:

In response to the findings in the CQC report, targeted specific face to face training was delivered to staff on identified wards and areas of high risk due to the complexity of patients.

Monthly training continues to be offered to nursing staff as part of ward development days, with programmes running across the Emergency Department, Acute Medicine, Senior

Health, Trauma and Orthopaedics, Surgery, Neurosciences, Haematology, Oncology and Renal. There is on-going work with practice educators across the trust to identify, develop and tailor content for setting specific training targeting nurses.

In the medium to long term, it is hoped that where face to face training continues to be indicated, Practice Educators could deliver agreed programmes that are setting specific following train the trainer sessions, but this initiative is resource and priority dependent.

Training of junior doctors has been improved via the inclusion of face to face MCA and DoLS training on the post graduate medical education programme this year which covers F1s, F2s and CMTs levels 1-3. Regular training is provided to doctors in the Emergency Department, typically at the point of inductions. Sessions have also been delivered on request to doctors and the wider MDT in Elderly Care and Neurorehabilitation. A series of 8 open drop in teaching sessions were run during February 2018 supported by trust wide communications.

4.2 Increasing the quality and accessibility of training:

It was recognised that the scope of practice in relation to the MCA differed across professionals and grades, and that the resources for training delivery and the size and scope of the training need were poorly matched. To address these issues a Trust-wide Training Needs Analysis was produced in November 2017. Four levels of competency based training were identified based on a nationally recognised framework. To increase the accessibility of training, E-learning versions of Levels 1 and 2 were proposed. Level 1 e-learning was developed in conjunction with an external provider, SGH users and key stakeholders and launched trust wide in April 2018.

4.3 Headline Training Figures:

No of Trust staff who have completed MCA training since central records began (2016)	**2050**
No of Trust staff identified as needing face to face or computer based MCA training (2018):	**5341 (all levels)**
No of staff currently mapped to Level 1 MCA Training:	**2322 (just need level 1)**
No of current Trust staff who have completed Level 1 MCA Training*	**1354 (58.3%)**

*Trust target is for 85% of appropriate staff to have completed level 1 training by September 2018.

Next steps (planned within the current financial year 2018/19):

- MCA Practitioner to present with panel of speakers to the Grand Round on the MCA in May 2018
- Level 2 e-learning is currently being developed which will include videos of specific clinical scenarios which will be implemented in September 2018.
- Face to face level 3 training for senior staff dealing with complex or escalated issues relating to the MCA is currently tabled for completion in early 2019.

5.0 MCA Audit

Following the 2016 CQC inspection four wards (Dalby, Allingham, Rodney Smith and Gwynne Holford) were identified as having poor areas of practice in relation the MCA. In response to this an audit tool was developed by the MCA/DoLs practitioner based on guidelines, best practice and discussion with national leads on MCA/DoLs. In October 2016 and January 2017 the medical notes from these wards were internally audited to gauge compliance with the MCA, with interim training delivered in line with the each ward's needs. The January audit suggested that, in three of the four wards, there were some areas of good practice but MCA compliance remained variable overall. In one of the four wards (Gwynne Holford) however, relatively good practice was found, which probably reflected an intensive and multi-disciplinary approach to training, documentation, and the integration of practice relating to the MCA into local systems and processes, all supported at a senior level across the MDT.

The findings from these audits were used to inform changes to training and policy and resource development. The immediate value of further audit was considered to be low given timeframe and extent of resource development required to cause significant elements of behavioural change in relation to use of the MCA . It was clear though, that further and more widespread interrogation of practice in relation to the MCA was required, and a target was set to begin this process during the 2017-18 financial year, initially taking a deep dive approach to specific patient notes to see how the MCA was applied when navigating serious or complex decisions and, more recently, piloting tools designed to test staff knowledge in relation to The MCA and DoLs.

In January 2018, a programme of monthly audits was commenced. Having revised the audit tool to better capture key elements of the MCA, staff across disciplines have been invited to participate in the audits to ensure the audit process not only provides a barometer of practice, but also education and information to team members who might then take a lead in

supporting others to deliver best practice in relation to the MCA. These deep dive audits have so far been completed on Wolfson on Thomas Young, The Acute Stroke Unit, Rodney Smith, Heberden and Gwynne Holford wards.

With no nationally recognised audit tool available, the audits since January 2018 have represented a pilot phase to inform the development of an assessment that aims to capture both the presence and quality of a clinical approach that incorporates the MCA. The 35 cases that have been audited so far include serious or complex decisions covering resuscitation status, serious medical treatment decisions and discharge decisions. With the audit tool still developing and the sample size still small at this point, wider trends cannot be reliably extrapolated. However, what is clear from the data and discussion with the teams involved is that:

- There are areas of very good practice in relation to the MCA, with some individual cases showing: Support from appropriate professionals like SLT and Psychology during decision making; Repeated attempts to provide information and answer questions well in advance of decisions; Well documented capacity assessments and Best Interests Decision making undertaken in a comprehensive, well rationalised and consultative way.
- The above good practice is not yet consistent, and that, in particular attempted or successful supportive consultation **with patients,** in relation to the decisions they face is not evident in many cases.
- Discussions that might represent support and consultation as required under key parts of the MCA were not always documented or the detail provided in any documentation was limited.
- There was limited evidence that patient's wishes, values and beliefs were considered when reaching Best Interests Decisions.

An audit of staff knowledge relating to the MCA was developed and piloted in February 2018 via the 'back to the floor' network. The majority of staff assessed were able to provide partially or completely correct answers to theory and scenario based questions relating to the MCA but the small number of questions and the increased error rates evident in scenario based questions suggest further support is required. These staff knowledge questions have also been incorporated into the ward accreditation system.

Next steps (planned within the current financial year 2018/19):

- Monthly Deep Dive Audits have been scheduled across The Trust up until the end of the 2018-19 financial year with a full audit report planned for April 2019
- Joint work with the Corporate Nursing Quality Team is underway to analyse and interpret questions from the observatory audit (completed monthly) that relate to the use of restrictions and restraint.
- Further staff knowledge audits are planned via 'back to the floor' on a rolling bases through the year.

6.0 MCA Awareness Raising and Resource Development

In addition to the awareness raising and education provided through face to face training sessions and the direct support provided for MCA and DoLS cases throughout the last year, a targeted campaign took place with the support of the communications team and other stakeholders in late 2017 and early 2018 with the aim of improving general awareness of the MCA; engaging staff at all levels with their roles and responsibilities in relation to The Act and highlighting new and existing resources and information to guide practice and provide support. Highlights include:

- November / December 2017: The presence of a manned MCA desk with posters, supporting literature for staff, and the delivery of a 'flash' presentation to matrons and other MDT staff at the Trust Quality Improvement week November /December 2017
- January 2018: The launch of a Trust Intranet site dedicated to the Mental Capacity Act and Deprivation of liberty safeguards: to support staff to understand and apply The Act. http://stg1wordpress01/wordpress/mcadols/
- January 2018: Trust-wide dissemination of posters highlighting key points relating to the Mental Capacity Act and signposting where further support available (e.g. the intranet site and key contacts). Presence of these posters on relevant wards audited via senior nursing's 'back to the floor' network. Six standing banners also produced and positioned at key sites throughout the Trust picked for high footfall and visibility.
- January 2018 – Interview with Mental Capacity Act Practitioners disseminated via eG.
- February 2018: Restrictions and Restraint Policy officially launched. Publicised trust wide by Communications team.
- February 2018: MCA Practitioner attended back to the floor session with senior members of the nursing team to highlight current activities and resources and introduce staff questionnaire in relation to the MCA.

- February 2018: Additional drop-in training sessions advertised via central comms
- The MCA/DoLs practitioner continued to deliver face to face training and completed a TNA for the launch of e learning level 1 in April 2018.

The physical presence of an MCA Practitioner has also improved visibility and greater prioritisation of the MCA and direct support of a wide variety of MDT staff is likely to have improved understanding of how the MCA applies to often complex cases.

Next steps (planned within the current financial year):

- Maintenance and development of the MCA / DoLs intranet Page
- Development and production of Standardised proformas for capacity assessment and best interests decision making. Currently in draft and scheduled to be piloted in quarter 2.
- Begin discussions with senior internal stakeholders about improving the ability of ICLip to capture required elements of MCA practice and allow the transposition of current paper resources into electronic form.
- Commence review of the application of paperwork and practice linked to the restrictions and restraint policy.

7.0 Risks to delivery and service

St George's is one of the UK's largest teaching hospital trusts, employing thousands of frontline staff in a variety of specialties. There is currently a dedicated resource of 1 WTE staff member (Mental Capacity Act Practitioner) to drive and support good practice in relation to the MCA across all Trust sites and specialties.

With the foundations laid for better coverage or training, audit and resources to support application of the MCA, it is likely that awareness of what 'good practice' looks like, and what it requires, will continue to improve.

Direct support in complex cases is an essential part of practice development because it contextualises learning and applied use of the MCA. However, as demand grows there is a risk that the ability to meet operational demands will be compromised.

The proposed legislation changes to the Deprivation of Liberty Safeguards and their potential evolution into the Liberty Protection Safeguards also add risk - of statutory non-compliance and an infringement of our patient's human rights if additional resource to adapt the strategic essentials of training, audit and resource development and standardisation to reflect the changes is not put in place. With an expected increase in the responsibilities of

hospitals to internally and objectively monitor and 'police' the new safeguards the operational demands are also likely to increase.

Without adequate resource, the momentum that is gradually building in relation to appropriate use of the MCA in practice could be adversely affected. This picture is likely to be compounded if the development, maintenance and review of education, assurance and trust-wide guidance on adopting systems and processes to capture use of the MCA is not adequately resourced.

In addition to the challenging scale of the task of delivering behavioural change, the size of the existing resource limits the pace of change delivery. Our patient's being at the centre of their care is one of the lynchpins of St George's Quality Improvement Plan, and the use of the MCA, as an enabling and equalising piece of legislation, is rightly being closely scrutinised by external assessors such as the CQC. Having been clearly criticised for poor performance in relation to the MCA, a protracted period without concrete evidence of improving practice risks further damage to organisational reputation, and the associated risks that accompany it.

In light of the above factors, the Trust has requested additional monies from NHS Improvement to increase the number of staff tasked with improving and embedding good practice in relation to the MCA. An increased resource will help mitigate some of the risks detailed. In addition following the implementation of level 2 and 3 MCA training the Practice Educators will be given an enhanced level of training to continue to act as a resource and support operational aspects of the MCA role. Only by recognising the need for change, and proactively working to change existing cultural practice will these risks be effectively tackled.

8.0 Conclusion

The CQC inspection in 2016 revealed variable knowledge and application of the Mental Capacity Act across the Trust. The employment of an MCA Practitioner at this time provided a resource to explore this issue in more detail and begin to address the issues raised.

Initial efforts focused on training and audit in high risk areas and offering open to all drop in sessions; and MCA policy development to provide an overview of local expectations and provisional guidance on applying The Act.

Simultaneously, operational support on a case by case basis was on-going. These efforts provided a growing amount of information and data about The MCA, which, in conjunction with networking with internal and external experts and stakeholders, allowed the development of a longer term action plan aimed at delivering embedded use of the MCA

across the Trust. This workstream forms a key part of St George's Quality Improvement Plan.

Recent milestones related to this plan have included:

- The development and launch of a Restrictions and Restraint Policy.
- The lunch of a Trust Intranet page providing advice and guidance on the MCA.
- Producing a training framework based on nationally recognised guidance.
- Securing funding for the development of Two MCA e-learning modules.
- Designing and refining audit tools, including the initiation of a programme of monthly deep dive audits, covering medical notes, staff knowledge and the use of restrictions to monitor practice provide education and inform future training and development needs.

Ward based practice and training sessions have provided anecdotal evidence of increased awareness of the MCA, but the process of measuring and reporting on this is still evolving. A pattern of increasing MCA referrals supports this suspected trend.

What is also clear is there is still a substantial amount of work to do to embed the MCA into routine practice in a more consistent way. Future plans include the roll out of a further two levels of MCA training covering more advanced topics and specific clinical scenarios, joint working with external partners to further refine tools to audit use of the MCA, and internal networks to explore key flashpoints such as discharge planning and use of the MCA. In addition, work is underway to further develop resources for staff to use as part of daily practice and ensure these are mapped onto electronic formats as the Trust moves towards paper light practice.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 July 2018	**Agenda No**	**4.1**
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 July 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 – July 2018

1.1 **Matters for the Board's Attention**

1.2 The DE&F updated the Committee on the current issue with the water infrastructure. There were still concerns around the issue. A new Authorised Engineer has been appointed, with a new Action Plan and Water Safety Plan produced. The DE&F noted that given the actions the Trust has taken and the interim arrangements of installing POU filters, the Authorised Engineer has given assurance that the Trust can continue to operate with managed risks to patients and staff, and the Trust has undertaken all achievable actions.

1.3 The COO noted the improvement in the A&E 4 Hour Operating Standard, which met the quarterly target for the Provider Sustainability Fund (PSF) and this had therefore been accrued. Work was now underway to ensure the target for Quarter 2 would be achieved. The CFO noted that 30% of the total PSF was related to ED and so there was a need to monitor the performance against this target on a monthly basis.

1.4 The Committee noted the challenges around CIP delivery, which was £0.6m adverse to plan at M3. The variance is driven by the under delivery of savings and income improvements within the Clinical Divisions.

1.5 The Committee noted the Community Services Detailed Plan, regarding the disinvestment programme. Notices for all ten services had been served. Challenge letters had been received for some of the services, with meetings being scheduled to discuss. The timescales for disinvestment in some services had been extended by mutual agreement to allow the commissioners to undertake a full procurement exercise.

1.6 The Committee noted the MRI Business Case and SWL Digital Bid, which were being put forward by the SWL STP.

1.7 The Committee approved the Reference Cost Assurance Process, which will inform the Trust of its efficiency compared to others.

1.8 The Committee approved the updated Procurement Policy, and noted that this would now be communicated widely so that there should be fewer breaches and waivers going forwards.

1.9 The Committee noted the progress made to date in improving the Trust's procurement processes. It noted a number of procurement initiatives had been undertaken to this end and strongly commended the Procurement team for the notable improvements.

2.0 Recommendation

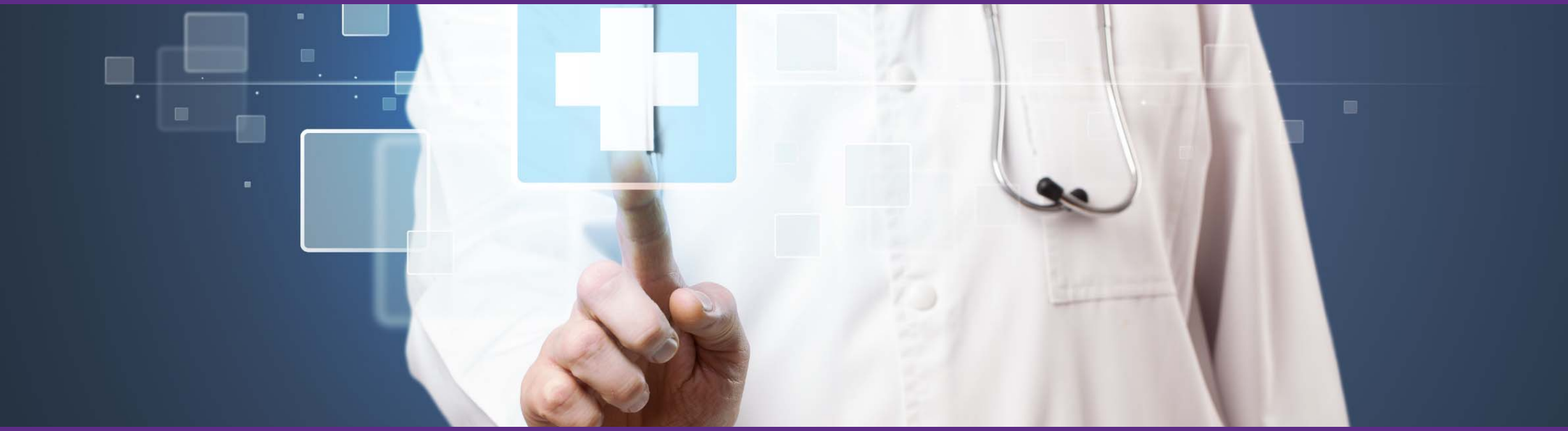
2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 19 July 2018 for information and assurance.

Ann Beasley
Finance and Investment Chair,
19 July 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**26th July 2018**	**Agenda No.**	
Report Title:	**M03 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 £12.5m at the end of Month 03 (June), which is on plan. Within the position, income is adverse to plan, which is offset by expenditure underspend.		
Recommendation:	The Trust Board notes the trust's financial performance in June.		
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:			
Resources:			
Previously Considered by:	The Finance & Investment Committee	**Date:**	19/07/18
Appendices:	None		

FI Jul 18 – Agenda item 4.1



St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 3 (June 2018)

Chief Finance Officer

26th July 2018.

Executive Summary – Month 3 (June)

St George's University Hospitals NHS
NHS Foundation Trust

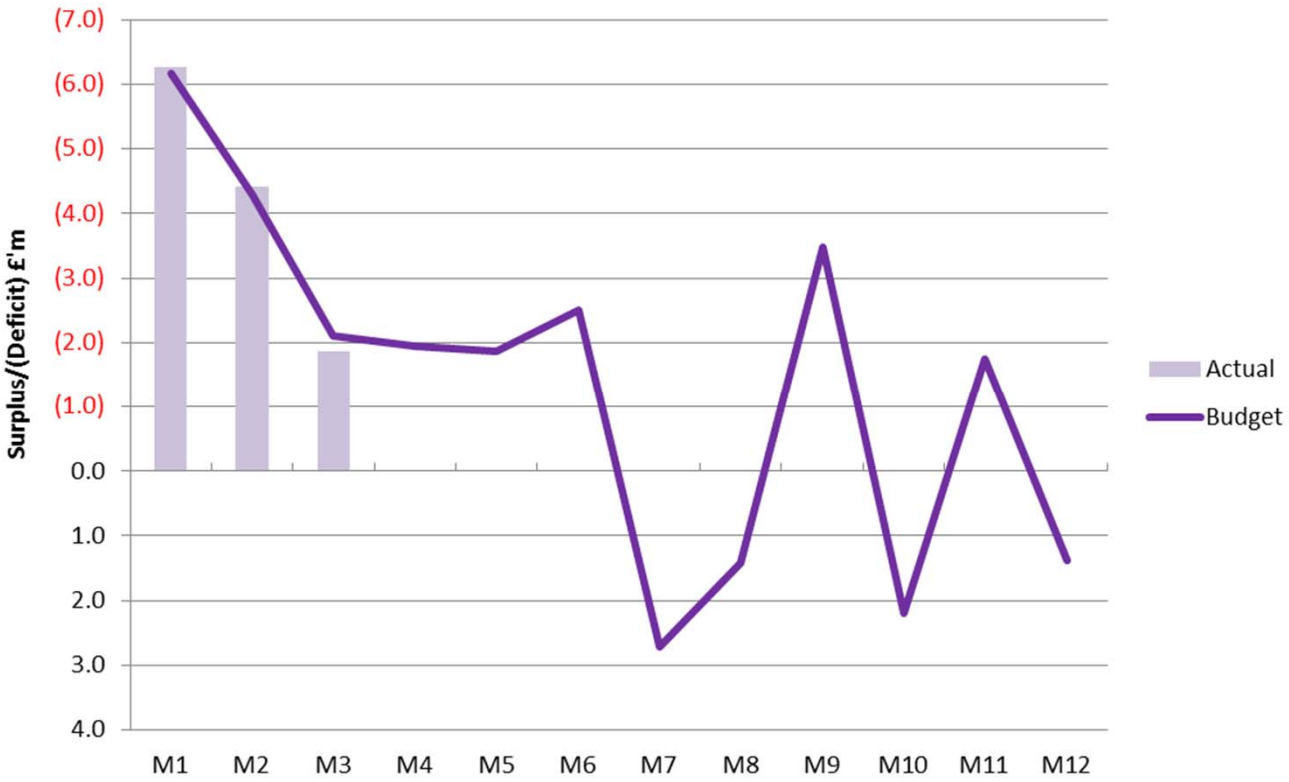
Note: All figures and commentary in this report refer to the revised Trust plan submitted to NHS Improvement on 20th June.

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £12.5m at the end of June, which is on plan. Within the position, income is adverse to plan, which is being offset by expenditure underspend. There remains an element of income estimation in the position which will need to be validated ahead of freeze dates. Returning income to plan remains the key action to ensure the delivery of the overall financial plan.	On plan	£0.2m Adv to plan
Income	Income is reported at £1.5m adverse to plan year to date. Elective is the main area of lower than planned performance; with shortfalls in volume being offset by pricing gains in other areas. Non-SLA income is on plan, with shortfalls in Pharmacy partially offset by underspends in drugs, and SWLP income fully offset by reduced Non Pay cost.	£1.4m Adv to plan	£2.4m Adv to plan
Expenditure	Expenditure is £1.2m favourable to plan year to date in June. The favourable position is in both Pay (£1.1m) and Non Pay (£0.1m). . Flexibilities in reserves have been used to help sustain the position at month 03. This cannot be maintained.	£1.2m Fav to plan	£2.2m Fav to plan
CIP	The Trust planned to deliver £6.7m of CIPs by the end of June. To date, £6.1m of CIPs have been delivered; which is £0.6m behind plan. Income actions of £2.1m and Expenditure reductions of £4.0m have impacted on the position.	£0.6m Adv to plan	On plan
Capital	Capital expenditure of £6.5m has been incurred year to date. This is £1.5m below plan YTD. The position is reported against the revised plan total submitted to NHSI on 29th June of £46m.	£1.5m Fav to plan	£1.1m Fav to plan
Cash	At the end of Month 3, the Trust's cash balance was £3.4m, which is better than plan by £0.4m. The Trust has borrowed £14.2m YTD which is £0.95m less than plan.	£0.4m Fav to plan	£0.5m Fav to plan
Use of Resources (UOR)	The Regulators Financial Risk Rating. At the end of June, the Trust's UOR score was 4 as per plan. This has been rated amber even though it is on plan due to the low level of the score.	Overall score 4	Overall score 4

Contents

1. Month 3 Financial Performance

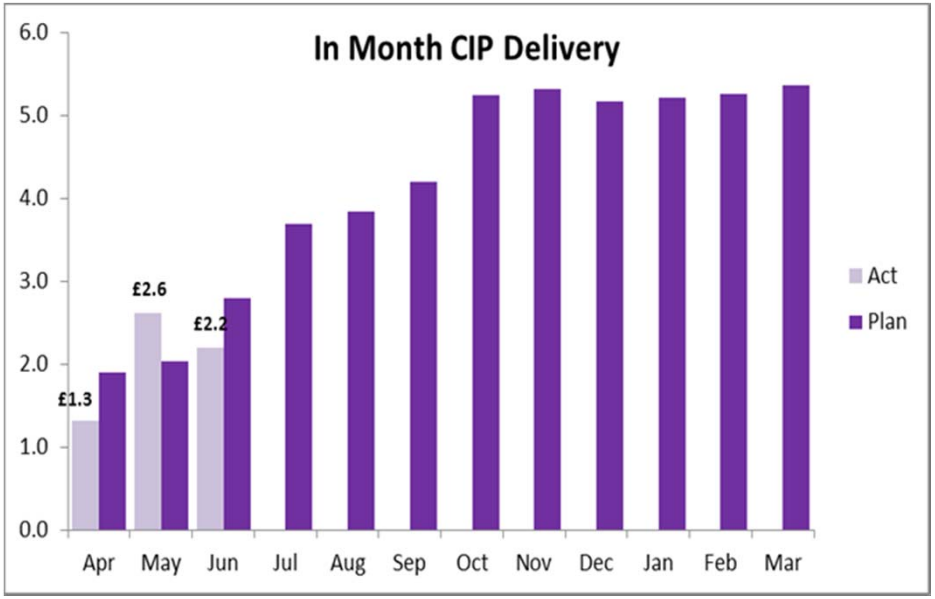
			Full Year Budget (£m)	M3 Budget (£m)	M3 Actual (£m)	M3 Variance (£m)	M3 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF	Income	SLA Income	669.8	54.9	55.5	0.7	1.2%	164.3	162.8	(1.5)	(0.9%)
		Other Income	152.6	18.9	19.2	0.3	1.4%	38.4	38.4	0.0	0.1%
	Income Total		**822.3**	**73.8**	**74.7**	**0.9**	**1.3%**	**202.7**	**201.2**	**(1.5)**	**(0.7%)**
	Expenditure	Pay	(509.7)	(48.9)	(47.9)	1.0	2.1%	(130.1)	(129.0)	1.1	0.8%
		Non Pay	(307.4)	(26.1)	(27.9)	(1.9)	(7.2%)	(78.7)	(78.6)	0.1	0.2%
	Expenditure Total		**(817.1)**	**(75.0)**	**(75.8)**	**(0.8)**	**(1.1%)**	**(208.8)**	**(207.6)**	**1.2**	**0.6%**
	Post Ebitda		(34.2)	(2.8)	(2.7)	0.1	4.9%	(8.4)	(8.1)	0.3	3.4%
Pre-PSF Total			**(29.0)**	**(4.0)**	**(3.8)**	**0.2**	**5.9%**	**(14.5)**	**(14.4)**	**0.0**	**0.2%**
PSF			12.6	1.9	1.9	0.0	0.0 %	1.9	1.9	0.0	0.0 %
Grand Total			**(16.4)**	**(2.1)**	**(1.9)**	**0.2**	**11.2%**	**(12.6)**	**(12.5)**	**0.0**	**0.2%**



Trust Overview

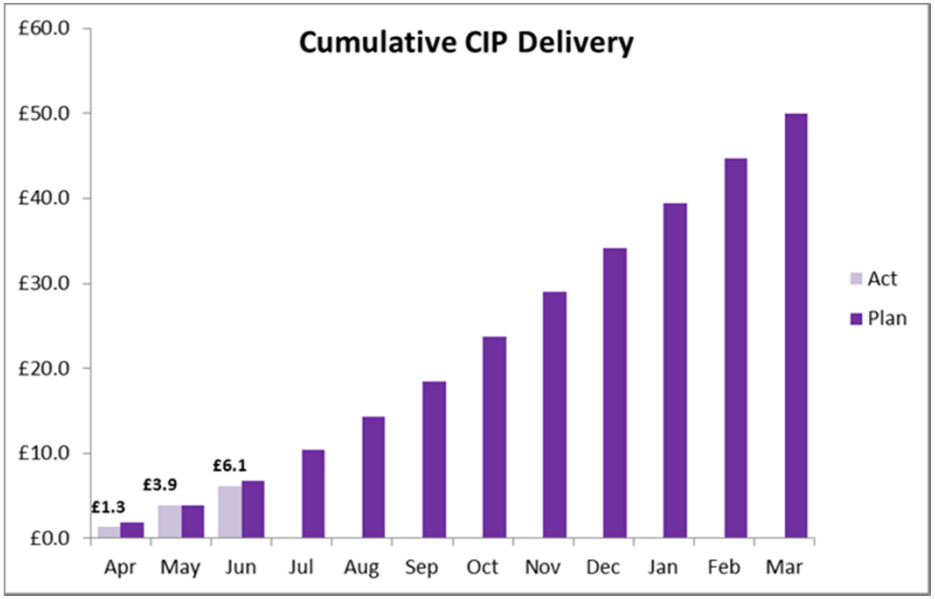
- Overall the Trust is reporting a deficit of £12.5m at the end of Month 3, which is on plan.
- **SLA Income** is £1.5m under plan. The main area of note is Elective where a material adverse volume variance (13%) is partly offset by positive price variance in some specialties.
- **Other income** is on plan.
- **Pay** is under plan by £1.1m. All major staff groups are underspending with the exception of medical pay. It should be noted that within staff groups there are areas of over as well as underspending. Agency has increased by £0.2m owing to increased vacancy cover.
- **Non-pay** is £0.1m underspent, owing to lower Energy, IT and External Facility costs.
- **PSF Income** is on plan, as the Trust has met the pre-PSF control total target and the A&E target for Q1. Financial performance makes up 70% of PSF contribution, A&E the remaining 30%.
- **CIP delivery** of £6.1m is £0.6m behind plan. The Clinical Divisions' shortfalls have been partially offset by Corporate, Estates and Central schemes. Delivery to plan is:
  - Pay £0.2m adverse
  - Non-pay £0.3m adverse
  - Income £0.2m adverse

2. Month 3 CIP Performance



CIP Overview

- At the end of Month 3, the Trust is reporting delivery of £6.1m of savings /additional income through its Cost Improvement Programme.
- This is against an external plan for to have delivered £6.7m of savings/ additional income by Month 3 (overall delivery is adverse of plan by £0.6m).
- The adverse year to date variance is driven by the under delivery of savings/income improvements within the Clinical Divisions, against their CIP plans, for example:
  - Pay: delays in delivering workforce reductions in critical care and CWDT. These are largely expected to be back on track for month 04.
  - Non-pay: Medicine optimisations. Assessment potentially cautious as no overall pressure on drugs budgets.
  - Income. Elective activity lower than plan, and some new activity flows not happening as planned. All under review.



Actions

- Review those green CIP plans, on a scheme by scheme basis, which have under delivered in Q1. This review is to be led by the Director of Financial Improvement and will be undertaken at the weekly CIP meetings on the 19th July. Mitigating actions are to be developed and agreed with the Divisional Directors of Operations.
- Identify a further £5m of CIPs (in addition to the £50m CIP target) to provide a first line of contingency against under delivery of existing green schemes – these are to start delivering financial benefit no later than October 2018 .
- Ensure project plans with milestones and the appropriate non financial KPIs are in place for all schemes where the value exceeds £100k and the schemes are either complex and /or carry a degree of delivery risk.
- Ensure that the performance management of Divisional CIP delivery includes focus on the full year and recurrent impact of CIPs which is required to improve the Trust's underlying position.

3. Balance Sheet as at Month 3

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**352.9**	**379.4**	**377.9**	**1.5**
Stock	6.2	6.2	7.9	-1.7
Debtors	107.2	107.6	107.4	0.2
Cash	3.0	3.0	3.4	-0.4
Creditors	-118.1	-124.1	-123.1	-1.0
Capital creditors	-2.3	-3.6	-7.2	3.6
PDC div creditor	0.0	-0.2	-0.2	0.0
Int payable creditor	-0.8	-2.0	-1.9	-0.1
Provisions< 1 year	-0.3	-0.2	-0.1	-0.1
Borrowings< 1 year	-9.0	-58.3	-57.8	-0.5
Net current assets/-liabilities	**-14.2**	**-71.5**	**-71.5**	**0.0**
Provisions> 1 year	-0.6	-0.8	-1.0	0.2
Borrowings> 1 year	-278.9	-255.7	-254.0	-1.7
Long-term liabilities	**-279.5**	**-256.5**	**-255.0**	**-1.5**
Net assets	**59.2**	**51.5**	**51.4**	**0.0**
Taxpayer's equity				
Public Dividend Capital	130.0	133.2	133.2	0.0
Retained Earnings	-161.1	-180.8	-180.8	0.0
Revaluation Reserve	89.1	97.9	97.9	0.0
Other reserves	1.2	1.2	1.2	0.0
Total taxpayer's equity	**59.2**	**51.4**	**51.4**	**0.0**

M01-M3 YTD Balance Sheet movement

- Fixed assets is £1.5m lower than plan due to lower capital spend from 17/18 funding.
- Stock position has increased £1.7m due to increase in month end Pharmacy stock holdings. This is under review.
- Overall debtors is £0.2m lower than plan. The Trust received £4.1m cash from local CCGs for 17/18 over-performance, however accrued debt has increased to offset this.
- The cash position is £0.4m better than plan due to delay in settlement of capital creditors pending completion of schemes.
- The Trust has borrowed £14.2m YTD for deficit financing which is £0.9m less than plan. The Trust will draw down £3.05m for deficit financing in July and has requested no loan for August. This will be less than the cumulative YTD plan. The deficit financing borrowings are subject to an interest rate of 6% for the amounts drawn up to October 17 and 3.5% for the amounts drawn since November 17. Also borrowings for new finance leases are lower than plan.
- The Trust has not drawn down any capital loans to date.

4. Month 3 YTD Analysis of Cash Movement

	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Cash balance 01.04	**3.5**	**3.5**	**0.0**
Income and expenditure deficit	-12.9	-12.9	-0.0
Depreciation	5.9	5.9	-0.0
Interest payable	2.6	2.5	-0.1
PDC dividend	0.2	0.2	0.0
Other non-cash items	-0.0	-0.0	0.0
Operating deficit	**-4.2**	**-4.3**	**-0.1**
Change in stock	0.2	-1.5	-1.7
Change in debtors	6.6	4.8	-1.8
Change in creditors	3.7	4.6	0.9
Net change in working capital	**10.5**	**7.9**	**-2.6**
Capital spend (excl leases)	-18.5	-14.7	3.8
Interest paid	-1.4	-1.3	0.1
PDC dividend paid	0.0	0.0	0.0
Other	-0.1	-0.0	-0.0
Investing activities	**-20.0**	**-16.1**	**3.9**
Revolving facility - repayment	0.0		0.0
Revolving facility - renewal	0.0		0.0
WCF borrowing - new	15.2	14.2	-1.0
Capital loans	0.0	0.0	0.0
Loan/finance lease repayments	-2.0	-1.9	0.1
Cash balance 30.06.18	**3.0**	**3.4**	**0.4**

M01-M3 YTD cash movement

- The cumulative M3 I&E deficit is £12.9m – Which is on plan. (*this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £12.9m, depreciation (£5.9m) does not impact cash. The charges for interest payable (£2.5m) and PDC dividend (£0.2m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £4.3m.
- The operating deficit variance from plan of £0.1m in cash is due to timing of creditor payments primarily for capital schemes.
- Working capital is below plan by £2.6m due to increases in stocks and lower than planned debt recovery – although it should be noted debts continue to reduce.
- The Trust has borrowed £14.2m YTD which is £1.0m less than plan. The Trust will draw down £3.05m in July and has not requested a drawdown for August. This will be better than the cumulative YTD plan. The borrowings are subject to an interest rate of 6% for the amounts drawn up to October 17 and 3.5% for the amounts drawn since November 17.
- The Trust has not drawn down any capital loans to date.

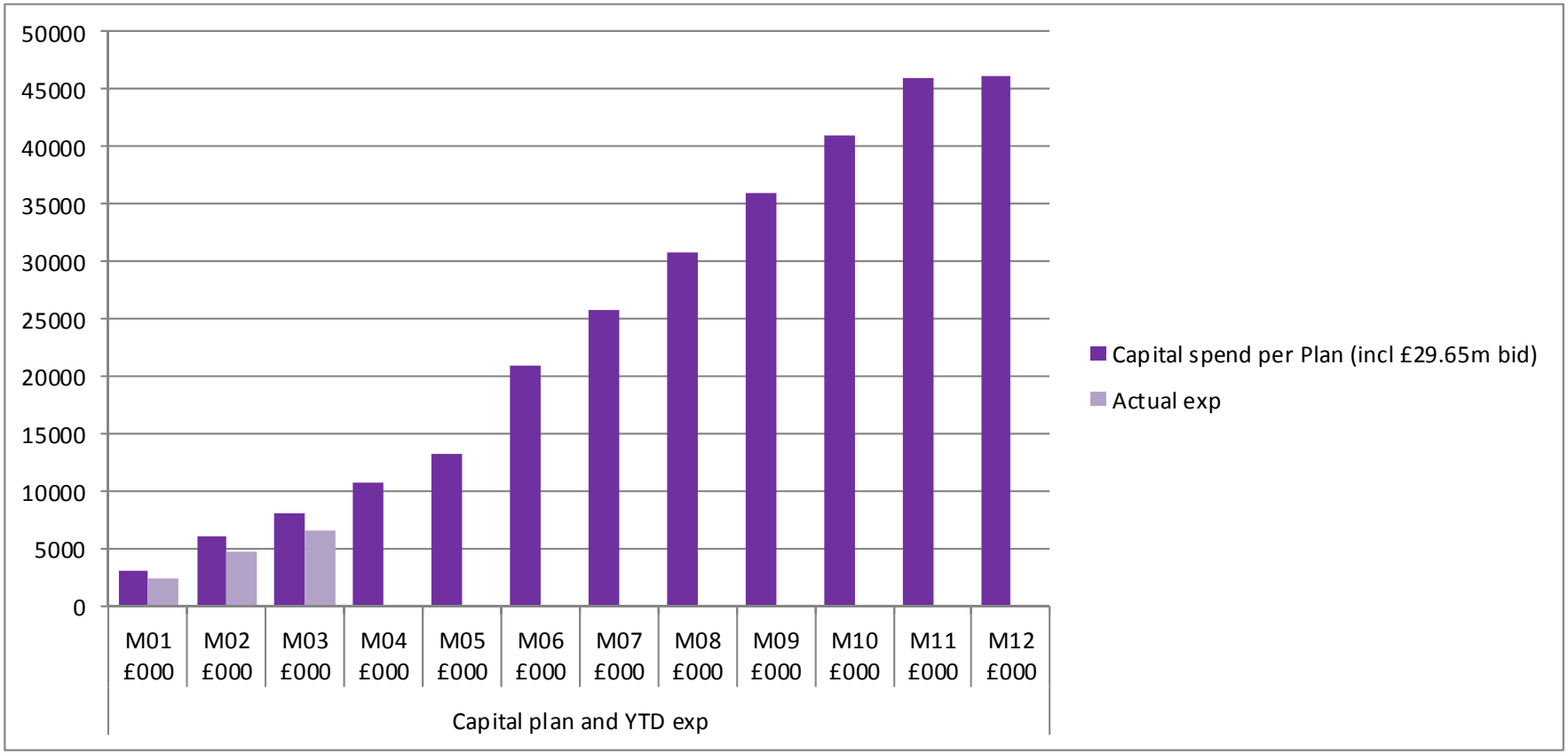
June cash position

- The July borrowing request has been approved and YTD receipts are currently behind plan but payments are also lower due to timing of capital payments. Therefore the Trust met its minimum £3m cash balance on 31 June 2018.

5. Month 3 Capital Programme- phased

- This slide shows total capital expenditure year to date at month 3 of £6.5m against a plan of £8m.
- The position is reported against the revised plan total submitted to NHSI on 29th June of £46m.

Capital plan 2018/19 (incl £29.65m bid - not approved) and YTD exp



6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M3 YTD)	Actual (M3 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[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of June, 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. The internal Trust cap
- The distance from plan score is worked out as the actual % I&E deficit (6.20%) minus planned % I&E deficit (6.10%). This value is -0.10% which generates a score of 2.
- Distance from plan score in this report refers to the Trust plan submitted to NHS Improvement on 20th June.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 July 2018	**Agenda No**	**5.1**
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 12 July 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 – July 2018

Matters for the Board's attention

1. **Audit recommendations:** The Committee considered a report tracking the recommendations of earlier audits. Of 47 open recommendations, 32 were not yet due but 15 recommendations had recently become overdue. The Committee noted the updates provided in relation to these overdue recommendations, and recognised that work was underway in relation to them. However, the Committee also expressed concern at the number of overdue actions had grown. It requested that the Executive set realistic and achievable due dates for each action, and noted that these dates were signed off by the responsible Executive Director. The Committee noted that progress updates would be brought to the Trust Executive Committee to ensure that pace in dealing with audit recommendations was sustained.

2. **2018/19 internal audit plan:** The Committee received a report on the 2018/19 internal audit plan. Six audits had been undertaken in Q1 2018/19 in line with the plan. Of these, two had been completed (consultants appraisal and revalidation; and GDPR compliance), and one was in draft (friends and family test). Fieldwork had been completed on the remaining three audits (outpatients departmental review; theatre productivity; estates and clinical engineering procurement) and exit meetings had been arranged with the executive sponsors. The internal auditors reported that progress was on track and the Committee noted the audits planned for the remainder of the year.

3. **Final audit reports:** Two final internal audits were considered by the Committee. The first concerned the assurance review of consultants (appraisal and revalidation), which had received an overall assurance assessment of 'reasonable assurance'. This was based on the progress demonstrated in implementing the business plan for improving the process for appraisal and revalidation at the Trust. The second concerned GDPR compliance, which had received a 'no assurance' rating. The Committee recognised that this had been anticipated given that the Trust had started its preparations for the introduction of the GDPR at a late stage, and recognised that since the audit had been undertaken the Board had received monthly progress reports, which had included a high level plan for becoming fully compliant over the next 12 months. Responsibility for overseeing GDPR compliance had returned to the CFO so that this work was undertaken in parallel with the Trust's information governance function. The Committee recognised that important progress had been made in recent months, but significant work remained necessary before the Trust would be in a compliant position.

4. **External Audit:** For completeness, the Trust's External Auditor set out its audit progress report for the year ending 31 March 2018 and its annual audit letter for the same period. The Committee noted that a draft had been considered at its previous meeting and by the Board in signing off the Annual report and Accounts in May. The external audit letter would be presented at the Trust's Annual Members' Meeting in September 2018.

5. **Counter fraud:** The Director of Financial Operations presented the Committee with a report on the work undertaken by the Trust's local counter fraud team between 1 April and 2 July 2018. The Committee heard that there had been 18 new contacts in this period. There were currently seven full cases and three information reports under consideration. Sentencing of an individual who had pleaded guilty to a £53,000 fraud was due the day after the Committee meeting. A series of awareness sessions had been held with staff to help them understand and recognise fraud, and further communications were planned. National standards were being met and there were robust deterrents in relation to payroll.

6. **Aged debt:** The Director of Financial Operations reported that £24.2m of debt had been recovered in Q1 2018/19, and that the recovery target for 2018/19 was to achieve a net improvement in the debt position of £17m. Around 15% of old debt had been recovered. Any write-offs would be reported to the Committee as appropriate.

7. **Whistleblowing:** The Director of Corporate Affairs reported on concerned raised under the Trust's whistleblowing policy in the period Q3 and Q4 2017/18 and Q1 2018/19 and presented the Trust's updated policy which had been approved by the Workforce and Education Committee in January 2018. The CQC had randomly selected five whistleblowing cases during its inspection visit in March 2018 and had found that staff were aware of the policy and that the cases had been handled appropriately. Central logging and tracking of whistleblowing cases was a work in progress and steps were being taken to strengthen this further, particularly in relation to the timeframes for investigating concerns. The Committee also emphasised the importance of support being made available to staff who raised concerns. The Committee noted that an internal audit on Freedom to Speak Up was due to begin shortly.

8. **Clinical audit programme:** The Committee considered a paper setting out the clinical audit programme for 2018/19 which had been approved by the Quality and Safety Committee. A number of mandatory audits were in progress and the Committee noted that clear governance processes were in place. The outcomes of clinical audits would be reported to the Quality and Safety Committee, alongside a recommendation tracker.

Recommendation

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

Sarah Wilton
Audit Committee Chair, NED
July 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	26 July 2018	**Agenda No**	**4.2**
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		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		

Executive Summary:

This paper brings to the Board the summary page of the Board Assurance Framework. The summary sheet of the BAF (appendix 1) gives an overview of the risk profile of the Trust and enables the Board to ensure its agenda is directed to improving control of these strategic risks. The BAF has been updated with the quarter 1 assurance rating and statements from the committees of the Board.

Assurance rating

The assurance rating for the following strategic risks has improved at the end of Q1:

SR 16 has improved from limited to partial assurance
SR 17 has improved from limited to partial assurance

There has been no deterioration in any assurance rating. Nine risks have a 'partial' assurance rating; eight risks have a 'limited' assurance rating (see appendix 2 for definitions).

Risk score

In Q1 18/19 five strategic risks have seen a reduction in risk score, two strategic risks have seen the risk score increase.

	Q4 17/18	Q1 18/19	Based on
SR 2	**16**	**15 ↓**	Sustained improvement in 2 week cancer performance standard.
SR 3	**12**	**10 ↓**	Improvement in identification and management of deteriorating patients
SR 7	**15**	**12 ↓**	Balance of risk between forward view and cost structure contributing CRR risks
SR 13	**15**	**20 ↑**	Water safety risk
SR 14	**16**	**20 ↑**	Capital funding for investment requirements not yet confirmed
SR 15	**12**	**9 ↓**	Delivery of actions to improve research links between university and Trust
SR 17	**12**	**10 ↓**	Sustained improvement in engagement with SWL STP

Recommendation:	The Board is asked: 1. For strategic risks reserved to itself (SR 9,16,17) to: • Confirm the risk rating • Agree the proposed assurance rating • Agree the proposed assurance statement (shown in italics) 2. For the 14 risks assigned to its assuring committees to: • Note the risk score, assurance rating and statement from the relevant assuring committee.		
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 Quality and Safety Committee Finance and Investment Committee	**Date**	14 June 17 July 19 July
Equality Impact Assessment:	N/A		
Appendices:	1. Summary Board Assurance Framework (BAF) 2. Assurance ratings - definitions		

Appendix 2 **Assurance ratings - definitions**

Significant assurance	There are robust controls operating effectively to ensure that risks are managed and objectives achieved.
Partial assurance	The controls are generally adequate and operating effectively but some improvements are required to ensure that risks are managed and objectives achieved.
Limited Assurance	The controls are generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and objectives achieved.
No Assurance	There is a fundamental breakdown or absence of controls requiring immediate action.

Appendix 1

Board Assurance Framework to Board July 2018
Q1 2018/19

BOARD ASSURANCE FRAMEWORK OVERVIEW											QUARTER 1
Strategic Objective	Risk appetite	15		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 risk score is unchanged. Workforce remains a significant area of risk for the Trust and the Committee continues to consider that it has insufficent evidence that controls for this risk are effective.	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 risk score has reduced from 16 to 15, it remains an extreme risk. The Committee has received assurance on the progress of the Elective Care Recovery Programme and the work to ensure that improvements in data quality will enable a return to reporting in January 2019. Performance against the emergency care 4hr operating standard has improved significantly. The Committee recognises the improvement but seeks assurance that this can be sustained when the system is under pressure.	Chief Operating Officer	Quality Committee	15↓
	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 risk score has reduced from 12 to 10, it remains a high risk. The Quality Improvement Academy is supporting the development of a consistent improvement methodology for the Trust and is supporting the delivery of the Quality Improvment Plan, however there are key indicators on the QIP dashboard that are not met or are not on trajectory.	Chief Nurse	Quality Committee	10↓
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				The risk score is unchanged. Work continues to develop relationships and pathways.	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 risk score is unchanged. The Committee received assurance that the cost improvement programmes (CIPs) are nearly complete, they are being closely monitored and that the control framework is in place. The Committee continues to be reasonably assured that controls are generally adequate but focus needs to remain on more rapid development of CIPs and ensuring action is taken swiftly to respond to any shortfalls in delivery.	Director of Finance	Finance and Investment Committee	16
	Low	*SR6*	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities	Limited				The risk score is unchanged. Although we are developing a greater understanding of our business there are still significant gaps. Divisions are building their capacity and capability to fully understand efficiency opportunities.	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 risk score has reduced from 15 to 12 it is a high risk. The financial and operational plan for 2018/19 is in place and reporting against Q1 performance is coming to the July Board meeting, the review of performance against objectives may lead to a change in the assurance rating following the Board's review.	Director of Finance	Finance and Investment Committee	12 ↓
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				The risk score is unchanged. The Committee received assurance through reports on the Staff Engagement Plan; the staff friends and family test and the leadership development programme. 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 risk score is unchanged. *Assurance that controls are generally adequate and effective can be taken from the analysis of the annual communications survey which shows improvement agianst two key questions: i)how easy it is to find out what's happening at the Trust and ii) how helpful staff find the communications team; improvement in relevant scores in the staff survey; and the delivery of programmes such as 'flu immunisation, that have a significant comms element.*	(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				The risk score is unchanged. The Committee received assurances through the mandatory training group report and the workforce KPIs. Manadatory training compliance and appraisal rates continue to be below target, this needs to improve for the Committee to be assured that controls are completely effective.	Director of HR and OD	Workforce and Education Committee (WEC)	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 risk score is unchanged. The Committee continues to be assured that the controls are generally adequate through the leadership development report and workforce KPIs.	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 risk score is unchanged. There has been no material improvement or deterioration since the Q4 17/18 report. The level of risk continues to be 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 risk score has increased from 15 to 20 it is an extreme risk. The Authorised Engineer has provided assurance that the steps being taken to strengthen controls over water safety are adequate. Assurance remains limited on the overall control of this risk. The Premises Assurance Matrix is being finalised.	Director of Estates and Facilities	Finance and Investment Committee	20 ↑
	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				The risk rating has increased from 16 to 20 it remains an extreme risk. The Trust has not yet been able to confirm additional capital funding to support all known investment requirements. A range of bids have been submitted and the Trust awaits the responses on these. Work is progressing on identifying alternate sources of funding to support these activities.	Chief Executive	Board	20 ↑
	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.	Partial				The risk score is unchanged. *Assurance that controls are generally adequate and effective is taken from the monthly highlight reports to the Board meeting (part B). The strategy development project plan was approved by Board at its March meeting and highlight reports demonstrate that the project is being delivered as planned, no exceptions have been reported.*	(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.	Partial				The risk score has reduced from 12 to 10, it remains a high risk. *The strategic risk score has reduced as the contributing risk concerning lack of engagement with the STP has reduced. Since Jan 18 all STP meetings have been attended by appropriate senior managers from the Trust. Monthly highlight reports to the Board meeting (part B) provide positive assurance on delivery of actions to improve partnership working.*	Chief Executive	Board	10↓
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 risk score has reduced from 12 to 9 it remains a moderate risk. The Committee is assured by the delivery of actions to control the risks identified by the research team that control of this risk is generally adequate and effective.	Medical Director	Quality Committee	9↓