St George's University Hospitals NHS
NHS Foundation Trust

Board Walkabout - Thursday 30th August 2018, 08:30 – 09:45

Meet in the Hyde Park Room at 08:30

At the time of your visit the wards and departments will be extremely busy. This is one of the busiest times for areas with morning ward rounds, medication and assistance with patient care being completed.

Please ensure that your team is in the Hyde Park room for 09:45 to provide verbal feedback on your areas visited. Please nominate one individual to provide a summary of the findings who will be given 3 minutes to complete this.

During your visit to areas this is an opportunity to meet with staff and understand the breadth of services that are provided. You are encouraged to discuss with staff the services they provide and challenges they may face.

In addition to this we would ask that you continue to observe environmental cleanliness and infection control principles and therefore the following points may assist you in this process.

1. **Are staff bare below the elbows in clinical areas and adhering to principles of hand washing?**
2. **Is the ward/department clutter free?**
3. **What impression are you given on entering?**
4. **Is the ward calm and organised? Is the ward odor free?**
5. **Are signs and notice boards clear and well displayed?**
6. **Is any unused equipment clean and labeled as clean and ready for use?**
7. **Are resus trollies, ledges etc free from dust?**
8. **Are there any outstanding urgent estates or maintenance issues?**
9. **What do staff enjoy most about working at St Georges Hospital?**
10. **What do staff feel the barriers are to undertaking their job?**
11. **How do staff feel the board can support them in delivering care to patients or undertaking their job?**
12. **Are there any outstanding urgent estates or maintenance issues?**

These visits are not “inspections” as these will be done using a more formalised approach.

Practicalities

- This is usually conducive to visiting two clinical / non clinical areas but need to be flexible and go to another area if it is not a suitable to visit at that time or visit finishes early.
- When arriving in a clinical area always ask to speak to Nurse in Charge (NIC), if NIC and other staff are busy ask for the Matron or Head of Nursing to be bleeped if they are not already on the ward.
- Board members must be ‘bare below the elbow’, including the removal of any rings with stones.
- All belongings can be left in the Hyde Park room as a member of staff will stay with the belongings while you are out visiting the wards.
- If you need to make notes please do so and let the staff know that you are doing so to feedback to the Board.

The table overleaf sets out group and areas to visit. We will start from the Hyde Park Room at 08:30 and return to there for 09:45 to report our observations and findings to the other groups at the start of the Board meeting at 10:00.

Finally – enjoy! Staff really appreciate visits by Board members and welcome the opportunity to speak to us directly.

Groupings- 30th August 2018

NED	Exec / Divisional Chair	Divisional Representation	Area Visiting, 08:30 – 09:45
Gillian Norton, Chair	Kevin Howell	Mary Prior (Assistant Dir Estates & Facilities) Jennifer Randell (Head of Nursing)	Security Office (Ground Floor GVR) AMU (Ground Floor STJ)
Tim Wright	Suzanne Marsello James Friend	Louise Ramadhan (Matron)	Gray Ward (4th Floor STJ) Transport Lounge (Ground Floor GVR)
Ann Beasley	Ellis Pullinger Andrew Grimshaw	Sandra Linton (Matron) Doreen Mangion (Head of Nursing)	Fetal Medicine Unit (3rd Floor LNS) Phlebotomy Outpatients (Ground Floor LNS)
Stephen Collier	Jacqueline Totterdell Robert Bleasdale	Kelly Davies (Head of Nursing)	Benjamin Weir Ward (1st Floor AMW) CCU (1st Floor AMW)
Sir Norman Williams	Harbhajan Brar Stephen Jones	Victoria Morrison (Head of Nursing) Tracy Watford (Lead Dental Nurse)	Pre Operative Assessment (Willow Annex) Max Fax Unit (Perimeter Road)
Prof Jenny Higham	Andrew Rhodes	David McCall (Matron) Caroline Knox (Health Records Manager)	Cavell (4th Floor STJ) Medical records (Ground Floor GVR)

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Trust Board Meeting

Date and Time: **Thursday 30th August: 10:00 – 13:00**

Venue: **Hyde Park Room, 1st Floor, Lanesborough Wing**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the Tooting site**	**Board Members**	-	Oral
OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	-	Oral
	1.2	**Declarations of interest**	All	-	Oral
	1.3	**Minutes of meeting on 26 July 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**	**St George's Hospital Charity report**	**Anna Walker** Charity Chairman	Inform	Oral
QUALITY & PERFORMANCE					
11:10	**3.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
	3.2	**Integrated Quality & Performance report**	**James Friend** Director of Delivery, Efficiency & Transformation	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	**Learning From Deaths Q1 Report**	**Andrew Rhodes** Medical Director	Assure	Report
	3.6	**CQC Inspection Report** • **Action Plan for Requirement Actions** • **Trust Post Inspection Action Plan**	**Andrew Rhodes** Medical Director	Assure	Report
FINANCE					
11:50	**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**	**Workforce and Education Committee Report**	**Stephen Collier** Committee Chair	Assure	Report
	5.2	**Guardian of Safe Working Report**	**Andrew Rhodes** Medical Director	Assure	Report
CLOSING ADMINISTRATION					
12:25	**6.1**	**Questions from the public**	-	-	Oral

Time	Item	Subject	Lead	Action	Format
	6.2	**Any new risks or issues identified**	**All**	-	-
	6.3	**Any Other Business**	**All**	-	-
	6.4	**Reflection on meeting**	**All**	-	Oral
12:40	**STAFF/PATIENT STORY**				
13:00	**CLOSE**				

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

Date of next meeting: Thursday 27 September 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

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting

Thursday 26 July 2018, 10:30 – 13:30, H2.8, Hunter Wing, St George's Hospital

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
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
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director, NHS Improvement	QID
APOLOGIES		
Jenny Higham	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: Brodie Ward, McKissock, Jungle Ward, Dragon Centre, Keate Ward, Acute Gynaecology Unit, Apheresis Unit, Trevor Howell Day Unit, Dalby Ward, Neonatal Unit and Paediatric ITU.

The CFO reported that they had seen a well laid out physical environment, with patients being complimentary and staff feeling positive and engaged. The challenges witnessed were related to attention to detail and a struggle to recruit to vacancies on a permanent basis. There were also low response rates for the Friends and Family test. It was noted that there had been some churn of senior staff, so it would be important to ensure that staff felt supported.

Tim Wright reported that Jungle Ward appeared to be running efficiently and the senior nurse was pleased with how it was operating. Challenges faced were largely environmental, with the ward being

in the centre of the site without any external windows. There was also poor Wi-Fi coverage. Dragon Centre felt spacious and the treatment rooms were used intensively. Wheelchair access and car parking were difficult. There were electronic kiosks in place, although these did not seem to be being used to their full potential.

The CN reported that the Acute Gynaecology Unit provided a number of services from one place, including outpatients. The layout was not ideal and was in need of review. Patient experience could be improved with some simple changes. Keate Ward had challenges in relation to the mix of skills required from staff. There were dedicated days in place to ensure staff were confident and competent in provision of care. The group had been impressed with the ward and noted that it had been small details which prevented the ward from gaining gold when reviewed under the Ward Accreditation programme.

The DCA reported that the group had visited a number of other areas, as well as the Apheresis and Trevor Howell Day Units. The new Ward Manager in the Trevor Howell Day Unit was dynamic and had made an impact. The ward had good Friends and Family Test responses and were performing well on infection control. However there were some challenges in relation to recruitment. The corridors were also a little cluttered. The Gordon Smith Ward had been awarded a bronze under the Ward Accreditation Scheme and was keen to achieve silver in September. The staff in the Apheresis Unit were very pleased with the new unit and would be making a presentation at the August senior leaders event. The group had heard that Apheresis nurses were in particularly short supply and their skills were highly valued by the Trust. The group had, in addition, visited the Ambulatory Oncology Unit, which was intended to provide a better service for cancer patients who were feeling ill to come straight to the unit rather that going through the ED, at the same time taking some pressure off ED.

The DS reported that the Dalby Ward refurbishment was impressive, as it was Dementia friendly. The electronic information board was very impressive and the group had suggested the team apply for a grant from the charity in order to roll this out to other areas. There were some issues with staff retention on the Neonatal Unit, however they were as flexible as possible to encourage those staff returning from maternity leave to remain there. There were some environmental issues noted, although these were things that were within the power of the ward itself to address. The heat had been causing some problems, but staff had praised the efforts of the Estates team.

Sir Norman Williams agreed that the electronic information board on Dalby Ward was very good. He also noted that the refurbishment costs seemed to be reasonable and it was obvious how much care and attention had gone into the details. The Paediatric ITU appeared cluttered, although there was a plan in place to make better use of the space available. The staff had reported having to turn away patients due to a lack of beds. The CEO noted that bed usage in the unit was highly dependent on the season, with greater demand in the winter.

The DCA stated that the Board Visits Action Tracker had been circulated for information and would be included quarterly to give assurance that feedback provided was being acted upon. The CEO noted that some parts of the Trust had not been visited as frequently as others and she knew that staff were keen to see Board members there. She asked that that the planning of future Board visits ensured that members had the opportunity to go to these less frequently visited parts of the site.

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 Jenny Higham and Sarah Wilton, Non-Executive Directors.
Declarations of Interest	
1.2	No declarations of interest were made.
Minutes of previous meetings	
1.3	The minutes of the meeting held on 28 June 2018 were agreed as a true and accurate record.
Action log and matters arising	
1.4	The Board noted the action log and the following updates: • TB. 29.03.18/ 77 – The DHROD stated that the Staff Survey report would be discussed at the August Workforce and Education Committee meeting. • TB. 31.05.18/ 78 – The CEO reported that further meetings with staff had taken place and conversations remained ongoing. The action was agreed for closure. • TB. 28.06.18/ 81 – The Corporate Objectives were noted as an agenda item. • TB. 28.06.18/ 82 – It was noted that GIRFT was an agenda item for the August Quality and Safety Committee meeting. The action was agreed for closure. • TB. 28.06.18/ 85 – It was noted that one of the planned Board Seminar sessions would be dedicated to diversity and inclusion. • TB. 28.06.18/ 86 – Medical staffing risks would be reviewed by the Workforce and Education Committee at the August meeting.
1.5	**CEO's update**
	The CEO reported that the final CQC report had been received. Staff had been briefed and had the opportunity to ask questions. Changes had been made since the last inspection and the report showed that improvements had been made and recognised. An action plan would need to be submitted to the CQC in August, prior to the August Board meeting, and would need to be reviewed by the Board on email circulation before submission. The Chairman noted that the Chair of NHS Improvement had contacted her to congratulate the Trust on the progress made. The CEO also drew attention the staff achievements in her report and emphasised how proud she was of those involved. A number of academic successes had been recognised, as well as the Trust being named top of the transplant performance list. It was noted that an energy saving programme had been launched in the Trust. The CEO praised staff who had been involved in the NHS70 events. She also drew attention to the MD and Dr Moss from

	the Emergency Department, who would be taking part in the Ride London 100 on 29 July to raise money for charity. The CEO reported that the Trust Executive Committee had given approval for the development of a full business case for the refurbishment of Cardiac Catheter Labs, and that around £300k would be spent on this; the full business case would come to the Board later in the year. It was also noted that Kathy McLean, Executive Medical Director and Chief Operating Officer, at NHS Improvement, had been very impressed by the Trust Ward Accreditation Programme during a recent visit to the Trust. The Board noted the report.
STRATEGY	
2.1	**Corporate Objectives 2018-19**
	The DS stated that the report showed progress against the quarter one milestones, along with the mitigations in place. All notable risks had been indicated, with RAG ratings given for progress made. The Board were asked to consider whether these were accurate and the mitigations suitable. Tim Wright noted that the RAG ratings did not appear to be reflective of the position, with the potential for disappointment in the future if they were too optimistic (the green rated items might appear to suggest that the particular issue was resolved, whereas the rating simply referred to progress against a specific objective). The DS stated that the ratings reflected progress against agreed actions as opposed to risk ratings. The Chairman noted the importance of recognising the progress made. Ann Beasley queried why two red actions, in relation to theatres and RTT, had not yet been delivered. The COO noted that these were covered elsewhere on the agenda. The DS stated that the real test would be from the performance reported in quarter two, which would show how much progress had been achieved and whether the mitigations for quarter one actions had been effective. The Chairman thanked the DS for her work and for developing a very helpful tool. She asked for assurance in relation to action 13.4, which remained amber. The CN reported that a great deal of work had been undertaken around serious incidents and never events. The team were clear about what needed to be done to prevent recurrence of issues. There was a strong audit trail and robust system in place. The same methodology was also being used to improve the complaints process. Testing the practice was the final outstanding piece of work to be carried out, some of which was being picked up through the Ward Accreditation programme. Ann Beasley asked whether there would be any opportunity for learning from the clinical audit plan. Sir Norman Williams highlighted the importance of closing the audit loop. It was noted that there were often informal audits, such as those carried out by medical students, which were not formally used by the Trust.

	TB. 26.07.18/ 87 - Information from both formal and informal clinical audits to be used as a learning tool to prevent recurrence of SIs and NEs The QID noted that the Trust holding itself to account and delivering on its action plan would be key to meeting regulatory requirements. The DHROD queried whether it would be more prudent to have more conservative ratings, given the potential for similarly rated actions to have different overall scores. The DS stated that this was a decision for the Trust Executive Committee. **TB. 26.07.18/ 88 - RAG rating methodology to be reviewed by executive team** The Board noted the report.
QUALITY & PERFORMANCE	
3.1	**Quality & Safety Committee Report**
	The Committee Chair reported that there had been a marked improvement in quality over the course of the previous two years. There was still work to be done, but the achievement should be recognised. The QIP Dashboard had shown that mandatory training had improved. The estates indicator for responsiveness to urgent issues had increased, from 54% to 82%. Emergency patients were receiving intravenous antibiotics much more quickly, which the Committee was pleased to see. The Committee had also been told that C. difficile cases were back under target levels and should remain as such for the year overall. There had been three serious incidents in maternity, which were being investigated as a group, with the report due to be discussed at the Committee as soon as available. The CQC would be returning to the Trust within six months, with Outpatient services due to be re-inspected as part of that visit. The General Manager in Outpatients was undertaking a programme of work to ensure the transformation process was implemented. Ann Beasley asked whether mental health liaison arrangements were fit for purpose, given the breach that had recently taken place within the Emergency Department. The CEO noted that all 12 hour trolley breaches had been mental health patients in the current year. Discussions were taking place with South West London and St George's Trust (SWLStG) and the issue had been escalated to Wandsworth and Merton CCGs. SWLStG had been very helpful and consideration was being given to moving mental health patients to their hospital for assessment to get them right the first time. The MD also noted that staff within the Trust with mental health experience were being brought together to set up an advisory board. Ann Beasley noted that assurance had been given previously to the Committee in relation to deaths, that was later found to be inaccurate. She queried what other assurance there was aside from that which had been reported. The Committee Chair stated that there was a quarterly mortality review which gave further detailed assurance. A proposal for funding for a Trust Medical Examiner post was also being developed. The QID stated that a more

	detailed explanation to the Board would be helpful, particularly as this was an area that the CQC were likely to look at. Dr Nigel Kinnear, Associate Medical Director attended Board periodically to report on learning from deaths and the next report was due at the August 2018 Board meeting. The CN reported that the terms of reference for the Patient, Partnership and Experience group had been approved. Work was now needed to ensure the strategy was credible and had undergone proper scrutiny. While the CN hoped to bring the strategy to the September Board, the Chairman noted that it would be important to get the content right, even if that meant deferring the Board's consideration of the strategy to October. The Board noted the report.
3.2	**Integrated Quality & Performance Report**
	The DDET reported that the balanced scorecard approach had been better highlighted and aligned with the summary report. Red areas had been pulled out in greater detail, with an aim of focussing on exception reporting. However it would be important not to lose the granularity of detail. He reported that outpatient productivity was positive, with further areas of opportunity to be identified within theatre productivity. Sir Norman Williams stated that the national GIRFT Board had a programme of work in place and queried how the Trust was engaging with it. The DDET reported that the Trust was part of the first wave of those engaged and would be focussing on benchmarking and data sharing to begin with. There would also be the opportunity to improve consistency of application across the organisation. The COO noted that a hands-on approach was being applied in relation to scheduling to ensure that lists were being booked appropriately. This was giving oversight to long standing issues, with improvement seen over the preceding few weeks. Stephen Collier stated that there was some anxiety in relation to the elective care figures, particularly in relation to theatre scheduling. **TB. 26.07.18/ 90 - Action plan to be taken to August 2018 FIC meeting regarding elective care theatre schedules** Tim Wright noted that it was evident there was a great deal of data, which could be better presented on the balanced scorecard so as to be more understandable to non-clinical Board members. The Chairman asked that this be discussed outside of the meeting to ensure the report was as useful an assurance tool as possible. **TB. 26.07.18/ 91 - Discussion re best way to present balanced score card to ensure it is an effective assurance tool, to take place with NEDs** The DHROD reported that a regulatory notice in relation to appraisal rates had been received from the CQC, and that continuous improvement was being shown thanks to engagement with divisions. An electronic appraisal system was also being sought to better implement the process across the Trust. The CN reported that no patients had developed MRSA Bacteraemia within the Trust for a year, which was something to be proud of.

	The Board noted the report.
3.3	**Elective Care Recovery Programme**
	The COO reported that there had been a commitment to conclude phase one of the historical Patient Tracking List validation process. This had fallen behind schedule, although a review of the inconclusive patients had been completed. Phase two was expected to be completed by the end of 2018 and would cover lower risk patients. A slow training process had caused delays and divisional directors had been instructed to prioritise this in order to regain time lost. Sir Norman Williams queried whether there were any notable patterns in relation to patients with severe or notable harm and whether cancer was included in the figures presented. The MD noted that it may be helpful to present a more detailed report to the Quality and Safety Committee. **TB. 26.07.18/ 92 - Report on PTL validation in relation to cancer care to be taken to the August 2018 QSC meeting** Ann Beasley stated that a more detailed breakdown of the figures would be useful to see. **TB. 26.07.18/ 93 - Breakdown of PTL validation figures to be circulated to the Board** The Board noted the report.
3.4	**Emergency Care Performance**
	The COO reported that the Trust continued to deliver well, at 93% against a target of 95%, compared with other Trusts across London and nationally. The paper set out a breakdown of reasons for breaches of the Four Hour Standard. There was a focus on reducing Emergency Department breaches, with a targeted approach in place. Bed modelling had proven difficult, with quarter one figures showing where there was more work to be done. The CEO noted that the STP and commissioners were pleased with the Trust approach to this. The COO indicated that there may be the need for a winter ward this year, although this would require executive agreement which had not yet been sought. Stephen Collier asked what the cut-off date for the July data had been, as the initial figures for the second half of the month showed that there was room for optimism. It was clarified that 16 July had been the end date for the reported figures. The CFO reported that the Trust was now eligible for Provider Sustainability Fund (PSF) funding. Payment of this was linked in part with the Trust's Emergency Department performance for each quarter. It was therefore important to recognise that failure to hit the agreed performance trajectory in any quarter could impact on the level of PSF available to the Trust. The Board noted the report.

3.5	**Transformation Update: Quarterly Report**
	The DDET reported that three main principles formed the basis of the transformation work which was undertaken. These were: getting patients to the most appropriate place for diagnosis, treatment and care; capacity planning; the right thing for patients being made the easiest thing for staff to do. The next significant piece of work would be to make the Trust paper light. A methodology was in place, which would also apply to the delivery of cost and quality improvements. The DDET stated that further cultural change would be needed across the Trust in order to fully embed change. The executive team were using KPIs to hold themselves accountable. The admitted pathway performance was at 95% the previous day. Detailed reviews of DNA rates were being undertaken, which seemed to be indicating that the Trust had been over-declaring. Surgical wards were trialling 'exemplar patients'. Tim Wright noted that MADE had made a significant difference to discharge rates. He queried why this was an 'event' and not used on a permanent basis. The DDET stated that there was an integrated discharge sequence in place to embed the learning sustainably. Labelling it as an event enabled it to be used to draw attention of senior people in a way that was not possible on a day to day basis. The Board noted the report.
3.6	**MCA/DoLS Annual Report**
	The CN reported that the item had been reviewed by the Quality and Safety Committee. She had been interviewed by NHS Improvement on this topic as part of Provider Oversight. A great deal of work had been undertaken and it was clear where there was more left to do. The Trust needed to be mindful of the risks involved and a bid had been placed with NHS Improvement for additional project support. The Board approved the report.
FINANCE	
4.1	**Finance & Investment Committee Report**
	The Committee Chair reported that the Committee had considered the Board Assurance Framework risks that it was responsible for and also focussed on water safety. The engineer had reported that some of the plans in place had not been carried out as thoroughly as expected. However he had given assurance that the system was operating safely for patients and staff. The Committee also heard that month three financial performance was on plan for the most part, although this would get more difficult to achieve as the year went on so would need to be carefully monitored. They had been satisfied with the progress in relation to community services, noting that some would continue to be provided past the contract end date to allow commissioners time to undertake a procurement exercise. The Committee had agreed the revised Procurement Policy, noting the robust systems put in place and the reduction in numbers of waivers and breaches. A great deal of awareness

	raising had been taking place with staff. Sir Norman Williams noted that CIPs were concerning and queried whether the Committee had reviewed them in sufficient detail. The Committee Chair stated that this was a key agenda item for the August meeting. Executives were also holding fortnightly run rate and CIPs meetings for assurance purposes. They were confident that CIPs could be delivered in year. The Board noted the report.
4.2	**Month 3 Finance Report**
	The CFO reported that there was a £12.5m deficit at the end of the first quarter, which was slightly above plan. There was some variation noted, however the PSF for the quarter had been secured. This position needed to be maintained. It had previously been noted that financial risk remained a key area of focus for the Trust. Cash was slightly ahead of plan and the Trust had been able to borrow slightly less than planned. Discussions with NHS Improvement in relation to expenditure were ongoing in order to ensure a secure position. Assurance was taking place via the Finance and Investment Committee. Tim Wright queried how the NHS pay award was being funded. The CFO stated that the stated financial position included the initial 1% uplift and that this was what Trusts had been instructed to make provision for in their budgets. The next 2.5% would be funded directly by the Department of Health, based on 2017/18 staff figures. This would mean there was potential for pressure where there was variation in agency spend. However this was a marginal pressure and most of the cost was funded. Doctors and Very Senior Managers were not part of the pay award, so confirmation on funding was still required centrally. The Board noted the report.
GOVERNANCE	
5.1	**Audit Committee Report**
	Ann Beasley reported in the absence of the Committee Chair. She reported that a number of Internal Audit recommendations remained outstanding beyond their due date. The Committee had requested assurance that timescales for audit actions be realistic when agreed by lead Executives. Internal audit work was on plan, with no assurance given in relation to the GDPR audit, as had been expected given that work on GDPR readiness had only recently started. There had been 18 new counter fraud contacts and awareness sessions were being run for staff. The Committee also heard that good progress had been made against aged debt. The Committee had received the first of its regular reports on whistleblowing and had welcomed this, but had also asked for further assurances that staff felt supported to raise concerns. The DCA stated that the Internal Auditors were due to attend the Trust Executive Committee in August 2018, to report the next phase of the plan. Sir Norman Williams noted that they had been complimentary in relation to the ease of the process compared with previous years.

	The Board noted the report.
5.2	**Board Assurance Framework**
	The CN reported that assurance ratings and the rationales against these had been updated. Risks had been reviewed by the appropriate sub-committees of the Board. Two risks had increased assurance ratings, with none decreasing. Overall the picture was improving. The Board were asked to confirm that they were content with the position of those risks for which it reserved responsibility. Ann Beasley queried why SR2 had previously been scored as 16 and was now 15, meaning that both the impact and likelihood had changed. The CN explained that the overall risk was scored according to the highest scored sub-risk within that group, which was now 15. She also noted that judgment was used and in this case the executives felt the score was appropriate. The Chairman noted the need for a further workshop on the Board Assurance Framework in order to review progress and consider whether any more fundamental changes were needed. . **TB. 26.07.18/ 94 - Board workshop on BAF to be arranged** The DDET stated that, in relation to SR6, capability development had been undertaken. There was a need to ensure more consistent outputs. There were a number of interim and fixed term staff in key positions. Permanent appointments were being sought. A further review of the risk score would take place once they were in post. The Board agreed 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 The Board agreed for the 14 risks assigned to its assuring committees to: • Note the risk score, assurance rating and statement from the relevant assuring committee.
CLOSING ADMINISTRATION	
6.1	**Questions from the public**
	Khaled Simmons asked how much of the vocational rehabilitation programme was tailored to individual needs. Trudy Kemp stated that everything was tailored based on personal requirements. The DDET responded to a question received by email from Hazel Ingram, a Trust Governor, who had asked how a virtual fracture clinic would work in practice. The DDET encouraged those present to look at Westminster as a particularly good example of how this type of clinic worked. It had improved patient experience immensely and 35% of their activity had become virtual. The Chairman thanked members of the public for their questions.
6.2	**Any new risks identified**

	No new risks were identified.
6.3	**Any Other Business**
	No other items of business were raised.
6.4	**Reflection on the meeting**
	Stephen Collier expressed his support for the Chairman's focussed approach to discussions on reports, asking for high level discussions where they had already been scrutinised in detail by sub-committees of the Board. The CEO noted that many of the recent patient stories had been positive and, while it was good to hear that people were happy with their care, it would be more helpful to also hear from people that had criticism to give so that improvements could be made. **TB. 26.07.18/ 95 - Ensure mix of both positive and negative patient stories are brought to Board**
	PATIENT STORY
	Trudy Kemp attended the meeting to give the Board an account of her experience of being a patient at the Trust. She noted that she had previously been a director within the Trust, so knew the organisation and a number of staff very well. She told the Board that she had been at an event at King's College Hospital when she collapsed. It had been very lucky that she was on the hospital site at the time as she was able to be diagnosed and treated very quickly. She remained unconscious for four months and had aneurisms coiled at King's College before being transferred to St George's Hospital. She had also spent six months doing rehabilitation at Queen Mary's Hospital. The CEO asked if there was anything that could have been done differently. Trudy said that her family had told her they were impressed with St George's, as she had no memory of her stay as an inpatient. Her husband had been given a parking permit, which whilst a small thing had made a big difference to him. Flexible visiting hours had also been a great help and were really appreciated. He had found it difficult to identify who Trudy's doctor was however. Jane Kelly, Head of Nursing for Neuroscience stated that open visiting hours were being trialled across wards. She was concerned that the consultant was not easily identifiable, as this should have been visible on the board in the ward. She told the Board that there was now an allied health professional day centre at Queen Mary's Hospital, which allowed patients to carry out their rehabilitation as outpatients. Sir Norman Williams asked if the parking and flexible visiting were perks due to Trudy having been known to staff. Sarah Duncan, Patient Advice and Involvement Manager, stated that all in patients were able to have a parking pass for £10 per week.

	Trudy told the Board that she had attended an interview that morning, with the intention of returning to work. She had been supported to do this by the vocational programme provided by the Trust. The Chairman thanked Trudy, Jane and Sarah for their time.

Date and time of next meeting: Thursday 30 August 2018, 10:00 – 13:00
Hyde Park Room, St George's Hospital

Trust Board Action Log - July 2018

Action Ref	Theme	Action	Due	Lead	Commentary	Status
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	Workforce and Educaton Committee to consider report on 9 August, and update to be including in Committee Chair's report to August Board.	OPEN
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 noted final version of objectives and considered Q1 report at July Board meeting.	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 2018/19. In progress.	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	Reviewed at Workforce & Education Committee meeting - August 2018	PROPOSE FOR CLOSURE
TB. 26.07.18/ 87	**Corporate Objectives 2018-19**	Information from both formal and informal clinical audits to be used as a learning tool to prevent recurrence of SIs and NEs	27.09.18	CN		OPEN
TB. 26.07.18/ 88	**Corporate Objectives 2018-19**	RAG rating methodology to be reviewed by executive team	31.10.18	DS	To be reported to October 2018 Board meeting.	OPEN
TB. 26.07.18/ 90	**Integrated Quality & Performance Report**	Action plan to be taken to August 2018 FIC meeting regarding elective care theatre schedules	23.08.18	COO	In RTT (ECRP) paper to FIC for 23.8.18	PROPOSE FOR CLOSURE
TB. 26.07.18/ 91	**Integrated Quality & Performance Report**	Balanced scorecard approach to be developed further to ensure it is an effective assurance tool, with input from NEDs.	30.08.18	DDET	Now included in Board report. TEC agreed a Balanced Scorecard approach for Divisional Performance Reporting. Supports clear bottom to top performance line of sight to the Trust Board.	PROPOSE FOR CLOSURE
TB. 26.07.18/ 92	**Elective Care Recovery Programme**	Report on PTL validation in relation to cancer care to be taken to QSC	23.08.18	MD/COO	Report to provide this information to September QSC	OPEN
TB. 26.07.18/ 93	**Elective Care Recovery Programme**	Breakdown of PTL validation figures to be circulated to the Board	30.08.18	COO	To be included in August 2018 ECRP report to the Board	PROPOSE FOR CLOSURE
TB. 26.07.18/ 94	**Board Assurance Framework**	Board workshop on BAF to be arranged	30.08.18	CN/DCA	Upcoming Board development dates being sought for the rest of 2018/19. In progess.	OPEN
TB. 26.07.18/ 95	**Reflection on meeting**	Ensure mix of both positive and negative patient stories are brought to Board	30.08.18	CN	CN is working with the complaints team and directorates to help identify patient stories that demonstrate a greater mix of experiences	PROPOSE FOR CLOSURE

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 August 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 – August 2018

Cardiac surgery

I want to begin my report by talking about the findings of Professor Bewick's review of our cardiac surgery service.

The headlines are now well known, but I want to reiterate that however difficult it may be, we are doing the right thing in challenging the unacceptable behaviours evidenced in the report, as this is the only way to deliver the fundamental changes required to improve the service for our patients. As uncomfortable as the media coverage may have been, this is in part a symptom of the organisation taking action to address the deep-seated issues highlighted by the review.

It is important to emphasise that the cardiac surgery service remains safe. In response to the widespread media coverage, the Royal College of Surgeons and Society for Cardiothoracic Surgeons this month made a public statement making clear that "cardiac surgery in the UK is amongst the safest in the world and St George's has always shown that early survival for their patients is within what is regarded as the UK standard. It has never been below the standard".

What is also clear from Professor Bewick's review is that significant improvements are needed, and we are taking robust action to address the unacceptable behaviours within the unit highlighted in the review. As I stressed in my message to staff when the report was published, however, the vast majority of our staff both inside and outside cardiac surgery are committed to our Trust values.

NHS 10-year plan and priorities

I write this at the beginning of a period of significant change for the NHS. A new Secretary of State for Health and Social Care is now in office, and the NHS 10-year plan to determine where increased funding will be spent is due to be published in the Autumn.

There will be tough choices, but NHS England Chief Executive Simon Stevens has identified mental health, cancer, cardiovascular disease, children's services and health inequalities as the top priorities for the spending.

Investment in any of these areas at St George's would be welcome, but these priorities do not ultimately change the overarching aim of the Trust – which is to provide Outstanding Care, Every Time for all of our patients, wherever they are treated.

Of course, improving healthcare will depend not only on increased funding but also on the ability of the NHS to use its resources efficiently and innovatively.

New ways of working and improvement projects rely on frontline teams to make the changes needed to benefit patients and the Trust, and the St George's Quality Improvement Academy is currently providing the training, resources and time for teams to bring about improvements.

Innovation and research

A great example of successful staff innovation is the work of Dr Shai Betteridge, Consultant Clinical Neuropsychologist at the Trust.

I was delighted to hear that she has won the Practitioner of the Year Award from the Division of Neuropsychology – part of the British Psychological Society. This was for a novel client-centred neurorehabilitation method which has proved highly effective in managing complex problems treated in the community.

The rehabilitation model has both improved the quality of our service, the flow of patients from hospital to recovering at home, as well as improving the experience of patients.

Congratulations also go to St George's cardiologists Professor Sanjay Sharma and Dr Aneil Malhotra for having a significant piece of research published in the prestigious New England Journal of Medicine.

Their study has found that death from cardiac disease in young footballers is far higher than estimated, and it highlights the importance of more regular heart screenings to detect these conditions, which, in most cases, are treatable.

It's great to see that patients will benefit from our clinicians pushing boundaries, and pioneering new approaches to health conditions.

Elective Care Recovery Plan

Our Elective Care Recovery Plan to address our Referral to Treatment Time (RTT) and waiting list management challenges is progressing, after significant validation of our waiting lists throughout 2017/18.

We continue to work with our main commissioner and NHS Improvement on finalising our return to reporting RTT data to NHS England in late 2018/19.

This is a positive step, and testament to the huge amount of effort put into getting us to this point.

What is vital now is that we continue to input patient data accurately to safeguard patients and improve data quality, and so targeted training for the teams who use the system to track patients on a RTT pathway the most continues.

As well as this, work has started on a wider training strategy for both the St George's and Queen Mary Hospital sites.

Annual Report and Annual Members' Meeting

Finally, our Annual Report and Accounts 2017/18 has now been published on the Trust's website, and copies are being distributed to our external stakeholders as per our regulatory requirements.

The report will be formally received by our Governors at our Annual Members' Meeting on 27 September.

Jacqueline Totterdell,
Chief Executive

Charity & Trust: An Update

Forward Together

Chair: Anna Walker CB

Interim CEO: Paul Sarfaty

Forward Together

Charity's Progress and Ambitions

Trust/Charity Relationship

Challenges

Next Steps

St George's Hospital Charity Performance

Year	Income (£m)	Grants (£m)
2015/16	2.1	4.0
2016/17	1.8	2.0
2017/18	1.7	1.6
2018/19 Budget	2.2	1.7

London NHS Hospital Charities

Charity	Year	Income (£m)	Assets (£m)
Guys and St Thomas's	2016/17	27.1	750
Barts	2016/17	17.4	422
Chelsea + Westminster (15 months)	2017/18	8.9	46
Kings College	2016/17	4.3	25
Imperial	2016/17	4.0	86
St George's Hospital Charity	2017/18	1.7	15
Kingston Hospital Charity	2016/17	0.4	2
Epsom & St Helier Charitable Fund	2016/17	0.4	2
Croydon Health Services Charitable Fund	2016/17	0.3	1

Charity Achievements 2017/18

- **Grants Awarded**:

£673K	Staff Development & Welfare
£436K	Patient & Family Experience
£318K	Research (plus £600K committed but not yet spent)
£175K	Medical Equipment

- **Current Major Appeals:**

New Children's Appeal	£500K recently launched
Cardiac	£200K
Neuro	£100K

AMERJIT CHOHAN

2017+ **Imperial College Healthcare Charity**
Director of Development and Communications
Focus on grants, major appeals (income doubled), volunteering and charity visibility

2013-7 **Smile Train UK**
UK Fundraising Director

Non-Executive Roles:

2013+	**De La Warr Pavilion**	Trustee
2012+	**Dame Kelly Holmes Trust**	Deputy Chair

Trust/Charity Relationship Progress

Appointment of a Trust NED as Trustee

Excellent new working relationship:

- Chair-to-Chair Meetings
- CE engagement with Executive Team and Strategy

Formation of Medical Advisory Group

Staff Recognition Awards launched successfully

Trust/Charity Relationship

The Trust gets what it needs from the Charity

The Charity gets what it needs from the Trust

+

The Charity can deliver more for the Trust

Challenges

We recognise the major challenges of the Trust, **but**:

- It can appear **unresponsive**
- Progress in **defining projects** can be slow
- **Grants** not always spent in a timely manner
- **Special Purpose Funds (SPFs)** expenditure can be slow
- SPF Income **declining**
- Greater Trust engagement needed with **Major Donors**

Next Steps

- Build on the **strong Trust/Charity relationship**

- **Charity** needs to**:**

  - **increase its fundraising/ambitions** significantly
  - gain support for **visible branding** across the estate

- We need the **Trust** to:

  - define what it wants from the Charity
  - help **turn proposals into projects that happen**
  - work with us on **SPF income/expenditure**
  - engage with **major donors**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 August 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 23 August 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 – August 2018

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 23 August 2018 and agreed to bring the following matters to the Board's attention:

1. **CQC Inspection Update**
   The Committee heard from the Quality Improvement Director that action plans, to address both the regulatory actions and the must do and should do actions from the CQC report, have been developed and were submitted to the CQC on 16 August 2018. The action plan, which also had input from NHSI, addressed the key areas of concern which were:

   - Leadership in the emergency department
   - Leadership in the outpatient department
   - Treatment and care of patients with mental health needs in the emergency department
   - Embedding understanding and implementation of the Mental Capacity Act (MCA) across the Trust
   - Return to reporting for the referral to treatment (RTT) standard.

   The action plans are being presented to this meeting of the Board (30 August).

2. **Integrated Quality & Performance Report**
   The Committee received the report and noted that a further three C.diff cases in July brought the year to date total to thirteen, against a target of no more than 30 cases in 2018/19. This is a slight worsening of performance compared with the same point last year. The Chief Nurse assured the committee that root-cause investigations of each of these cases have found no evidence of failures in care.

   The Committee heard that a quality dashboard for maternity services is in development; once this is populated it will be a regular report to the Committee and will strengthen oversight of maternity services. The Committee was told that the recent submission to NHS Resolution setting out the compliance of our maternity services with ten standards for maternity care has been successful. The Trust has received a 10% rebate of our financial contribution to CNST and this will be used to further improve the safety of maternity services.

   The Medical Director advised the Committee that mortality indicators remain below the national average; however he drew attention to the importance of ensuring that the aggregated data did not mask any underlying issues in specific service groups. The Committee was assured that the Mortality Monitoring Group looks at the data at service level. The Medical Director advised that a mortality alert had been received from the National Joint Registry which related to hip replacement surgery. The Committee was told that the alert concerned eight patients over a five year period and the all the cases have been reviewed. The patients were all multi-trauma patients or otherwise complex

who had died as a result of their injuries or of underlying co-morbidities such as cancer. The Committee was assured that both the Trust and the National Joint Registry are content that the alert is not a matter of concern.

The Committee welcomed the more detailed information included in the report regarding same day surgical cancellations, the Chief Nurse explained that cancellations on the day were largely due to emergency patients having to take priority or operating lists overrunning due to complex patients. The number of cancelled on the day operations has remained relatively constant over the past year.

3. Elective Care Recovery Programme

The Committee heard that work is on-going to cleanse and maintain the waiting list and that additional funding for staff training to support this work had been agreed.

The Committee discussed the coding of patients and the potential barriers to ensuring patient episodes were closed down accurately on the system, in part due to adequate supervision of junior doctors in discharging patients when appropriate. The Chief Operating Officer (COO) advised that it is the responsibility of the operational management teams to ensure that clinics are correctly reconciled, and to challenge clinical teams to ensure all patients have an outcome code; further comprehensive training is being delivered to support this.

The COO provided assurance to the Trust Chairman and the Committee that the data quality metrics are on target to allow a return to reporting at the end of 2018. The challenge is to ensure that the improvement is sustained and the staff training programme is designed to ensure this happens.

4. Getting it Right First Time (GIRFT)

The Committee received a report on the progress made by clinical teams with the national GIRFT programme. This programme supports frontline clinicians with the identification and reduction of unwanted variation to improve and sustain quality. Variation is highlighted through speciality specific data packs with national and peer group comparators.

There are 10 specialties currently in the programme at St Georges:

- Orthopaedic surgery, vascular surgery, cranial neurosurgery, cardiothoracic surgery, urology surgery, oral and maxillofacial surgery, obstetrics and gynaecology, paediatric surgery, general surgery, critical care and radiology.

GIRFT external reviews and the GIRFT dashboard demonstrate that the opportunities from the programme for the Trust are not about improvement in use of resources but rather in wider quality improvement. Formal links are being established between GIRFT teams and the trust's Quality Improvement Academy to ensure consistent and widespread application of our QI methodology and to provide support and specialist coaching to teams. A formal 6-monthly review process is being implemented and will give the Board oversight on progress made by specialities and the improvements made.

The Committee noted the improvement seen in Trauma and Orthopaedics following a second GIRFT visit and the high level of engagement from the speciality teams involved in the programme.

5. Cardiac Surgery

The Committee was updated on the work undertaken to date in cardiac surgery. The Committee received a paper in November 2017 that set out the action being taken in response to the first NICOR alert. The Bewick review was commissioned by the Trust following discussion at this Committee of a second NICOR alert for the period 2014-17 that showed increased mortality for patients receiving cardiac surgery at the Trust. The Bewick review followed on from the two days of team mediation in December 2017 and the existing agreement and action plan overseen by the cardiac surgery taskforce.

The review made 15 recommendations and immediate actions have been implemented including:

- Single speciality practice;
- Strengthened data reporting;
- Recruitment of two locum consultants, starting in Sep and Oct;
- Project support;
- A review by an independent human resources specialist into key workforce themes, an interim report has been received;
- Internal and external briefings;
- Communications plan;
- External support in place from Guy's and St Thomas', on-site support from a named consultant providing advisory and leadership support.

A steering group chaired by the Medical Director will oversee the implementation of the action plan which will be delivered through five task and finish groups; safety and governance; operational; workforce and behaviour; teaching and training and transformation and networking.

The Committee heard that the CQC were conducting an unannounced inspection of cardiac surgery at the Trust that day, the outcome of which would be reported to the Committee and to the Board. Further work was planned to ensure the actions being taken to address the concerns identified by Professor Bewick were being taken forward at pace.

The Committee heard that at the governors briefing, held earlier in the day, a staff governor had said that wider staff groups in the cardiac surgery services are feeling well supported by management.

6. Water Safety

The Committee received an update report on the water safety plan to improve water quality and safety. Progress with the elimination and monitoring of the bacterial contamination of the water supply is on target to meet completion dates in the programme timetable.

The Director of Estates told the Committee about the action plan being delivered to manage pseudomonas in the drainage system; this followed a chlorination incident that was identified when a patient who died was found to have the particular strain of

pseudomonas found at St George's. The pseudomonas in the drainage system is being managed through cleaning and chlorination.

The Committee asked for pseudomonas to be added to the water safety report and heard that in the future they will receive a combined report covering water, ventilation and electrical safety.

7. Learning from Deaths

The Committee received a paper updating them on the work of the Mortality Monitoring Committee (MMC). The MMC carried out an independent review of 300 deaths in Q1 18/19, this is 82% of deaths and significantly above the target of 70%. Two deaths were judged to have been 'probably avoidable' and were escalated to the Serious Incident Decision Meeting (SIDM) for consideration of further investigation.

The MMC actively supports families and has worked directly with two families that wanted further information about the death of their loved one in this reporting period. The MMC Chair worked closely with the families to understand their questions and concerns and carried out a full investigation, supported by a multidisciplinary team. Learning was identified and shared with the family and the Coroner and has led to changes in practice. This process resulted in the Coroner deciding that an inquest was not necessary. National guidance on support of families published on 11 July is being reviewed and will be incorporated into the learning from deaths policy.

A key learning theme concerns the recognition of the end of life and ensuring that the time for active or palliative care is correctly understood. In quarter 1 85.3% of patients whose death was reviewed had a DNACPR order in place, similar to previous quarters. The treatment escalation plan (TEP) has been introduced and reviewers are seeing an increasing number of patients with these in place to assist with management of the period around end of life.

The Committee was reminded that the MMC reviews cases when an external body raises a mortality alert. The MMC reviewed and reported on the cases included in the cardiac surgery mortality alert and the National Joint Registry alert as discussed earlier by the Committee. The MMC also monitors information from a range of sources, the national audits, the HSMR and SHMI and information from Dr Foster and follows up with mortality reviews when an increase is seen in mortality. This happens at clinician level and before changes reach a level that would trigger an alert from an external body.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 30th August 2018
Reporting period – July 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 – July 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 under utilising 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 currently below plan. Cases per session are below previous highs in ENT and Cardiac Surgery and as a Trust below the same period last year. Recent improvements have been seen in Gynaecology and Maxillo Facial. Overall theatre touchtime utilisation is tracked weekly and are currently performing at 73% against the 85% threshold targeted. Recent increase seen within ENT, General Surgery and Urology. The percentage of daycase procedures has increased by 3% compared to last years average, meaning we are treating more patients on the day compared to an overnight stay.

Our Patients

- The Trust reported three patients with attributable Clostridium Difficile infection in July, against an annual target set at 30 cases in 2018/19. The Trust is reporting thirteen cases year to date and is above the threshold trajectory for the period between April and July.
- 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 July was 93.3%, which was below the monthly improvement trajectory of 95%. The improvement trajectory requires the delivery of 94% performance in August 2018 and relies upon continued improvement in the experience for patients not requiring admission. Performance against the number of patient handover delays within 30 minutes of arrival have continued to improve in the month of July.
- The Trust achieved four of the seven national mandated cancer standards in the month of June, continuing to achieve 62 day compliance, however both the 14 day standard and 14 day breast symptomatic standard were not met reporting 83% and 22% respectively primarily due the performance within the Breast pathway. The 62 day screening target was also not met reporting 84.6% against a target of 90%.
- The target for the number of elective patients cancelled for non-clinical reasons was reduced in June and continued in July cancelling fewer than two patients per day. Focus remains on reducing this further and on ensuring that all patients are always rebooked within 28 days which has seen a significant improvement in July re-booking 94.4% of patients within 28 days.

Our People

- Staff sickness remains above the trust target of 3% for the month of July.
- Both Non Medical and medical appraisal rates remain below expectation however positive improvement of 3% within non medical rates.
- For July, the Trust's total pay was £0.17m adverse to the plan with the biggest area of overspend within interim posts.

St George's University Hospitals NHS
NHS Foundation Trust

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

															Average length of Stay			
Directorate	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Discharges in the last month	2017-18	2018-19	Variance	Trend
Acute Medicine	2.8	3.1	2.8	2.9	3.0	3.2	3.4	3.5	2.8	2.9	2.7	2.6	2.7	2,313	3.0	2.7	-0.27	
Cardiothoracic	8.7	8.6	8.5	8.2	9.2	8.8	9.4	8.3	9.0	9.0	8.7	7.8	8.3	290	8.8	8.5	-0.32	
Childrens & Women	3.5	3.9	3.1	3.7	3.4	3.4	3.9	3.3	3.2	4.4	3.5	2.9	3.8	443	3.3	3.6	0.35	
Neurosciences	10.4	8.0	10.7	10.1	9.5	10.6	9.4	8.7	10.6	8.9	10.6	11.6	9.2	299	9.4	10.1	0.65	
Senior Health	12.2	13.6	19.3	19.2	8.9	9.5	9.9	9.3	8.4	11.3	10.2	11.8	7.6	96	12.9	10.2	-2.74	
Specialist Medicine	7.9	6.2	8.4	7.0	6.8	9.7	7.7	9.7	7.6	6.1	9.2	7.3	6.0	245	7.8	7.1	-0.62	
Surgery & Trauma	4.8	4.3	4.4	5.0	4.6	4.4	4.8	5.0	4.3	4.6	4.0	4.4	3.2	1,073	4.5	4.0	-0.43	
Theraputics	8.2	12.8	18.0	20.7	7.8	17.2	6.1	7.5	13.2	9.4	9.8	3.6	18.8	28	11.9	10.4	-1.48	
Grand Total	**4.6**	**4.4**	**4.5**	**4.7**	**4.4**	**4.8**	**4.8**	**4.9**	**4.5**	**4.5**	**4.4**	**4.3**	**4.0**	**4,787**	**4.4**	**4.3**	-0.10	

Briefing

- Over the last twelve months patients admitted to the hospital via an emergency pathway spend on average 4.4 days in a hospital bed, this includes patients with a zero length of stay. At Trust level this is in line with National Model Hospital data.
- This has decreased in recent months within Acute medicine, this has been due to the implementation 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)

Directorate	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Discharges in the last month	Average length of Stay 2017-18	Average length of Stay 2018-19	Variance	Trend
Cardiothoracic	4.7	4.2	4.3	4.8	4.4	4.4	4.5	4.2	4.8	4.1	4.0	4.4	4.2	208	4.4	4.2	-0.25	
Childrens & Women	3.9	2.2	2.6	2.4	2.1	3.6	2.8	2.0	2.1	2.3	3.2	2.7	2.2	103	2.7	2.6	-0.11	
Neurosciences	10.0	9.3	12.0	7.5	9.8	11.3	11.9	7.8	12.7	8.7	7.3	12.8	7.1	178	10.0	9.0	-1.02	
Surgery & Trauma	3.4	4.9	3.7	4.4	4.5	4.0	4.4	3.1	3.2	3.8	4.1	3.7	3.4	388	3.9	3.8	-0.17	
Grand Total	3.8	3.9	3.8	3.6	3.9	3.9	4.1	3.2	4.2	3.4	3.4	4.1	4.2	**877**	**4.0**	**3.8**	-0.24	

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 0.2 days compared to last year, and showing a decrease over one day length of stay within Neurosciences.

Theatre – Touch Time Utilisation

Theatre Utilisation

Main List Specialty	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Number of Patients in the last month
Cardiothoracic	74%	75%	66%	78%	69%	68%	65%	69%	58%	71%	66%	69%	63%	51
ENT	70%	72%	69%	73%	65%	68%	64%	69%	72%	71%	74%	73%	76%	154
General Surgery	76%	72%	76%	76%	75%	72%	73%	72%	71%	74%	71%	73%	77%	163
Gynaecology	66%	70%	72%	67%	70%	72%	73%	71%	71%	69%	70%	70%	70%	119
Neurosurgery	72%	74%	70%	77%	78%	70%	75%	72%	75%	71%	80%	74%	69%	145
Oral and Maxillo Facial Surgery	44%	61%	54%	64%	69%	50%	77%	65%	58%	56%	65%	71%	68%	22
Paediatric Dentistry	39%	55%	41%	53%	55%	56%	45%	42%	56%	59%	52%	45%	50%	39
Paediatric Surgery	70%	74%	75%	71%	69%	73%	70%	72%	69%	71%	79%	75%	76%	105
Plastic Surgery	64%	67%	68%	71%	73%	67%	63%	64%	64%	69%	70%	69%	73%	161
Renal Medicine & Surgery	73%	55%	66%	69%	64%	70%	69%	74%	69%	60%	66%	61%	66%	20
Trauma & Orthopaedics	75%	70%	72%	72%	72%	67%	68%	77%	71%	75%	70%	75%	75%	123
Urology	79%	72%	79%	76%	77%	69%	71%	75%	76%	74%	78%	76%	80%	177
Vascular Surgery	70%	69%	73%	75%	69%	65%	62%	73%	73%	73%	74%	74%	71%	61
Grand Total	**72%**	**71%**	**72%**	**73%**	**72%**	**69%**	**69%**	**71%**	**70%**	**71%**	**73%**	**72%**	**73%**	**1,340**

Theatre Average Cases per Session

Main List Specialty	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Cardiothoracic	1.9	1.9	1.6	1.4	1.6	1.4	1.6	1.5	1.5	1.6	1.6	1.8	1.8
ENT	1.9	2.0	1.8	1.8	1.6	1.5	1.6	1.4	1.6	1.8	2.0	1.8	1.7
General Surgery	1.6	2.0	1.9	2.0	1.9	1.9	1.7	1.8	1.9	1.8	1.9	1.8	1.8
Gynaecology	2.4	2.2	2.2	2.4	2.3	2.2	2.3	1.9	2.5	2.3	2.3	2.2	2.7
Neurosurgery	1.2	1.1	1.1	1.3	1.3	1.0	1.2	1.1	1.2	1.2	1.2	1.1	1.1
Oral and Maxillo Facial Surgery	3.1	2.9	2.9	3.2	3.2	1.9	3.9	3.6	3.3	3.0	3.6	3.0	4.0
Paediatric Dentistry	4.5	4.4	4.4	3.7	4.7	3.8	3.6	4.0	4.3	4.3	3.7	4.2	4.0
Paediatric Surgery	2.6	2.6	2.4	2.5	2.6	2.4	2.5	2.6	2.7	2.4	2.6	2.4	2.6
Plastic Surgery	2.1	2.1	2.1	2.2	2.0	1.8	2.0	1.9	2.2	2.1	1.9	2.0	2.0
Renal Medicine & Surgery	1.5	2.1	1.8	1.5	1.4	1.7	1.3	1.9	1.4	1.9	1.5	1.8	1.4
Trauma & Orthopaedics	1.4	1.6	1.8	1.7	1.7	1.8	1.5	1.7	1.5	1.5	1.4	1.5	1.4
Urology	1.9	1.8	1.7	1.8	1.7	2.0	1.8	1.7	2.0	2.1	2.0	2.1	2.0
Vascular Surgery	1.2	1.0	1.1	1.2	1.1	1.0	1.0	1.2	1.2	1.2	1.3	1.0	1.1
Grand Total	**1.8**	**1.8**	**1.8**	**1.9**	**1.8**	**1.7**	**1.7**	**1.7**	**1.8**	**1.8**	**1.8**	**1.7**	**1.7**

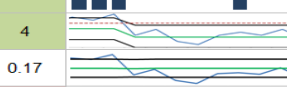
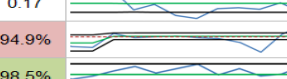
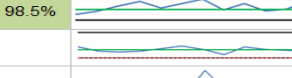
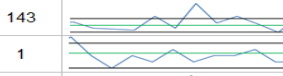
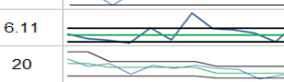
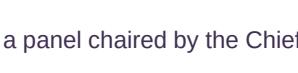
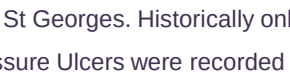
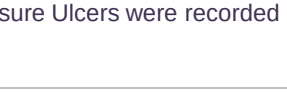
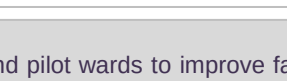
Briefing

Touchtime Utilisation on average for the past 12 months is at 71% against a targeted threshold of 85%. Work is on-going across all specialties to support an increase in utilisation and increase in theatre case bookings

Actions

- Identified DQ issues with informatics team which will identify increased theatre utilisation
- SNCT finance manager has completed service specific one pagers in conjunction with the FEI to identify actions required to support SLA achievement
- Increased support in DSU to ensure that the first 2 patients are ready for theatres prior to commencement of team brief
- New theatre schedule to commence 03.09.18 – additional sessions added into St James's Wing Theatre 7 to support SNCT services achieve weekly targets.

Patient Safety

Indicator Description	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend (12 months)
Number of Never Events in Month	0	1	0	0	1	0	0	1	0	2	1	0	0	0	
Number of SIs where Medication is a significant factor	0	1	1	1	0	0	0	0	0	1	0	0	0	0	
Number of Serious Incidents	8 / mth	10	9	11	4	6	2	1	4	5	4	6	3	4	
Serious Incidents - per 1000 bed days	N/A	0.40	0.38	0.45	0.16	0.24	0.08	0.04	0.18	0.19	0.17	0.26	0.13	0.17	
Safety Thermometer - % of patients with harm free care (all harm)	95%	93.8%	93.8%	95.7%	94.9%	95.0%	95.1%	94.9%	94.8%	94.3%	93.1%	95.3%	96.5%	94.9%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.5%	97.8%	98.3%	98.7%	98.1%	98.5%	98.9%	97.9%	98.5%	97.8%	98.0%	98.7%	98.5%	
Percentage of patients who have a VTE risk assessment	95%	95.8%	95.7%	95.4%	96.1%	96.4%	96.0%	95.4%	96.3%	96.0%	95.9%	95.8%	96.0%		
Number of Patient Falls	N/A	143	127	125	122	157	127	189	140	157	138	117	155	143	
Falls (Moderate and Above Severity)	N/A	5	2	0	2	1	3	1	2	2	3	1	1	1	
Number of patient falls- per 1000 bed days	N/A	5.71	5.29	5.15	4.89	6.23	5.17	7.49	6.15	6.05	5.77	5.01	6.70	6.11	
Number of Grade 2 Pressure Ulcers	N/A	23	15	18	7	16	13	16	13	12	2	6	10	20	
Acquired Grade 2 Pressure Ulcers per 1000 bed days	N/A	0.92	0.63	0.74	0.28	0.64	0.53	0.63	0.57	0.46	0.08	0.26	0.43	0.85	
Avoidable Grade 3 & 4 Pressure Ulcers	0	1	1	2	0	0	0	0	0	0	5	0	2	2	
Avoidable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0	0.04	0.04	0.08	0	0	0	0	0	0	0.21	0	0.09	0.09	
Acquired Grade 3 Pressure Ulcers						15	6	9	6	6	11	4	6	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 July.
- The Trust declared four Serious Incidents in July, with a total of seventeen year to date.
- The number of falls reported in July decreased from 155 in June to 143. Of the falls reported, 132 resulted in No Harm.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had a 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 July two avoidable Grade 3 and 4 Pressure Ulcers were recorded out of 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. Hybrid mattress implementation continues in September to ensure all Medical Wards in St James wing have the new mattresses to minimise delay to pressure relieving mattress.

Infection Control

Indicator Description	Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	YTD Actual	YTD Theshold	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Cdiff Incidences (in month)	30	2	3	1	4	0	0	0	1	2	6	1	3	3	13	10	
MSSA	25	4	4	1	1	2	3	0	3	1	2	2	1	1	6	8.3	
E-Coli	60	9	6	8	6	2	5	5	5	5	1	9	6	4	20	20	

Briefing

- The C Diff annual threshold for 2018/19 is 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 July the Trust reported three cases, totalling thirteen 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 twenty cases, four of which occurred in July.
- 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 six cases since April 2018.
- There are no reported cases of MRSA Bacteraemia in July.

Actions

All July 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

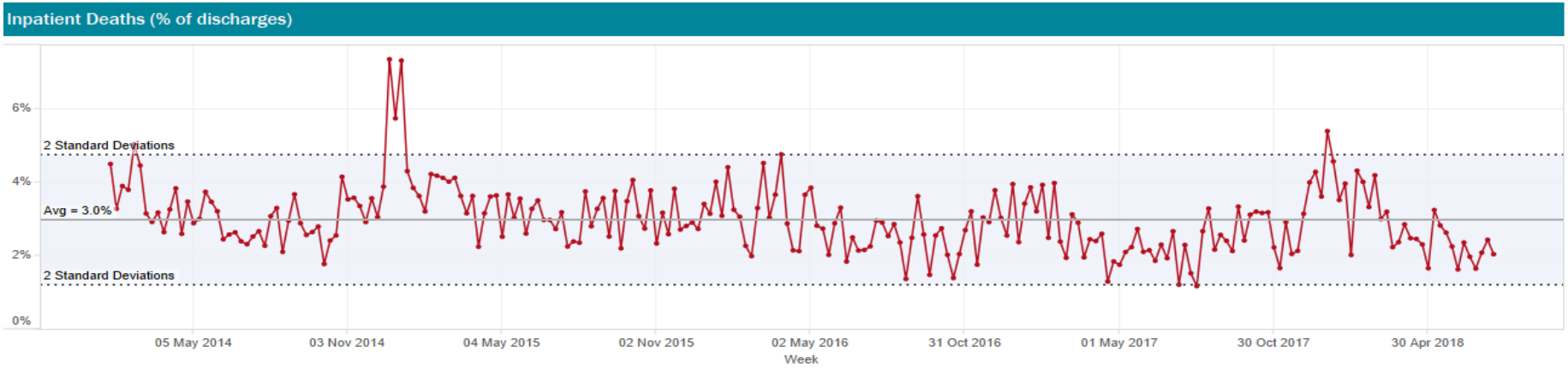
Mortality and Readmissions

Indicator Description	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	82.9	79.7	81.1	80.6	81.3	81.4	82.2	80.8	81.1	81.9	83.4	85.6	86.2	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	78.9	76.4	77.4	77.2	77.5	76.6	77	77.1	76.8	77.8	78.5	79.7	79.8	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	85.4	81.3	81.8	81.2	82	83.8	84.1	83.7	86.7	89.7	91.8	94.4	95.9	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.83	0.83	0.83	0.83	0.82	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	TBC	8.9%	9.0%	9.7%	10.2%	9.2%	9.4%	8.9%	9.0%	9.2%	8.7%	8.8%	8.3%		

Please note SHMI data is reflective of the period January to December 2017 based on a rolling 12 month period (published 19th July).
HSMR data reflective of period April 2017 – March 18 based on a rolling 12 month period (published 19th July).

Briefing

Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over performance and also under performance. In particular we are aware of mortality signals in cardiac surgery, general intensive care and total hip replacement surgery that are under investigation as well as a number of more discrete diagnostic and procedure codes from Dr Foster that are reviewed monthly by the Mortality Monitoring Committee.



Maternity

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

Indicator Description	Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend
C Section Rate - Emergency and Non Elective	28%	29.5%	24.9%	30.2%	29.7%	31.9%	25.4%	23.6%	23.1%	26.9%	25.4%	29.2%	26.7%	26.4%	
Admission of full term babies to neo-natal care		21	20	15	10	16	6	11	7	4	10	13	9	5	

Patient Voice

Indicator Description	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend
Emergency Department FFT - % positive responses	90%	83.9%	85.9%	83.5%	86.4%	84.1%	86.5%	82.2%	81.0%	81.4%	84.0%	85.0%	85.5%	83.7%	
Inpatient FFT - % positive responses	95%	96.6%	96.8%	96.5%	96.5%	95.7%	95.6%	94.7%	96.0%	96.3%	97.2%	97.3%	97.1%	96.7%	
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	97.2%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	87.1%	96.4%	100.0%	92.6%	96.0%	100.0%	99.0%	90.4%	100.0%	100.0%	98.4%	100.0%	100.0%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	98%	100%	100%	91.6%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	
Community FFT - % positive responses	90%	94.5%	98.3%	94.1%	98.9%	95.7%	96.5%	99.2%	93.3%	98.3%	97.1%	98.5%	98.3%	98.0%	
Outpatient FFT - % positive responses	90%	94.2%	96.2%	94.4%	96.3%	94.3%	98.2%	97.6%	96.1%	98.4%	97.3%	97.3%	97.4%	97.4%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		66	97	80	96	77	68	90	80	94	96	85	79	120	
PALS Received		284	244	203	198	305	262	290	236	259	264	317	292	337	

Briefing

- ED Friends and Family Test (FFT) – The score has seen a slight decrease in July reporting 83.7% in the recommended rate..
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96.7% in July 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 July was 120, this is an increase of over one complaint per day compared to June. 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 June 57% were responded to within 25 working days, this is against a trajectory to achieve 85% by September 2018. For 40 day complaints received in May 72% were responded to within 40 working days, working towards a trajectory of 95% by the end of September.

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.

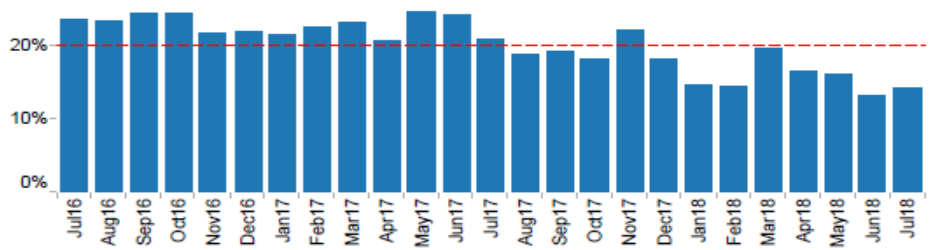
Patient Voice

CARING – Friends and Family Test

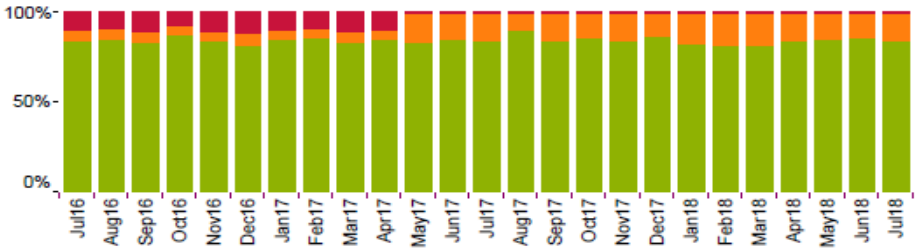
--- Target ¢ MetricMeasure Numerator Neutral Denominator

A&E Friends & Family Response Rate

Target: 20% Jun 18: 13.05% Jul 18: 14.11% Movement: ▲1.06%

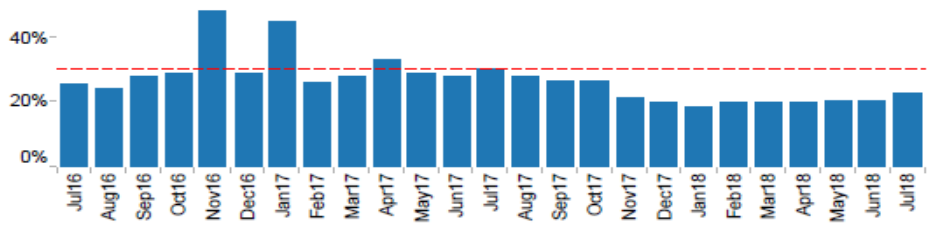


A&E Friends & Family Recommend Rate
The expected target is 90%

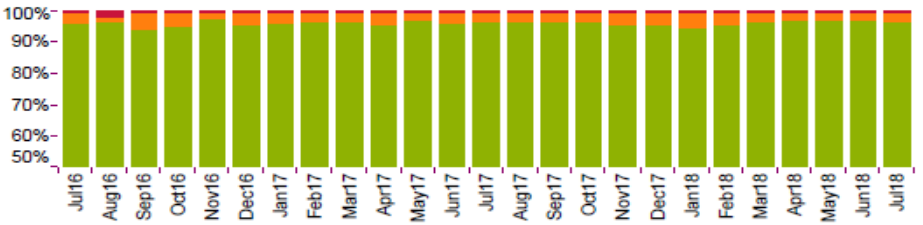


IP Friends & Family Response Rate

Target: 30% Jun 18: 20.07% Jul 18: 22.41% Movement: ▲2.34%

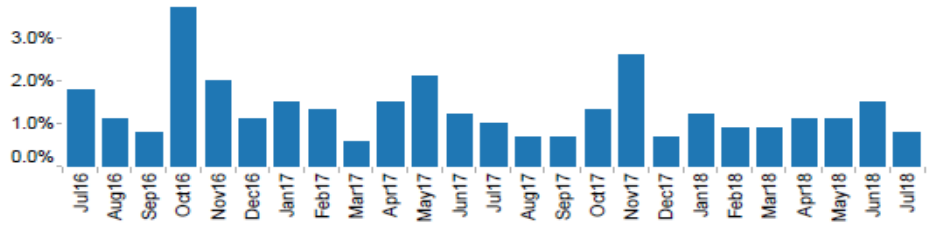


IP Friends & Family Recommend Rate
The expected target is 95%

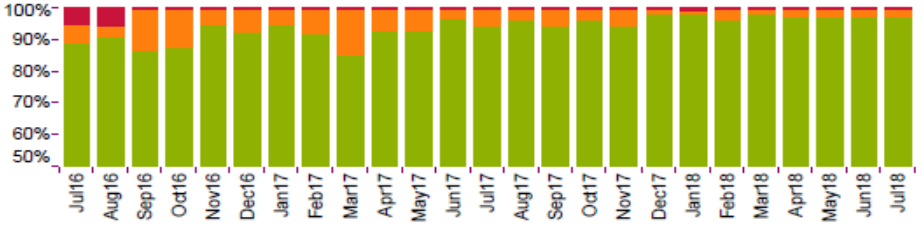


OP Friends & Family Response Rate

Target: 20% Jun 18: 1.50% Jul 18: 0.80% Movement: ▼-0.70%



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



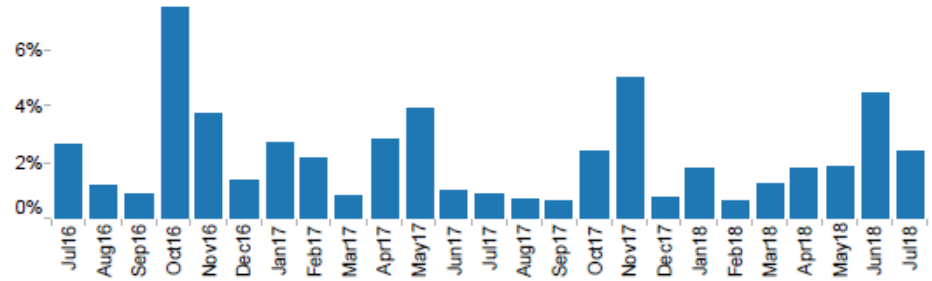
Patient Voice

CARING – Friends and Family Test

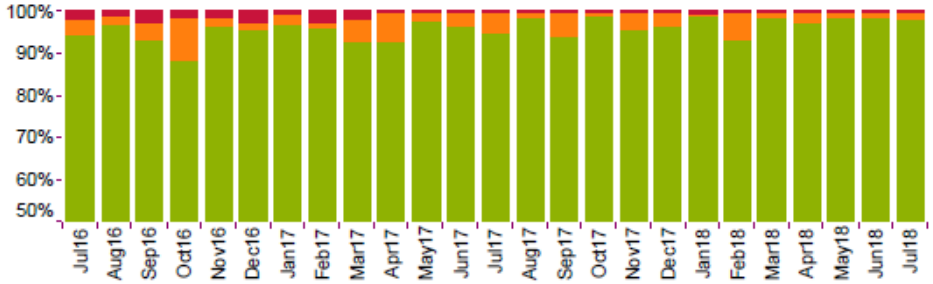
--- Target ¢ MetricMeasure Numerator Neutral Denominator

Community Friends & Family Response Rate

Target: 20% Jun 18: 4.44% Jul 18: 2.36% Movement: ▼-2.08%

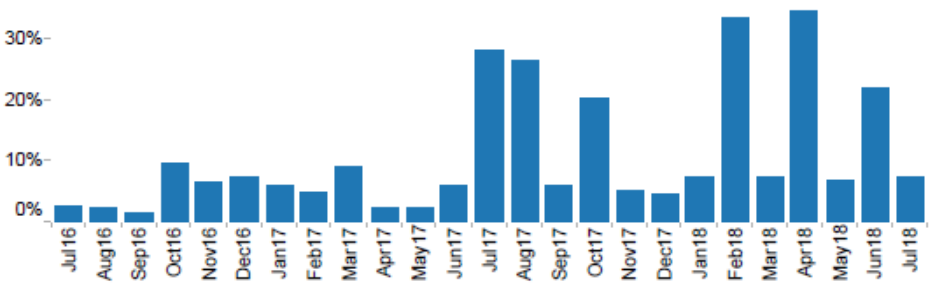


Community Friends & Family Recommend Rate
The expected target is 90%

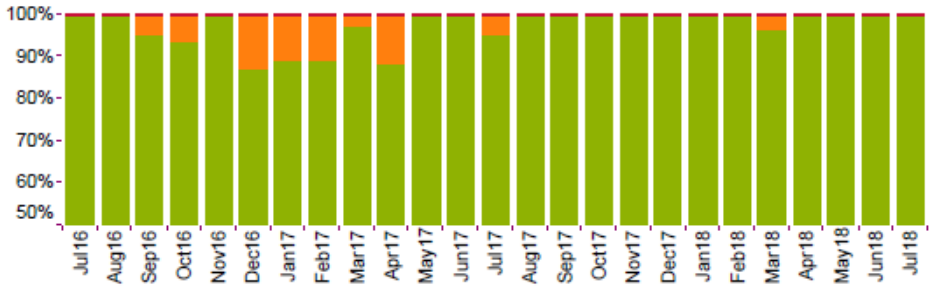


Maternity (Birth) Friends & Family Response Rate

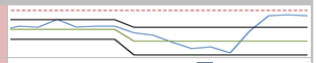
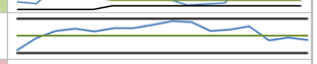
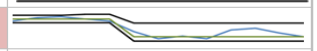
Target: 20% Jun 18: 21.70% Jul 18: 7.37% Movement: ▼-14.33%



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



Emergency Flow

Indicator Description	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend
4 Hour Operating Standard	95%	89.8%	90.1%	90.0%	88.0%	87.2%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	93.3%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	0	0	1	0	0	0	2	1	1	0	1	
Time to Treatment (number of patients seen within 60 minutes)	60%	56.0%	56.2%	54.1%	54.2%	54.2%	54.1%	51.7%	52.2%	52.6%	61.5%	63.5%	65.5%	63.7%	
Admitted patients with a length of stay 7 Days or Greater		346	336	349	348	362	376	373	337	343	356	301	313	304	
Ambulance Turnaround - % under 15 minutes	100%	48.9%	51.8%	50.9%	49.9%	49.0%	44.3%	41.0%	42.2%	41.0%	45.0%	45.7%	43.6%	42.0%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	46.4%	47.0%	46.5%	45.1%	46.1%	42.1%	41.4%	42.2%	41.1%	45.2%	45.7%	47.4%	46.7%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	53	84	71	57	82	112	180	135	105	92	65	72	75	
Ambulance Turnaround - % under 30 minutes	100%	97.4%	96.0%	96.6%	97.4%	96.2%	94.8%	91.3%	93.2%	94.5%	95.3%	96.8%	96.3%	98.5%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	93.2%	93.1%	92.2%	91.9%	91.7%	91.6%	86.7%	87.4%	87.5%	88.8%	91.9%	93.7%	93.1%	
Ambulance Turnaround - number over 60 minutes	0	1	1	0	0	0	2	3	3	10	1	0	0	0	

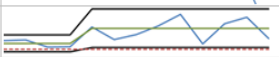
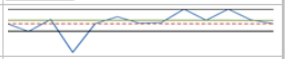
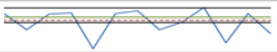
Briefing

- The Trust delivered the aggregate position for Quarter 1 against the four hour standard however in July the reportable position is at 93.3% and was below the monthly trajectory target of 95%. August trajectory is 94%.
- 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 since April reporting above London average against 30 minute turnaround target.

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	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	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	67.4%	80.3%	89.7%	94.0%	96.1%	97.3%	98.5%	94.8%	96.7%	96.8%	93.1%	93.3%	83.0%	1,376	
Cancer 14 Day Standard Breast Symptomatic	93%	62.9%	86.9%	90.3%	98.2%	99.6%	98.0%	97.3%	95.9%	96.5%	96.8%	94.4%	79.4%	22.2%	189	
Cancer 31 Day Diagnosis to Treatment	96%	96.8%	96.9%	96.2%	96.2%	98.1%	96.9%	97.4%	98.2%	99.3%	96.5%	98.4%	99.0%	97.0%	201	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	94.2%	90.9%	95.8%	82.4%	94.1%	96.9%	94.3%	94.6%	100.0%	95.5%	100.0%	95.7%	94.1%	17	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	101	
Cancer 62 Day Referral to Treatment Standard	85%	85.4%	77.8%	75.6%	76.7%	85.5%	80.8%	86.8%	77.8%	80.8%	88.1%	92.3%	85.9%	89.6%	72	
Cancer 62 Day Referral to Treatment Screening	90%	92.5%	86.1%	92.5%	93.0%	78.4%	92.7%	93.9%	86.1%	89.1%	95.2%	80.8%	92.7%	84.6%	26	

Briefing

- The Trust met four of the seven Cancer standards in the month of June, continuing to achieve 62 day standard reporting 89.6% and internally reporting 93.1%.
- Performance against the 14 day Standard's was not compliant in the month of June reporting 83% and below the 93% target in eight tumour groups
- Two week wait performance within Suspected Breast and Breast Symptomatic have fallen under the national requirement and remains non compliant in the month of June reporting 22% with a total of 147 patients breaching, this is due to a combination of factors meaning capacity in May fell.

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%
Jun-18	85%	89.2%	93.1%

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.
- Capacity within the Breast pathway has been created within diagnostics through the addition of a new ultrasound machine at St Georges Rose Centre site increasing the minimum weekly capacity by 60 slots weekly. On-going recruitment of vacant consultant posts, the creation of a new consultant post, and the introduction of a trainee position will further increase capacity by 60 slots and provide a more flexible and responsive service in the current year and a further 50 slots in year 2 once training is completed. Further capacity sourced from another brings the demand and capacity into balance. This will enable the backlog to be eliminated by the first week of August and a return to compliance against 2 Week Rule breast symptomatic from the WC 06th August 2018

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	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	No of Patients
Brain	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	4
Breast	93%	69.5%	76.4%	93.4%	94.1%	97.4%	98.4%	98.2%	96.0%	96.5%	93.9%	94.8%	91.9%	61.2%	224
Children's	93%	66.7%	80.0%	100.0%	100.0%	100.0%	71.4%	100.0%	87.5%	100.0%	100.0%	80.0%	100.0%	100.0%	8
Gynaecology	93%	75.6%	93.4%	90.4%	91.1%	90.8%	95.0%	97.6%	98.0%	96.8%	94.3%	94.9%	91.9%	86.1%	115
Haematology	93%	76.9%	95.7%	100.0%	100.0%	96.8%	100.0%	94.7%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	19
Head & Neck	93%	82.4%	88.0%	82.4%	90.6%	99.1%	99.4%	98.4%	100.0%	97.6%	100.0%	100.0%	97.5%	92.3%	169
Lower Gastrointestinal	93%	44.4%	60.0%	73.9%	94.6%	97.4%	97.7%	99.3%	95.2%	100.0%	97.8%	94.1%	90.3%	67.5%	228
Lung	93%	91.2%	95.6%	100.0%	94.1%	97.7%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	96.3%	90.9%	55
Skin	93%	26.9%	74.3%	96.6%	93.4%	95.0%	95.5%	97.9%	92.7%	94.8%	95.9%	94.1%	93.8%	92.7%	368
Upper Gastrointestinal	93%	93.8%	97.6%	98.8%	98.8%	98.5%	99.0%	100.0%	89.0%	97.3%	95.3%	85.2%	88.1%	89.9%	74
Urology	93%	82.3%	93.8%	97.0%	96.4%	93.3%	97.1%	98.9%	95.0%	95.1%	98.2%	81.3%	92.9%	96.5%	112

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	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	No of Patients
Brain	85%	0.0%	100.0%	0.0%	100.0%	-	100.0%	-	-	-	-	-	-	-	0
Breast	85%	100.0%	87.5%	100.0%	91.7%	100.0%	95.2%	100.0%	71.4%	100.0%	88.9%	94.1%	84.6%	91.7%	12
Children's	85%	-	-	0.0%	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	61.5%	100.0%	50.0%	83.3%	75.0%	67.0%	80.0%	77.8%	0.0%	100.0%	80.0%	100.0%	3
Haematology	85%	100.0%	100.0%	100.0%	88.9%	100.0%	-	100.0%	88.9%	83.3%	81.8%	100.0%	63.6%	100.0%	6
Head & Neck	85%	46.2%	66.7%	71.4%	87.5%	78.6%	81.8%	71.0%	100.0%	83.3%	80.0%	100.0%	90.0%	75.0%	2
Lower Gastrointestinal	85%	100.0%	60.0%	100.0%	66.7%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	4
Lung	85%	64.3%	41.7%	47.4%	72.2%	72.7%	41.2%	33.0%	90.9%	57.1%	100.0%	100.0%	87.5%	83.3%	6
Skin	85%	95.7%	100.0%	76.5%	93.8%	90.9%	91.7%	93.0%	86.7%	100.0%	100.0%	100.0%	90.9%	100.0%	8
Upper Gastrointestinal	85%	100.0%	100.0%	77.8%	0.0%	100.0%	84.0%	100.0%	33.3%	57.1%	66.7%	87.5%	33.3%	80.0%	5
Urology	85%	81.8%	63.0%	64.3%	77.4%	100.0%	72.7%	91.0%	60.7%	70.0%	96.7%	80.5%	84.6%	84.9%	26.5

Diagnostics

Indicator Description	Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend
6 Week Diagnostic Performance	1%	2.7%	2.0%	1.4%	0.3%	1.9%	0.1%	0.1%	0.0%	0.2%	0.2%	0.2%	0.3%	0.3%	
6 Week Diagnostic Breaches	N/A	190	154	98	22	143	6	10	3	17	15	14	25	24	
6 Week Diagnostic Waiting List Size	N/A	6,988	7,751	7,184	7,072	7,534	6,440	6,884	7,232	7,075	7,956	7,735	7,809	7,236	

Indicator Description	Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend
MRI	1%	0.8%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.4%	0.0%	
CT	1%	0.2%	0.3%	1.2%	0.3%	0.1%	0.0%	0.1%	0.0%	0.3%	0.1%	0.0%	0.3%	0.0%	
Non Obstetric Ultrasound	1%	1.1%	0.9%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	4.6%	5.7%	4.5%	0.0%	17.4%	0.0%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	
Echocardiography	1%	3.0%	0.3%	0.3%	0.3%	0.8%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	
Electrophysiology	1%	75.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.8%	0.0%	0.0%	0.0%	0.0%	0.3%	0.9%	0.0%	0.4%	0.2%	0.0%	0.0%	0.0%	
Sleep Studies	1%					26.8%	0.0%	0.0%	0.4%	0.6%	0.0%	0.0%	0.0%	1.1%	
Urodynamics	1%	64.2%	50.6%	37.0%	16.7%	6.7%	0.0%	0.0%	0.0%	9.1%	5.0%	23.9%	6.3%	26.5%	
Colonoscopy	1%	1.8%	0.0%	0.4%	1.1%	0.0%	0.0%	0.0%	0.6%	0.7%	0.6%	0.4%	0.0%	0.0%	
Flexi Sigmoidoscopy	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%	0.0%	
Cystoscopy	1%	14.0%	12.3%	14.7%	4.0%	1.8%	1.5%	2.8%	0.7%	0.0%	1.0%	0.8%	3.0%	1.8%	
Gastroscopy	1%	11.2%	6.7%	0.8%	0.0%	0.8%	0.4%	0.0%	0.0%	1.8%	1.0%	0.0%	0.0%	1.8%	

Briefing

- The Trust has continued to achieve performance in July reporting a total of twenty-four 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 thirteen patients waiting beyond six weeks this is due to capacity constraints within the service. An action plan has been agreed that will increase capacity by two sessions per month and will be implemented in September. In addition five Gastroenterology breaches were reported due to staffing issues within Paediatrics.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend
Number of on the Day Cancellations		84	54	49	52	86	100	94	55	86	64	87	42	54	
Number of on the Day cancellations re-booked within 28 Days		70	43	43	34	76	67	76	48	76	60	80	33	51	
% of Patients re-booked within 28 Days	100%	83.3%	79.6%	87.8%	65.4%	88.4%	67.0%	80.9%	87.3%	88.4%	93.8%	92.0%	78.6%	94.4%	

Briefing

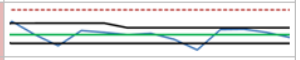
- In July 94.4% of our on the day cancelled patients were-rebooked within 28 days.
- Of the 54 patients cancelled on the day, 3 patients were not re-booked within 28 days
- Of the 54 cancellations reported, 39% were due to emergency cases taking priority.

Cancellation Reason	% cancelled
Timing - Emergency case took priority	38.9%
Timing - Complication - previous case/-s	20.4%
Other	18.5%
Timing - Surgeon / Anaesthetist late starting	5.6%
Timing - List over booked	5.6%
Staffing - Surgeon unavailable	5.6%
Administrative error - Booking error	3.7%
Timing - List Cancelled	1.9%

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	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Trend
Trust Level Sickness Rate	3%	3.6%	3.7%	3.6%	3.4%	3.8%	3.6%	4.1%	4.0%	3.6%	3.2%	3.2%	3.6%	3.5%	
Trust Vacancy Rate	10%	16.1%	16.5%	14.8%	16.1%	12.7%	13.0%	13.4%	13.5%	13.3%	12.6%	11.3%	11.0%	10.6%	
Trust Turnover Rate* Excludes Junior Doctors	13%	18.4%	19.6%	18.5%	18.5%	18.3%	18.4%	17.9%	17.6%	17.2%	16.9%	17.0%	17.3%	17.3%	
Total Funded Establishment		9,879	9,855	9,794	9,808	9,470	9,474	9,515	9,540	9,497	9,469	9,318	9,242	9,239	
IPR Appraisal Rate - Medical Staff	90%	84.8%	79.0%	74.0%	80.7%	80.0%	78.9%	79.6%	76.9%	72.2%	81.1%	81.3%	79.9%	77.7%	
IPR Appraisal Rate - Non Medical Staff	90%	76.1%	75.1%	79.4%	73.5%	70.2%	70.2%	67.2%	65.9%	61.6%	61.2%	63.4%	64.6%	67.6%	
% of Staff who have completed MAST training (in the last 12 months)		86%	86%	85%	86%	87%	86%	87%	87%	87%	87%	87%	87%	89%	
Ward Staffing Unfilled Duty Hours	10%	5.9%	6.5%	5.9%	6.1%	6.6%	7.8%	7.7%	7.9%	8.9%	6.5%	5.1%	4.9%	5.8%	
Safe Staffing Alerts	0	2	1	0	1	2	2	4	1	1	1	0	2	0	

* Excludes Junior doctors

Briefing

- Funded Establishment has continued to fall compared to the previous month reporting 9,239 WTE in July, 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 July reporting 10.6% in month.
- The Trust sickness level has remained above target of 3% reporting 3.5% in the month of July
- Mandatory and Statutory Training figures for July were recorded at 89%
- Medical Appraisal rates have fallen in July reporting 77.7% showing non compliance against a target of 90%
- Non-medical appraisal rates have seen a 3% improvement. Performance in July was 67.6% 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 to improve recording levels for non-medical staff, and a similar system for medical staff. In addition, Medical appraisers will be offered additional appraiser training. The new pay award links to appraisal and the importance of appraisal will be communicated to staff.

St George's University Hospitals NHS
NHS Foundation Trust

Workforce - Mandatory Training Compliance

By Staff Group

Staff Group	Compliance
Add Prof Scientific and Technic	91.65%
Additional Clinical Services	92.91%
Administrative and Clerical	90.08%
Allied Health Professionals	93.14%
Estates and Ancillary	92.07%
Healthcare Scientists	94.80%
Medical and Dental	68.55%
Nursing and Midwifery Registered	93.29%
Grand Total	89.63%

- All staff groups except for Medical have reached the 90% target.
- As Medical & Dental are a large staff group, this has brought down the Trust average to below 90%.
- Overall Trust compliance has increased from 83% in February .

By Division

Division	Compliance
Capital Division	84.09%
Children and Women's Diagnostic and Therapy Services Division	91.11%
Corporate Division	85.53%
Estates and Facilities Division	91.84%
Medicine and Cardiovascular Division	89.36%
Refund Posts Division	25.17%
Research & Development Division	90.52%
Surgery & Neurosciences Division	87.39%
SWL Pathology Division	94.28%
Grand Total	89.63%

- Only 4 divisions have reached the 90% target.
- Children and Women's Diagnostic and Therapy Services Division are the largest of the Clinical Divisions, and also have the highest compliance rate.

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NHS Foundation Trust

Workforce – Mandatory Training Compliance

Top five Care Groups*

Care Group	Division	Compliance
SWLP Microbiology	SWL Pathology Division	98.93%
Cancer	Surgery & Neurosciences Division	98.84%
Estates	Estates and Facilities Division	97.27%
Energy and Engineering	Estates and Facilities Division	97.07%
Outpatients	Children and Women's Diagnostic and Therapy Services Division	96.87%

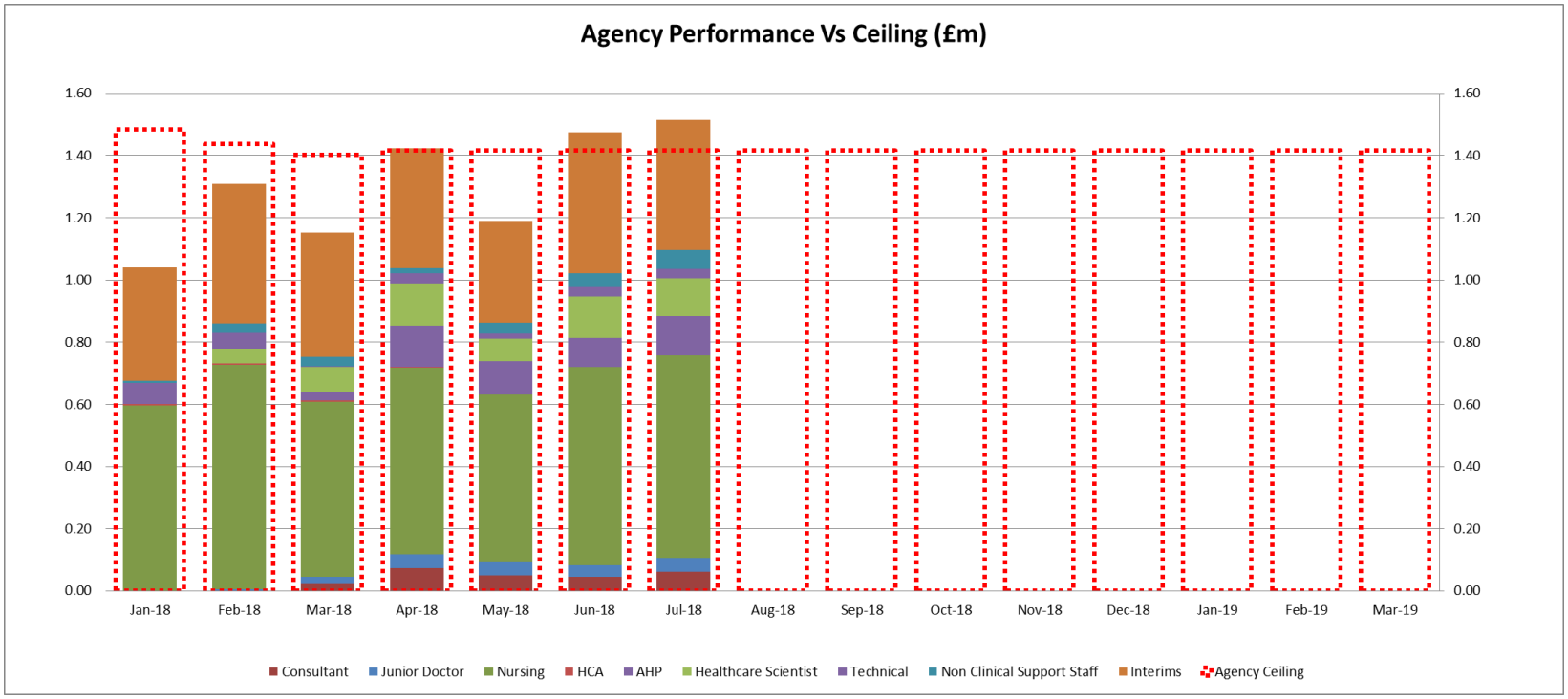
- No Medicine & Cardiovascular care groups appear in the top ten.
- Out of a total of 96 Care Groups, 56 have achieved over 90% compliance.

Bottom five Care Groups*

Care Group	Division	Compliance
Pathology - STG	Corporate Division	38.03%
Max Fax	Surgery & Neurosciences Division	68.52%
General Surgery	Surgery & Neurosciences Division	71.70%
Chief Executive	Corporate Division	72.50%
Finance Directorate	Corporate Division	77.14%

*Only Care Groups with more than 20 employees are included

Agency Use



- **Please note that the figures in the table have been restated to reflect the underlying agency spend.**
- **The Trust's total pay for July was £43.02m. This is £0.17m adverse to a plan of £42.84m.**
- 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 July was £1.51m or 3.5% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For July, the monthly target set was £1.42m. The total agency cost is worse than the target by £0.10m.
- Agency cost increased by £0.04m compared to June. There has been increases across most staff groups: mainly AHP (£0.03m) and Consultant (£0.02m). This is offset by decreases in Interims (£0.04m).
- The increase in Consultant costs is due to 2 agency Consultants in Acute Medicine this year.
- The increase in AHP is offset by a decrease in bank costs.
- The biggest area of overspend was in Interims, which breached the target by £0.12m.

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Meeting Title:	Trust Board (Part 1)		
Date:	30 August 2018	**Agenda No**	**3.3**
Report Title:	Elective Care Recovery Programme (ECRP) update		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Matthew Davenport, Deputy Director Elective Care		
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) Clinical Harm Review update 4) Return to reporting of the RTT standard as a Trust in 2018/19 5) ECRP updates 6) Findings of the RM Partners report into the reporting and delivery of cancer services provided at this Trust. The RM Partners report is provided in full in this paper.		
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		
Risks:	ECRP risks to be reviewed		
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	July 2018	
Equality Impact Assessment:	N/A		
Appendices:	• Appendix A – RM Partners Cancer Actions and Assurance Report		

Elective Care Recovery Programme Update

Trust Board (Part 1)

30 August 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. The overall size of the PTL is also reducing and we are expecting this to be ahead of trajectory as of the end of August 2018.
- 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

- The Trust has approved additional funding to be made available to support the accurate recording of patient pathway activity on the Trust's IT system.
- Targeted training for the teams who use the Trust's IT system most to track patients on a RTT pathway continues.
- The completion of the RTT e-learning modules has been mandated by each of the Divisional management team and is being tracked through the new weekly Access Meeting, chaired by the Divisional Director of Operations for Surgery, Cancer, Neurosciences and Theatres and supported by the Deputy Director of Elective Care.

3) Clinical Harm Review Update

Further to the July Trust Board paper, this paper provides an update on the additional validation being undertaken by GP practices post the phase 1 validation of historical patient records.

- This review continues. To date only 19 patients have been referred back to the Trust for a clinical review. Each patient is now being clinically validated by the relevant service. Any

patient requiring an appointment after clinical review will be booked as a priority. To date there have been no cases of clinical harm identified as a result of this process.

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

Phase 2 Current and Historical Validations

Good progress is being made on the validation of historical validation.

- By definition this cohort of patients is significantly lower risk than the cohort within Phase 1 and as described in the July Trust Board paper.

- 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 (SGH) site, 6,000 at Queen Mary's (QMH).

- 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 now 3,676 (1,831 at St George's and 1,845 at Queen Mary's.)

- QMH have now reviewed 1,615 of their 1,845 records across Audiology, Care of the Elderly, ENT, Gastroenterology, Gynaecology, Medical Cardiology, Orthopaedic Surgery, Plastic Surgery and Rehab. Services have confirmed these cases can be closed.

- The patient information for SGH has now been sent to the appropriate services to start the review process. Each week, service teams will update on the progress of this work.

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.

The Trust continues to work with its main Commissioners, the Intensive Support Team and NHS Improvement on finalising its return to reporting work plan.

5) ECRP update to the August 2018 trust Board

Further to the July Trust Board an agreed action was to bring the RM Partners external review of cancer services to the August Trust Board meeting. The Trust Executive Committee received this report in July 2018 and accepted all the recommendations within it. The main recommendation from the report was to prioritise the tracking of patients on a cancer pathway on its IT systems.

No immediate concerns were raised from this report and good progress is being made against the 7 key actions recommended.

The majority of the actions recommended by the review have been implemented with the remaining actions having plans to be implemented in the coming weeks.

Royal Marsden Partners were commissioned by the Trust and funded by NHSi to provide independent assurance of the Trust's response to and actions taken, to address risks of tracking cancer patients at Queen Mary's Hospital Roehampton. The scope of this work included, recovery of 62 day performance, a review of inter trust transfer of patients and to embed policy and procedure to the tracking of patients on a cancer pathway.

The report identified a number of pathway risks and a number of mitigating actions were recommended.

The RMP assurance report can be found in Appendix A.

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Appendix A

NHS

RM Partners St George's University Hospitals NHS Foundation Trust

Action and Assurance Plan

09 April 2018

Final version 2.0

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Item 3: Discussion Pack

#	Item
1	Executive Summary
2	Background and Context
3	Scope
4	Assurance of MBI report
5	Actions and Assurance
6	Review in September 2018
7	Appendices
7.1	Regulator Assurance
7.2	SOPs
7.3	Infoflex CIMS Scope of Work and Specification
7.4	Action Plan
7.5	Issues Log

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Executive Summary

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Executive Summary

This report provides the Trust and NHSi with independent assurance of the Trust's response to and actions taken, to address risks of tracking cancer patients at Queen Mary's Hospital Roehampton. These will be fully completed following the Cerner upgrade planned for Q4 18/19 ***(ref MBI report 2017)***

Improvements and recommendations for the operational management of cancer services are summarised in this report and the Cancer Management Team received a detailed action plan. The Trust has been commended for its prompt adoption of these recommendations, a further review in September 2018 will ensure that these changes are fully embedded.

RMP is continuing to support the Trust's operational management and transformation agenda.

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Background and Context

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Background and Context of External Support

- RMP was commissioned to work with the Trust to identify improvements to 62 day performance
- In addition to meeting this constitutional standard this also supported access to the ongoing transformation funding
- A number of operational and pathway risks were identified
- RMP supported the Trust in taking immediate action to mitigate risk and address issues as they were identified
- A wide range of staff with both operational and clinical remits both within the Trust and other partner organisations were engaged at all levels (Interview schedule attached at Appendix 6.5)
- RMP are continuing to support the Trust's transformation in the following areas:
  - Colorectal redesign pathway
  - Optimal lung pathway
  - Upper GI MDC
  - RAPID Prostate pathway
  - Investment in diagnostics
  - Digital solutions, including Infoflex business case

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Scope

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Scope of Work

The following was agreed as the initial scope of work:

- Support sustainable recovery of 62-day performance
- ITT and 38-day performance review
- Provide further assurance to the sector and regulators
- Embed policies and procedures of PTL meetings
- Review QMH
    - Analysis of cancer pathways at QMH to include:
    - Process of adding patients to Infoflex from Clinicom;
    - Deep dive into data recording within Infoflex
    - Tracking patients on the QMH site
    - Tracking patients between organisations / sites
    - Clinical governance ownership of patients being tracked between different organisations / sites
    - Activity and Reporting ownership of patients being tracked between different organisations / sites
    - Resource Requirements to enable more effective tracking, MDT preparation and delivery
    - PTL review and further redesign

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Assurance of MBI report 2017

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Review of MBI (Complete and reported to NHSI) 1 of 2

No	Issue	Comment	RAG	Date
1	Urgently implement one of two solutions to cancer outcomes. Outcomes forms used and available within 24 hours (and this to be tightly monitored) or, letters for attendances available within 24 hours for all cancer patients. This will undoubtedly require a review of resourcing depending on the option the Trust chooses. Using outcome forms would mean MDT coordinators would no longer need to interpret clinical letters.	All cancer patients at QMH tracked by SGH MDT coordinators under the Cancer Management Team and processes. (See BAU section for risk re embeddedness).	G	Mar 2018
2	PTL meetings to cover 2WW and 31 day PTLs	Complete	G	Mar 2018
3	Escalation protocols for lack of capacity need clarification	Complete	G	Mar 2018
4	The Trust should move to make all MDT meeting data entry live. This will require having the appropriate equipment and infrastructure in MDT meeting rooms.	Trust Board has approved the Business Case for Cerner upgrade	A	Q4 18/19
5	Ensure that all QMH team members detail their routine work in Standard Operating Procedures	NA see above		
6	Identify which staff at QMH need to have access to Infoflex in order to update it.	NA see above		

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Review of MBI (Complete and reported to NHSI) 1 of 2

No	Issue	Comment	RAG	Date
7	If the St. George's site approach is adopted, the MDT Coordinator at QMH would use Infoflex to comprehensively record each patient's pathway. Currently the QMH site has just one MDT Coordinator.	NA see above		
8	All 2ww referrals at QMH need to be added to Infoflex. This can be done either manually or alternatively by developing an automatic download from the QMH PAS into Infoflex mirroring the download from the St. George's Cerner PAS.	Complete	G	Mar 2018
9	Clarify with Kingston Hospital their involvement in tracking and reporting patients seen at the QMH site. With QMH patients recorded on Infoflex there should be no need for Kingston to report 2WW performance for St. George's Trust.	Complete	G	Mar 2018
10	With access to QMH PAS and clinic letters the MDT Coordinators at QMH will be pivotal in adding data to Infoflex and may need additional support in the first instance.	NA see above		
11	Reach an agreement with Kingston Hospital NHS Foundation Trust to take control of reporting 2WW performance data.	Complete	G	Mar 2018

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Actions and Assurance

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Recommendations

No	Issue	Comment	Owner	RAG	Date
1	PTL management	Extended meetings in place for day zero management of PTL	SGH	G	Mar 2018
2	Data and analytics team	Additional resource and expertise in place	SGH	G	Mar 2018
3	TW office	The office is now appropriately resourced and managing all SGH referrals. Daily escalation of capacity issues. SOP in place	SGH	G	Mar 2018
4	Senior input to PTL meetings reinstated	Services with specific issues identified and supported. Expectations for MDT co-ordinators and service managers are clear. Escalation of capacity issues embedded	SGH	G	Mar 2018
5	KHT reporting for QMH TWR patients	Agreement reached for SGH to report TWR data	SGH / KHT	G	Mar 2018
6	IT Governance	Peter Ebioke aware and a review to be undertaken	SGH	A	Mar 2018

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Recommendations

No	Issue	Comment	Owner	RAG	Date
7	Risk of stand-alone dermatology MDT coordinator at QMH. Need to retain good practice whilst ensuring resilience	Confirm Patient Navigator role of Dermatology MDT coordinator at QMH. JD and HR reporting route into cancer team.	SGH	A	April 2018
8	Dummy 'duplicate' records on PTL	Risk eradicated by TWR managing all SGH patients and tracking via SGH MDT coordinators. Shared weekly PTL with Kingston to ensure no gaps between organisations.	SGH	G	Mar 2018
9	Patient risk identified for duplicates prior to new system being implemented	Backlog review fully complete	SGH	G	Mar 2018
10	Poor performance of Infoflex	A high level specification has been submitted to Infoflex to undertake diagnostic and remedial work to identify the reasons and resolve the issues. Appendix 3	SGH	G	Mar 2018

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Recommendations

No	Issue	Comment	Owner	RAG	Date
11	Head and Neck service redesign				
	High number of H&N breaches	Breach review completed. Themes identified	RMP	G	Feb 2018
	Delays in composite surgeries for Max Facs	On going. Explore Graham Smith surgery move to RMH	RMP	A	May 2018
	H&N Internal performance good but access policy not being adhered to for patients originating from 'spoke' partner trusts	Review hub and spoke criteria including patient criteria / eligibility for MDT	RMP	A	May 2018
12	Colorectal	Job planning review to be undertaken	KHT	A	May 2018
13	Prostate - RAPID	Now fully implemented at QMH	RMP	G	Mar 2018
14	Lung - NOLP	Progressing according to plan	RMP	G	Mar 2018
15	ITT management resulting in avoidable breaches, no breach review meeting in place, poor reporting accuracy and 'surprise' breaches	Weekly joint PTL meetings including ITT breach reviews, in place but not yet embedded	STP	A	Oct 2018

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Recommendations

No	Issue	Comment	Owner	RAG	Date
16	Escalation of diagnostic capacity	Facilitated increased diagnostic capacity and additional clinics to support real-time capacity flexibility to meet demand	SGH	G	
17	SGH profile and reputation	Cancer Manager attendance at SLF and other STP meetings, COO or DDO for Surgery to the Delivery Group.	SGH	G	
18	Perception of fluctuating patient level detail.	Clear defined route for reporting performance. Senior sign off of any un-validated numbers	SGH	G	

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Further Assurance Business as Usual Review

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Recommendations (Review in September 2018)

No	Issue	Comment	Owner	RAG	Date
1	Maintain the seniority of management input to the PTL meetings		SGH	TBC	Sept 2018
2	Joint PTL and breach review of QMH patients with Kingston.		SGH	TBC	Sept 2018
3	Accurate and timely reporting of the numbers, through an approved escalation route, to STP and NHSI		SGH	TBC	Sept 2018
4	TWR SOPs recently refreshed. Further efficiencies are still to be gained. Daily call with TWR and escalation to cancer manager for resourcing in place but not yet embedded		SGH	TBC	Sept 2018
5	Full Cerner implementation plan at QMH		SGH	TBC	Dec 2018
6	Review colorectal pathway following job planning		KHT	TBC	Sept 2018
7	Full implementation of Best Practice pathways		RMP	TBC	Sept 2018
8	Continue to deliver transformation pathways		RMP	TBC	Sept 2018
9	Align the KHT patient review with the embedded SWL ITT weekly review process		STP	TBC	Sept 2018

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Appendices

Operational Grip at St Georges

- RMP has provided SGH with further intensive support to ensure that required changes were embedded and improvement sustainable including:
  - Senior input to PTL meetings reinstated; 'man marking' of key senior managers, coaching and training of MDT co-ordinators and service managers
  - Facilitated clinical discussions to increase diagnostic capacity and to run additional clinics to support real-time demand & capacity flex

- The Trust has:
  - Established extended PTL meetings for Day Zero management of patients
  - Strengthened data and analytic team and function
  - TWR office appropriately resourced
  - Taken immediate actions to prevent TWR delay impacting on 62 (as it had previously)
  - Further work includes TWR process review and SOPs

An RMP assurance report confirms the above actions and commends the trust for taking immediate action as issues were uncovered. The report also includes QMH pathway review and addresses the previous MBI report risks.

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SOPs

Standard Operating Procedure for TWR patients booked at QMH

Background

All patients referred to St Georges or Queen Mary's Hospital (QMH) with a suspected diagnosis of cancer is booked an appointment by the Two Week Rule (TWR) office based in Trident House.

QMH has a separate PAS system to that in use on the STG main site

Patients seen by Kingston based consultants who are not discharged may continue their pathway at Kingston Hospital.

All patients who have an appointment or diagnostic booked at QMH appear on each tumour type PTL as well as the TWR PTL

Responsibilities

There is a dedicated MDT co-ordinator for skin based at QMH, they will continue to track skin patients at QMH

All other MDT co-ordinators will track all patients on their tumour type specific PTL.

Process

At the weekly tumour site specific PTL meeting all patients will be discussed and assurance provided of the next event date and progress against 62 days.

All patients will be tracked down to day zero.

Patients seen at QMH that are new to the PTL will be identified and added to a list for discussion with Kingston Hospital MDT co-ordinators

The MDT co-ordinator at STG will ring their counterpart at Kingston to identify the patients that have been taken over by Kingston

The MDT co-ordinator will discharge all patients identified as being taken over by Kingston and confirm this action by email to the MDT co-ordinator clearly documenting this as the reason on infoflex.

All other QMH patients will be tracked in the usual way remaining on their 62 day pathway at STG.

Review

This SOP will be reviewed once Cerner is introduced at QMH

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Infoflex Scope of Work

CIMS

CHAMELEON INFORMATION MANAGEMENT SERVICES LTD

59-61 High Street, Rickmansworth, Hertfordshire, WD3 1RH
Tel: 01923 896939 Fax: 01923 896526 Email: cims@infoflex-cims.co.uk

Our Ref: Q116NW171108F

David Gray, General Manager
Cancer Services and Macmillan Programme
St George's University Hospitals NHS Foundation Trust
Blackshaw Road
Tooting
London SW17 0QT

Email: david.gray22@nhs.net

8th November 2017

Dear David,

Re: InfoFlex Design Consultancy

Following your discussions with my colleague Nirjhor Biswas, I have pleasure in attaching a quotation to provide InfoFlex Design Consultancy to address issues that you have identified in your email of 27th October 2017.

I have listed the issues below as per your email and referred to these in the attached quotation.

1. Establish pathways across all tumour types within the InfoFlex system – such as the Optimal Lung Pathway
2. Validate and rewrite queries, where necessary, for all reports.
3. Validate the Data Warehouse (DWH) and Cerner data feeds into InfoFlex. Why are there more patients in Cerner than InfoFlex? Why are there duplicates?
4. Support transition of reporting via DWH into Tableau to provide transparency and widen access
5. Remove unnecessary customisation to speed up the system
6. Upgrade to latest server version
7. Cleansing of the PTL
8. PTL to move into tableau with visual representation of 14, 28, 31 and 62 day pathways
9. Diagnostic work on macro – what does this do and what are the risks

In order to support this project, we have kept our costs to a minimum and it is essential that the appropriate resources are allocated by the Trust.

Yours sincerely,

Nigel Waters
Director of Account Management

Encs

Registered Office: 59-61 High Street, Rickmansworth, Hertfordshire, WD3 1RH. Registered in England No 3072160

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Interview Schedule

Anne Pye	Hasan Qazi
Sandra Howard	Barry Mullholland
Raminder Aul	Peter Ebioke
Andrew Poullis	Anna Clough
Sharon Esser	Jennifer MBI
Sam Zamai	Ayse Hassan
Lucy Titheridge	Nicola Kane
Rami Issi	Diagnostics DDO
Adrian Fawcett	Angela Hawley
Rami Issi	Adrian Draper
Debbie Ball	Janice Minter
Anne Dunleavy	Rob Samuel
Dermatology reception	Charlotte Carne
Paul Nicholas	Lizzie Peggers
Tunde Odutoye	Toks Apata
Ellis Pullinger	Sarah Adams
James Eaton	Tim Bill
Stuart Reeves	David Gray
Lucy Titherage	Nazeem Udin
David Gray	Monique Usher
Kim Barrow	Peter Ebioke (TBC)
Andrew Irvin	Martine Blackwood
All MDT co-ordinators and service managers - PTL meetings	

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Detailed Action Plan and Issues log

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	30 August 2018	**Agenda No.**	3.4
Report Title:	Emergency Care Performance Update – August 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 update on performance against the 95% Emergency Care Operating Standard and agreed trajectory linked to £3.7m Sustainability and Transformation Funding (STF). • The paper summarises the key issues impacting upon current performance and the actions and resources required in order to improve performance in line with the trajectory.		
Executive Summary:	• In 2018/19 £3.7m of STF opportunity is linked to the delivery of Emergency Care Performance in line with the agreed quarterly trajectory. • For Q1 the Trust achieved the quarterly target, delivering 91.84% against the trajectory to deliver 91%. • In July 2018, the Trust delivered performance of 93.28% against the improvement trajectory target and national standard of 95%. • Emergency care performance has deteriorated in August across admitted and non-admitted pathways. The Trust is currently delivering 90.32%, against a trajectory of 94% for August. • Performance for Q2 is currently 92.35% against a target of 94.67%. Year to date, performance is 92.01% against the trajectory of 92% for 2018/19 as at 15 August. • The key factors affecting performance and the actions being taken to recover are described in the paper. The service expects performance to improve in August to deliver a minimum of 92%.		
Recommendation:	• It is recommended that the Trust Board note the update on performance against the 4 hour Emergency Care Operating Standard and the actions being taken to improve performance.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person. Right care, right place, right time.		
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		
Legal/Regulatory:	NHS Operating Standard.		
Resources:	N/A		
Previously Considered by:	Finance and Improvement Committee	**Date:**	23.08.18
Appendices:	1		

1.0 Purpose

1.1 This paper presents an update on performance against the 95% Emergency Care Standard and agreed trajectory linked to £3.7m Sustainability and Transformation Funding (STF).

1.2 The paper summarises the key issues impacting upon current performance and the actions and resources required in order to improve performance in line with the trajectory.

2.0 Current Emergency Care Performance

2.1 The Trust delivered 93.28% performance against the national standard and trajectory target for July 2018 of 95%. This is a slight deterioration compared to June's performance of 93.59%, however represents a 3.5% improvement compared to performance in July 2017 of 89.76%. Performance has deteriorated further in August to 90.32% as at 15 August 2018 against the trajectory target of 94%.

2.2 Year to date for 2018/19, performance stands at 92.01% against the trajectory to deliver 92% across the year. The Trust is behind trajectory for Q2 with performance of 92.35% against a target of 94.67% for the quarter, linked to Sustainability and Transformation Fund (STF) opportunity. The trajectory targets for Q3 and Q4 are 92% and 91.67% respectively. The table below shows the target and performance to date against the quarterly trajectory:

Quarter	Target performance	Actual performance
Q1	91%	91.84%
Q2	94.67%	92.35%
Q3	92%	
Q4	91.67%	

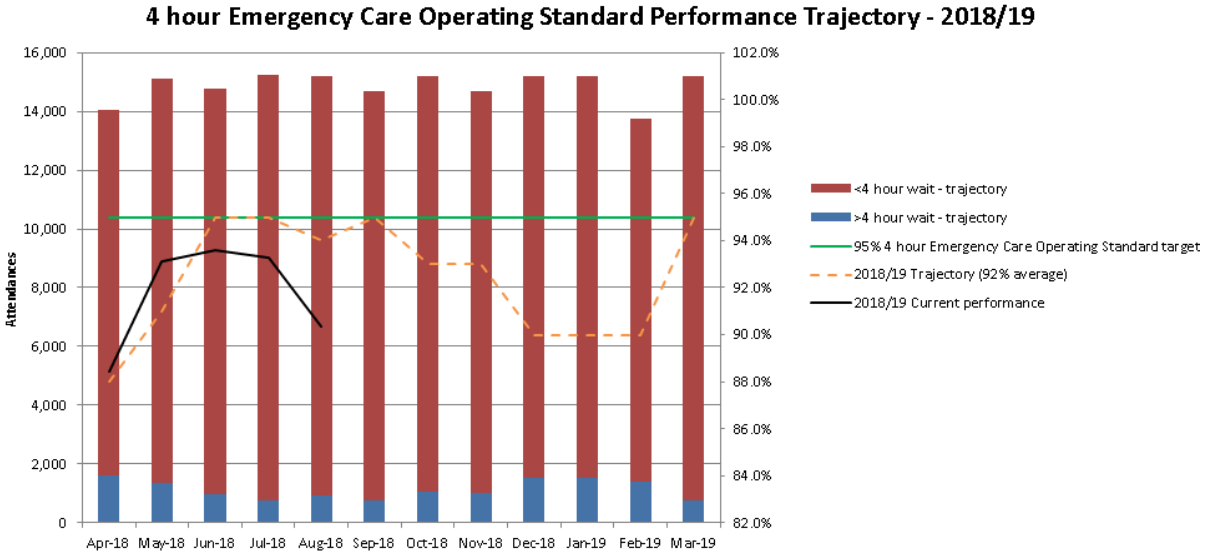
2.3 In July 2018, The Trust saw total attendances of 15,230 (Type 1 and Type 3) compared to 14,763 in June, in line with a national rise in attendances. There were medical staffing shortages due to vacancies within ED throughout July including 14.0 WTE junior vacancies and a locum fill rate of 82.5%, impacting on both admitted and non-admitted pathways. During the first two weeks of August, bed occupancy increased to 93.1% compared to 92.39% in July affecting admitted performance. During the week ending 15 August, 37.81% of patients had a length of stay of 7 days or more compared to a 6 week average of 36.75% and 14.56% of patients had a length of stay of 21 days or more, up from 13.79% across the previous 6 weeks. Performance in August will also have been affected by the junior doctor changeover.

2.4 Ambulance handover performance improved in July 2018, with 98.5% of handovers achieved within 30 minutes compared to 96.8% in June. The London average for July was 93.1%. There were no 60 minute ambulance breaches in July 2018.

2.5 The Trust incurred one 12 hour trolley breach in July, which related to the care of a mental health patient. There have been 331 breaches of the 4 hour standard for mental health reasons (6.27% of total) since April 2018 and three 12 hour breaches since April 2018 relating to mental health patients.

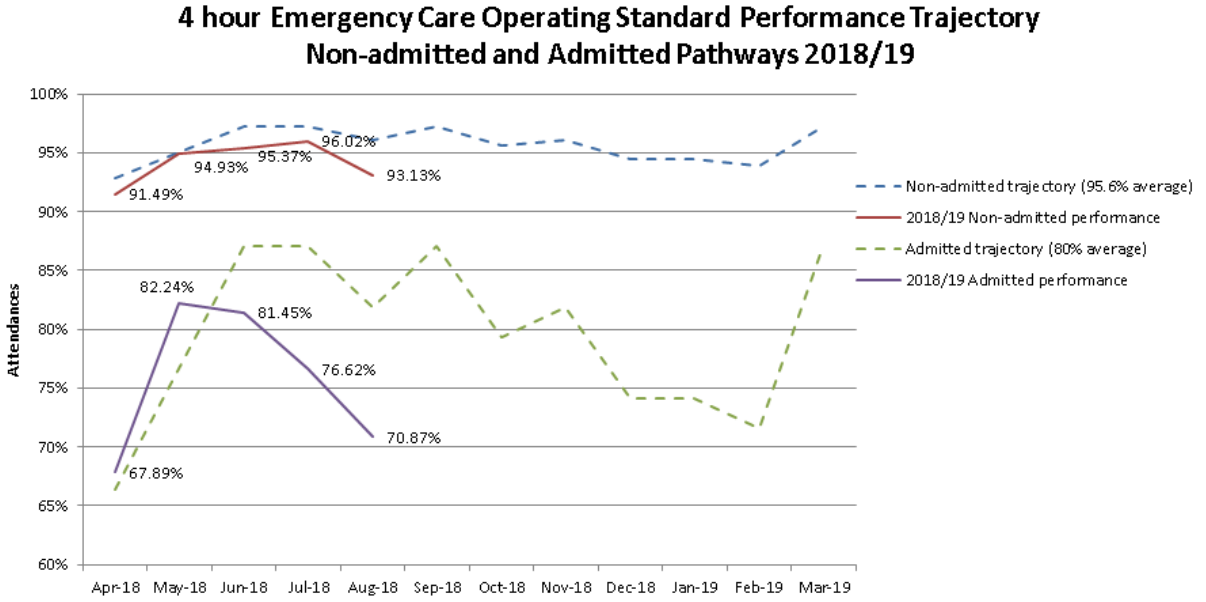
2.6 The chart (Fig 1) below outlines current performance against trajectory as at 15 August 2018 and 2017/18 performance. Figure 2 shows performance against trajectory for admitted and non-admitted pathways.

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%	93.28%	90.32%							

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%	96.02%	93.13%							
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%	81.45%	76.62%	70.87%							

2.7 Performance across the non-admitted pathway continued to improve in July to 96.02% but has seen a decline to 93.13% in August. The service aims to deliver non-

admitted performance of 97-98% consistently for non-admitted patients. Admitted pathway performance remains a concern. The Trust saw deterioration in July to 76.62%, followed by further deterioration in August to 70.87%. The service is targeting the delivery of 80% performance consistently for the admitted pathway.

2.8 The table below summarises the key issues currently impacting upon performance and the key actions and mitigation. The service expects to recover performance to deliver a minimum of 92% performance for August, a breach tolerance of 30 per day. A breach tolerance of 20 per day would deliver 93% performance. The trajectory for Q2 of 94.67% is challenged. The actions described below and continued efforts to further embed actions described in the 15 Point Plan for the remainder of Q2 are expected to recover performance to as close to 94.67% as possible. The Trust aims to deliver minimum performance of 92.5% for Q2 based on the current position.

Key issue	Plan	Impact
ED staffing gaps in July due to junior doctor vacancies and locum fill rate	• Staffing levels have improved in August, vacancies reduced from 14 to 5 WTE. • 2 Advanced Clinical Practitioners and 3 Physician Associates recruited to fill remaining vacancies and to contribute to a sustainable ED workforce. • Second review of ED rotas underway with support from ECIP to be completed by 14 September 2018.	Admitted and non-admitted pathway
Increase in bed occupancy and proportion of stranded and super stranded patients	• External support to undertake a review of length of stay and opportunities. • Review of discharge model underway led by Deputy Chief Nurse to be completed by September 2018. • Extended ambulatory care opening hours in place from 23 July 2018. • Minimum standards workshop to be held on 18 September 2018 supported by Transformation team.	Admitted pathway
Shift leadership within the ED remains inconsistent (15 PP 1, 2, 3, 8)	• Conclusion of roles and responsibilities QI work by end August 2018. • Training needs analysis to be undertaken by 14 September 2018.	Admitted and non-admitted pathway
Leadership changes within the ED	• Interim Head of Nursing in post and recruitment is in progress. • Matron post recruited to with a start date in October.	Admitted and non-admitted pathway
Patient flow co-ordination within ED (15 PP 14)	• Business case developed to increase patient flow co-ordinator presence from 9.45 – 22.45 to 7.30 – 6.30 7 days a week. To be presented to IDG on 4 September 2018.	Admitted and non-admitted pathway
Specialty response times within 30 minutes remain variable	• Inter-professional standards to be re-launched and widely communicated. • Specialty specific action plans monitored	Admitted and non-admitted pathway

(15 PP 4,13)	weekly via Emergency Care Performance Improvement Group.	

3.0 Progress against 15 Point Plan

3.1 The 15 Point Plan dashboard is included in Appendix 1. Whilst there have been demonstrable improvements against some metrics compared to Q1 2017/18, including a reduction in the number of breaches due to bed management (40%), ED capacity (67%) and specialist opinion (14%), some areas require increased focus, including patients leaving ED within 30 minutes of bed allocation and strengthening shift leadership and patient flow co-ordinator presence within ED. Each of the objectives has been RAG rated based on the associated KPI and completeness. The number of objectives under each category is as follows:

15 Point Plan Objectives	5	9	1

3.2 The key areas of focus in order to recover ED performance, including key and expected time of impact include:

1. **Emergency Department Assessment, Treatment Decisions and Shift Leadership**
   - Increase in breaches due to ED assessment (100%) and treatment decisions (20%) compared to Q1 2017/18
   - Delivery of action plan to reduce ED assessment and treatment decision breaches to no more than 20% and 15% of total breaches sustainably from August 2018 onwards, monitored via ECPIG (Q2).

2. **Inpatient and Discharge Processes**
   - Review of ED to AMU flow and time from bed allocation to patient leaving ED, including data quality. Minimum 95% of patients to leave ED within 30 minutes of bed allocation for remainder of Q2 onwards.
   - Reduce proportion of stranded patients (>7 day LOS) to Trust best in May 2018 of 32.5% and super stranded (>21 day LOS) to 12.5% by end Q2.
   - Increase admission avoidance in medicine to 5 per day through enhanced ambulatory care model for remainder of Q2 onwards.
   - Introduction of minimum standards for enabling flow by October 2018 (Q3).
   - Introduction of Integrated Discharge Team by October 2018 (Q3).
   - Open additional bed capacity (winter ward) as part of Trust's winter plan (Q3).

3. **Speciality Response Times, including Mental Health**
   - Re-launch and wider communication of Inter-professional Standards (Q2)
   - Delivery of specialty action plans to reduce breaches due to waiting for specialist opinion. All services to deliver minimum 60% by end Q2, including mental health.

4.0 Recommendations

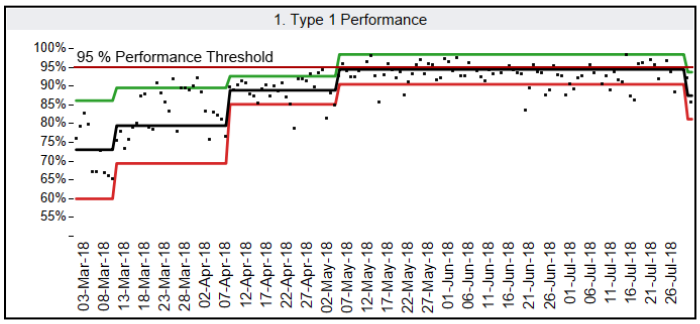
4.1 The Trust Board is asked to note current performance against the 4 hour Emergency Care Operating Standard and the actions being taken to recover performance in line with the trajectory.

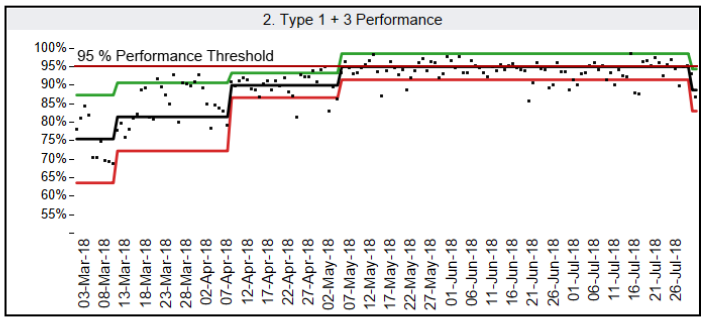
St George's University Hospitals NHS
NHS Foundation Trust

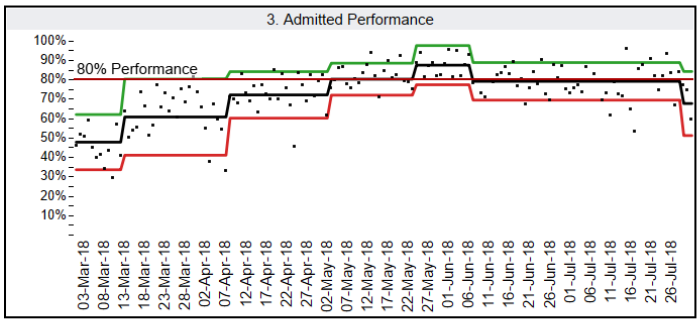
Appendix 1 – 15 Point Plan Dashboard

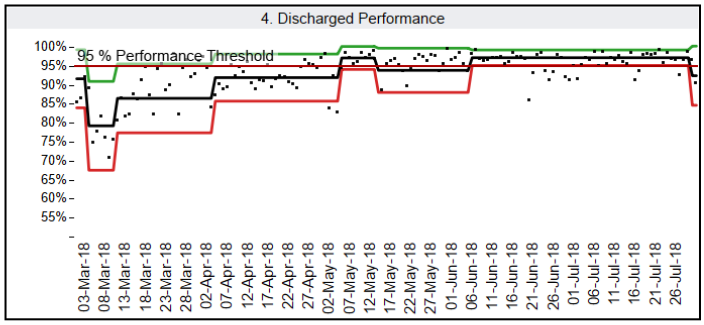
Four Hour Operating Standard Performance

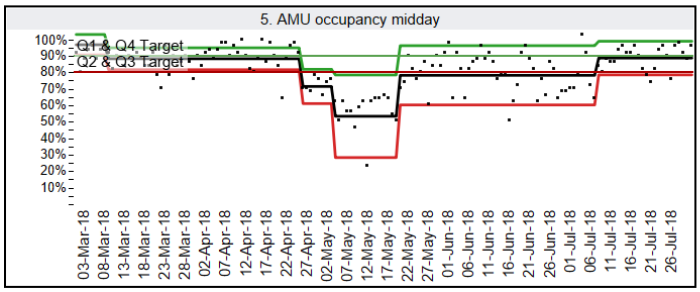
St George's University Hospitals NHS
NHS Foundation Trust

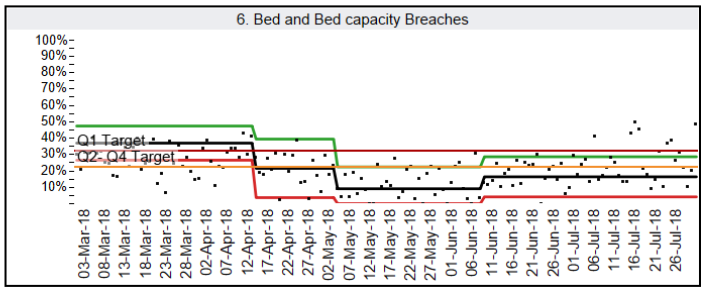


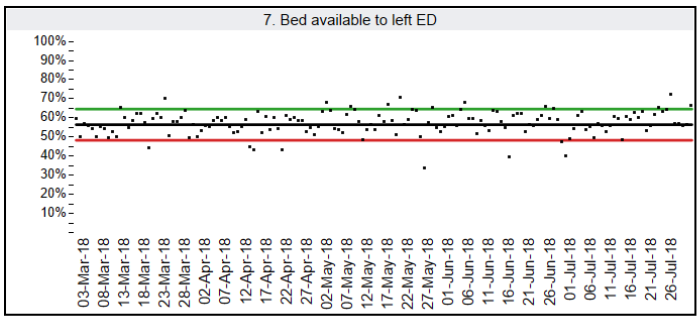


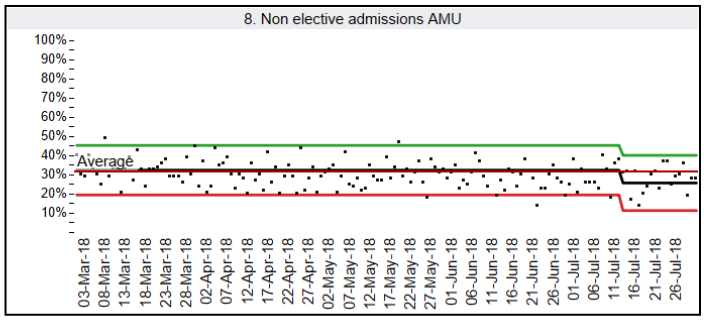


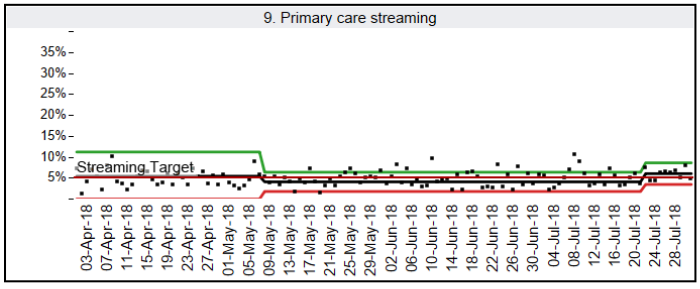


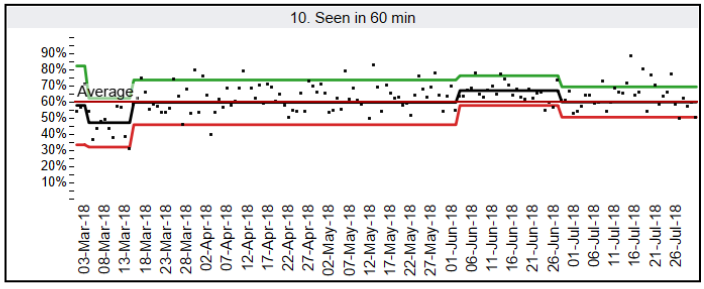


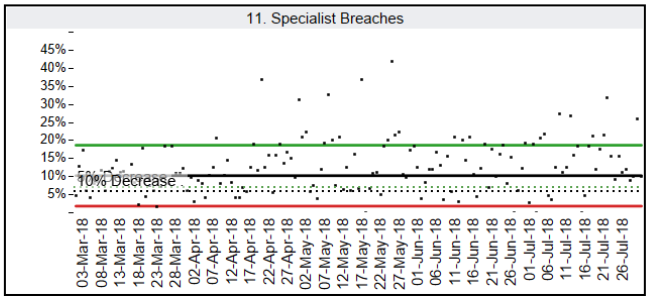












Meeting Title:	**Trust Board**		
Date:	30th August 2018	**Agenda No**	3.5
Report Title:	Learning from Deaths Q1 Report		
Lead Director/ Manager:	Professor Andrew Rhodes, Chief Medical Officer		
Report Author:	Dr Nigel Kennea, Chair Mortality Monitoring Committee, Associate Medical Director. Kate Hutt, Clinical Effectiveness Manager		
FOIA Status:	Unrestricted		
Presented for:	Discussion Update		
Executive Summary:	The paper provides an update on the work of the MMC for Q1 2018/19. It includes a summary of the independent reviews completed and details the most recent learning. It also summarises progress against implementation of the 'Learning from Deaths' framework launched in March 2017 and identifies priorities for 2018/19.		
Recommendation:	• For the Board to be updated on work to date implementing the 'Learning from Deaths' national framework and to support next steps in this process. • To take assurance that SGUH has a robust process for assessing deaths and from learning any lessons that arise from them. • For divisional teams to use this report to take learning back to their services. • To note the specialty areas where mortality signals are present.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	This work will identify issues impacting on care quality day to day, and will identify risks that are escalated to trust and divisional governance teams. The 'Learning from Deaths' framework continues to evolve and requires ongoing change in process that requires resource, even with a mature mortality monitoring process. There is a risk that published mortality data and learning will not only be used for quality improvement, and that identifying problems in care could lead to adverse publicity.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by Care Quality Commission and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:	There are resource implications associated with these works that are being worked through and can be discussed with this paper.		
Previously Considered by:	Patient Safety & Quality Board Quality & Safety Committee	**Date**	18/07/18 23/08/18
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

MORTALITY MONITORING COMMITTEE UPDATE

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Patient Safety and Quality Board with an update on the work of the Mortality Monitoring Committee (MMC), focussing on information and learning identified through independent case record review of deaths for the first quarter of 2018/19. Also provided is an update on the delivery of requirements of the Learning from Deaths framework.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK

2.1 Achievements

- Secured resource and recruited a consultant to the MMC review team to replace Dr Ollie Minton.
- Continued to be active nationally and regionally in the Learning from Deaths agenda. This has been achieved through consultation with NHS Improvement on policy development and discussion with the Health Innovation Network with a view to founding a Community of Practice. We have also continued working with peers, such as Imperial and Lewisham in order to share approaches.
- The Chairs of the MMC and Wandsworth CDOP (Child Death Overview Panel) have presented and contributed directly to a recent strategic meeting with the Healthy London Partnership related to implementation and opportunities of new child death review processes.

2.2 Guidance Development

In May the MMC Chair was asked by the Head of Patient Safety Policy at NHS Improvement to review draft guidance for Trusts on working with bereaved families and also the draft of information to be provided to families. The first version of guidance was published on 11th July 2018. We will now review the guidance and determine what changes are needed to our approach. Once we have agreed how any required change will be implemented we will update our Learning from Deaths policy accordingly.

2.3 Priorities for MMC in 2018/19

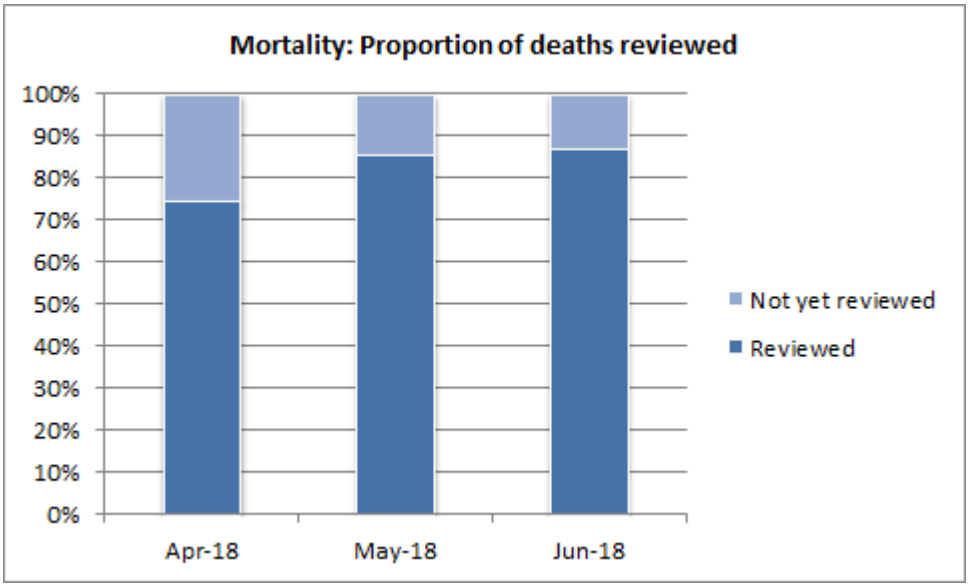
- Refine fields added to RCP Structured Judgement Review (SJR) to strengthen the quality and impact of our data locally and to implement SJR tool for all mortality reviews requested by MMC. These will include better documentation of escalation routes where concerns are raised and identification of mental health diagnoses.
- Make training available to clinicians on use of SJR methodology.
- Strengthen systems for monitoring the outcome of escalations to Risk and clinical teams.
- Complete the restructure of the Clinical Effectiveness (CE) Department to allow the CE manager to specialise in mortality governance, which will ensure existing processes are developed and strengthened.
- To review the Learning from Deaths Policy in line with publication of national guidance on engagement with families and carers. This guidance was published on 11th July 2018.
- Research and implement a Medical Examiner function that supports and enhances the work already underway by the MMC.
- Strengthen central understanding of local M&M processes and provide guidance and support to ensure that we maximise learning.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

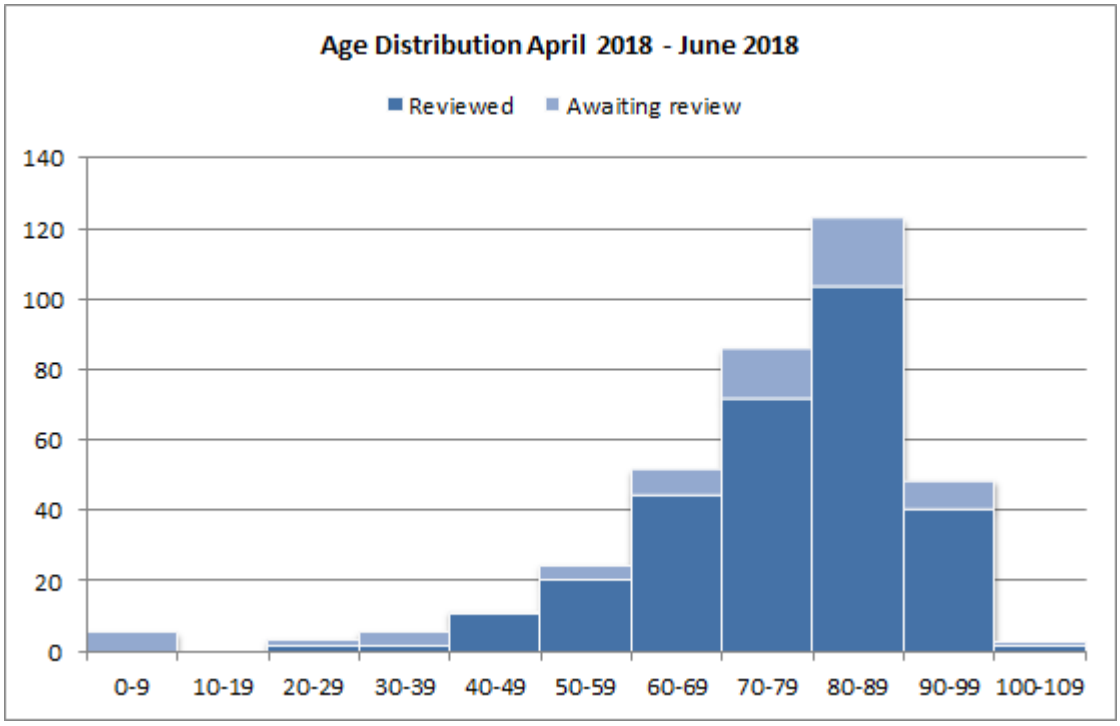
3.1 The following analyses include all deaths and do not consider deaths of patients with learning disabilities separately; however, this is required for the national dashboard. Our data reported in the format of the National Quality Board dashboard is shown in Appendix 1.

3.2 **Overview of April to June 2018**

Between April and June 2018 there have been 366 deaths. Members of the MMC have carried out independent review of 300 deaths, using our locally developed online screening tool and structured review tool, both based on the RCP tool. This represents 82% of deaths, which is significantly above our target of reviewing 70% of deaths each quarter. All child deaths are reviewed by local teams and by the Wandsworth CDOP.



The age distribution chart shows that the majority of patients that died are in the 80-89 age group.



This quarter, one or more problems in healthcare have been identified in 10.7% of the cases reviewed. This is lower than the proportion found in 2017/18 which was 15.8%. It should be noted that not all of these problems will have led to harm and may include recognised complications of treatment.

Problems in healthcare	**April**	**May**	**June**	**TOTAL**
No	91	94	83	**268**
Yes	8	19	5	**32**

Where there was a problem identified reviewers felt that it did not lead to harm in 32.5% of cases, probably led to harm in 35% and did cause harm in 32.5%. This quarter the most commonly occurring problem as defined by the structured judgement review is related to the treatment and management plan (n=15). This is unusual in comparison to data over the 15 months since implementation, where problems are most commonly related to procedure, resuscitation or monitoring. This year we plan to enhance the categorisation of problems in healthcare so that if patterns exist they can be better understood and acted upon.

Problems in healthcare: Quarter 1	**No harm**	**Probably harm**	**Harm**	**Total**
Assessment, investigation or diagnosis	2	2	1	**5**
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	1	0	1	**2**
Related to treatment and management plan	3	5	7	**15**
Infection control	0	1	0	**1**
Operation/invasive procedure	1	1	2	**4**
Clinical monitoring	3	1	1	**5**
Resuscitation following a cardiac or respiratory arrest	0	2	0	**2**
Other	3	2	1	**6**
TOTAL	**13**	**14**	**13**	**40**

A judgement regarding avoidability of death is made for all reviews. The large majority (96.7%) of deaths were assessed as definitely not avoidable, and no deaths were thought to be definitely avoidable. Two deaths (0.7%) were judged to be more than likely avoidable, for that moment in time. ***Any death that the MMC review suggests may be avoidable is escalated to the Risk Team to consider investigation. Any significant problem of care, whether or not it affected outcome, is highlighted to the clinical team for discussion and local learning.***

Avoidability of death judgement score	**April**	**May**	**June**	**TOTAL**
6 = Definitely not avoidable	97	106	87	**290**
5 = Slight evidence of avoidability	1	3	0	**4**
4 = Possibly avoidable but not very likely (less than 50:50)	0	3	1	**4**
3 = Probably avoidable (more than 50:50)	1	1	0	**2**
2 = Strong evidence of avoidability	0	0	0	**0**
1 = Definitely avoidable	0	0	0	**0**
TOTAL	99	113	88	**300**

4.0 THEMES AND LEARNING

The following summary provides an update on a number of issues previously highlighted and learning from the independent review of cases and MMC activity this quarter.

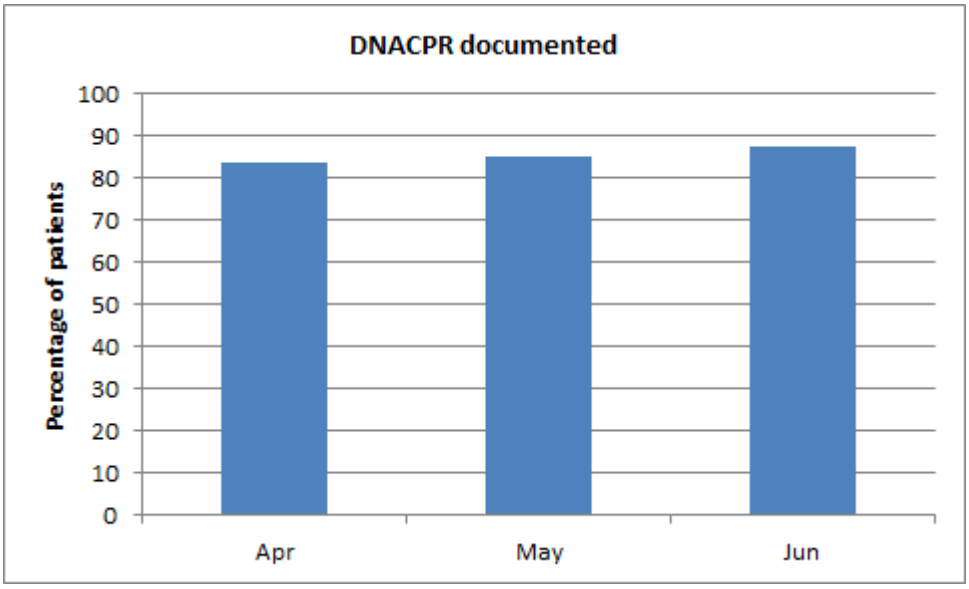
4.1 Support of families

This quarter we have worked with two families that wanted further information about the death of their loved one. One of these cases was particularly complex and was also being addressed through a complaint and was the subject of an inquest. Through working closely with the family to understand their questions and concerns the MMC Chair was able to carry out a full investigation, supported by a multidisciplinary team. Learning was identified as a result and shared with the family and we have an open offer to meet with them if that would be helpful. The report was also shared with the Coroner and the inquest was cancelled as a result.

We continue to publicise ways in which families can contact us, including our email address Learningfromdeaths@stgeorges.nhs.uk . We will review the national guidance published on 11th July and incorporate this into our practice to strengthen our support of families.

4.2 DNACPR discussions and Treatment Escalation Plan (TEP)

Data suggests that DNACPR discussions are held and documented at a consistent level across the Trust. This quarter 85.3% of patients reviewed have had a DNACPR order in place, which is very similar to the previous two quarters, when 84.9 and 84.5 per cent had an order in place. The reviewers are appreciating increasing numbers of patients with treatment escalation plans to manage the period around end of life.



4.3 Specific learning identified in the latest quarter

The MMC constantly seek to strengthen the monitoring of actions taken as a result of raising queries with clinical services or referrals to the Risk Team. This will enable us to better identify and share learning. Changes to the review tools that will be implemented in quarter 2 are designed in part to facilitate this. This will be further enhanced once the Clinical Audit Team restructure becomes embedded and the Clinical Effectiveness Manager is able to dedicate more time to mortality governance.

This quarter there have been a number of cases escalated for further review and learning is already evident in some of these.

- 13 cases have been referred to the service for M&M review and reflection. Issues that have been highlighted for discussion include documentation, clarity of escalation plans, teamwork, the appropriateness of transfer, and management of the end of life including ceilings of care and appropriateness of DNACPR decisions.
- 3 cases have been referred to the Deteriorating Adults Group for investigation.
- 4 cases have been flagged to the Risk Team for consideration of rapid review and/or SI declaration. The sharing of information between the mortality review team and risk team continues to strengthen, improving the completeness of information and opportunities to identify and share learning. The MMC reviewed a stillbirth and based on detailed review asked the governance team to reconsider SI declaration which was subsequently enacted.
- 2 cases have been flagged to other hospitals for investigation of the care they delivered in the patient pathway.

Examples of learning include a case referred to the clinical team where a frail, elderly patient with multiple comorbidities developed severe AKI (acute kidney injury), electrolyte disturbance and sepsis following removal of urinary catheter and subsequent urinary retention. The case was reviewed by Senior Health and in addition to highlighting the importance of good documentation, review of the case has led to implementation of a new inpatient protocol to perform a bladder scan 6 hours post TWOC (trial without catheter).

The case referred to earlier which was investigated in detail following a request from the next of kin, has also led to changes in practice. The Senior Health care group has implemented a system of peer review for patients with a long length of stay, so that a fresh perspective may identify any issues in the patient pathway or treatment. In addition, Radiology have changed their process for reviewing images in order that they look for, and report, unexpected findings as in this example a TMJ dislocation was missed, although it was visible on a CT brain scan ordered for another reason.

The MMC are keen to also recognise and share good practice and have provided positive feedback to a colleague on record keeping that reflected high quality care and communication with clinical teams and the patient's family.

5.0 SERVICES OPEN TO EXTERNAL SCRUTINY OF MORTALITY

5.1 National Adult Cardiac Surgery

In April the Medical Director received notification from the National Institute for Cardiovascular Outcomes Research that analysis of the National Adult Cardiac Surgery Audit for the period 1st April 2014 to 31st March 2017 showed that our survival rate was lower than expected. The data shows our outcomes to be at alert status (2 SD from mean). A similar alert was received in 2017 for the period 1st April 2013 to 31st March 2016 and a full investigation was conducted at that time.

The latest review built on this work by looking at the cases from the April 2016 to March 2017. As there is considerable overlap with the period previously investigated and the data period predates the alert letter received in 2017, the investigation presented similar findings. Key issues for action were around communication, team working and handover. The Trust has asked for an external review to be conducted, which will focus on delivery of the action plan developed last year by the task force.

6.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

6.1 Summary Hospital-level Mortality Indicator (SHMI) [source: NHS Digital]

The SHMI for October 2016 to September 2017 was published on 22nd March 2018. For this period our mortality is 'lower than expected' at 0.83. We are one of 17 trusts nationwide in this category. There has been a delay to the national publication of the SHMI for the period January 2017 to December 2017; this is expected on 19th July.

6.2 Hospital Standardised Mortality Ratio (HSMR) [source: Dr Foster]

Analysis	Period	Score	Banding
HSMR	Apr17-Mar18	85.6	Significantly better than expected
HSMR: Weekday emergency admissions	Apr17-Mar18	79.7	Significantly better than expected
HSMR: Weekend emergency admissions	Apr17-Mar18	94.4	Not significantly different to expected

Appendix 1: National Quality Board Dashboard – data to June 2018

NHS St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2018-19

Department of Health

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities, but includes paediatrics and obstetrics)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
102	129	88	113	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
365	543	299	460	2	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
365	1739	299	1456	2	15

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1

Total Deaths Reviewed by RCP Methodology Score

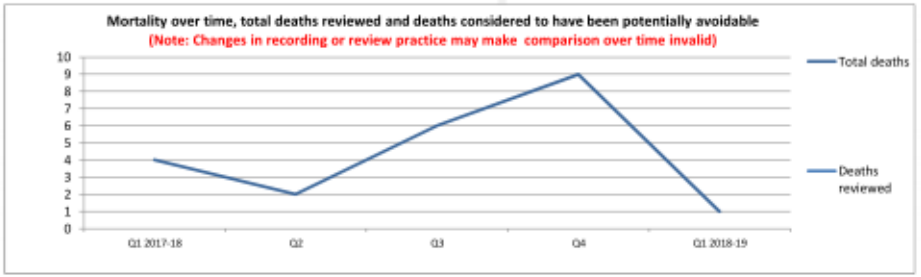
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	1.1%	This Month	0	0.0%	This Month	87	98.9%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	0.7%	This Quarter (QTD)	4	1.3%	This Quarter (QTD)	4	1.3%	This Quarter (QTD	289	96.7%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	0.7%	This Year (YTD)	4	1.3%	This Year (YTD)	4	1.3%	This Year (YTD)	289	96.7%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology (Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process)

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	9	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	21	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	**23 August 2018**	**Agenda No**	**3.6**
Report Title:	**CQC Inspection Report:** • **Action Plan for Requirement Actions** • **Trust Post Inspection Action Plan**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse** **Andrew Rhodes, Acting Medical Director**		
Report Author:	**Alison Benincasa, Quality Improvement Director**		
Presented for:	**Approval Decision Ratification Assurance Discussion Update Steer Review**		
Executive Summary:	**1.Background** The Trust received the formal outcome of the recent CQC inspection in July 2018 and has moved from a rating of inadequate to requires improvement. There are a number of concerns identified during the inspection highlighted in the supporting documentation, but the over-arching areas for the Trust are: • Leadership in Emergency Department • Leadership in Outpatients • Mental Health in Emergency Department • MCA and DoLs Trust wide • RTT and return to reporting **2.Action taken since CQC inspection outcome** **2.1Regulatory Requirement Actions** The Trust has developed a detailed response on the actions it is taking and plans to take with reference to the regulated activities, see appendix 1. This report was sent to the CQC on 16 August 2018. **2.2 Trust Inspection Response Action Plan (MUST do's and SHOULD do's) and observations checklist** The Trust inspection response action plan to address the MUST do's and SHOULD do's, including the regulatory requirement actions, has been developed and circulated to divisions, see appendix 2. The observations checklist which captures all negative comments documented within the published inspection evidence appendix has been developed and circulated to divisions, see appendix 3. Action trackers for both are owned by divisions and will be monitored through local governance routes reporting in to the Trust Executive Committee (TEC). Weekly progress reports to the Trust's Quality Improvement Director have commenced.		
Recommendation:	1. To note submission of the Trust response to the CQC Report on Regulated Requirement Actions (appendix 1) 2. To note the Trust Inspection Response Action Plan (including MUST and SHOULD do's) – appendix 2		
Supports			
Trust Strategic Objective:	• Treat the patient, treat the person • Right care, right place, right time • Build a better St George's		
CQC Theme:	Safety, Effectiveness, Responsive, Caring and Well led		

Single Oversight Framework Theme:	1. Quality of Care (safe, effective, caring, responsive) 2. Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Failure to deliver quality improvements in line with the expectations of the QiP will result in reputational damage, loss of confidence in the organisation, and perceived failure of leadership		
Legal/Regulatory:	Level of compliance with CQC key lines of enquiry		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date**	22 August 2018
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1: Report on Regulated Requirement Actions Appendix 2: Trust Inspection Response Action Plan (MUST and SHOULD do's)		

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RJ7
Our reference	INS2-4577742500
Trust name	St George's University Hospitals NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 1. The Trust was not reporting RTT data to NHS England.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has a significant focus on data quality as part of the Quality Improvement Plan and Elective Care Recovery Programme.

We want to establish an effective patient tracking system for the future, meaning the treatment plans for new patients referred to both St George's and Queen Mary's Hospitals are tracked and monitored effectively.

As part of these plans the Trust has a clear return-to-reporting plan in place which involves a range of activities that can be summarised as follows:

1. Ensure waiting list data is accurate
2. Ensure processes are in place to keep waiting list data accurate
3. Implement iCLIP at Queen Mary's Hospital

The current plan is forecasting a return to national reporting by the end of 2018 with clear milestones and review points in place. This plan is monitored weekly at an executive level and monthly by the Trust board. National reporting will commence once the Trust Board has assurance from three consecutive monthly reports.

Who is responsible for the action?	**Chief Operating Officer**

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
A key component of the Trust's return-to-reporting plan relates to sustainability of the actions we are taking. We have developed a weekly, comprehensive set of KPIs which track performance against a set of indicators which we have sought external assurance on, and agreed with regulatory and commissioner colleagues. For example, a list of regular audits are constantly carried out to ensure that current waiting list data is accurate, particularly focussing on where clock stops have been added. We are additionally tracking over 20 data quality measures on a daily basis to ensure that processes we have added to ensure cleanliness of the waiting list are maintained. Lastly, our activity plans for both theatres and outpatients are monitored on a daily basis to ensure that our increased activity levels are directed at our longest waiting patients. The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.	
Who is responsible?	Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
A resource plan is in place to address waiting list accuracy and the retraining of staff. A detailed action plan has been developed and agreed by the Trust Board. This work is being progressed at risk while to trust works to confirm funding, including bidding for emergency capital funding from NHSi.	
Date actions will be completed:	31 March 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
To ensure that the Trust does not lose sight of waiting patients the Trust will continue to undertake frequent audits as outlined above to keep the current waiting list data accurate.

Completed by:	Barry Mulholland MBI Healthgroup
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Ellis Pullinger Chief Operating Officer
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 2. There was a large maintenance backlog of the Trust's estate.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Estates Department has had historic issues with both backlog of reactive work and high backlog maintenance costs. The Trust estate is 35+ years old with large parts of the engineering infrastructure requiring replenishment.

The poor condition of the Trust estate led to increasing amounts of reactive work and the diversion of limited financial resources from servicing and planned preventative maintenance (PPM).

To address the on-going concerns about the condition of the Trust estate the Trust will focus its resources in a planned manner on both estates re-active maintenance and estates backlog maintenance to ensure the prioritisation of works is managed effectively.

To address the estates re-active maintenance the Trust will:

- Identify dedicated resources to carry out PPMs; including seasonal planning (i.e. in the summer carry out the service for the components needed for winter). This will reduce the risk of breakdowns
- Provide additional resources to reduce immediate backlog of tasks. This includes the commissioning of external companies as a short term measure to support the reduction of the number of outstanding tasks
- Identify dedicated resources to carry out emergency reactive work
- Continue with the current arrangements of dedicating two team members in each discipline to carry out PPMs and emergency reactive work. (This change in practice has seen a significant improvement in the estates internal key performance indicators within 6 months from 15% to approximately 60% for reactive jobs completed on time). As this scheme progresses additional personnel will be assigned to PPMs as the level of re-active work reduces. This will be monitored and targeted through the Computer Aided Facilities Management (CAFM) system

To address the estates backlog maintenance the Trust will ensure that all infrastructure and plant upgrade projects are prioritised according to the corporate risk rating and are supported by an appropriate business case for capital funding. This will reduce the overall backlog maintenance capital cost as well as reduce the number of reactive work required as new plant and infrastructure is less likely fail and produce re-active maintenance work.

Who is responsible for the action?	Director of Estates and Facilities

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

The improvements will be monitored and targeted continuously through the CAFM system. The CAFM system will measure:

- The percentage of reactive work resolved within time. The target is 80% for emergency work resolution within 6 hours and for routine work resolution within 5 days.
- The number of outstanding re-active work. The target is to have no outstanding tasks on system for longer than 30 days
- The number of PPMs completed. This is currently being increased on a month by month basis and monitored to ensure that the tasks are achievable against the available resources.

As more PPMs are completed the Trust anticipates a proportional decline in the number of re-active work ensuring a sustainable model. However, with the aging estate there is no guarantee of this, and further analysis will be conducted if the internal targets set are not achieved.

Estates backlog maintenance capital schemes will be completed through the Projects Directorate in collaboration with the Estates Department.

The measures listed out above will be monitored as part of the Quality Improvement Programme performance dashboard with reports to the Trust Executive Committee, Quality and Safety Committee and the Trust Board.

Who is responsible?	Director of Estates and Facilities

What resources (if any) are needed to implement the change(s) and are these resources available?

The PPM team is in place. The Trust is committed to scaling resources in line with the need identified by the CAFM work due to be completed by 31 January 2019.

Full determination of the on-going requirements for the PPM can only be established once a full asset, PPM and life cycle survey is conducted which will be completed by 31 March 2019.

Capital backlog is currently valued in excess of £100m. An emergency bid of £5.7m is in the process of being submitted to NHSi for funds to address priority issues in 2018/19. Work is on-going to identify sources of funding to address the remainder.

Date actions will be completed:	31 March 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Our patients will not be put at risk because the prioritisation of planned and reactive works will ensure that all high risk work is completed quickly. The patients under our care will see reactive maintenance and planned maintenance taking place in the Trust. Our patients may have a negative impression of the condition of Trust estate awaiting repair which may impact on their experience.

Completed by:	Rathan Nagendra Assistant Director Estates and Facilities
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Kevin Howell Director of Estates and Facilities
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 3. The IT system was vulnerable to breaches and half of the clinical areas were not prescribing electronically.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
The provision of the right IT infrastructure is a fundamental part of the Trust's Quality Improvement Programme. We want to provide the right IT infrastructure to support clinical and management systems for our staff. On 19 July 2018 the Trust commenced a project to roll out and standardise the use of iClip in the wards at St Georges which covers both clinical noting and e-Prescribing. The aim is that by 31 December 2018 all wards will use electronic records for capturing clinical details, requesting and viewing test results and prescribing and administering medication. Staff will be trained and supported in standard use of the system, with controlled access rights.	
Who is responsible for the action?	Chief Finance Officer
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
This project is a continuation of current processes already in use in 44% of wards at St George's Hospital. Therefore all clinical staff will be using the same processes in every ward, and will not be changing between different processes. All staff utilising this part of the system will be trained on every ward prior to implementation and 'at the elbow' support will be provided post go-live on an on-going basis. The improvements will be monitored by visits to the wards and by monitoring the use of the system and quality of data entered.	
Who is responsible?	Chief Finance Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
This project requires capital and revenue funding which was included in the business case agreed by the Trust Executive. Business as usual support, training, project and technical support is already in place within ICT which requires some enhancing for the project. The largest amount of resource is for the training of super users within each ward area for them to become fully confident in supporting their colleagues during go-live and on an on-going basis.	

Date actions will be completed:	31 December 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The users will continue using current processes with heightened awareness that they are changing and that it has been recognised that they need to change. The plan an incremental go live on a ward by ward basis, so there will be a gradual improvement from September 2018. Prior to go-live, each ward will be considering current process in the light of the new, so there will be increased scrutiny surrounding the way things are done.

Completed by:	Elizabeth White Chief Information Officer
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Andrew Grimshaw Chief Finance Officer
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 4. In the emergency department, staff were not recording when patients had been restrained or had rapid tranquilisation administered.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The rapid tranquilisation protocol is currently being reviewed and updated by an Emergency Department (ED) Consultant (with advice and input from a Consultant Psychiatrist) to ensure that the protocol:

- Reflects current Royal College of Emergency Medicine guidance and NICE guidelines (Violence and aggression: short-term management in mental health, health and community settings)
- Provides best practice guidance to staff guidance on actions to take, the drugs available, documentation standards, observations required and frequency, and criteria for patient transfer to a resuscitation room

To support standardisation in the ED the rapid tranquilisation protocol will be similar to procedural sedation. It is intended that the protocol will be shorter and simpler to follow and will ensure that all staff provide and document best practice care and treatment to patients who have been restrained or have had rapid tranquilisation administered.

The revised rapid tranquilisation protocol will be approved through a rapid clinical governance process including final ratification at the Trust's Patient Safety and Quality Group.

Who is responsible for the action?	Chief Nurse and DIPC

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

The following actions will be undertaken to ensure and monitor sustainable improvement:

- Communication of the revised protocol at morning emergency department inter-professional handover so that all staff are aware
- Staff will be familiarised with the revised protocol at the weekly teaching sessions in the emergency department
- Staff will be informed about how to access all ED and Trust protocols on all nurse and doctor inductions
- An audit of practice will be undertaken 4 weeks following introduction of new the protocol
- A 6 monthly audit cycle will be implemented to demonstrate continued compliance
- Regular teaching on rapid tranquilisation on doctor and nurse training programmes will be

provided

- DATIX incident reporting (the Trust's electronic incident reporting system) will be undertaken for all cases of rapid tranquilisation administration
- Supervision and support will be provided for junior staff by ED Consultants and senior nursing staff

The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.

Who is responsible?	**Chief Nurse and DIPC**

What resources (if any) are needed to implement the change(s) and are these resources available?

The following resources to implement the change are available, therefore no additional resources are required:

- Communication to staff at morning emergency department inter-professional handover
- Teaching sessions on doctor and nursing training programmes
- Supervision and support for junior staff by ED Consultants and senior nursing staff

Date actions will be completed:	12 September 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?

To ensure that patients who require rapid tranquilisation are carefully and safely managed, rapid tranquilisation will only be provided under the direct supervision of an ED Consultant.

From the week commencing 30 July 2018 all clinical staff were reminded at morning inter-professional handover to use the current rapid tranquilisation guidelines, to document the rationale and procedure in the patient notes and to ensure the required frequency of observations are provided.

An incident report will be submitted on DATIX for every case of rapid tranquilisation to ensure review and monitoring of each occurrence.

The patient notes for all mental health patients will be reviewed daily by the mental health team to monitor if rapid tranquilisation was undertaken in line with best practice.

Completed by:	Lee Patient Head of Nursing
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Avey Bhatia Chief Nurse & DIPC
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 5. In the emergency department, not all risks identified during the inspection were on the risk register and those on the risk register had not been fully actioned. Some risks had been on the risk register since 2014.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

To ensure the risk register for the Emergency Department (ED) reflects all identified risks the Trust has taken the following actions:

1. The emergency department (ED) risk register has been reviewed and updated by the ED Directorate team. The risk score has been reviewed and amended for the risk relating to non-compliance with the national Emergency Care Operating standard which has been on the Directorate risk register since 2014. This risk has been split into two separate risks: one relating to the quality of care and patient safety risks associated with not meeting the required 95% standard; and the second relating to the reputational risk to the organisation of continued non-compliance with the national standard. Since the March 2018 inspections ED performance has improved and the Trust has met the standard for over 93% of patients in June and July 2018.
2. The ED risk register is on the agenda at monthly ED Directorate meetings and at weekly ED Senior Team meetings.
3. The ED Directorate has set up a new monthly meeting at which the risk register will be reviewed and updated by the Clinical Director, Head of Nursing, Clinical Governance Lead and General Manager. These meetings will also be attended and supported by the Governance Manager for the Medicine and Cardiovascular Division.
4. Monthly Clinical Governance Meetings are in place with the ED Directorate team (Head of Nursing, Clinical Director, Clinical Governance Lead and General Manager) to meet with the Medicine and Cardiovascular Divisional Management Team (Divisional Chair, Divisional Director of Operations and Divisional Director of Nursing and Governance). The risk register is a standing agenda item at this meeting.
5. All risks highlighted in the inspection report have been reviewed. New risks are in the process of being drafted and submitted to the Divisional Governance Board for approval to go on to the risk register including:
    - Risks relating to incomplete clinical documentation, including safeguarding assessments for adults and children, recording of restraint and rapid tranquilisation, recording of patient consent and best interest decisions, pain scores and recording of a patient's deteriorating condition
    - Risk to patients living with mental health problems attending the ED and their holistic

needs not being met within the department • Risk due to compliance with management of sharps and hazardous substances within the ED	
Who is responsible for the action?	Chief Operating Officer
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
The steps taken to ensure that the ED risk register is reviewed on a regular basis at both Directorate and Divisional level will ensure the improvements are sustainable. Minutes and actions of the meetings outlined above will be kept to enable good governance with regard to the management of risks and evidence compliance with the regulation. The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.	
Who is responsible?	Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
The Directorate has requested support from the Divisional Governance Manager for the Medicine and Cardiovascular Division to attend the local meetings where the risk register is reviewed and updated. Although this resource is available, this resource was not used in this way previously.	
Date actions will be completed:	12 September 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The actions described above to ensure good governance of the ED risk register and timely review of risks should ensure that people using the service are not affected.

Completed by:	Gemma Phillips General Manager
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Ellis Pullinger Chief Operating Officer
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 6. In the emergency department, the holistic needs of people living with mental health issues were not always met.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

To ensure that the holistic needs of people living with mental health issues are consistently identified and met the Trust has taken/ plans to take the following actions:

1. Two full time registered mental health nurses (RMN) have been employed to work over a 7 day period in the emergency department (ED)
2. The RMNs provide support and advice to staff caring for the needs of this vulnerable group of patients
3. Patient specific care plans have been implemented which are developed in conjunction with the patient, the mental health team and the ED team
4. A nursing care plan for patients with mental health issues is currently being developed. The nursing care plan will support a consistent and standardised approach and be used for all patients with mental health needs in the ED. The nursing care plan will be completed by either the named nurses or RMN. The nursing care plan will also include guidelines for completion and expectations for the roles and responsibilities of the staff delivering care
5. Safe facilities will be maintained in the ED to assist and support patient needs including access to food and drink, toilets, washing facilities and a bed

Who is responsible for the action?	Chief Nurse and DIPC

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

The following actions will continue and be undertaken to ensure and monitor sustainable improvement:

1. Staff to be familiarised with relevant documentation and the importance of addressing the holistic needs of mental health patients is now included on all nurse and doctor inductions
2. From 1 August 2018 regular audits of the notes for mental health patients has commenced and will continue every 6 months to demonstrate that holistic needs are being identified and met
3. Regular teaching on the needs of mental health patients will continue to be provided on doctor and nurse training programmes
4. Supervision and support will continue to be provided for junior staff by ED Consultants and senior nursing staff

The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.	
Who is responsible?	Chief Nurse and DIPC
What resources (if any) are needed to implement the change(s) and are these resources available?	
The following resources to implement the change are available, therefore no additional resources are required: • Communication to staff at morning emergency department inter-professional handover • Teaching sessions on doctor and nursing training programmes • Supervision and support for junior staff by ED Consultants and senior nursing staff	
Date actions will be completed:	12 September 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The Trust has employed two RMNs who work in ED 7 days a week to directly support patients with mental health conditions in ED and to provide advice and support to staff. The presence of the RMNs will ensure enhanced awareness of the holistic needs of our patients with mental health conditions whilst the Trust makes the improvements outlined above. Our staff providing care for patients with mental health conditions will be supported by senior medical and nursing staff. In addition, from the week commencing 30 July 2018 all clinical staff have been reminded at morning inter-professional handover in the ED to identify the holistic needs of patients with mental health conditions.

Completed by:	Lee Patient Head of Nursing
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Avey Bhatia Chief Nurse & DIPC
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 7. In surgery at St George's Hospital, nursing staff sometimes used a stamp to sign the controlled drug (CD) book, rather than actively signing it.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The CD record books have been reviewed by the Heads of Nursing within the surgical wards and theatre areas. The Head of Nursing, Theatres and Medication Safety Officer have also jointly reviewed the CD record books within theatre areas.

This review has confirmed that nursing staff do not use a stamp to sign the CD record book and are not encouraged to do so. The continued use of a stamp by a registered pharmacy technician which bears the name of the individual and their General Pharmaceutical Council registration number has been reinforced to continue. The stamp entry is in ink so as to be indelible. Staff have been reminded to continue to date the stamp entry and to counter sign their name in full beside the stamp entry and not to use initials.

The Trust will ensure that pharmacy staff work in accordance with best practice in line with Regulation 20 of the 2001 Misuse of Drugs Regulations. Which states that the main requirement is that the entry is in ink or otherwise so as to be indelible. And that the entry is dated and that the staff member has signed beside the stamp.

Who is responsible for the action?	Medical Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

All staff have been reminded of the best practice requirement outlined above via email on 20 July 2018 and in a series of meetings which were completed by 23 July 2018.

To check the consistency of application of best practice quarterly CD record book checks and monthly MUST DO checks will continue. Exceptions or deviations will be reported to the Patient Safety Quality Board.

The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.

Who is responsible?	Medical Director

What resources (if any) are needed to implement the change(s) and are these resources

available?	
No additional resources required.	
Date actions will be completed:	COMPLETE: 31 July 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There will be no impact on patients or staff by the Trust not meeting this regulation until 31 July 2018. Current practice requires a minor adjustment to include the full signature of the staff member rather than their initials.

Completed by:	Vinodh Kumar Chief Pharmacist
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Professor Andrew Rhodes Medical Director
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 8. On the paediatric wards, there were not adequate monitoring systems in place to monitor the risk to fire safety.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has a comprehensive fire risk assessment programme in place. The fire risk assessment will be separately reviewed for paediatric wards to ensure it is fit for purpose. This has commenced and will be completed by 31 September 2018.

In the paediatric wards the following actions will continue to ensure the safety of our patients and staff in the event of a fire:

1. Fire warden training delivered for all qualified nursing staff
2. Fire warden on each shift day and night
3. Scheduled annual fire safety training in place
4. Scheduled annual fire drill/ evacuation exercise for each ward
5. Weekly fire alarm testing on all paediatric wards
6. Schedule of visits from Authorised Fire Safety Engineer to assure on strategy fire risk assessment programme for the internal fire team

In addition, the Trust Authorised Engineer (AE) for Fire has completed a Fire Safety Audit for the Trust and the Trust is awaiting the report.

Who is responsible for the action?	Director of Estates and Facilities

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

The Trust will ensure that the improvements have been made as part of the on-going monitoring of the fire risk assessment programme which will be tested regularly through the back to the floor audits.

The continuance of the actions outlined above will continue to be monitored through the Trust Health, Safety and Fire Committee.

The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.

Who is responsible?	Director of Estates and Facilities

What resources (if any) are needed to implement the change(s) and are these resources available?

The Trust is committed to supporting any costs which result from this work to ensure appropriate standards are achieved.	
Date actions will be completed:	31 September 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Existing fire safety checks and monitoring will ensure that there is minimal risk to the patients under our care.

Completed by:	Stephanie Sweeney Divisional Director of Nursing and Governance Rathan Nagendra Assistant Director of Estates and Facilities
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Kevin Howell Director of Estates and Facilities
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 9. In the outpatients department at St George's Hospital, records were not always stored securely and relevant incidents were not always reported.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has a clinical record management transformation programme as part of our current Quality Improvement Programme. We want to protect our patients by ensuring patient notes are stored safely in clinical areas and corporate areas, ensuring there is no opportunity for unauthorised access to patient records and to ensure that we know where patient notes are at any one time.

The current programme of work focusses on the following:

1. Safe storage of clinical records
2. Consistent availability of clinical notes
3. Reduction in the number of duplicate records
4. Reduction in the number of temporary records
5. Records compliant with clinical records audit standards

We will continue to progress the improvement actions associated with the five key areas above.

During August and September 2018 an audit of all outpatient clinics will be undertaken with a specific focus on the methods of clinical records storage and access rights to iClip. Based on the findings of the audit, a corrective action plan will be developed and implemented to address the identified issues.

As part of our Quality Improvement Programme we also want to promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events and are empowered to make changes. To ensure that relevant incidents are always reported in outpatient services commencing 22 August 2018 we will hold awareness raising sessions at team meetings and ensure the agenda for the outpatient department weekly and monthly meeting includes incident monitoring, emerging themes and learning from incidents.

Who is responsible for the action?	Chief Operating Officer

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

We will continue to conduct weekly back to the floor visits with a specific focus on the storage of records and access rights and we will continue to monitor progress at the Clinical Records Transformation Programme Steering Group. We will also continue with the current programme of audit, validation and monitoring of Outpatient clinic storage of records to maintain a cycle of continuous improvement.

We will monitor the number of incidents with a specific focus on clinical records and ensure that learning from incidents is shared at weekly team meetings. The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.	
Who is responsible?	Chief Operating Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
No additional resource required	
Date actions will be completed:	31 September 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Information related to our patients may be inadvertently viewed by others. Incidents relating to clinical records will be recorded to enable constant surveillance of affected patients and facilitate further learning and corrective actions.

Completed by:	Angela Knibb Outpatients Transformation Manager
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Ellis Pullinger Chief Operating Officer
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
	How the regulation was not being met:
	Systems or processes were not established and operated effectively to ensure compliance with the requirements with this Regulation because; 10 In surgery at Queen Mary's Hospital (QMH), staff did not use a recognised tool for monitoring deteriorating patients and there was not a policy for the treatment/transfer of patients who deteriorated and required a higher level of care.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

We want to provide early recognition, escalation and treatment by ensuring that our staff feel confident and have the skills, training and support to recognise deteriorating patients. The Trust has a significant focus on the early recognition of deteriorating patients as part of the Quality Improvement Plan and recognises the need to ensure this work also focusses on patients under our care in our non-acute settings.

The following will continue and/ or be undertaken:

- Early Warning Scores, the recognised Trust wide tool for monitoring deteriorating patients as outlined in the Trust Deteriorating Adult Policy, continue to be used in the day case unit at QMH
- All staff at QMH to be reminded of the Trust's Deteriorating Adults Policy and the use of early warning scores to promote the early recognition of a deteriorating patient
- All staff at QMH to be reminded of the existing Medical Emergencies Policy at QMH to support the treatment/ transfer of patients who deteriorate and who require a higher level of care
- Senior leaders at QMH together with the Trust's resuscitation lead, Head of Nursing for Specialist Medicine and the Consultant Nurse for Critical Care to review the escalation process in the Deteriorating Adults Policy for non-acute settings e.g. day case theatres and endoscopy
- NEWS2 will be implemented as per national mandate and in line with Trust wide implementation plans

Who is responsible for the action?	Medical Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Discussion about the early recognition, escalation and treatment of deteriorating patients will feature in team meetings and at the QMH Nursing Forum.

We will ensure that all relevant staff (staff list including signatures) have confirmed that they have read and understood the Trust's Deteriorating Adult Policy and the Medical Emergencies Policy at QMH.

We will continue with the back to the floor audit programme to continue to check the understanding and awareness of our staff. Our findings and any resultant action plans will be reported through

directorate and divisional governance meetings and at the QMH Clinical Partnership Board. The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.	
Who is responsible?	Medical Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
N/A	
Date actions will be completed:	24 August 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Staff at Queen Mary's Hospital will utilise early warning scores to support early recognition of the deteriorating adult in line with the Trust's Deteriorating Adults Policy and the Medical Emergencies Policy at QMH to support care and treatment of patients requiring a higher level of care.

Completed by:	Lucy Titheridge General manager & Clinical Lead
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Professor Andrew Rhodes Medical Director
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing
	How the regulation was not being met:
	The provider was not meeting this regulation because: 1. Staff mandatory training attendance was much lower than the Trust's target of 85%. Regulation 18 (1), (2) (a)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust is now meeting this regulation. The Trust's current compliance rate is 89% and has shown steady upward progression since February 2018 (see table below). The Trust will continue to take steps to improve compliance rates, especially for those staff groups who are not meeting the target. For example, new ways of engaging with Medical and Dental staff, who typically have lower compliance rates than other staff groups in the Trust, are being explored to increase their levels of compliance. For the August Junior Doctor rotation, assessment only options for a number of MAST (core statutory/ mandatory) subjects are being piloted.

The Trust intends to maintain compliance with Regulation 18 HSCA (RA) 2014 Staffing.

Month	Overall Compliance Rate
February	83%
March	85%
April	85%
May	86%
June	87%
July	89%

Who is responsible for the action?	Director of Human Resources and Organisational Development

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

To ensure sustainability the following actions will be undertaken:

Upgrading the Trust's Learning Management System:

The Trust's existing Learning Management System (LMS) is being upgraded as it is not currently available to staff working off-site and away from the Trust's IT network. This will enhance accessibility and improve staff compliance for staff based off the main hospital site. It is recognised this has been a barrier to achieving the required compliance levels in the past. Our vision for the LMS is to invest in upgrading the system to both open up access to outside the Trust and to gain access to a wider pool of nationally approved eLearning modules. Our aim is to adopt more blended learning opportunities to provide MAST incorporating both eLearning and classroom based sessions in order to equip our staff with the necessary knowledge and skills to provide safe care and to further improve the Trust's compliance.

Review of Training Needs Analysis:

The Trust has undertaken a full revision of the Training Needs Analysis (TNA) for a number of subjects including resuscitation. This will assist further improvements in compliance by providing clarity over which topic staff are required to complete and will enable improved capacity planning for the Resuscitation team.

TNAs will be adjusted to reflect organisational changes e.g. loss of services and movement of cost centres. The Trust has established mechanisms to identify on a monthly basis any changes to the organisation's structure/ hierarchies which enables topic TNAs to be adjusted on a more constant and consistent basis. Working with subject matter expert colleagues, the Trust will also conduct annualised reviews of the TNAs for the core statutory and mandatory topics.

Development of the Reporting Interfaces for Staff Compliance:

Whilst accuracy of reporting has been improved over the last 12 months, the Trust will continue to refine the reporting interfaces to improve usability of data in a more structured way. This will provide clarity for staff to determine what MAST training they are required to undertake in accordance with the TNA.

The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.

Who is responsible?	Director of Human Resources and Organisational Development
What resources (if any) are needed to implement the change(s) and are these resources available?	
Training needs analysis reviews on-going/ annual – no resources required	
Date actions will be completed:	COMPLETE: 31/03/2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
N/A – regulation 18 is now met, actions have been identified to sustain the position

Completed by:	Hasan Cagirtgan Head of Corporate Training and Organisation Development
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Harbhajan Brar Director of Human Resources & Organisational Development
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing
	How the regulation was not being met:
	The provider was not meeting this regulation because: • The Trust's Workforce Race Equality Standard (WRES) results were poor and some indicators got worse than the previous year. Regulation 18 (1), (2) (a)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Staff Engagement is an integral part of the Trust's Quality Improvement Programme in the form of a two year focussed Staff Engagement Plan 2017-2019.

We have re-established a Diversity and Inclusion post and have appointed at Diversity and Inclusion Manager.

We have already seen some improvements in some of the WRES indicators (e.g. indicator 9, the percentage difference between the organisation's voting membership and its overall workforce). We have already put in to place review tools that measure adverse impact with regard to indicator 3 (Relative likelihood of staff entering the formal disciplinary process, as measured by entry in to a formal disciplinary investigation). We now produce on-line diversity analysis reports for our divisions to use to produce local strategies.

In line with the Staff Engagement Plan the Trust strategy for Equality, Diversity and Inclusion will be re-launched and implemented in August 2018 and will incorporate clear and targeted actions to address the Trust's performance against the WRES.

Included in the strategy are the following;

- Divisional Director of Operations performance/appraisal objective linked to bullying and harassment. Senior managers will have responsibility to reduce bullying and harassment complaints in directorates
- Introduce Executive lead and responsibility for specific protected characteristics, providing visible, involved commitment from the executive team
- Equality impact analysis (EIA) of recruitment and selection process will commence to identify and address any potential discriminatory practices
- Embed inclusive communication and staff network programmes
- Design and deliver mandatory equality, diversity and inclusion workshops for managers to improve understanding and support and provide early resolution of complaints and grievance before human resource department involvement
- A Positive Action programme to improve representation of BME staff and improve progression
- Review of people management systems including the Trust's disciplinary process, grievance procedure and performance review

Who is responsible for the action?	Director of Human Resources and Organisational

	Development
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
The Equality, Diversity and Inclusion Strategy will be ratified and launched by the Trust Board to the Trust by quarter three 2018. The Workforce Diversity and Inclusion committee will review the progress against the strategy on a half yearly basis. Measures of success have been included in the strategy. The Workforce Diversity and Inclusion Manager reports directly to the Director of Human Resources and Organisational Development and will manage the delivery of the strategy. The Staff Engagement network will review progress and completion. The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.	
Who is responsible?	Director of Human Resources and Organisational Development
What resources (if any) are needed to implement the change(s) and are these resources available?	
The Workforce Diversity and Inclusion Manager is the sole staff resource available, some of the implementations require the involvement of other teams and directorates. We have identified this as a priority area in our bid for NHSi improvement monies. Given the current resource constraints, it has to be recognised that it will require a longer lead time to deliver the actions required.	
Date actions will be completed:	31 December 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The focus of our Equality, Diversity and Inclusion Strategy is primarily on our current and future workforce who in turn deliver services to a diverse set of local communities. Failure to address these issues will mean that we will not improve our WRES indicators. Failure to deliver will also mean that we will not have an engaged and motivated workforce.

Completed by:	Celia Oke Diversity and Inclusion Manager
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Harbhajan Brar Director of Human Resources & Organisational Development
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing
	How the regulation was not being met:
	The provider was not meeting this regulation because: • In children and young people services, there weren't always sufficient numbers of suitably qualified staff on each shift to provide safe care. Regulation 18 (1), (2) (a)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
The Chief Nurse and Deputy Chief Nurse completed an establishment review of all wards (including paediatric wards) in line with National Quality Board guidance and in conjunction with the ward managers. The reviewed establishment figures were then shared with NHSi. The Trust is currently completing our 6 monthly establishment review. In August 2018 in order to apply further rigour to our current establishment review the Trust will commission an external expert review of staffing on paediatric wards and the paediatric intensive care unit. The results are expected by 31 October 2018.	
Who is responsible for the action?	Chief Nurse & DIPC
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
The Trust will apply the Safe Staffing Levels Policy which supports daily assessments and reporting of safe staffing levels against the safe care module. The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution.	
Who is responsible?	Chief Nurse & DIPC
What resources (if any) are needed to implement the change(s) and are these resources available?	
TBC - external review	
Date actions will be completed:	31 October 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The Trust uses the Safe Nursing Care Tool with oversight from matrons, Divisional Directors of Nursing and the Hospital site team. As required mitigating actions are put in place to ensure safe staffing levels across the hospital site and therefore ensure patient safety.

Completed by:	Helen McHugh Divisional Director of Nursing and Governance
Edit:	Alison Benincasa

	Quality Improvement Director
Final approval:	Avey Bhatia Chief Nurse & DIPC
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
	How the regulation was not being met:
	The provider did not always act in accordance with the Mental Capacity Act 2005 in the following areas, (St George's Hospital) emergency department and medical care; (Queen Mary's Hospital) surgery and outpatients. Regulation 11 (3)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has a significant focus on embedding dementia, the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) as part of the Quality Improvement Plan and recognise we have more to do.

We want to ensure that there is no decision without the patient's involvement, and the patient's wishes and values are at the centre of their care and treatment. We want to continue to focus on improving the patient and carer experience for patients with cognitive impairment.

The Trust has undertaken the following actions in relation to training and awareness:

- Launched Level 1 e-learning in April 2018. As part of a wider multi-level training package (based on a nationally recognised MCA training needs analysis from Bournemouth University). This e-learning programme was designed from scratch to focus on how staff working at the Trust should apply the MCA and make links to local resources. The package uses case studies and clinical examples to contextualise learning. Since April 2018, 62% of the 2293 staff enrolled have completed the module. The module contains an integrated assessment with a pass rate of 80%, which is required to indicate compliance.
- Level 2 training, for more senior staff, is currently in the development stage. At the time of writing, staff have supported the scripting, development and shooting of video content which makes up the backbone of an interactive scenario based learning module. Support has been obtained from an external content developer and engagement from professional actors and our staff.
- On-going work with the Emergency Department team to deliver extra-curricular face to face training for nursing staff and on rotational inductions for doctors in the use of the MCA with relevant and applicable examples and case studies.
- On-going work with practice educators across divisions to deliver face to face training for nurses and health care assistants (HCA)
- On-going teaching on the MCA on HCA induction programme
- Bespoke setting specific training delivered on request (e.g. infectious diseases team, theatres)
- In May 2018 presentation on the MCA to the Grand Round with panel of speakers
- In June 2018 presentation to Wandsworth Patient and Public Involvement group on MCA, and role of the MCA practitioner at the Trust

- In July 2018 the first MCA annual report was presented to Patient Quality and Safety Committee and Patient Quality Board and onwards to the Trust Board
- In July 2018 social media updates were made on the Trust's production of video content for Level 2 MCA training

The Trust plans to undertake the following actions in relation to training and awareness:

- Launch of Level 2 e-learning training in September 2018
- Level 3 training pilot. The MCA Practitioner is currently working with the Simulation Suite to deliver face to face training for very senior decision makers which will centre around live scenarios relating to the application of the MCA. Pilots for this programme are planned for December 2018 and January 2019
- Joint working with Intensive Care Unit (ICU) teams to develop training films with an ICU focus for local teaching
- Presenting and launching mini questionnaire at Wandsworth Healthwatch event in September 2018
- Communications campaign to promote the launch of level 2 e-learning
- On-going maintenance of MCA / DoLs Trust Intranet site.

To further ensure that the Trust acts in accordance with the MCA we will identify a non-executive lead for MCA and DoLs to increase the exposure and understanding of the Trust Board of the improvement work underway.

We will develop and implement a Trust Strategy for MCA and DoLs to set out a structured and time-specific delivery framework linked to our service improvement work.

We will establish and MCA and DoLs Steering Group to oversee the implementation of the Trust strategy supported by a comprehensive terms of reference to ensure effective representation of key stakeholders in the Trust.

We will develop an MCA and DoLs performance dashboard with agreed improvement trajectories for areas of development work e.g. training, to help us to monitor our performance and take mitigating action when required if performance is not as expected.

Who is responsible for the action?	Chief Nurse and DIPC

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

The Trust completed Back to the Floor audits looking at staff knowledge in February and June 2018 and will continue with a programme of monthly to six weekly deep dive audits on a ward by ward basis using a home grown audit tool. The audit will focus on assessing the use of the MCA in serious medical treatment and discharge decisions.

We will continue to refine the audit questions to interrogate the use of restrictions and restraint (under the MCA) as part of the Quality Observatory which form a key part of the ward accreditation (grading) process.

We will produce an interim audit report in September 2018 and a full pan-trust audit report in April 2019. The audit results will continue to inform our service improvement agenda linked to the Trust's strategy for MCA and DoLs.

We will continue our joint working with Kingston Hospital and NHSi to further refine the current deep dive audit tool and explore and interpret themes across more than one Trust.

We will continue with the programme of spot check audits of MCA appropriate use of restrictions and restraints planned with Quality Team. We are also developing a regular staff questionnaire on knowledge of the MCA as part of a wider communications plan. The Trust will undertake bi-monthly reporting to the adult safeguarding meeting and continue to produce an annual report to the Patient Quality and Safety Committee. The MCA and DoLS Steering group will provide monthly monitoring of the implementation of the Trust MCA and DoLS Strategy. The Trust Executive Committee will receive fortnightly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.	
Who is responsible?	Chief Nurse and DIPC
What resources (if any) are needed to implement the change(s) and are these resources available?	
Capacity Assessment and Best Interests Proformas were developed and disseminated to a small number of stakeholders for review in May 2018, within existing resources. Elderly Care Teams across the Trust have been requested to pilot Capacity and Best Interests Proformas commencing August 2018, within existing resources. Work has commenced with IT and Corporate nursing to contribute to the development of electronic templates and clerking systems to maximise the opportunity to capture the applied use of the MCA. Funding has been approved as part of the Trust's bid for quality special measures funding for an additional band 7 MCA and DoLs practitioner (fixed term) to support the existing 1.0 wte band 7.	
Date actions will be completed:	31 December 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The activities that the Trust has taken to date and plan to take will help to ensure appropriate and consistent management of all patients under our care and minimise occasions where the Trust is found lacking.

Completed by:	James Godber Mental Capacity Act Practitioner
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Avey Bhatia Chief Nurse & DIPC
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) regulations 2014 Premises and equipment
	How the regulation was not being met:
	All premises were not suitable for the purposes for which they are being used or were being properly maintained because; 1. At St George's Hospital, theatres waiting refurbishment were not fit for purpose and were not adequately maintained. Some theatre doors were also not closable or kept closed when not in use. Regulation 15 (1) (c) (d) (e)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust is committed to ensuring that theatres awaiting any level of refurbishment remain safe and suitable for use. In addition to the daily environment checks and planned preventative maintenance the Trust has instigated the following:

- Undertaken individual theatre surveys to the confirm status of each element and works required
- Develop and clearly define a list of maintenance and condition checks for each theatre
- Define a hybrid scope of works
- Plan and implement a shutdown programme (continuous cycle of planned maintenance) for theatres in conjunction with the Theatre Working Group to enable identified works to be conducted and carried out including the provision of temporary theatres
- Document works conducted and any works not able to be completed that still require attention
- Gain sign off from estates and theatre management teams to ensure both are aware of progress and requirements
- File reports and compliance certificates in line with statutory regulations in accordance with the Premises Assurance Model (PAM) and with a copy to Infection Control

A number of urgent actions have been identified (uninterruptable power supply and air handling). These represent a risk in the event of failure and prompt recovery, rather than a risk to on-going operations. A programme of works has been developed to address these issues and a bid for emergency funding will be submitted to NHSi in August 2018. This work could take up to 2 years to complete.

Whilst the theatres would benefit from modernisation, the theatres still remain compliant in terms of statutory compliance regulation surrounding the accreditation levels when built.

Please note:

The issue identified at the time of inspection with the theatre doors not being able to close properly have been fully rectified.

Who is responsible for the action?	Director of Estates and Facilities

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

The following measures will be put in place to ensure sustainability:

- All statements on compliance to be assured by an Independent External Authorised Engineer
- All craftsmen to sign completion of works
- All works to be checked by works officers and signed as confirmed completed. Non-conformities or issues to be identified and escalated
- Estates senior management team and senior sister/ manager of theatres to confirm acceptance of condition of the works in writing as part of the sign off sheet
- Results to be filed with compliance certificates and any additional actions required will be reinstated as a recorded auditable task with defined time parameters for completion
- Documented evidence will be provided to the Premises Assurance Model (PAM)

The Trust Executive Committee will receive monthly reports on performance against identified regulated activities. Issues will be identified as required for resolution at the divisional performance meetings.

Who is responsible?	**Director of Estates and Facilities**
What resources (if any) are needed to implement the change(s) and are these resources available?	
Additional resources have been made available to Estates and Facilities to support the enhanced review and PPM outlined above. An emergency capital bid is being developed by the Trust to support a number of urgent safety actions within 2018/19, while the Trust continues to work to identify medium term sources of capital to support work over the next 2 years.	
Date actions will be completed:	31 March 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There should be a minimal impact on our patients during any theatre refurbishment programme.
The regular monitoring of theatres e.g. temperature checks and air quality will ensure that theatres are fit for purpose in terms of environmental safety. Pre-requisite validation certificates from accredited external companies will be issued.
Our focus on theatre efficiency and data quality as part of the Quality Improvement Programme will ensure that our patients waiting for treatment are tracked and monitored effectively.

Completed by:	Rathan Nagendra Assistant Director of Estates and Facilities
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Kevin Howell Director of Estates and Facilities Andrew Grimshaw Chief Finance Officer
Date:	15 August 2018

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment
	How the regulation was not being met:
	The provider was not meeting this regulation because: 1. At Queen Mary's Hospital, there was a lack of compliance with the WHO surgical safety checklist. We saw examples of the checklist not being confirmed aloud and time out sections of the checklist not completed. The swab and instrument count were not carried out according to national recommendations for safe practice. The instrument checklist was not visualised and swabs and sundries were not recorded on the count board according to the trust's policy. The procedures in theatre for the swab and instrument count did not follow the department's guidelines. Regulation 12 (2) (b)

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has a significant focus on improving our theatre efficiency as part of the Quality Improvement Plan with the expectation that we achieve 100% compliance with the completion of the WHO surgical safety checklist.

When the inspection team informed us of their concerns in the week of the inspection we immediately communicated with all nursing and medical staff to raise awareness of the concerns to ensure full compliance with the WHO surgical safety checklist.

In particular staff were reminded to:

1. Confirm the WHO checklist aloud
2. Carry out the swab and instrument count according to national recommendations for safe practice
3. Visualise the instrument checklist and record swabs and sundries on the count board according to Trust policy

On 21 March 2018 an audit of compliance with the WHO surgical safety checklist was undertaken at QMH. The audit results were fed back to the teams.

Who is responsible for the action?	Medical Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Re-audit of compliance with WHO surgical safety checklist will continue on a monthly basis.

Audit results will continue to be reported monthly in Divisional Quality Observatory reports.

Audit results and any resultant corrective action plans will continue to be monitored at Divisional level in Divisional Governance meetings and at Trust level via Divisional reports to the Patient Safety and Quality Group.

Who is responsible?	Medical Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
Not applicable – implementation of required changes is complete	
Date actions will be completed:	COMPLETE: 31 March 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Not applicable – implementation of required changes is complete

Completed by:	Lucy Titheridge General Manager and Clinical lead
Edit:	Alison Benincasa Quality Improvement Director
Final approval:	Professor Andrew Rhodes Medical Director
Date:	15 August 2018

24/08/2018 *Last updated*

MASTER DOCUMENT

DRAFT (requires formal sign off at Trust Board)

PURPLE indicates a requirement action in line with regulated activities

RAG key:
Green = Complete
Amber = In progress (on target)
Red = Overdue

Considerations: No financial impact; x required and covered in budget; x required and funded; x required and funding TBC

Trust Action Plan July 2018 (in response to CQC Inspection March 2018)
Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'
Based on : 5th June 2018 Draft Report and updated following receipt of final CQC inspection report received 19 July 2018

Ref	Theme	CQC Recommendation	Location	Service	Must/Should /Could Do	Trust Actions	1. Sources of Assurance / 2. Monitoring group	Executive Lead	Responsible Lead(s)	Expected Completion Date	Delivery Status (RAG)	Progress / Comments	Evidence of expected outcome	Closed Date	On-going monitoring	QiP alignment	Financial implications
1	Estates	Ensure the environment on paediatric wards are routinely monitored and appropriate actions are taken to ensure patients are safe and comfortable. These includes ensuring ventilation systems are in a good state of repair and bed spaces comply with the department of health building note.	SGH Tooting	Children & Young People	SHOULD	1. Address all areas of backlog maintenance, fire, water, heating and ventilation safety. 2.1 Resolve emergency estate calls (priority 1) within 6 hours. 2.2 Resolve standard routine work (priority 3.5) within 8 working days	1. Status reports on progress against Estates Recovery Plan, Back to the Floor audit, ward accreditation, executive visits, QiP KPI EF07 and EF08. 2. TEC, FIC, Q&S and Trust Board	KHowell	RNagendra	31/03/19			Improved FFT scores compared to April 2018			Enabler: Estates & IT	No financial impact
2	Estates	Consider improving the environment in the infusion suite to make it less cramped for staff and patients.	SGH Tooting	Outpatients	SHOULD	1. Extend current Outpatients Improvement Plan to include focus on Infusion Suite environment	1. Status reports on progress against Outpatients Improvement Plan, QiP KPI FC072. Outpatient Transformation Steering Group, TEC, Q&S and Trust Board	KHowell	RNagendra	31/12/18		17/08/18 Visits have been made by the Director of E&F. A full environmental risk assessment to be carried out. A plan will be put in place in relation to the works required and funding application	Improved FFT scores compared to April 2018			Enabler: Estates & IT	Confirm what needs to happen, the cost and source of funding
3	Estates	Improve the signage make the system for blood testing in Lanesborough clearer for patients.	SGH Tooting	Outpatients	SHOULD	1. Extend current Outpatients Improvement Plan to include focus on Infusion Suite environment	1. Status reports on progress against Outpatients Improvement Plan, QiP KPI FC072. Outpatient Transformation Steering Group, TEC, Q&S and Trust Board	KHowell	RNagendra	31/12/18			Improved FFT scores compared to April 2018			Enabler: Estates & IT	Confirm what needs to happen, the cost and source of funding
4. Regulation 15	Estates	Continue to work to ensure that theatres are fit for purpose. In addition to continuing to refurbish the theatre suite, the division must ensure that those theatres awaiting refurbishment remain fit for purpose and are adequately maintained. The division must ensure that the door to the main theatres is closable and kept closed when not in use.	SGH Tooting	Surgery	MUST	1. Undertake individual theatre surveys to confirm status of each element and works required 2. Develop and clearly define a list of maintenance and condition checks for each theatre 3. Develop and clearly define a list of maintenance and condition checks for each theatre 4. Plan and implement a shutdown programme (continuous cycle of planned maintenance) for theatres in conjunction with the Theatre Working Group to enable identified works to be conducted and carried out including the provision of temporary theatres 5. Document works conducted and any works not able to be completed that still require attention 6. Gain sign off from estates and theatre management teams to ensure both are aware of progress and requirements 7. File reports and compliance certificates in line with statutory regulations in accordance with the Premises Assurance Model (PAM) and with a copy to Infection Control 8. Develop an emergency capital bid to support urgent safety actions within 2018/19	1. Outcome of emergency capital bid; status reports on progress against Estates Recovery Plan; Back to the Floor audit; executive visits; QiP KPI EF07 and EF08. 2. TEC, FIC, Q&S, Trust Board	KHowell	RNagendra	31/03/19		The air balancers have been repaired and adaptions have been made to the door closers within the theatres.	Increase in theatre productivity			Enabler: Estates & IT	Bid to be made for emergency funds. Confirmation required re scope of works to be undertaken

5	Estates	Deal with the five risks linked to the environment within the ED in a timely way to meet the timescales.	SGH Tooting	Urgent & Emergency	SHOULD	1. Undertake assessment of need in relation to the work required re: lack of compliant cubicle for patients with mental health conditions; Lack of bed head (O2 and Suction)services to Childrens Emergency Department (CED) Urgent Care/triage area; Lack of sufficient wall mounted oxygen and suction in the ambulance off load area of majors; ED Streaming Assessment Queue - Inappropriate outdoor environment; and lack of comprehensive emergency call bell system in the Emergency Department. 2. Develop a time specific plan for delivery. If assessment of need indicates works are not required this needs to be clear and approval provided at DGB and PSQB 2. Update divisional risk register to reflect delivery plan	1. Status reports on progress against delivery plan. 2. DGB, TEC, RMC	KHowell	RNagendra	31/03/19		All 5 risks are detailed within the ED risk register, monitored and progress reported monthly. ED are currently working with Estates to develop a clear plan of works associated with the 5 risks with clear timeframes for delivery. **17/08/18 update** ED walk-around with Director of Estates and Facilities arranged for 24/08/18. Plan linked to prioritization and timeframes for delivery to follow.	Improved FFT scores compared to April 2018			Enabler: Estates & IT	Assessment of work to be undertaken or not and value. Where work not being undertaken clear statement of why not required
6. Regulation 17	Estates	Improve the maintenance backlog of its estate, so that clinical areas are safe and fit for purpose.	Trust wide	Provider Level	MUST	1. Identify dedicatedresources to carry out PPM 2. Provide additional resources to reduce immediate bcaklog tasks 3. Identify dedicated resources to carry out emergency reactive work 4. Continue with the current arrangements of dedicating two team members in each discipline to carry out PPMs and emergency reactive work 5. To address the estates backlog maintenance the Trust will ensure that all infrastructure and plant upgrade projects are prioritised according to the corporate risk rating and are supported by an appropriate business case for capital	1. Computer aided facilities managemnt system. 2. Status reports on progress against Estates Recovery Plan; Back to the Floor audit; ward accreditation; executive visits; QiP KPI EF07 and EF08. 3. TEC, FIC, Q&S, Trust Board	KHowell	RNagendra	31/03/19		£5 million identified from emergency funding this year. Firm plans in place for planned preventative maintainence and re-active maintainence with funded team	Improved FFT scores compared to April 2018 (patient voice and staff recommend SGH as place to work)			Enabler: Estates & IT	Bid to be made for emergency funds. Confirmation required re scope of works to be undertaken
7	Governance (Clinical & Audits)	In outpatient develop, where appropriate, action plans following audits and complete the audit cycle following audits.	QMH	Outpatients & Surgery	SHOULD	1. Undertake audit as required in line with departmental/ Trust audit schedule. Develop a targeted action plan to address areas for improvement. 3. Report findings of audit and audit action plan to relevant meetings. 4. Re-audit as per audit schedule. 5. Monthly feedback to staff	1. Audit results and audit action plans. 2. Minutes of care group, Directorate and DGB meetings.	JRichards	HMcHugh	31/12/18		17/8/18 day case (surgery) at QMH audit schedule drawn up . Actions plans to be written up and shared with staff. 15/08/18 For outpatients on all sites an cction plan has been developed and there is a meeting planned 22 August 2018 for the initial launch for all outpatient areas. This is being led by the GM and HoN for outpatients. An accreditation tool is in development for outpatient area and this will be the tool for ongoing monitoring.	Improved FFT scores compared to April 2018 (patient voice and staff recommend SGH as place to work)		15.08.18 Accreditation tool & complaints and compliments	Quality & Risk: Effective risk management & Governance	No financial impact
Removed from final report	Governance (Clinical & Audits)	In the day care unit review and improve staff involvement in clinical governance including audits.	QMH	Outpatients & Surgery													
8	Governance (Clinical & Audits)	Review and improve staff involvement in clinical governance including audits.	QMH	Surgery	SHOULD	1. Undertake audit as required in line with departmental/ Trust audit schedule. 2. Develop a targeted action plan to address areas for improvement. 3. Report findings of audit and audit action plan to relevant meetings. 4. Re-audit as per audit schedule. 5. Monthly feedback to staff	1. Audit results and audit action plans. 2. Minutes of care group, Directorate and DGB meetings.	Lisa Pickering	MArmatrading	31/12/18		17/8/18 for surgery - audit schedule drawn up . Actions plans to be written up and shared with staff	Improved FFT scores compared to April 2018 (patient voice and staff recommend SGH as place to work)			Quality & Risk: New project - Audit driven service improvement	No financial impact
9	Governance (Clinical & Audits)	Devise plans to improve their performance in National Diabetes Inpatient Audit 2016 and National Audit of Inpatient Falls.	SGH Tooting	Medical Care	SHOULD	1. Review findings of National Diabetes in-patient audit and National audit of in-patient falls and identify improvement actions. 2. Develop a Trust wide Diabetes action plan and a Falls action plan to address required improvement actions.	1. In-patient Diabetes and Falls action plans. 2. Status reports to PSQG and Q&SC.	Lisa Pickering	MArmatrading	31/12/18		**17/08/18** **Falls update** HoN part of Trust falls steering group, local falls groups & champions to action improvements required. Falls data reviewed monthly. **Diabetes update 17.08.18** Diabetes team were part of a national bid with Wandsworth CCG lead for SW London in getting funding for 2 Band 7s,2 band 6 and 1 Band 3 to have a specific inpatient nursing team until March 2019. 2 Band 6s and 1 Band 3 coordinator has been recruited until March 2019. A business case is being put together to go to IDDG for permanent funding for 1 wte Band 7, 2 wte Band 6 and 1wte Band 3 coordinator. The trust needs to purchase blood ketone testing equipment for ED, and medical wards. Working with procurement to find out cost which will determine if business case required. In house training for ward areas has commenced and is on going. Diabetes and insulin training for FY 1 and FY2 to be confirmed by Clinical Lead as now back from annual leave. Registered with the national HARMS audit. Planning to have an e MAST course for all staff who prescribe and administer insulin.	Improved audit results when compared to last previous audit results. Therefore improved outcomes for patients			Quality & Risk: New project - Audit driven service improvement	Need to establish what is needed to improve performance, any investment required?

10	Governance (Clinical & Audits)	Ensure the management of hazardous substances complies with Control of Substances Hazardous to Health (COSHH) regulations 2002.	SGH Tooting	Urgent & Emergency	SHOULD	1. Undertake audit of current practice. 2. Develop action plan to address improvement actions required. 3. Monitor progress of action plan delivery. 4. Re-audit as required	1. Audit results and audit action plans. 2. Minutes of care group, Directorate and DGB meetings.	Lisa Pickering	MArmatrading	31/10/18		17/08/18 Updated from estates: General sharps paper to be presented to the ICC on 15/8/18, Sharps working group TOR to be approved at that meeting. Report is understood to relate to local management of sharp instruments which is being addressed by the local management rather than a strategic issue. Quarterly audit will be carried out by the H&S department. 01/08/17 New lockable cupboards ordered to go into sluice to ensure COSHH regulations are met. Audit to be undertaken in September 2018.	Hazardous substances managed appropriately with associated reduced risk for staff			Quality & Risk: Learn from incidents	Need to establish if this is a one-off or are there more non-compliant cupbards throughout the Trust?
11	Governance (Clinical & Audits)	Ensure the management of sharps complies with Health and Safety (sharps instruments in healthcare) regulation 2013.	SGH Tooting	Urgent & Emergency	SHOULD	1. Undertake audit of current practice. 2. Develop action plan to address improvement actions required. 3. Monitor progress of action plan delivery. 4. Re-audit as required	1. Audit results and audit action plans. 2. Minutes of care group, Directorate and DGB meetings.	Lisa Pickering	MArmatrading	31/10/18		New lockable cupboards ordered to go into sluice to ensure COSHH regulations are met. Audit to be undertaken in September 2018.	Sharps managed appropriately with associated reduced risk for staff			Quality & Risk: Learn from incidents	No financial impact
Removed from final report	Governance (Clinical & Audits)	Develop and implement a local audit programme and continue to work to improve their results from national audits.	SGH Tooting	Urgent & Emergency Services													
12. Regulation 17	Governance (Clinical & Audits)	Continue with the Elective Care Recovery Programme and Clinical Harm Review Group with regards to RTT data.	Trust wide	Provider Level	MUST	1. Progress Elective Care Recovery Programme including improving the accuracy of waiting list data, and implementation of iClip at QMH 2. Develop and implement capability to commence shadow RTT reporting to Trust Board September 2018 3. Commence national RTT reporting December 2018 4. Progress and complete the associated Clinical Harm Review process 5. Develop bid for emergency capital funding from NHSi	1. Weekly SGH & QMH ECRP performance pack; Return to RTT national reporting; Clinical Harm Review process completed 2. TEC, Q&S, Trust Board, POM	EPullinger	AClough	31/03/19		Weekly comprehensive set of KPIs in place to track performance against a set of agreed indicators. Regular audits undertaken to ensure current waiting list data is accurate. 20 Quality measures tracked on a daily basis to ensure new added processes (as we get ready for return to national reporting) keep the waiting list accurate.	Accurate waiting list data. Capacity plans in place to treat patients as per constitutional requirements. RTT national reporting. Improved FFT scores compared to April 2018 (patient voice)			Flow & Clinical Transformation: Data quality	X required and funded
13	Governance (Clinical & Audits)	Continually review the systems in place for infection prevention and control.	Trust wide	Provider Level	SHOULD	1. Conduct a deep dive in to Trust wide performance in infection prevention and control 2. Develop division specific improvement actions supported by quality improvement methodology. 3. Monitor progress and adjust improvement actions accordingly	1.Reports and minutes of deep dive; improvement action plans; status reports, back to the floor; quality observatory, ward accreditation scheme. 2. Divisional performance reviews, PS&QG, Q&SC	ABhatia	Rbleasedale	31/12/18			Consistent application of infection prevention and control procedures. Reduction in cdif, MRSA, etc			Safe & Effective: Fundamentals of Care	No financial impact
14	Governance (Clinical & Audits)	Ensure governance arrangements on the Queen Mary's Hospital site are consistent with those on the St George's Hospital site.	Trust wide	Provider Level	SHOULD	1. Review current governance arrangements at QMH and revise as appropriate. 2. Approve revised QMH governance arrangements at TEC. 3. Ensure effective communication	1. QMH Governance Framework in line with SGH 2. QMH Clinical partnership Group, TEC	ARhodes	Sreeves	31/12/18			QMH Governance framework in place and communicated with staff			Quality & Risk: Effective risk management and governance	No financial impact
Removed from final report	IT, Information & Systems	Ensure access for agency staff to the trust computer systems including the trust electronic incident reporting system.	QMH	Inpatient Services													
15	Governance (Clinical & Audits)	Review and update where appropriate, all policies in line with agreed timescales	QMH	Surgery	SHOULD	1. Ensure all policies relating to the day case unit at QMH are included in Trust wide policy review. 2. Ensure Trust Policy Hub holds up to date policies	1. Status reports on Trust wide Policy review project 2. PSQG, Q&S, Trust Board	ABhatia	Marmatrading / LTitheridge	31/03/19			The Trust has up to date policies which reflect best practice. Staff are supported at work with access to best practice policy documents			Quality & Risk: Effective risk management and governance	No financial impact
16	IT, Information & Systems	Collect and make available data on the number of cancelled procedures and the reason why they were cancelled.	QMH	Surgery	SHOULD	1. Develop process to capture and report on cancelled procedures in day case at QMH 2. Commence reporting. 3. Develop and deliver improvement plans based on performance	1. QMH cancelled procedures performance report. 2. Operational Delivery Group; QMH Clinical Partnership Group;	Lisa Pickering	MArmatrading	31/12/18		17/8/18 - infomatics request to genarate monthly report	Improved performance compared with previous month			Flow & Clinical Transformation: Data quality	No financial impact
17	IT, Information & Systems	Continue to work to move to an electronic rather than paper system for patient information including referrals to ensure patients records are accessible to staff who work across all sites.	QMH	Surgery	SHOULD	1. Implement iClip at QMH	16/08/2018 1.1 Business case agreed at TEC and Trust Board. 1.2 Project team being formed. 2. Monthly progress reporting to IGG and to the TEC.	EWhite	SPatel	31/09/19		16/08/2018 1. Full Business Case agreed at TEC 20/06/2018 and Trust Board at 28/06/2018 (subject to validation of remaining costs). 2. Project team in place and project commenced July 2018. 3. Communicated at Senior Leader's Briefing on 06/07/2018	Improved access to patient records for staff working across SGH and QMH sites			Enabler: Estates & IT	X required and funded

18. Regulation 17	Estates	Ensure adequate monitoring systems are in place to monitor the risk to fire safety on paediatric wards.	SGH Tooting	Children & Young People	MUST	1. Review fire risk assessment for paediatric wards to ensure it is fit for purpose (by 31 September 2018) 2. Ensure continuation of the following actions: Fire warden training delivered for all qualified nursing staff; Fire warden on each shift day and night; Scheduled annual fire safety training in place; Scheduled annual fire drill/ evacuation exercise for each ward; Weekly fire alarm testing on all paediatric wards 3. Ensure the planned schedule of visits from Authorised Fire Safety Engineer take place to assure on strategy fire risk assessment programme for the internal fire team 4. Receive report from Trust Authorised Engineer for fire and identify as appropriate required corrective actions	1. Fire safety monitoring systems action plan for paediatric wards; Two yearly fire warden training reflected on the MAPS system; Fire warden staff member identified on the allocation board for each shift; Annual fire safety training completed via MAST; report on ward fire drills; Ski sheet training provided for all wards; Part of pre planned maintenance programme by Facilities; 2. DGB, PSQG, Trust Health, Safety and Fire committee and Q&SC	KHowell	RNagendra	31/09/18		The Trust Authorised Engineer for Fire has completed a Fire Safety Audit - report awaited	Comprehensive and effective fire safety monitoring systems are in place			Enabler: Estates & IT	Bid to be made for emergency funds. Confirmation required re scope of works to be undertaken
Removed from final report	IT, Information & Systems	Review and ensure the systems for monitoring and improving the quality and safety of care and treatment provided are effective.	SGH Tooting	Urgent & Emergency Services			1. ED Quality Observatory										
19. Regulation 17	IT, Information & Systems	Improve the IT system, so that it was less vulnerable to breaches and more areas were able to prescribe electronically.	Trust wide	Provider Level	MUST	1. Business case to IDDG to fund project to roll out and standardise use of iClip in the wards at St Georges (covers clinical noting and e-Prescribing). 2. Deliver iClip project to roll out and standardise the use of iClip in the wards at St georges which covers both clinical noting and e-Prescribing	1. 1 Business case agreed at Trust Executive Committee. 1.2 Project team in place 2. Monthly progress reporting to Informatics Governing Group and to the Trust Executive Committee.	AGrimshaw	EWhite	31/12/18		1. Business case agreed at Trust Executive Committee 18/07/2018. 2. Project team in place and project commenced 19/07/2018. 3. All staff communication 02/08/2018	All wards will use electronic records for capturing clinical details, requesting and viewing test results and prescribing and administering medication. Staff will be trained and supported in standard use of system, with controlled access rights.			Enabler: Estates & IT	X required and funded
20	Mental Health	Ensure that staff are aware of all the potential and actual signs of physical and mental abuse.	QMH	Outpatients & Surgery	SHOULD	1. Review MAST performance for Adult and Child Safeguarding and MCA/DoLs. 2. Identify staff in need of training and line managers adopt a targeted approach utilising MCA/DoLs flash card training approach. 3. Deliver training sessions at QMH as required. 4. Ensure awareness information available for staff	1. MAST performance; Back to the floor and audit; Number of training workshops held and sign in sheets; Staff awareness information visible in departments 2. DGB, PSQB 3. Produce exception report when necessary to identify areas where compliance levels are particularly low ensure the TNA is up to date to make sure that the correct staff groups are being targeted to do this training.	JRichards	ALudlam	31/12/18			Staff are aware of all the potential and actual signs of physical and mental abuse.			Safe & Effective Care: Embed dementia, MCA & DoLs	No financial impact
21	Mental Health	Ensure all works scheduled for the anti-ligature bay on Frederick Hewitt Ward are completed.	SGH Tooting	Children & Young People	SHOULD	COMPLETE: No further action required	1. Curtain rails replaced with drop down rails to prevent a ligature injury; Window blinds replaced with anti ligature blinds; Anti ligature furniture in place; Wash hand basin replaced with sensor operation; Bathrooms/ toilets upgraded to current anti ligature safety standards; Call bells installed in the bathrooms; Shatter proof glass in main door to the ward; Swipe card access added to door between Frederick Hewitt ward and adjacent ward 2. Health and safety Committee, PSQG	KHowell	RNagendra	24/07/18		All works completed as detailed in tab H	Improved environment to support anti-ligature requirements	24/07/2018	Back to the floor, ward accreditation scheme, exec visits	Enabler: Estates & IT	No financial impact

22	Mental Health	Ensure the privacy and dignity of patients are protected on all paediatric wards, in particular, in the anti-ligature bay on Frederick Hewitt Ward.	SGH Tooting	Children & Young People	SHOULD	COMPLETED: Replaced curtains in all paediatric wards with standard NHS supply. 2. Lower all curtain rails in paediatric wards and ensure rails snap away if weight applied.	COMPLETED: Replacement curtains installed 2. DGB, PSQB	JRichards	HMcHugh	31/04/18		COMPLETED	Privacy and dignity ensured for our paediatric patients	24/07/2018	Ward accreditation scheme, back to the floor	Enabler: Estates & IT	No financial impact
23	Mental Health	Ensure consistency in the use of 'Forget me not' stickers **(SHOULD READ BUTTERFLY SCHEME)** on patient records and on whiteboards to indicate that a patient was living with dementia, where appropriate.	SGH Tooting	Medical Care	SHOULD	1. Identify a pilot ward 2. Review current practice to establish performance baseline 3. Adopt quality improvement methodology. 4. Undertake PDSA. 5. Evaluate pilot and make requirement adjustments 6. Develop and deliver Trust wide implementation plan	1. Pilot outcome; implementation plan including communication strategy 2. DGB, PSQB	Lisa Pickering	MArmatrading	31/12/18		17/08/18: Forget me not scheme not used at Trust, butterfly scheme used. Patients identified with butterfly icon on handover, notes and on white boards. Information on butterfly scheme available on each ward.	Promotes awareness of dementia patients under our care			Safe & Effective Care: Embed dementia, MCA & DoLs	No financial impact
24. Regulation 11	Mental Health	Ensure that the required documentation for Mental Capacity Act assessments and Deprivation of Liberty Safeguards is completed fully and consistently across all the medical wards.	SGH Tooting	Medical care (including older people's care)	MUST	1. Identify a non-executive lead for MCA/DoLs 2. Develop a Trust strategy for MCA/DoLs 3. Establish and MCA/DoLs Steering Group to oversee the implementation of the Trust strategy 4.Develop an MCA/DoLs performance dashboard	1.1 Non executive lead. 1.2 Strategy in place. 1.3 Steering group in place 1.4 Performance dashboard in place 2. MCA/DoLS Steering Group; PSQG, Q&SC	ABhatia	Lisa Pickering	31/12/2018			Improved FFT performance compared with April 2018. Meets regulation 12.			Safe & Effective Care: Embed dementia, MCA & DoLs	X required and funded
25. Regulation 17	Mental Health	Review and monitor mental health patients who are subject to the use of restraint and/or rapid tranquillisation in line with National Institute for Health and Care guidance.	SGH Tooting	Urgent & Emergency	MUST	1. Review and update the rapid tranquilisation protocol 2. Approve updated protocol through a rapid clinical governance process including final ratification at the Trust's Patient Safety and Quality Group 3. Communicate revised protocol at morning emergency department inter-professional handover so that all staff are aware 4. Familiarise staff with the revised protocol at the weekly teaching sessions in the emergency department 5. Inform staff about how to access all ED and Trust protocols on all nurse and doctor inductions 6. Undertake an audit of practice 4 weeks following introduction of new the protocol 7. Implement 6 monthly audit cycle to demonstrate continued compliance 8. Provide regular teaching on rapid tranquilisation on doctor and nurse training programmes 9. DATIX all cases of rapid tranquilisation administration 10. Provide supervision and support for junior staff by ED Consultants and senior nursing staff	1. Audit results and audit action plans. 2. Minutes of care group, Directorate and DGB meetings.	ABhatia	Lisa Pickering	31/12/2018		x 2 RMNs on shift 7 days a week. Rapid tranquilisation only provided under the supervision of an ED consultant. All occasions of rapid tranquilisation reported on datix. All staff re-minded of current guidelines at morning handover. Mental health teams now review all records for attending mental health patients. **17/08/18 update** Lead consultant for Mental Health within ED has developed new guideline and circulated for comments to be used in the interim and until Trust wide policy is updated. Audit of current practice to be undertaken in September. Audit template developed by ED HoN.	Care delivered in line with best practice guidelines and Trust protocol			Safe & Effective Care: Embed dementia, MCA & DoLs	No financial impact
Removed from final report	Mental Health	Ensure patients who are at risk as a result of their mental health needs are managed by the provision of one to one nursing where indicated following risk assessment.	SGH Tooting	Urgent & Emergency													
26	Mental Health	Have specific arrangements to meet the needs of patients with dementia and have a means of identifying them.	SGH Tooting	Urgent & Emergency	SHOULD	1. Review current practice re use of Butterfly Scheme to establish performance baseline 2. Adopt quality improvement methodology. 3. Undertake PDSA. 4. Evaluate pilot and make requirement adjustments 5. Develop and deliver implementation plan	1. Implementation plan including communication strategy 2. DGB, PSQB	Lisa Pickering	MArmatrading	31/12/18		ED Head of Nursing is liaising with the Trust dementia lead on how best to identify patients, including electronically with the introduction of paperlite. The ED will ensure compliance with the Trust's sticker scheme. **17/08/18 update** ED HoN to meet with Trust dementia lead w/c 20th August 2018 to agree plan.	Promotes awareness of dementia patients under our care			Safe & Effective Care: Embed dementia, MCA & DoLs	No financial impact
27. Regulation 11	Mental Health	Ensure the needs of people with mental health problems are met and staff have access to appropriate policies and training to provide safe effective care.	SGH Tooting	Urgent & Emergency Services	MUST	1. Undertake gap analysis of training needs and knowledge of appropriate policies within the ED 2. Develop and deliver training plan linked to gaps identified 3. Develop holistic care plans for mental health patients attending ED , jointly with psychiatric liaison team. 4. Address outstanding environmental risks within designated mental health cubicle.	1. Action plan 2. ED Directorate and Governance Meetings, DGB, Joint Psychiatric Liaison meeting with mental health partners.	A Bhatia	MArmatrading	31/12/18		17/08/18 - updated from estates: The environment has been upgraded and alarms reviewed and agreed with the GM for ED **17/08/18 update** RMNs within the ED to undertake gap analysis of training needs supported by Matron and HoN for ED by the end of September 2018. Initial meeting held with Practice Education Team.	Care delivered in line with best practice guidelines and Trust Policy			Safe & Effective Care: Embed dementia, MCA & DoLs	X required and funded
Removed from final report	Mental Health	Ensure staff receive training and are aware of their responsibility in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).	SGH Tooting	Urgent & Emergency Services													
28. Regulation 11	Mental Health	Ensure staff receive training, are aware of their responsibility and apply the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).	Trust wide	Provider Level	MUST	1. Deliver MCA/DoLs training as part of MAST programme 2. Achieve MCA/DoLs MAST performance target of 90% 3. Check understanding and staff awareness as part of back to the floor visits and ward accreditation scheme	1. MCA/DoLs MAST performance figures; findings from back to the floor and ward accreditation scheme 2. DGB, PSQB, MCA/DoLs Steering Group, Q&S Committee, Trust Board	ABhatia	DDNGs	31/12/18		Current training programme further developed and extended 15.08 18 CWDT DDNG monitoring and sending out reminders to areas with outstanding completion. Also raised at DGB monthly.	Staff appropriately trained and staff have improved awareness		15.08.18 Mast training is monitored through DGB and PSQB.	Safe & Effective Care: Embed dementia, MCA & DoLs	X required and funded

29	Performance	Improve access and flow in order to reduce bed occupancy rates to safe levels and minimise bed moves including some at nights and at weekends.	SGH Tooting	Medical Care	SHOULD	1. Continue to progress Unplanned and Admitted care improvement programme	1. Minutes of UPAC steering group; KPI metrics 2. UPCA steering group; TEC; FIC, Q&SC, Trust Board	LPickering	FAshworth	31/03/19		17/08/18: The Medicine and Cardiovascular Division is bringing in an interim for a 3 month period to focus on improvements in management of complex discharges with a view to reducing the number of patients with a LOS of >7 and >21 days and improve flow. Review of Trust wide discharge model underway led by Deputy Chief Nurse. Ambulatory Care opening ours extended to 08.00 24.00 hours from 23/7/18 to further contribute to improvements in flow and admission avoidance, reducing occupancy on AMU.	Care delivered in line with best practice guidelines and Trust Policy			Flow & Clinical Transformation: Improve unplanned & admitted care	No financial impact
30	Performance	Meet the Royal College of Emergency Medicine recommendation that the time patients should wait from time of arrival to receiving treatment is no more than one hour.	SGH Tooting	Urgent & Emergency	SHOULD	1. Review ED processes and identify opportunities to improve time to treatment within one hour 2. Implement new RAD model in UCC	1. Weekly progress monitored via Emergency Care Performance Improvement Group (ECPIG) 2. Weekly, cross-Divisional ECPIC chaired by COO, monthly paper on emergency care performance at TEC, FIC and Trust Board.	LPickering	FAshworth	31/12/18		The Trust is now consistently meeting this standard for more than 60% of patients. This key metric is subject to weekly review at the Emergency Care Performance Improvement Group, chaired by the COO and the Trust Board is updated on a monthly basis.	Care delivered in line with best practice guidelines and Trust Policy			Flow & Clinical Transformation: Improve unplanned & admitted care	No financial impact
Removed from final report	Record Keeping	Improve patient record keeping in particular on Mary Seacole Ward.	QMH	Inpatient Services													
Removed from final report	Record Keeping	In outpatients store all records securely.	QMH	Outpatients & Surgery													
31. Regulation 17	Record Keeping	Review the storage of medical records in all clinics to ensure that they cannot be accessed by unauthorised persons.	SGH Tooting	Outpatients	MUST	1. Audit all OP clinics storage of Med records and access rights 2. Develop and implement corrective action where required.	1. Management assurance processes; on-going audit, validation and monitoring of OP clinics storage of records and access rights. 2. DGB, TEC, PSQB	EPullinger	ATerry	31/09/2018		Extended team meeting organised for 22 August 2018 and fortnightly thereafter to focus on delivery of outpatients improvement plan	100% compliance scores			Quality & Risk: Clinical Record Management	Need to establish if compliant storage solutions are available in all wards and departments and if not what is the value of investment required?
32. Regulation 17	Record Keeping	Ensure that staff actively sign the controlled drug (CD) book, rather than using a stamp.	SGH Tooting	Surgery	MUST	1. Audit current practices in all areas 2. Implement best practice in line with Regulation 20 of the 2001 Misuse of Drugs Regulations 3. Maintain audit cycle	1. Email communication to all staff, monthly MUST do audits and quarterly CD record book checks 2. PSQB reports, TEC reports	ABhatia	Vin Kumar	31/07/18		Full audit of CD record books. Nursing staff do NOT use a stamp. The continued use of a stamp by a registered pharmacy technician which bears the name of the individual and their General Pharmaceutical Council registration number has been reinforced and staff members counter sign in full.	100% compliance scores	31/07/2018		Safe and Effective Care: use of medicines	No financial impact
33	Record Keeping	Ensure medical records are held securely and are completed consistently.	SGH Tooting	Urgent & Emergency	SHOULD	1. Audit storage of Med records and access rights 2. Develop and implement corrective action where required.	1. Management assurance processes; on-going audit, validation and monitoring of OP clinics storage of records and access rights. 2. DGB, TEC, PSQB	LPickering	MArmatrading	14/09/18		The ED has ordered and received a new lockable notes trolley to be located in majors.	100% compliance scores			Quality & Risk: Clinical Record Management	Need to establish if compliant storage solutions are available in all wards and departments and if not what is the value of investment required?
Removed from final report	Record Keeping	Take action to ensure staff document all information if a patient's condition deteriorates in the appropriate record.	SGH Tooting	Urgent & Emergency Services													
34	Record Keeping	Ensure patient records are kept securely and recorded accurately.	Trust wide	Provider Level	SHOULD	1. Audit storage of Med records and access rights 2. Develop and implement corrective action where required.	1. Management assurance processes; on-going audit, validation and monitoring of OP clinics storage of records and access rights. 2. DGB, TEC, PSQB	ARhodes	DivChairs	14/09/18			100% compliance scores			Quality & Risk: Clinical Record Management	Need to establish if compliant storage solutions are available in all wards and departments and if not what is the value of investment required?
35	Risk, Corporate Governance & Strategy	Ensure that risks are suitably recorded and managed between ward and divisional level.	QMH	Inpatient Services	SHOULD	1. Review agenda for MSW ward team meetings to ensure that risk management is a standing item 2. Review current process for the recording and reporting of risks 3. Identify and implement areas for improvement	1. MSW team meeting agenda and action notes; Directorate Governance meeting minutes; Directorate of Community services risk register; CWDT risk register 2. Directorate and Divisional Governance meetings, QMH Clinical partnership meeting, Risk Management meeting	ARhodes	ALudlam	31/08/18			MSW risks reported on directorate and divisional risk register. Increased awareness of risk reporting process at ward level			Quality & Risk: Effective risk management & governance	No financial impact
Removed from final report	Risk, Corporate Governance & Strategy	Ensure all polices are reviewed, and updated where appropriate in line with agreed timescales.	QMH	Outpatients & Surgery													

36	Risk, Corporate Governance & Strategy	Ensure that all risks on the OPD risk register have associated actions, a date for review and a date by which actions are to be completed.	SGH Tooting	Outpatients	SHOULD	1. Review agenda for weekly outpatient team meetings to ensure that risk management is a standing item 2. Review current process for the recording and reporting of risks 3. Identify and implement areas for improvement	1. OPD team meeting agenda and action notes; Directorate Governance meeting minutes; Outpatients risk register; CWDT risk register 2. OPD weekly operational meeting, Directorate and Divisional Governance meetings, QMH Clinical partnership meeting, Risk Management meeting	JRichards	ATerry	31/08/18			Risk register completed in full and monitored			Quality & Risk: Effective risk management & governance	Need to establish if there are any associated estates risks (or other) that require investment. If so what is the value of investment required?
37	Risk, Corporate Governance & Strategy	Investigate and close complaints in line with the trust policy of 85% of complaints being responded to within 25 working days of receipt.	SGH Tooting	Urgent & Emergency	SHOULD	1. Review current process in line with Trust policy and QiP work stream 2. Discuss application of Quality Improvement methodology with Quality Academy and identify division/ service area to pilot 3. Review findings of pilot with Quality Improvement academy and adjust process accordingly 4. Roll out revised process across the trust with continued focus on weekly progress indicators at comcell in line with agreed trajectory	1. Revised process, weekly progress report at comcell, monthly KPI against trajectory 2. Comcell, DGB, PSQB, Q&S Committee, Trust Board	ABhatia	EPalmer	31/03/19		**17/08/18 update** Management trainee has been supporting ED with investigation of complaints since April 2018. Currently 6 open complaints and 3 re-opened all within timeframes.	Performance in line with trust policy and target for 85%			Quality & Risk: Complaints management	No financial impact
Removed from final report	Risk, Corporate Governance & Strategy	Improve the Board Assurance Framework (BAF), so that it gave the board greater assurance.	Trust wide	Provider Level													
38	Risk, Corporate Governance & Strategy	Work to improve the pace of change in order that substantial improvements to the quality and safety of patient care are evident.	Trust wide	Provider Level	SHOULD	1. Align CQC inspection concerns to the QiP 2. Develop, implement and monitor the Trust action plan in response to the inspection report 3. Revise the QiP governance framework 4. Establish close working relationship with Quality Academy, Transformation Team and divisional SROs for the QiP	1. QiP, Trust action plan in response to inspection report, QiP governance framework, QiP performance dashboard, reports to TEC, PSQG and Trust Board	ABhatia	ABenincasa	31/03/19			QiP delivery, exit quality special measures			QiP: All	X required and funded
39	Risk, Corporate Governance & Strategy	Improve and develop its engagement with the local sustainability and transformation partnership (STP) in South West London.	Trust wide	Provider Level	SHOULD	1. Schedule executive attendance 2. Link with overall Trust Strategy 3 Provide monthly update reports	1. STP meeting minutes, progress reports 2. TEC, Trust Board	SMarsello	TEllis	31/03/19			Consistent SGH presence/ influence in STP discussions and developments			Enabler: leadership	No financial impact
40	Risk, Corporate Governance & Strategy	Speed up the implementation of an **overall strategy**, clinical strategy, estate strategy and workforce strategy.	Trust wide	Provider Level	SHOULD	1. Review progress to date, identify time specified dates for delivery supported by key milestones including stakeholder engagement and communication strategy 2. Monthly progress updates to TEC, FIC and Trust Board 3. Provide Strategy Training to senior leaders as part of an existing leadership programme or as a stand alone module	1. Progress reports, Trust Strategy, quarterly updates re delivery against Trust objectives 2. TEC, FIC, Trust Board	SMarsello	TEllis	31/03/19		17/08/18 Monthly reporting to TEC and Trust Board have been in place since March 2018. Monthly Board Seminars to consider clinical service strategies are in diaries: Cardioloy was considered in July; Cancer in August and agreed topics planned through to November initially. Two additional Strategy Team staff will be in post beginning of September to facilitate progress. Additional project support from NHSI for 3 months agreed in principle - final details being agreed and project manager will potentially be in place early-mid september as additional support. Engagement workshops with staff and stakeholders were held in July. Training for senior leaders is planned for Jan 2019	Trust strategy in place. Improved staff awareness			Enabler: leadership	No financial impact
41	Risk, Corporate Governance & Strategy	Speed up the implementation of an overall strategy, **clinical strategy,** estate strategy and workforce strategy.	Trust wide	Provider Level	SHOULD	1. Review progress to date, identify time specified dates for delivery supported by key milestones including stakeholder engagement and communication strategy 2. Monthly progress updates to TEC, Q&S Committee and Trust Board	1. Progress reports, Clinical Strategy, quarterly updates re delivery against objectives 2. TEC, FIC, Trust Board	SMarsello	TEllis	31/03/19		As above (ref 40)	Trust strategy in place. Improved staff awareness			Enabler: leadership	No financial impact
42	Risk, Corporate Governance & Strategy	Speed up the implementation of an overall strategy, clinical strategy, **estate strategy** and workforce strategy.	Trust wide	Provider Level	SHOULD	1. Review progress to date, identify time specified dates for delivery supported by key milestones including stakeholder engagement and communication strategy 2. Monthly progress updates to TEC, FIC and Trust Board	1. Progress reports, Clinical Strategy, quarterly updates re delivery against objectives 2. TEC, FIC, Trust Board	KHowell	RNagendra	31/03/19			Trust strategy in place. Improved staff awareness			Enabler: leadership	No financial impact
43	Risk, Corporate Governance & Strategy	Speed up the implementation of an overall strategy, clinical strategy, estate strategy and **workforce strategy.**	Trust wide	Provider Level	SHOULD	1. Review progress to date, identify time specified dates for delivery supported by key milestones including stakeholder engagement and communication strategy 2. Monthly progress updates to TEC, WEC and Trust Board	1. Progress reports, Clinical Strategy, quarterly updates re delivery against objectives 2. TEC, WEC, Trust Board	HBrar	JMcCullough	31/03/19			Trust strategy in place. Improved staff awareness			Enabler: leadership	No financial impact
44	Safe Effective Care	Ensure that care is provided in line with current best practice guidelines.	QMH	Inpatient Services	SHOULD	1. Undertake a review of healthcare records for patients on MSW to identify areas for improvement re provision of best practice care e.g. appropriate escalations in place for patients with high malnutrition scores and peripheral venous cannulation. 2. Develop and deliver a time specific improvement plan	1. Improvement plan; progress reports; minutes of meetings; audit results and resultant action plans	JRichards	ALudlam	31/12/18			Care delivered in line with best practice guidelines and Trust Policy			Safe & Effective care: fundamentals of care	No financial impact

45	Safe Effective Care	Ensure medicines are stored and managed suitably.	QMH	Inpatient Services	SHOULD	1. Undertake a review of medicines management practice on MSW to identify areas for improvement re provision of best practice care e.g. ensure medicines resources folder on the ward includes up-to-date policies only 2. Develop and deliver a time specific improvement plan	1. Improvement plan; progress reports; minutes of meetings; audit results and resultant action plans	JRichards	ALudlam	31/12/18			Medicines management in line with Trust Policy			Quality & Risk: Clinical Record Management	Need to establish if compliant storage solutions are available in all wards and departments and if not what is the value of investment required?
46. Regulation 12	Safe Effective Care	Ensure staff following the trust's policy in relation to swab and instrument count.	QMH	Surgery	MUST	1. Raise awareness with all nursing and medical staff re WHO Checklist. 2. Audit compliance. 3. Deliver associated improvement actions. 4. Ensure sustained compliance via matron (day case unit manager) checks, weekly back to the floor audit, monthly audit.	1. Audit 2. Divisional Governance Board; QMH Clinical Partnership Group	ARhodes	MArmatrading/ LTitheridge	31/03/18		Communication with all staff. Compliance audit undertaken and on-going. Reports to monitoring committees. **14/08/18 update** Audit completed monthly - white board for swab count installed. Policy signed and confirmation of read by all theatre staff in unit.	100% compliance scores	24/07/2018	Back to the floor and departmental audit cycle	Safe & Effective care: fundamentals of care	No financial impact
47. Regulation 17	Safe Effective Care	Ensure staff use a recognised tool for monitoring deteriorating patients and a policy made available for the treatment/transfer of patients who deteriorate and require a higher level of care.	QMH	Surgery	MUST	1. Early Warning Scores, the recognised Trust wide tool for monitoring deteriorating patients as outlined in the Trust Deteriorating Adult Policy, to continue to be used in the day case unit at QMH 2. Remind all staff at QMH of the Trust's Deteriorating Adults Policy and the use of early warning scores to promote the early recognition of a deteriorating patient 3. Remind all staff at QMH of the existing Medical Emergencies Policy at QMH to support the treatment/ transfer of patients who deteriorate and who require a higher level of care 4. Senior leaders at QMH together with the Trust's resuscitation lead, Head of Nursing for Specialist Medicine and the Consultant Nurse for Critical Care to review the escalation process in the Deteriorating Adults Policy for non-acute settings e.g. day case theatres and endoscopy 5. Implement NEWS2 as per national mandate and in line with Trust wide implementation plans	1. Back to the floor audit results 2. DGB, PSQB, QMH Clinical partnership Meeting	ABhatia	MArmatrading/ LTitheridge	24/08/19		Meeting scheduled for 14.8.2018 with EWS Trust lead, Resus officer, HoN (Med.card) and GM OPD QMH **14/08/18 update** Meeting held with endoscopy staff, Trust resus leads and EWS lead to identify local escalation to fit in with NEWS - for PSQB 15/08/18 and re-meeting 21/09/18 to update local policy. ILS local training booked 28/11/18	Trust Deteriorating Adult Policy utilised in all Trust sites			Safe & Effective care: Recognise deteriorating patients	No financial impact
48. Regulation 12	Safe Effective Care	Review and ensure there is full compliance with the WHO surgical safety checklist.	QMH	Surgery	MUST	1. Raise awareness with all nursing and medical staff re WHO Checklist. 2. Audit compliance. 3. Deliver associated improvement actions. 4. Ensure sustained compliance via matron checks, weekly back to the floor audit, monthly audit.	1. Audit 2. Divisional Governance Board; QMH Clinical Partnership Group	ARhodes	MArmatrading/ LTitheridge	31/03/18		Communication with all staff. Compliance audit undertaken and on-going. Reports to monitoring committees. **14/08/18 update** Repeat of 46 above	100% compliance scores	24/07/2018	Back to the floor and department audit cycle	Safe & Effective care: fundamentals of care	No financial impact
49	Safe Effective Care	Ensure all staff comply with local and national guidance regarding consent including where oral consent is given.	QMH	Surgery	SHOULD	1. All staff requested to read Trust policy on consent 2. Discuss Trust Consent Policy at team and at care group meetings 3. Raise awareness re consent issues at QMH Nursing Forum 4. Check all new doctors at QMH asked have read and understood Trust Consent Policy	1. Staff list (with staff signatures) confirming consent policy has been read; Notes of team / care group meeting; QMH Nursing Forum 2. DGB, QMH Clinical Partnership Committee	Lisa Pickering	MArmatrading/ LTitheridge	31/03/18		Completed: all staff have read Trust Consent Policy, audit of compliance undertaken. Part of on-going audit cycle. 17/8/18 Local audit to be taken for consent with action plans and feedback	100% compliance scores	26/07/2018	Back to the floor and department audit cycle	Safe & Effective care: fundamentals of care	No financial impact
Removed from final report	Safe Effective Care	Ensure the provision of seven-day services for speech and language therapy (SALT) and occupational therapy (OT) medicine and cardiovascular division.	SGH Tooting	Medical Care													
50. Regulation 17	Safe Effective Care	Ensure all incidents are reported to enable appropriate oversight.	SGH Tooting	Outpatients	MUST	1. Create a standard agenda for outpatient department monthly meetings to include incident monitoring, emerging themes and learning from incidents 2. Promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events and are empowered to make changes	1. Day Case Unit meeting agenda; Day Case Unit incidents reported on datix 2. DGB, QMH Clinical Partnership Meeting	EPullinger	JRichards	31/09/18		Extended team meeting organised for 22 August 2018 and fortnightly thereafter to focus on delivery of outpatients improvement plan	Learning from incidents is implemented throughout the Trust, so as to reduce the opportunity of repeat occurrences of any issues			Quality & Risk: Learning from incidents	No financial impact
51	Safe Effective Care	Review the placement of the resuscitation trolley in Lanesborough Wing to ensure emergency equipment and drugs are readily available for all clinics.	SGH Tooting	Outpatients	SHOULD	1. Review current arrangements re placement of resuscitation trolley in lanesborough wing outpatients. 2. Identify and implement areas for improvement	1. Anaphylaxis pack available and staff aware; resus officer review of equipment requirements; 2. DGB, Trust Resus meeting	JRichards	HMcHugh	31/03/18		Anaphylaxis pack available in clinic and all staff are aware. Resus Officer checked and provided equipment needed in the clinic area. All staff reminded of actions to take when someone calls for help. Additional training provided to the team working in Clinic C. Clinic C reminded of additional access to resus trolley in Moorfields clinic.	Emergency equipment accessible to staff	26/07/2018	Back to the floor and department audit cycle	Safe & Effective care: fundamentals of care	No financial impact
52	Safe Effective Care	Complete and record safeguarding assessments for children and adults	SGH Tooting	Urgent & Emergency	SHOULD	1. Reinforce completion of safeguarding assessments within ED and review of safeguarding SOPs 2. Undertake audit of current practice. 3. Develop action plan to address improvement actions required. 4. Monitor progress of action plan delivery. 5. Re-audit as required	1. Audit results 2. ED Directorate meeting, ED Directorate Governance meeting, DGB	Lisa Pickering	MArmatrading	31/10/18		Full documentation audit to be undertaken in September 2018.	Improved compliance with completion of safeguarding assessments in local audit results.			Safe & Effective care: NEW fundamentals of care (safeguarding)	No financial impact

53	Safe Effective Care	Record patient consent and best interest decisions in patients' notes.	SGH Tooting	Urgent & Emergency	SHOULD	1. Reinforce documentation standards including recording of consent and best interest decisions 2. Undertake audit of current practice. 3. Develop action plan to address improvement actions required. 4. Monitor progress of action plan delivery. 5. Re-audit as required	1. Audit results 2. ED Directorate meeting, ED Directorate Governance meeting, DGB	Lisa Pickering	MArmatrading	31/10/18		Full documentation audit to be undertaken in September 2018.	Improved compliance with documentation of patient consent and best interest decisions in notes in local audit results.			Safe & Effective care: NEW fundamentals of care (consent)	No financial impact
Removed from final report	Safe Effective Care	Ensure pain scores tools are completed and timely pain relief is administered.	SGH Tooting	Urgent & Emergency Services													
Removed from final report	Safe Effective Care	Ensure there are no instances where patients have their privacy and dignity compromised.	SGH Tooting	Urgent & Emergency Services													
54	Safe Effective Care	Ensure the Department of Health's standard for 95% emergency departments to admit, transfer or discharge patients within four hours is met.	SGH Tooting	Urgent & Emergency Services	SHOULD	1. Delivery of actions linked to admitted and non-admitted performance. 2. Specialty action plans to be presented for regular review at ECPIG. 3. Review of internal processes within ED to improve non-admitted performance to 97-98%.	1. Weekly progress report at Trust and ED comcell, 15 point plan in place and delivery monitored via Emergency Care Performance Improvement Group (ECPIG) 2. Weekly, cross-Divisional ECPIC chaired by COO, monthly paper on emergency care performance at TEC, FIC and Trust Board.	Lisa Pickering	MArmatrading	30/03/19		The Trust met the standard for 93.28% of patients in July and 93.59%. The Trust has a robust 15 point plan to deliver sustainable improvements in emergency care performance, monitored at weekly ECPIG meetings, chaired by the COO. **18/08/18 update** Emergency care performance currently 90.32% for August. Detailed review of 15 point plan to be undertaken in August and review of actions to improve performance across admitted and non-admitted performance.	Delivery of emergency care performance in line with agreed trajectory for 2018/19.			Flow & Clinical Transformation: Improve unplanned & admitted care	X required and funding TBC
55	Safe Effective Care	Ensure that patients' pain is assessed, recorded and actioned; and their pain relief monitored, particularly for patients living with a terminal illness.	Trust wide	Provider Level	SHOULD	1. Review current ward practice in relation to the application of the pain assessment tool 2. develop and implement a time specific improvement plan	1. Improvement plan; progress reports; minutes of meetings; audit results and resultant action plans 2. DGB, PSQB	ABhatia	DDNGs	31/12/18		15.08.18 Peadiatric areas pain tool is audited monthly and fed back to ward areas.	Pain assessments undertaken in line with best practice guidelines		15.08.18 DGB & PASB	Safe & Effective care: NEW fundamentals of care (pain)	No financial impact
56	Safe Effective Care	Make the Quality Improvement Plan clearer, so that the names of meetings/committees are consistent, when referring to the same one.	Trust wide	Provider Level	SHOULD	1. Review current governance arrangements and revise as appropriate. 2. Approve revised QiP governance arrangements at TEC. 3. Develop a process to test the impact of the QiP programme through the assurance mechanisms in the trust 5. Ensure effective communication	1. QiP governance framework 2. TEC, PSQG, Q&SC	ABhatia	ABenincasa	31/08/18			Revised governance framework in place			QiP: All	X required and funded
57	Staffing & Culture	Ensure effective senior leadership on Mary Seacole Ward.	QMH	Inpatient Services	SHOULD	COMPLETE: No further action required	1. Senior leadership posts in place 2. DGB	JRichards	ALudlam	31/04/18		Senior leadership recruitment complete	Senior leadership team in place	24/07/2018		Enabler: Leadership	No financial impact
58	Staffing & Culture	Ensure that staffing numbers are suitable to meet the needs of patients, including one-to-one care and patients with more complex needs.	QMH	Inpatient Services	SHOULD	1. Undertake safe staffing assessment daily in line with Trust policy and ensure patient acuity factored in to assessment	1. Staff staffing alerts; ward rotas	JRichards	ALudlam	25/07/18		Daily safe staffing assessments undertaken.	Safe staffing	25/07/2018	Safe staffing	Quality & Risk: Effective risk management & governance	No financial impact
59	Staffing & Culture	Take steps to effectively reduce observed high levels of staff stress and work overload on Mary Seacole Ward.	QMH	Inpatient Services	SHOULD	1. Ensure regular ward meetings in place 2. Hold LiA big conversation with the ward team 3. Monitor ward sickness levels 4. Encourage nursing staff to attend QMH Nursing Forum 5. Raise awareness of Health and Wellbeing Strategy	1. Ward meetings in place; LiA big conversation held; outcome of big conversation; progress reports on outcome and actions required and delivered 2. DGB; QMH Clinical Partnership Committee	JRichards	ALudlam	31/12/18			Improved FFT performance compared with April 2018			Enabler: Engagement	No financial impact
60	Staffing & Culture	Ensure that senior management and specialist nurses from the St George's Hospital are visible and accessible by staff at Queen Mary's Hospital.	QMH	Outpatients	SHOULD	1. Review ToR and membership of QMH Nursing forum to include specialist nurses from SGH 2. Create a forward schedule of specialist nurse seminars/ward & department visits/ QMH Nurse Forum attendance and publish widely at QMH 3. Create a forward schedule of senior management attendance at monthly QMH road shows and weekly Back to the Floor visits	1. Forward schedules for QMH nursing forum, QMH monthly road shows and QMH Back to the Floor visits; revised TOR for QMH Nursing Forum 2. DGB, QMH Clinical Partnership Meeting	JRichards	ALudlam	31/12/18		17/08/18: E&F are planning dedicated management resources at site from early 2019; monthly and weekly site visits are in place already	Improved FFT performance compared with April 2018			Enabler: leadership	No financial impact
61	Staffing & Culture	Create a culture where all staff are enabled to challenge/question poor/unfamiliar practice.	QMH	Surgery	SHOULD	1. Create a standard agenda for day case unit monthly meetings to include incident monitoring, emerging themes and learning from incidents 2. Promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events and are empowered to make changes	1. Day Case Unit meeting agenda; Day Case Unit incidents reported on datix 2. DGB, QMH Clinical Partnership Meeting	Lisa Pickering	MArmatradin g/ LTitheridge	31/12/18		17/8/18 Staff meeting agenda revised	Increase in number of reported incidents compared with March 2018			Quality & Risk: Learn from incidents	No financial impact

62	Staffing & Culture	Continue to review and recruit to nursing posts to ensure there is consistent effective leadership and oversight of the DCU.	QMH	Surgery	SHOULD	1. Review current vacancies in day case unit at QMH. 2. Develop recruitment plan including trajectory to reach and maintain funded establishment. 3. Monitor recruitment plan on a monthly basis at DGB and QMH Clinical Partnership Meeting	1. Staff in post; recruitment plan and progress reports; minutes of DGB and QMH Partnership Committee 2. DGB, QMH Partnership Committee	Lisa Pickering	MArmatradin g/ LTitheridge	31/03/19		**14/08/18 update** Since inspection 2 band 5 staff have been appointed and started and one further band 5 is in the pipeline. The GM for spec med is leading on a staffing review.	Funded posts filled with substantive post holder			Enabler: Engagement	No financial impact
63	Staffing & Culture	Improve the completion of appraisals.	QMH	Surgery	SHOULD	1. Review appraisal performance. 2. Identify staff in need of appraisal 3. line managers adopt a targeted approach to appraisal completion. 4. Centrally link incremental pay progression to appraisal and PDRs for AfC staff. 5. HR & OD make appraisal and pdr process available online on the Trust learning management system	1. Appraisal performance figures; appraisal performance information visible in departments 2. Care Group and Directorate meetings, DGB, PSQB	Lisa Pickering	MArmatradin g/ LTitheridge	31/03/19		**14/08/18 update** 5 staff outstanding. Dates for appraisals booked with aim to complete end September 2018.	Meet staff target of 90%; staff feel valued; improved FFT scores compared with April 2018; improved NHS staff survey scores			Enabler: Leadership	Establish the value of investment required for the software to support electronic appraisals and the funding source
64. Regulation 18	Staffing & Culture	Ensure there are sufficient numbers of suitably qualified staff on each shift to provide safe care.	SGH Tooting	Children & Young People	MUST	1. Review and agree current establishments in line with National Quality Board Guidance in conjunction with ward managers 2. Implement Safe Care Module 3. Commission external expert review of staffing on paediatric wards and PICU and respond to findings	1. Ward establishment lists, fill rates, safe staffing alerts	ABhatia	HMcHugh	31/10/18		15.08.18 NNU staffing review held with NHSi (14.08.18) with recomendations made. Safe Care roll out to wards is almost completed in paediatrics. Paediatric wards review of staffing to be arranged. 01.08.18 The Chief Nurse and Deputy Chief Nurse completed the review in conjunction with the ward managers. The Trust is completing its current establishment review in line with National Quality Board guidance. The Trust has commissioned an external independent review of the staffing levels of paediatric wards and paediatric intensive care.			15.08.18 though rostering challenge meetings, staffing alerts and incedents reported related to stafing.	Quality & Risk: Effective risk management & governance	X required and funding TBC
Removed from final report	Staffing & Culture	Ensure that nurse staffing levels on wards meet the establishment levels for safe care.	SGH Tooting	Surgery													
65	Staffing & Culture	Ensure appraisals rates for nursing staff meet the trust target of 90%.	SGH Tooting	Urgent & Emergency	SHOULD	1. Review appraisal performance. 2. Identify staff in need of appraisal 3. line managers adopt a targeted approach to appraisal completion. 4. Centrally link incremental pay progression to appraisal and PDRs for AfC staff. 5. HR & OD make appraisal and p	1. Appraisal performance figures; appraisal performance information visible in departments 2. Care Group and Directorate meetings, DGB, PSQB	Lisa Pickering	MArmatradin g	31/03/19		The ED Head of Nursing is leading on improving compiance with the expectation that we will be compliant by 31/10/18. **18/08/18 update** All staff with an appraisal identified as outstanding have been contacted and dates to be agreed before end October 2018. Data validation in progress with support from HR.				Enabler: Leadership	No financial impact
Removed from final report	Staffing & Culture	Review and ensure nurse staffing levels in the paediatric ED are line with guidance from The Royal College of Paediatrics and Children's Health (RCPCH).	SGH Tooting	Urgent & Emergency Services													
66. Regulation 18	Staffing & Culture	Ensure the Workforce Race Equality Standard action plan is implemented.	Trust wide	Provider Level	SHOULD	1.Develop time specific implementation plan for delivery	1. Progress reports to WEC; WEC minutes 2. WEC; Trust Board	HBrar	COke	31/12/18		We have re-established the D&I manager post and new staff member in post. The Trust Strategy for Equality, Diversity and Inclusion is in development and progress will be presented to the next Workforce and Education Committee meeting on 09 August 2018.	Improvement in WRES indicators and results when compared with 2017			Enabler: Leadership	X required and funding TBC
67	Training	Improve training completion rates for mandatory training, particularly for life support modules.	QMH	Inpatient Services	SHOULD	1. Review MAST performance for BLS and ALS. 2. Identify staff in need of training and line managers adopt a targeted approach to ensure completion 3. Deliver training sessions at QMH as required. 4. Ensure training information available for staff 5. Review the TNA for ALS and BLS to ensure that the right group of staff are targeted to complete this training	1. MAST performance; Back to the floor and audit; Number of training workshops held and sign in sheets; Staff awareness information visible in departments 2. DGB, PSQB	JRichards	ALudlam	31/12/18		15/08/2018 TNA review has commenced	MAST target met re BLS and ALS			Quality & Risk: Effective risk management & governance	No financial impact
68	Training	Ensure staff receive feedback from learning from incidents.	QMH	Outpatients	SHOULD	1. Create a standard agenda for outpatient department monthly meetings to include incident monitoring, emerging themes and learning from incidents 2. Promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events and are empowered to make changes	1. Day Case Unit meeting agenda; Day Case Unit incidents reported on datix 2. DGB, QMH Clinical Partnership Meeting	JRichards	ALudlam	31/12/18		14/8/18 Staff meetings scheduled for rest of year - agenda to follow OPD management agenda	Learning from incidents is implemented throughout the Trust, so as to reduce the opportunity of repeat occurrences			Quality & Risk: Learn from incidents	No financial impact
69	Staffing & Culture	Obtain feedback from patients and relatives to improve the quality of service as the feedback from the FFT was low	QMH	Outpatients	SHOULD	1. Review current process to capture FFT process in QMH outpatients 2. Identify areas for improvement. 3. Develop delivery plan and commence implementation	1.FFT response improvement plan; FFT figures and performance for QMH outpatients 2. DGB, QMH Clinical Partnership Meeting	JRichards	ALudlam	31/12/18			Increase in number of patients responding to FFT when compared with April 2018			Engagement: NEW engage our staff and patients	No financial impact
Removed from final report	Training	Continue to obtain feedback from patients and relatives to improve the quality of services and make the results available.	QMH	Outpatients & Surgery													

70	Training	Ensure information is available about the uptake of all training for all staff groups.	QMH	Surgery	SHOULD	1. Create training compliance report by site. 2. Deploy on ARIS the trust's compliance reporting tool. The report will be updated daily and be available to anyone on the trust network.	1. Totara (Learning Management System) and ARIS (Compliance Reporting Tool) 2. MAST Appraisal Steering Committee	LPickering	SJames	31/12/18			Access to site specific MAST performance reports to facilitate targeted support to sustained performance against Trust target			Enabler: Leadership	No financial impact
71	Training	Improve staff awareness of the signs and management of sepsis including the trust policy.	QMH	Surgery	SHOULD	1. Invite Trust lead to department meeting to raise awareness 2. Include sepsis awareness information in day case unit. 3. Ensure all staff in day case have read and understand the Trust Policy for the management of sepsis 4. Provide regular updates on sepsis management at QMH Nursing Forum and QMH road shows	1. Departmental meeting minutes/ action notes; sepsis information for staff available in day case unit; record of staff list (with signatures) confirming read and understood management of sepsis policy;	JRichards	ALudlam	31/12/18		14/8/18 6 stages of Sepsis signs fully available within dept. ILS SD booked for all staff November 2018	Sepsis awareness			Safe and Effective care: recognise deteriorating patients	No financial impact
Removed from final report	Training	Ensure all staff working in the infusion suite know what action to take in the event of a cytotoxic spillage.	SGH Tooting	Outpatients													
72. Regulation 18	Training	Ensure mandatory training meets the trust target of 85% in all of the mandatory areas.	Trust wide	Provider Level	MUST	1. Focus on staff groups who are not meeting the target. 2. Identify and implement new ways of engaging with Medical and Dental staff. 3. Develop a pilot scheme to support assessment only options for a number of MAST (core statutory/mandatory) subjects to support August Junior Doctor rotation. 3. Continue to raise awareness through staff forums and at 1:1s 4. Upgrade the Trust's existing Learning Management System to enhance accessibility and improve staff compliance	1. Monthly performance figures 2. DGB, PS&QG, WEC, TEC, Trust Board	HBrar	JMcCullough	31/03/18		15/08/2018 The compliance rate is now 90%. Junior Doctor uptake of the pre-starting e-learning materials for the August induction was low.	Meet Trust target or above	24/07/2018	DGB, PSQG, WEC, Q&SC, Trust Board	Enabler: Leadership	No financial impact
73. Regulation 17	Risk, Corporate Governance & Strategy	In the emergency department, not all risks identified during the inspection were on the risk register and those on the risk register had not been fully actioned. Some risks had been on the risk register since 2014.	SGH Tooting	Urgent & Emergency	Regulation concern	1. Review and update risk register in ED 2. Establish local monitoring and reporting system	1. Minutes from local monitoring groups; revised risk register 2. DGB	EPullinger	LPickering	12/09/2018		ED risk register updated. Standing item on DGB agenda and monthly clinical governance meeting. Additional support provided from clinical governance manager to local meetings.					Need to establish if there are any associated estates risks (or other) that require investment. If so what is the value of

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 August 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 23 August 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

1.0 Matters for the Board's Attention

1.1 Theatre Utilisation planning- the COO noted the areas identified for improvement in the theatre scheduling '6,4,2' process. There have been examples where lists are not given back to theatres by services to reallocate to other areas, with the intention that the patient and/or surgeon will be found closer to the time (which then does not materialise). It was noted that, whilst not ideal, in examples where patients/surgeons are not on lists on the day of the list, the staff are reallocated to other areas. The recruitment of 3 more patient pathway coordinators and a change in approach to list planning is expected to ameliorate the situation.

1.2 Shift leadership support in A&E- the Deputy COO updated on the latest position with A&E performance data and trajectories for quarter 2 and the rest of 2018/19. It was noted that there was still dependence on the quality of shift leadership, and that changes in clinical leadership recently put in place would help.

1.3 Support agreed for RTT & training required- the COO confirmed the £1m that was required in order to support the Trust's return to reporting RTT. This investment included additional support on training staff on the RTT pathway. He noted the challenge on training staff on the complex RTT pathway rules and Cerner's role in this. The committee agreed this £1m investment whilst expressing disappointment that this was not brought to the attention of the group earlier. The COO noted that having the live patient tracking list since February had led to the identification of need for further training.

1.4 Financial Position & forecast at M4- the Deputy CFO noted the £1.7m adverse variance in July. He noted the progress against agreed actions underway to address the risks in the latest financial forecast. The CFO noted that the style of intervention with budget holders will now move from supportive and training-based to prescriptive in some areas.

1.5 Capital Spend at risk- the committee noted the prioritisation of capital expenditure and application for an emergency capital loan to NHS Improvement. The committee approved the loan application. While the approval process is ongoing, the Trust has begun to spend at risk in some of the key safety-related areas.

1.6 Other areas- the committee was updated on the CIP programme, the cash position, Estates risks, ICT, and the SWL STP Business case- Interoperability Phase 2. There was also an update on other planning issues in this and next financial year.

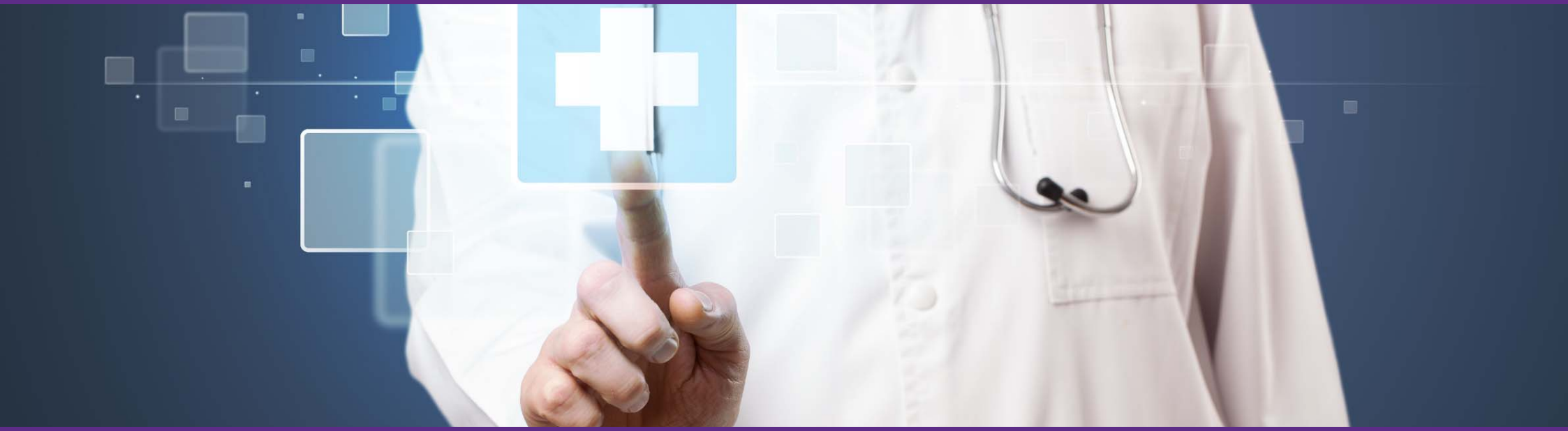
2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 23 August 2018 for information and assurance.

Ann Beasley
Finance and Investment Chair, Trust Chairman
August 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**30th August 2018**	**Agenda No.**	**4.2**
Report Title:	**M04 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 to date of £16.2m at the end of Month 04 (July), which is £1.7m adverse to plan. Within the position, income is adverse to plan, which is partially 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:**	23/08/18
Appendices:	None		



St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 4 (July 2018)

Chief Finance Officer

30th August 2018

Executive Summary – Month 4 (July)

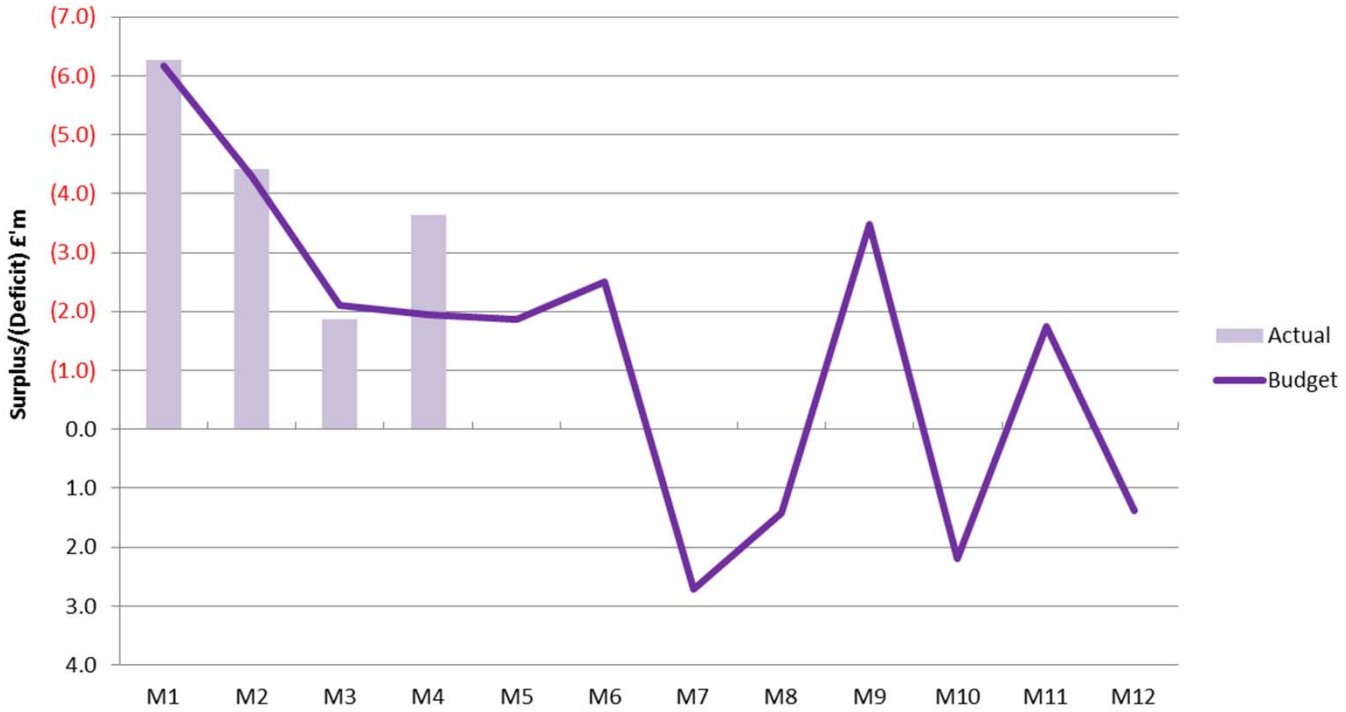
Note: All figures and commentary in this report refer to the revised Trust plan submitted to NHS Improvement on 20th June.

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £16.2m at the end of July, which is £1.7m adverse to plan. Within the position, income is adverse to plan, which is now only partially 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.	£1.7m Adv to plan	On plan
Income	Income is reported at £2.4m 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 also adverse to plan, with shortfalls in commercial Pharmacy partially offset by underspends in drugs, and SWLP income fully offset by reduced Non Pay cost. There is also a shortfall in private patients income.	£2.4m Adv to plan	£1.4m Adv to plan
Expenditure	Expenditure is £0.6m favourable to plan year to date in July. The favourable position is in Pay (£0.8m), with Non Pay £0.2m adverse. Unfilled vacancies are leading to the favourable variance in pay, and CIP delivery is causing the adverse variance in non-pay.	£0.6m Fav to plan	£1.2m Fav to plan
CIP	The Trust planned to deliver £10.4m of CIPs by the end of June. To date, £9.5m of CIPs have been delivered; which is £0.9m behind plan. Income actions of £3.0m and Expenditure reductions of £6.5m have impacted on the position.	£0.9m Adv to plan	£0.6m Adv to plan
Capital	Capital expenditure of £8.8m has been incurred year to date. This is £2.3m below plan YTD. The position is reported against the internally finances plan of £18.5m. This does not include DH capital loans (to be secured) of £29.65m.	£2.3m Fav to plan	£1.5m Fav to plan
Cash	At the end of Month 4, the Trust's cash balance was £7.8m, which is better than plan by £4.8m. The Trust has borrowed £17.2m YTD which is £1.0m less than plan. As reported last month the Trust did not request a loan drawdown for August but has requested a loan draw down of £3.2m for September. If approved this will bring cumulative borrowings to M06 in line with plan. The borrowings drawn this year are subject to an interest rate 3.5%.	£4.8m Fav to plan	£0.4m Fav to plan
Use of Resources (UOR)	The Regulators Financial Risk Rating. At the end of July, 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 4 Financial Performance

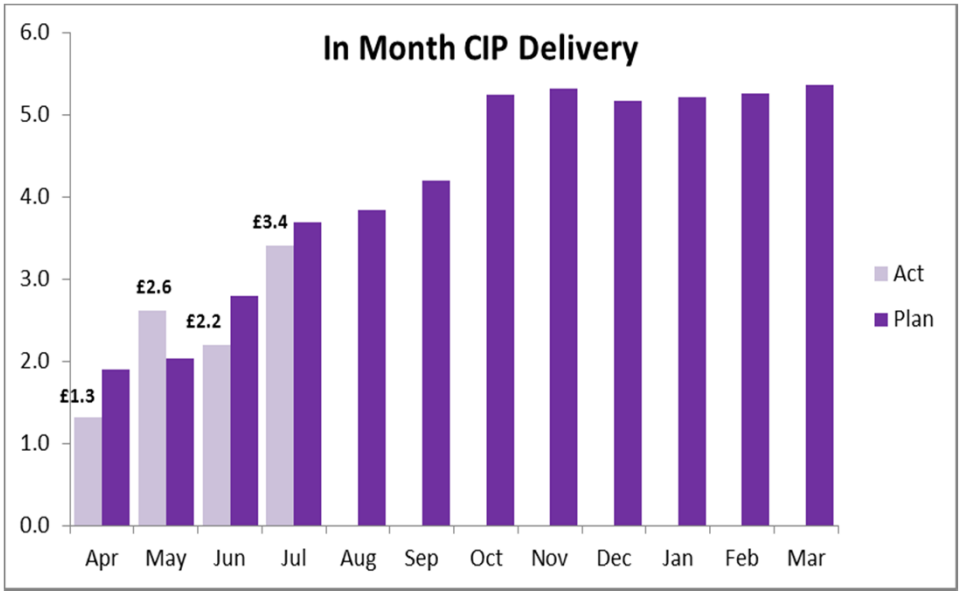
			Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	M4 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF	**Income**	SLA Income	668.7	55.0	54.4	(0.6)	(1.2%)	219.3	217.2	(2.2)	(1.0%)
		Other Income	153.7	13.7	13.3	(0.3)	(2.3%)	52.0	51.8	(0.3)	(0.5%)
	Income Total		**822.3**	**68.7**	**67.7**	**(1.0)**	**(1.4%)**	**271.4**	**268.9**	**(2.4)**	**(0.9%)**
	Expenditure	Pay	(509.7)	(42.8)	(43.0)	(0.2)	(0.4%)	(172.9)	(172.0)	0.9	0.5%
		Non Pay	(307.6)	(26.0)	(26.4)	(0.4)	(1.5%)	(104.7)	(104.9)	(0.3)	(0.2%)
	Expenditure Total		**(817.3)**	**(68.8)**	**(69.4)**	**(0.6)**	**(0.8%)**	**(277.6)**	**(277.0)**	**0.6**	**0.2%**
	Post Ebitda		(34.0)	(2.7)	(2.8)	(0.2)	(5.9%)	(11.0)	(10.9)	0.1	1.2%
Pre-PSF Total			**(29.0)**	**(2.8)**	**(4.5)**	**(1.7)**	**(60.6%)**	**(17.2)**	**(18.9)**	**(1.7)**	**(9.7%)**
PSF			12.6	0.8	0.8	0.0	0.0 %	2.7	2.7	0.0	0.0 %
Grand Total			**(16.4)**	**(1.9)**	**(3.6)**	**(1.7)**	**(86.8%)**	**(14.5)**	**(16.2)**	**(1.7)**	**(11.5%)**



Trust Overview

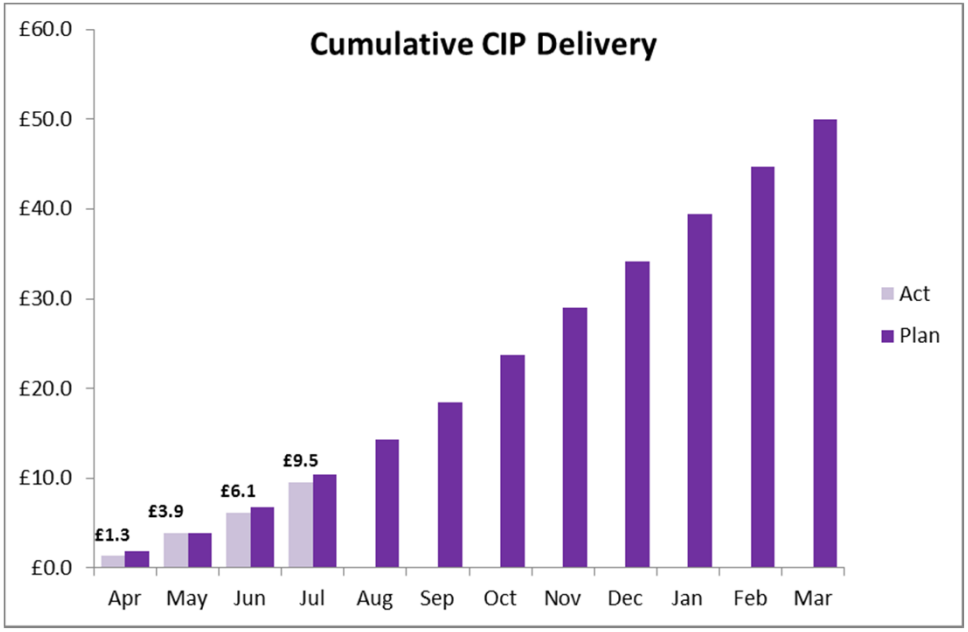
- Overall the Trust is reporting a deficit of £16.2m at the end of Month 4, which is £1.7m behind plan.
- **SLA Income** is £2.2m under plan. The main area of note is Elective where a material adverse volume variance (£3.9m) is partly offset by positive price variance (£1.6m) in some specialties.
- **Other income** is £0.3m, which is primarily Pharmacy income shortfall. This is offset by reduced Non-Pay expenditure.
- **Pay** is under plan by £0.9m. 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 £0.3m overspent, with an in-month adverse variance of £0.9m in SWLP offset with other income.
- **PSF Income** is on plan, as the Trust has met the pre-PSF control total target and the A&E target for Q1 **and are expected to be met in Q2.** The NHSI assessment of Q2 performance is made for M6 reporting, so does not take into account the adverse variance against control total in July. Financial performance makes up 70% of PSF contribution, A&E the remaining 30%. The value of PSF income reported in the in month position is £842k, with £590k of this dependant on recovering position against plan for Q2.
- **CIP delivery** of £9.5m is £0.9m behind plan. The Clinical Divisions' shortfalls have been partially offset by Corporate, Estates and Central schemes. Delivery to plan is:
  - Pay – on plan
  - Non-pay £0.4m adverse
  - Income £0.5m adverse

2. Month 4 CIP Performance



CIP Delivery Overview

- At the end of Month 4, the Trust is reporting delivery of £9.5m of savings /additional income through its Cost Improvement Programme.
- This is against an external plan for to have delivered £10.4m of savings/ additional income by Month 4 (overall delivery is adverse of plan by £0.9m).
- 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:
  - Adverse performance against elective income SLA targets have restricted some specialties ability to generate benefit from productivity related CIP plans
  - High acuity patients, specifically within Neuro services, have impacted on expected an establishment reduction within Critical Care



Year End Forecast & Actions

- Under a 'do nothing' scenario current divisional forecasts indicate that £45.8m of improvements will be delivered by 31st March 2019; resulting in a £4.2m shortfall against the £50m CIP Target. This shortfall will be mitigated through a range of actions within the CIP Recovery Plan (these are detailed in the full CIP Update Report).
- In addition to the CIP Recovery Plan, stretch targets have been set for Income and Estates. These form part of the Trust's overall financial recovery plan to support delivery of its financial control total.
- Divisions are being supported and challenged at weekly CIP meetings to ensure that savings delivery, forecasts, recurrent and run rate impact are maximised and underpinned by robust assumptions. This will ensure that there is sufficient lead time to implement mitigating actions and that the greatest positive impact can be achieved on the underlying financial position.

3. Balance Sheet as at Month 4

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**377.2**	**380.1**	**378.3**	**1.8**
Stock	**6.4**	6.0	7.6	-1.6
Debtors	**112.3**	107.0	103.9	3.1
Cash	**3.5**	3.0	7.8	-4.8
Creditors	**-118.4**	-122.5	-125.2	2.7
Capital creditors	**-15.4**	-3.8	-6.3	2.5
PDC div creditor	**0.0**	-0.3	-0.3	0.0
Int payable creditor	**-0.7**	-2.3	-2.3	0.0
Provisions< 1 year	**-0.2**	-0.2	-0.2	0.0
Borrowings< 1 year	**-57.7**	-58.3	-57.6	-0.7
Net current assets/-liabilities	**-70.2**	**-71.4**	**-72.6**	**1.2**
Provisions> 1 year	**-1.0**	-0.8	-1.0	0.2
Borrowings> 1 year	**-241.6**	-258.4	-256.9	-1.5
Long-term liabilities	**-242.6**	**-259.2**	**-257.9**	**-1.3**
Net assets	**64.4**	**49.5**	**47.8**	**1.7**
Taxpayer's equity				
Public Dividend Capital	**133.2**	133.2	133.2	0.0
Retained Earnings	**-167.9**	-182.8	-184.5	1.7
Revaluation Reserve	**97.9**	97.9	97.9	0.0
Other reserves	**1.2**	1.2	1.2	0.0
Total taxpayer's equity	**64.4**	**49.5**	**47.8**	**1.7**

M01-M4 YTD Balance Sheet movement

- Fixed assets are £1.8m lower than plan due to lower capital spend than plan.
- Stock reduced in month by £0.4m but remains £1.6m higher than plan due mainly to increase in Pharmacy stock. In advance of a new pharmacy robot being commissioned in August, stock levels were increased to reduce risk to supply. The new robot will be fully functional in early August at which point pharmacy stock levels should start to reduce.
- Overall debtors are £3.1m lower than plan.
- Creditors are £2.7m lower than plan
- The cash position is £4.8m better than plan due to the temporary benefit of the deferral of CNST premiums and also late invoicing by NHS Property Services.
- The Trust has borrowed £17.2m YTD for deficit financing which is £1.0m less than plan. The Trust did not draw down in August but has requested a £3.2m for September to support deficit funding and the delay in receipt of STF/PST funding. This will bring loans in line with 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. A capital bid for approx £29m is due to be submitted to NHSI shortly.

4. Month 4 YTD Analysis of Cash Movement

	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Cash balance 01.04.18	**3.5**	**3.5**	**0.0**
Income and expenditure deficit	-14.9	-16.6	-1.7
Depreciation	7.8	7.8	0.0
Interest payable	3.5	3.4	-0.1
PDC dividend	0.3	0.3	0.0
Other non-cash items	-0.1	-0.1	0.0
Operating deficit	**-3.4**	**-5.2**	**-1.8**
Change in stock	0.4	-1.1	-1.5
Change in debtors	7.3	8.4	1.1
Change in creditors	2.2	6.8	4.6
Net change in working capital	**9.9**	**14.1**	**4.2**
Capital spend (excl leases)	-20.9	-17.7	3.2
Interest paid	-2.0	-1.9	0.1
PDC dividend paid	0.0	0.0	0.0
Other	-0.1	-0.1	0.0
Investing activities	**-23.0**	**-19.7**	**3.3**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	18.2	17.3	-0.9
Capital loans	0.0	0.0	0.0
Loan/finance lease repayments	-2.2	-2.2	0.0
Cash balance 31.07.18	**3.0**	**7.8**	**4.8**

M01-M4 YTD cash movement

- The cumulative M4 I&E deficit is £16.6, £1.7m adverse to plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £16.6m, depreciation (£7.9m) does not impact cash. The charges for interest payable (£3.4m) and PDC dividend (£0.3m) 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 £5.0m.
- The operating deficit variance from plan of £1.6m in cash is due to timing of creditor payments primarily for the CNST premiums and other NHS bodies.
- Working capital is better than plan by £4.1m.
- The Trust has borrowed £17.3m YTD which is £1.0m less than plan. The Trust will not draw down in August but has requested a drawdown for September of £3.2m. This will be in line with 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.

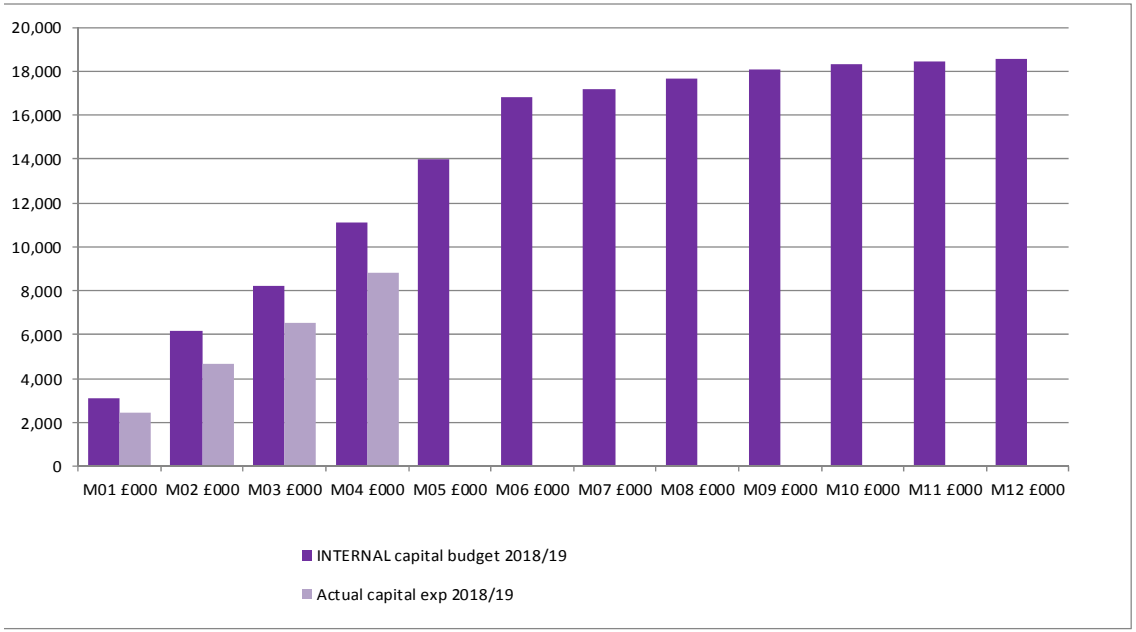
July cash position

- The Trust achieved a cash balance of £7.8m on 31 July 2018, £4.8m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 17 week cash flow submitted last month. The Trust continues to benefit from the agreed deferral of CNST premiums and also from late invoicing of material rental charges from NHSPS. T**he Trust will remain dependent on monthly borrowing from DH given the continuing I&E deficit.**

5. Capital Spend against the £18.5m internal budget

Spend category	Internal Budget £000	M04 YTD budget £000	M04 YTD exp £000	M04 YTD var £000
Infrastructure renewal	**5,732**	3,142	1,698	1,444
IT	**3,015**	2,260	2,413	-153
Medical equipment	**1,890**	960	748	212
Major projects	**5,756**	3,372	2,838	534
Other	**888**	422	323	99
SWLP	**545**	371	75	296
Urgent £11.8m March 2018 projects	**711**	581	734	-153
Total	**18,538**	11,107	8,829	2,278

INTERNAL capital budget 2018/19 (excl £29.65m bid - not approved) and YTD exp



- The Trust's internally funded capital expenditure budget for 2018/19 is £18.5m
- The Trust has incurred capital expenditure of £8.8m in the first four months of the year against the YTD internal capital budget of £11.1m
- The main component of the year to date under spend relates to the biggest project – the Lanesborough wing stand-by generators project (Infra Renewal category) which is under spent by £1.3m as at M04. The project is behind schedule but is forecast to come within budget and so the M04 YTD underspend represent a temporary timing difference.
- Within the Major Projects category the Dental lab is £0.3m under spent (slippage) and the SWLP spend category is under spent due to the profiling of the spend for the replacement of the LIMS system. Both these projects are expected to spend to budget.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M4 YTD)	Actual (M4 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 July, 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 (6.00%) minus planned % I&E deficit (5.30%). This value is -0.70% 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:	Board Meeting		
Date:	30 August 2018	**Agenda No.**	**5.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Harbhajan Brar, HR & OD Director		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 9th August 2018, including commenting on assurance to the Board on key risks allocated to the Committee.		
Recommendation:	Receive this report		
Supports			
Trust Strategic Objective:	Champion Team St. George's		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Leadership and improvement capability		
Implications			
Risk:			
Legal/Regulatory:			
Resources:			
Previously Considered by:		**Date:**	
Equality Impact Assessment:			
Appendices:			

1. Committee Chair's Overview

This paper reports on the Workforce and Education Committee held on 9 August. Despite it being peak holiday season we had good attendance with two of the three Divisions and most other operational areas represented, and we are appreciative of people making the time to attend. Given the number of apologies we had received from regular attendees who were on holiday, we had anticipated the meeting being more of a progress update. However there were some important items for review and it was good to have time to discuss these in reasonable depth.

The Committee was concerned that it had not yet seen the workforce plan for the current year. Members felt that it was important that it should do so, in order to triangulate with the Cost Improvement Programmes and assure itself that all of the Trust's plans were co-ordinated and robust. Whilst Executives present were confident that good progress was being made, the Committee nevertheless felt it should review the plan in some detail at its next meeting.

We received a further update from our new Diversity and Inclusion lead (Celia Oke), and her initial thoughts on the Trust's overall strategy in this area, and a plan setting out initial actions to be progressed. This will form the basis of a workshop that Celia will lead with the Board as a whole, to take place in early September. The Trust's Responsible Officer, Karen Daly was also able to attend and present an update report on progress on revalidation (see below).

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

2. Key points:-

Board Assurance - The Committee ended its meeting by reviewing the four[2] **Trust-level risks** that have been assigned to the Committee to monitor, and provide assurance on mitigation. There were no changes in circumstances or in our assessment of respective risks that required us to change our present assurance rating.

Theme 1 - Engagement

The Trust's **Diversity and Inclusion** Lead, Celia Oke, set out the **proposed strategy and associated plan** to begin to address a number of the factors that held back diversity across the Trust. This set out six goals, with underpinning actions for the current year, through to March 2019. Celia was clear that the Trust's approach needed to consider and act on all protected characteristics, not simply race. The Committee discussed the Report and plan fully, and a number of suggestions were made to help it gain traction. Celia will attend the Trust Board in September to present the plan, and communication of the plan will include road shows for staff. The Committee also suggested that a set of aspirational timescales could be developed, together with a set of stretching or aspirational results for the staff survey. These would not be formal targets, but would set out what we would currently regard as indicators of solid progress being achieved.

[1] Being (1) engagement; (2) leadership and development; (3) workforce planning; and (4) compliance.
[2] Being: SR1 workforce strategy (role design, skill-mix, recruitment and retention); SR8, culture; SR10, training; and SR11, leadership and development.

Alison Benincasa updated us on progress on the Trust's **Engagement Plan**, by reference to a comprehensive paper which had been circulated and which set out the status of current and planned activities. Good progress was reported generally, and the actions were on track against the timescales agreed. Alison and Celia also confirmed to us that whilst Celia owned and was leading on the diversity and inclusion agenda, certain actions within that would, for completeness, continue to be reported through the Engagement Plan.

In the absence on holiday of Dr Jonathan Round, the Trusts Director of Postgraduate Medical Education, we received a report from him setting out the results of a **GMC survey of our junior doctors**, and their assessment of our medical training across 38 specialty areas. Although we scored well in many areas (and very well in some areas[3]), our trainees' rating of four of our specialty areas[4] were within the lowest 10% of all hospital training organisations. Jonathan had already initiated action to address this and we agreed with his proposals. We also asked that when the results of the online survey of our poorly performing training specialties are received, Jonathan present them to us together with the corrective plans being developed.

Jacqueline McCullough reported on the **pan-London staff survey results**. This compared the results achieved by the Trust in its 2017 staff survey[5] over the 2016 survey results, and by comparison with those achieved by 35 other pan-London Trusts. Whilst St George's was one of only four Trusts which achieved 10 or more significant improvements[6] across the 32 domains, the fact remains that in aggregate its overall results place it in 32nd or 33rd place overall. It is also disappointing that the one area of significant deterioration related to the behaviour of patients and visitors, something which is much more difficult for the Trust to control – see footnote 6 below. There remains much to do to get off the bottom decile of the league table.

Theme 2 – Leadership and Progression

Sarah James reported on the follow-on actions to the **development centre** which had been undertaken for the Trust by The King's Fund. The availability of funding for that follow-on support had been identified as an issue, and Harbhajan had approached NHSI to see whether funding might be available to support this. Initial indications were that this might be the case, although a definitive response to this request has not yet been received. We have asked to be kept updated.

Theme 3 - Workforce Planning

We have been advised that good progress is being made on the current year's **Workforce Plan**. At present we cannot confirm that this is the case, as the plan has not yet been made available to us. We see the achievement of this plan as a material factor in the Trust achieving its budget for the year, and at present cannot give any assurance about this.

Ranjit Soor updated us briefly on the further development of the Trust's **Workforce Strategy**. Ranjit referred to the paper that had been circulated and reported that work on the Strategy continued.

Sion Pennant-Williams presented the most recent **workforce report**. Sion referred to a number of KPIs. As at the end of June, the vacancy rate had fallen to 10.97% and turnover had risen marginally to 17.34%. Staff sickness rate had increased marginally, to 3.36% - although rates across divisions and individual care groups

[3] Notably: cardiothoracic surgery; neurology; renal and ENT – all of which were top 10%.
[4] Bottom 10% in: anaesthetics; cardiology; haematology; and junior surgery (a new category).
[5] The 2017 Staff Survey reflects sampling undertaken within the Trust October to December 2016, and likewise the 2016 Staff Survey reflects results from the survey work done in the period October to December 2015.
[6] With one domain significantly worsened – that of staff experiencing racial harassment, bullying or abuse **from patients or relatives** in the last 12 months.

occupied a broad range, and targeted intervention continued to be directed at areas of notably higher sickness. The MAST rates had increased to 89% and we were now above the rate achieved in the previous year. Indications for July were that we would break the 90% threshold - based on the snapshot of compliance taken on the day the committee met.

The Trust's move of its **Medical Bank rates** to the Pan-London Break Glass Ceiling levels earlier in the summer had not been matched by other London Trusts, leading to major challenges in filling rota gaps for pre-consultant cover. As a result the Trust had had to revert to the previous (higher) rates. London Trusts have now all agreed to reduce their locum rates to match the new pan-London rates with effect from 3 September. The reduction in rates will be c 20% and, given the close match between demand and supply in this area, the lower rates may be something of an inflection point. It will be critical to monitor continuity of supply of locums carefully as we move back to the new rates, and to check that other Trusts adhere to the agreed rates.

June **agency spend**[7] nudged our monthly cap, but did not breach it. Indications for July were that we will continue to use agency staff at broadly the same rate as June due to national shortages in some specialities.

Claire Low confirmed that the new **Medical Workforce Committee** had met, and would be reporting back quarterly.

Ms Karen Daly, the Trust's **GMC Responsible Officer reported on the latest Annual Organisational Audit** return made to the GMC, and their response to it received at the end of July. The Trust was able to report good progress in a number of areas (funding and managerial capacity; undertaking of an internal audit; monitoring of fitness to practice). However, it was clear from Karen's report that the Trust has not yet fully sorted out its appraisal processes and the wider governance that sits around this. This is clearly seen in the rates of completed appraisal achieved within the Trust, compared with other similar Trusts[8]. Karen summarised the steps being taken to correct this, and the internal focus that this is getting from the newly-established Appraisal and Revalidation Advisory Group. We will look for further updates from Karen as this work progresses.

We also reviewed the internal audit prepared in respect of the Trust's appraisal and revalidation, noting that it contained no 'Urgent' actions, two 'Important' actions, and four 'Routine' actions. The responsibilities and timescales for corrective action had been agreed. Against that background, we were able to affirm that, notwithstanding the work on improving appraisal processes and completion rates, the Trust is in compliance with the Revalidation regulations.

Theme 4 – Compliance.

In the absence of Sunil Dasan on holiday, Claire Low summarised the written report on **Safe Working** prepared by Sunil. The number of exception reports had been reduced significantly (by 82%), down from 203 the previous quarter to 35 during the April to June quarter, with no fines levied in the quarter. In particular the position of general surgery is no longer an outlier.

This represents extremely encouraging (and rapid) progress and we are grateful to all who have worked to deliver this improvement, and we hope that it can be maintained across the July to September quarter.

Stephen J Collier
16 August 2018

[7] POST MEETING NOTE – this is as reported to the Committee, but subsequently the actual position changed , for the worse
[8] The GMC response uses the descriptor 'Designated Bodies in sector'.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	30 August 2018	**Agenda No**	5.2
Report Title:	Guardian of Safe Working Quarter 1 Report		
Lead Director/ Manager:	Professor Andrew Rhodes		
Report Author:	Dr Sunil Dasan, Guardian of Safe Working		
Freedomof Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Guardian of Safe Working's Quarter 1 Report summarises progress in providing assurance that doctors are safely rostered and work hours that are safe. This report covers the period from 01/04/2018 – 30/06/2018 35 episodes of trainees working outside of their work schedules have been reported during Quarter 1. This represents an 82% reduction in exception reporting compared to the previous quarter. The reasons for this significant reduction in exception reporting are unknown. This may be due to an easing of 'winter pressures'. However, this data needs to be reviewed in light of information regarding rota gaps and previously reported pressures on trainees not to exception report.		
Recommendation:	The Trust Board are asked to note the significant reduction in exception reporting this quarter and triangulate this information with other workforce intelligence to give an accurate picture of the areas of pressure within the medical workforce at St George's		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	Lack of information on rota gaps risks poor oversight of areas of staff shortages within the medical workforce		
Legal/Regulatory:	Compliance with the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016		
Resources:	An electronic system for rota management is required		
Previously Considered by:	Medical Workforce Committee Workforce Committee	**Date**	04/07/2018
Equality Impact Assessment:	N/A		
Appendices:	One		

Guardian of Safe Working Quarter 1 Report
Medical Workforce Committee 11/07/2018

1.0 PURPOSE

1.1 This paper provides assurance to the Board via the Medical Workforce Committee (MWC) and Workforce Education Committee (WEC) on progress being made to ensure that doctors' working hours are safe

1.2 This report asks the MWC to note the significant reduction in the numbers of exceptions reported. This needs to be investigated further and triangulated with other workforce data to ensure that this reflects an actual improvement in rotas or whether this represents a poor reporting culture due to pressure not to exception report.

2.0 BACKGROUND

2.1 203 episodes of trainees working outside of their work schedules were reported January-March 2018. Fines totalling £6437.46 were levied and several work schedule reviews concluded though there were significant concerns expressed regarding ongoing issues in ENT and General Surgery.

3.0 ANALYSIS

Fines

3.1 No fines were levied from 1 April 2018 – 30 June 2018

Exception reports

3.2 35 exceptions were reported in the period 1 April 2018 – 30 June 2018

3.3 The breakdown is as follows:

Division	Number of exceptions	Breakdown
Medicine and Cardiovascular	16	8 Gastroenterology 4 Acute Medicine 2 Haematology 1 Senior Health 1 Endocrinology
Children's, Women's, Diagnostics and Therapeutics	10	6 Obstetrics & Gynaecology 3 Paediatric Medicine 1 Neonatology
Surgery, Theatres, Neurosciences and Cancer	9	5 General Surgery 3 ENT 1 Plastic Surgery

3.4 A further breakdown shows:

- All 35 exceptions related to working hours /conditions
  - 29 of these were where trainees had worked in excess of their hours
  - 5 exceptions where there was difference in the support available (where the number of staff on duty was less than it should have been)
  - 1 exception where a trainee had missed their break

- No exceptions were related to missed training opportunities

Immediate safety concerns

3.5 Two exceptions were highlighted as immediate safety concerns

One related to the absence of a more junior trainee (SHO) to support a more senior trainee (Registrar) during a weekend on-call duty in ENT. The immediate safety concern stated:

> *"Absence of SHO from the rota - predictable gap - not filled. Therefore I was required to work on-site 8am-8pm holding first on call bleep and covering duties of both the SHO and SpR. I was supported by the on call consultant but missed 2 opportunities for emergency operating due to the demands of the SHO duties (ie: covering referrals from Surgical Admissions Unit and A&E). 12 hour on-site shift followed by 12 hour non-resident oncall, before continuing with further 24hr shift (still to come). Supported by Consultant for ward round and reviews. Surgical Admissions Unit and ward informed of lack of SHO to minimise non-acute bleeps. Overnight team asked to minimise non-acute calls but that senior cover remains in place whenever needed"*

This situation had occurred despite the efforts by managers over the previous 3 weeks to arrange cover for this shift.

The second immediate safety concern occurred within the Senior Health service. This stated:

> *"Stayed back extra hours to ensure all patients reviewed on the ward. Day was understaffed and multiple very sick patients. Unable to have lunch break until 4pm. Reported to covering consultant. Distributed and prioritised work load. Enlisted help from colleague on neighbouring ward to help with a few jobs"*

The duty consultant confirmed that no patient came to harm and that the main risk for the doctor had been fatigue due to having to work through their lunch break due to understaffing. Time off in lieu was offered to the doctor and accepted

Work schedule reviews

3.6 No work schedule reviews took place from 1 April 2018 – 30 June 2018

Rota gaps

3.7 Rota gap information is shown in Appendix A. This lists vacant trainee, clinical fellow and trust doctor posts across St George's. This does not include vacant physician assistant or other advanced practitioner posts. This data shows that there are 53 vacancies across St George's, a decrease from the 69 reported in March 2018.

Lead employer for General Practice training

3.8 St George's is the Lead Employer for General Practice training across South London. No exceptions were reported by GP trainees working in Practice during Quarter 1.

Junior Doctor Forum

3.9 The Junior Doctor Forum (JDF) continues to meet monthly. To date it has not spent the £9,322.49 accrued to date in fine monies. Consideration has been given to using this money to refurbish the Doctors' Mess plus to purchase a managed teleconferencing solution to widen participation in the JDF. However, this is subject to further discussion.

4.0 IMPLICATIONS

Risks

4.1 Risk that significant reduction in exception reporting reflects a poor reporting culture due to pressure not to exception report rather than an actual improvement in rotas

Legal Regulatory

4.2 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

Resources

4.3 To ensure robust information on unfilled shifts and vacant posts within the medical workforce, an electronic rota management system will be required

5.0 NEXT STEPS

5.1 To survey of trainees, supervisors and managers on their views of exception reporting

6.0 RECOMMENDATION

6.1 The Trust Board are asked, to receive this report.

Author: **Dr Sunil Dasan, Guardian of Safe Working**
Date: **04/07/2018**