Trust Board Meeting

Date and Time: Thursday 9 November 2017, 10:00 – 13:00
Venue: Hyde Park Room, 1st Floor, Lanesborough Wing

Time	Item	Subject and Lead	Action	Format
		FEEDBACK FROM BOARD WALKABOUT		
10:00		**Visits to Various Parts of the Tooting Site** *Board Members*	-	Oral
		OPENING ADMINISTRATION		
10:30	**1.1**	**Welcome and Apologies** *Chairman, Gillian Norton*	-	Oral
	1.2	**Declarations of Interest** *All*	-	Oral
	1.3	**Minutes of Meeting held on 05.10.17** *Chairman, Gillian Norton*	Approve	Paper
	1.4	**Action Log and Matters Arising** *All*	Review	Paper
	1.5	**CEO's Update** *Chief Executive, Jacqueline Totterdell*	Inform	Paper
		STRATEGY		
10:40	**2.1**	**Trust Strategic Objectives** *Chief Executive, Jacqueline Totterdell*	Approve	Paper
		QUALITY		
11:00	**3.1**	**Quality & Safety Committee Report** *Chair of Committee, Sir Norman Williams*	Assure	Paper
		PERFORMANCE		
11.20	**4.1**	**Integrated Quality & Performance Report** *Executive Team*	Review	Paper
	4.2	**Elective Care Recovery Programme – Action Plan** *Chief Operating Officer, Ellis Pullinger*	Assure	Paper
		FINANCE		
11.55	**5.1**	**Finance & Performance Committee Report** *Chair of Committee, Ann Beasley*	Assure	Paper
	5.2	**Month 6 Finance Report** *Chief Financial Officer, Andrew Grimshaw*	Assure	Paper
		ICT		
12:15	**6.1**	**ICT Risk Review** *Chief Financial Officer, Andrew Grimshaw*	Review	Paper
		WORKFORCE		
12:20	**7.1**	**Quarterly Report of Compliance with the Fit & Proper Persons Regulations** *Director of Human Resources & Organisational Development, Harbhajan Brar*	Assure	Paper
		GOVERNANCE		
12:25	**8.1**	**Overview of New Board and Committee Arrangements from January 2018** *Fiona Barr, Trust Secretary & Head of Corporate Governance*	Approve	Paper

CLOSING ADMINISTRATION				
12.35	**8.1**	**Questions from the Public**	-	Oral
	8.2	**Any New Risks or Issues** *All*		-
	8.3	**Any Other Business** *Chairman*	-	-
	8.4	**Reflection on Meeting** *All*	-	Oral

12:40	**PATIENT STORY**
Greta Adedeji is the carer of Tajudeen (Taj) who has a learning disability. She will be accompanied by Padraic Costello, Clinical Nurse Specialist Learning Disabilities who will be able to talk about how he assists patients, helping staff to make reasonable adjustments.	

13:00	**Close**

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

Date and Time of Next Meeting: Thursday 7 December 2017

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 2017 (Thursdays)
07.12.17 10:00 – 13:00

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

St George's University Hospitals NHS
NHS Foundation Trust

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

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Richard Hancock	Interim Director of Estates & Facilities	DE&F
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director - NHS Improvement	QID
APOLOGIES		
None		
SECRETARIAT		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec
Richard Coxon	Membership & Engagement Manager	MEM

Feedback from Board Walkabout

The Board members began by giving feedback from the departments visited which included: Staff Bank Office, Pre-Operative Assessment, Max Fax Unit, Thomas Addison Unit, Dermatology & Lymphoedema Outpatients, Heberden Ward, Neuro Outpatients, McKissok Ward, Paul Calvert Theatres, Sterile Services Department, St James's X-Ray and Children's Emergency Department. Themes included generally good staff morale and good compliance with the Bare Below the Elbow (BBE) policy – including evidence of staff challenging other staff who were not BBE in clinical areas.

General observations included suggestions on how space could be better used to improve layout and storage. Board members who visited outpatient areas commented on two main areas of inconsistency:

i. Check-in facilities – in some areas, check-in facilities were electronic and in others they were desk-based. Board members felt that electronic check-in facilities probably provided a better patient experience as it speeded up the process
ii. "Customer service" – in some areas, staff were very helpful and engaging with patients and in others appeared to be "chatting" and not responding to patients.

In Sterile Services, Board members were impressed by the high volumes of instruments which staff were decontaminating every day – sometimes using equipment which was very old, though there were no complaints. One of the NEDs visited CommCell, the weekly internal review of Trust performance, and commented that it was very positive to see the wide cross-section of staff in attendance and the engagement with actions to improve performance week on week.

1. OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and advised there were no apologies. Tim Wright, new Non-Executive Director, was welcomed to his first Board Meeting and the Chairman also noted that Anne Brierley, the new Director of the South West London Acute Provider Collaborative, was in attendance.
Declarations of Interest	
1.2	There were no declarations of interest.
Minutes of Meeting held on 07.09.17	
1.3	The Chairman advised that she had separately received a note from Hazel Ingram regarding the point she made in section 7.2 of the minutes and these would be amended to reflect this. Other minor amendments included: i. page 1: add the Rose Centre to list of places visited ii. page 5: replace "pharmacy" with "drug related' in 4.1 iii. page 7: amend 6.1 to clarify that only if staff refused the offer to attend safeguarding training would they be stopped from working.
1.4	Otherwise the minutes were accepted as a true and accurate record of the meeting held on 07.09.17.
Action Log and Matters Arising	
1.5	The Board noted that most actions on the Action Log were proposed for closure as they were either on the agenda for discussion or because appropriate action had been taken outside the meeting. The DHROD gave a verbal update on action TB.06.07.17/38 advising that a new Tableau report would provide details of gender, equality and diversity and over time the Trust would be able to report on all the Protected Characteristics.
CEO's Report	
1.6	The CEO gave a brief report, advising that two new Directors had been appointed in recent weeks, Suzanne Marsello as Director of Strategy and Kevin Howell as Director of Estates & Facilities. Both were very experienced Directors and would start in early January 2018.
1.7	She noted that the Trust's performance on Referral to Treatment standards remained an area of considerable focus. An action plan would be discussed in the public part of the November Board meeting, formally setting out progress and how risks and issues were being managed to ensure patient safety was paramount.
1.8	The Annual Members Meeting which took place after the Board Meeting on 07.09.17 had been a big success with over 70 attendees. The feedback had been very positive and would be used to plan next year's event.
1.9	The CEO apologised for the late issue and quality of some of the Board Papers and advised of action she was taking to address this to ensure that her Executive Team produced high quality papers and presented these to the Trust Secretary for issue to the Board, one week before the Board meeting. The Chairman looked forward to seeing an improvement.
STRATEGY	
Trust Response to *Providing High Quality Healthcare Services 2020 to 2030*	
2.1	The CEO introduced the joint response agreed with Kingston Hospital and Croydon

	University Hospital to the *Providing High Quality Healthcare Services 2020 to 2030* engagement document published by Epsom & St Helier University Hospitals NHS Trust. She noted that the appointment of the new Director of Strategy would help the Trust produce its clinical strategy and support wider links with other key trusts in South West London.
2.2	The Board received the response.
QUALITY	
Quality Committee Report	
3.1	Sir Norman Williams, Chair of the Quality Committee (QC) gave an update report from the meeting held on 27.09.17, apologising that the agenda indicated it would be a written report when it was oral.
3.2	The Quality Improvement Plan (QIP) was reviewed by the QC which recognised the amount of work that had been put into it and commended the report. However, it had not been quite ready to be finally approved so the QC deferred this decision to the Board
3.3	The new Complaints Policy was discussed and the QC broadly welcomed the improvements put forward such as categorisation based on severity (Red, Amber, Green) and the number of days for responding to and addressing the complaint based on severity. However, the committee felt that the new process was "not quite there" and asked the Executive to focus on responding and resolving as quickly as possible and learning from results and being able to demonstrate this.
3.4	There was some discussion around Serious Incident (SI) reporting which had increased with no clear reason for this but was being monitored. It was felt that the quality of the SI reports were improving though more work was required to confirm actions were completed and lessons learned and embedded.
3.5	The QC had been briefed on plans to prepare for another CQC inspection at the end of November and was pleased with plans and felt the Trust was in reasonable shape. There will be a mock CQC inspection in which Governors and Patient Representatives will be invited to participate.
3.6	The QC identified a new risk as a result of the paper on the Caldicott Guardian and the new General Data Protection Regulations (GDPR). The Committee felt that there needed to be greater clarity and visibility on the action being taken to respond to the legislation. It also noted the punitive penalties for any breach of the Regulation (up to 2-4% of operating revenue). It learned that the CIO was leading the recruitment of a new Data Protection Officer (required by the legislation) and also looking to strengthen the Trust's information governance team which the report indicated was under-resourced. Given the magnitude of change that GDPR would bring, the QC requested regular updates on GDPR progress.
3.7	The QC had received a progress update on the Cardiac Surgery department noting the use of an external HR company to support the department review and address its team dynamics. The QC was assured that the Executive was overseeing a process with the department that ensured patient safety remained paramount.
3.8	The Committee received the report.
Quality Improvement Plan	
3.9	The CN introduced the QIP and advised of the work still underway to refine the outcome measures and address some minor inconsistencies. The Board generally welcomed the Plan and noted that it would continue to evolve as new priorities emerged. The Board approved the QIP subject to these amendments being made.

PERFORMANCE	
Integrated Quality & Performance Report (IQPR)	
4.1	The DDET introduced the IQPR and advised that day case activity had increased though two theatres were closed for refurbishment which demonstrated a much more efficient theatre utilisation – this was welcomed. However the Trust was still underperforming against the Four Hour Operating Standard and achieved 89.9% in August 2017 and this had a knock-on impact to patient experience which was lower when the Emergency Department was busy; also patients who waited for more than four hours in pre-admission spent an extra day at the Trust. The NEDs expressed concern about the performance against the Four Hour Operating Standard and asked what actions were being taken to address this. These included: i. Reviewing best practice from Croydon Emergency Department and how something similar could be introduced at St George's. ii. Introducing an A&E hub concept, enabling patients who were triaged to see a GP to be iii. able to see one on site. iv. Working with the Local Authorities and other partners to manage demand from care homes differently – eg rather than ambulance conveyance to St George's, investigating if a GP could attend in the first instance to "see and treat".
4.2	The Board noted the increase in the number of complaints and Serious Incidents which had been discussed at the last Quality Committee and would continue to be kept under close review. The Board discussed Safety Thermometer and noted that some patients were admitted to the Trust with pre-existing "harms", such as Pressure Ulcers and the CN explained that, if there were themes emerging around poor care in specific areas, these were raised with commissioners. In the case of "new harms" as a result of a patient's stay in hospital, the acting MD proposed that the Trust should analyse the 5% of patients who came to harm and thus ascertain the further improvements required. He agreed to explore this further with the Quality Committee.
TB.05.10.17/46	**Quality Committee to explore how further improvements can be made for all and new harms.** **LEAD: Acting Medical Director, Andy Rhodes**
4.3	The COO advised that only three out of the eight cancer standards were met in July and diagnostic performance remained below the 99% Trust standard. However the unvalidated performance for August for both cancer and diagnostics looked much more positive
4.4	The DHROD noted some planned changes for workforce reporting in the IQPR which he had discussed at the Workforce & Education Committee. He noted that whilst reducing the recruitment process from 70 to 40 days, it was still difficult to recruit in some areas – for example on particular wards or in some specialities where there was a nationwide shortage of clinicians (eg neuroscience). However efforts were unstinting to recruit to these posts and present St George's as an attractive place to work and an employer of choice – not least because staff shortages could have a big impact on performance and patient experience. The DRHOD advised of work with NHS Improvement to improve staff recruitment and retention.
4.5	The Board received the report noting the position on a range of performance indicators.
Emergency Prevention Preparedness & Response (EPRR) – Assurance and Compliance Report	
4.6	The COO presented the report which set out the self-assessment which the Trust had completed and submitted in September as part of the 2017 NHS England EPRR assurance process. There would be a follow-up meeting in October to formally review the return and consider the Trust's role as a Strategic Asset and Major Trauma Centre. The self-assessment was against the Trust's compliance with the core standards of the Civil Contingencies Act (2004) as a category 1 responder.

4.7	Whilst the Trust had rated itself green in most areas (fully compliant with the core standard) and had no areas which were red (not compliant with core standard and no evidence of progress), it did rate itself as amber in five core standards (not compliant but with evidence of progress). The Board noted that one of these core standards (20) covered utilities, IT and telecommunications failure which continued to be the focus of considerable management attention. The whole return, and particularly the areas rated amber, had previously been discussed at the Trust's Risk Management Committee.
4.8	The report was received but the Board requested a further update after the NHS England follow-up visit.
TB.05.10.17/47	**Board to receive a further update on the Trust's compliance with core standards against its duties as a Category 1 responder following the review by NHS England. LEAD: Chief Operating Officer, Ellis Pullinger**
FINANCE	
Finance & Performance Committee Report	
5.1	Ann Beasley, Chair of the Finance & Performance Committee (FPC), gave a verbal update from the meeting on 27.09.17 advising that the Committee particularly focused on a number of areas of underperformance against key standards, eg for cancer, diagnostics, the Four Hour Operating Standard, which had already been covered in the meeting. Whilst the Committee had welcomed the improved theatre utilisation, it had been very clear that the levels of efficiency must be maintained when both theatres were returned to operation. She also expressed concern with the likely financial outturn for 2017-18, noting that the current performance was slightly adverse to plan though the plan assumes a significant improvement in the latter half of the year.
5.2	On a positive note, she confirmed that the Committee welcomed the efforts by the Executive to bring the budget planning process forward and to use a zero based approach to budget planning for 2018-19. Whilst the Committee had approved a capital business case, it had noted some deficiencies in the overall business case process which the Executive agreed to address.
5.3	Regarding agency usage, the Committee Chair confirmed that it was in line with plan but was concerned that there was insufficient evidence of month on month reductions. The CN, MD and DHROD all confirmed that the management had a much tighter grip on agency spend – not least through Divisions being scrutinised every two weeks on their agency spend and adherence to their Divisional agency cap.
5.4	The report was received.
Month 5 Finance Report	
5.5	The CFO presented the Month 5 Finance Report which showed a cumulative deficit of £33.9m at the end of August 2017 which was adverse to plan by £1.3m. He confirmed that whilst the position was not in line with the plan agreed with NHSI, to end the year with a £45m deficit and run rate, performance was broadly in line with the Trust's forecast plan of a £55m year-end deficit. As with previous months, income was adverse to plan and the overall financial position was being partly offset by expenditure underspends. Whilst the cost improvement programmes (CIPs) were showing ahead of schedule, this was due to how they had been profiled and the Trust was still slightly short of the full value of the CIP plan: around £42-43m had been identified against an internal target of £47m (to provide a level of contingency).
5.6	Particularly for the second six months of the year, the CFO confirmed that the Trust needed to maintain a continued focus on control, both in the development and delivery of CIPs and the tracking of activity but also in challenging expenditure and finding opportunities to reduce it safely. At Divisional meetings all aspects of financial performance were being challenged and this was a key part of exerting grip on the Trust's

	financial position. The CEO explained how she wanted to devolve budget management and responsibility down to the lowest possible level to enable wards and departments to take greater ownership and accountability for budget performance. The NEDs welcomed this approach but there must be a relentless focus on keeping within budget. They encouraged the Executive to consider how good budget management could be rewarded (and poor budget management result in sanctions).
5.7	The Board received the report noting the financial position.
WORKFORCE	
Workforce & Education Committee Report (including Update from Guardian for Safe Working)	
6.1	Stephen Collier, Chair of the Workforce & Education Committee, provided a verbal report from the meeting held the previous day (04.10.17). The latest Friends & Family Test (F&FT) results showed that 79% of staff would recommend the Trust as a place for treatment (up 2% from last quarter), and 51% would recommend the Trust as a place to work (up 7% from last quarter). These were encouraging results which he hoped would carry through to the NHS Staff Survey which would launch formally on 09.10.17 and close before Christmas.
6.2	The Committee learned that the St George's Charity had approved £80k funding to support 50 overseas qualified nurses currently working at the Trust as Healthcare Assistants (HCAs) to complete a conversion course to become UK registered nurses. In addition the Charity had approved £50k part year funding to establish a bursary fund to support staff in their continued professional development, where no other funds were available. This generous support was welcomed by the Committee.
6.3	The Committee received the latest quarterly report on junior doctors' working hours from Sunil Dasan, Guardian of Safe Working (GSW), which highlighted two instances that had raised specific patient safety concerns. The Committee was concerned with the apparent lack of progress in General Surgery, noting that it would receive a further fine, though the issues were more systemic to the Trust rather than specific to General Surgery. The Committee agreed that both issues should be discussed in more detail at the next available Executive Management Team (EMT) meeting and that future reports of the GSW should be routed through the EMT before being presented to the Committee.
6.4	In addition, the Committee approved a Staff Engagement Plan, a Workforce Race Equality Standard Engagement Plan, endorsed the Trust Chairman, Gillian Norton, as the Trust's Board Champion for Equality & Diversity, agreed an approach to awarding staff based on contribution rather than length of service and proposed to investigate pensions flexibility.
6.5	The Board received the report.
GOVERNANCE	
Audit Committee Report	
7.1	Sarah Wilton, Chair of the Audit Committee (AC) reported from the meeting held on 13.09.17 where the AC received a number of final Internal Audit reports which had an opinion of limited assurance, two of which were for 2017-18 and covered key audit areas. To ensure that the overall Head of Internal Audit Opinion for 2017-18 was one of at least reasonable assurance, it would be essential for the majority of this year's Internal Audits reviews to return a position of reasonable assurance or better. The Committee also stressed to Executives responsible for actions arising from these audits that they must be completed within agreed timescales. The Committee also welcomed the CEO's direct involvement in agreeing any extension to deadlines. Proposals to update the current year's Internal Audit Plan to reflect changing priorities and the need for assurance in a number of new areas was discussed and this would be considered again at the November AC meeting.

7.2	The Committee was still not adequately assured that the learning from completed Counter Fraud cases was always being disseminated to reduce the risk of similar frauds occurring in the future and encouraged the Counter Fraud team to work with the Communications team to agree how awareness across the Trust could be improved. The AC also recommended that EMT received a regular report on Counter Fraud.
7.3	In closing, the AC Chair urged the Executive to improve its production of papers and attendance at Committee meetings and noted the action taken by the CEO to minimise recurrence.
7.4	The Board received the report.
Corporate Risk Register	
7.5	The CN introduced the report and advised that she and her team were doing more work to understand these risks and how they had been scored. She assured the Board that all the risks had all been subjected to a full discussion at the Risk Management Committee and as a result some risk descriptions would be updated and scores reduced (for example for the risk around water safety management). Two new risks around electrical infrastructure had also been added.
7.6	The Executive assured the Board that by the next Board meeting, the scoring on the two IM&T risks would be reduced from 25 to 20 as a result of a full review of both risks and an assessment of the controls and mitigations in place. In addition the Executive agreed to arrange a Board seminar on the Trust's IT programme and plans for IT investment.
TB.05.10.17/48	**Present the two updated IM&T risks on the Corporate Risk Register (covering data quality, completeness or consistency, and ICT infrastructure failure) to the November Board meeting setting out revised risk scores which more accurately reflect the controls and mitigations in place.** **LEAD: Chief Financial Officer, Andrew Grimshaw**
TB.05.10.17/49	**Arrange a Board seminar on the Trust's IT programme and plans for IT investment** **LEAD: Chief Financial Officer, Andrew Grimshaw, and Trust Secretary, Fiona Barr**
7.7	The Board received the report and noted the actions underway to update the Corporate Risk Register and manage the risks contained within it. Whilst the Board required an update on the IM&T risks at the November meeting, it asked the Executive to complete more work on the Corporate Risk Register before re-presenting to a future meeting for assurance and review.
8. CLOSING ADMINISTRATION	
Questions from Public	
8.1	Khaled Simmons, Public Governor for Merton, welcomed the programme governance on the QIP but asked how he could find out more about the work underpinning the workstreams. The CN advised that this was available to drill down from the staff intranet and would look into how this could be made visible to the public as well as staff.
TB.05.10.17/49	**Consider how to make the information underpinning the Quality Improvement Plan available to the public online.** **LEAD: Chief Nurse, Avey Bhatia**
8.2	Hazel Ingram, Patient Experience Representative, welcomed the news that Suzanne Marsello was returning to the Trust as Director of Strategy. She was also pleased to know that the Trust Board was sampling patient food at lunchtime, which she thought was excellent. However when she had spoken to patients, she found that they were not always aware of the choices available and/or get offered an alternative menu. This was noted.
8.3	Hilary Harland, Public Governor for Merton, asked what was being done to improve the Trust's performance against the two week cancer wait target. The COO explained that the national reporting for cancer treatment figures was always one month in arrears and the

	unvalidated position from the Cancer Team showed that over 90% patients are seen within two weeks (this was being tracked weekly). He also explained that some patients opted to be seen outside the two week window (out of their own choice) though he and the team were working with the clinicians to encourage patients to be seen as quickly as possible and to closely track their progress.
New Risks or Issues and Any Other Business	
	There were no new risks or issues and no items of any other business. In closing the meeting, the Chairman thanked Gemma Stott, Consultant Dietitian & Professional Lead, Jenni Doman, Assistant Director – Facilities, as well as the Mitie team, for organising the patient food for sampling over lunch.

Date and Time of Next Meeting: Thursday 9 November 2017, from 10:00

Trust Board Action Tracker - 09.11.17

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.06.07.17/35	**Fit & Proper Persons Regulations**	Provide a quarterly and annual report on compliance with the Fit & Proper Persons Regulation to the Board.	TB.09.11.17		DHROD	On forward plan for TB.09.11.17. Next due Feb 2018.	Ongoing
TB.06.07.17/36	**St George's Charity**	Schedule a meeting with between the Board and the Trustees of the St George's Charity every six months.	TB Jan 2018		Trust Sec	On forward plan.	Ongoing
TB.06.07.17/38	**Staff Engagement and E&D Statistics**	Regularly report on staff engagement and metrics on equality, diversity and inclusion in the workforce element of the IPR.	Q3 2017-18		DHROD	The new workforce reporting will first be presented to WEC.	Open
TB.07.09.17/43	**Consultant Attribution**	Advise how consultant attribution is agreed and report this to the Quality Committee.	QC.29.11.17		Acting MD & Nigel Kennea	Scheduled for QC.29.11.17.	Open
TB.07.09.17/44	**Medical Revalidation**	Provide interim reports Medical Revalidation to the Workforce & Education Committee.	Q3 2017-18		Acting MD & Karen Daly	Medical revalidation is part of the WEC remit and when exactly it will fall in the annual cycle is currently under consideration and will be presented as part of the revised terms of reference and annual cycle to the next meeting.	Open
TB.05.10.17/46	**All and New Harms**	Quality Committee to explore how further improvements can be made for all and new harms.	QC during Q3 2017-18		MD	Item transferred to Quality Committee forward plan.	Open
TB.05.10.17/47	**Emergency Prevention Prepardness & Response**	Board to receive a further update on the Trust's compliance with core standards against its duties as a Category 1 responder following the review by NHS England.	TB Jan 2018		COO	No yet due.	Open
TB.05.10.17/48	**Corporate Risk Register**	Present the two updated IM&T risks on the Corporate Risk Register (covering data quality, completeness or consistency, and ICT infrastructure failure) to the November Board meeting setting out revised risk scores which more accurately reflect the controls and mitigations in place.	TB.09.11.17		CFO	On agenda	Proposed for closure
TB.05.10.17/49	**Corporate Risk Register**	Arrange a Board seminar on the Trust's IT programme and plans for IT investment	TBA		CFO/Trust Sec	A suitable date is being sought alongside other Board seminars.	Open
TB.05.10.17/49	**Quality Improvement Plan**	Consider how to make the information underpinning the Quality Improvement Plan available to the public online.			CN	Under consideration.	Open

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 November 2017	**Agenda No.**	1.5
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, CEO		
Report Author:	Chris Rolfe, Associate Director of Communications		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	Overview of the Trust activity since the last Board Meeting.		
Recommendation:	The Board to receive this report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led, Safe, Caring, Effective and Responsive		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	

Chief Executive Officer's Update
Trust Board, 9 November 2017

1. PURPOSE

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

1.2 I have now been at the Trust six months and, whilst enormous challenges remain, I do feel we are making progress. Of course, we aren't moving as fast as we would like in some areas – and operational performance is a particular challenge at the moment. However, the launch of our Quality Improvement Plan in October represents a major step forward for St George's towards our ambition of providing *Outstanding Care, Every Time*. This is exciting for the Trust, and I want us to build on the positivity that the launch of the plan has generated.

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

2. Executive Director Appointments

2.1 Since the last Trust Board meeting in October, I am pleased to say we have appointed Kevin Howell as our new Director of Estates and Facilities.

2.2 Kevin joins us from West Hertfordshire Hospitals NHS Trust, where he has been Director of Environment since 2014. Kevin has over 30 years' experience in the NHS, and has held a number of senior and executive estates and facilities roles in the London area – including at the Princess Royal University Hospital, Barnet and Chase Farm and North Middlesex University Hospital.

2.3 Kevin will start in post in January 2018, and Richard Hancock, our current Director of Estates and Facilities, will continue in his role until then. As previously communicated, Suzanne Marsello, our new Director of Strategy, also joins us in the New Year.

2.4 We recently advertised for a substantive Director of Corporate Affairs, and hope to be in a position to announce the name of the successful candidate ahead of the Trust Board meeting in December. Interviews are scheduled for later this month.

3. Performance

3.1 Performance of key services remains a challenge, particularly against the four hour operating standard. In September, 90.03% of patients visiting the Emergency Department at St George's were seen, treated and either admitted or discharged within 4 hours.

3.2 This is below the improvement trajectory we have agreed with NHS Improvement but, more importantly, also means that some patients are waiting longer than they should to be treated.

3.3 I am confident that staff across the Trust – including in the Emergency Department – are working as hard as they can to tackle the problem. However, I am naturally concerned that performance is not where it needs to be at present, particularly with winter and the performance challenge it brings still ahead of us.

3.4 We are finalising our winter plan, which includes moving forward at pace with a range of initiatives to improve performance for the benefit of patients – including better forward planning of staff rotas, and a review of the effectiveness of ambulance handovers. We are also linking closely with our local community partners to ensure a joined up approach.

3.5 I have also arranged for a summit on emergency performance to take place before the end of November, which clinical and managerial staff from across the organisation will be expected to attend.

3.6 Successful delivery of the four hour operating standard requires the involvement of all specialties; in other words, it's not just the Emergency Department's problem to solve.

4. Elective Care Recovery Programme

4.1 I am pleased to say we are making progress with the Elective Care Recovery Programme, although the scale of the challenge we still face should not be underestimated.

4.2 As we've discussed at length, our efforts are focussed on i) treating those people who are waiting longer than they should for planned care; ii) validating and cleansing historical records and iii) creating patient tracking systems and processes that are sustainable, so preventing the same problem being repeated again in the future.

4.3 Progress is being made, and today the Trust Board will see the first action plan that starts to describe how we move to a better position in terms of treating patients more quickly, and re-commencing formal reporting.

4.4. The roll-out of new Clinical Decision Outcome Forms across six specialties has seen a completion rate of 96% - which is a great improvement although, again, this is a basic requirement for <u>all</u> patients, and anything less than 100% shows there is still more work to do.

4.5 However, the feedback from clinical teams is that the forms we've introduced are easier to use and understand, which is a real positive, and something that gives us confidence ahead of a wider roll-out of the forms in the near future.

4.6 The Elective Care Recovery Programme remains an absolute priority for the organisation, and our ability to treat patients waiting longer than they should is another reason why we need to ensure consistent delivery of our performance priorities.

5. Outstanding Care, Every Time – our Quality Improvement Plan

5.1 In October, we launched our Quality Improvement Plan, which is a big part of our commitment to provide Outstanding Care, Every Time for all of our patients, wherever they are treated.

5.2 The launch of the plan was communicated extensively to staff, and our partners and external stakeholders – and the response has been very positive, showing there is a real desire across the organisation, and amongst the communities we serve, to improve and make St George's better.

5.3 Of course, the key now is to build on the momentum we have generated from the launch of the plan, and I am hopeful that a Quality Improvement Week planned for the end of November will help to focus minds, and showcase the many initiatives we are pushing ahead with across our hospital and community services.

5.4 It remains imperative that we work jointly to meet our quality, performance and financial commitments – and this is something I stress on a regular basis with staff, and the people I meet every day.

6. Academic promotions, and baby Abi Peters

6.1 Finally, I would like to congratulate those members of staff recognised in the annual round of academic promotions awarded by the university.

6.2 The following people have been awarded promotions: Dr Nicoletta Fossati, Reader (Honorary); Mr Peter Holt, Professor; Dr Patrick Kiely, Reader (Honorary); Dr Shamez Ladhani, Reader (Honorary); Dr Marco Mula, Reader (Honorary); Dr Dagan Lonsdale, Senior Lecturer (Honorary); and Dr Leighton Seal, Reader (Honorary).

6.3 This is a significant achievement for all of those listed above, and is something we have celebrated internally with staff, and on our website and social media channels.

6.4 Last week also saw baby Abi Peters celebrate her one year birthday. As you may recall, Abi was born at just 23 weeks gestation, and underwent surgery at St George's shortly after – making her the youngest patient our teams have ever operated on.

6.5 Abi's mother Louise spoke at our Annual Member's Meeting in October about the fantastic progress her daughter had made, and kindly agreed for us to share her story and birthday celebrations again with the media last week.

6.6 Abi's case – and the brilliant care she received from St George's surgeon Zahid Mukhtar, and countless others at the Trust – remains an inspiration to me, and many other people who've heard her story.

7. RECOMMENDATION

7.1 To receive the report for information.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 November 2017	**Agenda No.**	2.1
Report Title:	Trust Strategic Objectives		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The purpose of this paper is to summarise how we plan to deliver Outstanding Care, Every Time for our patients over the next 18 months – and to propose six strategic objectives for approval. The six strategic objectives we are proposing are: o *Treat the patient, treat the person* o *Deliver the right care, in the right place, at the right time* o *Champion Team St George's* o *Spend what we need, and save what we can* o *Build a better St George's* o *Develop tomorrow's treatments today*		
Recommendation:	To accept and agree the six strategic objectives set out in the paper.		
Supports			
Trust Strategic Objective:	As above.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-Led)		
Implications			
Risk:	There are no specific risks associated with this proposal. However, these objectives will be used to refine the Board Assurance Framework.		
Legal/Regulatory:	There are no legal or regulatory implications.		
Resources:	There are no direct resource implications, and the six objectives set out above summarise work just started, ongoing, and/or nearing completion.		
Previously Considered by:	N/A	**Date:**	

Strategic Objectives 2017-19
Thursday 9 November 2017

1.0 PURPOSE

1.1 Our aim is to provide *Outstanding Care, Every Time* for our patients, wherever they are treated.

1.2 This paper provides a brief overview of how we plan to deliver *Outstanding Care, Every Time* over the next 18 months.

1.3 This includes the six key strategic objectives we are proposing to improve care for patients, and make the working lives of our staff easier.

2.0 BACKGROUND

2.1 We face a range of financial, operational and quality challenges at the Trust, which the organisation is taking action to address.

2.2 Everything we are doing is designed to help us provide *Outstanding Care, Every Time* – but it is vital that this aim is supported by a clear and coherent set of organisational objectives.

2.3 These will give staff, patients, and our local and national stakeholders greater clarity about where we are focussing our energies, and where we want to improve.

2.4 Our organisational objectives will also help inform decision making at a local and strategic level; and also guide investment.

3.0 PROPOSAL

3.1 In order for us to provide Outstanding Care, Every Time for our patients, we are proposing six strategic objectives, which are to:

- *Treat the patient, treat the person*
- *Deliver the right care, in the right place, at the right time*
- *Champion Team St George's*
- *Spend what we need, and save what we can*
- *Build a better St George's*
- *Develop tomorrow's treatments today*

3.2 Everything we do will be driven by our organisational values, which are to be *Excellent, Kind, Responsible, Respectful.*

3.3 Over the next 18 months, we will work to deliver specific improvements for each of the six objectives above – and these are set out in table form below.

3.4 ***Please note:*** our recently published Quality Improvement Plan informs and will be intrinsically linked to the successful delivery of the six objectives set out above, and detailed below.

Objective	***Deliverables***
Treat the patient, treat the person	We will deliver the fundamentals of patient care to ensure our patients are kept safe and free of avoidable harm. We will continue to improve the experience for patients and their loved ones at the end of their life. We will ensure there is no decision without the patient's or carer's involvement, and that the patient's wishes are at the centre of their care We will recognise and manage deteriorating patients, and ensure staff support patients and their carers to make choices regarding their treatment We will ensure the safe and efficient storage and use of medicines, and continue to reduce the time patients wait for their medicines.
Right care, right place, right time	We will improve the timeliness of emergency care for patients, and consistently meet the A&E four hour operating standard. We will ensure we admit patients to the right ward or place of care first time, and ensure a positive experience for our patients. We will align our people and clinical capacity to pathway demand, and ensure our patients to the most appropriate environment for their assessment, treatment and care. We will reduce cancellations of operations and make efficient use of our operating theatres We will offer patients greater choice about how they access our services, and ensure we match capacity to patient demand. We will tackle our data quality and waiting list challenges, so ensuring patients are effectively tracked on our systems
Spend what we need, and save what we can	We will reduce our deficit, and aim to break-even in 2019 We will end the 2017/18 financial year with a break-even run rate – which means we are spending the same as we bring in by March 2018

	We will deliver organisational efficiencies – from the way we buy drugs to reducing the amount spent on agency staff
Build a better St George's	We will improve our everyday management systems (such as Agresso and ESR) so they are easier to use. We will modernise theatres and wards so they are better for patients and staff We will improve capacity in our ED, IT and Critical Care Unit We will address our maintenance backlog to ensure fire, water, heating, electrical and ventilation safety We will ensure maintenance requests are responded to and fixed quickly We will continue to stabilise and improve our IT infrastructure We will develop an organisational and clinical strategy that is informed and understood by our staff, and the communities we serve
Champion Team St George's	We will improve staff engagement We will address bullying and harassment We will improve equality and diversity We will develop a behaviour charter based on our values of being *Excellent; Kind; Responsible; Respectful*
Develop tomorrow's treatments today	We will work closely with St George's, University of London to train the healthcare professionals of the future We will embed research into clinical practice, to further foster a 'bench to bedside' culture within our organisation We will innovate, and ensure our patients have access to the latest treatments and surgical procedures. We will use the latest technology to improve outcomes for patients, and make it easier for staff to provide care safely and effectively.

4.0 IMPLICATIONS

Risks

4.1 There are no specific risks associated with this proposal. However, these objectives will be used to refine the Board Assurance Framework.

Legal Regulatory

4.2 There are no legal or regulatory implications.

Resources

4.3 There are no direct resource implications, and the six objectives set out above summarise work just started, on-going, and/or nearing completion.

5.0 NEXT STEPS

5.1 Pending approval, the objectives will be clearly communicated to our staff, patients, stakeholders, and the communities we serve.

5.2 The Chief Executive will provide regular progress reports to the Trust Board on progress against the six objectives, and our aim to provide *Outstanding Care, Every Time.*

6.0 RECOMMENDATION

6.1 The Trust Board is asked to approve the six strategic objectives set out above.

Author: Jacqueline Totterdell, Chief Executive
Date: 3/11/2017

REPORT TO THE BOARD FROM: Quality Committee

COMMITTEE CHAIR: Sir Norman Williams

DATE OF COMMITTEE MEETING: 26.10.17

1.0 MATTERS FOR THE BOARD'S ATTENTION

1.1 The Committee received a briefing on the progress with the Board Assurance Framework (BAF). The Committee is to act as the assuring committee for four strategic risks concerning: Referral to Treatment; learning and improvement; pathway integration with external partners; and research. Determination of risk appetite was discussed, the Committee agreed that it would consider the risk appetite for each of the strategic risks allocated to the Committee at the next meeting in November 2017 and present this to the Board in January 2018.

1.2 The Chief Nurse advised the Committee of the successful launch of the Quality Improvement Plan (QIP) though the Committee agreed to receive a further update at the November meeting on how the QIP would be monitored and its progress reviewed, particularly through a dashboard of metrics. The Committee will formally report on progress to each Board meeting.

1.3 In preparation for the next full inspection by the Care Quality Commission (CQC) a 'mock' inspection is planned for 15-16 November 2017. External Experts by Experience and Improvement Directors from NHS Improvement have been invited to lead inspection teams to give an objective assessment of the Trust's position. This will be supplemented with peer to peer reviews by internal inspection teams. In addition the Trust has planned a Quality Improvement Week and a two day programme with the Institute for Healthcare Improvement to build quality improvement capacity and capability in frontline teams.

1.4 The Committee heard about progress in the healthcare records workstream of the QIP. There continue to be significant risks in the availability and storage of healthcare records. This is on the risk register as an extreme risk. The risks were discussed and the importance of moving to have an electronic health record in use across the Trust was recognised. The Board is looking at the IT strategy in the next few weeks, the Committee will highlight the risks arising from the mixed model and the management of paper records at that meeting.

1.5 The Committee received an update on the delivery of improvement actions arising from the s.29a. It was confirmed that the warning notice was lifted but improvement actions remained. The electricity supply programme of work is in progress, the Committee asked for confirmation to be brought to the November meeting that the electrical safety requirements had been met.

1.6 The Committee welcomed the report which pulled together the information about incidents, complaints, inquests and litigation. Further analysis will be conducted to map this data against location and service and will be presented to QC.29.11.17. The Committee noted a high number of incident reports in obstetrics but was assured that this was not unusual. Embedding a culture of learning from incidents and preventing recurrence is a key part of the Committee's duties and this new report represented a good start from which to review and strengthen these processes. In addition, the Committee considered the visibility of litigation and concurred that the Board should receive an annual report on litigation.

1.7 Performance – particularly against the Four Hour Operating Standard and Cancer targets – remained a challenge and the Committee requested a report to the November meeting on cancer patients waiting over 104 days. In addition, the Committee was briefed on a failure to report sleep studies and stress echoes which had recently been identified. The Trust had notified NHS Improvement and a recovery plan was in production. Whilst it was pleased that this failure to report had been found and was being rectified, the Committee remained concerned about how this failure to report could have been missed. .

1.8 Two new cases of MRSA were noted. Although one case appeared to have been acquired outside the hospital, the second patient was not decolonised fully (having had four, not five, days of treatment). The Chair asked for assurance that there was not a wider problem in the Trust as these follow four cases earlier in the year. The Chief Nurse and Director for Infection Prevention & Control reported that she did not believe there to be a problem as none of the earlier cases were linked to decolonisation; however action plans were in place. A full analysis of the MRSA cases would be brought to the November meeting for review. The Committee was informed by the Chief Nurse of the death of a patient with Legionella and a full investigation as to the cause was in progress

1.9 The Committee was joined by Vin Kumar, Acting Chief Pharmacist, who presented an annual review of medication incidents and controlled drugs. He explained that the number of incidents reported had increased by 21% though the level of harm had fallen providing assurance that incidents were being identified and that learning from them leading to improvement had been achieved; this was welcomed by the Committee. Electronic prescribing had been successfully deployed in 42% of the Trust meaning that the Trust operated dual systems for prescribing (paper and electronic) and as separate systems, both operated successfully. However, this had created an artificial interface and for patients transferring across this interface, there was a potential for increased risk. He reported that there was no trend of errors linked with dual prescribing systems and the transition of patients across the interface. Further, to mitigate risk, the Pharmacy team had developed an algorithm to support the safe transition of patients though it was acknowledged that there was a need to roll out electronic prescribing and medicines administration to the entire organisation to remove the potential for risk. Two serious medication errors in recent months had been made in the prescription of anti-coagulants and it was likely that the controls in the electronic prescribing system would have prevented these errors.

1.10 The update on the Elective Care Recovery Programme provided assurance that the plan is being delivered though a significant number of patients were still waiting over 30-40 weeks. The Committee drew confidence that phase 1 of validation was complete and the plan was moving into phase 2 and that the Trust would return to national reporting.

1.11 The Medical Director updated on the review in cardiac surgery prompted by a NICOR alert. The Associate Medical Director leading on mortality reviews had been asked to present a paper to the next meeting on cardiac mortality reviews.

2.0 RECOMMENDATION

2.1 To receive the update from the QC.26.10.17 for information and assurance.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Trust Board – 9th November 2017
Reporting period - September 2017

Excellence in specialist and community healthcare

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

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

		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Sep-16	Sep-17	Variance	Plan Sept-17	Variance	YTD 16/17	YTD 17/18	Variance	Plan YTD	Variance
ED	Emergency Department Type 1 Attendances	13,792	13,519	-1.98%	14,240	-5.06%	82,883	83,180	0.36%	86,863	-4.24%
Inpatient	Non Elective	4,007	3,804	-5.07%	4,228	-10.03%	24,457	23,295	-4.75%	25,790	-9.67%
	Elective & Daycase	4,546	4,358	-4.14%	4,679	-6.86%	25,777	27,238	5.67%	27,260	-0.08%
Outpatient	OP Attendances	55,024	51,412	-6.56%	53,474	-3.86%	324,361	317,740	-2.04%	311,702	1.94%

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

Source: SLAM

Executive Summary – September 2017

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- No new patient Never Events were reported in September. The Trust has reported two events year to date. There were 13 Serious Incidents (SI's) declared in the month.
- In September the Trust reported one patient with hospital attributable Clostridium Difficile infection, which brings the trust year to date total to nine cases for the year, the threshold is 31.
- No patients acquired an MRSA Bacteraemia in month, the trust total year to date is 4 against a ceiling of 0.
- Patient safety thermometer - % of patients with harm free care (new harm) remains consistently above the 95% threshold. [*The 'new harm' patient safety thermometer looks at harms acquired by patients while in hospital.*]

Clinical Effectiveness

- Mortality is lower than expected for our patient group when benchmarked against national comparators
- Maternity indicators continue to show expected performance and a consistent trend

Access and Responsiveness

- The Four Hour Operating Standard was not achieved in September reporting a performance of 90.03% of patients admitted, discharged or transferred within four hours of arrival. This was below the improvement trajectory agreed with NHS Improvement.
- Six out of eight cancer standards were met in September
- Diagnostic performance remains above the 1% standard at Trust level, however ahead of agreed local trajectory. Recovery actions have been agreed for those modalities not meeting the standard

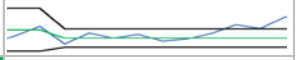
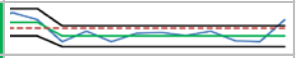
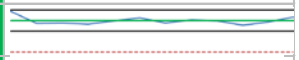
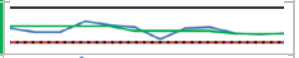
Patient Experience

- The Friends and Family Test (FFT) recommendation rate for inpatients was 96.54% in September and remains above threshold. Response rates are strong for inpatients and the recommendation score provides reasonable assurance on the quality of patient experience.

Workforce

- Staff sickness remains above the trust target of 3%
- Non Medical Appraisal Rates have remained consistent with previous months.

Patient Safety

Indicator Description	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
Number of Never Events in Month	0	0	0	0	0	1	0	0	0	1	1	0	0	
Number of SIs where Medication is a significant factor	0	0	2	0	1	0	0	0	0	0	1	1	1	
Number of Serious Incidents	N/A	7	10	4	8	6	8	5	6	8	10	9	13	
Serious Incidents - per 1000 bed days	N/A	0.29	0.42	0.17	0.32	0.26	0.31	0.21	0.24	0.33	0.40	0.38	0.54	
Safety Thermometer - % of patients with harm free care (all harm)	95%	96.5%	95.8%	93.7%	94.7%	93.7%	94.5%	94.6%	94.3%	94.7%	93.8%	93.8%	95.8%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.8%	97.7%	97.7%	97.6%	97.9%	98.2%	97.7%	98.0%	97.9%	97.5%	97.8%	98.3%	
Percentage of patients who have a VTE risk assessment	95%	96.2%	95.9%	95.9%	96.8%	96.5%	96.3%	95.3%	96.2%	96.3%	95.8%	95.7%	95.8%	
Number of Patient Falls	N/A	128	154	116	161	137	154	111	137	132	143	127	125	
Number of patient falls- per 1000 bed days	N/A	5.38	6.47	4.88	6.52	5.85	6.03	4.73	5.39	5.48	5.71	5.29	5.15	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	1.43	0.42	0.80	0.53	1.20	0.78	0.72	0.28	1.16	0.92	0.63	0.74	
Number of Grade 3 & 4 Pressure Ulcers	N/A	0	0	1	3	2	3	2	1	0	1	1	2	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.00	0.00	0.04	0.12	0.09	0.12	0.09	0.04	0.00	0.04	0.04	0.08	
Number of overdue CAS Alerts	0	1	1	1	1	1	1	1	1	0	0	0	0	

Briefing

- No Never Events reported in September, the Trust total remains two, year to date.
- The Trust declared 13 serious incidents in September 2017
- The falls rate has been recalculated to reflect the rate used in national audits and is shown above for the past 12 months. Using this rate we can benchmark ourselves against the rate of 6.6 falls per 1000 bed days that was found in acute hospital settings by the *National Audit of Inpatient Falls (2015), Royal College of Physicians.* Our falls rate has been lower than that found by the RCP for the past 12 months.

Actions: The three serious incidents where medication was a significant factor have all had, or are having, a full investigation and will have actions plans designed to prevent recurrence.

Infection Control

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

Briefing

- There was one patient reported who suffered with a hospital acquired Clostridium Difficile Infection in September.
- C Diff threshold for 2017/18 remains the same as the previous year at 31 cases. Four incidents were reported in August one of which has been downgraded. There have been nine cases year to date.
- Root cause analysis is undertaken for each case to ensure that any opportunities for learning are captured and appropriate actions taken to prevent similar avoidable infections in the future
- There were zero patients who acquired an MRSA Bacteraemia in September. The Trust year to date total remains at four.

Actions:

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

Mortality and Readmissions

Indicator Description	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	88.9	84.1	84.1	84.1	83.3	82.5	83.5	81.3	81.3	79.7	81.1	80.6	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	86.6	84.2	82.4	82.4	81.1	79.2	80.1	78.2	78.2	81.3	77.4	77.2	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	94.4	92	86.7	86.7	86.8	84.0	86.0	83.5	83.0	76.0	81.8	81.2	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.9	0.9	0.88	0.88	0.88	0.86	0.86	0.86	0.84	0.84	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell	TBC	9.1%	9.3%	9.8%	8.9%	10.2%	9.3%	9.5%	9.7%	9.7%	8.9%	8.8%	8.4%	

Briefing

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

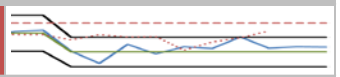
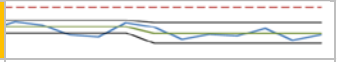
Maternity

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

Indicator Description	Threshold	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
C Section Rate - Emergency and Non Elective	28%	26.8%	26.1%	28.4%	28.8%	29.6%	34.1%	29.9%	29.1%	24.6%	29.5%	24.9%	30.2%	
Admission of full term babies to neo-natal care		13	1	2	2	7	2	11	2	16	21	20	15	

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

Emergency Flow

Indicator Description	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
4 Hour Operating Standard	95%	93.21%	93.50%	89.14%	86.63%	90.59%	89.09%	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	1	0	1	0	0	1	0	0	0	0	
Ambulance Turnaround - % under 15 minutes	100%	52.1%	53.8%	49.9%	46.9%	52.4%	50.2%	46.0%	48.4%	51.9%	48.9%	50.5%	50.9%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	43.8%	43.2%	39.7%	38.9%	42.5%	43.4%	43.7%	45.3%	47.5%	46.4%	47.0%	46.5%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	40	48	76	81	37	53	79	72	71	53	84	71	
Ambulance Turnaround - % under 30 minutes	100%	98.2%	97.8%	96.6%	96.4%	98.1%	97.6%	96.1%	96.7%	96.5%	97.4%	96.0%	96.6%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	90.8%	90.1%	86.7%	85.4%	90.3%	90.7%	91.8%	92.3%	93.3%	93.2%	93.1%	92.2%	
Ambulance Turnaround - number over 60 minutes	0	0	0	0	0	0	0	0	1	0	0	1	0	

Briefing

- The Four Hour Operating Standard was not achieved in September reporting a performance of 90.03%. This was also below the improvement trajectory agreed with NHSI.
- Ambulance turnaround performance has recently been stable however performance increased in the month of September within the Trust, and both 15 and 30 minute handover times remain higher than the London average.
- Much work is underway to further improve patient flow (expanding space for ambulatory care) and thus improve patient safety and experience and improve our ability to deliver performance.
- A four hour operating standard remedial action plan has been drafted covering the root causes of performance shortfalls to expectation.

Actions

- Weekly “Communications Cell” in place to review the previous week’s performance and share lessons learned and agree actions.
- Daily forward look of staffing levels to ensure clinical staffing best matches time of attendances.
- A key action is to review ambulance handover processes to reduce delays in handover.
- The unplanned and admitted patient care programme led by divisional chair for Medicine and Cardiothoracic Division supported by clinicians throughout the Trust has been launched with the aim of providing patients with alternatives to emergency admission and of accelerating discharge to reduce overall bed occupancy.
- SAFER bundle is being rolled out to improve patient safety and remove non added value delays in the inpatient journey.

Cancer

Indicator Description	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend (12 months)
Cancer 14 Day Standard	93%	93.2%	85.7%	93.3%	87.9%	87.9%	86.0%	75.4%	76.6%	67.4%	80.3%	89.7%	93.98%	
Cancer 14 Day Standard Breast Symptomatic	93%	98.9%	94.8%	93.2%	94.0%	93.4%	87.2%	82.7%	84.1%	62.9%	86.9%	90.3%	98.2%	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	98.8%	96.0%	96.0%	95.1%	100.0%	94.6%	96.4%	95.9%	94.2%	90.9%	95.8%	82.4%	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	98.4%	100.0%	100%	99%	100%	100%	100%	100%	100%	100%	100%	
Cancer 31 Day Diagnosis to Treatment	96%	97.2%	96.9%	96.6%	96.4%	97.5%	96.7%	96.4%	96.4%	96.8%	96.9%	96.2%	96.2%	
Cancer 62 Day Referral to Treatment Standard	85%	88.8%	80.0%	85.2%	87.7%	86.6%	86.3%	89.0%	87.3%	85.4%	77.8%	75.6%	76.7%	
Cancer 62 Day Referral to Treatment Screening	90%	96.2%	92.7%	92.7%	93.0%	96.2%	92.6%	92.7%	92.4%	92.5%	86.1%	92.5%	93.0%	
Cancer 62 Day Consultant Upgrade	85%	92.6%	87.5%	97.1%	100.0%	97.7%	85.7%	88.9%	100.0%	100.0%	100.0%	66.7%	100.0%	

- In September the trust met 6 of the 8 standards, with non-compliance against the 31 Day Surgery and 62 Day treatment standard. The national standard to see all suspected cancer patients within 14 days of referral was achieved in September, reporting 93.98% for the14 day standard and 98.2% for Breast symptomatic, the highest seen in the last 6 months. Data by tumour type for September will be available in next month report. Increased leadership and management support given to Two Week Rule office has increased performance against both 7 day booking and contact with patients within 48 hours.
- There has previously been significant capacity shortfall in Urology and Lower Gastrointestinal, the later seeing a 31% increase in referrals within the last 3 months, additional capacity was provided and backlog cleared within the first 2 weeks of August.
- The 62 day standard was also below target reporting 76.7% for the month an improvement on last months performance.
- In September the number of patients waiting greater than 62 days on the patient tracking list (PTL) has seen a significant reduction as well as a reduction in those patients waiting more than 104 days.

Actions

- Increased leadership and management support given to Two Week Wait office. Additional staff from central booking office provided to help clear backlog.
- Fine Needle Aspiration Procedure (FNA) capacity issue raised with commissioners to identify a system wide solution to identify local health system solution to support Croydon.
- To increase number of patients treated in September to help achieve recovery within 62 day performance

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Brain	93%	100.0%	100.0%	85.7%	100.0%	66.7%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%
Breast	93%	98.6%	96.1%	95.1%	93.0%	96.1%	89.9%	92.3%	88.7%	84.7%	69.5%	76.4%	93.4%
Childrens	93%	100.0%	100.0%	55.6%	100.0%	100.0%	100.0%	90.0%	66.7%	80.0%	66.7%	80.0%	100.0%
Gynaecology	93%	93.3%	89.8%	93.0%	95.7%	76.0%	75.4%	87.1%	64.6%	66.7%	75.6%	93.4%	90.4%
Haematology	93%	96.3%	95.2%	90.9%	100.0%	100.0%	100.0%	95.8%	76.2%	96.9%	76.9%	95.7%	100.0%
Head & Neck	93%	94.5%	95.4%	96.3%	95.9%	98.4%	97.4%	97.9%	90.9%	84.9%	82.4%	88.0%	82.4%
Lower Gastrointestinal	93%	95.3%	94.4%	93.6%	98.3%	95.7%	95.7%	90.5%	75.1%	90.7%	44.4%	60.0%	73.9%
Lung	93%	100.0%	97.9%	94.9%	100.0%	98.2%	100.0%	100.0%	96.2%	91.1%	91.2%	95.6%	100.0%
Skin	93%	92.1%	86.3%	59.8%	79.4%	67.1%	67.7%	57.4%	29.4%	48.1%	26.9%	74.3%	96.6%
Upper Gastrointestinal	93%	87.9%	100.0%	98.6%	96.6%	87.8%	95.3%	94.2%	88.8%	96.1%	93.8%	97.6%	98.8%
Urology	93%	90.5%	95.8%	96.3%	96.9%	98.1%	95.0%	98.4%	96.1%	90.1%	82.3%	93.8%	97.0%

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Brain	85%	-	100.0%	100.0%	-	-	-	100.0%	50.0%	-	0.0%	100.0%	0.0%
Breast	85%	100.0%	100.0%	100.0%	86.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%
Childrens	85%	-	-	-	-	-	100.0%	-	-	-	-	-	0.0%
Gynaecology	85%	60.0%	100.0%	80.0%	92.3%	100.0%	100.0%	50.0%	100.0%	90.9%	100.0%	61.5%	100.0%
Haematology	85%	87.5%	100.0%	100.0%	70.0%	80.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Head & Neck	85%	80.0%	85.7%	50.0%	100.0%	63.6%	72.7%	75.0%	58.3%	85.7%	46.2%	66.7%	71.4%
Lower Gastrointestinal	85%	83.3%	83.3%	66.7%	93.3%	76.5%	66.7%	71.4%	-	62.5%	100.0%	60.0%	100.0%
Lung	85%	100.0%	69.6%	68.8%	66.7%	80.0%	78.6%	73.7%	85.7%	85.7%	64.3%	41.7%	47.4%
Skin	85%	96.8%	92.3%	80.0%	100.0%	100.0%	95.5%	100.0%	93.3%	96.4%	95.7%	100.0%	76.5%
Upper Gastrointestinal	85%	100.0%	66.7%	85.7%	100.0%	50.0%	11.1%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%
Urology	85%	81.3%	93.5%	72.7%	70.4%	85.2%	87.9%	83.9%	90.0%	67.9%	81.8%	63.0%	64.3%

Diagnostics

Indicator Description	Threshold	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
6 Week Diagnostic Performance	1%	0.8%	0.7%	2.2%	5.1%	2.8%	2.9%	4.1%	3.3%	2.6%	2.7%	2.0%	1.4%	
6 Week Diagnostic Breaches	N/A	57	50	151	372	219	222	313	248	197	190	158	102	
6 Week Diagnostic Waiting List Size	N/A	6,834	6,878	6,906	7,358	7,871	7,678	7,559	7,443	7,584	6,989	7,766	7,243	

Indicator Description	Threshold	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
MRI	1%	1.0%	1.1%	1.7%	9.6%	4.3%	3.3%	2.6%	1.1%	0.6%	0.8%	0.2%	0.1%	
CT	1%	0.0%	0.0%	0.1%	0.6%	0.0%	0.7%	1.5%	0.5%	0.2%	0.2%	0.3%	1.2%	
Non Obstetric Ultrasound	1%	0.0%	0.1%	1.0%	3.0%	1.9%	3.0%	4.0%	2.5%	0.3%	1.1%	0.9%	0.0%	
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Audiology Assessments	1%	0.0%	0.0%	0.0%	0.0%	4.5%	2.5%	6.5%	10.1%	11.3%	4.6%	5.7%	4.5%	
Echocardiography	1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%	1.2%	9.4%	2.0%	3.0%	0.3%	0.3%	
Electrophysiology	1%	25.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	75.0%	75.0%	100.0%	0.0%	
Peripheral Neorophys	1%	1.2%	2.6%	0.4%	0.5%	0.0%	0.5%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	
Sleep Studies	1%													
Urodynamics	1%	47.1%	80.0%	15.4%	0.0%	52.6%	55.0%	65.5%	75.6%	64.4%	64.2%	50.6%	37.0%	
Colonoscopy	1%	2.3%	1.4%	3.6%	20.2%	5.7%	8.7%	5.7%	4.7%	0.5%	1.8%	0.0%	0.4%	
Flexi Sigmoidoscopy	1%	5.3%	0.0%	10.5%	20.8%	12.0%	8.4%	6.7%	0.0%	1.1%	4.9%	0.7%	1.5%	
Cystoscopy	1%	2.8%	10.6%	28.3%	14.4%	9.9%	2.6%	15.0%	11.5%	24.4%	14.0%	12.3%	14.7%	
Gastroscopy	1%	4.0%	0.9%	7.2%	10.1%	3.2%	4.5%	12.7%	10.0%	9.2%	11.2%	6.7%	0.8%	

Briefing: In September 1.4% of our patients were waiting greater than 6 weeks for a diagnostic procedure against a standard of 1% reporting in total 102 breaches, reducing by 35% compared to August. Patients waiting beyond 6 weeks remain largely within Audiology, Cystoscopy and Urodynamic where recovery plans are in place.

Actions

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

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
Number of on the Day Cancellations		52	103	60	104	91	63	65	47	56	84	54	49	
Number of on the Day cancellations re-booked within 28 Days		49	88	45	92	89	56	61	45	52	70	43	43	
% of Patients re-booked within 28 Days	100%	94.2%	85.4%	75.0%	88.5%	97.8%	88.9%	93.8%	95.7%	92.9%	83.3%	79.6%	87.8%	

Briefing

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

Actions

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

Patient Experience

Patient Voice

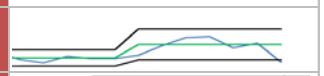
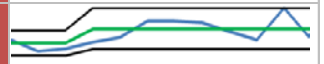
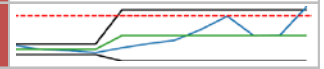
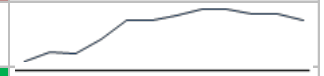
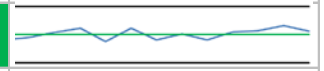
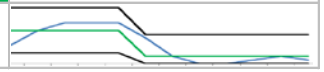
Indicator Description	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
Emergency Department FFT - % positive responses	90%	83.1%	86.6%	84.4%	82.3%	85.0%	86.3%	82.8%	85.2%	83.0%	85.2%	83.9%	85.9%	83.5%	
Inpatient FFT - % positive responses	95%	94.4%	95.4%	97.5%	95.9%	96.2%	96.9%	96.7%	95.8%	97.3%	96.0%	96.6%	96.8%	96.5%	
Maternity FFT - Antenatal - % positive responses	90%	No Responses						100%		85.7%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	95.0%	93.0%	100%	87.0%	89.0%	93.0%	97.0%	88.2%	100.0%	100.0%	95.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	96.0%	92.0%	95.0%	95.0%	95.0%	93.0%	90.0%	94.1%	97.9%	95.4%	87.1%	96.4%	100.0%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	93.0%	100%	100%	100%	100.0%	100%	100%	100%	100%	100%	98%	100%	
Community FFT - % positive responses	90%	93.2%	88.2%	96.5%	94.7%	96.6%	96.2%	93.0%	93.0%	97.6%	96.3%	94.5%	98.3%	94.1%	
Outpatient FFT - % positive responses	90%	86.9%	87.6%	94.9%	92.3%	94.8%	91.7%	88.1%	92.6%	95.6%	96.6%	94.2%	96.2%	94.4%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints		91	67	92	56	85	73	79	63	76	75	61	99	82	

- ED Friends and Family Test (FFT) – The score has decreased slightly in September reporting 83.5% meaning that the percentage of patients recommending the service decreased. However the percentage has remained stable and compared to our London peers our response rate is one of the best in London.
- Maternity FFT – The score for maternity care are above local threshold and work to increase the number of patients responding continues, Significant improvements were made with the percentage of patients responding increasing by 22.41% in July and again in August, however in September the score has fallen.
- Following a spike in August the number of patient complaints has come down to 82 in the month of September.

Actions: The ED management team are reviewing the results from the FFT survey for the last quarter to determine any further themes for improvement, an example being to review of staffing model to ensure response nurse available to support high volume periods and minimise delays for patients. Complaints: To improve the timeliness and quality of complaint responses new time frames for responses are being introduced from the beginning of November. The time frames will reflect the complexity of the issues to be investigated and are consistent, for the most serious complaints, with the investigation of a serious incident. Reporting against these timeframes will start in January 2018 and is part of a programme of work on improving complaints management in the Quality Improvement Plan (QIP).

St George's University Hospitals NHS
NHS Foundation Trust

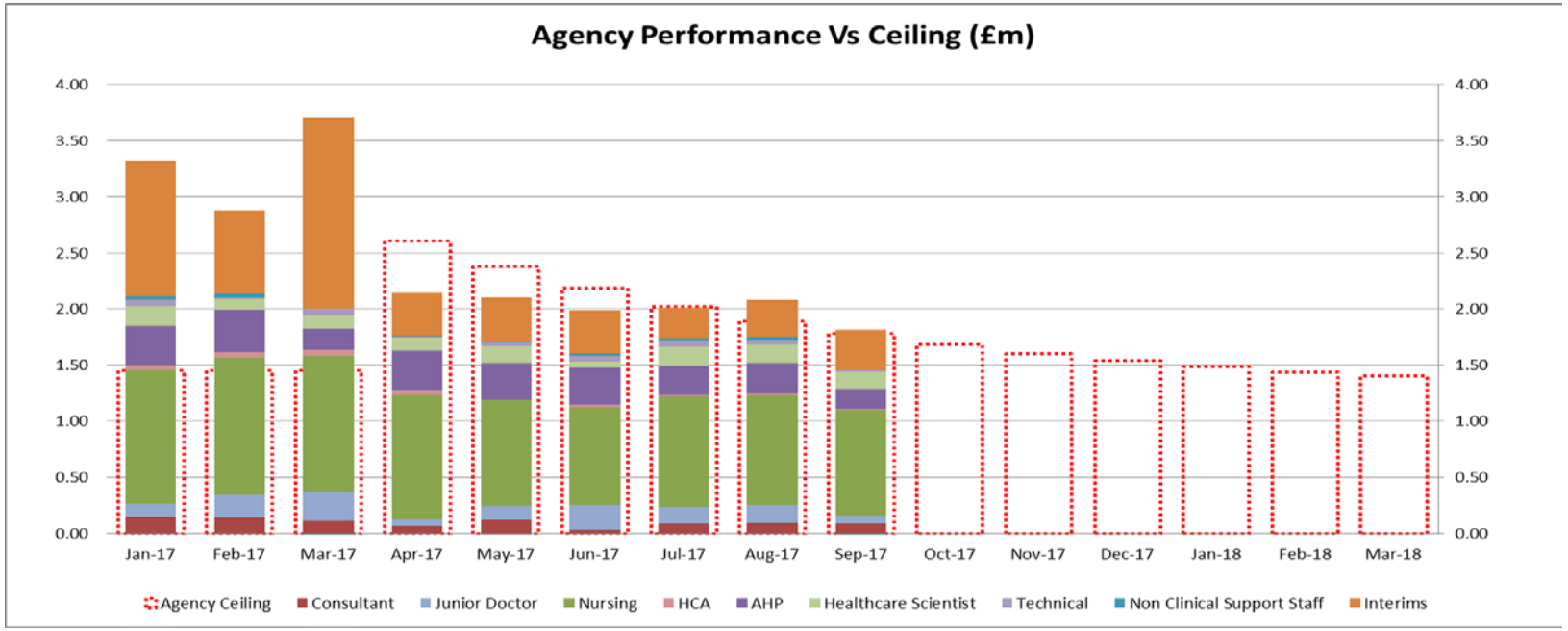
Workforce

Indicator Description	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
Trust Level Sickness Rate	3%	3.6%	3.8%	3.7%	4.2%	3.8%	3.3%	3.2%	3.4%	3.4%	3.6%	3.7%	3.6%	
Trust Vacancy Rate	10%	15.0%	14.7%	15.3%	15.1%	15.1%	15.4%	16.3%	17.0%	17.1%	16.1%	16.5%	14.8%	
Trust Turnover Rate* Excludes Junior Doctors	10%	18.5%	18.0%	18.1%	18.4%	18.5%	19.1%	19.1%	19.1%	18.8%	18.4%	19.6%	18.5%	
Total Funded Establishment		9,782.73	9,788.42	9,804.22	9,856.56	9,834.97	9,798.10	9,784.10	9,924.93	9,947.77	9,878.79	9,855.40	9,794.00	
IPR Appraisal Rate - Medical Staff	90%	82.2%	80.5%	76.0%	79.2%	81.3%	77.3%	82.4%	82.0%	74.2%	84.8%	79.0%	74.0%	
IPR Appraisal Rate - Non Medical Staff	90%	66.2%	65.6%	64.1%	67.5%	70.4%	72.8%	80.3%	78.2%	76.1%	76.1%	75.1%	79.4%	
% of Staff who have completed MAST training (in the last 12 months)		78.3%	80.0%	79.7%	81.9%	85.0%	85.0%	85.9%	87.0%	87.0%	86.0%	86.0%	85.0%	
Ward Staffing Unfilled Duty Hours	10%	5.1%	5.7%	6.2%	4.6%	6.2%	4.8%	5.5%	4.8%	5.8%	5.9%	6.5%	5.9%	
Safe Staffing Alerts	0	9	11	11	11	7	2	0	0	1	2	1	0	

Briefing

- Funded Establishment decreased by 61.4 WTE to 9,794 WTE in September
- Vacancy Rate decreased from 16.5% to 14.8%
- Sickness has decreased to 3.6% compared to 3.7% in the month previous
- Mandatory and Statutory Training figures for September were recorded at 85%
- Appraisal rates remain below target, both Medical and Non Medical. Non medical appraisal rate increased in September with performance of 79.4% and shows an on-going improvement on last year.

Agency Use



Briefing

- The Trust's annual agency spend target set by NHSI is £24.5m. There is an internal annual agency target of £22.0m. For September, the monthly target set was £1.78m.
- Total agency cost in September was £1.81m or 4.5% of the total pay costs. From M1-5 2017/18, the average agency cost was 5.1% of total pay costs.
- Agency cost decreased by £0.16m compared to August. In 2017/18 YTD, the Trust has performed better than the planned target by £0.74m.
- In September, there has mainly been decreases in AHP (£0.10m), Junior Doctor (£0.09m), Nursing (£0.04m) and Non Clinical (£0.03m), offset by an increase in Interims (£0.03m).
- The biggest area of overspend was in Healthcare Scientist, which breached the target by £0.07m.
- These figures are compared to the internal target of £22.0m.

Meeting Title:	Trust Board - Public		
Date:	9 November 2017	**Agenda No.**	4.2
Report Title:	Elective Care Recovery Programme (ERCP) – Action Plan		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Barry Mulholland Elective Care Recovery Programme Director		
Executive Summary:	**The ERCP Action Plan** 1. The Board is asked to note that the Trust's Quality and Safety Committee received a detailed report on the ERCP in October 2017 where progress with developing the action plan in this paper was discussed. The purpose of bringing this paper to Board is to ensure that the Trust has the right structure and action plan in place to deliver this high priority programme. 2. Since September 2017, the ERCP Director has been tasked with refreshing the programme to ensure that the Trust is able to meet all its obligations against the referral to treatment, cancer and diagnostic access targets in due course. Please refer to the programme governance structure for how the workstreams' have been organised and the leadership roles within it. 3. The ERCP has three key workstreams running in parallel across the Tooting (St George's) and Roehampton (Queen Mary's) sites. They are as follows: • Treating patients • Return to reporting patients on a referral to treatment pathway (i.e. 92% of patients should be seen and treated within 18 weeks of first referral). • Technology and training (to make sure the Trust uses its clinical IT systems correctly, every time for the effective delivery of patient care). 4. The ERCP has two further workstreams associated with elective care. They are in Cancer and Diagnostics. 5. Each workstream is supported by the need to provide clear communications and engagement with our patients', GP's, staff and other stakeholders. 6. Please refer to the 'ERCP Milestone Plan' (appendix 1) which provides a timeline of the all the workstream key actions up to March 2018 on a page. Please note that there are a number of acronyms in the milestone plan which will not be easy to understand. The purpose of providing this plan as part of the paper is to give the Trust Board oversight of all actions required in what order before March 2018. Of particular note, is the action to deploy the Cerner Iclip system onto the Roehampton (Queen Mary's) site.		

	Key actions underway as part of the ERCP milestone plan 1. The Trust plan is to move to a new single, improved patient tracking list (vital to track patients on their clinical pathway in the Trust) is on track to be delivered in December 2017. 2. As referenced in the Chief Executive's report to Trust Board, continued good progress is being made to 'validate' patients on both the Tooting and Roehampton current patient tracking lists who may require a further appointment with the Trust. This second phase of validation work is due to complete in February 2018. The Board is reminded that the first phase of validation work was completed earlier this year has formally been signed off by the Trust Executive. 3. The Trust has successfully introduced an improved 'Clinical Decision Outcome Forms (CDOF)' in 6 care groups with an average of 96% completion rate. This is vitally important to ensure that the Trust continues to 'track' patients safely through their clinical pathways. The plan to roll-out to all the other specialties in the Trust by the 12 February 2018.
Recommendation:	The Trust Board is asked to note the updated action plan to deliver the elective care recovery programme.
Supports	
Trust Strategic Objective:	1. To deliver the Trust's transformation programme in order to meet its operational and financial obligations to its patients. 2. To ensure the Trust has an unwavering focus on all measures of quality, safety and patient experience.
CQC Theme:	Well led, Safe, Effective
Single Oversight Framework Theme:	Operational performance
Implications	
Risks:	1) Continued increased risk of patients coming to harm as a consequence of waiting in excess of 18 weeks for treatment. 2) Return to reporting against the national referral to treatment standard will be delayed with an increased loss of income as the length of time the Trust is fined for non-reporting is extended. 3) Continued reputational damage to the Trust from patients, GP's and other partner organisations in not being able to deliver a safe and timely clinical service against the referral to treatment standard.
Legal/Regulatory:	1) Delivery of the programme will support the Trust returning to reporting of the RTT standard which is a requirement of the NHS constitution 2) Delivery of the programme will help address issues raised in the CQC inspection.
Resources:	The Trust has an established budget and workforce plan for the delivery of the ERCP
Previously Considered by:	Executive Management Team Meeting Safety and Quality Committee — **Date**: October 2017
Appendices:	Appendix 1 – ERCP Milestone Plan

Elective Care Recovery Programme (ERCP) – Action Plan

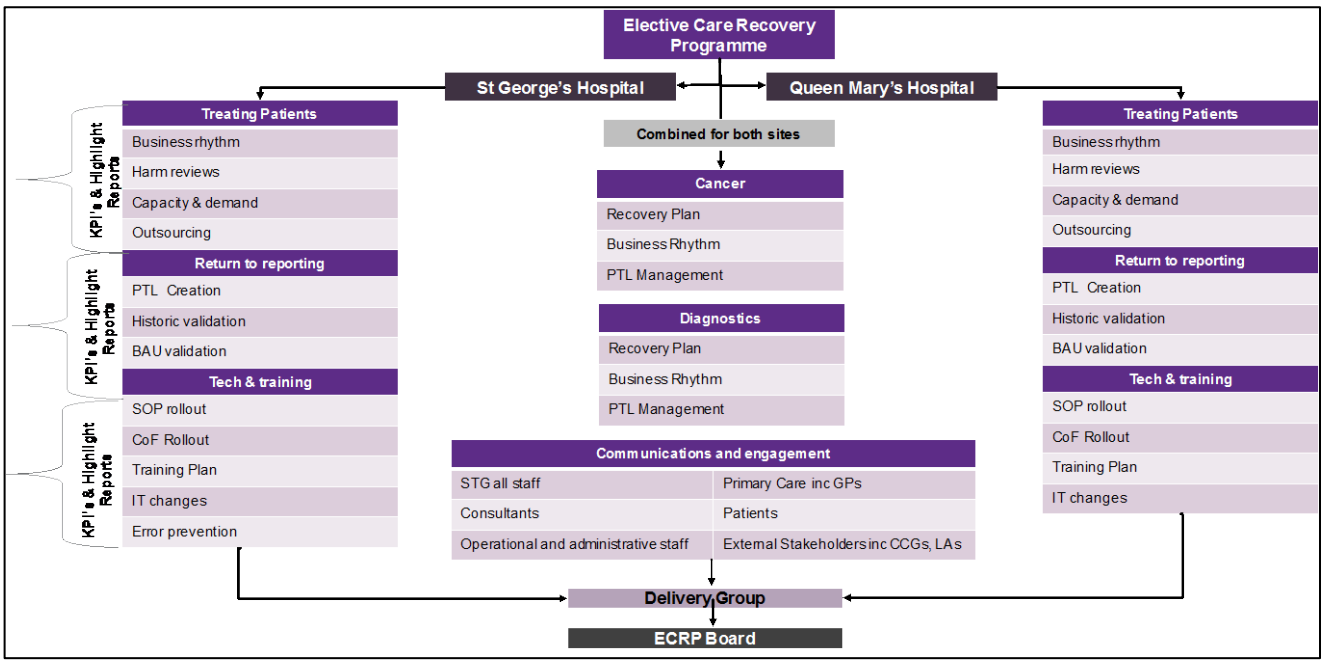
Trust Board - Public
9 November 2017

ERCP Programme Structure

As part of the refresh of the programme plan the Elective Care Recovery Director has restructured the workstreams in order to place greater focus on ensuring patients being referred now to the Trust are being managed appropriately.

In addition to the ERCP structure as listed in the diagram, as below, the Trust's Executive Team receives a monthly status report on the programme. In turn, this same status report is presented to the Trust's Safety and Quality sub-Committee of the Trust Board.

The Board is also asked to note that the Trust attends an alternate week 'oversight' meeting in partnership with our local Commissioners with NHS Improvement and NHS England to outline how the South West London response to the ERCP is being managed.



Clinical Decision Outcome Forms (CDOF)

Rollout of the CDOF has been completed in 6 specialties to date with significant improvements in performance achieved.

Speciality	Baseline Performance	Current Performance	Percentage Improvement
Neurosurgery	70%	89%	19%
Neurology	83%	97%	14%
Chronic Pain	90%	96%	6%
Gynaecology	82%	95%	13%
Gastroenterology	63%	95%	32%
Paediatrics	59%	TBC	TBC

The programme of rollout to all specialties is on track to deliver by February 2018 with the following go-live dates:

9 Care Groups (32%)

Care Group	Go-Live date
Neurology	02/10/2017
Neurosurgery	18/09/2017
Chronic Pain	02/10/2017
Gynaecology	25/09/2017
Gastro & Endoscopy	09/10/2017
Paediatrics Acute	16/10/2017
Paediatrics Specialist	16/10/2017
Paediatrics Neonatal	16/10/2017
Paediatrics Surgery	16/10/2017

10 Care Groups (34%)

Care Group	Go-Live date
ENT & Audiology	06/11/2017
Dermatology & Lymphoedema	13/11/2017
Trauma & Orthopaedics	20/11/2017
General Surgery	27/11/2017
Urology	04/12/2017
Cardiology	11/12/2017
Chest Medicine	11/12/2017
Cardiac Surgery	18/12/2017
Thoracic Surgery	18/12/2017

10 Care Groups (34%)

Care Group	Go-Live date
Vascular Surgery	15/01/2018
Haematology	15/01/2018
Oncology & Palliative	22/01/2018
Renal	22/01/2018
Clinical Infection Unit	29/01/2018
Diabetes & Endocrinology	29/01/2018
Rheumatology Care Group	05/02/2018
Dentistry	05/02/2018
Maxillofacial	12/02/2018
Plastic Surgery	12/02/2018

ERCP Priorities for Delivery in 2017/18

- Development of capacity plans across services to support reductions in waits for new appointments. (Ongoing)
- Recruit substantively into the programme in order to deliver objectives and reduce dependency on external support. (December 2017/January 2018).
- Increase the number of patients operated on through the Trust's Theatres to treat more patients who have already waited more than 18 weeks for their first treatment.
- Scale the Trust's ability to review large number of follow-up patients virtually / over the phone. (November 2017)
- Develop and train against the highest priority standard operating procedures to make sure that all our staff use the IT clinical systems effectively and in the interests of excellent patient care.(From November 2017)
- Move to electronic outcome recording for every patient seen. (Quarter 4 2017/18)
- Create new waiting lists that track all patients correctly. (December 2017)
- Roll-out of a new patient administration system at QMH. (Planning for this deployment has started)
- Continue to clean historic data through validation. (February 2018)

- **RECOMMENDATION**

The Trust Board is asked to note the updated action plan to deliver the elective care recovery programme.

Author: Barry Mulholland
Elective Care Recovery Programme Director

Date: **3 November 2017**

DRAFT

St George's and Queen Mary's Hospital Elective Care Recovery Programme Plan

Version 1.3.1 (updated 02 November 2017)

DRAFT

Delivery Status:

Backwards Look: Missed 01/01 | Complete 01/01

Forwards Look: Not Commenced 01/01 | Recovery Action in Place 01/01 | On Schedule 01/01 | Date Assumed TBC

Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18

Programme

- Project weekly meetings commenced 02/10
- Draft programme plan base-lined 13/10
- Draft programme plan on a page available 23/10
- First programme plan submission to NHSI 29/09
- Delivery Group initaited 26/10
- 27/10 Programme Governance agreed

Communications

- MD newsletter article CDOF 14/09
- CDOF - All Outpatients staff briefing note 12/09
- 12/09
- Better data safer patients campaign launch (posters in all staff areas)
- eG STG all-staff CDOF Update 26/10
- MD newsletter ECRP General Update 16/11
- E Learning go live campaign by Service Launched 13/12
- Full Patient reminder card rolled out commenced 01/12
- eG STG RTT backlog article published 07/12
- eG STG all-staff CDOF Update 30/11
- MD newsletter CDOF Update TBC
- STG all-staff ECRP Update 09/02
- Patient reminder card rolled out complete 19/01
- eG STG all-staff CDOF Update 28/12
- eG STG all-staff CDOF Update 25/01
- eG STG all-staff CDOF Update 22/02
- E Learning campaign end TBC
- MD newsletter CDOF Update TBC

St George's Hospital

Treating Patients

Backlog and Waiting list Management

- 30/11 Identify opportunities for outsourcing where internal capacity is insufficient to meet demand
- 31/12 Development of a trajectory to reduce the number of patients waiting over 52 weeks on Trust PTL
- 31/12 Profile review of PTL to determine specialities with potential capacity issues for initial RTT Backlog Recovery
- Implement best practise for waiting list management and patient tracking 31/03
- Review of Booking and Scheduling for First Appointments to support RTT Recovery 31/03

Harm Reviews

- 15/11 Revised Dashboard implemented
- 01/12 BAU process for CH implemented

Return to Reporting

PTL Creation

- Review Cohorting Rules 17/10
- Install PMM for Development 20/10
- 'Live feed' between Cerner PAS and Cymbio PMM 20/10
- Draft design of PTLs in PMM 24/10
- PMM data model updated & daily feed setup 24/10
- SQL view available to Cymbio 27/10
- Create PTL Specification 03/11
- Soliton view for Cymbio 10/11
- Review PMM PTLS Views 18/11
- Produce Initial Dataset 24/11
- Build PTL Views for the 5 PTLs 24/11
- Configure PMM 25/11
- 01/12 Reconcile Current PTLs with the New PTL
- 01/12 Testing: Transfer to live data feed
- 31/12 Live data monitoring and testing
- 31/12 Testing of reports and SQL views
- Operational Test to new PTL to ensure that it is robust 31/03

Historic Validation

- Weekly contract meeting in place 09/10
- Phase 2 Cerner system correction protocol 25/10
- Mobilisation of agreed approach to book patients requiring an appointment TBC
- 10/11 Confirmation and prioritisation of validation cohorts for Phase 2
- Weekly operational meeting with Trust & Cymbio 31/12
- 27/10 Establish Phase 2 metrics
- Quality assurance of Phase 2 validation 31/12
- 31/10 Identification of patients requiring appointments following validation

BAU Validation

- Validation of Trust PTL to 40 weeks 08/10
- BAU Validation of Trust PTL TBC
- Reduce unknown clock starts to an average of 9,000 across the non-admitted pathways 31/12
- Development and implementation of an accurate and robust Incomplete Pathways PTL 31/03
- Validated pathway information updated on Cerner 31/03
- Review of pathways with 52 week breach dates between 25/11/2017 and 31/03/2018 31/03
- Review of pathways waiting 18 to 25 weeks TBC
- RTT Validation Team Recruited 31/03
- Planned Waiting List Validation & Management 31/03
- Management of Nullified Pathways TBC
- Assurance of Cerner RTT pathway accuracy TBC

Technology and Training

SOP Rollout

- Development of 5 high priority SOPs 26/10
- Develop SOP matrix 15/11
- Purchase of SOP database of 200+ SOPs 30/11
- 30/11 Finilise approach for Roll out of the 5 SOPs
- 29/12 Establishment of SOP lead
- 29/12 SOP Sign-off committee established and held
- 29/12 SOP Database and version control in place
- All SOPs finalised by working group 31/03
- Rollout of all SOPs 31/03

CDOF Rollout

- Training complete (phase 1) 13/10
- Operational Preparedness Checklist (phase 1) 13/10
- Go live (phase 1) 16/10
- Phase 2a Rollout Planning
- CDOF project handover (phase 1) 03/11
- Lessons learned (phase 1) 27/10
- Go live gate review (phase 2a) 13/12
- Training complete (phase 2a) 15/12
- Operational Preparedness Checklist (phase 2a) 15/12
- Go live (phase 2a) 18/12
- CDOF project handover (phase 2a) 08/01
- Training complete (phase 2b) 09/02
- Operational Preparedness Checklist (phase 2b) 05/02
- Go live gate review (2b) 09/02
- 12/02 Go live (phase 2a)
- CDOF project handover (phase 2a) 05/03

Training Plan

- BAU training resources identified and scheduled to deliver required training across the project 22/11
- Patient Pathway Management (PPM) project training delivery TBC
- 13/12 NHSi RTT e-modules available for delivery
- 11/01 A Trust wide BAU Training strategy to be designed
- 29/12 All NHSi e-modules to be completed by staff

Error Prevantion

- Pre-Reg Override Locked Down 31/12
- Orphaned Encounters validated 31/12
- Ensure all appointments are outcome at end of clinic (DNA or Checked Out) and linked to 18w pathway 31/12
- Clock Start populated for all Internal Referrals (UCS) 31/12
- Incorrect booking workflows locked down 31/12
- 31/01 Request List Used for F/Up monitoring

Queen Mary's Hospital

Treating Patients

Business Rhythm

- Letter backlog reduced by 25% 13/10
- Reporting line to non-SGH providers fully established 18/10
- Letter backlog reduced by 25% 27/10
- Letter backlog reduced by 25% 10/11
- 14/11 Tracking mechanism in place providing assurance that operational processes are robust
- 17/11 Letter backlog reduction addressed
- 15/12 Reporting line to EC Access Committee fully established and functioning
- 07/12 Service Manager capacity gap filled

Harm Reviews

- BAU process for CH implemented 08/10
- 14/10 Quality assurance process revised to review Clinical Harm Assessment forms
- Revised Dashboard implemented 15/11
- 31/11 Monthly reporting and learning process implemented

Capacity and Demand

- Agreed approach to the management of long wait patients TBC
- Assessment of base-line capacity at QMH complete 10/11
- Recruitment assessment of Consultants/medical staff/nurses and agreement of waiting list initiatives TBC
- Agree joined up demand management programme with Commissioners TBC
- Sustainable capacity plans in place (repeated for each specialty as required) TBC
- Identify efficiency opportunities 31/03

Outsourcing

- Develop outsourcing resource requirements 31/12
- Funding agreement with Commissioners TBC
- Establish outsourcing team if required, across SGH & QMH TBC
- Implement outsourcing strategy TBC

Return to Reporting

PTL Creation

- Design of Cymbio PMM database confirmed 09/10
- 'Live feed' between Clinicom PAS and Cymbio PMM established 11/10
- Training of use of PMM database & PTL views 23/11
- Build of Cymbio database complete 24/11
- Migration of data into PMM database 26/11
- 04/12 Release of PTLs for operational use

Historic Validation

- 04/10 Release of PTLs for operational use
- Contract extension signed 06/10
- Mobilisation plan delivered 06/10
- Weekly contract meeting in place 06/10
- Agree approach TBC
- Approach to conclude validation of records where Cymbio outcome requires an appointment agreed TBC
- Mobilisation of agreed approach TBC

BAU Validation

- Validation cohorts agreed and prioritised 04/10
- Weekly validation established 06/10
- Validation team leader recruited and in post 11/12
- BAU team established and in place 11/12
- Validation complete 01/02

Technology and Training

SOP Rollout

- Roll out of Booking and Scheduling SOP 01/11
- Roll out of Clinic Cashing Up SOP 01/11
- Roll out of Referral Triage SOP 01/11
- 14/11 Roll out of Episode Management SOP

CDOF Rollout

- Relaunch Clinic Outcome Forms at QMH 06/11

Training Plan

Dual Site

IT

- Obtain approval to proceed with Cerner 13/11
- Stand up project team 14/11
- Preparation for replacement of current Clinicom PAS with Cerner iCLIP 09/03

Cancer

Operational

- Revised PTL Assurance meeting implemented 16/10
- Cancer Performance Meetings revised 30/11
- Integration of TWR into Central Booking Service 30/11
- 31/12 Data Quality improved within Infoflex system
- 31/12 Daily tracking process of cancer patients refined
- 31/12 MDT (Live recording) reviewed and improved
- Pathway reviews of key tumour sites completed 31/03
- Improve 38 day performance to ensure optimal patient pathway timelines are implemented 31/03

QMH

- Baseline of the multi provider relationships at QMH to include a view of the operational, clinical governance and financial position 31/03

Data Feed and Reporting

- Creation of Cancer Dashboard 26/01
- Infoflex/Cerner data feed revised and reviewed 28/02
- 28/02 Decision made for managing Cancer referrals at QMH

Diagnostics

- Removal of invalid exclusion rules 23/11
- Performance Management & Visibility 31/11
- 31/12 Audiology - demand and capacity modelling completed
- Urodynamics - demand and capacity performance improvement 15/01
- 31/01 Endoscopy - demand and capacity modelling to be completed
- All intended patient procedures input with OPCS Code TBC

Currently Here

St George's University Hospitals NHS
NHS Foundation Trust

Report to the Board from: Finance and Performance Committee

Committee Chair: Ann Beasley

Date of Committee Meeting: 25 October 2017

1.0 Matters for the Board's Attention

1.1 The Committee considered the Operational Performance Report, focusing on activity levels compared with the plan agreed with Commissioners. It discussed the steps being taken to improve performance in the Emergency Department, particularly with respect to the 4 hour operating standard and agreed to have a more detailed look into Ambulance Handover performance at its next meeting. A day of care audit of a sample of patients across the Trust had revealed opportunities for more patients to have been discharged, opportunities which were now being pursued.

1.2 The Committee welcomed improvements in the performance against Cancer standards but noted that targets had not yet been reached. It was informed that some issues had come to light in regard to the completeness of reporting under diagnostics, and was assured that these issues were been actively followed up and had been reported to relevant external bodies.

1.3 The Committee did not consider quality elements of the performance report since these were due to be considered by the Quality Committee.

1.4 The Finance Report based on month six outcomes was discussed and the Committee noted that current financial performance was in line with the Trust's internal forecast for year-end deficit but not yet with the position agreed with NHS Improvement. It was reassured by the rigour of the internal reviews and challenges that were being undertaken regularly with each division. The Committee took some comfort from the improved in month pay position and the reduction in the use of agency staff. The Committee furthermore approved the 17 week cash flow forecast and agreed to recommend to the Board approval of the use of the delegated authority for working capital facility loans.

1.5 The Committee welcomed the improved position in regard to Green CIPs as shown in the latest Finance Special Measures report but recognised that the focus needed to move onto planning for 2018/19. In that vein it considered the developing plans for setting budgets for 2018/19 and stressed the importance of reaching an agreed budget position before the start of the new financial year.

1.6 A paper was presented on debt recovery and the Committee acknowledged that this needed to be reviewed regularly. Another paper on Income Data Quality met with some disappointment that faster progress was not being made albeit it was recognised that Commissioners required considerable advance notification before recognising the impact of coding changes.

1.7 Two business cases were submitted for approval by the Committee, one for Moorfield's Ward and Theatre refurbishment and one for replacing a CT scanner in the Emergency Department. The Committee approved them but noted that whilst progress was being made with respect to the presentation of business cases further work was required.

1.8 The Committee welcomed a report on the Finance Development Plan developed by and for staff in the Finance Department and in particular the plans to step up finance training for staff more widely within the Trust.

2.0 Recommendation

2.1 The Board is recommended to receive the update from the FPC on 25 October 2017 for information and assurance.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 November 2017	**Agenda No.**	5.2
Report Title:	Finance Report Month 06 (September 2017)		
Lead Director/ Manager:	Andrew Grimshaw, Chief Finance Officer		
Report Author:	Andrew Grimshaw, Chief Finance Officer		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Trust is reporting a deficit of £38.7m at the end of the September, an adverse variance to plan of £2.8m. While this position is not in line with plan, it is consistent with the current forecast reported to NHS Improvement. Within the position, income is adverse to plan with this being partly offset by expenditure underspends. The Executive Team continue to work to improve the position and move as close to the year-end planned deficit of £45m as possible.		
Recommendation:	The Board is asked to receive the update and confirm agreement on next steps.		
Supports			
Trust Strategic Objective:	We deliver efficient and sustainable services.		
CQC Theme:	Well-led.		
Single Oversight Framework Theme:	Finance and Use of Resources.		
Implications			
Risk:	Financial efficiency, forecasting and accountability is not seen as a priority for service managers or our wider workforce, resulting in overspending, poor budgetary management which could lead to poor service delivery and regulatory action.		
Legal/Regulatory	NHSI Finance and User of Resources Risk Rating.		
Previously Considered by:	Finance & Performance Committee	**Date:**	25.10.17
Appendices:	Month 6 Finance Report		

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 6 (September 2017)

Chief Finance Officer

2nd November 2017.

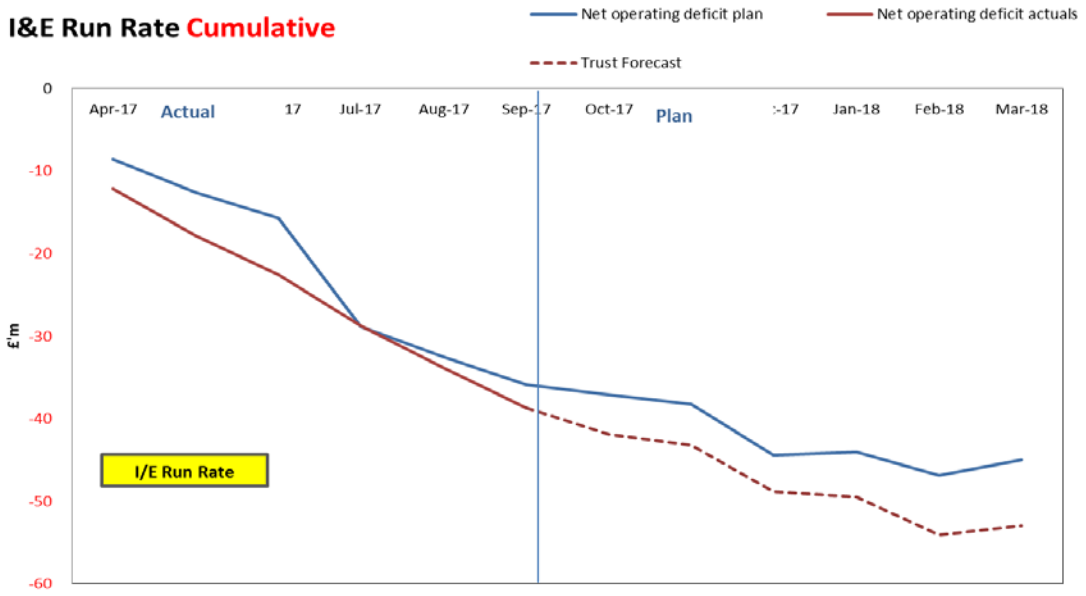
Executive Summary – Month 06 (September)

St George's University Hospitals NHS
NHS Foundation Trust

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £38.7m at the end of the September, an adverse variance to plan of £2.8m. However, the over delivery of CIPs totalling £3.8m is supporting this position. If these CIPs were excluded, the underlying position would be £6.6m adverse to plan. Within the position income is adverse to plan, with this being partly offset by expenditure underspends.	£2.8m Adv to plan	£1.3m Adv to plan
Income	Income is being reported at £8.7m adverse to plan year to date, with an adverse movement in month of £1.5m. Included within the month 6 results are £1.1m of income relating to prior periods. There is a lower than planned income of £3.9m in Elective and Non Elective of £0.9m. Exclusions income is lower by £3.3m, but will be offset by reduced expenditure. Non-SLA income is also under plan by £2.3m as well, although £1.3m of this is also offset.	£8.7m Adv to plan	£7.2m Adv to plan
Expenditure	Expenditure is £5.7m favourable to plan at month 6, £0.1m favourable in month. The majority of the favourable position is in pay, £6.2m YTD with underspends seen in Nursing, Non Clinical and ST&T categories. Non-pay is £0.5m overspent, with the main drivers being IT MSA costs and RTA bad debt provisions.	£5.7m Fav to plan	£5.6m Fav to plan
CIP	The Trust planned to deliver £10.0m of CIPs by the end of September. To date, £13.8m of CIPs have been reported; £5.4m of income actions and £8.4m of expenditure reductions. As noted above, the over delivery of CIPs is supporting the trust's bottom line. If these were excluded then the overall favourable variance from the planned deficit would move to a £6.6m adverse position.	£3.8m Fav to plan	£2.3m Fav to plan
Capital	Capital expenditure of £21.9m has been incurred year to date. This is £0.1m below plan YTD. The capital budget has been formulated on the expectation that the Trust will secure further DH capital funding of approx £8.4m to finance extensive investment in the IT infrastructure. Despite an independent audit recommending approval of £8.4m of this bid, the Trust has not received approval from NHSI. Therefore the Trust is in the process of undertaking a re-forecasting and re-prioritisation exercise to ensure the minimum level of IT capital investment required this year may be accommodated within the original capital budget of £43.9m in the event the bid is not approved.	£0.1m Fav to plan	£0.4m Fav to plan
Cash	At the end of Month 6, the Trust's cash balance was £5.6m, which is better than plan by £2.6m. The Trust borrowed approx.£11m from working capital facilities in M06 and has borrowed £30m YTD which is less than plan. The Trust has received £4.5m borrowing in October and has requested a further approx. £9.6m for November to finance the on-going deficit. These working capital borrowings are subject to an interest rate of 6% because the Trust is in financial special measures.	£2.6m Fav to plan	£3.3m Fav to plan
Financial Risk Rating-Use of Resources (UOR)	At the end of September, the Trust's UOR score was: Capital service cover rating: Plan – 4; Actual – 4 Liquidity rating: Plan – 4; Actual – 4 I&E margin rating: Plan – 4; Actual – 4 Distance from financial plan: Plan – n/a; Actual – 2 Agency rating: Plan – 1; Actual – 1	Overall score 4	Overall score 4

1a. Month 6 Financial Performance

L2	L3 Cat	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	M6 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %	Full Year Budget (£m)
⊟ Income	SLA Income	56.3	54.9	(1.4)	(2.4%)	334.1	327.7	(6.4)	(1.9%)	675.3
	Other Income	9.9	9.8	(0.1)	(1.1%)	58.0	55.7	(2.3)	(4.0%)	116.5
Income Total		66.2	64.7	(1.5)	(2.2%)	392.1	383.4	(8.7)	(2.2%)	791.8
⊟ Expenditure	Pay	(40.5)	(40.4)	0.1	0.4%	(249.4)	(243.3)	6.2	2.5%	(487.8)
	Non Pay	(26.2)	(26.3)	(0.1)	(0.3%)	(161.6)	(162.1)	(0.5)	(0.3%)	(315.0)
Expenditure Total		(66.7)	(66.7)	0.1	0.1%	(411.0)	(405.3)	5.7	1.4%	(802.8)
⊞ Post Ebitda		(2.8)	(2.9)	(0.0)	(0.8%)	(17.0)	(16.8)	0.2	1.5%	(34.0)
Grand Total		(3.4)	(4.8)	(1.4)	(42.7%)	(35.9)	(38.7)	(2.8)	(7.7%)	(45.0)



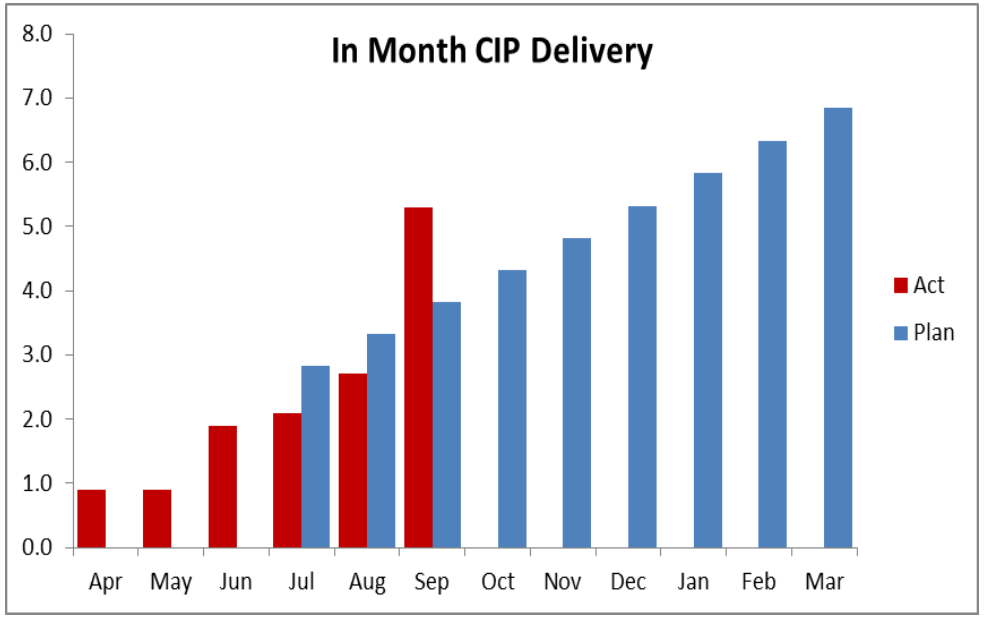
Trust Overview

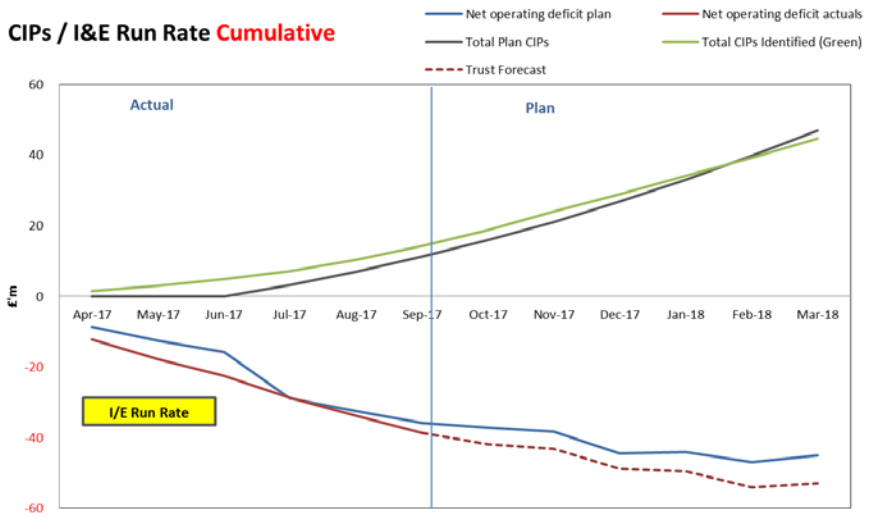
- Overall the Trust is reporting a deficit of £38.7m at the end of Month 06, an adverse variance to plan of £2.8m.
- **Income** is £8.7m adverse to plan. £4.3m of the under recovery of income is directly offset with underspends in expenditure (SLA Pass-through £3.0m, South West London Pathology £1.3m).
- **SLA Income** is £6.4m under plan, owing to shortfalls of £3.0m on pass-through, £3.9m in Elective and £0.9m in Non Elective offset by £1.3m over performance in Outpatients, Beddays and A&E. A £1.1m prior period SLA income catch-up in month is driven by both price of £0.1m and volume of £0.9m.
- **Other income** under plan by £2.3m; with the key drivers being Diagnostics (£1.3m) which is directly offset in SLA income and non-pay, lower than planned private patients income (£0.8m), and an under-performance on direct access pathology income.
- **Pay** is £6.2m favourable, with all major staff groups underspending with the exception of medical pay.
- **Non-pay** is £0.5m overspent, due to higher than planned spend in IT and Estates (£2m) which is forecast to come back within budget by year end, a pharmacy stock adjustment (£0.5m) and RTA bad debt (£0.4m), offset by pass-through underspends.
- **CIP delivery** of £13.8m is £3.8m ahead of plan. If this were excluded from the reported position then the overall position would show an adverse variance to plan of £6.6m. This indicates there is overall pressure in the Trusts baseline financial position at month 06, with the primary driver lower than planned income recovery

ACTION REQUIRED

- Validate income recovery; depth of coding and reporting.
- Review and validate pathology income underperformance

2. Month 6 CIP Performance





CIP Overview

- At the end of Month 6, the Trust is reporting the cumulative delivery of £13.8m of savings from Cost Improvement Programmes (CIPs)
- £5.3m of savings were reported in September. In addition to the continuation of existing schemes benefits from a number of new schemes were reported on for the first time. The savings from these had accrued in previous months (and were within the reported run rate) but had not been finalised for CIP reporting purposes.

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

Actions

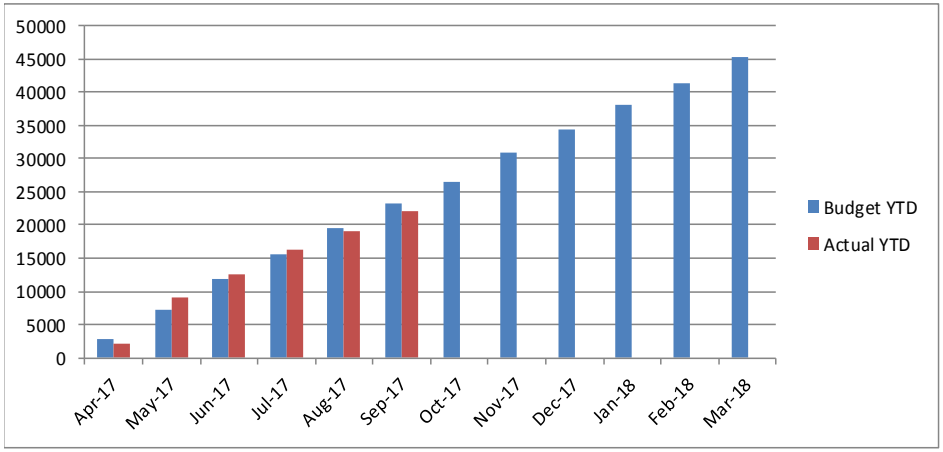
- The Trust requires CIP plans which deliver £47.0m of savings in 2017/18 and an on going 'Pipeline' of schemes in development for 2018/19
- As reported at October's FSM meeting £43.9m of the Trust's schemes have been rated 'Green'. To provide assurance that the CIP plans will deliver the required level of savings the Trust needs to progress a further £3.1m of CIP plans to 'Green' . It is also critical that the existing Green schemes deliver their planned savings in line with expectations to support the achievement of the year end financial position
- The Trust needs to identify and implement the recovery actions necessary so that it can deliver its target year end deficit of £53m. Further CIP plans or financial controls may be required to mitigate any shortfall or additional in-year pressures

3. Month 6 Capital Programme

Capital expenditure summary M06 2017/18

Spend category	2017/18 Budget** £000	M06 YTD Budget £000	M06 YTD actual £000	*M06 YTD Variance*
Energy Perform Contract	**5,555**	**5,555**	**5,372**	*183*
Infra Renewal	**10,492**	**4,374**	**2,736**	*1,638*
Med Eqpt	**3,194**	**2,585**	**2,537**	*48*
Major Projs	**21,094**	**7,802**	**5,491**	*2,311*
IMT	**2,567**	**2,567**	**5,124**	*-2,557*
Other	**601**	**222**	**681**	*-459*
SWL PATH	**684**	**155**	**102**	*53*
Contingency	**1,096**	**45**	**0**	*45*
Total	**45,283**	**23,305**	**22,043**	***1,262***

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



- The capital budget for 2017/18 has been increased from £43.9m to £45.3m for two new sources of funding for new projects: £0.98m PDC for ambulatory care and £0.43m donated capital grant for a new helipad fire safety system.
- Capital expenditure in September was £2.95m and M06 YTD expenditure is £22m giving rise to an under spend of £1.3m YTD.
- The capital budget was formulated at the beginning of the year on the basis the Trust would secure DH capital of £8.4m to finance investment in IT infrastructure. Despite an independent audit recommending approval of this bid, the Trust has not received approval from NHSI. The Trust is proceeding with the investment in IT required to deal with the emergency issues identified.
- In light of this, the Trust has been undertaking a re-forecasting and re-prioritisation exercise to ensure the emergency level of IT capital investment required this year may still be accommodated within the existing budget. This exercise has involved identifying expenditure in other categories, which may be rescheduled to next year, and significant progress has been made. The M06 forecast outturn is £47.4m against the updated budget of £45.3m i.e. a forecast overspend of £2.1m (c/f M04: £7m and M05: £4.7m). The Trust needs to reduce the forecast by a further £2.1m in order to balance the budget.
- A separate paper on the current forecast for the capital programme is on the Finance and Performance Committee agenda for this month.

4. Month 6 YTD Analysis of Cash Movement

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

		Actual M06 vs Plan M06	
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*
Cash balance 01.04.17	5.0	6.0	*1.0*
Income and expenditure deficit	-36.5	-39.3	*-2.8*
Depreciation	13.5	12.0	*-1.5*
Interest payable	3.8	3.7	*0.0*
PDC dividend	1.7	1.6	*-0.1*
Other non-cash items	-0.1	-0.1	*0.0*
Operating deficit	**-17.6**	**-22.0**	-4.4
Change in stock	-0.3	-0.4	*-0.1*
Change in debtors	-11.1	-19.2	*-8.2*
Change in creditors	13.0	26.8	*13.8*
Net change in working capital	1.7	7.1	5.5
Capital spend (excl leases)	-25.1	-22.3	*2.8*
Interest paid	-3.5	-3.5	*0.0*
PDC dividend paid	-1.7	-1.7	*0.0*
Other	-0.2	-0.2	*0.0*
Investing activities	-30.4	-27.7	2.7
WCF borrowing	32.9	30.0	*-2.9*
Capital loans	16.2	16.2	*0.0*
Loan/finance lease repayments	-4.7	-4.0	*0.7*
Cash balance 30.09.17	**3.0**	**5.6**	*2.6*

M06 YTD cash movement

- The cumulative M06 I&E deficit was £39.3m – £2.8m worse than plan.
- Within the I&E deficit of £39.3m, depreciation (£12m) does not impact cash. The charges for interest payable (£3.7m) and PDC dividend (£1.6m) 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 £22m.
- The operating variance from plan of £4.4m in cash is, in part, attributable to the lower depreciation charge.
- Working capital performed overall £5.5m better than plan.
- The Trust borrowed approx.£11m from working capital facilities in M06 and has borrowed £30m YTD, which is £2.9m less than plan. The Trust has received £4.488m more borrowing in October and has requested a further approx. £9.6m for November to finance the on-going deficit. These working capital borrowings are subject to an interest rate of 6% because the Trust is in financial special measures.
- The Trust has drawn down its £16.2m capital loan in full to finance expenditure on the NHSI-financed capital projects per the successful bid made last year.

5. Balance Sheet as at Month 6 2017/18

Balance sheet SEPTEMBER 2017

	Mar-17 Audited £000	Sep-17 Plan £000	Sep-17 Actual £000	*YTD Variance £000*	**Explanations of balance sheet variances**
Fixed assets	335,834	345,736	345,966	*-230*	Lower depreciation charge than plan
Stock	6,575	6,875	7,002	*-127*	Year end stock higher than 16/17 plan: movement since y/e in line with 17/18 plan.
Debtors	101,837	112,898	121,058	*-8,160*	Collection of 16/17 SLA debt delayed by CCGs pending finalisation of challenges
Cash	6,022	3,000	5,662	*-2,662*	Higher opening cash than plan.
Creditors	-118,305	-130,303	-145,098	*14,795*	Agreed deferral of CNST payments to later in the year.
Capital creditors	-5,284	-2,284	-4,901	*2,617*	Timing of capital payments has increased capital creditors at M06
PDC div creditor	0	-84	0	*-84*	
Int payable creditor	-259	-510	-492	*-18*	
Provisions< 1 year	-335	-335	-107	*-228*	
Borrowings< 1 year	-55,206	-56,991	-56,804	*-187*	Lower drawdowns due to higher opening cash bal & lower capital spend than plan
Net current assets/-liabilities	**-64,955**	**-67,734**	**-73,680**	*5,945*	
Provisions> 1 year	-988	-808	-988	*180*	
Borrowings> 1 year	-164,524	-208,373	-205,246	*-3,127*	Lower drawdowns due to higher opening cash bal & lower capital spend than plan
Long-term liabilities	**-165,512**	**-209,181**	**-206,234**	*-2,947*	
Net assets	**105,367**	**68,821**	**66,052**	*2,769*	
Taxpayer's equity					
Public Dividend Capital	129,956	129,956	129,956	*0*	
Retained Earnings	-114,843	-151,389	-154,121	*2,732*	Higher I&E deficit than plan
Revaluation Reserve	89,103	89,103	89,066	*37*	
Other reserves	1,150	1,150	1,150	*0*	
Total taxpayer's equity	**105,367**	**68,821**	**66,052**	*2,769*	

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M5 YTD)	Actual (M5 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%

- 1 represents the best score, with 4 being the worst.
- At the end of September, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. Furthermore, interim spend has reduced significantly this year due to the IT MSA, with costs now being reflected in non-pay.
- The distance from plan score of 2 is based on being £2.7m away from plan at M6.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board Meeting		
Date:	9 November 2017	Agenda No	6.1
Report Title:	ICT Risk Review		
Lead Director/ Manager:	Andrew Grimshaw, CFO		
Report Author:	Larry Murphy - CIO		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	St. George's Trust has recognised, for a considerable length of time that the state of the ICT infrastructure, systems and operation poses a significant risk to the smooth and continuous running of the Trust. Late in 2016 several ICT risks were identified and recorded on the risk register, several were high rated risks but no individual risk had a score above 20. Consolidation of these risks heightened the overall risk score and visibility of the contributing risks was limited. This paper describes how these risks will be made visible and the governance process for rating the risk, and the assurance level for the strategic risk.		
Recommendation:	It is recommended that the Trust Board support the ICT risk assessment as outlined in this paper.		
Supports			
Trust Strategic Objective:	Modernising our building and internal systems: To ensure our internal processes, information technology, and buildings and facilities are sound.		
CQC Theme:	Well-led, effective, responsive		
Implications			
Risk:	Failure to adequately deal with the ICT risks and reduce the likelihood and / or impact is highly likely to result in serious disruption to the Trust services.		
Resources:	Adequate resources are currently in place to progress the assessment stage of the proposal; subsequent mitigating plans may require additional resource and funding.		
Previously Considered by:	N/A	Date	
Equality Impact Assessment:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

ICT Risk Review – November 2017

Trust Board, 09.11.2017

1 PURPOSE

1.1 The purpose of this paper is to provide the Board with clarity about the risk that the state of ICT poses to the smooth and continuous operation of the Trust and summarise the approach being undertaken to improve the risk position. This follows the presentation of an overarching ICT risk of 25 to the October 2017 meeting of the Trust Board.

2 CONTEXT

2.1 St. George's Trust has recognised, for a considerable length of time that the state of the ICT infrastructure, systems and operation poses a significant risk to the smooth and continuous running of the Trust.

2.2 Late in 2016 several ICT risks were identified and recorded on the risk register, several were high rated risks but no individual risk had a score above 20. Consolidation of these risks heightened the overall risk score and visibility of the contributing risks was limited.

2.2 Since 2016 considerable progress has been made in reducing the risk level of individual risks. The assessment of the CIO is that none of the individual ICT related risks should be scored higher than 20, and that for the four items currently rated red specific additional support and oversight is in place to ensure ongoing safe operation in the short run.

2.3 In recent months, the Board has been working with Deloitte to identify strategic risks to the Trust and improve the governance of the risk management process. The strategic risks to achieving the Trusts objectives were agreed in October, one of these strategic risks relates to ICT.

[Risk that] Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.

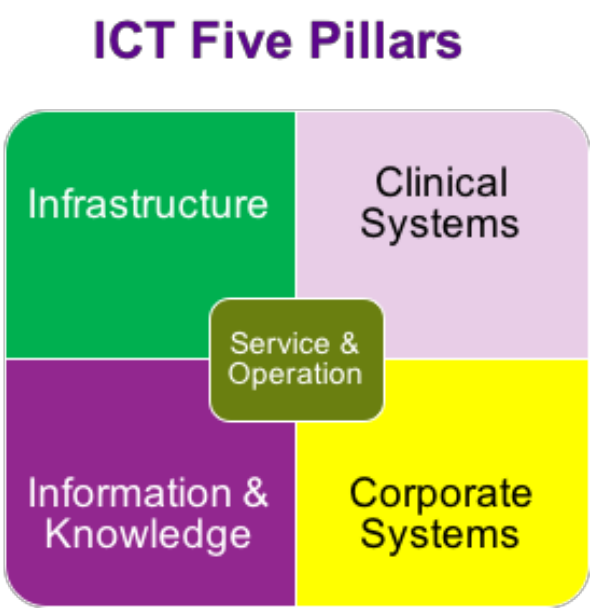
2.4 The assurance committee accountable for this risk is the Finance and Investment Committee. The Director of IM&T is the executive lead. The individual ICT risks contribute to the strategic risk and will be considered by the F&I Committee who will make a decision on the level of the overall strategic risk.

3 RISK REVIEW AND APPROACH TO MITIGATION

Scope

3.1 The scope of ICT Risk has been categorised into five key areas:

1) **ICT Infrastructure**
2) **Clinical Systems**
3) **Corporate Systems**
4) **Information and Knowledge**
5) **Service and Operation**



Risk Assessment

3.2 The proposal is to carry out a new risk assessment of each of the ICT components identifying the level of risk each pillar presents to the Trust being able to continue to operate safely. The risk assessments will describe what has been done to mitigate each risk and the level of risk that remains to be managed. Plans will then be presented on two levels for each of the five pillars:

- **Tactical Remediation Plan**; this will address the urgent high-risks and reduce the Trust exposure to a more acceptable level in the short-term.
- **Strategic Programmes;** these will correct the overall ICT situation in the long-term resulting in a fit-for-purpose and sustainable ICT future ("Silent IT").

3.3 When the individual risks that contribute to the strategic risk have been fully assessed the decision on the rating of this strategic risk and the level of assurance will be made by the assuring committee (Finance and Investment Committee). This will be based on the evidence it receives on the mitigating action being taken and the strength of controls. The key areas of ICT risk described in 3.1 will be evaluated and reported to the Finance and Investment Committee in November. The full BAF will be presented to the Board in January for assurance.

3.4 It is proposed that the Tactical Remediation Plan be presented to the December Board. The governance required to manage and oversee the progress of the Strategic Programmes will also be presented at the December Board. The CIO is working closely with Tim Wright (Non-executive director with ICT experience) to ensure the presentation made to the Trust Board is comprehensive and provides adequate assurance.

3.5 It is also proposed that the long-term Strategic Programmes will be presented to the January Board for approval, in the form of a Strategy. An update of progress against the Tactical Remediation Plan will also be presented to the January Board.

4 IMPLICATIONS

Risks/ Issues

4.1 Failure to adequately deal with the ICT risks and reduce the likelihood and / or impact is highly likely to result in serious disruption to the Trust services.

Resources

4.2 Adequate resources are currently in place to progress the assessment stage of the proposal; subsequent mitigating plans may require additional resource and funding.

5 RECOMMENDATION

5.1 It is recommended that the Trust Board note the overall risk position for ICT and support the approach to risk review and reduction as outlined in this paper.

Author: Larry Murphy, CIO
Date: 09.11.17

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 November 2017	**Agenda No.**	7.1
Report Title:	Fit and Proper Persons Quarterly Update Report		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Report Author:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	The Board has request that the HRD provide a quarterly update on FPP compliance against Regulation 5 during the year 2017/18 and annually thereafter. The purpose of this paper is to give the Board on-going assurance that the Trust is now fully compliant with Regulation 5. Fit and Proper Persons : Directors		
Recommendation:	That the Board is asked to note the current assurance around the fit and proper persons assessment.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-Led)		
Implications			
Risk:	Failure to meet the FFP requirements could result in further regulatory actions being taken against the Trust		
Legal/Regulatory:	The requirement to meeting the FFP test is outlined in Regulation 5: Fit and Proper Persons		
Resources:	No additional resources required		
Previously Considered by:	Board and Executive Director	**Date:**	September 2017
Equality Impact Assessment:	Not undertaken. Policy applied to every Board member		
Appendices:	Appendix A - Exec and Non Exec FPPR compliance list		

St George's University Hospitals NHS
NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust's Compliance with Regulation 5: Fit and Proper Persons

Trust Board - 9th November 2017

1.0 PURPOSE

1.1 The purpose of this paper is to give the Board on-going assurance that the Trust is fully compliant with Regulation 5. Fit and Proper Persons Directors

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2.0 BACKGROUND

2.1 The Trust was served a Section 29A Warning Notice in August 2016 due to breaches in the implementation of this regulation and subsequently agreed enforcement undertakings with NHS Improvement in November 2016 to make the required improvements.

3.0 OUTLINE OF KEY ISSUES

CQC unannounced inspection - May 2017

3.1 The CQC undertook an unannounced follow-up inspection in May 2017 to assess the Trust's compliance with the Section 29A Warning Notice, including compliance with the fit and proper person's regulation. CQC continued to find non-compliance against this regulation and they raised a number of wider governance concerns in relation to the false assurance received by the Trust Board and regulators.

4.0 NHSI Concerns

4.1 NHS Improvement indicated that they took the concerns raised by the CQC very seriously.

5.0 NHSI Requirements

5.1 NHSI considered the options available to them and in advance of considering whether any further regulatory action should be taken.

5.2 In their letter, NHSI asked that a number of rapid improvements be made to ensure compliance with this regulation which have all been formally actioned. They also asked that additional assurance mechanisms are put in place to ensure that the improvements are fully embedded.

5.3 As part of the assurance process they requested that the Board ask the HRD provide a quarterly update on FPP compliance against Regulation 5 during the year 2017/18 and annually thereafter

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8. Recommendation

It is recommended that the Board:-

8.1 Note that the Trust continues to be fully compliant with Regulation 5. Fit and Proper Persons: Directors.

Tim Wright has met all the FPP requirements before taking up his role as NED

Suzanne Marsello & Kevin Howell's FPP checks are still in progress and they will not commence in their new roles until these have been completed.

Author: **Harbhajan Brar**
Date: **20th October 2017**

Name	Fit and Proper Persons Test - Declaration Form	Employment History	References	Professional Registration	Essential Qualifications	Occupational Health	Right to Work	Identity Check	DBS/Criminal Conviction Checks	Search of Insolvency and Bankruptcy Register	Search of Disqualified Directors	Social Media Search	Complete	FPPR Met
Jacqueline Totterdell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Avey Bhatia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Rhodes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Harbhajan Brar	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Grimshaw	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
James Friend	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ellis Pullinger	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fiona Barr	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Marsello														
Kevin Howells														
Director of Corporate Affairs														
Richard Hancock	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Larry Murphy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gillian Norton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Norman Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ann Beasley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Higham	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Wilton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stephen Collier	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tim Wright	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

St George's University Hospitals NHS
NHS Foundation Trust

Meeting:	Trust Board		
Date:	9 November 2017	**Agenda No**	8.1
Report Title:	Rationale for a Revised Board and Committee Structure and Meetings Cycle from January 2018		
Lead Director/ Manager:	Gillian Norton, Trust Chairman Jacqueline Totterdell, Chief Executive		
Report Author:	Fiona Barr, Trust Secretary & Head of Corporate Governance		
Action Required:	Approval		
Executive Summary:	This paper sets out a revised Board and Committee structure following a detailed review of external governance by Deloitte and further consideration at Board and Committee level.		
Recommendation:	The Board is invited to approve the rationale for a Revised Board and Committee Structure and Meetings Cycle from January 2018.		
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well led)		
Implications			
Risk:	There are no risks associated with this proposal.		
Legal/Regulatory:	Any changes to Committee Terms of Reference will be made in line with existing best practice. Reports required by statute or guidance will be included in the Annual Cycle of Business.		
Resources:	There are no resource implications associated with this proposal.		
Previously Considered by:	Board EMT	**Date**	Aug 2017 30.10.17
Appendices:	**Appendix 1:** Schedule of Dates for Board & Committee Meetings Jan 2018 – Mar 2019 **Appendix 2:** Schematic of New Board Structure		

St George's University Hospitals NHS
NHS Foundation Trust

Rationale for a Revised Board and Committee Structure
Trust Board 09.11.17

1.0 PURPOSE

1.1 This paper sets out a revised Board and Committee structure and supporting processes for implementation from 01.01.18.

2.0 BACKGROUND

2.1 Throughout 2017, the Board and the Executive Team have embarked on a programme to improve the Trust's corporate governance arrangements following reports from TIAA, the Trust's Internal Auditors, and advice from Deloitte, brought in to support the Trust under the Quality Special Measures programme.

3.0 PROPOSAL

3.1 Following consideration by the Executive Team and the Board, a revised Board and Committee structure and operating framework has been set out for implementation based on the following principles:

i. The Board meetings are structured to enable the Board to understand and challenge the current position on risk and performance as well as providing sufficient time for strategy and development. The Board is supported by Assurance Committees and an Executive Committee. Its work is guided by an Annual Cycle of Business and supplemented by a Board Development Plan. Board meetings are timed to enable the Board to consider performance of the previous month and in time for any statutory or regulatory returns to be made. From January 2018, Board meetings are brought forward to the **last Thursday of the month.**

ii. The Committees have a clear purpose and function which are reviewed and validated annually by the Board. Their responsibilities are reflected in their Terms of Reference and Annual Cycles of Business. Meetings of the Assurance Committees of the Board occur on a Thursday and the Executive Committee of the Board on a Wednesday.

iii. There are Committees of the Board which cover: Finance, Quality and Workforce & Education (these are discretionary Committees); Audit and Remuneration/Nomination (these are statutory Committees) and also Executive/Operational matters. The new Executive Committee of the Board is an addition to the current Board Committee structure.

iv. Committees covering Finance and Quality are both monthly and occur one week before the Board meeting. The Executive Committee of the Board meets twice a month and its timing is linked to the Board cycle. The Board Remuneration Committee will take place on the day of Board meetings and meetings of the Audit Committee and Workforce & Education Committee will take place broadly every quarter on the second Thursday of the month.

v. To maximise Non-Executive Director (NED) time, on days when Committees meet, two meetings will be organised (morning and afternoon).

vi. The Board will formally consider the Trust's performance at each of its meetings and the Executive's opinion on the performance of the organisation will be informed through a series of Divisional Performance Review meetings in the run up to the Board meeting. This will provide an opportunity for the Executive to "check and challenge" and fully validate the position before it is presented to the Board.

vii. Performance against quality and financial metrics will be subject to detailed review by the Committees responsible for Quality and Finance respectively one week before the Board meeting.

viii. To supplement both the IQPR and the CEO's report, from January 2018 to each Board meeting there will be a report from each of the Directors setting out their key priorities and achievements for the previous month and highlighting issues, risks or actions for focus for the following month.

ix. The responsibility of managing risk is not delegated to one Committee; instead the Board and all of its Committees will review the risks within the purview of each. The Board will receive the Board Assurance Framework and other reports on risk on a regular basis.

x. The Assurance Committees are chaired by Board members with the most appropriate skills and experience and the Executive Committee of the Board is chaired by the Chief Executive.

xi. In the case of Board Assurance Committee membership, Executive and Non-Executive (ie voting) Directors have equal status and are all members. Any other Directors are in attendance.

xii. Each Committee has an identified Executive Lead who will work with the Committee Chairman to prepare the meeting agenda and the report to the Board and review the Committee's Terms of Reference and Annual Business Cycle annually with support from the Trusts Secretary.

xiii. The Committee Chairman is responsible for ensuring that clear actions are agreed and decisions made. The Committee Chairman is also responsible for producing a written report to the Board following each meeting and for escalating matters of control to the Audit Committee as well as ensuring an accurate record is made of each meeting.

xiv. The servicing and meeting administration for the Board and its Committees will be handled by the Trust Secretary who will also ensure standard templates for recording minutes, actions, Terms of Reference and Annual Cycles.

4.0 NEW COMMITTEE STRUCTURE

4.1 The following summarises changes to the Board Committee structure:

Current	Changes to	Rationale
Audit Committee	Audit Committee	The Terms of Reference of the Audit Committee will be updated to follow best practice though no material change will be made to the purpose of this Committee which is to independently monitor, review and report to the Board on the Trust's systems of governance, risk and internal control.
Remuneration & Nominations Committee	Remuneration & Nominations Committee	There will be no significant change to this Committee save that its Terms of Reference and Annual Cycle will be reviewed in line with current best practice.
Quality Committee	Quality & Safety Committee	This focus of this Committee will be realigned to the principles set out in *High Quality of Care for All* and have a clearer focus on safety, clinical effectiveness and patient experience. This Committee will also oversee progress on the Enforcement Actions arising from Quality Special Measures, for example by receiving regular reports on the Elective Care Recovery Programme and the Quality Improvement Plan.
Finance & Performance Committee	Finance & Investment Committee	Performance will be overseen by the Executive Team and the Board and this Committee will focus predominantly on the effective management and optimisation of the Trust's finances, assets and infrastructure. It will also have a key role in looking at investment and disinvestment opportunities and oversee financial governance arrangements.
Workforce & Education Committee	Workforce & Education Committee	There will be no significant change to this Committee save that its Terms of Reference and Annual Cycle will be reviewed in line with current best practice.
Executive Management Team (EMT)	Trust Executive Committee	EMT will be re-purposed into a Trust Executive Committee and will formally report on executive, management and operational matters to the Board through the Chief Executive.

4.2 This is set out as a schematic in Appendix 2.

5.0 NEXT STEPS AND TIMETABLE

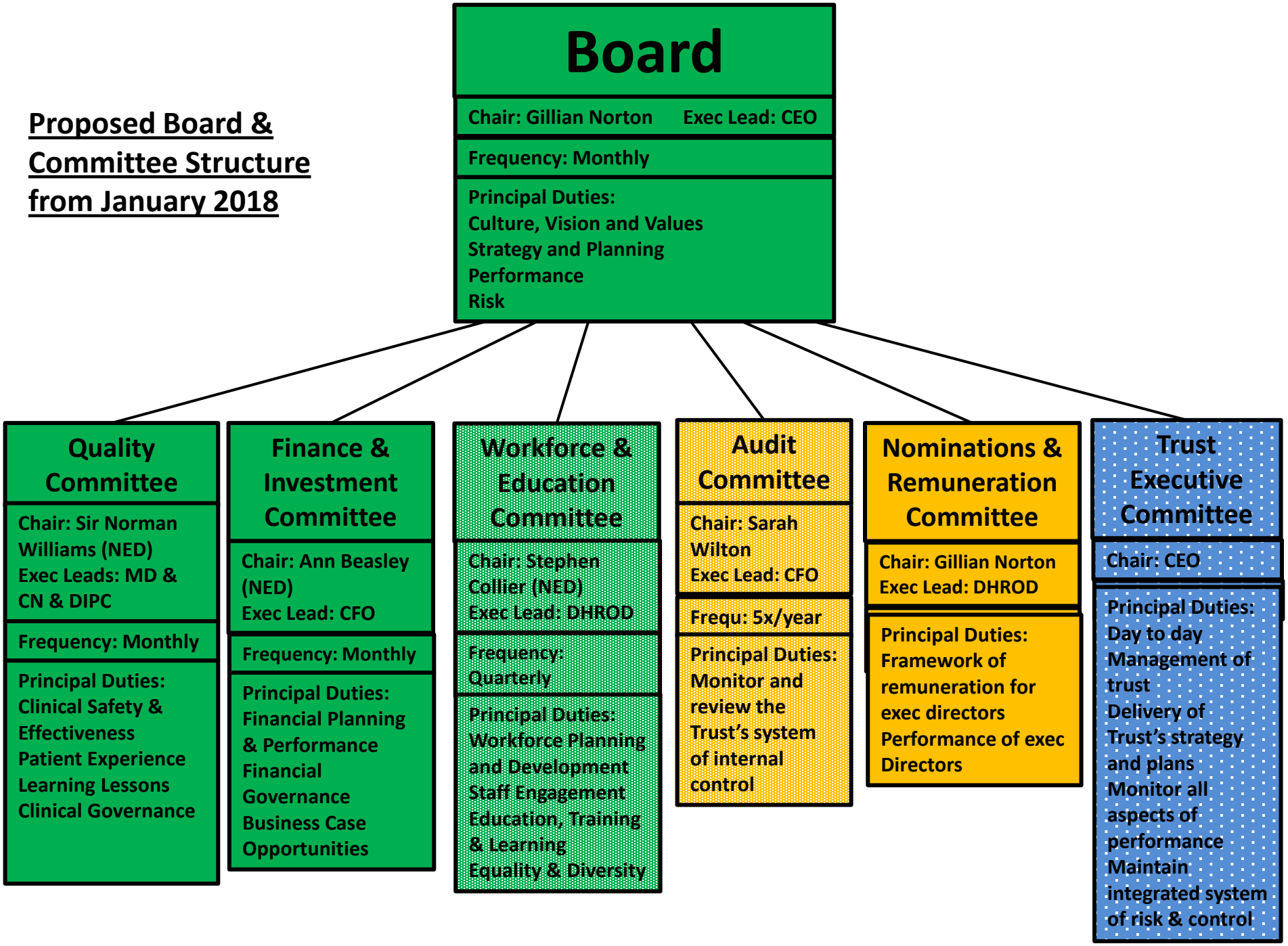
5.1 Work is well underway to transition to these new arrangements from January 2018. Between now and then, the Committee Terms of Reference and Annual Cycles of Business will be drawn up and dates of meetings confirmed and set in diaries. Attached at Appendix 1 are the proposed dates for the new Board and Committee meetings including the Trust Executive Committee (formerly EMT). The Terms of Reference for the new Committees will be presented to the Board, along with the Annual Cycles of Business, to the January 2018 Board meeting.

6.0 RECOMMENDATIONS

6.1 The Board is invited to approve the rationale for a Revised Board and Committee Structure and Meetings Cycle from January 2018.

Author: **Fiona Barr, Trust Secretary & Head of Corporate Governance**
Date: **03.11.17**

Proposed Board & Committee Structure from January 2018



Proposed Trust Executive Committee, Board and Board Committee Dates January 2018 - March 2019						
	Trust Executive Committee Meetings (09:00-12:00) WEDNESDAY	**Workforce & Education Committee (10:00-13:00) SECOND THURSDAY**	**Audit Committee (14:00-17:00) SECOND THURSDAY**	**Finance & Investment Committee (10:00-13:00) THURSDAY BEFORE BOARD**	**Quality & Safety Committee (14:30-17:00) THURSDAY BEFORE BOARD**	**Board & RemCom (All Day) LAST THURSDAY**
January 2018	**03.01.18 Room GVR2.19 17.01.18 Room GVR2.20**	**11.01.18 Room GVR2.19**	**11.01.18 Room GVR2.19**	**18.01.18 Room GVR2.20**	**18.01.18 Room GVR2.20**	**25.01.18 Room GVR2.20**
February 2018	**14.02.18 Room GVR2.19 28.02.18 Room GVR2.19**			**15.02.18 Room GVR2.20**	***13.02.18 Room - TBC***	**22.02.18 Room GVR2.20**
March 2018	**07.03.18 Room GVR2.19 21.03.18 Room GVR2.20**			**22.03.18 Room GVR2.20**	**22.03.18 Room GVR2.20**	**29.03.18 Room GVR2.20**
April 2018	**04.04.18 Room GVR2.19 18.04.18 Room GVR2.20**	**12.04.18 Room GVR2.19**	**12.04.18 Room GVR2.19**	**19.04.18 Room GVR2.19**	**19.04.18 Room GVR2.19**	**26.04.18 Room GVR2.20**
May 2018	**09.05.18 Room GVR2.19 23.05.18 Room GVR2.19**		**17.05.17 Accounts Workshop Room GVR2.19 21.05.17 ARA Sign-off**	**24.05.18 Room GVR2.19**	**24.05.18 Room GVR2.19**	**24.05.17 Room GVR2.19 13:00--14:00 (approve accs) 31.05.18 Room H2.5**
June 2018	**06.06.18 Room GVR2.19 20.06.18 Room GVR2.20**			**21.06.18 Room GVR2.19**	**21.06.18 Room GVR2.19**	**28.06.18 Room GVR2.20**
July 2018	**04.07.18 Room GVR2.19 18.07.18 Room H2.5**	**12.07.18 Room GVR2.19**	**12.07.18 Room GVR2.19**	**19.07.18 Room GVR2.19**	***17.07.18 - TBC***	**26.07.18 Room H2.8**
August 2018	**08.08.18 Room GVR2.19 22.08.18 Room GVR2.19**			**23.08.18 Room GVR2.19**	**23.08.18 Room GVR2.19**	**30.08.18 Room GVR2.20**
September 2018	**05.09.18 Room GVR2.19 19.09.18 Room GVR2.20**			**19.09.18 Room GVR2.20**	**19.09.18 Room GVR2.20**	**27.09.18 Room GVR2.20 Also AMM (18:30)**
October 2018	**03.10.18 Room GVR2.19 17.10.18 Room GVR2.20**	**11.10.18 Room GVR2.19**	**11.10.18 Room GVR2.19**	**18.10.18 Room GVR2.19**	**18.10.18 Room GVR2.19**	**25.10.18 Room GVR2.20**
November 2018	**07.11.19 Room GVR2.19 21.11.19 Room GVR2.20**			**22.11.18 Room GVR2.19**	**22.11.18 Room GVR2.19**	**29.11.18 Room GVR2.20**
December 2018	**12.12.19 Room GVR2.19**			**13.12.18 Room GVR2.19**	**13.12.18 Room GVR2.19**	**20.12.18 Room GVR2.20**
January 2019	**09.01.18 Room GVR2.19 23.01.19 Room GVR2.19**	**10.01.19 Room GVR2.19**	**10.01.19 Room GVR2.19**	**24.01.19 Room GVR2.19**	**24.01.19 Room GVR2.19**	**31.01.19 Room GVR2.19**
February 2019	**06.02.19 Room GVR2.19 20.02.19 Room GVR2.19**			**21.02.19 Room GVR2.19**	**21.02.19 Room GVR2.19**	**28.02.19 Room GVR2.19**
March 2019	**06.03.19 Room GVR2.19 20.03.19 Room GVR2.19**			**21.03.19 Room GVR2.19**	**21.03.19 Room GVR2.19**	**28.03.19 Room GVR2.19**