Trust Board Meeting

Date and Time: Thursday 25 January 2018, 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 07.12.17** *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
		QUALITY		
10:40	**2.1**	**Quality & Safety Committee Report** *Chair of Committee, Sir Norman Williams*	Assure	Paper
		PERFORMANCE		
10.55	**3.1**	**Integrated Quality & Performance Report** *Executive Team*	Review	Paper
	3.2	**Elective Care Recovery Programme – Action Plan** *Chief Operating Officer, Ellis Pullinger*	Assure	Paper
	3.3	**NHS EPRR Assurance** *Chief Operating Officer, Ellis Pullinger*	Assure	Paper
	3.4	**Guardian for Safe Working** *Director of Human Resources & Organisational Development Harbhajan Brar*	Assure	Paper
	3.5	**Mortality/Learning from Patient Death** *Dr Nigel Kennea, Associate Medical Director*	Assure	Paper
		FINANCE		
11.55	**4.1**	**Finance & Performance Committee Report** *Chair of Committee, Ann Beasley*	Assure	Paper
	4.2	**Month 9 Finance Report** *Chief Financial Officer, Andrew Grimshaw*	Assure	Paper
		WORKFORCE		
12:20	**5.1**	**Workforce and Education Committee Report** *Chair of Committee, Stephen Collier*	Assure	Paper
		GOVERNANCE		
12:25	**6.1**	**Audit Committee Report** *Chair of Committee, Sarah Wilton*	Approve	Paper
	6.2	**Board Assurance Framework** *Chief Nurse & Director of Infection Control, Avey Bhatia*	Assure	Paper
		CLOSING ADMINISTRATION		
12.35	**7.1**	**Questions from the Public**	-	Oral

	7.2	**Any New Risks or Issues** *All*		-
	7.3	**Any Other Business** *Chairman*	-	-
	7.4	**Reflection on Meeting** *All*	-	Oral
12:40		**PATIENT STORY**		
Steven Lambert, shares his experience of End of Life/Organ Donation supported by Jo Cox, Alicia Hayley Bell.				
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 22 February 2018

Trust Board
Purpose, Meetings and Membership

Trust Board Purpose:	The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Meetings in 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
7 December 2017 – from 10:00, Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
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 & DIPC
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
Tom Shearer	Acting Director of Financial Performance & Planning (for Andrew Grimshaw)	DFPP
APOLOGIES		
Ann Beasley	Non-Executive Director	NED
Andrew Grimshaw	Chief Finance Officer	CFO
Mike Murphy	Quality Improvement Director - NHS Improvement	QID
SECRETARIAT		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec
Richard Coxon	Membership & Engagement Manager	MEM

GOVERNORS IN ATTENDANCE

Mike Grahn	Appointed Governor, Healthwatch Wandsworth
David Kirk	Public Governor, Wandsworth
Yvonne Langley	Public Governor, Wandsworth

Feedback from Board Walkabout

The Board members began by giving feedback from the departments visited which included: Cavell Ward, Nye Bevan Unit, Cardiac ICU, Belgrave Ward, Day Surgery Unit, Max Fax, Therapies Outpatients, Pathology, Surgical Admissions Lounge and Macmillan Information Centre.

General observations included a continued need for refurbishment in some areas though it was noted that the Estates department had plans in place to do this. Nevertheless some day to day maintenance issues remained problematic and effort needed to continue to be directed to getting these sorted. The wards visited were all busy and well run with positive staff. The Macmillan Information Office staff had spoken enthusiastically about their work and how they had explored opportunities for funding. There was discussion around the need to bring together all the surgical admission areas to improve patient flow and experience as well as overall efficiency.

The Flu vaccination rate was currently at 81% and Patricia Campbell, Flu Lead gave a presentation on how this was achieved later in the meeting.

1. OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and noted the apologies as set out above. A welcome was given to Tom Shearer, Director of Financial Planning, who was attending on behalf of the Chief Financial Officer and also to Suzanne Marsello, incoming Director of Strategy, who was attending as a member of the public.
Declarations of Interest	
1.2	There were no declarations of interest.
Minutes of Meeting held on 09.11.17	
1.3	The minutes of the meeting of 09.11.17 were agreed as a correct and accurate record.
Action Log and Matters Arising	
1.4	The Board noted that most actions on the Action Log were not yet due or had been closed because appropriate action had been taken outside the meeting. Regarding TB.09.11.17/ 51, the DDET noted that, after further discussions with the team, it had emerged that Genomes DNA testing was not an appropriate option for Board member participation though an alternative around testing pain control and pain tolerance was offered instead. This action would be removed from the Action Log and any interested Board members should pursue this through the DDET.
CEO's Report	
1.5	The CEO reported that a new Director of Corporate Affairs, Stephen Jones, had been appointed and would start in February/March 2018 and since the last Board meeting, Avey Bhatia, Chief Nurse and Director of Infection Prevention & Control, and James Friend, Director of Delivery, Efficiency and Transformation, had also been appointed substantively to their roles. In addition, Matt Laundy, Consultant Microbiologist and Clinical Director of Specialist Medicine, had been appointed to the important role of Chief Clinical Information Officer. His appointment would be critical in shaping the Trust's clinical IT priorities and moving forward to a paperless medical records system.
1.6	She noted that the Board seminar on ICT held in November had been very useful in ensuring that the Board was absolutely clear on the current state of the Trust's ICT and had a shared understanding of risks and priorities. More work would be done to produce a detailed plan which would be presented to the Trust Board in January 2018.
TB.07.12.17/53	**Present a detailed plan for the future of the Trust's ICT to the Board in January 2018. LEAD: Andrew Grimshaw, Chief Financial Officer**
1.7	The CEO reminded the Board of the significance of the challenges with the estate but advised that changes had been made to improve the team's responsiveness and enable staff to keep track of Estates queries that they had raised.
1.8	The CEO went on to thank Richard Hancock, Interim Director of Estates & Facilities, for all his dedication and hard work over the last 18 months. He would leave the Trust at the end of December 2017. She also expressed thanks to Fiona Barr, Interim Trust Secretary & Head of Corporate Governance, who was also leaving in December 2017, for her tireless work to improve the Trust's corporate governance arrangements and improve the running of the Board.

STRATEGY	
Business Planning 2018/19	
2.1	The DFPP introduced the paper which set out the Business Planning work that had been completed to date and the timetable for action over the coming months. It was noted that Business Planning guidance for 2018-19 had not yet been issued by NHS Improvement (NHSI) so last year's guidance was being used for reference, though this would be updated as soon as the new requirements were received.
2.2	Already meetings had been held between the Trust and its commissioners as well as with Divisions and Specialities to discuss their plans for next year. A demand and capacity model was being used to inform staffing requirements and the workforce plan was being developed as part of the Business Planning process.
2.3	The Board welcomed the progress which was being made and felt that plans were further advanced than in previous years. There was a general feeling that there still remained opportunities to explore with other trusts in South West London to consolidate back office functions and improve overall efficiency in the sector.
2.4	The report was received.
Trust Strategic Objectives	
2.5	The CEO introduced the paper which set out a final set of strategic objectives for the next 18 months following comments made by Board members at the November 2017 meeting.
2.6	These were approved and the Board resolved to receive a quarterly update on progress against the strategic objectives.
TB.07.12.17/54	**Present a quarterly update on progress against the Trust's strategic objectives.** **LEAD: Suzanne Marsello, Director of Strategy**
South West London (SWL) Strategy Sustainability & Transformation Partnership (STP) Refresh	
2.7	The MD presented a discussion document on the SWL STP refresh for information which set out an updated strategy for health and care in SWL following a year of engagement with stakeholders and local people since the publication of the SWL STP in November 2016.
2.8	Generally there was disappointment about the results of the refresh which the Board felt was a missed opportunity particularly in terms of population health. There was discussion around St George's role as the largest NHS provider in the SWL sector and it was felt that the Trust should take more of a lead role to help to shape and drive change. Whilst a number of internal challenges remained at St George's, the NEDs felt that the Executive team had now been strengthened and was beginning to stabilise which should release some capacity for the Trust to focus on its position in the STP. This was an important priority given the Trust's size and status as a teaching hospital, as well as its key links with academic partners and other partners in the sector.
2.9	The Board resolved to receive a regular update on the Trust's progress within the STP at its meetings in private.
TB.07.12.17/55	**Present a regular update on the Trust's progress with the SWL STP to its meeting in private.** **LEAD: Suzanne Marsello, Director of Strategy**
QUALITY	
Quality Committee Report	
3.1	Sir Norman Williams, Chair of the Quality & Safety Committee (QSC), briefly talked through his report of the meeting held on 29.11.17, noting the following: i. A new Quality Improvement Dashboard was in development which would track the delivery of the Quality Improvement Plan (QIP). Once the information had been

	validated on the Dashboard, it would be published regularly on the Trust's website. The Committee had received a briefing on an episode of probable hospital acquired legionella infection. There had been low counts found from two outlets in the area where the patient was treated, the counts were in a range not usually considered to be significant. Action had been taken immediately to ensure the area was safe with filters put in place across the unit. ii. The report on Cardiac Surgery provided significant assurance to the Committee that the department was running safe services and not an outlier in terms of mortality. Work was ongoing to further improve performance in the department, particularly communication within and between teams. iii. The Dementia Lead had given a comprehensive presentation on the Dementia workstream of the QIP. The workstream had delivered the first of its objectives to introduce a dementia carer passport and the uptake of the carer's survey had improved since it was linked to the Friends & Family Test (FFT) questionnaire. The team had an ambition to make the Trust a Dementia Friendly hospital which the Board strongly supported. iv. Response rates for the FFT outside in-patient areas were low leading to little assurance being provided by the good recommendation scores. A business case had been made to improve this by using text messaging which was working well in other parts of the hospital.
3.2	The report was received.
PERFORMANCE	
Integrated Quality & Performance Report (IQPR)	
4.1	The DDET introduced the first part of the report and confirmed that the Four Hour Operating Standard had not been achieved in October (88.0%). There had been especially high numbers of patients in the Emergency Department (ED) on certain days which had created a problem with overall flow through the hospital. Thanks were given to all the clinical teams who had completed additional ward rounds in the last week to discharge patients due to the large number of patients being admitted for treatment.
4.2	The Board was advised that the ED Summit on 21.11.17 had been attended by over 100 staff who collectively set out ways in which the Trust's performance against the ED standard could be improved; these improvements were being implemented and monitored through the weekly CommCell meetings.
4.3	As part of the new Ambulatory Care model, the team was looking at how to better manage patients who frequently attended and was working with nursing homes in Wandsworth and Merton to improve support to elderly patients in care.
4.4	The COO reported that, in October, the Trust had met seven of the eight standards for Cancer waiting times which was a significant improvement. This was welcomed.
4.5	The DHROD reported an improvement in the use of agency staff usage.
4.6	As the quality metrics had been discussed in detail at the QSC, and the highlights presented through the Committee report, these were not discussed by the Board.
4.7	The Board received the report.
Elective Care Recovery Programme (ERCP) – Action Plan	
4.8	The COO gave an update on the progress of the ERCP Action Plan which had made significant progress over the last month.
4.9	There was an implementation of a maximum waiting cap for new outpatients and a continued focus on longest wait patients and increased emphasis on speciality plans.
4.10	The Chairman noted the step change and level of activity on the programme and thanked the ECRP team on behalf of the Board.

Winter Plan	
4.11	The COO presented the Winter Plan which had been considered in detail by the Executive Management Team. Elements of the Plan had already been discussed, such as the new Ambulatory Care model, and the Board's attention was drawn to the revised escalation plans in place to deal with increases in demand. The plan had been agreed with commissioners.
4.12	The report was approved.
FINANCE	
Finance & Investment Committee Report	
5.1	The report from the Finance & Investment Committee was taken as read.
Month 7 Finance Report	
5.2	The DFPP presented the Month 7 Finance Report which showed a cumulative deficit of £41.9 at the end of October, an adverse variance to plan of £4.8m. While this position was not in line with the overall plan to achieve a year-end deficit of £45m, it was consistent with the current forecast reported to NHSI and the Executive Team continued to work to improve the position from the current year-end forecast deficit of is £53m. The Board emphasised the importance of these focussed efforts, recognising in particular the elements of risk.
5.3	The Board received the report and noted the current financial position and forecast.
ESTATES	
PLACE Audit Report and Action Plan	
6.1	The DE&F presented the annual appraisal from the Patient Led Assessment of the Care Environment (PLACE) 2017. Thanks were given to the dedicated patient representatives who had participated in the PLACE audit over 10 years with special thanks to Leslie Robertson and other members of the Patient Experience team.
6.2	Over 25% of the St George's Hospital services had been assessed including wards, outpatient areas and ED (different areas were selected each year) at the Tooting site had been assessed; Food and Hydration had been reviewed at both the Queen Mary and Tooting sites.
6.3	The Board was disappointed with the overall performance against the PLACE audit and did not consider below average to be at all acceptable. It was noted that whilst some improvements would only be made through the completion of refurbishment works, such as the programme to replace and upgrade the patient bathrooms, others could be actioned through better compliance with the Trust's systems and procedures. An Action Plan had been drawn up in response to the findings which would be monitored closely by the Executive Team.
6.4	Leslie Robertson thanked all her fellow patient representatives for their time and commitment and singled out Mary Prior, General Manager - Facilities for praise.
6.5	The Report and Action Plan were received.
GOVERNANCE	
Audit Committee Report	
7.1	Sarah Wilton, Chairman of the Audit Committee, gave a summary of the issues discussed at the Audit Committee on 15.11.17. She particularly noted:

	I. Procurement – breaches and waivers are still high but appropriate controls were in place, there just needed to be greater compliance with them II. Grant Thornton has been re-appointed as External Auditors through approval by the Council of Governors on 06.12.17. However there had been a lack of choice of bidders.
7.2	The report was received.
Single Oversight Framework	
8.1	The DDET introduced the paper which set out the NHSI Single Oversight Framework which has evolved to apply to all NHS trust providers in England. The presentation had been provided as a reference guide and sets out the changes in each domain whilst at the same time highlighting what has remained the same.
8.2	The report had been provided for information only at this stage in preparation for the review of the Well Led Framework. In preparation, the Executive was undertaking an internal review of compliance with key line of enquiry number six: *Is appropriate and accurate information being effectively challenged and acted on?* The results of this would be presented to the Board on 25.01.18.
TB.07.12.17/56	**Present to the Board on 25.01.18 the results of the review against Key Line of Enquiry 6 *Is appropriate and accurate information being effectively challenged and acted on?*** **LEAD: James Friend, Director of Delivery, Efficiency & Transformation**
CLOSING ADMINISTRATION	
Questions from the Public	
9.1	Hazel Ingram commented that she believed that the experience of the Trust's services as an in-patient was good though due to the timing of the PLACE audit, this did not always appear to be the case. For example there were beautifully kept gardens at the Tooting site, though these were not shown to best effect as the PLACE audit took place when the gardens were not in full bloom. It was noted though that the Trust has no authority over when the PLACE audit is scheduled.
New Risks or Issues and Any Other Business	
9.2	There were no new risks or issues and no items of any other business. In closing the meeting, the Chairman thanked everyone for their input.
Reflection on Meeting	
9.2	The Board generally felt that there had been a good discussion with everyone contributing effectively.
Staff Story	
Patricia (Pat) Campbell, Flu Lead, explained to the Board how she had achieved 81% of staff receiving a flu inoculation this year. Pat had been supported by Michael Reynolds from the communications team using social media and designing effective awareness-raising posters to encourage people to get their flu jab. Pat felt that a key part of people's reluctance to get immunised against flu was a misunderstanding about the potential side effects or how the inoculation worked – so she worked hard to provide a full briefing on flu immunisation and be prepared for any questions which may arise. To overcome this the Board thanked Patricia for her tireless drive and enthusiasm and achievement of such a great result.	

Patient Story
Nadine King, 43, a single mum with two daughters, shared her story of being a patient with malignant melanoma. She had been diagnosed in 1999 and had been treated at St George's since 2009 undergoing all types of therapy including having her lymph glands removed and having chemotherapy; she was still receiving palliative care and some radiotherapy. She explained the huge changes since more support had been provided through Macmillan – which had freed up Macmillan Melanoma Clinical Nurse Specialist, Carol Cuthbert, to concentrate on clinical duties whilst Sheila Horsman, Macmillan Support Worker, focused more on the administration of cancer support and providing a personal service to patients who were attending for treatment, for example meeting them on arrival and making them feel comfortable. The Chairman and the Board thanked Nadine for sharing her inspiring story and to Carol and Sheila for their commitment and support.

Date and Time of Next Meeting: Thursday 25 January 2018, from 10:00 (feedback from Board Walkabout) and 10:30 (meeting proper)

Trust Board Action Tracker - 25.01.18

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.06.07.17/35	**Fit & Proper Persons Regulations**	Provide a quarterly and annual report on compliance with the Fit & Proper Persons Regulation to the Board.	TB.22.02.18		DHROD	This was reviewed at the November Board meeting and this scheduled date for review is TB.22.02.18.	Ongoing
TB.06.07.17/36	**St George's Charity**	Schedule a meeting with between the Board and the Trustees of the St George's Charity every six months.	TB.25.01.18		Trust Sec	Not yet due.	Ongoing
TB.07.09.17/43	**Consultant Attribution**	Advise how consultant attribution is agreed and report this to the Quality Committee.	QSC.21.12.17		Acting MD & Nigel Kennea	As the agenda was very full with additional items to consider, this item was deferred to the December 2017 meeting of the Committee.	Open
TB.07.09.17/44	**Medical Revalidation**	Provide interim reports Medical Revalidation to the Workforce & Education Committee.	Q4 2017-18		Acting MD & Karen Daly	Medical revalidation is part of the WEC remit and when exactly it will fall in the annual cycle is currently under consideration and will be presented as part of the revised terms of reference and annual cycle to the next meeting (January 2018).	Open
TB.05.10.17/46	**All and New Harms**	Quality Committee to explore how further improvements can be made for all and new harms.	QC during Q3 2017-18		MD	Item transferred to Quality Committee forward plan.	Open
TB.05.10.17/47	**Emergency Prepardness, Resilience & Response**	Board to receive a further update on the Trust's compliance with core standards against its duties as a Category 1 responder following the review by NHS England.	TB.25.01.18		COO	Not yet due.	Open
TB.09.11.17/52	**Board Assurance Framework**	Present a fully populated Board Assurance Framework to the Board in January 2018.	TB.25.01.18			On agenda	Proposed for closure
TB.07.12.17/53	**ICT**	Present a detailed plan for the future of the Trust's ICT to the Board in January 2018	TB.25.01.18		CFO	On agenda	Proposed for closure
TB.07.12.17/54	**Trust's Strategic Objectives**	Present a quarterly update on progress against the Trust's strategic objectives.	Mar-18		DOS	Not yet due.	Open
TB.07.12.17/55	**SWL STP**	Present a regular update on the Trust's progress with the SWL STP to its meeting in private.	Feb-18		DOS	Not yet due.	Open
TB.07.12.17/56	**Single Oversight Framework**	Present to the Board on 25.01.18 the results of the review against Key Line of Enquiry 6 Is appropriate and accurate information being effectively challenged and acted on?	TB.25.01.18		DDET	On agenda	Proposed for closure

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	25 January 2018	**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, 25 January 2018

1.0 PURPOSE

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

1.2 I am pleased to say that the past few weeks have been productive as well as challenging – although the operational pressures on the Trust, and the wider NHS as a whole, have been significant.

1.3 As we all know, the NHS – and its ability to cope with 'winter pressures' – has been a permanent fixture in the national news over Christmas and the New Year period.

1.4 At St George's, I believe we have coped reasonably well with the increased demand on our services – but I also know there are lessons to be learned so we can do better in the future, and I will touch on this briefly in this report to the Board.

1.5 Operational pressures aside, I have been impressed by the commitment that staff – both clinical and non-clinical - have shown to the cause and, whilst we don't always work as efficiently or as effectively as we might, there is no doubting everyone's desire to make things better.

2.0 LEADERSHIP UPDATE

2.1 I would also like to formally welcome Kevin Howell (Director of Estates and Facilities) and Suzanne Marsello (Director of Strategy) to their first Trust Board – it is great to finally have them as key members of the team.

3.0 OPERATIONAL PRESSURES

3.1 We worked hard to maintain performance of key services over the Christmas period, although we saw a deterioration in key areas, such as the Emergency Department at St George's.

3.2 Our performance for the Christmas and New Year period was in the region of 80% for the number of patients seen, treated or admitted and discharged from our ED within four hours.

3.2 This is significantly below where we want and need this key performance indicator to be. Patient satisfaction with the service remains high, which is a positive, but we want to see performance improve. Indeed, I want us to look at how we managed operational pressures over the Christmas and New Year period, and what lessons can be learned. We were impacted by outbreaks of flu and, to a lesser extent, Norovirus - but, despite this, we could have improved patient flow, and improved performance, by getting the basics right in some areas.

3.3 For example, in some areas, ward rounds aren't starting until 11am - this is frustrating in terms of being able to manage discharge effectively, but is also not good for patients, many of whom will be fit and well, and ready to go home. Communication between different teams also needs to improve - in some cases, we have had medical or surgical beds available, but patients requiring admission waiting in ED for a bed.

3.4 I remain optimistic, however. We continue to look at new ways of improving ED performance and flow through the hospital - and the comm cell meeting we run each Wednesday morning helps to crystallise our thinking, and ensure learnings are shared across the organisation. I am confident we will get there, but there is a huge amount still to do.

4.0 ELECTIVE CARE RECOVERY PROGRAMME

4.1 As you know, our Elective Care Recovery Programme is making sure we tackle our historical data quality challenges at the Trust and, as important, equipping us with systems for tracking patients that are truly fit for purpose.

4.2 This month, we reached an important milestone in the project, with a new patient tracking list (PTL) being rolled out across our Tooting site. This represents a major change for the organisation, but an extremely positive one - and gives us greater confidence that patient pathways are being effectively logged and tracked.

4.3 Of course, this doesn't solve the problem that some patients are still waiting longer than they should for treatment. Indeed, there is going to be a short-term increase in the length of some of our waiting lists, as some patients identified through the historical validation exercise we have carried out are added back onto our live waiting lists.

4.4 However, this shouldn't detract from the fact that we are now moving into a new phase of the project – which brings us closer to potentially being able to return to reporting of our national figures.

5.0 OUR FINANCIAL POSITION, AND PLANNING FOR 2018/19

5.1 As well as addressing our performance and quality challenges, we remain focussed on delivering our year end deficit of not more than £53 million.

5.2 Balancing our books is a key part of delivering Outstanding Care, Every Time for our patients - this is going to be challenging, but the more progress we make towards reducing the deficit this year, the healthier position we put ourselves in for delivering further savings in 2018/19.

5.3 A number of our cost improvement plans are delivering in line with projections - for example, spending on agency staff is on track to be half what it was in 2016/17 - and

we continue to look at new and additional ways of saving money without negatively impacting on patient care.

5.4 We are also developing cost improvement plans for 2018/19, which is so important if we are to start the next financial year as we mean to go on. All of our plans will be subject to quality impact assessments, as it is crucial we don't compromise quality and performance, even if the financial imperative is so acute.

5.5 Next year will be incredibly tough as, whilst we expect to have reduced our annual deficit, we have not been able to reduce our run rate significantly.

5.6 Many areas of the Trust are now managing and taking responsibility for their budgets, which is a real improvement. However, it is also very clear that many wards and departments are not at this point yet, but we need them to be.

5.7 We have started to run training and development sessions for areas that are struggling and, in undertaking bottom up budget setting for next year, there should be no reason why managers do not have the right budget for the services their teams provide.

5.8 In developing a new accountability framework, we will be expecting individuals to take responsibility for managing their budgets, whilst also reducing expenditure.

6.0 CELEBRATING OUR STAFF, AND THEIR ACHIEVEMENTS

6.1 I want to end by talking briefly about our staff, and their achievements over recent weeks.

6.2 I am pleased to say that over 87% of our staff have now had their flu vaccination - a phenomenal achievement.

6.3 ITV London profiled our flu campaign last week as an example of best practice for others to follow - although we want to do better next year !

6.4 The 100th episode of 24 Hours in A&E at St George's was broadcast in mid-January, giving our ED team a reason (were it needed) to celebrate the work they do, and the contribution they make to the hospital.

6.5 The feedback we get about the series is so positive, and the attention and praise our ED team has had this past week is well deserved.

6.6 This week also saw the official launch of our surgical education partnership with the Royal College of Surgeons.

6.7 Our simulation and skills centre will deliver the College's education courses for the next three years, becoming its education hub for the south of England. This is a fantastic for St George's, and an important relationship for the Trust.

6.8 Finally, I am pleased that we have received over 100 nominations already for the staff appreciation awards.

6.9 The awards ceremony in March promises to be a fantastic event, and we are extremely grateful to the St George's Hospital Charity for organising and championing the event.

7.0 RECOMMENDATION

7.1 To receive the report for information.

Date of the Committee Meeting: 21 December 2017

1. Matters for the Board's Attention

1.1. QIP Workstream Deep Dive- Thematic Learning Serious Incidents

Renate Wendler, Associate Medical Director informed the committee that the aim is to promote a culture where all staff are confident to report incidents and have access to learning from investigations and feel empowered to make changes to prevent repeated incidents happening in future.

The report detailed:

- An overview of completed initiatives to enhance learning from incidents
- Results from thematic SI analysis from 2016/17 Sis with resulting recommendations for further Trust wide and Divisional actions
- Results from a "snap shot" staff survey on learning from incidents during Quality Improvement week
- Data on Duty of Candour compliance and timely completion/ quality of SI investigations
- Further initiatives planned by the work steam

It was agreed that an action plan of policies was required with dates of completion and responsible owners and this would be presented at the January 2018 committee.

The committee agreed that clear, brief one page policies should be made available to all staff and that this piece of work requires to be undertaken. The committee was also informed that the Executive Directors were responsible for their departments' policies.

1.2. Quality and Performance

The committee received the Integrated Quality and Performance Report. The Committee noted that the complaints performance has fallen against the new timescales for complex complaints and the 25 working day timescale. The Committee was also concerned about the quality of the responses. The Chief Nurse told the committee that different models will be considered and presented to the committee in January 2018 with a view to making changes by April 2018.

The committee noted the missing VTE data for October and November. The Chief Nurse informed the committee that she would investigate why the data was missing and report back at the following committee.

The committee agreed that the Quality Improvement Plan Dashboard will be regularly reviewed at the committee.

1.3. Water Quality- dates of implementation

The committee agreed that the action plan should be tabled at the committee on a quarterly basis as it is currently being reviewed monthly at the Water Safety Committee.

The committee were assured that actions are being carried out as agreed and reported to the Water Safety Committee.

The committee requested that the Water Safety Committee develop an action plan including completion dates and to report back to the Quality and Safety Committee in February 2018

Queen Mary hospital should also be included in the actions to be carried out and these should also be reported to the Water Safety Committee.

1.4. Annual Report on Litigation- increase in premium

The committee received the annual report on litigation and inquests. The Committee were informed that the Trust contribution to NHS Resolution (NHSR) has increased significantly since NHSR moved to assessing trusts on the basis of their claims history and stopped discounting contributions based on compliance with risk management standards.

1.5. Board Assurance Framework (BAF)- further work required by the committee

The committee agreed the ratings for strategic risks assigned to the Committee are correct but were not in a position to approve the assurance rating as further work is required. The committee were informed that the risk appetite statements will appear in the BAF report once agreed by the Board. Elizabeth Palmer informed the committee that the risk levels of the corporate risks are reviewed and agreed at the Risk Management Executive.

Report to the Board from: Quality and Safety Committee

Committee Chair: Sir Norman Williams

Date of the Committee Meeting: 18 January 2018

1. Matters for the Board's Attention

1.1. Mortality Monitoring Committee Report

Dr Nigel Kennea, Associate Medical Director provided an update on the work of the Mortality Monitoring Committee for the first 3 quarters of 2017/18. The report included a summary of the independent reviews completed and detailed the most recent learning. It also summarised progress against implementation of the 'Learning from Deaths' framework launched in March 2017. Our work has been highlighted and presented at the national 'Learning from deaths-one year on' event in December 2017.

The committee agreed that the Mortality Report should be added as an agenda item to the January Trust Board.

1.2. Outpatient Deep Dive

The committee received a deep dive report from the outpatient workstream of the Quality Improvement Plan on what has been delivered within Outpatients, particularly in relation to the current 'inadequate' CQC rating.

Good progress has been made to date against the CQC feedback including a 3.8% reduction in DNA rates since the time of inspection, 38% of outpatients are seen with an electronic record on EDM (electronic document management) outcome forms are in use in 79% of Outpatients appointments, Knightsbridge Wing has been fully decommissioned and Lanesborough footfall has been reduced by 15%, however use of outcome forms is below 80%. The committee recognised the good work in progress however felt that the 'inadequate' rating given to outpatients in the Trust's recent self-assessment was appropriate at this time.

1.3. Quality Improvement Plan Dashboard

The committee received an update and noted the improvement and that the dashboard was well presented.

The dashboard provided an overview of the KPIs against the CQC domains, and had been extended to show each KPI mapped to core service and domain.

1.4. Elective Care Recovery Programme Update

The committee received an update from the Chief Operating Officer.

The committee noted that the Elective Care Programme was heading in the right direction however it remained concerned regarding the Deloittes' Governance report and advised that clinicians were required to take ownership.

The committee were informed that the Trust now has a new PTL circa 37,000 patients. This is much closer to estimates of PTL size when benchmarking the Trust to other similar Trusts.

1.5. Report of proceedings of the PSQG - December 2017

The committee received an update of proceedings of the meeting held on 20 December 2017.

The committee was informed that that there have been a further 3 'Wrong Blood in Tube' (WBIT) incidents reported, bringing the total number reported for 2017/18 to thirteen. These specific incidents caused no harm to a patient, however the potential for serious harm from a WBIT incident is high. There is an electronic solution to this problem and a business case is being submitted to address the problem.

The committee noted the gaps identified in the November 2017 Quality Review and the action taken. The Committee was told about the programmes of audit and review being carried out across the Trust. These include the monthly Quality Observatory inspections and the weekly audits reported at the Back to the Floor meeting attended by the senior nurses of the Trust. The Committee asked for an overview of this work.

1.6. Developing our complaints service

The committee asked at its December meeting for alternative models of complaint handling to be considered. Three models were presented to the committee and it was noted that all options have an impact on the resourcing of complaint handling at St George's. The models are being worked up as an options appraisal for consultation to support a business case.

1.7. Consent Audit

The committee received the results of the consent audit and noted that the results show no improvement on the previous audit. . The Committee were informed that consent is identified as a workstream in the Quality Improvement Plan; the full project has not yet been defined. The project will have terms of reference drafted and will be taken to the Quality Delivery Meeting for approval.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 25th January 2018
Reporting period - December 2017

Excellence in specialist and community healthcare

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

Data for the month of December

Daycase and Elective Surgery operations

Actual
3,682

Target 3,799

Discharges before 11am

Actual 13.1%

Target 30%

Four Hour Emergency Standard

Actual
85%

Target 95%

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
84%

Target
83%

Whole Trust Inpatient Friends and Family Test

Actual
96%

Target
95%

Outpatient First Appointment

Actual 13,081

Target 14,258

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	
		Dec-16	Dec-17	Variance	Plan Dec-17	Variance	YTD 16/17	YTD 17/18	Variance	Plan YTD	Variance
ED	ED Attendances	13,575	13,532	-0.32%	14,715	-8.04%	123,918	124,788	0.70%	130,533	-4.40%
Inpatient	Elective & Daycase	3,988	3,682	-7.67%	3,805	-3.23%	39,128	40,673	3.95%	40,859	-0.45%
	Non Elective	4,010	3,898	-2.79%	4,369	-10.78%	36,441	35,079	-3.74%	38,756	-9.49%
Outpatient	OP Attendances	47,394	42,095	-11.18%	42,589	-1.16%	484,641	473,793	-2.24%	463,469	2.23%

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

Source: SLAM

Executive Summary – December 2017

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- No Never Events reported in December. The Trust has reported three events year to date. There were two Serious Incidents declared in the month.
- In December the Trust reported no patients with hospital attributable Clostridium Difficile infection, year to date the trust remains at thirteen cases.
- No patients acquired an MRSA Bacteraemia in month, the trust total year to date is four against a ceiling of zero.
- Patient safety thermometer – the percentage of patients with harm free care (new harm) remains consistently better than the 95% threshold. [*The 'new harm' patient safety thermometer looks at harms acquired by patients while in hospital.*]

Clinical Effectiveness

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

Access and Responsiveness

- The Four Hour Operating Standard was not achieved in December reporting a performance of 85.0% of patients admitted, discharged or transferred within four hours of arrival. This was below the improvement trajectory agreed with NHS Improvement and the trust wide Delivery Risk Summit is being followed up to review the impact of the agreed immediate actions for recovery.
- Cancer 62 day Standard Trust performance was below target in November reporting 80.5%, however internally this was achieved with a performance of 90%, all other cancer standards were achieved.
- The Trust has returned to compliance against the 6 week Diagnostic Access standard, reporting 0.1% of our patients waiting greater than six weeks for a diagnostic procedure.

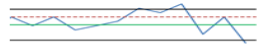
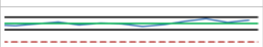
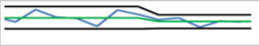
Patient Experience

- The Friends and Family Test (FFT) recommendation rate for inpatients was 95.6% and for Outpatients was 98.2% in December. This remains above threshold. Response rates are strong for inpatients but below expectations for Outpatients. The recommendation score for inpatients provides reasonable assurance on the quality of patient experience. Given the low response rate for outpatients the assurance it provides on patient experience is less significant. This is being addressed by the outpatient transformation team as part of the Quality Improvement Programme.

Workforce

- Staff sickness remains above the trust target of 3% for the month of December
- Non Medical appraisal rates have seen a decline in performance within the reporting period at 72.2%. Medical appraisal rates have decreased to 78.9%, both remain below target.
- The Trust has significantly reduced agency cost, reducing from £42m to a forecasted position of less than £22m for year end.

Patient Safety

Indicator Description	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend (12 months)
Number of Never Events in Month	0	0	1	0	0	0	1	1	0	0	1	0	0	
Number of SIs where Medication is a significant factor	0	1	0	0	0	0	0	1	1	1	0	0	0	
Number of Serious Incidents	8 / mth	8	6	8	5	6	7	10	9	11	4	8	2	
Serious Incidents - per 1000 bed days	N/A	0.32	0.26	0.31	0.21	0.24	0.29	0.40	0.38	0.45	0.16	0.32	0.08	
Safety Thermometer - % of patients with harm free care (all harm)	95%	94.7%	93.7%	94.5%	94.6%	94.3%	94.7%	93.8%	93.8%	95.7%	94.9%	95.0%	95.1%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.6%	97.9%	98.2%	97.7%	98.0%	97.9%	97.5%	97.8%	98.3%	98.7%	98.1%	98.5%	
Percentage of patients who have a VTE risk assessment	95%	96.8%	96.5%	96.3%	95.3%	96.2%	96.3%	95.8%	95.7%	95.4%	TBC	TBC	TBC	
Number of Patient Falls	N/A	161	137	154	111	137	132	143	127	125	123	156	127	
Number of patient falls- per 1000 bed days	N/A	6.52	5.85	6.03	4.73	5.39	5.48	5.71	5.29	5.15	4.93	6.19	5.20	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	0.53	1.20	0.78	0.72	0.28	1.16	0.92	0.63	0.74	0.28	0.64	0.53	
Number of Grade 3 & 4 Pressure Ulcers	N/A	3	2	3	2	1	0	1	1	2	0	0	0	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.12	0.09	0.12	0.09	0.04	0.00	0.04	0.04	0.08	0.00	0.00	0.00	
Number of overdue CAS Alerts	0	1	1	1	1	1	0	0	0	0	0	0	0	

Briefing

- No Never Events reported in December, the Trust total remains at three year to date.
- The Trust declared two serious incidents in December 2017. A number of serious incidents have been de-escalated and are reflected in the table above.
- The falls rate is calculated to reflect the rate used in national audits and is shown above for the past 12 months. Using this rate we can benchmark ourselves against the rate of 6.6 falls per 1000 bed days that was found in acute hospital settings by the *National Audit of Inpatient Falls (2015), Royal College of Physicians.* Our falls rate has been lower than that found by the RCP for the past 12 months, observing a decrease in December reporting 5.20 falls per 1000 bed days.

Infection Control

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

Briefing

- There were zero patients reported to have suffered with a hospital acquired Clostridium Difficile Infection in December.
- C Diff threshold for 2017/18 remains the same as the previous year at 31 cases. There have been thirteen cases year to date.
- No reported cases of MRSA Bacteraemia in December. The Trust year to date total stands at 4

Mortality and Readmissions

Indicator Description	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	84.1	83.3	82.5	82.5	83.5	81.3	82.9	79.7	81.1	80.6	81.3	81.4	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	82.4	81.1	79.9	79.2	80.1	78.2	78.9	76.4	77.4	77.2	77.5	76.6	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	86.7	86.8	85.6	84.2	86.0	83.5	85.4	81.3	81.8	81.2	82	83.8	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.88	0.88	0.86	0.86	0.86	0.84	0.84	0.84	0.84	0.84	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	TBC	8.9%	10.2%	9.3%	9.5%	9.7%	9.7%	8.9%	9.0%	9.7%	10.2%	9.20%		

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 observed a decrease in November reporting 9.2 of patients were re-admitted to hospital within 30 days of discharge. Analysis shows that 24.6% of these patients are over the age of 80 with patients diagnosis including: Bronchitis, Urinary tract infection, sepsis.

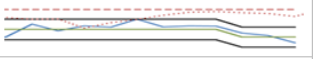
Maternity

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

Indicator Description	Threshold	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
C Section Rate - Emergency and Non Elective	28%	28.8%	29.6%	34.1%	29.9%	29.1%	24.6%	29.5%	24.9%	30.2%	29.7%	31.8%	25.4%	
Admission of full term babies to neo-natal care		2	7	2	11	2	16	21	20	15	10	16	6	

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 incident reporting through the addition of subcategories to assist in thematic reviews. A review of local and national data is to be completed.

Emergency Flow

Indicator Description	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
4 Hour Operating Standard	95%	86.63%	90.59%	89.09%	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	87.17%	84.99%	
Patients Waiting in ED for over 12 hours following DTA	0	0	1	0	0	1	0	0	0	0	0	1	0	
Ambulance Turnaround - % under 15 minutes	100%	46.9%	52.4%	50.2%	46.0%	48.4%	51.9%	48.9%	50.5%	50.9%	49.9%	49.0%	41.7%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	38.9%	42.5%	43.4%	43.7%	45.3%	47.5%	46.4%	47.0%	46.5%	45.1%	46.1%	40.6%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	81	37	53	79	72	71	53	84	71	57	82	106	
Ambulance Turnaround - % under 30 minutes	100%	96.4%	98.1%	97.6%	96.1%	96.7%	96.5%	97.4%	96.0%	96.6%	97.4%	96.2%	96.9%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	85.4%	90.3%	90.7%	91.8%	92.3%	93.3%	93.2%	93.1%	92.2%	91.9%	91.7%	91.6%	
Ambulance Turnaround - number over 60 minutes	0	0	0	0	1	1	0	1	1	0	0	0	2	

- The Four Hour Operating Standard was not achieved in December reporting a performance of 85.0%. This was also below the improvement trajectory agreed with NHSI.
- Ambulance turnaround performance has seen a stable trend, with 30 minute handover reporting 96.9% in December and remaining above London average, however a performance decrease was observed within 15 minute handover times. Two ambulance handover 60 minute breaches were reported.
- 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. Bed occupancy for our acute wards remains above 90% with further bed pressures due to norovirus and Flu.

Actions

- Delivery Risk summit held in November 2017 identified and agreed a series of immediate remedial actions. A subsequent Risk Summit on 4 hour operating performance is to be held on 18/01/2018 Chaired by the Chief Executive with Executive members, Senior Managers, Clinical Care Group Leads, Senior Nurses and Allied Health Professionals to review impact at specialty level Junior Doctors.
- The unplanned and admitted patient care programme led by divisional chair for Medicine and Cardiothoracic Division supported by clinicians throughout the Trust aims to provide patients with alternatives to emergency admission and to accelerate discharge to reduce overall bed occupancy.
- SAFER bundle is being rolled out to improve patient safety and remove non added value delays in the inpatient journey.
- Revised Trust Internal Professional Standards and Escalation policies have been launched
- Partnership working has been escalated to free inpatient capacity by lowering the number of patients awaiting continuing care elsewhere including repatriation to other Acute Hospitals. Delayed Transfers of Care levels remain at a nationally low level.

Cancer

Indicator Description	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Trend (12 months)
Cancer 14 Day Standard	93%	87.9%	87.9%	86.0%	75.4%	76.6%	67.4%	80.3%	89.7%	93.98%	96.05%	97.25%	
Cancer 14 Day Standard Breast Symptomatic	93%	94.0%	93.4%	87.2%	82.7%	84.1%	62.9%	86.9%	90.3%	98.2%	99.6%	98.0%	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	95.1%	100.0%	94.6%	96.4%	95.9%	94.2%	90.9%	95.8%	82.4%	94.1%	96.9%	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Cancer 31 Day Diagnosis to Treatment	96%	96.4%	97.5%	96.7%	96.4%	96.4%	96.8%	96.9%	96.2%	96.2%	98.1%	96.9%	
Cancer 62 Day Referral to Treatment Standard	85%	87.7%	86.6%	86.3%	89.0%	87.3%	85.4%	77.8%	75.6%	76.7%	85.5%	80.8%	
Cancer 62 Day Referral to Treatment Screening	90%	93.0%	96.2%	92.6%	92.7%	92.4%	92.5%	86.1%	92.5%	93.0%	78.4%	92.7%	
Cancer 62 Day Consultant Upgrade	85%	100.0%	97.7%	85.7%	88.9%	100.0%	100.0%	100.0%	66.7%	100.0%	87.5%	100.0%	

- The Trust has continued to observe significant improvement against the eight cancer standards, achieving seven out of eight standards in the month of November.
- The 14 day standard was achieved reporting 97.25%, above the national standard for a third consecutive month. Increased leadership and management support given to Two Week Rule office has increased performance against both 10 day booking observing a significant shift and contact with patients within 48 hours. Pro-active escalation and response time to capacity issues has also further enhanced the booking process.
- The Trust did not meet the 62 day urgent GP referral standard with a performance of 80.8%. However, the Trust exceeded the target internally (St Georges patients alone) with a performance of 90%. In total 9.5 patients started treatment above the 62 day standard.

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

	Target	Actual Performance	Internal Performance
Sep-17	85%	76.7%	82%
Oct-17	85%	85.5%	100%
Nov-17	85%	80.8%	90%

Breakdown

Shared Breaches (6.5)

- 5 Late Inter Trust Transfers from other provider (defined as after day 38)
- 1 Complex pathway
- 0.5 Patient unfit for Surgery

Internal Breaches (3)

- 2 Delay in pathway management
- 1 Capacity

Actions

- Increased leadership and management has been given to the Two Week Wait office.
- The Trust are reviewing patient pathways of key tumour sites as part of the work with RM Partners in order to improve time to treatment for patients referred from other providers.
- New profile trajectories to be set for 14 day booking with an aim of achieving 10 day booking by the end of January.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Brain	93%	100.0%	66.7%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast	93%	93.0%	96.1%	89.9%	92.3%	88.7%	84.7%	69.5%	76.4%	93.4%	94.1%	97.4%	98.4%
Childrens	93%	100.0%	100.0%	100.0%	90.0%	66.7%	80.0%	66.7%	80.0%	100.0%	100.0%	100.0%	71.4%
Gynaecology	93%	95.7%	76.0%	75.4%	87.1%	64.6%	66.7%	75.6%	93.4%	90.4%	91.1%	90.8%	95.0%
Haematology	93%	100.0%	100.0%	100.0%	95.8%	76.2%	96.9%	76.9%	95.7%	100.0%	100.0%	96.8%	100.0%
Head & Neck	93%	95.9%	98.4%	97.4%	97.9%	90.9%	84.9%	82.4%	88.0%	82.4%	90.6%	99.1%	99.4%
Lower Gastrointestinal	93%	98.3%	95.7%	95.7%	90.5%	75.1%	90.7%	44.4%	60.0%	73.9%	94.6%	97.4%	97.7%
Lung	93%	100.0%	98.2%	100.0%	100.0%	96.2%	91.1%	91.2%	95.6%	100.0%	94.1%	97.7%	100.0%
Skin	93%	79.4%	67.1%	67.7%	57.4%	29.4%	48.1%	26.9%	74.3%	96.6%	93.4%	95.0%	95.5%
Upper Gastrointestinal	93%	96.6%	87.8%	95.3%	94.2%	88.8%	96.1%	93.8%	97.6%	98.8%	98.8%	98.5%	99.0%
Urology	93%	96.9%	98.1%	95.0%	98.4%	96.1%	90.1%	82.3%	93.8%	97.0%	96.4%	93.3%	97.1%

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Brain	85%	-	-	-	100.0%	50.0%	-	0.0%	100.0%	0.0%	100.0%	-	100.0%
Breast	85%	86.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	91.7%	100.0%	95.2%
Childrens	85%	-	-	100.0%	-	-	-	-	-	0.0%	-	-	-
Gynaecology	85%	92.3%	100.0%	100.0%	50.0%	100.0%	90.9%	100.0%	61.5%	100.0%	50.0%	83.3%	75.0%
Haematology	85%	70.0%	80.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	-
Head & Neck	85%	100.0%	63.6%	72.7%	75.0%	58.3%	85.7%	46.2%	66.7%	71.4%	87.5%	78.6%	81.8%
Lower Gastrointestinal	85%	93.3%	76.5%	66.7%	71.4%	-	62.5%	100.0%	60.0%	100.0%	66.7%	100.0%	80.0%
Lung	85%	66.7%	80.0%	78.6%	73.7%	85.7%	85.7%	64.3%	41.7%	47.4%	72.2%	72.7%	41.2%
Skin	85%	100.0%	100.0%	95.5%	100.0%	93.3%	96.4%	95.7%	100.0%	76.5%	93.8%	90.9%	91.7%
Upper Gastrointestinal	85%	100.0%	50.0%	11.1%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%	0.0%	100.0%	84.0%
Urology	85%	70.4%	85.2%	87.9%	83.9%	90.0%	67.9%	81.8%	63.0%	64.3%	77.4%	100.0%	72.7%

Diagnostics

Indicator Description	Threshold	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
6 Week Diagnostic Performance	1%	5.1%	2.8%	2.9%	4.1%	3.3%	2.2%	2.7%	2.0%	1.4%	0.3%	1.9%	0.1%	
6 Week Diagnostic Breaches	N/A	372	219	222	312	248	173	190	154	98	22	143	6	
6 Week Diagnostic Waiting List Size	N/A	7,358	7,871	7,678	7,550	7,442	7,843	6,988	7,751	7,184	7,072	7,534	6,440	

Indicator Description	Threshold	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
MRI	1%	9.6%	4.3%	3.3%	2.6%	1.1%	0.6%	0.8%	0.2%	0.1%	0.0%	0.0%	0.0%	
CT	1%	0.6%	0.0%	0.7%	1.5%	0.5%	0.2%	0.2%	0.3%	1.2%	0.3%	0.1%	0.0%	
Non Obstetric Ultrasound	1%	3.0%	1.9%	3.0%	4.0%	2.5%	0.3%	1.1%	0.9%	0.0%	0.0%	0.0%	0.1%	
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%	4.5%	2.5%	6.5%	10.1%	11.3%	4.6%	5.7%	4.5%	0.0%	17.4%	0.0%	
Echocardiography	1%	0.1%	0.1%	0.3%	1.2%	9.4%	2.0%	3.0%	0.3%	0.3%	0.3%	0.8%	0.0%	
Electrophysiology	1%	0.0%	100.0%	0.0%	0.0%	0.0%	75.0%	75.0%	100.0%	0.0%	100.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.5%	0.0%	0.5%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.3%	
Sleep Studies	1%											26.8%	0.0%	
Urodynamics	1%	0.0%	52.6%	55.0%	65.5%	75.6%	64.4%	64.2%	50.6%	37.0%	16.7%	6.7%	0.0%	
Colonoscopy	1%	20.2%	5.7%	8.7%	5.7%	4.7%	0.5%	1.8%	0.0%	0.4%	1.1%	0.0%	0.0%	
Flexi Sigmoidoscopy	1%	20.8%	12.0%	8.4%	6.7%	0.0%	1.1%	4.9%	0.7%	1.5%	0.0%	0.6%	0.0%	
Cystoscopy	1%	14.4%	9.9%	2.6%	15.0%	11.5%	24.4%	14.0%	12.3%	14.7%	4.0%	1.8%	1.5%	
Gastroscopy	1%	10.1%	3.2%	4.5%	12.7%	10.0%	9.2%	11.2%	6.7%	0.8%	0.0%	0.8%	0.4%	

Briefing: In December the Trust returned to compliance reporting 0.1% of patients waiting greater than 6 week for a diagnostic procedure.

After starting to report sleep studies in the Trust's November position, additional capacity and outsourcing was provided to reduce long waiting patients and the trajectory has been met and reporting zero breaches for December. The trajectory will continue to be monitored as part of the Trust's weekly escalation to ensure that the standard is maintained in all areas.

Actions

- Additional capacity and outsourcing to continue within Sleep Studies to aid sustainability. Business Case required for additional technician.
- Weekly Escalation meetings in place chaired by the Divisional Director of Operations.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
Number of on the Day Cancellations		104	91	63	58	72	64	84	54	49	52	86	100	
Number of on the Day cancellations re-booked within 28 Days		92	89	56	54	70	54	70	43	43	34	76	67	
% of Patients re-booked within 28 Days	100%	88.5%	97.8%	88.9%	93.1%	97.2%	84.4%	83.3%	79.6%	87.8%	65.4%	88.4%	67.0%	

Briefing

- The table above shows that the number of patient procedures cancelled on the day has remained in line with previous months.
- In December 100 patients were cancelled on the day for non clinical reasons of which 67 patients were re-booked within the 28 day standard. In Quarter 3, there were a total of 238 non clinical cancellations, of which 74.4% were rebooked within 28 days.
- When compared with our peers, St George's has a high number of reportable on the day cancelled operations and services are working to improve this across all areas. The top three reasons for last minute cancelled operations are: 1. lack of theatre time, 2. an emergency case taking priority, 3. bed unavailability. These three reasons account for approximately 67% of last minute cancellations.

Actions

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

Patient Experience

Patient Voice

Indicator Description	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
Emergency Department FFT - % positive responses	90%	85.0%	86.3%	82.8%	85.2%	83.0%	85.2%	83.9%	85.9%	83.5%	86.4%	84.1%	86.5%	
Inpatient FFT - % positive responses	95%	96.2%	96.9%	96.7%	95.8%	97.3%	96.0%	96.6%	96.8%	96.5%	96.5%	95.7%	95.6%	
Maternity FFT - Antenatal - % positive responses	90%	No Responses		100%		85.7%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	89.0%	93.0%	97.0%	88.2%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	95.0%	93.0%	90.0%	94.1%	97.9%	95.4%	87.1%	96.4%	100.0%	92.6%	96.0%	100.0%	
Maternity FFT - Postnatal Community Care - % positive response	90%	100%	100.0%	100%	100%	100%	100%	100%	98%	100%	100%	91.6%		
Community FFT - % positive responses	90%	96.6%	96.2%	93.0%	93.0%	97.6%	96.3%	94.5%	98.3%	94.1%	98.9%	95.7%	96.5%	
Outpatient FFT - % positive responses	90%	94.8%	91.7%	88.1%	92.6%	95.6%	96.6%	94.2%	96.2%	94.4%	96.3%	94.3%	98.2%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		85	73	79	63	76	75	61	99	80	96	78	69	
PALS Received		363	346	294	299	299	234	268	170	203	185	298	262	

- ED Friends and Family Test (FFT) – The score has increased in December reporting 86.5% meaning that the percentage of patients recommending the service increased slightly compared to November. Performance has remained stable and compared to our London peers our response rate is one of the best in London.
- Maternity FFT – The score for maternity care are above local threshold and work to increase the number of patients responding continues.
- The number of complaints fell in the month of December reporting 69 compared to 78 in November. All complaints are now assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days, by the week commencing 27 February 2018 it will be possible to report on response times for all categories of complaints received in November (60 working days after the end of November). For 25 day complaints received in November 55% (29) were responded to within this time against the target of 85%. For 40 day complaints received in the first week of November 50% (5) have been closed within the 40 working day target. The full position for 40 day complaints will be available in week commencing 30 January 2018. Two 60 day complaints were received in November, neither of which have yet been closed however the targets for completion have not been reached.

Actions: The ED management team are reviewing the results from the FFT survey for the last quarter to determine any further themes for improvement, an example being the review of staffing model to ensure response nurses are available to support high volume periods and minimise delays for patients. Complaints and PALS: Reporting against the new timeframes for complaint responses will start in January 2018 and is part of a programme of work on improving complaints management in the Quality Improvement Plan (QIP).

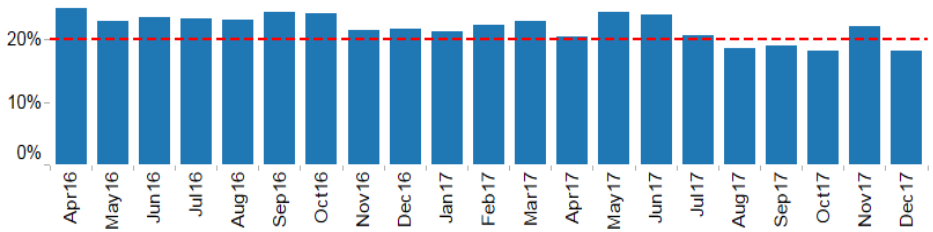
Patient Voice

CARING – Friends and Family Test

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

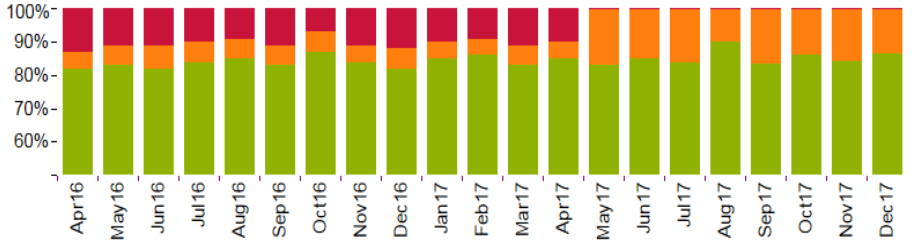
A&E Friends & Family Response Rate

Target: 20% Nov 17: 22.10% Dec 17: 18.09% Movement: ▼-4.01%



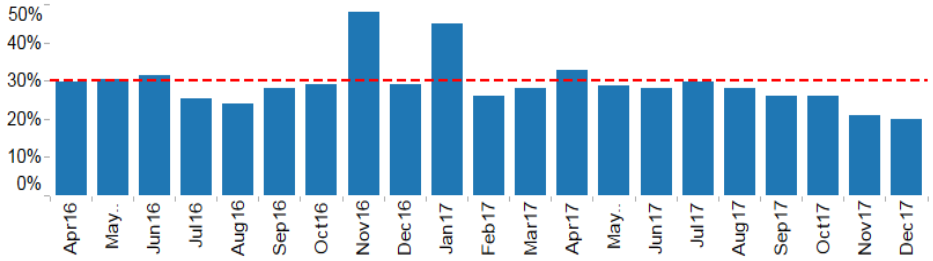
A&E Friends & Family Recommend Rate

The expected target is 90%



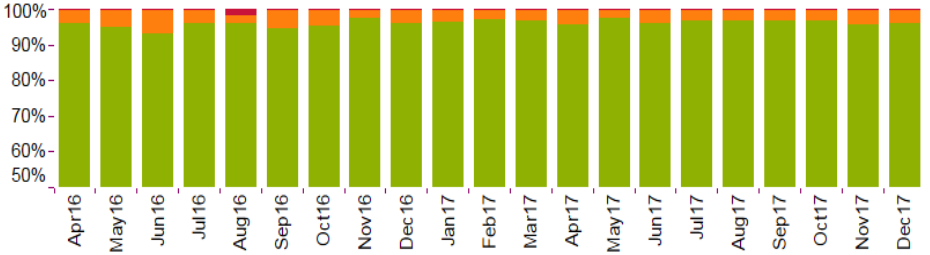
IP Friends & Family Response Rate

Target: 30% Nov 17: 21.10% Dec 17: 19.88% Movement: ▼-1.22%



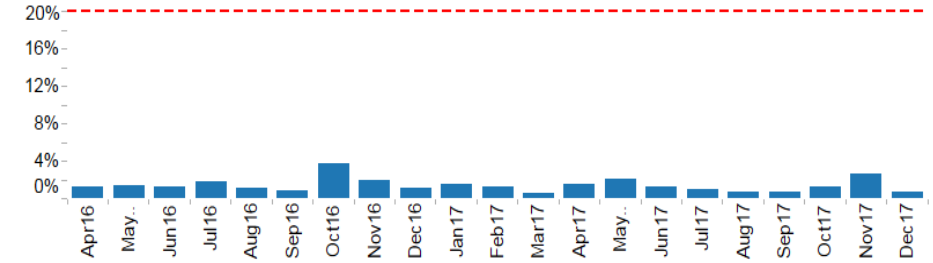
IP Friends & Family Recommend Rate

The expected target is 95%



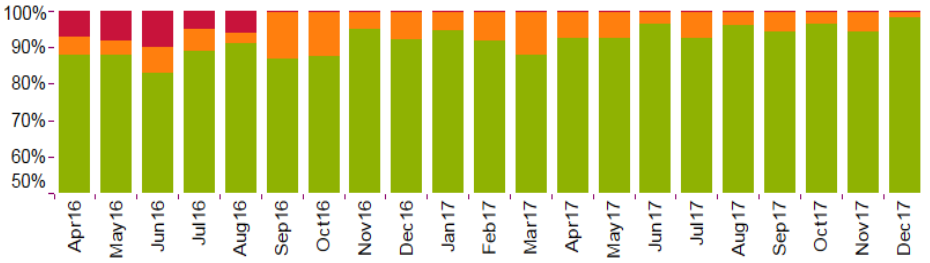
OP Friends & Family Response Rate

Target: 20% Nov 17: 2.60% Dec 17: 0.70% Movement: ▼-1.90%



OP Friends & Family Recommend Rate

The expected target is 90%



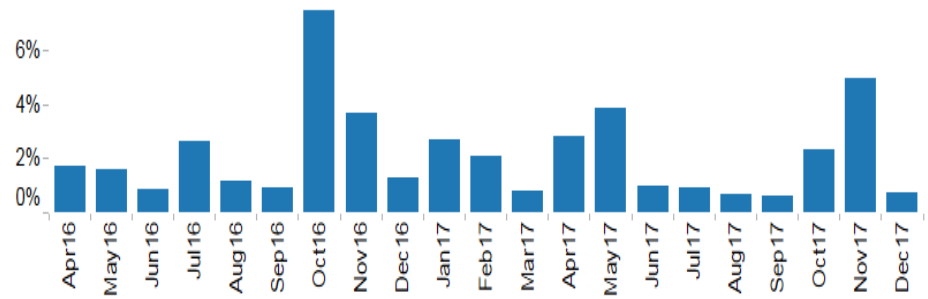
Patient Voice

CARING – Friends and Family Test

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

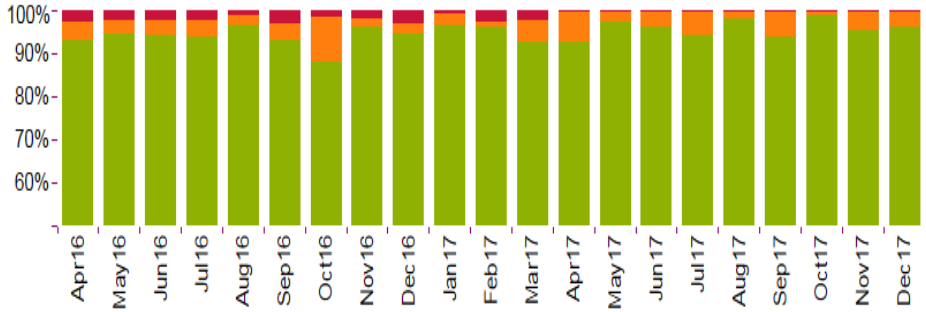
Community Friends & Family Response Rate

Target: 20% Nov 17: 5.00% Dec 17: 0.74% Movement: ▼-4.26%



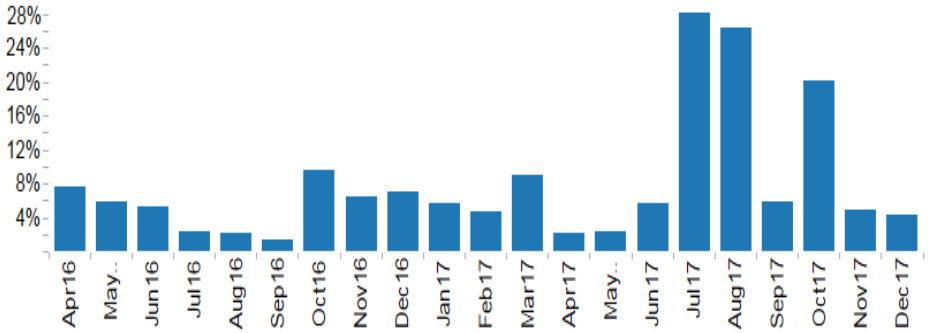
Community Friends & Family Recommend Rate

The expected target is 90%



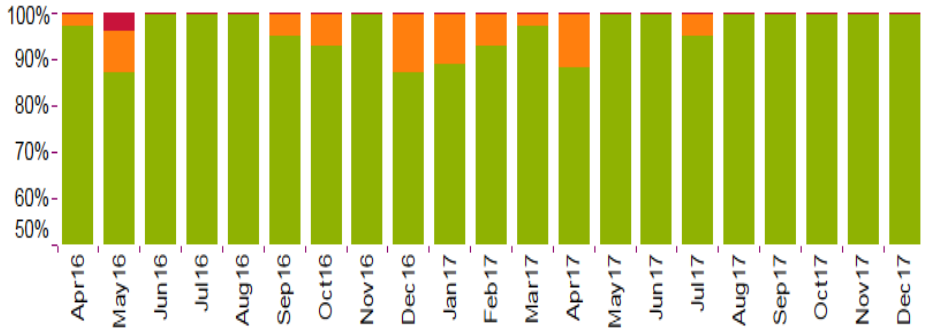
Maternity (Birth) Friends & Family Response Rate

Target: 20% Nov 17: 4.80% Dec 17: 4.37% Movement: ▼-0.43%



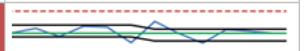
Maternity (Birth) Friends & Family Recommend Rate

The expected target is 90%



St George's University Hospitals NHS
NHS Foundation Trust

Workforce

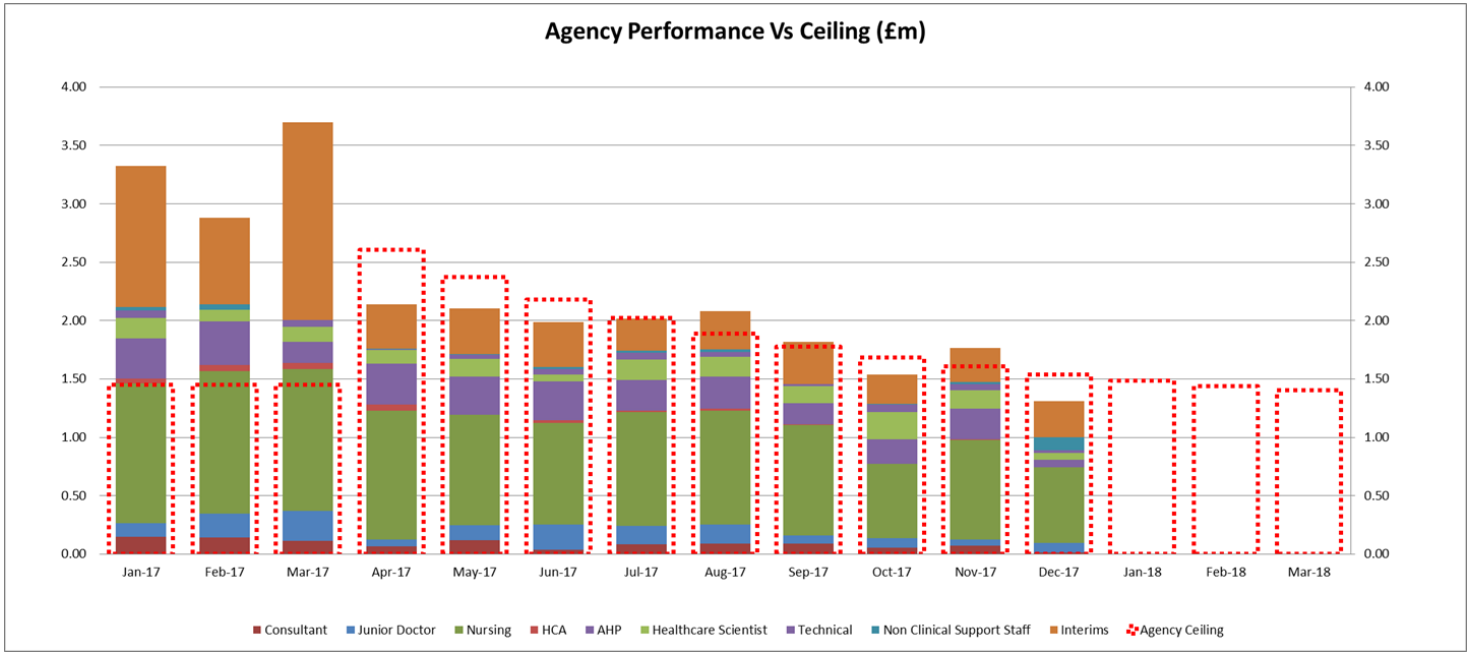
Indicator Description	Target	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Trend
Trust Level Sickness Rate	3%	3.7%	4.2%	3.8%	3.3%	3.2%	3.4%	3.4%	3.6%	3.7%	3.6%	3.4%	3.8%	3.6%	
Trust Vacancy Rate	10%	15.3%	15.1%	15.1%	15.4%	16.3%	17.0%	17.1%	16.1%	16.5%	14.8%	16.1%	12.7%	13.0%	
Trust Turnover Rate* Excludes Junior Doctors	10%	18.1%	18.4%	18.5%	19.1%	19.1%	19.1%	18.8%	18.4%	19.6%	18.5%	18.5%	18.3%	18.4%	
Total Funded Establishment		9,804.22	9,856.56	9,834.97	9,798.10	9,784.10	9,924.93	9,947.77	9,878.79	9,855.40	9,794.00	9,808.00	9,470.02	9,474.19	
IPR Appraisal Rate - Medical Staff	90%	76.0%	79.2%	81.3%	77.3%	82.4%	82.0%	74.2%	84.8%	79.0%	74.0%	80.7%	80.0%	78.9%	
IPR Appraisal Rate - Non Medical Staff	90%	64.1%	67.5%	70.4%	72.8%	80.3%	78.2%	76.1%	76.1%	75.1%	79.4%	73.5%	70.2%	70.2%	
% of Staff who have completed MAST training (in the last 12 months)		79.7%	81.9%	85.0%	85.0%	85.9%	87.0%	87.0%	86.0%	86.0%	85.0%	86.0%	87.0%	86.0%	
Ward Staffing Unfilled Duty Hours	10%	6.2%	4.6%	6.2%	4.8%	5.5%	4.8%	5.8%	5.9%	6.5%	5.9%	6.1%	6.6%	7.8%	
Safe Staffing Alerts	0	11	11	7	2	0	0	1	2	1	0	1	2	2	

* Excludes Junior doctors

Briefing

- Funded Establishment remained in line with previous month reporting 9,474 WTE in December.
- Vacancy Rate increased from 12.7% to 13%.
- Sickness has remained above 3% target reporting 3.6% in December.
- Mandatory and Statutory Training figures for December were recorded at 86%
- Appraisal rates remain below target, both Medical and Non Medical. Non medical appraisal rate remained at 70.2% in December and medical appraisal rate decreased with a performance of 78.9%.
- Percentage of Staff vaccinated against seasonal Influenza is 86% as at the 11th January 2018.

Agency Use



- The Trust's annual agency spend target set by NHSI is £24.5m. There is an internal annual agency target of £22.0m. For December, the monthly target set was £1.54m.
- Total agency cost in December was £1.31m or 3.3% of the total pay costs. From M1-9 2017/18, the average agency cost was 4.8% of total pay costs.
- Agency cost decreased by £0.46m compared to November. In 2017/18 YTD, the Trust has performed better than the planned target by £0.96m.
- In December, there has mainly been decreases in Nursing (£0.20m), AHP (£0.20m) and Healthcare Scientists (£0.10m), partially offset by an increase in Non Clinical Support Staff (£0.09m). In Nursing, there was a reduction in volume of hours due to the Christmas period.
- The biggest area of overspend was in Non Clinical Support Staff, which breached the target by £0.11m.
- These figures are compared to the internal target of £22.0m.

Meeting Title:	Trust Board (Part 1)		
Date:	25th January 2018	**Agenda No.**	**3.2**
Report Title:	Elective Care Recovery Programme Update		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Barry Mulholland Elective Care Recovery Programme Director		

Executive Summary:

Cancer

- Good progress being made on the operational milestones within the plan at SGH and work is underway to further enhance the Infoflex system (the IT system used to track patients through their treatment pathway).

Diagnostics

- Achieved compliance in December 2017 against the national waiting time standard of six weeks and the Trust is expecting to continue to meet this standard for Quarter 4 2017/18.
- Work underway on the development of a new diagnostic PTL for the Trust with expected delivery in March 2018.

Treating Patients

Cohort A (patients waiting greater than or equal to 40 weeks wait as at 01/09/17):

- Completed as per plan on 31st December 2017.

Cohort B (patients with a 52-week breach date between 25/11/17 and 31/03/18)

- Significant progress being made to reduce the numbers from the original baseline. On track to be completed as per plan by 31st March 2018.

Return to Reporting

- New referral to treatment (RTT) and planned Patient Tracking List (PTL) in place on the Tooting site of the Trust.
- The Queen Mary's Hospital site of the Trust PTL is now delivered but without RTT functionality (The Trust Board is asked to note that this RTT functionality will only be available once the PAS upgrade i.e. the Cerner deployment is complete).
- Three further PTLs are in development for the Trust – they will cover diagnostics (as referenced above), active monitoring and follow-up patients. The planned implementation date for these new PTL's is March 2018.
- The Trust has contacted all patients who had the potential to need an appointment as a result of the Phase 1 validation.

	Training • E-Learning in place and being rolled-out to 3500 Trust staff. • IClip (Cerner) refresher training incorporated into the training plan – roll-out to commence next month. **NEXT STEPS** • Implementation of maximum waiting cap for new outpatient appointments – working to bring this cap down week on week. • Continual focus on longest wait patients on our new PTL's. • Increased emphasis on specialty capacity plans so the Trust can see more of its patients within the national 18-week target. • Actioning the responses from contacting the patients that have the potential to need an appointment as a result of the Phase 1 validation. • Increased focus on error prevention when staff are putting data on the Cerner IT system incorrectly – the implemented new data quality dashboard now allows the Trust to review data quality issues which, in turn, allows for targeted support and additional training where required. • Continuation of progress with outcome form completion
Risks:	1. Planning and delivery of robust capacity plans to treat more patients within the expected 18-week national standard 2. Standard operating protocol (SOP) development to ensure front line staff are working to agreed waiting list management rules 3. Training resource to train staff on the right way to process patients [SOP's] and RTT knowledge through the Trust e-learning packages. 4. Any delay to the proposed Cerner implementation at QMH beyond 2018
Recommendation:	1. The Trust Board is asked to note this report
Appendix	1. ECRP Programme Risks

Programme Level Highlight Reports – Tooting Site

Cancer – Progress Against Milestones

Overall Project RAG	

Workstream	RAG	Executive Summary
Operational		Progress continues across all the Cancer work streams. At the start of the month there were a number of patients sitting on the QMH cancer PTL without a known clock stop. These patients have all been reviewed with a number being sent to services for final validation. Further to the funding being identified an agreement has been reached with CIMs who own Infoflex to undertake diagnostic and improvement work with the initial meeting scheduled for January.
QMH		Mobilisation of Royal Marsden Partners site review team underway.
Data Feed & Reporting		Progress on a cancer dashboard has slowed while the focus remains on improving tracking and developing usable Cancer PTLs

Treating Patients – Progress Against Milestones

Project RAG	

Workstream	RAG	Executive Summary
Backlog and Waiting List management		**Cohort A** (patients waiting greater than or equal to 40 weeks wait as at 01/09/17.) Cohort A Trajectory has delivered against the plan and is currently: • **97.8%** against the 95% delivery target. **Cohort B** (patients with a 52 week breach date between 25/11/17 and 31/03/18) Significant progress continues to reduce the numbers form the original baseline. On track to be completed as per plan by 31st March 2018
Harm Reviews		Throughout December the main objective was to conclude all clinical harm reviews needing service input - which has now been achieved. The main objective for next month is to complete all 'in progress' reviews and conclude Phase 1 by 31st January 2018.

Return to Reporting – Progress Against Milestones

Project RAG	

Workstream	RAG	Executive Summary
PTL Creation		New RTT and Planned PTL in place.
Historic Validation		Validation completed 31st December.
BAU Validation		The new PTL will mean that a new plan for BAU validation will need to developed. This is underway.

Training – Progress Against Milestones

Project RAG	

Workstream	RAG	Executive Summary
SOP Rollout		A revised Paper outlining the significant training resource uplift including the proposal for the purchasing of a SOP database rests with the Exec team for sign. • A new GP Referrals process and Consultant to Consultant guide is complete and shared with CBS and an Action plan has been produced outlining recommendations, improvements and issues, aimed at improving the use of Cerner with better use of available appointment slots, and better patient care.
CDOF Rollout		66% of all Care Groups are live with the new CDOF and significant performance improvement has seen to date. **Training**: • Total of 900 staff trained
Training Plan		The Data Quality and Business as Usual Training Process for Error Prevention and Resolution has been formalised by the BAU Trg team and the number of errors made on the system have been on average declining. To support this new approach further training has been undertaken for the Champion Users in order to refresh all in he correct processes to ensure they are appropriately trained to support of their staff.
Error Prevention		The Outpatient Pre-Registration Workflow error has now been understood and the Programme recommendation of locking down the error so the message can not be overridden has been endorsed by the Exec team. As such this system change will be made inline with IT Change Board priorities and executed in the near future. New DQ dashboard implemented – this will require a plan put in place to rectify errors identified.

Programme Level Highlight Reports – QMH

Treating Patients – Progress Against Milestones

Overall Project RAG	

Workstream	RAG	Executive Summary
Business Rhythm		Letter backlog has been cleared and the weekly QMH site meeting continues. Resourcing of substantive management and administrative posts exists, which is currently mitigated by interims.
Capacity and Demand		The majority of capacity and demand work will commence in early 2018. Progress was made around agreeing the approach to managing long wait patients in December. A prioritisation paper was drafted and reviewed to understand the impact of these waiting lists on services.
Harm Reviews		QMH Harm plan now in place. This plan is the same as that in place at SGH.

Return to Reporting – Progress Against Milestones

Overall Project RAG	

Workstream	RAG	Executive Summary
PTL Creation		PTL in place.
Historic Validation		Historic validation has completed, with letters being sent to patients. Phase 2 has commenced with expected completion earlier than planned.
BAU Validation		BAU validation trajectory has been revised in the light of planned resources not being available by 21st November. Revised date of completion is currently 12th March 2018.

Training – Progress Against Milestones

Project RAG	

Workstream	RAG	Executive Summary
SOP Rollout		All SOPs have been completed and are the in the process of being delivered to administrative teams. The CDOF has been rolled out since 6th November. The action plan is now complete.

IT – Progress Against Milestones

Overall Project RAG	

Workstream	RAG	Executive Summary
IT Changes		The 'QMH ICLIP Plan' has been developed in anticipation of the CERNER roll-out at QMH. There are however a number of approvals it will need to go through before any project is commenced. This is likely to have a negative impact on the time it takes to have RTT functionality at QMH.

Programme Top Risks (1 of 2)

St George's University Hospitals NHS
NHS Foundation Trust

Key Risks			
Risk / Cause / Impact	**RAG Score**	**Executive Owner**	**Mitigating action/s**
High numbers of errors being added to the PTL **Risk**: There is a risk that the validation burden could continue to increase until key SOPs are embedded into the organisation at the earliest opportunity to mitigate some of the causes of the cohorts which require validation. **Cause**: Incorrect entries into Cerner **Impact**: An increase in the time for the Trust to return to National Reporting and the requirement of a significantly sized validation team. Large scale validation requirement needed to continually clean the errors being made.	20	Ellis Pullinger	**Controls in place**: Strong communications on the need and consequences. **Actions**: • 'How to guides' developed to address requirements in short term • Data Quality Dashboard in place to track errors on a daily basis • Have trained 839 staff including 353 clinicians on CDOF • E-Learning training in place and mapped to 3500 staff for roll-out • Keeping PTLs clean workstream pursuing a targeted, data driven approach to 'support' and retrain' those that are consistently making the largest amount of errors – this will be monitored by refined workstream KPIs.
Insufficient outpatient and inpatient capacity to reduce RTT backlogs **Risk**: There is a risk that current capacity plans are not sufficient to reduce RTT backlogs on both SGH and QMH sites. **Cause**: Operational Planning **Impact**: An increase in the time for the Trust to return to National Reporting and the requirement of a significantly sized validation team. Excessive waiting times continue in some specialties.	20	Ellis Pullinger	**Controls in place**: Capacity planning process linked to contractual discussions **Actions**: • Development of backlog reduction plan – signed off by services • Outpatient clinic template clean-up: undefined slots • Increased outpatient new slots made available to CBS and ERS • Where necessary – outsourcing plans developed.
Adherence to Trust access policy: chronological booking and management of DNAs **Risk**: There is a risk that current capacity not being utilised effectively – particularly with regard booking patients in date order and removing patients who fail to attend. **Cause**: Booking from PTL / Process for managing DNAs **Impact**: Capacity wasteage / patients booked inappropriately.	16	Ellis Pullinger	**Controls in place**: Enhanced waiting list management, validation and review of all patients within current defined criteria **Actions**: • Launch of new Trust-wide PTL • PTL rollout to CBS and PPCs • Data Quality Dashboard tracking DNAs on a daily basis • Specialty level PTL management meetings in place

Risk score	Risk Rating
1-5	Low
6-10	Medium
11-15	Elevated
16-20	High
21-25	Significant

Programme Top Risks (2 of 2)

St George's University Hospitals NHS
NHS Foundation Trust

Key Risks			
Risk / Cause / Impact	**RAG Score**	**Executive Owner**	**Mitigating action/s**
Time needed to rollout Cerner at QMH **Risk**: Trust cannot return to national reporting without an RTT compliant PAS system **Cause**: Non-RTT compliant PAS system at QMH **Impact**: The time needed to rollout Cerner at QMH will reduce the Trust's ability to strategically develop the site with other services and will limit the overall success of this Programme and the Trusts aspirations to return to National Reporting..	**16**	Larry Murphy	**Controls in place**: Strong project management and robust plans to tackle the use and rollout of Cerner as well as appropriate Trust resources made available as part of the implementation phase. **Actions**: • Engagement form the Executive team with NHSI to ensure the funding is approved for Cerner at QMH as a matter of priority (Milestone for funding approval currently missed) • 'How to guides' SOPs and revising the training approach to ensure the correct use of Cerner is incorporated into BAU training as a Programme priority and resourced appropriately
Consultant not completing the outcome functionality after training and implementation **Risk**: There is a risk that patients may be subject to harm if Consultants do not complete the outcome functionality appropriately **Cause**: patient outcome is not recorded and therefore tracked and monitored appropriately **Impact**: Patients maybe subject to harm and furthermore this creates incomplete data and erodes confidence in PTLs which in turn impacts the overall progress towards returning to National Reporting	**12**	Andy Rhodes	**Controls in place**: Strong leadership from the Divisions and outcomes reported as part of the governance around access **Actions:** • CDOF rollout, training and support to users across the Trust • Clinician engagement and training to be discussed with AR to drive improvement in Clinician training % and subsequent form completion • The move to Electronic Outcomes as a priority for the Trust
I**dentification of patients at risk of potential harm** **Risk**: There is a risk that patients maybe subject to potential harm due to the current pathway challenges **Cause**: 'Dirty' PTL, non standardised processes and the incorrect use of Cerner **Impact:** Patients at potential risk of avoidable harm	**9**	Andy Rhodes	**Controls in place**: Enhanced waiting list management, validation and review of all patients within current defined criteria **Actions**: • Harm review criteria under review • Creation of new PTL • Introduction of CDOF and SOPs as well as revising BAU staff training

Risk score	Risk Rating
1-5	Low
6-10	Medium
11-15	Elevated
16-20	High
21-25	Significant

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board Meeting, 25 January 2018		
Date:	12/01/2018	**Agenda No.**	**3.3**
Report Title:	NHS England EPRR Assurance		
Lead Director/ Manager:	Ellis Pullinger		
Report Author:	Emergency Preparedness Manager (Kristel McDevitt)		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	Further to the Board Meeting in October (where this paper was originally presented) this report provides an update on the NHS England Emergency Preparedness, Resilience and Response (EPRR) assurance result for 2017. The main points follow; ➢ NHS England EPRR assurance was conducted with the trust on 29 November. This was a self-assessment process with a confirm and challenge meeting with NHS England ➢ After reviewing the assurance standards, evidence and discussion, it was agreed that there were no significant issues identified ➢ It was recommended that the trust review our business continuity arrangements, and critical activities, site risk assessment for a chemical incident and to highlight the EPRR results to the Trust Board ➢ The trust was granted a **Substantial** marking on the EPRR return (trusts are marked as non-compliant, partial, substantial or full). ➢ Progress on the recommended actions will be shared with NHS England by the Emergency Preparedness Manager.		
Recommendation:	To note the NHS England EPRR assurance findings and the Substantial rating.		
Supports			
Trust Strategic Objective:	Ensure the Trust has unwavering focus on all measures of quality and safety, and patient experience		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Operational performance		
Implications			
Risk:	If the work is not maintained, there is a risk that the trust will not be prepared in the event of a Major Incident or Significant Business Continuity event.		
Legal/Regulatory:	Emergency Preparedness, Resilience and Response standards are a requirement under the NHS England EPRR framework 2015 which are aligned to the Legislative duties under the Civil Contingencies Act 2004, and the Health and Safety Act 2012.		

Resources:	n/a		
Previously Considered by:	n/a	**Date:**	12/01/2018
Appendices:	1		

2017 EMERGENCY PREPAREDNESS, RESILIENCE and RESPONSE (EPRR)

ASSURANCE RESPONSE TO NHS ENGLAND

1.0 PURPOSE

1.1 This paper outlines the acceptance, response and subsequent actions in regards to the NHS England (London) EPRR Assurance process of 2017.

2.0 BACKGROUND

2.1 The NHS England EPRR assurance process was conducted with St George's University Hospitals NHS Foundation Trust on 29 November. This was attended by our Clinical Director for Trauma, Clinical Director for Emergency Department, the Head of IT, Head of Operations, Emergency Preparedness Manager and I, representing St George's University Hospitals NHS Foundation Trust.

3.0 EPRR ASSURANCE FINDINGS

3.1 I am pleased to note that there were no significant issues identified by NHS England and they felt the main areas for prioritisation were as follows;

3.2 The key priorities for the next twelve months include:

- Further development of the Corporate Business Continuity Plan.
- Further development of the Major Incident Plan.
- Continued identification of Critical Services.
- Chemical, Biological, Radiological, Nuclear and explosives (CBRNe) or Hazardous Material risk assessment to be updated.

Continuing areas of good practice including:

- Good organisational EPRR governance procedures
- Robust clinical engagement with the EPRR process
- Full integration and leadership of the South West London Trauma Network

3.3 The Trust was assessed against 8 Core Standards of EPRR which incorporated a total of fifty two (52) supporting standards. The standards were given a Red, Amber or Green (RAG) status. Of the fifty two supporting standards there were **no** Red ratings with two core Amber ratings and the rest assessed as Green.

3.4 The two core trust amber ratings were for standard 9 – 'Corporate Business Continuity Plan' and standard 26 – 'Critical activities'. Further action on these items has been highlighted and we agreed further work is needed

3.5 The CBRNe assurance identified one amber rating, core Standard 55 for 'CBRNe Risk Assessment'. This has been addressed and corrected for future training sessions.

3.6 In respect of the Deep Dive assurance (Governance), the Trust had 2 'Amber' ratings: However these do not affect the trust level of compliance but have been noted as being addressed in 2018.

3.7 These are included in Appendix 1.

4.0 RECOMMENDATION

4.1 As the Accountable Emergency Officer I have been asked to assign an overall single level of compliance for the Trust in line with the 2017 EPRR Assurance letter. In consultation with the Emergency Preparedness Manager, I am pleased to confirm that St George's University Hospitals NHS Foundation Trust agreed with the rating of Substantial

5.0 NEXT STEPS

5.1 The initial action plan to address the amber areas of the 2017 assurance process can be found on the appendix attached. This will be updated as a work programme is developed.

5.2 I am satisfied that the actions I have agreed with the Emergency Preparedness Manager will address these areas for improvement and will ensure that the 2018 EPRR Assurance strives to maintain compliance with the EPRR Standards.

Author: Ellis Pullinger

Date: 12/01/2018

APPENDIX 1

St Georges Trust response to NHS England Assurance

EPRR Core Standard no	Clarifying information	Trust Compliance	St Georges Work plan	Timeline
9	Duty to maintain plans –Corporate and Service level Business Continuity (aligned to National Business Continuity standards)	**Amber**	The trust has agreed to take forward a review and update of the existing Corporate Business Continuity plan by the Emergency planning team. There is currently a proposal underway for increased resources to allow dedicated Business Continuity support.	To be agreed post the results of the Internal audit due early 2018 and decision on support for the increased resource.
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	**Amber**	As above Business Continuity will be prioritised in 2018 as part of a reviewed Business Continuity work programme	As above.

CBRNe Core Standard	Clarifying information	Trust Compliance	St Georges Work plan	Timeline
55	CBRNe / Hazardous Material decontamination risk assessments are in place which are appropriate to the organisation.	**Amber**	In future CBRNe / Hazardous Material assessments will be incorporated into the training	Next training on 16 January 2018 to be trailed and thereafter included in subsequent monthly training sessions

Deep Dive	Clarifying information	Trust Compliance	St Georges Work plan	Timeline
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	**Amber**	Retrospectively shared 2016/17 assurance was shared with the trust board in August 2017. The NHS assurance review for 2017 was highlighted to the Trust Board in October 2017 and the results of the Assurance on the agenda for the Trust Board meeting in January 2018	January 2018.
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	**Amber**	This was not identified as a specific line in the Annual report published last year, however a marker has been added for the 2018 Annual report	Communications have been advised that a paragraph on EPRR will need to be included in the 2018 Annual Report.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Workforce and Education Committee		
Date:	11/01/2018	**Agenda No**	
Report Title:	Guardian of Safe Working Report		
Lead Director/ Manager:	Professor Andrew Rhodes		
Report Author:	Dr Sunil Dasan, Guardian of Safe Working		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Guardian of Safe Working's report summarises progress in providing assurance that doctors are safely rostered and work hours that are safe. This report covers the period from 27/09/2017 – 03/01/2018 263 episodes of trainees working outside of their work schedules have been reported. Fines totalling £10,527.48 have been levied during this period compared to £227.43 during the same period last year. The majority of fines have arisen due to staff working significantly beyond their hours in General Surgery.		
Recommendation:	The Trust Board are asked to note the number and nature of exceptions reported by trainees and in particular consider plans to resolve recurring themes around Foundation Year 1 workload in General Surgery		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	Risk of further fines being levied for breaches of the 48 hour and 72 hour working time limits in General Surgery		
Legal/Regulatory:	Compliance with the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016		
Resources:	Resources may be required to prevent further fines being levied in General Surgery		
Previously Considered by:	None	**Date**	03/01/2018
Equality Impact Assessment:	N/A		
Appendices:	One		

Guardian of Safe Working Report
Workforce and Education Committee 11/01/2018

1.0 PURPOSE

1.1 This paper provides assurance to the Board on progress being made to ensure that doctors' working hours are safe

1.2 This report asks the Board to note the fines levied due to breaches in the 48 hour and 72 hour working time limits, particularly in General Surgery and consider strategies to prevent further breaches and fines in future

2.0 BACKGROUND

2.1 The 2016 Terms and Conditions of Service (TCS) for Doctors in Training have been implemented at St George's in line with the national timeline. All trainees are now employed on the new Terms and Conditions of Service.

2.2 The first Guardian of Safe Working report in January 2017 gave details of one fine levied against General Surgery due to a Foundation Year 1 doctor working in excess of 76 hours over a 7 day period in December 2016. The value of this fine was £227.43.

2.3 Changes were made to rotas in General surgery and no further fines were levied. However, recently the situation has deteriorated significantly.

3.0 ANALYSIS

Fines

3.1 In the last three months a further 11 fines have been levied, details of which are shown below:

Specialty	Breach reason	Fine (£)
General Surgery	Eight breaches of 48 hour average working week limit by Foundation Year 1 doctors	9074.15
	Single breach of 72 hour working week limit by Foundation Year 1 doctor (83 hours and 15 minutes worked)	574.31
Gastroenterology	Single breach of 48 hour average working week limit by Foundation Year 2 doctor	738.63
Senior Health	Single breach of 48 hour average working week limit by Foundation Year 1 doctor	140.39
	TOTAL	**£10,527.48**

3.2 The Trust Board are reminded that the 2016 TCS state the following:

"The details of the guardian fines will be published in the organisation's annual financial report (accounts), which are subject to independent audit. The guardian's annual report will include clear detail on how the money has been spent"

To date none of the fine monies have been spent.

Exception reports

3.3 263 exceptions were reported in the period 27 September 2017 – 3 January 2018

3.4 The breakdown is as follows:

Division	Number of exceptions	Breakdown
Surgery, Theatres, Neurosciences and Cancer	205	204 General Surgery 1 Plastic Surgery
Medicine and Cardiovascular	48	19 Renal Transplantation 13 Senior Health 12 Gastroenterology 3 Acute Medicine 1 Endocrinology
Children and Women Diagnostics, Therapeutics and Critical Care	3	1 Obstetrics & Gynaecology 1 Paediatrics 1 Adult Critical Care
Community Services	1	1 Elderly Rehabilitation

St George's is the Lead Employer for General Practice across South London. Six exceptions were reported by this cohort of doctors in training.

3.5 A further breakdown shows:

- 261 exceptions related to working hours /conditions
  - 253 of these were where trainees worked in excess of their hours
  - 4 exceptions where trainees had missed breaks and
  - 4 exceptions were due to differences in the support available during service commitments
- Two related to missed training opportunities due to service pressures

3.6 No exception reports were highlighted as immediate safety concerns

Work schedule reviews

3.7 No work schedule reviews were requested during this period. However a work schedule review in General Surgery has yet to conclude despite being requested over three months ago. In that time eight further fines have been levied due to significant breaches of existing work schedules.

Rota gaps

3.8 Rota gap information is shown in Appendix A. This lists vacant trainee, clinical fellow and trust doctor posts across St George's. This does not include vacant physician assistant or other advanced practitioner posts. This data shows that there are 100 vacancies across St George's, an increase from the 60 reported in October 2017.

3.9 The Trust Board are reminded that the 2016 TCS state the following:

"A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account, which must be signed off by the trust chief executive."

Junior Doctor Forum

3.10 The Junior Doctor Forum attendance has increased substantially due to the efforts of the new Chair, Deputy Chair and a Less Than Full Time trainee representative. Recent meetings

have seen the Trust's Medical Director, Chief Executive and Director of HR take questions. These sessions have been extremely well received though have highlighted significant concerns related to the Trust's ability to respond to individual queries from doctors in training (including those employed under the Lead Employer arrangement) regarding contracts, pay and work schedules. Assurances have been given that these concerns will be addressed.

Access to rest facilities

3.11 Schedule 12 of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 details the facilities that should be made available to doctors who work during the overnight period.

3.12 A number of departments have made efforts to establish rest areas where staff can take 'night naps' during their shifts. It is unclear however whether these facilities can be used by all staff working during the night shift (doctors, nursing, AHP, non-clinical staff). Further clarification is being sought on this.

4.0 IMPLICATIONS

Risks

4.1 Risk of further fines for breaches of the 48 hour and 72 hour working time limits for Foundation Year 1 doctors in General Surgery. Details of fines to be published in the Trust's 2017/18 finanical accounts.

4.2 Risk of work schedule review in Renal Transplantation due to volume of exceptions reported.

4.3 Risk of rota gaps. Details of plans to reduce rota gaps to be included in a statement in the Trust's Quality Account for 2017/18 which must be signed off by the Chief Executive.

4.4 Risk of lack of compliance with Schedule 12 of the 2016 TCS due to a lack of clarity on the access to rest facilities for doctors working the overnight period and how this relates to other staff groups.

Legal Regulatory

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

Resources

4.6 Resources to adequately staff the Foundation year 1 rota in General Surgery to prevent further working time breaches and fines

5.0 NEXT STEPS

5.1 To further monitor the situation amongst Foundation Year 1 doctors in General Surgery

5.2 To consider a work schedule review in Renal Transplantation

5.3 To seek clarification on concerns relating to the Trusts ability to respond to individual trainee queries on contracts, pay and work schedules and to seek clarification on the issue of 'night naps' for all staff working the overnight period

6.0 RECOMMENDATION

6.1 The Trust Board are asked to note the number and nature of exceptions reported and in particular consider urgent action to prevent further working time breaches by Foundation Year 1 doctors and fines in General Surgery.

6.2 The Board are asked to include details of fines in the Trust's 2017/18 financial accounts.

6.3 The Board are asked to include a statement on rota gaps and the plan for improvement to reduce these gaps in the Trust's 2017/18 Quality Account, which must be signed off by the Chief Executive

Author: **Dr Sunil Dasan, Guardian of Safe Working**
Date: **03/01/2018**

Specialty	Total ST1-2 Vacancies	Total ST3+ Vacancies	CF/TDs (All Grades)
Children and Women,Diagnostics,therapeutics & Community			
Histopathology	1		
Obs & Gynae		1	3
Paediatrics	1	4	4
Neonates			3
Radiology		3	
Medicine & Cardiovascular			
A & E	3		
AMU	3	1	5
Cardiology	2	4	3
Cardiothoracic Surgery			2
Diabeted and Endocrinology		1	
Geriatrics	3		1
Haematology		1	1
ID & Microbiology		3	
Oncology			4
Renal Medicine			2
Respiratory		2	
Rheumatology		2	
Surgery, Anaesthetics & Neurosciences			
Anaesthetics		9	6
ENT	1		2
General Surgery	1	1	4
Max Fax			5
Neurology	1	1	
Neurosurgery			2
T&O			3
Urology			1
	16	33	51

Total - 100

Meeting Title:	Trust Board		
Date:	25 January 2018	**Agenda No**	**3.5**
Report Title:	Mortality Monitoring Committee Report		
Lead Director/ Manager:	Professor Andrew Rhodes, Chief Medical Officer		
Report Author:	Dr Nigel Kennea, Chair Mortality Monitoring Committee, Associate Medical Director Kate Hutt, Clinical Effectiveness & Audit Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Discussion Update		
Executive Summary:	The paper provides an update on the work of the Mortality Monitoring Committee for the first 3 quarters of 2017/18. It includes a summary of the independent reviews completed and details the most recent learning. It also summarises progress against implementation of the 'Learning from Deaths' framework launched in March 2017. Our work has been highlighted and presented at the national 'Learning from deaths-one year on' event in December 2017.		
Recommendation:	• For PSQB/QSC to be updated on work to date implementing the 'Learning from Deaths' national framework and to support next steps in this process. • To take assurance that SGUH has a robust process for assessing deaths and from learning any lessons that arise from them.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	This work will identify issues impacting on care quality day to day, and will identify risks that are escalated to trust and divisional governance teams. The new 'Learning from Deaths' framework represents a significant change in process that requires resource, even with a mature mortality monitoring process. There is a risk that published mortality data		

	and learning will not only be used for quality improvement, and that identifying problems in care could lead to adverse publicity.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by Care Quality Commission and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:	There are resource implications associated with these works that are being worked through and can be discussed with this paper.		
Previously Considered by:	N/A	**Date**	10.1.18
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

MORTALITY MONITORING UPDATE

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Patient Safety and Quality Board / Quality and Safety Committee with a high-level update on the work of the Mortality Monitoring Committee (MMC), focussing on information and learning identified through independent case record review of deaths for the first three quarters of 2017/18. Also provided is a summary of implementation of the Learning from Deaths framework.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK

2.1 Achievements

We have a dedicated independent team supporting the bereavement office, and reviewing deaths in a timely way. This year since April, the team have reviewed 1008 deaths and provided clinical and risk teams information for learning and improvement. All patients where a care issue may have contributed to death are escalated to the risk team the same day and included in SIDM discussions.

Work in the bereavement office supports families with better processes, clarification of information for families, and we have also set up an email account to help support families if requested (learningfromdeaths@stgeorges.nhs.uk).

The MMC review team was one of only 3 trusts invited to present to the national event 'Learning from Deaths – one year on' on 14th December 2017. NHS Improvement and the Department of Health held the seminar for NHS trusts to share how they're changing their practice to learn from deaths. NHS trusts, NHS organisations, and families attended along with the Secretary of State for Health. Discussions were held around emerging practice in NHS trusts; how to improve engagement with families; the continued need to improve patient safety; and how the NHS learns from death. Dr Nigel Kennea presented our experience and progress to date and this was included as a case study on the NHSi website and event literature.

We have published some of our learning in a BMJ publication to promote this work more widely.
http://blogs.bmj.com/bmj/2017/11/02/ollie-minton-et-al-learning-from-deaths/

2.2 Guidance Development

The NHS England guidance development steering group met before Christmas to discuss the first draft of guidance for trusts on engaging families. The deadline has moved from the end of January to spring to enable true co-production with families and ensure the guidance is right. It is expected that a draft will be shared with Trusts for comment in January 2018. We are committed to being at the forefront of this developing work.

2.3 Immediate priorities for MMC

- To continue to review and secure necessary resource to continue this work. We need to recruit a consultant to the MMC review team to replace Dr Ollie Minton who is leaving the Trust, and has been instrumental in embedding independent review.

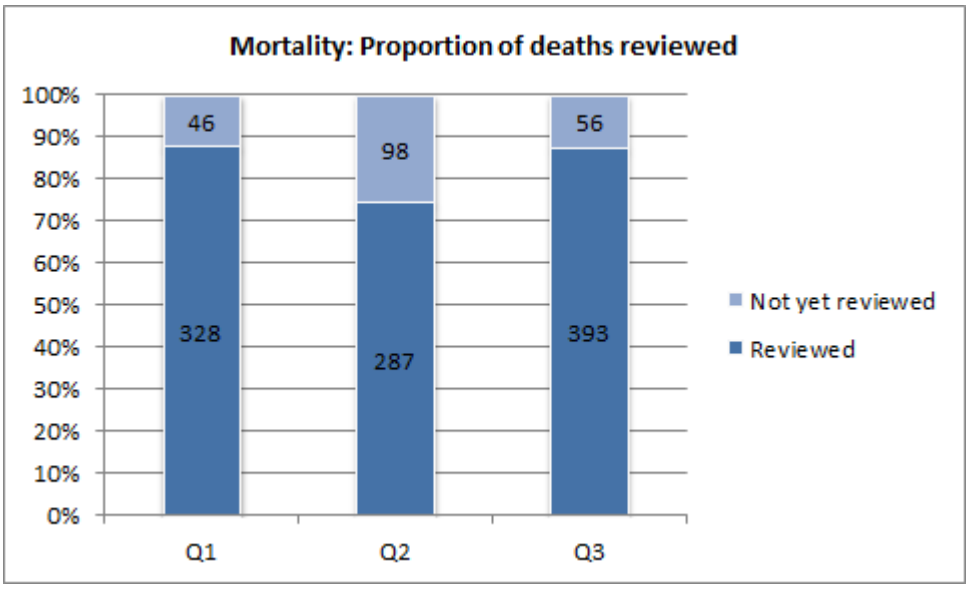
- Complete the restructure of the Clinical Effectiveness (CE) Department to allow the CE manager to specialise in mortality governance, which will ensure existing processes are developed and strengthened. Recruitment is underway but insufficient time is available due to vacancies in the clinical effectiveness team
- Strengthen systems for monitoring the outcome of escalations to Risk and clinical teams; at present the MMG feed into local MDTs and SIDM.
- To review the Learning from Deaths Policy in line with publication of national guidance on engagement with families and carers. The national guidance is still evolving and we endeavour to keep up with this. The Trust policy may need early revision to reflect changes.
- Refine fields added to RCP Structured Judgement Review (SJR) to strengthen the quality and impact of our data locally and to implement SJR tool for all mortality reviews requested by MMC.
- Make training available to clinicians on use of SJR methodology.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

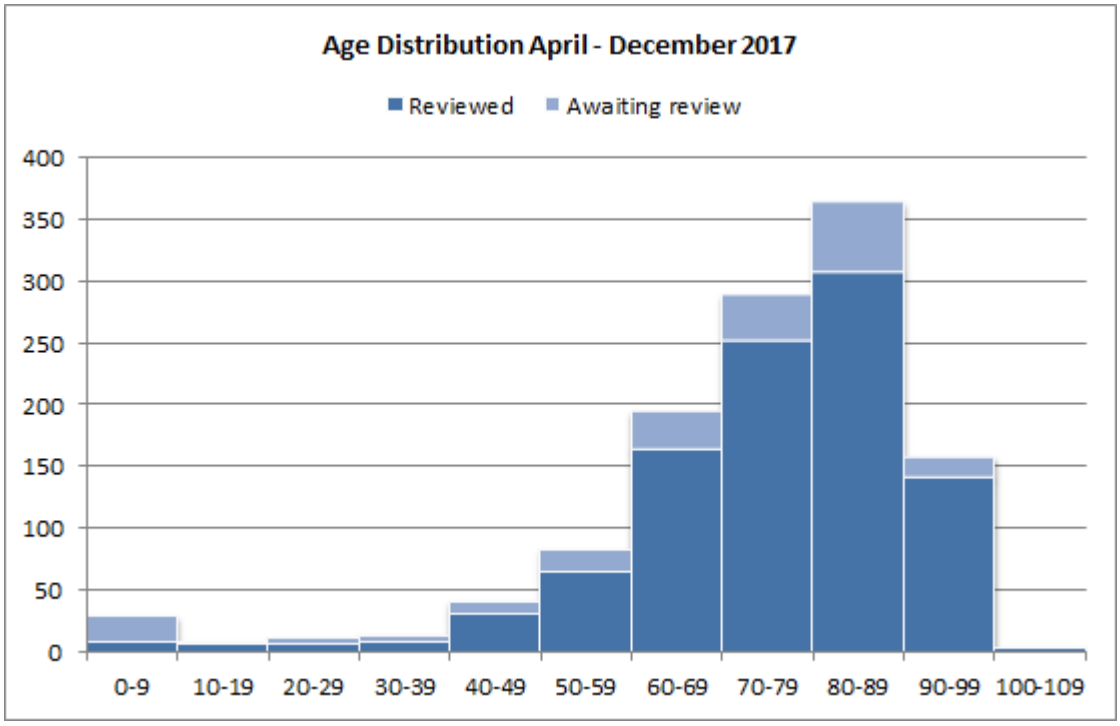
3.1 The following analysis includes all deaths and does not consider deaths of patients with learning disabilities separately; however, this is required for the national dashboard. A draft of the National Quality Board dashboard is shown in Appendix 1.

3.2 Overview of April to December 2017

Between April and September 2017 there have been 1208 deaths. Since April 2017 members of the MMC have carried out independent review of deaths, using a locally developed online screening tool and structured review tool based on RCP tool. To date 1008 (83.4%) deaths have been reviewed using this approach. We set an initial target of reviewing 70% of deaths each quarter and achieved 87.7% in Q1, 74.5% in Q2 and 87.5% in Q3. These data include the full months of Oct, Nov, Dec and reflects the timely nature of review.



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



For the year to date, one or more problems in healthcare have been identified in 15.1% of the cases reviewed. In the latest quarter this figure is 15.3%. Some problems in healthcare can result from exemplary care (for example a recognised complication of treatment).

Problems in healthcare	**Q1**	**Q2**	**Q3**	**TOTAL**
No	276	247	333	**856**
Yes	52	40	60	**152**

In Q3 where there was a problem in healthcare identified reviewers felt that it 'did not lead to harm' in 57.7% of cases, 'probably led to harm' in 17.5% and did cause harm in 24.7%. For the year to date the proportions are 48.0%, 27.5% and 24.5% respectively. This quarter, the most commonly occurring problem as defined by the structured judgement review is related to resuscitation following a cardiac or respiratory arrest (n=21). Many of these patients were frail elderly patients and the reviewers felt there were opportunities for consideration of earlier DNACPR orders. Constructive dialogue has occurred between MMG and acute medical team in such cases, and discussion at local MDT.

Between April and December 2017 problems related to operation/invasive procedure were most common (n=37), many being recognised complications of the procedure.

Problems in healthcare: Quarter 3	Yes - no harm	Yes - probably harm	Yes - harm	Total
Assessment, investigation or diagnosis	2	1	1	**4**
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	2	1	1	**4**
Related to treatment and management plan	4	2	2	**8**
Infection control	2	0	1	**3**
Operation/invasive procedure	5	4	4	**13**
Clinical monitoring	14	0	3	**17**
Resuscitation following a cardiac or respiratory arrest	9	2	9	**20**
Other	18	7	3	**28**
TOTAL	**56**	**17**	**24**	**97**

A judgement regarding avoidability of death is made for all reviews. Some problems in healthcare may occur with excellent care, others may occur and not affect the outcome as the patient would have not survived by that point, or the problem did not affect the clinical course in any way. The large majority (96.0%) of deaths were assessed as being 'definitely not avoidable', and no deaths were thought to be 'definitely avoidable'. Over the three quarters to date a total of 12 deaths (1.2%) were judged to be more than likely avoidable, for that moment in time. Any death that review suggests may be avoidable is escalated to the Risk team to consider possible investigation and rapid response via the SI process. Any significant problem of care, whether or not it affected outcome, is highlighted to the clinical team for discussion and learning at local M+M.

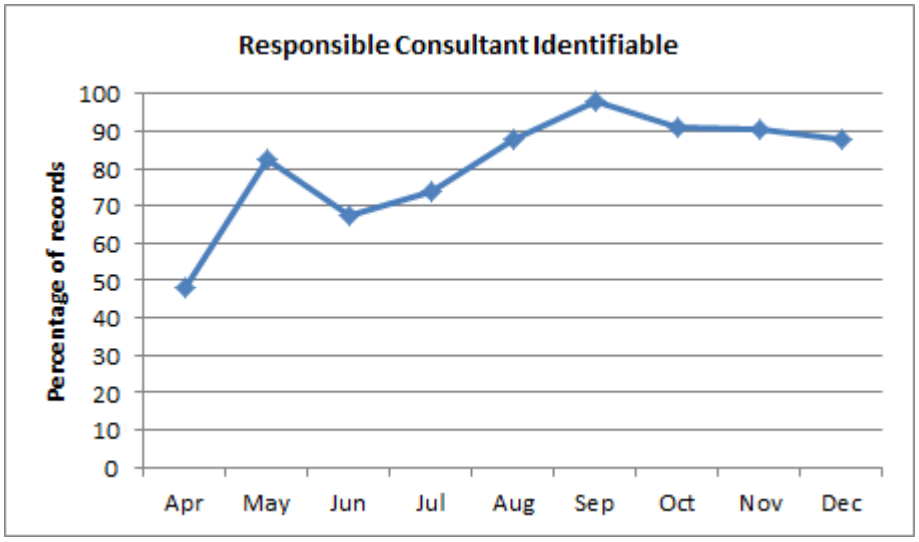
Avoidability of death judgement score	Q1	Q2	Q3	TOTAL
6 = Definitely not avoidable	306	276	386	**968**
5 = Slight evidence of avoidability	10	5	3	**18**
4 = Possibly avoidable but not very likely (less than 50:50)	6	2	2	**10**
3 = Probably avoidable (more than 50:50)	2	3	1	**6**
2 = Strong evidence of avoidability	4	1	1	**6**
1 = Definitely avoidable	0	0	0	**0**
TOTAL	328	287	393	**1008**

4.0 THEMES AND LEARNING

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

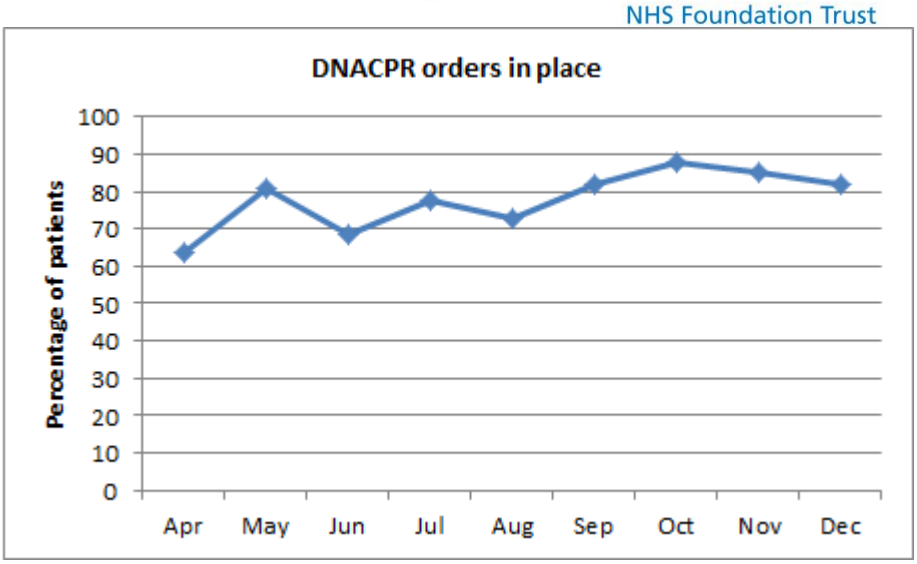
4.1 Responsible consultant

There has been improvement in identification of responsible consultant in the healthcare record. Early in the year this was escalated to Divisional teams for action and to the Care Group leads in areas requiring particular improvement. Ongoing monitoring shows improvement; however, it should be noted that this may be attributed in part to better data collection by reviewers. Responsible consultant may not be identified in deaths occurring in ED.

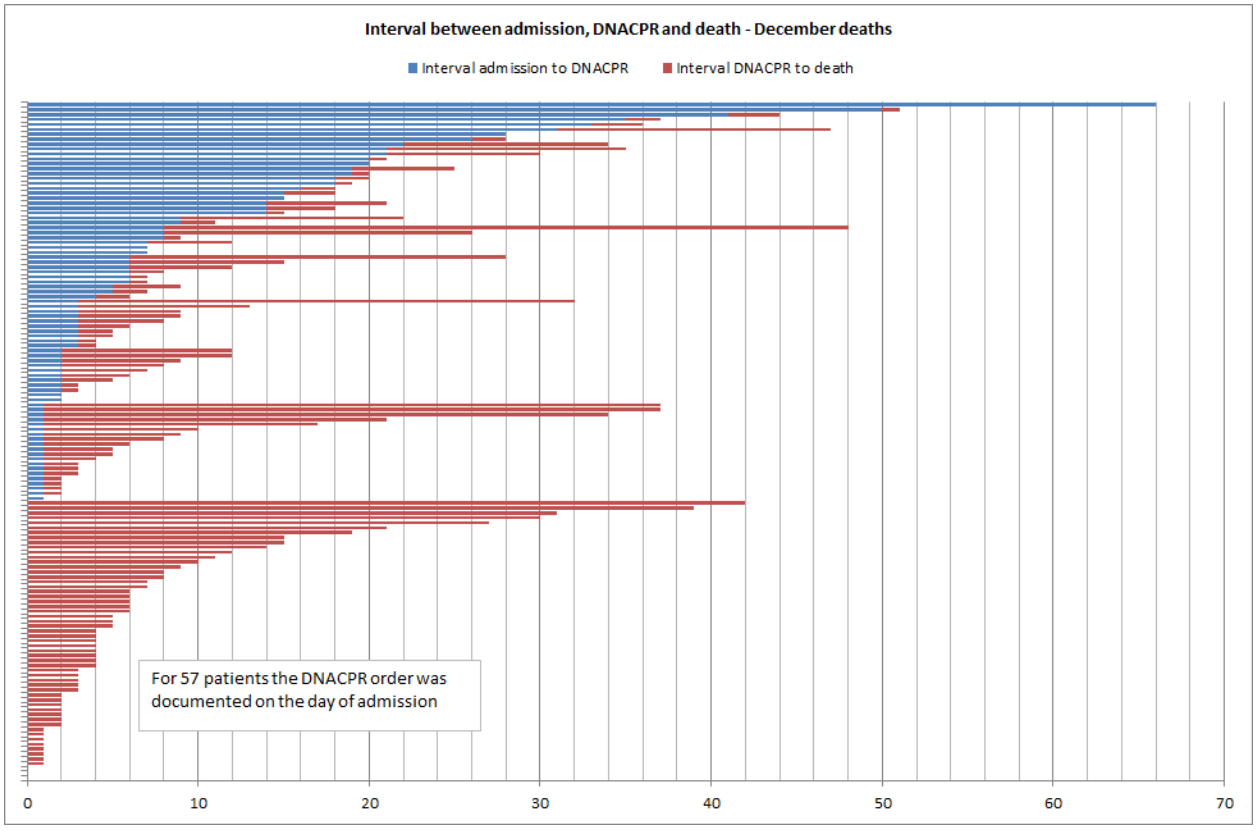


4.2 DNACPR discussions

This work has highlighted the essential role of our palliative care team. A very high proportion of patients dying in our trust (52.4%, July 16 - June17) are coded as having specialist palliative care input; this is much better than the national average (31.1%). The Trust need to continually review palliative care provision; a consultant post is currently advertised to replace a colleague leaving but more staff are likely to be required to maintain this excellent service. For the year to date, 78.3% of patients reviewed have had a DNACPR order in place, with 84.5% in place in the most recent quarter. This is good and reflects strong ongoing focus on end of life planning.



In addition to monitoring the presence of an order we have started to look at timings of the DNACPR order. For December timings were available for 138 of the 141 orders. In 57 cases the DNACPR form was completed on the day of admission, and the day following admission in a further 20. The chart below plots the interval from admission to DNACPR and the interval between DNACPR and death.



There were 12 instances where the DNACPR order was documented on the day of death; however in 3 cases this was equal to the day of admission and in 1 case it was the day following admission. DNAR and death occurred 2 days post admission in 2 cases and a week post admission in 2 cases. In the remaining 4 cases the interval between admission and death was 15 days, 20 days, 28 days and 66

days. The MMC provide a verbal report to the End of Life steering Group and continue to promote the essential nature of planning escalation of care or end of life care in frail comorbid patients.

4.3 Specific learning identified in the latest quarter

We are continually trying to improve our monitoring of actions taken as a result of raising queries with the services or referrals to the Risk team. This quarter there have been a number of cases escalated for further review.

- 13 cases have been referred to the service for M&M review and reflection. Issues that have been highlighted include the appropriateness of inter-hospital transfer and the need for consultant-level discussion, ward frequency of consultant review, MDT discussion and decision making between teams (this has been improved in the cardiac surgical service and monitored via taskforce and SI action plan) , ceilings of care and appropriateness of DNACPR decisions.
- 13 cases have been referred to the Deteriorating Adults Group for investigation as out of ICU arrests; the majority occurred as a failure to make a clear end of life plan.
- 5 cases have been flagged to the Risk Team for consideration of rapid review and/or SI declaration. The flow of information between the mortality review team and risk team continues to strengthen, improving the completeness of information.

There has been one maternal death this quarter and a full investigation is underway using nationally-defined processes.

5.0 SERVICES OPEN TO EXTERNAL SCRUTINY OF MORTALITY

5.1 **National Adult Cardiac Surgery**

The MMC have provided a detailed review and report related to cardiac surgery deaths which has been presented to the clinical team and QSC in November. It provided detailed information for service development; improvements in practice and process have been monitored at Board-level.

5.2 **Intracranial injury**

The MMC reported a CQC outlier for this diagnostic group. The case notes review identified that this signal was entirely derived from the major trauma case mix and that care provided was generally excellent. The review identified a high proportion of unsurvivable injuries.

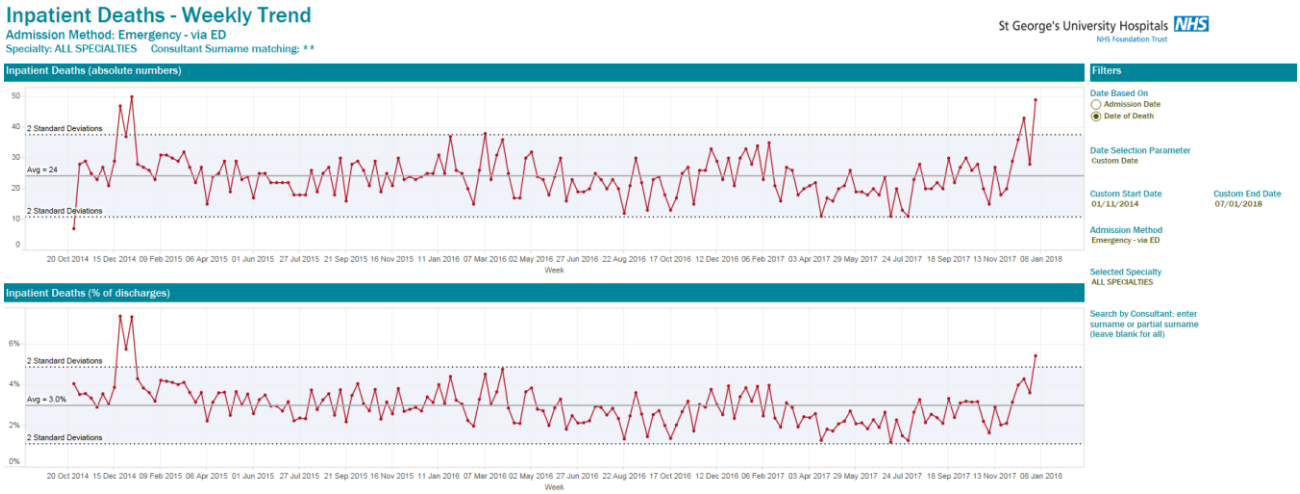
5.3 **Orthopaedics: Hip fracture mortality and National Joint Registry**

The MMC have reported on hip fracture mortality that was higher than expected in 2016 from the national hip fracture database. This report has been shared, and identified the importance of prioritising this vulnerable patient group for theatre, trying to avoid orthopaedic ward outliers, and the importance of regular orthogeriatric review. All such patients now go through improved MDT processes and an enhanced local mortality process to review best practice criteria, and identify learning where appropriate, has been created.

There has been a 5 year mortality outlier notice for total hip replacement in the Trust. In this alert there were 7 patient deaths in this group over 5 years. Case note review has occurred with the orthopaedic team and MMC using the RCP structured judgement review processes. This alert is generated by case mix. St George's does not do uncomplicated total hip replacements as these patients are managed at SWLEOC. The patients that died in this group were complex patients with

complex pelvic trauma, or pathological hip fracture from malignancy. None of the patients died as a direct result of the operation; majority died later due to comorbidities, other injuries and those with cancer died as a result of their malignancy.

6.0 RAW MORTALITY



The trust has had exceptional pressures over this wintertime and this is reflected in increased mortality. The need to support the clinical teams has been well described. The bereavement team and mortality review team have continued to work exceptionally hard to support a high quality service for patients' families and review processes/outcomes.

7.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

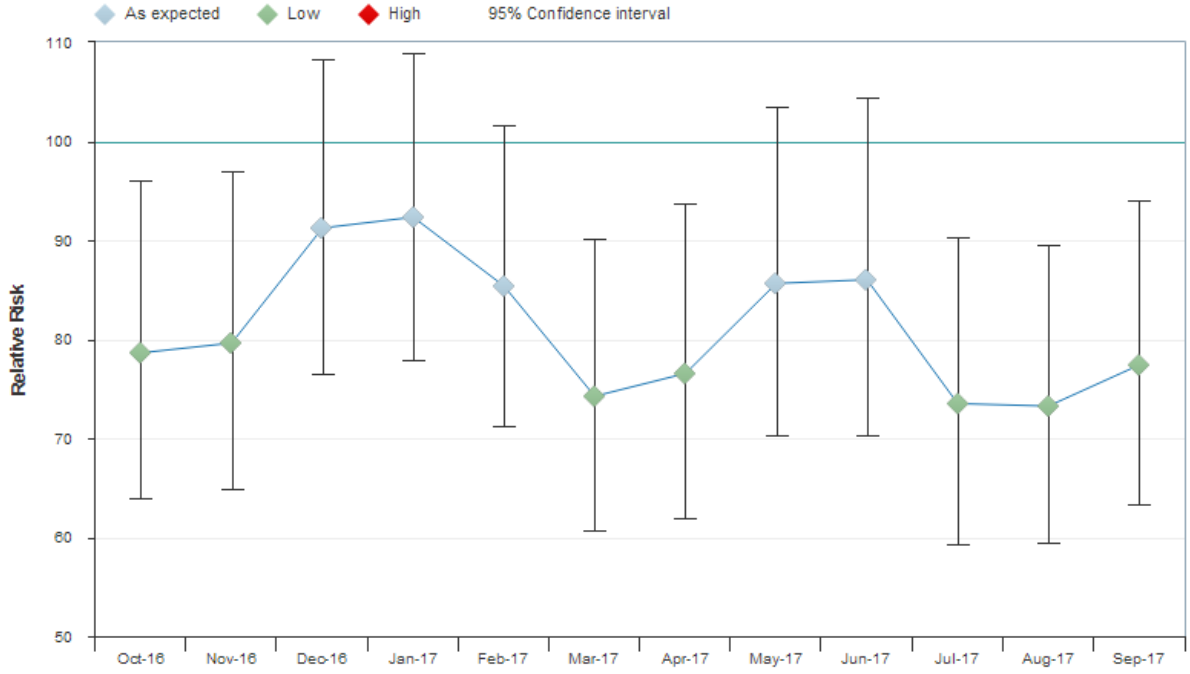
The SHMI for July 2016 to June 2017 was published on 14th December 2017. For this period our mortality is 'lower than expected' at 0.84. We are one of 16 trusts nationwide in this category.

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

Analysis	Period	Score	Banding
HSMR	Oct 2016 – Sep 2017	81.4	Significantly better than expected
HSMR: Weekday emergency admissions	Oct 2016 – Sep 2017	76.6	Significantly better than expected
HSMR: Weekend emergency admissions	Oct 2016 – Sep 2017	83.8	Significantly better than expected

Diagnoses - HSMR | Mortality (in-hospital) | Oct 2016 - Sep 2017 | Trend (month)

Period: **Month**



Appendix 1: Draft NQB Dashboard for 2017/18 YTD – data to December 2017

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - December 2017-18

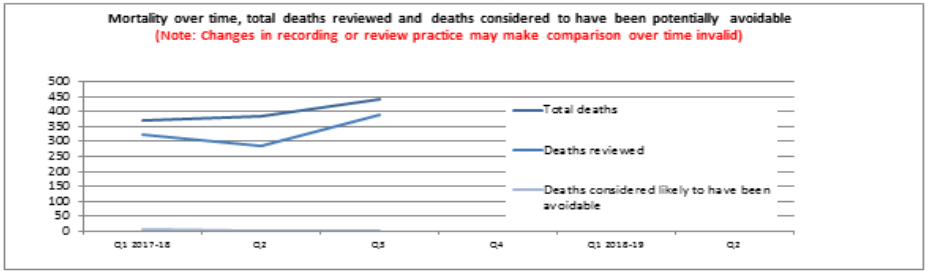
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
193	109	173	91	0	2
This Quarter (QTD	Last Quarter	This Quarter (QTD	Last Quarter	This Quarter (QTD)	Last Quarter
443	383	387	285	2	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1196	0	996	0	12	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

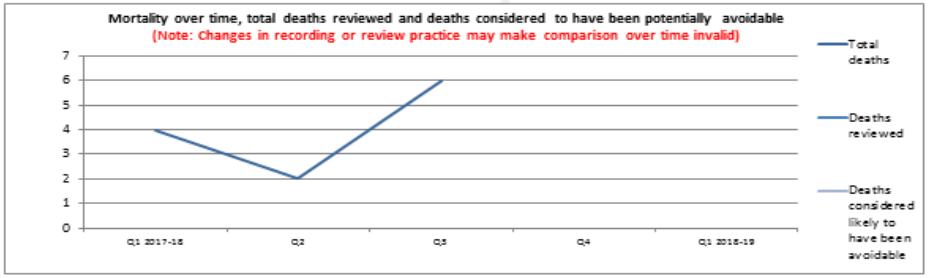
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	0.6%	This Month	170	99.4%
This Quarter (Q	0	0.0%	This Quarter (Q	0	0.0%	This Quarter (QTI	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	1	0.3%	This Quarter (	380	99.7%
This Year (YTD)	0	0.0%	This Year (YTD	6	0.6%	This Year (YTD)	6	0.6%	This Year (YTD)	10	1.0%	This Year (YTD)	17	1.7%	This Year (YT	957	96.1%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	2	0	0	0	0
This Quarter (QTD	Last Quarter	This Quarter (QTD	Last Quarter	This Quarter (QTD)	Last Quarter
6	2	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
12	0	0	0	0	0

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



Report to the Board from: Finance and Investment Committee

Committee Chair: Ann Beasley

Date of Committee Meeting: 18 January 2018

1.0 Matters for the Board's Attention

1.1 The Committee considered the remaining two risks on estates and ICT which had been allocated to it as part of the Board Assurance Framework. Following debate it concluded that there was only limited assurance for both of these risks and it would need to consider them more regularly until it was assured that further mitigations were in place. It felt that the Board itself might want to consider the BAF more regularly until these issues were resolved.

1.2 There was a discussion on the performance in the Emergency Department in December and the early part of January which generally remained between 80-85%. Whilst there is no doubt that the increase in flu had affected both attendance at A&E and staff attendance, it was agreed that there remained an issue of leaders ensuring appropriate actions were taken in a more timely fashion. A further A&E risk summit was planned for later in the same day as the FIC meeting.

1.3 The Committee was pleased to note the improvement in cancer performance and encouraged that diagnostic performance had returned to compliance. The Committee was concerned to note that on the day cancellations for non-clinical reasons had not been reported since October and asked that more detailed analysis was undertaken on both why it had not been reported and the accuracy of any figures.

1.4 The Committee considered the monthly finance report based on data up to the end of December and the forecast for Income and Expenditure until the end of the year. It was noted that year to date expenditure against income showed a deficit of £53.3million, equating to the forecast deficit for the whole year. Members reflected that whilst the forecast was unchanged from last month, it remained both challenging to achieve and still in excess of the deficit target agreed with NHSI. Members took some assurance from the actions being taken to keep the forecast out turn at (£53m) but noted that a number of these were based on non-recurrent items which would have knock on implications for 2018/19. In particular the Committee noted the risk in relation to PSS spending of £7m which had previously been reimbursed by NHSE but this responsibility had been transferred to CCGs without the requisite funding. The Committee noted that if this issue was not resolved satisfactorily the forecast out turn would increase to a deficit of (£60m).

1.5 On business and financial planning for 2018/19, the Committee took some assurance from the thoroughness of the process but acknowledged that the more challenging financial performance this year would make next year even more difficult. Two workshop sessions have been scheduled to allow Board members to understand fully the implications of budget settlements for next year and sign off an appropriate budget.

1.6 The Committee approved a request to recommend to the Board that the Trust would seek to borrow a further £7.4 million in February.

1.7 The Committee took a detailed report on procurement and was pleased to note the progress that has been made. It also took comfort from the plans reported to it to update the long term financial model. Indeed members were encouraged by the overall improvement in the standard of reporting to the Committee and in the work of the finance team to improve underlying financial management, and expressed their gratitude to those responsible.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 18 January 2018 for information and assurance.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**25th January 2018**	**Agenda No.**	**4.2**
Report Title:	**M9 Finance Report**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	Overall the Trust is reporting a YTD deficit of £53.3m at the end of Month 9 (December), an adverse variance to plan of £8.8m. This position is consistent with the forecast presented to the last Board meeting. Within the position, income is adverse to plan, which is partly offset by Pay expenditure underspend. The Trust planned to deliver £24.5m of CIPs by the end of December. To date, £25.2m of CIPs have been delivered; £8.3m of income actions and £16.9m of expenditure reductions. The Trust forecast outturn remains a £53m deficit at year end.		
Recommendation:	The Trust Board notes the trust's financial performance to date at month 9 and forecast outturn.		
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:			
Resources:			
Previously Considered by:	The Finance & Investment Committee	**Date:**	18/01/2018
Appendices:	None		

TB Dec 17 – Agenda item x.x

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 9 (December 2017)

Chief Finance Officer

25th January 2018.

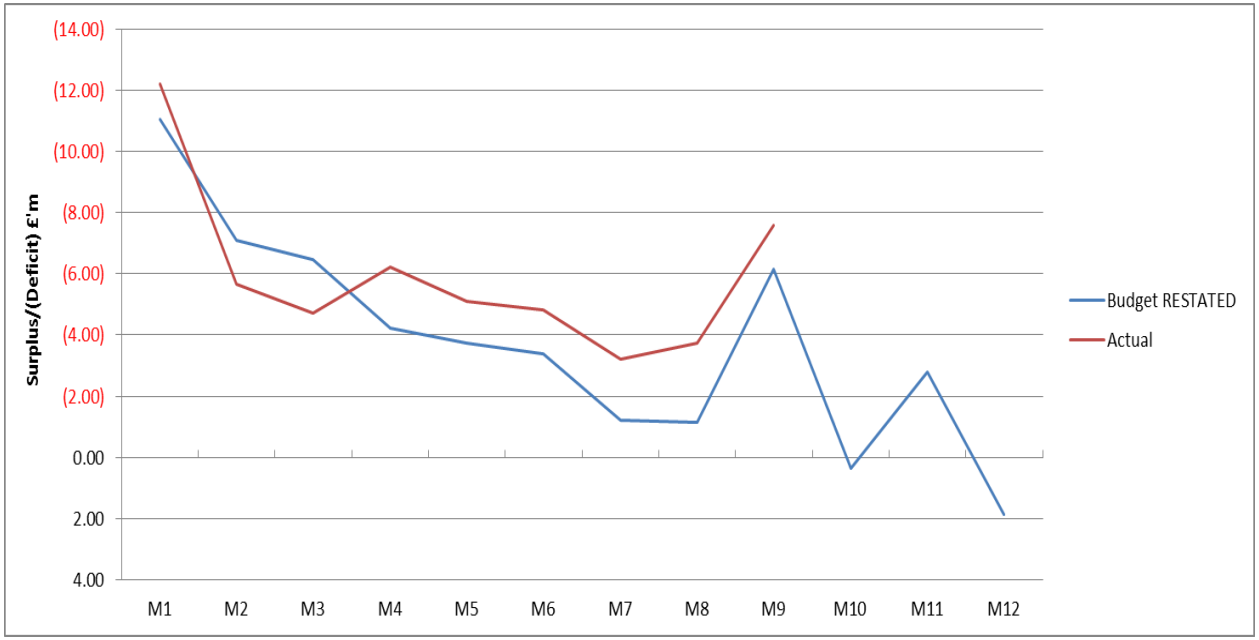
Executive Summary – Month 09 (December)

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 £53.3m at the end of the December, an adverse variance to plan of £8.8m. However, the over delivery of CIPs totalling £0.7m is supporting this position. If these CIPs were excluded, the underlying position would be £9.5m adverse to plan. Within the position income is adverse to plan, with this being partly offset by Pay expenditure underspend.	£8.8m Adv to plan	£7.4m Adv to plan
Income	Income is being reported at £11.4m adverse to plan year to date, with an adverse movement in month of £1.5m. Included within the month 9 results are £0.1m of income relating to prior periods. There is lower than planned income of £5.4m in Elective YTD. Exclusions income is lower by £5.2m, but is offset by reduced expenditure. Non-SLA income is also under plan by £2.1m as well, although £1.2m of this is offset in SWLP.	£11.4m Adv to plan	£9.9m Adv to plan
Expenditure	Expenditure is £1.9m favourable to plan at month 9, £0.1m adverse in month. The majority of the favourable position is in pay, £6.7m YTD, with underspends seen in Nursing, Non Clinical and ST&T categories. Non-pay is £4.8m overspent, and the main drivers being IT MSA costs, RTA bad debt and the impact of the removal of tendered community services.	£1.9m Fav to plan	£2.0m Fav to plan
CIP	The Trust planned to deliver £24.5m of CIPs by the end of December. To date, £25.2m of CIPs have been delivered; £8.3m of income actions and £16.9m 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 be a £9.5m adverse position.	£0.7m Fav to plan	£1.9m Fav to plan
Capital	Capital expenditure of £29.5m has been incurred year to date. This is £2.5m below plan 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. Consequently the Trust needed to complete a re-forecasting and re-prioritisation exercise to ensure the minimum level of IT capital investment required this year may still be accommodated within the existing budget. This exercise involved identifying expenditure in other categories which may be rescheduled to next year.	£2.5m Fav to plan	£3.5m Fav to plan
Cash	At the end of Month 9, the Trust's cash balance was £7.4m, which is better than plan by £4.4m. The Trust borrowed approx.£6.1m from DH working capital facilities in M09 and £50.2m YTD which is £8.7m more than plan. The Trust has not needed to borrow in January but will need to do so I February and March. These borrowings are subject to an interest rate of 6% for the amounts drawn up to October and 3.5% for the amounts drawn since November.	£4.4m Fav to plan	£5.0m Fav to plan
Financial Risk Rating- Use of Resources (UOR)	At the end of December, the Trust's UOR score was: Capital service cover rating: Plan – 4; Actual – 4 Liquidity rating: Plan – 4; Actual – 4 I&E margin rating: Plan – 4; Actual – 4 Distance from financial plan: Plan – n/a; Actual – 3 Agency rating: Plan – 1; Actual – 1	Overall score 4	Overall score 4

1. Month 9 Financial Performance

L2 Cat	L3 Cat	M9 Budget (£m)	M9 Actual (£m)	M9 Variance (£m)	M9 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %	Full Year Budget (£m)
⊟Income	SLA Income	52.56	51.18	(1.38)	(2.6%)	502.77	493.50	(9.27)	(1.8%)	675.53
	Other Income	9.63	9.52	(0.12)	(1.2%)	87.06	84.92	(2.14)	(2.5%)	116.26
Income Total		**62.19**	**60.70**	**(1.50)**	**(2.4%)**	**589.83**	**578.42**	**(11.41)**	**(1.9%)**	**791.79**
⊟Expenditure	Pay	(39.84)	(39.78)	0.06	0.2%	(369.61)	(362.86)	6.75	1.8%	(487.80)
	Non Pay	(25.67)	(25.79)	(0.12)	(0.5%)	(239.16)	(243.97)	(4.81)	(2.0%)	(314.98)
Expenditure Total		**(65.51)**	**(65.57)**	**(0.06)**	**(0.1%)**	**(608.77)**	**(606.84)**	**1.94**	**0.3%**	**(802.77)**
⊞Post Ebitda		(2.83)	(2.72)	0.12	4.1%	(25.51)	(24.84)	0.67	2.6%	(34.02)
Grand Total		**(6.15)**	**(7.60)**	**(1.44)**	**(23.5%)**	**(44.46)**	**(53.26)**	**(8.80)**	**(19.8%)**	**(45.00)**



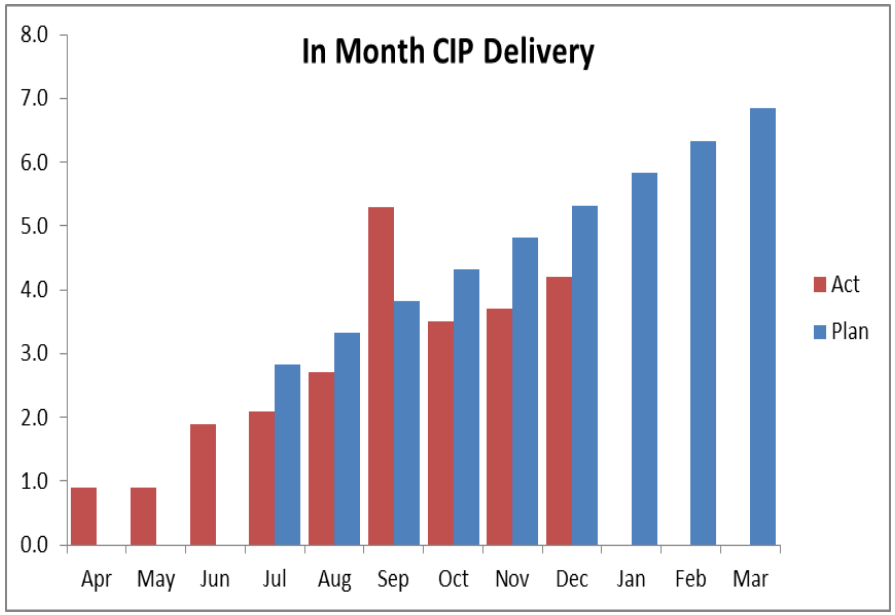
Trust Overview

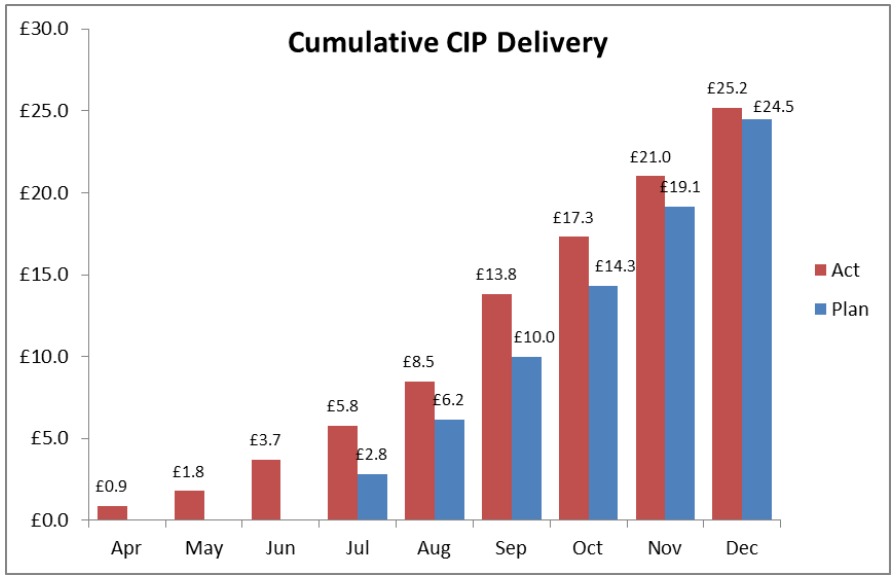
- Overall the Trust is reporting a deficit of £53.3m at the end of Month 9, an adverse variance to plan of £8.8m.
- **Income** is £11.4m adverse to plan. £5.9m of the under recovery of income is directly offset with underspends in expenditure (SLA Pass-through £4.7m, South West London Pathology £1.2m).
- **SLA Income** is £9.3m under plan, owing to shortfalls of £4.7m on pass-through, £5.4m in Elective and £4.2m higher challenges, offset by Daycase £2.3m, Outpatients of £1.7m, and £1.0m CQUIN. A £0.1m prior period SLA income catch-up in month is mainly volume.
- **Other income** is under plan by £2.1m; the key drivers are SWLP Diagnostics (£1.2m) and lower than planned private patients income (£1.1m). These are partially offset by other smaller variances (£0.2m adverse).
- **Pay** is £6.7m favourable, with all major staff groups underspending with the exception of medical pay.
- **Non-pay** is £4.8m overspent, due to expenditure on the ECRP project that was budgeted within income (challenges) (£2.9m), as well as higher than planned spend in IT and Estates (£1.0m) which is forecast to come back within budget by year end, and bad debt for RTA income of £0.4m. There are other smaller variances in Non Pay that total £0.5m.
- **CIP delivery** of £25.2m is £0.7m ahead of plan. If this were excluded from the reported position then the overall position would show an adverse variance to plan of £9.5m. This indicates there is overall pressure in the Trusts baseline financial position at month 09, 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 9 CIP Performance





CIP Overview

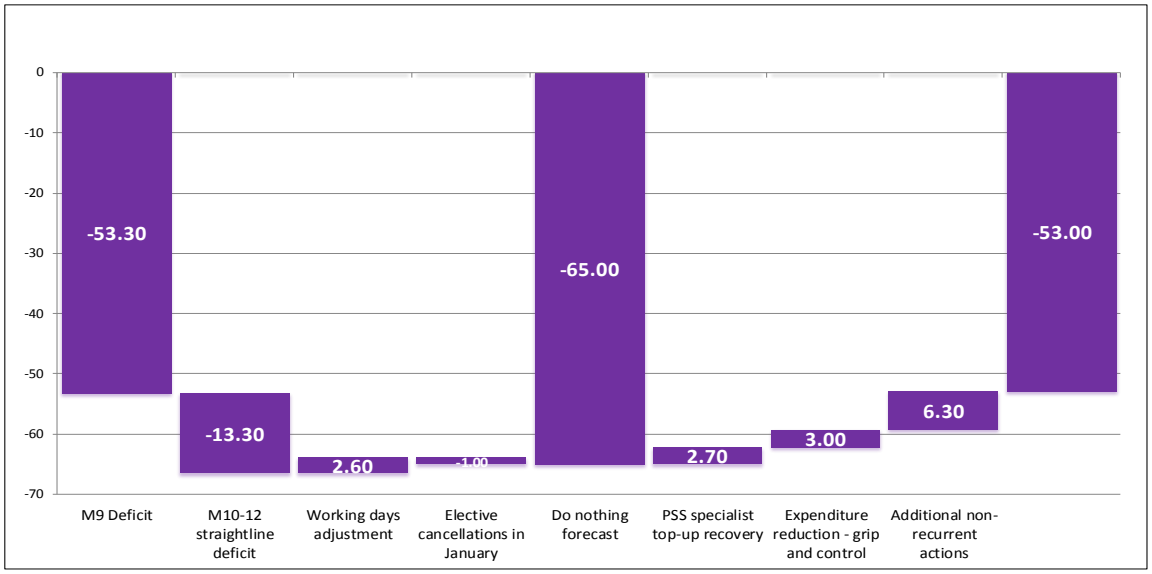
- At the end of Month 9, the Trust is reporting a cumulative delivery of £25.2 m of savings from Cost Improvement Programmes (CIPs)
- £4.2m of savings were reported in December. As highlighted previously, the additional savings reported in September related to the confirmation of a number of schemes, which although within run rate in previous months, where reported as CIPs for the first time.

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

Actions

- The 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.
- It is critical that the existing Green schemes deliver their planned savings in line with expectations to support the achievement of the year end financial position.
- The Trust needs to identify and implement additional recovery actions necessary so that it can deliver its forecast year end deficit of £53m. Further CIP plans and/or financial controls will be required to mitigate any shortfall or additional in-year pressures.

17/18 Year End Forecast



- The Trust has maintained the working forecast at £53.0m.
- While further improvements have been identified, these have been required to mitigate other emerging pressures. Notably:
  - Elective income underperformance as a result of bed pressures within surgical specialties (Urology, Max Fax, General Surgery) expected to continue in Q4
  - Pay run rate challenges in CWDT
- Additional expenditure control of £3m is planned, and managed through divisional run rate sessions and well as TRIG.
- £6.3m of non-recurrent actions are included within the forecast position to be delivered in Q4.
- Risk associated with PSS funding from NHSE to CCGs is not included in the forecast position. The delivery of £53m deficit is dependent on both the specialist top-up element of this activity (£2.7m), and the budget transfer from NHSE to CCG's to allow payment of this activity to the Trust.

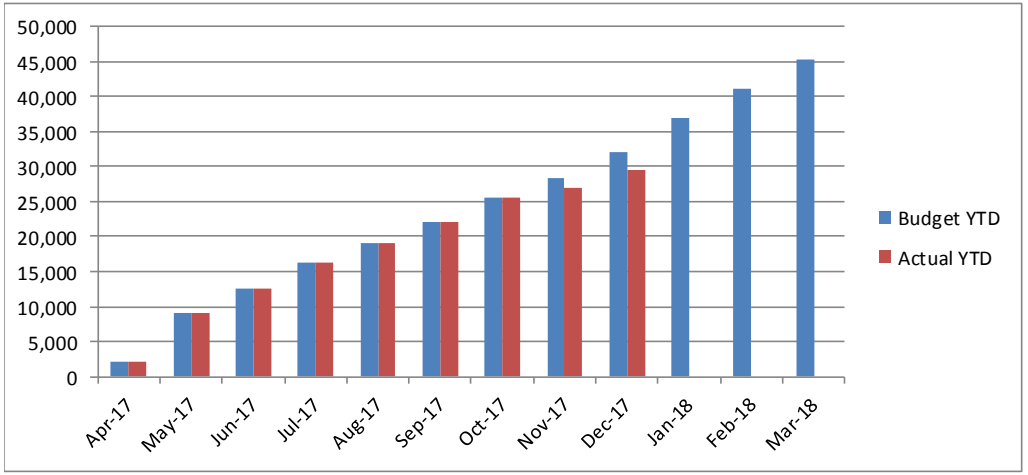
	Revised Forecast £m	Comment
Most likely	(53.0)	• Run rate pressures emerging within divisional forecasts. • PSS pressure assumed to be covered by NHSE transferring funds to CCGs. • Some non-recurrent balance sheet actions now included in position.
Best	(50.0)	• As per most likely case above. • Other gains increasingly being absorbed to hold the median case.
Worst	(60.0)	• As per median case. • NHSE do not fund CCGs for the PSS adjustment. • No further run rate pressures emerge.

3. Month 9 Capital Programme

Capital expenditure summary M09 2017/18

Spend category	2017/18 Original Budget £000	2017/18 Revised budget £000	M09 YTD Budget £000	M09 YTD actual £000	*M07 YTD Variancevs Revised budget*
Energy Perform Contract	**5,555**	**5,719**	**5,719**	**5,444**	*275*
Infra Renewal	**10,492**	**6,826**	**3,917**	**4,524**	*-607*
Med Eqpt	**3,194**	**4,257**	**3,632**	**2,856**	*776*
Major Projs	**22,210**	**14,445**	**8,130**	**7,936**	*194*
IMT	**2,567**	**11,859**	**8,782**	**7,145**	*1,637*
Other	**601**	**1,610**	**1,332**	**1,190**	*142*
SWL PATH	**684**	**684**	**515**	**411**	*104*
Contingency/Headroom	**1,096**	**1,000**	**0**	**0**	*0*
Total	**46,400**	**46,400**	**32,027**	**29,506**	***2,521***

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



- Capital expenditure in December was £2.53m, £0.9m lower than budget and M09 YTD expenditure is £29.5m giving rise to an under spend of £2.5m YTD against the ***revised capital budget*** – see below.
- 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.
- Consequently the Trust needed to complete a re-forecasting and re-prioritisation exercise to ensure the minimum level of IT capital investment required this year may still be accommodated within the existing budget. This exercise involved identifying expenditure in other categories which may be rescheduled to next year.
- **The Trust has revised the capital budgets following the completion of the re-forecasting and re-prioritisation exercise in M07. The budgets have been revised in accordance with the forecast spend position per the M07 capital update paper submitted to FIC. For example IMT's revised capital budget is now £11.8m compared to £2.6m per the original budget – recognising the non-receipt of the emergency DH capital allocation.**

4. Month 9 YTD Analysis of Cash Movement

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

		Actual M09 vs Plan M09	
	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	-45.4	-54.4	*-9.0*
Depreciation	20.3	17.3	*-3.0*
Interest payable	6.1	6.1	*0.0*
PDC dividend	2.5	2.5	*0.0*
Other non-cash items	-0.1	-0.1	*0.0*
Operating deficit	**-16.6**	**-28.7**	-12.1
Change in stock	-0.7	-1.3	*-0.6*
Change in debtors	-11.4	0.2	*11.7*
Change in creditors	16.4	4.6	*-11.7*
Net change in working capital	4.2	3.5	-0.6
Capital spend (excl leases)	-33.8	-27.9	*5.9*
Interest paid	-4.6	-4.5	*0.1*
PDC dividend paid	-1.7	-1.7	*0.0*
Other	-0.3	-0.2	*0.1*
Investing activities	-40.3	-34.2	6.1
WCF borrowing	41.6	50.3	*8.7*
Capital loans	16.2	16.2	*0.0*
Loan/finance lease repayments	-7.0	-5.7	*1.3*
Cash balance 31.12.17	**3.0**	**7.4**	*4.4*

M01-M09 YTD cash movement

- The cumulative M09 I&E deficit is £54.4m* – £9m worse than plan.

(*this includes the £1.1m impact of donated grants and depreciation which is excluded from the NHSI performance total).

- Within the I&E deficit of £54.4m, depreciation (£17.3m) does not impact cash. The charges for interest payable (£6.1m) and PDC dividend (£2.5m) 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 £28.7m.
- The operating variance from plan of £12.1m in cash is in part attributable to the lower depreciation charge.
- Working capital performed slightly worse than plan.
- Capital spend is £5.9m lower than plan due to the re-forecasting exercise deferring spend to the last quarter.
- The Trust borrowed approx.£6.1m from DH working capital facilities in M09 and has borrowed £50.2m YTD which is £8.7m more than plan. The Trust has not needed to borrow in January but will need to do so I February and March. These borrowings are subject to an interest rate of 6% for the amounts drawn up to October and 3.5% for the amounts drawn since November.
- 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 9 2017/18

St George's University Hospitals NHS
NHS Foundation Trust

Balance sheet DECEMBER 2017

	Mar-17 Audited £000	Dec-17 Plan £000	Dec-17 Actual £000	*YTD Variance £000*	Explanations of balance sheet variances
Fixed assets	335,834	349,553	348,226	*406*	Lower depreciation charge than plan
Stock	6,575	7,309	7,861	*-1,246*	Main targets agreed to reduce adverse YTD variance by year end
Debtors	101,837	113,256	101,597	*12,601*	Debt lower than plan but higher than the M09 Debt Reduction Plan target
Cash	6,022	3,000	7,405	*-4,405*	Higher opening cash than plan and capital under spend YTD.
Creditors	-118,305	-133,633	-122,902	*-8,958*	Higher levels of creditor payments in M09.
Capital creditors	-5,284	-2,284	-6,346	*4,062*	Timing of capital payments has increased capital creditors at M09
PDC div creditor	0	-867	-826	*220*	
Int payable creditor	-259	-1,788	-1,808	*461*	
Provisions< 1 year	-335	-335	-335	*0*	
Borrowings< 1 year	-55,206	-57,259	-56,858	*-288*	Lower value of finance leases - some leases extended rather than renewed
Net current assets/-liabilities	**-64,955**	**-72,601**	**-72,213**	*2,448*	
Provisions> 1 year	-988	-718	-822	*74*	
Borrowings> 1 year	-164,524	-216,235	-224,193	*12,326*	Borrowing higher due to higher deficit than plan.
Long-term liabilities	**-165,512**	**-216,953**	**-225,015**	*12,400*	
Net assets	**105,367**	**59,999**	**50,998**	*15,254*	
Taxpayer's equity					
Public Dividend Capital	129,956	129,956	129,956	*0*	
Retained Earnings	-114,843	-160,211	-169,145	*15,188*	Higher I&E deficit than plan
Revaluation Reserve	89,103	89,103	89,037	*66*	
Other reserves	1,150	1,150	1,150	*0*	
Total taxpayer's equity	**105,367**	**59,999**	**50,998**	*15,254*	

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M9 YTD)	Actual (M9 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	3
Agency rating	1	1

Basis of the scoring mechanism

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

- 1 represents the best score, with 4 being the worst.
- At the end of December, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. Furthermore, interim spend has reduced significantly this year due to the IT MSA, with costs now being reflected in non-pay.
- The distance from plan score is worked out as the actual % I&E deficit (9.21%) minus planned % I&E deficit (7.54%). This value is -1.67% which generates a score of 3. To score a 4, the Trust would need to have a value of -2%, which would be a YTD deficit of £55.2m, £1.9m worse than the current YTD deficit.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Board Meeting		
Date:	25th January 2018	**Agenda No.**	**5.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Harbhajan Brar, HR & OD Director		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 11th January 2018.		
Recommendation:	Receive this report		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		
Implications			
Risk:			
Legal/Regulatory:			
Resources:			
Previously Considered by:		**Date:**	
Equality Impact Assessment:			
Appendices:			

1. Committee Chair's Overview

This paper reports on the Workforce and Education Committee held on 11 January with good attendance and strong and engaged contribution from all present. We were pleased that the Trust's Chair and its Chief Executive were able to be present, as if nothing else (and there was plenty else) it is good for Committee members to see for themselves that they are in a position of influence, and the work is being taken seriously by the top of the office.

I was however particularly disappointed that – despite the very direct comments made after the last meeting and with one honourable exception - the divisions were still not sending representatives to the meeting, despite having been invited. This is particularly an issue given that a number of the issues and programmes discussed will affect them directly, and would benefit from their input.

In its work, the Committee is trying to take a position which focuses on getting assurance on those areas which support the achievement of its four strategic theme priorities. However there are other areas of policy and practice where it can contribute. We will continue to balance these demands on Committee time. The other challenge remains one of making sure the Committee does not try to micro-manage, whilst at the same time being supportive and encouraging on the wider work of staff. The Committee is not there to second-guess (or act as cheerleader for) the HR team, but really does appreciate the work they do and the energy and commitment they bring.

Finally within this introduction, please note that a number of items discussed at the Committee and reported on below have implications for more than one of our four[1] strategic theme priorities. The reporting of these under any specific theme should not be taken to imply that these wider implications are not also considered.

2. Key points:-

Board Assurance - The Committee began the meeting by reviewing the four **Trust-level risks** that it was proposed be assigned to the Committee to monitor, and provide assurance on mitigation. We had a very full discussion (led by Elizabeth Palmer) on the scope of the risks, their respective weighting, and the actions currently under way to help mitigate these risks. The Committee concluded that (i) it understood - and was content to take on the monitoring and mitigation assurance responsibility for - these risks; (ii) the risks needed to be re-stated to ensure that the importance of development and succession planning, and of change to working practices were both explicitly included. The restatement is now being undertaken. The content of the HRD Update Report prepared by the Trust's Director of HR and OD ('*HB*') was discussed extensively. Rather than summarise the discussion here it will be referred to within the commentary on the relevant Strategic Theme, below. We agreed that the **Committee Terms of Reference**, agreed at the previous meeting, would be treated as final – given that no further comments had been received from the Trust Secretariat.

[1] Being (1) engagement; (2) leadership and development; (3) workforce planning; and (4) compliance.

Theme 1 - Engagement – the Committee reviewed the current and planned staff engagement actions across the Trust, noting progress on the **Engagement Plan** and the activities planned for the remainder of the year. Alison Benincasa had led a complex process which was beginning to develop real traction. In support of this initial conclusion, HB reported on the good progress on staff opinion shown in the latest **staff survey** (not repeated here due to the fact that still embargoed) and he also set out the future areas of focus. A shorter, sharper **Staff Wellbeing Strategy** (with a description of current and planned initiatives) was introduced by Dr Rhia Gohel. This was endorsed, and Rhia thanked for the good work she had done. Jacqueline McCulloch reported on a recent **survey of exiting staff**, focussing specifically on reasons for leaving and how their initial expectations of working at the Trust had not been met. Jacqueline had set out a comprehensive series of conclusions from the research, and the proposed remedial actions - which were then refined in the discussion at the Committee. There were some wider pointers which would be carried into the recruitment process. Jacqueline will progress these. **Recognition initiatives** were also discussed, and a sub-group has taken this away to progress.

Theme 2 – Leadership and Progression. Sarah James reported on progress on the **development centre**, to be undertaken by King's Fund. This would involve 250 of the Trust's managers, and comprise an off-site day, with a follow-on half-day. Participation would be mandatory for eligible managers, and is directed at identifying development needs and then setting frameworks for meeting these. The Trust would need to ensure diary space was created for those attending. Total cost of this particular programme (not including time cost of the time away from the Trust) is £200k, of which £150k has been externally sourced. Sarah also emphasised that the Trust's other leadership **development and effectiveness training** was continuing as well, and reported on attendances at these (c 475 attendances across 8 course modules in the nine months to December 17). Measuring the impact of all this development activity is not going to be easy, but the Committee is clear on the need to evaluate the effectiveness of training and development spend, and we will return to this question later in the year when we begin to see the evaluations back from the development centre.

Theme 3 - Workforce Planning. Sion Pennant-Williams reported to us on **Workforce KPIs**. We were concerned about the continuing steady deterioration in the levels of appraisals and HB confirmed that the HR team was addressing this through the divisional meetings. Sion reviewed the reduction in the Trust's establishment, reminding us that this was largely a consequence of the loss of certain Community staff who had TUPE'd across to a new employer. However, the current planning process for 2018-19 on which we were briefed (see below) might well lead to a further reduction in establishment, and the removal of apparently open yet unfilled posts. The Committee was particularly pleased to see, within the data reviewed at the meeting, the very positive performance on agency spend in December (though also concerned about whether this could be maintained in January). Ranjit Soor then introduced the **Workforce Strategy** which she had begun to draw together since joining the Trust in November. RS was clear that, in the absence of more detail on the Trust's proposed activity for 18-19, and therefore clarity on the required workforce, this could not be further progressed. RS and HB summarised the planning and budgeting processes being undertaken jointly by finance and HR as part of the budget-setting for 18-19. The outcomes from these would be (a) an activity and finance budget, and (b) a workforce plan, linked to planned activity and reconciled to budgeted pay spend. The Committee agreed with HB's suggestion that therefore RS would shift focus for the next quarter

to the **Workforce Plan, 2018-19** and setting a right-sized establishment for next year, and return to longer term strategic considerations once this had been completed. The need for progressively changed ways of working, and changing role responsibilities within the Trust's workforce was emphasised by a number of Committee members. Finalisation of the Trust's Workforce Plan for 18-19 will be a key activity for the HR team over the next quarter, and pivotal in the Trust having a realistic and achievable budget. The discussion at Committee suggested the HR team is appropriately sighted on this, and its importance.

Theme 4 – Compliance. We received a report from Sunil Dasan, our **Guardian of Safe Working**. In a very comprehensive report, he highlighted continuing problems in general surgery. Although of real concern to us, Sunil reminded us that this report had not yet been reviewed by executive management and he anticipated that they would take action once they had reviewed it. We therefore accepted Sunil's suggestion that he report back to us, once he has discussed its contents with management (which he will have done by the time this Report is considered at the Trust Board Meeting, so this will serve as a request for an initial update at the Board from Prof Jones on this specific point). At a wider level, we noted that over 85% of the fines levied within the last 9 months (£10.5k) are attributable solely to general surgery. We also noted (and in fairness to management, we accept) that the situation driving non-compliances is made materially more complex by the number of gaps (100) in trainee staff complement, across most specialties, and across all grades / seniorities. However, even against that background, general surgery still looks to be an outlier.

We reviewed and endorsed an updated **Whistleblowing Policy**. Proposed updates to our **Induction Policy** and our **Work Experience Policy** were discussed, and a number of comments made to help their operation. It was agreed that the content of these would be finalised outside the meeting (along the lines discussed), but subject to that being done they were also approved.

Stephen J Collier

18th January 2018

Report to the Board from: Audit Committee

Committee Chair: Sarah Wilton

Date of the Committee Meeting: 11.01.2018

1.0 Matters for the Board's Attention

1.1 The Committee was updated on the Final Internal Audit reports. The Audi Committee were very concerned to receive only limited assurance on IA of patient records.

1.2 The Chief Financial Officer assured the committee that clear guidance is available to staff however it requires tightening and to ensure it is addressed appropriately in the re-presentation of SFI's and the acceptable use of them. It was questioned whether there are staff that repeatedly breach. The Head of Procurement responded that it is necessary for staff to be trained and understand the procedures in order for them to sign the policy agreeing that they understand the rules enabling stricter policing.

1.3 The committee were informed that two senior interim managers are expected to join the procurement team which should provide the committee with some assurance.

1.4 The Director of Financial Operations informed the committee that changes have been proposed to the Scheme of Delegation as the current limits are seen as restrictive and create delay in the ordering of goods and surplus. He informed the committee that the new controls are seen to provide a smoother process whilst ensuring effective control is maintained.

1.5 He informed the committee ongoing training is being given to budget holders and that regular robust financial reviews are in place on a corporate level and with individuals on a monthly basis. He assured the committee that it will be actively reviewed to ensure no discretions.

1.6 The committee approved the changes to Schedule A Summary Financial limits of the Scheme of Delegation to the Trust Board, on an exception basis that it was monitored closely and that reports to the committee any discretion. The committee requested the final Scheme of Delegation with all its documents at the following committee in April 2018.

2.0 Recommendation

2.1 To receive the update from the Audit Committee meeting on 11 January 2018 for information and assurance.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	25 January 2018	**Agenda No**	
Report Title:	Board Assurance Framework (BAF)		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	In October 17 the Board agreed the strategic risks to the Trust's objectives and assigned an executive lead and assuring committee for each risk. The Board delegated 14 risks to its assuring committees and retained 3 risks to itself for review of the assurances. The BAF is presented to the Board on the understanding that it will continue to develop, improve and change. The BAF populated with contributing risks from the corporate and divisional risk registers and records a risk score and an assurance rating for each strategic risk. The summary sheet of the BAF gives an overview of the risk profile of the Trust and will ensure that the Board agenda is directed to improving control of these strategic risks. The BAF will continue to develop, improve and change The Workforce and Education Committee has discussed **SR11** and proposes that a redrafting of this risk may better reflect the risk to the Trust. This redraft is brought to the Board for discussion and approval. The BAF is designed to be reviewed by the Board after the close of each quarter, however while assurances are limited it is proposed that the assuring committees provide a monthly update on the delivery of actions designed to improve controls and thus strengthen assurances.		
Recommendation:	The Board is asked: 1. To note the risk score, assurance rating and rationale recommended by the assuring committees for strategic risks 1-8, 10-13 and 15. 2. To discuss and agree the proposed risk score and assurance rating for strategic risks 9, 16 and 17, which the Board reserved to itself. 3. To discuss and approve the redrafted text for strategic risk 11. 4. To agree that monthly updates are provided to the Board until the assurance position improves.		
Supports			
Trust Strategic Objective:	All		

CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously Considered by:	Finance and Investment Committee Workforce and Education Committee Quality and Safety Committee	**Date**	Dec 17 and Jan 18
Equality Impact Assessment:	N/A		
Appendices:	Full Board Assurance Framework (BAF)		

Board Assurance Framework

Trust Board 25 January 2018

1.0 PURPOSE

1.1 This paper brings the BAF back to the Board; it is populated with contributing risks from the corporate and divisional risk registers and records a risk score and an assurance rating for each strategic risk. The summary sheet of the BAF gives an overview of the risk profile of the Trust and will ensure that the Board agenda is directed to improving control of these strategic risks.

2.0 BACKGROUND

2.1 In October 17 the Board agreed the strategic risks to the Trust's objectives and assigned an executive lead and assuring committee for each risk. The Board delegated 14 risks to its assuring committees and retained 3 risks to itself for review of the assurances.

2.2 In quarter 3 the BAF has been reviewed at each of the assuring committees; Workforce and Education; Quality and Safety and Finance and Investment. During the quarter the corporate and divisional risks have also been reviewed to ensure that the population of the BAF reflects the risks identified on these registers accurately. The Risk Management Executive has reviewed and agreed changes to the risks on the corporate and divisional risk registers where this has been recommended.

3.0 THE BOARD ASSURANCE FRAMEWORK

3.1 The BAF is designed for presentation to the Board after the close of each quarter to provide assurance on the delivery of actions to control the strategic risks. It will develop further as it becomes embedded in the risk management tools of the Trust.

3.2 At present there is limited assurance available on the control of a number of strategic risks and it is proposed that an update on the position with the delivery of actions to control risk and assurances available is provided by the Committees on a monthly basis until the levels of assurance improve.

3.3 The Workforce and Education Committee propose a redrafting of strategic risk 11. The risks were agreed by the Board in October and the proposed redrafting is set out below for the Board to consider and agree whether the proposed text more accurately reflects the risk to the Trust.

***Original wording**: We fail to stabilise and invest on our leadership and management teams over the longer term, resulting in a lack of continuity, organisational memory and ownership in relation to our plans and priorities.*

Proposed wording: We fail to effectively develop our leaders which could lead to a lack of ownership of their contribution to delivering our plans and priorities. We need to provide real clarity on their full range of accountabilities. Failure to do so will lead to low job satisfaction resulting in both high turnover and on-going instability in leadership teams.

5.0 RECOMMENDATION

5.1 The Board is asked:

1. To note the risk score, assurance rating and rationale recommended by the assuring committees for strategic risks 1-8, 10-13 and 15.

2. To discuss and agree the proposed risk score and assurance rating for strategic risks 9, 16 and 17, which the Board reserved to itself.

3. To discuss and approve the redrafted text for strategic risk 11.

4. To agree that monthly updates are provided to the Board until the assurance position improves.

BOARD ASSURANCE FRAMEWORK OVERVIEW										QUARTER 3
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
				Q1	Q2	Q3	Q4				
Treat the patient, treat the person	*To be established by the Board*	*SR1*	We are unable to recruit and retain staff, resulting in care which is below minimum standards.			Partial		The Committee recognised a lot of activity going on in the recruitment space, but with turnover remaining at around 18%, the Committee was only able to give limited assurance on this risk. The Committee noted the on- going work in the areas of Bank and agency was well as the significant reductions in the number of overall vacancies.	Director of HR and OD	Workforce and Education Committee	16
		SR2	Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway are not timely or robust, resulting in poor, delayed or missed treatment.			Limited		The Committee recognises the significant improvement in management of our waiting lists and the launch of the new Patient Tracking List (PTL), but assurance remains limited recognising the scale of the task and the significant work still to do.	Chief Operating Officer	Quality Committee	16
		SR3	We do not have effective, accessible and widely utilised learning and improvement methodologies, resulting in care which is below local and national standards and best practice.			Partial		The Committee is assured that the Quality Improvement Plan (QIP) for learning is being delivered and achieving key objectives but a number of key indicators in the QIP dashboard are yet to be met.	Chief Nurse	Quality Committee	12
Right care, right place, right time	*To be established by the Board*	*SR4*	Our pathways are not well integrated with, or supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.			Limited		The Committee notes that the controls and assurances are cross referenced to SR17 and the increase in director level capacity to build and develop relationships within the local health economy.	Medical Director	Quality Committee	8
Balance the books, invest in our future	*To be established by the Board*	*SR5*	Financial efficiency, forecasting and accountability is not seen as a priority for service managers or our wider workforce, resulting in overspending, poor budgetary management which could lead to poor service delivery and regulatory action.			Partial		The Trust needs to ensure that when staff take on roles with financial responsibility they are adequately trained to fulfil the role. Some controls need to be aligned more closely with operational requirements to ensure the smooth procurement of goods and services.	Director of Finance	Finance and Investment Committee	16
		SR6	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities			Limited		Divisions still lack the capacity and capability to fully understand efficiency opportunities in their business	Director of Efficiency and Transformation	Finance and Investment Committee	20
		SR7	We do not have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories. This results in the Trust having incomplete plans and management action becoming reactive.			Limited		The Trust currently does not have in place a medium term financial and operational plan.	Director of Finance	Finance and Investment Committee	15
Champion team St George's	*To be established by the Board*	*SR8*	Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative/punitive or does not foster accountability amongst our workforce.			Partial		Increasing participation of staff in the staff survey and increased engagement in events across the Trust.	Director of HR and OD	Workforce Committee	10
		SR9	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.			Partial		To be completed following discussion at January 2018 Board meeting.	(CEO) Director of Corproate Affairs	Board	12
		SR10	We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction and poor care for patients.			Partial		Compliance with mandatory and statutory training steadily improving, high compliance with appraisal and professional development planning.	Director of HR and OD	Workforce Committee	9
		SR11	We fail to effectively develop our leaders which could lead to a lack of ownership of their contribution to delivering our plans and priorities. We need to provide real clarity on their full range of accountabilities. Failure to do so will lead to low job satisfaction resulting in both high turnover and on-going instability in leadership teams.			Partial		To be completed following discussion at January 2018 Board meeting and the Board approval of the redrafted risk.	Director of HR and OD	Workforce Committee	9
Build a better St George's	*To be established by the Board*	*SR12*	Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.			Limited		The workshop held in December highlighted the need for more assurance on improving clinical systems and achieving a resilient infrastructure. The committee agreed that any workshop would be beneficial to agree priorities	Chief Information Officer (CIO)	Finance and Investment Committee	20
		SR13	Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting delivery and risking patient safety.			Limited		The Director of Estates and Facilities joined the Trust in Jan 18 and is in the process of undertaking a due diligence review of regulatory compliance.	Director of Estates and Facilities	Finance and Investment Committee	15
		SR14	We are unable to secure the investment required to address our IT and estates challenges and as a result are unable to transform our services and achieve future sustainability.			Limited		Reporting deficits for the last years has stressed the Trust's working capital and limited it's ability to secure external finance.	Chief Executive	Board	16
Develop tomorrow's treatments today	*To be established by the Board*	*SR15*	We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.			Partial		Wider assurances on action to increase the research profile of the Trust working with SGUL. Cross reference to SR17	Medical Director	Quality Committee	12
Build a better St George's	*To be establised by the Board*	*SR16*	We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clincial service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.			Limited		To be completed following discussion at January 2018 Board meeting.	(CEO) Director of Strategy	Board	12
		SR17	A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.			Limited		To be completed followingJanuary 2018 Board meeting.	Chief Executive	Board	12

Strategic Objective	Treat the patient, treat the person			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**16**	**Committee**	Workforce and Education Committee
SR1	**We are unable to recruit and retain staff, resulting in care which is below minimum standards.**	**Current Risk Score**	**16**	**Executive lead**	Director of HR and OD

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
	Limited	Limited	Partial	

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
CRR-0025	Failure to recruit and retain staff at target levels	Director of HR and OD	Workforce and Education Committee	15	16	16	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
CRR-0025	Workforce priority plan with underpinning action plan	Monitoring by the Workforce and Education Committee. Report to Board that identifies key trends, including tracker of SAFE nursing staffing compliance and of staffing alerts that have been reported	Oct-17
	A medical workforce group meets every Tuesday led by the Medical Director.	The group will report to the workforce and education committee	
	Shorter Recruitment process time for nursing		

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
CRR-0025	No coherent recruitment strategy in place	Develop recruitment strategy	Jan-18
	11% target voluntary turnover possibly not reflective of current workforce trends	Implement Workforce priority plan	Jan-18
	External political & economic environment impacting on implementation of workforce plan		
	Vacancy level and turnover remain constant		

Strategic Objective	Treat the patient, treat the person			Risk appetite		
				To be established by the Board		
Ref	**Strategic Risk**		**Initial Risk Score**	**20**	**Committee**	Quality Committee
SR2	**Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway are not timely or robust, resulting in poor, delayed or missed treatment.**		**Current Risk Score**	**16**	**Executive lead**	Chief Operating Officer
Assurance rating (quarterly)	**Q1**	**Q2**	**Q3**		**Q4**	
	Limited	Limited	Limited			

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
CRR-0011	Below target performance against the emergency care 4hr operating standard	COO	EMT	15	15	15	
CRR-0012	Risk of harm to patients due to long waiting lists or poor management of pathways	COO	Clinical Harm Review Group	20	20	20	
CRR-0023	Risk of harm to patients as the trust fails to achieve the 2 week cancer performance standard	COO	EMT	16	16	16	
CRR-0019	Risk that we do not recognise, communicate or act upon incidental findings of diagnostic tests	Medial Director	PSQG	16	16	16	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
CRR-0011	Interprofessional standards and Trust escalation policy in place	Weekly performance meeting (CommCel) to review performance data - led by Director of DET	10-Jan-18
	Increased capacity:Mental health provision within ED; additional SpR in the stroke team in evenings; Surgical Assessment Unit in place to support improved flow	Monthly Integrated Quality and Performance Report to Board	Nov-17
	QIP Unscheduled and Admitted Care Programme 1) Front door streaming 2) ED process efficiency 3) Ambulatory care 4) Inpatient processes 5) Discharge processes.	Monthly reporting to Quality Delivery Meeting - KPIs and milestones	Jan-18
	Programme actions – led by COO and Emergency Care Delivery Board	Reports to Emergency Care Delivery Board	
CRR-0012	NHSI approved recovery plan in place led by a programme director	Project milestones agreed with NHSI and Trust Board up to march 2018	Mar-18
	Clinical harm review process	Reports to multi agency Clinical Harm Review	Dec-17
	Validation strategy in place	Validation - trust is above baseline trajectory. 69% of the total pathways in the cerner system	Oct-17
	Elective Care Recovery Programme (ECR) project board and programme	Weekly project meetings in place for all 5 projects. Monthly reporting to Quality and Safety Committee. Fortnightly reporting to EMT	Oct-17
	Specialties increased capacity to shorten waiting time	Weekly access committee monitors the capacity programme of reduction of list Increase of 85 new outpatients monthly	Mar-18
CRR-0023	Cancer performance recovery	Programme overseen by Cancer lead. The weekly cancer KPIs show that less than 25% of patients are contacted within 24 hours	Jan-18
	Recovery plans completed. All services to increase short term capacity to clear the backlog but also provide sufficient core capacity in the longer term	Increased short and long term capacity	Sep-17
	Management of 2week rule transferred to Central Booking Service (CBS)		
	Daily circulation of 2ww booking position identifying patient appointments outstanding by specialty for service capacity identification	60% of patients being booked within one week	Dec-17
CRR-0019	Strengthened radiology safety net system. Includes e-mail to MDT for unexpected cancer		
	SOPs for diagnostic tests in each Care Group		
	Cerner enables sign off once reports read		

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
CRR-0011	Pressures on beds / OOH causing reduced flow of patients out of ED.	Unscheduled and Admitted Care Programme to oversee improvements	Mar-18
	Physical capacity within ED is insufficient to cope with point of rapid surge	Complete planning strategy to increase ambulatory capacity	Feb-18
	Insufficient bed capacity within mental health services to provide for demand	Psych strategy for ED, including recruitment of RMNs within dept	Jan-18
	Trust not meeting 95% performance standards		
CRR-0012	National reporting (NHSE) of mandatory data reporting of RTT suspended	complete implementation of RTT work plan and the implementation of Cerner on the QMH site	Sep-18
	Not enough theatre capacity / OPD capacity to accommodate the additional activity necessary to clear backlogs and reduce waiting list sizes	Continue to explore outsourcing and partnership arrangements through with other suppliers Capacity opportunity plans to be developed by the ECR Programme	Mar-18
	There is insufficient resource within the 18 week RTT team to complete all the required validation.	Weekly meeting to determine workload and priority areas. Increased manpower into the 18 week Team.	Dec-17
	Currently three separate PTLs which contain a number of data quality errors which make it difficult to accurately monitor waiting times and manage the patient journey	Incomplete and planned PTLs to be built and operationally implemented	Dec-17
	Limited availability of SOPs	Complete SOPs (10 SOPs by Feb 2018 - 40 SOPs by March 2018);	Mar-18
	Clinical decision outcome forms not in place	outcome forms training plans under development. Complete Roll out of CDOF	Feb-18
CRR-0023	Demand management systems not fully implemented		
	Shortage of staff (CNS, admin staff)		
	Patient Choice – patients choosing to be seen outside of the 14 day access standard, even when a choice of dates are offered.	To review the process for contacting patients within 48 hours of referral,	Dec-17
	The demand and capacity analysis showed that a number of services are providing up to 50% `		
CRR-0019	Radiology safety net not reliable as emails are not sent to right staff	Re-audit SOPs to ensure fit for purpose	Feb-17
	Significant proportion of results are attributed to the wrong consultant making the electrical sign off inconsistent	ECR programme to review administrative system to improve data quality	Dec-17
	Not all results are reported via iClip		
	There is limited ability to track compliance through Tableau of other results at the present		

Strategic Objective	Treat the patient, treat the person			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**15**	**Committee**	Quality Committee
SR3	**We do not have effective, accessible and widely utilised learning and improvement methodologies, resulting in care which is below local and national standards and best practice.**	**Current Risk Score**	**12**	**Executive lead**	Chief Nurse

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
CRR-1143	Risk that we fail to recognise, escalate and respond to the signs of deteriorating patient	Medical Director	Deteriorating Patients Group	20	15	15	
CN1179	Failure to comply with the regulatory framework and fully implement the QIP	Chief Nurse	Trust Executive Group	12	12	12	
CN1166	Failure to learn from incidents	Chief Nurse	Patient Safety and Quality	12	12	12	
CN1357	Failure to develop and implement a quality improvement methodology	Chief Nurse	Patient Safety and Quality			6	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
CRR-1143	Policy in place	Deteriorating Adult Group (DAG) monthly meeting reviews compliance, reporting to CQRM and PSQB	Dec-17
	Critical care liaison project team rolling out the 12 week quality improvement project plan	Audit demonstrate improvement in 3/4 key standards	Jul-17
	EWS training delivered by Resus, Simulation and Practice Educators, induction programme for doctors, training also on MAST	34 training sessions scheduled between September 2017 and March 2018	Dec-17
	Patient followed up once discharged from ICU		
	Review /monitoring of serious incidents / adverse incidents / mortality data / audit cardiac arrest calls / self assessment form for learning	increase in peri arrest calls and decrease in cardiac arrest calls / trend for lower hospital mortality	Jul-17
	Local monthly audits programme on RATE		
	nEWS workstream as part of QIP	Monthly reports to Quality Delivery meeting	Dec-17
CN1179	Quality improvement plan (Oct 16) to manage all actions identified in CQC inspection prep programme and CQC report findings	Letter from CQC confirming they are satisfied that the requirements of the 29A warning notice have been met	Sep-17
	Quality Improvement Plan (Oct 17), 3 programmes and 2 enabler programmes to deliver sustained compliance with fundamental standards through continuous improvement	QIP governance framework ensures delivery is monitored and risks to delivery are identified early. Weekly workstream reports to Quality Delivery Group Fortnightly reports to Trust Recovery and Improvement Group	Dec-17
	Quality Observatory (overarching care audit) all patient areas included.	Ward accreditations	
	Thematic 'back to the floor' weekly visits and audits	Weekly review at Friday 'back to the floor' meeting	Nov-17
CN1166	Monthly Divisional Performance meetings provide forum for challenge services around repeated SIs and local actions to address	Minutes of Divisional Performance Meetings	
	Sharing of learning through monthly AMD governance newsletters/quarterly CLIPI report and learning from SIs report	Quarterly CLIPI report to PSQB showing good reporting culture	Oct-17
	Trust working with CCG to identify themes to focus on at CQRG to ensure learning and actions to address.	Pressure Ulcer thematic analysis report presented at CQR and PSQB showing how the trust is continuing to identify new initiatives	Dec-17
	Identification of actions based on intelligence from SIs/incidents thematic analysis including service and location data	SI thematic analysis report sent to Quality Committee	Dec-17
	QIP work stream 'learning from Incidents'	Quality Delivery Meeting progress reports	

CN1357	Diagnostic of quality improvement activity at SGH by Institute for Healthcare Improvement	IHI report discussed at TB	Sep-17
	Training programme in quality improvement methodology for staff leading QIP work streams		
	Engagement of clinical staff who have quality improvement skills and lead improvement projects.		

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
CRR-1143	Agency staff variable understanding of Trust policies, agency contract is explicit on knowledge of observation tools	Review of agency staff contract to ensure requirements (understanding of NEWS) are clearly stated	Jan-18
	QMH and Prison not part of quality improvement project plan, currently a separate workstream	Work with QMH and Prison to review escalation programme	Jan-18
	EWS training no longer covered in Nurse induction	Develop a booklet for nurse induction, nEWS section to be included	Dec-17
CN1179	Quality improvement metrics and milestone dashboard continue to develop	Finalise the Quality Improvement Plan dashboard, trajectories and Quality Improvement Plan milestones dashboard	Dec-17
CN 1166	No standardised processes for distribution of key messages for learning throughout all divisions	Develop and implement standardised processes for distributing key messages for learning throughout all divisions	Mar-18
	No Trust wide communication on feedback to staff on incidents	Monthly communication to staff on learning from incidents and SIs via eG	Feb-18
CN1357	No consistent approach to quality improvement	Collaboration with IHI launched at Quality Imp Week	Nov-17
	Insufficient staff able to act as quality improvement leaders	Provide access to training in quality improvement	Mar-18

Strategic Objective	Right care, right place, right time			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**10**	**Committee**	Quality Committee
SR4	**Our pathways are not well integrated with, or supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.**	**Current Risk Score**	**8**	**Executive lead**	Medical Director

Assurance rating (quarterly)	**Q1**	**Q2**	**Q3**	**Q4**
			Limited	

				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
MD 1362	Risk that should other local acute hospitals 'fall over' we would be unable to manage / control patient flow and demand for our services.	Medical Director	Trust Executive Committee			8	

Key controls in place		**Assurance that controls are effective**	**Date**
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
MD1362	Working closely with CCGs in order to re-set priorities	Reports to Trust Executive Committee	
	We are working in an acute provider collaborative with other local hospitals to prioritise patients treatment	Xref: assurance sources SR17	
	Active member of the STP		

Significant gaps in control / assurance		**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for*
MD1362	Implementation of controls are dependent upon coordinated assistance from other organisations		

Strategic Objective	Balance the books, invest in our future			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**16**	**Committee**	Finance and Investment Committee
SR5	**Financial efficiency, forecasting and accountability is not seen as a priority for service managers or our wider workforce, resulting in overspending, poor budgetary management which could lead to poor service delivery and regulatory action.**	**Current Risk Score**	**16**	**Executive lead**	Director of Finance

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
HR1365	Inability to control agency and temporary staffing costs	Director of HR and OD	Workforce and Education Committee			9	
CRR-0028	Risk that we do not have an effective financial control environment	Director of Finance	Finance and Performance Committee	16	16	16	
CRR-1411	Managing Income & Expenditure in line with budget	Director of Finance	Finance and Performance Committee			16	
Fin-1412	Identifying and delivering CIPs	Director of Finance	Finance and Performance Committee			12	
Fin-1083	Maintaining an effective procurement environment	Director of Finance	Finance and Performance Committee	12	12	12	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
HR1365	Monthly data analysis which shows reasons for request and rates of use by ward level		
	All requests for agency are required to be booked through the Central Bank Office following approval from Chief Nurse for Nursing, DDOs for medical staff, Medical Director on day booking	Agency cap reports are produced weekly for NHSI The Trust is below target of agency cap spending. Cap has not been breached in the last seven months	November 2017
	Nursing rostering prepared 8 weeks in advance		
	Vacancy control panel (VCP) approving posts		
CRR-0028	Financial performance management in place at divisional level		
	Internal audit plan agreed which reflects known risks within the control environment		
	Controls on key financial systems are in place		
Fin-1411	Budgets are agreed with budget holders	Trust Board approves financial plan prior to start of financial year	
	CIPs are embedded in budgets	Finance reports to TRIG	
	Financial performance management process in place		
Fin-1412	CIPs are supported by detailed milestone implementation plans	All CIPs are supported by Quality Impact Assessment	
	CIPs are owned by the responsible manager/ budget holder	Trust Board and key finance committee scrurtineses CIP planning and delivery	
Fin-1083	Policies and procedure in place		

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
HR1365	Trust has not yet joined PAN London	review PAN proposal	Nov-17
	STG in phase two of roll out (not completed) of South West London Bank which agree max rates across London and offer banks rates to each other	Roll out of SWL Bank for bands 2 and 5 so they can work shifts at SGH and at Kingston or ESH	Jan-18
	Booking process are not fully followed		
CRR-0028	SFIs and SOs for approval from Audit Com	Review SFIs/SOs documents and take to Audit Com for approval	Jan-18
	Limited knowledge of policies and procedure / awareness of responsibility	Agree training plan for SFI/SO / finance training programme	Mar-18
	Limited understanding of Scheme of Delegation	Review of Scheme of Delegation to be completed with proposed changes to be taken through audit committee	Jan-18
	Financial performance management not in place at care group level	Financial performance management framework to be rolled out below divisional level (care group)	Feb-18
	Financial systems do not address risks No interface with other cost organisational ICT systems (ESR, data warehouse, JAC)	Review of financial systems	Feb-18
	Business case process not up to update	Further review of business case templates and process to be undertake	Feb-18
Fin-1411	No methodology in place to ensure budgets are signed off at cost centre and account code level	Challenge sessions to be held with each budget holder ahead of 18/19 to ensure budgets are signed off at cost centre and account code level	Mar-18
	Budgets does not reflect expected patterns of spend (establishments, capacity plans)	Activity targets to be analysed through demand and capacity model to ensure consistency with resource (both staffing and physical)	Mar-18
	Not all CIPs are embedded in budgets	100% 'green schemes' required by March 18, with 50% required by Feb 18	Mar-18
	Finance is not integrated in the performance review management	Finance to be included on monthly integrated performance review agendas, as well as fortnightly run rate meetings	Feb-18
	No supporting management information for budget holders	DoF(P) to devise clear and standardised set of reports to go out with budget statements on a monthly basis	Feb-18
Fin-1412	Milestones not clearly defined	Review milestones as part of CIP planning 18/19	Mar-18
	Not all green schemes are embedded within budgets	100% 'green schemes' required by march 18, with 50% required by Feb 18	Mar-18
	Insufficient capacity and capability to deliver CIPs	Operational and financial restructures planned to address capacity and capability	Feb-18
Fin-1083	Procurement strategy, policies and procedures not	Update procurement strategy, policies and procedures	Feb-18
	No procurement training / support to staff in place	Procurement teams to form training plan	Feb-18
	Limited capacity and capability within procurement department	HoP to continue recruitment to new structure to ensure team is able to deliver departmental aims	Mar-18
	Limited involvement of clinical staff in procurement decision making	Clinical staff to be engaged and trained in decision making where appropriate	Mar-18

Strategic Objective	Balance the books, invest in our future			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**20**	**Committee**	Finance and Investment Committee
SR6	**We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities**	**Current Risk Score**	**20**	**Executive lead**	Director of Efficiency and Transformation

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
	Limited	Limited	Limited	

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
CRR-1228	The Trust does not deliver on transformation and its cost improvement programme leading the Trust to breach its control total and remaining in special measures	Director of Efficiency and Transformation	Finance and Performance Committee	20	20	20	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
CRR-1228	Transformation programme in place	Report to Finance & Performance Committee monthly to present progress, challenges, resulting action/ next steps	Dec-17
	Financial recovery plan, ensuring robust processes in place for tracking, resourcing, change control. Divisional finance managers signoff financial scoping for each scheme and own benefit realisation	Bi-monthly Run Rate / CIP review meetings held with Divisional Director, Head of Finance and General Managers, to manage delivery performance	Dec-17
	Divisional steering groups, meet weekly and approve all schemes		
	Executive SRO has oversight of each programme to ensure adherence to scope, timescales and realisation of benefits		
	Non Executive Director observation of performance of TAB and holding workstreams to account in terms of both financial targets and milestone achievements		
	Supporting documentation for CIP developed by divisions	Daily tracking of CIP progress through Control activities with	

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
CRR-1228	Monthly Divisional performance meetings have not been consistently held		
	Limited clarity on the change control process		
	No co-ordinated view of high impact risk across all programmes	Create cross programme risk/issue log to identify and manage variance against delivery plans. Complete monthly cross-programme/project risk review	Jan-18

Strategic Objective	Balance the books, invest in our future			Risk appetite	
				To be establisded by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**15**	**Committee**	Finance and Investment Committee
SR7	**We do not have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories. This results in the Trust having incomplete plans and management action becoming reactive.**	**Current Risk Score**	**15**	**Executive lead**	Director of Finance

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
	Limited	Limited	Limited	

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
Fin - 1372	Failure to understand current cost structures	Director of Finance	Finance and Investment Committee	15	15	12	
CRR-1413	Maintaining a five year forward view	Director of Finance	Finance and Investment Committee			16	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
Fin - 1372	Costing systems in place and effectively resourced		
	Service Line reporting		
CRR - 1413			

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
Fin - 1372	Sevice Line reports (SLR) to be tested with clinical staff; used to inform decisions; discussed at FPC	First cut produced by Costing Working Group, being socialised with care groups across Q4. Costing to be added as quarterly agenda item to FPC	Mar-18
		Meeting to be arranged with care group leads / First cut action plan to be developed with each care group as part of reviews	Mar-18
	Costing and SLR information to be used to inform benchmarking	Benchmarks to be identified and reported to EMT/FPC	Mar-18
CRR - 1413	The Trust does not have a long term financial model (LRFM) covering the next 5 years	Build an LTFM by end of Q4 to inform the 18/19 plan approval.	Mar-18
	No regular report provided to FPC on forward financials (beyound next 12 months)		
	Financial assessment does not take accont of both national high level planning issues as well as specific organisational objectives		
	Plans do not include I&E, balance sheet, capital and cash flows forecasts.	Review Finance Dept structure to endure capacity in place to maintain on going maintenance and review	Mar-18
	Future CIP requirements not included in plans		

Strategic Objective	Champion team St George's			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**20**	**Committee**	Workforce Committee
SR8	**Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative/punitive or does not foster accountability amongst our workforce.**	**Current Risk Score**	**10**	**Executive lead**	Director of HR and OD

Assurance rating (quarterly)	**Q1**	**Q2**	**Q3**	**Q4**
	Limited	Limited	Partial	

Contributory risks from risk registers				**Risk Score**			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
HR1361	A risk that we do not recognise success or good practice amongst our workforce.	Director of HR and OD	Workforce and Education Committee			9	
HR1364	Enhanced risk of disengagement of staff and do not live the trust values due to: perceived poor staff engagement from senior manager; perceived inadequate management of bullying and harassment episodes; perceived inconsistent application of equality and diversity standards	Director of HR and OD	Workforce and Education Committee	20	16	12	

Key controls in place		**Assurance that controls are effective**	**Date**
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
HR1361	Award ceremony; long service award		
	Staff Engagement programme includes 'Raising the profile of our staff recognition' approach		
HR1364	Delivery of HR priorities plan with focus on right staff, right time, right place, right skills	Progress against workforce action plan reports to Workforce and Education Committee	Oct-17
	Support from staff side representatives and governors in engaging staff (SNAG)		
	Listening into Action with a focus on bullying and harrassment		
	Chair and CEO Exec briefings and Team briefings (monthly)		
	Stress Management policy & Dignity at Work: Bullying & Harassment policy	The Friends and Family test gives the opportunity to identify areas where there is an increase in pressure	Dec-17
	Leadership Development Programmes		
	Conflict resolution / standard management / effective people management training		
	Regular contact with Staff side reps who raise issues of concern		
	Executive walk about		
	'Would you like to join us for lunch' events		

Significant gaps in control / assurance		**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
HR1361	Staff engagement plan not yet implemented	Implementation of staff engagement action plan	Mar-18
HR1364	Levels of turnover amongst some managers may mean it is difficult to embed the change	Implementation of actions as a result of 2017 staff survey	Dec-18
	Not all managers are able to hold team meetings consistently due to work pressures	Complete recruitment programme	Mar-18

Strategic Objective	Champion team St George's		Risk appetite
			To be established by the Board

Ref	Strategic Risk	Initial Risk Score	12	Committee	Board
SR9	**Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.**	Current Risk Score	12	Executive lead	(CEO) Director of Corproate Affairs

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
			Partial	

Contributory risks from risk registers				Risk Score			
Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
Comms 1419	There is a risk that we do not communicate effectively with our staff and that staff may not be engaged and clear about their contribution to achieving the Trust objectives.	Director of Comms	EMT Trust Board			12	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
Comms 1419	Communication Strategy	Annual Communication Survey	Mar-18
		Communication Strategy approved	Jul-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
Comms 1419	The main area of weakness is the cascade of corporate information by managers across all levels of the organisation	Implementation of the Communication Strategy	Jul-18
	Limitations of current intranet	Business case for upgrade of intranet	Mar-18

Strategic Objective	Champion team St George's			Risk appetite			
				To be established by the Board			
Ref	**Strategic Risk**		**Initial Risk Score**	**9**	**Committee**	Workforce Committee	
SR10	**We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction and poor care for patients.**		**Current Risk Score**	**9**	**Executive lead**	Director of HR and OD	
Assurance rating (quarterly)	**Q1**	**Q2**	**Q3**		**Q4**		
	Partial	Partial	Partial				

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
HR882	Failure to achieve and maintain required MAST training compliance levels	Director of HR and OD	Workforce Committee	9	9	9	
HR1360	We do not ensure that our senior manager are developed to have the right leadership skills	Director of HR and OD	Workforce Committee			9	
HR1363	Risk that we do not ensure all of our staff have a high quality appraisal.	Director of HR and OD	Workforce Committee			9	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
HR882	eMAST in place across the Trust. All managers are responsible for their staff MAST compliance as part of the Appraisal process	Compliance targets monitored at MAST Steering Group - currently 87% Compliance of 95% by March 2018	Dec-17
	Quarterly Mandatory training governance meeting includes Chief Nurse, Medical Director and Director of HR/OD to review content and staff cohorts of mandatory training		
	Mandatory training included in the regular workforce meetings with Divisions as well as appraisal rates		
	Specialist training teams, lead of the recording for their MAST topics		
	Appraisal (PDR) paperwork includes MAST training monitoring		
HR1360	Action plan on leadership development key components: development centre for senior leadership (top 200 staff)		
	Effective people management programme management skills for people and budgets		
HR1363	Performance and Development Review (Appraisal) policy up to date	performance is monitored at the appraisal group sub-committee of Workforce and Education. Staff survey 2016 results reported an increase in the quality of appraisals from 2015 putting the Trust above the national average for this area	Nov-17
	Appraisal training sessions and support in place	Feedback from the standalone training remains consistently very good or excellent.	

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
HR882	Lack of capacity to deliver identified training – in particular face to face sessions e.g. Moving & Handling, Resus and Child Safeguarding Level 3		
HR1360	Staff are not clear what is expected from them	review of senior spans and layers to ensure managers understand expectations	Jun-18
HR1363	Appraisal target 90%.Trust current position is 82%		

Strategic Objective	Champion team St George's	Risk appetite
		To be established by the Board

Ref	Strategic Risk	Initial Risk Score	9	Committee	Workforce Committee
SR11	We fail to effectively develop our leaders which could lead to a lack of ownership of their contribution to delivering our plans and priorities. We need to provide real clarity on their full range of accountabilities. Failure to do so will lead to low job satisfaction resulting in both high turnover and on-going instability in leadership teams.	Current Risk Score	9	Executive lead	Director of HR and OD

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
			Partial	

Contributory risks from risk registers				Risk Score			
Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*

Strategic Objective	Build a better St George's			Risk appetite		
				To be established by the Board		
Ref	**Strategic Risk**		**Initial Risk Score**	**20**	**Committee**	Finance and Investment Committee
SR12	**Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.**		**Current Risk Score**	**20**	**Executive lead**	Chief Information Officer (CIO)
Assurance rating (quarterly)	**Q1**	**Q2**	**Q3**		**Q4**	
	Limited	Limited	Limited			

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
CRR-0013	Infrastructure - Exposure to Cyber or Malware attack	Chief Information Officer (CIO)	Information Governing Group (IGG)	20	20	20	
CRR-803 CRR-810 CRR-1292 CRR-1395	Infrastructure - Risk of long spell outages due to old and ageing hardware and lack of adequate plan in ICT Disaster Recovery	Chief Information Officer (CIO)	Information Governing Group (IGG)	16	20	20	
CRR-1312 CRR-1387 CRR-1388	Information - Data Warehouse/ Information Management (MI) Fragmentation	Chief Information Officer (CIO)	Information Governing Group (IGG)		16	16	
CRR-1020 CRR-1403 CRR-1393 CRR-1394	Clinical systems - Failed Discharge Summary Standards	Chief Information Officer (CIO)	Information Governing Group (IGG)	12	12	16	
CRR-1391	Corporate Systems Old email exchange is old and more vulnerable to cyber attach	Chief Information Officer (CIO)	Information Governing Group (IGG)			15	
CRR-1320	Service & Operation Compliance with General data Protection Regulation (GDPR)	Chief Information Officer (CIO)	Information Governing Group (IGG)			15	
CRR-1398	Clinical Systems - Risk that care is compromised due to the fragmented healthcare records across multiple systems	Chief Information Officer (CIO)	Information Governing Group (IGG)			16	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
CRR-0013	NHS N3 gateway anti malware software and local Websense anti malware software is deployed		
	New intrusion prevention system (IPS) added to the N3 firewall		
	Local Anti-virus software deployed		
	Regular and repeated user education and communication		
	Continuous monitoring and alerts of reported infections	reports presented at the ICT meetings	
	Microsoft XP security patches have been applied to the entire estate		
	Regular CareCERT (NHS Digital) cyber security bulletins in place to warn the Trust of any potential risks and issues	Tactical Programme Board in place to monitor progress of projects including XP exceptions, network and storage	
	Cloud Back-Up is in place which gives ability to restore corrupted file(s)		

CRR-803 CRR-810 CRR-1292 CRR-1395	Contract in place for some emergency IT service provision	Weekly ICT Project progress meeting in place	
	Management on-call rota in place to deal with major incidents		
	On-going maintenance of network hardware and configuration, with management of changes	Re-configuration of existing core has lessened the number of users impacted in event of the core (ICT's single point of failure) failing	
	Expansion of ICT Service Desk on-call operating hours	Service desk statistical analysis reporting (HEAT Portal)	
CRR-1312 CRR-1387 CRR-1388	Historical technical knowledge enlisted through NHS Bank to provide some technical assistance	The additional technical support via the NHS Bank staff has resulted in less frequent data warehousing file failures	
	Initial review of the Data Warehouse ingestion process has been completed		
	SUS/SLAM Analyst has been temporarily recruited	SUS/SLAM can still be completed. Changes implemented by the seconded Operations technical specialist has increased the speed of report production	
	Additional technical specialist has been seconded to help stabilise the Data Warehouse		
CRR-1020 CRR-1403 CRR-1393 CRR-1394	44% of discharge summaries has been delivered	Agreed and managed by commissioners not to impose £300,000 monthly fine for 2017/18	
	Project to resolve the remaining 56% is covered within the scope of the Clinical Information Systems Programme		
CRR-1391	Server patching maintained		
CRR-1320			
CRR-1398	Cymbio currently validating RTT pathways for QMH PAS and SG Cerner (part of the Elective Care Programme		

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
CRR-0013	A number of machines still running on Windows XP	Remaining exception XP machines to be eradicated from the Trust Estate, where possible.	Sep-18
	Unproven and out of date ICT Business Continuity plan and Disaster Recovery plan	Initiate and implement Disaster Recovery (DR) and Business Continuity testing and a robust plan.	Nov-18
	New ransomware and cyber attacks are created daily - the Trust is vulnerable until security patches have been created by vendors and successfully rolled out across the estate	Initiate and complete the DoH funded Cyber Security project aimed at improving various aspects of the Trust's cyber security systems.	May-18
	50% of the Back-up solution not implemented	Completion of Back-Up solution project	Jan-18
CRR-803 CRR-810 CRR-1292 CRR-1395	The emergency IT service provision agreement in place but has not been tested and is not part of an understood plan.	Start ICT Project to Review existing policies/strategies	Mar-18
	Inconsistent historical infrastructure fixes has led to issues which have yet to be identified and diagnosed.	Review, revise, update, and test the ICT DR plan.	May-18
	ITO currently paused. Without strategic direction, long-term decisions cannot be made, investments justified, and delivery projects completed	Undertake ITO.	Jan-18
CRR-1312 CRR-1387 CRR-1388	A robust and documented data ingestion process which includes full testing of data sources, data sets, and data storage	Creation of a clear approach to managing data quality centrally	Jan-18
	Limited skilled technical resources that have a full understanding of the technical complexities of data warehouse design		
	No tactical strategy to stabilise the current MI function including the technical components of the data warehouse solution	Assessment of the current skills and resources within the MI team to be conducted.	

	Absence of clarity in data integrity and data quality has created lack of confidence with the reporting	Creation of a clear approach to managing data quality centrally	Jan-18
	No robust and tested assessment of the overall data warehouse and data set	Start to track and monitor the data quality issues with a view to resolving or mitigating risk to poor data	Jan-18
CRR-1020 CRR-1403 CRR-1393 CRR-1394	56% of Discharge Summaries still non-compliant	Commence discharge summary project for remaining 56% in April 2017 to meet national requirements	Mar-18
CRR-1391	Desktop patching is not maintained	Review desktop patching	Jan-18
CRR-1320	No data protection officer	appoint data protection officer	Jan-18
CRR-1398	No patient tracking across QMH and STG outpatients including single patient identifier, referral management (and associated RTT reporting) and electronic clinical outcome forms	Deploy Cerner Electronic Patient Record (EPR) solution to Queen Mary's Hospital (QMH). Current forecast Oct 2018.	Oct-18
	Single patient identifier		
	Single clinical and administrative record	Deploy Cerner Electronic Patient Record (EPR) solution to remaining areas	Apr-19

Strategic Objective	Build a better St George's			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**20**	**Committee**	Finance and Investment Committee
SR13	**Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting delivery and risking patient safety.**	**Current Risk Score**	**15**	**Executive lead**	Director of Estates and Facilities

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
	Limited	Limited	Limited	

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
CRR-0016	Bacterial contamination of water supply	Chief Nurse	Water Safety	20	20	15	
CRR-1311	Electrical Infrastructure - No compliance with Electricity at Work Regulations and BS7671	Director of Estates and Facilities			16	16	
CRR-1310	Potential interruptions / failure to electrical supply	Director of Estates and Facilities			15	15	
CRR-0008	Inability to address backlog maintenance to maintain safe site	Director of Estates and Facilities		20	20	20	
CRR-0007	Potential closure of parts of the estate due to non-compliance with regulation	Director of Estates and Facilities		20	15	15	
CRR-1376	Theatre closures due to backlogs in maintenance and failure of ventilation systems	Director of Estates and Facilities		16	16	16	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
CRR-0016	Trust water safety policy ensuring compliance with HTM04 Safe Water in Healthcare premises, L8 and HSG274	Compliance with water safety monitored at the monthly Water Safety Committee	Mar-17
	Replacement of dead legs /sinks /taps programme	Ex Health Safety Executive inspector satisfied the Trust had undertaken adequate testing, monitoring and remedial action to mitigate risks in water temperature	
	Flushing programme in place	legionella - 100% flushing of low use outlet pseudomonas - 100% flushing	Oct-17
	Water safety manager working alongside the Compliance Manager for compliance related activities		
CRR-1311	Thermographic imaging surveys completed as a temporary measure until the fixed wire testing project is complete.	Electrical Safety Group has oversight of project /works	
	Fixed wire testing completed in Lanesborough wing, level 5 and Moorfields Eye Hospital.	Certification of completion provided	
	Updated method of testing to enable more circuits to be tested live		
CRR-1310	Essential loads are covered by Standby emergency generators		
	Checking programme in place to determine whether Transformers are within acceptable limits.		
	LV / HV APs to manually operate switch gear in the event of failure		

	Temporary generators back up 100% of Lanesborough Wing. Older generators provide back up to remainder of the estate	Lanesborough Wing generator replacement project approved by the Board	
CRR-0008	Engagement between Capital Projects & Estates to manage backlog projects	Mandatory weekly summary reports by Estate PM and PPM team	
	PMO tracks activity in line with plans on the project schedule and report any deviations from plans to senior management providing assurance to senior management		
	Closer relations with a dedicated Procurement resource for Estates to mitigate for delays in tender processes		
	First stage of PAM self-assessment questionnaire completed		
CRR-0007	Project schedule implemented	Completed projects: Fire alarms sytem replaced in Lanesborough wing; Fire doors replaed in Grosvenor wing; Fire dampers testing and repairs completed; NHS Hazard Notice received in relation to Fire Dampers is now closed.	Oct-17
	Internal FRAs of Clinical areas are carried out annually in line with statutory requirements. LFB have full oversight of Trust FRA's. Also purchased new FRA software to enhance and speed-up delivery.	Memorandum of Understanding with LFB ensures regular meetings/ communication held with Fire Brigade to check progress of ensuring fire safety. LFB carried out face to face training with SGH Staff	May-17
	Fire safety training schedule in place and approved at the beginning of each calendar year		
	Fire safety mandatory as part of MAST training	Required number of fire wardens trained (1400) has been met and target exceeded	Oct-17
CRR-1376	Theatre Refurbishment programme underway, additional electrical capacity project underway to provide necessary additional power to St. James Wing resulting in a reduction of failures.	Theatres continue operating with minimal downtime during refurbishment period	
	Ventilation Committee has been re-launched and met on 25 September.	Committee provides report to infection control and reviewed determining actions required for compliance.	Sep-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
CRR-0016	TMVs not serviced as not known where they have been fitted	Review all sites for hidden TMVs	Jan-18
	Lack of fitted drawings for water supply - mapping of pipes		
	Audit relating to sign-off procedures and documented data regarding water safety project/management not undertaken	Undertake Audit relating to sign-off procedures and documented data regarding water safety project/management	Mar-18
	Inadequate water system balancing having an impact on water temperature variability		
	HSE action plan and Risk assessment action plan from March 2017 not fully implemented	Implement HSE and risk assessment action plan	Jul-18
	The Trust has not reached consecutive 3 months of 100% pseudomonas flushing returns		
CRR-1311	Delivery of plan not completed	Complete the fixed wire testing project	Mar-18
	6 vacancies - Only one AP appointed for HV and LV		
CRR-1310	No further action can be taken in relation to changeover controllers until LW Electrical HV/LV project is underway.		
	Lanesborough Wing generator replacement project on-going / not completed	Energy Centre project in the pipeline - replacement of LV generators and HV switchgear due to age, condition and N+1 ability.	Nov-18
	There is presently no funding for the replacement of switchgear. Awaiting 2018/19 budgets to be finalised.	St. James Wing HV/LV project to replace generators, switchgear and transformers.	Jan-19

	No business continuity in case of failure		
CRR-0008	Not all PPM jobs are held within the Estates system presently.	Divisional Project Board to be set up to provide assurance and visibility of all E&F projects	Jan-18
	Review of Six Facet Survey not completed to produce an action plan with Capital Projects.	Complete review of Six Facet Survey and develop programme	Jan-18
	Large number of vacancies in Estates team at both management level and trade level -	Recruitment process underway	Jan-18
	Tender processes, whilst improved, are still delayed due to the approval processes relating to purchase orders		
	No decant space to isolate major services		
CRR-0007	All main blocks have been assessed for Fire Alarm safety. Completion of projects are subject to funding	Fire Risk Assessments planned as follows: 1. International Fire Consultants will be requested to carry out annual fire risk assessment of Lanesborough Wing 2. BRE to create fire strategy for trust 3. RSP to carry out review of ne installed fire alarm	Jan-18
	There is an increasing number of modular builds on the Tooting campus site, however these are not flagged as a fire risk. These require fire risk assessments.	Installation of L1 alarm to replace L2 alarms. Review of FRAs for modular buildings	Jul-19
	Maintenance contract / Repair and maintenance of compartmentation not completed	set up maintenance contract	Apr-18
CRR-1376	There is no maintenance schedule in place for the maintenance of theatres.	The Theatre's Refurbishment programme includes 3 week timescales for maintenance of theatres to be completed.	Feb-19
	There is no Authorising Engineer appointed for Ventilation	Recruitment is underway however the authorised person [in place] cannot be formally appointed until we have an AE.	Jan-18
	AIRIS Q report needs reviewing to extract necessary actions. No Authorising engineer or person in place to take this forward.		

Strategic Objective	Build a better St George's			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**16**	**Committee**	Board
SR14	**We are unable to secure the investment required to address our IT and estates challenges and as a result are unable to transform our services and achieve future sustainability.**	**Current Risk Score**	**16**	**Executive lead**	Chief Executive

Assurance rating (quarterly)	**Q1**	**Q2**	**Q3**	**Q4**
	Limited	Limited	Limited	

Contributory risks from risk registers				**Risk Score**			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
CRR-1414	Five year investment plan	Director of Finance	Finance and Investment Committee			16	
CRR-1415	Processes to deliver agreed investment	Director of Finance	Finance and Investment Committee			16	
Fin - 1416	Future cash requirements are understood	Director of Finance	Finance and Investment Committee			12	
CRR-1417	Processes to manage cash and working capital	Director of Finance	Finance and Investment Committee			16	

Key controls in place		**Assurance that controls are effective**	**Date**
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
Fin - 1414	First cut capital investment plan developed covering next 5 years	Report to Finance and Investment Committee (FIC)	Sep-17
	Process for identifying all potential investment requirements developed		
	Scoping for sources of capital funding	Report to FIC	Sep-17
Fin - 1415	Capital Working Group oversees/manages investment		
	Managers are responsible for capital investment		
Fin - 1416	13 week cash flow in place	Cash reporting to FIC. 13 week cash flow report	Dec-17
	Investment policy		
	Cash management contingency have been scoped		
	Impact on cash included in IDDG business case process		
Fin - 1417	Cash management contingencies have been scoped		

Significant gaps in control / assurance		**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
	Not all investment requirements are included in the first cut of the 5 year plan	Complete investment plan, engaging with operational management and clinical staff to identify all potential investment requirements	Mar-18
Fin -	Business case supporting the need for all proposed investment partially in place	Build prospective business case process to be managed through IDDG	Mar-18

1414	No formal procedures to support prioritisation of proposed investment against available resources	Prioritisation process to be developed	Mar-18
	No clear understanding of revenue consequences of proposed investments	Business case processes scopes revenue consequences. Need to build into planning process	Mar-18
Fin - 1415	CWG ToR not up to date	CWG ToR to be reviewed	Feb-18
	No clear milestones in place for capital investment plans	all approved projects to have milestone plan developed and agreed	Feb-18
	Delivery of approved schemes not always timely and in line with plan	Provide training and support to improve on delivery of schemes	Feb-18
	No contingency maintained within the capital plan to adress unexpectged needs	Contingency to be built into 17/18 and beyond	Mar-18
	Forecasting process not adhered	Tighten forecasting. To be addressed through CWG	Mar-18
Fin - 1416	12 month cash flow to be finalised	Review and finalise the 12 month cash flow	Mar-18
	LTFM not in place	Develop LTFM as part of 18/19 planning	Mar-18
	Policy is not up to date	Update policy	Feb-18
	Cash management contingencies require review at FPC	Review cash management contingency	Feb-18
	Trust liquidity score not maintained	Develop plan to improve liquidity score as part of 18/19 plan and conclusion of FSM	Mar-18
	Limited understanding of cash across senior management	Training package to include understanding of cash	Mar-18
	The impact on cash not consistently followed/understood	Impact on cash to be reviewed and strengthened	Mar-18
Fin - 1417	No clear cash collection processes	Debt management improvement plan to be presented on a monthly basis to FPC	Jan-18
	No clear aged debt plan	Working capital management plan to be scoped and presented to FPC	Jan-18
	Trust is put on stop by suppliers due to the non-payment of invoices. Increased interest		
	No clear creditor payments processes		

Strategic Objective	Develop tomorrow's treatments today			Risk appetite	
				To be established by the Board	
Ref	**Strategic Risk**	**Initial Risk Score**	**12**	**Committee**	Quality Committee
SR15	**We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.**	**Current Risk Score**	**12**	**Executive lead**	Medical Director

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	

Contributory risks from risk registers				Risk Score			
Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
MD1132	Risk of Clinical Research recruitment reduction due to inconsistent infrastructure	Associate Medical Director	Research Governance Meeting	12	12	12	
MD1133	Risk of the profile of research in SGHT being low	Associate Medical Director	Research Governance Meeting	12	12	12	
MD1405	Risk of failing to retain MHRA accreditation for the research department due to poor infrastructure / compliance	Associate Medical Director	Research Governance Meeting			12	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
MD1132	'Easy win' process studies to balance portfolio against lower recruiting more intensive studies to maintain overall recruitment level	Monthly reviews of trial recruitment. Regular strategic and performance focused meeting with research team(s). 2016/17 SGUH 20th place out of 155 Acute NHS	
	Implementation of new process for identification of studies/teams/ investigators that would benefit from CRF support to increase recruitment		
MD1133	JREO and CRF attending clinical group meeting to raise awareness on research		
	The funding of consultant PAs aligned to new framework		
MD1405	Head of Research Governance and Delivery oversees a structure responsible for research governance compliance		
	CRF manages a number of high risk trials.		
	Contracted support provided for submission of MHRA GCP dossier for inspection.		
	Creation of formal risk assessment review of sponsored clinical research projects		

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
MD1132	NIHR CRN funding model- based on retrospective recruitment period. Decreases in levels of recruitment to NIHR CRN studies will negatively impact future funding and the ability of the Trust to provide a consistent research delivery model	Training to be provided to the all JREO members of staff on identifying potentially eligible studies/sources of funding. . Escalation to Head of Research Governance and Delivery where any issues arise.	*Mar-18*
	Delays in study set up (reduction in patient recruitment window)	Defined study start up and delivery process to ensure consistent measures.	*Jan-18*
	Unclear/ inconsistent pathway to request/gain Clinical Research Facility support	Installation of a "pipeline"/ horizon scanning process. Limited mitigation as model is decided at a regional (South London) level.	*Mar-18*
MD1133	Poor communication of research internally in SGHT. Lack of NIHR Senior Investigator applications (£75k per successful appoint for the Trust)	Review of process to ensure that there remains sufficient activity (commercial, grant and NIHR) to provide sufficient funding	*Mar-18*
MD1405	JREO processes may not be reflective of changing research governance landscape.	Review of JREO SOPs and systems against current guidelines	Mar-18

Strategic Objective	Build a better St George's	Risk appetite
		To be establised by the Board

Ref	Strategic Risk	Initial Risk Score	12	Committee	Board
SR16	**We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clincial service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.**	Current Risk Score	12	Executive lead	(CEO) Director of Strategy

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
			Limited	

Contributory risks from risk registers				Risk Score			
Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
STR01	The lack of an agreed clinical strategy means that we are not able to agree our supporting strategies for estates and IT and identify priorities beyond the immediate 12 month period	CEO (Director of Strategy)	Trust Executive Group			12	
STR02	Lack of capacity in Strategy Team to undertake the work required to enable Board to consider and agree a new Clinical Strategy	CEO (Director of Strategy)	Trust Executive Group			12	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
STR01	Director of Strategy started in post 2nd January 2018		Jan-18
STR02	Recruitment to key strategy team posts and business intelligence/ strategic finance support from corporate departments agreed		
STR01	Demonstrable commitment of the Board to strategic priorities when there are competing operational and finance priorites.	Board workshop IT strategy Board meeting minutes	Dec-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
STR02	No strategy team in place	Financial resource agreed for strategy team; recruitment process to commence February 2018	Jul-18
STR01	Strategy process (including timescales) needs to be approved by Trust Board	Director of Strategy to devise proposed process and timescales in collaboration with Chair and CEO for Board to consider	Mar-18
STR02	Strategic finance and business intelligence support to be agreed.	Chief Finance Officer to agree	End Jan 18

Strategic Objective	Build a better St George's	Risk appetite: To be establised by the Board

Ref	Strategic Risk	Initial Risk Score	12	Committee	Board
SR17	**A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.**	Current Risk Score	12	Executive lead	Chief Executive

Assurance rating (quarterly)	Q1	Q2	Q3	Q4
			Limited	

Contributory risks from risk registers				Risk Score			
Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
STR03	Establishing close working relationships with King's, GSTT and King's Health Partners is essential to agreeing what specialist/ tertiary services we will improve and deliver in partnership, which is required to inform the Clinical Strategy	CEO	Trust Executive Group				
STR04	There is a risk that we are not fully engaged in the SWL STP (including developing the refreshed STP strategy), and that at present we do not have the leadership and management capacity to do this.	CEO	Trust Executive Group				
STR05	There is a risk that a lack of shared understanding of the clinical and research priorities of SGUH and SGUL means that discussions with KHP may result in strategic decisons being made that inadvertently disadvantage one of the organisations.	Medical Director	Trust Executive Group				
STR06	There is a risk that other acute provider organisations in SWL will pursue clinical/ commercial relationships with other tertiary NHS providers that pose a strategic and financial threat to SGUH	CEO	Trust Executive Group				

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
STR04	Appointment of Director of Strategy provides additional capacity at director level to support the CEO in engaging with key stakeholders and developing productive relationships	Director level attendance at all key meetings. STP meeting minutes Reports to Board on the STP (CE reports)	
STR05	Close links with SGUL - principal of SGUL is a non-executive director of the SGUH Board.		

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
STR03	A stakeholder engagement plan to develop stakeholder relationships more broadly		
STR05	A refreshed Research Strategy that is informed by both the SGUH Clinical Strategy and the SGUL Strategy	Ensure a joint understanding of strategically important specialties for each organisation - produce a report which can be considered by both organisations	Xref SR15