Trust Board Meeting

Date and Time: Thursday 22 February 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 25.01.18** *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		
10.50	**3.1**	**Integrated Quality & Performance Report** *Executive Team*	Review	Paper
	3.2	**Elective Care Recovery Programme Update** *Chief Operating Officer, Ellis Pullinger*	Assure	Review
		FINANCE		
11.10	**4.1**	**Finance & Performance Committee Report** *Chair of Committee, Ann Beasley*	Assure	Paper
	4.2	**Month 10 Finance Report** *Chief Financial Officer, Andrew Grimshaw*	Assure	Paper
		Strategy		
11:40	**5.1**	**ICT Strategy** *Chief Financial Officer, Andrew Grimshaw*	Assure	Paper
		GOVERNANCE		
11:50	**6.1**	**Committee Terms of Reference** *Interim Trust Secretary & Director of Governance, Michael Wuestefeld-Gray*	Approve	Paper
	6.2	**Board Assurance Framework** *Chief Nurse & Director of Infection Control, Avey Bhatia*	Assure	Paper
	6.3	**Risk Appetite** *Chief Nurse & Director of Infection Control, Avey Bhatia*	Approve	Paper
	6.4	**Fit and Proper Person Regulation- Compliance** *Director of Human Resources & Organisational Development, Harbhajan Brar*	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**		
Patient Sara Watson shares her experience of care received from the Wandsworth Community Neuro Team at St John's Therapy Centre accompanied by Sorrel Scott, Physiotherapist.				
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 29 March 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**
Michael Wuestefeld-Gray	Interim Trust Secretary & Director of Governance	Trust Sec
Nora Hussein	Assistant Trust Board Secretary	Assis Trus Sec

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting
25 January 2018 – from 10:00, Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Stephen Collier	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
Andrew Grimshaw	Chief Financial Officer	CFO
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Kevin Howell	Interim Director of Estates & Facilities	DE&F
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director	QID
Dr Nigel Kennea *(Item 3.5)*	Associate Medical Director	AMD
APOLOGIES		
Sir Norman Williams	Non-Executive Director	NED
SECRETARIAT		
Michael Wuestefeld-Gray	Interim Trust Secretary	Trust Sec
Nora Hussein	Interim Assistant Trust Secretary	Assis Trus Sec

GOVERNORS IN ATTENDANCE

Mike Grahn	Appointed Governor, Healthwatch Wandsworth
David Kirk	Public Governor, Wandsworth
Yvonne Langley	Public Governor, Wandsworth
Nigel Brindley	Public Governor, Wandsworth
Kathryn Harrison	Public Governor, Rest of England
Mia Bayles	Public Governor, Rest of England
Jenni Doman	

Feedback from Board Walkabout

The Board members gavefeedback from the departments visited which included: the Transport Office; Central Stores; Phlebotomy Outpatients; the Acute Gynaecology Unit; Neurology Outpatients; the Thomas Addison Unit (diabetes and endocrine); the Pharmacy Department; the Bereavement Service; Therapies Outpatients; Radiology; Cavell Ward; McEntee Ward; the Emergency Department; and the Departure and Discharge Lounge.

It was noted that the Transport Office has an issue with a surge in discharges at 5pm. This causes delays in journeys which has a knock on effect on the bed availability on wards. There may be a need to review the relatively high proportion of patients taking hospital provided transport, also how the wards are planning discharges; DE&F was asked to look at this. It was observed that Receipt and Deliver had no heating and a lack of power, which was due to be resolved 27-28 January, but despite this staff remained positive.

Estates and Facilities Action 25.01.18 /01: DE&F to review the high portion of patients taking hospital provided transport.

Phlebotomy Outpatients faced staff shortage due to sickness absence. The Department remains challenged since the CQC visit in 2016 – however, it is currently recruiting to four posts to meet demand.
Acute Gynaecology was noted to be a very good service, but would benefit from co-location with other acute services rather than being in outpatients. The DDET confirmed that this was part of proposals under consideration.

The Board noted that the concerns raised previously with the Thomas Addison Unit had been addressed. However, there needed to be a continuing focus on timescales of electrical equipment checks – for example, equipment testing in the Unit was not up to date.

Estates and Facilities Action 25.01.18 /02: DE&F to review medical equipment testing in the Diabetic and Endocrinology Unit.

It was observed that the Neurology OP department was not busy,and a concern was raised about unresponsive staff at reception who did not acknowledge the people waiting for a number of minutes. The CN & DIPC responded that she would investigate the matter.
Action T.B 25.01.18 17/57 CN & DIPC to investigate concerns regarding unresponsive staff at the Neurology OP reception.

Consultants at the Neurology OP department had commented that there was a growing need for chaperones whilst examining patients. The CN & DIPC noted the point and agreed to investigate what this might mean in terms of availability of chaperones to support clinical activity continuing in a timely manner.
Action TB 25.01.18 17/58: The CN & DIPC to explore chaperone options for patients being examined.

Poor lighting was observed within the Pharmacy department where for three weeks temporary lighting was being used. The Chief Pharmacist outlined plans for developing a commercial pharmacy and a pilot funded by Health Education England to develop Advanced Pharmacy Practitioners training. There was an issue about fridge temperature compliance and this was being investigated.
Estates and Facilities Action 25.01.18 /03: DE&F to investigate concerns regarding fridge temperature compliance within pharmacy.

Bereavement Services were planning to raise charitable funds to improve their surroundings. Staff raised frustrations regarding completion of death certification for patients who died at weekends, or when clinical staff are on annual leave. Alison Benincasa agreed to take the sign off/paperwork issue forward as part of the End of Life work.
Action TB 25.01.18 17/59Alison Benincasa to incorporate the bereavement office sign off/paperwork issues into the End of Life Work.

Therapies Outpatients were observed to be upbeat despite pressures on the service.

Radiology staff were also raising charitable funds for their department, and even offering to carry out decorative works themselves. It was noted that a toilet had been out of order for three months, partly because this is a complex problem to address. Radiology's reception area is large and could be utilised more effectively. The Chairman asked the DE&F to take this forward, and to ensure there was effective communication to staff.
Estates and Facilities Action 25.01.18 /04: DE&F to address the radiology department's issues regarding out of order children's toilet, effective utilisation of reception area and to ensure units had effective communication on maintenance issues.

The infectious diseases ward (McEntee) is made up of 18 single occupancy rooms. The ward is 30 years old so its equipment is aging. £250,000 of charitable funds is being held for ward improvements focussed on a dedicated area to help reduce risk to staff.

The short stay ward (Cavell) has 28 beds and has very recently been re-designated. There was a concern about secure access and that it was a paper based ward; technology could be better utilised to improve patient flow. It was confirmed swipe card access was being installed.

The Emergency Department was very busy but well run, and calm. It has introduced a rapid-triage system that is working well and there is ongoing work to improve ambulance handover. Plans include improvements to the ambulance bay. The Trust-wide response to A&E has improved and this is appreciated.

There are intractable rota gaps with 20% turnover of Band 5 staff. Currently putting leaving staff on the bank is a cumbersome process and streamlining this will help.

Patient feedback from the Departure and Discharge Lounge was positive. The Lounge staff asked wards to book transport early; patient needs are met well while they are waiting.

The Chairman thanked colleagues for their feedback and noted that whilst a number of issues were in hand the visits had flagged up others or reinforced the need for attention in particular areas as highlighted.

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 Suzanne Marsello, Director of Strategy, Kevin Howell, Director of Estates and Facilities and to Stephen Jones, incoming Director of Corporate Affairs who was attending as a member of the public. The Chairman informed the Board that Sir Norman Williams would join Part 2 of the meeting.

Declarations of Interest

1.2	There were no declarations of interest.

Minutes of Meeting held on 07.12.17

1.3	The minutes of the meeting of 07.12.17 were agreed as a correct and accurate record following the agreed amendments: • 6.3-the item related to basic repairs • 6.4 - amend to reflect sense of working in partnership • Patient story – this should be amended to make the last sentence clearer

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. • 17/35 not yet due • 17/36 date to be arranged • 17/43 this did not go to the December Quality and Safety Committee and a date will be found for it to go • 17/44 this will now go to the April Workforce and Education Committee • 17/46 can be closed as it has now gone to the Quality and Safety Committee • 17/47 is on the agenda and can be closed • 17/53 Paper to be presented in Part 1 and Part 2 of February 2018 Trust Board • 17/54 Paper to be presented at April 2018 Trust Board to align with Trust business processes. • 17/55 Not yet due • 17/56 the single oversight framework was discussed at the Board workshop on 24 January. This item can be closed. There were no matters arising.

CEO's Report	
1.5	The CEO welcomed Kevin Howell, Director of Estates and Facilities and Suzanne Marsello, Director of Strategy to their first Trust Board. The Board was informed that the Trust maintained performance of key services over the Christmas period and the CEO discussed opportunites for lessons to be learned as winter pressures continued, both at the Trust and in the NHS more widely She informed the Board that due to winter pressure challenges remain around flow through the hospital and that some beds and wards are currently closed due to flu and Norovirus. She stressed the importance of learning from this winter in advance of next winter. The Board was informed that an interim Director of Emergency Care is now in post to implement improving flow through the hospital. The Board was also informed that a new patient tracking list (PTL) is being rolled out across St George's. The Referral to Treatment Position is improving and in due course the Board will have to consider when to start re-reporting. The CEO informed the Board that the Trust remains focussed on delivering the year end deficit of not more than £53 million, and the financial outturn position is significantly improved on 2016/17. However, next year is expected to be tough as the Trust has not been able to reduce the run rate significantly. It was noted that the planning guidance has not yet been received which is an important issue in being able to plan for the necessary Board and Sub-Committee approvals. The Board was informed that over 90% of staff have now had their flu vaccination which is the highest in London and that ITV London featured the Trust's flu campaign as an example of best practice. St George's celebrated its 100th episode of 24 Hours in A&E and the Board was advised that positive feedback is often received. The CEO informed the Board that the Trust saw the official launch of the surgical education partnership with the Royal College of Surgeons. The 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. The Trust received a visit from the Chief Executive of NHS Providers who was particularly impressed with the neonatal unit and maternity, and the board that shows the clinical areas visited by directors each month. The Board was informed that over 240 nominations had been received for the staff appreciation awards. The update was received by the Trust Board.
QUALITY	
2.1	**Quality and Safety Report**
	Sarah Wilton, Non-Executive Director presented the report in Sir Norman Williams' absence. The Board was informed that the Committee was impressed with the significant improvement in thematic learning from serious incidents. The Committee had requested that the Water Safety Committee develop an action plan including completion dates and report back to the Quality and Safety Committee in February. Queen Mary's Hospital should also be included in the actions to be carried out and these should also be reported

	to the Water Safety Committee. The Board was informed that Dr Nigel Kennea, Associate Medical Director, provided an excellent update on the work of the Mortality Monitoring Committee for the first three 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. The Committee had requested and received a deep dive into performance by Outpatients. The Committee recognised the good work in progress but that more needs to be done. The MD echoed the concerns about quality in Outpatients. The Committee is now receiving regular Elective Care Programme reports and noted that the Elective Care Programme was moving in the right direction. However, it remained concerned about the point emphasised in the Deloitte's Governance report about clinicians needing to take ownership. The Committee remained disappointed and concerned with the quality of the complaints responses and process. The Chief Executive highlighted the importance of understanding where things had gone wrong and how to amend and manage them for an acceptable outcome. She stressed that a clear plan of improvement is required and is being actively progressed. The consent audit report evidenced no improvements in the re-audit. A taskforce is being set up in order to improve performance. The Chief Nurse and Director of Infection Prevention Control informed the Board that one of the trends, and examples of learning highlighted in the report is Wrong Blood in Tube, and that work is being carried out for an electronic solution to this problem with a business case under development. The report was received by the Trust Board.
PERFORMANCE	
3.1	**Integrated Quality & Performance Report** The MD informed the Board that the report had been presented to the Quality and Safety Committee. The Trust had faced a busy winter which is highlighted within the four hour emergency standard report. Performance has affected ambulance turnover and there has been an increase in elective surgery operations being cancelled. He informed the Board that despite these pressures no Never Events or Serious Incidents were reported in December 2017. No patients acquired an MRSA Bacteraemia in the month. The Board was informed that overall this was positive and reassuring for safety issues, although mortality rates had increased due to a greater proportion of patients being frail and elderly More positively regarding performance targets, cancer is in the right place and diagnostics has improved. The CN & DIPC Control informed the Board that regarding patient experience the response rate for complaints had dropped and she is focusing on understanding the reasons for this. The Executive Director team is reviewing the results from the FTT survey for the last quarter to determine any further themes for improvement. The Board was informed that performance remains stable compared to other London Trusts. The COO highlighted that the Trust had on occasions experienced particularly busy days but overall had managed this well. Day surgery cancellations are at a high number, and he apologised to those whose operations had been cancelled. He is focusing on the 28 day rebooking standard in response to this. Tim Wright, NED suggested that different ways of presenting the performance report could be explored as the visual red, amber and green presentation can mask the underlying story told by

	data. The Chairman suggested that the Non-Executive Directors share their advice/thoughts with the DDET who agreed to consider different ways of presenting the information. Sarah Wilton, NED, noted her disappointment on the number of on the day cancellations re-booked within 28 days and requested further understanding of this. She also noted the Trust's ability to put effective measures in place when the hospital is particularly busy and asked if it was possible to put these measures in place, gradually, as business as usual rather than an extraordinary response. The DDET advised that it is challenging to predict problems in advance. There are finite clinical skills to deploy at the Trust and there is work underway to explore how to deploy them better. Early indicators and responding rapidly is a challenge the Trust faces. The SAFER approach is being rolled out across all wards to ensure patients understand the discharge process, once this happens consistently performance should improve. The COO added that new units due to come online in February and March will help with this. The QID questioned why the VTE risk assessment data for three months was missing. The CN & DIPC responded that there had been technical problems with Cerner but these have now been resolved and this will be available at the next meeting. The Board was informed that this was also raised at the Quality and Safety Committee. The DHR&OD informed the Board that workforce performance remained in line with the previous month, and compared with neighbouring trusts the Trust is in a relatively good place. Vacancy rate had increased from 12.7%to 13%. Agency spend was £1m below the target spend but the Board was asked to note that the overall saving is £6 million, not £20m as posts have been filled substantively. The Board received the report.
3.2	**Elective Care Recovery Programme- Action Plan** The COO informed the Board that the report had been presented to the Quality and Safety Committee. Work is underway on the development of a new diagnostic PTL with expected delivery in March 2018. A roll out of staff training on Cerner is also underway to ensure it is used correctly and the data can be relied upon. The Board was informed that a quality dashboard is now in place to allow the Trust to review data quality issues which in turn allows for targeted support and additional training where required. Ann Beasley, NED, questioned if the Trust is now in the position to track all patients accurately. She also questioned when the Trust will return to reporting. The COO responded that while there can never be 100% assurance on this there is now the ability through the quality dashboard to assess where errors are made by staff. His assessment was the Trust is probably now in a position similar to many other trusts with a broadly reliable PTL. The CEO noted that Cerner is not yet rolled out to Queen Mary's Hospital, and this is due to happen later in 2018. Tim Wright, NED stressed the importance of developing a clear IT strategy in particular to move away from paper to electronic data. The CFO responded that the IT strategy will be presented to the Board at the February meeting. The Board noted its thanks to the COO and his team for the PTL work and recognised that it would bring the Trust to full reporting though the precise timing of that would need further consideration and Board approval. The Board also resolved to have at least two meetings per year at the Queen Mary's Hospital site, recognising this will mean addressing challenges with finding an adequate space to do so effectively. The Board received the report.

3.3	**NHS EPRR Assurance** The COO asked the Board to note the visit from NHS England to review the Trust's EPRR assurance process. The Trust received a substantial rating with four recommendations for key priorities over the next twelve months, detailed in the report. The Board noted the EPRR assurance findings and the Substantial rating.
3.4	**Guardian for Safe Working** The MD informed the Board that the report had been presented to the Workforce Committee and the Trust Executive Committee. It was noted this is a statutory report to make to the Board. He informed the Board that it is important to note that Junior Doctors experiences provide information and triangulation as to where the stresses and strains in the hospital are. A rested team of clinicians is important in itself and for patient safety. The report detailed that there are concerns within general surgery and renal transplantation which are being addressed with the individual teams to ensure the health and wellbeing of trainees and patient safety. Stephen Collier, NED, said the Workforce and Education Committee is maintaining an oversight of the issues raised and highlighted that rota gaps are a significant problem. The DHROD informed the Board that as part of the developing Workforce Strategy the Trust is looking at new ways of working to assist with these issues. . The Chairman advised it was important that the Board pays attention to these issues and that regular updates are presented to the Board. The Board noted the report.
3.5	**Mortality/ Learning from Patient Death** Dr Nigel Kennea, Associate Medical Director informed the Board that the report had been presented to the Patient Safety and Quality Board and the Quality and Safety Committee. He informed the Board that both HSMI and HSMR (risk adjusted mortality indices) remain good (defined as better than expected when adjusted for complexity) . Exceptional winter pressures (e.g. impact of flu on vulnerable patients) have impacted mortality. This has been documented as a national issue. A Mortality Monitoring Committee has been established that independently reviews deaths in a timely manner. (This is in addition to the usual review that is still undertaken within the Clinical Divisions.) Support has been given to the bereavement office to enable the Trust to review 90% of deaths since the Learning from Deaths agenda was set earlier this year. The Mortality Monitoring Committee links directly to the risk team so any death where care may have been a factor is escalated in real time. The Board was informed that for the first time three negative comments had been received in a survey to the bereavement office regarding timescales of death certificates. This had been picked up following Quality and Safety Committee and in the Board visit reported earlier with appropriate follow up action. Dr Kennea stated that a lot of good care can be seen at the Trust, but occasionally sub-optimal care does occur. Sometimes this is procedural (e.g. some things have been picked up around mortality risk and consent). However St George's is one of the top two Trusts nationally for patients who receive specialist palliative care and the derivation of avoidable deaths as a proportion, following national guidance, is at 1.2%. In addition there is a separate programme of review for child deaths,

	and there are links to other programmes such as those related to disability or mental health. It was noted all child deaths are reviewed by the local Wandsworth Child Death Review Panel and the coroner. Tim Wright, NED questioned whether there is a clear protocol for Do Not Resuscitate patients within the Trust and whether this is applied consistently. Dr Kennea responded that there is an End of Life (EOL) Steering Group that has an emphasis on trying to identify patients that are in their last year of life and to discuss what they would like to happen in their end of life care, which ais documented. Dr Kennea confirmed there is increasing consistency. He informed the Board that there is learning to be done within cardiology and respiratory medicine. He requested that with the permission of the Board he would forward the report to all of the clinical teams. Stephen Collier, NED, asked if a hip fracture mortality alert would be triggered by raw numbers? Dr Kennea explained that an alert is not triggered by raw numbers. There have been two orthopaedic mortality reviews, on the joint registry and total hip replacements. These were triggered by the case mix, where fractures were due to cancer or trauma. In addition hip fractures have been reviewed by the CQC against best practice and a number of learning points have been identified, both operational and in terms of data recording. The MD emphasised there are no concerns around hip replacements, but learning points around hip fractures. The casemix of hip fractures seen at St. George's is complex, as the routine procedures are undertaken at the South West London Elective Orthopaedic Centre. Stephen Collier also asked if best practice tariffs depended on length of stay. Dr Kennea advised they rely on a number of factors including length of time waiting in A&E and being seen by the right clinician on the ward. Sarah Wilton, NED informed the Board in her capacity as the EOL NED lead that the EOL Steering Group has been looking at compliance across the Trust, identifying where there are issues and ensuring training is addressed. She highlighted the feedback she gave previously to the Board about her visit to the Bereavement Service. She suggested an EOL Steering Group could be set up that reports to the Board. Dr Nigel Kennea clarified that flu deaths are low figures. Avoidable deaths should be picked up on the raw data however focus remains on a number of wards challenged by infection control and flu issues. The CEO reflected how the Trust can ensure it involves colleagues from the coroner's office and Wandsworth Town Hall in winter planning and how best to support bereaved families. The Chief Executive reflected on how the Trust can work with other out of hospital services and with patients who are dying in hospital but would prefer to die elsewhere. Sarah Wilton, NED responded that the Community Team are key members of the EOL Steering Group, and actively engaged in these matters. The Chairman thanked Dr Kennea on behalf of the Board. The Board received the report and was assured by the robustness of the work and its reporting.
FINANCE	
4.1	**Finance and Performance Report** Ann Beasley, NED, presented the report of the Finance and Investment Committee's meeting in December. She highlighted that the Committee considered the remaining two risks on estates and ICT which had been allocated to it as part of the Board Assurance Framework. At present only limited assurance can be given for both of these risks and the Committee will review 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. This was agreed. She informed the Board that the Committee considered the monthly finance report based on data up

	to the end of December. It was noted that year to date expenditure against income showed a deficit of £53.3 million, 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 outturn at (£53m) but noted that a number of these were based on non-recurrent items which would have knock on implications for 2018/19. The committee considered the business and financial planning for 2018/19 and took some assurance from the thoroughness of the process whilst recognising 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. Ann expressed her gratitude to the finance team for their hard work. he Committee received a detailed report on procurement and was pleased to note the progress that has been made. The CEO noted that £43 million of the Trust's cost improvement programme had been delivered and only some of this was based on non-recurrent items. However, the month by month run rate still needs to be tackled. The DE&F asked about the governance of the Board Assurance Framework: who reconciles differing views of risks held by different committees? The Chair confirmed this is done by the Board.
4.2	**Month 9 Finance Report**
	The report was taken as read. The CFO informed the Board that the Trust is reporting a YTD deficit of 53.3m at the end of Month 9, an adverse variance to plan of £8.8m but in line with forecast. Additional expenditure control of £3m is planned and will be managed through the divisional run rate sessions and TRIG. He also advised the Board that the Trust may need to incur some costs in order to make savings (spend to save). The Board was advised that whilst further improvements have been identified, elective income underperformance as a result of bed pressures within surgical specialities are expected to continue in Quarter 4 (in line with the instruction from NHS Improvement that elective surgical activity should be cancelled in January) and that challenges remain in pay spend in CWDT. The Board was informed that the risk associated with PSS funding from NHSE to CCGs is not included in the forecast position. The delivery of the £53m deficit is dependent on both the specialist top-up element of this activity (2.7m), and the budget transfer from NHSE to CCGs to allow payment of this activity to the Trust. This risk has been highlighted to NHS Improvement. The CFO informed the Board that the Trust had been instructed by NHSI to review the forecast to check where further savings could be made. It is possible the Trust may be able reach a deficit of £51m however it is more likely the deficit will remain as predicted at £53m. The Board received the update and endorsed the note on non-recurrent savings and run rate.
WORKFORCE	
5.1	**Workforce and Education Committee Report**
	Stephen Collier, NED informed the Board that the report captures a summary of themes within the workforce. He raised disappointment 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 matters and

	programmes discussed will affect them directly, and would benefit from their input. He informed the Board that four meetings annually is not enough to run the committee effectively. He proposed additional meetings or to create sub committees. It was agreed that additional meetings were required. The Committee reviewed the four Trust-level risks that it was proposed be assigned to the Committee to monitor and provide assurance on mitigation. A full discussion was had on the scope of the risks, their respective weighting, and the actions currently under way to help mitigate these risks, which is reflected in the BAF report later on the agenda. The Committee concluded that it understood and was content to take on the monitoring and mitigation assurance responsibility for these risks. The Committee agreed that its Terms of Reference, agreed at the previous meeting, would be treated as final. In addition the Committee looked at rates of completion of mandatory and statutory training, and appraisals. Ann Beasley, NED commented that transformational thinking in relation to workforce was not yet properly reflected in the BAF and it was agreed it would be picked up in the BAF discussion. The DHROD agreed with these comments. The CEO also commented that the Trust is willing to look at new roles and this has started within pharmacy. Other examples include physician associates and advanced nurse practitionersThe Trust can link with Health Education England (HEE) which should support developing workforce plans and actions. Stephen Collier, NED advised that further work in equality, diversity and inclusion is required and that the DHROD has this on his agenda of work. This is an area that the Workforce and Education Committee can help maintain pace through its assurance role. The DHROD responded that this needed to be embedded within all workstreams and that the Trust is reinstating the role of Equality and Diversity Lead.to focus on this. The report was received.
GOVERNANCE	
6.1	**Audit Committee Report** Sarah Wilton, NED informed the Board that five internal audit reports had been presented to the Committee and for the first time in a while there was substantial assurance around sickness absence. Patient records received only limited assurance, as the policy is not up to date and there are issues around scanning documents. The Committee also considered the Standing Financial Instructions and their use. There are a significant number of breaches and waivers. Work is being undertaken to streamline processes and apply controls. 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 it reports to the Committee any discretion. The Committee requested the final Scheme of Delegation with all its documents at its next meeting in April 2018. The Committee was informed that ongoing training is being given to budget holders and that regular robust financial reviews are in place at a corporate level and with individuals on a monthly basis. The Committee was assured that the Director of Financial Operations will actively review this to ensure compliance.
6.2	**Board Assurance Framework**
	The CN & DIPC presented the BAF. She informed the Board that it will continue to develop, improve and change.

She reminded the Board that the BAF template was approved with the support of Deloitte. The Trust objectives and strategic risks were developed by the Board and aligned with the Trust's risk registers.

The Board was informed that the strategic risks were signed off at each of the assuring committees however some risks remain to be discussed at this meeting Additionally, risk appetite remains outstanding and the frequency of review of the BAF is still to be agreed. She proposed that it should be reviewed on a monthly basis.

The Chairman suggested that the BAF will report to the Trust Board on a monthly basis for now and that the Board would focus on risk appetite at a future meeting.

Action TB 25.01.18 17/60: Assist Trust Sec to add to agenda.

In regards to Risk SR9- *Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uniformed and unvalued* the DHROD commented that in his view the assurance should remain partial as whilst there is an engagement plan in place developing the right culture is a very significant piece of work, though the Trust is moving in the right direction. The Board agreed the risk score and that the assurance rating should be partial. The Board agreed that a comment should be included stating that there is a good communication strategy that is being implemented however there are issues around access and engagement.

Action TB.25.01.18 17/61: The MD and CN & DIPC to include commentary to risk SR9 regarding communication strategy and access and engagement issues.

In regards to Risk SR11- *We fail to effectively develop our leaders which could lead to lack of ownership* ….it was agreed that the words needed some further editing for clarification.

Ann Beasley, NED referred to her earlier concern about a transformational workforce plan.

ActionTB.25.01.18 17/62: The DHROD agreed to reword the risk and to ensure it that it reflects a transformational approach to job design, recruitment and retention.

In regards to Risk SR16 and SR17 *Build a better St George's* the DS informed the Board that there are two gaps in control to deliver this in relation to capacity to deliver and the plan and process. She informed the Board that there is agreement for funding for new posts and that a plan and process will be presented to the Board. The Board agreed with the suggested risk score and a limited assurance rating.

ActionTB.25.01.18 17/63: The DS to provide commentary for SR16 and SR17.

ActionTB.25.01.18 17/64: The CEO requested that the Executive Team ensured that the links between the risk register and the BAF are understood by all staff over the next two months.

The CFO commented that it was important the departments acknowledge and take responsibility for their risks to ensure the Trust meets its objectives.

The Chairman thanked all involved in developing the BAF and recognised that it was a good start but that it was work in progress.

The Board:

- Noted the risk score, assurance rating and rationale recommended by the assuring committees for strategic risks 1-8, 10-13 and 15.
- Discussed and agreed the proposed risk score and assurance rating for strategic risks 9, 16 and 17.
- Discussed a redrafted text for strategic risk 11 to be submitted to next Board
- Agreed monthly updates are provided to the Board and risk appetite for next Board.

CLOSING ADMINSTRATION	
7.1	**Questions from the Public** Kathryn Harrison, Lead Governor raised concerns of the lack of IT Strategy Update. The Chairman referred to the planned Board Workshop and presentation of the strategy at the February meeting (action log minute relates)
7.2	**An new Risks or Issues**
7.3	**Any other Business** The CFO informed the Board that the Trust is involved in a tender for Genomics work with Guy's and St Thomas' Hospitals NHS FT. He requested permission for Chairman's action to approve any actions required ahead of the next Board Meeting. The Board agreed to his request.
7.4	**Reflection on Meeting**
	PATIENT STORY
	Steven Lambert attended to share his experience of End of Life Care and Organ Donation with the support of two Special Organ Donation Nurses. Steven Lambert's mother Rosemary had been in generally good health but collapsed suddenly with a brain haemorrhage and died at St George's aged 63. He noted his thanks to the hospital and that the family had received exceptional treatment however the bereavement room was not adequate at this time as there were several families who needed privacy. Organ donation was discussed with the family as Rosemary was receiving respiratory help but there was no sign of brain function. The facilitation of saying goodbye was managed very well by the staff. Steven felt that being aware of her medical history may have helped when the family had been discussing donation and could have taken away some of the concerns they had. Steven felt that the extent of the testing that was carried out was unclear and that it was a very intrusive process for a family to have to witness. . He advised that more information on this in advance would have been helpful. He thanked the Transplant Coordinator and the excellent way she had dealt with the emotions of the family. She had phoned Stephen the following day to confirm the donation had taken place and the family had received letters from the recipients (for the family members who wished to do so).. Stephen was pleased to see the organ tree based at St George's with donor names attached and informed the Board that he and his family would be more than happy to support work on spreading the importance of organ donation. However, there is no further space on the Organ Tree and this will need to be addressed. Stephen thanked the Board for being invited to voice his experience. The Chairman thanked him for attending and sharing the family's experiences in such a frank and open way. The Senior Organ Donation Nurses outlined their roles to the Board and provided a document of the work they do. The Chairman thanked them for the extensive work they do. The CEO asked how the nurses receive the support they require. The Nurses responded that there is no formal debriefing or counselling however it is available if requested. They responded that the Nurses support each other. The Chairman advised that the CEO should explore this. Kathryn Harrison, Lead Governor and Chairman of the Organ Donation Committee asked the Board to encourage clinicians to attend Committee meetings.

Date and Time of Next Meeting: Thursday22 February2018, 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. On the agenda	Proposed for closure
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	Date required and to be added to the forward programme	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	MD to report to QSC and inform the Assis Trust Sec of the committee date it is to be presented on . Added to the April OSC forward plan- CCIO to review.	Proposed for closure
TB.07.09.17/44	**Medical Revalidation**	Provide interim reports Medical Revalidation to the Workforce & Education Committee.	Q4 2017-18		Acting MD & Karen Daly	Action log to be prsented at the April TB	Open
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	TB.22.02.18	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.	TB.26.04.18		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.	T.B.22.02.18		DOS	on agenda	Proposed for closure
TB.25.01.18 17/57	**Feedback from Board Walkabout**	CN & DIPC to investigate concerns regarding unresponsive staff at the Neurology reception.	TB.22.02.18		CN & DIPC	This has been discussed with the Head of Nursing for Outpatients and Clinical Director who are discussing this feedback with the team directly and making expectations clear and ensuring relevant training has taken place.	Proposed for closure
TB 25.01.18 17/58	**Feedback from Board Walkabout**	The CN & DIPC to explore chaperone options for patients being examined.	TB.22.02.18		CN & DIPC	The expectation for Chaperone requirements and provision are clear to protect patients and staff. The required staffing is available in outpatient settings but may mean on occasions that there is a delay in patients being seen.	Proposed for closure
TB 25.01.18 17/59	**Feedback from Board Walkabout**	Alison Benincasa to incorporate the bereavement office sign off/paperwork issues into the End of Life Work.	TB.22.02.18		Alison Benincasa/ MD	discussed at Feb QSC	Proposed for closure

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	19 February 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:**	22 February

Chief Executive Officer's Update
Trust Board, 22 February 2018

In my January report to the Board, I talked about the operational pressures the Trust faced, particularly over the Christmas and New Year period.

Unfortunately, despite a huge amount of work, we are not yet where we want to be with regards to performance, and our Emergency Department at St George's is particularly challenged.

Despite this, and the importance of achieving our year-end financial targets, I remain pleased overall by the progress we are making, particularly with regards to our quality agenda.

As you will see from this report, the evidence suggests we are getting to grips with some key issues – such as hand hygiene compliance.

We have been stressing to staff the importance of getting the basics right. We are a teaching hospital, and everybody is committed to providing Outstanding Care, Every Time for our patients – but this starts and ends by getting the fundamentals of patient care right.

There is still a long way to go, but progress is being made (and felt) in many areas.

Our quality agenda:

We launched our Quality Improvement Plan in October last year, and we are seeing improvements as a result of hard work across many of the different workstreams and projects.

These include:

- Trust-wide avoidable Grade 3 and 4 pressure ulcers were reported as zero for December 2017, compared to a monthly average of two in 2017.
- Zero patient falls in December 2017 resulting in moderate or serious harm, compared to a yearly average to date of two falls.
- Dementia care plan is helping us become a 'Dementia friendly hospital'
- 98% hand hygiene audit compliance met for November/December.

Of course, we mustn't be complacent and, whilst we have seen progress in some areas, there is a lot more to do.

However, I am pleased how enthusiastically staff are taking this improvement work forward – this is crucial, as without organisational buy-in to what we are trying to achieve, we face an uphill struggle. But the signs are promising.

The future of ICT at St George's:

We all know that our existing ICT infrastructure is not fit for purpose. We have moved swiftly to tackle the areas of biggest concern, but our focus now needs to be on planning for (and delivering) the bigger, systemic changes all of our staff want to see – and have been waiting years for.

Matt Laundy is our new Chief Clinical Information Officer, and has spent the last two months talking to staff about the challenges they face with our current IT infrastructure. The problems are numerous and varied – but in many cases, staff are using systems that hinder rather than help, which can be frustrating and demoralising.

Our new ICT strategy is unlikely to deliver many quick wins – and we need to be up front and realistic with staff about this.

However, the long-term goal of delivering a system that is truly fit for purpose has the full backing of the Trust Board, and I am confident that, over time, we will deliver the step-change we all want, and which our staff deserve.

I have asked Matt to provide regular updates to the executive team – and the Trust Board – on progress, although I am also clear he can't do this on his own; and that we all need to ensure this work is consistently prioritised over the coming weeks and months, particularly given the financial challenges we face.

South West London Sustainability and Transformation Programme:

I have also asked Suzanne Marsello, our new Director of Strategy, to provide regular updates to the Trust Board on progress with the South West London Sustainability and Transformation Programme.

As you will all be aware, the focus of the programme is shifting to borough level, with the proposed development of Local Health and Care Delivery Plans.

We remain heavily involved with the programme, and as Chief Executive, I am committing a significant amount of my own time to discussions, although very much welcome Suzanne's increasing involvement.

The key for me in all discussions is that St George's is fully represented, given our position as the single biggest provider of health services in the area. This remains a priority for me, and the Trust Board.

Positive news:

I am delighted that we have been confirmed this month as a designated centre for mechanical thrombectomy.

The service we provide for patients is innovative, and truly ground-breaking – and the model of best practice we've established at St George's is one that others are now opting to follow.

I would like to say well done to the multi-disciplinary team involved in delivering the service, who have worked exceptionally hard to create a service that we should be rightly proud of.

I'm also delighted to welcome six new public governors to our Council of Governors following recent elections.

As well as these new faces, two public governors have been re-elected, and the remainder stay in post as they are mid-way through their terms. This is in addition to three new staff governors being appointed to the Council.

Finally, I would also like to say a big thank you to the St George's Hospital Charity, in particular their support for the Staff Appreciation Awards.

The awards evening organised for 15 March is going to be fantastic, and a great opportunity for us to celebrate our excellent staff.

I would also like to say thank you to Martyn Willis, Chief Executive for the charity, who is stepping down from his role at the end of the month.

Jacqueline Totterdell,

Chief Executive

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 22nd February 2018
Reporting period – January 2018

Excellence in specialist and community healthcare

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

January 2018

Daycase and Elective Surgery operations

Actual
4,263

Target 4,897

Discharges before 11am

Actual 12.2%

Target 30%

Four Hour Emergency Standard

Actual
83%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
95%

Target
95%

Outpatient First Appointment

Actual 17,006

Target 18,178

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
84%

Target
83%

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	
		Jan-17	Jan-18	Variance	Plan Jan-18	Variance	YTD 16/17	YTD 17/18	Variance	Plan YTD	Variance
ED	ED Attendances	13,529	13,472	-0.42%	14,715	-8.44%	137,447	137,776	0.24%	145,247	-5.14%
Inpatient	Elective & Daycase	4,321	4,263	-1.34%	4,897	-12.95%	43,449	45,232	4.10%	45,756	-1.14%
	Non Elective	4,029	4,002	-0.67%	4,369	-8.40%	40,470	39,021	-3.58%	43,125	-9.52%
Outpatient	OP Attendances	54,855	55,000	0.26%	54,589	0.75%	539,496	530,440	-1.68%	518,058	2.39%

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

Source: SLAM

Executive Summary – January 2018

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- No Never Events reported in January. The Trust has reported three events year to date. There were three Serious Incidents declared in the month.
- In January 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.

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 January reporting a performance of 83% 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.
- The Trust achieved all eight cancer standards in the month of December, with an improved position on 62 day standard reporting 86.8% against a target of 85%.
- The Trust has returned to compliance against the 6 week Diagnostic Access standard in December and continued to achieve this is January, reporting 0.1% of our patients waiting greater than six weeks for a diagnostic procedure.

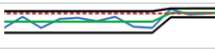
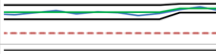
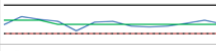
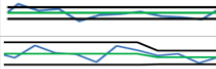
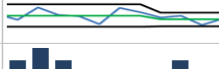
Patient Experience

- The Friends and Family Test (FFT) recommendation rate for inpatients was 94.7% and for Outpatients was 97.6% in January. 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 January reporting 4.1%
- Non Medical appraisal rates have seen a further decline in performance within the reporting period at 67%. Medical appraisal rates have decreased to 79.6%, 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	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend (12 months)
Number of Never Events in Month	0	1	0	0	0	1	1	0	0	1	0	0	0	
Number of SIs where Medication is a significant factor	0	0	0	0	0	0	1	1	1	0	0	0	0	
Number of Serious Incidents	8 / mth	6	8	5	6	7	10	9	11	4	8	2	3	
Serious Incidents - per 1000 bed days	N/A	0.26	0.31	0.21	0.24	0.29	0.40	0.38	0.45	0.16	0.32	0.08	0.12	
Safety Thermometer - % of patients with harm free care (all harm)	95%	93.7%	94.5%	94.6%	94.3%	94.7%	93.8%	93.8%	95.7%	94.9%	95.0%	95.1%	94.9%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.9%	98.2%	97.7%	98.0%	97.9%	97.5%	97.8%	98.3%	98.7%	98.1%	98.5%	98.9%	
Percentage of patients who have a VTE risk assessment	95%	96.5%	96.3%	95.3%	96.2%	96.3%	95.8%	95.7%	95.4%	96.1%	96.4%	96.0%	95.4%	
Number of Patient Falls	N/A	137	154	111	137	132	143	127	125	123	156	127	192	
Number of patient falls- per 1000 bed days	N/A	5.85	6.03	4.73	5.39	5.48	5.71	5.29	5.15	4.93	6.19	5.17	7.61	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	1.20	0.78	0.72	0.28	1.16	0.92	0.63	0.74	0.28	0.64	0.53	0.63	
Number of Grade 3 & 4 Pressure Ulcers	N/A	2	3	2	1	0	1	1	2	0	0	0	0	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.09	0.12	0.09	0.04	0.00	0.04	0.04	0.08	0.00	0.00	0.00	0.00	
Number of overdue CAS Alerts	0	1	1	1	1	0	0	0	0	0	0	0	0	

Briefing

- No Never Events reported in January, the Trust total remains at three year to date.
- The Trust declared three serious incidents in January 2018.
- The number of falls reported in January shows a significant increase on previous months, the falls practitioner is looking at individual falls to identify themes and working with the Falls Group to revise the falls risk assessment tool to reflect national requirements. In 160 of the 192 falls reported the patient came to no harm, 31 had low harm with one serious incident which is being investigated. To note: the number of emergency admissions where the patient was 70+ increased in January by over 15%, the increase in the number of frail elderly patients may have contributed to the increase in falls.

Infection Control

Indicator Description	Threshold	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend (12 months)
MRSA Incidences (in month)	0	1	0	2	0	2	0	0	0	0	0	0	0	
Cdiff Incidences (in month)	31	4	3	1	1	1	2	3	1	4	0	0	0	
MSSA	N/A	2	2	3	2	4	4	4	1	1	2	3	0	
E-Coli	N/A	3	11	4	2	5	9	6	8	6	2	5	5	

Briefing

- There were no patients reported to have suffered with a hospital acquired Clostridium Difficile Infection in January.
- 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 January. The Trust year to date total stands at 4

Mortality and Readmissions

Indicator Description	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	83.3	82.5	82.5	83.5	81.3	82.9	79.7	81.1	80.6	81.3	81.4	82.2	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	81.1	79.9	79.2	80.1	78.2	78.9	76.4	77.4	77.2	77.5	76.6	77	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	86.8	85.6	84.2	86.0	83.5	85.4	81.3	81.8	81.2	82	83.8	84.1	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.88	0.86	0.86	0.86	0.84	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	10.2%	9.3%	9.5%	9.7%	9.7%	8.9%	9.0%	9.7%	10.2%	9.20%	9.38%		

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 slight increase in December reporting 9.38% of patients that were re-admitted to hospital within 30 days of discharge. Analysis shows that 26.2% of these patients are over the age of 80 with patients diagnosis including: Bronchitis, Urinary tract infection, sepsis.

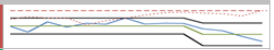
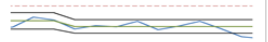
Maternity

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

Indicator Description	Threshold	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend
C Section Rate - Emergency and Non Elective	28%	29.6%	34.1%	29.9%	29.1%	24.6%	29.5%	24.9%	30.2%	29.7%	31.8%	25.4%	31.1%	
Admission of full term babies to neo-natal care		7	2	11	2	16	21	20	15	10	16	6	11	

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

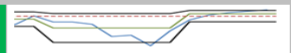
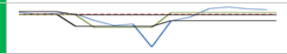
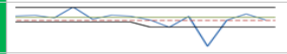
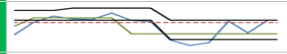
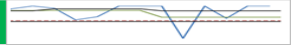
Indicator Description	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend
4 Hour Operating Standard	95%	90.59%	89.09%	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	87.17%	84.99%	83.03%	
Patients Waiting in ED for over 12 hours following DTA	0	1	0	0	1	0	0	0	0	0	1	0	0	
Ambulance Turnaround - % under 15 minutes	100%	52.4%	50.2%	46.0%	48.4%	51.9%	48.9%	51.8%	50.9%	49.9%	49.0%	44.3%		
Ambulance Turnaround - % under 15 minutes (London Average)	100%	42.5%	43.4%	43.7%	45.3%	47.5%	46.4%	47.0%	46.5%	45.1%	46.1%	42.1%		
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	37	53	79	72	71	53	84	71	57	82	112		
Ambulance Turnaround - % under 30 minutes	100%	98.1%	97.6%	96.1%	96.7%	96.5%	97.4%	96.0%	96.6%	97.4%	96.2%	94.8%		
Ambulance Turnaround - % under 30 minutes (London Average)	100%	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	1	1	0	1	1	0	0	0	2	2	

- The Four Hour Operating Standard in January was 83% which falls below both the national target and the improvement trajectory agreed with NHSI, however January has seen severe winter pressures and a Flu outbreak. Several recent initiatives have offered a protective effect on emergency flow :
    - Implementation of a Rapid Assessment and Discharge model began in late November – early analysis indicates approx. 20 more patients per day are seen, treated and discharged from the Front Door area, helping to decongest ED Majors and maintain patient flow through the department
    - A Point-of-Care Flu test device was installed in ED in December after the team won funding from the Quality Week Dragons' Den competition (POCT turnaround = 18 mins; laboratory = approx. 90 mins). More than 500 patients have been tested, ~57% confirmed negative for flu allowing safe admission to ward beds rather than waiting for side rooms, maintaining patient flow. The test also differentiates between strains which enabled cohorting to designated 'Flu A' and 'Flu B' wards, supporting admitted patient flow
- A 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 was held on 18/01/2018 chaired by the Chief Executive with Executive members, Senior Managers, Clinical Care Group Leads, Senior Nurses, Junior Doctors and Allied Health Professionals to review impact at specialty level. Actions included clarification of the referral pathway from ED and better visibility of specialty response time data
- Medical Admission and Ambulatory Assessment capacity have been reduced due to infection control issues and building works, constraining flow from the Emergency Department and the ability to assess and treat new patients in a timely manner.
- 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.

Actions

- The Unplanned and Admitted Patient Care programme, led by divisional chair for Medicine and Cardiothoracic Division and supported by clinicians throughout the Trust, aims to provide patients with alternatives to emergency admission and to accelerate discharge to reduce overall bed occupancy
- The new Ambulatory and Acute Assessment unit is due to open 5th March 2018. In preparation for this the Emergency Department senior team are working with Acute Medicine to develop an Standard Operating Procedure for efficient streaming to the new unit.
- SAFER bundle is being rolled out to improve patient safety and remove delays in the inpatient journey
- Revised Trust Internal Professional Standards are in development and Escalation policies have been launched

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	Dec-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%	98.51%	
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%	97.3%	
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%	97.4%	
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%	94.3%	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
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%	86.8%	
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%	93.9%	
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%	100.0%	

Briefing

- The Trust has continued to observe significant improvement against the eight cancer standards, achieving eight out of eight standards in the month of December.
- Compliance against all 8 cancer standard was last achieved in December 2016.
- The 14 day standard was achieved reporting 98.51%, above the national standard for a fourth consecutive month and complaint in all tumour groups. Increased leadership and management support given to Two Week Rule office has increased performance. Pro-active escalation and response time to capacity issues has also further enhanced the booking process. The Trust is now working toward booking patients within 10 days.
- The Trust also met the 62 day urgent GP referral standard with a performance of 86.8% with an internal position of 97% compliance.

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%
Dec-17	85%	86.8%	97%

Breakdown

Shared Breaches (6)

- 4 Late Inter Trust Transfers from other provider (defined as after day 38)
- 0.5 Delay in pathway management
- 0.5 Patient unfit for Surgery
- 1 Complex Pathway

Internal Breaches (1)

- 1 Delay in pathway management

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	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
Brain	93%	66.7%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast	93%	96.1%	89.9%	92.3%	88.7%	84.7%	69.5%	76.4%	93.4%	94.1%	97.4%	98.4%	98.2%
Childrens	93%	100.0%	100.0%	90.0%	66.7%	80.0%	66.7%	80.0%	100.0%	100.0%	100.0%	71.4%	100.0%
Gynaecology	93%	76.0%	75.4%	87.1%	64.6%	66.7%	75.6%	93.4%	90.4%	91.1%	90.8%	95.0%	97.6%
Haematology	93%	100.0%	100.0%	95.8%	76.2%	96.9%	76.9%	95.7%	100.0%	100.0%	96.8%	100.0%	94.7%
Head & Neck	93%	98.4%	97.4%	97.9%	90.9%	84.9%	82.4%	88.0%	82.4%	90.6%	99.1%	99.4%	98.4%
Lower Gastrointestinal	93%	95.7%	95.7%	90.5%	75.1%	90.7%	44.4%	60.0%	73.9%	94.6%	97.4%	97.7%	99.3%
Lung	93%	98.2%	100.0%	100.0%	96.2%	91.1%	91.2%	95.6%	100.0%	94.1%	97.7%	100.0%	100.0%
Skin	93%	67.1%	67.7%	57.4%	29.4%	48.1%	26.9%	74.3%	96.6%	93.4%	95.0%	95.5%	97.9%
Upper Gastrointestinal	93%	87.8%	95.3%	94.2%	88.8%	96.1%	93.8%	97.6%	98.8%	98.8%	98.5%	99.0%	100.0%
Urology	93%	98.1%	95.0%	98.4%	96.1%	90.1%	82.3%	93.8%	97.0%	96.4%	93.3%	97.1%	98.9%

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	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
Brain	85%	-	-	100.0%	50.0%	-	0.0%	100.0%	0.0%	100.0%	-	100.0%	-
Breast	85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	91.7%	100.0%	95.2%	100.0%
Childrens	85%	-	100.0%	-	-	-	-	-	0.0%	-	-	-	-
Gynaecology	85%	100.0%	100.0%	50.0%	100.0%	90.9%	100.0%	61.5%	100.0%	50.0%	83.3%	75.0%	67.0%
Haematology	85%	80.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	-	100.0%
Head & Neck	85%	63.6%	72.7%	75.0%	58.3%	85.7%	46.2%	66.7%	71.4%	87.5%	78.6%	81.8%	71.0%
Lower Gastrointestinal	85%	76.5%	66.7%	71.4%	-	62.5%	100.0%	60.0%	100.0%	66.7%	100.0%	80.0%	100.0%
Lung	85%	80.0%	78.6%	73.7%	85.7%	85.7%	64.3%	41.7%	47.4%	72.2%	72.7%	41.2%	33.0%
Skin	85%	100.0%	95.5%	100.0%	93.3%	96.4%	95.7%	100.0%	76.5%	93.8%	90.9%	91.7%	93.0%
Upper Gastrointestinal	85%	50.0%	11.1%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%	0.0%	100.0%	84.0%	100.0%
Urology	85%	85.2%	87.9%	83.9%	90.0%	67.9%	81.8%	63.0%	64.3%	77.4%	100.0%	72.7%	91.0%

Diagnostics

Indicator Description	Threshold	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend
6 Week Diagnostic Performance	1%	2.8%	2.9%	4.1%	3.3%	2.2%	2.7%	2.0%	1.4%	0.3%	1.9%	0.1%	0.1%	
6 Week Diagnostic Breaches	N/A	219	222	312	248	173	190	154	98	22	143	6	10	
6 Week Diagnostic Waiting List Size	N/A	7,871	7,678	7,550	7,442	7,843	6,988	7,751	7,184	7,072	7,534	6,440	6,884	

Indicator Description	Threshold	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend
MRI	1%	4.3%	3.3%	2.6%	1.1%	0.6%	0.8%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	
CT	1%	0.0%	0.7%	1.5%	0.5%	0.2%	0.2%	0.3%	1.2%	0.3%	0.1%	0.0%	0.1%	
Non Obstetric Ultrasound	1%	1.9%	3.0%	4.0%	2.5%	0.3%	1.1%	0.9%	0.0%	0.0%	0.0%	0.1%	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%	4.5%	2.5%	6.5%	10.1%	11.3%	4.6%	5.7%	4.5%	0.0%	17.4%	0.0%	0.0%	
Echocardiography	1%	0.1%	0.3%	1.2%	9.4%	2.0%	3.0%	0.3%	0.3%	0.3%	0.8%	0.0%	0.0%	
Electrophysiology	1%	100.0%	0.0%	0.0%	0.0%	75.0%	75.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.0%	0.5%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.3%	0.9%	
Sleep Studies	1%										26.8%	0.0%	0.0%	
Urodynamics	1%	52.6%	55.0%	65.5%	75.6%	64.4%	64.2%	50.6%	37.0%	16.7%	6.7%	0.0%	0.0%	
Colonoscopy	1%	5.7%	8.7%	5.7%	4.7%	0.5%	1.8%	0.0%	0.4%	1.1%	0.0%	0.0%	0.0%	
Flexi Sigmoidoscopy	1%	12.0%	8.4%	6.7%	0.0%	1.1%	4.9%	0.7%	1.5%	0.0%	0.6%	0.0%	0.0%	
Cystoscopy	1%	9.9%	2.6%	15.0%	11.5%	24.4%	14.0%	12.3%	14.7%	4.0%	1.8%	1.5%	2.8%	
Gastroscopy	1%	3.2%	4.5%	12.7%	10.0%	9.2%	11.2%	6.7%	0.8%	0.0%	0.8%	0.4%	0.0%	

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

The Trust has sustained performance in January reporting a total of ten patients waiting longer than 6 weeks, 0.1% of the total waiting list.

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

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	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend
Number of on the Day Cancellations		91	63	58	72	64	84	54	49	52	86	100	94	
Number of on the Day cancellations re-booked within 28 Days		89	56	54	70	54	70	43	43	34	76	67	76	
% of Patients re-booked within 28 Days	100%	97.8%	88.9%	93.1%	97.2%	84.4%	83.3%	79.6%	87.8%	65.4%	88.4%	67.0%	80.9%	

Briefing

- The table above shows that the number of patient procedures cancelled on the day has increased within the winter months
- In Quarter 3, there were a total of 238 non clinical cancellations, of which 74.4% were rebooked within 28 days.
- In January 94 patients were cancelled for non clinical reasons on the day of their procedure and 80.9% of these patients were re-booked within 28 days. Operations were cancelled due to bed unavailability, where an emergency case taking priority and lack of theatre time.
- 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.

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	Jan-18	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%	82.2%	
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%	94.7%	
Maternity FFT - Antenatal - % positive responses	90%	No Responses		100%		85.7%	100.0%	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%	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%	99.0%	
Maternity FFT - Postnatal Community Care - % positive response	90%	100%	100.0%	100%	100%	100%	100%	100%	98%	100%	100%	91.6%		100.0%	
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%	99.2%	
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%	97.6%	
Mixed Sex Breaches	0	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	85	
PALS Received		363	346	294	299	299	234	268	170	203	185	298	262	283	

Briefing

- ED Friends and Family Test (FFT) – The score has decreased in January reporting 82.2% meaning that the percentage of patients recommending the service has decreased compared to December.
- 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 increased in the month of January reporting 85 compared to 69 in December. 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 green (25 day) complaints received in November 58% were responded to within 25 working days against the target of 85%. For December the position is 60%. For amber (45 day) complaints received in November 36% were closed within the 40 working day target.

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: A complaints handling improvement plan to address the timeliness and quality of complaint responses and which considers different models for handling complaints is being considered by the Trust Executive in February.

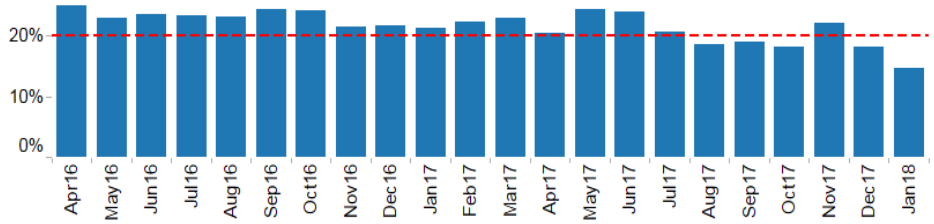
Patient Voice

CARING – Friends and Family Test

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

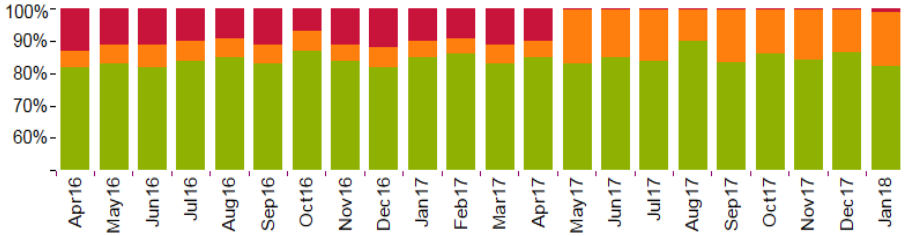
A&E Friends & Family Response Rate

Target: 20% Dec 17: 18.10% Jan 18: 14.63% Movement: ▼-3.47%



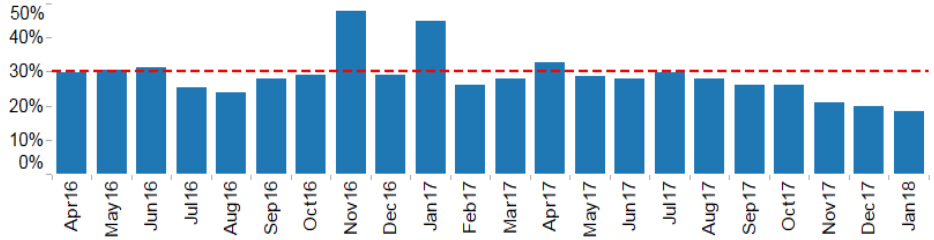
A&E Friends & Family Recommend Rate

The expected target is 90%



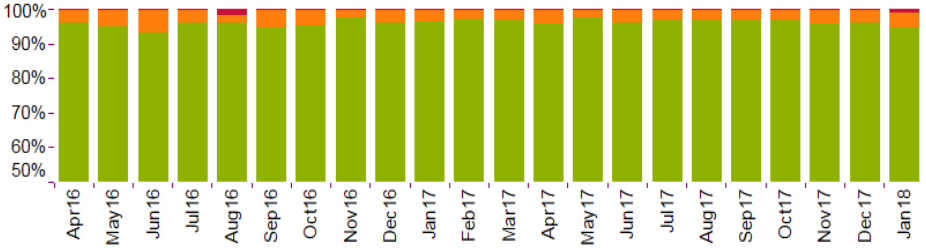
IP Friends & Family Response Rate

Target: 30% Dec 17: 19.90% Jan 18: 18.47% Movement: ▼-1.43%



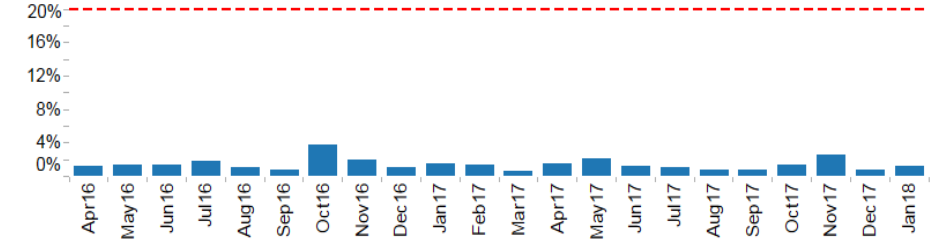
IP Friends & Family Recommend Rate

The expected target is 95%



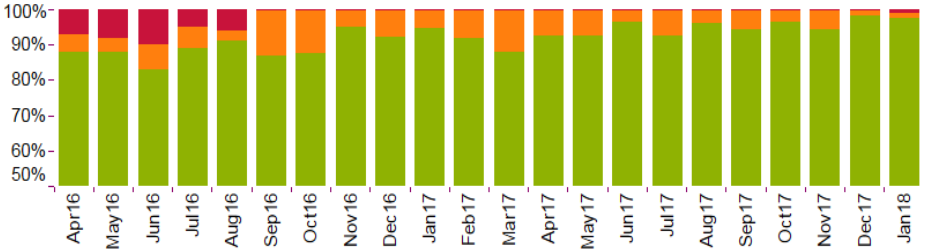
OP Friends & Family Response Rate

Target: 20% Dec 17: 0.70% Jan 18: 1.20% Movement: ▲0.50%



OP Friends & Family Recommend Rate

The expected target is 90%



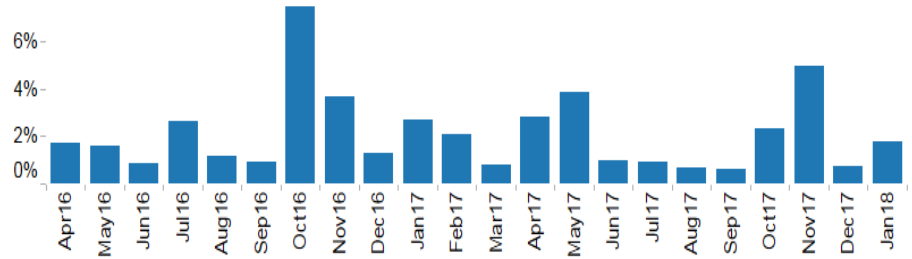
Patient Voice

CARING – Friends and Family Test

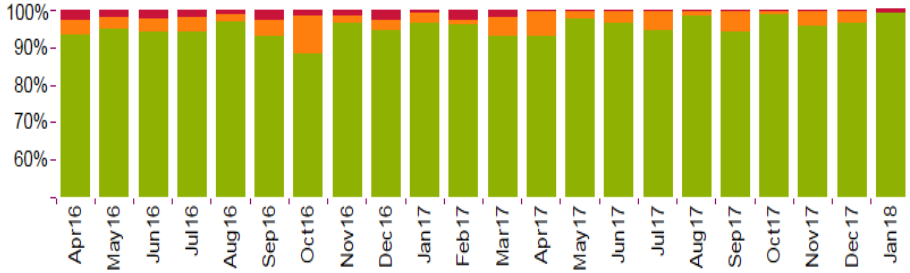
--- Target ¢ MetricMeasure Percentage Recommended Neutral Percentage Not Recommended

Community Friends & Family Response Rate

Target: 20% Dec 17: 0.70% Jan 18: 1.78% Movement: ▲1.08%

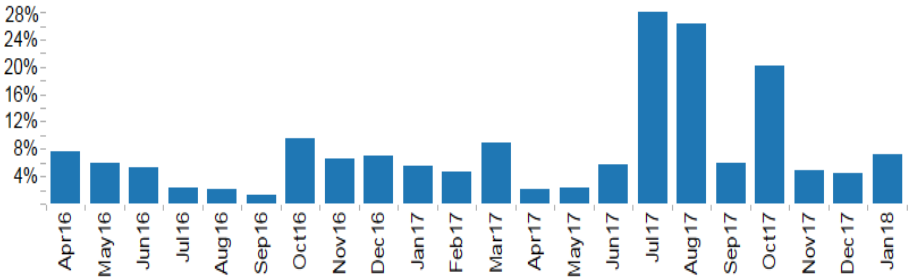


Community Friends & Family Recommend Rate
The expected target is 90%

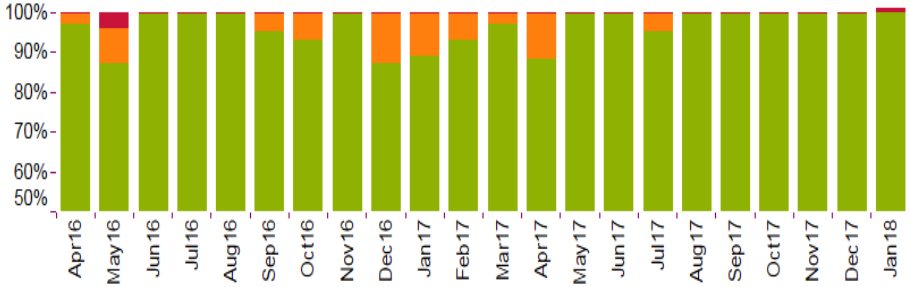


Maternity (Birth) Friends & Family Response Rate

Target: 20% Dec 17: 4.40% Jan 18: 7.27% Movement: ▲2.87%



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



St George's University Hospitals NHS
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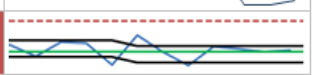
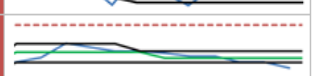
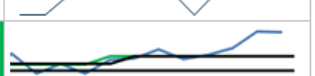
Workforce

Indicator Description	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Trend
Trust Level Sickness Rate	3%	3.8%	3.3%	3.2%	3.4%	3.4%	3.6%	3.7%	3.6%	3.4%	3.8%	3.6%	4.1%	
Trust Vacancy Rate	10%	15.1%	15.4%	16.3%	17.0%	17.1%	16.1%	16.5%	14.8%	16.1%	12.7%	13.0%	13.4%	
Trust Turnover Rate* Excludes Junior Doctors	10%	18.5%	19.1%	19.1%	19.1%	18.8%	18.4%	19.6%	18.5%	18.5%	18.3%	18.4%	17.9%	
Total Funded Establishment		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	9,514.51	
IPR Appraisal Rate - Medical Staff	90%	81.3%	77.3%	82.4%	82.0%	74.2%	84.8%	79.0%	74.0%	80.7%	80.0%	78.9%	79.6%	
IPR Appraisal Rate - Non Medical Staff	90%	70.4%	72.8%	80.3%	78.2%	76.1%	76.1%	75.1%	79.4%	73.5%	70.2%	70.2%	67.2%	
% of Staff who have completed MAST training (in the last 12 months)		85%	85%	86%	87%	87%	86%	86%	85%	86%	87%	86%	87%	
Ward Staffing Unfilled Duty Hours	10%	6.2%	4.8%	5.5%	4.8%	5.8%	5.9%	6.5%	5.9%	6.1%	6.6%	7.8%	7.7%	
Safe Staffing Alerts	0	7	2	0	0	1	2	1	0	1	2	2	4	

Briefing

- Funded Establishment remained in line with previous month reporting 9,514 WTE in January.
- Vacancy Rate increased from 13% to 13.4%.
- Sickness has remained above 3% target reporting an increase in January to 4.1%
- Mandatory and Statutory Training figures for January were recorded at 87%
- Appraisal rates remain below target, both Medical and Non Medical. Non medical appraisal rate further decreased to 67% in January and medical appraisal rate was reported at 79.6%
- Percentage of Staff vaccinated against seasonal Influenza is 90% as at the 5th February 2018.

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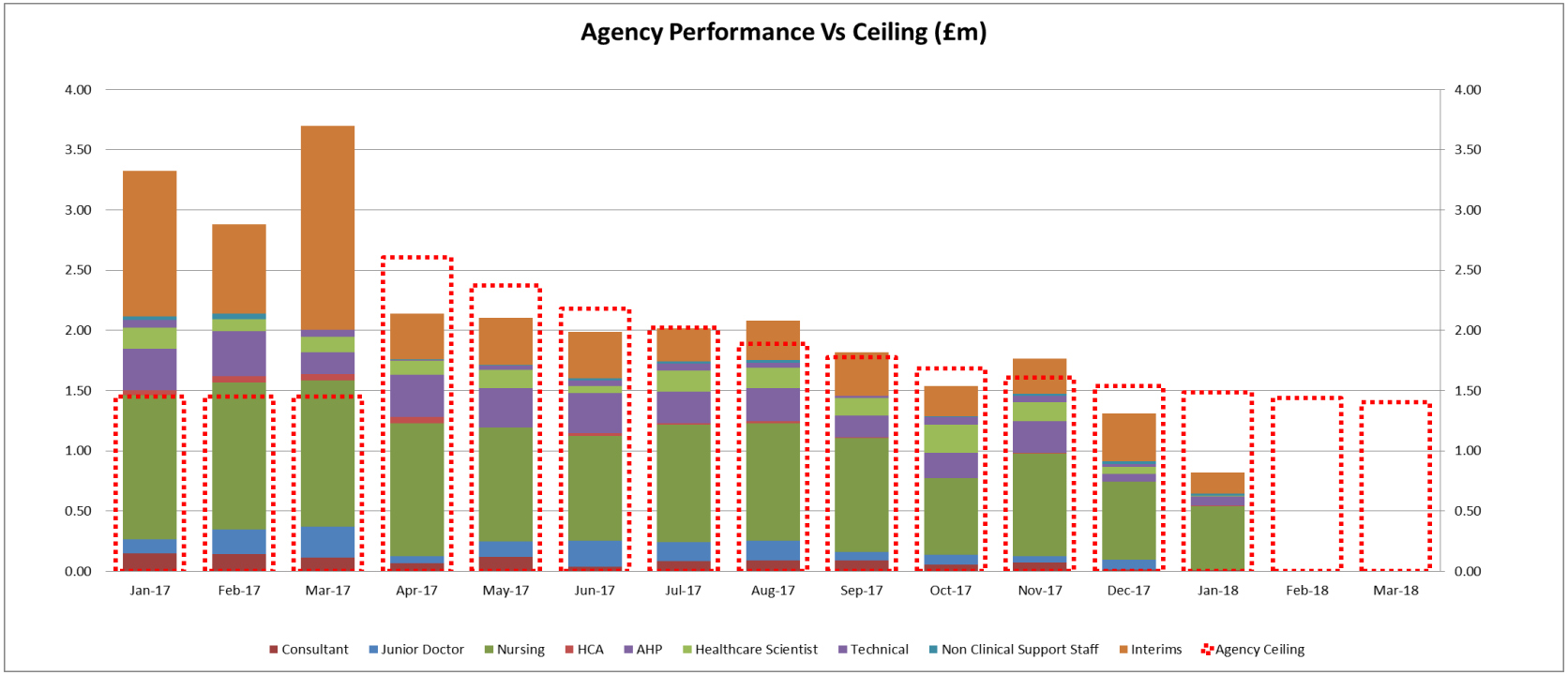
Agency Use



- The Trust's total pay for January was £40.00m, which is £0.22m higher than December. This is £0.38m adverse to a plan of £39.62m and £0.70m adverse to a forecast of £39.30m.
- The Trust's annual agency spend target set by NHSI is £24.5m. There is an internal annual agency target of £22.0m. For January, the monthly target set was £1.48m.
- Total agency cost in January was £0.82m or 2.0% of the total pay costs. From M1-10 2017/18, the average agency cost was 4.4% of total pay costs.
- Agency cost decreased by £0.49m compared to December. In 2017/18 YTD, the Trust has performed better than the planned target by £1.62m.
- In January, there has mainly been decreases in Junior Doctor (£0.23m), Interims (£0.15m) and Technical (£0.08m), partially offset by an increase in AHP (£0.08m).
- The decrease and negative value in Junior Doctor is due to the release of accruals in SNCT (£0.26m), following a review of the accrual methodology. There was a similar release of accrual in Technical staffing.
- The biggest area of overspend was in AHP and Non Clinical Support Staff, which both breached the target by £0.02m.

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:	Andy Irvine Elective Care Recovery Programme Manager		

Executive Summary:

Cancer

- Performance continues to stabalise and further work has commenced to enhance the Infoflex system. An independent review by Royal Marsden partnership of the QMH site, commissioned by the Trust, will report its recommendations at the end of March

Diagnostics

- Achieved compliance in January and forecast to continue.
- A new substantive Divisional Director of Operations commenced on 6th February to further strengthen the senior leadership in this area.
- Much more control and grip in place on a weekly basis through a confirm and challenge approach.
- Work underway on the development of a new diagnostic PTL as part of the overall programme. This is due to be completed by 31st 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.

The new PTL launched on 13th February 2018 will give the Trust the ability to manage patient pathways and start to get more visibility of the capacity required to achieve the NHS constitutional standards within 18 weeks.

Return to Reporting

- New RTT and Planned PTL in place at Tooting and training on the new tool is ongoing.
- QMH PTL delivered without RTT functionality (PAS upgrade dependent).
- 3 further PTLs in development – due by 31st March 2018
- The reply date for patients to contact the Trust using the freepost

	envelop provided has passed. Services are preparing to action those patients who have requested an appointment. **Training** • E-Learning in place and being rolled-out to 3500 staff. Communication campaign has been successful. • A targeted approach being taken from errors that are being picked up through validation and data quality reports to close the loop and start to reduce errors at source. **NEXT STEPS** • Implementation of maximum waiting cap for new outpatients – working to bring this cap down week on week • Continued training and understanding of the new PTL tool • Increased emphasis on specialty capacity plans using the new PTL • Actioning the responses from contacting the patients that have the potential to need appointment as a result of Phase 1 validation • Wider and more strategic approach to training • Continuation of progress with outcome form completion including auditing the content and accuracy, then feeding back lessons learnt
Risks:	1. Planning and delivery of robust capacity plans 2. SOP development to ensure front line staff are working to agreed rules 3. Training resource to train staff on the right way to process patients [SOP's] and RTT knowledge through e-learning packages. 4. Delayed Cerner implementation at QMH

Overall Programme Risks

Key Risks			
Risk / Cause / Impact	**RAG Score**	**Executive Owner**	**Mitigating action/s**
High numbers of errors being added to the PTL **Risk**: There is a risk that the validation burden could continue to increase until key SOPs are embedded into the organisation at the earliest opportunity to mitigate some of the causes of the cohorts which require validation. **Cause**: Incorrect entries into Cerner **Impact**: An increase in the time for the Trust to return to National Reporting and the requirement of a significantly sized validation team. Large scale validation requirement needed to continually clean the errors being made.	20	Ellis Pullinger	**Controls in place**: Strong communications on the need and consequences. **Actions**: • 'How to guides' developed to address requirements in short term • Data Quality Dashboard in place to track errors on a daily basis • Have trained 839 staff including 353 clinicians on CDOF • E-Learning training in place and mapped to 3500 staff for roll-out • Keeping PTLs clean workstream pursuing a targeted, data driven approach to 'support' and retrain' those that are consistently making the largest amount of errors – this will be monitored by refined workstream KPIs.
Insufficient outpatient and inpatient capacity to reduce RTT backlogs **Risk**: There is a risk that current capacity plans are not sufficient to reduce RTT backlogs on both SGH and QMH sites. **Cause**: Operational Planning **Impact**: An increase in the time for the Trust to return to National Reporting and the requirement of a significantly sized validation team. Excessive waiting times continue in some specialties.	20	Ellis Pullinger	**Controls in place**: Capacity planning process linked to contractual discussions **Actions**: • Development of backlog reduction plan – signed off by services • Outpatient clinic template clean-up: undefined slots • Increased outpatient new slots made available to CBS and ERS • Where necessary – outsourcing plans developed.
Adherence to Trust access policy: chronological booking and management of DNAs **Risk**: There is a risk that current capacity not being utilised effectively – particularly with regard booking patients in date order and removing patients who fail to attend. **Cause**: Booking from PTL / Process for managing DNAs **Impact**: Capacity wasteage / patients booked inappropriately.	16	Ellis Pullinger	**Controls in place**: Enhanced waiting list management, validation and review of all patients within current defined criteria **Actions**: • Launch of new Trust-wide PTL • PTL rollout to CBS and PPCs • Data Quality Dashboard tracking DNAs on a daily basis • Specialty level PTL management meetings in place
Time needed to rollout Cerner at QMH **Risk**: Trust cannot return to national reporting without an RTT compliant PAS system **Cause**: Non-RTT compliant PAS system at QMH **Impact**: The time needed to rollout Cerner at QMH will 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
Identification of patients at risk of potential harm **Risk**: There is a risk that patients maybe subject to potential harm due to the current pathway challenges **Cause**: 'Dirty' PTL, non standardised processes and the incorrect use of Cerner **Impact:** Patients at potential risk of avoidable harm	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

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**22nd February 2018**	**Agenda No.**	**4.2**
Report Title:	**M10 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 £52.9m at the end of Month 10 (January), an adverse variance to plan by £8.8m. Within the position, income is adverse to plan, which is partly offset by Pay expenditure underspend. The Trust planned to deliver £30.3m of CIPs by the end of January. To date, £30.7m of CIPs have been delivered; £10.7m of income actions and £20.0m 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 10 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:**	15/02/2018
Appendices:	None		

TB Jan 18 – Agenda item 4.2.1

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 10 (January 2018)

Chief Finance Officer

15th February 2018.

Executive Summary – Month 10 (January)

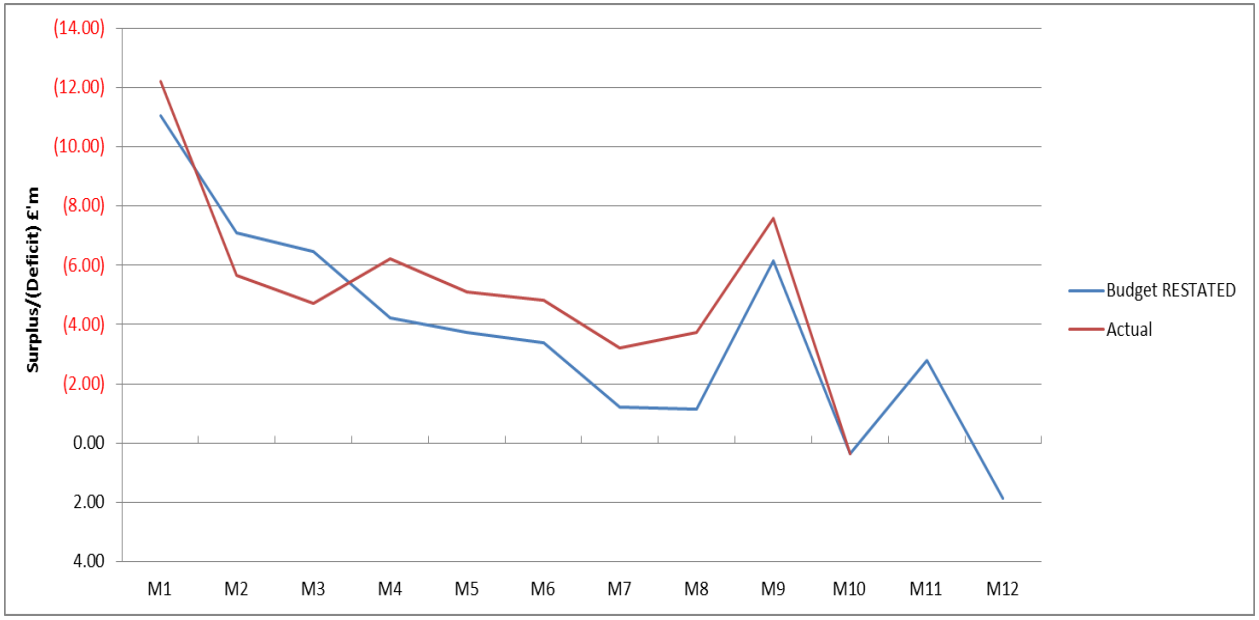
St George's University Hospitals NHS
NHS Foundation Trust

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £52.9m at the end of the January, an adverse variance to plan of £8.8m. However, the over delivery of CIPs totalling £0.4m is supporting this position. If these CIPs were excluded, the underlying position would be £9.2m 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	£8.8m Adv to plan
Income	Income is being reported at £12.8m adverse to plan year to date, with an adverse movement in month of £1.4m. Included within the month 10 results are £0.7m of income relating to prior periods. There is lower than planned income of £6.9m in Elective YTD. Exclusions income is lower by £6.0m, but is offset by reduced expenditure. Non-SLA income is also under plan by £1.0m as well, although £0.8m of this is offset in SWLP.	£12.8m Adv to plan	£11.4m Adv to plan
Expenditure	Expenditure is £4.0m favourable to plan at month 10, £1.4m favourable in month. The majority of the favourable position is in pay, £6.4m YTD, with underspends seen in Nursing, Non Clinical and ST&T categories. Non-pay is £3.9m overspent, and the main drivers being IT MSA costs, RTA bad debt and the impact of the removal of tendered community services. Post-EBITDA costs are £1.5m underspent; depreciation is causing the majority of this.	£4.0m Fav to plan	£2.6m Fav to plan
CIP	The Trust planned to deliver £30.3m of CIPs by the end of January. To date, £30.7m of CIPs have been delivered; £10.7m of income actions and £20.0m 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 £9.2m adverse position.	£0.4m Fav to plan	£0.7m Fav to plan
Capital	Capital expenditure of £36.9m has been incurred year to date. This is £4.6m 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.	£4.6m Fav to plan	£2.5m Fav to plan
Cash	At the end of Month 10, the Trust's cash balance was £3.8m, which is better than plan by £0.8m. The Trust has borrowed £50.3m YTD which is £5.1m more than plan. The Trust did not need to borrow in January but will draw down in £4.98m in February and has requested £5.1m for March. The 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.	£0.8m Fav to plan	£4.4m Fav to plan
Financial Risk Rating-Use of Resources (UOR)	At the end of January, 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 10 Financial Performance

St George's University Hospitals NHS
NHS Foundation Trust

L2 Cat	L3 Cat	M10 Budget (£m)	M10 Actual (£m)	M10 Variance (£m)	M10 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %	Full Year Budget (£m)
⊟Income	SLA Income	58.41	55.90	(2.50)	(4.3%)	561.18	549.40	(11.77)	(2.1%)	675.32
	Other Income	9.89	11.01	1.11	11.2%	96.96	95.93	(1.03)	(1.1%)	116.47
Income Total		**68.30**	**66.91**	**(1.39)**	**(2.0%)**	**658.13**	**645.33**	**(12.80)**	**(1.9%)**	**791.79**
⊟Expenditure	Pay	(39.62)	(40.00)	(0.38)	(1.0%)	(409.23)	(402.86)	6.37	1.6%	(487.80)
	Non Pay	(25.48)	(24.56)	0.92	3.6%	(264.64)	(268.53)	(3.89)	(1.5%)	(314.98)
Expenditure Total		**(65.10)**	**(64.56)**	**0.54**	**0.8%**	**(673.87)**	**(671.40)**	**2.48**	**0.4%**	**(802.77)**
⊞Post Ebitda		(2.83)	(2.00)	0.84	29.6%	(28.35)	(26.84)	1.51	5.3%	(34.02)
Grand Total		**0.37**	**0.36**	**(0.02)**	**(4.1%)**	**(44.09)**	**(52.90)**	**(8.81)**	**(20.0%)**	**(45.00)**



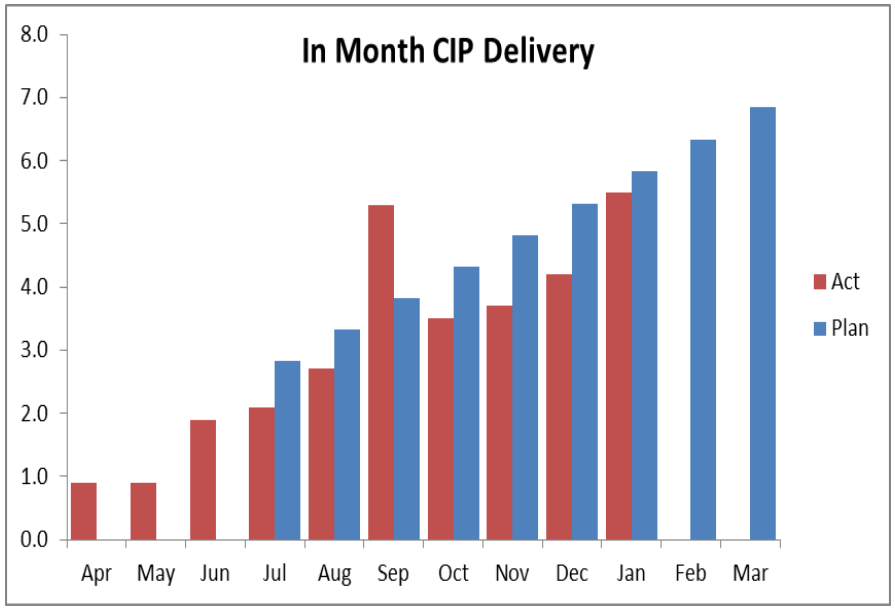
Trust Overview

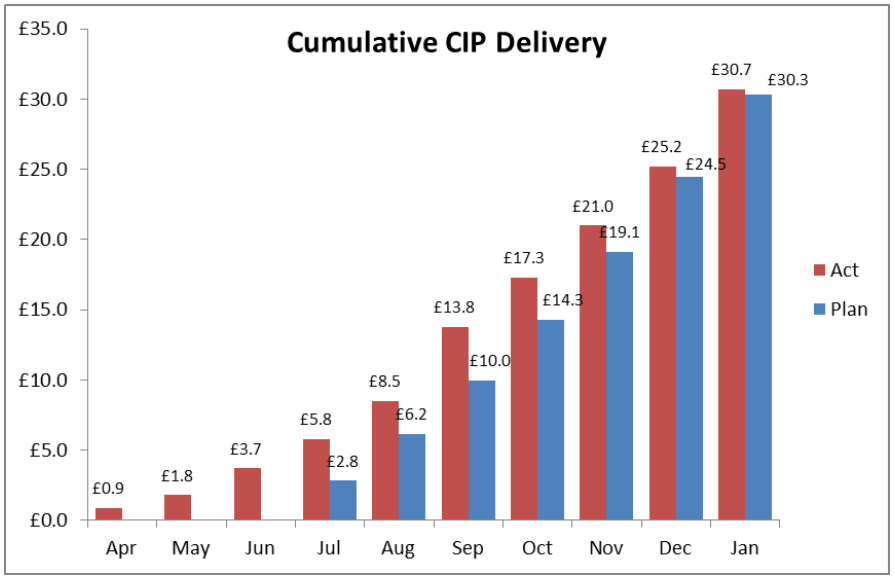
- Overall the Trust is reporting a deficit of £52.9m at the end of Month 10, an adverse variance to plan of £8.8m.
- **Income** is £12.8m adverse to plan. £6.3m of the under recovery of income is directly offset with underspends in expenditure (SLA Pass-through £5.5m, South West London Pathology £0.8m).
- **SLA Income** is £11.8m under plan, owing to shortfalls of £5.5m on pass-through, £6.9m in Elective and £4.0m higher challenges, offset by Daycase £2.5m, Outpatients of £1.8m, and £1.1m CQUIN. Smaller variances sum to £0.8m adverse. A £0.7m prior period SLA income catch-up is mainly price.
- **Other income** is under plan by £1.0m; the key driver is lower than planned private patients income (£1.2m), partially offset by other smaller variances (£0.2m favourable).
- **Pay** is £6.4m favourable, with all major staff groups underspending with the exception of medical pay. The in month position has moved adversely to budget as a result of an increasing level of CIPs being phased into the position
- **Non-pay** is £3.9m overspent, due to expenditure on the ECRP project that was budgeted within income (challenges) (£2.6m), as well as higher than planned spend in IT and Estates (£1.4m) which is forecast to come back within budget by year end, and bad debt for RTA income of £0.7m. There are other smaller variances in Non Pay that total £0.8m favourable.
- **CIP delivery** of £30.7m is £0.4m ahead of plan. If this were excluded from the reported position then the overall position would show an adverse variance to plan of £9.2m. This indicates there is overall pressure in the Trusts baseline financial position at month 10, 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 10 CIP Performance





CIP Overview

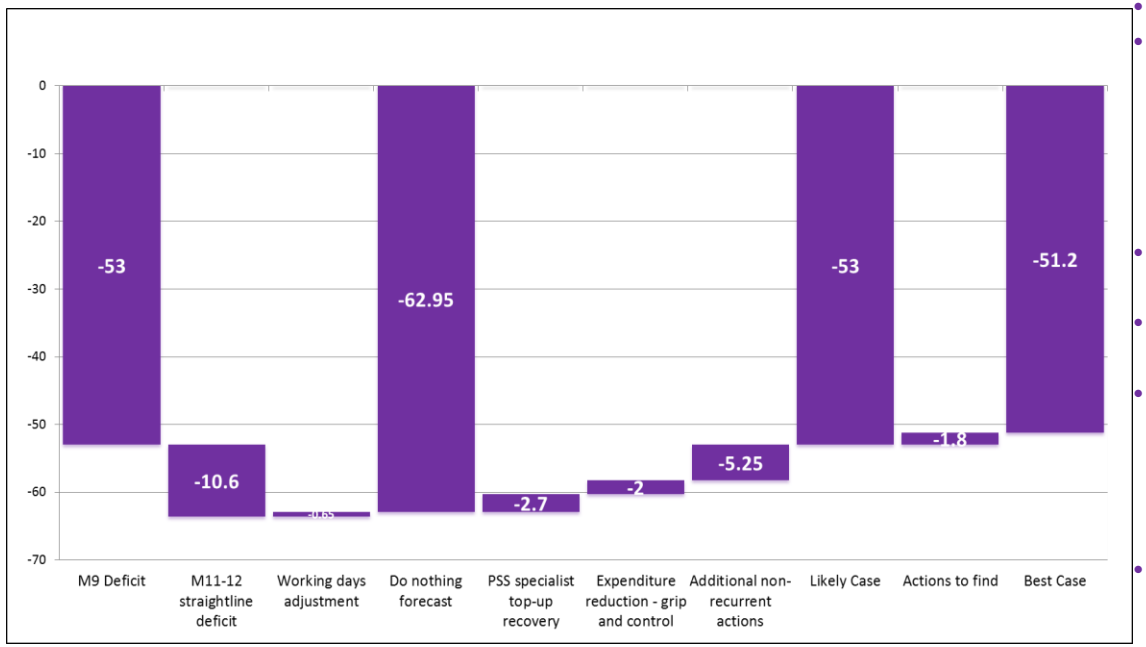
- At the end of Month 10, the Trust is reporting a cumulative delivery of £30.7m of savings from Cost Improvement Programmes (CIPs)
- 5.5m of savings were reported in January. As highlighted previously, the additional savings reported in September related to the confirmation of a number of schemes, which 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 that it's original CIPs, supported by some one off actions, deliver £43.5m of savings in 2017/18 (£47m less £3.5m contingency). This is to achieve the forecast £53m year end deficit.
- The use of some non-recurrent items, to achieve the 17/18 forecast outturn, has put pressure on the exit run rate of the Trust. Reducing the run rate in the final months must be a priority.
- Exiting the 2017/18 financial year, with a higher than planned run rate, means that the need to find savings in 2018/19 is higher than it may otherwise have been. The challenge from NHSI for the Trust to submit a 2018/19 financial plan with a deficit of less that £20m also adds to the scale of savings that are going to be required during the next financial year. Focus on the 2018-19 CIP Programme is critical.

3. 2017/18 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, only partially offset with non-elective over performance
  - Pay run rate challenges in across 3 acute divisions
- Additional expenditure control of £2m is planned, and managed through divisional run rate sessions and well as TRIG.
- £5.25m of additional non-recurrent actions are included within the forecast position to be delivered in M11 and M12.
- 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 CCGs to allow payment of this activity to the Trust.
- SWL CCGS have indicated they do not wish to agree a year end settlement for 2017/18 despite nearly reaching agreement. This could add more risk to the forecast of CCGs adopt a very aggressive approach to the year end.

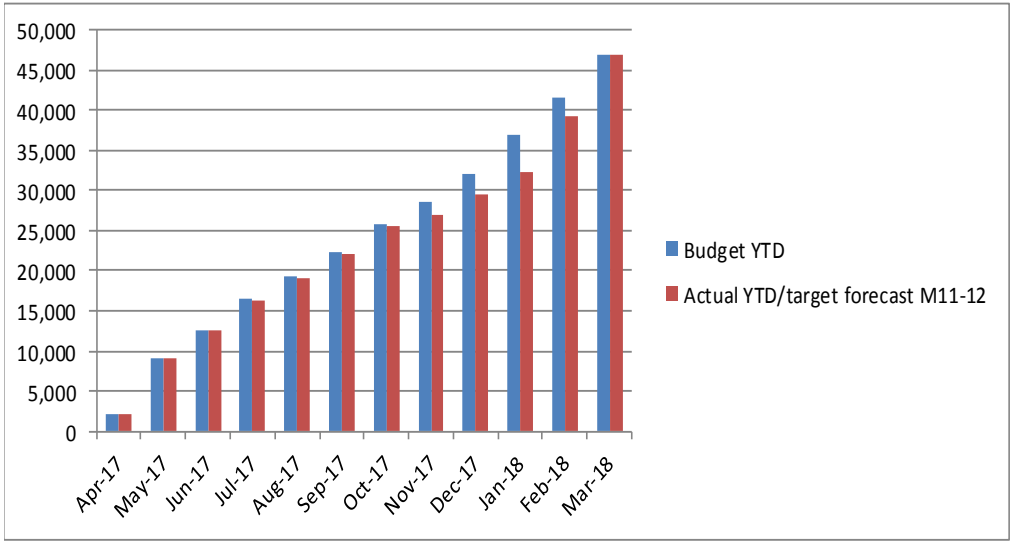
	Revised Forecast £m	Comment
Most likely	(53.0)	• Run rate pressures emerging within divisional forecasts. • PSS pressure assumed to be covered by NHSE transferring funds to CCGs. • Some non-recurrent balance sheet actions now included in position.
Best	(51.2)	• As per most likely case above. • Other gains increasingly being absorbed to hold the median case.
Worst	(64.6)	• PSS income of £7m not secured from NHSE, either directly or via CCGs. • CCGs adopt aggressive approach to year end settlement. • No further run rate pressures emerge.

4. Month 10 Capital Programme

Capital expenditure summary M10 2017/18

Spend category	2017/18 Original Budget £000	2017/18 Revised budget £000	M10 YTD Budget £000	M10 YTD actual £000	*YTD Variance vs Revised budget*
Energy Perform Contract	5,555	5,555	5,555	5,446	*109*
Infra Renewal	10,492	6,825	5,465	4,784	*681*
Med Eqpt	3,194	4,457	4,155	3,043	*1,112*
Major Projs	22,210	14,434	9,724	8,782	*942*
IMT	2,567	12,602	9,982	7,544	*2,438*
Other	601	1,634	1,424	2,302	*-878*
SWL PATH	684	684	589	420	*169*
Contingency/Headroom	1,096	776	0	0	*0*
Total	46,400	46,967	36,894	32,321	*4,573*

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



- Capital expenditure in January was £2.8m and M10 YTD expenditure is £36.9m giving rise to an under spend of £4.6m YTD against the ***revised capital budget.*** 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 completed 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 and so the Trust has revised the capital budgets 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 £12.6m compared to £2.6m per the original budget – recognising the non-receipt of the emergency DH capital allocation.
- It should be noted the M10 expenditure figure includes approx £1m of costs transferred from revenue to capital – this is subject to review in M11. Further revenue to capital transfers totalling £2m are included in the year end forecast which shows the Trust spending the budget in full by year end**. This will require total capital expenditure of £14.6m in the last two months of the year - an historically very high level of capital expenditure.**

5. Month 10 YTD Analysis of Cash Movement

CASH: Source and application of funds - cash movement analysis

	Plan	ACTUAL	*Actual*	Plan	***Forecast***	*Forecast*
	2017/18 M10 YTD £m	2017/18 M10 YTD £m	*YTD VAR £m*	2017/18 Year £m	**2017/18 *Outturn £m***	*2017/18 VAR £m*
Cash balance 01.04	5.0	6.0	*1.0*	5.0	***6.0***	*1.0*
Income and expenditure deficit	-45.1	-53.7	*-8.6*	-46.2	***-53.5***	***-7.3***
Depreciation	22.5	18.4	*-4.1*	27.0	***21.6***	***-5.5***
Interest payable	6.9	6.9	*0.0*	8.6	***8.6***	***0.0***
PDC dividend	2.8	2.6	*-0.2*	3.3	***3.1***	***-0.2***
Other non-cash items	-0.2	-0.2	*0.0*	-0.2	***-0.2***	***0.0***
Operating deficit	**-13.1**	**-25.9**	-12.9	-7.5	**-20.4**	***-12.9***
Change in stock	-0.6	-1.1	*-0.5*	0.4	***0.4***	***0.0***
Change in debtors	-11.4	1.6	*13.0*	-5.4	***15.6***	***21.0***
Change in creditors	13.4	3.7	*-9.6*	0.9	***-14.7***	***-15.6***
Net change in working capital	1.4	4.3	2.9	-4.1	**1.3**	***5.4***
Capital spend (excl leases)	-36.4	-34.1	*2.3*	-40.9	***-43.6***	***-2.8***
Interest paid	-5.8	-5.1	*0.7*	-8.0	***-7.4***	***0.6***
PDC dividend paid	-1.7	-1.7	*0.0*	-3.3	***-3.1***	***0.2***
Other	-0.3	-0.2	*0.1*	-0.4	***-0.4***	***0.0***
Investing activities	-44.1	-41.1	3.1	-52.6	**-54.5**	***-1.9***
Revolving facility - repayment						
Revolving facility - renewal						
WCF borrowing - new	45.2	50.3	*5.1*	55.8	***60.3***	***4.6***
Capital loans	16.2	16.3	*0.1*	16.2	***17.3***	***1.1***
Loan/finance lease repayments	-7.5	-6.1	*1.4*	-9.8	***-7.0***	***2.7***
Cash balance 31.03	**3.0**	**3.8**	*0.8*	3.0	**3.0**	***0.0***

M01-M10 YTD cash movement

- The cumulative M10 I&E deficit is £53.7m* – £8.6m worse than plan. (*this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £53.7m, depreciation (£18.4m) does not impact cash. The charges for interest payable (£6.9m) and PDC dividend (£2.6m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £25.9m.
- The operating variance from plan of £12.9m in cash is in part attributable to the lower depreciation charge.
- Working capital performed better than plan.
- Capital spend is £2.3m lower than plan due to the re-forecasting exercise deferring spend to the last quarter.
- The Trust has borrowed £50.3m YTD which is £5.1m more than plan. The Trust did not need to borrow in January but will draw down in £4.98m in February and has requested £5.1m for March. The 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.

Year end cash position

- **The year end cash position is dependent on securing the £5.1m borrowing requested for March and receipts from overdue debt recovery – please see the separate Borrowings paper which provides a number of scenario cash flow forecasts and the contingency measures which may need to be implemented.**

6. Balance Sheet as at Month 10 2017/18

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department
Balance sheet JANUARY 2018

	Mar-17 Audited £000	Jan-18 Plan £000	Jan-18 Actual £000	*YTD Variance £000*	Explanations of balance sheet variances
Fixed assets	335,834	350,106	349,873	*-1,240*	Lower capital exoenditure on new assets than plan
Stock	6,575	7,155	7,676	*-1,061*	Main targets agreed to reduce adverse YTD variance by year end
Debtors	101,837	113,256	100,202	*13,996*	Debt lower than plan but overdue debt higher than M08 Debt Redn Plan target
Cash	6,022	3,000	3,793	*-793*	Higher opening cash than plan and capital under spend YTD.
Creditors	-118,305	-130,653	-122,045	*-9,815*	Higher levels of creditor payments.
Capital creditors	-5,284	-2,284	-2,946	*662*	Timing of payments has reduced capital creditors at M10 (EPC now complete).
PDC div creditor	0	-1,128	-934	*328*	
Int payable creditor	-259	-1,344	-2,028	*681*	Borrowing higher due to higher deficit than plan.
Provisions< 1 year	-335	-335	-335	*0*	
Borrowings< 1 year	-55,206	-57,300	-56,896	*-250*	Lower value of finance leases - some leases extended rather than renewed
Net current assets/-liabilities	**-64,955**	**-69,633**	**-73,514**	*3,748*	
Provisions> 1 year	-988	-688	-781	*33*	
Borrowings> 1 year	-164,524	-219,516	-223,878	*12,011*	Borrowing higher due to higher deficit than plan.
Long-term liabilities	**-165,512**	**-220,204**	**-224,659**	*12,044*	
Net assets	**105,367**	**60,269**	**51,700**	*14,552*	
Taxpayer's equity					
Public Dividend Capital	129,956	129,956	129,956	*0*	
Retained Earnings	-114,843	-159,941	-168,435	*14,477*	Higher I&E deficit than plan
Revaluation Reserve	89,103	89,103	89,029	*74*	
Other reserves	1,150	1,150	1,150	*0*	
Total taxpayer's equity	**105,367**	**60,269**	**51,701**	*14,551*	

7. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M10 YTD)	Actual (M10 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 January, 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 (8.20%) minus planned % I&E deficit (6.70%). This value is -1.50% 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 £56.1m, £3.2m worse than the current YTD deficit.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**22nd February 2018**	**Agenda No.**	**5.1**
Report Title:	ICT Report		
Lead Director/ Manager:	Andrew Grimshaw, CFO		
Report Author:	Larry Murphy, CIO		
Presented for:	Update		
Executive Summary:	This paper provides an update for the Trust Board on the work being undertaken to ensure there is clarity about the current operation and improvement actions in relation to the Trust ICT. The paper will cover; • Trust Board Seminars on ICT • ICT risk register development. • Governance arrangements to support the effective management of ICT		
Recommendation:	The Board is asked to note this paper.		
Supports			
Trust Strategic Objective:			
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 12: Our IT systems**		
Legal/Regulatory:	Supporting safe clinical operations and compliance with information governance requirements.		
Resources:	Capital investment required		
Previously Considered by:	ICT Risks considered by the Finance & Investment Committee	**Date:**	15/02/2018
Appendices:	None		

St George's University Hospitals NHS
NHS Foundation Trust

Trust Board

ICT Report

February 2018

1 PURPOSE

1.1 This paper provides an update for the Trust Board on the work being undertaken to ensure there is clarity about the current operation and improvement actions in relation to the Trust ICT. The paper will cover;

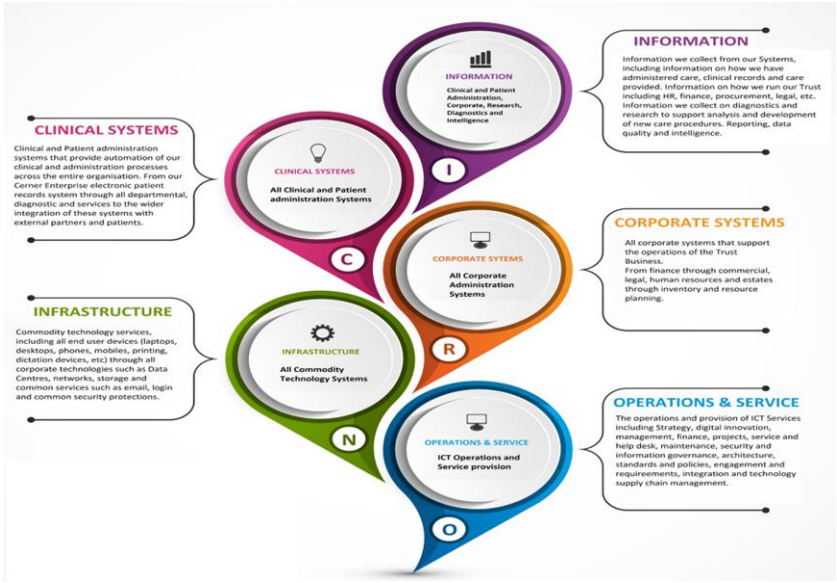
- Trust Board Seminars on ICT
- ICT risk register development.
- Governance arrangements to support the effective management of ICT.

2 DEVELOPING AN ICT STRATEGY: TRUST BOARD SEMINARS

2.1 The Trust Board is holding a range of seminars in order to help develop a clear, deliverable ICT Strategy that is visible to and supported by the organisation. The strategy will identify a target ICT operating model together with the path to deliver that. The Strategy will take 3-6 months to develop to ensure it is both complete, as well as being understood and owned across the organisation – this will require active engagement with staff across the Trust.

2.2 An initial Board seminar was held in November 2017 to help ensure the Trust Board had a clear and agreed view of the current condition of the Trust's ICT environment. The seminar was attended by the majority of the Board and was chaired by the Trust Chair.

2.3 The seminar was structured around five pillars of ICT as illustrated in the following chart.



2.4 The seminar focused on three of the five pillars, Infrastructure, Clinical Systems and Operations and Service. The focus was on these three to ensure sufficient time to review each area. The remaining two pillars, Corporate systems and Information will be addressed in a second seminar on 19th February 2018.

2.5 The outcome of the first seminar has helped to inform a risk assessment of the ICT environment and associated actions to address these risks. Following the February seminar a detailed action plan of immediate actions will be agreed and presented to Part 2 of the February 22nd Trust Board, together with a timeline for the development of the full ICT Strategy.

3 RISK ASSESSMENT SUMMARY

3.1 The Trust Board has identified one strategic risks in relation to ICT, this is included in the Board Assurance Framework and summarised below.

Strategic Risk		Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
		Q1	Q2	Q3	Q4				
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.	Chief Information Officer (CIO)	Finance and Investment Committee	20

3.2 In support of this strategic risk the ICT Department has developed a detailed risk assessment across the five key pillars of ICT as outlined in the Board seminar:

- Infrastructure
- Clinical Systems
- Corporate Systems
- Information & Knowledge
- Service & Operations.

3.3 The work to date has identified 31 risks. The table below provides a summary of the current risk scores. This is continually changing as further information is uncovered and mitigation continues:

Pillar	Red (15-25)	Amber (8 – 12)	Green	Total
Infrastructure	5	4	3	12
Clinical Systems	5			5
Information & Knowledge	3	5		8
Corporate Systems	3	2		5
ICT Operating Model	1			1
TOTAL	17	11	3	31

Table 1 - Current Risk Position

3.4 The detailed risk assessments have been presented to and discussed at to both the Trusts Finance and Information Committee and Risk Management committee. The level of and number of risks identified illustrates the need for urgent and immediate mitigation. Action plans are being developed to ensure that risk levels can be reduced to more acceptable levels, and where necessary immediate actions have been taken to ensure the continuation of safe operations. None of the red risks score 25.

3.5 As previously reported to the Trust Board additional capital resources have been made available to the ICT department to support improvement actions. Work continues to seek further funding from NHSI to expand and speed up this activity.

4 GOVERNANCE ARRANGEMENTS FOR ICT

4.1 The Trust has established an Information Governance Group (IGG) to lead the work to improve the Trusts ICT environment. The IGG is chaired by the Chief Finance Officer, and the membership includes the Chief Clinical Information Officer, the Medical Director, Chief Information Officer, the Chief Operating Officer and the Director of Efficiency and Transformation.

4.2 The work of the IGG has been organised around the five pillars of ICT outlined above. Terms of Reference have been developed to support this and the IGG will report to the Trust Executive Committee.

4.3 The Trust will be moving to appoint a permanent Chief Information Officer over the next 3-4 months. Where necessary, additional capacity has been engaged to support improvement in the ICT department.

4.4 The IGG will work to develop the ICT Strategy. Progress against this will be reported to future meetings of the Trust Board – the development of the Strategy is a specific focus of the February Trust Board Seminar.

5 SUMMARY

5.1 The Trust Board is requested to note this paper.

5.2 A summary of the actions from the Trust Board ICT seminar on the 19th February will be presented to the Trust Board (part 2) on the 22nd February.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board Meeting		
Date:	22 February 2018	**Agenda No.**	**6.1**
Report Title:	Committee Terms of Reference		
Lead Director/ Manager:	Michael Wuestefeld-Gray, Interim Trust Secretary		
Report Author:	Michael Wuestefeld-Gray, Interim Trust Secretary		
Presented for:	Approval		
Executive Summary:	As part of changes to the structure of Board Committees agreed by the Board at its meeting of 9 November 2017 all committees of the Board are reviewing and updating their terms of reference. The first four of these reviews are complete and the terms of reference of the following committees are attached: • Audit Committee (approved at the Audit Committee meeting of 15 November 2018) • Finance and Investment Committee (approved at the Finance and Investment Committee meeting of 29 November 2017) • Quality and Safety Committee (approved at the Quality and Safety Committee meeting of 29 November 2017) The next steps with other committee terms of reference are: • The Trust Executive Committee terms of reference have been drafted and subject to final amendments will come to the Board in March or April, depending on deadlines. • The Workforce and Education Committee terms of reference have been drafted and subject to final amendments will come to the Board in March or April, depending on deadlines. • The Nominations and Remuneration Committee terms of reference are due for review in March 2018, and thought they may not require any changes the timing of this review means including those terms of reference in the next group for approval by the Board appropriate.		
Recommendation:	The Board is asked to approve the attached terms of reference.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well led)		

Implications			
Risk:	Without appropriate terms of reference there is a risk that the Trust may not have effective decision making structures which could result in either poor decisions being taken, or a delay to decisions being taken with a consequent impact on operational, quality or financial standards.		
Legal/Regulatory:	The Audit Committee and Nominations and Remuneration Committee are statutory committees; and the activity of all committees must support and assure compliance with the Trust's licence; Constitution; and standing orders.		
Resources:	No additional resources are required for the implementation of these terms of reference		
Previously Considered by:	• Audit Committee • Finance and Investment Committee • Quality and Safety Committee	**Date:**	• 15/11/17 • 29/11/17 • 29/11/17
Appendices:	1. Audit Committee Terms of Reference 2. Finance and Investment Committee Terms of Reference 3. Quality and Safety Committee Terms of Reference		

Audit Committee Terms of Reference and Annual Cycle of Business

Audit Committee

Terms of Reference

1. NAME

Audit Committee.

2. AUTHORITY

Establishment: The Audit Committee has been established as a Committee of the Trust Board. It is a statutory Committee as set out in the NHS Act 2006 (as amended) and is accountable to the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

Powers: The Audit Committee is authorised by the Board of Directors to:

i. investigate any activity within its terms of reference.
ii. seek any information it requires and all staff are required to cooperate with any request made by the Committee.
iii. request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: This is a standing, statutory Committee. Such a Committee can only be disbanded or its remit amended on the authority of the Board.

3. PURPOSE OF THE GROUP

The Audit Committee (the Committee) shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance. The Committee shall also review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.

4. DUTIES OF THE GROUP

The Audit Committee will discharge the following duties on behalf of the Board:

Governance, Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

1. Review the risk and control related disclosure statements prior to endorsement by the Board; this shall include the Annual Governance Statement, Head of Internal Audit opinion, External Audit opinion and/or other appropriate independent assurances.
2. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.

3. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's corporate objectives.
4. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks; this shall include Clinical Audit programme overseen by the Trust's Quality & Safety Committee.
5. Review the adequacy and effectiveness of policies and procedures:
   a. by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern
   b. to ensure compliance with relevant regulatory, legal and conduct requirements.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

1. Review and approve the Internal Audit Strategy and annual Internal Audit Plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework).
2. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring co-ordination between the work of internal audit and external audit to optimise audit resources.
3. Conduct a regular review of the effectiveness of the internal audit function.
4. Periodically consider the provision, cost and independence of the Internal Audit service.

External Audit

The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular the Committee shall:

1. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the annual plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
2. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board;.
3. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
4. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.

The Committee shall also work with the Council of Governors on the appointment or retention of the External Auditors.

Financial Reporting and Accounts Review

The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. The Committee shall review financial reporting through the year and the financial statements and annual report before submission to the Board, particularly focusing on:

1. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
2. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
3. Changes in, and compliance with, accounting policies, practices and estimation techniques.
4. The meaning and significance of the figures, notes and significant changes.
5. Areas where judgement has been exercised and any qualitative aspects of financial reporting.

6. Explanation of estimates or provisions having material effect.
7. The schedule of losses and special payments, ensuring these have received appropriate approval.
8. Any unadjusted (mis)statements.
9. Significant adjustments arising from the audit.
10. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
11. The Letter of Representation.

In line with the Trust's Scheme of Delegation (sections 11.1 and 11.2) the Committee shall also monitor the integrity of the Trust's financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them, to ensure the completeness and accuracy of information provided to the Board.

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

1. Adequate measures to comply with the Directions to NHS Bodies and Special Health Authorities respect of Counter Fraud 2017.
2. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
3. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions.

Raising Concerns

The Committee shall review arrangements that allow staff of the Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that:

1. there are systems in place that allow individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations.
2. arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
3. concerns are promptly addressed.
4. safeguards for those who raise concerns are in place and operating effectively.

Governance Manual

1. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
2. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
3. Review the schemes of delegation and authority.
4. Review compliance against the Constitution, Licence and Code of Governance.

Management

The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control

and may also request specific reports from individual functions within the Trust as necessary.

Annual Work Plan and Committee Effectiveness

Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

5. COMMITTEE CHAIR AND COMMITTEE EXECUTIVE LEAD

A Non-Executive Director will chair the Audit Commitee and his/her absence, an individual to be nominated by the remaining members of the Committee will take the chair.

The Chief Financial Officer and Trust Secretary will be the Executive Leads for the Audit Committee.

6. COMPOSITION OF MEMBERSHIP

This is a Non-Executive Director Committee and the following individuals will be the members. Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting.

Name	Title	Role in the Group
Sarah Wilton	Non-Executive Director	Committee Chair
Ann Beasley	Non-Executive Director	Member
Tim Wright	Non-Executive Director	Member

7. ATTENDANCE

The following individuals are not members of the group with full rights and are instead expected to be in attendance for the purpose outlined below:

In Attendance - Trust		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec
Robert Flanagan	Director of Financial Operations	DFO
Andrew Grimshaw	Chief Financial Officer	CFO
Pauline Lewis	Head of Counter Fraud	HCF
Elizabeth Palmer	Director for Quality Governance	DQG
Harbhajan Brar	Director of Human Resources & Organisation Development (for matters relating to raising concerns)	DHROD
Jacqueline Totterdell	Chief Executive (for Annual Report, Annual Governance Statement & Accounts approval)	CEO
In Attendance - Audit		
Paul Dossett	External Audit - Head of Public Sector Assurance, Grant Thornton	EA
Jamie Bewick	External Audit – Senior Manager, Grant Thornton	EA
Tom Slaughter	External Audit – Assistant Manager, Grant Thornton	
Kevin Limn	Internal Audit – Director, TIAA	IA
Ashley Norman	Internal Audit – Director of Audit, TIAA	IA
Secretariat		
Richard Coxon	Membership & Engagement Manager	MEM

In addition, it is expected that Executive Directors who have Internal Audit reports on areas within their purview which have an opinion of Limited Assurance, shall attend the Audit Committee meeting at which the final report is presented.

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

In addition to anyone listed above as an attendee, at the discretion of the Chair, the Committee may also request individuals to attend on an ad-hoc basis to provide advice in support of specific items.

8. QUORACY

The quorum for any meeting of the Audit Committee shall be the attendance of a minimum of two members.

Non-Quorate Meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting.

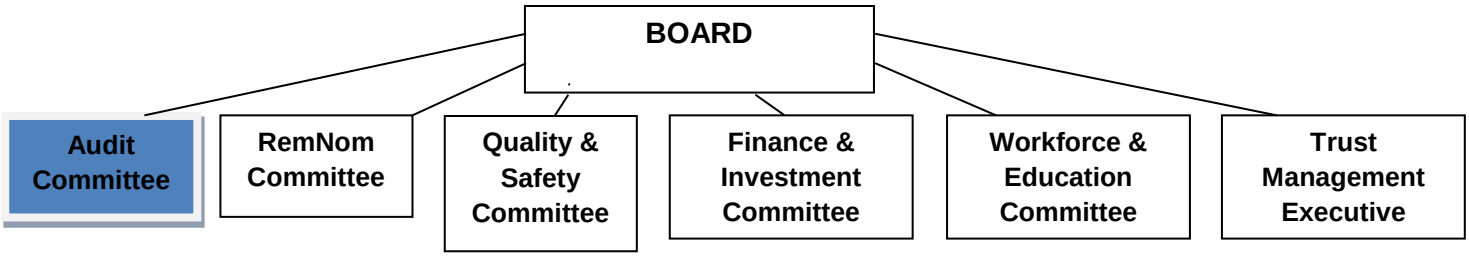
9. DECLARATION OF INTERESTS

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

10. MEETING FREQUENCY

Meetings of the shall be held five times a year, usually on the second Thursday of the month.

11. RELATIONSHIP WITH OTHER COMMITTEES



12. MEETING ARRANGEMENTS / SECRETARIAL

i. An annual schedule of meetings of the Audit Committee shall be established prior to the start of each financial year;
ii. The Trust Secretary will arrange secretarial support for the Audit Committee. This will include taking accurate minutes, producing an action log and issuing and following up actions.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair, Executive Lead and Trust Secretary.
iv. All papers and reports to be presented at the Audit Committee must be submitted as final Executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days ahead of the meeting.

13. AGENDA AND FORWARD CYCLE OF BUSINESS

Standing Agenda Items

i. Apologies.
ii. Minutes/Action Notes of the Previous Meeting.
iii. Matters Arising and Action Log.
iv. Declarations of Interest.
v. Reflection on Meeting Effectiveness.

Annual Cycle of Business

An Annual Cycle of items and reports to be received by the Committee is included at Appendix 1 of this Terms of Reference. This shall be used to set the agenda for each meeting.

The Annual Cycle shall be reviewed annually prior to the start of the financial year.

14. REVIEW OF TERMS OF REFERENCE

These Terms of Reference shall be subject to an annual, scheduled review as set out on the Annual Cycle. This review should consider the performance of the Audit Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned cycle of business.

MEETINGS FROM JANUARY 2018 – MARCH 2019

Date and Time	Venue
11.08.18, 14:00 – 17:00	GVR2.19
12.04.18, 14:00 – 17:00	GVR2.19
17.05.18, 14:00 – 17:00 (Accounts Workshop)	GVR2.19
21.05.17 Annual Report & Accounts Approval	GVR2.19
12.07.18, 14:00 – 17:00	GVR2.19
11.10.18, 14:00 – 17:00	GVR2.19
10.01.19, 14:00 – 17:00	GVR2.19
14.03.19, 14:00 – 17:00	Room TBC

St George's University Hospitals NHS
NHS Foundation Trust

Finance & Investment Committee

Terms of Reference

1. NAME

Finance & Committee (FIC).
This Committee was previously known as the Finance & Performance Committee.

2. AUTHORITY

Establishment: The FIC has been established as a Committee of the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

Powers: The FIC is authorised by the Board of Directors to:

i. investigate any activity within its terms of reference
ii. seek any information it requires and all staff are required to cooperate with any request made by the FIC
iii. request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: There will always be a standing Committee of the Board with responsibility for Finance though the name, purpose and remit may change from time to time. Such a Committee can only be disbanded on the authority of the Board.

3. PURPOSE OF THE COMMITTEE

The Committee has been established to assist the Trust maximise its healthcare provision subject to its financial constraints. In its thinking, the Committee considers patient safety to be of paramount importance. It achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensure:

i. detailed consideration is given to the Trust's financial, investment and associated performance issues to ensure that the Trust uses public funds wisely; and
ii. by ensuring that adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies and achievement of the Trust's strategic aims and objectives;
iii. the impact of operational performance against the Trust's financial position is closely monitored.

This Committee will monitor the effectiveness of measures to tackle Financial Special Measures and return the Trust to a position of financial and run rate balance.

4. DUTIES OF THE COMMITTEE

The following comprise the FIC's main duties as delegated by the Board of Directors:

Financial and Business Planning

1. Consider the content of, planning assumptions and principles underpinning the Annual Plan and Long Term Financial Model prior to submission to the Board for approval.
2. Agree the size and allocation of the Capital Programme as part of the budget setting process.
3. Approve the process for the submission of the National Reference Cost Return prior to

submission and review the results.

4. Regularly review Patient Level Costing reports to understand efficiency, productivity and profitablility by service line, workforce group etc.

Financial Strategy and Management

1. Review financial performance and forecast against income, expenditure, working capital and capital and seek assurance that the position is in line with approved plans, targets and milestones and that any corrective measures that are being taken are effective.
2. Review all significant financial risks and measure the Trust's financial risk rating using the scoring metrics in the Single Oversight Framework.
3. Recommend the Managing Operating Cash Policy to the Board, receive reports in accordance with the Managing Operating Cash Policy and approve institutions.
4. Review arrangements for effective compliance reporting in respect of loan covenants in place or other requirements relating to borrowed funds..

Contract Management

1. Review the Trust's negotiating position prior to annual contracting round with commissioners.
2. Review financial and performance activity against contracts and if corrective action is required, be assured that the measures being taken are effective.
3. Consider any tender opportunities with an annual income value exceeding £1m.

Procurement

1. Oversee the implementation of the Trust's Procurement Strategy.
2. Receive an annual report in respect of the Annual Procurement Plan.

Business Cases, Benefits Realisation and Return on Investment

On behalf of the Board:

1. undertake a robust appraisal of new business cases and re-investment business cases valued at over £1m, ensuring that the outcomes and benefits are clearly defined, measurable, support the delivery of key objectives for the Trust and that they are affordable.
2. review benefits realisation and return on investment of major projects.

Capex

1. Consider any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.
2. Review the Medical Equipment Strategy and assurances around the Medical Equipment Replacement programme.
3. Monitor the implementation of the Trust's Information Technology strategy and Estates Strategy.
4. Consider any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy and recommend to the Board.
5. Review the Trust's arrangements for facilities management.

Transformation and Cost Improvement

1. Seek assurance on the arrangements to ensure delivery of the Cost Improvement Programme and income growth, including monitoring performance against plan and any proposed in-year changes.

Risk

1. On behalf of the Board, the Committee shall regularly scrutinise the Trust's significant risks in relation to finance, satisfying itself of the adequacy of the controls in place to mitigate the risks.

General Governance

1. To consider matters referred to the FIC by the Board or by the groups which report to it
2. Every year, to set an annual Work Plan and conduct a review of the Committee's effectiveness (including the achievement of the Work Plan and a review of the Committee terms of reference) and report this to the Board
3. To ensure a system is in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.
4. As required, to review any relevant Trust strategies relevant to the Committee's terms of reference (eg those associated with procurement) prior to approval by the Board (if required) and monitor their implementation and progress.

5. COMMITTEE CHAIR AND COMMITTEE EXECUTIVE LEAD

A Non-Executive Director will chair the FIC and in his/her absence, an individual to be nominated by the remaining members of the Committee will take the chair.

The Chief Financial Officer will be the Executive Lead for FIC.

6. COMPOSITION OF THE COMMITTEE MEMBERSHIP

The following individuals will be members of the group with full rights. Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting.

Name	Title	Role in the group
Ann Beasley	Non-Executive Director	Committee Chair
Stephen Collier	Non-Executive Director	Member
Sarah Wilton	Non-Executive Director	Member
Andrew Grimshaw	Chief Financial Officer	Member
Andy Rhodes (acting)	Medical Director	Member
Avey Bhatia	Chief Nurse & Director of Infection Prevention Control	Member

ATTENDANCE

The following individuals are not members of the group with full rights and are instead expected to be in attendance for the purpose outlined below:

Name	Title	Attendance Guide
Michael Armour	Head of Financial Reporting	Every Meeting
Fiona Barr	Trust Secretary & Head of Corporate Governance	Every Meeting
Harbhajan Brar	Director of HR & OD	Every Meeting
Robert Flanagan	Director of Financial Operations	Every Meeting
James Friend	Director of Delivery, Efficiency & Transformation	Every Meeting
Richard Hancock	Director of Estates & Facilities	Every Meeting

Name	Title	Attendance Guide
Larry Murphy	Chief Information Officer	Every Meeting
Ellis Pullinger	Chief Operations Officer	Every Meeting
Tom Shearer	Director of Financial Planning	Every Meeting

Senior representatives from each of the Trust's Divisions, eg Divisional Chair or Divisional Director of Operations, will attend each meeting.

Whilst the Trust is in Financial Special Measures the NHS Improvement Financial Improvement Director will be a regular attendee.

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

In addition to anyone listed above as a member or attendee, at the discretion of the chairperson the group may also request individuals to attend on an ad-hoc basis to provide advice in support of specific items.

Governors shall be invited to attend the meeting.

7. QUORACY

The quorum for any meeting of the FIC shall be the attendance of a minimum of three members including at least one Executive, two Non-Executives (one of whom shall be the Chair).

Non-quorate meetings: Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting.

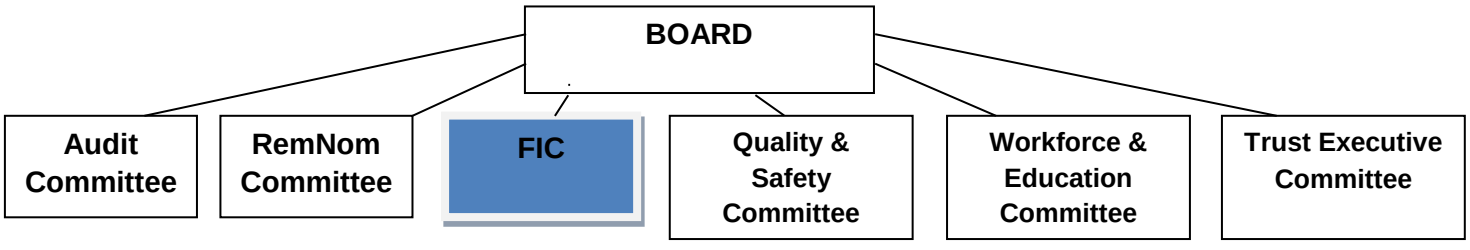
8. DECLARATION OF INTERESTS

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

9. MEETING FREQUENCY

Meetings of the FIC shall be held monthly, one week before the Board.

10. RELATIONSHIP WITH OTHER COMMITTEES



11. MEETING ARRANGEMENTS / SECRETARIAL

i. An annual schedule of meetings of the FIC shall be established prior to the start of each financial year;
ii. The Trust Secretary will oversee secretariat support for the FIC. This will include taking accurate minutes, producing an action log and issuing and following up actions.

iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair, Executive Lead and Trust Secretary.
iv. All papers and reports to be presented at the FIC must be submitted as final Executive approved reports on the Tuesday before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days of the meeting.

12. ANNUAL CYCLE OF BUSINESS AND AGENDA PLANNING

An Annual Cycle of Business setting out the items and reports to be received by the Committee is included at Appendix 1 of this Terms of Reference. This should be referred to when setting the agenda for this Committee. This also sets out the Standing Agenda Items for the Committee.

The forward cycle of business will be reviewed, along with these Terms of Reference, on an annual basis prior to the start of the financial year.

13. REVIEW OF TERMS OF REFERENCE

These Terms of Reference shall be subject to an annual, scheduled review as set out on the Annual Cycle of Business at Appendix 1. This review should consider the performance of the FIC including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business.

APPENDIX 1

MEETINGS FROM JANUARY 2018 – MARCH 2019

Date and Time (Every Thursday before Board)	Venue
18.01.18, 10:00-13:00	Room GVR2.20
15.02.18, 10:00-13:00	Room GVR2.20
22.03.18, 10:00-13:00	Room GVR2.20
19.04.18, 10:00-13:00	Room GVR2.19
24.05.18, 10:00-13:00	Room GVR2.19
21.06.18, 10:00-13:00	Room GVR2.19
19.07.18, 10:00-13:00	Room GVR2.19
23.08.18, 10:00-13:00	Room GVR2.19
20.09.18, 10:00-13:00	Room GVR2.20
18.10.18, 10:00-13:00	Room GVR2.19
22.11.18, 10:00-13:00	Room GVR2.19
13.12.18, 10:00-13:00	Room GVR2.19
24.01.19, 10:00-13:00	Room GVR2.19
21.02.19, 10:00-13:00	Room GVR2.19
21.03.19, 10:00-13:00	Room GVR2.19

Annual Cycle of Business for the Finance & Investment Committee

Theme		Action/Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		Month reported	**(12)**	**(01)**	**(02)**	**(03)**	**(04)**	**(05)**	**(06)**	**(07)**		**(09)**	**(10)**	**(11)**
Financial Performance	1	Review financial performance (integrated finance report to include SoCI, SoP, Cashflow).	X	X	X	X	X	X	X	X	X	X	X	X
	2	Capital expenditure Programme.	X	X	X	X	X	X	X	X		X	X	X
	3	Financial Recovery Board	X	X	X	X	X	X	X	X	X	X	X	X
	4	Income and Expenditure Forecast.			X		X		X			X	X	X
Financial Planning and Investment	5	Financial Planning and the annual planning	X				X	X		X	X	X	X	X
	6	Long Term Financial Model: review		X			X			X		X		X
	7	Material Business Cases in support of the Trust Strategy												
	8	Review the Investment Strategy						X						
Financial Governance	10	Review of assurances around the financial control environment	X			X			X			X		
	11	Set Annual Workplan for the Committee												X
	12	Review the range and quality of financial information provided to the Committee		X						X				
	13	Review Financial Policies			X							X		
	14	Technical Releases and publications				X						X		
	15	Self-assessment of the Committees performance											X	
Other associated issues	16	Procurement Report	X			X			X			X		

Standing Items for All Committee Meetings

Opening Administration	Items at Every Meeting	Closing Administration
Apologies Declarations of Interest Minutes Matters Arising & Action Log	Reports from other groups Action Plans arising from Reviews or Investigations (as required) Review of Risks Allocated to the Committee Internal Audit Reports	New Risks or Issues Items for Escalation or Control Issues to Audit Committee Comments/Observations from Governors Report to the Board Forward Plan for Next Meeting Reflection on Meeting

St George's University Hospitals NHS
NHS Foundation Trust

Quality & Safety Committee

Terms of Reference

1. NAME

Quality & Safety Committee (QSC)
This Committee was previously known as the Quality Committee and before that the Quality & Risk Committee.

2. AUTHORITY

Establishment: The QSC has been established as a Committee of the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

Powers: The QSC is authorised by the Board of Directors to:

- investigate any activity within its terms of reference
- seek any information it requires and all staff are required to cooperate with any request made by the QSC
- request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: There will always be a standing Committee of the Board with responsibility for Quality though the name, purpose and remit may change from time to time. Such a Committee can only be disbanded on the authority of the Board.

3. PURPOSE OF THE GROUP

The QSC functions as the Trust's umbrella clinical and quality governance Committee. It enables the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to enable it to deliver a quality service according to each of the dimensions of quality set out in *High Quality Care for All* and enshrined through the Health & Social Care Act 2012:

- **Safety** – achieving high and improving levels of patient and staff safety and identifying, prioritising and managing risk arising from the delivery of clinical care.
- **Clinical Effectiveness** – consistently achieving good clinical outcomes and high levels of productivity through evidence-based clinical practice.
- **Patient Experience** – promoting safety and excellence to deliver an excellent patient experience as measured by direct interaction with, and feedback from, those using the Trust's services.

It particularly supports the following Trust strategic objectives:

i. The patient, treat the person
ii. Right care right place, right time
iii. Development tomorrow's treatments today

4. DUTIES OF THE GROUP

The QSC will discharge the following duties as delegated by the Trust Board:

Performance Against Quality Measures

i. To undertake a thorough review of the Trust's performance against quality and safety measures, undertaking deep dive reviews on any areas of concern.

ii. To monitor performance against the Quality Improvement Plan and consider any changes to the plan in light of new priorities or other factors.

iii. To scrutinise the Trust's arrangements for responding to the Enforcement Actions and Licence Conditions which gave rise to the Trust being placed in Quality Special Measures. Monitor the progress against the Trust's plans to return to a position of regulatory compliance in respect of Quality.

iv. To receive a regular report from the Trust's Clinical Governance Committee.

Evidence-Based Clinical Practice

i. To receive assurance on action taken to improve mortality rates as part of the Trust's mortality review process.

ii. To ensure there is a well-functioning and effective process for considering and implementing guidance from the National Institute for Health and Clinical Excellence (NICE) and National Service Frameworks, recommendations from the National Confidential Enquiry national audits and responding to National Patient Safety Agency (NPSA) Alerts.

iii. To receive assurance in respect of the delivery of any action plans arising from reviews or investigations into safety and or quality by healthcare regulators, inspectorates, accrediting bodies or Royal Colleges.

Compliance

i. To monitor compliance with the Care Quality Commission's (CQC) fundamental standards and oversee any remedial action required.

ii. To undertake an annual "deep-dive" review into the work of each Division to review performance against:
- Fundamental Standards
- Quality Indicators

iii. To receive regular reports on the Trust's infection control arrangements and receive assurance on remedial measures taken to handle any outbreak of infection.

iv. To receive regular reports on the Trust's compliance with Safeguarding requirements and matters concerning Deprivation of Liberty and Mental Capacity Act.

v. To receive recommendations on the Trust's annual Quality Account priorities and monitor their in-year progress.

vi. To monitor any relevant submissions to NHS Improvement.

Audit

i. To receive the annual Clinical Audit Programme and ensure that it is in line with the audit needs of the Trust prior to commending it for approval by the Board. Monitor its in-year progress including actions taken to address audit concerns.

ii. To make recommendations concerning the annual programme of Internal Audit work to the extent that it applies to matters within the remit of the QSC and consider the major findings of quality related internal audit reports (including the management response).

Research and Development

i. To ensure the Trust has an effective Research and Development strategy in place and produces an annual Research and Development Report to the Trust Board.

ii. To review governance arrangements for Research and Development activity within the Trust including clinical ethics.

Learning when Things Go Wrong

i. To review the risks allocated to the QSC from the Board Assurance Framework and receive assurance that actions are in place to effectively manage and control the risks identified.

ii. To ensure there are clearly defined and well understood processes for escalating safety and quality issues and meeting the Trust's obligations in respect of duty of candour with patients and families.

iii. To undertake regular "deep dive" reviews into Serious Incidents (SIs) and Complaints to receive assurance that changes in Trust practice have been made and sustained, and that the lessons learned have been widely disseminated throughout the Trust.

iv. To consider regular reports identifying the trends and themes arising from claims, litigation, incidents (including SIs) and complaints and the management actions being taken to reduce risks and learn lessons.

Patient Experience

i. To review the Trust's arrangements for managing complaints and Patent Advice & Liaison Service contacts.

ii. To ensure the Trust has an effective system for patient feedback (including Friends and Family Test, patient environment and amenities) and patient involvement.

iii. To undertake a review of the findings of any national patient surveys including any relevant action plans.

iv. To consider and review any issues relating to equality and diversity which may impact on patient experience or care.

General Governance

i. To consider matters referred to the QSC by the Board or by the groups which report to it

ii. Every year, to set an annual Work Plan and conduct a review of the Committee's effectiveness (including the achievement of the Work Plan and a review of the Committee terms of reference) and report this to the Board

iii. To ensure a system is in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.

iv. As required, to review any relevant Trust strategies relevant to the Committee's terms of

reference (eg those associated with clinical quality, clinical effectiveness, health and safety, patient experience) prior to approval by the Board and monitor their implementation and progress.

v. To consider the arrangements for the assessment by the Medical Director and Chief Nurse on the safety and quality impact of the schemes within the Trust's Cost Improvement and Transformation Programme.

vi. On behalf of the Finance & Investment Committee, to consider the clinical and safety aspects of all business cases worth more than £1m prior to their consideration by the Trust Board.

5. COMMITTEE CHAIR AND COMMITTEE EXECUTIVE LEAD

A Non-Executive Director will chair the QSC and in his/her absence, an individual to be nominated by the remaining members of the Committee will take the chair.

The Medical Director and the Chief Nurse & Director of Infection Prevention Control will be the Executive Leads for QSC.

6. COMPOSITION OF THE GROUP
MEMBERSHIP

The following individuals will be members of the group with full rights. Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting.

Name	Title	Role in the group
Sir Norman Williams	Non-Executive Director	Committee Chair
Jenny Higham	Non-Executive Director	Member
Sarah Wilton	Non-Executive Director	Member
Andy Rhodes	Acting Medical Director	Member
Avey Bhatia	Chief Nurse & Director of Infection Prevention Control	Member

ATTENDANCE

The following individuals are not members of the group with full rights and are instead expected to be in attendance for the purpose outlined below:

Name	Title	Attendance Guide
Stephen Jones	Director of Corporate Affairs	Every Meeting
Elizabeth Palmer	Director for Quality Governance	Every Meeting
Ellis Pullinger	Chief Operating Officer	Every Meeting
Mark Hamilton	Associate Medical Director (*Caldicott Guardian, General Data Protection Regulations, Patient Confidentiality)*	As required
Nigel Kennea	Associate Medical Director *(learning from patient deaths)*	As required
Renate Wendler	Associate Medical Director *(learning when things go wrong)*	As required
Vin Kumar	Acting Chief Pharmacist *(Medicines Optimisation and Controlled Drugs)*	As required
Kate Hutt	Clinical Audit & Effectiveness Manager *(Clinical Audit Plan)*	As required
Matthew Laundy	Consultant (Antimicrobial Resistance)	As required

Name	Title	Attendance Guide
Jeremy Isaacs	Consultant Neurologist and Dementia Clinical Lead *(Dementia)*	As required

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

In addition to anyone listed above as a member or attendee, at the discretion of the chairperson the group may also request individuals to attend on an ad-hoc basis to provide advice in support of specific items.

7. QUORACY

The quorum for any meeting of the QSC shall be the attendance of a minimum of three members of which one shall be a Non-Executive Director and one shall be either the Medical Director or the Chief Nurse.

Non-quorate meetings: Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting.

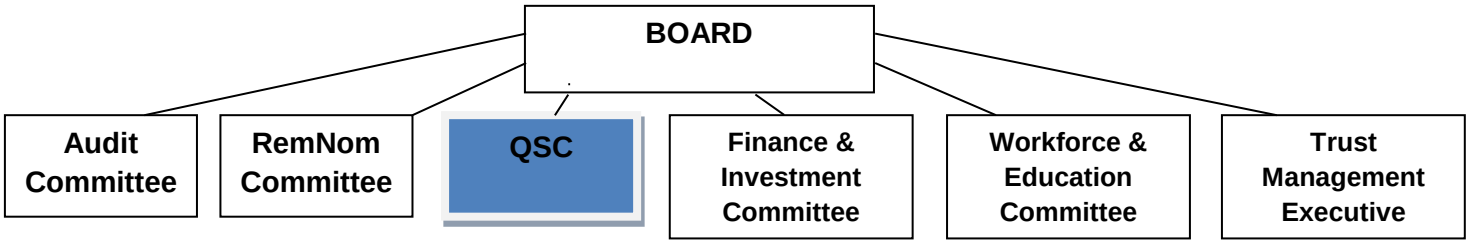
8. DECLARATION OF INTERESTS

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

9. MEETING FREQUENCY

Meetings of the QSC shall be held monthly, one week before the Board.

10. RELATIONSHIP WITH OTHER COMMITTEES



11. MEETING ARRANGEMENTS / SECRETARIAL

i. An annual schedule of meetings of the QSC shall be established prior to the start of each financial year;
ii. The Trust Secretary will arrange secretarial support for the QSC. This will include taking accurate minutes, producing an action log and issuing and following up actions.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair, Executive Lead and Trust Secretary.
iv. All papers and reports to be presented at the QSC must be submitted as final Executive approved reports on the Tuesday before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days of the meeting.

12. AGENDA AND FORWARD CYCLE OF BUSINESS

Standing Agenda Items

i. Apologies;
ii. Minutes/Action Notes of the Previous Meeting;
iii. Matters Arising and Action Log;
iv. Declarations of Interest;
v. Review of any Risks identified;
vi. Items for Escalation;
vii. Reflection on Meeting Effectiveness
viii. Other standing items that will appear at every meeting of the group to be added to this list as appropriate.

Forward Cycle of Business

A forward plan for the items and reports to be received by the Committee is included at Appendix 1 of this Terms of Reference. This should be referred to when setting the agenda for ach iteration of this group.

The forward cycle of business will be reviewed, along with these Terms of Reference, on an annual basis prior to the start of the financial year.

13. REVIEW OF TERMS OF REFERENCE

These Terms of Reference shall be subject to an annual, scheduled review as scheduled on the forward cycle of business at Appendix 1. This review should consider the performance of the QSC including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business.

APPENDIX 1

MEETINGS FROM JANUARY 2018 – MARCH 2019

Date and Time (Every Thursday before Board)	Venue
18.01.18, 14:00-17:00	Room GVR2.20
13.02.18, 14:00-17:00	Room GVR2.20
22.03.18, 14:00-17:00	Room GVR2.20
19.04.18, 14:00-17:00	Room GVR2.19
24.05.18, 14:00-17:00	Room GVR2.19
21.06.18, 14:00-17:00	Room GVR2.19
17.07.18, 14:00-17:00	Room GVR2.19
23.08.18, 14:00-17:00	Room GVR2.19
20.09.18, 14:00-17:00	Room GVR2.20
18.10.18, 14:00-17:00	Room GVR2.19
22.11.18, 14:00-17:00	Room GVR2.19
13.12.18, 14:00-17:00	Room GVR2.19
24.01.19, 14:00-17:00	Room GVR2.19
21.02.19, 14:00-17:00	Room GVR2.19
21.03.19, 14:00-17:00	Room GVR2.19

Annual Quality & Safety Committee Cycle of Business

Item (Standing Items – see below)	Report Lead	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
SAFETY													
Quality Improvement Plan and Workstream Deep Dive (2017-18)	**CN/MD**	x	x	x	x	x	x	Med Recs	Deme ntia	Thematic Learning	x	x	x
Report on Compliance with Fundamental Standards of Care (inc Divisional Deep Dive)	**DQG**	x		x		x		x		x		x	
CQC Preparedness (2017-18)	**CN/MD**				x		x	x	x	x	x	x	x
Safeguarding Adults Report	**CN**		X Ann Rpt				x				x		
Safeguarding Children Report	**CN**				X Ann Rpt				x				x
Infection Prevention and Control Report (Annual Report in Sept from 2018)	**CN**		x				x Ann Rpt				x		
Report from the Infection Control Committee (as and when ICC reports)	**DIPC**												
Anti-microbial Resistance	**CN**		x				x				x		
Review of Safe Staffing	**CN**				x						x		
Mortality / Learning from Patient Deaths	**MD**	(Board)		x	(Board)X		X & Review of Policy	(Board)		x	(Board)		x
EFFECTIVENESS													
Clinical Audit Plan (CAP)	**MD**		x			x			x			x	
NICE, NCE & NPSA compliance	**TBC**			x			x			x			x
Medicines Management / Controlled Drugs report	**MD**	x			x			x			x		
Research Strategy and Annual Report	**MD**		X Ann Rpt			x			x			x	
Annual Audit of End of Life Care	**MD**		x										
Dementia Care	**MD**								x			x (SA)	
Review of Clinical Ethics	**MD**								x				
Caldicott Guardian Report	**MD**						x						
Review of Ward Accreditation	**CN/DQG**												
Report from HTA Designated Individual	**MD**	x											

Item	Report lead	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
EXPERIENCE													
Patient Experience report	**CN**		x				x				x		
Update from Patient Engagement & Experience Forum (not yet established)	**DQG**												
Thematic reporting (complaints, litigation, incidents and PALS) and Lessons Learned	**CN**			x			x			x			x
Annual Complaints Report	**CN**								x	(Board)			
Annual Inpatient Survey	**CN**		x										
Being Open requirements	**CN**						x						x
PLACE Audit	**DE&F/CN**								x				
Quality Account	**CN**		x Commend to Board								x Project plan		X Draft
Agreement of annual quality priorities	**CN/MD**												x
STRATEGY AND RISK													
Annual review and refresh of Quality Strategy	**CN/MD**												x
Quality impact assessment and post-implementation review of major cost reduction plans (as and when)	**CN/MD**		x						x				
Review of relevant BAF and corporate risk register risks	**Trust Sec**	x	x	x	x	x	x	x	x	x	x	x	x
Annual Litigation Report	**CN/DQG**										x	(Board)	
GOVERNANCE AND OTHER MATTERS													
Review of Clinical Governance – QMH	**MD**								x				
Review of Clinical Governance – SWLP	**MD**										x		
Review of Quality Committee effectiveness	**Trust Sec**												x
Review of ToR & Annual Business Cycle	**Trust Sec**												x

Standing Items for All Committee Meetings

Opening Administration	Items at Every Meeting	Closing Administration
Apologies Declarations of Interest Minutes Matters Arising & Action Log	Report from the Trust's Clinical Governance Group Review of Performance & Quality Report Action Plans arising from Reviews or Investigations (as required) Review of Risks Allocated to the Committee Internal Audit Reports	New Risks or Issues Items for Escalation or Control Issues to Audit Committee Comments/Observations from Healthwatch/Governors/etc Report to the Board Forward Plan Reflection on Meeting

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	22 February 2018	**Agenda No**	**6.2**
Report Title:	Board Assurance Framework (BAF)		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This paper brings to the Board the summary page of the Board Assurance Framework this has been updated following the Board review in January. It shows the assurance rating and risk level as confirmed for the risks reserved to the Board and the new wording for strategic risk 11 also as discussed and approved at January Board. The Board has asked to be updated monthly on: • any significant change in risks contributing to a strategic risk • assurance available in month on the effectiveness of the controls. The paper summarises the updates received by the assuring committees in February.		
Recommendation:	The Board is asked: 1. To note strategic risks 9, 16 and 17, which are reserved to the Board, have been updated following the Board review in January. 2. To note strategic risk 11 has been amended as agreed at the January Board. 3. To note updated assurances and actions delivered to deadline.		
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 Quality and Safety Committee	**Date**	Feb 18 Feb 18
Equality Impact Assessment:	N/A		
Appendices:	App 1 BAF summary sheet		

Board Assurance Framework

Trust Board 22 February 2018

1.0 PURPOSE

1.1 This paper provides an update on the BAF strategic risks, where available updates on assurances for contributing risks are reported and an update on delivery of action plans.

2.0 BACKGROUND

2.1 The BAF is designed to come to the Board quarterly and will show changes in both assurance and risk ratings of the strategic risks across the year.

The Q3 2017/18 Board Assurance Framework (BAF), brought to the Board in January 2018, gave an assurance position where 9 of the 17 strategic risks had an assurance rating of *limited*, the remaining 8 strategic risks had a rating of *partial* assurance.

2.2 Given the current low level of assurance across the strategic risks the Board have asked the assuring committees to receive monthly updates on; significant change to a contributing risk; sources of assurance that have become available in month; and the timely delivery of actions to improve control of a contributing risk, the assuring committees then to provide a monthly update to the Board. Risk and assurance ratings for the strategic risks will be updated quarterly; these will not change month to month. Monthly updates with a quarterly reassessment of the overall risk and assurance position is likely to continue until the Board sees a shift to assurance levels that are a mix of *significan*t and *partial* across the strategic risks.

2.3 Risk and assurance ratings for the strategic risks will be updated quarterly; these will not change month to month

2.4 At the Board meeting in January the assurance rating and risk level was confirmed for the risks reserved to the Board. Strategic risk 11 was reworded following discussion at Board. The summary BAF (appendix 1) is attached with the changes shown in blue.

3.0 UPDATE ON ASSURANCE and ACTIONS

3.1 The **Quality and Safety Committee** met on 13 February and received the following updates.

3.2 **Strategic Risk 2:** 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.

The Committee received an update and discussed the challenges in the delivery of the four hour operating standard. The committee also received a detailed update on the elective care recovery programme and noted the progress that had been made with the establishment of a new patient tracking list.

The Committee noted that we have achieved compliance with all 8 cancer standards and the assurance this provides on control of this area of the strategic risk.

Actions for the risks contributing to SR2 have been delivered within the deadlines set out in the Q3 BAF.

3.3 **Strategic Risk 3:** 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.

The Committee received the Quality Improvement Dashboard which is now being actively used to monitor improvement in quality and is a source of assurance against this risk. For the majority of the 77 indicators in the dashboard there is an agreed trajectory and threshold.

Actions for the risks contributing to SR3 have been delivered within the deadlines shown in the Q3 BAF.

3.5 The **Finance and Investment Committee** met on 15 February and received updates on:

Strategic Risk 12: 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.

There are five groups of ICT risks that contribute to the strategic risk: infrastructure; clinical systems; corporate systems; information and knowledge and service and operations.

The Committee heard that governance arrangements have been established with an Information Governance Group (IGG) leading the work to improve the Trust's ICT environment. This is chaired by the Chief Finance Officer. The IGG is developing the ICT Strategy.

The Committee noted that there is a Board workshop on 19 February to discuss next steps options, and progress since last workshop will provide the Board with a review of progress since the November workshop and an update on progress with risk reduction.

4.0 RECOMMENDATION

4.1 The Board is asked:

- To note strategic risks 9, 16 and 17, which are reserved to the Board, have been updated following the Board review in January.
- To note strategic risk 11 has been amended as agreed at the January Board.
- To note the updated assurances and actions delivered to deadline.

Appendix 1

Summary Board Assurance Framework
(to accompany February 2018 BAF update)

BOARD ASSURANCE FRAMEWORK OVERVIEW										QUARTER 3
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating Q1	Q2	Q3	Q4	Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
Treat the patient, treat the person	*To be established by the Board*	*SR1*	We are unable to develop new and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could result in care which is below the minimum standard.			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
	To be established by the Board	*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
	To be established by the Board	*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
	To be established by the Board	*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
	To be established by the Board	*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
	To be established by the Board	*SR9*	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.			Partial		The Board recognises the communication strategy and its delivery over the past year. A key assurance on its impact, the annual communication survey, will be available in April 2018. The Board asked for assurances concerning the staff engagement strategy to be mapped to this risk (xref SR8).	(CEO) Director of Corproate Affairs	Board	12
	To be established by the Board	*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
	To be established by the Board	*SR11*	We fail to develop our future leaders and we fail to provide clarity to them about their roles and accountabilities, which leads to low job satisfaction, high turn-over and on-going instability amongst our senior leaders.			Partial		Redrafted strategic risk approved by Board Jan 2018.	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
	To be established by the Board	*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
	To be established by the 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.			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 established 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		The Board recognises that a key action to address this risk has now been delivered with the arrival of the new Director of Strategy in January 2018. Funding has been agreed for a team but this will not be fully in place until July 2018. The strategy process is in development.	(CEO) Director of Strategy	Board	12
	To be established by the 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.			Limited		The Board recognises that the additional director capacity needed to build and develop external relationships is now in place but this is new (January 18) and assurance about the impact on this risk is not yet available.	Chief Executive	Board	12

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	22 February 2018	**Agenda No**	6.3
Report Title:	Risk Appetite Statement 2018/19		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This paper brings the proposed risk appetite statement 2018/19 to the Board for approval. The statement gives guidance to decision makers on the Board's appetite for taking risk across areas of risk linked to our strategic objectives. The statement has been discussed at the Quality and Safety Committee and the Finance and Investment Committee and they recommend it to the Board. If approved the Board is asked to consider the proposed risk appetite for each strategic risk based on the risk appetite statement (appendix 1)		
Recommendation:	The Board is asked to: • Approve the risk appetite statement 2018/19 • Approve the risk appetite allocated to each strategic risk on the BAF		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	Risk management tool		
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:	Quality and Safety Committee Finance and Investment Committee	**Date**	13/02/18 15/02/18
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1 – Strategic risk and risk appetite summary		

Risk Appetite Statement 2018/19

Trust Board 22 February 2018

1. CONTEXT

We have recently agreed and published our new strategic objectives to enable us to achieve our vision of 'Outstanding Care, Every Time'. Our objectives are designed to improve care for patients, the working lives of our staff and to develop and build relationships with local and national partners and stakeholders.

Risk taking is a necessary part of achieving objectives for all organisations and decision makers need to understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation, while encouraging enterprise and innovation.

The Trust's aim is to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making. Decision-makers need to be clear what level of risk is acceptable and where steps must be taken to reduce the level of risk to which the Trust is exposed.

2. PURPOSE

Risk appetite is the amount of risk that the organisation is willing to accept in its efforts to achieve its strategic objectives and vision. The purpose of a risk appetite statement is to articulate the Trust Board's position with regard to how it will approach different areas of risk:

Appetite	Approach to risk	Described as:
None	Avoid	The avoidance of risk and uncertainty is a key organisational objective
Low	Minimal	A low risk appetite doesn't mean no appetite but rather a preference for ultra-safe delivery options that have a low degree of inherent risk. The balance of risk has to be weighed up against the potential for reward even with a low risk appetite
Moderate	Cautious	A preference for safe delivery options that have a low degree of inherent. The balance of risk has to be weighed up against the potential for reward even with a moderate risk appetite
High	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and value for money
Significant	Seek	Eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk

The purpose of the risk appetite statement is to give guidance to decision makers on the Board's appetite for taking risk across the following areas of risk linked to our strategic objectives:

- Patient safety and clinical quality (Treat the patient, treat the person)
- Patient experience (Treat the patient, treat the person)

- Workforce (Champion team St George's)
- Organisational performance (Right care, right place, right time)
- Statutory compliance frameworks (All strategic objectives)
- Financial duties (Balance the books, invest in the future)
- Reputation (Champion team St George's and Build a better St George's)
- Stakeholder relationships and involvement (Build a better St George's)
- Innovation and research (Develop tomorrow's treatments today)

3. PROPOSED RISK APPETITE STATEMENT 2018/19

As an NHS healthcare organisation we are broadly risk averse, the following statements reflect this, in only limited areas do the opportunities presented lead to a greater appetite for risk.

Patient safety and clinical quality: The Trust has a **low appetite** for risks that impact on patient safety and clinical quality.

Patient experience: The Trust has a **low appetite** for risks that impact on patient experience but it is higher than the appetite for those that impact on patient safety. This recognises that when patient experience is in conflict with providing a safe service that safety will always be the highest priority.

Workforce: There are significant challenges in recruiting and retaining staff and to mitigate the risks associated with staffing shortfalls new and innovative roles are being developed and various recruitment strategies are being used some with greater reward then others. To enable the workforce to change and develop to meet future needs requires the Trust to have a **moderate appetite** for risk with workforce.

Organisational performance: The Trust has a **low appetite** for risks that impact on performance and efficiency but it is higher than the appetite for those that impact on patient safety.

Statutory compliance frameworks: Non-compliance with statutory requirements has the potential to cause harm, undermines patient and wider stakeholder confidence in the Trust and may lead to regulators taking legal action. For these reasons the Trust has a **low appetite** in relation to risks in this area and has a strong preference for options that do not threaten statutory obligations.

Financial duties: The Trust has a **low appetite** for risks that will threaten the Trust's ability to deliver services within our financial resources and achieve the targets set by our regulators.

Reputation: The confidence of our patients and wider stakeholders is essential to ensure the Trust's future as a major provider of healthcare in London and the Trust has a cautious approach to opportunities where there are reputational risks, the Trust has a **moderate appetite** for these risks.

Stakeholder relationships and involvement: The Trust is actively seeking to develop its relationships with other health and care providers through the South West London Health and

Care Partnership. The Trust has an open approach and a **high appetite** for risk, and will seize opportunities for developing and extending relationships with our stakeholders whilst recognising that there may be risks associated with developing innovative solutions and building productive partnerships and collaborative working.

Innovation and research: The Trust has a **high appetite** and an open approach to pursuing innovation and challenging current working practices in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

3.1 Summary of risk appetite for each area of risk

Risk area	Risk Appetite				
	None	Low	Moderate	High	Significant
Patient safety and clinical quality		√			
Patient experience		√			
Workforce			√		
Organisational performance		√			
Statutory compliance frameworks		√			
Financial duties		√			
Reputation			√		
Stakeholder relationships and involvement				√	
Innovation and research				√	

This is an assessment at a point in time and reflects our current understanding and may change if the assessment is undertaken again at a later date.

The purpose of the risk appetite statement is ultimately to drive action in areas where the risk assessment in a particular area is greater than the risk appetite range stated.

4. RECOMMENDATION

The Board is asked to approve the risk appetite statement.

And then:

The Board is asked to approve the risk appetite level for each strategic risk in the BAF as shown in appendix 1

Appendix 1 Risk appetite proposed for each strategic risk
(based on Board approval of the Risk Appetite Statement 2018/19)

Strategic objective	Strategic risk		Risk appetite
Treat the patient, treat the person	SR1	We are unable to develop new and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could result in care which is below the minimum standard.	Moderate
	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.	Low
	SR3	We do not have effective, accessible and widely utilised learning and improvement methodologies, resulting in care which is below local and national standards and best practice.	Low
Right care, right place, right time	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.	Low
Balance the books, invest in our future	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.	Low
	SR6	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities	Low
	SR7	We do not have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories. This results in the Trust having incomplete plans and management action becoming reactive.	Low
Champion team St George's	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.	Low
	SR9	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.	Moderate
	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.	Low
	SR11	We fail to develop our future leaders and we fail to provide clarity to them about their roles and accountabilities, which leads to low job satisfaction, high turn-over and on-going instability amongst our senior leaders.	Moderate
Build a better St George's	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.	Low
	SR13	Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting delivery and risking patient safety.	Low
	SR14	We are unable to secure the investment required to address our IT and estates challenges and as a result are unable to transform our services and achieve future sustainability.	Low
Develop tomorrow's treatments today	SR15	We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.	High
Build a better St George's	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.	Moderate
	SR17	A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.	Moderate

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	22nd February 2018	**Agenda No.**	**6.4**
Report Title:	Fit and Proper Persons Quarterly Update Report		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Report Author:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	The Board has request that the HRD provide a quarterly update on FPP compliance against Regulation 5 during the year 2017/18 and annually thereafter. The purpose of this paper is to give the Board on-going assurance that the Trust is now fully compliant with Regulation 5. Fit and Proper Persons : Directors. The Trust Board are asked to note that the CQC has published updated Regulation 5: Fit and Proper Persons: Director guidance for providers and CQC inspectors (copy attached as Annexe C)		
Recommendation:	That the Board is asked to note the current assurance around the fit and proper persons assessment.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-Led)		
Implications			
Risk:	Failure to meet the FFP requirements could result in further regulatory actions being taken against the Trust		
Legal/Regulatory:	The requirement to meeting the FFP test is outlined in Regulation 5: Fit and Proper Persons		
Resources:	No additional resources required		
Previously Considered by:	Board and Executive Director	**Date:**	September and November 17

Equality Impact Assessment:	Not undertaken. Policy applied to every Board member
Appendices:	Appendix A - Exec and Non Exec FPPR compliance list Appendix B – Checklist Appendix C - Link to latest CQC Guidance

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

Trust Board – 2nd February 2018

1.0 PURPOSE

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

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2.0 BACKGROUND

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

3.0 OUTLINE OF KEY ISSUES

CQC unannounced inspection - May 2017

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

4.0 NHSI Concerns and Requirements

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

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

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

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

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5. UPDATES CQC GUIDANCE

5.1 CQC have updated their guidance on Regulation 5 - the fit and proper persons requirement for directors – Copy attached as Annex C

5.2 The new guidance provides a more detailed explanation of what CQC interprets as serious mismanagement and serious misconduct.

5.3 The new guidance also offers greater clarity about the obligations and responsibilities of those holding director roles.

5.4 In summary, the guidance reminds providers that they are responsible for appointing, managing and dismissing their directors, and must carry out appropriate checks to make sure directors are suitable for their role.

5.5 CQC's role is to make sure that providers have appropriate recruitment and performance management processes in place. CQC will take action against a provider if they believe that a provider is failing to meet the requirements. It is not their role to regulate individuals or to assure that any individual is fit or proper.

6. Recommendation

It is recommended that the Board:-

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

6.2 Both Suzanne Marcello and Kevin Howells have met all the FPP requirements before starting their roles as Executive Directors.

6.3 Stephen Jones FPP checks are still being completed and he will not commence in his new role until these have been completed.

Annex A

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

Annex B

Fit & Proper Persons Checklist

Document	Checked by	Date
Fit & Proper Persons Test/Declaration Form		
Employment History		
References		
Professional Registration		
Essential Qualifications		
Occupational Health Clearance		
Right to Work		
Identity Check		
DBS Check/Criminal Conviction Check		
Search of Insolvency & Bankruptcy Register		
Search of Disqualified Directors		
Social Media Search		

FPPT Completed	
HR Director Print Name	
HR Director Signature	
Date	

Annex C

Regulation 5: Fit and proper persons: directors

Guidance for providers and CQC inspectors

January 2018

http://www.cqc.org.uk/sites/default/files/20180119_FPPR_guidance.pdf