Trust Board Meeting

Date and Time: **Thursday 28 June 2018, 10:00 – 13:30**

Venue: **QMH, 2nd Floor, Barnes, Richmond & Sheen Rooms**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the Queen Mary's Hospital site**	**Board Members**	-	Oral
OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	-	Oral
	1.2	**Declarations of interest**	All	-	Oral
	1.3	**Minutes of meetings: 24 May 2018 31 May 2018 14 June 2018**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
	1.5	**CEO's update**	**Jacqueline Totterdell** Chief Executive	Inform	Report
STRATEGY					
10.45	**2.1**	**Corporate Objectives 2018-19**	**Suzanne Marsello** Director of Strategy	Update	Report
QUALITY & PERFORMANCE					
11:10	**3.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
	3.2	**Integrated Quality & Performance report**	**Executive Team**	Inform	Report
	3.3	**Elective Care Recovery Programme**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
	3.4	**Emergency Care Performance**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
	3.5	**Safeguarding Adults Annual Report**	**Avey Bhatia** Chief Nurse & DIPC	Assure	Report
	3.6	**Learning from Deaths – Quarterly Report**	**Andrew Rhodes** Acting Medical Director	Assure	Report
	3.7	**CNST Incentive Scheme for Maternity**	**Andrew Rhodes** Acting Medical Director	Approve	Report
FINANCE					
12:05	**4.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
	4.2	**Month 2 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
WORKFORCE					
12:35	**5.1**	**Workforce and Education Committee report**	**Stephen Collier** Committee Chair	Assure	Report
	5.2	**Fit and Proper Persons Regulation – quarterly update**	**Harbhajan Brar** Director of Human Resources &	Assure	Report

Time	Item	Subject	Lead	Action	Format
			Organisational Development		
CLOSING ADMINISTRATION					
13:00	**6.1**	**Questions from the public**	-	-	Oral
	6.2	**Any new risks or issues identified**	**All**	-	-
	6.3	**Any Other Business**	**All**	-	-
	6.4	**Reflection on meeting**	**All**	-	Oral
13:10	**STAFF/PATIENT STORY**				
13:30	**CLOSE**				

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

Date of next meeting: Thursday 26 July 2018, 10.00 – 13.00 Hyde Park Room, St George's Hospital

Trust Board
Purpose, Meetings and Membership

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

Meetings in 2018-19 (Thursdays)									
25.01.18	22.02.18	29.03.18	26.04.18	31.05.18	28.06.18	26.07.18	30.08.18	27.09.18	25.10.18
29.11.18	20.11.18	20.12.18	31.01.19	28.02.19	28.03.19				

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Sir Norman Williams	Non-Executive Director/Senior Independent Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse & Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
In Attendance	**Designation**	**Abbreviation**
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Mike Murphy	Quality Improvement Director – NHS Improvement	QID
Ellis Pullinger	Chief Operating Officer	COO
Secretariat	**Designation**	**Abbreviation**
Terri Burns	Interim Assistant Trust Secretary	ATS

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting

Thursday 24th May 2018, 13.00 – 13.30, 2.19, 2nd Floor, Grosvenor Wing

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

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed everyone. Apologies had been received from Jenny Higham and Sarah Wilton.
ANNUAL REPORT & ACCOUNTS	
2.1	**Annual Report & Accounts and Quality Account 2017/18**
	The Chairman reported that the Annual Report and Accounts, including the Quality Report,

	had been substantially scrutinised by Board members and been through a thorough governance process. This included consideration at a workshop of the Audit Committee on 17 May and at a meeting of the Committee on 21 May, during which it had agreed to recommend that the Board approve the Annual Report and Accounts 2017/18. The Interim Director of Financial Services noted that there had been one change to the accounts since the Audit Committee on 21 May 2018, relating to reclassification of income. This had not materially affected the accounts and was a technicality. The DCA reported that the draft Annual Report itself had been reviewed by the Audit Committee on three occasions and the draft before the Board reflected comments from the Committee and Board members. The Annual Report and the Quality Report contained references to the Trust's position in relation to information governance; a note in relation to the March 2018 Information Governance Toolkit submission had been included which acknowledged that the Trust had subsequently identified gaps in its self-assessment against the IG Toolkit which may have an impact on the Trust's overall percentage score. This had been reported to the May Audit Committee. Additional wording to reflect this in both the Annual Report and Quality report was agreed. The Director of Quality Governance reported that statements relating to the Guardian of Safe Working and Referral-To-Treatment had now been included in the Quality Report, as well as the statutory Clinical Commissioning Group statement. The Chairman noted that the process for producing the report was much improved compared with previous years and thanked those involved for their hard work. The Board approved the Annual Report and Accounts 2017/18, including the Quality Report.
2.2	**External Audit Findings**
	The CFO reported that the External Audit Findings report had been reviewed by the Audit Committee on 21 May 2018, and accepted as an accurate report. An adverse opinion had been given in relation to value for money and this reflected the fact that the Trust was currently in financial special measures and had ended the year with a £53.1m deficit. The Board noted the report.
2.3	**Letter of Representation - Accounts**
	The CFO reported that the letter presented was standard wording and was recommended for approval by the Audit Committee. The Board approved the letter.
2.4	**Letter of Representation – Quality Report**
	The Director of Quality Governance reported that the letter presented was standard wording and was recommended for approval by the Audit Committee.

	The Board approved the letter.
CLOSING ADMINSTRATION	
3.1	**Any other business**
	No other business was raised.
CLOSE	

Date of next meeting: Thursday 31 May 2018 at 10:00

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting

Thursday 31 May 2018, 10:00 – 13:00, Hyde Park Room, 1st Floor, Lanesborough Wing

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

Feedback from Walkabout

Members of the Board gave feedback on the departments they had visited ahead of the meeting. These areas included; Cardiac Cath Labs, James Hope Ward, Courtyard Clinic, Renal Dialysis Unit, Frederick Hewitt Ward, Nicholls Ward, Dermatology and Lymphoedeama, Heberden Ward, Gwillim Ward, Carmen, Blue Sky Centre Ward, Education Centre and Recruitment.

Observations highlighted where staff felt that investment was needed, particularly in relation to the environment in and around wards. The CFO noted that the executive team were aware there was a need and were working to try to resolve funding challenges.

There was found to be pressure on space in James Hope Ward, as well as a need for some equipment to be upgraded. Cardiac Catheter Lab equipment was in use several years past its anticipated lifespan, with concerns around reliability. Staff reported that they felt empowered to speak up when there was a problem, more so than they had done historically. There was also a British Airways pilot

present at the time of the visit. He and his team had been working with Cardiac staff on the transfer of learning from the aviation industry around embedding safety. The Chairman noted that the ward was a successful example of a nurse led ward.

The visit to the Renal Dialysis Unit included trucks which were used due to capacity issues. They were clean and well maintained. The team had reconfigured the space available following learning from an incident. The Courtyard Clinic had also moved. The staff were found to be positive and engaged. They had been training patients to enable them to have dialysis at home. It was noted that capital was needed for development, to enable the removal of the trucks.

Key issues identified in relation to Freddie Hewitt and Nicholls wards were nurse vacancies. It was noted that full recruitment was expected by September 2018 and that current staff were very committed. Environment was again raised, with refurbishment and capacity being highlighted as areas for improvement.

Environment was again raised as an issue regarding Heberden Ward and Dermatology and Lymphoedeama services. Staff had been looking for innovative solutions. Heberden Ward was highly dementia friendly, with calm and assured staff. However, there were a significant number of patients who were ready for discharge but remained on the ward. It was noted that there was a long waiting list for the Dermatology service, although there was flexibility built in for urgent cases. The MD stated that pilot schemes were under development to help prevent delays.

It was reported that Carmen had undergone impressive refurbishment in the birthing areas. However, the triage room was often used as an additional birthing room. There was also only one shower and bathroom, which was not an inviting area and had leaks. Gwillim was much larger but would often overflow into Carmen, as the nature of patient's needs led to difficulty in planning for capacity. The bathrooms again were in need of attention, with cosmetic work needed. Staff were busy but coping well and notice boards were well maintained, with up to date information.

Staff in the Education Centre and Recruitment team noted the need for refurbishments. There was also a great deal of capacity that was not being well utilised due to the layout. Disability access to the first floor was not possible, limiting use of teaching rooms. It was noted that the St George's Charity had recently made a grant for improvement of disability access. Reliance on paper was an inhibitor within Recruitment, although this had already been identified as an area for improvement and alternatives were being reviewed. Staff were generally happy and showed dedication.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed members of the public and a number of the Trust's Governors. Apologies had been received from Jacqueline Totterdell, Chief Executive, and Ellis Pullinger, Chief Operating Officer.
Declarations of Interest	
1.2	Sir Norman Williams noted that he had been appointed as Chair of the National Clinical Improvement Programme.

Minutes of the meeting held on 26 April 2018	
1.3	The minutes of the Board meeting held on 26 April 2018 were approved as an accurate record.
Action log and matters arising	
1.4	The outstanding actions were noted, with a Board Seminar date confirmed for 7th June and a charity presentation to the Board due over the Summer.
1.5	**CEO's update**
	The CFO reported in place of the CEO. He reported that the May 2018 visit by the Secretary of State for Health was an opportunity to focus on the positive work carried out by the Trust in relation to learning from incidents. It was also noted that strategy development sessions were taking place with staff and stakeholders. A briefing had been made to staff and stakeholders in relation to the Trust withdrawing as the provider of some community services. The Chairman noted that there had been some concern raised by staff and stakeholders, who seemed uncertain as to the future of the service with a different provider. It was noted that the services were not being stopped, but the Trust's role within them would pass to a different provider. **TB. 31.05.18/ 78: Ensure clear messages communicated to staff regarding the Trust's withdrawal from provision of certain community services.** Ann Beasley queried whether there was a better way for patients to access the Blue Sky Ward and whether GPs could refer directly, rather than going via the Emergency Department. The DDET noted that the design was currently under review, with a particular focus on patients who had been referred by their GP. Sarah Wilton requested that future reports contain details of meetings with networks and other relevant organisations, such as the STP, for the benefit of the Non-Executive Directors. An invitation to the Giant Tea Party and all other NHS at 70 events was extended to all staff within the Trust.
QUALITY & PERFORMANCE	
2.1	**Quality & Safety Committee Report**
	The Committee Chair reported that the QIP dashboard had been improving. The Committee had been informed about two never events involving nasogastric tubes and had been assured by Dr Rafik Bedair, Consultant in GICU, that actions were in place to address the underlying causes. An increase in the number of C. Difficile cases had been reported, however the Committee had been assured that this was not an epidemic. The Committee had approved the Terms of Reference for a Cardiac Surgery review, which would be carried out externally. The Committee had been assured that the nursing establishment was safe and were informed that £2m had been taken out of the budget for QIP without affecting safety. The Committee Chair also noted the reduction of two risk ratings in relation to

	likelihood. Sarah Wilton noted that the Premises Assurance Model would need to provide assurance on water safety review. The DEF stated that this was planned for discussion at the Board Seminar on 7th June 2018. An external assurance report would also be carried out later in the Summer, to give assurance in addition to the internal work already in place. Timothy Wright queried whether there was anything additional that could be done to remedy the issues faced. The DEF reported that some of the dead legs had been removed, as well as the introduction of new systems. Any large works undertaken would include water refurbishments. The DEF reported that he had been liaising with Moorfields in relation to fire safety and had put in place operational mitigations to ensure compliance with legislation. The Trust's risk team had also been working with their Moorfields counterparts to address the disparity in risk scores. The CN&DIPC noted that she would be meeting with the neonatal team to address any concerns about the safe staffing review. Jenny Higham noted that she would like to see how the review would be extended to other staffing areas of the Trust. Ann Beasley expressed concern that the improvement in performance appeared to be in tandem with a reduction in efficiency. The DDET stated that the clinical team were clear that there had to be a focus on both quality and efficiency. Getting the right system in place ahead of surgery would be key. This would mean that more patients would be prepared for theatre to use the capacity available. The ACOO noted that work had been undertaken to address the level of cancellations within surgery, which had resulted in a significant improvement in the last month. The Committee Chair noted that the Trust had previously had a lower day case rate than other providers, as well as lower enhanced recovery rates. The DDET stated that this had been identified, with teams being challenged to make improvements against this. The enhanced recovery programme had been sporadic, so required work to ensure it was implemented effectively. Sarah Wilton queried why mortality rates continued to reduce, except at weekends. The MD stated that rates overall remained lower than expected, with weekend rates being recognised as a multifaceted national issue. It had already been agreed that seven day care data would be reported to the Quality & Safety Committee for assurance. The Board noted the report.
2.2	**Integrated Quality & Performance Report**
	The DDET reported that the Trust was underperforming in relation to the number of elective and day case operations carried out. The Friends & Family test was positive at 98%. However it was noted that the response rate itself was low. A higher rate would give greater credibility to the results. Cancer delivery standards had been reached for March 2018 and delivery against diagnostics continued. The focus was on rebooking cancellations. Stephen Collier noted that it would be helpful to have an understanding of the reasons for sub-

	optimal numbers of elective and day cases. The CFO noted that there were some planning issues identified that could be improved upon, as well as waiting list initiatives being used in a constructive way as part of work to drive forwards efficiencies. Both short term and structural changes were taking place. Stephen Collier was assured that this was not a trend, although was a concern. The QID expressed surprise that variance from the previous year's plan was around four per cent. It would also be helpful to see greater detail in relation to DNA rates and length of stay and occupancy rates. The CFO reported that performance was off plan for one week only and not the whole month. This was discussed in detail with all operational areas, whilst also having to recognise the effect of special measures. There was a management focus on fine tuning the plan, with fortnightly divisional meetings being used to ensure capacity was utilised. The DDET noted that DNA rates had been particularly impacted in one week, in which some patients had not received appointment letters. Text reminders were being rolled out more widely, with two way reminders being introduced later in the year. The Length of stay and bed occupancy rates had been identified by clinicians as an opportunity for review and would be reported in greater detail at the Finance & Investment Committee. The DHROD reported that sickness absence continued to see a reduction and work was ongoing to improve appraisal rates. The DDET reported that the style of report would continue to evolve for Finance & Investment Committee and that Board member input would be welcomed. **TB. 31.05.18/ 79: NED opinions to be sought regarding new style of report before returning to FIC.** The Board noted the report.
2.3	**Elective Care Recovery Programme**
	The ACOO reported that the Trust had a good performance in cancer for March and was concluding assurance work with a partner, with a draft report and action plan in preparation. Overall performance improvement was beginning to be seen. There had been a consistent achievement of the two week operating standard over the last six months. Diagnostics delivery was well within target and there continued to be improvements in the 52 week wait list. The Board was also informed that there was a great of work taking place in relation to training, with a clear plan and trajectory in place for continuing this. Standard Operating Procedures were also being reviewed to ensure patients were moving through the pathway as efficiently as possible. The Board noted the report.
2.4	**Emergency Care Performance**
	The ACOO reported that the Trust had struggled to deliver the four hour target in 2017/18. A 15 point plan had been developed with NHS Improvement to address this. Both admitted

	and non-admitted performance had improved, with 95% performance required to meet the planned target for June 2018. The Trust was one of the best performing Trusts in relation to ambulance hand overs, being the highest performing Trust across London in the last week. Where deterioration had been seen, teams were being asked to prepare plans to recover performance. Different pathway options were also being considered. The Chairman noted that the Trust should be seeking to go beyond targets in performance and continue the upward trajectory. Sir Norman Williams asked how the Trust was performing in comparison to the same period in the previous year. The ACOO stated that performance had improved by four per cent. It was also noted that there had been a 12 hour trolley wait, with work in progress to address the reasons with mental health partners. The Board agreed the admitted and non-admitted trajectories, with the caveat that the Trust should strive to deliver further improvements towards achieving the 95% target sustainably.
FINANCE	
3.1	**Finance & Investment Committee Report**
	The Committee Chair reported that the Committee had welcomed the new Chief Information Officer to the Trust. Improvements needed to be assured around IT had been set out for the Committee. They had been pleased with the productivity metrics reported and had requested more detailed plans. They had also recognised that a great deal of work had been undertaken to progress Emergency Department performance, as well as CIPs where 90% had now been identified. The Committee wanted to see the outstanding balance identified from the pay budget. The Committee had reviewed its membership and agreed that no changes to the membership were required at this time and that it was appropriate for the CEO and Trust Chairman to continue attending whilst the Trust remained in special measures. The Board noted the report.
3.2	**Month 1 Finance Report**
	The CFO reported that this was a bridging report, which would return to its normal format the following month. The Annual Accounts had been submitted to NHS Improvement with an unqualified opinion. Pay would be an area of focus in relation to control of budget costs, with actions in place to address gaps identified. There was underspend on non-pay and CIPs were progressing as planned. Sir Norman Williams queried the overspend on junior doctors. The CFO noted that rota gaps were being investigated and that new ways of addressing under recruitment were being investigated. There were also some control issues which required further investigation. The Board noted the report.
GOVERNANCE	
4.1	**Audit Committee Report**
	Ann Beasley reported in the Committee Chair's absence. The Committee had reviewed the

	Annual report & Accounts. They had been pleased with the improvements made to the report from the previous year. The External Auditors were also very positive and had reported good staff engagement from the Trust. There had been no additional audit charges. They had also been pleased with the review of quality indicators and given an unqualified opinion. The Committee had noted the Value for Money opinion, which had been expected. The Committee had recommended that the Board agree the report and accounts. The Head of Internal Audit Opinion had given reasonable assurance, which was an improvement on the previous year. The Trust Chairman noted that the Board had signed off the Annual report and Accounts accordingly, at a special meeting on 24th May. The Committee had also noted a report on the Information Governance Toolkit submission. The Trust had submitted a self-assessment in March 2018 which was later found to be incorrect during audit. It was not possible to amend the submission, but it had been noted by the Committee with actions in place to address the gaps prior to the next submission in October 2018. The Committee would receive a further update at its meeting in July 2018. The Board noted the report.
4.2	**Board Assurance Framework**
	The CN reported that the risks had been reviewed by the appropriate Board sub-committees. A further review of progress would be undertaken at the end of quarter one. Tim Wright noted that he would be meeting the new Chief Information Officer to review the ICT risk and better understand the associated mitigations. The Chairman queried whether there was a need for the Board to review the Framework every month, as it had now matured and was a better assurance tool with very little movement seen within the space of a month. The Board agreed that a quarterly report would show more significant movement, with any issues of note being brought to the attention of the Board monthly and monthly reporting to and consideration by sub-committees remaining in place. **TB. 31.05.18/ 80: BAF reporting to Trust Board to move to every quarter.** The Board noted the report.
4.3	**Annual Self-Assessment of Compliance with Foundation Trust License**
	The DCA reported that the Trust was required to self-certify against compliance with provider license conditions annually. The report noted the Trust position in relation to financial special measures and that compliance would be subject to meeting the deficit agreed with NHS Improvement. The Board approved the proposed declaration.
CLOSING ADMINISTRATION	
5.1	**Questions from the public**
	Members of the public asked what the never events discussed in the meeting had been. The

	MD stated that these were nasogastric tube incidents and one occurrence of air being administered instead of oxygen. The Board were also asked what had happened to 11 letters that were not received in relation to a planned clinic. The DDET stated that this was still being investigated as the letters had been sent. However all patients affected had been rebooked. One question had been submitted prior to the meeting: 'Why staff are not held personally accountable for poor attitude, and why the Trust protects them just because they are a consultant. If they were a junior member they would be held to account.' The CN stated that all complaints were taken seriously, irrespective of the seniority of staff involved. She apologised for the delay in arranging a meeting in this case. However it was noted that staff who were the subject of a complaint were not usually in attendance at meetings with complainants. A Governor asked what the scope of improvement work was in relation to data quality, noting that some studies had suggested that weekend emergency admissions were likely to be because of more serious conditions. The CFO responded the performance report looked at finance and quality to ensure that the focus was on the correct areas. Performance meetings also reviewed the variance and performance against plan. The MD also noted that mortality data should be reviewed in conjunction with severity data, advocating caution as the data itself was in need of improvement. The Chairman thanked everyone for their questions.
5.2	**Any new risks identified**
	No new issues or risks were identified.
5.3	**Any Other Business**
	No other items of business were raised.
5.4	**Reflection on the meeting**
	The Chairman noted that there had been good contributions from everyone and expressed her thanks.
	PATIENT STORY
	Elizabeth Mackessy had been a patient at St George's for many years under the care of the Rheumatology and Trauma and Orthopaedics Departments. She participated in a video interview about some of her experiences at the Trust, many of which were positive but one of which (poor communication following an Orthopaedic clinic appointment) necessitated her seeking assistance from the Patient Advice and Liaison Service. Sarah Duncan, the Patient Experience Manager, explained that Ms Mackessy had contacted her with some concerns about a consultant letter in which she did not recognise the details given as relating to herself, such as being able to stand unaided. Ms Duncan ensured that another appointment was arranged and spoke to the medical secretaries in relation to the communication issues which had been identified. She noted that this was not a common theme, but had happened on occasion in the past. The Board were keen to

	ensure that the clinicians involved received feedback on Ms Mackessy's experience and the issues she had faced. The Board were pleased to see that Ms Mackessy was able to be seen so quickly by the Orthopaedic team. They thanked Ms Mackessy and Ms Duncan for their time and for being prepared to experiment with a video recording, which had worked well.

Date and time of next meeting: Thursday 28 June 2018, 10:00 – 13:00
(Queen Mary's Hospital)

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting

Thursday 14 June 2018, 09.15 – 10.00, Room 52, 1st Floor, Grosvenor Wing

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

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed everyone. Apologies had been received from Ann Beasley, Sarah Wilton, Tim Wright, Avey Bhatia, Stephen Jones and Suzanne Marsello.
2018/19 Financial and Operating Plan	
2.1	The CFO reported that, in a letter from Ian Dalton the Trust has been requested to resubmit its 2018/19 Operating plan (Finance, Activity and Workforce) by midday 20th June. The resubmitted plans required Board review and sign off.

The CFO presented a paper to the Board, he indicated this sought to achieve the following;

1. Provide the Board with sight of the key financial metrics and highlight any changes proposed from the position agreed by the Board in April.
2. Address the issues raised by Ian Dalton in his June letter.
3. Feedback on the Triangulation session held with NHSI on 12th April.

Key issues noted were;

1. NHSI had indicated that the Trust's control total would be adjusted from the current £6m deficit before STF. The Trust was still awaiting confirmation of what this would change would be. It was noted the Trust continued to report a planned £29m deficit; if the control total was changed to this value then the Trust should be eligible for STF.
2. An increase in the turnover of the Trust to £822m following the move to Whole Government Accounting, whereby recharges are shown net.
3. A change in the mix and phasing of CIP schemes to reflect the current position, with this resulting in minor changes to the overall I&E phasing. CIPs were reported as all low or medium risk, with 85% being recurrent. It was reported NHSI had reviewed and assured the majority of CIPs over £100k.
4. No material changes were expected in the balance sheet, capital, cash flow or use of resources metrics.
5. The activity plan had been corrected following the identification of errors in the original submission. The Board was informed these errors were in the presentation of the Activity plan template to NHSI and they did not impact on the overall planning process. The revised Activity plan had been discussed with NHSI.
6. A revised Workforce Plan was presented to reflect the changes in the WTE impact of the CIP.

The paper presented to the Board addressed each of the issues raised by Ian Dalton and where appropriate clearly stated any adjustments necessary to the Plan. Feedback was also provided from the NHSI Triangulation session, with the report including NHSI's view on each of the points addressed; positive assurance being demonstrated on all points with one exception where further work is required (elective capacity and assurance around target productivity improvement).

The CFO noted that the material risks to the delivery of the Financial Plan related to;

1. Delivering target elective activity levels.
2. Delivery of the CIP.
3. Achieving the required run rate reduction.

No material changes were expected in the balance sheet, capital, cash flow or use of resources. None of the key issues raised in the letter had any material differences to be reported. The main financial changes related to GP LEO and the loss of the community services contract, which the Board were aware of. The risks in the CIPs were NHS Improvement risks, with the Trust having no high red risk schemes. NHS Improvement had reviewed the CIPs and were satisfied with them. Reasonable assurance could be shown against areas addressed in their letter.

	Stephen Collier queried what the result would be if elective productivity benefits were not realised. The CFO stated that activity levels would remain the same as the previous year. He added a new theatre manager had been recruited and external support was in the process of being engaged to help ensure theatres were well managed and efficiencies driven forwards. The Director of Delivery, Efficiency & Transformation noted that the Trust was absolutely capable of delivering these targets and was achieving the required levels in some week. The Chairman noted that there was a great deal of further potential for workforce CIPs given the opportunities highlighted in the Model Hospital datasets and requested the Executive Team remain focused on identifying and delivering workforce efficiencies. Stephen Collier requested that workforce trends were shown with community services data removed to provide a comparison of the underlying pattern. The Chairman requested that the Executive Team maintain focus on the delivery of the all aspects of the Plan as presented to help support the Trust moving out of Financial Special measures. She requested that any update of the Control Total be reported at the next Board meeting. The Board approved the proposed changes to the Finance, Activity and Workforce plans, and agreed that authority would be delegated to the Chairman and Chief Executive should any further changes be required ahead of the submission date.
CLOSING ADMINSTRATION	
3.1	**Any other business**
	No other business was raised.
CLOSE	

Date of next meeting: Thursday 28 June 2018 at 10:00

Trust Board Action Log - 31 May 2018

Action Ref	Theme	Action	Due	Lead	Commentary	Status
TB. 22.02.18/ 67	**Fit & Proper Person Regulation (Matrix)**	DHROD to give consideration to updating the FPP matrix to clarify which roles require professional qualifications / registrations.	28.06.2018	DHROD	FPP update on agenda 28.06.18	PROPOSE FOR CLOSURE
TB 29.03.18/ 68	**Fit & Proper Person Regulation (Frequency of reporting to the Board)**	DHROD to report to the Board on a quarterly basis on the Trust's compliance for a full year (throughout 2018/19), after which the frequency of reporting would be	28.06.2018	DHROD	Quarterly reporting on compliance with FPP scheduled for June, September, December 2018 and March 2019. On agenda 28.06.18 and forward planner.	PROPOSE FOR CLOSURE
TB. 29.03.18/ 76	**Freedom to Speak Up**	Board to receive report after the next Workforce & Education Committee (WEC) meeting and subsequent regular reports	28.06.2018	DHROD	Committee meets next on 14 June - FTSU to be added to agenda. Consideration to be given to frequency of reporting to the Board.	OPEN
TB. 29.03.18/ 77	**NHS Staff Survey 2017**	Staff Survey action plan to be considered by the Board after the discussion at next meeting of the Workforce and Education Committee	28.06.2018	DHROD	Committee meets next on 14 June - action plan to be added to WEC agenda and to June Trust Board agenda.	OPEN
TB. 31.05.18/ 78	**CEO Update**	Ensure clear messages communicated to staff regarding the Trust's withdrawal from provision of certain community services	28.06.18	DS & DCA		OPEN
TB. 31.05.18/ 79	**Integrated Quality & Performance Report**	NED opinions to be sought regarding new style of report before returning to FIC	28.06.18	DDET		OPEN
TB. 31.05.18/ 80	**Board Assurance Framework**	BAF reporting to Trust Board to move to every quarter	28.06.18	CN&DIPC	Board Committees to continue considering BAF risks assigned to them on monthly basis and to escalate issues to the Board as appropriate. On forward planner.	PROPOSE FOR CLOSURE

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	22 June 2018	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

Chief Executive's report to the Trust Board – June 2018

This month, I want to begin my report by talking again about strategy development, which Suzanne Marsello, our Director of Strategy, is leading.

Strategy development:

I am pleased to say there are staff and stakeholder workshops taking place across our hospitals – and in the community – throughout July.

We already have over 70 people signed up to the sessions, and I am confident the numbers will increase as the events draw nearer.

Staff in particular have told us repeatedly that they want clarity about our future strategy, but also that they don't want it to be a 'top-down' decision. As a result, giving people the chance to help shape the strategy, particularly during the initial development phase, is essential.

Of course, this doesn't mean everybody will be happy with the final strategy we agree. If we are to change the way we work, then we will have to take informed but sometimes difficult decisions along the way. Otherwise, we will just continue as we are, which we know isn't sustainable; from a performance, quality or financial perspective.

We already have clarity on some issues, specifically: we want to be the main provider of tertiary and specialist services in south west London and Surrey; we want to be a provider of excellent secondary care services to the people of Wandsworth and Merton; and we want to work collaboratively with the other acute providers in south west London to ensure the sustainability of the acute provider system.

However, we need a strategy that builds on these principles, and that gives us a clear mandate for change; and getting there is our goal over the coming months.

Corporate Objectives:

Last year, we set out our priorities for 2017-19, all of which are designed to help us provide ***Outstanding Care, Every Time*** for our patients.

The corporate objectives paper presented at today's meeting provides more granular detail about how we are measuring success, although I am pleased to say that, looking back at what we agreed towards the end of 2017, it is clear that in many areas, we are making improvements.

For example, one of our objectives is to ***Champion Team St George's***, a part of which involves making sure we have the right people and skill-mix to ensure our staff feel supported, and able to deliver the care we all aspire to. With this in mind, I am pleased to say that our vacancy rate has reduced from a historical high of 19% to our current position of under 12%; and the average time taken to recruit staff once a post becomes vacant has reduced from 75 to 35 days. This is real progress.

The same is true of ***Right Care, Right Place, Right Time***, another one of our objectives. I am pleased to say emergency care performance continues to improve, but we must not be complacent, as we would expect improvements during the summer months. Our cancer performance is consistently strong, however, meaning patients are getting the care they need, when they need it.

Our Elective Care Recovery Programme is progressing all the time and, whilst there is still some way to go, our aspiration is to return to national reporting of our data as soon as possible; and this remains a priority for the organization.

These are just two examples, and it is clear that – in other areas – we are not where we need to be. We know ***Balance the Books, Invest in our Future*** is going to be challenging this year, but we delivered the planned deficit last year of £53 million, and our target deficit for the coming year (£29 million) is non-negotiable – meaning (again) that some difficult decisions will need to be taken, although we will ensure quality of care is not affected.

So, lots of work to do, but real evidence of progress, which is positive. The Care Quality Commission (CQC) inspection report – which we expect to be published in the coming months – will also tell us where we have improved, and where we need to focus our energies going forward.

ICT:

Our ICT infrastructure remains fragile, but we were pleased to announce some funding last month for our critical care service.

We have invested £1.65 million in new clinical IT equipment across our Cardiothoracic Intensive Care Unit (CICU), Neuro Intensive Care Unit (NICU) and General Intensive Care Unit (GICU) – so enabling full roll-out of the electronic patient record.

To date, the roll-out of the electronic paper record across critical care has been patchy, which is less than ideal for staff, and can sometimes make accessing patient details quickly and effectively more challenging than it should be.

The new investment has helped pay for new computers and IT equipment for critical care and, whilst a very small step, it helps to demonstrate to the organization how important we view this key challenge at the Trust.

This year, our plan and intention is to invest more in IT, at both our main sites, with our immediate priority being Queen Mary's Hospital. Upgrading our IT infrastructure will support our elective care recovery programme but also, and as important, make it easier for staff to go about their every day jobs.

Staff achievements and NHS 70:

As always, there is a huge amount to celebrate, and I am really excited about the different events we are holding at St George's and Queen Mary's on 5 July to mark the NHS at 70.

Our staff continue to do great things; for example, Heather Jarman, our excellent Consultant Nurse for Emergency Care at St George's, is a finalist in the 2018 RCNi Nurse Awards, one of the UK's most prestigious nursing awards ceremonies. Our communications team was also short-listed for two awards at the annual UK Public Sector Communications awards.

Our urology team has also been recognized as a host training centre by the European Robotic Society, which is evidence of the fantastic care they provide. Our renal transplant team have also been highly rated in a recent peer review, and continue to record excellent outcomes for their patients.

Our staff are our greatest asset, which is why I was also pleased to attend a thank you event last month organized for 80 members of staff in the House of Parliament, and hosted by Siobhain McDonagh MP.

The event reminded me how highly regarded the organization is by the communities we serve, and this, again, is down to the staff who work in and run our various services.

Jacqueline Totterdell, Chief Executive

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	28th June 2018	**Agenda No**	**2.1**
Report Title:	2018/19 Corporate Objectives		
Lead Director	Suzanne Marsello, Director of Strategy		
Report Author:	Tom Ellis, Head of Business Planning		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	In December 2017, the trust agreed a new set of Corporate Objectives – Outstanding Care, Every Time. The Trust Board has asked for a quarterly report on progress against these objectives through 2018/19, with the June Trust Board to finalise the milestones and SMART (Specific, Measureable, Achievable, Relevant, Time-bound) measures of success. Following discussion at the May Trust Board, the draft Corporate Objectives have been reviewed by Executive Directors. Limited changes have been made as a result of this review, though the section on *"Build a Better St. George's – Estates"* has been significantly updated since previous iterations. The draft Corporate Objectives were approved at TEC on 20th June, for final submission to Trust Board. An update will be brought to the Board meetings in July, October, January and April 2019 updating Board members on progress against the agreed Corporate Objectives and quarterly actions.		
Recommendation:	The Trust Board is asked to: 1. Approve the finalised 2018/19 Corporate Objectives and the associated actions, milestones and SMART measures of success		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change		

	▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	▪ Any risks associated with the corporate objectives are covered within the BAF, Trust Risk Register or local risk registers		
Legal/Regulatory:	N/a		
Resources:	N/a		
Previously Considered by:	Trust Board Diary Meeting TEC	**Date:**	31/05/18 13/06/18 20/06/18

2018/19 Corporate Objectives
Trust Board 20th June 2018

1.0 Purpose

1.1 In December 2017, the trust agreed a new set of Corporate Objectives – Outstanding Care, Every Time. These built on the Quality Improvement Plan, published by the organisation in September 2017. These two documents set out, at a high level, the trusts aspirations for 2018/19. The Trust Board has asked for a quarterly report on progress against these objectives, through 2018/19, with the June Trust Board to finalise the milestones and SMART (Specific, Measureable, Achievable, Relevant, Time-bound) measures of success. Progress against these milestones will then be reported on a quarterly basis, starting in July 2018.

2.0 Progress to date

2.1 Following discussion at the May Trust Board, the draft Corporate Objectives have been reviewed and amended, where felt appropriate, by the relevant Executive Director. It should be noted that changes have been minimal though the section on *"Build a Better St. George's – Estates"* has been significantly updated since previous iterations. The draft Corporate Objectives were discussed and agreed at TEC on the 20th June, and approved for submission to Trust Board.

3.0 Quarterly Monitoring

3.1 An update will be brought to the Board meetings in July, October, January and April 2019 updating Board members on progress against the agreed Corporate Objectives and quarterly actions.

3.2 It should be noted that for 2019/20 the corporate objectives will be developed as part of the business planning process, at an earlier stage in the process so that these can be used to inform the Divisional business plans.

4.0 Recommendation

The Trust Board is asked to:

1. Approve the finalised 2018/19 Corporate Objectives and the associated actions, milestones and SMART measures of success.

Author: **Tom Ellis, Head of Business Planning**
Date: **15th June 2018**

Outstanding Care, Every Time

Organisational Objectives 2018/19

Annual Delivery Plan and Monitoring

Delivery of our 18/19 Corporate Objectives

At St George's, our aim is to provide Outstanding Care, Every Time for all of our patients, wherever they are treated.

As part of this, we have agreed a set of strategic objectives – all of which are designed to improve care for patients, and the working lives of our staff. These are:

- Treat the patient, treat the person
- Right care, right place, right time
- Balance the books, invest in our future
- Build a better St. George's
- Champion Team St. George's
- Develop tomorrow's treatments today

We are confident these will give staff, patients, and our local and national stakeholders much greater clarity about where we are focussing our energies, and where we want to improve.

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



Governance: Reviewing progress

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

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

Objective: Treat the patient, treat the person

1. Fundamentals of Care

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

Objective: Treat the patient, treat the person

2. End of Life Care

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

Objective: Treat the patient, treat the person

3. Patient involvement in decision making

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

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

Objective: Treat the patient, treat the person

4. Deteriorating Patients

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

Objective: Treat the patient, treat the person

5. Medicine Management

Aim	Ensure the safe and efficient storage and use of medicine and to continue to reduce the time a patient waits for their medicine				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
Ensure safe and secure handling of medicines focusing on room and fridge temperature monitoring solution for medicines	▪ N/a	▪ Scoping exercise with Estates for automated temperature monitoring solutions for medicines storage	▪ Seek IDG approval for required investments	▪ Rollout of solution	▪ Installation of automated temperature monitoring solutions for medicines storage
Continue to improve discharge medication turnaround times for patients to improve the patient experience and patient flow through the Trust	▪ N/a	▪ Add LW satellite dispensing unit to data tracker	▪ Tender to external partners for monitored dosage systems	▪ Increase the use of an external partner to provide monitored dosage systems to prevent delayed discharge ▪ Increase the number of prescribing and transcribing pharmacists	▪ 90% of medication to take out (TTOs) dispensed in satellite dispensing units ▪ 80% of pharmacists actively prescribing ▪ 90% of Monitored Dosage System dispensed by external partners ▪ 90% of TTO's completed in less than 60 minutes in satellite dispensing units

Objective: Right care, right place, right time

6. Emergency Care

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

Objective: Right care, right place, right time

7. Unplanned and admitted care

Aim	▪ We will ensure we admit patients to the right ward or place of care first time, and ensure a positive experience for our patients ▪ We will align our people and clinical capacity to pathway demand, and ensure our patient are taken to the most appropriate environment for their assessment, treatment and care				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
Admit patients to the right ward, discharge them efficiently and ensure a positive patient experience	▪ AMU bed occupancy at Midday =<80% ▪ Model Hospital and Get it Right First Time (GIRFT) benchmarked Length of stay and Daycase rate performance to be identified	▪ AMU bed occupancy at Midday =<85% ▪ Implementation plan agreed with given GIRFT specialties	▪ AMU bed occupancy at Midday =<90% ▪ Implementation underway	▪ AMU bed occupancy at Midday =<90 ▪ Demonstrable reduction in length of stay	▪ AMU bed occupancy at Midday =<85% ▪ Reduced variation to GIRFT opportunity benchmarks
Develop boundary-less flow to minimise LOS for patient requiring on-going treatment or care, and create the flexibility with hospital to maintain a steady state during periods of increased demand	▪ Partnership working at and in support of Wandsworth & Merton Urgent & Emergency Care Transformation and Delivery Board (UECTB) ▪ Agreement of repatriation protocol at SWL UECTDB	▪ Partnership working at and in support of Wandsworth & Merton UECTB	▪ Launch of Smartboard in AMU ▪ Launch of auto-populated Repatriation Communications with partner hospitals ▪ Partnership working at and in support of Wandsworth & Merton UECTB	▪ Launch of Smartboard in Cavell, Nye Bevan and AAA ▪ Partnership working at and in support of Wandsworth & Merton UECTB	▪ All areas of virtual emergency floor to be simultaneously visible to clinical and patient flow decision makers ▪ % of beds occupied by patients identified as delayed transfer of care to be <3%
Achieve SAFER compliance on wards	▪ UAPC Steering Group agree minimum expectations of ward teams	▪ 30% compliance	▪ 60% compliance	▪ 90% compliance	▪ 90% of wards using SAFER ▪ Achieved in line with quarterly milestones

Estates will draw up and assist with physical plans/options to support emerging operations plans/strategy	▪ Review current plans with Local Health Economy and partake in bidding for transitional / sustainable projects with the STB	▪ On emergence of clinical strategy for South West London produce first draft of proposed Estates Strategy of St George's. This will be done following the production of the Space Utilisation Review which should be finished in August / September	▪ First draft of Estates Strategy to Board in December dependent on the production of the Clinical Strategy.	▪ Approval and ratification of Estates Strategy to be undertaken at Board in March dependent on clinical strategy production. Including a timescale and final requests.	▪ Award of funding from central capital ▪ Board paper on Estate Strategy Assurance

Objective: Right care, right place, right time

8. Theatres

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

* Subject to securing of external capital funding

Objective: Right care, right place, right time

9. Patient choice

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

Objective: Right care, right place, right time

10. Waiting lists and RTT

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

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

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

Objective: Build a Better St. George's

12. Strategy and engagement

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

Objective: Build a Better St. George's

13. Governance

Aim	We will improve our governance arrangements, as well as our everyday management systems (such as Agresso and ESR)				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
Undertaken an independent review of our corporate governance function	▪ Agree new corporate governance team structure and roles ▪ Develop clear Board forward work programme for 2018/19 ▪ Agree new Terms of Reference for Trust Executive Committee	▪ Complete review of corporate governance structures below Board Committees and agree future structural design and reporting lines	▪ N/a	▪ N/a	▪ New corporate governance team structure in place ▪ New corporate governance structure fully implemented
More engagement and involvement of patients, front line staff and partner organisations	▪ Agree action plan based on results of the annual communications survey	▪ N/a	▪ Launch of new Trust branding	▪ Launch of new intranet and website	▪ Improved NHS staff survey engagement scores
Use the CQC Well-Led Framework to ensure we are meeting our regulatory requirements	▪ Receive CQC report which will detail new ratings across all domains for the 6 core services inspected in March / April 2018 ▪ Refresh QIP priorities accordingly whilst maintaining focus on the basics	▪ Self-assess our services against CQC domains ▪ Assess ourselves against well-led framework	▪ Mock quality review in September / October 2018	▪ N/a	▪ For CQC to recommend exit from Quality Special Measure by March 2019 at the latest

Ensure the appropriate governance measures are in place to learn from incidents and complaints	▪ Evidence of learning from complaints to be captured on DATIX and reported to Patient Safety and Quality Board (PSQB) and QSC ▪ Evidence of organisational learning by testing in practice	▪ Develop a tool and use to audit learning in practice and report findings	▪ N/a	▪ N/a	▪ 6 monthly reports to demonstrate learning from Sis, incidents and complaints ▪ Audit results
Continue to monitor compliance with the risk management policy and improve risk registers at every level	▪ Continue to review risk registers at Risk Management Committee and challenge ratings, mitigation and progress to inform the BAF ▪ Ensure Divisional Governance Boards are reviewing and challenging their risks prior to presentation at RMC ▪ Ensure all risks that should be captured are captured accurately	▪ N/a	▪ N/a	▪ Sufficient progress to show that extreme risks have reduced	▪ 0 Moderate/ high /extreme risks with overdue actions ▪ 0 Moderate/high /extreme risks with no mitigating actions

Objective: Build a Better St. George's

14. Information Technology

Aim	We will continue to stabilise and improve our IT infrastructure				
We will	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
Improve patient experience and reduce harm by enabling and supporting the Financial recovery Programme	▪ FIC on 24th May agreed IT priorities would be presented to the June Trust Board ▪ The Corporate Objectives relating to IT will therefore be informed by that paper and subsequent Board decisions ▪ Actions and milestones will be updated as and when Board sign-off is complete.				▪
Improve Trust staff experience of using IT					▪
Improve the timeliness and availability of data to support clinical and administrative decision making					▪

Objective: Build a Better St. George's

15. Estates

We will	Quarter 1 milestones	Quarter 2 milestones	Quarter 3 milestones	Quarter 4 milestones	SMART Measures of Success
We will undertake substantial reviews and surveys of the overall Estate and Environment. This will clearly identify the back-log maintenance position and allow for investment in such areas as Ward Refurbishment, Theatre Refurbishment and	▪ By June contracts will be in place to undertake surveys both physical and desk top including the Fixed Facet Survey and Engineering Asset Review. This will be linked to the population and production of PAM and the overview of our statutory regulatory items	▪ In line with the PAM documentation and the outcome of the surveys, publish the revised back-log maintenance list and identify high risk projects. ▪ Those projects such as Theatres and Ward Refurbishment will include within any bids made for upgrade of general infrastructure as part of the bidding process for emergency funding. Surveys	▪ Reviews will be undertaken of progress and action plan/project plan and 5/10 year BM investment plan will be created with revised backlog maintenance number. ▪ Create a review of any emerging risk appetite issues to share with Risk management Executive.	▪ A full report on backlog maintenance and any increased levels of risk will be reported to the Board by March 2019 with a look forward to potential expenditure/investment in the new financial year	▪ Results of detailed surveys ▪ Publication of PAM results ▪ Programme requests via Committee to Board ▪ Result of emergency capital loan funding published

replacement of large Diagnostics dependent on Trust's priorities		will be underway with the majority reported by end of September.			
Undertake a market review of substantive contracts including the FM contract. Instigate the implementation of a potential measured equipment service governing in the first instance Medical Equipment and large Diagnostic equipment	▪ From the framework identify and appoint an advisory company for the creation of a brief to go to Market	▪ Undertake market review and tendering process of Phase One of MES Contract with bolt on allowances for the expansion of the MES Contract of other service provision contracts not only within Estates and Facilities but within the Trust generally	▪ Undertake substantial review of Contracts and equipment within the hospital to find existing baseline. Update contact information in the first instance to negate any historical non-productive contracts and remove for savings plan linked to CIP. ▪ Present to the Board findings of the overall Risk Strategy, the need for Risk appetite and identify investment portfolio from the emerging issues	▪ Appoint and commence overall management contract with preferred supplier.	▪ Appointment of Consultants ▪ Tender returns adjudicated ▪ Finally secured ▪ MES Contract awarded
We will ensure a safe environment with plans to achieve relevant statutory standards as our baseline	▪ Introduce and commence population of the PAM documentation and review the Risk Register set for the Estates and Facilities Directorate.	▪ In conjunction with the Risk Management Group, Infection Control and the Safety and Quality Committee, review all high level risks and identify what the risk appetite for the Trust which will then be presented for ratification to the Board	▪ Monitor and report via PAM quarterly report to Board performance against all domains.	▪ Prepare the Annual Report for the coming year and give state of the Estate address in March to Board ▪	▪ Board review of PAM at development days ▪ Quarterly review of PAM results commencing December 2018.

Objective: Champion Team St. George's

16. Leadership and Engagement

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

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

Objective: Develop Tomorrow's Treatments Today

17. Education & Training

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

Develop Tomorrow's Treatments Today

18. Research & Innovation

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

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

* Subject to securing of external capital funding

Appendix 1 - Corporate Objective Link to Board Assurance Framework

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

Strategic Objective	Risk Appetite	Strategic Risk	Current Risk Score	Linked Corporate Objective (No.)
Treat the patient, treat the person	Moderate	We are unable to develop new roles, changes in skill mix and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could result in care which is below the minimum standard.	**16**	**6**
	Low	Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway are not timely or robust, resulting in poor, delayed or missed treatment.	**16**	**1, 4, 5, 6, 7, 8, 9, 10**
	Low	We do not have effective, accessible and widely utilised learning and improvement methodologies, resulting in care which is below local and national standards and best practice.	**12**	**2, 3, 13**
Right care, right time, right place	Low	Our pathways are not well integrated with, or supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.	**8**	**4, 7**
Balance the books, invest in our future	Low	Financial efficiency, forecasting and accountability is not seen as a priority for service managers or our wider workforce, resulting in overspending, poor budgetary management which could lead to poor service delivery and regulatory action	**16**	**11**
	Low	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities	**20**	**11**
	Low	We do not have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories. This results in the Trust having incomplete plans and management action becoming reactive.	**15**	**11, 12**
	Low	Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative/punitive or does not foster accountability amongst our workforce.	**10**	**13, 16**

Champion Team St. George's	Moderate	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.	**12**	**13, 16**
	Low	We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction and poor care for patients.	**9**	**2, 17**
	Moderate	We fail to develop our future leaders and we fail to provide clarity to them about their roles and accountabilities, which leads to low job satisfaction, high turn-over and on-going instability amongst our senior leaders	**9**	**16**
Build a better St. George's	Low	Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.	**20**	**10, 14**
	Low	Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting delivery and risking patient safety.	**15**	**15**
	Low	We are unable to secure the investment required to address our IT and estates challenges and as a result are unable to transform our services and achieve future sustainability.	**16**	**13**
	Moderate	We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clinical service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.	**12**	**12**
	Moderate	A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.	**12**	**12**
Develop tomorrow's treatments today	High	We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.	**12**	**18**

Appendix 2 – Progress Tracker – Position at Q1

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

Organisational Objective	Green	Amber	Red	Consolidated Quarterly Position	Comments
Treat the patient, treat the person					
Right care, right place, right time					
Balance the books, invest in our future					
Build a better St. George's					
Champion Team St. George's					
Develop tomorrow's treatments today					

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 June 2018	**Agenda No**	**3.1**
Report Title:	**Quality and Safety Committee report**		
Lead Director/ Manager:	Sir Norman Williams, Chairman of the Quality and Safety Committee		
Report Author:	Sir Norman Williams, Chairman of the Quality and Safety Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 21 June 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	N/A		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality and Safety Committee Report – June 2018

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 21 June 2018 and agreed to bring the following matters to the Board's attention:

1. **CQC Inspection Update**
   The Committee heard from the Chief Nurse that the draft CQC inspection report has been received and that the factual accuracy check has been completed and returned to the CQC. The CQC will let the Trust know whether or not it accepts the factual accuracy corrections and the final report is expected to be published in the first week of July.

2. **Quality Improvement Plan Dashboard**
   The QIP dashboard was received by the Committee. The Committee noted the limitations of 'traffic light' indicators when monitoring quality improvement and agreed that where possible in the future SPC charts should be used so that the significance of movement in the indicators is clear.

   The Committee noted improvements in the RAG rated performance in 6/78 KPIs and a deterioration in RAG rated performance in 5/78 KPIs. Improved performance was noted in the 4 hour admitted standard; outpatient follow ups per month and first attendances; never events and avoidable grade 3 and 4 pressure ulcers. Deterioration was noted in on the day cancellations for theatre and percentage utilisation of pre-op appointments.

   The Committee noted that the percentage of patients in the emergency department with sepsis receiving antibiotics within an hour has fallen to 81%. The Committee asked to hear the outcome of the detailed analysis that has been carried out by the sepsis lead and the actions to improve performance.

   The Committee also noted the improvement in meeting complaint response times with 84% of complaints with a 25 day response time responded to within that time frame. However the Committee was clear that while this was a good start it wants to see sustained and consistent performance.

3. **Integrated Quality & Performance Report**
   The Committee received the report and noted that there have been no new never events in the reporting period; that improvements could be seen in the number of falls and in all pressure ulcers. The Committee asked for focus to be maintained with on the day cancellations and achieving discharges before 11am.

4. **QIP deep dive: Learning from Incidents**
   In January 2018 NHSI published the Never Events List 2018, there are 14 never events on the list that are applicable to acute trusts. The Learning from Incidents workstream of the QIP has carried out a review of the organisational barriers in place to prevent each of these never events happening. A detailed risk assessment has been carried out for each never event and the barriers in place.

   Where there is limited assurance that all barriers are in place and effective the workstream has identified priorities for immediate improvement within the next three months in three specific areas:

   - Wrong site surgery/wrong implant/retained foreign object

- Overdose of insulin
- Misplacement of naso-gastric tubes

Delivery of the action plans will be monitored through the Quality Delivery Meeting and the Patient Safety Quality Meeting.

The Committee heard that these events are rare and random and that most staff will not be involved with one during their working life. This makes a rolling programme of education on all potential never events very necessary, both to maintain organisational memory and to ensure systematic, regular review of the barriers in place to prevent them happening.

5. Elective Care Recovery Programme

The Committee heard from the Chief Operating Officer that following a period of shadow reporting from September to December 2018 it is planned that the Trust will return to national reporting on referral to treatment times in the last quarter of 2018/19.

6. Patient Safety & Quality Group

The Committee noted that PSQG had received the Q3 and Q4 17/18 legal services report and that of the 16 claims concluded in the period seven had been settled. The Committee asked for assurance that learning from claims is shared across the Trust. The Committee heard that learning is linked with learning from incidents and is shared with divisions and directorates. The Director of Quality Governance has confirmed that monthly reports on learning applicable across the Trust are in place and are being circulated widely.

7. Safeguarding Adults Annual report

The Committee received this report which is also being presented to this meeting of the Board.

8. Ward Accreditation Report

The Committee received the report on the ward accreditation process. The current position for the 34 wards that have been inspected is:

- Gold – 2 wards
- Silver: 17 wards
- Bronze: 12 wards
- Requires improvement: 3 wards

The Committee found the report very encouraging and was pleased to hear how those wards rated as gold standard are sharing what they do with others and how those who need to improve are being supported.

9. CNST Incentive Scheme for Maternity

The Department of Health is rewarding those services that have taken action to improve maternity safety. For services that can demonstrate compliance against ten safety actions NHS Resolution will return a percentage of the maternity contribution to the Clinical Negligence Scheme for Trusts (CNST). The Committee heard from the Director of Midwifery about the self-assessment process that has been carried out of our compliance against these ten actions and the evidence supporting our assessment.

The Committee commended the team for their work and noted that the Trust can demonstrate compliance with all ten standards.

The Committee recommends the self-assessment to the Board and recommends approval of the self-declaration.

10. Mortality Report

The Committee received the report which provided an update on the work of the Mortality Monitoring Committee and an overview of data for the entire year. The Trust's progress against the 'Learning from Deaths' framework has been strong with the team invited to present to the national 'Learning from Deaths – one year on' event to share our experience of how mortality review has improved care processes.

The Trust is sharing cases and learning with neighbouring trusts and substantial work has occurred in a number of services to improve care processes for patients with fractured neck of femur and cardiac surgery where mortality case note review identified opportunities to improve.

The NQB Learning from Deaths Dashboard for the Trust is being presented to this meeting of the Board.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	28th June 2018	Agenda No.	3.2
Report Title:	Integrated Quality and Performance Report		
Lead Director/ Manager:	James Friend		
Report Author:	Kaye Glover & Emma Hedges		
Presented for:	Information about Quality and Performance for the year to Month 2.		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access, performance and workforce objectives. This month, the report has been set out in a balanced scorecard approach identifying each of the four perspectives. An Executive Summary of key points to note is set out at the beginning of the report. The trust is performing positively against a number of delivery indicators. Significant improvements have been made in reducing patient waiting times against the Four Hour Operating Standard achieving above trajectory for April and May as well as maintaining performance within the 14 and 62 day cancer standards and diagnostic waits.		
Recommendation:	The Committee is requested to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	Safe Caring Responsive Effective Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal / Regulatory:	The trust remains in Quality Special Measures based on the assessment of the Regulator NHS Improvement		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Previously Considered by:	Quality & Safety Committee Finance & Investment Committee	**Date: 21/6/18** **Date: 25/6/18**	
Appendices:	Integrated Quality and Performance Report		

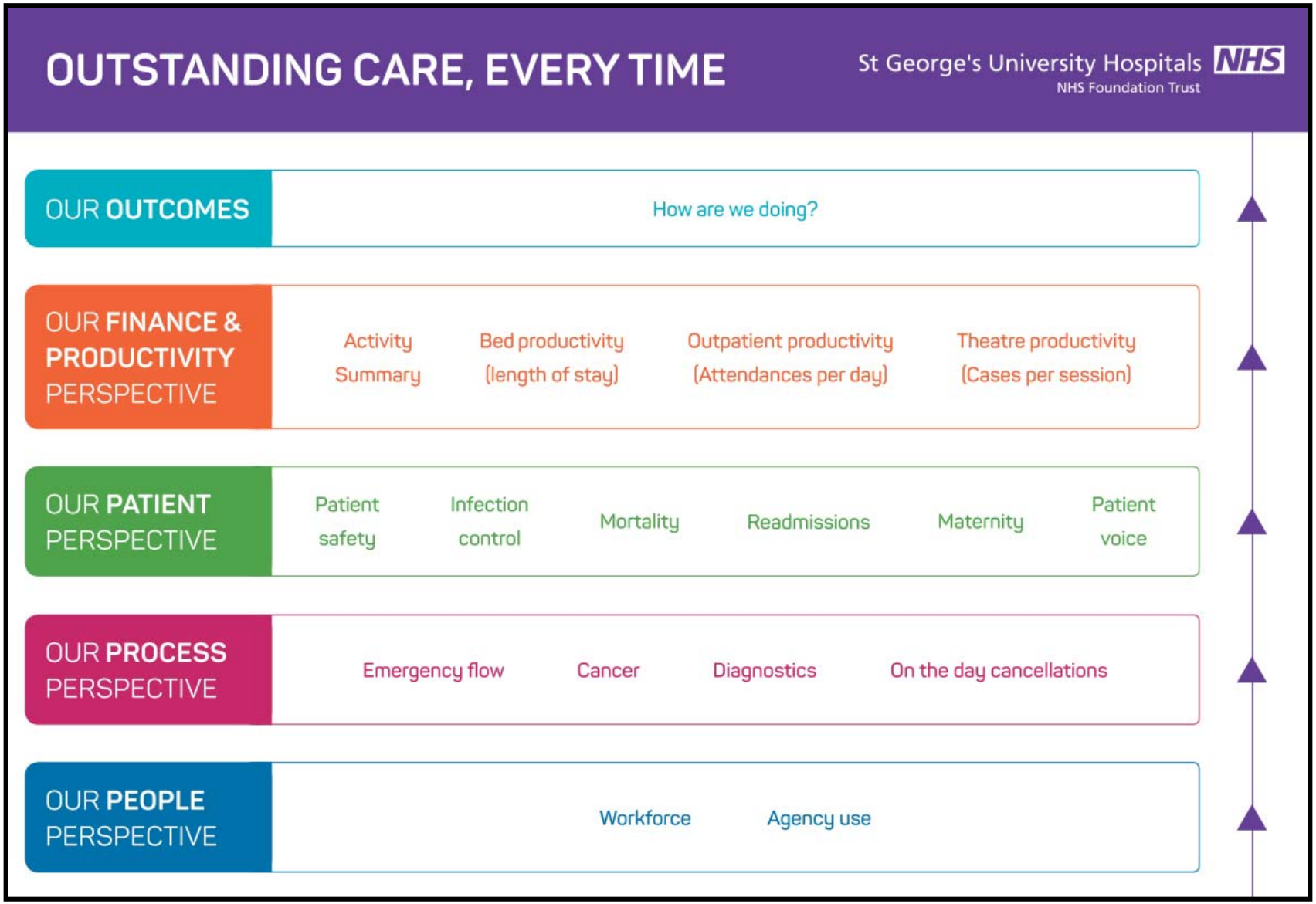
excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 28 June 2018
Reporting period – May 2018

Outstanding care, every time


OUTSTANDING CARE, EVERY TIME
St George's University Hospitals NHS
NHS Foundation Trust
OUR OUTCOMES
How are we doing?
OUR FINANCE & PRODUCTIVITY PERSPECTIVE
Activity Summary
Bed productivity (length of stay)
Outpatient productivity (Attendances per day)
Theatre productivity (Cases per session)
OUR PATIENT PERSPECTIVE
Patient safety
Infection control
Mortality
Readmissions
Maternity
Patient voice
OUR PROCESS PERSPECTIVE
Emergency flow
Cancer
Diagnostics
On the day cancellations
OUR PEOPLE PERSPECTIVE
Workforce
Agency use

Executive Summary – May 2018

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- No patients were reported with a Never Event was reported in May. There were five Serious Incidents declared in the month.
- The Trust reported one patient with hospital attributable Clostridium Difficile infection in May, against an annual target set at 30 cases in 2018/19.
- No patients acquired an MRSA Bacteraemia in month.
- The number of falls per 1,000 bed days decreased in May to 4.97, compared to 5.78 in April.

Clinical Effectiveness

- The Trust's mortality rates are significantly better than expected in all measures and analysis shows that we are 17% lower than expected from typical hospitals and practice in this country.
- Maternity indicators continue to show expected levels of performance.

Access and Responsiveness

- Elective and Day case activity shows a 7% decrease compared to the same period last year, and is currently below plan for May 2018.
- Performance against the Four Hour Operating Standard in May was 93.3%, which was 2% higher than the improvement trajectory of 91%. The improvement trajectory requires the delivery of 95% performance in June 2018.
- The Trust achieved six of the seven national mandated cancer standards in the month of April, continuing to achieve 14 day standard and achieving 62 day compliance.
- The Trust remains compliant against the 6 week Diagnostic Access standard at the end of May reporting only 0.2% of our patients waiting greater than six weeks for a diagnostic procedure, this represents fourteen patients in total.

Patient Experience

- The Friends and Family Test (FFT) recommendation rate for both inpatients and outpatients was over 97% in May. This remains above threshold. The recommendation score for inpatients provides reasonable assurance on the quality of patient experience. The recommendation rate for the Emergency Department increased to 85%.

Workforce

- Staff sickness remains above the trust target of 3% for the month of May however an improved position is observed reporting 3.2%.
- Non Medical appraisal rates have seen a recent decline in performance however this has increased by 2% in May reporting period 63%.
- Medical appraisal rates have seen a positive improvement reporting a compliance of 81% against a target of 90%.
- The Trust's total pay for April was £40.43m. This is £0.13m adverse favourable to a plan of £40.56m.

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

May 2018

Daycase and Elective Surgery operations

Actual
4,553

Target 4,890

Discharges before 11am

Actual 15.9%

Target 30%

Four Hour Emergency Standard

Actual
93.31%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
97%

Target 95%

Outpatient First Appointment

Actual 17,005

Target 16,730

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
89%

Target
88%

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	
		May-17	May-18	Variance	Plan May-18	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	14,587	14,512	-0.51%	14,398	0.79%	28,367	28,027	-1.20%	28,331	-1.07%
Inpatient	Elective & Daycase	4,901	4,553	-7.10%	4,887	-6.83%	8,949	8,839	-1.23%	9,543	-7.37%
	Non Elective	4,095	4,302	5.05%	4,107	4.74%	7,876	8,182	3.89%	8,073	1.35%
Outpatient	OP Attendances	55,170	54,670	-0.91%	53,940	1.35%	100,631	105,778	5.11%	105,391	0.37%

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

Source: SLAM

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

Care Group	May-17	Jun-17	Jul-17	Aug-17	Sept-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Discharges	LOS Trend
Audiology & ENT	1.4	1.9	1.7	1.7	1.9	2.8	1.9	2.4	2.4	2.9	2.3	2.4	2.2	236	
Cardiac Surgery	13.1	13.6	11.3	10.9	12.4	13.5	15.3	10.3	13.9	11.1	14.1	14.0	10.2	69	
Cardiology	6.6	6.1	7.7	7.7	7.2	6.8	7.3	8.5	8.0	7.7	7.9	7.5	7.8	225	
Clinical Haematology	6.0	9.8	7.3	9.3	7.6	9.5	13.9	7.7	9.5	15.4	7.4	5.4	23.4	21	
Clinical Infection Unit	12.8	8.1	10.4	8.1	25.1	13.2	13.2	21.0	9.9	13.3	12.3	10.2	9.1	30	
Diabetes & Endocrinology	6.6	19.3	39.0	5.0	5.0	5.6	9.8	18.4	15.2	17.1	8.7	12.4	12.9	51	
General Medicine	2.7	3.0	2.8	3.1	2.7	2.9	3.1	3.2	3.4	3.6	2.8	2.9	2.8	2361	
General Surgery	4.6	4.8	5.1	4.5	5.2	5.3	4.9	5.7	4.7	6.7	3.8	5.0	4.5	326	
Gynaecology	1.1	1.5	1.8	2.5	2.0	2.2	1.6	2.7	4.3	1.3	1.0	1.4	2.1	29	
Intensive Care	14.3	7.0	8.2	12.8	18.0	20.7	7.8	17.2	6.1	7.5	13.2	9.8	10.4	15	
Neurorehabilitation	21.0	57.0	37.0	140.5	233.0	24.0	86.5	124.0	100.5	70.5	40.3	5.0	69.0	3	
Neurology	5.4	5.6	9.8	4.8	8.3	7.3	6.4	8.8	5.6	6.9	8.6	7.4	9.0	169	
Neurosurgery	13.0	9.7	10.8	9.8	10.5	13.7	12.0	11.0	13.4	9.8	12.9	10.8	10.5	122	
Obstetrics	1.4	1.4	2.1	2.1	0.7	2.3	2.0	2.5	1.8	2.1	2.0	1.5	0.7	15	
Oncology	5.4	5.0	4.5	4.7	6.0	7.6	4.2	5.7	5.5	7.0	5.5	2.8	3.9	63	
Paediatric Medicine	4.0	4.4	4.0	4.8	3.4	4.3	3.9	3.8	4.5	3.8	3.8	5.1	4.5	352	
Paediatric Surgery	2.7	2.9	3.4	2.5	3.3	2.0	3.3	1.8	1.9	2.0	1.8	3.2	4.3	56	
Plastic Surgery	0.9	0.9	0.6	0.9	1.1	1.1	0.9	0.9	0.9	1.7	0.8	0.9	0.7	276	
Renal Medicine & Surgery	5.5	6.3	6.3	6.3	7.1	4.6	5.3	8.2	5.8	5.1	7.6	4.1	5.7	67	
Rheumatology	6.6	5.0	8.7	15.0	10.0	3.0	15.5	4.5	6.8	27.3	4.5	10.3	17.0	1	
Senior Health	11.0	11.2	12.2	13.6	19.3	18.8	8.9	9.5	9.9	9.3	8.3	11.2	10.3	80	
Trauma & Orthopaedics	11.5	9.1	10.8	10.5	9.1	11.1	11.4	7.9	11.1	9.3	8.8	10.9	7.3	180	
Urology	3.5	3.4	4.0	2.9	3.5	3.5	3.1	2.9	4.6	3.1	5.2	3.6	5.0	61	
Grand Total	**4.1**	**4.3**	**4.5**	**4.3**	**4.4**	**4.6**	**4.4**	**4.6**	**4.7**	**4.8**	**4.4**	**4.4**	**4.3**	**4,899**	

Length of Stay

Elective Length of Stay (Including Daycase)

Care Group	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Discharges	Trend
Audiology & ENT	0.6	0.6	0.7	1.3	0.7	0.7	0.7	1.0	0.6	0.8	0.8	0.9	0.7	188	
Cardiac Surgery	5.8	5.3	5.1	5.5	5.6	6.6	5.3	5.3	5.7	5.0	6.9	4.9	5.2	129	
Cardiology	0.6	0.6	1.0	0.7	0.7	0.8	0.7	0.6	0.7	0.8	0.6	0.7	0.8	280	
Clinical Haematology	0.2	0.2	0.3	0.3	0.3	0.2	0.3	0.5	0.2	0.1	0.3	0.3	0.1	698	
Dentistry & Oral Surgery	0.0	0.0	0.2	0.0	0.0	0.1	0.0	0.0	0.1	0.0	0.3	0.0	0.0	36	
Dermatology	80.0	0.0	46.0	0.0	0.0	0.0	0.0	0.0	5.6	0.0	0.0	0.0	0.0	1	
Diabetes & Endocrinology	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.3	0.0	39	
General Medicine	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	1015	
General Surgery	0.7	0.7	0.9	1.0	0.7	0.7	1.0	0.6	1.0	0.8	0.8	0.8	1.1	822	
Gynaecology	0.6	0.4	0.9	0.5	0.6	0.3	0.4	0.7	0.5	0.5	0.7	0.6	0.4	191	
Neurorehabilitation	3.0	5.2	2.3	3.0	6.4	2.0	2.9	4.0	3.6	3.7	7.1	2.4	1.7	181	
Neurology	1.2	0.6	1.6	1.2	0.5	0.8	1.0	1.4	1.1	0.6	0.8	0.9	0.5	394	
Neurosurgery	2.9	2.9	4.2	3.0	4.2	3.2	3.1	3.4	3.6	3.4	4.2	3.4	3.6	147	
Obstetrics	2.0	1.1	1.2	2.0	0.0	0.6	0.0	0.0	0.0	0.3	0.5	0.3	0.7	7	
Oncology	0.2	0.2	0.2	0.1	0.1	0.2	0.3	0.1	0.1	0.1	0.1	0.2	0.1	802	
Paediatric Medicine	0.3	0.2	0.9	0.2	0.3	0.3	0.3	0.1	0.2	0.1	0.3	0.2	0.5	203	
Paediatric Surgery	0.8	0.4	0.5	0.4	0.5	0.4	0.3	1.2	0.5	0.3	0.3	0.5	0.6	167	
Plastic Surgery	0.4	0.4	0.8	0.4	0.3	1.0	0.6	0.6	0.4	0.4	0.4	0.3	0.5	355	
Renal Medicine & Surgery	0.4	0.4	0.2	0.1	0.2	0.2	0.1	0.1	0.1	0.3	0.2	0.1	0.2	646	
Trauma & Orthopaedics	2.8	3.1	1.4	3.6	1.9	3.0	2.6	2.9	2.4	1.3	1.7	1.7	1.4	118	
Urology	0.9	0.9	1.1	1.0	1.6	1.2	1.3	0.9	1.1	1.1	1.3	1.5	1.3	218	
Grand Total	**0.7**	**0.7**	**0.8**	**0.8**	**0.7**	**0.7**	**0.8**	**0.8**	**0.8**	**0.6**	**0.9**	**0.7**	**0.6**	**6,958**	

Outpatient Productivity

First Attendances (average per working day)

Division	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
C&W, Diagnostics, Therapies	136	141	133	128	141	139	138	126	137	129	122	123	138	
Medicine and Cardiovascular	279	261	263	243	255	251	274	223	262	259	266	240	262	
Surgery and Neurosciences	403	389	377	358	388	417	432	362	391	379	405	402	410	
Grand Total	**818**	**790**	**773**	**730**	**785**	**806**	**844**	**711**	**790**	**767**	**793**	**765**	**810**	

Follow Up Attendances (average per working day)

Division	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
C&W, Diagnostics, Therapies	145	137	137	130	147	151	166	142	163	160	138	135	146	
Medicine and Cardiovascular	867	842	821	801	821	808	842	754	850	817	852	825	857	
Surgery and Neurosciences	624	590	540	527	569	577	610	536	594	563	578	574	600	
Grand Total	**1,636**	**1,569**	**1,498**	**1,458**	**1,537**	**1,536**	**1,618**	**1,432**	**1,606**	**1,540**	**1,568**	**1,533**	**1,603**	

First and Follow Up DNA rates (by month)

Division	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
C&W, Diagnostics, Therapies	10.3%	10.2%	10.4%	11.1%	10.0%	10.1%	10.6%	11.6%	11.7%	11.4%	12.3%	13.4%	12.4%	
Medicine and Cardiovascular	10.8%	10.8%	10.2%	10.6%	10.6%	11.5%	10.7%	11.6%	11.8%	12.1%	11.7%	13.3%	11.2%	
Surgery and Neurosciences	9.9%	10.0%	9.7%	9.7%	9.6%	9.5%	9.5%	9.7%	9.7%	10.1%	10.4%	11.4%	10.2%	
Grand Total	**10.4%**	**10.3%**	**10.2%**	**10.5%**	**10.1%**	**10.4%**	**10.3%**	**11.0%**	**11.1%**	**11.2%**	**11.4%**	**12.7%**	**11.3%**	

First and Follow Up Ratio

Division	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
C&W, Diagnostics, Therapies	1.07	0.98	1.03	1.01	1.05	1.09	1.20	1.13	1.19	1.23	1.13	1.10	1.06	
Medicine and Cardiovascular	3.11	3.23	3.13	3.29	3.22	3.22	3.07	3.38	3.24	3.16	3.20	3.43	3.27	
Surgery and Neurosciences	1.55	1.52	1.43	1.47	1.46	1.38	1.41	1.48	1.52	1.49	1.43	1.43	1.46	
Grand Total	**2.00**	**1.99**	**1.94**	**2.00**	**1.96**	**1.91**	**1.92**	**2.01**	**2.03**	**2.01**	**1.98**	**2.01**	**1.98**	

Briefing

- Across the three divisions, First Outpatient attendances averaged 810 per working day, this is an increase compared to previous months and comparable with the same month the previous year.
- Follow-up attendances on average increased by 4.6% per day compared to April, with the increases seen across all three divisions.
- Did Not Attend rates have fluctuated over the last twelve months with a decrease seen in May.

Actions:

- Implementation of NetCall (telephony system) to contact patients to confirm clinic attendance and reduce Did Not Attend rates
- Switch off for paper referrals from Primary Care will take place in July 2018 with eRS (electronic Referral Services) being the only commissioned access method.

Productivity

St George's University Hospitals NHS
NHS Foundation Trust

Theatre Productivity

Session Utilisation	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Cardiac Surgery	89%	86%	86%	84%	83%	79%	83%	72%	77%	35%	74%	76%	78%
Cardiothoracic	88%	89%	89%	89%	89%	87%	91%	83%	83%	47%	80%	84%	72%
ENT	81%	82%	83%	82%	87%	82%	86%	79%	77%	82%	80%	80%	84%
General Surgery	89%	84%	84%	87%	85%	86%	84%	88%	87%	86%	85%	84%	81%
Obstetrics and Gynaecology	88%	85%	82%	83%	83%	85%	84%	82%	81%	84%	86%	82%	86%
Oral and Maxillofacial	94%	84%	88%	81%	88%	75%	85%	89%	87%	86%	90%	90%	89%
Neurosurgery	79%	80%	81%	85%	83%	82%	88%	89%	79%	83%	83%	84%	85%
Paediatric Dentistry	73%	74%	71%	70%	75%	65%	72%	78%	76%	73%	68%	68%	73%
Paediatric Surgery	94%	94%	95%	93%	97%	97%	94%	92%	95%	94%	94%	93%	92%
Plastic Surgery	77%	77%	80%	81%	81%	82%	87%	84%	82%	81%	79%	78%	80%
Renal Medicine & Surgery	82%	85%	79%	84%	80%	86%	81%	84%	86%	83%	84%	93%	88%
Trauma & Orthopaedics	82%	82%	90%	86%	90%	83%	85%	88%	81%	85%	81%	87%	82%
Urology	84%	87%	81%	90%	84%	88%	88%	86%	83%	86%	80%	85%	85%
Vascular Surgery	64%	77%	76%	85%	75%	82%	84%	81%	70%	77%	68%	82%	81%
Total	**84%**	**83%**	**84%**	**85%**	**85%**	**84%**	**86%**	**84%**	**82%**	**83%**	**82%**	**83%**	**83%**

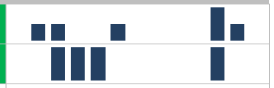
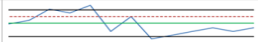
Average Cases Per Session	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Cardiac Surgery	0.76	0.82	0.80	0.74	0.73	0.76	0.66	0.65	0.68	0.70	0.66	0.77	0.77
Cardiothoracic	1.62	1.61	1.69	1.65	1.61	1.48	1.54	1.34	1.56	1.48	1.46	1.61	1.59
ENT	1.86	1.88	1.91	1.97	1.87	1.80	1.59	1.52	1.63	1.43	1.59	1.81	1.92
General Surgery	1.79	1.95	1.69	2.12	2.00	2.01	1.88	1.94	1.72	1.82	1.89	1.86	1.87
Obstetrics and Gynaecology	2.23	2.13	2.47	2.29	2.48	2.51	2.48	2.30	2.35	2.00	2.58	2.35	2.27
Oral and Maxillofacial	1.61	1.50	1.45	1.79	1.55	1.61	1.73	1.42	1.74	1.99	1.92	1.95	1.82
Neurosurgery	1.16	1.20	1.16	1.16	1.13	1.32	1.25	1.05	1.16	1.18	1.18	1.20	1.23
Paediatric Dentistry	4.91	4.93	4.54	4.37	4.13	3.74	4.65	4.16	3.63	4.00	4.27	4.33	3.73
Paediatric Surgery	2.41	2.40	2.48	2.61	2.34	2.50	2.54	2.45	2.51	2.63	2.65	2.41	2.62
Plastic Surgery	2.00	1.90	2.06	2.11	2.13	2.24	2.07	1.87	2.01	1.91	2.17	2.16	1.97
Renal Medicine & Surgery	1.62	1.33	1.52	2.06	1.52	1.52	1.32	1.66	1.33	1.86	1.40	1.76	1.45
Trauma & Orthopaedics	1.63	1.70	1.53	1.69	1.86	1.71	1.79	1.98	1.66	1.75	1.53	1.58	1.47
Urology	2.12	1.94	1.91	1.84	1.74	1.82	1.76	2.08	1.78	1.83	2.00	2.13	2.06
Vascular Surgery	1.11	1.05	1.22	0.98	1.09	1.17	1.03	0.99	0.95	1.09	1.13	1.15	1.26
Grand Total	**1.67**	**1.62**	**1.62**	**1.71**	**1.69**	**1.72**	**1.62**	**1.62**	**1.57**	**1.58**	**1.65**	**1.68**	**1.66**

Briefing - In May the Trust averaged 1.66 theatre cases per session across the Day Surgery Unit (DSU) and the Main Inpatient Theatres. ENT improved the number of cases per list compared to the previous month however Trauma and Orthopaedics, Obstetrics and Gynaecology and Plastic Surgery saw falls in productivity.

Actions

- A new Theatre Manager has started and additional operational management capacity is being identified in order to increase the number of patients per day case list .
- The Lead Clinician for theatres improvement has challenged care group teams to add one more patient to each day surgery session to increase the utilisation of available theatre time and staff
- Patient reminder calls are being made 72 hours before the scheduled operation to reduce non-attendance rates and allow time to find alternative patients if needed
- Patient Pathway Co-ordinators are accelerating communication with the Pre-Operative Assessment Units to increase the numbers of patients being assessed each week and trying to establish a pool of patients available to be contacted for a procedure at short notice.

Patient Safety

Indicator Description	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend (12 months)
Number of Never Events in Month	0	0	1	1	0	0	1	0	0	0	0	2	1	0	
Number of SIs where Medication is a significant factor	0	0	0	1	1	1	0	0	0	0	0	1	0	0	
Number of Serious Incidents	8 / mth	6	7	10	9	11	4	8	2	3	4	5	4	5	
Serious Incidents - per 1000 bed days	N/A	0.24	0.29	0.40	0.38	0.45	0.16	0.32	0.08	0.12	0.18	0.19	0.17	0.21	
Safety Thermometer - % of patients with harm free care (all harm)	95%	94.3%	94.7%	93.8%	93.8%	95.7%	94.9%	95.0%	95.1%	94.9%	94.8%	94.3%	93.1%	95.3%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.0%	97.9%	97.5%	97.8%	98.3%	98.7%	98.1%	98.5%	98.9%	97.9%	98.5%	97.8%	98.0%	
Percentage of patients who have a VTE risk assessment	95%	96.2%	96.3%	95.8%	95.7%	95.4%	96.1%	96.4%	96.0%	95.4%	96.3%	96.0%	95.9%		
Number of Patient Falls	N/A	137	131	143	127	125	122	157	127	189	140	157	138	117	
Falls (Moderate and Above Severity)	N/A	0	3	5	2	0	2	1	3	1	2	2	3	1	
Number of patient falls- per 1000 bed days	N/A	5.39	5.43	5.71	5.29	5.15	4.89	6.23	5.17	7.49	6.15	6.05	5.78	4.97	
Number of Grade 2 Pressure Ulcers	N/A	7	28	23	15	18	7	16	13	16	13	12	2	6	
Acquired Grade 2 Pressure Ulcers per 1000 bed days	N/A	0.28	1.16	0.92	0.63	0.74	0.28	0.64	0.53	0.63	0.57	0.46	0.08	0.25	
Avoidable Grade 3 & 4 Pressure Ulcers	N/A	1	0	1	1	2	0	0	0	0	0	0	5	0	
Avoidable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0	0.04	0	0.04	0.04	0.08	0	0	0	0	0	0	0.21	0	
Acquired Grade 3 Pressure Ulcers								15	6	9	6	6	10	4	
Number of overdue CAS Alerts	0	1	0	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- No Never Event's were reported in May.
- The Trust declared five Serious Incidents in May.
- The number of falls reported in May decreased from 138 in April to 117 in May, and is lower when compared to 131 falls for the same period last year. The rate of 4.97 per 1,000 bed days is an improvement and the lowest seen in the previous six months. Of the falls reported, 103 resulted in No Harm.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had an Root Cause Analysis completed. These are now reviewed by a panel chaired by the Chief Nurse to establish their avoidability. From April 2018 all grade 3 and 4 pressure ulcers are reported to the Board that have been acquired at St Georges. Historically only grade 3 or 4 pressure ulcers that met the threshold for Serious Incident declaration were reported. In May no avoidable Grade 3 and 4 Pressure Ulcers were recorded and four patients with Acquired Grade 3 Pressure Ulcers.

Actions: All falls are looked at individually to identify themes. The Falls co-ordinator is revising the falls risk assessment tool in collaboration with the Falls Group so that it reflects national requirements.
The Trust is participating in NHSI Pressure Ulcer Collaborative

Infection Control

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

Briefing

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

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

Mortality and Readmissions

Indicator Description	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	83.5	81.3	82.9	79.7	81.1	80.6	81.3	81.4	82.2	80.8	81.1	81.9	83.4	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	80.1	78.2	78.9	76.4	77.4	77.2	77.5	76.6	77	77.1	76.8	77.8	78.5	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	86.0	83.5	85.4	81.3	81.8	81.2	82	83.8	84.1	83.7	86.7	89.7	91.8	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.86	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.83	0.83	0.83	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	TBC	9.7%	9.7%	8.9%	9.0%	9.7%	10.2%	9.20%	9.38%	8.85%	9.0%	9.20%	8.80%		

Briefing

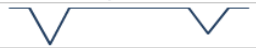
- The Trust's mortality rates are significantly better than expected in all measures and analysis shows that the Trust are 17% lower than expected from typical hospitals and practice in this country.
- Readmission rates following a non-elective spell observed a slight decrease in the month of May, reporting 8% of patients that were re-admitted to hospital within 30 days of discharge, this is comparable to the same period last year.

Maternity

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

Indicator Description	Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
C Section Rate - Emergency and Non Elective	28%	29.1%	24.6%	29.5%	24.9%	30.2%	29.7%	31.9%	25.4%	23.6%	23.1%	26.9%	25.4%	29.9%	
Admission of full term babies to neo-natal care		2	16	21	20	15	10	16	6	11	7	4	10	13	

Patient Voice

Indicator Description	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
Emergency Department FFT - % positive responses	90%	83.0%	85.2%	83.9%	85.9%	83.5%	86.4%	84.1%	86.5%	82.2%	81.0%	81.4%	84.0%	85.0%	
Inpatient FFT - % positive responses	95%	97.3%	96.0%	96.6%	96.8%	96.5%	96.5%	95.7%	95.6%	94.7%	96.0%	96.3%	97.2%	97.3%	
Maternity FFT - Antenatal - % positive responses	90%	85.7%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	97.2%	
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	97.9%	95.4%	87.1%	96.4%	100.0%	92.6%	96.0%	100.0%	99.0%	90.4%	100.0%	100.0%	98.4%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	100%	100%	98%	100%	100%	91.6%		100.0%	100.0%	100.0%		100.0%	
Community FFT - % positive responses	90%	97.6%	96.3%	94.5%	98.3%	94.1%	98.9%	95.7%	96.5%	99.2%	93.3%	98.3%	97.1%	98.5%	
Outpatient FFT - % positive responses	90%	95.6%	96.6%	94.2%	96.2%	94.4%	96.3%	94.3%	98.2%	97.6%	96.1%	98.4%	97.3%	97.3%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		76	75	61	99	80	96	78	69	85	82	97	97	85	
PALS Received		299	234	268	170	203	185	298	262	283	234	257	193	230	

Briefing

- ED Friends and Family Test (FFT) – The score has seen an improvement in May reporting a 1% increase in the recommended rate, this is observed in line with a decrease in waiting times.
- Maternity FFT – The score for maternity care remain above local threshold with work continuing to improve the number of patients responding.
- The number of complaints received in the month of May was 85. All complaints are now assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days. For 25 day complaints received in April, 84% were responded to within 25 working days against the target of 85%, this metric has seen a great improvement since first reporting 58% in November. For 40 day complaints received in April, the final percentage is not yet available but the interim position is 67%. For 60 day complaints received in March, 60% were responded to within 60 working days.

Actions: A complaints handling improvement plan to address the timeliness and quality of complaint responses and which considers different models for handling complaints is being implemented. A review of the classification of complaints between the 25 and 40 day response categories is underway to ensure they accurately reflect the complexity of individual complaints.

Complaints and PALS: An organisational focus on responding to complainants as the Trust says it will improve its responsiveness to complaints. The weekly CommCell is being used to highlight to all services where the Trust is achieving response rates and where teams need to improve responsiveness.

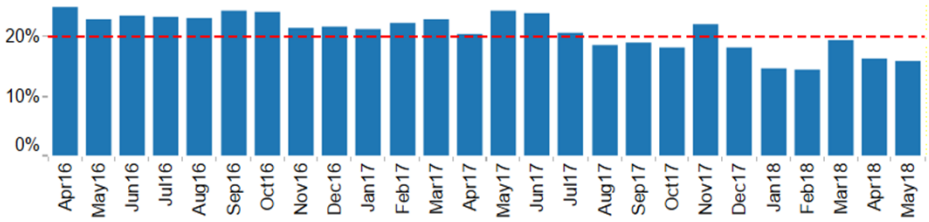
Patient Voice

CARING – Friends and Family Test

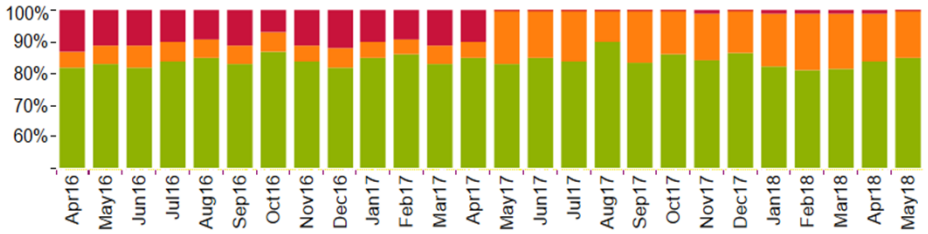
--- Target ¢ MetricMeasure Percentage Recommended Neutral Percentage Not Recommended

A&E Friends & Family Response Rate

Target: 20% Apr 18: 16.39% May 18: 15.99% Movement: ▼-0.40%

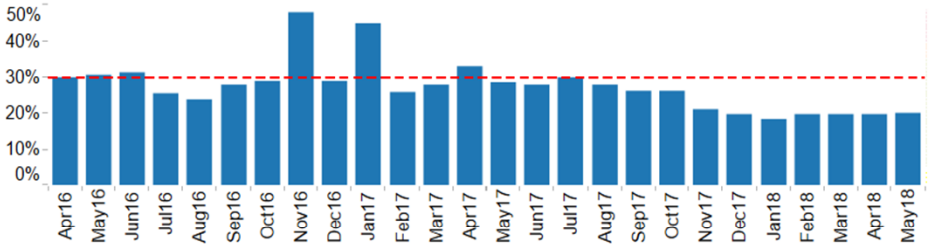


A&E Friends & Family Recommend Rate
The expected target is 90%

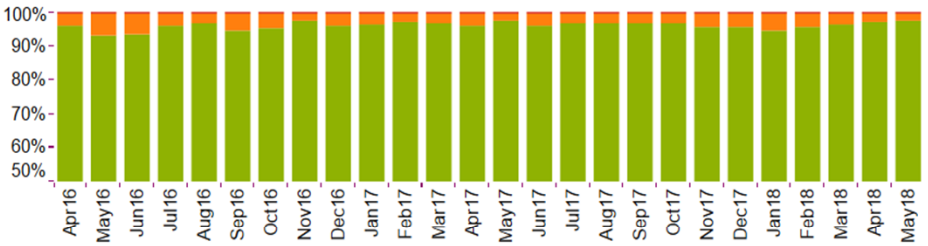


IP Friends & Family Response Rate

Target: 30% Apr 18: 19.67% May 18: 19.95% Movement: ▲0.28%

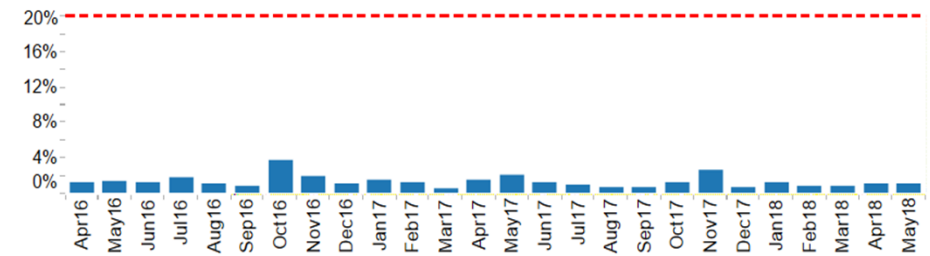


IP Friends & Family Recommend Rate
The expected target is 95%

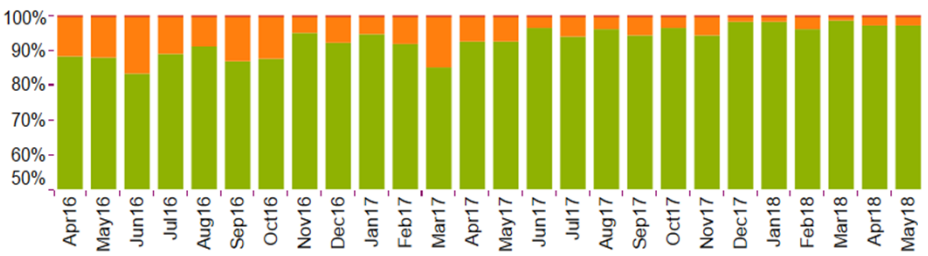


OP Friends & Family Response Rate

Target: 20% Apr 18: 1.10% May 18: 1.10% Movement: ▸0.00%



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



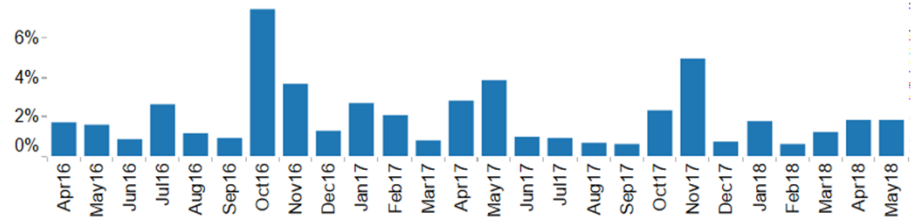
Patient Voice

CARING – Friends and Family Test

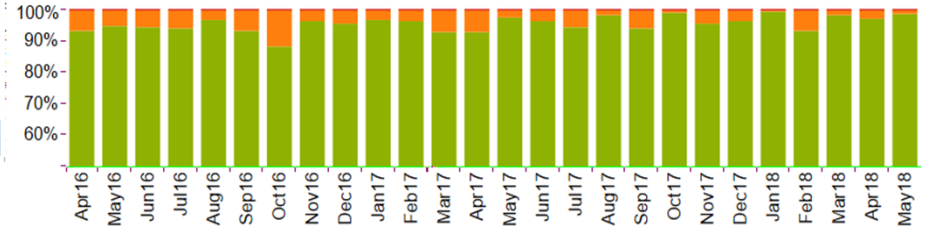
--- Target ¢ MetricMeasure Percentage Recommended Neutral Percentage Not Recommended

Community Friends & Family Response Rate

Target: 20% Apr 18: 1.82% May 18: 1.83% Movement: ▲0.01%

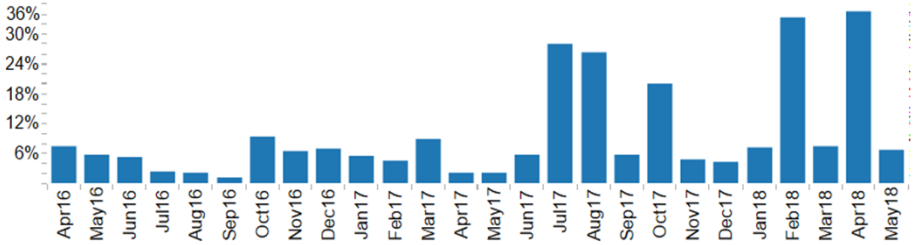


Community Friends & Family Recommend Rate
The expected target is 90%

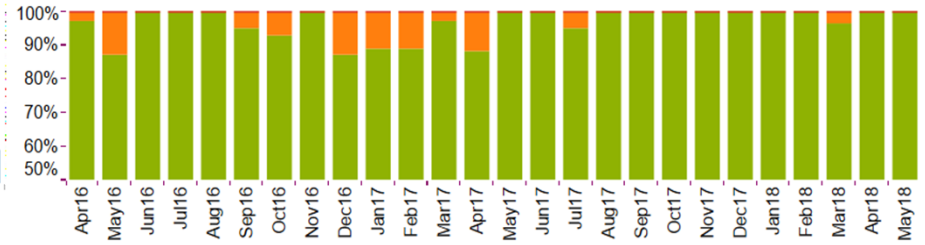


Maternity (Birth) Friends & Family Response Rate

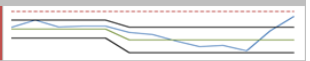
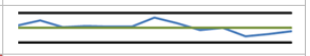
Target: 20% Apr 18: 34.62% May 18: 6.80% Movement: ▼-27.82%



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



Emergency Flow

Indicator Description	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
4 Hour Operating Standard	95%	89.7%	92.1%	89.8%	90.1%	90.0%	88.0%	87.2%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	
Patients Waiting in ED for over 12 hours following DTA	0	1	0	0	0	0	0	1	0	0	0	2	0	1	
Time to Treatment (number of patients seen within 60 minutes)	60%	52.3%	58.8%	56.0%	56.2%	54.1%	54.2%	54.2%	54.1%	51.7%	52.2%	52.6%	61.5%	63.5%	
Admitted patients with a length of stay 7 Days or Greater		310	326	305	309	307	307	336	318	296	304	277	284	293	
Ambulance Turnaround - % under 15 minutes	100%	48.4%	51.9%	48.9%	51.8%	50.9%	49.9%	49.0%	44.3%	41.0%	42.2%	41.0%	45.0%	45.7%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	45.3%	47.5%	46.4%	47.0%	46.5%	45.1%	46.1%	42.1%	41.4%	42.2%	41.1%	45.2%	45.7%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	72	71	53	84	71	57	82	112	180	135	105	92	65	
Ambulance Turnaround - % under 30 minutes	100%	96.7%	96.5%	97.4%	96.0%	96.6%	97.4%	96.2%	94.8%	91.3%	93.2%	94.5%	95.3%	96.8%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	92.3%	93.3%	93.2%	93.1%	92.2%	91.9%	91.7%	91.6%	86.7%	87.4%	87.5%	88.8%	91.9%	
Ambulance Turnaround - number over 60 minutes	0	1	0	1	1	0	0	0	2	3	3	10	1	0	

Briefing

- Performance against the Four Hour Operating Standard in May was 93.3%, representing over delivery of the improvement trajectory target of 91% for the month agreed at Trust Board.
- The number of patients seen within 60 minutes continues to show improvement reporting 63.5% in May
- Enhanced adult's and children's ambulatory services launched in March 2018, with improvements noted against the core KPIs including a reduction in Four Hour breaches attributable to bed management, reduced admissions to AMU and reduced bed occupancy on AMU.
- Positive upwards movement against both admitted and non admitted four hour standard against a trajectory signed off by Trust Board. Consultant in charge has oversight of non-admitted pathways and assessment times.
- One patient waiting over 12 hours following a decision to admit was reported in May concerning a Mental Health patient, root cause analysis to be completed with a deeper look into pathways currently in place.

Actions

- The Trust Executive Committee has agreed a 15 point remedial action plan covering the Emergency and Non-Elective pathway from arrival to discharge. The plan includes aspects of leadership, grip and control together with some short term process improvements to facilitate consistent delivery. As recommended by the National Emergency Care Improvement Programme, four key metrics are being tracked: Ambulance handover, Time to Treatment, Four Hour Operating Standard (admitted and discharged patients) and stranded patients (Length of Stay over 7 and 21 days)
- The next key transformational change will be the release of emergency department clinical administrative task time through the implementation of a 'PaperLite' digital working environment. Further estates enhancements are also underway.
- Effective system working continues and reviewing patient pathways within the Emergency Department
- Minors Breach Reduction Programme Action Plan currently being developed in response to the National initiative to target a reduction in the number of minors breaches of the Four Hour Operating Standard.

Cancer

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	75.4%	76.6%	67.4%	80.3%	89.7%	93.98%	96.05%	97.25%	98.51%	94.76%	96.70%	96.80%	93.10%	1,127	
Cancer 14 Day Standard Breast Symptomatic	93%	82.7%	84.1%	62.9%	86.9%	90.3%	98.2%	99.6%	98.0%	97.3%	95.9%	96.5%	96.8%	94.4%	215	
Cancer 31 Day Diagnosis to Treatment	96%	96.4%	96.4%	96.8%	96.9%	96.2%	96.2%	98.1%	96.9%	97.4%	98.2%	99.3%	96.5%	98.4%	185	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	96.4%	95.9%	94.2%	90.9%	95.8%	82.4%	94.1%	96.9%	94.3%	94.6%	100.0%	95.5%	100.0%	18	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	89	
Cancer 62 Day Referral to Treatment Standard	85%	89.0%	87.3%	85.4%	77.8%	75.6%	76.7%	85.5%	80.8%	86.8%	77.8%	80.8%	88.1%	92.3%	71	
Cancer 62 Day Referral to Treatment Screening	90%	92.7%	92.4%	92.5%	86.1%	92.5%	93.0%	78.4%	92.7%	93.9%	86.1%	89.1%	95.2%	80.8%	24	

Briefing

- The Trust achieved six of the seven National mandated Cancer standards in the month of April, continuing to achieve 14 day standard and achieving 62 day compliance.
- The Trust continues to achieve performance against the 14 day standard, reporting 93.10%, ensuring our patients are seen within 14 days of referral.
- Cancer 62 day Standard Referral to Treatment was achieved. A total of 5.5 patients were treated beyond target this included reasons of referrals being received late in the pathway from other providers, complexity in the patients pathway and patient choice.

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

Month	Target	Actual Performance	Internal Performance
Sep-17	85%	76.70%	82%
Oct-17	85%	85.50%	100%
Nov-17	85%	80.80%	90%
Dec-17	85%	86.80%	97%
Jan-18	85%	77.80%	79%
Feb-18	85%	80.80%	84.60%
Mar-18	85%	88.10%	87.50%
Apr-18	85%	92.25%	96.67%

- There is a continued focus on improving internal processes and a current action plan as part of the Elective Care Recovery Programme.
- The Trust are looking at a number of patient pathways to improve waiting times and quicker access to diagnostics and treatment.
- The introduction of the 31 Day PTL will help drive further improvements and further visibility of the patient pathway.
- This year there will be improved reporting within 62 day standard where the waiting times National database will record breaches that occur between each provider. The National reallocation policy will go live from July 2018.
- There has been a significant increase in the number of 14 day referrals being received into the Trust in May, demand and capacity plans are being reviewed and adjusted to meet this requirement, particularly within the Skin tumour group.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	No of Patients
Brain	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1
Breast	93%	69.5%	76.4%	93.4%	94.1%	97.4%	98.4%	98.2%	96.0%	96.5%	93.9%	94.8%	174
Childrens	93%	66.7%	80.0%	100.0%	100.0%	100.0%	71.4%	100.0%	87.5%	100.0%	100.0%	80.0%	10
Gynaecology	93%	75.6%	93.4%	90.4%	91.1%	90.8%	95.0%	97.6%	98.0%	96.8%	94.3%	94.9%	99
Haematology	93%	76.9%	95.7%	100.0%	100.0%	96.8%	100.0%	94.7%	91.7%	100.0%	100.0%	100.0%	27
Head & Neck	93%	82.4%	88.0%	82.4%	90.6%	99.1%	99.4%	98.4%	100.0%	97.6%	100.0%	100.0%	121
Lower Gastrointestinal	93%	44.4%	60.0%	73.9%	94.6%	97.4%	97.7%	99.3%	95.2%	100.0%	97.8%	94.1%	187
Lung	93%	91.2%	95.6%	100.0%	94.1%	97.7%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	48
Skin	93%	26.9%	74.3%	96.6%	93.4%	95.0%	95.5%	97.9%	92.7%	94.8%	95.9%	94.1%	254
Upper Gastrointestinal	93%	93.8%	97.6%	98.8%	98.8%	98.5%	99.0%	100.0%	89.0%	97.3%	95.3%	85.2%	61
Urology	93%	82.3%	93.8%	97.0%	96.4%	93.3%	97.1%	98.9%	95.0%	95.1%	98.2%	81.3%	145

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	No of Patients
Brain	85%	0.0%	100.0%	0.0%	100.0%	-	100.0%	-	-	-	-	-	0
Breast	85%	100.0%	87.5%	100.0%	91.7%	100.0%	95.2%	100.0%	71.4%	100.0%	88.9%	94.1%	8.5
Childrens	85%	-	-	0.0%	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	61.5%	100.0%	50.0%	83.3%	75.0%	67.0%	80.0%	77.8%	0.0%	100.0%	2
Haematology	85%	100.0%	100.0%	100.0%	88.9%	100.0%	-	100.0%	88.9%	83.3%	81.8%	100.0%	6
Head & Neck	85%	46.2%	66.7%	71.4%	87.5%	78.6%	81.8%	71.0%	100.0%	83.3%	80.0%	100.0%	4.5
Lower Gastrointestinal	85%	100.0%	60.0%	100.0%	66.7%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	100.0%	1
Lung	85%	64.3%	41.7%	47.4%	72.2%	72.7%	41.2%	33.0%	90.9%	57.1%	100.0%	100.0%	3
Skin	85%	95.7%	100.0%	76.5%	93.8%	90.9%	91.7%	93.0%	86.7%	100.0%	100.0%	100.0%	21
Sarcoma	85%	-	-	-	-	-	-	-	-	100.0%	-	-	0
Upper Gastrointestinal	85%	100.0%	100.0%	77.8%	0.0%	100.0%	84.0%	100.0%	33.3%	57.1%	66.7%	87.5%	4
Urology	85%	81.8%	63.0%	64.3%	77.4%	100.0%	72.7%	91.0%	60.7%	70.0%	96.7%	80.5%	20.5

Diagnostics

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

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

Briefing

- The Trust has continued to achieve performance in May reporting a total of fourteen patients waiting longer than 6 weeks, 0.2% of the total waiting list.
- Compliance has been achieved in all modalities with the exception of Urodynamics with 11 patients waiting beyond six weeks out of 46 patients on the waiting list due to capacity following equipment failure.

Actions:

- Confirm if additional Friday lists can be accommodated for Urodynamics
- Reprioritise clinical use of the scan room to accommodate the breaches if additional lists cannot be found

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
Number of on the Day Cancellations		64	84	54	49	52	86	100	94	55	86	64	87	
Number of on the Day cancellations re-booked within 28 Days		54	70	43	43	34	76	67	76	48	76	60	79	
% of Patients re-booked within 28 Days	100%	84.4%	83.3%	79.6%	87.8%	65.4%	88.4%	67.0%	80.9%	87.3%	88.4%	93.8%	90.8%	

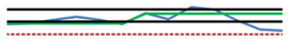
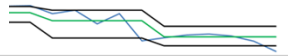
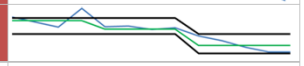
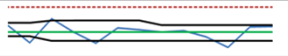
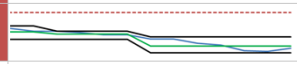
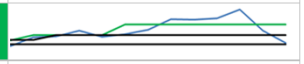
Briefing

- In May 91% of our on the day cancelled patients were-rebooked within 28 days.
- The number of patients cancelled on the day for non clinical reasons have also increased this month, reporting 87 cancellations compared to 64 last month.
- Of the 87 cancellations reported, 44% were due to emergency cases taking priority.

Actions

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

Workforce

Indicator Description	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Trend
Trust Level Sickness Rate	3%	3.4%	3.4%	3.6%	3.7%	3.6%	3.4%	3.8%	3.6%	4.1%	4.0%	3.6%	3.2%	3.2%	
Trust Vacancy Rate	10%	17.0%	17.1%	16.1%	16.5%	14.8%	16.1%	12.7%	13.0%	13.4%	13.5%	13.3%	12.6%	11.3%	
Trust Turnover Rate* Excludes Junior Doctors	10%	19.1%	18.8%	18.4%	19.6%	18.5%	18.5%	18.3%	18.4%	17.9%	17.6%	17.2%	16.9%	17.0%	
Total Funded Establishment		9,925	9,948	9,879	9,855	9,794	9,808	9,470	9,474	9,515	9,540	9,497	9,469	9,318	
IPR Appraisal Rate - Medical Staff	90%	82.0%	74.2%	84.8%	79.0%	74.0%	80.7%	80.0%	78.9%	79.6%	76.9%	72.2%	81.1%	81.3%	
IPR Appraisal Rate - Non Medical Staff	90%	78.2%	76.1%	76.1%	75.1%	79.4%	73.5%	70.2%	70.2%	67.2%	65.9%	61.6%	61.2%	63.4%	
% of Staff who have completed MAST training (in the last 12 months)		87%	87%	86%	86%	85%	86%	87%	86%	87%	87%	87%	87%	87%	
Ward Staffing Unfilled Duty Hours	10%	4.8%	5.8%	5.9%	6.5%	5.9%	6.1%	6.6%	7.8%	7.7%	7.9%	8.9%	6.5%	5.1%	
Safe Staffing Alerts	0	0	1	2	1	0	1	2	2	4	1	1	1	1	

Briefing

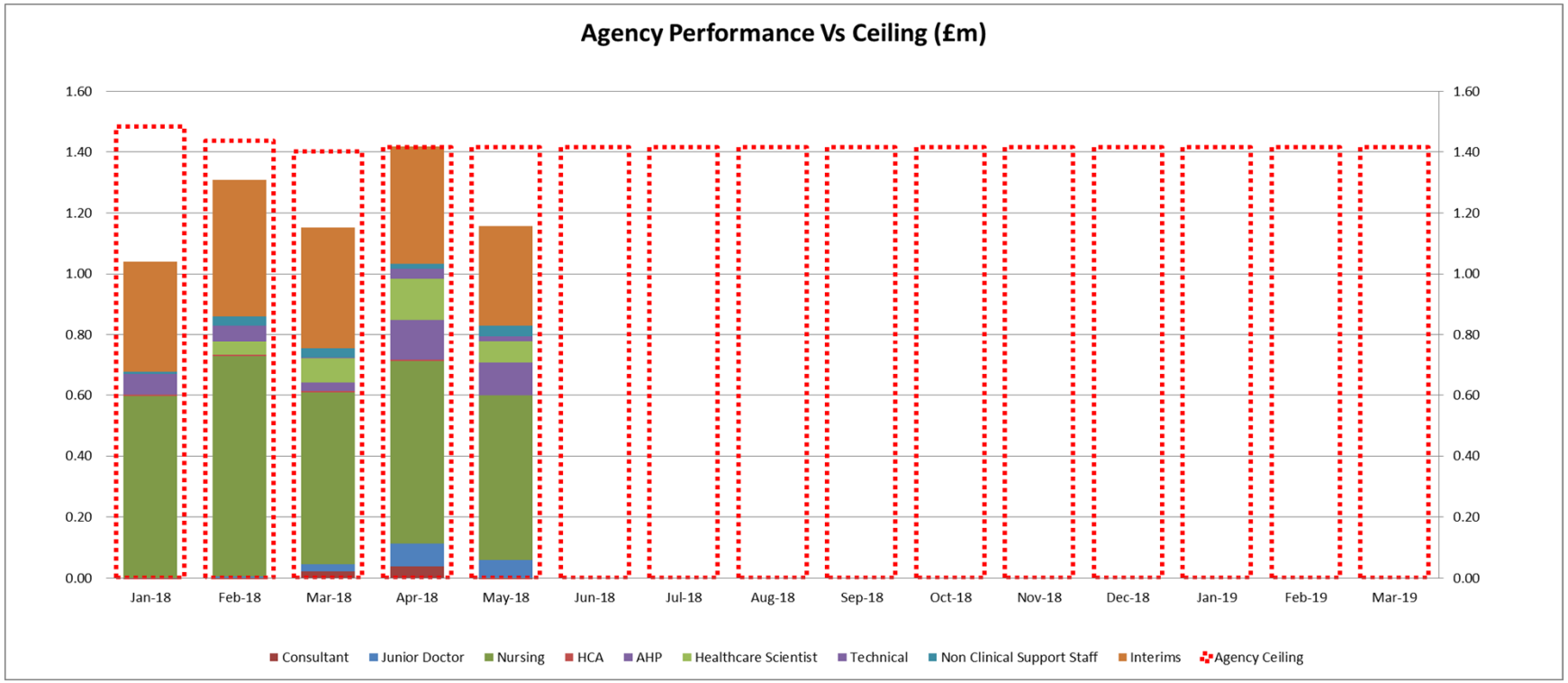
- Funded Establishment fell compared to the previous month reporting 9,318 WTE in May, a reduction of 6% reduction from 2017 as a result of the changes to the Community Division.
- The Trust Vacancy Rate continues to decrease in May reporting 11.3% in month.
- Following focused management of sickness and long absence the sickness rate in May has reduced to 11.3%.
- Mandatory and Statutory Training figures for May were recorded at 87%
- Medical Appraisal rates in May at 81% showing compliance against a target of 90%
- Non-medical appraisal rates have seen a slight improvement after a downward trend. Performance in May was 63.4% against a 90% target.

Actions:

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

Workforce

Agency Use



Briefing

- The Trust's total pay for May was £40.43m. This is £0.13m favourable to a plan of £40.56m.
- The Trust's 2018/19 annual agency spend target set by NHSI is £21.30m. There is an internal annual agency target of £17.00m.
- Total agency cost in May was £1.15m or 2.9% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For May, the monthly target set was £1.42m. The total agency cost is better than the target by £0.26m.
- Agency cost decreased by £0.27m compared to April. There has been decreases across most staff groups: Nursing (£0.06m), Healthcare Scientist (£0.06m), Interims (£0.06m), Consultant (£0.04m), Junior Doctor (£0.02m), AHP (£0.02m) and Technical (£0.02m). This is offset by increases in Non Clinical Staff (£0.02m).
- The biggest area of overspend was in Interims, which breached the target by £0.03m.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board (Part 1)		
Date:	28 June 2018	**Agenda No**	**3.3**
Report Title:	Elective Care Recovery Programme (ECRP) update		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Kim Barrow Director, ECRP		
Presented for:	Update		
Executive Summary:	This is the monthly update on ECRP to the Trust Board. This report will provide an update on the following items: 1) Treating patients against the referral to treatment (RTT) standard. 2) The next steps required for the Trust to start the process of reporting its RTT waiting time data publicly again. The Board is reminded that the Trust stopped reporting this data externally in June 2016 but is now able to track, internally only, the waiting times of patients confidently. 3) Training our staff to record patient activity accurately on the Trust's IT system. 4) Cancer performance – April 2018 5) Diagnostics performance – May 2018 6) A forward look of items for the Board's attention in July. **In addition, it is important to summarise that the ECRP has three key objectives in 2018/19:** 1) To deliver the plan to allow the Trust Board to make the decision, in partnership with our main Commissioner, to return to reporting at the end of the 2018/19 financial year. Please note that the Trust will only be able to report the waiting times for patients publicly for the St George's (Tooting) site. 2) Linked to objective 1, the ECRP to continue to support the waiting time improvements on the Queen Mary's Hospital (Roehampton site) while the IT system is updated in order for it to return to reporting for RTT as well in 2019/20. 3) To continue to reduce the RTT waiting times for patients referred and treated at this Trust. The Trust is not expecting to meet the national 92% standard in this financial year but is prioritising getting the actual Trust performance reported in public.		
Recommendation:	The Trust Board is asked to receive this report		
Trust Strategic Objective:	Treat the patient, treat the person Right Care, Right Place, Right Time		
CQC Theme:	Well-led, Safe, Caring and Responsive		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Risk:	The programme risks for ECRP continue to be reviewed and will be shared in part 1 of the Trust Board in July 2018 to reflect the additional work required to		

	return to reporting for RTT in 2018/19		
Legal/Regulatory:	Referral to treatment standard is a regulatory target		
Resources:	As part of the Elective Care Recovery Programme		
Previously Considered by:	Monthly update received by the Trust Executive Group and Quality and Safety Committee	June 2018	
Equality Impact Assessment:	N/A		
Appendices:	N/A		

Elective Care Recovery Programme Update
Trust Board (Part 1)

28 June 2018

1) Treating Patients

a) The Trust has now established five patient tracking lists (PTL's). They are as follows:

- Active (the live PTL)
- Planned
- Active Monitoring
- Diagnostics
- Cancer

b) A daily update on the size of the live PTL is available for all staff to view. This daily update tells the teams' how long each patient has been waiting. The focus on getting patients treated who have been waiting the longest for their next episode of care continues to be the priority. The number of patients waiting too long for their treatment continues to reduce.

c) All patients from the phase one historical validation, that required an appointment, have now been seen. No harm was identified. There is a further piece of validation work for those patients who did not respond to the Trust letter in the phase 1 validation process that the referring GP's are now checking that they definitely do not need any further clinical input from the Trust. The timeframe for this piece of work is still to be confirmed and there will be a requirement to update the Board on this in future meetings.

d) An update of progress for completing phase two of the historical validation will be given in July 2018.

2) Return to Reporting

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

3) Training

- The Trust Board has received a previous update on the progress with this training programme. The current position is that over 50% of the identified staff has now undertaken the required training modules which mean the Trust continues to improve its understanding of RTT.
- Targeted training has commenced to include a focus on key staff members and services.
- Super-user training in progress, to identify department based specialty trainers and users.

4) Cancer Performance

The Trust delivered 6 out of the 7 national cancer standards in April 2018. The 62 day referral to treatment screening standard was missed at 80.8% compliance against a target of 90%. For clarification the 62 day referral to treatment standard was achieved at 92.3% against the 85% standard.

The action plan in response to the RM Partners report on cancer services at the Trust will be presented as part of the ECRP update in July 2018.

5) Diagnostics Performance

The Trust reported a performance of 0.2% in May 2018 (the standard is 1%) with a total of 14 breaches. Compliance has been achieved in all modalities with the exception of the Urodynamics service with 11 breaches due to capacity issues following equipment failure. The equipment issue has now been resolved.

6) Forward Look for the ECRP update to the July 2018 Trust Board

- Historical validation in phases 1 and 2
- Progress with the percentage of staff trained on the RTT modules
- RM Partners recommendations on cancer services at the Trust
- Return to reporting
- Programme risks to reflect the return to reporting work stream

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	28th June 2018	**Agenda No.**	3.4
Report Title:	Emergency Care Performance Update – June 2018		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Gemma Phillips, General Manager for Emergency Department and Acute Medicine		
Presented for:	• This paper presents an updated position on the Trust's performance against the 95% Emergency Care Operating Standard and agreed improvement trajectories. • This paper also presents the progress against the 15 Point Plan for Emergency Care and associated KPIs.		
Executive Summary:	• The Trust's performance against the 4 hour Emergency Care Operating Standard continues to improve. In May 2018, the Trust delivered performance of 93.31% against the improvement trajectory target of 91%. • The Trust is currently performing at 94.08% for June, 0.92% behind the agreed trajectory of 95% performance for the month. Year to date, Emergency Care Performance is 91.84% as at 24 June 2018. • The initial outputs of the inpatient demand and capacity model, led by the Trust's information team have been received. The model is being worked through by the Divisions to inform the Trust's winter plan.		
Recommendation:	• It is recommended that the Trust Board note the update on progress against the 4 hour Emergency Care Operating Standard and delivery of the 15 Point Plan. • The Trust Board is also asked to note the update on progress with the inpatient demand and capacity model which will inform the Trust's winter plan.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person. Right care, right place, right time. Build a better St George's.		
CQC Theme:	Safe, Effective, Responsive, Well-led		
Single Oversight Framework Theme:	Operational Performance, Leadership and Improvement, Quality of Care		
Implications			
Risk:	Emergency Care Performance is on the Divisional risk register. Risks to delivery are summarised in this paper.		
Legal/Regulatory:	NHS Operating Standard.		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee Finance and Improvement Committee	**Date:**	20.06.18 25.06.18
Appendices:	2		

1.0 Purpose

1.1 This paper is being presented to provide update on Emergency Care Performance and delivery of the 15 Point Plan for the month of June 2018. The paper outlines current performance against the improvement trajectory for the 4 hour Emergency Care Operating standard in 2018/19. An update is also presented on performance against the trajectories for admitted and non-admitted pathways which were approved by the Trust Board in May 2018.

1.2 The paper also provides an update on progress with the inpatient demand and capacity model that is being undertaken by the Trust's information team and the Divisions to inform the Trust's winter plan.

2.0 Background

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

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

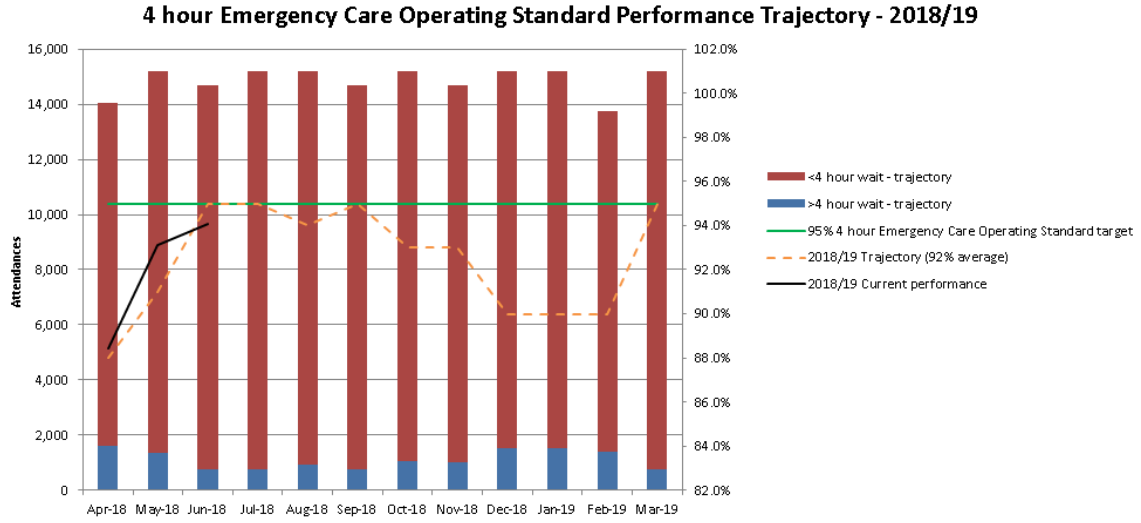
3.0 Current Emergency Care Performance

3.1 Performance against the 4 hour Emergency Care Operating Standard continues to improve. The Trust delivered 93.31% against the agreed trajectory of 91% in May 2018 and is currently performing at 94.08% for June, 0.92% behind the agreed trajectory of 95% performance for the month. Year to date, Emergency Care Performance is 91.84% as at 24 June 2018. The Trust was delivering 94.70% performance until 17 June 2018, which was followed by a more challenging week with performance dropping to 92.52% for the week beginning 18 June 2018 due to a high volume of ambulances, high acuity and dependency, bed capacity constraints and medical staffing shortages in ED.

3.2 In May 2018, the Trust achieved 96.8% of ambulance handovers within 30 minutes, an improved position on the April 2018 position of 95.3%. There were no 60 minute ambulance breaches in May 2018. The Trust incurred one 12 hour trolley breach in May 2018 which related to a delay in the provision of an appropriate mental health bed. The Trust is working with mental health partner organisations to identify opportunities to improve the care of patients with primary mental health needs attending the Emergency Department. There were 175 breaches of the 4 hour standard for mental health patients in April and May 2018 (5.82% of total breaches) and one 12 hour trolley breach during this period.

3.3 The chart (Fig 1) below outlines current performance against trajectory as at 24 June 2018 and 2017/18 performance. The latest Urgent and Emergency Care Dashboard is included in Appendix 2.

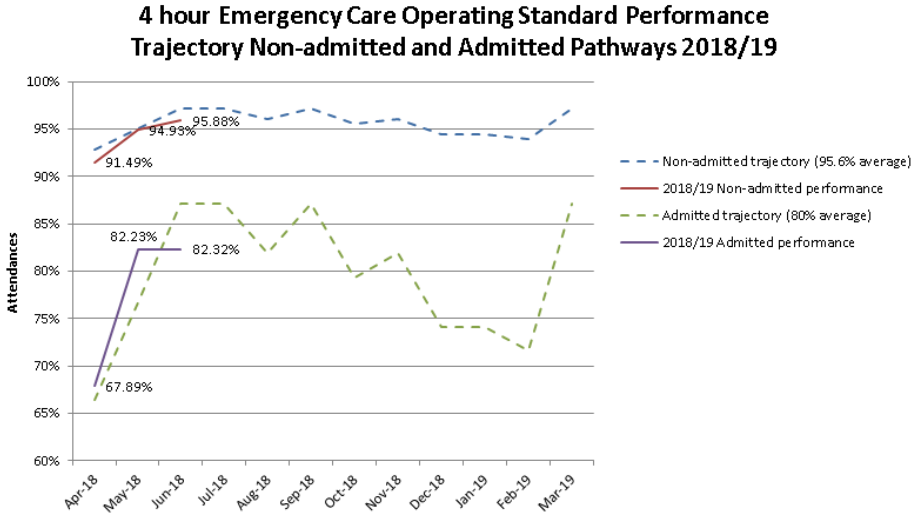
Fig 1. Emergency Care Performance against Trajectory



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2017/18 Performance	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	87.17%	84.99%	83.02%	83.52%	81.50%
2018/19 Trajectory	88%	91%	95%	95%	94%	95%	93%	93%	90%	90%	90%	95%
2018/19 Current performance	88.41%	93.31%	94.08%									

3.4 Performance across both non-admitted and admitted patient pathways is improving. In May 2018, the Trust delivered 94.93% performance against the 4 hour Emergency Care Operating Standard for non-admitted patients and 82.23% for admitted patients. The Trust is currently delivering non-admitted pathway performance of 95.88% and admitted pathway performance of 82.32% as at 24 June 2018. The chart below (Fig 2) demonstrates current performance against the agreed trajectories for non-admitted and admitted pathways agreed by the Trust Board in May 2018.

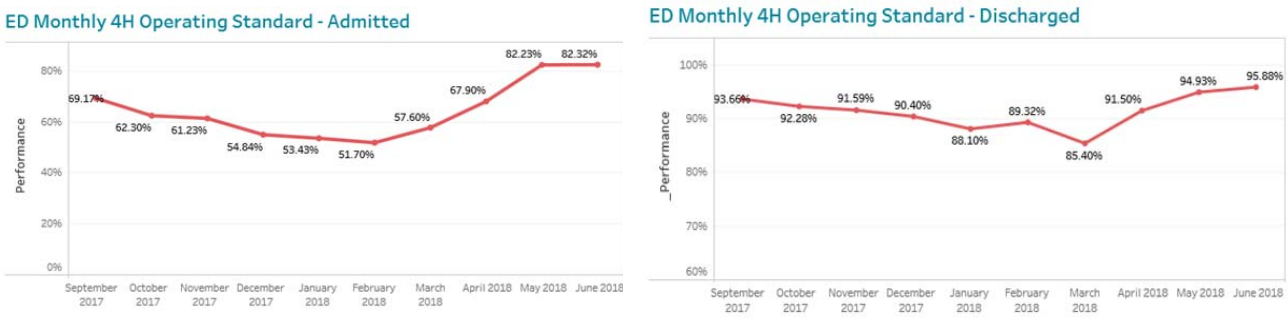
Fig 2. Admitted and Non-admitted Performance against Trajectory



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Non-admitted trajectory (95.6% average)	93.4%	95.0%	97.2%	97.2%	96.1%	97.2%	95.6%	96.1%	94.5%	94.5%	93.9%	97.2%
Non-admitted Current performance	91.49%	94.93%	95.88%									
Admitted trajectory (80% average)	69.0%	76.7%	87.1%	87.1%	81.9%	87.1%	79.3%	81.9%	74.1%	74.1%	71.6%	87.1%
Admitted Current performance	67.89%	82.23%	82.32%									

3.5 The Trust has seen a continuous improvement in admitted performance since February 2018 and an improvement in non-admitted performance since March 2018 (see Fig 3). Admitted pathway performance has been impacted by an increase in bed occupancy in June 2018 as demonstrated by an increase in AMU occupancy and an increase in the proportion of breaches due to bed management and ED capacity compared to trend (see Appendix 1). This is being addressed through daily meetings to reduce the proportion of stranded (>7 days LOS) and super stranded (>21 days LOS) across the Trust and a new weekly cross-Divisional meeting to review and improved the discharge model of care.

Fig 3. Admitted and Non-admitted Performance Trend



4.0 Progress against 15 Point Plan

4.1 The 15 Point Plan Dashboard is included in Appendix 1. This continues to be reviewed on a weekly basis at the Emergency Care Performance Improvement Group (ECPIG) Meeting.

4.2 Specialty response time to the Emergency Department remains variable and a large number of specialties are not meeting the requirement to addend the ED within 30 minutes of a referral consistently. The proportion of breaches due to waiting for specialist opinion is currently 12.52% up from 11.61% in 2017/18. Improvement plans are being driven by the Emergency Care Performance Improvement Group (ECPIG) and Divisional Chairs and there has been a particular focus on improving pathways and performance in paediatrics and trauma and orthopaedic pathways in June with targeted actions for each area. Action plans for paediatrics and surgical specialties have been presented for discussion at ECPIG and will be subject to regular review and monitoring with the expectation that a minimum of 95% performance will be delivered at all times. There is a commitment from the Children's Women's Diagnostics Therapies and Community (CWDTC) Division and the Surgery, Neurosciences, Cancer and Theatres (SNCT) Division to achieve this.

4.3 A reduction of speciality breach times to below 10% against a current position of 12.52% is being targeted for the remainder of June and July. The Divisions are leading on this plan supported by the COO and Medical Director through the ECPIG governance structure.

4.4 23.54% of the breaches of the 4 hour standard since 1 April 2018 are due to ED assessment and a further 18.35% are due to treatment decisions. These areas are being addressed by the ED as part of detailed demand and capacity modelling, review of rotas, and through strengthening shift leadership within the department in line with the 15 Point Plan. The ED is engaging staff in the review and rewriting of roles and responsibilities within the ED.

It is planned that these actions will contribute to a reduction in breaches due to ED assessment to 20% of the total will be achieved in July and August with an action plan due to the ECPIG at the beginning of July. This will require patients to move out of the ED in a timely way to release capacity for ED assessment in addition optimisation of clinical space and consistency of delivery across roles and responsibilities within the ED itself.

4.5 The Divisional Chair for the Medicine and Cardiovascular Division is also supporting ED on the review of medical rotas in order to optimise staffing to meet the highest demand times, this is expected to be completed in July. Additionally ED have also commenced a workforce reconfiguration plan which will offer resilience in staffing for the future by the introduction of new roles including Physician Associates (PAs) and Advanced Clinical Practitioners (ACPs), this is already in progress. This is anticipated to reduce the medical vacancy rate in ED and contribute to further reductions in breaches due to ED assessment and treatment decisions from September 2018 once these roles are recruited to. The ED aims to reduce ED assessment breaches to no more than 20% of the total breaches and treatment decisions to no more than 15% of the total sustainably from September 2018.

4.6 The new Ambulatory Assessment Area and process model is working well and contributing to improvements in flow and performance. The proportion of breaches attributable to bed management and ED capacity remain significantly lower than in 2017/18. Bed management breaches account for 11.36% since April and ED capacity breaches 8.59%. The opening hours for the unit will be extended from 23 July 2018, to 8am to 12 am 7 days a week in line with the business case. This is expected to contribute to delivery of improvements in admitted pathway performance in line with the trajectory and sustain a minimum 20% reduction in breaches due to bed management and ED capacity in 2018/19 compared to the previous year as per the business case.

4.7 The proportion of stranded patients (>7 day LOS) for the week ending 20 June 2018 was 36.90%, a slight increase compared to the Trust's 6 week average of 35.14%. The proportion of super stranded (>21 day LOS) patients is 14.15%, compared to a 6 week average of 13.07%. Improvements will be required to reduce this number sustainably and in line with Trust and national expectations through improved discharge processes. A weekly cross-Divisional meeting on discharge team structure

and processes has been established with effect from 18 June, led by the Divisional Director of Operations for the Medicine and Cardiovascular Division and supported by the Deputy Chief Nurse.

5.0 Risks and Mitigation

5.1 The key risks to delivery of Emergency Care Performance in line with the trajectory and updated mitigating actions are outlined in the table below:

Risk	Mitigation
1. Lack of organisational compliance including the non-admitted pathway	Weekly cross-Divisional ECPIG meeting established with effect from 9 April 2018. Clear executive steer that Emergency Care performance is an organisational priority. Clear governance structure established. Strong focus within ED on improving non-admitted performance. Work on-going to improve specialty response times and clinical pathways.
2. Increase in activity for admitted and non-admitted patients	Delivery of improvements in non-admitted pathway. Improvements length of stay, discharge processes and pathways through UAPC. Focus on reducing 'stranded' and 'super stranded' patients through daily review and strengthening of discharge team structure and processes. Strengthening of streaming pathways within the ED and optimisation of ambulatory care units.
3. Increase in bed occupancy	UAPC programme, including implementation of SAFER as part of inpatient processes work stream and discharge work streams. Embedding of new ambulatory models of care.
4. Non-delivery of benefits aligned to Unplanned and Admitted Patient Care Programme	Programme and work stream reporting/ escalation as part of Trust governance processes.
5. System wide support is not sustained in winter months due to capacity challenges	Established system partner meetings/working groups e.g. Emergency Care Delivery Board, MADE events and inclusion of key system partners within programme/project teams. Initial discussions with system partners regarding winter planning commenced. Winter planning forum to be established to meet in July with key stakeholders.

6. Medical rota gaps within the ED and Acute Medicine impacting upon emergency care performance	Agreement of other London Trusts to adhere to break glass ceiling rates. Introduction of ACP and PAs within the ED.

6.0 Inpatient Demand and Capacity Model

6.1 The initial outputs of the inpatient demand and capacity model which has been developed by the Trust's Information Team have been received and shared with the Divisional Management Teams. This covers the adult inpatient bed base, excluding critical care and maternity services at this stage. The paediatric demand and capacity modelling is being worked through separately and will be available as part of the July Emergency Care Performance Update.

6.2 The model is based on the 2018/19 SLA plan for activity and length of stay for each month of 2017/18. The model assumes bed occupancy of 92.5% for inpatient wards and 85% for assessment and acute speciality areas, including the Acute Medical Unit, Nye Bevan Surgical Assessment Unit, Hyper Acute Stroke Unit and the Coronary Care Units. Bed occupancy of 92.5% is recognised by the Emergency Care Improvement Programme as the occupancy at which quality and safety can be maintained on general wards. 85% occupancy for the assessment and acute care units is recognised by the Trust as the optimal occupancy that is required to maintain flow and accommodate patients requiring specialist care and treatment in emergency to these units providing specialist acute care.

6.3 The initial outputs of the model at specialty group level are outlined below (see Fig 4). Overall, the model indicates that the Trust has a deficit of 32 adult beds on average for 2018/19, including a deficit of 43 beds on average across the six months from October 2018 to March 2019. The specialties with the largest deficit in winter include Medicine and Senior Health with an average deficit of 38 beds across the same period, Neurosciences with a deficit of 9 beds at 92.5% occupancy. This includes a benefit of 6 beds linked to the Ambulatory Assessment Area in Medicine and the closure of 7 Oncology to facilitate the delivery of ambulatory care which has already occurred. The model does not currently include any changes to LOS that may have been made by services since 2017/18 and this is being worked through by the Divisions as part of further refining the model.

Fig 4. Inpatient Demand and Capacity Model (92.5% occupancy)

Specialty	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cardiac & Thoracic Surgery & Cardiology	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2
Clinical Infection	-6	-6	-3	-6	-6	0	-3	-6	-3	-6	-3	-5
Gynaecology	-1	-1	-1	-1	-1	-1	-1	-1	0	-1	-1	-1
Haematology & Oncology	-8	-10	-9	-4	-6	-6	-1	-6	-6	-4	-4	-8
Medicine & Senior Health	23	37	36	18	21	32	18	41	30	53	61	28
Neurosciences (all)	3	-1	-4	16	-6	12	13	8	-4	4	12	20
Renal	-2	-4	-3	-2	-2	-2	-4	-3	-1	-3	-3	-3
Surgery	0	-2	0	0	-1	2	7	3	-5	6	7	-1
Trauma & Orthopaedics	-3	5	-2	0	3	-1	6	5	-2	4	-5	-3
Vascular	7	7	7	7	7	7	7	7	7	7	7	7
Trust Total	**10**	**23**	**18**	**25**	**8**	**41**	**40**	**46**	**13**	**60**	**68**	**32**

Note: Negative number (green) denotes surplus beds compared to demand. Positive number (red) denotes a deficit.

6.4 Bed occupancy of 95% across 2018/19 would reduce the Trust-wise bed deficit across the year to an average of 18 beds and 28 beds between October 2018 and March 2019, but this has significant potential to compromise flow, emergency care performance and quality of care.

6.5 The Trust currently has 2 closed wards with a total capacity of 45 beds, including 22 beds on Dalby ward and 23 beds on Caesar Hawkins ward. The initial outputs of the model need to be concluded to determine whether the opening of a further ward is required to mitigate against the deficit of beds across winter months. Further mitigations will be expected through LOS improvements and opportunities to improve clinical pathways and discharge models of care Trust-wide. A proposal was presented to the Investment and Disinvestment Group in January 2018 for cost pressure funding for an additional ward for 6 months in 2018/19. Further consideration will need to be given regarding the potential use of one of these wards as a cohorted flu ward in winter 2018/19.

6.6 It is recognised that there are further opportunities to reduce length of stay across the Trust, including through reducing the proportion of stranded (>7 day LOS) and super stranded (>21 day LOS) patients. This is being worked through at specialty level and will inform the Trust's winter plan. An update on this work will be provided in the Emergency Care Performance Update in July 2018 with a further iteration of the model.

6.7 Further opportunities exist in improving models of care and pathways into community services. Mary Seacole Ward (42 beds, elderly rehabilitation) at Queen Mary's Hospital (QMH) operated at an average occupancy of 92% in 2017/18. Increasing the occupancy to 98% in 2018/19 would provide capacity equivalent to 2 further beds. A safe target occupancy level for the ward is still to be confirmed in collaboration with clinical and nursing colleagues. There are likely to be further opportunities to release additional capacity through reducing length of stay at QMH, the identification and delivery of these improvements is being led by the Senior Health team in conjunction with the CWTDC Division and supported by Transformation.

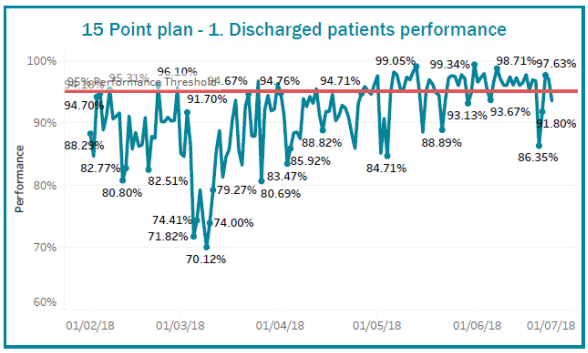
6.8 Winter planning discussions have commenced internally as well as with system partners, supported by the Commissioning Support Unit. A fortnightly winter planning forum will be established from July, with clinical representation across the Divisions to agree how the model will inform the internal bed configuration as part of the Trust's winter plan.

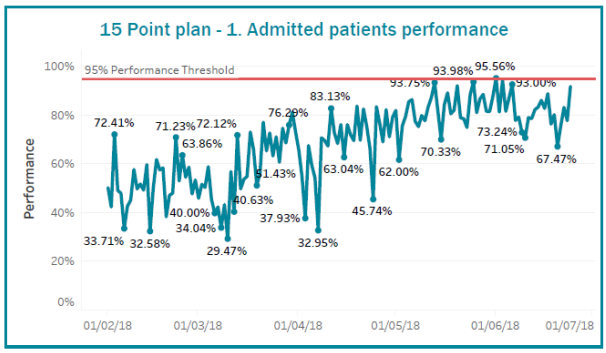
7.0 Recommendations

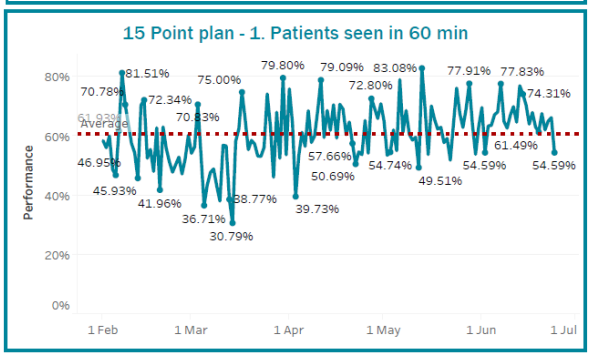
7.1 It is recommended that the Trust Board note the update on progress against the 4 hour Emergency Care Operating Standard and delivery of the 15 Point Plan as outlined in the 15 Point Plan Dashboard.

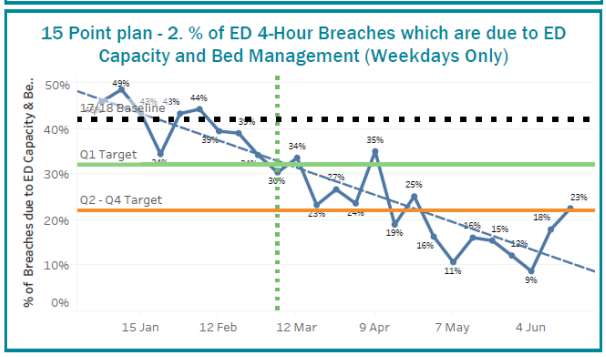
7.2 The Trust Board is asked to note the update on progress with the adult inpatient demand and capacity modelling which is being worked through by the Divisions, under the leadership of the COO to inform the Trust's internal bed configuration and winter plan. A further iteration of the inpatient demand and capacity model in addition to the resulting operational plan will be available in July 2018 and presented through the Trust Executive Committee and Finance and Improvement Committee and Trust Board.

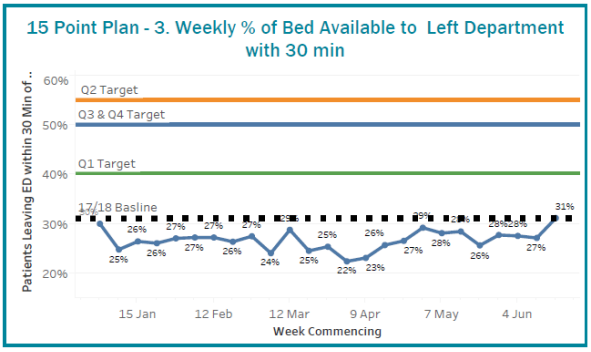
Appendix 1 15 Point Plan Dashboard as at 24 June 2018

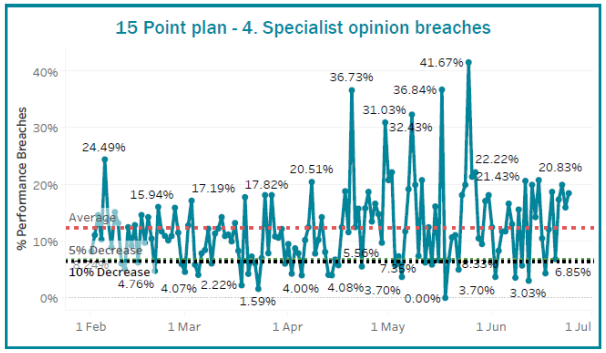


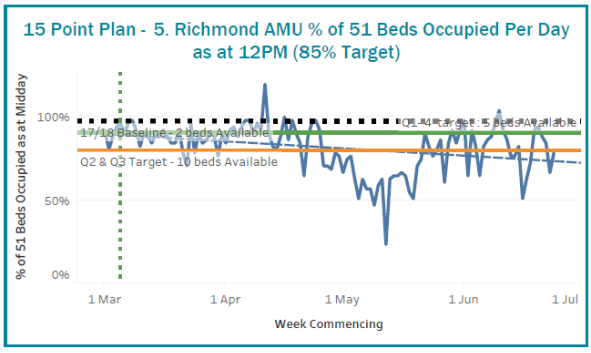


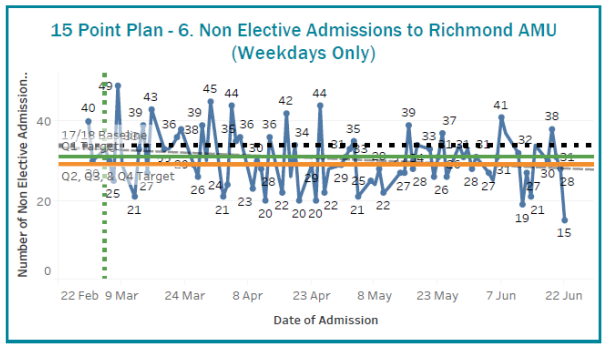


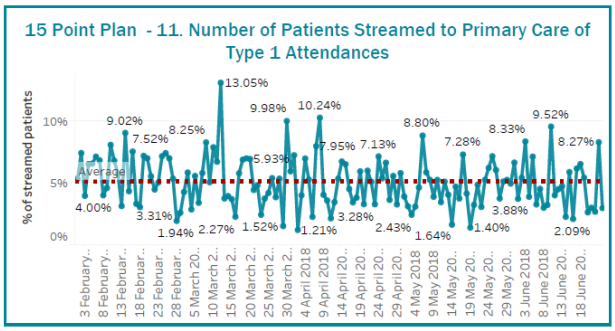




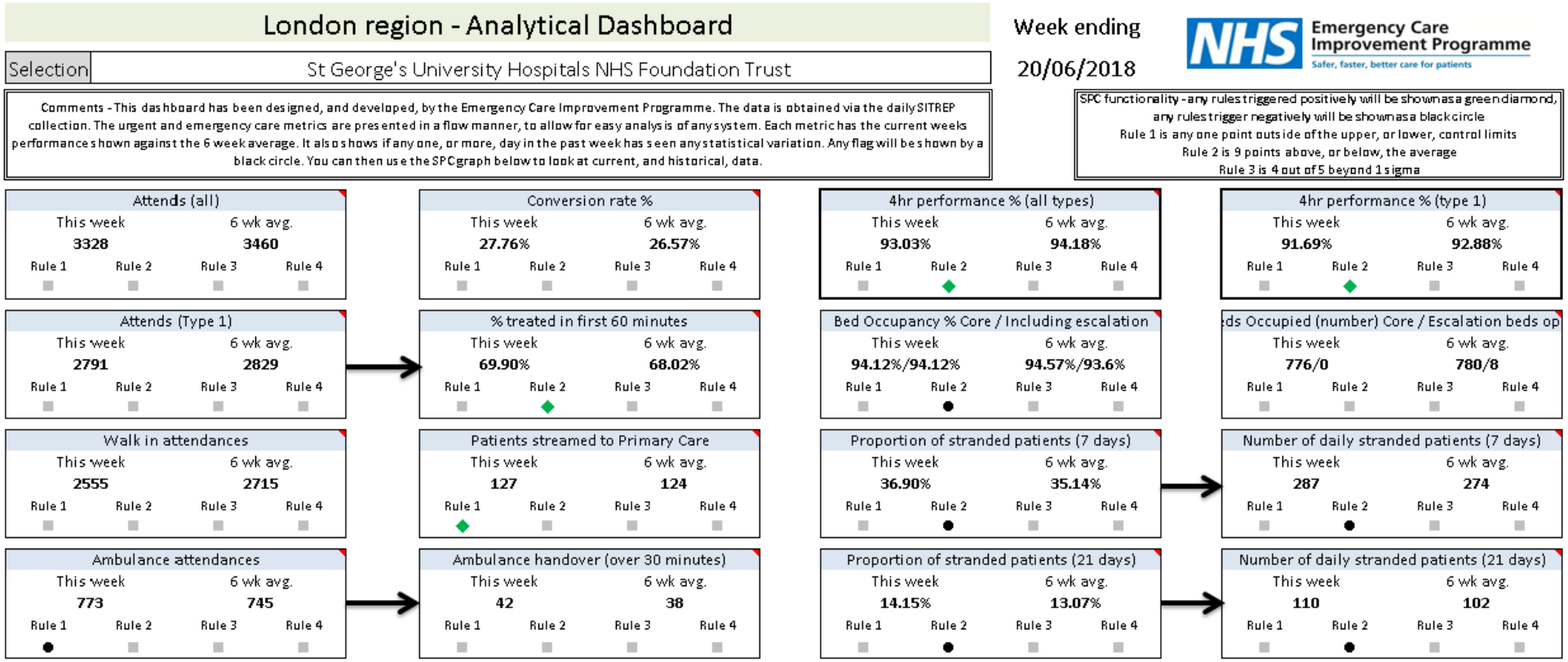







15 Point Plan - 11. Number of Patients Streamed to Primary Care of Type 1 Attendances
% of streamed patients
10%
5%
0%
Average
4.00%
9.02%
7.52%
3.31%
8.25%
1.94%
2.27%
13.05%
9.98%
5.93%
1.52%
10.24%
1.21%
7.95%
3.28%
7.13%
2.43%
8.80%
1.64%
7.28%
1.40%
8.33%
3.88%
9.52%
2.09%
8.27%
3 February..
8 February..
13 Februar..
18 Februar..
23 Februar..
28 Februar..
5 March 20..
10 March 2..
15 March 2..
20 March 2..
25 March 2..
30 March 2..
4 April 2018
9 April 2018
14 April 20..
19 April 20..
24 April 20..
29 April 20..
4 May 2018
9 May 2018
14 May 20..
19 May 20..
24 May 20..
29 May 20..
3 June 2018
8 June 2018
13 June 20..
18 June 20..

Appendix 2 Urgent and Emergency Care Dashboard



4hr performance weekly rank (all Types)	
National	Region
52/137	5/18

4hr performance weekly rank (Type 1)	
National	Region
44/137	5/18

Meeting Title:	Trust Board		
Date:	28 June 2018	**Agenda No**	3.5
Report Title:	Annual Safeguarding Report		
Lead Director/ Manager:	Avey Bhatia – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	David Flood, Named Nurse for Safeguarding Adults, Bill Turner – Head of Safeguarding		
Presented for:	Assurance		
Executive Summary:	The report highlights some of the key achievements of, and areas of challenge for, the Safeguarding Adults team over the previous financial year, as well as seeking to set out key future pressures, challenges and opportunities for the Adult Safeguarding Service at the Trust. The work of the Adult Safeguarding Team covers 4 aspects (Safeguarding Adults, Learning Disabilities, MCA/DoLs and Prevent). Given the importance and diversity of these portfolios separate annual reports for Learning Disabilities, MCA and DoLs and Safeguarding Children will be provided. The Trust received 813 contacts regarding safeguarding in 2017/18 of which 316 resulted in formal referrals to the local authority social services. There have been no referrals against St George's for the care provided to patients that have been subject to a section 42 investigatory process. The safeguarding team works in partnership with the local authorities through attendance at Safeguarding Boards and Serious Adult Reviews. In addition representatives of the local borough safeguarding teams are invited to attend the Safeguarding Committee meetings at St George's. Safeguarding training compliance has remained above the trust target of 85% and the team are reviewing the content to ensure this matches current practice. Prevent compliance has increased following joint working with NHSE to increase training at the Trust and roll out of an elearning module. A recovery trajectory to achieve 85% compliance has been established, and the Trust aims to deliver compliance by August 2018.		
Recommendation:	That the committee discuss the report, and provide any feedback, challenge or scrutiny regarding Safeguarding Adults at the Trust.		
Supports			
Trust Strategic Objective:	- Treat the patient – treat the person - Right care, right place, right time		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:			
Implications			
Risk:	The Annual Report identifies potential areas of risk		
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duties in this area		
Resources:	The Annual Report references the currently available resources.		

Previously Considered by:	N/A	**Date:**	18/06/2018
Appendices:	Nil		

Safeguarding Adults – Annual Report 2017/18

1. Introduction

St George's University Hospitals NHS Foundation Trust has a commitment and responsibility to ensure that all patients receive safe, effective and dignified care. In particular we have a duty under Care Quality Commission's '*Fundamental Standards'* to ensure that those adults most at risk should "not suffer any form of abuse or improper treatment while receiving care. This includes: neglect, degrading treatment, unnecessary or disproportionate restraint and inappropriate limits on their freedom."

This report provides a summary of activity with regard to safeguarding adults' activity at the Trust and highlights how St George's responds to and reports on concerns and allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice.

It is important to note that the Care Act 2014 sets out in primary legislation to which adult safeguarding duties apply; a key difference to safeguarding children is that there is *not* a universal definition. It is set out in full below.

In the context of the legislation, specific adult safeguarding duties apply to any adult who:
- ***Has care and support needs****, and*
- *Is experiencing, or is at risk of, abuse or neglect, and*
- *Is unable to protect themselves from either the risk of, or the experience of abuse or neglect, because of those needs.*

Within *the scope of this definition are:*

- *All adults who meet the above criteria regardless of their mental capacity to make decisions about their own safety or other decisions relating to safeguarding processes and activities;*
- *Adults who manage their own care and support through personal or health budgets;*
- *Adults whose needs for care and support have not been assessed as eligible or which have been assessed as below the level of eligibility for support;*
- *Adults who fund their own care and support;*

This Annual Report addresses the specific Safeguarding Adults activity at the Trust. This report does not cover Mental Capacity Act, Deprivation of Liberty Safe guards and Learning Disabilities activities as these will be presented in a separate report.

2. Safeguarding Structure and Policy

St George's utilises the Pan-London Adult Safeguarding Procedures which were revised and published in January 2016 in an attempt to provide a consistent approach and response from all agencies involved in adult safeguarding across London. These procedures were developed following the introduction of the Care Act 2014 which stands as the key piece of legislation in relation to Safeguarding Adults. These procedures have been adopted by our local partner agencies and by St Georges Adult Safeguarding Committee.

St George's local safeguarding guidance, revised in light of the Care Act, sits alongside the Pan London procedures to ensure staff respond appropriately and proportionately to safeguarding concerns.

The current staff resources in the Adult Safeguarding team are:

***Head of Safeguarding Children and Adults**:* 1 Wte Band 8B. The postholder of the newly created post commenced in January 2018. The postholder is responsible for leading the Safeguarding Children and Safeguarding Adults function at the Trust, so approximately 0.5 of the post holder's time specifically relates to Safeguarding Adults.

***Lead Nurse for Safeguarding Adults*:** 1.0 WTE Band 8A

Safeguarding Administrator: 1.0 WTE (this postholder covers both the Children and Adults functions)

There are also three key staff with specific roles related to specific functions who form part of the Safeguarding Adults team.

***Lead Nurse: Learning Disabilities*:** 1.0 WTE Band 7

***Learning Disabilities Nurse*:** 1.0 WTE Band 6

***Mental Capacity Act/Deprivation of Liberty Safeguarding Practitioner*:** 1.0 WTE Band 7

3. Safeguarding Alerts April 2017-March 2018

There have been a combined total of 1045 referrals / contacts in respect of safeguarding and Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) in the period covering 1 April 2017 to 31 March 2018. Of these 813 relate to safeguarding cases.

Of these referrals, 316 were formally referred to local authority social services as safeguarding concerns. Excluding referrals relating to MCA/DoLS (of which there were 244 for2017/18), this represents around 39% of all contacts, a slight rise on last year which may indicate either a broadening of safeguarding thresholds or a rise in the complexity and associated risk of safeguarding cases.

Table 1:

Number of referrals / contacts by year

Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Number of referrals (contacts)	502	602	825	855	971	841	813
Number of formal safeguarding investigations	133	240	294	290	322	307	316

N.B the figures up to and including 2015/16 included referrals in relation to MCA/DoLS. As of 2016/17 we are now recording MCA/DoLS figures separately.

Table 2:

Breakdown of referrals (contacts) by type

Neglect	215
Physical	80
Emotional	38
Sexual	22
Financial	43
Domestic Violence	30
Self neglect	67
Discharge issues and concerns	45
Pressure Ulcer screening	92
Advice/Information exchange	176
Other	5

N.B the Safeguarding Lead Nurse can receive referrals in respect of domestic violence, which may or may not present alongside another safeguarding issue. The Lead Nurse works closely with the Clinical Nurse Specialist for Domestic Violence and reviews on a case by case basis who the most appropriate practitioner to respond to these referrals is.

Outcomes of formal referrals to Social Services

There have been **NO** referrals of significant concerns that have progressed through the formal section 42 investigatory procedures for 2017/18.

Breakdown of referrals by Local Authority (Excluding DoLs referrals)

As seen below the largest proportion of Safeguarding referrals at the Trust relate to Wandsworth. Both Merton and Wandsworth have a team of social workers located at the Hospital, who are able to undertake Safeguarding work alongside social care assessment and care management work. For any Safeguarding matter potentially related to the provision of patient care at the Trust, the London Borough of Wandsworth is the lead authority.

Table 3:

Number of Adult Safeguarding referrals during the financial year 2017/18 per local authority.

Wandsworth	404
Merton	169
Lambeth	52
Croydon	44
Kingston	22
Sutton	29
Richmond	11
Surrey	21
Other	61

4. Patient Story (a vignette illustrated different aspects of Adult Safeguarding at the Trust)

“Pauline” was admitted to the emergency department following an overdose. On interview she disclosed that she had recently split with her boyfriend which had resulted in some increased stress and anxiety. Pauline has a learning disability (LD) and was referred to our LD nurses for support, in addition to seeing our mental health liaison team. One of our LD nurses (in conjunction with the mental health nurses) spoke at length with Pauline. During the discussion Pauline indicated that she had experienced sexual exploitation. This was

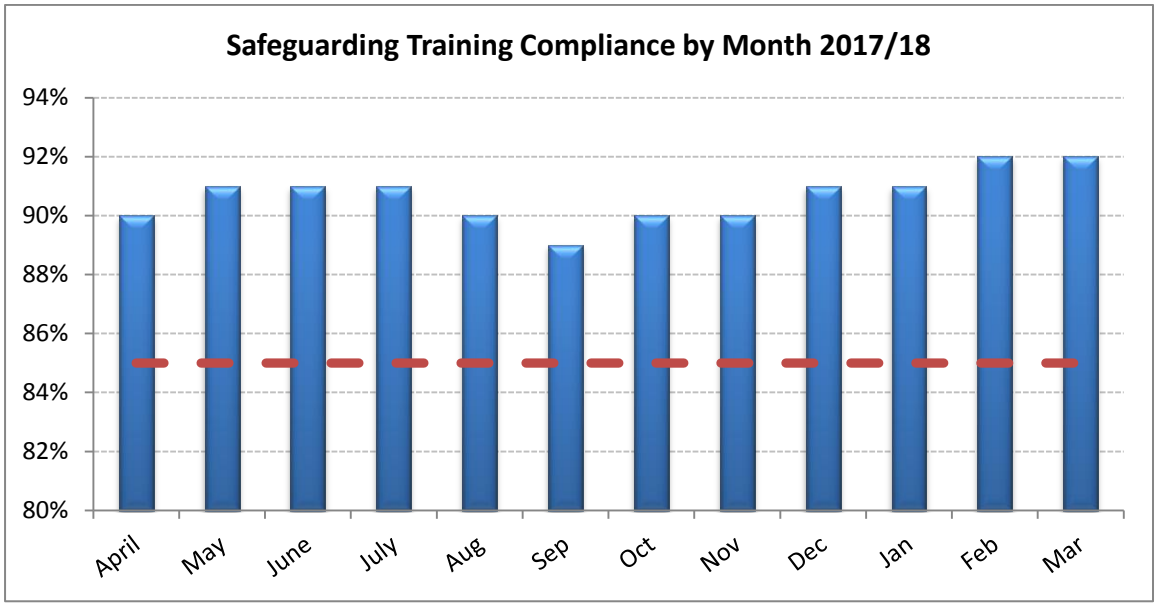
reported to the police and to the local authority; a protection plan was implemented to ensure Pauline was kept safe in hospital and psychological support instigated.
Police subsequently made arrests and a safe discharge plan was put in place to ensure Pauline's ongoing welfare and safety was appropriately supported

5. Learning Review/Partnership Working specific to Adult Safeguarding

Practitioners form our community teams attended a learning event in May 2017 following a Serious Adult Review and report into the case of a client in the community passing away following a house fire. Learning from this has subsequently been shared with community teams to help try to reduce the risk of such incidents in the future and to promote closer working with the fire service. In addition the lead for adult safeguarding utilises the learning in teaching session to teams, particularly in respect of self-neglect

The lead nurse for adult safeguarding attends the monthly community multi agency meetings for high risk cases across Wandsworth. These are an opportunity for teams across Wandsworth to present complex cases to senior operational leads across social services, mental health, police, housing, acute health and fire with a view to mitigating risk. Themes include self-neglect, hoarding, disengagement from services, drug and alcohol use and housing issues. There have been a number of successful outcomes for clients through this process.

6. Training Compliance 2017/18



Adult safeguarding basic awareness is part of the e-MAST mandatory training of which all staff complete initially at induction and then every three years. NHS England is currently consulting regarding potential changes to Adult Safeguarding training within NHS Trusts, with a view to moving the training onto a similar footing to Children's Safeguarding which is provided at Levels 1, 2 and 3 with level 3 being a face to face teaching session.

Currently the Lead Nurse makes a specific contribution to training for new Health Care Assistants joining the trust, and provides ad hoc training as needed or on request.

If the Trust was required to provide face to face training for Adult Safeguarding at the same (or similar) level as is currently the case in respect of Safeguarding Children then there

would be a significant resourcing implication for the Team/Trust given the size of the current Safeguarding Adults' team.

7: Partnership Working:

Adult's teams are actively engaged in partnership working at a local level. Safeguarding is a continuum and our responsibility to ensure vulnerable adult patients are appropriately safeguarded does not begin and end with their attendance/admittance and discharged from hospital.

Furthermore the Safeguarding team seek to make long term contributions towards safeguarding outcomes wherever possible i.e. attending planning meetings with partners to plan long term care for specific patients, or with the Lead Nurse for Adult Safeguarding attending Wandsworth Community Multiagency Risk Assessment Panel which meets on a monthly basis to seek to mitigate risk on high risk vulnerable adults living in Wandsworth. The Named Nurse for Safeguarding Children, the Lead Nurse for Adult Safeguarding and the Head of Safeguarding all contribute more widely to Safeguarding activity via local Children's and Adults' Safeguarding Boards.

There has been a recent merger of Wandsworth and Richmond upon Thames' Safeguarding Adults Boards (the two authorities having merged a large number of wider services) and as a result there has been a hiatus of activity in terms of this Board, which has recently been re-launched.

One area of partnership working which remains a challenge is in respect of Housing, particularly in respect of homeless families or patients who have an additional housing need due to a medical condition or disability. Whilst queries to the Safeguarding team about a vulnerable person who cannot be discharged, or whose discharge is delayed due to what is in effect a Housing matter are relatively infrequent, when they do occur they are often highly complex and challenging to resolve.

The Head of Safeguarding is seeking to develop contacts in local boroughs so that there are clearer routes for escalation in respect of such cases, when they do occur, although given the immense pressure on the housing market across London it seems unlikely this will be an area of work in which there are any obvious or easy solutions.

In respect of Policing, there are very substantial changes to the Metropolitan Police's response to Safeguarding in terms of the organisation of the Command dealing with Child Abuse, Domestic Violence and Sexual Offences. Whilst this should not have an impact on the day to day work of the Safeguarding Adults' team or of other Trust staff, it will be important to bear in mind when working with the Police on complex operational matters. The Head of Safeguarding will continue to monitor the potential impact of these developments at the Safeguarding Boards.

The Safeguarding Team have recently developed closer links between Safeguarding counterparts at Moorfields Eye Hospital who provide a number of services on the St George's site, as there are a some areas in which a closer working relationship would be beneficial.

In general, and as would be expected, the Trust has strongly developed partnership working arrangements, and regular contact at a range of levels with both Wandsworth and Merton Councils and Safeguarding Boards

It is notable however that both the Children and Adults Safeguarding Teams are increasingly asked to provide input in relation to a number of patients from a wider range of boroughs,

specifically (but not exclusively) Lambeth, Croydon and Surrey; these being areas in which we have fewer current links. Developing more effective operational and strategic links with these boroughs is a priority for the future.

A specific area of partnership working which it has been challenging to develop with the existing capacity of the team is with the local residential and nursing care sector, to ensure that both the Trust and residential/nursing homes consistently meet best practice standards when patients are admitted from, or discharged to, these settings.

There are a number of specific areas of work undertaken by the Safeguarding Team which extend across both the Children's and Adults Safeguarding strands. The report will provide a brief commentary on each of these.

Domestic Violence:

- The Trust employs a Clinical Nurse Specialist for Domestic Violence and Female Genital Mutilation, who works in close partnership with a Senior Independent Domestic Violence Advisor who is an employee of Victim Support based on site at St George's. Both these staff members can be contacted by staff across the Trust, and work either directly with patients who may be experiencing domestic abuse, either during their time in hospital, or after they have been discharged, or provide advice and guidance to staff to support them in patient care in relation to domestic violence.

- The Independent Domestic Abuse Advisor (who is not a Trust employee) is also able support to provide advice and support to staff experiencing domestic violence in their personal life.

- There is also a Clinical Midwife Specialist for Domestic Abuse works closely with the team when required.

- The Clinical Nurse Specialist has both an operational and strategic role, and the team are working to ensure that staff across the Trust are aware of the support and expertise the postholder can provide. The postholder is also involved in delivering the Trust's training offer but the team is considering ways of extending this.

- The Clinical Nurse Specialist is also the Trust's MARAC lead (Multiagency Risk Assessment Conference) and takes part in three local MARACs (each London Borough has its own MARAC). As an Acute Trust having contact with a very large number of patients this is a key part of the role, and a significant demand on the Clinical Nurse Specialist's time. [please see below for an explanation of MARAC]

- Each borough MARAC is essentially a multiagency body with set up with the purpose of increasing the safety, health and well-being of victims/survivors, adults and their children
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability, and
- Improve support for staff involved in high-risk domestic abuse cases *(taken from Richmond upon Thames MARAC website, June 2018)*

Female Genital Mutilation FGM:

The Trust's work in the area of FGM prevention has developed during the course of the year, and the Trust now employs a full time Clinical Specialist Midwife for FGM and Perineal Health, who works in close partnership with the Clinical Nurse Specialist for Domestic Violence and FGM (who leads on FGM issues outside of the maternity department). The NHS and other public bodies have been on a public 'learning journey' in relation to female genital mutilation in recent years and there have been a number of important changes for Acute Trusts to respond to.

The Trust has now implemented the FGM-IS system, led by NHS Digital, which is a Smartcard based system designed to add an indicator to the Health records of a female infant or child with a family history of FGM. The Trust also uses our Enhanced RATE system to record contact with patients with FGM, and, along with all Trusts nationally, share anonymised data with NHS England about the number of patents seen at the Trust who have undergone FGM. Over and above the foregoing the Safeguarding team also ensures that FGM is treated as a Safeguarding issue where required.

Partnership working is an essential part of the effective response to FGM and the Trust convenes a bimonthly Working Group, which is also attended by colleagues from Wandsworth Council. The Trust's response and that of other agencies, in respect of FGM related practice is also reviewed by the Local Safeguarding Children's Boards.

FGM training is an important part of Level III Safeguarding Children's training and a more basic introduction to FGM forms part of the Trust Induction for all new starters to the Trust, whatever their role. We have also produced a leaflet for patients in partnership with Wandsworth Council, designed for patients who may have questions about FGM- the leaflet will be made available in key languages to increase its impact.

Prevent:

Prevent (short for 'Preventing Radicalisation' work conducted under the auspices of the Government's counter-terrorism strategy) work at the Trust encompasses both the Children's and Adults team and engagement with the NHS England Regional Prevent Co-ordinator as well as local partnerships.

A key theme of Prevent work in the Trust is seeking to improve uptake of Prevent training, which is a statutory requirement. In May 2018 the Trust launched the Level 3 Prevent Training as an E-learning product, which we anticipate, alongside a communications strategy and engagement with managers, will enable the Trust to meet our 85% compliance target agreed with the CCG by September 2018.

The Head of Safeguarding is the Trust Prevent lead and the contact person for referrals. As there is a general lack of published information regarding the role of Acute Trusts in the Prevent strategy it is important for the Trust Lead to develop and maintain the existing working relationship with NHS England Regional Prevent Lead to ensure that we are up to date with any developments, as well as horizon scanning more generally.

The new online training seeks to ensure that staff are aware that Prevent activity is not exclusive to adherents of any specific religion or ideology, and also highlights the growing importance of the far-right terrorist threat. The principal reference to the NHS in the Government's updated Counter Terrorism Strategy (Contest: Home Office (June 2018) refers in the main to Mental Health services but Prevent nonetheless remains an important area of the Trust's work.

Prevent Level 1 Training Compliance – Adults 2018/19									
Lead Director	Feb	March	April	May	June	July	2018/2019 Target	Forecast August 2018	Date expected to meet standard
CN	50%	64%	70%	73%			85%		August

Prevent Level 3 Training Compliance – Adults 2018/19									
Lead Director	Feb	March	April	May	June	July	2018/2019 Target	Forecast August 2018	Date expected to meet standard
CN	50%	57%	63%	70%			85%		August

8: Safeguarding Adult Reviews:

The Trust is an active participant in Safeguarding Adult Reviews (SAR). Whilst numbers are too small to establish a definitive hypothesis, there is a tendency for cases which are the subject of a SAR to come from a wider geographical area than solely from the Boards of which we are members, or the Local Authorities with whom we work closely with on a regular basis. It is likely this is linked to the Trust's status as a trauma and tertiary referral centre insofar as the Trust admits patients from a wider arena in respect of complex, challenging and serious medical presentations.

At the time of writing the Trust is engaged with two Safeguarding Adult Reviews. The Trust has been an active participant in the SAR process in each case, and approaches any review process both to reflect on and learn from issues specifically related to the Trust, but also to make a contribution towards 'partnership safeguarding'. In respect of Safeguarding Children the Trust also takes part in Learning Reviews, which are essentially a formal multiagency review of practice, in a specific case, in which the formal threshold for a serious case review has not been met. The current multiagency safeguarding arrangements also do not readily lend themselves towards multiagency review of less 'critical' or indeed 'routine' cases, where reflection but not in depth review may be useful and work at this level, in respect of Safeguarding Adults, is considerably more limited.

Two Safeguarding Adults Reviews are in process. Whilst fuller details will only be available once the reviews are published, it is notable that neither review concerns an 'older adult' despite work with older adults being such a substantial focus of the team's work.

As with Serious Case Reviews in respect of children the team is seeking to develop a strategy to more effectively harness learning from reviews on a national level – this is more challenging as there is no central collation of SARs nationally. A project led by SCIE (Social Care Institute for Excellent) is apparently underway to address this deficit and we will follow developments closely.

An area of work for future development relates to SARs published nationally which contain important learning for Acute Hospitals- there are often reviews published in other areas which may contain potentially important learning for Acute Trusts on a national basis. Although.

9: The wider picture

There is a large cohort of adult patients at the Trust who fall outside the fairly closely defined remit in the Care Act 2014 of adult safeguarding (see above). This is not to say that there

are not a large number of patients at the Trust who would benefit from additional support or intervention of one kind or another. One group in such a category are young people who present at the Hospital following injury incurred as a result of peer or peer violence. Another group 'missing' from Safeguarding Adults legislation are young people who, as children, were in the care of the local authority – i.e. 'care leavers' (whether or not they are formally receiving a leaving care service).

When considering the care and support needs of young people at the Trust, we work closely with the Redthread Youth Violence Intervention Programme. They have a co-located team of youth workers based in the Emergency Department who provide a high quality and responsive service to young people aged 11 to 24 who have experienced or are at risk of serious violence, domestic violence, sexual assault, or exploitation.

There are also significant areas of work and pressure within the Trust which impact patients who are defined as vulnerable adults within the Care Act, but which are indirectly, as opposed to directly linked to Safeguarding, such as issues around safe discharge and adult social care packages.

10. Key Risks for Adult Safeguarding

The key risk for the service which are being managed as follows:

- Responding to increasing demand due to the scope of adult safeguarding work being although well-defined inconsistently applied and thus generating very high numbers of referrals
- Ability to respond and engage efficiently with all local agencies / authorities across wide geographical area the Trust serves
- Ability to respond to future changes in training requirements

11. Conclusion:

In essence the work of the Safeguarding Adults' team encompasses four strands, and all areas will need to be considered and addressed in the Service Development Plan, which will need to take into account available resources.

i) Operational safeguarding work; i.e. the provision of advice, active involvement in identified safeguarding cases (ranging for limited to extensive involvement) and the provision of Safeguarding Adults training.

ii) 'Strategic' safeguarding work: developing practice across the Trust to ensure that systems, processes and workplace culture create an environment in which Safeguarding matters can be identified, and when they are identified, effectively addressed. This involves developing internal and external working relationships, the review of available resources and ensuring that quality assurance mechanisms are agile and fit for purpose.

iii) Quality assurance and reporting: There are a considerable volume of reporting requirements in respect of the Safeguarding Adults team, including CCG and local Safeguarding Adult Boards as well as to NHS England (who are sent quarterly figures on priority areas such as FGM and Prevent) and where required the CQC and through internal governance processes within the Trust.

iv) Partnership safeguarding activity: This involves 'formal' Safeguarding Partnerships at Local Safeguarding Adult Boards but also the development and maintenance of effective working relationships between organisations. As identified earlier in the report, the Trust would benefit

from developing partnerships or closer working relationships with a wider range of local authorities specifically Lambeth, Surrey and Croydon.

It is hoped that this report gives an indication of the depth and complexity of the work undertaken by the Safeguarding Adults team, and provides assurance that there are appropriate structures and training in place to support safeguarding principles as defined in the Care Act.

Inevitably an Annual Report involves looking back and reviewing the previous year, however the future year will involve the production and implementation of a Service Development plan, a review of training of the Trust's Adult Safeguarding Training needs and capacity, and the closer integration of Domestic Violence into both Children and Adults safeguarding work at the Trust.

In the coming months we will also be reviewing our internal governance, our relationship and audit structures, including a review of the Adults Safeguarding Committee to ensure that the Committee's work is as effective as possible. As part of this review we will be approaching our CCG colleagues to ensure that our working relationship and reporting structures are as productive and strategic as they can be.

We are also keen to focus partnership working activity, within the available capacity of the team, into activity which has a clear focus on improving outcomes, and which is successful in doing so. The Team take part in a variety of London wide discussions with Safeguarding Adults colleagues in provider Trusts and seeking to capture best practice regionally will be a theme of the year ahead.

Another aspiration of partnership working is to seek to achieve an effective level of patient-centred, responsive interagency safeguarding practice on a consistent basis, regardless of whether the patient is a resident of a 'local' local authority where we have existing close working relationships, or whether they reside further afield.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	June 2018	**Agenda No**	**3.6**
Report Title:	Learning from Deaths - Mortality Monitoring Committee Report		
Lead Director/ Manager:	Professor Andrew Rhodes, Chief Medical Officer		
Report Author:	Dr Nigel Kennea, Chair Mortality Monitoring Committee, Associate Medical Director Kate Hutt, Clinical Effectiveness & Audit Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	This dashboard reflects a high level review of a full report presented to Patient Safety & Quality Board in April 2018 and Quality & Safety Committee in June 2018. The full paper provides an update of the work of the Mortality Monitoring Committee and an overview of data for the entire year. It includes a summary of the independent reviews completed and details the most recent learning. It also summarises progress against implementation of the 'Learning from Deaths' framework launched in March 2017. Our work has been highlighted and presented at the national 'Learning from deaths - one year on' event in December 2017 and at the inaugural London network for Learning from Deaths (NHSi, March 2018).		
Recommendation:	• For Board to be updated on work to date implementing the 'Learning from Deaths' national framework and to support next steps in this process. • To take assurance that SGUH has a robust process for assessing deaths and from learning any lessons that arise from them.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	This work will identify issues impacting on care quality day to day, and will identify risks that are escalated to trust and divisional governance teams. The 'Learning from Deaths' framework represents a significant change in process that requires resource, even with a mature mortality monitoring process. There is a risk that published mortality data and learning will not only be used for quality improvement, and that		

	identifying problems in care could lead to adverse publicity.		
Legal/Regulatory:	‘Learning from Deaths’ framework is regulated by Care Quality Commission and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:	There are resource implications associated with these works that are being worked through.		
Previously Considered by:	Patient Safety & Quality Board Quality & Safety Committee	**Date**	April 18 June 18
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

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

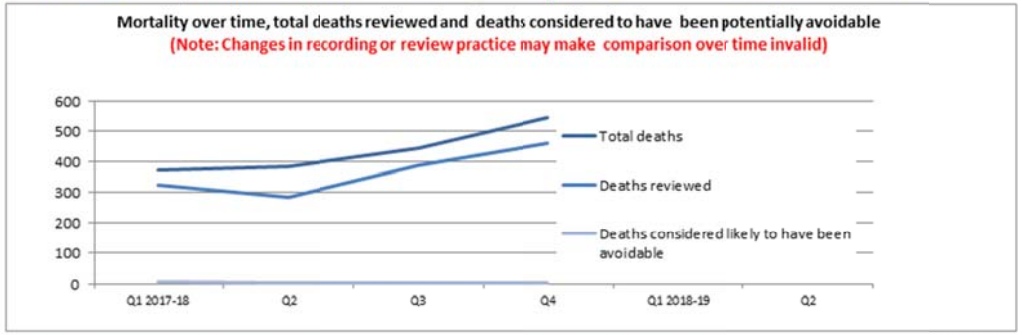
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lesscns can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
160	177	136	149	0	3
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
543	443	460	387	3	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1739	0	1456	0	15	0

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



Total Deaths Reviewed by RCP Methodology Score

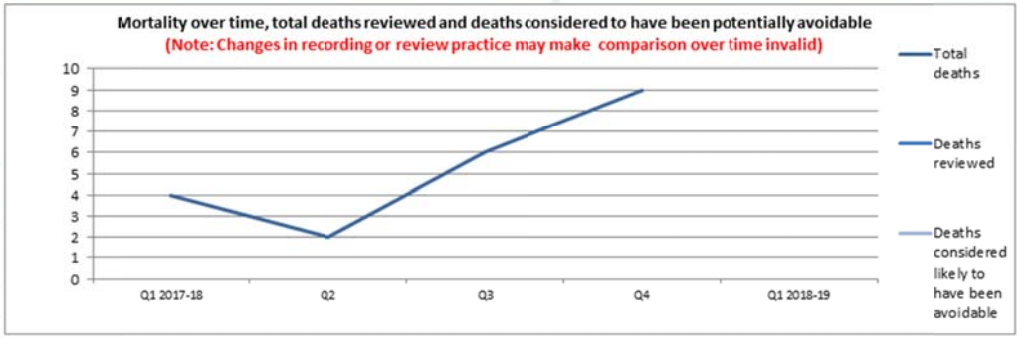
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	1.5%	This Month	1	0.7%	This Month	133	97.8%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	0.2%	This Quarter (QTD)	2	0.4%	This Quarter (QTD)	3	0.7%	This Quarter (QTD	8	1.7%	This Quarter (QTL	446	97.0%
This Year (YTD)	0	0.0%	This Year (YTD)	7	0.5%	This Year (YTD)	8	0.5%	This Year (YTD)	13	0.9%	This Year (YTD)	25	1.7%	This Year (YTD)	1403	96.4%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
4	3	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
9	6	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
21	0	0	0	0	0

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



Meeting Title:	**Trust Board**		
Date:	28/06/2018	**Agenda No.**	**3.7**
Report Title:	**Progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions**		
Lead Director/ Manager:	Justin Richards, Divisional Chair		
Report Author:	Julian Sutton, Lead Midwife Governance		
Freedom of Information Act (FOIA) Status:			
Presented for:	Approval		
Executive Summary:	This report has been through TEC and the Quality and Safety Assurance Committee for assurance, and has been approved. NHS Resolution require Trust Board sign off of the Trust evidence. The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety. To support this, the scheme has been set up to reward local services that take steps to improve delivery of best practice in maternity and neonatal services. NHS Resolution has built in provision for an incentive fund into our maternity pricing for 2018/19 of the CNST, collecting an additional 10% of the maternity contribution from members. Trusts that are able to demonstrate compliance against ten actions will recover the element of their contribution relating to the CNST maternity incentive fund and a share of any unallocated funds. Those making insufficient progress may benefit from a lesser sum to help them improve their position. For St George's the potential value of this rebate is up to £900k. This standard template report sets out St George's Maternity Services' progress towards these actions and the evidence available to demonstrate this progress is contained within the appendices. The guidance from NHS Resolution states that "*the expectation is that trusts will be able to demonstrate the required progress against all 10 of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund.*" Those Trusts who are unable to demonstrate required progress may be eligible for a smaller rebate, which is expected to be invested in making progress towards the required standards. The maternity service can demonstrate compliance against all ten standards. We believe we have supplied sufficient evidence to meet the expectation set out above, however any rebate is entirely at the discretion of NHS Resolution based on a review of plans by The National Maternity Safety Champions and Steering Group NHS Resolution. The		

	self-report will be validated against external data sources by NHS Resolution. The completed report needs to be signed off by the Trust Board and submitted to NHS Resolution by 29 June 2018. It is still to be discussed with commissioners as set out in the guidance. An outcome is expected at the end of July 2018 and NHS Resolution will confirm and pay discounts by the end of August 2018. Trusts are not required to submit their supporting evidence to NHS Resolution. This assurance is to be provided to the Board with only the final results sent through to NHS Resolution		
Recommendation:	To accept the self-report of progress against the CNST safety standards as approved by the Quality and Safety Committee and TEC and sign off before submission to NHS Resolution as the Trust's position.		
Supports			
Trust Strategic Objective:	1. **High Quality Care**: To ensure consistently high quality care for patients by ensuring it is safe, effective and patient led. 2. **Financial sustainability**: To make the Trust financially sustainable with effective financial monitoring and reporting systems.		
CQC Theme:	Safe (currently rated as Good)		
Single Oversight Framework Theme:			
Implications			
Risk:	**Finance:** CIP 18-19-3081, value up to £900k. If we do not submit the self-assessment and/or cannot demonstrate required progress towards the 10 standards we will not deliver this £900k CIP. **Quality:** The 10 safety standards are designed to measure how safe a maternity service is; failure to meet the required progress towards these standards could demonstrate a safety / quality issue within the service.		
Legal/Regulatory:	Indemnity agreement with NHS Resolution		
Resources:	CIP 18-19-3081 £900k		
Previously Considered by:	Trust Executive Committee CWDT Divisional Governance Board (Approved)	**Date:**	06.06.18 10.05.18
Appendices:	Evidence for actions listed in a table at the end of the document.		

Board report on St George's University Hospitals NHS Foundation Trust's progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Trust Executive Committee 6 June 2018

1.0 PURPOSE

1.1 This paper summarises each of the 10 CNST actions that are part of the incentive scheme to promote patient safety. The table below sets out Maternity's position in relation to each of the actions and details the evidential documents that accompany the report.

1.2 NHS Resolution expects trust Boards to self-certify declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which the Advisory group will escalate within the system for further exploration. They will also take steps to recover in full any incentive payment that has been made under the scheme.

1.3 The expectation is that trusts will be able to demonstrate the required progress against **all 10** of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia).

2.0 BACKGROUND

2.1 Maternity safety is an important issue for all members of the Clinical Negligence Scheme for Trusts (CNST). Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend. Of the clinical negligence claims notified to us in 2016/17, obstetric claims represented 10% of the volume and 50% of the value.

2.2 NHS Resolution has joined forces with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, to support the delivery of safer maternity care through the introduction of an incentive element to the contribution to the CNST. Introducing such incentives received support through their 2016 consultation on CNST pricing.

2.3 These actions were agreed by the National Maternity Safety Champions as reflecting best practice in maternity safety improvement which could be evidenced to demonstrate progress against them. Implementing these actions should deliver a qualitative difference in trusts' performance on improving maternity safety and by doing this, trusts would be expected to reduce incidents of harm that lead to clinical negligence claims. The scheme will therefore reward those trusts who are have implemented the **10 maternity safety actions.**

3.0 EVIDENCE OF TRUST'S PROGRESS AGAINST 10 SAFETY ACTIONS

3.1

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	St George's is compliant with this standard. The concept and principles for a national Perinatal Mortality Review Tool (PMRT) were established by a stakeholder group convened by the Department of Health and the stillbirth and neonatal death charity, Sands in 2012. The PMRT has been designed to support the review of the care of the following babies: • All late fetal losses 22+0 to 23+6; • All antepartum and intrapartum stillbirths; • All neonatal deaths from birth to 28 days after birth; • All post-neonatal deaths where the baby dies after 28 days following care in a neonatal unit. Stillbirth and Early Neonatal death summaries to Mortality Monitoring Committee up to end 2017/18. (Summary of PMRT reviews will go quarterly for 2018/19). Submissions to NPMRT – 2 cases from 2017/18 started on tool. Monthly multidisciplinary meeting arranged to review cases on an ongoing basis. **Evidence to support our compliance:** • Notes of review meetings (SI panel) • Minutes of Trust Mortality Monitoring Committee (PMRT discussion as of April 2018) The Multidisciplinary PMRT group formally commenced on 23 May 2018	**Y**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	St George's is compliant with this standard. The Maternity Services Data Set (MSDS) collects information on each stage of care for women as they go through pregnancy. The Maternity Services Data Set (MSDS) sets out national definitions for the extraction of data for: - routine booking appointment activities - maternity care plan - dating scan - antenatal screening tests - structural foetal anomaly screening - labour & delivery - newborn screening - maternal or neonatal death The MSDS provides a national standard for gathering data from Maternity healthcare providers in England. It covers key information captured from NHS-funded maternity services.	**Y**

	This data set standard will be used both locally and nationally to generate 'secondary uses' information, i.e. for a purpose other than direct clinical care. The MSDS will provide reliable information for: payment of Maternity Services local and national monitoring reporting for effective commissioning monitoring outcomes addressing health inequalities The data for January, February and March has been submitted to Exeter and includes all the data fields requested. **Evidence to support our compliance:** - Summary of fields submitted - MSDS specification	
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	St George's is compliant with this standard. Although we do not have a separate Transitional care unit, infants with transitional care needs are cared for on the Postnatal Ward. In the financial year 2017/18 there were 2104 babies requiring transitional care, totalling 4468 transitional care days. **ATAIN (Avoiding Term Admissions Into Neonatal units)** All neonatal admissions are entered onto the neonatal Badgernet system. Admissions from the ward can be identified easily and are regularly discussed with the maternity risk team. Prior to Autumn 2017, all term (>37 weeks) neonatal admissions were entered on to the Datix incident system under one heading whether admitted from the neonatal unit or from the postnatal ward. Since Autumn 2017, separate categories have been created mirroring the categories: • respiratory conditions • hypoglycaemia • jaundice • asphyxia (perinatal hypoxia–ischaemia). These categories will assist in the ongoing review and monitoring of neonatal admissions **Evidence to support our compliance:** - Maternity guideline regarding transitional care - Neonatal handbook regarding transitional care.	**Y**
4). Can you demonstrate an effective system of medical workforce planning?	St George's is compliant with this standard. Data has been submitted to RCOG to cover the period of 1-28 March 2018 and demonstrates that we did not require a Consultant to act down to middle grade level at any point during this period. Our Labour Ward planned rotas pair a ST3+ doctor with a Consultant during the day and an ST3+ and ST5+ overnight with a resident Consultant for on average, 144 hours per week.	**Y**

	Evidence to support our compliance: - Completed spreadsheet sent to RCOG - Medirota entries for this period	
5). Can you demonstrate an effective system of midwifery workforce planning?	St George's is compliant with this standard. A Birthrate Plus review was undertaken in 2017 and reported in 2018. This informed internal Trust discussions regarding workforce planning and an establishment review undertaken in 2017/18. The Labour Ward co-ordinator role is supported to be supernumerary in the current establishment, with local guidelines stating that the person acting in this role would not normally take patients. This guideline will be updated to specify the supernumerary status of the co-ordinator in addition to their not taken on a specific patient caseload. **Evidence to support our compliance:** - Birthrate Plus Review - Local Establishment Review - Guideline (latest version)	**Y**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	St George's is compliant with this standard. The Saving Babies' Lives care bundle is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice: 1. Reducing smoking in pregnancy 2. Risk assessment and surveillance for fetal growth restriction 3. Raising awareness of reduced fetal movement 4. Effective fetal monitoring during labour At the last submission we declared non-compliance in section 4. We are now fully compliant following the updating of the unit fetal monitoring guideline and staff testing process. Training was previous annual with testing carried out biannual. Testing is now annual for all staff **Evidence to support our compliance** - Survey 9 spreadsheet - Updated and ratified local guideline including the use of fresh eyes for continuous and intermittent fetal heart monitoring	**Y**
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on	St George's is compliant with this standard. We have an active MVP who meet on a regular basis and carry out 'walk the patch' events. A range of staff, including midwives and obstetricians attend these meetings and provide feedback. The MVP co-chairs are members of the Maternity Transformation Steering Group, working with staff to ensure that women are key partners in service developments. The obstetric anaesthesia Consultants regularly collect feedback from women who have used their service and use this to make changes in practice. A specific project has been set up to look at women's experience in obstetric theatre and to	**Y**

feedback?	co-design improvements with staff. In the postnatal ward, the 'you said, we did' board captures actions that the team have taken to make changes based on feedback from women using this ward. **Evidence to support our compliance:** - Minutes from MVP meetings - New Beginnings Project Summary and information sheets.	
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	St George's is compliant with this standard. For St George's maternity unit, 'in house' emergency training is defined as the following: Maternity and Gynaecology Update Day (Includes deteriorating patient and obstetric skills and drills) Skills and Drills (classroom) Skills and Drills (simulation) Neonatal and adult basic life support Fetal monitoring (classroom) Fetal monitoring (case study sessions) Physiological breech birth Within the last 12 months the maternity unit has achieved over 90% attendance for multi-professional maternity emergency training. Training data for the individual staff designations is presented in the table in the appendix and highlights the percentage of eligible staff trained in a multi-professional setting within each group. The figures presented in this paper do not include data for staff of any level or speciality who have attended external multi-professional training sessions. **Evidence to support our compliance:** - Emergency training summary	**Y**
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	St George's is compliant with this standard. Meeting of the maternity safety champions (Director of Midwifery and Gynaecology and Clinical Director for Women's) and board level champion (Director of Delivery, Efficiency and Transformation) incorporated into Maternity Transformation meeting in order to give a broader overview The maternity transformation steering group takes place monthly and reports on the business of the unit and actions related to improving the maternity service for women. **Evidence to support our compliance:** - Terms of Reference - Maternity Transformation - Minutes 16.05.18	**Y**
10). Have you reported 100% of qualifying 2017/18 incidents under	St George's is compliant with this standard. NHS Resolution has identified some early indicators to incentivise improvements in maternity safety which are aligned with elements of	**Y**

NHS Resolution's Early Notification scheme?	the Royal College of Obstetricians and Gynaecologists' (RCOG) Each Baby Counts (EBC) national quality improvement programme. It is now a requirement for trusts to report all maternity incidents occurring on after 1 April 2017 which are likely to result in severe brain injury (based on EBC criteria). NHSR will then be able to increase the level of support they provide to teams when these rare incidents occur. The following process is: - Data is submitted to the RCOG Each Baby Counts programme as usual. - The trust legal services department is informed within 14 days of the incident that a notifiable severe brain injury incident under the Early Notification Scheme has occurred using the Early Notification report form - The trust legal services department should then report the incident to NHS Resolution within 30 days of the incident. **St George's current status:** The maternity unit had 8 babies in 2017/18 admitted to the neonatal unit with hypoxic ischaemic encephalopathy (HIE) stage 3 or requiring therapeutic cooling. 2 babies were delivered to mothers who were not in labour so do not meet the criteria for Each baby Counts and thus were not reported to the NHSR. 2 babies were early neonatal deaths and were reported however both were rejected. 4 remaining babies were reported to NHSR **Evidence to support our compliance:** - Anonymised spreadsheet taken from the neonatal BadgerNet system showing case breakdown	

4.0 IMPLICATIONS

Risks

4.1 Only trusts that meet the required progress against all 10 maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet the 10 out of 10 threshold may be eligible for a discretionary payment from the incentive fund to help them to make progress against one or more of the 10 actions. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

4.2 **Finance:** NHS Resolution built in provision for an incentive fund into our maternity pricing for 2018/19 of the CNST, collecting an additional 10% of the maternity contribution from members CIP 18-19-3081, value up to £900k. If we do not submit the self-assessment and/or cannot demonstrate required progress towards the 10 standards we will not deliver this £900k CIP

4.3 **Quality:** The 10 safety standards are designed to measure how safe a maternity service is; failure to meet the required progress towards these standards could demonstrate a safety / quality issue within the service.

Legal/Regulatory

4.7 CNST is the indemnity provided by NHS Resolution to manage claims against trusts when clinical incidents are alleged to have taken place

Resources

4.8 This project has highlighted the issues around the system for recording attendance at the maternity specific training. It is hoped that the savings made could be used to appoint a new training database co-ordinator post across all specialities in the department to input data in the training database and/or the standard Trust training system as appropriate. This will allow the service to record and report on attendance regularly. Secondly, establishing a clear programme of training and timetable will ensure that sufficient places are available to all staff groups over the year to maintain and improve the 90% compliance.

5.0 TIMELINE

5.1 Trusts are able to submit self-certification reports and action plan to NHS Resolution from Friday 1 June. The deadline for trust self-certification reports and action plan is 23:59 Friday 29 June

5.2 Review of final results/business cases by NHS Resolution is in July with processing of incentive scheme payments in August

6.0 RECOMMENDATION/ FURTHER ACTION REQUIRED

6.1 This project has highlighted the issues around the system for recording attendance at the maternity specific training. It is hoped that the savings made could be used to appoint a new training database co-ordinator post across all specialities in the department to input data in the training database and/or the standard Trust training system as appropriate. This will allow the service to record and report on attendance regularly. Secondly, establishing a clear programme of training and timetable will ensure that sufficient places are available to all staff groups over the year to maintain and improve the 90% compliance. This will be coordinated by the new Training Administrator and overseen by the training leads within each discipline.

- Appointment of Training Database Co-ordinator with responsibility for recording all multi-disciplinary training
- Use of Trust training database to record attendance, allowing computation of attendance by all staff groups
- Timetable of training with clearly identified places for all staff groups to ensure maintenance and improvement of the 90% compliance

7.0 SIGN OFF

7.1 Declaration

……..

For and on behalf of the Board of St George's University Hospitals NHS Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section 6**

Position: ……

Date: ……

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

8.0 LIST OF EVIDENTIAL APPENDICES

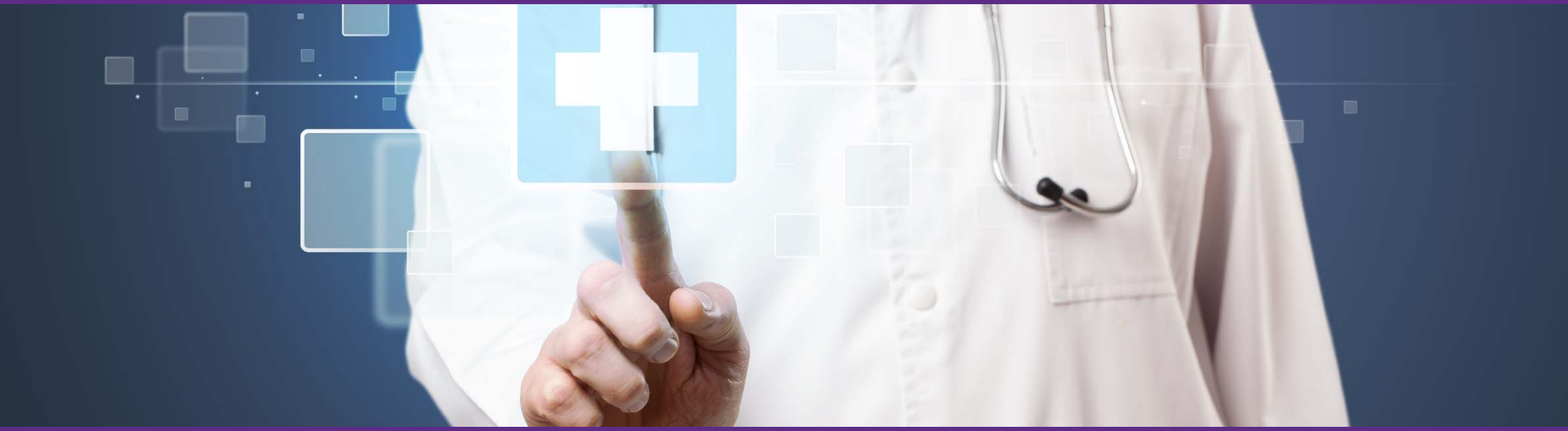
Applicable Action	Appendix Name
Action 1	CNST Action 1a SI panel Minutes 18th April 2018
	CNST Action 1b Mortality Monitoring Committee March 18
Action 2	CNST Action 2a Summary of Fields Submitted
	CNST Action 2b MSDS specification
Action 3	CNST Action 3a Chapter 32 Care and Examination of the Newborn
	CNST Action 3b NNU guidelines
Action 4	CNST Action 4a Medical Staffing extracted 01.05.18
	CNST Action 4b Medical Workforce Template March 2018 - FINAL
Action 5	CNST Action 5a St Georges Final Birthrate+ Report_9 1 18
	CNST Action 5b Chapter 1 Miscellaneous Information
Action 6	CNST Action 6a St George's RJ7 Survey 9
	CNST Action 6b Chapter 6 Fetal Monitoring
Action 7	CNST Action 7a MVP Meeting 6th February 2018
	CNST Action 7b MVP Meeting 28th March 2018
	CNST Action 7c MVP SGH Agenda Mar2018
	CNST Action 7d Information for Women and Families New beginnings
Action 8	CNST Action 8a Emergency training summary
Action 9	CNST Action 9a Terms of Reference - Maternity Transformation v4
	CNST Action 9b Minutes 16.05.18
Action 10	CNST Action 10a each baby counts BadgerNet download

Author: **Julian Sutton Lead Midwife for Clinical Governance**
Date: **30/05/2018**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**28th June 2018**	**Agenda No.**	**4.2**
Report Title:	**M02 Finance Report**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	Overall the Trust is reporting a deficit of £10.7m at the end of Month 02 (May), with an adverse variance to plan year to date of £0.2m. Within the position, income is adverse to plan, which is largely offset by expenditure underspend.		
Recommendation:	The Trust Board notes the trust's financial performance in May.		
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:**	25/06/2018
Appendices:	None		

TB Jun 18 – Agenda item x.x



St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 2 (May 2018)

Chief Finance Officer

28th June 2018.

Executive Summary – Month 2 (May)

St George's University Hospitals NHS
NHS Foundation Trust

Note: All figures and commentary in this report refer to the Trust plan submitted to NHS Improvement on 30th April, not the revised plan submitted on 20th June

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £10.7m at the end of May, an adverse variance to plan of £0.2m. Within the position, income is adverse to plan, which is being partly offset by expenditure underspend. There remains an element of estimation in the position which will need to be validated ahead of freeze dates.	£0.2m Adv to plan	£0.1m Adv to plan
Income	Income is being reported at £2.4m adverse to plan year to date. There is lower than planned income of £1.2m in Elective, £0.1m Daycase, £0.1m Beddays and £0.1m in Outpatients. SLA Exclusions contribute £0.4m of the variance which is offset within drugs and consumables. Non-SLA income is also under plan by £0.2m, with shortfalls in Pharmacy partially offset but underspends in drugs, and SWLP income fully offset by reduced Non Pay cost.	£2.4m Adv to plan	£0.7m Adv to plan
Expenditure	Expenditure is £2.2m favourable to plan in May. The favourable position is in Non Pay (£2.0m), with underspends seen in Consumables and Premises.	£2.2m Fav to plan	£0.6m Fav to plan
CIP	The Trust planned to deliver £3.9m of CIPs by the end of May. To date, £3.9m of CIPs have been delivered; which is on plan. Income actions of £0.8m and Expenditure reductions of £2.6m have impacted on the position.	On plan	
Capital	Capital expenditure of £4.3m has been incurred year to date. This is £1.7m below plan YTD.	£1.1m Fav to plan	
Cash	At the end of Month 2, the Trust's cash balance was £3.5m, which is better than plan by £0.5m. The Trust has borrowed £9.7m YTD which is £0.9m less than plan. The Trust will draw down £4.5m in June and has requested £3.0m for July. This will be in line with the cumulative YTD plan. The borrowings are subject to an interest rate of 6% for the amounts drawn up to October 17 and 3.5% for the amounts drawn since November 17.	£0.5m Fav to plan	
Financial Risk Rating- Use of Resources (UOR)	At the end of May, the Trust's UOR score was 4.	Overall score 4	Overall score 4

Contents

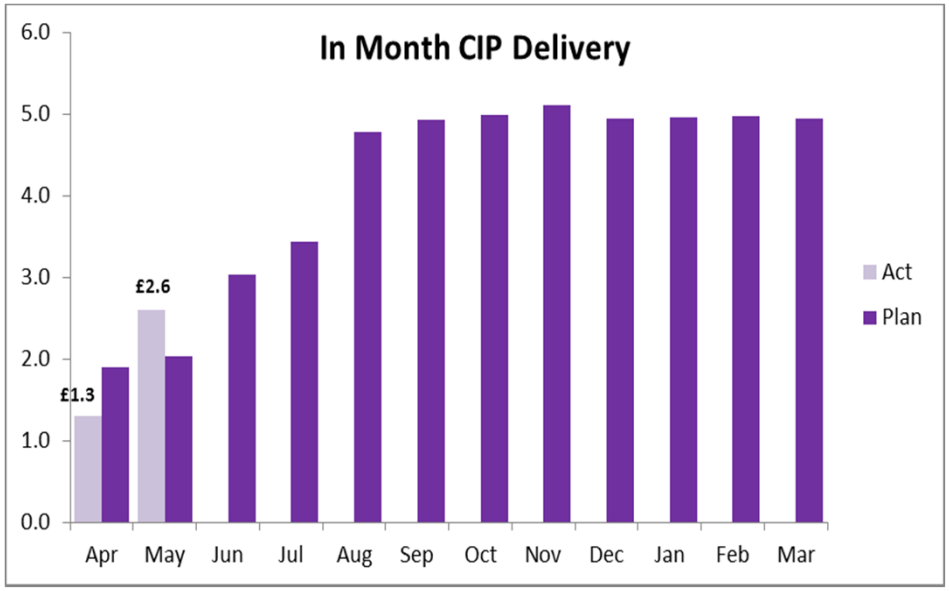
1. Month 2 Financial Performance

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	M2 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Income	SLA Income	666.31	55.62	53.69	(1.94)	(3.5%)	109.46	107.27	(2.19)	(2.0%)
	Other Income	116.04	9.70	9.90	0.20	2.1%	19.44	19.23	(0.21)	(1.1%)
Income Total		**782.35**	**65.32**	**63.58**	**(1.73)**	**(2.7%)**	**128.89**	**126.50**	**(2.40)**	**(1.9%)**
Expenditure	Pay	(467.56)	(40.56)	(40.43)	0.13	0.3%	(81.14)	(81.12)	0.02	0.0%
	Non Pay	(309.61)	(26.25)	(24.97)	1.28	4.9%	(52.66)	(50.64)	2.01	3.8%
Expenditure Total		**(777.17)**	**(66.81)**	**(65.40)**	**1.41**	**2.1%**	**(133.80)**	**(131.76)**	**2.04**	**1.5%**
Post Ebitda		(34.18)	(2.80)	(2.60)	0.20	7.3%	(5.56)	(5.41)	0.15	2.6%
Grand Total		**(29.00)**	**(4.29)**	**(4.41)**	**(0.12)**	**(2.7%)**	**(10.46)**	**(10.67)**	**(0.21)**	**(2.0%)**

Trust Overview

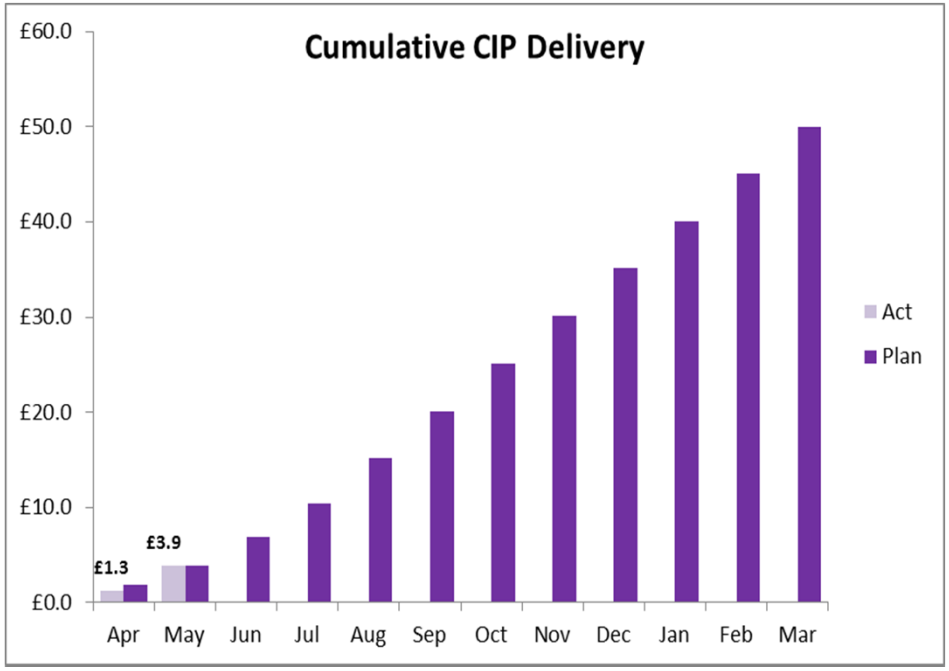
- Overall the Trust is reporting a deficit of £10.7m at the end of Month 2, an adverse variance to plan of £0.2m.
- **SLA Income** is £2.2m under plan, owing to lower than planned income of £1.2m in Elective, £0.1m Daycase, £0.1m Beddays and £0.1m in Outpatients. SLA Exclusions contribute £0.4m of the variance which is offset within drugs and consumables.
- **Other income** is under plan by £0.2m; the key driver is lower than planned pharmacy income, which is offset in non-pay.
- **Pay** is on plan, with all major staff groups underspending with the exception of medical pay. Agency has reduced in month.
- **Non-pay** is £2.0m underspent, owing to consumables underspend of £0.7m, premises underspend of £0.5m and central phasing adjustments for CIP.
- **CIP delivery** of £3.4m is £0.5m behind plan. The adverse performance is mainly driven by shortfalls against plan in the following areas: Clinical Divisions; Corporate & Estates; and SLA Income data quality improvements

2. Month 2 CIP Performance



CIP Overview

- At the end of Month 2, the Trust is reporting delivery of £3.9m of savings /additional income against its Cost Improvement Programme.
- This is against an external plan for Month 2 to have delivered £3.9m (overall delivery is on plan).
- The performance is the aggregate result of the following:
  - Clinical Divisions are adverse of plan (£1.0m)
  - Corporate & Estates are adverse of plan (£0.1m)
  - A phasing adjustment of £1.0m (favourable) is required to match the YTD plan value of Green rated schemes to the plan submitted to NHSI on 30th April
- The Month 2 over performance shown in the graph (left) was driven by a validation (on a line by line basis) of Month 1 delivery; this was adversely impacted by lack of data availability at the time of reporting.



Actions

- Divisions need to complete any outstanding documentation/ information requests to ensure that their minimum Green rated CIP values are robust and can be assured by NHSI.
- The final £5m of the CIP, to move from £45m to a £50m Green rated plan, needs to be progressed through the Trust's CIP Process. This includes £0.9m medical staff cost reduction through reduced admin and ANR PA's, £2.1m outpatient cost reduction opportunity through productivity gain (supported by FEI to achieve pace of delivery needed to maximise CIP opportunity in year) and £2.1m from SLM and Model Hospital/ GIRFT opportunities.
- Any Divisional CIP underperformance is to be investigated on a scheme by scheme basis, led by the Director of Financial Improvement. Mitigating actions, to bring performance back to forecast values, are to be agreed with the CFO as part of the Run Rate meetings. These will then be followed up as part of the weekly Divisional CIP meetings.

3. Balance Sheet as at Month 2

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**352.9**	**379.4**	**377.8**	**1.6**
Stock	6.2	6.4	7.6	-1.2
Debtors	107.2	108.3	102.4	5.9
Cash	3.0	3.0	3.6	-0.6
Creditors	-118.1	-122.6	-118.4	-4.2
Capital creditors	-2.3	-6.9	-8.7	1.8
PDC div creditor	0.0	-0.1	-0.1	0.0
Int payable creditor	-0.8	-1.5	-1.5	-0.0
Provisions< 1 year	-0.3	-0.2	-0.1	-0.1
Borrowings< 1 year	-9.0	-58.4	-57.8	-0.6
Net current assets/-liabilities	**-14.2**	**-72.1**	**-73.0**	**1.0**
Provisions> 1 year	-0.6	-0.9	-1.0	0.1
Borrowings> 1 year	-278.9	-252.8	-250.4	-2.4
Long-term liabilities	**-279.5**	**-253.6**	**-251.4**	**-2.2**
Net assets	**59.2**	**53.7**	**53.4**	**0.3**
Taxpayer's equity				
Public Dividend Capital	130.0	133.2	133.2	0.0
Retained Earnings	-161.1	-178.6	-178.9	0.3
Revaluation Reserve	89.1	97.9	97.9	0.0
Other reserves	1.2	1.2	1.2	0.0
Total taxpayer's equity	**59.2**	**53.7**	**53.4**	**0.3**

M01-M2 YTD Balance Sheet movement

- Fixed assets is £1.6m lower than plan due to lower capital spend from 17/18 funding.
- Stock position has increased £1.2m due to increase in month end Pharmacy stock holdings. This is under review.
- Overall debtors is £5.9m lower than plan. The Trust received £2.3m cash from NHSE for 17/18 over-performance and also settlement of some other aged SLA debts and accrued debt has reduced.
- The cash position is £0.6m better than plan due to delay in settlement of capital creditors pending completion of schemes.
- The Trust has borrowed £9.7m YTD for deficit financing which is £0.9m less than plan. The Trust will draw down £4.5m for deficit financing in June and has requested £3.0m for July. This will be in line with the cumulative YTD plan. The deficit financing borrowings are subject to an interest rate of 6% for the amounts drawn up to October 17 and 3.5% for the amounts drawn since November 17. Also borrowings for new finance leases are lower than plan.
- The Trust has not drawn down any capital loans to date. Capital bids to NHSI are due to be submitted.

4. Month 2 YTD Analysis of Cash Movement

	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Cash balance 01.04	**3.5**	**3.5**	**0.0**
Income and expenditure deficit	-10.7	-11.0	-0.3
Depreciation	3.9	3.9	-0.0
Interest payable	1.7	1.8	0.0
PDC dividend	0.1	0.1	0.0
Other non-cash items	-0.0	-0.0	0.0
Operating deficit	**-4.9**	**-5.2**	**-0.2**
Change in stock	0.0	-1.2	-1.2
Change in debtors	6.0	9.9	3.9
Change in creditors	2.2	-0.0	-2.2
Net change in working capital	**8.2**	**8.6**	**0.4**
Capital spend (excl leases)	-12.5	-11.1	1.4
Interest paid	-1.0	-1.0	-0.0
PDC dividend paid	0.0	0.0	0.0
Other	-0.1	-0.0	0.1
Investing activities	**-13.5**	**-12.1**	**1.4**
Revolving facility - repayment	0.0		0.0
Revolving facility - renewal	0.0		0.0
WCF borrowing - new	10.7	9.7	-1.0
Capital loans	0.0	0.0	0.0
Loan/finance lease repayments	-0.9	-1.0	-0.1
Cash balance 31.05	3.0	3.6	0.6
Cash balance 31.03	**3.0**	**3.6**	**0.6**

M01-M2 YTD cash movement

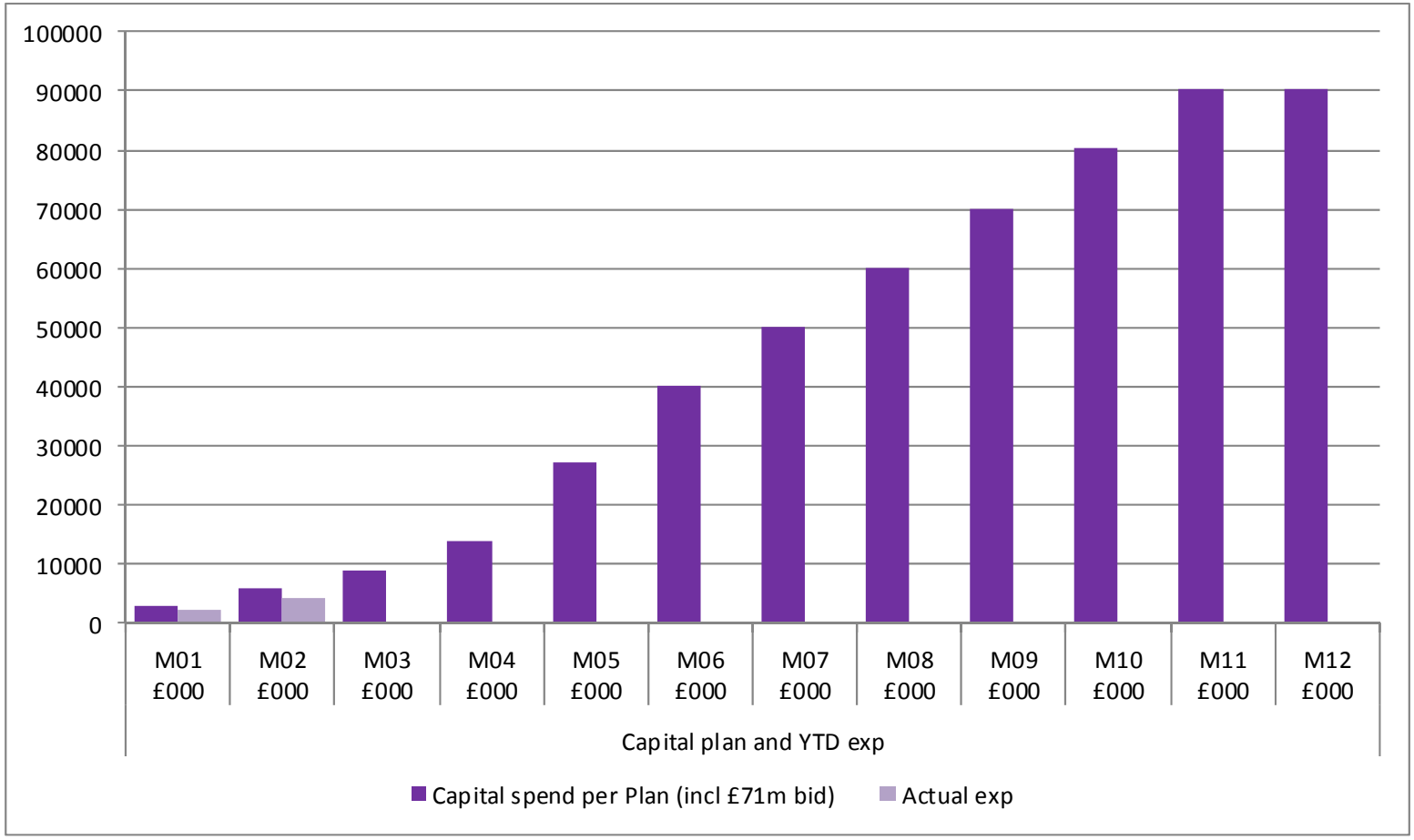
- The cumulative M2 I&E deficit is £11m – £0.3m worse than plan. (*this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £11m, depreciation (£3.9m) does not impact cash. The charges for interest payable (£1.8m) and PDC dividend (£0.1m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £5.2m.
- The operating deficit variance from plan of £0.2m in cash is due to timing of creditor payments primarily for capital schemes.
- Working capital performed better than plan by £0.4m.
- The Trust has borrowed £9.7m YTD which is £0.9m less than plan. The Trust will draw down £4.5m in June and has requested £3.0m for July. This will be in line with the cumulative YTD plan. The borrowings are subject to an interest rate of 6% for the amounts drawn up to October 17 and 3.5% for the amounts drawn since November 17.
- The Trust has not drawn down any capital loans to date. Capital bids to NHSI are due to be submitted.

May cash position

- The June borrowing request has been approved and YTD receipts are currently behind plan but payments are also lower due to timing of capital payments. Therefore the Trust meet its minimum £3m cash balance on 31 May 2018 **but remains dependent on monthly borrowing from DH given the continuing I&E deficit.**

5. Month 2 Capital Programme- phased

- This slide shows total capital expenditure year to date at month 2 of £4.3m against a plan of £6m.
- The position is reported against the original plan total submitted to NHSI of £91m. This has been revised to £46m. This will be adjusted in month 03.



6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M2 YTD)	Actual (M2 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	2
Agency rating	1	1

Basis of the scoring mechanism

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

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of May, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. The internal Trust cap
- The distance from plan score is worked out as the actual % I&E deficit (8.44%) minus planned % I&E deficit (8.12%). This value is -0.32% which generates a score of 2.
- Distance from plan score in this report refers to the Trust plan submitted to NHS Improvement on 30th April.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Board Meeting		
Date:	28 June 2018	**Agenda No.**	**5.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Harbhajan Brar, HR & OD Director		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 14th June 2018, including commenting on assurance to the Board on key risks allocated to the Committee.		
Recommendation:	Receive this report		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		
Implications			
Risk:			
Legal/Regulatory:			
Resources:			
Previously Considered by:		**Date:**	
Equality Impact Assessment:			
Appendices:			

1. Committee Chair's Overview

This paper reports on the Workforce and Education Committee held on 14 June. We had good attendance and a strong contribution from all present. It was also good that all three Divisions were represented and we are appreciative of people making the time to attend. The Trust's Chief Executive and Chair were also able to be present for part of the meeting, as was our interim CMO, Prof Rhodes and our Responsible Officer, Karen Daly. Their attendance and input was extremely helpful and much appreciated.

This meeting was more operationally-focussed than previously, and whilst planning and preparation is important it is good that a number of posts and roles have been filled, and we are now moving into a more progress-oriented phase of activity. It is also good to see action being taken on areas where we have expressed concern (such as junior doctor workforce planning; resources available to our medical appraisal and revalidation; and the critical importance of personal development planning for all staff through effective annual reviews).

The preparation of a Workforce Plan to support the Trust's Cost Improvement Plan is not something that the Committee has been particularly engaged in, so we will have a full report back on this at our next meeting. However, we understand that good progress is being made, and some of the operational implications of this are evident – such as the work to re-set the Trust's establishment, on which we did receive a report (see below).

It is also good that we now have a Diversity and Inclusion lead (Celia Oke) in post, and we appreciated her initial assessment of the Trust's position, her focus on a broader set of characteristics that we should be concentrating on supporting, and her clarity on the achievable next steps for us as a Trust.

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

2. Key points:-

Board Assurance - The Committee ended its meeting by reviewing the four[2] **Trust-level risks** that have been assigned to the Committee to monitor, and provide assurance on mitigation. On each of these, we noted that progress was being made but this was not sufficiently embedded at this stage to change our present assurance rating. The Board should however take comfort from the fact that across all four risk areas, there is good work being done which, over time, will help mitigate these risks.

Theme 1 - Engagement

We welcomed the Trust's new **Diversity and Inclusion** Lead, Celia Oke, who had been in post for six weeks. Celia summarised her initial assessment of the Trust's position, the emerging areas that she was intending to recommend become her focus, and her initial thoughts about the form of a manageable composite delivery plan that could be put in place to ensure a Trust-wide consistent approach to diversity and inclusion (D&I).

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

Celia made a number of important points:- current D&I delivery is fragmented; it is targeted at compliance with the Workforce Race Equality Standard; any action should be directed at removing discrimination or unfavourable treatment as a result of any protected characteristic; the objective should be a shift in the working environment and Trust culture to one of openness and inclusion, rather than simply compliance.

There was a lively discussion about how these might be framed as achievable objectives, and how staff could be engaged in helping secure them. We agreed that Celia would continue with her work and bring a proposed implementation plan for review to the next meeting of the Committee (9 August) and if that was accepted we would ask her to present it at the September meeting of the Trust Board.

In the absence of Alison Benincasa, Harbhajan updated us on progress on the Trust's **Engagement Plan**, and current and planned activities. A number of actions had been initiated following the results of the 2017 Staff Survey. Good progress was reported.

Jacqueline McCullough reported on the results of the most recent **survey of joiners and leavers** to the Trust's staff, pointing out that statistically 47% would leave within two years. The survey was able to provide further insight on the specific[3] reasons for this (in a number of cases, expectations of the Trust were not being met), and feedback on the Trust's recruitment processes – which had been speeded up. The influence of each joiner's immediate manager, and the influence they had on the joiner' decision to remain, was clear. The HR-led 'Stay interviews' were crystallising a discussion at the three month point, but it was less clear how line managers were being directed to influence retention through simple steps to engage with their staff, both through appraisal and regular informal engagement and checking. Harbhajan and Jacqueline would reflect on the results, and consider how (often busy) line managers could ensure they were focused on making time for routine progress discussions with new joiners. Divisional HR advisors could support this, but responsibility lay with line management. Divisional representatives present concurred.

Related to this is the importance of effective **annual personal development reviews** (appraisals), and their completion for each member of staff as part of a process of continuing engagement and career planning. We were therefore pleased to have a proposal, with teeth, to ensure that this was undertaken. Sarah James brought forward a paper setting out a phased approach to improving our appraisal rate from its present 63%, to somewhere closer to (initially) 85%+, a revised content for those appraisals, and a new Trust policy. There was agreement that this needed to be progressed with vigour. The timescale for the phasing required - balancing full implementation against the operational requirements to ensure service delivery was maintained - was discussed with the divisional representatives present, and we concluded that the implementation phase would run through to the calendar year end. Divisions agreed to support this, and the proposed potential financial consequences for managers who had not completed this task by the year end.

Theme 2 – Leadership and Progression

We had a short update from Sarah James on progress with the **development centre** which was being undertaken for the Trust by The King's Fund. Non-attendance rates had improved materially since the last update. The projected throughput for the programme was over 200 senior managers. The Committee discussed the follow-on training and mentor support need being identified, and the critical importance of responding constructively to this.

[3] Top 5 reasons (with % of surveyed leavers citing):- not feeling valued, 40%; poor communication by management, 39%; lack of promotion opportunities, 37%; lack of training and development, 36%; low morale, 36%.

Whilst some follow-on opportunities could be offered within the Trust, others would require to be paid for. The availability of funding for that follow-on support was an issue, though Harbhajan indicated that certain funding might be available from NHSI. He would progress this.

Theme 3 - Workforce Planning

Ranjit Soor updated us briefly on the **Workforce Strategy**. Ranjit referred to her paper and reported that work on the Strategy continued. Ranjit cited a number of areas where a more flexible approach was proposed. It was anticipated that a completed strategy would be brought forward in the autumn, once the Workforce Plan for the current year had been finalised.

In relation to the **Workforce Plan** for the current year, Harbhajan reported that work on this continued as part of the Trust's wider Cost Improvement Plan, and good progress was being made. A report had been provided to the Board on that earlier in the day. We agreed on the need for a full discussion of the proposed Plan, and its implications, at the next meeting of the Committee.

Sion Pennant-Williams presented the most recent **workforce report**. Sion reported that a recent data cleanse of the Trust's establishment had been undertaken leading to its reduction by just over 150[4] FTEs, and this would have an impact on the reported turnover and vacancy rates. Where changes were seen to these, at least part of the reason for that was likely to be the re-set of the establishment number. As at the end of May, the vacancy rate stood at 11.32% and turnover at 16.96% (both down in actual terms, even allowing for the impact of the data cleanse). Staff sickness rate had declined marginally, to 3.15% - although rates across divisions and individual care groups occupied a broad range, and targeted intervention was being directed at areas of notably higher sickness. The MAST rates had increased to 87.38% and whist the continuing month-on-month improvement since January was welcome, we were still below the rate achieved in the previous year. The Committee agreed that for our junior doctors on rotation, verifiable and in-date completion of mandatory training in a previous employer should count as compliance for Trust purposes – in other words there should be portability of mandatory training.

At the operational level, over 400 staff are now using the 'MeApp' to book **bank shifts** within the Trust, as part of the South West London (SWL) Bank Consortium. The Trust has moved its **Medical Bank rates** to the Pan-London Break Glass Ceiling levels, with other SWL Trusts having committed to match this by the end of June. Analysis of performance shows that the Trust has a low (and relative to other London Trusts, extremely low) proportion of agency sessions (c5%[5]) which breach this ceiling. April **agency spend** nudged our monthly cap, but Harbhajan indicated that May's performance was well below the ceiling. The Trust has not been able to recycle the full £2m it contributes by way of **Apprenticeship Levy** and so an initiative is being launched to improve our number and use of modern apprentices. The Trust's **whistleblowing policy** (Raising Concerns at Work) has now been reviewed and updated, as agreed at the previous meeting of the Nomination & Remuneration Committee in May 2018.

Claire Low referred to her paper setting out a **proposal for a Medical Workforce Committee** and draft Terms of Reference. This was being brought forward following a discussion initiated at the previous meeting prompted by a report from our Guardian of Safe Working, in which Prof Rhodes had agreed to evaluate how our medical workforce wider job planning (particularly in the pre-consultant workforce) could be improved.

[4] We did not in the time available consider the impact of this on the Trust's Baseline Budget as presented to NHSI, but this may be a helpful analysis to undertake.
[5] In fact the underlying data is 0.41 hours per locum session [of 8 hours] = c 5%

The paper set out the results of a recent audit of the Trust's job-planning of its medical workforce, and some encouraging results. The proposal was warmly received, and adopted. We agreed that reports would come to our Committee quarterly, or otherwise where circumstances required an escalation.

Theme 4 – Compliance.

Harbhajan provided us with formal confirmation of continuing compliance by the Trust with the requirements of the **Fit and Proper Persons** processes.

Karen Daly, our Responsible Officer and Associate Medical Director, presented a report on **medical appraisal and revalidation,** and our annual audit submission to NHS England which had been submitted earlier in the month. Karen reported on an improvement over the previous year in (a) the funds and resources being made available by the Trust to the appraisal and revalidation processes and (b) the monitoring system in place within the Trust over doctors' fitness to practice.

However, there was still concern over the wider appraisal system, both in terms of its robustness and the rate of required appraisals[6] being achieved. We had a discussion of the remedial actions required and the direct targeting of those care groups where performance had been poor. Divisional representatives present agreed to support this actively, and Prof Rhodes indicated that it will be an area of early focus for the new Medical Workforce Committee. Given the seriousness of this, we will look for an update on the position at our September meeting.

We had a minutes reflective silence during the meeting to respect those who lost their lives in the Grenfell fire.

Finally, I will not be at the next meeting of the Board due to a family holiday, so Harbhajan has kindly agreed to present this report. Thank you.

Stephen J Collier
17 June 2018

[6] Our completed appraisal rate for the year stood at 75%, against a cohort benchmark of 86%. This was part of the reason for our reduced revalidation rate against prior year: Consultants, 83% (down from 85%); and short term contract doctors, 63% (down from 75%).

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	28th June 2018	**Agenda No.**	**5.2**
Report Title:	Fit and Proper Persons (FPP) 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 continues to provide a quarterly updates on FPP compliance against Regulation 5 during the year 2018/19 until such time that the CQC finds that Fit and Proper Persons checks of Directors are in place. The purpose of this paper is to give the Board on-going assurance that the Trust is remains fully compliant with Regulation 5. Fit and Proper Persons: Directors.		
Recommendation:	The Board is asked to: Note that the Trust continues to be fully compliant with Regulation 5. Fit and Proper Persons: Directors. Notes that Stephen Jones has met all the FPP requirements.		
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:**	Quarterly - Feb 18
Equality Impact Assessment:	Not undertaken. Policy applied to every Board member		
Appendices:	Appendix A - Exec and Non Exec FPPR compliance list		

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

Trust Board – 28th June 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.

4.5 The Board has request that the HRD continues to provide a quarterly updates on FPP compliance against Regulation 5 during the year 2018/19, until such time that the CQC finds that Fit and Proper Persons checks of Directors are in place

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5. Recommendation

It is recommended that the Board:-

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

5.2 Notes that Stephen Jones has met all the FPP requirements.

Name	Fit and Proper Persons Test - Declaration Form	Employment History	References	Professional Registration	Expire/Revalidation Date	Essential Qualifications/ Copies	Occupational Health	Right to Work	Identity Check	DBS/Criminal Conviction Checks	Search of Insolvency and Bankruptcy Register	Search of Disqualified Directors	Social Media Search	Complete	FPPR Met
Jacqueline Totterdell	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Avey Bhatia	✓	✓	✓	✓	20/11/2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Rhodes	✓	✓	✓	✓	28/07/2018	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Harbhajan Brar	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Grimshaw	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
James Friend	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ellis Pullinger	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Marsello	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kevin Howells	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stephen Jones	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gillian Norton	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Norman Williams	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ann Beasley	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Higham	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Wilton	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stephen Collier	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tim Wright	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Date 27/04/18