St George's University Hospitals NHS
NHS Foundation Trust

Board Walkabout - Thursday 31st May 2018, 08:30 – 09:45

Meet in the Hyde Park Room at 08:30

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

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

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

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

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

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

Practicalities

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

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

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

Groupings- 31st May 2018

NED	Exec / Divisional Chair	Divisional Representation	Area Visiting, 08:30 – 09:45
Gillian Norton, Chair	Stephen Jones Lisa Pickering	Kelly Davies (Head of Nursing) Matt Jarratt (General Manager)	Cardiac Cath Labs (1st Floor AMW) James Hope Ward (1st Floor AMW)
Tim Wright	Andrew Rhodes James Friend	Marlene Johnson (Head of Nursing)	Court Yard Clinic (Perimeter Road) Renal Dialysis Unit (Perimeter Road)
Ann Beasley	Avey Bhatia	Helen McHugh (Divisional Director of Nursing)	Frederick Hewitt Ward (5th Floor Lanesborough Wing) Nicholls Ward (5th Floor Lanesborough Wing)
Stephen Collier	Fiona Ashworth Andrew Grimshaw	Tessa Longney (Head of Nursing)	Heberden Ward (3rd Floor Lanesborough Wing) Dermatology and Lymphodeama Outpatient (Ground Floor Lanesborough)
Sir Norman Williams	Suzanne Marsello Tunde Odutoye	Charlotte James (Director of Midwifery)	Gwillim Ward (4th Floor Lanesborough) Carmen (4th Floor Lanesborough)
Prof Jenny Higham	Harbhajan Brar Kevin Howell	Sarah James Sarah Mortimer	Education Centre (Perimeter Road) Recruitment (Blackshaw Annex)

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Trust Board Meeting

Date and Time: **Thursday 31 May 2018, 10:00 – 13:00**

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

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the Tooting site**	**Board Members**	-	Oral
OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	-	Oral
	1.2	**Declarations of interest**	All	-	Oral
	1.3	**Minutes of meeting held on 26 April 2018**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
	1.5	**CEO's update**	**Andrew Grimshaw** Chief Financial Officer	Inform	Report
QUALITY & PERFORMANCE					
10:55	**2.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
	2.2	**Integrated Quality & Performance report**	**Executive Team**	Inform	Report
	2.3	**Elective Care Recovery Programme**	**Fiona Ashworth** Acting Chief Operating Officer	Assure	Report
	2.4	**Emergency Care Performance**	**Fiona Ashworth** Acting Chief Operating Officer	Assure	Report
FINANCE					
11:35	**3.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
	3.2	**Month 1 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
GOVERNANCE					
12:10	**4.1**	**Audit Committee report**	**Sarah Wilton** Committee Chair	Assure	Report
	4.2	**Board Assurance Framework**	**Avey Bhatia** Chief Nurse & DIPC	Assure	Report
	4.3	**Annual Self-Assessment of Compliance with Foundation Trust Licence**	**Stephen Jones** Director of Corporate Affairs	Approve	Report
CLOSING ADMINISTRATION					
12:35	**5.1**	**Questions from the public**	-	-	Oral
	5.2	**Any new risks or issues identified**	**All**	-	-
	5.3	**Any Other Business**	**All**	-	-
	5.4	**Reflection on meeting**	**All**	-	Oral

Time	Item	Subject	Lead	Action	Format
12:40		**PATIENT STORY**			
13:00		**CLOSE**			

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

Date of next meeting: Thursday 28 June 2018, 10.00 – 13.00 (Queen Mary 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
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
Fiona Ashworth	Acting Chief Operating Officer	ACOO
Mike Murphy	Quality Improvement Director – NHS Improvement	QID
Secretariat	**Designation**	**Abbreviation**
Terri Burns	Interim Assistant Trust Secretary	ATS

Minutes of Trust Board Meeting

Thursday 26 April 2018, 10:00 – 13:00, Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
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
APOLOGIES		
Andrew Rhodes	Acting Medical Director	MD
Mike Murphy	Quality Improvement Director, NHS Improvement	QID
SECRETARIAT		
Shanaz Islam	Interim Assistant Trust Board Secretary (Minutes)	ATBS

Feedback from Walkabout

Members of the Board gave feedback on the departments visited, which included: Cardiothoracic Intensive Care Unit (CTICU), Cardiothoracic Recovery, Heart Failure Unit, CCU, Neuro Day Unit, William Drummond, Clinical Research Facility, Hand Unit, Lanesborough Theatres, Jungle Ward, Trevor Howell Day Unit, Gordon Smith, Rodney Smith and Gunning Ward.

General observations included the importance of training in staff retention, the flow of information from Senior Leaders' briefings down through the organisation, and estates and information technology issues. The Heart Failure Unit was the first such unit in the country and, although small, had been nominated for a BMJ award and other Trusts were keen to learn from the Unit. There had been significant improvements in the length of patient stays in CCU. The Hand Unit had been very successful but was small and was struggling to cope with demand. Patient feedback was consistently

strong. Likewise, Jungle Ward, a paediatric day case ward, struggled to keep up with demand of patients; it had 15 beds but saw between 30 and 60 patients a day, with beds turning over between 3 and 4 times a day. The gynaecological team worked at Lanesborough Theatres often but did not have a permanent home. This meant that staff and equipment needed to be moved across the Trust.

In terms of workforce, effective leadership at ward level was emphasised as a key factor in Gunning's gold rating in the ward accreditation scheme. Gunning was not without its challenges (a 20% vacancy rate, a 14% turnover rate) but had achieved gold despite these. In Lanesborough Theatres, staff morale was high even though many worked beyond their hours to keep the service running effectively. In the Heart Failure Unit, staff reported on-going challenges around rota gaps. On Trevor Howell, staff emphasised the importance of training in nurse retention and reported a lack of training budgets which could impact on retention, which the DHROD agreed to look into. The cascade of information to staff from the Senior Leaders briefings was also raised on a number of wards.

Estates issues were raised on a number of the wards visited. In the Hand Unit, there was currently no hot water and the air conditioning unit could not be switched off. On the Neuro Day Unit, a number of surfaces were dusty and the Wifi fee of £6 a day was a concern among younger patients. On William Drummond, there had been problems with a macerator, but a new unit had been delivered. On Jungle, there had been two flooding incidents in recent weeks and while both had been resolved, lighting damaged during the first flood had not yet been fixed. Litter was an issue in the Atkinson Morley Wing and litter bins were needed. In the Heart Failure Unit staff had to walk a significant distance between areas. IT issues were reported in CCU where one of the red screens was slow and there were IT problems in Rodney Smith where only two out of four computers were currently working.

The Chairman concluded by observing that there had been a change in the overall content of the feedback from ward visits over the past year; staff seemed focused on the issues and potential solutions.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed members of the public and a number the Trust's governors. Apologies had been received from Professor Andrew Rhodes, Acting Medical Director, and Mike Murphy, Quality Improvement Director, NHS Improvement.
Declarations of Interest	
1.2	There were no declarations of interest to note.
Minutes of the meeting held on 29 March 2018	
1.3	The minutes of the Board meeting held on 29 March 2018 were approved as an accurate record.
Action log and matters arising	
1.4	The Board noted that most actions on the Action Log were not yet due or had been closed because appropriate action had been taken outside the meeting. It was noted that the Chair of St George's Hospital Charity was not available to attend Board in May 2018 and that an appropriate alternative date would be found. There were no matters arising.

1.5	**CEO's update**
	The Chief Executive reported to the Board on the Pan London Student Nurse Congress event that she and the Chairman had attended on 18 April. The event had been well organised by Nikki Yun, a new staff nurse, who had brought together a number of senior national nursing representatives and the CEO and Chairman had each spoken about the significant contribution of nurses across the Trust. In relation to emergency care performance, the CEO noted that this had been varied but there was no reason why, with consistent support, the Trust could not achieve the 95% national standard. The introduction of three new ambulatory care units in Paediatrics, General Medicine and Oncology in recent months had already started to make a positive difference in assisting emergency care performance. In response, Ann Beasley noted that the paper later on the agenda did not propose a figure of 95% in some quarters and emphasised that the Board needed to understand what it would take to achieve that figure. The CEO reflected on the recent unannounced CQC inspection in March, the CQC Well Led inspection in April, and the recent Board to Board meeting with NHS Improvement, noting that this had been a critical time and had involved a significant amount of work. The outcome of the inspections was expected in the summer. Noting the earlier discussion about staff development, the CEO highlighted that significant progress had been made over the past year; the recruitment process had been improved, vacancy rates had come down, and 250 leaders across the organisation were going through a leadership training programme run by the King's Fund, about which there had been very positive feedback.
STRATEGY	
2.1	**Research update**
	Jenny Higham presented the report in the absence of the Acting Medical Director, accompanied by Dan Forton. Leadership of the Joint Research and Enterprise Service (JRES), a joint department of the University and the Hospital, had recently been strengthened with the appointment of Mark Cranmer, Director of JRES. Following this, its core functions, which included clinical research governance, financial management and grant applications had been streamlined and were working more effectively. Jenny Higham highlighted that there has been a significant increase (25%) in the number of patients recruited to clinical trials and that the Trust was leading more clinical trials and commended the whole team on this achievement. Forward priorities were to ensure closer collaboration with the Charity and to lever the potential for use of common resources, given the Trust and University shared a single site. She also emphasised the forthcoming appointment of the Deputy Principal Leadership and Enterprise Director would be key to delivering this. Dan Forton reported that the report also encompassed the results of the first a survey of research activity. In response to Ann Beasley's enquiry regarding the reasons for the previously poor reputation in research management as detailed in the report, Dan Forton agreed that timeliness and a lack of good governance processes within the JRES were the cause of this, and had been significantly improved by Mark Cranmer, as well as through the recruitment of other high calibre of staff. Tim Wright queried how closely the focus of research aligned with, or was driven by, the Trust's strategy. Dan Forton replied that the report reflected strong areas of research where close working between the University and Trust occurred, but observed that there were clear opportunities to align both strategies much more closely. The DS agreed and also suggested consideration of more detailed data

	around yearly income and trends, as well as benchmarking data against other teaching and research hospitals would be helpful. Sir Norman Williams expressed his wish to understand the sources of funding and to see a strategy for measuring productivity. Sarah Wilton reported positively from her earlier Board Walkabout of the Clinical Research facility and asked if the governance structure was well understood by staff and whether it was effective in supporting the research agenda. Dan Forton clarified the current committee structure and offered assurance this was robust. The Board noted the report and approved the recommendations and next steps, noting that this supported the Trust's vision to 'Develop tomorrow's treatments today'.
QUALITY	
3.1	**Quality & Safety Committee report**
	Sir Norman Williams, Chair of the Committee, reported on the meeting held on 19 April 2018. The Quality Improvement Plan (QIP) dashboard demonstrated improvements in key areas but progress had slowed around outpatients. As such, the Committee had requested the Trust undertake a further self-assessment against the CQC fundamental standards in relation to outpatients within the next two months to provide assurance that compliance was improving. There had been 4 cases of MRSA in 2017/18 but changes to the reporting process meant that there would no longer be recourse to arbitration in cases of suspected MRSA. Internally, robust root cause analysis would continue to take place for every new case identified. There had been 2 cases of C.difficile in March 2018 and, the Committee had heard that performance had improved significantly in recent years. The Clinical Harm Review Group reviewed all potential clinical harms in relation to cancer pathways and 104 day breaches and the Committee Chair noted his concerns that such delays were said to have resulted in no harm. The CN agreed with this and advised that she and the MD had asked the Group to respond. Complaints performance remained problematic and an action plan had been received by the Committee. A report on medication incidents was also received; the Trust had a high level of reporting on medication incidents which was a good indicator of a positive safety culture. The Committee had also asked for a report on the quality of care in Offender Health. The Committee had considered the Trust's draft Quality report which would be integrated into the Annual Report and Accounts. Sir Norman Williams also noted that there had been an alert related to cardiac surgery in 2016-17 which was now under investigation. Ann Beasley requested further assurance that the high level of reported medication incidents was not suggestive of safety concerns and requested a more forensic interrogation of the incident data in this regard. The CEO responded that themes and levels of harm were crucial to understand whether there was an underlying safety issue. The Chairman noted that senior Pharmacists were undertaking daily audits which should give the Board some assurance. In addition Sir Norman Williams clarified that thematic analysis was included in the regular medication report to the Committee, which also provides information on levels of harm which at present, was relatively low. The Board noted the report.
PERFORMANCE	
4.1	**Integrated Quality & Performance Report**
	The DDET presented this report and observed that the Trust was performing positively

	against a number of indicators. However, the Four Hour Operating Standard, 62 Day Cancer Access Standards, and operations cancelled for non-clinical reasons remained a challenge. The Trust had maintained compliance against the diagnostic access target and continued to manage the use of agency workforce. March was reported as having been a demanding month with the number of cancellations having increased from February. Despite this, the COO reported that the 28 day re-booking procedure was being managed well and there were robust processes in place. The DHROD informed the Committee that staff sickness absence and vacancy rates had improved and that the time taken to recruit staff had almost halved. There had been detailed discussions at the Workforce and Education Committee around an electronic solution for appraisals and it was noted that monthly mandatory and statutory training numbers fluctuated, especially when new modules were introduced. This would be monitored by the Workforce and Education Committee for a period of six months to ensure there was no significant fluctuation without an adequate explanation. At the beginning of 2017/18 the agency spend had been £43m annually. However, during 2017/18, this was reduced to £19.9m against an NHS Improvement target of £24m. For 2018/19, the agency cap had been set at £17m and the aim was to exceed this target through recruitment of substantive staff and this would also ensure consistent patient care. The CN reported that the increasing trend in unfilled duty hours since December correlated with the staff working on dedicated flu wards being unable to cross cover other wards due to possible cross infection. The Committee was assured that the trend should decrease as the ward was now closed. The Board noted the report.
4.2	**Elective Care Recovery Programme**
	The COO introduced the report which provided an update on the Elective Care Recovery Programme. The COO highlighted that following a detailed report last month, the training uptake had now increased with more staff using the e-modules; 50% were now trained and the COO expected this figure to increase over the coming weeks. The COO also thanked Tim Wright for spending time with the Elective Care Programme team to provide advice and insight. Stephen Collier said that he was encouraged that there was greater grip of training and progress around new ways of working which were becoming embedded as business as usual. The CN referred to the overall programme risk log which showed risk scores at 20 and 16; she asked that these be confirmed through the regular report to the Risk Management Executive to ensure correct escalation to the Board Assurance Framework. Tim Wright noted that there appeared to be challenges in releasing staff to undertake training due to staffing pressures and he queried whether there was a lack of commitment in some parts of the Trust to release staff, given that the success of the programme was dependent upon this. The CEO, as chair of the RTT Recovery Board, advised that a Training Needs Analysis had been commissioned for both this and wider training requirement. She agreed that training opportunities had to be provided and that some training may also need to be mandated. It would be important to ensure ownership and accountability for those who do not attend or update their training particularly where errors continue to be made. The Board noted the report.
4.3	**Emergency Care Performance**
	The COO updated the Board that that the Trust had triggered its most recent OPEL three status on 25 April 2018, in order to highlight the extent of the challenge and that this provided context for the report. The report presented an updated position on the Trust's

	emergency care performance, the 15 point plan and presented a revised performance trajectory for approval. In relation to the non-admitted performance and moving patients through the department within four hours, the COO agreed that this was within the Trust's gift and observed that performance had improved significantly in April. In terms of admitted performance, the COO acknowledged that the report did not contain sufficient detail around the trajectory for reducing bed occupancy and length of stay and this was being developed. Sarah Wilton sought clarity around timescales for delivery in the 15 Point Plan as these were not clear in the report and she emphasised the importance of seeing monthly reporting against the Plan. Ann Beasley further challenged whether the Trust was confident it would achieve the 95% target by March 2019 and stated that she was uncomfortable with agreeing a target below 95%. She also questioned whether there was more that could be done to improve on the current process, which was not encompassed within the report. Stephen Collier commented he was also uneasy about moving from 95%. In response, the COO confirmed metrics would be applied to the 15 point plan and noted that the intention was to set a realistic target for improvement. Jenny Higham commented that as a tertiary centre the Trust often fell victim to delays in repatriating patients and asked what more we could do to address this. The COO responded that repatriation was an on-going challenge particularly with out of area patients. However, there was an established escalation process for this. The CEO added that several of our referring hospitals are very good at receiving patient back in a timely way. The DDET stressed the infrastructure is able to support the required improvements and emphasised the tremendous efforts made by Wandsworth and Merton colleagues in improving out of hospital capacity across the winter. The CEO echoed this and highlighted that there were many reasons for delayed transfers of care many not attributable to social care. The Chairman summarised the discussion, and concluded that the plan appeared unfinished in a sense that it is not evidence-based but rather based upon the COO's professional judgement around what was achievable. She proposed that the Board signed off the plan in principle, noting that the Board's assurance on this was based purely on the professional judgement of the COO. However, this in principle support was based on the condition that the Board receive monthly reports with more detailed figures. On this basis, the Board agreed to approve the plan. **Action TB.26.04.18/01 COO to bring monthly reports to the Board on emergency care performance**
FINANCE	
5.1	**Finance & Investment Committee report**
	Ann Beasley presented this report and set out the key issues discussed and agreed by the Committee at its meeting on 19 April 2018. Further discussions had taken place around risks within the remit of the Committee and in particular the Estates risks, which were now much better understood. The Trust had delivered its forecast outturn of £53m and Ann Beasley explained that whilst this did not achieve the NHS Improvement target of £45m deficit, the fact the forecast had remained accurate over a number of months and was delivered showed an improved level of maturity and grip within the organisation. There had been very late notification capital funding, received in March, and this had been wisely spent, although earlier notification of the funding could have resulted in a more risk-based allocation of funds. Ann Beasley noted that discussions had taken place around the budget

	for the coming year and the importance of agreeing cost improvement plans, as well as financial implications around RTT and the backlog. A new Director had been appointed to help with the management of the cash position. A review of the effectiveness of the Committee had shown significant improvement in the past year, and this was emphasised by the Chairman. The Board noted the report.
5.2	**2017-18 Outturn Finance report (March)**
	The CFO reported that, overall, the Trust reported a deficit of £53.1m at the end of the financial year 2017/18, which was adverse to plan by £8.1m. In 2017/18, the Trust had delivered £43.6m of Cost Improvement Plan (CIP) savings and this had been £0.1m better than plan. Capital expenditure against the Capital Delegated Expenditure Limit (CDEL) of £51.8m had been incurred year-to-date. The information before the Board was an abridged pack as the draft accounts had been submitted to auditors and had not yet been submitted to NHS Improvement; this would follow consideration of the Accounts by the Audit Committee on 21 May and the Trust Board on 24 May. The Chairman expressed the Board's thanks to executive, and staff across the Trust, for delivery of the £53.1m year-end deficit which, while not where the Trust wanted to be, was nonetheless a significant improvement on the previous year's deficit and demonstrated that the Trust was improving its financial performance. The Chairman observed that improving on this in 2018/19 was a key Board priority and fundamental to coming out of financial special measures. The Board noted the report.
5.3	**Annual Plan 2018-19**
	The CFO summarised the 2018/19 Financial Plan which had previously been considered by the Trust Executive Board (TEC), Finance and Investment Committee and the Board at an earlier private meeting. The CFO highlighted that three issues were in the process of being finalised with Commissioners: QIP plans, the impact of addressing the RTT backlog, and the commissioning arrangements of the ambulatory care unit. However, the CFO emphasised that none of these would present a material variance to the plan. The Trust was required to submit its financial plan for 2018/19 to NHS Improvement on 30 April 2018. A target deficit of £29m was forecast for 2018/19, and this would be an improvement of £24m on the previous year. This took into account inflation and the continued investment in quality improvement. There was a CIP target of £50m for 2018/19, £30m of which was 'green' with realistic plans in place for achieving this figure. A further £20m of CIPs was in the pipeline. The CFO stated that the full £50m of CIPs would be in place by 18 May 2018. Capital remained a challenge and the Trust was seeking funds from other sources including NHS Improvement and a bid for loan support would be submitted to NHSI before the end of May. It was noted that a control total had not yet been agreed with NHSI for 2018/19. The DS reported that alongside the financial plan, the Trust was required to submit to NHS Improvement an updated narrative plan (a two-year narrative had originally been submitted to NHSI in April 2017). The plan presented to the Board was of a prescribed template and length but that the draft reflected the feedback from Board members following earlier discussions. The DS explained that the financial section and references contained within the narrative plan to the 95% Four Hour Emergency Care Operating standard would need to be updated following the meeting ahead of final submission.

	Sarah Wilton enquired about the critical ICT spends and how confident the CFO was that funding would be made available without delay to progress the required work. The CFO confirmed that ICT was a priority area for investment and that this would support wider service and operational improvements and would not be delayed, pending the bid process to NHSI. The CFO explained that NHSI expected to receive the bid and were aware of the level of investment required. A prioritisation exercise was also being developed to examine the longer term capital programme. The Board noted the report and approved the narrative plan submission, subject to any final amendments required by Board prior to submission. The Board agreed to delegate authority for making any final amendments to the Vice Chairman and CEO; the Chairman was scheduled to be out of the country at the point the final plan was submitted to NHS Improvement.
WORKFORCE	
6.1	**Workforce and Education Committee report**
	The report set out the key issues reviewed and agreed by the Committee at its meeting on 12 April 2018. Stephen Collier reported on the change to its assessment of the assurance rating in relation to Strategic Risk 1 on the Board Assurance Framework (BAF), noting that the underlying risk had not materially changed. He intended to discuss this further with the CN as executive lead for the BAF. The Workforce Race Equality Standard was not where the Trust would want it to be. The CEO and DHROD agreed that there would be a twin track strategy going forward to progress this. The Committee had received two adverse reports from the Guardian of Safe Working and there was a programme of correction and agreed next steps which was being led by the MD. Tim Wright commented that the staff survey indicated the need for training and to ensure that the necessary support was in place for staff. DHROD agreed and assured him that this remained an important are of focus. The Board noted the report.
GOVERNANCE	
7.1	**Audit Committee report**
	The report set out the key issues discussed and agreed by the Committee at its meeting on 12 April 2018. Sarah Wilton highlighted that there was concern around limited assurance in relation to the Business Continuity Plan. In response, the COO noted the Business Continuity Steering Group had been reinstated to oversee the required improvement and he would chair this. The Committee had received the interim Head of Internal Audit Opinion and this had concluded that reasonable assurance could be given that there was a generally sound system of internal control. Sarah Wilton reported that the Committee had been concerned with the high volumes of breaches and waivers but that there was now more rigorous challenge and procurement training was being rolled out to staff. She also noted that as Chair of the Committee she had approve the write-off of approximately £153,000 of non-recoverable debt. The Committee had approved changes to the Trust's Standing Orders (SOs), Scheme of Delegation and Standing Financial Instructions (SFIs) and had considered a draft of the Trust's Annual Report and Quality Report. The CEO enquired about the scheme of delegation and how clearly this was understood by staff. The CFO replied that budget training was underway to ensure staff understood their responsibilities and that the Executive team must lead by example. Once staff were fully trained and supported to comply, a system needed to be put in place to ensure on-going compliance. The Board noted the report.

7.2	**Board Assurance Framework**
	A summary report was provided to the Board which gave an overview of the risk profile of the Trust which had been updated with the Quarter 4 assurance ratings and statements from Committee Chairs. The CN reported that there had been a review of the assurance ratings and that while there had been little movement, this was attributable to the complexity of the risks involved. The Workforce and Education Committee, as noted earlier in the meeting, had changed the assurance rating for Strategic Risk 1 to limited assurance. The Board confirmed the updated risk and assurance ratings and statements for those risks reserved to the Board (SR9, SR16 and SR17) and accepted the recommendations of the assuring Committees for the remaining risks. The CEO thanked the CN and team for the work in developing the BAF. The Board noted the report.
7.3	**Interim report on NHS Premises Assurance Model (PAM)**
	The Board received the interim report which set out the purpose of the Premises Assurance Model (PAM), and heard that the PAM had been developed to create a common framework for assuring and demonstrating statutory compliance on estates matters. The DEF reported that he had also conducted a review of statutory compliance issues across the Trust but this was not yet comprehensive and was based on available information. As a result, this review provided limited assurance. The DEF planned to undertake a full review in July 2018. The intention was to hold a Board workshop on the PAM in June so that Board members could explore the Model in more detail. Once fully developed, the PAM would enable the Trust to demonstrate to patients, commissioners and regulators that robust systems were in place to assure that the Trust's premises were safe and have confidence in measuring its compliance with statutory requirements. Ann Beasley welcomed the report and noted that estates risks on the BAF were overseen by the Finance and Investment Committee, which would have an interest in its development, particularly in light of earlier Board discussions around estates issues. The Board noted the report. **Action TB.26.04.18/02 Plan and schedule Board workshop on the NHS Premises Assurance Model**
7.4	**St George's Hospital Charity: Quarterly report**
	The DS reported that as part of the revised link between the Trust and St George's Hospital Charity, it had been agreed that a quarterly report would be provided to the Board to provide an update on the activities of the Charity and an overview of the grants awarded. The DS noted that, as discussed earlier in the meeting, the Interim CEO and Chair of the Charity had been invited to attend Board in the coming months. The Chairman expressed the Board's thanks for the contribution of the former CEO of the charity, Martin Willis, who had retired the previous month and acknowledged the Charity's support for the Trust's first Annual Staff Appreciation Awards in March. The Board noted the report.
CLOSING ADMINISTRATION	
8.1	**Questions from the public** A member of the public asked about the two Never Events which had been reported in March. The CN said that the first related to a misplaced naso-gastric tube and the second concerned an incorrect connection to an airflow meter. John Hallmark, a public governor from Wandsworth, asked about the deficit figures for 2017/18 and in particular the reference to the £53m year-end deficit being £8m over the figure agreed by NHS Improvement. The CFO replied that there were a range of factors that explained this, which had been covered

	in earlier Board papers and he committed to share these earlier reports. The CFO confirmed that he had received a question about best practice tariff and the compliance of the tariff. The CFO said that there were 18 best practice tariffs in place and the Trust complied with 14 of these. The DCA reported that two two questions from a member of the public had been received by email shortly before the meeting. The first related to the implications of the divisional restructure for services provided on the Roehampton site. The second was in relation to training at the QMH site. COO explained that the QMH site had been integrated into the Children and Women, Diagnostics, Therapeutics and Critical Care Division (CWDT) and that the division provided leadership for the services provided from the QMH site. The CEO noted that senior leadership was in place on the site as part of the community services provision and this would not change in the new structure. It was agreed that a written response would be provided to the individual.
8.2	**Any new risks identified**
	No new issues or risks were identified.
8.3	**Any Other Business**
	The DEF reported further to the earlier walkabout the hand unit and lights were back in operation.
8.4	**Reflection on the meeting**
	The Chairman thanked the members of the Board for their contribution to the meeting.
	VOLUNTEER STORY
	The Chairman welcomed Angela Lodge, Winner of year volunteer award, and Moira Rowan, Dementia and Delirium Nurse, and asked Angela about her experiences as a volunteer at the Trust, including the high and lows. Angela explained that she worked as a child minder three days a week and volunteered on the other days. She had applied for to become a dementia volunteer in order to learn more about dementia and had worked on the Rodney Smith Ward. Her daily interaction with dementia patients included talking with them, playing music they enjoyed as this often stimulated happy memories for them. Some patients sang along to the music. Typically, Angela stayed with the patients between 4 and 6 hours a day. She said the key was trying to prompt happy memories. Moira Rowan explained that one of her colleagues was currently studying for a masters degree and as part of her dissertation she had focused on patient experience. Various surveys were handed out to staff and the feedback was that staff did not have time to undertake the activities on top of their existing commitments. A colleague then had suggested approaching volunteers and providing training to them so they could look after patients with dementia. The Board thanked Angela and Moira for sharing their experiences and for their work with dementia patients at the Trust.

Date and time of next meeting: Thursday 31 May 2018, 10:00 – 13:00

Trust Board Action Log - 26 April 2018 - Draft as of 27.04.2018

Action Ref	Theme	Action	Due	Lead	Commentary	Status
TB. 06.07.17/ 36	**St George's Charity**	Schedule a meeting with between the Board and the Trustees of the St George's Charity every six months.	31.05.2018	DCA	Charity to be invited to the Trust Board meeting in the coming months (date needs to be workable for both Charity Chair and Jenny Higham).	OPEN
TB. 07.12.17/ 54	**Trust Strategic Objectives**	Present a quarterly update on progress against the Trust's strategic objectives.	31.05.2018	DS	Added to May Board agenda	PROPOSED FOR CLOSURE
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		OPEN
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.	OPEN
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. 26.04.18/ 01	**Emergency Care Performance**	COO to bring monthly reports to the Board on emergency care performance	31.05.2018	COO	Added to the Board forward work plan.	OPEN
TB. 26.04.18/ 02	**NHS PAM**	Plan and schedule Board workshop on the NHS Premesis Assurance model	31.05.2018	DEF	Identifying a suitable date in June 2018	OPEN

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 May 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 – May 2018

I want to begin my report this month by talking about a visit to the Trust in early May from Jeremy Hunt, Secretary of State for Health and Social Care.

During his visit, Mr Hunt spoke to 50 of our staff about patient safety, and the positive steps being taken nationally to reduce harm, and learn lessons when mistakes are made.

It was an excellent opportunity for our staff to ask Mr Hunt questions but, as important, to also share examples of good practice in patient safety that are being pioneered at the Trust.

I was delighted for Renate Wendler, one of our excellent consultant anaesthetists and associate medical directors, to have an opportunity to talk about the work we are doing to learn from incidents. Mr Hunt seemed genuinely impressed, and rightly so – there are many positive examples at St George's (Renate included) of our clinicians leading the way when it comes to patient safety.

Another prime example is Dr Nigel Kennea, one of our consultant neonatologists, who has raised the bar when it comes to learning from deaths – and the practice he has established at St George's, with the help of many others, is a model that many others nationally are now choosing to follow.

I raise this at the start of my report because it is all too easy, given the challenges we face, to forget the huge amount of good work we are doing, and we must celebrate this, because it reminds us of the great things we are capable of.

Strategy development

We have talked for a long time about the importance of developing a clinical strategy for the organisation.

Suzanne Marsello joined as our new Director of Strategy in January this year and, as agreed at Trust Board last month, Suzanne is now moving forward at pace with development of the new strategy.

We have organised staff and stakeholder workshops for July, which is a crucial part of the strategy development – as are the meetings Suzanne is already having with clinical teams across the organisation.

We need to look at every service in detail, so are also developing data sets for each area, which clinical teams will feed into.

We know that our vision is to provide Outstanding Care, Every Time for our patients – but we need a clear and coherent strategy to get us there, so I am pleased we have now begun this important piece of work.

The new strategy will be agreed by the Trust Board, and will set out a clear direction of travel for the future. It won't solve every challenge we face, but it will give staff, stakeholders and patients clarity about what we want to achieve, both now and in the longer-term.

Community services

Earlier in May, we announced our intention to withdraw from the provision of some community services, although we will still continue to deliver a number of them going forward.

We briefed staff and key stakeholders about our plans, and the rationale for them – a big part of which is making sure we are able to focus on delivering the much needed improvements at our two main hospital sites (namely St George's Hospital, Tooting and Queen Mary's Hospital, Roehampton).

I will be meeting staff directly affected over the coming weeks although, as you would expect, I have already had some feedback – chief of which is simply disappointment from staff who enjoy being part of the Trust.

I'm confident the decision we have taken is in the best long-term interests of the Trust. But I also know how staff must feel.

As a result, I have made clear that until the services in question transfer, our focus remains on making sure patients receive high quality care, and that staff running the services feel supported.

Emergency care performance

I have talked repeatedly about the need to deliver improved emergency care performance consistently, and the challenges of the last few months have been well-documented.

I am pleased to say that performance is slowly improving, and during the first week of May, we were the best performing Trust in London for emergency care.

However, the key word here is consistency – and we need to deliver improved performance day in, day out, which is never going to be easy. There will always be difficult days, and I know that we will sometimes try new initiatives to improve patient flow that won't always hit the mark first time.

But I do see signs of progress; for example, we have launched new internal professional standards to improve the way ED and clinical specialities work with each other. These will take time to bed in, but it is an important step in the right direction. Our new ambulatory care services are also working well and starting to make a difference.

So, more work to do, but I am reassured by the collective will there is within the organisation to succeed, and to put meaningful, long-term changes in place to improve emergency care at the Trust.

Openings and events, plus NHS 70

As always, there is a lot happening at the Trust, and I am fortunate, as Chief Executive, to be invited to lots of events and openings.

During the past month, our staff have organised a number of events and openings; including the brilliant International Day of the Midwife and International Nurses Day, as well as awareness weeks to mark Dying Matters, and diversity and inclusion.

I was also pleased to attend the official opening of the Ambulatory Assessment Area on Richmond ward at St George's last week. A huge amount of work has gone into making this and other ambulatory facilities a reality, for which I am very grateful.

Finally, I want to touch on our upcoming NHS 70 celebrations on 5 July, which centre around a giant tea party that will be held in the Atkinson Morley Wing courtyard.

70 members of our staff are also doing a sponsored walk from our original site at Hyde Park Corner all the way to our current home at Tooting – which is also very exciting.

The NHS 70 celebrations are a fantastic opportunity for us to celebrate what we do here at the Trust, so I would urge the entire Trust Board – and members of the public – to join in and come along if they wish!

Jacqueline Totterdell, Chief Executive

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31st May 2018	**Agenda No**	**2.1**
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 24th May 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 – May 2018

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 24th May 2018 and agreed to bring the following matters to the Board's attention:

1. **Quality Improvement Plan (QIP) dashboard**
   The Committee received the QIP dashboard which provided an overview of the Key Performance Indicators against the CQC domains and each core service. Increases in the number of hospital acquired thrombosis; falls with moderate or above harm and avoidable grade 3 and 4 pressure ulcers were noted. It was noted that a degree of refinement was needed in relation to RAG ratings, as they did not always convey a full picture, where possible SPC charts will be used. Discussion took place around Never Events, with the Committee being assured that adequate actions were being taken to manage them. Dr Rafik Bedair attended the meeting and gave assurances in relation to both short and longer term measures being put in place relating to two incidents involving the misplacement of nasogastric tubes. Six cases of C.difficile were noted in April, the Committee was assured that this was not an outbreak by the outcome of the root cause analysis, which found no similarity in the ribotypes and that each case was on a separate ward.

2. **Integrated Quality and Performance report**
   The Committee noted that there had been a decrease in the total number of falls; however there had been three which had resulted in moderate harm. The Committee heard that the increase in the number of avoidable grade three and four pressure ulcers might be attributable to the higher degree of scrutiny of all grade 3 and 4 pressure ulcers to determine avoidability. It was noted that the threshold for hospital acquired C.difficile in 18/19 is 30 for St George's.

3. **Elective Care Recovery Programme**
   The Committee received an update report on the Programme. It was noted that there had been a reduction in the number of 52 week waits and there were no 90 week waits. The Committee also noted that the Board would be receiving a report for discussion around the return to reporting on RTT at the May meeting. The Committee noted that return to reporting would be conditional upon the Board being able to be assured that the data they were receiving was correct and detailed enough for a period of three consecutive months.

4. **QIP deep dive: Theatres**
   The Committee received a report which showed improvements across the service and thanked the team for their hard work in ensuring progress was continuing. However, Committee members were concerned with the rate of same day cancellations. The Committee noted that surgical teams were having scenario based, multidisciplinary training sessions and that these were very well evaluated by the teams involved.

5. **Patient Safety Quality Group Report**
   The Committee noted that Moorfields, which provides an outpatient eye service at St George's, had raised a concern relating to fire safety. The Trust health and safety team are working with Moorfields to ensure this risk is mitigated and has the correct risk score. The Committee were also informed that the Trust continues to be compliant with serious incident reporting and investigation and duty of candour reporting.

6. Infection, Prevention & Control update

The Committee received a report which gave assurance that the Trust was among the top performers within the provider sector in relation to infection, prevention and control. However there was concern about legionella infections which required continual vigilance and measures to address the inherent risks in the water supply.

They were informed that some work was needed in relation to increased screening for gram-negative bacteria, a report relating to which would be taken to the Board at a later date.

7. Nursing & Midwifery Safe staffing Review

The Committee received a report setting out the process that had been undertaken to review the nursing staff establishment. Following the review nursing and midwifery staff numbers are deemed to be safe and compliant with national standards and a cost improvement of £2m has been delivered. The Committee heard that there have been some challenges from services about a reduction in staff, these have all been reviewed and confirmed as compliant and safe. One area, the neonatal unit, is going through a final validation before the staffing is agreed. The Committee also heard that establishment reviews are ongoing and scheduled to take place every six months. The Committee were assured that the review process was robust and noted the outcome.

8. Update on Cardiac Surgery

The Committee received an update on cardiac surgery, noting that the service had received a mortality alert in the previous year. The Committee was informed that whilst current indicators show improvements in cardiac services for patients, an external review was being commissioned in order to give further assurance. The Committee agreed the Terms of Reference for this review.

9. Patient Partnership and Engagement

A progress report was presented to the Committee, which was found to be encouraging. The Committee, as well as Healthwatch and Governor representatives were keen that the momentum which had been built up would continue and that lessons would be taken from outside the Trust where other organisations were performing well.

10. End of Life Care Strategy – Year one audit

The Committee noted that positive progress had been made and that there were actions in place where gaps had been identified, particularly in relation to 24 hour certification of deaths.

11. Board Assurance Framework

The Committee considered the strategic risks allocated to it in its terms of reference (SR2, SR3, SR4 and SR15). The Committee agreed the risk and assurance ratings, noting that CRR-0012 relating to RTT had been reduced from 20 to 15. CRR-1143 had also been reduced from 15 to 10. Both of these reductions related to a reduction of likelihood of occurrence.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 31st May 2018
Reporting period – April 2018

Excellence in specialist and community healthcare

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

April 2018

Daycase and Elective Surgery operations

Actual
4,087

Target 4,652

Discharges before 11am

Actual 16.4%

Target 30%

Four Hour Emergency Standard

Actual
88.41%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
98%

Target
95%

Outpatient First Appointment

Actual 15,292

Target 15,783

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
87%

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	
		Apr-17	Apr-18	Variance	Plan Apr-18	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	13,780	13,244	-3.89%	13,933	-4.95%	13,780	13,244	-3.89%	13,933	-4.95%
Inpatient	Elective & Daycase	4,048	4,087	0.96%	4,656	-12.22%	4,048	4,087	0.96%	4,656	-12.22%
	Non Elective	3,781	3,920	3.68%	3,966	-1.16%	3,781	3,920	3.68%	3,966	-1.16%
Outpatient	OP Attendances	46,555	48,846	4.92%	50,661	-3.58%	46,555	48,846	4.92%	50,661	-3.58%

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

Source: SLAM

Executive Summary – April 2018

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- One patient Never Event was reported in April. There were four Serious Incidents declared in the month.
- The Trust reported six patients with hospital attributable Clostridium Difficile infection in April, 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 April to 5.78, compared to 6.05 in March.

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 0.96% increase compared to the same period last year, however below plan for April 2018.
- Performance against the Four Hour Operating Standard in April was 88.4%, which was in line with the improvement trajectory of 88% for the month agreed at Trust Board. The improvement trajectory requires the delivery of 91% performance in May 2018.
- The Trust achieved all national mandated cancer standards in the month of March, 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 April reporting only 0.2% of our patients waiting greater than six weeks for a diagnostic procedure, this represents fifteen patients in total.

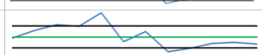
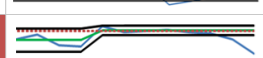
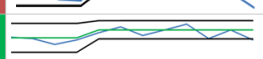
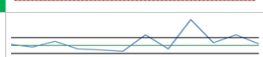
Patient Experience

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

Workforce

- Staff sickness remains above the trust target of 3% for the month of April however an improved position is observed reporting 3.2%.
- Non Medical appraisal rates have seen a further decline in performance within the reporting period at 61%.
- Medical appraisal rates have seen a positive improvement of 9% compared to previous month reporting a compliance of 81% against a target of 90%.
- The Trust's total pay for April was £40.69m. This is £0.11m adverse to a plan of £40.59m.

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	Trend (12 months)
Number of Never Events in Month	0	0	1	1	0	0	1	0	0	0	0	2	1	
Number of SIs where Medication is a significant factor	0	0	0	1	1	1	0	0	0	0	0	1	0	
Number of Serious Incidents	8 / mth	6	7	10	9	11	4	8	2	3	4	5	4	
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	
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%	
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%	
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	
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	
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	
Avoidable Grade 3 & 4 Pressure Ulcers	N/A	1	0	1	1	2	0	0	0	0	0	0	5	
Avoidable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.04	0.00	0.04	0.04	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.21	
Acquired Grade 3 Pressure Ulcers								15	6	9	6	6	10	
Number of overdue CAS Alerts	0	1	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- One Never Event was reported in April.
- The Trust declared four Serious Incidents in April 2018.
- The number of falls reported in April decreased from 157 in March to 138 in April, comparable to the same period last year. The rate of 5.78 per 1,000 bed days is an improvement. Of the falls reported, 118 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 deemed to be avoidable. Historically only grade 3 or 4 pressure ulcers that met the threshold for Serious Incident declaration were reported.

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.

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	Trend (12 months)
MRSA Incidences (in month)	0	0	2	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	
MSSA	TBC	2	4	4	4	1	1	2	3	0	3	1	2	
E-Coli	TBC	2	5	9	6	8	6	2	5	5	5	5	1	

Briefing

- C Diff threshold for 2018/19 reduces by one case with an annual threshold of 30 cases. There have been six cases declared in April. For 2018-2019 the time limit for apportioning healthcare onset versus community onset will be 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.
- E coli, a total of 236 episodes occurred with 67 apportioned to the Trust for the year 2017-18. For 2018-19, a reduction of 10% for the year has been agreed with the CCG for Healthcare-Acquired Infections. So the Trust target for E coli is 212 for 2018-19.
- There are no National thresholds for MSSA bacteraemia at present. The Trust has the second lowest rate. We have had two cases of MSSA since April 2018. The Infection Control Committee is reviewing this to establish a Trust threshold.
- There are no reported cases of MRSA Bacteraemia in April.

- Actions: All C Diff cases have undergone a Root Cause Analysis (RCA) and each area has had a period of increased surveillance and audit. No lapses in care have been identified from these cases and all six were in different wards. Ribotyping results to date show no similarities, thus this does not represent an outbreak of a single strain and may simply represent temporal clustering in a low incidence environment.

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	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	
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	
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	
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	
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%	8.25%		

Briefing

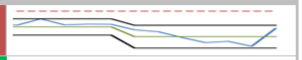
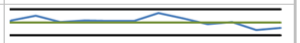
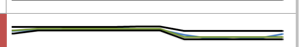
- The Trust's mortality rates are significantly better than expected in all measures and analysis shows that the Trust are 17% lower than expected from typical hospitals and practice in this country.
- Readmission rates following a non-elective spell observed a slight increase in the month of April, 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	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%	
Admission of full term babies to neo-natal care		2	16	21	20	15	10	16	6	11	7	4	10	

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	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%	
Patients Waiting in ED for over 12 hours following DTA	0	1	0	0	0	0	0	1	0	0	0	2	0	
Time to Treatment (number of patients seen within 60 minutes)		52.3%	58.8%	56.0%	56.2%	54.1%	54.2%	54.2%	54.1%	51.7%	52.2%	52.6%	61.5%	
Admitted patients with a length of stay 7 Days or Greater		310	326	305	309	307	307	336	318	296	304	277	284	
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%	
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%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	72	71	53	84	71	57	82	112	180	135	105	92	
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%	
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%	
Ambulance Turnaround - number over 60 minutes	0	1	0	1	1	0	0	0	2	3	3	10	1	

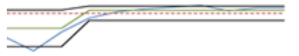
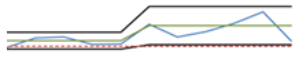
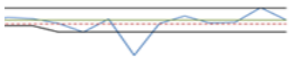
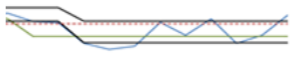
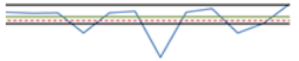
Briefing

- Performance against the Four Hour Operating Standard in April was 88.4%, which was in line with the improvement trajectory of 88% for the month agreed at Trust Board.
- The number of patients seen within 60 minutes (Time to Treatment metric) also observed an improvement to 61.5%, this key metric is now being monitored closely .
- 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. Phase 2 of the Oncology Ambulatory Care Unit was also recently launched.
- Ambulance turnaround within 30 minutes shows continued improvement in April showing that the Trust are performing 6% above the London average.
- Review of inpatients with a stay above seven days shows significant reductions from February 2018. Daily Delayed Transfers of Care and long Length of Stay patient reviews are proving very productive.

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.

Cancer

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	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	76.6%	67.4%	80.3%	89.7%	93.98%	96.05%	97.25%	98.51%	94.76%	96.70%	96.80%	1,186	
Cancer 14 Day Standard Breast Symptomatic	93%	84.1%	62.9%	86.9%	90.3%	98.2%	99.6%	98.0%	97.3%	95.9%	96.5%	96.8%	218	
Cancer 31 Day Diagnosis to Treatment	96%	96.4%	96.8%	96.9%	96.2%	96.2%	98.1%	96.9%	97.4%	98.2%	99.3%	96.5%	172	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	95.9%	94.2%	90.9%	95.8%	82.4%	94.1%	96.9%	94.3%	94.6%	100.0%	95.5%	22	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	111	
Cancer 62 Day Referral to Treatment Standard	85%	87.3%	85.4%	77.8%	75.6%	76.7%	85.5%	80.8%	86.8%	77.8%	80.8%	88.1%	54.5	
Cancer 62 Day Referral to Treatment Screening	90%	92.4%	92.5%	86.1%	92.5%	93.0%	78.4%	92.7%	93.9%	86.1%	89.1%	95.2%	21	

Briefing

- The Trust achieved all National mandated Cancer standards in the month of March, continuing to achieve 14 day standard and achieving 62 day compliance.
- The Trust continues to achieve performance against the 14 day standard, reporting 96.80%, ensuring our patients are seen within 14 days of referral.
- Cancer 62 day Standard Referral to Treatment was achieved. A total of 6.5 patients were treated beyond target this included reasons of referrals being received late in the pathway from other providers 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%

- 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.
- 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.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	No of Patients
Brain	93%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	2
Breast	93%	84.7%	69.5%	76.4%	93.4%	94.1%	97.4%	98.4%	98.2%	96.0%	96.5%	93.9%	180
Childrens	93%	80.0%	66.7%	80.0%	100.0%	100.0%	100.0%	71.4%	100.0%	87.5%	100.0%	100.0%	6
Gynaecology	93%	66.7%	75.6%	93.4%	90.4%	91.1%	90.8%	95.0%	97.6%	98.0%	96.8%	94.3%	87
Haematology	93%	96.9%	76.9%	95.7%	100.0%	100.0%	96.8%	100.0%	94.7%	91.7%	100.0%	100.0%	25
Head & Neck	93%	84.9%	82.4%	88.0%	82.4%	90.6%	99.1%	99.4%	98.4%	100.0%	97.6%	100.0%	167
Lower Gastrointestinal	93%	90.7%	44.4%	60.0%	73.9%	94.6%	97.4%	97.7%	99.3%	95.2%	100.0%	97.8%	178
Lung	93%	91.1%	91.2%	95.6%	100.0%	94.1%	97.7%	100.0%	100.0%	92.3%	100.0%	100.0%	47
Skin	93%	48.1%	26.9%	74.3%	96.6%	93.4%	95.0%	95.5%	97.9%	92.7%	94.8%	95.9%	267
Upper Gastrointestinal	93%	96.1%	93.8%	97.6%	98.8%	98.8%	98.5%	99.0%	100.0%	89.0%	97.3%	95.3%	106
Urology	93%	90.1%	82.3%	93.8%	97.0%	96.4%	93.3%	97.1%	98.9%	95.0%	95.1%	98.2%	111

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	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	No of Patients
Brain	85%	50.0%	-	0.0%	100.0%	0.0%	100.0%	-	100.0%	-	-	-	-	0
Breast	85%	100.0%	100.0%	100.0%	87.5%	100.0%	91.7%	100.0%	95.2%	100.0%	71.4%	100.0%	88.9%	9
Childrens	85%	-	-	-	-	0.0%	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	90.9%	100.0%	61.5%	100.0%	50.0%	83.3%	75.0%	67.0%	80.0%	77.8%	0.0%	1
Haematology	85%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	-	100.0%	88.9%	83.3%	81.8%	5.5
Head & Neck	85%	58.3%	85.7%	46.2%	66.7%	71.4%	87.5%	78.6%	81.8%	71.0%	100.0%	83.3%	80.0%	5
Lower Gastrointestinal	85%	-	62.5%	100.0%	60.0%	100.0%	66.7%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	2
Lung	85%	85.7%	85.7%	64.3%	41.7%	47.4%	72.2%	72.7%	41.2%	33.0%	90.9%	57.1%	100.0%	4
Skin	85%	93.3%	96.4%	95.7%	100.0%	76.5%	93.8%	90.9%	91.7%	93.0%	86.7%	100.0%	100.0%	6
Sarcoma	85%	-	-	-	-	-	-	-	-	-	-	100.0%	-	0
Upper Gastrointestinal	85%	100.0%	100.0%	100.0%	100.0%	77.8%	0.0%	100.0%	84.0%	100.0%	33.3%	57.1%	66.7%	6
Urology	85%	90.0%	67.9%	81.8%	63.0%	64.3%	77.4%	100.0%	72.7%	91.0%	60.7%	70.0%	96.7%	15

Diagnostics

Indicator Description	Threshold	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	Trend
6 Week Diagnostic Performance	1%	4.1%	3.3%	2.2%	2.7%	2.0%	1.4%	0.3%	1.9%	0.1%	0.1%	0.0%	0.2%	0.2%	
6 Week Diagnostic Breaches	N/A	312	248	173	190	154	98	22	143	6	10	3	17	15	
6 Week Diagnostic Waiting List Size	N/A	7,550	7,442	7,843	6,988	7,751	7,184	7,072	7,534	6,440	6,884	7,232	7,075	7,956	

Indicator Description	Threshold	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	Trend
MRI	1%	2.6%	1.1%	0.6%	0.8%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	
CT	1%	1.5%	0.5%	0.2%	0.2%	0.3%	1.2%	0.3%	0.1%	0.0%	0.1%	0.0%	0.3%	0.1%	
Non Obstetric Ultrasound	1%	4.0%	2.5%	0.3%	1.1%	0.9%	0.0%	0.0%	0.0%	0.1%	0.1%	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%	0.0%	
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Audiology Assessments	1%	6.5%	10.1%	11.3%	4.6%	5.7%	4.5%	0.0%	17.4%	0.0%	0.0%	0.0%	0.0%	5.4%	
Echocardiography	1%	1.2%	9.4%	2.0%	3.0%	0.3%	0.3%	0.3%	0.8%	0.0%	0.0%	0.0%	0.0%	0.2%	
Electrophysiology	1%	0.0%	0.0%	75.0%	75.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.3%	0.9%	0.0%	0.4%	0.2%	
Sleep Studies	1%								26.8%	0.0%	0.0%	0.4%	0.6%	0.0%	
Urodynamics	1%	65.5%	75.6%	64.4%	64.2%	50.6%	37.0%	16.7%	6.7%	0.0%	0.0%	0.0%	9.1%	5.0%	
Colonoscopy	1%	5.7%	4.7%	0.5%	1.8%	0.0%	0.4%	1.1%	0.0%	0.0%	0.0%	0.6%	0.7%	0.6%	
Flexi Sigmoidoscopy	1%	6.7%	0.0%	1.1%	4.9%	0.7%	1.5%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	1.0%	
Cystoscopy	1%	15.0%	11.5%	24.4%	14.0%	12.3%	14.7%	4.0%	1.8%	1.5%	2.8%	0.7%	0.0%	1.0%	
Gastroscopy	1%	12.7%	10.0%	9.2%	11.2%	6.7%	0.8%	0.0%	0.8%	0.4%	0.0%	0.0%	1.8%	1.0%	

Briefing

- The Trust has continued to achieve performance in April reporting a total of fifteen 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 two breaches due to capacity following equipment failure.
- The Diagnostic waiting list grew by 12% in the month influenced by the Easter holiday period.

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

On the Day Cancellations for Non-Clinical Reasons

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	Trend
Number of on the Day Cancellations		72	64	84	54	49	52	86	100	94	55	86	64	
Number of on the Day cancellations re-booked within 28 Days		70	54	70	43	43	34	76	67	76	48	76	60	
% of Patients re-booked within 28 Days	100%	97.2%	84.4%	83.3%	79.6%	87.8%	65.4%	88.4%	67.0%	80.9%	87.3%	88.4%	93.8%	

Briefing

- Management of the re-booking process significantly improved in April reporting that 94% of our cancelled patients were-rebooked within 28 days.
- The number of patients cancelled on the day for non clinical reasons have also reduced reporting 64 cancellations.
- Of the 64 cancellations reported, 31% 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
- Introduce a call to every patient before surgery to check that they are Ready, Fit and Able to attend.
- 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.

Theatre Productivity

Average Cases Per Session

Specialty	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-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
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
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
General Surgery	1.79	1.95	1.69	2.12	2.00	2.01	1.88	1.95	1.72	1.82	1.89	1.86
Obstetrics and Gynaecology	2.23	2.13	2.47	2.29	2.48	2.64	2.48	2.48	2.33	2.12	2.60	2.35
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
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
Paediatric Dentistry	4.91	4.93	4.54	4.37	4.13	3.74	4.71	4.16	3.63	4.00	4.27	4.33
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
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
Renal Medicine & Surgery	1.62	1.48	1.52	2.06	1.52	1.52	1.32	1.66	1.33	1.86	1.40	1.76
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
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
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
Grand Total	**1.67**	**1.62**	**1.62**	**1.71**	**1.69**	**1.74**	**1.62**	**1.63**	**1.57**	**1.59**	**1.66**	**1.68**

Briefing

- In April the Trust averaged 1.68 theatre cases per session across the Day Surgery Unit (DSU) and the Main Inpatient Theatres. This was the highest level since October 2017, the period when fewer theatres were operational, but is not yet a statistical improvement.
- Urology, ENT, Vascular Surgery and Oral & Maxillofacial all saw improved positions in cases per theatre session.

Actions

- In order to deliver overall expected activity levels and to enable more patients to benefit from our theatre infrastructure and receive treatment, a number of improvement actions are underway
- 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.

Outpatient Productivity

First Attendances (average per working day)

Division	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	Trend
C&W, Diagnostics, Therapies	134	136	141	133	128	141	139	138	126	137	129	122	123	
Medicine and Cardiovascular	244	279	261	263	243	255	251	274	223	262	259	266	240	
Surgery and Neurosciences	384	403	389	377	358	388	417	432	362	391	379	405	402	
Grand Total	**762**	**818**	**790**	**773**	**730**	**785**	**806**	**844**	**711**	**790**	**767**	**793**	**765**	

Follow Up Attendances (average per working day)

Division	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	Trend
C&W, Diagnostics, Therapies	137	145	137	137	130	147	151	166	142	163	160	138	135	
Medicine and Cardiovascular	868	867	842	821	801	821	808	842	754	850	817	852	825	
Surgery and Neurosciences	587	624	590	540	527	569	577	610	536	594	563	578	574	
Grand Total	**1,592**	**1,636**	**1,569**	**1,498**	**1,458**	**1,537**	**1,536**	**1,618**	**1,432**	**1,606**	**1,540**	**1,568**	**1,533**	

First and Follow Up DNA rates (by month)

Division	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	Trend
C&W, Diagnostics, Therapies	9.9%	10.3%	10.2%	10.4%	11.1%	10.0%	10.1%	10.6%	11.6%	11.7%	11.4%	12.3%	13.4%	
Medicine and Cardiovascular	10.7%	10.8%	10.8%	10.2%	10.6%	10.6%	11.5%	10.7%	11.6%	11.8%	12.1%	11.7%	13.3%	
Surgery and Neurosciences	9.1%	9.9%	10.0%	9.7%	9.7%	9.6%	9.5%	9.5%	9.7%	9.7%	10.1%	10.4%	11.4%	
Grand Total	**9.9%**	**10.4%**	**10.3%**	**10.2%**	**10.5%**	**10.1%**	**10.4%**	**10.3%**	**11.0%**	**11.1%**	**11.2%**	**11.4%**	**12.7%**	

First and Follow Up Ratio

Division	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	Trend
C&W, Diagnostics, Therapies	1.02	1.07	0.98	1.03	1.01	1.05	1.09	1.20	1.13	1.19	1.23	1.13	1.10	
Medicine and Cardiovascular	3.56	3.11	3.23	3.13	3.29	3.22	3.22	3.07	3.38	3.24	3.16	3.20	3.43	
Surgery and Neurosciences	1.53	1.55	1.52	1.43	1.47	1.46	1.38	1.41	1.48	1.52	1.49	1.43	1.43	
Grand Total	**2.09**	**2.00**	**1.99**	**1.94**	**2.00**	**1.96**	**1.91**	**1.92**	**2.01**	**2.03**	**2.01**	**1.98**	**2.01**	

Briefing

- Across the three divisions, First Outpatient attendances averaged 765 per working day, comparable to previous year of 762 for the same month.
- Follow-up attendances on average fell by 2.2% per day as compared to the previous month, particularly within Medicine and Cardiovascular.
- Did Not Attend rates have fluctuated over the last twelve months however an increase has been observed in April reporting 12.7%.

Actions:

- Implementation of Netcall (telephony system) to contact patients to confirm clinic attendance and reduce Did Not Attend rates

Patient Experience

St George's University Hospitals NHS
NHS Foundation Trust

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	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%	
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%	
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%	
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%	
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%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	100%	100%	98%	100%	100%	91.6%		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%	
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%	
Mixed Sex Breaches	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	
PALS Received		299	234	268	170	203	185	298	262	283	234	257	193	

Briefing

- ED Friends and Family Test (FFT) – The score has seen an improvement in April reporting a 3% increase in the recommended rate, this is observed in line with an decrease in waiting times.
- Maternity FFT – The score for maternity care are above local threshold and work continues to improve on the number of patients responding.
- The number of complaints received in the month of April was 97, the number of complaints received in 2017/18 showed a 6% increase on 2016/17. 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 March, 69% 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 February, 44% were responded to within 40 working days. For 60 day complaints received in January, 100% 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 Comms Cell is being used to highlight to all services where the Trust is achieving and where the Trust needs to improve its responsiveness.

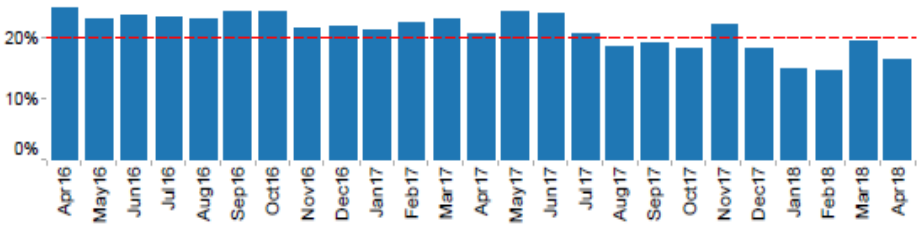
Patient Voice

CARING – Friends and Family Test

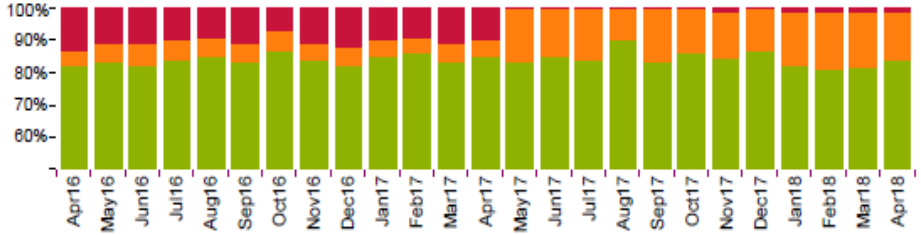
Target ¢ MetricMeasure | Percentage Recommended | Neutral | Percentage Not Recommended

A&E Friends & Family Response Rate

Target: 20% Mar 18: 19.52% Apr 18: 16.39% Movement: ▼-3.13%

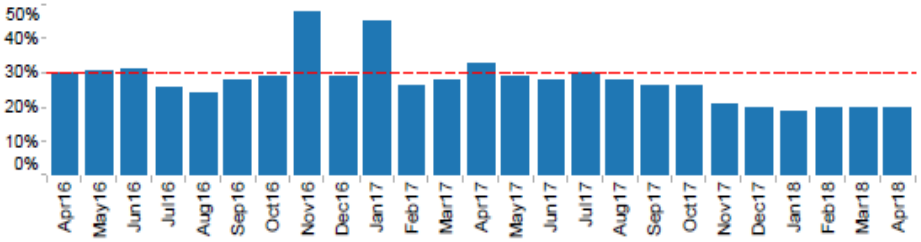


A&E Friends & Family Recommend Rate
The expected target is 90%

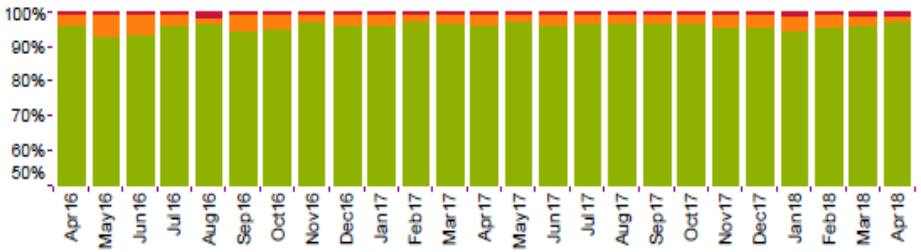


IP Friends & Family Response Rate

Target: 30% Mar 18: 19.70% Apr 18: 19.67% Movement: ▼-0.03%

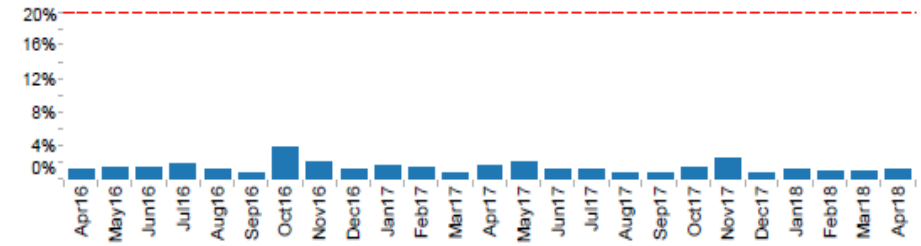


IP Friends & Family Recommend Rate
The expected target is 95%

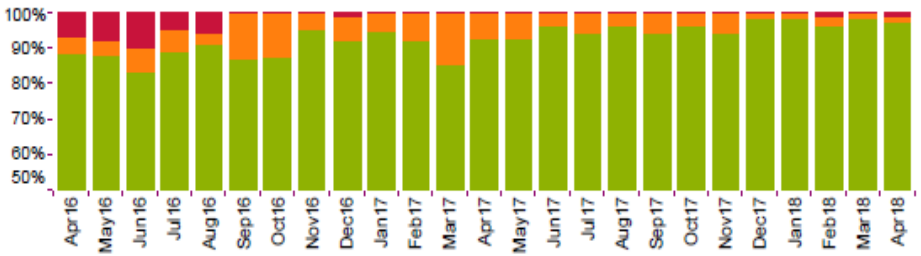


OP Friends & Family Response Rate

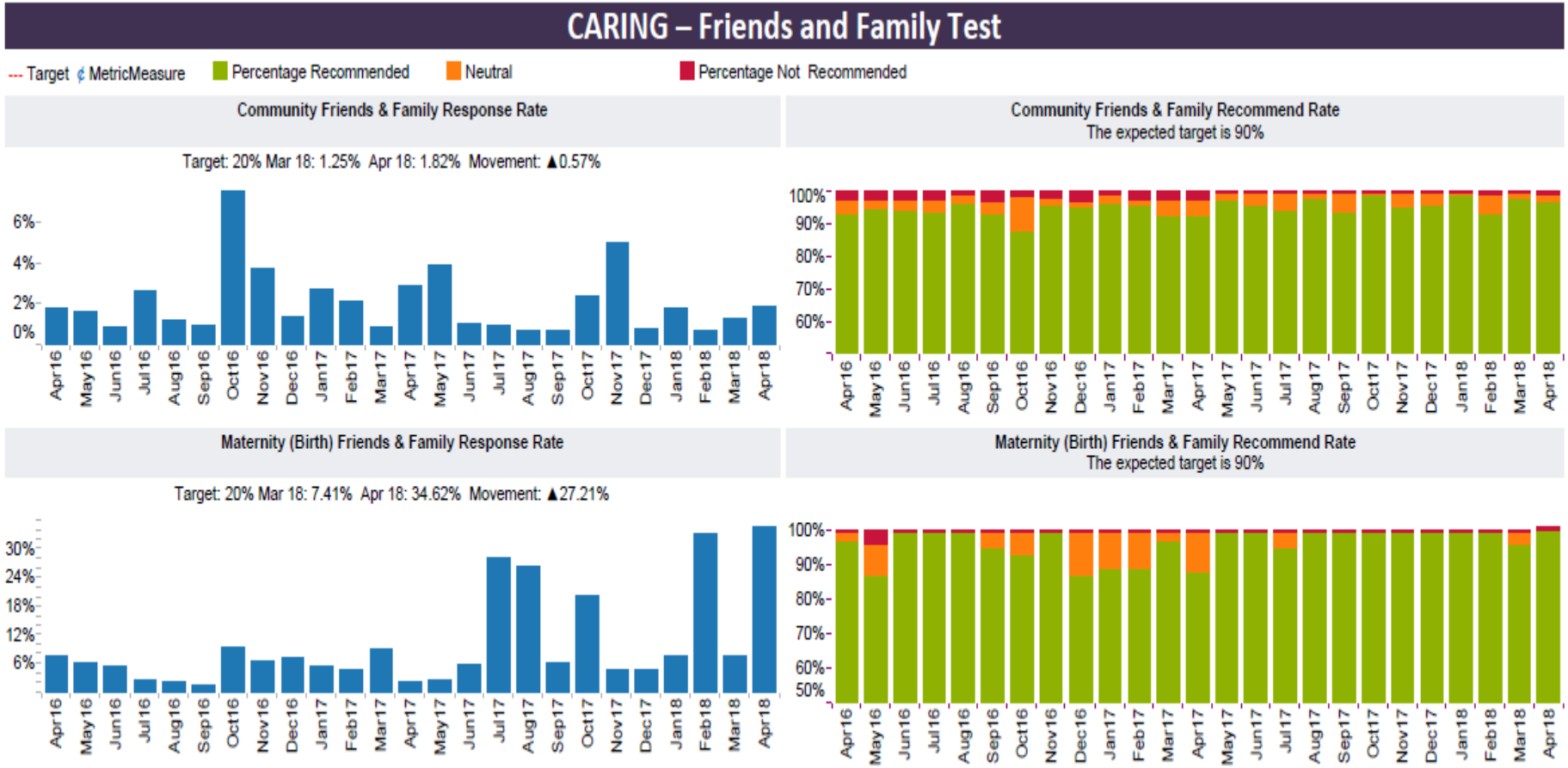
Target: 20% Mar 18: 0.90% Apr 18: 1.10% Movement: ▲0.20%



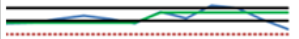
OP Friends & Family Recommend Rate
The expected target is 90%



Patient Voice



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	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%	
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%	
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%	
Total Funded Establishment		9,924.93	9,947.77	9,878.79	9,855.40	9,794.00	9,808.00	9,470.02	9,474.19	9,514.51	9,540.06	9,497.37	9469,72	
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%	
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%	
% of Staff who have completed MAST training (in the last 12 months)		87%	87%	86%	86%	85%	86%	87%	86%	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%	
Safe Staffing Alerts	0	0	1	2	1	0	1	2	2	4	1	1	1	

* Excludes Junior doctors

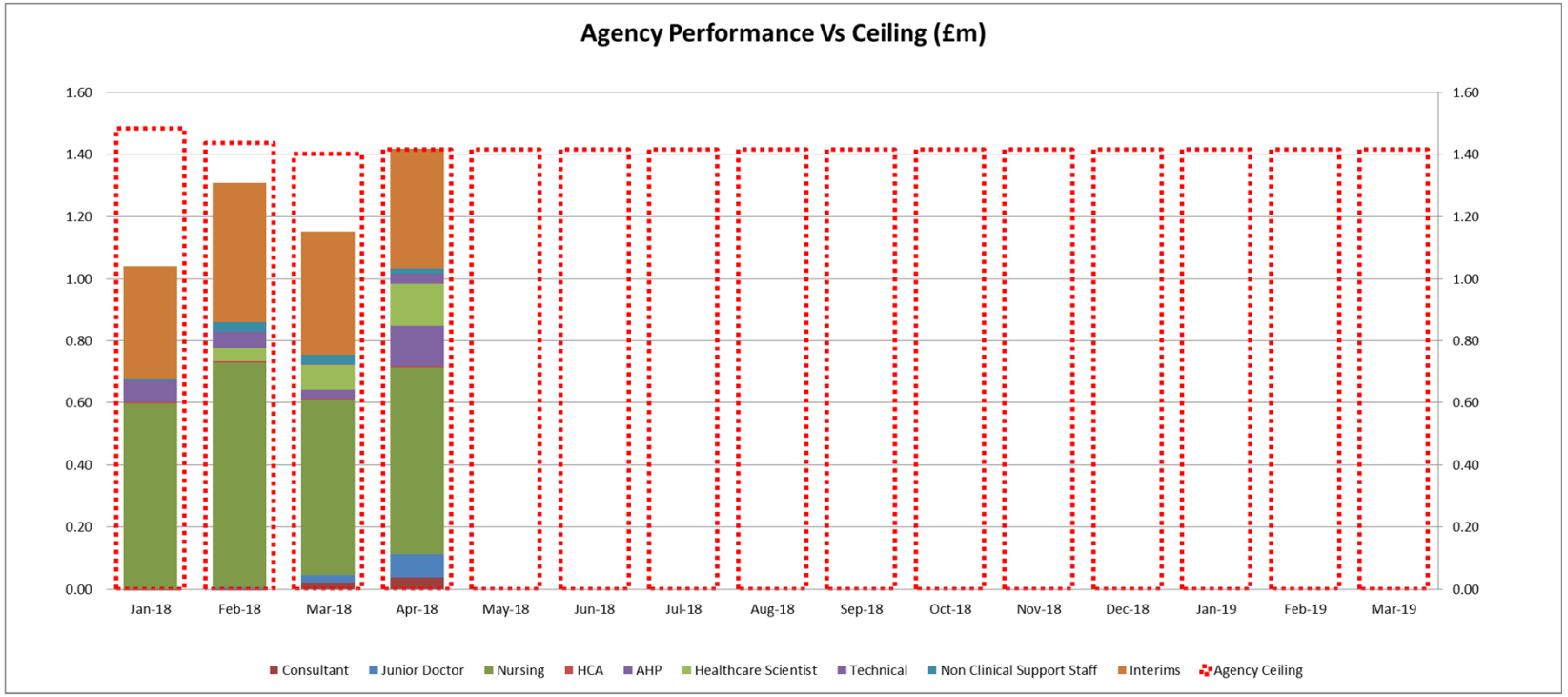
Briefing

- Funded Establishment fell compared to the previous month reporting 9,469.72 WTE in April, a reduction of 2.93% from April 2017 as a result of the changes to the Community Division.
- The Trust Vacancy Rate continues to decrease in April reporting 12.6% in month.
- Sickness was slightly above the 3% target, however observing improvement, reporting 3.2% in April.
- Mandatory and Statutory Training figures for March were recorded at 87%
- Medical Appraisal rates have increased by 9% in April, reporting 81% compliance against a target of 90%
- Non-medical appraisal rates have seen a downward step change reporting 61% compliance 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

St George's University Hospitals NHS
NHS Foundation Trust

Agency Use



- The Trust's total pay for April was £40.69m. This is £0.11m adverse to a plan of £40.59m.
- 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 April was £1.42m or 3.5% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For April, the monthly target set was £1.42m. The total agency cost is on plan with the target.
- Agency cost increased by £0.27m compared to March. There has increases across most staff groups: AHP (£0.10m), Healthcare Scientist (£0.06m), Junior Doctor (£0.05m), Nursing (£0.04m), Technical (£0.03m) and Consultant (£0.02m). This is offset by decreases in Non Clinical Support Staff (£0.01m) and Interims (£0.01m).
- The biggest area of overspend was in Interims, which breached the target by £0.09m.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 May 2018	**Agenda No.**	**2.3**
Report Title:	**Elective Care Recovery Programme Update**		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer Kim Barrow, Elective Care Recovery Programme Director		
Report Author:	Kim Barrow Elective Care Recovery Programme Director		
Presented for:	Assurance		
Executive Summary:	This report provides an update on the Elective Care Recovery Programme, including key highlights of the programme, an overview of the elective care pathways training plan, and a summary of overall programme risks.		
Recommendation	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Treat the patient, Treat the person Right Care, Right Place, Right Time		
CQC Theme:	Well-led, Safe, Caring, Responsive		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	BAF Strategic Risk 2		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously considered by:	Quality and Safety Committee	**Date:**	24 May 2018

ELECTIVE CARE RECOVERY PROGRAMME

1. **Purpose**
   The purpose of this paper is to provide an update of progress for the Elective Care Recovery Programme. To highlight areas of achievement, and areas of risk.
2. **Background**
   The Elective Care Recovery Programme is the overarching programme responsible for developing the key deliverables to improve, monitor and develop metrics that give assurance to the Trust Board, regulators and the public for the effective and timely management of patients along their pathway of care
3. **Update Report**

3.1 Cancer	• The final report from RM Partners has been received by the Trust and it is undergoing the normal management review before signing off the recommendations and preparing the action plan. One of the key deliverables for 18-19. • Successful work continues to upgrade and improve the cancer IT system with our partners at Infoflex. • Six consecutive months of achieving the two week rule [14 day from referral to consultation] cancer target which represents real progress and stabilisation. • Consistent high performance in the achievement of standards continues.
3.2 Diagnostics	• Achieved compliance and forecast to continue. • The substantive Divisional Director of Operations continues to strengthen the control and grip through a confirm and challenge approach. • Discussions regarding the patient tracking list for diagnostics continues, however patients are currently being managed and tracked effectively and treated in a timely manner.
3.3 Treating Patients	• Continued use of the Patient Tracking Systems is now embedding them into business as usual, with significant use by operational staff. • New and improved reports have developed by the business intelligence team to increase the type of tools available to clinical teams. Operational Managers will now help to refine and evolve them to ensure they work for them. • The number of patients waiting too long for their treatment continues to reduce.
3.4 Return to Reporting	• Data quality continues to be a priority for the Trust, both in the historical validation, and Business as usual validation • Trust Board Assurance Framework/ Dashboard in development • A robust training programme for Referral To Treatment patient pathways has commenced with a focused cohort, and an on-going training

	programme and training strategy is currently in development • Planning for capacity and demand assessment is currently in progress • All patients requiring appointments from Phase One will have been seen in May, with the exception of 9 patients which was due to patient choice.. Further assurance is to note that no further clinical harm has been identified during this reporting period. • A draft Return to Reporting Plan has been produced and is currently awaiting review from regulators, this will continue to progress.
3.5 Training	• Continued communication across the organisation to highlight the importance of undertaking the foundation and basic modules of the RTT e-learning modules. Uptake of this training has increased across the organization and we remain on target for 85% overall compliance (internal target) • Focused/targeted training is now underway. A longer term training strategy is currently in development to ensure all staff are trained and updated appropriately.
4.0 Next steps	Over the next month the programme will support: • Consistent reductions in the number of patients waiting too long for treatment • Continued focus on waiting times for first appointment at specialty level • Assess the impact of Training on error rates • Approval and subsequent delivery of programme milestone deliverables for 18/19, including the plan for Return to Reporting • Delivery of agreed activity plans for 18/19 • Continue to appoint the appropriate patients from phase one validation and identify any potential harm • Further alignment with the outpatient transformation and theatre improvement programmes
5.0 Risk	The Risk Register for the Programme is currently being updated, and will be presented through the Elective Care Recovery Committee for approval in June 2018. 1. Delivery of robust capacity plans that reflect demand 2. Sub specialty capacity pressures in Ear, Nose and Throat and General Surgery 3. Standard Operating Procedure [SOP] development to ensure front line staff are working to agreed rules 4. Training resource to train staff on the right way to process patients [SOP's] and RTT knowledge through e-learning packages. 5. Delayed Cerner implementation at QMH

Kim Barrow
Elective Care Recovery Programme Director
May 2018

Meeting Title:	**Trust Board**		
Date:	31 May 2018	**Agenda No.**	**2.4**
Report Title:	**Emergency Care Performance Update – May 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 Emergency Care Performance against the 95% Emergency Care Operating Standard. • This paper also presents the progress against the 15 Point Plan and associated KPIs encompassing the NHSI recommendations from the St George's site visit in February 2018.		
Executive Summary:	Emergency Care Performance at St George's University Hospitals NHS Foundation Trust deteriorated in 2017/18 despite a number of interventions. The Trust delivered care within 4 hours to 87.56% of our patients against the 95% standard for the year. A 15 point plan was drawn together in early February 2018 and the Trust secured additional support through a Service Improvement Director with the targeted aim of improvement and delivery of the 95% standard. Subsequently, in February 2018 NHSI visited the organisation due to its challenged performance to undertake a diagnostic review and submitted a number of recommendations for implementation. The Trust's performance against the 4 hour Emergency Care Standard has begun to improve, delivering 88.41% against the agreed trajectory of 88% in April 2018 and is on track to over deliver in May against the 91% trajectory. Year to date, Emergency Care Performance is 90.02% as at 17 May 2018. The proportion of stranded (over 7 days length of stay) and super stranded (over 21 days) patients has continued to reduce. Further improvement is required in order to improve speciality response times to the Emergency Department and non-admitted performance and this is being driven by the weekly cross-Divisional Emergency Care Performance Improvement Group (ECPIG).		
Recommendation:	• It is recommended that the Trust Board note the update on progress against the four hour Emergency Care Operating Standard and delivery of the 15 Point Plan • The Trust Board is asked to approve the Emergency Care Performance trajectories for admitted and non-admitted pathways aligned to the delivery of the overall trajectory of 92% for 2018/19 approved in principle by the Trust Board in April 2018		

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:**	23.05.2018 24.05.18
Appendices:	2		

1.0 Purpose

1.1 This paper is being presented to provide an update on Emergency Care Performance and delivery of the 15 Point Plan. This follows the paper that was presented to the Trust Executive Committee, Finance and Improvement Committee and Trust Board in April 2018.

1.2 The paper outlines the impact of the actions being taken on performance to date and outlines performance against the trajectory for improvement against the 4 hour Emergency Care standard in 2018/19.

2.0 Background

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

2.2 In February 2018, the NHSI undertook a visit to St George's Hospital to observe the emergency care pathway, with the report and series of recommendations being made available to the Trust in March 2018. These recommendations were aligned to the existing 15 Point Plan with a focus on the immediate to medium term changes required, whilst engaging with staff to ensure clear accountability and responsibility for the delivery of the 4 hour Emergency Care standard. The 15 Point Plan Dashboard is included in Appendix 1.

2.3 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. The trajectory is

compliant with the NHS Operational Planning and Contracting Guidance for 2018/19 which requires Trusts to deliver a minimum of 90% performance from September 2018 and exit March 2019 at 95% performance.

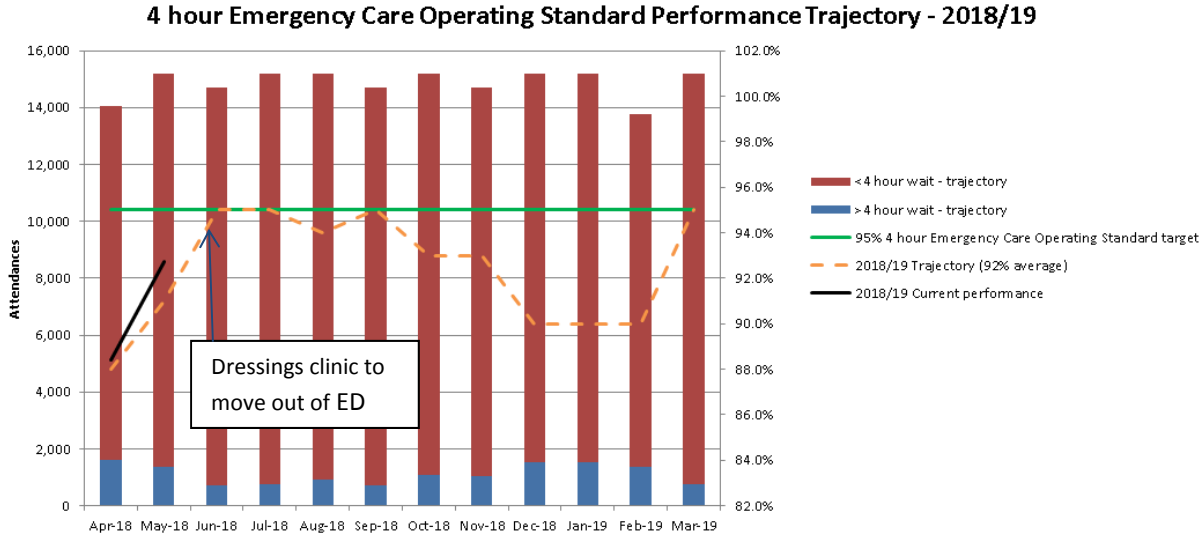
3.0 Current Emergency Care Performance

3.1 Performance against the 4 hour Emergency Care Operating Standard is improving. The Trust delivered 88.41% against the agreed trajectory of 88% in April 2018 and is on track to over deliver in May against the 91% trajectory, performing at 92.73% month to date as at 17 May 2018.

3.2 In April 2018, the Trust achieved 95.3% of ambulance handovers within 30 minutes, a slight improvement on the March 2018 position of 94.5%. The average for Trusts in London for the same period was 90.9%. Handovers within 15 minutes were achieved for 45% of patients, an improvement compared to 41% in March 2018 and in line with the London average of 45.2% for April. There was one 60 minute ambulance breach in April 2018, a significant improvement compared to 10 breaches in March 2018.

3.3 The chart below outlines current performance against trajectory and 2017/18 performance. Year to date performance for 2018/19 is currently 90.02%. The latest Urgent and Emergency Care Dashboard is included in Appendix 2.

Fig 1. Emergency Care Performance against Trajectory

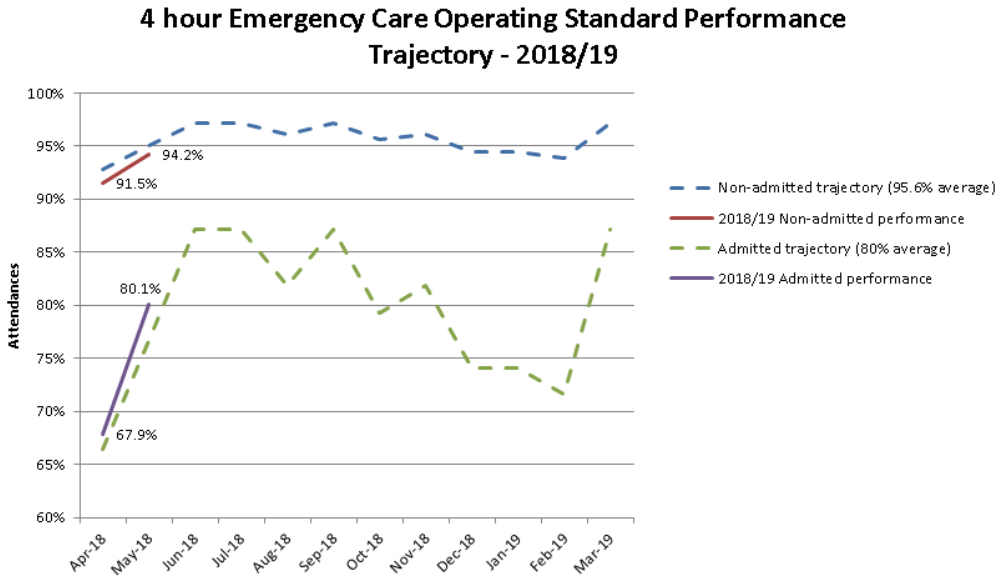


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2017/18 Performance	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	87.17%	84.99%	83.02%	83.52%	81.50%
2018/19 Trajectory	88%	91%	95%	95%	94%	95%	93%	93%	90%	90%	90%	95%
2018/19 Current performance	88.41%	92.73%										

3.4 The following trajectory (Fig 2) for admitted and non-admitted performance has been developed, based on delivery of the full year trajectory of 92% and the proportion of breaches in the admitted and non-admitted categories in 2017/18, taking account of seasonal capacity pressures. Demand and capacity modelling is being completed to

inform winter planning, the initial outputs of this are expected by the end of May 2018. The Trust is working with system partners to mitigate the impact of winter pressures on performance and identify further opportunities to reduce length of stay. The trajectories outlined would deliver an average of 80% performance for the admitted pathway and 95% for non-admitted across the year:

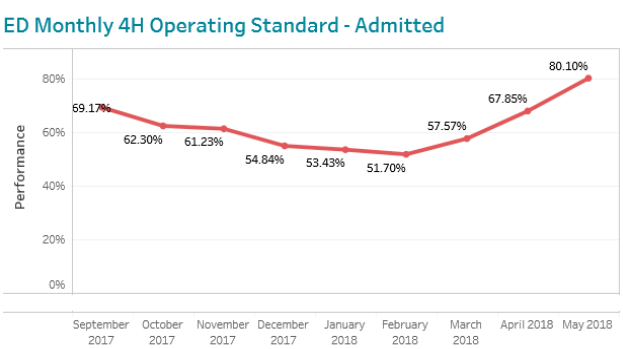
Fig 2. Admitted and Non-admitted Performance against Trajectory

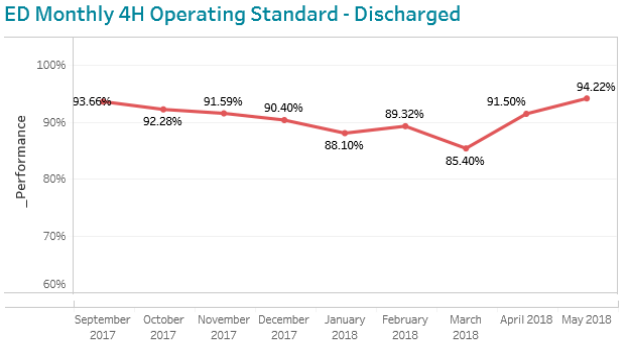


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Non-admitted trajectory (95.6% average)	93.4%	95.0%	97.2%	97.2%	96.1%	97.2%	95.6%	96.1%	94.5%	94.5%	93.9%	97.2%
Admitted trajectory (80% average)	69.0%	76.7%	87.1%	87.1%	81.9%	87.1%	79.3%	81.9%	74.1%	74.1%	71.6%	87.1%

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). In April 2018, the Trust achieved 67.85% admitted performance and 91.5% performance for non-admitted patients. In May 2018 to date this has improved to 80.10% and 94.22% respectively.

Fig 3. Admitted and Non-admitted Performance





4.0 Progress against 15 Point Plan

4.1 The 15 Point Plan Dashboard is included in Appendix 1. This is reviewed on a weekly basis at the Emergency Care Performance Improvement Group Meeting in line with the governance structure for Emergency Care Performance outlined in the previous paper.

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 has increased slightly from 11.61% in 2017/18 to 12.3% in 2018/19. Feedback from Pauline Philip, National Director for Urgent and Emergency Care has indicated that nationally, this indicator is likely to move to the requirement for specialty response within 20 minutes. Further work is required to improve specialty performance in line with this standard both in and out of hours and this is being driven by ECPIG.

4.3 The new Ambulatory Assessment Area and process model continues to contribute to improvements in flow and performance. The Trust has seen a reduction in the number of breaches of the Emergency Care standard attributable to bed management and ED capacity by 26% across March and April 2018, compared to the same period in 2017. AMU occupancy is operating at below the required 85% occupancy.

4.4 Significant progress has also been made in reducing the number of 'stranded' (patients with a length of stay of >7 days) and 'super stranded' patients (patients with a length of stay of >21 days across the organisation. The proportion of stranded patients for the week ending 13 May 2018 was 19.29% compared to the Trust's 6 week average of 33.72%. The proportion of super stranded patients is 7.05%, compared to a 6 week average of 12.04%. A Multi-disciplinary Accelerated Discharge (MADE) Event was held on 22 May 2018 with the support of system partners.

5.0 Risks and Mitigation

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

Risk	Mitigation
1. Lack of organisational compliance including the non-admitted pathway	Weekly cross-divisional meeting established and led by the Chief Operating Officer. Focus on delivery compliance of the 4 hour standard encompassing the 15 point plan.

2. Increase in activity for admitted and non-admitted patients	Focus in the 15 point plan on delivery of actions whilst managing variation in activity, including rotas and ways of working, delivery of improvements in non-admitted pathway. Improvements length of stay, discharge processes and pathways through UAPC.
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. Inability to recruit to vacancies to deliver required improvements, particularly in the Ambulatory Assessment Area	Remaining Advanced Nurse Practitioner vacancies re-advertised. If not successful, consider alternatives, including junior doctors, ACPs.
6. System wide support become challenged impacting on sustained flow in winter months.	Sustain the good working relationship with system partners through Emergency Care Delivery Board, MADE events and in line with the escalation / OPEL system plan. A winter planning forum has been established.

6.0 Quality Improvement Academy Support

6.1 12 members of staff from the Emergency Department participated in a Quality Improvement (QI) event on 26 April 2018. Feedback was positive and the department will be undertaking further QI events. During the day the ED team identified and prioritised a range of improvement projects. The first project is designed to improve internal ED processes, patient flow and communication within the ED.

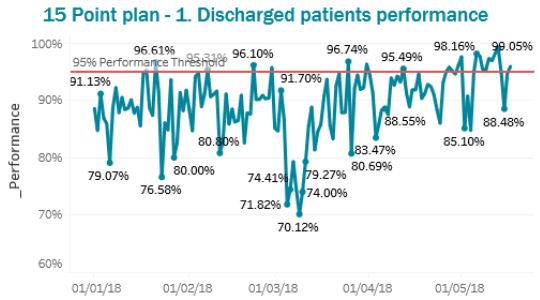
6.2 In addition, for four days in May and in collaboration with colleagues from the Institute for Health Improvement (IHI), 35 staff joined an intensive Accelerated Patient Safety Programme designed to describe the skills, theory and practical tools critical to developing a successful patient safety project, to work with their senior leaders to develop improvement projects for their area of responsibility and participate in an on-going patient safety community of practice. Each team has a dedicated Executive sponsor and will be actively supported by the Trust's Quality Improvement Academy (QIA) as they move into active project delivery.

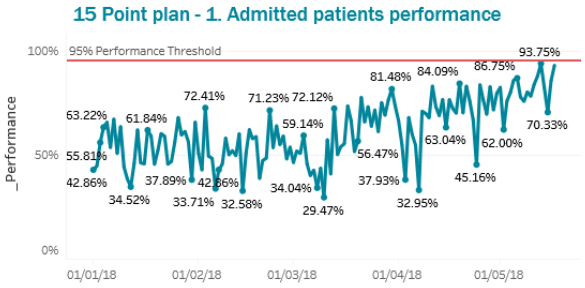
7.0 Recommendations

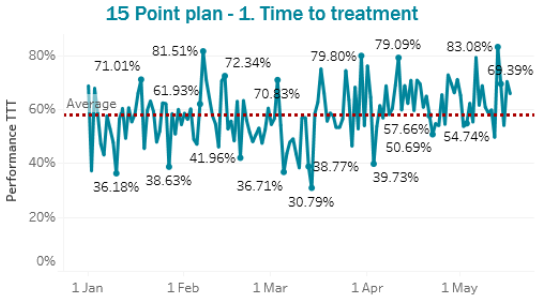
7.1 It is recommended that the Trust Board note the update on progress against the four hour Emergency Care Operating Standard and delivery of the 15 Point Plan as outlined in the 15 Point Plan Dashboard.

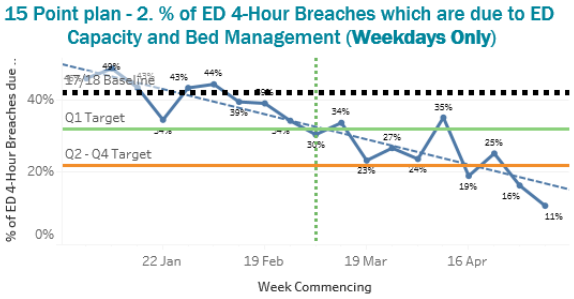
7.2 The Trust Board is asked to approve the Emergency Care Performance trajectories for admitted and non-admitted pathways, aligned to the delivery of the overall trajectory of 92% for 2018/19 which was approved in principle at the Trust Board meeting in April 2018, with the caveat that the Trust should strive to deliver further improvement towards achieving the 95% target sustainably.

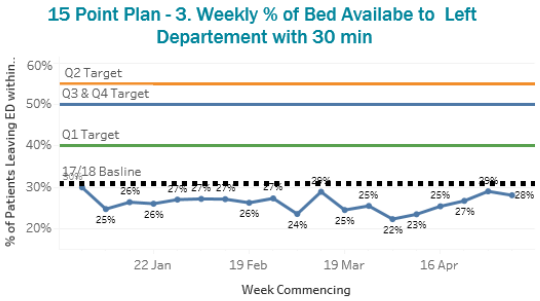
Appendix 1 15 Point Plan Dashboard

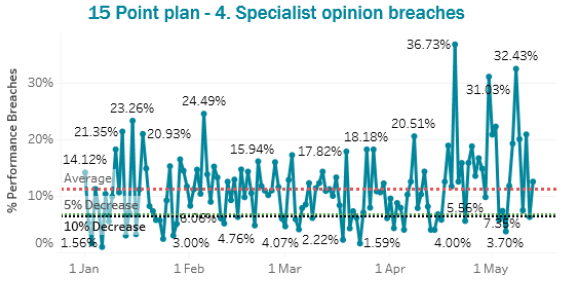


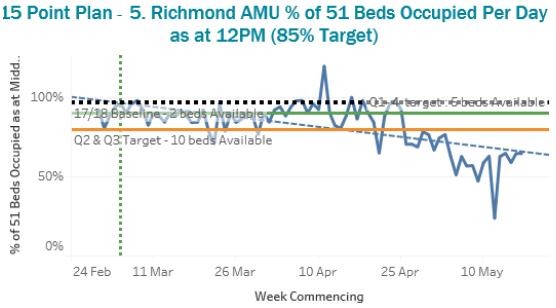


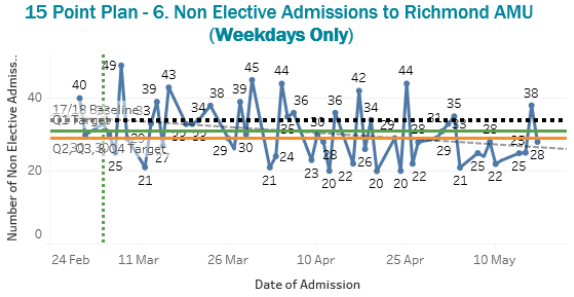


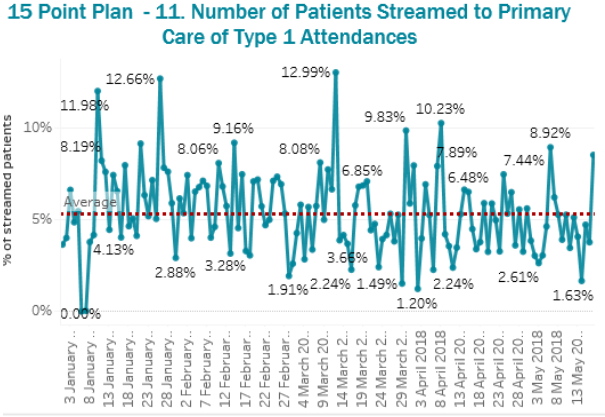




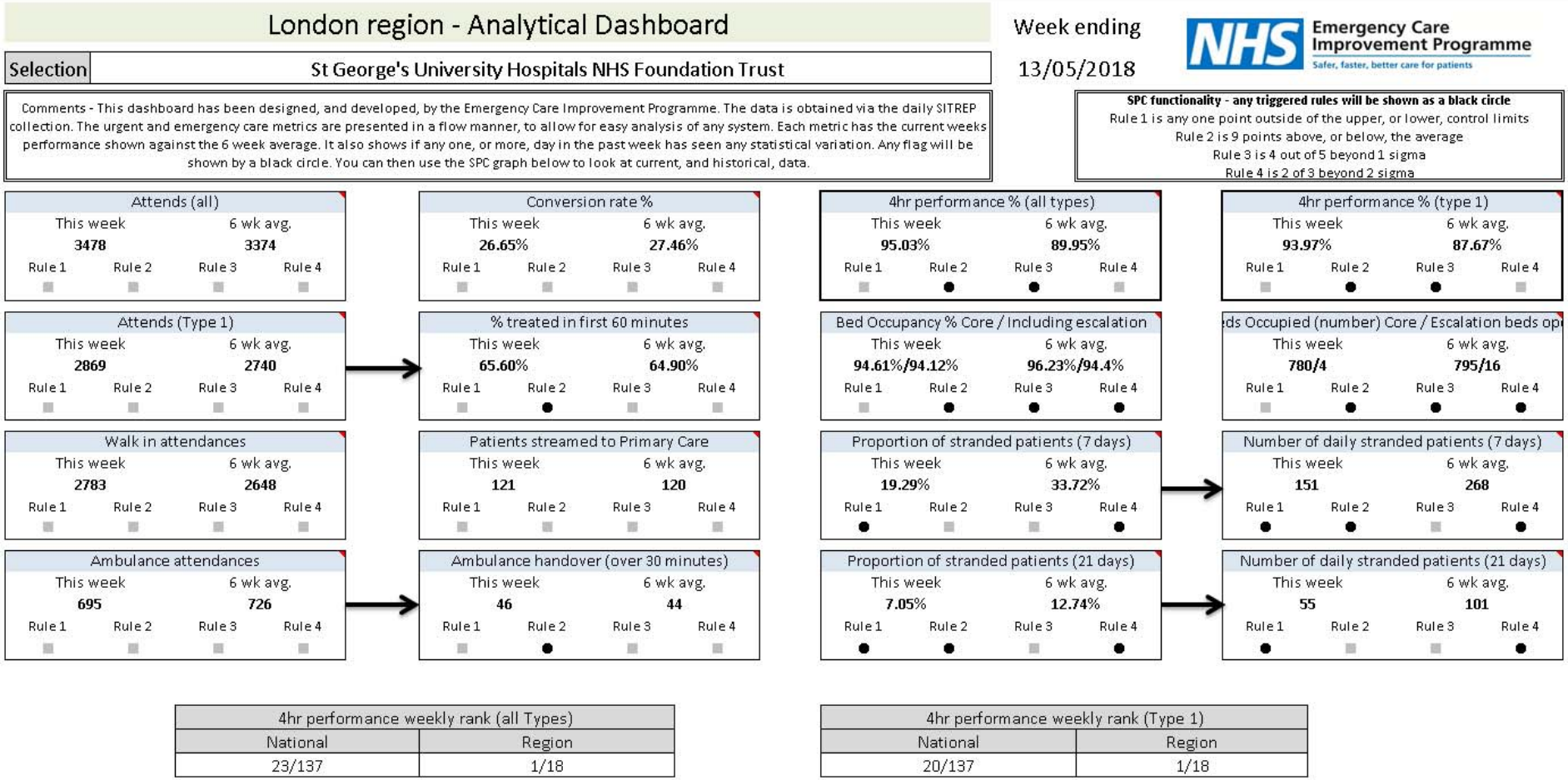








Appendix 2. Urgent and Emergency Care Dashboard



4hr performance weekly rank (all Types)	
National	Region
23/137	1/18

4hr performance weekly rank (Type 1)	
National	Region
20/137	1/18

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No**	**3.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 24 May 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee – May 2018

1.0 Matters for the Board's Attention

1.1 The Committee welcomed the new Chief Information Officer to discuss actions in place both to clarify and mitigate the IT risk, which had been allocated to it as part of the Board Assurance Framework. The Committee felt that the extent of the risks were now clear, as indeed was the timescale to reduce them to more acceptable levels. Whilst there was still only limited assurance, the Committee took some assurance from the plans outlined.

1.2 The Committee was pleased to see the addition of productivity metrics within the integrated quality and performance report and was able to discuss the opportunities for improving theatre productivity. Further suggestions were made on other metrics that would be useful, including the opportunity to triangulate activity data with the SLA plans by division. A further paper on PLICS confirmed that recent progress had been slow due to other priorities for the finance team but plans were now in place to undertake some deep dives.

1.3 There was a further discussion on the performance in the Emergency Department, and the Committee welcomed the addition of some of the interim targets, such as the Time to Treatment, to the Integrated Quality and Performance Report to allow a better understanding of where improvements need to be made. The Committee recognised the hard work by many staff throughout the Trust behind the recent improvements in ED performance.

1.4 The Committee noted the improvement in performance against Cancer targets in March and April, in line with the assurance it had received from the executive last month, but also that given increased volumes performance in May was likely to dip.

1.5 The Committee noted that the month 1 financial performance was broadly within plan, albeit some activity was below plan, adversely affecting income. The Committee acknowledged the importance of getting on top of under-performance on income early in the financial year, both to deliver the existing plan and to recover from any early underperformance . The Committee recognised that unless the pay award was fully funded, this could present a material risk to achieving an outturn deficit of £29m.

1.6 On business and financial planning for 2018/19, the Committee noted that significant progress had been made in developing Green Cost Improvement Programmes, with around 90% of the required plans now classified as Green and sufficient other plans identified in the pipeline for the target to be met. The Committee was keen that further CIPs were developed around pay reductions, where possible, and was encouraged by the planned actions to reduce any unneeded vacancies.

1.7 The Committee took the opportunity of its annual effectiveness review to consider both the information it received and its membership. Having welcomed the inclusion of more productivity information earlier in the meeting, it was keen to include further additions in the same vein. On membership it felt that given that the Committee was designed to allow NEDs to take assurance from the Executives, it was important to have a strong Executive presence, and that whilst the Trust remained in special measures this should include the CEO and the Trust Chair. The Trust Executive agreed to reflect on whether current attendees who were not part of the Executive needed to attend on a regular basis.

2.0 Recommendation

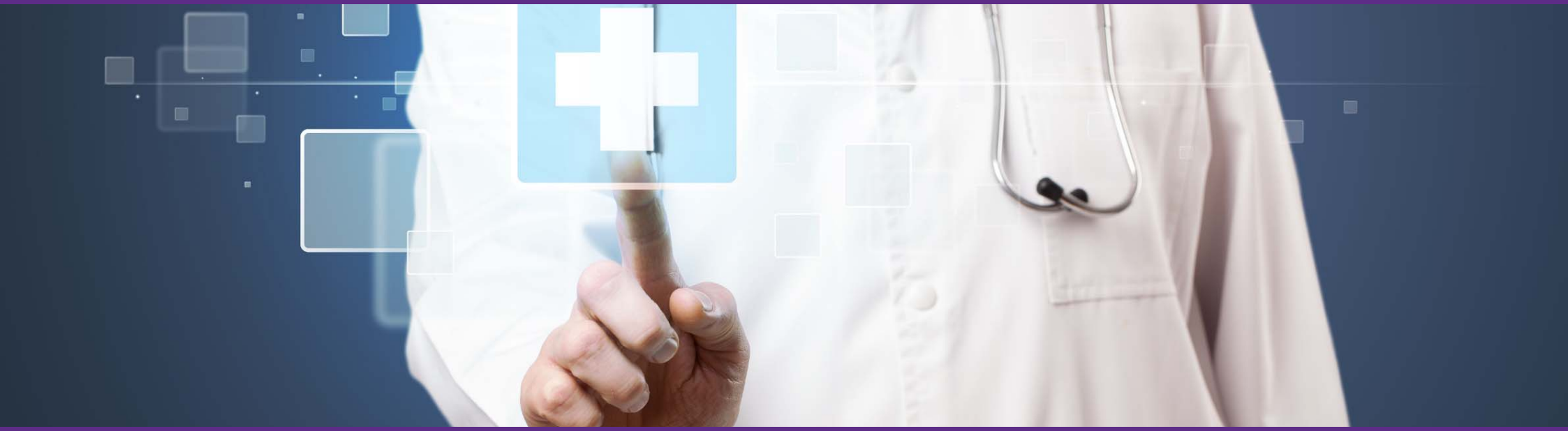
2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 24 May 2018 for information and assurance.

Ann Beasley
Finance and Investment Chair, NED
May 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**31st May 2018**	**Agenda No.**	**3.2**
Report Title:	**M01 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 £6.3m at the end of Month 01 (April), an adverse variance to plan of £0.1m. Within the position, income is adverse to plan, which is largely offset by expenditure underspend. The 2017/18 Final Accounts were submitted on time to NHSI. An unqualified audit opinion was issued by the Trust's External Auditors.		
Recommendation:	The Trust Board notes the trust's financial performance in April.		
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:**	24/05/2018
Appendices:	None		

TB May 18 – Agenda item x.x



St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 01 (April 2018)

Chief Finance Officer

31st May 2018

Executive Summary – Month 01 (April)

The Finance Report this month is limited to headline information due to time constraints resulting from completing the 2017/18 year end accounts. Normal reporting will resume for the June Board meeting.

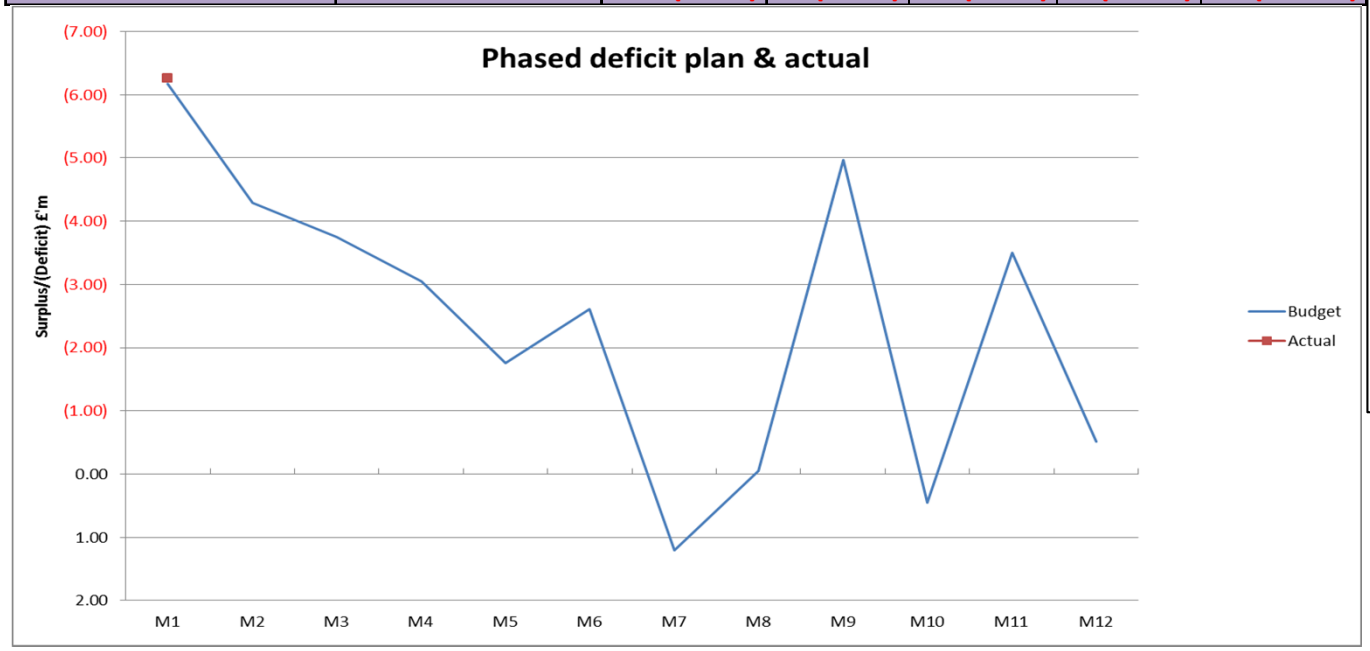
The 2017/18 Final Accounts were completed and submitted to NHSI on time following completion of the External Audit. Prior to submission the Final Accounts were reviewed in detail by the Audit Committee and Trust Board. The deficit reported was in line with the £53.1m reported to the Trust Board in April, and the Trust's External Auditors have issued an unqualified audit opinion.

Area	Key issues	Current month (YTD)
Target deficit	The trust is reporting a deficit of £6.3m for April, which is adverse to plan by £0.1m. Within the position, income and pay are adverse to plan, which is being partly offset by Non Pay expenditure underspend. INCOME REPORTING ISSUES IN MONTH HAVE RESULTED IN A HIGH LEVEL OF ESTIMATION. Work is underway to validate reported volumes and ensure coding is completed prior to the freeze date.	£0.1m Adv to plan
Income	Income is being reported at £0.7m adverse to plan. There is lower than planned income of £0.5m in Elective and £0.3m in Outpatients, offset by Non Elective favourable variance of £0.8m. SLA Exclusions contribute £0.3m of the variance which is offset within drugs and consumables. Non-SLA income is also under plan by £0.4m, with shortfalls in Pharmacy partially offset but underspends in drugs, and R&D income fully offset by reduced Non Pay cost.	£0.7m Adv to plan
Expenditure	Expenditure is £0.6m favourable to plan in April. The favourable position is in Non Pay (£0.7m), with underspends seen in Consumables and non-pass through Drugs. Pay is £0.1m adverse within SWLP, which is offset by income.	£0.6m Fav to plan

Contents

1. Month 01 Financial Performance

Category	Sub Category	M1 Budget (£m)	M1 Actual (£m)	M1 Variance (£m)	M1 Variance %	Annual Budget (£m)
Income	SLA Income	53.84	53.58	(0.25)	(0.5%)	666.88
	Other Income	9.74	9.33	(0.41)	(4.2%)	115.47
Income Total		**63.58**	**62.91**	**(0.66)**	**(1.0%)**	**782.35**
Expenditure	Pay	(40.59)	(40.69)	(0.11)	(0.3%)	(467.56)
	Non Pay	(26.40)	(25.67)	0.73	2.8%	(309.61)
Expenditure Total		**(66.99)**	**(66.36)**	**0.63**	**0.9%**	**(777.17)**
Post Ebitda		(2.76)	(2.81)	(0.06)	(2.1%)	(34.18)
Grand Total		**(6.17)**	**(6.27)**	**(0.10)**	**(1.6%)**	**(29.00)**



Trust Overview

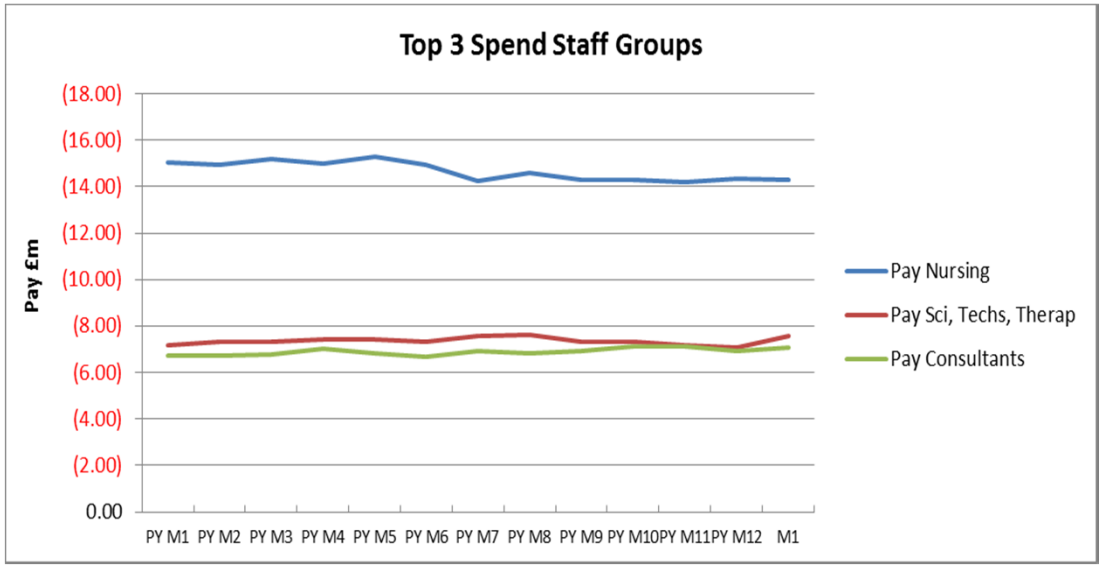
- Overall the Trust is reporting a deficit of £6.3m for Month 01, an adverse variance to plan of £0.1m.
- **Income** is £0.7m adverse to plan, with SLA Income £0.3m and Other Income £0.4m both reporting adverse positions.
- **SLA Income** is £0.3m under plan, owing to shortfalls in Elective (£0.5m), and Outpatients (£0.3m), offset by excess Non Elective Income (£0.8m). Reporting issues in month have resulted in a high level of estimation. Further work is being undertaken to validate this.
- **Other income** is under plan by £0.4m; the key driver is lower than planned pharmacy income (£0.3m) and R&D income (£0.1m). These are both offset in Non Pay expenditure
- **Pay** is £0.1m adverse, with underspends in Non Clinical (£0.2m) and Nursing (£0.3m) offset by overspend in the Junior Doctor and Consultant lines (£0.5m).
- **Non-pay** is £0.7m underspent, due to reduced expenditure on clinical consumables (£0.4m) and non-pass through drugs (£0.4m), offset by increased Premises costs (£0.1m)

ACTION REQUIRED

- Review SLA reporting to ensure complete and accurate, and to understand movements within and against the plan.
- Actions in Commercial Pharmacy to return to budget.
- Pay, address all overspending areas

5. Month 01 Pay Performance

FT Cat	M1 Budget (£m)	M1 Actual (£m)	M1 Variance (£m)	M1 Variance %	Full Year Budget (£m)
Pay Consultants	(6.98)	(7.09)	(0.11)	(1.6%)	(83.40)
Pay Jnr Drs	(4.33)	(4.68)	(0.35)	(8.1%)	(51.99)
Pay Nursing	(14.55)	(14.28)	0.27	1.8%	(173.78)
Pay Sci, Techs, Therap	(7.54)	(7.55)	(0.00)	(0.0%)	(91.01)
Pay Non Clinical	(7.10)	(6.91)	0.20	2.8%	(84.42)
Pay Other	(0.08)	(0.18)	(0.10)	(126.2%)	17.05
Grand Total	**(40.59)**	**(40.69)**	**(0.11)**	**(0.3%)**	**(467.56)**



Pay Overview

At M01 YTD, pay is £0.1m adverse to plan.
The key variances are:

- **£0.3m underspend in Non Clinical** due to vacancies across the board.
- **£0.2m underspend in Nursing** due to vacancies in non ward areas.
- **£0.1m overspend in Consultants** due to increased Bank and WLI spend above budgeted levels, largely within surgical specialties.
- **£0.3m Junior Doctor overspend** is across a number of specialties in all clinical divisions.
- **£0.1m adverse variance in 'Other'** is mainly in SWLP and R&D and is therefore offset with Income and Non Pay.

Actions

- **All overspent areas** in M1 to be challenged through divisional run rate meetings, with underspends identified for the possibility of maintaining.
- Service by service review of **junior doctor rotas** to improve coding of posts using information from Medical Staffing and Education departments.
- Review **temporary staffing costs** received in month 1.

WTE reporting is being reviewed by the divisional finance teams for improved accuracy in line with new workforce plans.

ESR is in the process of being reconciled with the new budget. An updated will be provided to the committee in month 2.

6. Month 01 Non-Pay Performance

FT Cat	FT Sub Cat	M1 Budget (£m)	M1 Actual (£m)	M1 Variance (£m)	M1 Variance %	Full Year Budget (£m)
⊞ Clinical Consumables		(8.41)	(8.00)	0.41	4.8%	(100.67)
⊞ Clinical Negligence		(2.20)	(2.18)	0.02	0.8%	(26.39)
⊟ Drugs	Drugs	(3.35)	(2.91)	0.44	13.2%	(39.57)
	Drugs - PbR Excluded	(3.50)	(3.54)	(0.04)	(1.2%)	(41.99)
⊞ Establishment		(0.98)	(0.93)	0.06	5.8%	(11.80)
⊞ General Supplies		(1.74)	(1.77)	(0.03)	(1.7%)	(21.00)
⊞ PFI Unitary payment		(0.47)	(0.50)	(0.03)	(7.3%)	(5.62)
⊞ Premises		(3.53)	(3.66)	(0.13)	(3.6%)	(42.20)
⊞ Non Pay Other		(2.23)	(2.19)	0.04	1.7%	(20.38)
Grand Total		**(26.40)**	**(25.67)**	**0.73**	**2.8%**	**(309.61)**

FT Cat	FT Sub Cat	PY M8 Actual (£m)	PY M9 Actual (£m)	PY M10 Actual (£m)	PY M11 Actual (£m)	PY M12 Actual (£m)	M1 Actual (£m)
⊞ Clinical Consumables		(7.81)	(8.85)	(6.99)	(8.01)	(7.62)	(8.00)
⊞ Clinical Negligence		(1.93)	(1.95)	(2.32)	(1.97)	(1.95)	(2.18)
⊟ Drugs	Drugs	(3.72)	(3.40)	(3.03)	(3.00)	(3.75)	(2.91)
	Drugs - PbR Excluded	(3.42)	(2.81)	(2.97)	(3.71)	(4.30)	(3.54)
⊞ Establishment		(0.83)	(1.05)	(1.24)	(0.81)	(0.64)	(0.93)
⊞ General Supplies		(1.58)	(1.56)	(1.60)	(1.57)	(1.53)	(1.77)
⊞ PFI Unitary payment		(0.63)	(0.63)	(0.63)	(0.63)	(0.63)	(0.50)
⊞ Premises		(3.83)	(3.11)	(3.23)	(2.90)	(2.96)	(3.66)
⊞ Non Pay Other		(4.08)	(2.44)	(2.56)	(1.40)	(4.61)	(2.19)
Grand Total		**(27.81)**	**(25.79)**	**(24.56)**	**(24.00)**	**(28.01)**	**(25.67)**

Non-Pay Overview

At M01, Non-Pay is broadly consistent with previous months trends, and £0.7m favourable to plan. The key variances are:

- £0.4m underspend from **clinical consumables**. This is being reviewed in line with the new budget.
- £0.4m underspend in **non pass-through drugs**, which is offset by lower than expected Commercial Pharmacy income.

Actions

- Work with Pharmacy to quantify risk and develop mitigating actions to recover **Commercial Pharmacy**.
- Use the **Spend Cube** from Procurement to understand the major suppliers and patterns of spend.
- Review non-pay budgets to ensure **accurate coding** of plan and actuals.
- Complete a **list of contracts** with regular invoices to inform Accounts Payable coding.
- Improve understanding of **stock adjustment** processes to ensure costs are accurately captured.
- Review expenditure to ensure all **relevant POs** are set up to avoid future problems, regarding timing of expenditure.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 May 2018	**Agenda No**	**4.1**
Report Title:	**Audit Committee report**		
Lead Director/ Manager:	Sarah Wilton, Chair of the Audit Committee		
Report Author:	Sarah Wilton, Chair of the Audit Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 21 May 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Audit Committee – May 2018

Matters for the Board's attention

1.1 The Committee met on 21 May principally to consider the Trust's Annual Report and Accounts 2017/18. It considered final drafts of the Annual Report, the Annual Accounts, and the Quality Report, which had been updated following a Committee workshop the previous week. The Committee noted that significant work from a number of teams had gone into the drafts and acknowledged that the process had been significantly smoother this year compared with previous years.

1.2 As part of its consideration of the Annual Report and Accounts, the Committee heard from the External Auditors, who presented a report on their audit findings. The Committee heard that in contrast to previous years, the audit process for the 2017/18 Annual Report and Accounts had been positive and the auditors had been pleased with the engagement from staff within the Trust. Work had been completed on time and no additional fees were required. The External Auditors reported that there were no significant findings to report and that the going concern and value for money opinions reflected the current external position. In relation to the Quality Report, as per the required quality indicator data testing, the External Auditors had tested the four hour emergency department and 62 day cancer wait times. The indicator selected by the Council of Governors relating to patient safety incidents had also been tested. The Committee heard that, overall, the auditors were pleased with the testing against these indicators. The outcome was positive and the process showed improvement from the previous year. The External Auditors reported that they expected to give an unqualified audit opinion this year.

1.3 The Committee also considered the letters of representation in relation to the Trust's financial statements for the year ending 31 March 2018 and for the Quality Report for the same period.

1.4 On the basis of the information presented to it, including the External Audit report, the Committee agreed to recommend to the Trust Board that it approve the Annual Report and Accounts 2017/18.

1.5 The Committee heard that the Head of Internal Audit had given an opinion of 'reasonable assurance' for the Trust in 2017/18. This was an improvement on the previous year, which had shown 'limited assurance'.

1.6 The Committee received an update on the Trust's Information Governance Toolkit submission, which had been made in March 2018. The Trust had self-assessed against the Information Governance Toolkit, at a level two and this had been reported in the Trust's annual submission. However, a subsequent audit showed a shortfall of evidence to support the level two submission. Some of the statements made as part of the submission had been incorrect and five out of 10 areas had insufficient assurance. The Committee heard that the error had been due in part to staffing issues in the Information

Governance team. Work was underway to address the issues identified ahead of the next submission in October 2018 for the new Data Security and Protection Toolkit, which has now replaced the IG Toolkit. The Committee was informed that interim Head of Information Governance and the Chief Information Officer were working to address the issues and develop a robust action plan. It also heard that the IG Toolkit submission from March could not be amended.

2.0 Recommendation

2.1 To receive the update from the Audit Committee meeting on 21 May 2018 for information and assurance.

Sarah Wilton
Audit Committee Chair, NED
May 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	31 May 2018	**Agenda No**	**4.2**
Report Title:	Board Assurance Framework (BAF)		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This paper brings to the Board the summary page of the Board Assurance Framework following the Board review of the Q4 assurance ratings in April. The Board has asked that it continues to be updated monthly on: • any significant change in risks contributing to a strategic risk and therefore assurance statements and • assurance available in month on the effectiveness of the controls if there has been any material change The Quality and Safety Committee (24 May) reviewed risks contributing to strategic risks 2, 3, 4 and 15. The Committee heard that two contributing risks have seen a reduction in their risk score as actions have been delivered and controls strengthened. The strategic risk scores remain unchanged. The Finance and Investment Committee (24 May) reviewed ICT risks contributing to strategic risk 12. The Committee heard that the risk scores for contributing risks remain unchanged and that the new Chief Information Officer is undertaking a review of all risk assessments contributing to this strategic risk. The strategic risk score remains unchanged. The Workforce and Education Committee – no meeting scheduled in May.		
Recommendation:	The Board is asked: • To note the updates from the assuring committees.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		

Previously Considered by:	Finance and Investment Committee Quality and Safety Committee	**Date**	24 May 18 24 May 18
Equality Impact Assessment:	N/A		
Appendices:	App 1 BAF summary sheet		

Appendix 1

Board Assurance Framework
April 2018

BOARD ASSURANCE FRAMEWORK OVERVIEW										QUARTER 4
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating Q1	Q2	Q3	Q4	Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
Treat the patient, treat the person	*Moderate*	*SR1*	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.				Limited	The Committee recognises that there has been improvement in the vacancy rate and in time taken to recruit, however the risk has not significantly reduced and the Committee have only limited assurance that the controls are effective for this risk.	Director of HR and OD	Workforce and Education Committee	16
	Low	*SR2*	Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway are not timely or robust, resulting in poor, delayed or missed treatment.				Limited	The Committee recognises the improvement in the management of our waiting lists and the impact of the Elective Care Recovery Programme. The Committee is assured that the Unplanned Admitted Care Programme will improve control of this risk but continues to have limited assurance from key performance indicators that controls are operating effectively at present.	Chief Operating Officer	Quality Committee	16
	Low	*SR3*	We do not have effective, accessible and widely utilised learning and improvement methodologies, resulting in care which is below local and national standards and best practice.				Partial	The Committee is assured that the Quality Improvement Plan (QIP) workstream for learning is being delivered and that the Quality Improvement Academy has been launched. However, assurance remains partial as a number of key indicators in the QIP Dashboard are yet to be met.	Chief Nurse	Quality Committee	12
Right care, right place, right time	*Low*	*SR4*	Our pathways are not well integrated with, or supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.				Limited	Work continues to develop relationships and pathways and the Committee received assurance that the Unplanned Admitted Care Programme will improve control of elements of the pathway risk. However, key performance indicators do not provide assurance that controls are operating effectively at present. This risk links with SR17.	Medical Director	Quality Committee	8
Balance the books, invest in our future	*Low*	*SR5*	Financial efficiency, forecasting and accountability is not seen as a priority for service managers or our wider workforce, resulting in overspending, poor budgetary management which could lead to poor service delivery and regulatory action.				Partial	The Committee received assurance that the training to support staff with managing finanicial matters is being delivered. The Committee is assured that the cost improvement programmes (CIPs) are closely monitored. The Committee is reasonably assured that controls are generally adequate but because of the number of CIPs rated as 'red' is of the view that greater focus is needed on developing robust CIP plans and moving them to a green assured position as quickly as possible.	Chief Finance Officer	Finance and Investment Committee	16
	Low	*SR6*	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities				Limited	Although we are starting to develop a greater understanding of our business there are still significant gaps. Divisions still lack capacity and capability to fully understand efficiency opportunities in their business.	Director of Efficiency and Transformation	Finance and Investment Committee	20
	Low	*SR7*	We do not have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories. This results in the Trust having incomplete plans and management action becoming reactive.				Limited	The Committee is assured that the financial and operational plan for 2018-19 is in the final stages of development but assurance that this risk is controlled remains limited until reporting against the plan across the first quarter of 2018/19 demonstrates its delivery.	Chief Finance Officer	Finance and Investment Committee	15
Champion team St George's	*Low*	*SR8*	Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative/punitive or does not foster accountability amongst our workforce.				Partial	Staff survey results have moved in a positive direction and the Committee is assured that the staff engagement programme is being delivered. The Committee has reasonable assurance that controls are generally adequate and effective but there are areas where further improvement is needed.	Director of HR and OD	Workforce and Education Committee	10
	Moderate	*SR9*	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.				Partial	The Annual Communications Survey has been carried out and is being analysed, this is a source of assurance on the control of this risk and will be available in the first quarter of 2018-19. Assurances available for SR8 are also relevant to this risk. The Board is assured that the controls are in place assurance on effectiveness is partial at present.	(CEO) Director of Corporate Affairs	Board	12
	Low	*SR10*	We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction and poor care for patients.				Partial	Key performance indicators for mandatory and statutory training and appraisal give partial assurance but improvement is needed for the Committee to be confident that the controls are effective.	Director of HR and OD	Workforce and Education Committee	9
	Moderate	*SR11*	We fail to develop our future leaders and we fail to provide clarity to them about their roles and accountabilities, which leads to low job satisfaction, high turn-over and on-going instability amongst our senior leaders.				Partial	The operational restructure designed to clarify roles, responsibilties and accountabilities is being implemented and the Kings Fund leadership development programme is underway. The Committee continues to be assured that the controls are generally adequate. However, assurance on the effectiveness of the controls is not available at present.	Director of HR and OD	Workforce and Education Committee	9
Build a better St George's	*Low*	*SR12*	Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.				Limited	The Committee heard that a prioritised work plan will be presented to the Board in May. The continuing level of risk is much higher than the Committee is content to accept and assurance remains limited on the control of this risk.	Chief Information Officer (CIO)	Finance and Investment Committee	20
	Low	*SR13*	Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting delivery and risking patient safety.				Limited	The Committee heard that the Premises Assurance Model (PAM), a key source of assurance, is currently being populated. The Board is to recieve an update paper in April and a Board seminar is planned for May. Assurance reports are being collated from the Authorised Engineers (external assurance). A full PAM review is being undertaken in July. Currently there is limited assurance due to lack of a centrally maintained information repository.	Director of Estates and Facilities	Finance and Investment Committee	15
	Low	*SR14*	We are unable to secure the investment required to address our IT and estates challenges and as a result are unable to transform our services and achieve future sustainability.				Limited	A bid for additional funding will be submitted to NHSI in May. The Trust is also investigating other sources of funding to help support capital funding; for example leasing and managed service contracts.	Chief Finance Officer	Finance and Investment Committee	16
Develop tomorrow's treatments today	*High*	*SR15*	We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.				Partial	The Committee is assured that the control of this risk is generally adequate while recognising that strengthening the links between the University and the Trust through the Joint Research Committee will improve their effectiveness.	Medical Director	Quality Committee	12
Build a better St George's	*Moderate*	*SR16*	We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clincial service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.				Limited	The Board agreed the strategy process and timescales in the March meeting. Two non-executive directors have been identified to act as links to the strategy development. The Board receives assurance from the monthly clinical strategy development highlight report which outlinines progress. Gaps in control remain regarding capacity to deliver, the recruitment to the two strategy posts is delayed as it is linked to the operational restructure of the Clinical Divisions; the Director of Financial Planning is not in post until the end of May.	(CEO) Director of Strategy	Board	12
	Moderate	*SR17*	A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.				Limited	The Board receives assurance through the partnership highlight report for this risk. The Director of Strategy has built relationships with key stakeholders both within and outside SWL; for key stakeholders regular meetings are in place; in addition the DoS regularly attends the relevant SWL Health and Care Partnership meetings. The CEO continues to provide a lead role within the Acute Provider Collaborative and at the SWL HCP system-wide Programme Board.	Chief Executive	Board	12

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	31 May 2018	**Agenda No**	**4.3**
Report Title:	Annual Self-Assessment of Compliance with Foundation Trust Licence		
Lead:	Stephen Jones, Director of Corporate Affairs		
Report Author:	Stephen Jones, Director of Corporate Affairs		
Presented for:	Approval		
Executive Summary:	Each year all Foundation Trusts must make a submission of their self-assessment of compliance with their licence conditions. The submission covers three licence conditions: • Appropriate risk management processes and systems are in place (condition G6) • There are sufficient resources to deliver services over the coming 12 months (condition CoS7(3)) • The Trust has appropriate governance structures and systems in place (condition FT4(8)) • The Trust has provided adequate and appropriate training to its Governors.		
Recommendation:	The Board is asked to review and approve the proposed response in each area so that the submission can be uploaded by the deadline.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five key themes: Safe, Effective, Caring, Responsive and Well-led		
Single Oversight Framework Theme:	Well-led		
Implications			
Risk:	N/A		
Legal/Regulatory:	An assessment of compliance with licence conditions is required annually.		
Resources:	There are no resource implications.		
Previously Considered by:	N/A	**Date**	N/A
Equality Impact Assessment:	N/A		
Appendix:	Key Questions and Proposed Response		

Annual Self-Assessment of Compliance with Foundation Trust Licence
Trust Board Meeting, 31 May 2018

1.0 PURPOSE

1.1 This paper sets out the Trust's self-assessment against its Licence.

2.0 BACKGROUND

2.1 NHS Improvement (NHSI) requires all Foundation Trusts to self-certify annually on three licence conditions and one further activity, the training of Governors. NHSI will ensure compliance by auditing selected trusts' responses.

3.0 WHAT IS REQUIRED?

3.1 The Trust must self-certify that it:

i. Has appropriate risk management processes and systems in place (condition G6)
ii. Has sufficient resources to deliver services over the coming 12 months (condition CoS7(3))
iii. Has appropriate governance structures and systems in place (condition FT4(8))
iv. Has provided adequate and appropriate training to its Governors.
v. The submission is made online.

3.2 For each condition or activity the Trust must either:

i. Confirm it has complied with the specific requirement; or
ii. Confirm it has not complied with the specific requirements, and explain why.

3.3 Where the Trust has complied, there is no option to include free text. However for the illustrative purposes, an explanation has been provided where the Executive team believes the Trust to be compliant. This is shown in italics and will not form part of the submission.

3.4 The deadline for submission of all self-certifications except for FT4 is 31 May 2018. For FT4 it is 30 June 2018, but there is no reason not to provide all responses at the same time. Submissions must also be published.

4.0 SELF-ASSESSMENT

4.1 The self-assessment set out at appendix 1 proposes to the Board that the Trust is compliant with all three conditions.

4.2 In relation to licence condition CoS7 (sufficient resources to deliver services over the coming 12 months), we propose to confirm that we are compliant. As the commentary explains, this is on the basis that the Trust has in place an annual plan which has agreed by the Board and submitted to NHS Improvement. While the plan forecasts a 2018/19 deficit of £29m and the Trust remains in financial special measures, we consider that the plan – and the fact that it has not been challenged by NHSI – provides the assurance that we can reasonable meet this licence condition. Last year, however, the Trust reported that it was non-compliant with CoS7 and at that point in time it did not have in place an agreed annual plan. Given the fact that the Trust remains in financial special measures, the Board is asked to consider whether it is content to approve a self-certification of compliance in relation to this condition.

5.0 RECOMMENDATION

5.1 The Board is asked to review and approve the proposed response in each area so that the submission can be made.

APPENDIX 1

Key Questions and Suggested Responses:

G6: Has the Trust taken appropriate steps to establish, review and maintain systems to identify and effectively manage risks?

Suggested response: Confirmed. *The Trust has taken appropriate steps to establish sound arrangements for risk management in the Trust. Following the external governance review conducted in 2017/18, the Board has developed and agreed a Board Assurance Framework. This is reviewed at each Board meeting and is supported by the Chief Nurse and DIPC and by the Director of Quality Governance. The Board has reserved four risks for itself, with the other BAF risks assigned to the Committees of the Board for assurance. Risks on the Corporate Risk Register are scrutinised monthly by the Risk Management Executive. Further work to refine the system of risk management at executive level is being taken forward as part of plans to refine the operation of the Trust Executive Committee.*

FT4(8): Does the Trust have in place the governance systems necessary achieve the objectives set out in the licence condition?

Suggested Response: Confirmed. *Guidance is that for 'confirmed' there should be effective Board and committee structures, reporting lines, and performance and risk management systems in place. Following the external review of governance undertaken in 2017/18, the Trust made changes to strengthen its Committee structures, reporting lines and risk management systems. While there is more the Trust intends to do in 2018/19 to improve its governance further, the scope for this does not prevent the Trust reporting compliance against this licence condition.*

CoS7(3): Does the Trust have a reasonable expectation that it will have the required resources available to deliver designated services for the next 12 months? These resources include management resources, financial resources, and facilities, personnel, physical and other assets.

Suggested Response: Confirmed. *The Trust is under both quality and financial special measures. However, unlike in May 2018 the Trust has in place an annual plan for 2018/19 which has been agreed by the Board and has been submitted to NHS Improvement. The plan forecasts a 2018/19 deficit of £29m and achieving this is subject to the delivery of an identified cost improvement programme. The Trust recognises that aspects of its IT infrastructure and estate, in particular, need to be addressed but does not regard this as posing a risk to the resources available to deliver services in the next 12 months. Management resources have been enhanced through substantive appointments to the Board and though other senior appointments. This is being further strengthened through a divisional restructure.*

Training of Governors: Has the Trust taken steps to ensure Governors are equipped with the skills and knowledge they require?

Suggested Response: Confirmed. *All new Governors receive a welcome letter from the Chairman and are invited to meet with the Membership Manager to complete their Code of Conduct and discuss what sort of training and induction they require. Governors, including those elected in February 2018, had a briefing on the role and responsibilities of Foundation Trust governors, NHS finances, and how services are commissioned on 21 February 2018. Governor visits have been organised to the Advanced Skills Lab (6 March 2018) and Queen Mary Hospital (23 April). In addition, governors have been invited to take part in PLACE inspections at both the Tooting and Roehampton sites. Governors also had an induction briefing on the major strategic issues facing the Trust on 10 May 2018. All Governors are both notified of and encouraged to attend events for Governors to increase their skills and knowledge and are supported to attend the NHS Providers*

Annual Conference for Governors. Governors receive Parts 1 and 2 Board papers and are welcome to attend Part 2 of the Board as well as the sub-Board Committees. This ensures Governors have a range of information available to help them perform their roles effectively. For 2018/19, we are establishing a new Membership Engagement Committee of Governors to review and improve the Trust's membership engagement strategy. We are also