Trust Board Meeting

Date and Time: **Thursday 25th October: 10:00 – 13:30**

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 on 27 September 2018**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
10.35	**1.5**	**CEO's update**	**Jacqueline Totterdell** Chief Executive	Inform	Report
QUALITY & PERFORMANCE					
10:45	**2.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
10:55	**2.2**	**Integrated Quality & Performance report**	**James Friend** Director of Delivery, Efficiency & Transformation	Inform	Report
11:00	**2.3**	**Elective Care Recovery Programme**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
11:05	**2.4**	**Cardiac Surgery report**	**Andrew Rhodes** Medical Director	Inform	Report
11.15	**2.5**	**Patient Partnership and Engagement Strategy**	**Avey Bhatia** Chief Nurse & DIPC	Approve	Report
11:25	**2.6**	**Transformation update: Q2 report**	**James Friend** Director of Delivery, Efficiency & Transformation	Inform	Report
11:35	**2.7**	**Learning from Deaths: Q2 report**	**Andrew Rhodes** Medical Director	Assure	Report
FINANCE					
11:45	**3.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
12:00	**3.2**	**Month 6 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
WORKFORCE					
12:05	**4.1**	**Workforce and Education Committee Report**	**Stephen Collier** Committee Chair	Assure	Report
12:15	**4.2**	**Diversity and Inclusion Strategy**	**Harbhajan Brar** Director of HR & OD	Approve	Report
STRATEGY					
12:25	**5.1**	**Corporate Objectives 2018-19: Quarterly update**	**Suzanne Marsello** Director of Strategy	Review	Report
12:35	**5.2**	**Trust Strategy Highlight Report**	**Suzanne Marsello**	Inform	Report

Time	Item	Subject	Lead	Action	Format
			Director of Strategy		
GOVERNANCE					
12:40	**6.1**	**Audit Committee Report**	**Sarah Wilton** Committee Chair	Assure	Report
12:55	**6.2**	**Board Assurance Framework**	**Avey Bhatia** Chief Nurse & DIPC	Approve	Report
13:05	**6.3**	**Board sub-Committee Terms of Reference:** • **Finance and Investment Committee** • **Audit Committee**	**Stephen Jones** Director of Corporate Affairs	Approve	Report
CLOSING ADMINISTRATION					
13:10	**7.1**	**Questions from the public**	-	-	Oral
	7.2	**Any new risks or issues identified**	**All**	-	-
	7.3	**Any Other Business**	**All**	-	-
	7.4	**Reflection on meeting**	**All**	-	Oral
13:15	**PATIENT/ STAFF STORY**				
13:30	**CLOSE**				

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

Date of next meeting: Thursday 29 November 2018, 10.00 – 13.00

Barnes, Richmond and Sheen Rooms, Queen Mary's Hospital

Trust Board
Purpose, Meetings and Membership

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

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

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

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting

Thursday 27 September 2018, 10:00 – 13:30, Hyde Park Room, St George's Hospital

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

Feedback from Walkabout

Members of the Board gave feedback on the departments they had visited ahead of the meeting. These included: Genetics, Cheselden Ward, Medical Physics, Marnham Ward, Mortuary, Rose Centre, Pharmacy, Nye Bevan Unit, Grey and Vernon Ward.

The DS reported that the Genetics team had presented a joint pilot project between the university and the hospital around gene sequencing for drug regimes which was intended to optimise patient benefits. The team were currently recruiting volunteers for a discreet and limited testing of gene sequencing and were actively seeking volunteers for this research. Cheselden Ward had a stable workforce. It currently held bronze accreditation and staff were eager to achieve gold but the ward faced some estates challenges including lack of storage for hoists and some VDUs which were not working. The DS reported that the ward was clean, calm and patients spoke extremely highly of nursing staff.

The DCA reported that Marnham Ward, which dealt with patients with respiratory issues, was performing strongly on the prevention of pressure ulcers, work that had been supported by NHSI. There was currently a 22% vacancy rate, but newly qualified nurses were starting shortly. The ward

held bronze accreditation but was eager to reach gold, and was getting ready to go live with the new work stations on wheels. Some estates issues were reported in relation to storage. Ann Beasley added that the team learned the ward had been named after an eminent doctor and suggested the Trust consider installing commemorative plaques to explain the naming of wards. The team heard from Medical Physics staff that the department was one of the most effective in the country for carrying out in-house repairs of medical equipment and that the department had generated approximately £500,000 of income. Medical Physics was essentially an ED for medical equipment.

Stephen Collier reported on a visit to the Mortuary and commented the Trust should be proud of the facilities for bereaved relatives. Mortuary staff reported significant challenges in recruitment. Working practices appeared well established but opportunities appeared to exist around standardisation of processes and closer working with the bereavement service which was not currently co-located. The Mortuary were planning for a Human Tissue Authority (HTA) inspection in December and further work was underway to strengthen quality governance.

The DDET reported that the team had visited the Blue Sky satellite pharmacy, originally intended to provide pharmacy services to paediatric ambulatory care but which was in fact servicing the whole of paediatrics and Lanesborough wing. The pharmacy team were proud of the significantly improved processing of discharge medications. The new pharmacy robot had been installed. The team heard from the Chief Pharmacist that further utilisation of the robot's capability would enable pharmacists to be realised for increased clinical practice. Rose Centre staff reported that they liked working in the centre which was a clean and fresh environment but that often outpatient staff rotated and were not able to get used to processes easily. A new matron was seeking to address this. Tablets for collating Friends and Family Scores were felt to be working well and the CN confirmed these had been rolled out across all outpatient areas.

The ADEF reported that the Nye Bevan unit, a surgical assessment unit, was very impressive and that leadership appeared to be strong. The unit had increased the number of direct discharges by 55% and the Senior Nurse had offered several further ideas for transformation. Staff reported a concern around the time it took for the orthopaedic team to respond. The team heard from Vernon ward staff that they had a passionate Senior Sister. However, two ward clerks were on long term sickness absence and there were delays with discharge letters. A new Clinical Nurse Specialist had made a difference to the service. Grey ward had recently experienced some leadership challenges which the Matron was actively working to resolve. Estates issues included two bathrooms being out of action. Grey staff fed back that there was good multidisciplinary working.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed members of the public and a number of the Trust's Governors. Apologies had been received from Tim Wright, Sir Norman Williams and Kevin Howell, for whom Jenni Doman was deputising.
Declarations of Interest	
1.2	There were no declarations of interest to note. The ADEF stated that she was present to deputise for the DEF and was not present in her role as Staff Governor at the Trust.
Minutes of previous meetings	

1.3	The minutes of the meeting held on 30 August 2018 were agreed as a true and accurate record.
Action log and matters arising	
1.4	The Board noted the action log and the following updates: • Those actions proposed for closure were agreed to be closed. • TB. 26.07.18/ 87: The Chairman advised that a helpful report had been presented to the Quality and Safety Committee however there was still further work to be done – the action was to remain open. The remaining actions were not yet due.
1.5	**CEO's update**
	The CEO reported that, during the previous month, the Trust had agreed with NHS Improvement and NHS England that patients requiring some of the most complex cardiac surgery would be treated at other London hospitals. This would enable the service the space required to introduce the improvements recommended by the independent report from Professor Bewick. Following discussions with the Trust, Health Education England (HEE) had withdrawn trainees from the cardiac surgery unit for an initial period of six months. Work was ongoing to implement the recommendations of the Bewick Report and there some evidence of improved multidisciplinary team working. The CEO reported that finances at month five were not where they needed to be at this stage in the financial year; action to improve the financial position was a key priority and steps were being taken to achieve this. Quality improvement continued with positive cultural change being promoted through the work of the Quality Improvement Academy. The CEO advised that Dr Richard Jennings had been appointed as Chief Medical Officer. She also congratulated Jenny Muir for having been appointed as Chief Nursing Information Officer, an important new post in the organisation working alongside the Chief Clinical Information Officer. The Board noted that the Annual Members' Meeting would take place that evening with a programme of events running throughout the day.
QUALITY & PERFORMANCE	
2.1	**Quality & Safety Committee Report**
	Jenny Higham reported on behalf of the Committee Chair that the Quality Improvement Dashboard had revealed a deterioration in Duty of Candour performance in Children's and Women's Services which had now been rectified and more resilience had been created to ensure there was no recurrence. Although the number of reported c:*difficile* cases had increased compared with the previous year, the Committee had been assured that there had been no lapses in care. The Committee were informed of the impressive work undertaken to improve clinical records storage and of the on-going actions arising from the thematic analysis of Serious Incidents which had begun to show a decrease in the numbers declared, particularly in relation to falls. The Committee had received a further report following thematic analysis of recent

	maternity serious incidents and had received assurance that there was no underlying trend but that actions to address training issues around interpretation of CTG monitoring were underway. The Committee heard that of approximately 1,000 health and safety issues reported across the previous six months, a significant proportion related to violence and aggression and sharps injuries. The Committee had challenged what additional actions could be done to reduce these types of incident. The Committee also received a report summarising the root cause analysis of all 12 hour trolley breaches and had noted that four of the six breaches reported related to delays in mental health beds being made available. The Committee was assured that work was underway to work more closely with neighbouring mental health trusts to remedy this. The CN confirmed that going forward the Committee would receive regular updates on progress against the CQC Action Plan in addition to the Quality Improvement Plan. **TB.27.09.18/97 Ensure regular reporting of CQC Action plan through QSC** The Board noted the report.
2.2	**Integrated Quality & Performance Report**
	The DDET reported that there had been some areas of improved performance as evidenced in the report. He reminded the Board that the Trust was the only Trust which reported its theatre and outpatient productivity publicly. The CN reiterated that in relation to patient experience tablets had now been introduced across all outpatient areas to collect Friends and Family Test (FFT) feedback. However, low response rates in the Emergency Department were still a challenge and new ways of tackling this were needed. This was a potential quality improvement project. An internal audit report upon FFT was due to come to the Audit Committee in October. The MD advised that in relation to mortality, the HSMR rate had increased and the SHMI had decreased. However, analysis by the Trust Mortality Monitoring Committee of the HSMR data had revealed that there had been some issues with the HSMR data as presented. The statistics were nevertheless better than expected and Dr Foster analysis had shown no new trends. Sarah Wilton asked about the progress of work undertaken to improve the complaints process and whether the required improvements had been delivered as planned. The CN responded that significant improvements in response rates had been seen and that the service was much improved but that it was still not stable. The CN confirmed that a full report would be submitted to the Quality and Safety Committee in October. The DHROD reported that agency use had continued to exceed the cap and this largely related to the use of interims. To address this, clear exit plans had been requested in each case. The vacancy rate was significantly improved at almost 10% and an electronic solution to improve appraisal processes would be coming on line shortly. The Chairman queried the timescale for implementation and the DRHOD confirmed it would be in the new year. In response to Stephen Collier's query around whether there was yet any feel for the impact of pan-London rates, the DRHOD advised that implementation across London had been patchy and as such it was too soon to tell.

	The Board received the report.
2.3	**Cardiac Surgery**
	The MD updated the Board upon progress against the 15 recommendations made in the Bewick report. He set out the steps already taken, and reminded the Board that some of the actions recommended by Professor Bewick, including appointing a new senior clinician to lead the service were longer term actions. Sarah Wilton requested a specific update on recommendation 14.b and 15, querying when these would happen. The MD confirmed that an SOP had been drafted and was due to be signed off the following week. The Chairman emphasised the importance of this update coming to the public Board meeting to provide assurance on progress in improving the service. The Board noted the report.
2.4	**Infection Prevention and Control Annual Report**
	Dr Peter Riley emphasised that the Trust had performed very well with the lowest number of cases of all teaching hospitals in 2017/18, but stressed that it was important not to be complacent. Infection control audits had shown positive progress throughout the year, in particular the introduction of the PISA model (Period of Increased Surveillance Audit) which would be triggered after a case of c:*difficile* on a ward and which had shown to help increase compliance across infection control audits. Dr Riley commended the work of the Anti-Microbial Stewardship group in the work undertaken which was fundamental to reducing the number of c:*dificile* cases. Dr Riley highlighted that surgical site surveillance, whilst improved, could benefit from further focus. He also reported that point of care testing for flu in ED, cohorting of patients, and the high levels of staff who had received the flu vaccine had resulted in the Trust performing extremely well across the previous winter. Dr Riley responded to a query from Sarah Wilton noting that the anti-microbial programme was undertaken every year and informed the antibiotic guidelines. Further, he was focussing on improving compliance across antibiotic audits, for which the target was 95%. The Chairman commended the team for their hard work and congratulated them upon the clear improvements achieved. The Board received and approved the report.
2.5	**Elective Care Recovery Programme**
	The COO summarised that the report provided a regular update to the Board providing assurance as to the Trust's ability to demonstrate readiness to commence shadow reporting for a period of three months. The aim remained that the Trust would return to reporting nationally in Q4 2018/19. The Board agreed the recommendation and noted the report.
2.6	**Quality Improvement Academy Report**
	The DDET presented the report and confirmed that this was the first regular quarterly update to the Board. The report set out how the team were shaping the Quality Improvement methodology to support wider and longer term pieces of work around cultural change, aligned to the CQC's Well Led domain. The DDET explained that a baseline assessment had been undertaken in March following which it had been important for Executive Directors to champion quality improvement work. The DHROD commented that achieving cultural change was important but inevitably took time to deliver.

	Sarah Wilton queried how the role of the Patient Experience and Engagement Panel aligned with this work. The DDET clarified that they would have an important role, adding that the team had presented to the panel earlier that week on the work of the Quality Academy. The Chairman reiterated the importance of achieving cultural change and the role of the Board in providing strong leadership in this area. The CEO referred to the forthcoming Board development day where the Board would be focussing in part on this. The Board agreed the recommendations and noted the report.
2.7	**Child Safeguarding Annual Report**
	The CN confirmed that the report had been discussed in detail at the Quality and Safety Committee. The CN confirmed that at the start of this financial year the team had begun to focus increasingly on integration with other services and had sought to ensure the correct resource was in place. Data capture had improved significantly since April and the CN cautioned that following comparison with the first quarter of the current year, the data contained within the report for 2017/18 was most likely to account for only one third of the actual activity. The CN updated the Board in relation to the Prevent agenda and advised that a new strategy had been launched and mandatory training was almost nearing the target of 85% of staff trained. The CN concluded that the Trust was delivering its statutory duties in relation to safeguarding children in line with the Act. The Chairman thanked the CN and team for the further work undertaken to improve the report and queried how confident the Board could be that staff were picking up the potential for other adults or children from the same household who may be victims of abuse. The CN confirmed that the training offered to staff focussed strongly upon wider consideration of other siblings and women. The DHROD also confirmed this was a focus of the HR team in relation to staff concerns. The Board received and approved the report.
FINANCE	
3.1	**Finance & Investment Committee Report**
	Ann Beasley reported that the Committee had received a detailed update from the DEF on risks within Estates and Facilities. The Committee had discussed ED performance at length, which was not where it needed to be and had noted that the COO had put in place additional support to address this. This could not be a long term solution, however, and remained a continuing concern. The Committee had considered the reasons for the shortfall in activity and had reflected on the need to set service-specific targets with tighter monitoring. The Committee had discussed the plans to recover the financial position and had noted CIPs were not on track which was a concern given the trajectory was becoming increasingly challenging. Ann Beasley also reported that cash management appeared to have been well gripped and it had been good to see planning for next year underway. Jenny Higham asked what the Executive response was to the worsening financial position. The CFO responded that there was a firm collective view that if something was not now done to arrest the shortfall it would become increasingly difficult to recover the position. The

	Chairman cautioned that the Board would need to see an improved position next month as would NHSI or confidence levels would fall. The Board noted the report.
3.2	**Month 5 Finance Report**
	The CFO reported that the Trust was currently £4.1m adverse to plan and that urgent action was required to recover the position. Failure to do this by month six would result in the Trust not qualifying for PSF funding. The Trust had achieved Q1 PSF funding of £2m and that the ED performance component of quarter two would be achieved, which amounted to 30% of the overall total of around £2.5 - £3m. However, at this point it looked very likely that the position may not be sufficiently recovered at end of month six for in order to qualify for the remaining 70%. The CFO stated that it was important now to understand what action the Trust needed to take to ensure it qualified for quarters three and four. The DDET offered assurance that there were 19% more elective bookings than two months ago. In addition, the operational teams had worked hard to improve data quality in order to convert activity into income. This was noted and the COO agreed to extend the Board's thanks to the team for the improvements achieved. The Board noted the report.
GOVERNANCE	
4.1	**Medical Revalidation Report**
	The MD informed the board that it was an annual requirement for the board to consider the statement of compliance which stated that that the medical workforce was fit for purpose, was of the right calibre and that this had been demonstrated through appraisal and the revalidation process. The MD advised that, in the coming year, a new IT system for revalidation would strengthen the process through triangulation of Serious Incidents, complaints and appraisals. Sarah Wilton noted the forthcoming improvements and asked whether the Board could be fully assured in order to make the required approvals. The MD stated that the revalidation of doctors was essential in order for them to practice and that this was the test from which the Board could draw assurance. However, he emphasised that the Trust recognised there was further work that could be done to strengthen the process and ensure that appraisals are of good quality. The Board approved the report.
4.2	**Fit and Proper Persons Test**
	The DHROD presented the report and reminded the Board that in 2016 the Trust had received a warning notice regarding the implementation of the Fit and Proper Persons test. Earlier in the year, the Board had agreed that a quarterly report should be brought to the Board until such time that it was sufficiently assured that the Trust was fully and consistently compliant with its obligations. The DHROD advised that the regulation may shortly be widened to include a legal duty upon Trusts to act on victimisation and welcomed this addition. The DHROD stated that the Trust was compliant and was now at the point where reporting to the Board could revert to an annual cycle.

	TB 27.09.18/98 Move to annual cycle of FPPT reporting. The Board agreed the recommendation to move to annual reporting and noted the report.
4.3	**Staff Survey**
	The DHROD updated the Board that the next staff survey would be undertaken between 8 October and 30 November. The report set out the actions taken in relation to the last staff survey which had been reported in detail to the Workforce and Education Committee. The Chairman commented that the Board did not spend significant time discussing culture and that this would be addressed. The DHROD clarified that the actions highlighted had been completed but were on-going, for example the work around publicising the role of the Freedom to Speak up Guardian. Sarah Wilton welcomed the fact that the Freedom to Speak Up Guardian and Whistleblowing audit report would be coming to a forthcoming Audit Committee and the DHROD confirmed that once the audit report was finalised a separate action plan to address the findings would be developed. In response to Sarah Wilton's second query around improving the quality of appraisals, the DHROD confirmed that the electronic system discussed earlier would address this and ensure a systematic quality assurance mechanism for all appraisals. The Chairman was keen to see quicker progress on the action point about thanking staff for good work. She also stated that the pipeline for patient stories to Board could be improved significantly so as to ensure the Board was effectively learning from these. The Board noted the report.
CLOSING ADMINISTRATION	
5.1	**Questions from the public**
	Elspeth Carruthers, junior doctor raised a concern on behalf of around 240 colleagues about the display of posters around the hospital site advising that costs may be recovered from non-UK residents receiving care. Ms Carruthers asked if the Trust would consider removal of the posters and whether an equalities impact assessment had been carried out in order to ensure the most vulnerable groups in society were not discouraged from seeking treatment. The CFO confirmed that the posters were displayed following a Department of Health (DH) national initiative to optimise recovery of payment from those who were not eligible to receive free care. The CFO advised that standard template had been used and agreed to review the wording of the posters with the aim of making it clearer that emergency care was free to all and that there was no requirement to pay upfront. In response to a question from Khaled Simmons, a public Governor, as to whether the cost to the NHS was quantifiable the CFO confirmed that the Finance and Investment Committee would be looking at this, and this would be reported back to the Board in future.
5.2	**Any new risks identified**
	No new risks were identified.
5.3	**Any Other Business**
	No other items of business were raised.

5.4	**Reflection on the meeting**
	The Chairman reflected that it had been helpful not to repeat the discussions which had been held at Board sub-committees, whose role it was to provide assurance to the Board. The Board agreed that it would be helpful to continue to move more reporting to the public meeting as opposed to private Board.
	STAFF STORY
	Dr Stephen Brecker, Consultant Cardiologist and Mr Graham Shaw, British Airways Pilot presented the recent safety initiative in the Cardiology Catheter Labs to improve patient safety using lessons learned from the aviation industry. Using a critical factors methodology, the aim of the initiative, which was bespoke to the Cardiology Department, was to embed cultural change and empower staff to innovate in order to improve safety and challenge what they may consider to be unsafe practice. The Board heard from a consultant within the team who reported that the initiative had been driven by consultants and had, for the most part, been embraced as positive. The consultant explained that he had felt better supported by colleagues as a result and that safety was central to the team's work. In response to the DHROD's question around how to engage the most junior of staff the team explained that this started with something as simple as the consultant introducing themselves on first name terms in order to break down traditional barriers which could prevent staff from feeling empowered to raise concern when they felt this was appropriate. The MD stated that it was hugely important, if the Trust was to bring about the type of culture change required, to take forward this kind of learning. The CEO commented that it was testament to the great leadership that the initiative had been so well adopted in Cardiology. It was agreed that ways of incorporating the methodology into the on-going work of the Quality Academy would be explored.

Date and time of next meeting: Thursday 25 October 2018, 10:30 – 13:30
Hyde Park Room, St George's Hospital

Trust Board Action Log - August 2018

Action Ref	Theme	Action	Due	Lead	Commentary	Status
TB. 28.06.18/85	**Workforce & Education Committee Report**	Diversity and inclusion Board seminar to be arranged	26.07.18	DHROD & DCA	Item on D&I on agenda. Follow up Board workshop planned for new year.	OPEN
TB. 26.07.18/87	**Corporate Objectives 2018-19**	Information from both formal and informal clinical audits to be used as a learning tool to prevent recurrence of SIs and NEs	27.09.18	CN	To be considered at QSC meeting in November.	OPEN
TB. 26.07.18/88	**Corporate Objectives 2018-19**	RAG rating methodology to be reviewed by executive team	31.10.18	DS	On agenda	PROPOSE FOR CLOSURE
TB. 26.07.18/94	**Board Assurance Framework**	Board workshop on BAF to be arranged	30.08.18	CN/DCA	Provisional date, as an additional Board workshop, identified for Nov 2018.	OPEN
TB.27.09.18/97	**Quality & Safety Committee Report**	Trust CQC Action plan: Regular updates to come to QSC and TB - to be added to the Trust Board Planner	31.10.18	DCA	Reflected on QSC and TB forward planner	PROPOSE FOR CLOSURE
TB.27.09.18/98	**Fit and Proper Persons**	Move from quaterly reporting to annual reporting to Trust Board	31.10.18	DHROD/DCA	Reflected on QSC and TB forward planner	PROPOSE FOR CLOSURE
TB.27.09.18/99	**Public Questions**	Review content of poster providing advice upon recovery of treatment costs for patients not resident in the UK	31.10.18	CFO/DCA	CFO due to meet with trainee doctors to discuss the concerns raised.	PROPOSE FOR CLOSURE

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 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 – October 2018

In this month's report to the Trust Board, I want to talk about important developments at a national level, as well as matters closer to home.

Our strategic environment:

Much is being made of the evolving NHS Long Term Plan, and rightly so – the next decade is a crucial one for the health service, and it is important providers like St George's are fully involved in its development.

I attended a meeting of provider NHS Trusts on Monday, and this was helpful in understanding how the plan is developing, and what benefits it might bring for acute Trusts, as well as the wider healthcare economy.

At a more operational level, NHS Improvement has recently published their proposals for the 2019 national tariff, which all Trusts are being asked to share their views on.

The proposals include some important changes – including a change to the default way of paying for urgent and emergency care – and this is something we will be keen to comment on, as are the recalculated marked forces factor values.

NHS Improvement has also published its first snapshot of the make-up and diversity of NHS provider boards – and it makes interesting reading.

The clear findings at a national level are that, despite some attempts to make Boards more diverse in terms of gender and ethnicity, Trusts are not doing enough.

We know we have a diverse workforce here at the Trust, and that this reflects the different communities we serve. However, the NHSI report is a reminder that we all need to do more in terms of our approach to diversity in the workplace, and that this must begin at the top of the organisation if it is something we expect the rest of our staff to value, and take seriously.

Our performance:

Last month's Board meeting represented a significant milestone for the Trust, as we formally agreed to begin the process that will, all being well, end with us being able to report our 18 week/ referral to treatment data for St George's again.

It is important we don't underestimate the significance of this milestone. This is something the Trust hasn't done since June 2016 so – provided we meet a set of criteria over the coming months – we expect to be in a position to start reporting again in the New Year.

Thanks to our elective care team, we now have robust waiting list data, and information about our patient pathways at St George's that we can trust – so it's a massive step forward for the organisation.

Of course, the ability to report robust and accurate data is something we should be doing routinely anyway, and it is the least our patients expect.

However, to have reached this point from where the organisation was two years ago – when some patients were effectively 'lost' on our waiting lists - is positive news, and a sign of real progress.

Elsewhere, one of our organisational priorities is to build a better a St George's, and a big part of this is improving the clinical systems we expect staff to use.

Matt Hancock, the new Secretary of State for Health and Social Care, rightly talks about the importance of agile IT to a modern healthcare service – and we are doing our best to upgrade the systems we expect staff to use here at the Trust.

With this in mind, I am delighted that we have this month started the roll-out of iClip (Cerner Millennium) to all inpatient wards at St George's.

I visited two wards at St George's as they were going through the go-live process and, whilst there were teething problems, these are to be expected, and the overwhelming response from staff has been extremely positive.

The roll-out of iClip will remove the increased clinical risk experienced by patients that move between 'paper' and electronic wards, and means staff will have access to electronic clinical documentation (eCD) and electronic prescribing medicines administration (ePMA).

This is an exciting development for everyone and, once the roll-out at St George's is complete, we will turn our focus to Queen Mary's, where the potential gains of a move to iClip are much greater, given the current absence of a modern, fit for purpose patient administration system at the hospital.

Our people:

This month, we launched the annual NHS Staff Survey, the results of which are an important barometer of the progress we are making, and how staff feel about working at the Trust.

Last year's results showed us to be one of the most improved Trusts – but the latest NHS Staff Friends and Family test results suggest that staff are finding life a bit harder at present.

It's important we understand this in more detail, and the staff briefings I held at Queen Mary's and St George's in October gave me a good insight into what staff feel is working well, but also where frustrations and significant challenges still exist.

On a positive note, there have been many things to celebrate in recent weeks – including fantastic media coverage, and (as important) recognition for groups of staff that regularly go above and beyond, but don't always get the limelight.

In the past week alone, I have spoken at a Trust event to mark the first ever National Allied Health Professional Day, as well as a celebration of National Pharmacy Technician Day.

I was struck at both events by the role these crucial professions play in the day to day running of our services – even if they don't always grab the limelight. For this reason, it is so important we recognise the work they do, and the contribution they make.

Three of our staff who were the subject of media headlines this month were Mr Zahid Mukhtar, Consultant Paediatric Surgeon; Dr Ruchi Kabra, Consultant Interventional Neuroradiologist and Professor Asma Khalil, Consultant Obstetrician.

Zahid , Ruchi and Asma were all named in the prestigious Evening Standard Progress 1000 list. The list is made up of the top 1000 most influential people in London, which is a huge achievement; and we were the only hospital to have three clinicians featured.

St George's Hospital Charity:

We received a helpful update on the work of St George's Hospital Charity at the Trust Executive Committee this week.

First of all, I am delighted to welcome Amerjit Chohan as Chief Executive of the charity. I have already met with Amerjit, and I was struck by his enthusiasm for the role, and his desire (and that of the charity's Trustees) to support the work of our staff, and the services they provide.

Amerjit has taken over from Paul Sarfary, who was Acting Chief Executive until the end of last month – and has now reverted to his role as a Trustee of the charity.

The work of the charity us vitally important to the Trust, and the update to TEC evidenced just some of the investments they've made – from software to help our maxillofacial colleagues, through to a new portable echo machine for our excellent Heart Failure Clinic.

Our relationship with the charity is so important, and I can only see it going from strength to strength over the coming weeks and months.

Other business:

I can confirm that there have been two uses of the Trust seal since the last Trust Board meeting. These relate to securing a new lease for use of the Blood Transfusion Unit at the Cranmer Terrace entrance to St George's; and the creation of new space on the ground floor of Queen Mary's for our Children's Therapy Service.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 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 18 October 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 – October 2018

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 18 October 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 and noted that for the majority of indicators the report told a story of improvement and of sustained performance. The Committee asked for further information on the metrics relating to duty of candour which had shown a significant deterioration in July, some improvement was shown in August but it continued to be significantly behind the target. The Director of Quality Improvement was able to provide information for September which was not available at the time of report, in September performance had improved to 97%. The Committee received a separate report on complaints performance where performance for 40 day responses had deteriorated. The number of staff responding to the staff friends and family test had increased to 346 from 222 in quarter 1; the Committee noted that the recommendation of St George's as a place to work had fallen below the target for this quarter. The Director of Quality Improvement told the Committee that the display of information in the dashboard is being moved to SPC charts and that using red/amber/green for each month will stop. Using run charts will provide the Committee with more useful information about performance over time and enable them to see more easily if there is improvement or not.

2. Trust Action Plan in response to CQC inspection 2018

The Committee heard from the Quality Improvement Director that the action plan in response to the CQC inspection in March 2016 which sets out the 'must do' and 'should do' actions is being monitored through the Operational Delivery Group weekly. Actions are escalated to the Chief Nurse if progress is not on track. The Committee felt reasonably assured by the report that the 'must do' and 'should do' actions will be achieved. The Committee noted that actions are not agreed as delivered until evidence is provided to the Quality Improvement Director and verified by the Chief Nurse.

3. Integrated Quality & Performance Report

The Committee received the report and noted that the Trust declared four serious incidents in September, with a total of 23 incidents year to date. A case of MRSA bacteraemia has been reported, this is the first case in 14 months, root cause analysis suggests that this arose from a pneumonia. There had been two cases of C.diff which brings the year to date number to 17 against a threshold of 15 for the year. The Medical Director informed the Committee that he had just been notified by South West London Pathology about a possible incident concerning a plasma transfusion, the patient involved has not been harmed but the incident may be a never event. The incident will be investigated and the Committee will be updated at its next meeting. Seven of the eight cancer targets are being achieved but the Committee heard that the September performance for the 62 day target looks challenged and is unlikely to be achieved.

4. Offender Healthcare Quality Report

The Committee received the Offender Quality Report and learnt that Her Majesty's Inspectorate of Prisons and the Care Quality Commission undertook an unannounced inspection of HMP Wandsworth in February and March 2018. The inspection of health services which are provided by a consortium arrangement between the Trust and South London and the Maudsley NHS Foundation Trust, formed part of a wider inspection of the prison services. Healthcare services at the prison are not given a separate rating but the overall theme of the inspection report was that 'healthcare was a reasonably good and developing service', the CQC found that the regulations were being met and identified two areas of good practice. The Committee commented on the improvement in the service and asked if more support was needed with safeguarding given the amount of self-harm seen in the prison population, the Clinical Lead for Offender Healthcare told the Committee that there is some room for improvement and that this is led primarily by the prison.

5. Patient Safety and Quality Group

The Committee received the report from the September PSQG. The Group had received the PLACE report and noted that scores for the St George's Hospital site had improved in seven of the eight domains, with meeting the needs of people with a disability being the exception. The site scores for Queen Mary's Hospital showed an improvement in three domains, the scores in the other domains fell slightly but remained well within the national average. The update on the Ward Accreditation scheme was attached and the Committee heard that one ward required improvement; the ward is being supported with an improvement plan in place which is being delivered.

6. Looked after Children Annual Report

The Committee received the annual report for 2017/18 from the Chief Nurse. The service is commissioned by Wandsworth Clinical Commissioning Group on behalf of the Wandsworth Children's Specialist Services. In late 2015, OFSTED inspected Wandsworth Children's Specialist Services and the overall rating given was 'inadequate'. An increase in the number of children being looked after occurred immediately following this which placed further pressure on the service. The number of children has continued to rise and an increase in number of posts has been challenging. All children taken into care should have an initial Health Assessment undertaken and healthcare plan within 20 days of the child becoming looked after. Performance against this indicator was poor with rates of between 0% and 18.2% per month a significant drop on the previous year. In almost all cases this was because notifications and referrals were received very late. The target was adjusted to achieve a healthcare plan within 15 days of a receipt of referral. In quarter four performance against this indicator was good at 84.4%

The Committee noted the Trust was working with Local Authority colleagues to ensure appropriate information is received within time and a joint operational meeting has been established with the Local Authority and CCG to review current processes and systems of escalation. The Local Authority Team also have an action plan to address backlog and have met regularly with the Chief Nurse to monitor progress and will report into the Trust Safeguarding Children meeting. The committee noted that there appeared to be some conflict of interest in the dual roles carried out by the designated doctor which needed to be understood and acted upon if necessary.

7. Cardiac Surgery

The report is also being presented to the October meeting of the Board. The Committee noted that the recruitment of junior trust grade medical staff has started and that the consultant establishment is now complete, two locums have joined the team. A standard operating procedure for the daily multi-disciplinary team (MDT) meeting has been agreed and MDT meetings are being held every morning and appear to be functioning better than previously.

8. Current Complaints Performance

The Committee noted its disappointment that the performance for the more complex complaints that have a 40 day response time had dropped significantly in July to 47%. The Director of Quality Governance agreed but was able to assure the Committee that the performance in August has shown improvement and is currently at 68%. In July the Trust received 25% more complaints than in other months. The Committee asked what confidence it could have that the targets would be achieved, and heard that for 25 day responses performance is within 5% of trajectory and should be achievable for complaints received in September. There is some evidence of an improvement in the quality of responses from the reopen rate which is below threshold.

9. Patient Partnership and Experience Strategy

The Chief Nurse presented the Patient Partnership and Experience Strategy for approval by the Committee. The strategy sets out the vision for engaging with service users, carers and families and has been developed by the Patient Partnership and Engagement Group which includes our patient partners, staff and other stakeholders. The strategy has been consulted on widely. The Committee approved the strategy.

10. Learning from Deaths Q2

This report is also being presented to the October meeting of the Board. The Committee heard from the Associate Medical Director that the national programme to establish the medical examiner role requires trusts to have this role in place by April 2019.

11. Board Assurance Framework

The Committee has delegated responsibility from the Board for receiving assurance on four strategic risks SR2, SR3, SR4 and SR15. The Committee heard that two risks have been escalated from the divisional risk registers to the BAF and contribute to SR2. CVT1660: risk to patient safety within cardiac surgery and CCAG1025: risk of closures of cardiac catheter labs due to age of equipment. Both risks are scored 15 (extreme). One risk contributing to SR2 has had a reduction in risk score approved by the Risk Management Executive. CRR0011: reputation risks arising from failing to achieve the emergency care operating standard, the risk score has been reduced from 15 to 12 (high).

The Committee agreed the risk scores for the four strategic risks – no change from quarter 1 scores. The Committee agreed that the assurance rating for SR2 should change to 'partial' assurance based on the assurances received for the Elective Care Recovery Programme and some improvement in performance against the 4 hour emergency operating standard. No change to the assurance ratings for SR3, SR4 and SR15 from quarter 1.

St George's University Hospitals NHS
NHS Foundation Trust

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excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 25th October 2018
Reporting period – September 2018

Outstanding care, every time

OUTSTANDING CARE, EVERY TIME

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE & PRODUCTIVITY** PERSPECTIVE	Activity Summary	Bed productivity (length of stay)	Outpatient productivity (Attendances per day)	Theatre productivity (cases per session)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations		
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

September 2018

Daycase and Elective Surgery operations

Actual
4,567

Target 4,882

Discharges before 11am

Actual 17.28%

Target 30%

Four Hour Emergency Standard

Actual
90.26%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
96%

Target 95%

Outpatient First Appointment

Actual 15,744

Target 16,072

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
90%

Target
88%

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

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

		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Sep-17	Sep-18	Variance	Plan Sep-18	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	13,541	13,789	1.83%	13,933	-1.04%	83,202	83,760	0.67%	84,993	-1.45%
Inpatient	Elective & Daycase	4,512	4,567	1.22%	4,882	-6.45%	27,397	28,621	4.47%	29,771	-3.86%
	Non Elective	3,791	3,960	4.46%	4,100	-3.41%	23,274	23,760	2.09%	25,003	-4.97%
Outpatient	OP Attendances	52,394	52,966	1.09%	53,783	-1.52%	312,268	328,034	5.05%	327,264	0.24%

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

Source: SLAM

Executive Summary – September 2018

St George's University Hospitals NHS
NHS Foundation Trust

Our Outcomes

- The area of greatest delivery challenge to the trust remains around Elective activity through our Theatres. Workforce planning, operational processes bottlenecks, including booking capacity, combine to mean that the Trust is under utilising main theatre capacity. An activity Recovery Plan is in place to provide assurance over the aspects of the delivery control framework and to set out eleven key improvements required.

Finance and Productivity

- Elective and Daycase activity is currently showing below plan however there is a considerable level of data catch up. Cases per session are below previous highs in Cardiothoracic, Trauma & Orthopaedics and General Surgery and as a Trust below the same period last year. Recent improvements have been seen within Oral and Maxillo Facial Surgery and Urology. Theatre touchtime utilisation is tracked weekly and is currently performing at 77% against the 85% threshold targeted. The number of daycase procedures per working day have seen an increase compared to the same month last year by 14 cases and elective by 4 cases, the best productivity so far we have seen this year. However year to date Elective patients is down by 8% following July and August position.

Our Patients

- The Trust reported two patients with attributable Clostridium Difficile infection in September, against an annual target set at 30 cases in 2018/19. There was also one reported case of MRSA Bacteraemia. The Trust is reporting seventeen cases year to date and is above the threshold trajectory for the period between April and September.
- Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns.

Process

- Performance against the Four Hour Operating Standard in September was 90.3%, which was below the monthly improvement trajectory of 95%. The improvement trajectory requires the delivery of 93% performance in October 2018 and relies upon continued improvement in the experience for patients not requiring admission.
- The Trust achieved six of the seven national mandated cancer standards in the month of August, continuing to achieve 14 day standard and 62 day compliance.
- Focus remains on reducing on the day non clinical cancellations and ensuring that all patients are rebooked within 28 days which has seen a significant improvement in August re-booking 84.1% of patients within 28 days.

Our People

- Staff sickness remains above the trust target of 3% for the month of August.
- Non-medical appraisal rates have seen a 2.1% improvement. Performance in August was 69.7% against a 90% target.
- For September, the Trust's total pay was £10k adverse to the plan and agency pay £40k adverse to plan.

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

Directorate	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Discharges in the last month	Average length of Stay 2017-18	Average length of Stay 2018-19	Variance	Trend
Acute Medicine	2.8	2.9	3.0	3.2	3.4	3.5	2.8	2.9	2.7	2.6	2.7	2.6	2.7	2474	3.0	2.7	-0.29	
Cardiothoracic	8.5	8.2	9.2	8.8	9.4	8.3	9.0	9.0	8.7	7.8	8.5	8.9	8.8	256	8.8	8.6	-0.16	
Childrens & Women	3.4	3.4	3.4	3.0	3.8	3.7	3.4	3.6	3.6	3.2	3.5	3.5	3.0	917	3.5	3.4	-0.14	
Neurosciences	10.7	10.1	9.5	10.6	9.4	8.7	10.6	8.9	10.6	11.6	9.4	9.6	6.2	255	9.4	9.4	-0.03	
Senior Health	19.3	19.2	8.9	9.5	9.9	9.3	8.4	11.3	10.2	11.8	7.4	12.1	7.9	86	11.5	10.1	-1.39	
Specialist Medicine	8.4	7.0	6.8	9.7	7.7	9.7	7.6	6.1	9.2	7.3	6.4	8.6	6.9	245	7.7	7.4	-0.32	
Surgery & Trauma	4.4	5.0	4.6	4.4	4.8	5.0	4.3	4.6	4.0	4.6	3.7	5.0	4.2	910	4.5	4.3	-0.15	
Theraputics	18.0	20.7	7.8	17.2	6.1	7.5	13.2	9.8	9.8	3.6	19.2	8.3	15.9	27	11.8	11.1	-0.68	
Grand Total	**4.4**	**4.6**	**4.4**	**4.6**	**4.7**	**4.8**	**4.4**	**4.4**	**4.3**	**4.3**	**4.1**	**4.4**	**3.8**	**5,170**	**4.5**	**4.2**	-0.23	

Briefing

- Over the last twelve months patients admitted to the hospital via an emergency pathway spend on average 4.4 days in a hospital bed, this includes patients with a zero length of stay. At Trust level this remains in line with National Model Hospital data.
- Compared to the previous year the Trust has seen a reduction in length of stay across all Directorates improving bed workflow and reducing the number of patients waiting for a hospital bed to become available from the Emergency Department
- The implementation of a fully embedded ambulatory care unit within Acute medicine continues to enable rapid access to same day assessment, diagnostics and treatment and increased usage of the discharge lounge.

Actions

- The Unplanned and Admitted Patient Care Programme is working to roll-out the SAFER and Red 2 Green initiatives to ensure that patients do not stay in hospital longer then necessary and that every patient moves towards discharge everyday.
- The Trust have held two successful “Minimum Standards for enabling patient flow and High Performing team” combined workshop event with engagement from clinicians, nursing and therapy staff. Minimum Standards for enabling patient flow is a clinician led framework that facilitates the safe discharge of patients who no longer require acute care and enables admission for those that do
- Commenced the roll out of the live tableau new real time non-assigned bed report to help operational colleagues identify bed availability
- The Trust is deploying iClip (Cerner Millenium) to the rest of the inpatient wards. This consists of electronic medical & nursing documentation (clindocs) and electronic Prescribing and Medicines Administration (ePMA).

Length of Stay

Elective Length of Stay (Excluding Daycase)

														Average length of Stay			
Directorate	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Discharges in the last month	2017-18	2018-19	Variance	Trend
Cardiothoracic	4.3	4.8	4.4	4.4	4.5	4.2	4.8	4.1	4.0	4.4	4.1	4.4	2.9	181	4.6	4.0	-0.60	
Childrens & Women	2.6	2.4	2.1	3.6	2.8	2.0	2.1	2.3	3.2	2.7	2.1	2.1	3.1	76	2.7	2.6	-0.11	
Neurosciences	12.0	7.5	9.8	11.3	11.9	7.8	12.7	8.7	7.3	12.8	7.1	8.9	9.7	175	10.1	9.1	-0.99	
Surgery & Trauma	3.7	4.4	4.5	4.0	4.4	3.1	3.2	3.8	4.1	3.7	3.3	4.3	3.5	390	3.9	3.8	-0.15	
Grand Total	**5.1**	**4.8**	**5.2**	**5.4**	**5.7**	**4.1**	**5.2**	**4.6**	**4.6**	**5.5**	**4.1**	**4.8**	**4.7**	**822**	**5.1**	**4.7**	-0.35	

Briefing

- Over the last twelve months patients admitted to the hospital via an elective pathway spend on average 4.9 days in a hospital bed, a reduction in length of stay has been observed compared to the previous years meaning patients can be discharged home ealier following their procedure.
- The Trust has observed significant improvement within Neurosciences compared to last year reducing the length of stay of our planned patients by one day.

Outpatient Productivity

First Outpatient Attendances (average per working day)

Directorate	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	First Outpatient Attendances 2017-18	2018-19	Variance	Variance	Trend
Other	67	31	35	31	33	35	33	42	38	41	40	34	32	54	38	-17	-30.5%	
Cardiothoracic & Vascular Services	70	62	72	53	65	59	63	65	62	63	60	54	51	66	59	-7	-10.7%	
Childrens Services	54	49	51	44	50	47	42	46	50	47	44	42	46	47	46	-1	-1.9%	
Neuro	78	89	98	81	91	85	90	97	83	80	77	67	75	83	80	-3	-3.4%	
Renal & Oncology	22	26	25	21	23	24	23	27	27	29	25	25	22	23	26	3	10.9%	
Specialist Medicine	141	142	156	129	151	152	155	154	153	150	148	129	135	145	145	0	0.1%	
Surgery	259	283	279	240	249	248	257	294	271	287	277	252	259	257	273	16	6.2%	
Womens Services	79	82	79	76	81	74	73	91	85	88	94	83	78	80	87	7	8.2%	
T&O	51	44	54	40	51	47	57	61	56	57	65	50	52	50	57	6	12.5%	
Total	**821**	**808**	**849**	**715**	**794**	**771**	**794**	**877**	**827**	**840**	**829**	**735**	**750**	**806**	**810**	**4**	**0.5%**	

Follow Up Outpatient Attendances (average per working day)

Directorate	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	FollowUp Outpatient Attendances 2017-18	2018-19	Variance	Variance	Trend
Other	91	89	84	76	89	88	81	110	98	90	93	86	90	89	95	5	5.8%	
Cardiothoracic & Vascular Services	110	113	119	96	119	107	103	135	116	108	112	100	102	111	112	2	1.5%	
Childrens Services	87	82	88	73	82	81	73	80	81	69	81	76	78	79	78	-1	-1.5%	
Neuro	102	96	116	98	112	104	112	127	113	108	114	104	108	102	112	10	9.7%	
Renal & Oncology	218	209	204	193	206	197	200	228	217	218	240	219	228	210	225	15	7.3%	
Specialist Medicine	467	461	494	442	500	489	524	555	520	478	533	475	501	484	510	27	5.5%	
Surgery	350	361	367	327	361	346	349	394	374	341	366	335	336	353	358	5	1.4%	
Womens Services	46	50	64	55	65	61	49	55	58	49	67	58	63	53	58	5	10.1%	
T&O	80	83	87	75	79	73	80	93	81	79	90	77	77	80	83	2	3.0%	
Total	**1,551**	**1,541**	**1,623**	**1,437**	**1,612**	**1,545**	**1,571**	**1,776**	**1,659**	**1,540**	**1,695**	**1,531**	**1,582**	**1,560**	**1,631**	**71**	**4.5%**	

Briefing

- Across the Directorates, First Outpatient attendances averaged 750 per working day, this is an increase compared to previous months and below the same month the previous year. The RAG rating applied compares to the SLA plan per working day which continues to be met.
- Follow-up attendances on average are in line with previous months activity and remains above plan, however new to follow up ratios are above where we need them to be against target.

Actions

- Switch off for paper referrals from Primary Care took place from July 2nd 2018 with eRS (electronic Referral Services) being the only commissioned access method.

Outpatient Productivity

First and Follow Up Ratio

Directorate	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	First to FollowUp Ratio 2017-18	2018-19	Variance	Variance	Trend
Other	1.35	2.87	2.37	2.51	2.68	2.49	2.44	2.62	2.58	2.20	2.33	2.53	2.81	1.90	2.51	0.61	32.0%	
Cardiothoracic & Vascular Services	1.58	1.81	1.66	1.80	1.84	1.80	1.63	2.08	1.87	1.71	1.87	1.85	2.00	1.68	1.90	0.22	13.0%	
Childrens Services	1.61	1.68	1.74	1.68	1.65	1.74	1.76	1.74	1.62	1.47	1.84	1.81	1.70	1.69	1.70	0.01	0.5%	
Neuro	1.31	1.07	1.19	1.20	1.24	1.23	1.24	1.31	1.36	1.35	1.48	1.55	1.44	1.24	1.42	0.17	14.0%	
Renal & Oncology	9.79	7.94	8.28	9.39	8.77	8.07	8.67	8.44	8.04	7.52	9.60	8.76	10.36	9.04	8.79	-0.25	-2.8%	
Specialist Medicine	3.32	3.25	3.17	3.44	3.30	3.22	3.38	3.60	3.40	3.19	3.60	3.68	3.71	3.35	3.53	0.18	5.5%	
Surgery	1.35	1.27	1.31	1.36	1.45	1.40	1.35	1.34	1.38	1.19	1.32	1.33	1.30	1.37	1.31	-0.06	-4.5%	
Womens Services	0.58	0.61	0.81	0.73	0.80	0.82	0.67	0.60	0.68	0.56	0.71	0.70	0.81	0.67	0.68	0.01	1.8%	
T&O	1.56	1.86	1.59	1.86	1.56	1.56	1.40	1.52	1.45	1.39	1.38	1.54	1.48	1.60	1.46	-0.14	-8.9%	
Total	**1.89**	**1.91**	**1.91**	**2.01**	**2.03**	**2.01**	**1.98**	**2.03**	**2.01**	**1.83**	**2.04**	**2.08**	**2.11**	**1.94**	**2.02**	**0.08**	4.1%	

First and Follow Up DNA Rates (by month)

Directorate	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	DNA patients in the last month	Patients not attending rate 2017-18	2018-19	Variance	Trend
Cardiothoracic & Vascular Services	8.7%	9.4%	9.6%	9.6%	9.9%	9.3%	10.3%	10.8%	10.2%	9.4%	12.2%	10.2%	9.4%	284	8.8%	10.4%	1.6%	
Childrens Services	10.9%	11.5%	12.1%	13.3%	11.5%	12.4%	13.3%	16.0%	14.1%	12.9%	14.2%	13.1%	10.0%	318	10.4%	13.4%	3.0%	
Neuro	8.0%	8.3%	7.3%	8.0%	9.3%	9.7%	9.2%	10.8%	10.9%	8.5%	9.5%	9.4%	10.0%	417	8.4%	9.8%	1.4%	
Other	11.5%	10.6%	12.7%	12.0%	10.6%	11.5%	14.0%	10.0%	9.5%	11.6%	12.9%	13.8%	12.4%	1,243	10.8%	11.7%	0.9%	
Renal & Oncology	9.2%	10.4%	10.1%	10.9%	11.8%	11.2%	10.6%	10.6%	11.0%	8.1%	11.1%	11.0%	10.5%	366	13.0%	10.4%	-2.6%	
Specialist Medicine	11.4%	11.9%	10.5%	12.2%	12.3%	12.7%	11.7%	14.3%	13.1%	11.3%	11.4%	11.8%	11.6%	1,532	10.9%	12.2%	1.3%	
Surgery	9.8%	9.6%	10.0%	10.1%	10.3%	10.1%	10.7%	12.1%	11.7%	9.0%	10.9%	10.9%	10.2%	1,364	9.9%	10.8%	0.9%	
Womens Services	8.0%	7.5%	7.4%	9.6%	7.9%	7.2%	8.4%	8.6%	8.7%	7.3%	8.4%	9.8%	8.2%	640	9.3%	8.5%	-0.8%	
T&O	10.8%	10.7%	11.0%	11.4%	12.0%	12.6%	12.0%	11.8%	13.7%	8.4%	9.2%	11.0%	10.7%	361	10.0%	10.8%	0.8%	
Grand Total	10.1%	10.4%	10.3%	11.0%	11.1%	11.2%	11.5%	12.6%	12.0%	10.1%	10.9%	11.3%	10.6%	6,525	10.2%	11.3%	1.1%	

Briefing

- The Netcall text reminder service has been bedded in during June and a reduction in DNA rate was seen. September observed an increase in the number of patients not attending their appointment with all areas seeing a negative decrease however in line with seasonality. September reports a DNA rate of 10.6%.
- Both Renal & Oncology and Women's services have seen a reduction in DNA rates compared to last year.

Actions

- Continue to roll out Netcall and develop two way text interaction to enable patients to rebook
- The migration to electronic Referral Services should enable patients to select the appointment date and time best suited to them

Theatre – Touch Time Utilisation

Theatre Utilisation

Main List Specialty	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Number of Patients in the last month
Cardiothoracic	90%	76%	89%	81%	76%	69%	74%	64%	79%	81%	75%	74%	69%	70%	64
ENT	75%	74%	79%	74%	71%	70%	75%	77%	75%	81%	77%	80%	84%	76%	144
General Surgery	77%	83%	80%	83%	78%	79%	78%	77%	79%	78%	80%	82%	79%	82%	185
Gynaecology	77%	79%	79%	76%	77%	84%	77%	78%	73%	76%	74%	81%	78%	70%	144
Neurosurgery	78%	76%	83%	86%	76%	81%	77%	83%	76%	87%	80%	74%	84%	78%	140
Oral and Maxillo Facial Surgery	73%	58%	72%	81%	50%	82%	76%	62%	58%	71%	73%	89%	75%	82%	26
Paediatric Dentistry	56%	38%	56%	61%	61%	51%	46%	57%	62%	53%	50%	53%	58%	55%	40
Paediatric Surgery	82%	82%	79%	74%	83%	79%	78%	74%	78%	82%	80%	81%	78%	75%	114
Plastic Surgery	74%	76%	79%	75%	71%	68%	68%	69%	73%	74%	73%	77%	75%	75%	190
Renal Medicine & Surgery	55%	78%	75%	68%	74%	77%	74%	79%	67%	76%	71%	72%	78%	61%	26
Trauma & Orthopaedics	87%	82%	87%	96%	80%	82%	86%	80%	87%	76%	85%	84%	79%	82%	111
Urology	76%	83%	80%	82%	74%	75%	79%	79%	77%	84%	78%	88%	84%	84%	216
Vascular Surgery	70%	76%	78%	73%	66%	65%	75%	77%	77%	77%	76%	72%	68%	74%	61
Grand Total	**78%**	**78%**	**81%**	**81%**	**75%**	**75%**	**76%**	**77%**	**77%**	**79%**	**78%**	**79%**	**79%**	**77%**	**1,461**

Theatre Average Cases per Session

Main List Specialty	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Cardiothoracic	1.7	1.6	1.5	1.5	1.3	1.6	1.5	1.5	1.6	1.6	1.8	1.8	1.5	1.3
ENT	2.0	1.9	1.8	1.6	1.5	1.7	1.4	1.6	1.8	1.9	1.8	1.7	1.8	1.7
General Surgery	2.1	2.0	2.0	1.9	2.0	1.7	1.8	1.9	1.9	1.9	1.8	1.8	1.7	1.7
Gynaecology	2.7	2.7	2.6	2.8	2.5	2.6	2.0	2.9	2.6	2.6	2.6	2.9	2.7	2.8
Neurosurgery	1.2	1.1	1.3	1.3	1.1	1.2	1.2	1.2	1.2	1.2	1.1	1.1	1.1	1.0
Oral and Maxillo Facial Surgery	2.9	2.9	3.2	3.2	1.9	3.9	3.6	3.3	3.0	3.6	3.0	4.0	3.7	3.9
Paediatric Dentistry	4.4	4.1	3.7	4.7	3.8	3.6	4.0	4.3	4.3	3.7	4.2	4.0	3.8	4.1
Paediatric Surgery	2.6	2.3	2.5	2.6	2.5	2.5	2.6	2.7	2.4	2.6	2.4	2.6	2.6	2.7
Plastic Surgery	2.1	2.1	2.3	2.1	1.9	2.0	1.9	2.2	2.2	2.0	2.0	2.0	2.2	2.2
Renal Medicine & Surgery	2.1	1.5	1.5	1.4	1.7	1.5	1.8	1.3	1.8	1.5	1.7	1.4	1.4	1.3
Trauma & Orthopaedics	1.8	1.9	1.8	1.8	2.0	1.7	1.8	1.5	1.6	1.4	1.6	1.6	1.5	1.6
Urology	1.8	1.7	1.8	1.8	2.1	1.8	1.8	2.0	2.1	2.1	2.1	2.0	2.1	2.1
Vascular Surgery	1.0	1.1	1.2	1.1	1.0	1.0	1.2	1.2	1.2	1.3	1.0	1.1	1.2	1.2
Grand Total	**1.9**	**1.9**	**1.9**	**1.8**	**1.8**	**1.7**	**1.7**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**

Briefing

Touchtime Utilisation on average for the past 12 months is at 78% against a targeted threshold of 85%. Work is on-going across all specialties to support an increase in utilisation and increase in theatre case bookings

Actions

- Clinicians are reviewing their lists to verify patient order and appropriate case mix, this is linked to theatre team review identifying theatre equipment requirements, skill mix and specialist equipment to be ordered as required. A newly developed tool will be introduced to robustly look at the list planning process.
- Theatre Schedules are locked down after review
- Actions form the weekly list planning are reviewed and discussed which is further reviewed and supported by General Managers and services. All actions are reviewed in list planning the following week.
- Increase to baseline Patient Pathway Coordinator (PPC) numbers has been agreed for financial year 18/19 to provide additional bank support to the teams to streamline processes particularly around the pre-assessment pathway and build a pool of pre assessed patients.
- The booking teams (PPC) will commence using the Four Eyes Insight scheduling tool this will provide accurate activity planning information along with the ability to schedule lists at 95-105 %.

Number of Elective Patients treated per Working Day

														Average No. of Patients per month		
Months	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**2017-18**	**2018-19**	**Variance**
Cardiology	6	5	6	5	5	6	6	7	8	9	6	8	7	5	8	41%
Clinical Haematology	1	0	1	1	1	0	1	1	1	1	1	1	1	1	1	8%
Endoscopy	0	0	0	1	1	0	0	1	1	1	0	1	1	0	1	90%
ENT	5	7	6	5	5	5	6	4	5	5	4	3	6	6	4	-25%
General Surgery	5	5	7	6	5	6	7	5	5	5	4	4	6	6	5	-13%
Gynaecology	3	3	3	3	2	3	4	3	3	3	2	3	3	3	3	-14%
Maxillofacial & Dental	2	2	3	3	4	3	3	3	3	3	2	3	3	3	3	3%
Neuro Surgery	6	5	6	5	5	6	7	6	6	6	6	5	7	6	6	6%
Neurology	1	2	2	2	1	2	1	2	1	2	2	2	2	2	2	1%
Oncology	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	-24%
Other	6	6	7	6	6	6	7	6	6	8	6	5	6	6	6	-3%
Paediatric Medicine	1	1	1	1	1	1	0	2	1	1	0	2	0	1	1	27%
Paediatric Surgery	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	-8%
Plastic Surgery	7	6	7	7	5	6	6	5	6	5	2	2	4	6	4	-35%
Renal Medicine	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	-6%
Trauma & Orthopaedics	2	3	3	3	3	2	4	3	2	2	2	3	3	3	2	-22%
Urology	6	6	6	5	5	6	7	8	6	6	5	6	7	7	6	-11%
Vascular Surgery	3	3	2	3	3	4	4	3	3	3	3	3	3	3	3	4%
Grand Total	58	59	62	58	53	60	66	59	58	61	45	54	62	61	56	-8%

Briefing

- The number of daycase procedures per working day have seen an increase compared to the same month last year by 14 cases and elective by 4 cases, the best productivity so far we have seen this year. However year to date Elective patients is down by 8% following July and August position.

- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions this is linked to a weekly task and finish group, highlighting and unblocking issues for long term sustainability and change; the work from the task and finish group will be shared across all theatre services.

Actions

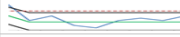
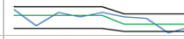
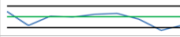
- Bespoke scheduling manuals for Day Surgery Unit services to support activity will be rolled out to inpatient services as phase 2
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases and utilisation.
- Identified data quality issues with informatics team which will identify increased theatre utilisation
- SNCT Division finance has completed service specific one pagers in conjunction with the FEI to identify actions required to support SLA achievement
- Additional admin support commenced on the 20th August for the centralised PPC team and is fully up to speed.

Number of Patient Daycases per Working Day

														Average No. of Patients per month		
Months	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**2017-18**	**2018-19**	**Variance**
Cardiology	9	9	8	7	8	9	7	7	8	8	9	8	8	8	8	-4%
Clinical Haematology	1	2	2	1	2	2	2	1	2	2	1	1	2	2	1	-20%
Diabetes/Endocrinology	2	2	2	1	1	2	1	2	2	1	2	2	2	2	2	13%
Endoscopy and General Medicine	53	52	49	53	46	51	50	54	60	60	55	55	56	53	57	7%
ENT	4	3	3	3	2	3	2	2	4	3	5	5	3	3	4	21%
General Surgery	5	4	5	4	4	4	4	4	5	5	5	4	5	4	5	16%
Maxillofacial & Dental	3	3	4	3	3	3	3	3	4	3	5	3	4	3	4	16%
Neuro Surgery	3	4	3	3	3	3	3	3	2	3	3	3	3	3	3	6%
Neurology	21	21	27	21	24	21	21	24	23	26	24	23	23	22	24	7%
Obstetrics and Gynaecology	7	8	8	6	7	7	7	7	7	7	9	8	8	7	8	8%
Oncology	1	1	2	1	2	1	1	1	1	1	1	1	1	2	1	-37%
Other	9	8	9	7	8	9	9	8	11	10	10	10	8	8	10	20%
Paediatric Medicine	7	8	8	8	9	8	7	9	9	7	10	8	8	8	8	2%
Paediatric Surgery	7	8	8	5	6	7	7	7	6	7	7	7	8	7	7	0%
Plastic Surgery	8	7	9	7	8	9	8	11	13	13	15	17	14	8	14	79%
Renal Medicine	3	3	3	4	4	3	3	4	4	4	4	4	4	3	4	25%
Trauma & Orthopaedics	4	4	5	5	4	4	4	4	5	5	6	4	4	4	5	11%
Urology	5	6	6	7	6	5	4	4	5	7	8	6	6	5	6	28%
Vascular Surgery	3	3	3	2	2	2	2	2	3	2	2	2	2	2	2	-8%
Grand Total	156	155	162	148	149	153	145	159	175	175	182	169	170	154	172	11%

Daycase as a percentage of all Activity	73%	72%	72%	72%	74%	72%	69%	73%	75%	74%	80%	76%	73%

Patient Safety

Indicator Description	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend (12 months)
Number of Never Events in Month	0	0	1	0	0	1	0	2	1	0	0	0	0	0	
Number of SIs where Medication is a significant factor	0	1	0	0	0	0	0	1	0	0	0	0	0	0	
Number of Serious Incidents	8 / mth	11	4	6	2	1	4	5	4	6	3	4	2	4	
Serious Incidents - per 1000 bed days	N/A	0.45	0.16	0.24	0.08	0.04	0.18	0.19	0.17	0.26	0.13	0.17	0.09	0.18	
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.7%	94.9%	95.0%	95.1%	94.9%	94.8%	94.3%	93.1%	95.3%	96.5%	94.9%	95.7%	96.3%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.3%	98.7%	98.1%	98.5%	98.9%	97.9%	98.5%	97.8%	98.0%	98.7%	98.5%	98.2%	99.0%	
Percentage of patients who have a VTE risk assessment	95%	95.4%	96.1%	96.4%	96.0%	95.4%	96.3%	96.0%	95.9%	95.8%	96.0%	96.9%	96.4%		
Number of Patient Falls	N/A	125	122	157	127	189	140	157	138	117	155	143	136	141	
Falls (Moderate and Above Severity)	N/A	0	2	1	3	1	2	2	3	1	1	1	1	0	
Number of patient falls- per 1000 bed days	N/A	5.15	4.89	6.23	5.17	7.49	6.15	6.05	5.77	5.01	6.70	6.11	5.91	6.27	
Acquired Category 2 Pressure Ulcers	N/A	18	7	16	13	16	13	12	2	6	10	20	15	9	
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.74	0.28	0.64	0.53	0.63	0.57	0.46	0.08	0.26	0.43	0.85	0.65	0.40	
Avoidable Category 3 & 4 Pressure Ulcers	0	2	0	0	0	0	0	0	5	0	2	2	3	2	
Avoidable Category 3 & 4 Pressure Ulcers per 1000 bed days	0	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.21	0.00	0.09	0.09	0.13	0.09	
Acquired Category 3 Pressure Ulcers				15	6	9	6	6	11	4	6	5	3	2	
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- No Never Events were reported in September
- The Trust declared four Serious Incidents in September, with a total of twenty-three incidents year to date.
- The number of falls reported in September were 141, equating to approximately 5 falls per day. Of the falls reported, all resulted in Low or No Harm.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had an Rapid Response Report completed. These are now reviewed by a panel chaired by the Chief Nurse to establish their avoidability. From April 2018 all grade 3 and 4 pressure ulcers are reported to the Board that have been acquired at St Georges. Historically only grade 3 or 4 pressure ulcers that met the threshold for Serious Incident declaration were reported. In September two patients acquired grade 3 pressure ulcers which following review were deemed to be avoidable.

Actions: The Falls co-ordinator is working with divisions, wards and falls champions to improve falls practice, promote best practice for falls prevention and is continuing to carry out bespoke falls education and training.

The Trust is participating in NHSI Pressure Ulcer Collaborative and focusing work on the 4 wards with the highest instance of pressure ulcers

Infection Control

Indicator Description	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD Actual	YTD Theshold	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	
Cdiff Incidences (in month)	30	1	4	0	0	0	1	2	6	1	3	3	2	2	17	15	
MSSA	25	1	1	2	3	0	3	1	2	2	1	1	2	1	9	12	
E-Coli	60	8	6	2	5	5	5	5	1	9	6	4	3	4	27	30	

Briefing

- The C Diff annual threshold for 2018/19 is 30 cases. For 2019-2020 the time limit for apportioning healthcare onset versus community onset is 48 hours rather than 72 hours. The data collected in 2018-19 for each Trust will be used to set the new targets for these categories. In the month of September the Trust reported two cases, totalling seventeen cases year to date.
- The Trust annual threshold for E coli is 60 for 2018-19 and year to date the Trust has reported twenty seven cases, four of which occurred in September.
- There are no National thresholds for MSSA bacteraemia at present however the Trust has set itself an internal target of a 10% reduction on last years position setting the threshold at 25 incidents for 2018/19 . The Trust is reporting nine cases since April 2018.
- There was one reported MRSA Bacteraemia in September and the Root Cause Analysis is underway.

Actions

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

The Trust is anticipating an NHSI collaborative to reduce E Coli infections, representation from this group includes colleagues from partner organisations and is multi professional

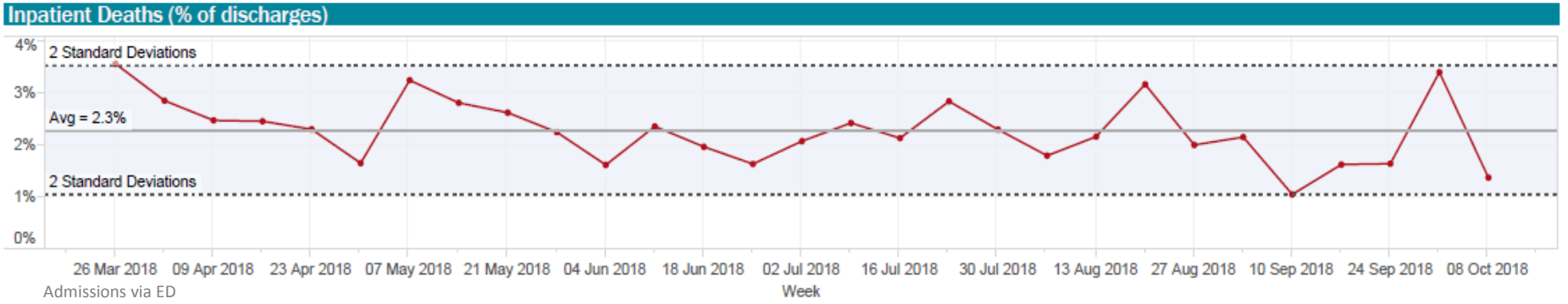
Mortality and Readmissions

Indicator Description	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	81.1	80.6	81.3	81.4	82.2	80.8	81.1	81.9	83.4	85.6	86.2	86.3	85.6	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	77.4	77.2	77.5	76.6	77	77.1	76.8	77.8	78.5	79.7	79.8	80.9	80.9	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	81.8	81.2	82	83.8	84.1	83.7	86.7	89.7	91.8	94.4	95.9	96.4	97.6	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.84	0.84	0.84	0.84	0.84	0.84	0.83	0.83	0.83	0.83	0.82	0.82	0.82	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	TBC	9.7%	10.2%	9.2%	9.4%	8.9%	9.0%	9.2%	8.7%	8.8%	8.3%	8.90%	8.10%		

Please note SHMI data is reflective of the period January to December 2017 based on a rolling 12 month period (published 19th July).
HSMR data reflective of period June 2017 – May 18 based on a rolling 12 month period (published 19th July).

Briefing

Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over performance and also under performance. In particular we are aware of mortality signals in cardiac surgery, general intensive care and total hip replacement surgery that are under investigation as well as a number of more discrete diagnostic and procedure codes from Dr Foster that are reviewed monthly by the Mortality Monitoring Committee.



Maternity

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

Indicator Description	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
C Section Rate - Emergency and Non Elective	28%	30.2%	29.7%	31.9%	25.4%	23.6%	23.1%	26.9%	25.4%	29.2%	26.7%	26.4%	22.4%	24.9%	
Admission of full term babies to neo-natal care		15	10	16	6	11	7	4	10	13	9	5	9	12	

The following ten metrics have been agreed for inclusion in this report going forward driven by the Maternity Dashboard.

1. Total births
2. Percentage of bookings before 12+6 weeks gestation
3. Total Caesarean section rate
4. Emergency Caesarean section rate
5. Number of hours during which Midwifery Led Unit (Carmen Suite) is closed
6. Unplanned Neonatal Unit admission >/= 34 weeks gestation
7. Hypoxic Ischaemic Encephalopathy
8. Stillbirths & Neonatal deaths </=7 days old
9. 3rd/4th degree perineal tears
10. Post partum haemorrhage (PPH) >1.5L

Patient Experience

St George's University Hospitals NHS
NHS Foundation Trust

Patient Voice

Indicator Description	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
Emergency Department FFT - % positive responses	90%	83.5%	86.4%	84.1%	86.5%	82.2%	81.0%	81.4%	84.0%	85.0%	85.5%	83.7%	84.6%	83.5%	
Inpatient FFT - % positive responses	95%	96.5%	96.5%	95.7%	95.6%	94.7%	96.0%	96.3%	97.2%	97.3%	97.1%	96.7%	96.6%	96.3%	
Maternity FFT - Antenatal - % positive responses	90%	100.0%		100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	92.6%	96.0%	100.0%	99.0%	90.4%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	98.7%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	100%	91.6%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	
Community FFT - % positive responses	90%	94.1%	98.9%	95.7%	96.5%	99.2%	93.3%	98.3%	97.1%	98.5%	98.3%	98.0%	98.4%	99.5%	
Outpatient FFT - % positive responses	90%	94.4%	96.3%	94.3%	98.2%	97.6%	96.1%	98.4%	97.3%	97.3%	97.4%	97.4%	97.1%	96.3%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		80	96	77	68	90	80	94	96	85	79	120	96	93	
PALS Received		203	198	305	262	290	236	259	264	317	292	337	294	335	

Briefing

- ED Friends and Family Test (FFT) – The score has seen a slight increase in September reporting 83.5% in the recommended rate..
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96.3% in September providing reasonable assurance on the quality of patient experience
- Maternity FFT – The score for maternity care remain above local threshold with work continuing to improve the number of patients responding.
- The number of complaints received in the month of September was 93, showing an increase compared to the same period last year. All complaints are assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days. For 25 day complaints received in August 71% were responded to within 25 working days, this is slightly below the trajectory (76%) to achieve 85% for complaints received in October 2018. For 40 day complaints received in July 47% were responded to within the timescale, in this month response times have fallen significantly below the 40 day trajectory (82%) to achieve 90% by the end of September. Alongside this disappointing drop in response time performance the number of complainants who have asked us to reopen their complaint fell to 6% for July complaints. July also saw a significant spike in numbers received with 25% more complaints received in July than is usual.

Actions

FFT action being taken to improve response rates includes: weekly feedback to all areas on their response rate, this is published on the Quality Posters at the entrance to the area; improving the accessibility of the FFT by increasing the number of tablets and using volunteers to assist patients with the survey; scoping other opportunities to improve accessibility for example putting FFT and other patient surveys on our public website.

Complaints and PALS: The weekly CommCell is being used to maintain organisational focus on meeting both timeliness and quality standards for complaint responses. There has been a significant improvement with responding to complaints in the time across the directorates. The 40 day complaints for July are being reviewed in detail to identify the reasons for the response timeline being missed and to identify the action needed to bring response times back on to the trajectory.

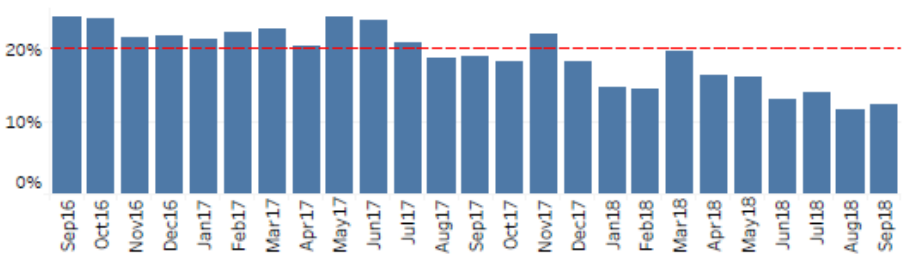
Patient Voice

CARING – Friends and Family Test

--- Target ¢ MetricMeasure Numerator Neutral Denominator

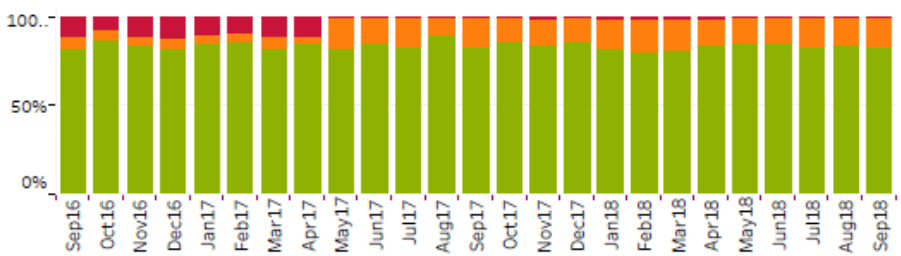
A&E Friends & Family Response Rate

Target: 20% Aug 18: 11.62% Sep 18: 12.29% Movement: ▲0.67%



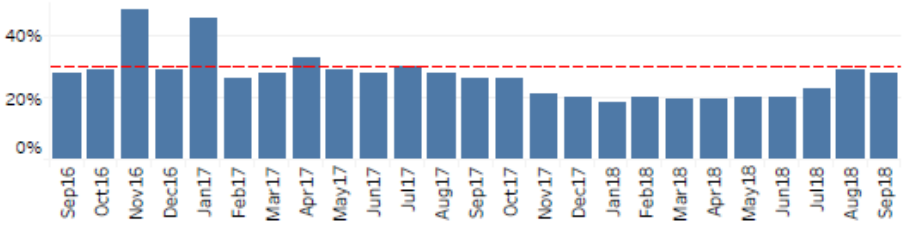
A&E Friends & Family Recommend Rate

The expected target is 90%



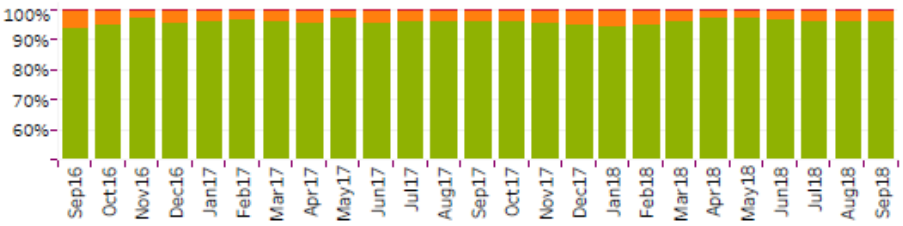
IP Friends & Family Response Rate

Target: 30% Aug 18: 28.62% Sep 18: 27.27% Movement: ▼-1.35%



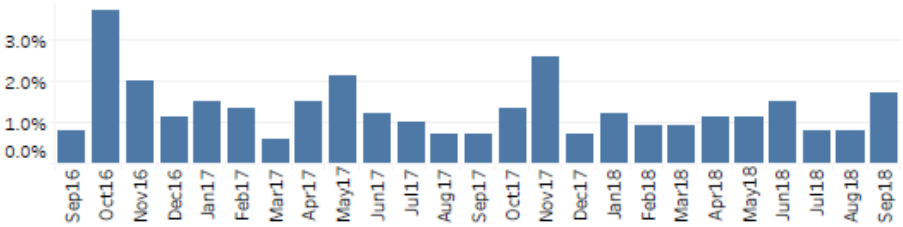
IP Friends & Family Recommend Rate

The expected target is 95%



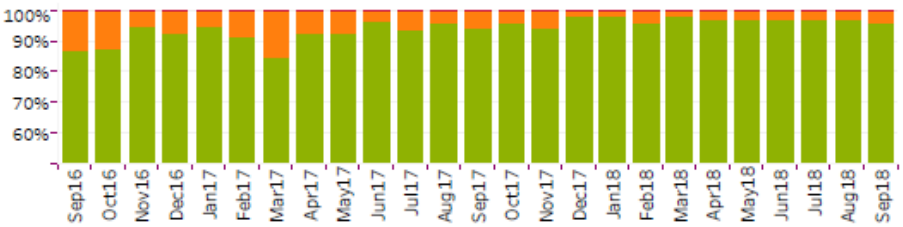
OP Friends & Family Response Rate

Target: 20% Aug 18: 0.80% Sep 18: 1.69% Movement: ▲0.89%



OP Friends & Family Recommend Rate

The expected target is 90%



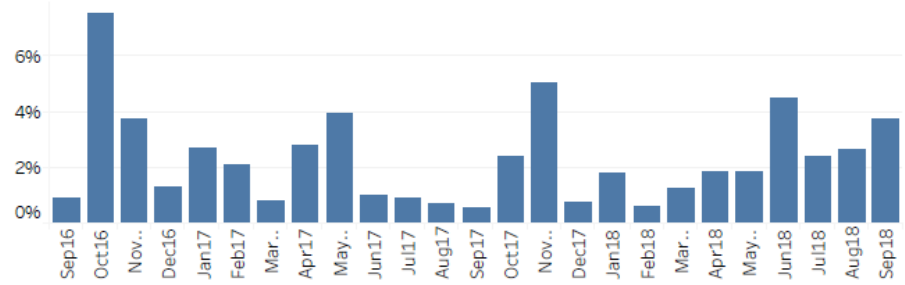
Patient Voice

CARING – Friends and Family 2

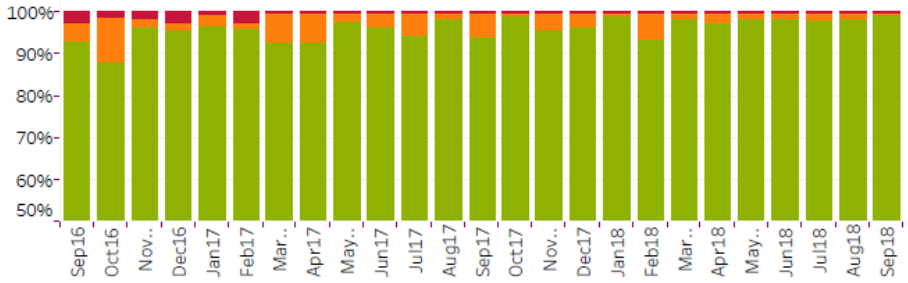
--- Target ¢ MetricMeasure Numerator Neutral Denominator

Community Friends & Family Response Rate

Target: 20% Aug 18: 2.63% Sep 18: 3.76% Movement: ▲1.13%

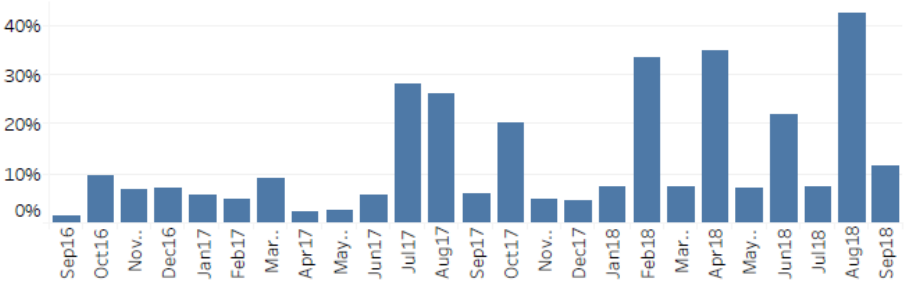


Community Friends & Family Recommend Rate
The expected target is 90%

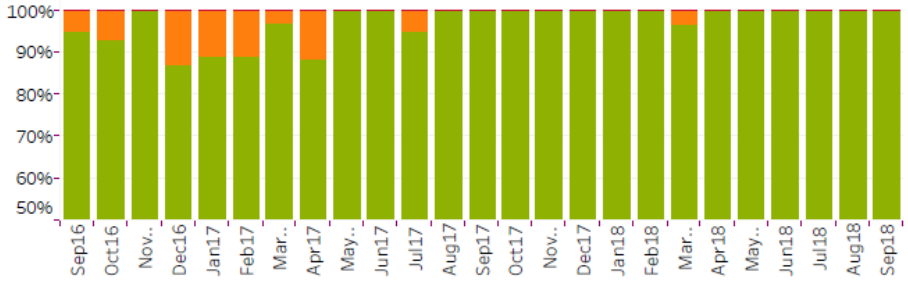


Maternity (Birth) Friends & Family Response Rate

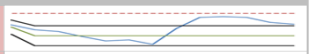
Target: 20% Aug 18: 42.50% Sep 18: 11.46% Movement: ▼-31.04%



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



Emergency Flow

Indicator Description	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
4 Hour Operating Standard	95%	90.0%	88.0%	87.2%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	93.3%	91.1%	90.3%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	1	0	0	0	2	1	1	0	1	0	1	
Time to Treatment (number of patients seen within 60 minutes)	60%	54.1%	54.2%	54.2%	54.1%	51.7%	52.2%	52.6%	61.5%	63.5%	65.5%	63.7%	70.3%	64.1%	
Admitted patients with a length of stay 7 Days or Greater		349	348	362	376	373	337	343	356	301	313	304	309	294	
Ambulance Turnaround - % under 15 minutes	100%	50.9%	49.9%	49.0%	44.3%	41.0%	42.2%	41.0%	45.0%	45.7%	43.6%	42.0%	42.3%		
Ambulance Turnaround - % under 15 minutes (London Average)	100%	46.5%	45.1%	46.1%	42.1%	41.4%	42.2%	41.1%	45.2%	45.7%	47.4%	46.7%	48.1%		
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	71	57	82	112	180	135	105	92	65	72	75	85		
Ambulance Turnaround - % under 30 minutes	100%	96.6%	97.4%	96.2%	94.8%	91.3%	93.2%	94.5%	95.3%	96.8%	96.3%	98.5%	95.5%		
Ambulance Turnaround - % under 30 minutes (London Average)	100%	92.2%	91.9%	91.7%	91.6%	86.7%	87.4%	87.5%	88.8%	91.9%	93.7%	93.1%	92.2%		
Ambulance Turnaround - number over 60 minutes	0	0	0	0	2	3	3	10	1	0	0	0	2		

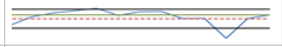
Briefing

- Performance against the Four Hour Operating Standard in September was 90.3%, which was below the monthly improvement of 95%. The improvement trajectory requires the delivery of 93% performance in October 2018 and relies upon continued improvement in the experience for patients not requiring admission
- Urgent and Emergency Care Attendances in September were 2% higher than in the same month in 2017, treating an additional ten patients per day. There is an emerging trend of a reduction in Urgent Care patients, with the increases coming in the more complex patients that require access to the full Majors Emergency facility. Four Hour Operating Standard performance for patients requiring admission during April and September has seen an improvement of 4% compared to the same period last year. Performance against the four Hour admitted standard for our Paediatric patients has seen a significant improvement compared to last year reporting a 16% increase.
- Through the concerted effort of the operational and ward teams, the average number of patients in September who have stayed more than 21 days in hospital fell by 12%.
- Key issues included delays in the Emergency Department assessment process, treatment to decision waiting times and four hour operating standard for patients referred to specialties, which fell to 70.6% in September.

Actions

- Non-Admitted Pathway: The introduction of ED Paperlight in November will shorten the processing and administrative time required of clinicians accelerating flow for all patients. Other actions include revisiting the consistency of shift leadership, extending the role of the Patient Flow Co-ordinators, ensuring clinical capacity is aligned to pathway demand particularly around lunchtime to ensure that the department does not become congested and extending the opening hours of the co-located Pathology Lab.
- Admitted Pathway: The key objective is to have no more than 80% bed occupancy on the Acute Medical Unit at 10am and at Midday. Ambulatory Care opening hours have been extended and key wards are focusing on earlier morning discharges. Other actions include ring-fencing Discharge Co-ordinator capacity on the wards, basing the site manager in ED, reviewing ward based therapies cover and the opportunity to create a patient transfer team to ensure that patients leave the Emergency Department as soon as a bed is available.
- Mental Health Pathway: - The Trust is starting to work more closely with colleagues in South West London St George's Mental Health NHS Trust to improve the patient experience for our shared patients with an ambition to have the best Four Hour Operating Standard for patients requiring Mental Health Assessment in London
- Flu Point of Care Testing to be re-launched for the Winter period, with the aim of reducing delays in the management of Flu, reducing the turnaround times from a minimum of 90 minutes to 18 minutes

Cancer

Indicator Description	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	89.7%	94.0%	96.1%	97.3%	98.5%	94.8%	96.7%	96.8%	93.1%	93.3%	90.5%	93.1%	95.0%	1,200	
Cancer 14 Day Standard Breast Symptomatic	93%	90.3%	98.2%	99.6%	98.0%	97.3%	95.9%	96.5%	96.8%	94.4%	79.4%	22.2%	55.2%	86.4%	220	
Cancer 31 Day Diagnosis to Treatment	96%	96.2%	96.2%	98.1%	96.9%	97.4%	98.2%	99.3%	96.5%	98.4%	99.0%	97.0%	98.4%	98.5%	206	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	95.8%	82.4%	94.1%	96.9%	94.3%	94.6%	100.0%	95.5%	100.0%	95.7%	94.1%	95.0%	96.6%	29	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94	
Cancer 62 Day Referral to Treatment Standard	85%	75.6%	76.7%	85.5%	80.8%	86.8%	77.8%	80.8%	88.1%	92.3%	85.9%	69.5%	85.7%	85.7%	77.0	
Cancer 62 Day Referral to Treatment Screening	90%	92.5%	93.0%	78.4%	92.7%	93.9%	86.1%	89.1%	95.2%	80.8%	92.7%	84.6%	73.8%	91.6%	36	

Briefing

- The Trust met six of the seven Cancer standards in the month of August, continuing to achieve 62 day standard reporting 85.7% and internally reporting 89.4%.
- Performance against the 14 day Standard's was compliant in the month of September reporting 95% and below the 93% target in three tumour groups
- Two week wait Breast Symptomatic performance is below the national requirement and has seen a significant improvement from June reporting 22% with a total of 147 patients breaching, to 86.4% in September with 30 breaches.

62 Day wait for First Treatment- GP referral to treatment (actual and internal performance)			
Month	Target	Actual Performance	Internal Performance
Apr-18	85%	92.3%	96.7%
May-18	85%	85.9%	87.1%
Jun-18	85%	89.2%	93.1%
Jul-18	85%	85.7%	89.4%
Aug-18	85%	85.7%	89.1%

Actions

- There is a continued focus on improving internal processes as well as working with local providers to improve 38 day performance. Improvement trajectories have been agreed with other SWL providers to improve waiting times and quicker access to diagnostics and treatment for shared patients
- Capacity within the Breast pathway has been created within diagnostics through the addition of a new ultrasound machine at St Georges Rose Centre site increasing the minimum weekly capacity by 60 slots weekly. On-going recruitment of vacant consultant posts, the creation of a new consultant post, and the introduction of a trainee position will further increase capacity by 60 slots and provide a more flexible and responsive service in the current year and a further 50 slots in year 2 once training is completed.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

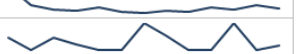
Tumour Site	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	No of Patients
Brain	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	1
Breast	93%	93.4%	94.1%	97.4%	98.4%	98.2%	96.0%	96.5%	93.9%	94.8%	91.9%	61.2%	87.4%	97.5%	122
Children's	93%	100.0%	100.0%	100.0%	71.4%	100.0%	87.5%	100.0%	100.0%	80.0%	100.0%	100.0%	90.9%	-	0
Gynaecology	93%	90.4%	91.1%	90.8%	95.0%	97.6%	98.0%	96.8%	94.3%	94.9%	91.9%	86.1%	91.7%	90.8%	120
Haematology	93%	100.0%	100.0%	96.8%	100.0%	94.7%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	20
Head & Neck	93%	82.4%	90.6%	99.1%	99.4%	98.4%	100.0%	97.6%	100.0%	100.0%	97.5%	92.3%	93.0%	95.6%	113
Lower Gastrointestinal	93%	73.9%	94.6%	97.4%	97.7%	99.3%	95.2%	100.0%	97.8%	94.1%	90.3%	67.5%	94.7%	98.9%	264
Lung	93%	100.0%	94.1%	97.7%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	96.3%	90.9%	97.6%	94.7%	38
Skin	93%	96.6%	93.4%	95.0%	95.5%	97.9%	92.7%	94.8%	95.9%	94.1%	93.8%	92.7%	93.3%	92.9%	353
Upper Gastrointestinal	93%	98.8%	98.8%	98.5%	99.0%	100.0%	89.0%	97.3%	95.3%	85.2%	88.1%	89.9%	96.6%	93.9%	82
Urology	93%	97.0%	96.4%	93.3%	97.1%	98.9%	95.0%	95.1%	98.2%	81.3%	92.9%	96.5%	95.2%	93.1%	87

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	No of Patients
Brain	85%	0.0%	100.0%	-	100.0%	-	-	-	-	-	-	-	-	-	0
Breast	85%	100.0%	91.7%	100.0%	95.2%	100.0%	71.4%	100.0%	88.9%	94.1%	84.6%	91.7%	90.9%	78.9%	9.5
Children's	85%	0.0%	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	50.0%	83.3%	75.0%	67.0%	80.0%	77.8%	0.0%	100.0%	80.0%	100.0%	75.0%	100.0%	3
Haematology	85%	100.0%	88.9%	100.0%	-	100.0%	88.9%	83.3%	81.8%	100.0%	63.6%	100.0%	100.0%	88.9%	4.5
Head & Neck	85%	71.4%	87.5%	78.6%	81.8%	71.0%	100.0%	83.3%	80.0%	100.0%	90.0%	75.0%	72.7%	81.8%	5.5
Lower Gastrointestinal	85%	100.0%	66.7%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	71.4%	83.3%	6
Lung	85%	47.4%	72.2%	72.7%	41.2%	33.0%	90.9%	57.1%	100.0%	100.0%	87.5%	83.3%	71.4%	66.7%	7.5
Skin	85%	76.5%	93.8%	90.9%	91.7%	93.0%	86.7%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	13.5
Upper Gastrointestinal	85%	77.8%	0.0%	100.0%	84.0%	100.0%	33.3%	57.1%	66.7%	87.5%	33.3%	80.0%	100.0%	78.9%	9.5
Urology	85%	64.3%	77.4%	100.0%	72.7%	91.0%	60.7%	70.0%	96.7%	80.5%	84.6%	84.9%	85.7%	88.2%	17
Other	85%	-	-	-	-	-	-	-	-	-	-	-	-	100.0%	1

Diagnostics

Indicator Description	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
6 Week Diagnostic Performance	1%	1.4%	0.3%	1.9%	0.1%	0.1%	0.0%	0.2%	0.2%	0.2%	0.3%	0.3%	0.2%	0.4%	
6 Week Diagnostic Breaches	N/A	98	22	143	6	10	3	17	15	14	25	24	15	30	
6 Week Diagnostic Waiting List Size	N/A	7,184	7,072	7,534	6,440	6,884	7,232	7,075	7,956	7,735	7,809	7,236	6,946	7,617	

Indicator Description	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
MRI	1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.4%	0.0%	0.3%	0.1%	
CT	1%	1.2%	0.3%	0.1%	0.0%	0.1%	0.0%	0.3%	0.1%	0.0%	0.3%	0.0%	0.0%	0.0%	
Non Obstetric Ultrasound	1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.1%	0.6%	
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%	0.7%	0.0%	
Audiology Assessments	1%	4.5%	0.0%	17.4%	0.0%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.3%	0.3%	0.8%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	
Electrophysiology	1%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.0%	0.0%	0.0%	0.3%	0.9%	0.0%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	
Sleep Studies	1%			26.8%	0.0%	0.0%	0.4%	0.6%	0.0%	0.0%	0.0%	1.1%	1.5%	0.0%	
Urodynamics	1%	37.0%	16.7%	6.7%	0.0%	0.0%	0.0%	9.1%	5.0%	23.9%	6.3%	26.5%	0.0%	13.9%	
Colonoscopy	1%	0.4%	1.1%	0.0%	0.0%	0.0%	0.6%	0.7%	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	
Flexi Sigmoidoscopy	1%	1.5%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cystoscopy	1%	14.7%	4.0%	1.8%	1.5%	2.8%	0.7%	0.0%	1.0%	0.8%	3.0%	1.8%	4.4%	2.6%	
Gastroscopy	1%	0.8%	0.0%	0.8%	0.4%	0.0%	0.0%	1.8%	1.0%	0.0%	0.0%	1.8%	0.0%	0.3%	

Briefing

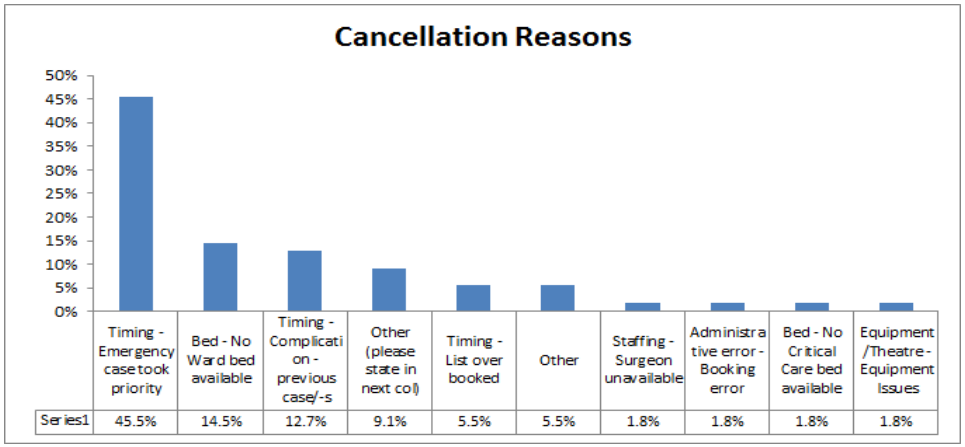
- The Trust has continued to achieve performance in September reporting a total of thirty patients waiting longer than 6 weeks, 0.4% of the total waiting list.
- Compliance has been achieved in all modalities with the exception of Urodynamics with five patients waiting beyond six weeks this is due to capacity constraints within the service. An action plan has been agreed that will increase capacity by two sessions per month.
- Performance continues to be monitored through the weekly performance meetings.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
Number of on the Day Cancellations		49	52	86	100	94	55	86	64	87	42	54	44	55	
Number of on the Day cancellations re-booked within 28 Days		43	34	76	67	76	48	76	60	80	33	51	37	49	
% of Patients re-booked within 28 Days	100%	87.8%	65.4%	88.4%	67.0%	80.9%	87.3%	88.4%	93.8%	92.0%	78.6%	94.4%	84.1%	84.1%	

Briefing

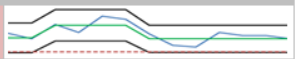
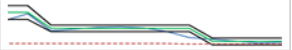
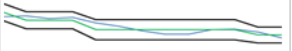
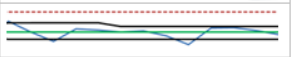
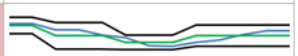
- In September 84.1% of our on the day cancelled patients were-rebooked within 28 days.
- Of the 55 cancellations reported, 45% were due to emergency cases taking priority and 14.5% due to no ward bed available.



Actions

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

Workforce

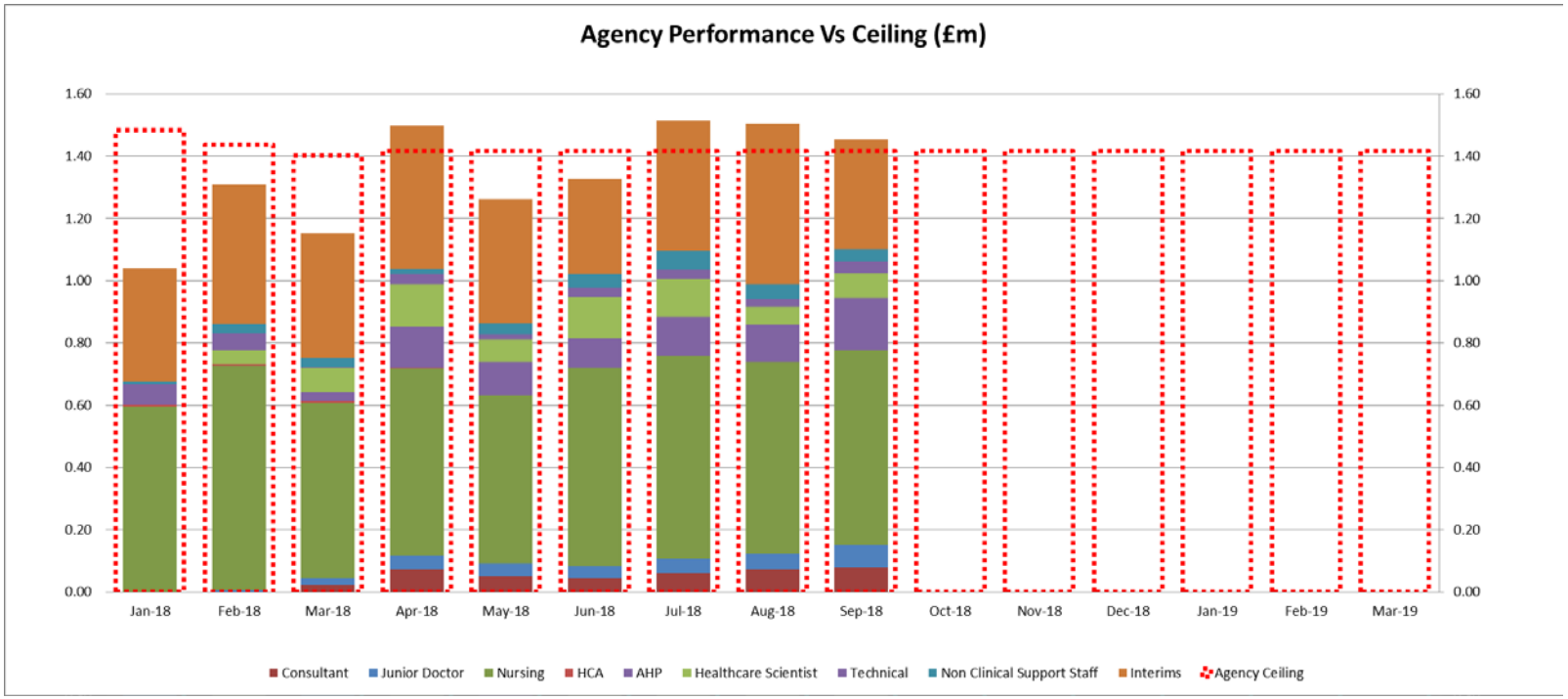
Indicator Description	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
Trust Level Sickness Rate	3%	3.6%	3.4%	3.8%	3.6%	4.1%	4.0%	3.6%	3.2%	3.2%	3.6%	3.5%	3.5%	3.4%	
Trust Vacancy Rate	10%	14.8%	16.1%	12.7%	13.0%	13.4%	13.5%	13.3%	12.6%	11.3%	11.0%	10.6%	10.2%	10.4%	
Trust Turnover Rate* Excludes Junior Doctors	13%	18.5%	18.5%	18.3%	18.4%	17.9%	17.6%	17.2%	16.9%	17.0%	17.3%	17.4%	17.1%	16.6%	
Total Funded Establishment		9,794	9,808	9,470	9,474	9,515	9,540	9,497	9,469	9,318	9,242	9,239	9,160	9,180	
IPR Appraisal Rate - Medical Staff	90%	74.0%	80.7%	80.0%	78.9%	79.6%	76.9%	72.2%	81.1%	81.3%	79.9%	77.7%			
IPR Appraisal Rate - Non Medical Staff	90%	79.4%	73.5%	70.2%	70.2%	67.2%	65.9%	61.6%	61.2%	63.4%	64.6%	67.6%	69.7%	69.7%	
% of Staff who have completed MAST training (in the last 12 months)		85%	86%	87%	86%	87%	87%	87%	87%	87%	87%	89%	88%	88%	
Ward Staffing Unfilled Duty Hours	10%	5.9%	6.1%	6.6%	7.8%	7.7%	7.9%	8.9%	6.5%	5.1%	4.9%	5.8%	5.5%	6.7%	
Safe Staffing Alerts	0	0	1	2	2	4	1	1	1	0	2	0	0	0	

* Excludes Junior doctors

Briefing

- Funded Establishment has increased compared to the previous month reporting 9,180 WTE in September, and a 6.2% reduction from 2017 as a result of the changes to the Community Division.
- The Trust Vacancy Rate increased in September reporting 10.4% in month.
- The Trust sickness level has remained above target of 3% reporting 3.4% in the month of September.
- Mandatory and Statutory Training figures for September were recorded at 88%. Compliance has been maintained during a period where we have seen large numbers of Junior Doctors and newly qualified nurses joining the organisation.
- Medical Appraisals rates are being reviewed and will not be reported this month.
- Non-medical appraisal rates have remained the same. Performance in September was 69.7% against a 90% target.

Agency Use



Please note that the figures in the table have been restated to reflect the underlying agency spend.

- The Trust's total pay for September was £42.74m. This is £0.01m adverse to a plan of £42.73m.
- 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 September was £1.45m or 3.4% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For September, the monthly target set was £1.42m. The total agency cost is worse than the target by £0.04m.
- Agency cost reduced by £0.06m compared to August. There has been a decrease in Interims (£0.16m). This offset by increases in AHP (£0.05m), Junior Doctor (£0.02m), Healthcare Scientist (£0.02m) and Technical (£0.01m).
- The biggest area of overspend was in Interims, which breached the target by £0.05m.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board (Part 1)**		
Date:	25 October 2018	**Agenda No**	2.3
Report Title:	Elective Care update		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Matthew Davenport, Deputy Director Elective Care		
Presented for:	Update		
Executive Summary:	This is the monthly update on Elective Care to the public Trust Board. The paper provides confirmation that the trust has started to shadow report September's month end data. This currently only applies to the Tooting site with a future R2R decision required for the Queen Mary's Site subject to a successful deployment of Cerner. This paper will specifically look at the progress made in - Performance – continued reduction in overall PTL size, Reduced long waiting patients, improvements in 5 data quality metrics. - Validation – additional validation resources has come online in October 2018. This will support our overall data quality and support our ability to demonstrate readiness to report nationally. - Training – A training strategy has been agreed. This outlines the method of training and the material being used to deliver the training. Training will be provided to existing staff and form part of induction for all staff joining the organisation. The roll out of training started in October. We are currently offering electronic learning modules and targeted training which will continue.		
Recommendation:	The Trust Board is asked to receive this report and note the recommendation to commence shadow reporting.		
Trust Strategic Objective:	Treat the patient, treat the person Right Care, Right Place, Right Time		
CQC Theme:	Well-led, Safe, Caring and Responsive		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Risk:			
Legal/Regulatory:	Referral to treatment standard is a regulatory target		
Resources:	Elective Care programme		
Previously Considered by:	Monthly update received by the Trust Executive Committee and Quality and Safety sub- Committee	July 2018	
Equality Impact Assessment:	N/A		
Appendices:			

Elective Care Recovery Programme Update

Trust Board (Part 1)

30 August 2018

1) Treating Patients

- The Trust continues to use and develop its five patient tracking lists (PTL's). They are as follows:

1) Active (the live PTL)
2) Planned
3) Active Monitoring
4) Diagnostics
5) Cancer

- A daily refreshed PTL is available to all staff. This includes length of wait at patient level. Continued focus is on the longer waiting patients and the overall number of long waiting patients is reducing. As reported at the August Board the total incomplete PTL size is ahead of trajectory. September to date is seeing further improvements and remains ahead of trajectory.
- As part of phase one of validation, all patients who required an appointment have been seen. Additional work is underway for those patients who did not respond. Section 3 of this report will provide more detail.
- There has been a reduction in the number of long waiting patients on the PTL.
- The Trust is ahead of trajectory for a number of data quality metrics as agreed with our regulators.
- The trust has seen an increased number of patients being booked for treatment and our overall utilisation is increasing.

2) Validation

- Following approval at Trust Board for additional validation support, the Trust has procured external validation resource for initial 5000 pathways, validation commenced on 17th October with an initial focus on duplicate pathway entries. Further procurement for the remaining pathways is required.

3) Training

- A new training implementation strategy has been approved.
- Training is to be provided for all new staff joining the organisation from October.
- Training for existing staff will also be provided from October.
- Training is currently being delivered within the existing ICLIP roll out training programme at the Tooting site.
- Targeted training is also currently being provided. This follows themes identified through our audit process.

4) Clinical Harm Review Update

Further to the August Board paper, this paper provides an update on the additional validation being undertaken by GP practices.

- To date all Practices have agreed to participate in reviewing their patients and the Practices have been securely sent their patient information. The current outcome from the reviews was that only 49 patients have been identified as possibly needing further investigation these patients will be clinically validated by services and of the 49 patients, 10 needed further review and these patients will be seen as a priority. To date the GPs have identified 5 cases a potentially at risk to clinical harm. The 5 QMH cases have been clinically reviewed and QMH has confirmed that no patients were at risk to any clinical harm.

- Crucially the Trust now has a 'live' Patient Tracking List (PTL) as from February 2018 that tracks and manages all patients that are referred to the Trust for diagnosis and treatment.

Phase 2 Current and Historical Validations

Good progress is being made on the validation of historical validation.

- By definition this cohort of patients is significantly lower risk than the cohort within Phase 1.

- The initial validation work undertaken by Cymbio identified 10,000 patients who appeared to have an 'inconclusive' pathway – i.e. no definitive outcome from their last contact with the Trust in order to confirm that their episode of care could be closed. Of the 10,000 patients, 4,000 appeared to be on the St George's site, 6,000 at Queen Mary's.

- Following further internal validation to remove patients with an appointment after October 2017 and patients on 'active monitoring' the total number of inconclusive records across both sites from the original 10,000 is now 3,676 (1,831 at St George's and 1,845 at Queen Mary's.)

- QMH have reviewed all of their records. There has been no harm identified.

- SGUH have 636 remaining cases to be reviewed and expected to be completed by the end of October. No clinical harm has been identified from the reviewed cases.

- By definition Phase 2 patients are a much lower risk cohort of patients and no clinical harm requests have been received.

5) Return to Reporting

The Trust Board took the decision to stop reporting its referral to treatment waiting times in 2016. Every non-reporting Trust is expected to agree and deliver a 'return to reporting' plan so it is able to assure itself that it can report RTT waiting times accurately to the public once the decision has been taken to do so. The Trust aim is to return to reporting in Q4 of 2018/19.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No.**	**2.4**
Report Title:	Cardiac Surgery report		
Lead Director/ Manager:	Professor Andrew Rhodes, Acting Medical Director		
Report Author:	Matt Jarratt, General Manager for Cardiac Surgery		
Presented for:	Information and Assurance		
Executive Summary:	The Board has received monthly updates on the challenges affecting the cardiac surgery unit at St. George's. The Bewick Review described a link between poor team behaviours and a postoperative mortality rate that was two standard deviations greater than what would be expected against the Trust's peer organizations. Progress is being made in implementing the Bewick recommendations, which the Trust accepted in full. A number of temporary changes to the service were introduced proactively by the Trust in September to ensure the service had the space necessary to implement a series of measures to improve the service, and address concerns regarding the stress that team members were being placed under and the potential impact of this. These measures, which have included the transfer of patients requiring the most complex cardiac surgery to other London hospitals and changes to the internal operation and governance of the service, have helped stabilise and improve the unit. These changes are being overseen by a number of external stakeholders that include commissioners, regulators and system partners. The Trust is actively managing the risks identified, which can be described under safety, sustainability and finance.		
Recommendation:	The Board is asked to note the update.		
Supports			
Trust Strategic Objective:	Right care, right place, right time. Champion Team St George's		
CQC Theme:	Safety Well Led		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive) Operational Performance Leadership and improvement capability		
Previously Considered by:	Quality and Safety Committee - 18th October		

CARDIAC SURGERY REPORT
TRUST BOARD, 25 OCTOBER 2018

1.0 PURPOSE

1.1. The Bewick Review (July 18) described a link between poor team behaviours and a post-operative mortality rate that was two standard deviations greater than what would be expected against our peer organizations.

1.2 Throughout the summer of 2018 the service received widespread publicity which contributed to adverse impacts on the wellbeing of our staff and their ability to deliver the service safely and effectively. This paper summarises progress in the last month to mitigate these concerns, and highlights headline risks.

2.0 CARDIAC SURGERY PLAN

The table below summarises key developments within the last month:

Objective	Progress
External oversight	• The independent scrutiny panel appointed by NHS Improvement at the Trust's request met for the first time in October, with an opening session that included in depth discussions with clinical and operational leadership of the service. The panel are continuing their work and will advise the Trust on its future decision making. • There has been a further quality summit with regulators (NHSI, NHSE, CQC, GMC, CCGs). The key message is that the temporary services changes are providing the service with the space required to reduce the pressure and make the changes needed. Our partners are naturally concerned to ensure the ongoing safety of patients and staff, and have been supportive of the actions we have put into place to mitigate the key risks. • The CQC have undertaken a review of the safety of the service, following which the formal report is imminently expected.
Undertaking of low risk cases and external transfer of high risk cases	• Two Quality Summits with NHS Improvement, NHS England, the CQC, HEE and GMC, as well as our neighbouring Trusts, agreed that the cardiac surgical practice at the Trust was restricted to low(er) risk work with higher risk cases being transferred to partner organizations. • This has been successful in terms of reducing service stress and complexity. • This may lead to an unintended consequence of de-skilling the surgical teams. It is recognized therefore that this can only be a short term intervention.
Consultant workforce	• Two fixed term consultants have joined the department. • These are relatively junior clinicians, albeit both post CCT level. • A bespoke mentoring and support package has been developed for these two clinicians given the wider pressures on the unit.

Junior doctor workforce	• Five new junior doctor appointments have been made. These are non-training grade doctors due to the removal of training status of the department by HEE. • When these doctors start work this will reduce the requirement for agency doctors to be working in the service. • It should be noted that there is a clear link between improved quality of service provision and training status of the department. • Although the risk of having less reliance on agency staff is improved, the risk is still greater than if training grade doctors were present.

3.0 SAFETY PERFORMANCE

3.1 An enhanced scrutiny and oversight programme has been instituted for cardiac surgery since the implementation of the lower risk strategy. This entails pathway leadership from cardiology, daily assessment of all incidents and risks, and oversight from NHSI and NHSE.

3.2 Cardiac surgery have implemented a consultant of the week practice model that provides daily MDT input for discussion of all cases and decisions and consultant level continuity of care.

3.3 Governance has been enhanced with leadership from the Associate Medical Director for governance as well as a seconded consultant cardiologist. A daily dashboard is now in operation that is shared with NHS Improvement. All incidents and deaths are reviewed and any that cause moderate or severe levels of harm will be sent to external providers for their overview and scrutiny.

3.4 The service is now better governed than it has been for some time, with enhanced ability to identify problems and challenges in near real-time so they can be escalated and addressed rapidly.

3.5 Stress levels in the service remain higher than desirable and ongoing work through the behavioural workstream is still required. Occupational health is providing support as necessary.

3.6 Although the safety concerns are being mitigated, this is at the expense of significant management and clinical leadership time which is needed to intervene and provide support on a daily basis. This has the potential to be at the expense of other Trust wide priorities unless managed well.

4.0 PROGRESS AGAINST BEWICK RECOMMENDATIONS

4.1 Progress against the Bewick report's recommendations is described in Appendix 1.

5.0 KEY RISKS

5.1 The key risks can be summarized into three themes:

1) **Patient safety.** The Trust has been clear that the cardiac surgery service is safe and the temporary service changes introduced in September have helped to address concerns around the stress under which the surgical team is operating, albeit that further improvements are necessary. The decision to continue only with lower risk cases at St George's has also helped address this risk.
2) **Service sustainability.** There has been a significant downward trend in the number of referrals into the service. This has been particularly marked since the negative publicity began in July 2018. This will endanger the service's long term viability unless corrected.
3) **Financial challenge.** The financial impact of these issues is very considerable. The consequence of this on the year end forecasts are described in the Board financial reports.

5.2 Key risks have now been discussed by the Division, the Cardiac Surgery Steering Group, Trust Executive Committee and the Quality and Safety Committee. They will feed into the Board Assurance Framework, and this is set out in the paper at agenda item 6.2.

6.0 DISCUSSIONS AT QUALITY AND SAFETY COMMITTEE

6.1 The Committee noted the Executive's concerns with regards the service challenges and how these still required significant input in order to continue to ensure patient safety.

6.2 The Committee was re-assured about the appointments made into the junior doctor workforce but noted that the risks were still higher than if the service was staffed with training grade doctors. It was noted that of the 16 junior doctors originally in the service that only five of these were trainees.

6.3 The Committee noted that the daily MDTs were happening and challenged the service about the numbers of low risk and high risk cases and sought assurance about these being transferred to other Trusts in a timely fashion.

6.4 The Committee challenged the team about proportions of low risk and high risk case so that they could understand the overall context and also the impact on activity.

7.0 RECOMMENDATIONS

7.1 The Board is asked to note the update.

Appendix 1. Update against the Recommendations from the Bewick Report.

	Recommendation	Update (19/10/18)
1	**The current consultant cardiac surgical team** membership is incompatible and requires **restructuring** with some urgency.	This recommendation remains under consideration with inputs being taken into the decision making process from the Hollywood review and following consultation and advice from the independent scrutiny panel.
2	To facilitate the required changes in practice to sustain and develop the service an expansion to 8 full time surgeons is required. This would allow for a surgeon of the week, expansion of sub-specialisation roles and increased research and ambassadorial roles.	During the Bewick review we had 5.5 WTE in the cardiac surgical consultant workforce. We are currently running on 8 WTE, although two of the consultants are junior and are being supported into fully independent practice.
3	**There is a need for an immediate appointment of 2 consultants** which will be challenging in the current climate. One should be straightforward as there is a suitable post CCT surgeon working in the unit who could be interviewed for initially a long term locum role.	Both of these appointments have now commenced.
4	**Seek out a proficient and credible cardiac surgeon to lead the unit**. One of the issues that was raised by many of the interviewees was to widen the recruitment process to seek a competent experienced surgeon with an interest in mitral valve repair. The pursuance of such a person, who would ideally be placed to offer a leadership role, should not be limited to the UK	This is a longer-term recommendation and needs to follow on from the re-structuring described in recommendation 1. We are currently discussions the possibility of on site leadership support with our partners but this is not yet agreed.
5	**Succession plan to be produced within 2 months**. To plan for the probable retirement of at least one surgeon succession planning should commence now to seek a 3rd surgeon. Again, this could be from a sub-speciality offering more innovative surgical procedures such as robotics or less invasive surgery. International candidates could be approached	Implementing this recommendation is subject to the re-structuring described in recommendation 1. Individual one to one conversations have been had with all surgeons. Succession plans are being developed.
6	**Skills development of junior surgeon(s).** To assist the unit in further expansion of its services (either at SGH or as part of a wider South London network) one of the less experienced surgeons to be offered a sabbatical at a specialist unit where specific new skills can be developed.	A bespoke support package has been created for the two new appointments. Senior mentors have been identified from both internally in the department and also externally from KHP. The seconded consultant has just returned to SGH following a month at GST. Further development opportunities are being considered but have yet to be finalized. We will need to develop a longer OD strategy for the team that takes skills development as well as training into account.
7	**Pathway leadership role**. To complement the role of CGL which concentrates on the operational and governance issues of the unit a	Pathway leadership has now been taken over by a consultant cardiologist who is running the daily MDTs and is providing overall

	new role supporting development of a 'total pathway of care' model, encouraging multi-speciality team working across pre-, peri-and post-operative care. We see this as an essential step in promoting more critical analysis and safer care for all patients, but particularly those in a 'high risk' category. This role, while open to anyone, would be suitable for a relatively new consultant who wishes to develop new managerial as well as leadership skills	leadership into the service. One surgical consultant has been reviewing all the pathways that are currently active at GST and is bringing the learning back to SGUH to see what can be implemented here.
8	**Move to a single speciality surgical practice only**. The unit should develop a policy of only employing single speciality surgeons. There is an increasing evidence base for splitting the role of cardiac and thoracic surgery and our recommendation is that this should be adopted by the Trust enhancing safe practice	This was implemented with immediate effect on the receipt of the Bewick report (July 2018).
9	**Sustainability of the unit. Develop senior ambassadorial roles**. The cardiac surgery service is under considerable scrutiny and there has been extensive media coverage about challenges within the service. The most senior clinicians (and new leaders as they come on stream) need to take responsibility for rebuilding trust in the unit. This will involve significant work with colleagues in 'feeder' units, academic and service links with other cardiac surgery centres in S London. SGH has a significant experience in sub-speciality working, examples being HOCM, Aortic Arch disease, Marfans and complex mitral valve repair. Only by demonstrating a single vision for the service as a revitalised and innovative one, will organisations be convinced of SGH's intent to build a better service. To achieve this senior surgeon's may have to temporarily reduce clinical commitments.	Over the last month there has been a significant reduction in referrals into the SGUH system. This, unless corrected, will have long lasting impacts into the sustainability of the service. Improvements in relationships with system partners are being targeted through both cardiac surgery and cardiology in order to strengthen our referral source and patient pathways.
10	**Unit project manager**, to support the expansion of consultant numbers and to develop a unit strategy the Trust should employ suitable project support.	A project manager is in place, back fill for General manager time has been provided so that the GM of the service can concentrate on this full time. Clinical backfill has been provided for Dr Raj Sharma (Clinical lead for Cardiology) so that he can take a FT leadership role in the pathway development and Dr Lisa Anderson has had time freed up to support the governance changes.
11	**Cardiac institute.** There is already cooperation between cardiologists and vascular surgeons across South London. There has been some reluctance to include cardiac surgery into the process. This should be revisited and, supported by lead clinicians and an executive director sponsor, lines of communication opened up with GST to commence meaningful negotiations	Longer term strategic discussions are taking place with our system partners –GST & KCH- facilitated by NHS England. A draft plan has been received that is now under consideration and will in due course be presented up to the Trust Board.
12	Technical advice to improve patient safety. The following we hope are practical steps to assist surgical and associated specialities in improving clinical outcomes. These are summarised in Appendix 5**.**	This recommendation involves the wider parts of the pathway, such as re-structuring the job plans and care provision in cardiac intensive care and cardiac anaesthesia. The Quality Improvement Academy is now focussing and supporting the care provision aspects of this

		recommendation. Job plan changes are still in discussion and have not progressed at the pace we would hope for.
13	**Improved data entry** Unsatisfactory at present.	
a	There needs to be clinical sign-off of each case accompanied by data validation / audit etc. This can be arranged internally – e.g. every month each surgeon checks at random the entries for one patient operated on by colleague. We note the trust is moving to surgeons entering their own data via the dendrite system and a definite start date would be helpful.	The Dendrite system is now in the Trust is due to go live mid-November. Governance SOPs are being finalized for how the system will work.
b	The current data manager is the sole authority on data quality in the unit and responsible for data extraction, entry and coding. We believe this to be unsafe for the unit as there are no checks and balances, leaves the Trust vulnerable if he departs and is professionally isolating for him. Even with adoption of the Dendrite system this will not change and the Trust is advised to manage this situation *so that further analytical support* is available	Line management has been moved to the GM, but clinical management in terms of data production under the CGL and therefore CD/Div Chair
14	**Outcome monitoring.**	
a	We have found little evidence of ongoing outcome monitoring of VLAD plots, until a surgeon feels under threat, nor significant engagement by surgeons in morbidity review – e.g. unexpected long ITU stay, unexpected long cross clamp time. Needs to be standing agenda item at M&M.	Data are now presented at the M&M meetings. An external (to cardiac surgery) governance lead (Associate Medical Director) has been identified who is working with the surgeons to develop reporting models.
b	We suggest that only the unit plot is shown to the meeting. CD or med director should review individual surgeons' plots quarterly and take appropriate action as needed. This we believe would allow good professional discourse and interaction.	Unit level VLAD plots have been shared with the team. Consultant level plots have been scrutinized by the leadership group and each individual consultant has been asked to reflect on their own data.
15	**Pooling patients** with decision on appropriate allocation at the MDT, led by 'surgeon of the week'. This is dependent on recruitment but is a clear need in the next few months (3-6).	Pooling of patients has been agreed and specific details of how this will work in practice are being drafted into a SOP that will get TEC sign off. This has not yet occurred. There remains limited assurance that this is now in place.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No**	2.5
Report Title:	Patient Partnership and Experience Strategy		
Lead Director/ Manager:	Avey Bhatia Chief Nurse & Director of Infection Prevention and Control		
Report Author:	Avey Bhatia Chief Nurse & Director of Infection Prevention and Control		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Patient Partnership & Experience Group (PPEG) has developed the attached Patient Partnership and Experience Strategy 2018/19. The strategy sets out the group's vision for engaging with service users, carers and families. There are 5 key strands to the strategy are as follows: 1. Our principles underpinning patient engagement 2. New roles and structures to facilitate engagement 3. Channels through which we will hear views from a diverse range of patients, carers, families and communities 4. Objectives for the first year of the Patient Partnership and Experience Group 5. How we will monitor progress and ensure robust governance The key areas of focus include: • Improving our ability to obtain a diverse range of feedback • Creating new communication channels to explain about patient involvement • Involving patient partners in a wide range of Trust activities, service developments and Trust business to ensure that the patients' voice and view is at the centre of everything we do • Focus on what matters most to our patients (which includes involvement in the discharge process, always listening to family and carers, always supporting patients' physical, social, spiritual, and emotional needs and ensuring family and/or carers will always receive information and education to facilitate self-care and for sufficient information to be provided so that patients know how they should expect to feel after their procedure or operation • Explore how patient partners can be involved in the serious incident process to provide an objective view • Supporting existing patient involvement groups and determining which other ones may need to be established This strategy has been developed by members of PPEG which include our staff and has been consulted on more widely including the Clinical Commissioning Group Patient Involvement Lead. The strategy was received by the Quality and Safety Committee. The Committee approved the strategy and submission for board approval. It was noted that we would work closely with the CCG Patient Involvement Group and that the one year delivery date will commence formally from the date the		

	strategy is approved at board albeit work was already underway.		
Recommendation:	The Board are asked to approve this strategy.		
Supports			
Trust Strategic Objective:	Strategic objective 1: Treat The Patient, Treat The Person Strategic objective 2: Right Care, Right Place, Right Time Strategic objective 3: Build A Better St George's		
CQC Theme:	Safe, Effective, Caring, Responsive & Well-led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement		
Implications			
Risk:	No risks identified at present		
Legal/Regulatory:	NA		
Resources:	Dedicated administration support is in place to coordinate PPEG and its activities to deliver the strategy.		
Previously Considered by:	Patient Partnership & Experience Group Council of Governors Trust Executive Committee Quality and Safety Committee	**Date**	25/09/18 04/09/18 17/09/18 18/09/18
Appendices:	Patient Partnership & Experience Strategy		

St George's University Hospitals NHS
NHS Foundation Trust

OUTSTANDING CARE EVERY TIME

Our Patient Partnership and Experience Strategy

Patient partnership

Our strategy for engaging with service users, carers and families: 2018/2019

Overview

This strategy sets out our vision for engaging with service users, carers and families. We recognise that their involvement is vital to our overall goal: to provide outstanding care, every time.

We want to be in the top 20 of NHS Trusts for friends and family test scores, and to ensure that we do everything possible to listen to the voices of all service users – including those who are seldom heard.

In this strategy we set out the steps we will take to engage patients, listen to their views, and act upon them. The strategy has been developed with input from service users and our staff.

1. Our principles underpinning patient engagement

- Work with patients as partners, respecting their lived experience and skills
- Listen with respect and an open mind and do whatever we can to act upon patients' suggestions
- Actively reach out to the widest possible range of patients so that we hear diverse voices across health conditions, ages and cultures
- Establish a variety of channels through which patients can contribute their voice in ways which are accessible and convenient to them. This includes easy read and a review of patient information to be available in a variety of languages
- Provide support so patients are able to contribute effectively and gain satisfaction from their involvement.This includes supporting patients to engage in meetings, ensuring they are briefed about issues, we won't use jargon and there's someone to talk to if they wish
- Provide feedback in an accessible way about how we are acting upon patients' ideas and how they can get involved. Patient partners will be actively involved in the redesign of the patient information on our Trust website
- Be transparent and honest when progress is difficult. We will explain the problems and do our best to give realistic assessments about what is possible, and what is not
- Reach out to the wider community in our geographical area, understanding the diversity of our patients and reaching out to the different communities so that they can become active patient partners, starting through our Foundation Trust membership
- Ensure that carers and family members can also contribute their views today, in the moment, so that we can make a difference whilst they are still in our care
- Work in a collaborative partnership with staff across all levels, patients, our local communities and other organisations

How patient engagement fits within our wider strategic framework

The main document underpinning our engagement strategy is the Trust's Quality Improvement Plan. This plan builds upon external perspectives including our post-Care Quality Commission (CQC) inspection action plan, our Quality Account priorities, Picker patient experience reports, and internal feedback from staff about specific actions to improve care. Our Quality Improvement Plan details step by step actions in specific service areas to achieve measurable goals. You can read the plan on our website: www.stgeorges.nhs.uk

The Trust's Values will also underpin our patient engagement work. They reflect our commitment to ensuring that all staff – clinical, managerial and administrative – are kind, excellent, responsible and respectful.

2. New roles and structures to facilitate engagement

There are two aspects to this:

- St George's already has many volunteers working alongside staff and clinicians in a variety of ways. We have now created a more formal role for some volunteers called Patient Partners. Partners are recruited on the basis of lived experience and skills. They will sit on a new Patient Partnership and Experience Group (PPEG). The group is co-chaired by a Patient Partner and operates at a senior level within the Trust.
- Secondly, staff and Patient Partners within PPEG will work with existing patient partner groups. These groups have been designed to support engagement and improve patient experience at ward or speciality level. An example is St George's VOICE - a group that focuses on cancer patient experience, which operates within wards, services and departments. These groups focus on local issues and ensure that patients' voices are heard in running and developing services. (For a list of current patient partnership groups please see section 5)

It will:

- Work as a hub to receive patient feedback from a variety of sources
- Monitor actions to improve patient engagement and patients' views to improve and shape our services
- Actively involve patients when we plan new services
- Make sure patients know how they can contribute their views and ideas
- Explain what has been done and showcase how patients have made a difference
- Reach out to the widest possible number of patients, carers and other local stakeholders
- Explore preferred ways in which Patient Partners can be involved in the Serious Incident (SI) investigation process

3. Channels through which we will hear views from a diverse range of patients, carers, families and communities

There are a variety of ways in which patients, carers, families and local and national stakeholders can contribute their views and become involved. In addition, we commit to actively reaching out to people who may find it more difficult to engage for reasons such as disability, age, language barriers and cultural issues.

Patient partnership groups at ward and service level, enable St George's to understand and respond to their needs, including those people who have the poorest health. This helps us to improve access to services and reduce differences in health in different communities. It helps us to see things through other people's eyes and to be innovative.

A fundamental task for PPEG will be to work with existing and new patient partnership groups and to become active partners in any improvement programmes, ensuring the patient voice and perspective are involved from the onset. The PPEG will also design guides to help staff and service users set up active patient partnership groups.

The main ways we will receive views are:

Surveys

In 2011, the Trust developed a new system of capturing real-time patient feedback through tablet computers and online surveys. Patients are given the opportunity to complete feedback as part of their stay at St George's. Our surveys incorporate the Friends and Family Test. This is a simple question that patients are asked about the care they have received from our services.

The question is "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" Patients are encouraged to explain why they gave a particular score, so the Trust can use this insight to target any improvement activity. Details such as gender, age, ethnicity and disability are also collected if provided.

Direct contact with patients

- Our Patient Advisory and Liaison Service (PALS) deals with issues, complaints and compliments. This is a rich source of information about what works well and what we can improve. PPEG will work closely with PALS to ensure both responsiveness to individual issues and learning that can be applied more widely
- There are many existing patient groups within the Trust for different health conditions including cancer, maternity, learning disabilities, and kidney problems. PPEG will create a database of these groups and how to contact them. It will invite them to present to PPEG, act on their issues and concerns, help spread good practice and identify wider trends of feedback across different health conditions. PPEG will also disseminate information about how to create new patient groups
- St George's has more than 200 volunteers working in a variety of less formal roles. They have invaluable insights and often ideas and suggestions for improvement

Outreach and communications

- PPEG will actively reach out to the voluntary sector and local associations to access the views of our local groups such as Healthwatch, the local Polish Association, Age UK, and a host of other local groups and communities, to seek their views and help develop additional engagement channels
- We will review the pathways through which patients can contribute their views and ensure that these are robust, clearly communicated, and accessible

Other partners and stakeholders

- Local and national patient organisations are a good source for patient views. These include local Healthwatch groups which champion patient issues, commissioners, local community groups and national voluntary organisations such as Macmillan and Diabetes UK
- St George's has been a Foundation Trust since 2015, and has a thriving membership of more than 21,000 members made up of people from our local community, our patients and 9,500 staff. We will support and grow this group to be a vibrant source of ideas and advice

Equally important will be creating channels to give feedback to patients about how we are acting on their views, and what progress we are making. We will have a dedicated web page and stakeholder events to cascade and inform our service users.

4. Objectives for the first year of the Patient Partnership and Experience Group (PPEG)

For the first year of PPEG, we have set objectives in two broad areas: setting up structures and communications channels to enable PPEG to work effectively; and working on care improvements as identified in the Trust's Quality Improvement Plan and Quality Account priorities.

Objectives for PPEG

Improve our ability to obtain a diverse range of feedback

We will:

- Work to ensure that all our patients, including those from vulnerable groups, are able to access our surveys
- Work with staff to improve our real-time feedback survey response rates to 50% in all individual areas
- Implement new strategies to capture feedback in other formats such as text and other digital responses
- Develop bespoke feedback methodologies to suit different patient groups. Our clinical divisions will drive improvements through local Patient Partnership Action Plans. This will include "you said we did" feedback posters for patients, service users, carers and families
- We will work with the communications team to ensure that there is clear information about the engagement that is happening and how people can be involved. We will provide feedback about how patients are making a difference and report on the progress of our projects

Create new communications channels to explain about patient involvement

We will:

- Create a map of the different ways in which a patient can contribute feedback or ideas and make sure this is available to patients across clinical areas and in a variety of formats e.g. posters, leaflets, and on the Trust's website
- Explore the possibility of suggestion boxes on wards
- Create a database of the various condition specific patient or support groups at St George's and how to contact them and ensure that this information is visible and accessible to patients

- Invite these groups to present to PPEG and share information and learning including producing case studies of how they have made a difference
- Disseminate information about how to set up a new patient or support group
- Signpost where other support is available from community or national voluntary sector groups

Focus on what matters most to our patients

We will:

- Focus on improving the areas that patients feel matter most to them. These are listed below.

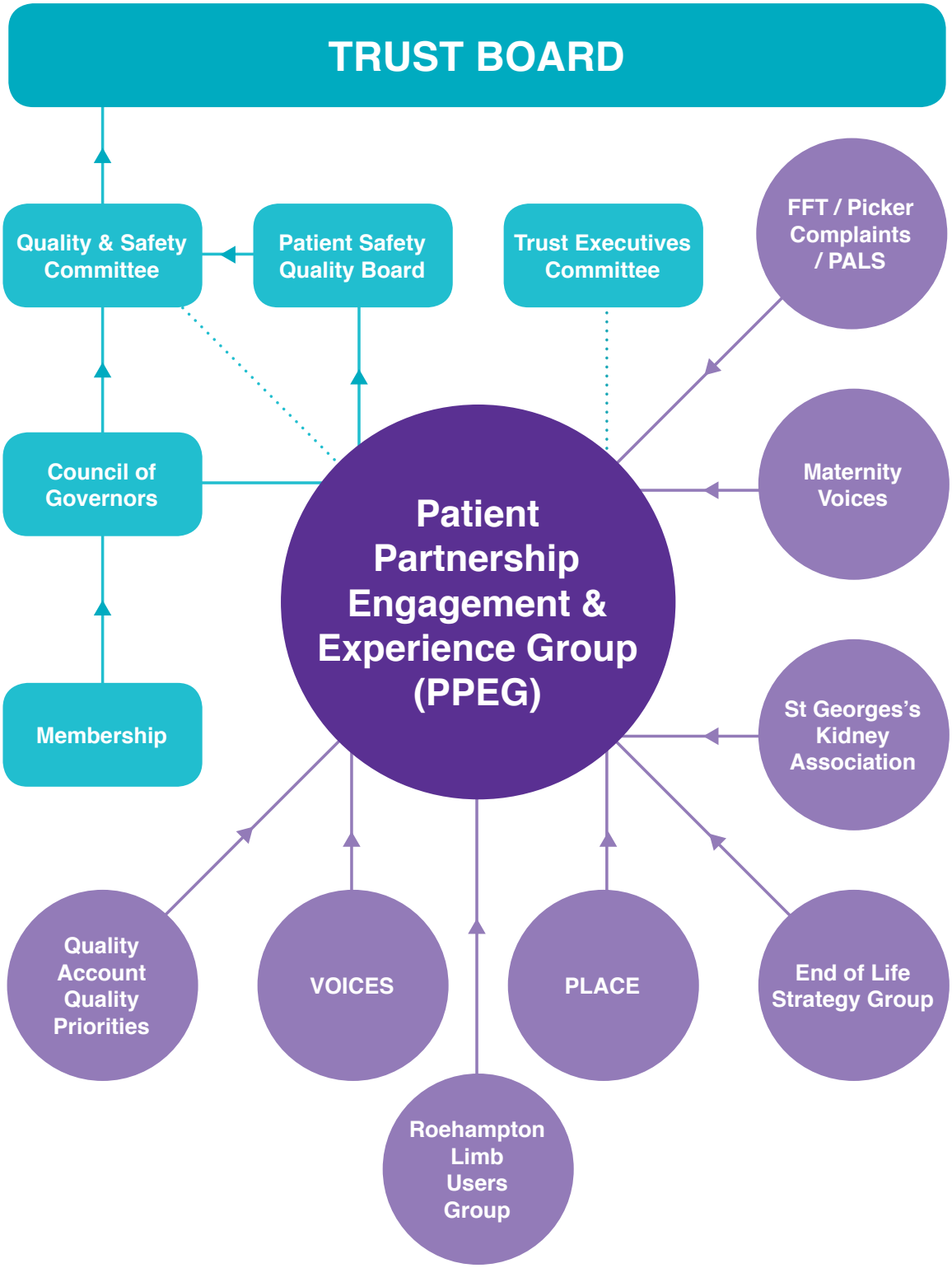
Patient experience priority number:	What matters most to our patients
1	Patients, family and/or carers will always be included in the discharge process
2	Patients family and carers will always be listened to
3	Patients' physical, social, spiritual and emotional needs will always be reviewed and supported appropriately
4	Patients, family and/or carers will always receive information and education to facilitate self-care, ensuring how patients would expect to feel after their operation or procedure

Source: CQC National Adult Inpatient Survey Results 2017

5. How we will monitor progress and ensure robust governance

How we will measure successes of PPEG:

- Patient Partners feel that their voices are heard, that PPEG is working effectively, and that patient involvement has improved across the Trust. This will be measured by surveys at the beginning and the end of year one
- PPEG will ensure that all transformation projects within the Trust will have a Patient Partner as a member of the team in any planning group
- PPEG will recruit 10-20 additional Patient Partners to supplement our existing Patient Partners who are actively involved in our assessment and evaluation of services role. This role supports teams in our ward accreditation scheme, Patient Lead Assessment of Clinical Environment inspections (PLACE), and supports the tendering process in services, such as Transport and Facilities (for more information, visit the Patient Partnership section of the Trust's website)
- PPEG will encourage and support the creation of 25% more patient partnership groups for different health conditions
- The wider local population, particularly organisations representing diverse groups, will have the chance to contribute their views via at least one stakeholder event, surveys and the use of quality improvement tools
- PPEG will plan and develop a longer term strategy for 2020 and beyond
- The diagram on page 8 shows where PPEG fits within the overall Trust governance structure:



PPEG has agreed terms of reference and will develop specific workstreams with measurable outcomes for the objectives identified on page 7. It will report to the Patient Safety and Quality Board. The Quality and Safety Committee will monitor the delivery of the outcomes stated within this strategy.

6. Next steps and further information

We will launch the strategy with a series of events across the Trust starting in Autumn/ Winter 2018.

The communications team will produce supporting information in a variety of formats and on the web. Visit www.stgeorges.nhs.uk for more information.

Alternatively you can email:
patient.partners@stgeorges.nhs.uk

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No.**	**2.6**
Report Title:	Transformation Quarter Two Report		
Lead Director/ Manager:	James Friend. Director of Delivery, Efficiency & Transformation		
Report Author:	James Friend. Director of Delivery, Efficiency & Transformation, with the programme team		
Presented for:	Information		
Executive Summary:	This is the second quarterly report setting out to the Trust Board the approach, progress and impact of the Transformation work underway. It is largely taken from monthly reports provided to internal stakeholders throughout the Trust. Overall, progress remains on track with most key change objectives. Interdependencies on IT change capacity and operational management capacity remain the most significant factors setting the pace of deliverable change and improvement. A separate update was provided last month on the work of the Quality Improvement Academy and so that area in not included in this report.		
Recommendation:	The Trust Board is asked to note the report.		
Supports			
Trust Strategic Objectives:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Themes:	• **Effective*:*** your care, treatment and support achieve good outcomes, help you to maintain quality of life and are based on the best available evidence. • **Responsive*:*** services are organised so that they meet your needs. • **Well-led*:*** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	• Strategic Change		
Implications			
Risk:	No additional risks are identified in this report		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee monthly	**Date:**	Monthly throughout Q2.
Appendices:	Appendix One – Key Performance Indicators Appendix Two - Key Deliverables for Next Quarter		

1. Transformation Programme 2018-19

1.1. The Trust's programmes of transformation for 2018-19 are embedded alongside operational improvement both for quality and performance and for use of resources. Transformation opportunities have been prioritised for resourcing based on their quality and financial impact and their alignment to the three Principles of Transformation:

- Getting our patients to the most appropriate environment for their Assessment, for their Treatment and for their Care
- Aligning our Clinical Capacity to Pathway Demand
- Making the right thing to do for our patients be the easiest thing to be done by our clinicians

1.2. Operational programmes of work are sponsored by lead clinicians and functional programmes are sponsored by Executive Directors. Each workstream within the programme is governed by an agreed Terms of Reference document that the Steering Group uses to set out their objectives and implementation plan.

1.3. As with the first quarter of the year, members of the Transformation Team have continued to support operational colleagues by being formally and informally seconded into business as usual roles to create the environments ready for Transformation. This has been particularly the case in supporting the Surgery, Cancer, Neurosciences and Trauma Division.

1.4. The Transformation team has continued to reduce in size, focusing on key priorities for change. Clinical Records Transformation and Workforce and OD expertise are both areas now led and resourced by the business as usual functions. Project management support is now being provided to the rollout of the Allocate solution for managing medical rotas.

1.5. The team focuses on being exemplars of the Trust's improvement methodology and dedicates time each week to learning and reviewing specific parts of the curriculum, with more detailed sessions monthly. This quarter the focus has been on improving stakeholder relationships, risk management and control frameworks.

1.6. Each week, the workstreams are held to account for delivery through the review of Weekly Workstream Monitoring Forms that set out the key operational, financial and workforce impacts of initiatives implemented to date and the plans for the delivery of immediately upcoming milestones.

2. Unplanned & Admitted Patient Care ("UAPC")

2.1. The Inpatient Processes workstream held a well-attended clinical workshop with representatives from across the trust to look at establishing Minimum Standards for the way that our wards to help patients move smoothly through their inpatient journey.

2.2. In advance of capturing some of the patient flow benefits of the full use of iClip on our inpatient wards, through the development and delivery of electronic bed management, two further live status Tableau reports have been launched. The first sets out patients with a Planned Date of Discharge in the past, today and tomorrow. This enables bed managers to help the ward teams get accurate information and assist with providing solutions where there are delays in patient pathways, helping more of our patients to go home safely.

2.3. The second live report enables the Bed Management team to see which beds are empty or awaiting cleaning and to confirm the acceptable patient gender to comply with Mixed Sex Accommodation objectives. This will be a fundamental to the revised AMU and Nye Bevan Bed

Management processes as the iClip rollout accelerates the pull and transfer of patients to downstream wards in line with the SAFER bundle principles. Preparing for this significant IT enabled operational process change will be the major focus of the Inpatient Processes workstream through October.

2.4. The project for the set-up of the conversion of the Queen Mary's Minor Injuries Unit into an Urgent Treatment Centre ("UTC") has made good progress completing the second analysis of the commissioner's assumptions on population growth, patient throughput and patient profiles (including the impact of the Clapham Urgent Care Centre changes and paediatric patient volumes). This also included an initial review of mental health patient activity. A final analysis is underway and will include mental health patients attending Urgent Treatment Centres for physical reasons, the numbers of patients attending UTCs via NHS111 and numbers of blood tests carried out which is currently under-estimated. The CCG have agreed with the outcomes from these first two phases of the analysis.

2.5. Emergency Department Front Door streaming rates continue to be good, with daily data available to track use of these alternate pathways. All CQUIN targets have been achieved, September's position shows for example:

Streaming to:	Target	Actual
Adult Primary Care	7.8%	8.5%
Paediatric Primary Care	5.0%	9.5%
Ambulatory Emergency Care	3.3%	6.5%

2.6. Significant data quality improvements have been made through collaborative working with the ED team, iClip back office team and Informatics. A Tableau dashboard was created to improve streaming visibility and has now been accepted by the CCG as a replacement for manual reporting, this is expected to deliver analyst time savings. The ED Efficiency survey debrief and response session was completed on 17 September.

2.7. The Mental Health CQUIN has now been handed over to ED management to lead. The Transformation Team are supporting the management of this CQUIN by co-developing a method of tracking and recording remote or off-site mental health support provided to the frequent attender cohort. This will support CQUIN delivery and better quality mental health care, and in turn this will improve continuity of care and ensure better governance.

2.8. The UAPC Flu Point-of-Care Testing (POCT) in ED project was announced as a finalist for the 'Acute Sector Innovation' Health Service Journal award. The Transformation and Clinical co-leads will present to a judging panel in October and winners will be announced in November. The flu project continues in ED with a POCT re-launch planned for October. In-situ testing of the point-of-care flu analyser & iClip interface and LIMS (Laboratory Information Management System) has been completed. A second flu machine has been provided to avoid queuing delays, new network points have been installed and IT interface testing is underway.

2.9. The Transformation Team was asked to support ED activity data quality where several issues were identified and an improvement plan commenced with the Income Recovery Team. Issues identified included missing notes and incorrect and incomplete coding. Work is underway to correct the data as required.

2.10. The Emergency Department Paperlight project is on schedule for launch on 6th November 2018, in alignment with the wider iClip ward level rollout.

2.11. During the Quarter there has continued to be considerable focus on system wide working to improving the processes around patient discharge. The Discharge Choice protocol, a whole system response to raising patient experience, has been agreed at both the Wandsworth and Merton Intermediate Care Rapid Response Task & Finish Group and the Urgent and

Emergency Care Transformation and Delivery Board. The whole system training and support plan will be developed and implemented in October.

2.12. The second Wandsworth Central London Community Healthcare, Maximising Independence and Keeping Independent through Enablement meeting happened on 25 September to outline go live plans for rehabilitation and re-enablement during October.

2.13. Wandsworth and Merton CCGs hosted an Out of Hospital Care Workshop as an opportunity for system partners to share local understanding and ideas about admission avoidance and rapid response. Three system workshops have been held to review overall capacity and demand schemes for winter 2018-19 and partner organisations have been asked to identify various initiatives to offset the modelled gap in inpatient capacity.

3. Planned Care

3.1. The rollout of one-way text reminders for outpatient appointments, pre-operative, day-case and diagnostic areas is now almost complete with over 95% of our appointment types either live or intentionally excluded. In September, with MRI and ultrasound appointment reminders now included, nearly 100,000 text reminders were sent. Effective communication with our patients is key to reducing Did Not Attend rates and includes the timely booking of appointments and initial letter distribution as well as appropriate reminders.

3.2. Two-way text message reminders allow our patients to confirm their attendance, reschedule or cancel and this rollout is now starting.

3.3. Self-check-in booths remain a key area of focus with an ambition of including increasing the utilisation of the existing booths (which in May was at 10%). In September, a booth was re-located to Cardiology and a further booth will be relocated to Dermatology in October. The key will be to ensure that where booths are available then most patients are able to use them.

3.4. To maximise the Cost Improvement Project benefit, it has been decided to switch the focus of the Hybrid Mail project away from a migration of suppliers on to the faster rollout of the existing prover model. Whilst this may cause a small element of rework if providers are switched later, it will bring the cash savings forward.

3.5. Results from the first month of the two-month testing phase of the Virtual Fracture Clinic (VFC) are now available. Based on VFC models successfully implemented in other Trusts it was anticipated that approximately 33% of fracture clinic patients would be managed on a virtual pathway. Of the 53 patients who have been reviewed since during September 51% have been discharged without requiring a face to face appointment. The project manager has been spending time in the Emergency Department engaging with the Emergency Nurse Practitioners and promoting this new way of working. The testing phase will finish at the end of October at which point a review and full roll-out will commence.

3.6. Engagement continues to drive forward the Virtual Consultation opportunities to provide a better experience for patients and free up clinic and waiting space for those that really do need to come here. Virtual Care has been agreed as a key element of our Planned Care strategy, and plans are underway for a Clinical Summit on 6 November to ensure that the Transformation team can meet the ambitions of each Care Group.

3.7. The first 6 month testing phase of the Gastroenterology Clinical Assessment Service (CAS) was completed in August demonstrating it is a worthwhile venture. 88 patients took part, 68% had all of their investigations undertaken prior to their first face to face attendance and 2 bowel cancers were picked up early. On average referral to treatment times reduced from 20 to 12 weeks.

3.8. The CAS model is a form of enhanced consultant triage enabling investigations to be undertaken prior to face to face attendances. Based on similar models used in other Trusts it is anticipated that 20% of patients will be managed without requiring a face to face appointment.

3.9. Primary Care engagement has taken place in September to share the findings and prepare to launch Phase 2 in October with 7 GP practices across Merton and Wandsworth. 40 GPs representing these 7 practices attended workshops with the Gastroenterologists demonstrating excellent clinical engagement across the system.

4. Maternity

4.1. Confirmation was received that the Trust met full compliance the maternity CNST incentive scheme from NHS Resolution and the £978k rebate has been received. A small number of actions have been identified to sustain performance.

4.2. The new Continuity of Carer team midwives (Willow Team) has taken on its first women, with numbers building slowly as the midwives complete rotations across to unit to ensure their skills are up to date in all areas. With the support of double running funding from SWL Local Maternity System we are aiming to have the team officially launched in early November and will organise communication to the Trust and wider community to coincide with this launch. A second Continuity of Carer team is in development for our most local women living in parts of SW17 and it is hoped to have this team running from January 2019.

4.3. The automation of the maternity dashboard has taken more time than expected, but interim data has been produced and shared across the trust and with stakeholders.

4.4. The drafting of the business case to upgrade or replace the maternity IT system at the end of the current supplier contract is almost complete and will be submitted for review through the relevant channels shortly. As with other system changes, the training and project management capacity required will be significant but the safety and efficiency benefits, particularly through integration with the main iClip system, will be value creating for patients, clinicians and the underlying cost base overall.

5. Recommendation

5.1. The Trust Board is asked to note the report.

Author: James Friend, Director of Delivery, Efficiency and Transformation

Date: 15 October 2018

Appendix One – Key Performance Indicators

No	Metric	Baseline (2017/18)	Target	Actual					
				April	May	June	July	August	Sept
1	Proportion of Outpatient Attendances that are Non-Face to Face	<2% overall	By year end: 1st Attendances = 20%	0.4%	0.6%	0.4%	0.5%	0.5%	0.4%
			By year end: Follow-up Attendances = 50%	4.1%	4.9%	4.9%	5.8%	5.1%	5.4%
			Overall, based on Follow-up to First Attendance Ratio of 2:1 = 40%	2.8%	3.4%	3.2%	4.0%	3.5%	3.7%
2	Outpatient Did Not Attend Rate	10.6%	8.0%	12.7%	12.0%	10.2%	10.9%	11.4%	10.0%
3	Admitted Pathway Four Hour Operating Standard	64.3%	April – 69.0% May – 76.7% June & July – 87.1% August – 81.9%	67.9%	82.2%	81.5%	76.6%	74.8%	71.2%
4	SAFER – Downstream Ward Transfers before Noon – Key Eight Wards	28.8%	33% (23.9% of Patients Admitted through ED Attend between 6am and 11am; 31.2% between 6am and Noon)	28.5%	28.1%	28.0%	28.0%	29.1%	23.8%
5	Number of Women booked on to a Midwifery Continuity of Care Pathway	0	20% of bookings by March 2019					2	17

Key:
Red – worse than Baseline
Amber – better than Baseline but not better than Target
Green – better than Target
(NB – Where the Target is less stretching than the Baseline, due to other changes, then the Amber coding is reversed - Amber – better than Target but not better than Baseline)

Appendix Two - Key Deliverables for Next Quarter

PROGRAMME	DELIVERABLE	MONTH
Unplanned & Admitted Patient Care	Re-launch of Point of Care flu testing in Emergency Department	October
	Outline go live plans for rehabilitation and re-enablement (Discharge Pathways)	October
	Launch revised Standard Operating Procedure for Emergency Department front door streaming	October
	Complete Queen Mary's Urgent Treatment Centre service model, operational policy and costs	October
	Launch of Paperlight processes in Emergency Department	November
	Launch of Electronic Bed Management processes for Medical Wards through Acute Medical Unit co-ordination, following iClip rollout	November
Planned Care	Rollout Virtual Consultations	Ongoing
	Intermediate Tier ENT model agreed	October
	Check-in booths will be relocated to Dermatology	October
	eRS Project Review with Outpatients	October
	Full rollout of Virtual Fracture Clinic following completion of test phase analysis	November
	Virtual Clinics Ambition workshop to be held with Care Group Clinical Leaders	November
	Launch NetCall two way text reminders for majority of appointment types	November
	Launch NetCall voice reminders for the majority of appointment types	December
	Launch NetCall clinic cancellation module to communicate more effectively with our patients	December
	Launch NetCall clinic utilisation module to offer patients short notice appointment slots	December
Maternity	Report of the national Digital Maturity Assessment	October
	Business case to upgrade or replace the maternity IT system	October
	Results of audit of Ivory Team midwives	October
	Official Launch of Continuity of Carer team	November
Medical Rostering	Medics eRoster pilot in ED and Cardiology completed	December
	Planning Trust-wide roll-out of Medics eRoster incorporating lessons learned from pilot	December

Meeting Title:	**Trust Board**		
Date:	26 October 2018	**Agenda No**	2.7
Report Title:	Learning from deaths		
Lead Director/ Manager:	Professor Andrew Rhodes, Chief Medical Officer		
Report Author:	Dr Nigel Kennea, Chair Mortality Monitoring Committee, Associate Medical Director Kate Hutt, Clinical Effectiveness Manager		
FOIA Status:	Unrestricted		
Presented for:	Discussion Update		
Executive Summary:	• The Trust is working to establish a new Medical Examiner system by the nationally mandated deadline of April 2019. • Between July and September 2018 there were 342 deaths. Members of the MMC have carried out independent review of 284 deaths, using our locally developed online screening tool and structured review tool, both based on the RCP tool. This represents 83% of deaths, which is significantly above our target of reviewing 70% of deaths each quarter. • This quarter, one or more problems in healthcare were identified in 16.2% of the cases reviewed. This is higher than the proportion found in quarter 1 of this year (10.7%), but is in line with the rate seen previously (15.8% in 2017/18). • External mortality signals have been received in the following specialties: primary hip replacement, adult cardiac surgery, general intensive care and hip fractures. • The SHMI for April 2017 to March 2018 was published on 20th September 2018. For this period our mortality is categorized as lower than expected at 0.84.		
Recommendation:	• For the TB to be updated on implementation of the 'Learning from Deaths' national framework. • To take assurance that SGUH has a robust process for assessing deaths and from learning any lessons that arise from them. • To note the specialty areas where mortality signals are present. •		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	This work will identify issues impacting on care quality day to day, and will identify risks that are escalated to trust and divisional governance teams. The 'Learning from Deaths' framework continues to evolve and requires ongoing change in process that requires resource, even with a mature mortality monitoring process. There is a risk that published mortality data and learning will not only be used for quality improvement, and that identifying problems in care could lead to adverse publicity.		

Legal/Regulatory:	'Learning from Deaths' framework is regulated by Care Quality Commission and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:	There are resource implications associated with this work, particularly introduction of the ME system that are being worked through and can be discussed with this paper.		
Previously Considered by:	PSQB on the 17th October 2018 Quality Committee on the 18th October	**Date**	N/A
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Trust Board with an update on the work of the Mortality Monitoring Committee (MMC), focussing on information and learning identified through independent case record review of deaths for the second quarter of 2018/19. Also provided is an update on the delivery of requirements of the Learning from Deaths framework.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK AND NATIONAL STRATEGY

2.1 Guidance Development and Implementation

We have continued to be actively involved in the national agenda around Learning from Deaths and wider national work around mortality, namely the implementation of the Medical Examiner system

2.2 Learning Disabilities Mortality Review (LeDeR) Programme

Lambeth CCG have commissioned a team of independent reviewers to assist with the LeDeR reviews. We have agreed, and started to share, our local independent mortality reviews for any relevant patients identified as having died in St George's. To date reviews of three patients that died in November 2017 and January 2018 have been shared, in order that this local evaluation can be used to inform and contribute to the wider LeDeR review.

2.3 Progress against priorities for MMC in 2018/19

- We have refined both our independent screening and structured judgement review tools to more robustly capture patients with a serious mental health diagnosis; to identify problems in healthcare related to communication; and to better track actions required following independent review. Analysis of this data will be included in the next quarterly report.
- Roll-out of the SJR methodology to specialty teams in underway, beginning with critical care (10/10/18). The amended version of the tool has been shared with governance leads and a training programme is being planned.
- Work has started locally to design and implement the Medical Examiner system, which will strengthen the work already underway by the MMC.

Over the coming quarter the MMC will continue to take these priorities forward, and will work to progress the remaining objectives detailed in the last report. Included is review of the Learning from Deaths policy to ensure it remains up to date and incorporates best practice in relation to working with families.

2.4 Implementation of the Medical Examiner system

A national network of Medical Examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries. In October 2017 Lord O'Shaughnessy, Parliamentary Under Secretary of State for Health, announced that a national system of Medical Examiners will be introduced from April 2019. A further announcement in June 2018 gave more detail, and was accompanied by publication of the response to the consultation and an impact assessment. https://www.gov.uk/government/consultations/death-certification-reforms

The Trust is working to establish a new Medical Examiner system by the nationally mandated deadline of April 2019. This will involve the creation of a full time Medical Examiner (ME) role and Medical Examiner's Officer (MEO) role.

Such systems have been piloted in a small number of trusts nationwide over the last decade. This reformed system will improve the quality and accuracy of Medical Certificates of Cause of Death (MCCD) and provide adequate scrutiny to identify poor practice; this system was initially driven as a response to the Shipman Inquiry.

The Medical Examiner (ME) would have a number of responsibilities which include:

- Independent scrutiny of Medical Certificates of Cause of Deaths (MCCD) for cremations and burials and consideration of associated information provided by the bereaved and the certifying doctor;
- Support of families and discussion about MCCD in cases not referred to the Coroner. The ME and MEO will provide opportunity to discuss care with the bereaved;
- National reporting and strong focus on sharing learning;
- Improved liaison with the Coroner and notification to the Coroner of a death under Section 18 regulations of the Coroners and Justice Act 2009 where duty arises during the course of ME scrutiny;
- Improved liaison with the Registrars of births and deaths;
- Reporting any concerns of a clinical governance nature, or of interest for public health surveillance;
- Identify training needs of doctors in completion of MCCD.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 The following analyses include all deaths and do not consider deaths of patients with learning disabilities separately; however, this is required for the national dashboard. Our data reported in the format of the National Quality Board dashboard is shown in Appendix 1.

3.2 Overview of July to September 2018

Between July and September 2018 there were 342 deaths. Members of the MMC have carried out independent review of 284 deaths, using our locally developed online screening tool and structured review tool, both based on the RCP tool. This represents 83% of deaths, which is significantly above our target of reviewing 70% of deaths each quarter. Looking at the year to date, 584 of 708 deaths have been independently reviewed in this way (82%). All child deaths are reviewed by local teams and by the Wandsworth CDOP. At the time of writing the MMC have logged reviews for 13 of the 46 adult deaths reported as not independently reviewed this quarter. Reviews from Trauma, Stroke, CTICU and Orthogeriatrics are visible and logged centrally.

This quarter, one or more problems in healthcare were identified in 16.2% of the cases reviewed. This is higher than the proportion found in quarter 1 of this year (10.7%), but is in line with the rate seen previously (15.8% in 2017/18). It should be noted that not all of these problems led to harm and may include recognised complications of treatment.

Where there was a problem identified reviewers felt that it did not lead to harm in 47.2% of cases, probably led to harm in 34.0% and did cause harm in 18.9%. This quarter, the most commonly occurring problem as defined by the structured judgement review, is related to the treatment and management plan (n=13). This is consistent with the profile observed last quarter. We have amended the screening and structured judgement review tools so that in quarter 3 we can begin to record any problems related to communication.

A judgement regarding avoidability of death is made for all reviews. The majority (93.7%) of deaths were assessed as definitely not avoidable, and no deaths were thought to be definitely avoidable. Three deaths (1.1%) were judged to be more than likely avoidable, for that moment in time. Any death that the MMC review suggests may be avoidable is escalated to the Risk Team to consider investigation. Any significant problem of care, whether or not it affected outcome, is highlighted to the clinical team for discussion and local learning.

Avoidability of death judgement score	Jul	Aug	Sep	TOTAL
6 = Definitely not avoidable	104	94	68	**266**
5 = Slight evidence of avoidability	4	5	5	**14**
4 = Possibly avoidable but not very likely (less than 50:50)	0	0	1	**1**
3 = Probably avoidable (more than 50:50)	0	2	1	**3**
2 = Strong evidence of avoidability	0	0	0	**0**
1 = Definitely avoidable	0	0	0	**0**
TOTAL	108	101	75	**284**

4.0 THEMES AND LEARNING

4.1 Support of families

Over the last few months we have worked with a family that raised a number of questions about the care received by their loved one in the last weeks of life. This was also raised as a formal complaint. Liaising closely with the family to understand their questions and concerns the MMC Chair, supported by a multidisciplinary team, has carried out a full investigation of this case. A report has been shared with the family and a meeting has been arranged to discuss the findings and any unresolved concerns. Other actions are being tracked by the End of Life steering group.

4.2 DNACPR discussions

Data suggests that DNACPR discussions are held and documented at a fairly consistent level across the Trust. This quarter 81.3% of patients reviewed have had a DNACPR order in place, which is slightly lower than previous quarters. The MMC are currently analysing the complete independent mortality review dataset to determine whether the timeliness of DNACPR decision making has improved.

5.0 NATIONAL MORTALITY DATA AND SERVICES OPEN TO EXTERNAL SCRUTINY

5.1 National Joint Registry

The Trust received notification in July that our mortality rate for hip replacements is at potential alarm status. Although acknowledged by the NJR that this is likely to be due to the number of more complex cases referred to the unit, the trust committed to review all cases to identify any themes or learning. Comparison of the cases to those from an alert in the previous year confirmed that no additional deaths had occurred. There were 9 deaths in total, between 2003 and 2016. All 9 cases were reviewed previously and findings from the 7 cases that occurred over the 5 year period of the alert (2012-2017) formed the basis of the previous investigation report, which is therefore still valid.

The MMC Chair has contacted the NJR team and informed them that there are no new cases and therefore the previous review is still valid. The trust has raised concerns about how NJR looks at repeated alerts, as this causes increased internal and, potentially, public concern. The NJR Operations Manager committed to raising this issue with the NJR Surgical Performance Committee and the analysis team.

5.2 National Adult Cardiac Surgery

In April the Medical Director received notification from the National Institute for Cardiovascular Outcomes Research (NICOR) that analysis of the National Adult Cardiac Surgery Audit for the period 1st April 2014 to 31st March 2017 showed that our survival rate was lower than expected. These data show our outcomes to be at alert status (2 SD from mean). A similar alert was received in 2017 for the period 1st April 2013 to 31st March 2016 and a full investigation was conducted at that time. It should be noted that NICOR has not yet published this outlier data due to possible methodology concerns.

Multiple strands of investigation and improvement work are ongoing, with systems for prospective daily surveillance and review established which includes all deaths being subject to independent review using the structured judgement review (SJR), a rapid response report, specialty review and external review. External stakeholders continue to scrutinise our performance and behaviours, including NHSE, NHSI, CQC, commissioners and the Coroner. All deaths are reported to the Coroner and a clear line of communication has been established between the Coroner and the AMD for Mortality.

Members of the MMC are working to support NHSI with the external retrospective review of mortality, which may include approximately 200 deaths over the last 5 and a half years. Clinical records have been obtained and existing reviews are being collated for all deaths recorded on the NICOR database. We are also identifying any other deaths that may need to be reviewed, as detailed below.

Source	Number of deaths
NICOR cohort	187
Trust information systems note specialty involvement	47*
SHMI July 2015 – March 2018	29*

*22 deaths are common to both lists

From July 2015 Summary Hospital-Level Mortality Indicator (SHMI) data has included local hospital numbers and we have therefore been able to identify deaths within 30 days of discharge recorded under cardiac surgery. A number of these cases do not appear in the NICOR cohort and we are reviewing them in order to understand the reasons, which may include that the death occurred at admission. Taking these into account, along with deaths where the hospital system records a cardiac surgery episode within the admission spell, results in a potential 241 deaths for review. The MMC are currently investigating the 22 deaths that appear on the SHMI list and hospital information systems under cardiac surgery.

5.3 ICNARC (Intensive Care National Audit and Research Centre) - General Critical Care Mortality Alert

NHS England's Specialised Services Quality Dashboard, issued in August 2018, showed the standardised mortality ratio for GICU of 1.15 (January - December 2017) as a negative alert, with increasing mortality in the last two quarters. The Medical Director asked clinical leaders within the unit to provide an explanation of the data and any resultant learning.

In addition to specialty information, the investigation has drawn on MMC independent reviews of mortality. In 96% of cases that had been reviewed in this way, death was found to be definitely not avoidable.

It is important to note that deaths within this grouping include patients that died on the unit, died in the hospital post discharge from GICU and also those that died in another hospital following discharge from St George's. This forms an important part of the investigation as the care delivered by other organisations may impact on this data. For example, of the 301 deaths included over the full year, 16 occurred following discharge from St George's, and of these 12 had an improved status on discharge.

The final report will be shared with the MMC in due course, but it should be noted that the latest data shows a much improved position.

5.4 National Hip Fracture Database (NHFD)

The MMC have previously reported on hip fracture mortality, which was identified by the NHFD as higher than expected in 2016. The investigation report identified the importance of prioritising this vulnerable patient group for theatre, trying to avoid orthopaedic ward outliers, the importance of regular orthogeriatric review and early mobilisation. Actions intended to address these points include strengthening clinical pathways to prioritise this patient group, improved MDT processes for all patients, and an enhanced local mortality process to review best practice criteria and identify learning where appropriate. There has also been work to reduce inpatient falls and resultant hip fracture and actions to improve coding.

6.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

The SHMI for April 2017 to March 2018 was published on 20th September 2018. For this period our mortality is categorised as lower than expected at 0.84. We are one of 15 trusts nationwide in this category. Associated VLAD (variable life adjusted display) charts, which show the difference between

the expected number of deaths and observed deaths over time for a number of diagnosis groups, do not reveal any areas that require further investigation.

NHS Digital also published the SHMI annual report. This shows St George's is one of 13 trusts which are lower than expected repeat outliers, meaning that our SHMI has been lower than expected for 2 consecutive years. Analysis of contextual indicators shows that we are largely similar to other lower than expected repeat outliers. There are some differences observed in relation to deprivation and depth of coding, but nothing exceptional is seen. Nationally the diagnosis groups with the highest number of deaths are pneumonia, septicaemia, acute cerebrovascular disease, congestive heart failure and aspiration pneumonitis. St George's has the same top 5, albeit in a different order.

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

Analysis	Period	Score	Banding
HSMR	Jul17-Jun18	85.6	Significantly better than expected
HSMR: Weekday emergency admissions	Jul17-Jun18	80.9	Significantly better than expected
HSMR: Weekend emergency admissions	Jul17-Jun18	97.6	Not significantly different to expected

The MMC continue to look at risk-adjusted mortality at both diagnosis and procedure group level and where data suggests our outcomes are significantly different to expected this is investigated. Our system of prospective review and the central recording of mortality reviews from a number of specialties support us to establish a clearer picture of care and identify in a timely way where they may be areas that require further investigation.

It is anticipated that in quarter 4 our supplier of mortality data and analysis tools will change from Dr Foster Intelligence to HED (Healthcare Evaluation Data), which is provided by University Hospitals Birmingham NHS Foundation Trust.

7.0 DISCUSSIONS AT QUALITY AND RISK COMMITTEE

7.1 The committee reviewed the paper and received the verbal report.

7.2 The committee was supportive of the moves to create a medical examiners function in the Trust

7.3 The committee reviewed the implications of the external cardiac review for cardiac surgery and took note of the likely patient numbers.

7.4 The committee noted the areas where the Trust had external mortality signals and also the overall mortality position as described by HSMR and SHMI.

8.0 RECOMMENDATIONS

8.1 For the Trust board to be updated on implementation of the 'Learning from Deaths' national framework.

8.2 To take assurance that SGUH has a robust process for assessing deaths and from learning any lessons that arise from them.

8.3 To note the specialty areas where mortality signals are present.

Appendix 1: National Quality Board Dashboard – data to September 2018

NHS — St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - September 2018-19

Department of Health

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

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
87	120	75	100	1	2
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
339	365	281	299	3	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
704	1739	580	1456	5	15

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

Total Deaths Reviewed by RCP Methodology Score

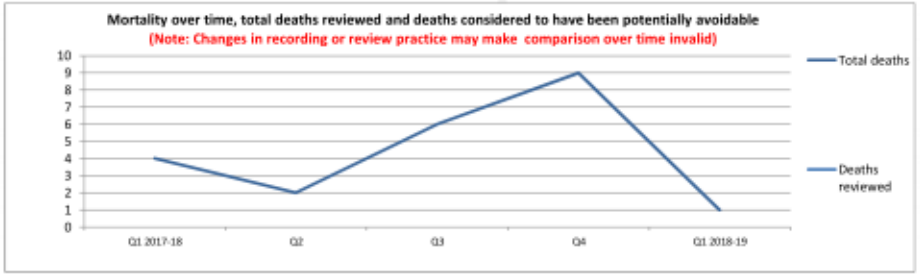
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	1	1.3%	This Month	1	1.3%	This Month	5	6.7%	This Month	68	90.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	3	1.1%	This Quarter (QTD)	1	0.4%	This Quarter (QTD)	14	5.0%	This Quarter (QTD	263	93.6%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	5	0.9%	This Year (YTD)	5	0.9%	This Year (YTD)	18	3.1%	This Year (YTD)	552	95.2%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	1	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	21	0	0	0	0

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



St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 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 18 October 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 – October 2018

1.1 Finance Risks- the Chief Financial Officer updated the Committee on the latest position on the finance risks. Whilst the rating of some individual risk elements had improved, the overall position remained one of limited assurance. The Committee sought assurance from the Executive team that the more detailed risk spreadsheets were reviewed elsewhere and the Chief Nurse noted that formal review was carried out at a local level, which then fed into the executive team through the risk committee.

1.2 ICT Risks- the Chief Information Officer updated on ICT risks, in particular highlighting that a number of the mitigating actions would not be complete until the first half of 2019. She noted the challenges of the recent email outages and the Committee agreed that the overall risk score should be unchanged.

1.3 Estates Risks- the Director of Estates & Facilities updated on Estates risks. He noted the challenges related to water safety, and the intention to come to the Trust Board in December with the completed Premises Assurance Model.

1.4 Activity performance- the Director of Delivery, Efficiency & Transformation noted the improvements in the Elective and Daycase income per working day in September compared to previous months, although performance still remained below the plan required. The Committee sought to understand why year to date performance was behind the plan that had been agreed at the start of the year and questioned whether activity targets in the financial year were too challenging. It was noted that in some weeks delivery targets were met, although consistent performance had yet to be achieved. Members agreed that delivering the target consistently required a strong grip on planning sufficiently far in advance and having a sufficient number of patients ready for admission.

1.5 Emergency Flow- the Deputy Chief Operating Officer noted latest performance and action plans in delivery of the 4 hour A&E target, which was below the planned trajectory, albeit in line with the performance of other trusts in London. It was noted that the performance varied by specialty and that those with largest numbers sometimes found it more difficult to achieve seeing the patient in ED within 30 minutes.

1.6 Financial Performance & Forecast- the Deputy CFO noted the continuing deterioration in the financial position with an adverse variance in Month 6 of £2.1m leading to an adverse variance in the year to date position of £6.2m compared to plan. As a consequence of this, the Trust will not be awarded PSF funding (£2.5m available) in quarter 2, including the 30% related to A&E performance. The Committee questioned the CFO on the implications of this for the forecast outturn for the year. He explained that based on bottom up forecasts from all of the divisions there were a number of scenarios, all of which inferred an end of year deficit of more than £29m and the Committee discussed a range of actions that would be required to secure the best case scenario.

1.7 The Committee explored some of the reasons for the deterioration, including Cardiac Surgery, Medical Expenditure, CIP shortfall and Coding opportunity. Some of these are expected to be mitigated in the best case scenario and the Executive team were asked about opportunities in these areas.

1.8 Cash & Associated Issues- The Interim Director of Financial Operations noted that borrowing was on plan and that the minimum cash position at month end was achieved. She noted an increased borrowing requirement of £3.3m in November in view of extra capital required. The Committee discussed the implications for cash of the various scenarios for the end of year forecast deficit and it was noted that the current cash risk related to the forecast

would need to be discussed with NHS Improvement at the Provider Oversight Meeting next week.

1.9 Capital – the CFO noted the current £1m of 'at-risk' expenditure committed to, on top of the £18.8m internally generated capital budget. The trusts is still awaiting news of the bid for £27.9m submitted to NHS Improvement.

1.10 SLR/PLICs update – the Director of Financial Planning noted the progress made to date in service profitability reviews. The Committee was pleased to receive a detailed presentation from the Care Group Lead for Vascular Surgery on the deep dive into their PLICS data. He noted the challenges in data quality in a number of cost allocation methodologies which have been reviewed in a detailed assessment of the profitability of the service. Committee members noted the importance of putting costs in the correct place, as well as thanking the service for finding opportunities to improve the Trust's position. The Committee encouraged the Care Group Lead to help in championing his approach with other consultant leads.

1.11 Commissioning in 2019/20 – this update was taken as read and would be discussed in more detail in the following month's planning update.

1.12 QMH IClip Business Case – the committee noted small updates made to the paper previously discussed at the Committee. The CFO noted that further updates would be required. The Committee agreed to recommend the investment to the Trust Board.

1.13 IDG update – this update was taken as read.

1.14 FIC Terms of Reference – the updated terms of reference were agreed and recommended to be approved at Trust Board.

1.15 SWLP Report – this update was taken as read and would be discussed in more detail at the next Finance & Investment Committee.

1.16 Procurement Report – this update was taken as read and the CFO noted that he has asked the Head of Procurement to review the actions needed to deliver the Carter targets outlined in Appendix A. The department are currently being assessed against the Level 1 procurement standard, and if achieved, St George's will be the first Trust in South West London to do so.

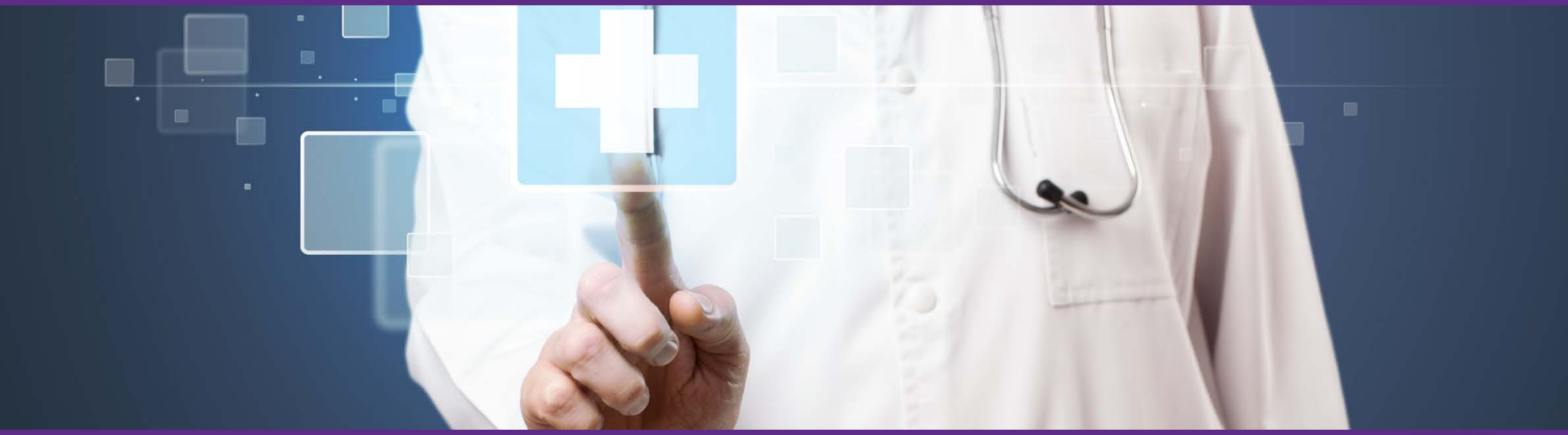
2.0 Recommendation

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

Ann Beasley
Finance and Investment Chair,
October 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**25th October 2018**	**Agenda No.**	3.2
Report Title:	**M06 Finance Report**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	The Trust is reporting cumulative deficit to date of £27.6m at the end of Month 06 (September), which is £8.7m adverse to plan. The in-month position remains adverse to plan with a deficit of £7.1m against a target of £4.6m. The scale of the reported deficit includes the loss of quarter 2 PSF monies due to the failure to achieve the core financial plan £2.5m. The key drivers for the adverse variance remain shortfalls on income recovery, run rate challenges and a shortfall against CIPs. Together with the loss of SPF monies. Delivery of the year-end target deficit is at risk. Internally funded capital expenditure remains within plan. A bid has been submitted for additional funding, feedback is expected shortly. The Trust has commenced work on some projects within this bid, this remains tightly controlled.		
Recommendation:	The Trust Board notes the trust's financial performance to date in September.		
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:	The Finance & Investment Committee Trust Executive Committee	Date	18/10/18 17/10/18
Appendices:	N/A		



St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 6 (September 2018)

Chief Finance Officer

25th October 2018

Executive Summary – Month 6 (September)

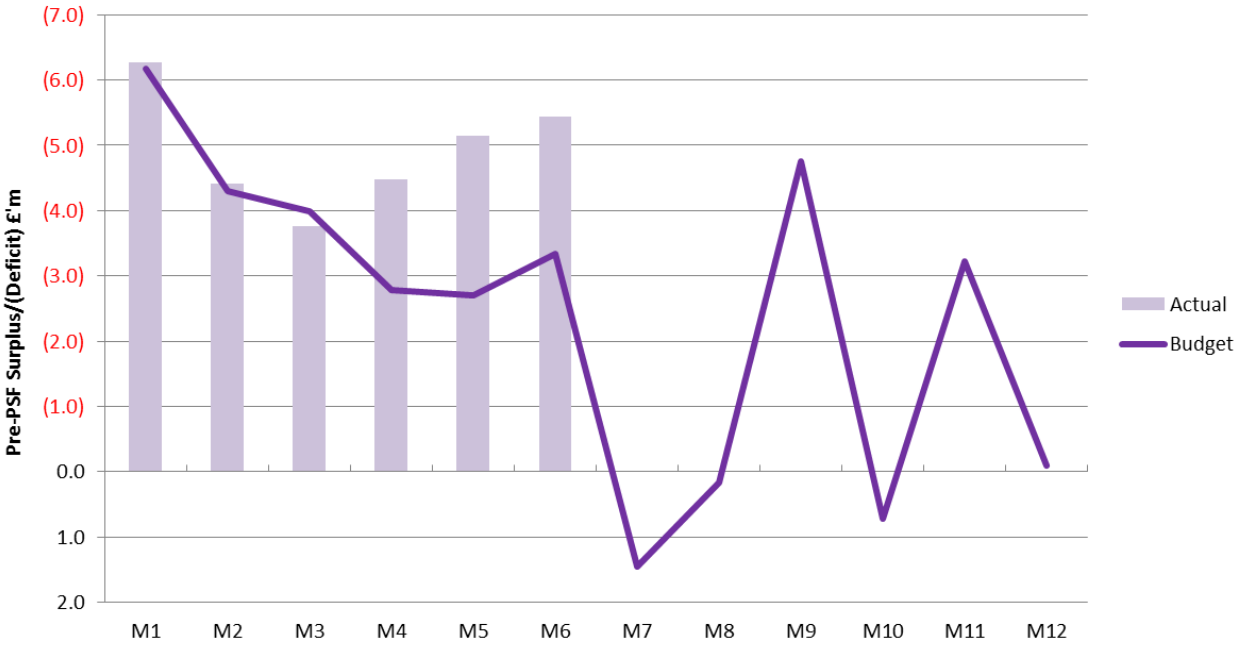
Note: All figures and commentary in this report refer to the revised Trust plan submitted to NHS Improvement on 20th June.

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF deficit of £29.5m** at the end of September, which is **£6.2m adverse to plan**. Within the position, income is adverse to plan by £4.7m, and expenditure is overspent by £1.5m. There also remains an element of income estimation in the position which will need to be validated ahead of freeze dates. **Q2 PSF income of £2.5m** in the plan has **not been achieved** in the Year-to-date position. £1.8m, (70%) related to financial delivery has not been earned and due to the 'financial override' confirmed in recent guidance, £0.8m (30%) related to A&E performance has also not been earned despite the Trust delivering on this metric.	£6.2m Adv to plan	£4.1m Adv to plan
Income	Income is reported at £4.7m adverse to plan year to date. Elective is the main area of lower than planned performance; with shortfalls in volume (£7.4m) being offset by pricing gains (£3.7m) in other areas. Non-SLA income is also adverse to plan, with shortfalls in commercial Pharmacy partially offset by underspends in drugs. There is also a shortfall in private & overseas' patients income.	£4.7m Adv to plan	£2.8m Adv to plan
Expenditure	Expenditure is £1.5m adverse to plan year to date in September. This is caused by Non Pay adverse variance of £2.2m (although a large proportion of this is offset in Income as pass-through is over-performing). Unfilled vacancies are leading to the favourable variance in pay, and CIP under delivery is causing most of the remaining adverse variance in non-pay.	£1.5m Adv to plan	£1.3m Adv to plan
CIP	The Trust planned to deliver £18.4m of CIPs by the end of September. To date, £16.7m of CIPs have been delivered; which is £1.8m behind plan. Income actions of £5.2m and Expenditure reductions of £11.5m have impacted on the position.	£1.8m Adv to plan	£1.3m Adv to plan
Capital	Capital expenditure of £14.4m has been incurred year to date. This is £2.4m below plan YTD. The position is reported against the internally financed plan of £18.8m. This does not include DH capital loans (to be secured) of £27.873m.	£2.4m Fav to plan	£1.9m Fav to plan
Cash	At the end of Month 6, the Trust's cash balance was £3.3m, which is better than plan by £0.2m. The Trust has borrowed £20.5m YTD which is in line with the plan. The Trust requested a loan drawdown for September of £3.2m and has a confirmed loan draw down of £0.75m for October and has requested £3.3m for November. If approved the November drawdown will exceed the cumulative borrowings to M08 that is in the plan due to the additional critical capital support required. The borrowings drawn this year are subject to an interest rate 3.5%.	£0.2m Fav to plan	£0.3m Fav to plan
Use of Resources (UOR)	The Regulators Financial Risk Rating. At the end of September, the Trust's UOR score was 4 as per plan.	Overall score 4	Overall score 4

Contents

1. Month 6 Financial Performance

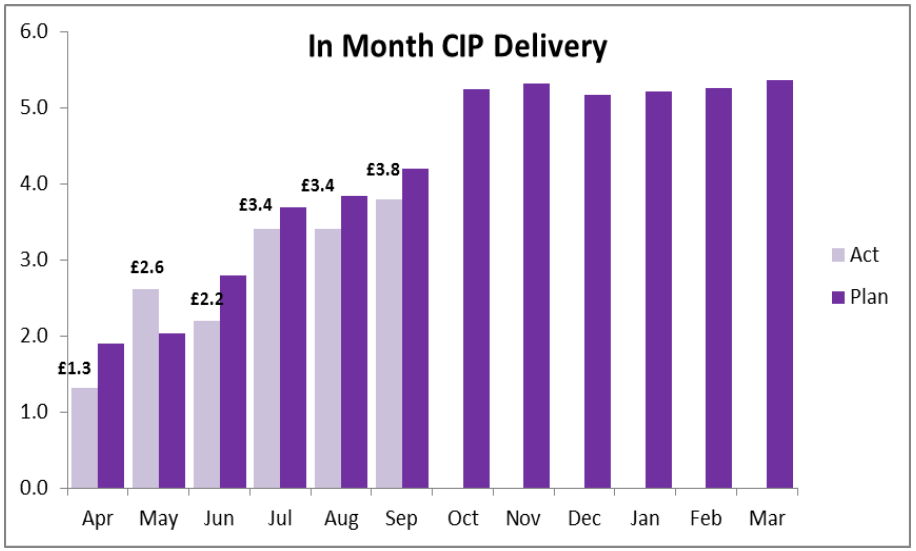
			Full Year Budget (£m)	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	M6 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF	**Income**	SLA Income	665.7	54.3	52.4	(1.9)	(3.5%)	327.2	323.2	(4.0)	(1.2%)
		Other Income	156.6	13.3	13.3	(0.0)	(0.0%)	80.5	79.8	(0.7)	(0.8%)
	Income Total		**822.3**	**67.7**	**65.7**	**(1.9)**	**(2.8%)**	**407.7**	**403.0**	**(4.7)**	**(1.2%)**
	Expenditure	Pay	(509.7)	(42.7)	(42.7)	(0.0)	(0.0%)	(258.5)	(258.0)	0.5	0.2%
		Non Pay	(307.6)	(25.4)	(25.6)	(0.2)	(0.8%)	(155.8)	(158.0)	(2.2)	(1.4%)
	Expenditure Total		**(817.3)**	**(68.2)**	**(68.4)**	**(0.2)**	**(0.3%)**	**(414.3)**	**(416.0)**	**(1.7)**	**(0.4%)**
	Post Ebitda		(34.0)	(2.8)	(2.8)	0.0	1.3%	(16.7)	(16.5)	0.2	1.2%
Pre-PSF Total			**(29.0)**	**(3.3)**	**(5.4)**	**(2.1)**	**(62.6%)**	**(23.3)**	**(29.5)**	**(6.2)**	**(26.6%)**
PSF			12.6	0.8	(1.7)	(2.5)	(300.1%)	4.4	1.9	(2.5)	(57.1%)
Grand Total			**(16.4)**	**(2.5)**	**(7.1)**	**(4.6)**	**(184.5%)**	**(18.9)**	**(27.6)**	**(8.7)**	**(46.2%)**



Trust Overview

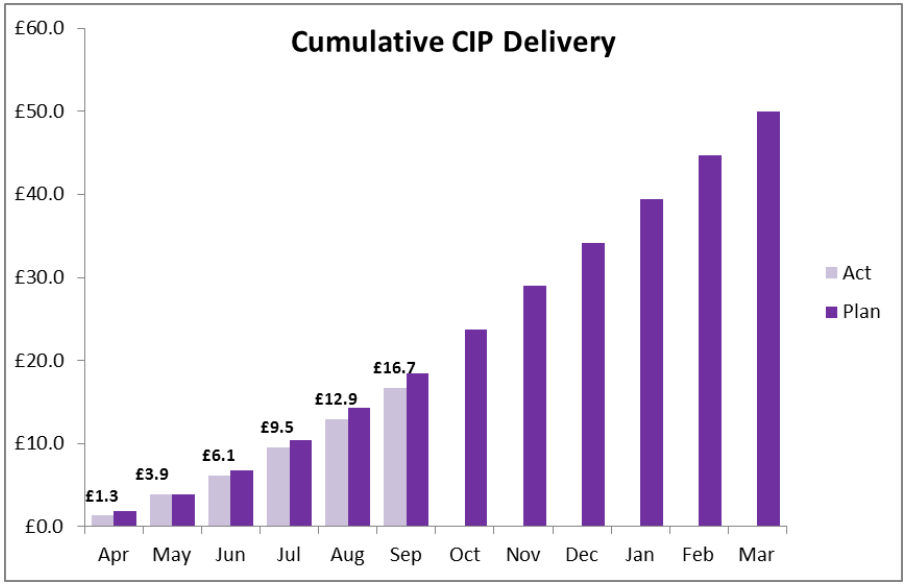
- Overall the Trust is reporting a Pre-PSF deficit of £29.5m at the end of Month 6, which is £6.2m behind plan.
- The in month Pre PSF adverse variance of £2.1m, compares to £2.4m last month. The Cardiac Surgery position has deteriorated in variance terms by £0.4m, meaning an improvement of £0.7m excluding Cardiac Surgery, largely due to improved in-patient income, and reduced pay spend.
- **SLA Income** is £4.0m under plan. The main area of note is Elective where a material adverse variance (£3.6m) which is driven by lower than planned volumes of activity (£7.4m) partially offset with increased income per case (£3.7m).
- **Other income** is £0.7m, which is primarily Commercial Pharmacy income shortfall. This is partially offset by reduced Non-Pay expenditure.
- **Pay** is under plan by £0.5m. All major staff groups are under spending with the exception of medical pay. It should be noted that within staff groups there are areas of over as well as under spending.
- **Non-pay** is £2.2m overspent, with an in-month adverse variance of £0.2m caused mainly by IT & Energy costs. The year to date overspent is mainly owing to increased pass-through costs.
- **PSF Income** is adverse to plan in M6, as the Trust has not met the pre-PSF control total target of a £23.3m deficit. Despite the Trust meeting the 90% A&E target for Q2, the 'finance override' means that none of the £2.5m PSF income can be awarded in the quarter.
- **CIP delivery** of £16.7m is £1.8m behind plan. The Clinical Divisions' shortfalls have been partially offset by Overheads and Central schemes. Delivery to plan is:
  - Pay £0.1m favourable
  - Non-pay £0.9m adverse
  - Income £1.0m adverse

2. Month 6 CIP Performance



CIP Delivery Overview

- At the end of Month 6, the Trust is reporting delivery of £16.7m of savings /additional income through its Cost Improvement Programme.
- This is against an external plan to have delivered £18.4m of savings/ additional income by Month 6 (overall delivery is adverse of plan by £1.8m).
- The adverse year to date variance is driven by the under delivery of savings/income improvements within the Clinical Divisions, against their CIP plans including:
  - Critical Care flexing of nursing staff - £0.3m
  - Closing of theatres – £0.1m
  - Increase in Pain capacity - £0.1m



Year End Forecast & Actions

- Current divisional forecasts indicate that £50m of improvements will be delivered by 31st March 2019; although additional focus is required to ensure the final £5m of this is achieved.
- The impact of the current CIP forecast shortfall and additional material CIP risks will be managed through a range of recovery actions (the CIP Recovery Plan).
- The net impact of these actions, when assessed for their likelihood, should enable the Trust to deliver a total of £50m CIPs in year.
- In addition to the CIP Recovery Plan, stretch targets have been set for Income recovery and Pay savings. These form part of the Trust's overall financial recovery plan to support delivery of its financial control total.
-

3. Balance Sheet as at Month 6

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**377.2**	**386.4**	**380.0**	**6.4**
Stock	**6.4**	5.9	7.3	-1.4
Debtors	**112.3**	105.0	104.0	1.0
Cash	**3.5**	3.1	3.3	-0.2
Creditors	**-118.4**	-125.6	-134.9	9.3
Capital creditors	**-15.4**	-6.6	-6.2	-0.4
PDC div creditor	**0.0**	0.0	0.0	0.0
Int payable creditor	**-0.7**	-1.0	-1.0	0.0
Provisions< 1 year	**-0.2**	-0.2	-0.2	0.0
Borrowings< 1 year	**-57.7**	-58.3	-57.7	-0.6
Net current assets/-liabilities	**-70.2**	**-77.7**	**-85.4**	**7.7**
Provisions> 1 year	**-1.0**	-0.7	-0.9	0.2
Borrowings> 1 year	**-241.6**	-263.2	-257.5	-5.7
Long-term liabilities	**-242.6**	**-263.9**	**-258.4**	**-5.5**
Net assets	**64.4**	**44.8**	**36.2**	**8.6**
Taxpayer's equity				
Public Dividend Capital	**133.2**	133.2	133.2	0.0
Retained Earnings	**-167.9**	-187.4	-196.1	8.7
Revaluation Reserve	**97.9**	97.9	97.9	0.0
Other reserves	**1.2**	1.2	1.2	0.0
Total taxpayer's equity	**64.4**	**44.9**	**36.2**	**8.7**

M01-M6 YTD Balance Sheet movement

- Fixed assets are £6.4m lower than plan due to lower capital spend than plan as capital bids are still being considered by the NHSI.
- Stock reduced in month by £0.1m but remains £1.4m higher than plan due mainly to increase in Pharmacy stock. Pharmacy stock should reduce significantly over the next few months as the new robot is now fully operational.
- Overall debtors are £1.0m lower than plan.
- Creditors are £8.9m higher than plan relating mainly to the rescheduling of the payment of NHSPS rental charges and other NHS suppliers.
- The cash position is £0.2m better than plan. Cash resources are tightly managed at the end of the month to ensure the £3.0m minimum cash balance is not exceeded.
- The Trust has borrowed £20.5m YTD for deficit financing which is in line with the plan. The Trust will drawdown £0.75m for October and has requested £3.3m for November comprising £0.6m to support deficit funding and £2.7m to support critical capital spend. This exceeds the borrowing requirement in the YTD plan by £2.7m.
- The Trust had not drawn down any capital loans to date. A capital bid for approx £27.9m was submitted to NHSI at the end of August and is currently being reviewed by NHSI.
- The deficit financing borrowings are subject to an interest rate 3.5%. Also borrowings for new finance leases are lower than plan.

4. Month 6 YTD Analysis of Cash Movement

	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Cash balance 01.04.18	**3.5**	**3.5**	**0.0**
Income and expenditure deficit	-19.5	-28.1	-8.6
Depreciation	11.7	11.6	-0.1
Interest payable	5.3	5.2	-0.1
PDC dividend	0.4	0.4	0.0
Other non-cash items	-0.1	-0.1	0.0
Operating deficit	**-2.2**	**-11.0**	**-8.8**
Change in stock	0.5	-0.9	-1.4
Change in debtors	9.2	8.3	-0.9
Change in creditors	5.2	16.5	11.3
Net change in working capital	**14.9**	**23.9**	**9.0**
Capital spend (excl leases)	-28.2	-23.4	4.8
Interest paid	-5.1	-5.0	0.1
PDC dividend paid	-0.4	-0.4	0.0
Other	-0.2	0.0	0.2
Investing activities	**-33.9**	**-28.8**	**5.1**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	20.5	20.5	0.0
Capital loans	4.9	0.0	-4.9
Loan/finance lease repayments	-4.6	-4.8	-0.2
Cash balance 30.09.18	**3.1**	**3.3**	**0.2**

M01-M6 YTD cash movement

- The cumulative M6 I&E deficit is £28.1m, £8.6m adverse to plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £28.1m, depreciation (£11.6m) does not impact cash. The charges for interest payable (£5.2m) and PDC dividend (£0.4m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £11.0m.
- The operating deficit variance from plan of £8.8m in cash is due to timing of creditor payments primarily for the CNST premiums and other NHS bodies.
- Working capital is better than plan by £9.0m.
- The Trust has borrowed £20.5m YTD which is in line with the YTD plan. The Trust drew down £3.2m September and has a drawdown agreed for October of £0.75m and requested £3.3m for November. If the November draw down is approved, cumulative working capital borrowings would be £2.7m more than the plan. The additional amount is required to fund critical capital spend while the capital bids are being considered by NHSI. The borrowings are subject to an interest rate of 3.5% for the amounts drawn since November 17.

September cash position

- The Trust achieved a cash balance of £3.3m on 30 September 2018, £0.3m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 17 week cash flow submitted last month. The Trust continues to benefit from the agreed deferral of CNST premiums and also from late invoicing of material rental charges from NHSPS.
- If the Trust continues to fail to meet its target deficit this will place increasing pressure on cash together with an associated reliance on borrowing.

5a. Capital Programme – total, internal and at risk

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	Internal Budget £000	M06 YTD budget £000	M06 YTD exp £000	M06 YTD var £000
Infrastructure renewal	**5,732**	**5,416**	4,021	1,395
IT	**3,015**	**3,013**	3,574	-561
Medical equipment	**1,890**	**1,289**	832	457
Major projects	**5,756**	**5,198**	4,378	820
Other	**1,108**	**618**	595	23
SWLP	**545**	**543**	103	440
Urgent £11.8m March 2018 projects	**711**	**708**	892	-184
Total	**18,758**	**16,785**	14,395	2,390

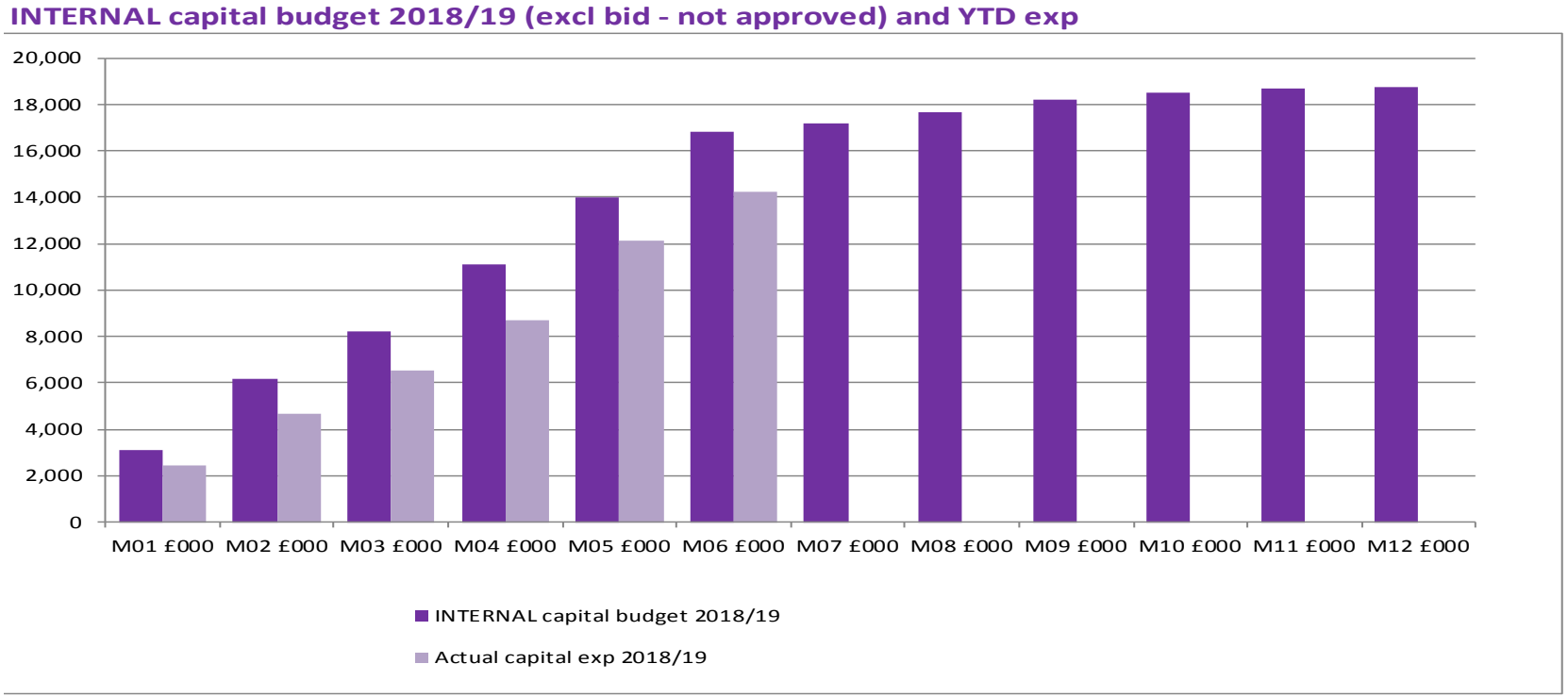
INTERNAL CAPITAL BUDGET only

Spend category	Internal Budget £000	M06 YTD budget £000	M06 YTD exp £000	M06 YTD var £000
Infrastructure renewal	**5,732**	**5,416**	4,021	1,395
IT	**3,015**	**3,013**	3,392	-379
Medical equipment	**1,890**	**1,289**	832	457
Major projects	**5,756**	**5,198**	4,378	820
Other	**1,108**	**618**	595	23
SWLP	**545**	**543**	103	440
Urgent £11.8m March 2018 projects	**711**	**708**	892	-184
Total	**18,758**	**16,785**	14,213	2,572

CAPITAL AT RISK EXPENDITURE only

Spend category			M06 YTD exp £000	M06 YTD var £000
Infrastructure renewal			0	0
IT			182	-182
Medical equipment			0	0
Major projects			0	0
Other			0	0
SWLP			0	0
Urgent £11.8m March 2018 projects			0	0
Total			182	-182

5b. Internal capital budget and expenditure M06



- The Trust's internally funded capital expenditure budget for 2018/19 is £18.8m
- The Trust has incurred capital expenditure of £14.2m in the first six months of the year against the YTD internal capital budget of £16.8m, an under spend of £2.6m.
- The main component of the year to date under spend relates to the biggest project – the Lanesborough wing stand-by generators project (Infra Renewal category) which is under spent by £1.5m as at M06. The project is behind schedule but is forecast to come within budget and so the M06 YTD underspend represent a temporary timing difference.
- Within the Major Projects category the Dental lab is £0.4m under spent (slippage). The medical equipment under spend relates to a short delay in the replacement of existing leased equipment.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M6 YTD)	Actual (M6 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	4
Agency rating	1	1

Basis of the scoring mechanism

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

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of September, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. The internal Trust cap is lower than the external cap of £21.3m.
- The distance from plan score is worked out as the actual % I&E deficit (6.80%) minus planned % I&E deficit (4.60%). This value is -2.20% which generates a score of 4.
- Distance from plan score in this report refers to the Trust plan submitted to NHS Improvement on 20th June.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No.**	4.1
Report Title:	**Workforce and Education Committee Report**		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Assurance		
Executive Summary:	This report sets out the key issues discussed and agreed by the Committee at its meeting on the on 11 October 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A		
Appendices:	N/A		

Workforce & Education Committee – October 2018

Matters for the Board's attention

1. Committee Chair's Overview

This paper reports on the Workforce and Education Committee held on 11 October. We had good attendance with two of the three Divisions represented, as well as the Chair of staff-side. Their contribution really helps us understand the operational implications of the plans and programmes discussed, and the capacity of the Trust to manage change.

The three big items for review were : (1) the (much improved) Diversity and Inclusion Strategy and Plan (which we had initially reviewed at our August meeting); (2) the results of the FY19 Q2 Staff Friends and Family Test (which represented a deterioration on prior quarters) and (3) the initial (mid-year) analysis of the Trust's Ethnicity Pay Gap (to provide the Committee with an informal snapshot ahead of a more detailed review at the financial year end in March 19. As such, the snapshot itself will not be published).

The Committee remained concerned that it had still not seen the workforce plan for the current year. I have discussed this with the Trust's CFO and he has committed to providing the relevant data, so I am presently defining exactly what data would be helpful to the Committee in order to help frame our request.

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

2. Key points:-

Board Assurance - The Committee ended its meeting by reviewing the four[2] **Trust-level risks** that have been assigned to the Committee to monitor, and provide assurance on mitigation. That discussion was led by Elizabeth Palmer who was able to help contextualise risk levels, and assurance. We agreed that there were no changes in circumstances or in our assessment of respective risks that required us to change our present assurance rating. However, in relation to SR1, role design, we were impressed with the commitment to - and now delivery of - innovative clinical support roles and the staff training programmes that have been implemented in recent months to help create a new cadre of Nursing Assistants, and Physician Assistants. Although these alone will not address the workforce pressures the Trust faces, they have the potential to make a real contribution. They are also a very public statement about the Trust's clear intent to invest in innovation, and its backing of the proposals from the nursing, medical and HR teams to deliver effective solutions in an increasingly tight market for staff. They are also an improving response to a core risk.

Theme 1 - Engagement

A Benincasa, the Trust's engagement lead, updated us on continuing progress on the initiatives within the agreed **Engagement Plan** and specifically the Health and Wellbeing Fair held within the last few weeks, and the preparation being undertaken for the NHS national Staff Survey (currently under way, and which will report by March 2019). The Trust has included four 'local' questions covering: living the Trust's values; diversity and inclusion; and health and wellbeing. The Trust has set itself a highly ambitious response target across the Trust's staff – 60%, as against 52% last year. The Staff

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

Engagement Steering Group had met recently, and its main focus had been the results of the most recent Staff Friends and Family Survey (summarised below).

Our Diversity and Inclusion Lead, Celia Oke, introduced the updated **Diversity and Inclusion Strategy and Plan** (D&ISP) which had been extensively revised since the version we saw back in August. It is now a shorter sharper document, which links squarely and clearly to the Trust's values, the objectives over the next three years, and the specific actions to be undertaken over the next six months to initiate momentum. Celia led an engaged discussion on the issue of whether specific targets should be set, outlining the arguments for and against. The outcome of that was that the Committee strongly supported an approach which did set ambitious medium term targets (which we were clear were there for achievement, not simply as an aspiration). Such targets would be stated explicitly in the D&ISP, probably on a three-year rolling basis. The Committee also agreed that it would internally own a set of year-on-year waymarks that would need to be achieved in order to deliver the target trajectory. These would be set by reference to current baselines. Celia agreed to work with Harbhajan and the operational leads to set the rolling targets, and the waymarks. We agreed that the D&ISP should be approved as presented, and we would delegate to Harbhajan responsibility to finalise the targets, based on the discussion at Committee and the data submitted as part of our 2018 WRES return. We anticipate that the version which comes to the Board will include these targets.

We had an in-depth discussion of the results of the **Staff Friends and Family Survey** for the period July – September 2018 (Q2-2018/19). The starting point was that the results had, for the first time in 18 months, gone backwards. The concern was as much about the reverse of the previous positive trend as about the absolute results themselves – see chart below. The verbatim comments from respondents to the survey made uncomfortable reading, and we confronted a number of the assertions made by respondents about behaviour that did not reflect the Trust's stated values.

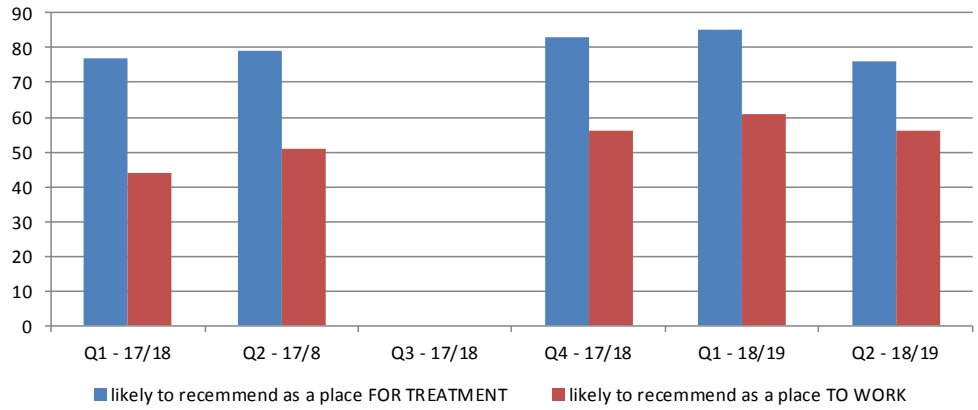


Chart 1 – Staff Friends and Family Survey results, April17 – Sept 18

What was encouraging was the realism within the discussion of what the results and comments were saying, the underlying causes of these and, importantly, the commitment to change in order to get future results back on track. A number of sensible suggestions had already been made through earlier discussions at the Staff Engagement Steering Group (which Alison summarised) and at TEC (which Harbhajan summarised). We agreed that these were appropriate, and that they also required a more staff-oriented approach from managers at all levels, and an open acknowledgement of the depth and number of the challenges the Trust was addressing – failing which there was the potential for improvement-fatigue to develop. The importance of face-to-face engagement with staff (in parallel with e-mail and MyGeorge) was reinforced by a number of attendees. We have asked to be kept up to date with developments and will look very carefully at the results of the next quarter's results (probably available in January) and the results of the wider staff survey (available in February or March).

This discussion also led us to consider two proposals that Sarah James had brought forward: one for a **Coaching and Mentoring Strategy**; and one for consolidation of the Trust's **organisational**

development initiatives, both of which were timely and well-thought through. We agreed the proposals.

Theme 2 – Leadership and Progression

The funding request to NHS Improvement has been agreed, and actions are currently underway to implement the key projects.

Theme 3 - Workforce Planning

In the absence of Sion Pennant-Williams, Harbhajan presented the most recent **workforce report**. As at the end of August, the vacancy rate had fallen further to 10.15% (from 17.8% a year ago) and turnover had fallen to 17.1% (from 18.4% a year ago). The MAST rates had fallen back slightly over the summer, and now stood at 87.9%. A push is under way to get the Trust to its 90% target.

Sion had also prepared a snapshot view of the Trust's **Ethnicity Pay Gap**, based on a snapshot date of 31st March. The intention behind this was to aid Celia Oke in assessing the baseline situation, and identify focus areas for the purposes of the Diversity and Inclusion Strategy and Plan (referenced above). The work undertaken by Sion is a draft analysis which is not intended for publication and it is not therefore appropriate to comment further in this Report – other than to indicate three things. First, there is clearly work to do. Second, Celia has reflected this in her proposed work plan, and Harbhajan and the HR team have the benefit of a clear assessment of the reality, rather than relying on inferences or supposition. Third, the Trust starts in a reasonable place. Of the 14 pay bands evaluated, in seven there was an ethnicity pay gap in favour of white staff, and in the other seven a pay gap in favour of black and minority ethnic staff. However, the gaps were clustered across particular staff groups, and so the picture is more complex than this summary may imply.

The Trust's move of its **Medical Bank rates** to the Pan-London Break Glass Ceiling levels was effected, as planned, from 3 September. Early indications are that the new (lower) rates were however quickly breached by hospitals across London, including SGH. The extent of this is not known, but hard data will be available from the end of October and we will look carefully at this, and at the impact on medical agency spend.

September **agency spend** was nearly back under our cap, which represents a really good achievement (and a lot of tight management) by the Divisions, given the breaches experienced over the summer. Equally, that tight management may have been one (amongst a number) of factors influencing the results of the Staff Friends and Family Survey, and executive management is working to secure the right balance between achieving budget and the environment we create for our staff.

Theme 4 – Compliance.

Individual areas of training, and the compliance rates across the Trust for each, were circulated. The compliance rates ranged from 97% to 21%. It is important to bear in mind that not all staff are required to undertake all training, but the segmentation has allowed executive management to target their intervention in specific areas. We will return to this at a subsequent meeting of the Committee.

Stephen J Collier
15 October 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No**	4.2
Report Title:	**Workforce Diversity and Inclusion (D&I) Strategy Plan**		
Lead Director/ Manager:	Harbhajan Brar; Executive Director, HR&OD		
Report Author:	Celia Oke; Workforce Diversity and Inclusion Manager		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This report asks the Trust Board to formally ratify the attached St George's University Hospitals NHS Foundation Trust D&I strategy and implementation plan that was approved at the October 2018 WEC meeting. This strategy has emerged as a direct result of the review of current practices and policies together with information gathered from staff data, surveys and consultations. The four key strategic aims are linked to our Trust values: • Visible, involved leadership - **Responsible** • Provide a culture of inclusivity, respect and trust - **Respect** • Deliver equality, honesty and fairness evident in our practices and policies – **Excellence** • Promote and support a diverse, involved, inclusive workforce – **Kind** Our key measures over the next three years are:- • 25% reduction in bullying and harassment complaints • Established Executive Diversity Champions and four Diversity Staff network groups by December 2018 • 10% improvement rate of BME applicants at the shortlist stage • 15% improved representation of BME and People with disabilities in AFC Bands 8a to 9		
Recommendation:	Ratification of the Strategy and measures Full launch to the Trust		
Supports			
Trust Strategic Objective:	Build a better St George's Champion team St George's		
CQC Theme:	Leadership and Engagement		
Implications			
Risk:	Immediate		
Legal/Regulatory:	Equality Act 2010; Employment Rights Act 1996; 18 HSCA (RA) Regulations 2014		
Previously Considered by:	Workforce and Education Committee	**Date**	11 October 2018
Appendices:	Appendix (1) Our Diversity and Inclusion Strategy Appendix (2) Our Diversity and Inclusion Strategic Plan 2018 – 2019;		

1. Purpose

1.1 The purpose of this paper is to provide the Board with a Workforce D&I strategy and a three year rolling delivery plan for ratification.

2. Summary

2.1. The D&I strategy has emerged as a direct result of the review of current practices and policies together with information gathered from staff data, surveys and consultations.

2.2. It has four key strategic aims:

- Provide visible and involved leadership
- Develop a culture of inclusivity, respect and trust
- Deliver equality, honesty and fairness evident in our practices and policies
- Promote and support a diverse, involved, inclusive workforce

2.3. The attached document outlines our strategic values, our priorities and actions for 2018/19, with measurable outcomes.

2.4. Our delivery plan is focused on immediate priorities, creating a robust foundation for our aim of being an NHS champion/beacon of Diversity. It will be reviewed annually to ensure it continues to support our values and ambitions.

3. Measures and Outcomes

3.1 To ensure the strategy and plan is effective with aims reflecting our commitments, we have set tangible, stretching targets and goals illustrating distinct responsibilities with embedded audit trails.

3.2 Some targets are linked to required actions for WRES, WDES and our assurance framework

4. Recommendations

4.1 It is recommended that the Board:-

- agree the D&I strategic aims
- approve the 2018/19 delivery plan and targets; and
- support a full launch and communication to the Trust

Author: Celia Oke, Workforce Diversity & Inclusion Manager **Date:** 11 October 2018

Executive Summary

At St George's we value, celebrate and embrace Equality, Diversity and Inclusion (EDI). Our Board and Executive Team drive our approach and commitment to EDI. Our aim is to provide **Outstanding Care, Every Time**. To achieve this it is important that we have an environment which promotes equality, inclusivity and champions the diversity of its workforce.

Our Aim

Our Diversity and Inclusion (D&I) strategy is underpinned by our aspiration to be recognised as an advocate. Our ambition is to go further than the letter of the law and create a culture where our equality commitments are embedded into every aspect of our business, our workforce truly represents all sections of our community and there is zero tolerance for behaviours and attitudes that have an adverse effect exclude and are unfair.

Our Values, Priorities and Objectives

Our values of Excellence, Respect, Responsibility and Kindness guide our people, inform their behaviours and decisions.

These values shape our D&I standards of:

Visible, involved leadership.
A culture of inclusivity, respect and trust.
Equality, honesty and fairness in our practices and policies
Promoting and supporting a diverse, involved, inclusive workforce

Our objectives have emerged in response to Big Conversations, staff surveys, focus groups and analysis of current systems and practices. This strategy sets out the priorities on which we will focus; these will be reviewed and set annually.

Headline Measures

Over the next three years we would like to achieve a :-

- 25% reduction in bullying and harassment complaints over three years, with an annual rolling target of 5%
- 10% improvement rate of BME applicants at the shortlist stage
- 8% improvement rate of people with disabilities (PWD) at the shortlist stage
- 20% reduction of disciplinary complaints against BME staff
- 15% improved BME and PWD representation at AFC Bands 8a to 9

Responsibility

Everyone has ownership of this strategy, we are all responsible and will be held accountable for upholding St George's position on D&I.

Visible, involved leadership	
What we will do	**How?**
Ensure senior leaders are equipped to promote and represent St George's commitment to an inclusive, fair and open environment, advocating equality and diversity	• Establish executive diversity champions for specific protected characteristics • Design and deliver Diversity Leadership programmes

A culture of inclusivity, respect and trust	
Create an environment where staff can work in a safe culture that promotes respect and inclusion; where there is zero tolerance for discrimination, bullying and harassment	• Implement a performance objective linked to bullying and harassment for senior managers • Employ a reverse mentoring programme • Commission programmes on cultural intelligence and other diversity subjects

Equality, honesty and fairness in our practices and policies	
1. Demonstrate our commitment to equality and diversity is central to all our procedures and policies. 2. Ensure our values and practices comply with equality legislation and good practice.	• Deliver a fair, and accessible recruitment and selection experience • Eliminate barriers that may potentially discriminate • Establish equality checks and balance procedures • Undertake actions identified in the Workforce Race and Disability standards • Gain accreditation from equality bodies

Promoting and supporting a diverse, involved, inclusive workforce	
1. Our workforce reflects our values, is fully representative, and diverse especially at senior levels. 2. We strive to make sure staff are suitably equipped and supported to progress and develop at St George's 3. Establish St George's as an employer of choice	• Establish opportunities for career development and progression, particularly for under-represented groups • Create equality staff networks • Commission Positive Action[1] programmes to include mentoring, project assignments, and career progression schemes

[1] Positive action: measures taken to increase the participation of underrepresented groups, do not unlawfully discriminate against another group, and is lawful.

Visible, involved leadership.			**Value: Responsible**
Priority 2018/2019 – Equipping our leaders			**Outcome/Measure**
Ensure senior leaders are equipped to promote and represent St George's commitment to an inclusive, fair and open environment, advocating equality and diversity	• Establish executive diversity champions for specific protected characteristics • Design and deliver Diversity Leadership programmes	D&I, E&D	Established Executive Diversity Champions - December 2018 Reverse mentoring programme launched – February 2019
A culture of inclusivity, respect and trust.			**Value: Respect**
Priority 2018/19 – Creating a safe, open working environment			**Outcome/Measure**
Create an environment where staff can work in a safe culture that promotes respect and inclusion, where there is zero tolerance for discrimination, bullying and harassment.	• Implement a performance objective linked to bullying and harassment for senior managers • Employ a reverse mentoring programme • Commission programmes on Cultural intelligence, and other diversity subjects.	D&I, E&D, LIASE; Staff Engagement; Wellbeing	25% reduction in bullying and harassment complaints over three years.
Equality, honesty and fairness in our practices and policies			**Value: Excellence**
Priority 2018/2019 – Eliminating barriers in processes and policies			**Outcome/Measure**
• Demonstrate our commitment to equality and diversity is central to all our procedures and policies. • Ensure our values and practices comply with equality legislation and good practice.	• Deliver a fair, and accessible recruitment and selection experience • Eliminate barriers that may potentially discriminate • Establish equality checks and balance procedures • Undertake actions identified in the Workforce Race and Disability standards • Gain accreditation from equality bodies	D&I, E&D Recruitment, HR,	10% improvement rate of BME applicants at the shortlist stage 8% improvement rate of people with disabilities (PWD) at the shortlist stage Stonewall workplace index and Disability Confident Level 2 gained by March 2019.

Promoting and supporting a diverse, involved, inclusive workforce			Value: Kind
Priority 2018-2019 Diverse, skilled workforce reflecting our community			**Outcome/Measure**
• Our workforce reflects our values, is fully representative and diverse particularly at senior grades • We strive to make sure staff are suitably equipped and supported to progress and develop at St George's • Establish St George's as an Employer of choice	• Establish opportunities for career development and progression, particularly for under-represented groups • Launch equality staff networks • Improve representation of specific PCs[2]	D&I, E&D, Staff Engagement Steering Group	20% reduction of disciplinary complaints against BME staff Establishment of staff diversity networks for BAME, Disability, LGBT and Women – December 2018 15% improved BME and PWD representation at AFC Bands 8a to 9

[2] Protected Characteristics

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No**	5.1
Report Title:	2018/19 Corporate Objectives – Quarter 2 report		
Lead Director	Suzanne Marsello, Director of Strategy		
Report Author:	Ralph Michell, Head of Strategy Tom Ellis, Head of Business Planning		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	In June 2018 the Trust Board approved the Corporate Objectives for 2018/19, based on the domains of "Outstanding Care, Every Time." It was agreed that progress against the objectives and their associated quarterly milestones would be reported to the Trust Board on a quarterly basis. The attached paper is an update on progress against Q2 objectives, for to the Board to approve.		
Recommendation:	Board is asked to asked to - Review the update, and in particular the assessment of where slippage presents a material risk to the year-end position - Approve the report		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	▪ Any risks associated with the corporate objectives are covered within the BAF, Trust Risk Register or local risk registers		
Legal/Regulatory:	As legal/regulatory issues associated with the Corporate Objectives are covered by the governance underpinning that particular area of delivery of the trusts work programme		
Resources:	Delivery core business as usual of the trust, and supported by trust leadership cohort		
Previously Considered by:	Trust Executive Committee	**Date:**	17/10/2018

Appendices:	Corporate Objectives report, Quarter 2 detail

2018/19 Corporate Objectives
Quarter Two Report
Board October 2018

1.0 Purpose

1.1 In June 2018 the Trust Board approved the Corporate Objectives for 2018/19, based on the domains of "Outstanding Care, Every Time."

1.2 It was agreed that progress against the objectives and their associated quarterly milestones would be reported to the Trust Board on a quarterly basis.

2.0 Progress against objectives in Q2

2.1 All corporate objectives for Q2 have been RAG rated on progress, as has each of the domains into which they are divided. Annex B sets out the methodology for arriving at RAG-ratings.

2.2 19 objectives have been rated green, 17 amber, and 9 red.

Organisational Objective	Green	Amber	Red	N/a (for quarter)	Quarterly Position	YTD Position (and change vs previous Q)
Treat the patient, treat the person	6	3				-
Right care, right place, right time	4	4	3	1		-
Balance the books, invest in our future	1	1	2			↓
Build a better St. George's	6	4	2	3		↓
Champion Team St. George's	1	4		1		↓
Develop tomorrow's treatments today	2	1	2			↓
OVERALL	19	17	9			↓

2.3 Of the objectives RAG-rated amber or red in Q1, all but 4 have now been delivered. Those 4 relate to use of restraints (e.g. bed rails), AMU occupancy, theatre productivity, and return to RTT reporting. In all these cases Q2 objectives are the same as/follow-on from objectives for Q1 - and so the update on progress vs Q2 objectives can be taken as a report on progress year to date.

3.0 Risks & mitigating action

3.1 The Q2 position represents a deterioration from Q1, when 36 objectives were rated green, 3 amber and 2 red.

3.2 However, for objectives rated amber/red in Q2, either work is sufficiently advanced at this stage, or sufficient remedial plans of action are in place, that in most cases the Trust Executive's view is that the slippage does not currently pose a material risk to the achievement of the corporate objectives by year end.

3.3 The exceptions to this are those objectives relating to the following areas, where slippage to date could pose a risk to delivery of the corporate objectives by the end of the year:

a) delivery of NHSI-agreed ED performance
b) theatre productivity
c) RTT (return to reporting, and elimination of 52-week waits)
d) Reduction of the deficit
e) Review of estates and securing external capital

3.4 All deliverables not met in Q2 are set out in Annex A, along with a progress update, mitigation and assessment of the extent to which slippage poses a material risk.

4.1 **Recommendations**

4.1 The Board is asked to note and agree the assessment of progress vs objectives, and the risks to year-end delivery

Annex A – Deliverables not met in Q2

Objective	Deliverables not delivered & causing amber or red RAG rating	Progress update	Mitigation	Link to BAF
Treat the patient, treat the person				
Improve our compliance with Mental Capacity Act Assessment (MCAA)	▪ Implement L2 MCA / Deprivation of Liberty Standards (DoLS) training.	elearning package has been completed, but not yet rolled out.	Implementation to start October.	Not a material risk to the trust at this stage, as the work to deliver is underway.
Improve the safe, effective and appropriate use of restraints (e.g. bed rails) throughout the Trust	▪ Ensure staff are trained	Level 1 training currently at 76.7%, level 2 training developed and being piloted.	Roll out of level 2 training from October	Not a material risk to the trust at this stage, as the work to deliver is underway.
Put in robust process to effectively identify patients who are at risk of deteriorating	▪ Review and make decision on requirements for Critical Care Outreach Team and our compliance against the relevant standards.	Business case drafted but decision not yet taken	Final business case and options appraisal expected to be completed by end of October	Not a material risk to the trust at this stage, as the work to deliver is underway.
Right care, right place, right time				
Enhance processes within ED to improve emergency care performance and patient care and experience	▪ Meet NHSI agreed ED performance of 95%. ▪ Implement ED paper-lite	▪ 91.58% performance in Q2. ▪ ED paper-lite not yet delivered, to synch with iClip roll-out	▪ Papers to board in Q2 set out action to address ED performance. ▪ ED paper-lite scheduled for go-live in November	**Potentially a material risk** to annual objective of meeting target performance agreed with NHSI
Admit patients to the right ward, discharge them efficiently and ensure a positive patient experience	▪ AMU bed occupancy at Midday =<85%.	▪ a number of initiatives implemented/ being implemented (e.g. exemplar patient, pre-11am early discharge, minimum standards, transfer of care bureau, weekend discharges pilot) but target occupancy not delivered.	▪ Remedial plan, including diagnostic to understand root causes, in place.	Not a material risk to the trust at this stage – remedial plan in place and end of year target of <90% occupancy still deliverable.

Estates will draw up and assist with physical plans/options to support emerging operations plans/strategy	▪ Undertake Space Utilisation Review to be completed by end September. This review to inform first draft St. George's Estate Strategy (timing contingent on emergence of clinical strategy for South West London).	▪ Not delivered	▪ Work scheduled to be completed December 2018	Not a material risk to the trust at this stage, as the work to deliver is underway.
Increase theatre productivity	▪ One theatre to be mothballed, following introduction of new service template delivering improved productivity.	▪ Decision taken in Q1 to change plan and keep theatre open.	▪ Plan to absorb CIP impact of decision via increased activity. New theatre template introduced in Sept with revised activity plan by specialty. New Theatre GM in place. Actions focused on increasing capacity and productivity for booking team, and on accelerating pre-op assessment and the time taken from initial referral to clinical decision that an operation is needed.	**Potentially a material risk**, despite remedial action in place. Final month 6 position, once published, will give clearer picture.
Offer patients greater choice in how they access acute specialties with alterative to face-to-face appointments	▪ Roll out of virtual notes review clinics and open access follow up appts (2nd tranche of services). ▪ Gastroenterology primary care pathway launched. ▪ Tele-dermatology service commences	▪ some services intended for inclusion in virtual notes review clinic roll out are not yet included, with delay intended to ensure greater use of automation vs manual data entry. ▪ Gastroenterology primary care pathway not launched due to issues	▪ Proposition sought from external supplier to further roll out virtual notes clinic, date tbc dependent on proposition ▪ Gastroenterology pathway expected to go live October	Not a material risk to the trust at this stage, as the work to deliver is underway.

		with processing data & payments. ▪ Tele-dermatology service delayed to reduce need for manual data entry through greater automation.	▪ Tele-dermatology service expected to go live November.	
Return Tooting campus to national reporting of the 18 week RTT standard and work to reduce waiting times against all national standards	▪ No patients waiting >52 weeks for all specialties apart from ENT & General Surgery. ▪ Implement cancer dashboard. ▪ RTT incomplete aggregate performance achievement - 79%.	▪ average of 6 patients now waiting >52 weeks in relevant specialties. ▪ Cancer dashboard developed and in use, but further developments still being undertaken ▪ RTT incomplete aggregate performance is 78.2%, just below target.	▪	**Potentially a material risk**, as in-quarter delays could affect an already challenging target
To lead clinical harm process relating to waiting delays	▪ To complete phase 2 of RTT programme ▪ Any harm identified and close down report presented to the Trust's Harm Review Team	▪ Good progress made but phase 2 not yet completed. Report to Harm Review Team subject to this (but no clinical harm identified to date).	▪ Recommendation to ECRP due in October. Report to Harm Review Team to follow this.	Not a material risk to the trust at this stage, as the work to deliver is underway.
Balance the books, invest in our future				
We will continue to reduce our deficit and aim to break even in 2019	▪ Meet target monthly deficit. ▪ Deliver CIP targets. ▪ Manage to budget.	▪ Not delivered, for reasons set out in detail in papers to FIC.	▪ Mitigating actions set out in papers to FIC.	**Potentially a material risk**, as slippage in Q2 makes an already challenging in-year target yet more difficult to meet
We will deliver organisational efficiencies – from the way we buy drugs to how we use our clinical IT systems	▪ Develop a clinical IT strategy.	▪ Not delivered	▪ Proposal to develop clinical IT strategy once clinical service strategy is complete	Not a material risk at this stage, as the target deliverable for the year (£7m procurement CIP) can be delivered on basis of CIP programme that has already been agreed and without development of new clinical IT strategy.

Estates will produce a timely and accurate delivery of CIPs including service contract negotiations and agreement of possible land sales	▪ Prepare business case for sale of land and submit initial proposals to Executive Team and then onto Board in September ▪ Appoint legal teams to challenge outstanding historical PFI Issues and appoint to new Business Management Team which is being set up and should be functional by September	▪ Business case for sale of land not delivered – DV appointed to review land values in light of development properties from CCG's. ▪ Legal team appointed and business management team partially in place but not fully recruited.	▪ Expect to deliver business case for sale of land by March 2019 ▪ Recruitment to business management team expected to be fully in place by February.	Not a material risk at this stage, Estates continue to deal with reactive maintenance.
Build a better St George's				
Undertaken an independent review of our corporate governance function	▪ Complete review of corporate governance structures below Board Committees and agree future structural design and reporting lines. ▪ Develop clear Board forward work programme for 2018/19. ▪ Agree new Terms of Reference for Trust Executive Committee.	▪ Review of corporate governance structures not delivered due unexpected demands on capacity due to cardiac surgery issues. ▪ Board forward work programme drafted but not yet agreed by board ▪ New ToR for TEC drafted but not yet agreed by TEC	▪ Corporate governance structure review expected to be completed Q4 ▪ Board forward look coming to board for agreement in November. ▪ TEC draft ToR to be considered by TEC on 31 October.	Not a material risk to the trust at this stage, as the work to deliver is underway.
Use the CQC Well-Led Framework to ensure we are meeting our regulatory requirements	▪ Self-assess our services against CQC domains ▪ Assess ourselves against well-led framework	▪ Milestones partially delivered – internal mock inspection completed with NHSI support against those services not inspected in 2018, plus outpatients and ED.	▪ Full review of our services and self-assessment to be completed in Q3.	Not a material risk to the trust at this stage, as the work to deliver is underway.
Renew local area network on Tooting site	▪ Network architecture agreed	▪ Design work commenced but not completed	▪ Completion expected in Q3	Not a material risk to the trust at this stage, as the work to deliver is underway.
Deploy iClip clinical	▪ Deployment commenced.	▪ Final preparations	▪ First ward	Not a material risk to the trust

documentation and e-prescribing across most remaining wards on Tooting site		complete, first ward deployments due 8 October.	deployments due 8 October.	at this stage, as the work to deliver is underway.
Roll out iClip to Queen Mary's Hospital Roehampton	▪ Changes and processes agreed and documented.	▪ All 'as is' processes documented; 'to be' processes developed for some areas	▪ All 'to be' processes expected to be developed for all areas in Q3	Not a material risk to the trust at this stage, as the work to deliver is underway.
We will undertake substantial reviews and surveys of the overall Estate and Environment. This will clearly identify the back-log maintenance position and allow for investment in such areas as Ward Refurbishment, Theatre Refurbishment and replacement of large Diagnostics dependent on Trust's priorities	▪ In line with the PAM documentation and the outcome of the surveys, publish the revised back-log maintenance list and identify high risk projects. ▪ Those projects such as Theatres and Ward Refurbishment will include within any bids made for upgrade of general infrastructure as part of the bidding process for emergency funding. Surveys will be underway with the majority reported by end of September.	▪ Not delivered - due to lack of capital, the Theatres and ward refurbishments strategy has been reviewed to develop a programme of essential works only in the highest priority areas ▪ Backlog maintenance capital bid for emergency monies has been made to eliminate operational failure.	▪ Mitigating actions currently being considered by TEC ▪ Authorised Engineer being asked to evaluate the potential risk of failure. Revenue money will be redirected if necessary and routine maintenance curtailed.	**Potentially a material risk** for trust to consider
Champion team St George's				
Improve staff engagement	▪ Pulse Survey ▪	▪ Not delivered. Trust has received funding to use a product call go-engage (funded by NHSI). Other pressures within the HR function has led to this project slipping. ▪	▪ Dep. Director of HR now leading this project. Work is due to commence in Q3.	Not a material risk to the trust at this stage, as the work to deliver is underway.
Improve equality and diversity	▪ Establish Staff networks	▪ Plans to set up network groups in D&I 2018/19 to be ratified at WEC in October 18. Exec sponsors for the four groups being identified.	▪ Groups to be launched following sign-off from WEC in October	Not a material risk to the trust at this stage, as the work to deliver is underway.

We will develop our leadership capacity and up skill our managers	▪ Develop and deliver an effective Leadership strategy, working with the Quality Academy, SGUL and IHI – focusing on coaching	▪ Work on-going – paper to WEC in development will outline next steps	▪ Mitigation/when expected completion?	Not a material risk to the trust at this stage, as the work to deliver is underway.
We will enhance communication for Estates and Facilities. We will be represented at relevant meetings and Divisional Joint meetings where we will publish a newsletters and action points linked to the PAM production. We will also performance dashboard for small works and reactive maintenance.	▪ Produce the initial draft for the newsletter for the Estates and Facilities Team and submit to Communications. ▪ Produce first draft of performance dashboard tracking work against small works and reactive maintenance	▪ Initial draft newsletter delayed due to capacity constraints ▪ Draft performance dashboard delayed due to capacity constraints	▪ Draft newsletter expected Q3 ▪ Draft performance dashboard expected Q3	Not a material risk to the trust at this stage, as the work to deliver is underway.
Develop tomorrow's treatments today				
We will work closely with St. George's University of London to train the healthcare professionals of tomorrow	▪ Implement and iterate Corporate Objectives	▪ Not delivered – objectives still being clarified	▪ Objectives expected to be agreed shortly	Not a material risk to the trust at this stage, as the work to deliver is underway.
We will use the latest technology to improve outcomes for patients and make it easier for staff to provide care safely and effectively	▪ Approval of QMH Cerner business case ▪ Approval for additional MRI at St. George's.	▪ QMH Cerner FBC approved by TEC and coming to F&I in October. ▪ Additional MRI - bid for as 19/20 capital via STP bid for transformation capital, awaiting decision.	▪ If STP capital unavailable, trust will need to look to lease or find an alternative finance solution in 19/20	**Potentially a material risk** to successful delivery of March 2019 deliverable of QMH Cerner and MRI installation.
We will plan to work with our existing Stakeholders to ensure that the Trust achieves better value for money and sustainability out of any investment available from central funds	▪ Dependent on the outcome from the bidding process and the potential production of a clinical strategy from South West London in September (the initial timetable stated) we will undertake capital work in line with the projected timetables submitted	▪ Not delivered – wave 5 bids to be reviewed and developed in Q3 and Q4.	▪ Wave 5 bids to be reviewed and developed in Q3 and Q4	**Potentially a material risk** that any further slippage in Q3 and Q4 could mean the trust being unable to spend any funds awarded in a way that maximises VFM.

Annex B - approach to RAG-rating

1. The RAG ratings for Q2 derived as follows. Each objective is shown as:

- green for Q2 if all its Q2 milestones have been delivered, or if the position is overwhelmingly close to that (e.g. 5 milestones delivered, 1 partially delivered but due for completion in first week October).
- amber for Q2 if some of the associated Q2 milestones have been delivered, and some not, or if the milestones are partially delivered.
- red if the milestones for Q2 have not been delivered.

2 Each domain is RAG-rated on the basis of the average RAG-rating of each of its component objectives (all weighted equally).

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	October 2018	**Agenda No**	5.2
Report Title:	**Clinical Strategy Highlight Report** ***Commercially in Confidence***		
Lead Director/ Manager:	Suzanne Marsello, Director of Strategy		
Report Author:	Laura Carberry, Strategy and Partnership Manager		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	In March 2018, the Board agreed to commence the development of a 5-year Clinical Service Strategy. This paper advises the Board on the development of the 5-year Clinical Service Strategy (due end March 2019) to date and the deliverables in October, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.		
Recommendation:	Board is asked to note the progress reported and the identified issues and risks.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Well-Led**		
Single Oversight Framework Theme:	▪ Strategic Change		
Implications			
Risk:	▪ As outlined in paper		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix 1: Clinical Strategy Development Timeline and Workstreams Appendix 2: Issues to be addressed as Clinical Strategy Development progresses		

St George's University Hospitals NHS
NHS Foundation Trust

Trust Strategy: Highlight Report

Commercially in Confidence

1.0 Purpose

1.1 This paper advises the Trust Executive Committee on the development of the 5-year Clinical Service Strategy (due end March 2019) to date and the deliverables in October, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.

2.0 Progress in October 2018:

2.1 All actions committed to are on plan for October 2018- although the Communications and Engagement workstream is behind in delivering on the Engagement Events logistics- there is a plan to recover this.

Deliverables/ Milestones for October 2018	Progress	Actions for November 2018	Completion Date/ RAG*
Overall Programme Plan (Workstream 1)	Overall Programme Plan to end March 2019 refreshed with a revision to 7 workstreams (see Appendix 1) Board to consider plan and workstreams (see Appendix 1) on 25 October 2018	Programme plan 'live' and ongoing progress on workstreams	**25.10.2018**
Development of Options (Workstream 2)	Board Seminar on Strategy for Neurosciences (17 October 2018)	Board Seminar on Strategy for Renal, Thoracic and Vascular as well as Women's (13 November) Completion of deliverables to enable Board Seminar to cover Critical Care (18 December 2018)	**On plan**
Alignment, Deliverability and Prioritisation (Workstream 3)	Currently progressing work on: • alignment of the different propositions for services; • considering the deliverability, and exploring the impact and implications, of those propositions; • defining a framework for the prioritisation of those propositions, and; • engagement and timeframe.	Completion of deliverables to enable and inform Board Seminar covering overall Specialist Services Wash-Up (18 December 2018)	**On plan**
Communication and Stakeholder Engagement (Workstream 4)	12 Engagement Events planned: • Public x 4 (Merton x 2 and Wandsworth x 2) • Staff x 9 *(both covering questions re Specialist Services)* Stakeholders x 2 *(covering questions re Outpatients*	Events end November/ early December 2018.	**Capacity and logistics are a risk**

	and Senior Health) Dates to be firmed up and email invitations to be sent out 12 October 2018 Approach, content and format to be finalised and signed-off (end October) Chairs, facilitators and presenters to be finalised and signed-off (end October 2018)		
'Into Delivery' Planning (Workstream 5)	Alignment to 2019/20 Business Planning i.e. Y1 of a 5yr Strategy. Completion of draft 2019/20 Business Planning template which includes a Delivery/ High-level Implementation Plan to 2023/24 as explicit link to Strategy.	Alignment and assurance of 2019/20- 2023/24 deliverables 'Challenge and Confirm' Sessions planned from November 2018 onwards	**On plan**
Enablers and Interdependencies (Workstream 6)	Initial discussions with Diagnostics, Finance, Information (for Modelling purposes) and Workforce to agree approach and plan (completed 19 October 2018)	TBC- based on discussions Initial discussions with Estates (early November)	**On plan**
Production and Publication of Strategy (Workstream 7)	Review of published Strategies of other Trusts (content, format, priorities, strengths, weaknesses)	TBC	**On plan**

** RAG rating refers to in-month progress of the work described here, rather than an assessment of risks related to the content covered.*

A Clinical Strategy Development Timeline is attached (Appendix 1) along with a description of the 7 workstreams.

3.0 Key Milestones for December 2018

- Board Seminar to cover Critical Care and an overall Specialist Services Wash-Up (18 December), and;

- Following agreement of 2 Board Seminars in January 2019 and 1 in early February 2019 by Chairman to cover DGH-level Medical and Surgical Specialties, dates to be confirmed by Corporate Office.

4.0 Issues and Risks

Capacity in the Clinical Divisions is the most significant risk to the strategy timescales.

No	Area	Description of Issue/ Risk	Mitigation	RAG
1.	Capacity (Clinical Divisions)	Bandwidth and breadth of challenges for Clinical and Managerial colleagues in the divisions and competing day-to-day priorities- finance, operational performance, quality standards- could lead to a lower prioritisation of strategy work leading to a delay in delivering a strategy	Strategy Team to engage and provide support, as far as possible, but clinical expertise and input will continue to be a key input and necessary requirement and resource restraint	

5.0 Recommendation

Trust Board is asked to:

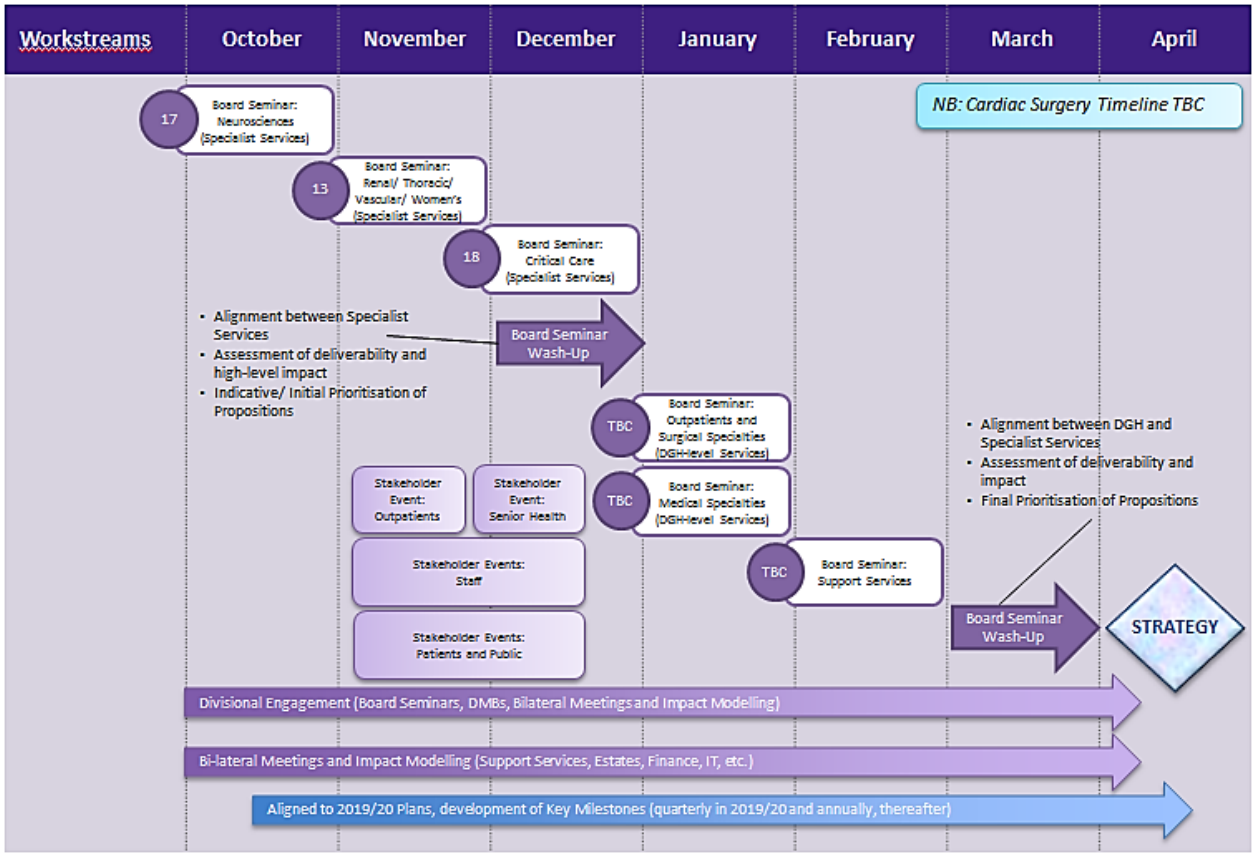
- Note the progress reported and the identified issues and risks.

Author: **Laura Carberry, Strategy and Partnership Manager**

Date: **18 October 2018**

Appendix 1: Clinical Strategy Development Timeline and Workstreams

Clinical Strategy Development Timeline



Clinical Strategy Workstreams

Workstream	Description
1. Programme Management	Programme plan, risk register, etc.
2. Development of Options	Development of options for board to consider, (e.g. as per work to date for board seminars)
3. Alignment, Deliverability and Prioritisation	Making sure that the board's preferred options align and that any conflicts/issues are visible & managed, enabling the board to prioritise where necessary, and ensuring that what goes into the strategy is realistic & deliverable (with reference to money, estates, workforce, reactions of competitors/commissioners etc.)
4. Communications and Stakeholder Engagement	In developing the strategy and then disseminating once published. Covering a) strategically important stakeholders such as commissioners, regulators and b) staff & public.
5. 'Into delivery' Planning	Development of high-level milestones over the next 5 years for implementing the strategy
6. Enablers and Interdependencies	Alignment with business planning round for 19/20, and strategies for estates, finance (medium term financial plan), IT, workforce, research.
7. Production and Publication of Strategy	Agreeing what it should look like / who it should speak to; drafting/writing it; graphic design; publishing etc.

Appendix 2: Issues to be addressed as Clinical Strategy Development progresses

These are issues that have been identified from early strategy discussions and are recorded to ensure that they are not lost during the development process.

- The clinical strategy needs to be developed taking account of research and education priorities: meeting held with Principal of SGUL; Medical Director is a member of Strategy Project Steering Group. Medical Director to convene meeting re development of Research Strategy.
- Clinical innovation is a core part of the strategy: to be considered with each service as plans developed.
- The external environment analysis should include systems outside of SWL e.g. South London (links to specialised commissioning reviews), Surrey and Sussex: presentation to Board Strategy Seminar in July.
- Working within the SWL system at borough level with primary care, mental health and community provider colleagues within the wider health system is important: this will be picked up as the strategy work for the secondary health/ local hospital services is developed.
- Maximising the relationship with St. George's, University of London is an important partnership: meeting held with Principal of SGUL. Input to Board Seminars and links to Research Strategy.
- Include Kingston University as a key partner regarding training of nurses and other professional groups.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No**	6.1
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 11 October 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 – October 2018

Matters for the Board's attention

1. **Audit recommendations:** The Committee considered a report tracking the recommendations of earlier audits. Of 36 open recommendations, 22 were not yet due but 14 recommendations were overdue. This was an improvement on the position compared with July, and the Committee noted that the Trust Executive Committee was considering internal audit actions on a monthly basis which was helping to ensure actions were followed up in a timely manner. However, the Committee's ambition was to ensure actions were agreed with realistic deadlines and closed on time. The majority of remaining open actions related to disaster recovery, business continuity, patient records and GDPR compliance.

2. **2018/19 internal audit plan:** The Committee received a report on the 2018/19 internal audit plan. The internal auditors reported that progress was on track and the Committee noted the audits planned for the remainder of the year, noting that a number of planned audits had been deferred to Q4 which was now a busier period for internal audit than usual.

3. **Final audit reports:** Five final internal audits were considered by the Committee. The first concerned dual prescribing and medical gasses, which had received an overall assurance assessment of 'reasonable assurance'. The second was the internal audit report on the Friends and Family Test, which had received 'limited assurance'. There was a need to improve performance particularly in relation to outpatients. 'Limited assurance' was given on the report on outpatients, where a number of improvements had been identified and clear actions had now been agreed. 'Reasonable assurance' had been achieved in relation to theatre utilisation, where a number of improvements had already been made, albeit that further refinements could still be introduced. The report on estates and facilities (procurement: estates and clinical engineering) achieved a rating of 'reasonable assurance' and a number of improvements had been delivered.

4. **Information Governance Annual Report:** The Chief Information Officer presented the IG Annual Report, which highlighted that the Trust was using the new Data Security and Protection Toolkit. This placed greater emphasis on cyber security and date protection and provided a mechanism for continuous monitoring by the Trust. Governance structures were being established. The Committee heard that there had been one complaint against the Trust to the Information Commissioner which had been closed with no action taken. Work to ensure compliance with GDPR was in progress and a plan was in place, albeit there remained significant work to do in this regard.

5. **Counter fraud:** The Committee received an update on fraud cases and on preventative actions being undertaken by the Trust. It noted that the Trust was sample testing qualifications in relation to staff appointments. The Committee considered the trends and in the types of fraud identified and where in the organisation these occurred, and asked for further information on this at the next meeting.

6. **Aged debt:** The Committee heard that the provision for bad debts had been increased by £0.5 million. A bad debt write-off of circa £1 million was under way and each debt older than six years was being reviewed. The external auditors confirmed that they reviewed and challenged debt write-offs and provisions, subject to materiality.

7. **Whistleblowing:** The Committee considered a report on concerns raised under the Trust's whistleblowing policy in Q2 2018/19, following its consideration of concerns raised in Q1 in July. The Committee noted that an internal audit had recently been completed in relation to the Trust's Freedom to Speak Up function, which was scheduled for discussion at the Committee's next meeting in January. It emphasised the importance of providing greater clarity within the policy about which concerns were "whistleblowing" and which were "Freedom to Speak Up" of the appropriate escalation routes involved. There was also a need for greater clarity in the policy about the responsibilities of the Non-Executive Director with responsibility in this area.

8. **Internal Audit Effectiveness Review:** The Committee considered the results of a survey of internal audit effectiveness. Members of the Committee, all Executive Directors, and managers whose work had been subject to internal audit over the past year were asked for their feedback on the effectiveness of the internal audit function. Overall, the survey identified that there were some areas in which the Trust and the internal audit function could work more effectively, for example in relation to the timely actioning of management responses and the way in which internal audit is used to drive change and improvement. However, no significant concerns were reported about the effectiveness of the function and there was general feedback that the function provided value for money. The Committee sought some further clarification on the details of the contract and noted that a decision would need to be taken shortly about whether to take up the option of extending the current contract for a period of 12 months.

9. **Terms of Reference:** The Committee considered some minor amendments to its terms of reference and agreed to recommend these to the Board (see Board agenda item 6.1). The changes update the list of expected attendees at each meeting and confirms the arrangements for reporting to the Board on the issues considered by the Committee at each meeting.

Recommendation

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

Sarah Wilton
Audit Committee Chair, NED
October 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No**	6.2
Report Title:	Board Assurance Framework (BAF)		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This paper brings to the Board the summary page of the Board Assurance Framework. The summary sheet of the BAF (appendix 1) gives an overview of the risk profile of the Trust and enables the Board to ensure its agenda is directed to improving control of these strategic risks. The BAF has been updated with the quarter 2 assurance rating and statements from the committees of the Board. **Assurance rating** The assurance rating for the following strategic risk has improved at the end of Q2: SR 2 has improved from limited to partial assurance There has been no deterioration in any assurance rating. Ten risks have a 'partial' assurance rating; seven risks have a 'limited' assurance rating (see appendix 2 for definitions). **Risk score** There has been no change in the risk score of the strategic risks since the Q1 report. In Q2 there have been new risks entered on to the Trust divisional and corporate risk registers that make a significant contribution to a strategic risk. These risks are set out in detail, together with controls, assurances and action plans, in the detailed extracts of the BAF monitored by the assuring Committees. The risks added in Q2 concern cardiac surgery services. These risks have not had an impact on the score of the strategic risks.		
Recommendation:	The Board is asked: 1. For strategic risks reserved to itself (SR 9,16,17) to: • Note the risk rating • Agree the proposed assurance rating • Agree the proposed assurance statement (shown in italics) 2. For the 14 risks assigned to its assuring committees to: • Note the risk score, assurance rating and statement from the relevant		

	assuring committee.		
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:	Workforce and Education Committee Quality and Safety Committee Finance and Investment Committee	**Date**	12 October 18 October 18 October
Equality Impact Assessment:	N/A		
Appendices:	1. Summary Board Assurance Framework (BAF) 2. Assurance ratings - definitions		

Appendix 2 **Assurance ratings - definitions**

Significant assurance	There are robust controls operating effectively to ensure that risks are managed and objectives achieved.
Partial assurance	The controls are generally adequate and operating effectively but some improvements are required to ensure that risks are managed and objectives achieved.
Limited Assurance	The controls are generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and objectives achieved.
No Assurance	There is a fundamental breakdown or absence of controls requiring immediate action.

Appendix 1

Board Assurance Framework to Board July 2018
Q2 2018/19

BOARD ASSURANCE FRAMEWORK OVERVIEW								QUARTER 2			
Strategic Objective	Risk appetite	15		Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
				Q1	Q2	Q3	Q4				
Treat the patient, treat the person	*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	Limited			The risk score is unchanged. Workforce remains a significant area of risk for the Trust and the Committee continues to consider that it has insufficent evidence that controls for this risk are effective.	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	Partial			The assurance rating has improved based on progress of the Elective Care Recovery Programme, the Trust has started shadow reporting and is on target to return to reporting in January 2019. Performance against the emergency care 4hr operating standard has shown some improvement. The risk score is unchanged and reflects a risk escalated to the BAF about patient safety in cardiac surgery services. The Committee recieved a report and is assured that the controls put in place for this risk are operating effectively.	Chief Operating Officer	Quality Committee	15
	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	Partial			The risk score is unchanged. The Quality Improvement Plan dashboard shows improvement but Committee is looking for the pace of change to increase. The Committee is assured that the 'must do' and 'should do' items in the Trust's response to the CQC inspection 2018 are being delivered as planned. Quality improvement methodology is being used to drive improvement projects.	Chief Nurse	Quality Committee	10
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	Limited			The risk score is unchanged. Work continues to develop relationships and pathways.	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	Partial			The risk score is unchanged. While good progress has been made in improving the working of the Finance function and how it supports the trusts operations, weaknesses remain in the organisations ability to manage to budget. While training is in place progress needs to improve. The full value of the CIP plan is in place although focus needs to be maintained on delivery. Good progress continues to be made in improving the working of Procurement. Improving the Trusts financial performance will improve the current risk rating.	Director of Finance	Finance and Investment Committee	16
	Low	*SR6*	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities	Limited	Limited			The risk score is unchanged. The impact of the new organisational structure is not yet evident as recruitment is completed and those in new roles become familiar with their responsibilities.	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	Limited			The risk score is unchanged. The Finance function has developed an initial long term financial look forward. The risk score has been maintained due to the challenges emerging in the financial environment of the NHS and the uncertainty this creates until there is clarity on all the changes proposed. To address this risk the Trust needs to define robust actions to mitigate these risks.	Director of Finance	Finance and Investment Committee	12
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	Partial			The risk score is unchanged. The Committee received assurance through reports on the developing Organisational Development Strategy and the staff friends and family test. The staff FFT indicates that this continues to be an area where 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	Partial			*The risk score is unchanged. The staff friends and family test indicates that this continues to be challenging.*	(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	Partial			The risk score is unchanged. The Committee received assurances through the mandatory training group report and the workforce KPIs. Mandatory training compliance has improved.	Director of HR and OD	Workforce and Education Committee (WEC)	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	Partial			The risk score is unchanged. The Committee continues to be assured that the controls are generally adequate through the delivery of the leadership development programme and workforce KPIs.	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	Limited			The risk score is unchanged. There has been no material improvement or deterioration since the Q1 18/19 report. The level of risk continues to be 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	Limited			The risk score is unchanged. Limited assurance available from the Authorised Engineer (AE) on water safety. Assurance remains limited on the overall control of this risk. Assurance received on compliance with mitigation of fire regulation risk from the AE. The AE has given assurance on mitigation plans for ventilation risks.	Director of Estates and Facilities	Finance and Investment Committee	20
	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	Limited			The risk score is unchanged. The Trust has not yet been able to confirm additional capital funding to support all known investment requirements. A range of bids have been submitted and the Trust awaits the responses on these.	Chief Executive	Board	20
	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.	Partial	Partial			**The risk score is unchanged.** *Assurance that controls are generally adequate and effective is taken from the monthly highlight reports to the Board meeting (part B). The strategy development project plan and highlight reports demonstrate that the project is being delivered as planned.*	(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.	Partial	Partial			**The risk score is unchanged.** *Since Jan 18 all STP meetings have been attended by appropriate senior managers from the Trust. Quarterly highlight reports to the Board meeting (part B) provide positive assurance on delivery of actions to improve partnership working.*	Chief Executive	Board	10
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	Partial			The risk score is unchanged. The Committee heard that recruitment to research studies is projected to show an increase of 50% compared with 17/18.	Medical Director	Quality Committee	9

Meeting Title:	**Trust Board**		
Date:	25 October 2018	**Agenda No.**	**6.3**
Report Title:	Board Sub-Committee Terms of Reference		
Lead Director/ Manager:	Stephen Jones, Director of Corporate Affairs		
Report Author:	Stephen Jones, Director of Corporate Affairs		
Presented for:	Approval		
Executive Summary:	In line with good practice, Board sub-Committees are in the process of reviewing their terms of reference to ensure these remain up-to-date and fit for purpose. In October, the Audit Committee and Finance and Investment Committee considered minor amendments to their respective terms of reference, and agreed to propose these to the Board for approval. Amendments recommended to the Finance and Investment Committee: • Updating the list of management attendees at Committee meetings; • Making explicit the current arrangements for reporting to the Trust Board following each Committee meeting. Amendments recommended to the Finance and Investment Committee: • Adding the Trust Chairman is added as an *ex-officio* member of the Committee counting towards the quorum, following some challenges with quoracy earlier in the year; • Updating the list of those required to attend every meeting, and making clear that senior representation from Divisions should attend meetings of the Committee as required; • Making a number of other minor amendments to clarify the drafting, setting out the revised arrangements for providing secretariat support, make explicit the current arrangements for reporting to the Board. Revised terms of reference to the remaining sub-Committees will be brought to the Board for approval in December.		
Recommendation:	The Board is asked to approve the attached terms of reference.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well led)		
Implications			
Risk:	Without appropriate terms of reference for its Committees there is a risk that the Trust may not have effective decision making structures which could result in either poor decisions or a delay in decision-making.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix A: Audit Committee Appendix B: Finance and Investment Committee Terms of Reference		

Appendix A

Audit Committee

Terms of Reference

1. NAME

The Committee shall be known as the "Audit Committee".

2. AUTHORITY

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

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

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

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

3. PURPOSE OF THE GROUP

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

4. DUTIES OF THE GROUP

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

Governance, Internal Control and Risk Management

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

1. Review the risk and control related disclosure statements prior to endorsement by the Board; this shall include the Annual Governance Statement, Head of Internal Audit opinion, External Audit opinion and/or other appropriate independent assurances.
2. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
3. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's corporate objectives.
4. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate

those risks; this shall include Clinical Audit programme overseen by the Trust's Quality & Safety Committee.
5. Review the adequacy and effectiveness of policies and procedures:
   a. by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern
   b. to ensure compliance with relevant regulatory, legal and conduct requirements.

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

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

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

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

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

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

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

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

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

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

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

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

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

Raising Concerns

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

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

Governance Manual

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

Management

The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

Annual Work Plan and Committee Effectiveness

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

5. COMMITTEE CHAIR AND COMMITTEE EXECUTIVE LEADS

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

The Chief Financial Officer and Director of Corporate Affairs will be the Executive Leads for the Audit Committee.

6. COMPOSITION OF MEMBERSHIP

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

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

7. ATTENDANCE

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

In Attendance - Trust		
Chief Financial Officer		CFO
Director of Corporate Affairs		DCA
Director of Financial Services		DFS
Head of Counter Fraud		HCF
Director for Quality Governance		DQG
Director of Human Resources & Organisation Development (for matters relating to raising concerns)		DHROD
Chief Executive (for Annual Report, Annual Governance Statement & Accounts approval)		CEO
In Attendance - Audit		
Paul Dossett	External Audit - Head of Public Sector Assurance, Grant Thornton	EA
Jamie Bewick	External Audit – Senior Manager, Grant Thornton	EA
Tom Slaughter	External Audit – Assistant Manager, Grant Thornton	
Kevin Limn	Internal Audit – Director, TIAA	IA
Ashley Norman	Internal Audit – Director of Audit, TIAA	IA
Secretariat		
Corporate Governance team		

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

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

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

8. QUORACY

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

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

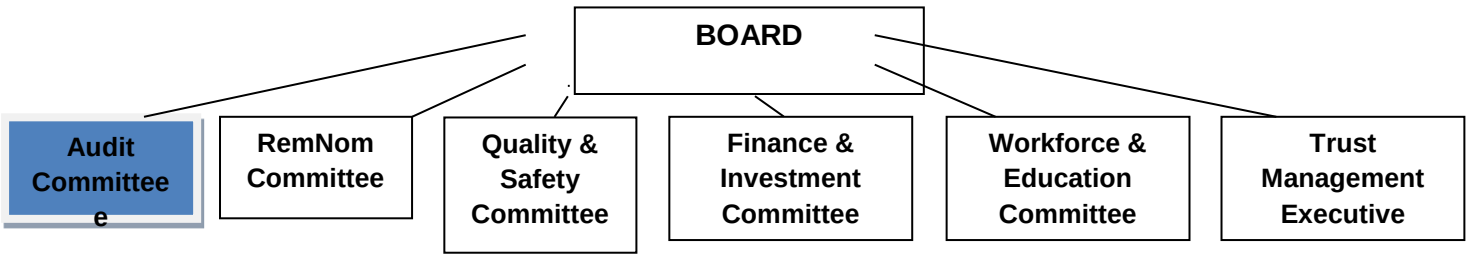
9. DECLARATION OF INTERESTS

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

10. MEETING FREQUENCY

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

11. RELATIONSHIP WITH OTHER COMMITTEES



12. MEETING ARRANGEMENTS / SECRETARIAL

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

13. REPORT TO THE TRUST BOARD

The Committee Chair will prepare a report for the Trust Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these.

14. AGENDA AND FORWARD CYCLE OF BUSINESS

Standing Agenda Items

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

Annual Cycle of Business

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

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

15. REVIEW OF TERMS OF REFERENCE

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

Appendix B

Finance & Investment Committee

Terms of Reference

16. NAME

The Committee shall be known as the "Finance & Investment Committee" (FIC). The Committee was previously known as the Finance & Performance Committee.

17. AUTHORITY

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

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

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

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

18. PURPOSE OF THE COMMITTEE

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

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

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

19. DUTIES OF THE COMMITTEE

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

(a) Financial and Business Planning

i. Consider the content of, planning assumptions and principles underpinning the Annual Plan and Long Term Financial Model prior to submission to the Board for approval.
ii. Agree the size and allocation of the Capital Programme as part of the budget setting process.
iii. Approve the process for the submission of the National Reference Cost Return prior to submission and review the results.
iv. Regularly review Patient Level Costing reports to understand efficiency, productivity

and profitablility by service line, workforce group etc.

(b) Financial Strategy and Management

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

(c) Contract Management

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

(d) Procurement

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

(e) Business Cases, Benefits Realisation and Return on Investment

On behalf of the Board:

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

(f) Capex

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

(g) Transformation and Cost Improvement

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

(h) Risk

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

(i) General Governance

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

20. COMMITTEE CHAIR AND COMMITTEE EXECUTIVE LEAD

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

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

21. COMPOSITION OF THE COMMITTEE
MEMBERSHIP

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

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

The Trust Chairman shall be an *ex-officio* member of the Committee with the same voting rights as other members of the Committee.

ATTENDANCE

The following individuals are not members of the group and do not therefore have full voting rights, and are instead expected to be in attendance for the purpose outlined below:

Role title	Attendance Guide
Chief Operating Officer	Every meeting
Director of Corporate Affairs	Every meeting
Director of Delivery, Efficiency and Transformation	Every meeting
Director of Estates and Facilities	Every meeting
Director of HR & OD	Every meeting

Role title	Attendance Guide
Director of Financial Performance	Every meeting
Director of Financial Planning	Every meeting
Director of Financial Operations	Every meeting
Head of Financial Reporting	Every meeting
Chief Information Officer	Every meeting

Senior representatives from each of the Trust's Divisions, e.g. Divisional Chair or Divisional Director of Operations, will attend the Committee as required.

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

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

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

Governors shall be invited to attend the meeting.

22. QUORACY

The quorum for any meeting of the FIC shall be the attendance of a minimum of three members including at least one Executive, two Non-Executives (one of whom shall be the Committee Chair). As an *ex-officio* member of the Committee, the Trust Chairman shall count towards the quorum for the Committee.

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

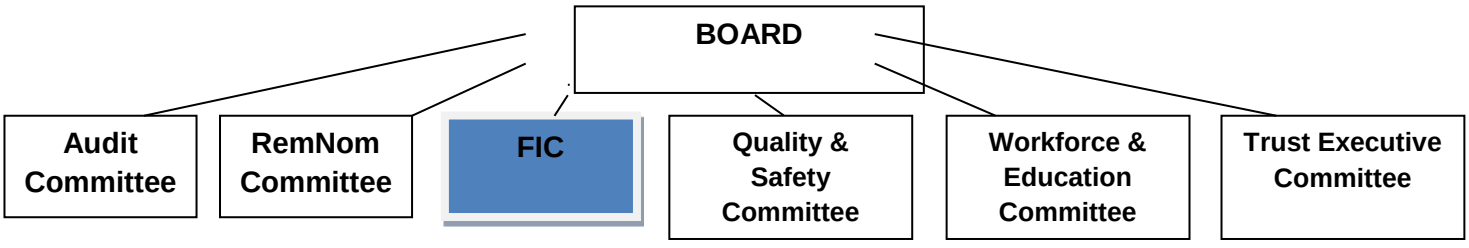
23. DECLARATION OF INTERESTS

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

24. MEETING FREQUENCY

Meetings of the FIC shall be held monthly, one week before the Board. The frequency of meetings may be changed only with the agreement of the Board.

25. RELATIONSHIP WITH OTHER COMMITTEES



26. MEETING ARRANGEMENTS / SECRETARIAL

vi. An annual schedule of meetings of the FIC shall be established prior to the start of each financial year;

vii. The Chief Finance Officer will oversee secretariat support for the FIC, and the secretary to the Committee will a member of the Finance team selected by the CFO. This will include taking accurate minutes, producing an action log and issuing and following up actions, ensuring that the planning for and outcomes of Committee meetings are shared appropriately with the Corporate Governance team.

viii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair, Executive Lead and the Director of Corporate Affairs.

ix. All papers and reports to be presented at the FIC must be submitted as final Executive approved reports on the Tuesday before the meeting.

x. The agenda and supporting papers for the meeting will be circulated not less than three working days of the meeting.

12. REPORT TO THE TRUST BOARD

The Committee Chair will prepare a report for the Trust Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these.

13. ANNUAL CYCLE OF BUSINESS AND AGENDA PLANNING

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

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

14. REVIEW OF TERMS OF REFERENCE

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