Trust Board Meeting
Part 1 - Public

Date and Time: **Thursday 25 April 2019: 10:00 – 13:30**

Venue: **Room H2.6, 2nd Floor, Hunter Wing, St George's Hospital**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the site**	**Board Members**	-	Oral
OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	-	Oral
	1.2	**Declarations of interest**	**All**	Assure	Report
	1.3	**Minutes of meeting on 28 March 2019**	**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
11:00	**2.2**	**Integrated Quality & Performance report**	**James Friend** Director of Delivery, Efficiency and Transformation	Review	Report
11:20	**2.3**	**Cardiac Surgery Update**	**Richard Jennings** Chief Medical Officer	Assure	Report
11:30	**2.4**	**Transformation Update**	**James Friend** Director of Delivery, Efficiency and Transformation	Inform	Report
FINANCE					
11:40	**3.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
11:50	**3.2**	**M12 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report

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Time	Item	Subject	Lead	Action	Format
STRATEGY					
12:00	**4.1**	**Corporate Objectives 2018/19: Q4 Review**	**Suzanne Marsello** Director of Strategy	Update	Report
WORKFORCE					
12:10	**5.1**	**Workforce and Education Committee Report**	**Stephen Collier** Committee Chair	Assure	Report
GOVERNANCE					
12:20	**6.1**	**Audit Committee Report**	**Sarah Wilton** Committee Chair	Assure	Report
12:30	**6.2**	**Fit and Proper Persons Test Annual Report**	**Harbhajan Brar** Director of HR & OD	Review	Report
12:40	**6.3**	**Board Assurance Framework:** • **Q4 BAF Report** • **Proposed changes to the BAF**	**Avey Bhatia** Chief Nurse and DIPC	Approve	Report
12:55	**6.4**	**Board Forward Work Plan 2019/20**	**Stephen Jones** Director of Corporate Affairs	Approve	Report
CLOSING ADMINISTRATION					
13:00	**7.1**	**Questions from the public**	-	-	Oral
	7.2	**Any new risks or issues identified**	All	-	
	7.3	**Any Other Business**		-	
	7.4	**Reflections on the meeting**		-	
13:10	**PATIENT STORY**				
13:20	**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 30 May 2019, 10.00 – 13.00

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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	20.12.18	31.01.19	28.02.19	28.03.19	25.04.19	30.05.19	27.06.19	25.07.19	29.08.19

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
Richard Jennings	Chief Medical Officer	CMO
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**
Michael Weaver	Interim Head of Corporate Governance	IHCG

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St George's University Hospitals NHS
NHS Foundation Trust

Board Walkabout - Thursday 25th April 2019, 08:30 – 09:45

Meet in the Hunter Wing Room H2.6 at 08:30

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

Please ensure that your team is in Hunter Wing Room H2.6 for 09:45 to provide verbal feedback on your areas visited. Please nominate one individual to provide a summary of the findings who will be given 3 minutes to complete this.

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

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

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

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

Practicalities

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

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

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

Groupings- 25th April 2019

NED	Exec	Divisional Representation	Area Visiting, 08:30 – 09:45
Gillian Norton, Chairman	Jacqueline Totterdell	David McCall (Matron)	Cavell Ward (5th Floor STJ) Marnham Ward (3rd Floor STJ)
Ann Beasley	Avey Bhatia	Alvin De Los Angeles David Wall (Service Manager) Tracy Watford (Lead Dental Nurse)	Day Surgery Unit (Parameter Road) Max Fax Unit (Parameter Road)
Sir Norman Williams	Kevin Howell Andrew Grimshaw	Siobhan Burke (Matron)	Richmond Ward (Ground Floor STJ) Ambulatory Care and Acute Dependency (Ground Floor STJ)
Sarah Wilton	Stephen Jones Harbhajan Brar	Louise Ramadhan (Matron)	Florence Ward (4th Floor STJ) Keate Ward (5th Floor STJ)
Prof Jenny Higham	Ellis Pullinger	David Robinson (Matron)	Belgrave Ward (1st Floor AMW) Heart Failure Unit (1st Floor AMW)
Stephen Collier	Richard Jennings James Friend	Tessa Longney (Head of Nursing)	Amyand Ward (3rd Floor STJ) Rodney Smith Ward (3rd Floor STJ)
Tim Wright	Suzanne Marsello	Sue Baillie (Chief Radiographer) Harvey Tortusa (Matron)	St James Radiology Fracture Clinic (STJ Outpatients)

Meeting Title:	**TRUST BOARD**		
Date:	**25 April 2019**	**Agenda No.**	**1.2**
Report Title:	**Board Member Declarations of Interest**		
Lead Director/ Manager:	**Stephen Jones, Director of Corporate Affairs**		
Report Author:	**Stephen Jones, Director of Corporate Affairs**		
Presented for:	**For Information**		
Executive Summary:	The updated Register of Board Members' interests is attached as Appendix A. It was agreed, in March, that a report on Board Members' Interests be presented at each Board meeting to ensure transparency, public record and afford members the opportunity to update their interests and to declare any conflicts.		
Recommendation:	For the Board to note, review and provide any relevant updates.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and improvement capability (well-led) – Effective boards and governance.		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The public rightly expect the highest standards of behaviour in the NHS. Decisions involving the use of NHS funds should not be influenced by outside interests or expectations or private gain.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix A. Register of Board Members' interests		

Appendix A. Register of Board Members' interests

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Gillian Norton	Chairman	Deputy Lieutenant (DL) Greater London Lieutenancy Representative DL for Richmond	October 2016	Present	
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	ACAS Independent Financial Adviser ACAS Audit Committee Member	December 2017	Present	Remunerated
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	Florence Nightingale Foundation, Mentor	April 2018	Present	Non remunerated
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	South West London and St George's mental Health NHS Trust, Chair	1 October 2018	Present	Remunerated
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: Healthcare Market News (monthly publication)	2015	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: Cielo Healthcare (Milwaukee, USA)	2015	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Health Leaders Panel: Nuffield Trust	2014	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Trustee: ReSurge Africa (medical charity)	2015	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	External Advisor: Schoen Klinik (German provider of mental health and surgical services)	2018	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	External Advisor: Imperial College, in relation to potential academic/research-led medical & technology developments/collaborations on the new White City campus	2016	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Independent Advisor to the Inquiry into Issues raised by Patterson	2018	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman of NHS professionals Limited (provider of managed staff services to the NHS	2018	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman and shareholder: Eden Futures (supported living provider)	2016	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman and shareholder: Cornerstone Healthcare group (dementia care provider)	2018	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Board Governor: Kingston University	November 2015	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Principal: St George's, University of London	November 2015	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Visiting Professor: Lee Kong Chian School of Medicine in Singapore	January 2010	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Honorary Consultant: Imperial College London	November 2011	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Chair: Medical Schools Council	August 2016	July 2019	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Trustee: Medical Schools Council Assessment Alliance	2013	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Trustee: Medical Schools Council Assessment Alliance	2013	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Non-remunerated Board Member	2017	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Chairman National Clinical Improvement Programme/Getting it Right First Time Board member: Overseeing the development of the National Clinical Improvement Programme within NHS Improvement (NHSI) and the Getting it Right First Time (GIRFT) programme.	May 2018	May 2020	One day per week- remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Consultant: TSALYS Medical Technology start-up company: Advisor to company and minimal shareholder.	2017	Present	Ad Hoc commitment. Remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Senior Clinical Advisor, Secretary of State for Health	September 2015	July 2018	Was regular advisor to Rt. Honourable Jeremy Hunt MP I-2 days per week. Remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Emeritus Professor, Queen Mary's University	August 2017	Present	Titular- Non remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Non-Executive Director Private Healthcare Information Network (PHIN)	2015	Present	Approx. 1 day per month.- remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	President, Bowel & Cancer Research	2011	Present	Titular- non remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Chairman of Panel, Gross Negligence Manslaughter in Healthcare review. Chaired panel and was author of report.	6 February 2018	30 June 2018	Remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Chairman, Steering Committee National Institute for Health Research (INHR) Diagnostic Evidence Co-operative, Leeds: Chairs meetings of the committee	March 2018	Present	Non remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Trustee Patient Safety Watch	2019	Present	Non remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Chairman Royal College of Surgeons of England Honours Committee	2018	Present	Non remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Non-Executive Director, and Audit and Risk Committee Chair - Capita Managing Agency Limited	2004	Present	
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Non-Executive Director, and Audit and Risk Committee Chair - Hampden Members' Agencies Limited	2008	Present	
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Trustee and Vice Chair - Paul's Cancer Support Centre	1995	Present	
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Magistrate - South West London Magistrates Court and Central London Family Court	2005	Present	
Timothy Wright	Non-Executive Director	Owner/Director, Isotate Consulting Limited	January 2013	Present	IT advisory and consulting services to private and public sector clients (none of whom are in the healthcare sector)
Timothy Wright	Non-Executive Director	Trustee, St George's Hospital Charity	19 January 2018	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Executive Board Members					
Jacqueline Totterdell	Chief Executive	Partner, NHS Interim Management and Support	2005	Present	
Avinderjit (Avey) Bhatia	Chief Nurse and Director of Infection Prevention and Control	None			
Harbhajan Brar	Director of Human Relations and Organisational Development	Ethics Committee Member, Institute for Arts in Therapy and Education (IATE)	1 May 2018	Present	Ad-hoc role
Andrew Grimshaw	Chief Finance Officer	None			
Dr Richard Jennings	Medical Director from December 2018	None			

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Executive Director of Delivery, Efficiency & Transformation	Special Advisor to Secretary of State, Department of Health	2016	2017	Remunerated Requirements of Civil Service code expires on April 2019
James Friend	Executive Director of Delivery, Efficiency & Transformation	Trustee, Carrie's Home Foundation	2018	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Trustee, Westcott Sports Club	2018	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Council Liaison Officer, Mole Valley Conservative Association	2017	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Member Hut Management Committee, Westcott	2012	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Trustee, Westcott Village Association	2010	Present	Non-remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Executive Director of Delivery, Efficiency & Transformation	District Councillor Westcott, Mole Valley District Council	2008	Present	Member of Audit Committee, Chair of Development Control Committee Remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Church Warden, St John's The Evangelist, Wotton	2004	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Volunteer, Radioway	1994	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Associate Member, Association of Corporate Treasurers	1998	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Member Westcott Cricket Club	1996	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Member Chartered Institute of Bankers	1996	Present	Non-remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Executive Director of Delivery, Efficiency & Transformation	Member, National Trust	1992	Present	Non-remunerated
Kevin Howell	Director of Estates and Facilities	None			
Stephen Jones	Director of Corporate Affairs	Wife is a senior manager at NHS England	5.3.18	Present	
Suzanne Marsello	Director of Strategy	None			
Ellis Pullinger	Chief Operating Officer	None			

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting In Public (Part One)
Thursday 28 March 2019, 10:00 – 13:30
Board Room H2.6, Second Floor, Hunter Wing, St Georges Hospital

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Dr Richard Jennings	Chief Medical Officer	CMO

IN ATTENDANCE		
Ellis Pullinger	Chief Operating Officer	COO
Harbhajan Brar	Director of HR& OD	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
Sally Herne	NHSI Improvement Director	NHSI-ID

APOLOGIES		
Sarah Wilton	Non-Executive Director	NED

SECRETARIAT		
Michael Weaver	Interim Head of Corporate Governance (Minutes)	IHoCG

	Action
Feedback from Board Visits Members of the Board provided feedback on the departments visited which included Dalby Ward, Herberden Ward, McKisson Ward, Brodie Ward, Champneys Ward, Gordon Smith, Jungle Ward, PICU, Gray Ward, Vernon Ward, Estates Office, Jasmin Annex, FMU and Acute Gynaecology Unit. The DS reported that staff on Dalby Ward were enthusiastic, engaged and caring and the ward felt calm but staff reported patchy iClip network coverage. Herberden Ward, currently accredited as silver, was one of only 200 wards nationally to have received the Royal College of Psychiatrists quality mark award for being dementia friendly. The biggest risk was controlling the ambient temperature, which could be very high particularly in the summer.	

	Action
Staff were proud of the contribution of their three dementia volunteers, one of whom had worked on the ward for 15 years, and volunteers were seen as part of the multidisciplinary team. A consultant geriatrician had devised a new delirium assessment on iClip and was keen to see it used consistently. Following the visits to McKissock and Brodie Wards, the DEF reported that he would return to Brodie Ward to discuss utilisation of space and the use of balconies for ongoing care. Ann Beasley reported it was great to see how staff had embraced the use of Quality Improvement (QI) initiatives to create a culture of continuous improvement and this was important if the Trust was to improve significantly its CQC rating. The CEO commented that McKissock Ward was not the optimum size to allow for efficiency and flexibility, but she had been impressed with how staff had embraced and implemented a QI approach in order to drive continuous improvement. The COO reported that on Gordon Smith there was an evident focus on the use of safe staffing. The oncology ambulatory unit had seen referral rates double over the last 12 months and the challenge now was how the unit could be staffed 24 hours a day, seven days a week, with one staff member reporting that they had worked 80 hours in the past week. Sir Norman Williams also highlighted problems with escorting patients when they visited the Royal Marsden. On Champneys Ward, patients had been complimentary about the service. One ongoing issue was the need to have a sluice in that area. A reduction in beds had also been a problem. The CEO reported that she had recently visited both wards and understood concerns in relation to staff working extra hours and advised that this would be looked at. The CN reported that staff on Jungle Ward had been informed during the visit that they would receive their clinical accreditation visit within the next half an hour. The biggest challenge for the unit was space hence staff had to be creative to provide the care needed. There were no vacancies, morale on the unit was good and staff worked as a multi-disciplinary professional team. Staff wanted the Board to note the work of Zed, a member of the domestic staff and Barbara the Ward Clerk, who were essential members of the team. In the Paediatric Intensive Care Unit (PICU), the CN commented that the unit was the lead centre for cancer, working closely with the Royal Marsden. It was busy but calm and staff were enthusiastic. One issue reported was the location of the four beds in the Paediatric step-down unit on the fifth floor which caused some problems for the unit. Jenny Higham observed that the visit to Gray Ward had identified similar themes to other visits. Gray Ward was seeking to achieve gold accreditation and was working to improve standards of documentation and addressing issues with the implementation of iClip. Vernon Ward was clean and tidy with a stable staff base. The Penile Cancer Service on Vernon Ward was a national specialist cancer service and a recognised centre of excellence. The ward had empowered staff to work as a team. Issues common to both wards were pre-11.00 a.m. discharges, the management of documentation, access to medical staff, discharges and medication on discharge. Stephen Collier reported that new boiler plant was very impressive and was making a real contribution to the Trust's Cost Improvement Plan (CIP). There were issues of legacy practice elsewhere that needed to be addressed with some processes regarded as overly bureaucratic. The team were working to adopt a more proactive approach. With the support of the DEF the team are working to implement a system of Planned Preventative Maintenance. Jasmin Annex was a busy unit with happy	

		Action
staff. The Trust was undertaking a deep dive into carriage costs following concerns the Trust may be being overcharged for the delivery of items to the Trust. Members of the Board had also received feedback from some members of staff on plans to outsource the payroll service, the consultation on which was currently underway. Tim Wright reported that 25,000 patients visited the Fetal Medicine Unit (FMU) per year and the Trust received referrals from across the south of England. The unit had a very calm environment with a very efficient patient flow. The unit lacked sufficient space for patient consultation which was particularly difficult when staff had to hold sensitive conversations. The Trust was one of the biggest recruiters of patients into research and over 3,500 women had signed up for the obstetrics and reproductive health research programme. The CMO reported that staff had said that the Friends and Family Test feedback would improve considerably if the unit had four tablet devices and the CN confirmed that these would be delivered later that day. The Chairman thanked members of the Board for their feedback on the visits, which had provided rich detail, but asked that future feedback be concise and focused to ensure the formal Board meeting could start on time.		
OPENING ADMINISTRATION		
1.1	**Welcome, Introductions and apologies**	
	The Chairman opened the meeting and welcomed everyone to the meeting. She explained that Sarah Wilton had apologised and would be joining the meeting as soon as she could.	
1.2	**Declarations of Interest**	
	The DCA explained that all members of the Board had been asked to update their interests in line with the requirements of the guidance issued by NHS England. The Register of Interests for Board Members would be published on the Trust's website and the Register would be included in the papers for each Board meeting in order to ensure transparency and provide an opportunity for updating interests and declaring any conflicts of interest in a timely fashion. Members of the Trust's Council of Governors had also been asked to complete Declarations of Interest forms. The Board noted the revised Declarations of Interest. It was noted that there were no new declarations of interest.	
1.3	**Minutes of the meeting held on 28 February 2019**	
	The minutes of the meeting held on 28 February 2019 were agreed as an accurate record subject to a minor amendment to Section 2.3 to include Steve Livesey's title as Associate Medical Director – Cardiac Surgery.	
1.4	**Action Log and Matters Arising**	
	The Board reviewed the action log and agreed to close the actions proposed for closure, noting that the reports on the gender pay gap and the ethnicity pay gap had been approved on circulation and would be published on the Trust's website later that day, and a Board seminar on performance reporting had been confirmed for 23 April 2019. In relation to the open items on the action log, the Board noted the following updates: • TB.31.01.2019/03 Board Assurance Framework (BAF): Action due to be reported on the Trust Board meeting in Public on 25 April 2019.	

		Action
	• TB.28.02.2019/1 Urology: The COO noted the update requested was in relation to cystoscopy and neurodynamics and a further action to take a recovery plan through Trust Executive Committee (TEC) and Finance and Investment Committee (FIC). With reference to the performance scorecard, cystoscopy was reported to be back within the long-term tolerance and although there has been a 2% improvement in neurodynamics performance on the previous month it remained an area of concern. The COO agreed to bring a report back to a future meeting of the Board. • TB.28.02.2019/2 Month 10 Finance Report: It had been agreed that the Trust's run rate should be included in future finance reports and it was noted that this information had been circulated to Board members the evening before Board. The Board agreed that on the basis that the information would be in the report in future the action could be closed. • TB.28.02.19/3 Workforce Race Equality Standard 2018 Report: The DHROD confirmed the report had been revised to clarify the presentation of statistics as discussed at the February 2019 meeting and the Board agreed to close the action. • TB.28.02.19/7 Patient Story: The CN was currently investigating whether the issues highlighted in the story were isolated or raised wider concerns, and the results of this would be presented to a future meeting of the Quality and Safety Committee.	
1.5	**Chief Executive Officer's Update**	
	The CEO provided an update on the following issues: • Subject to its approval by the Board at its private meeting later that day, the Trust planned to launch its new clinical strategy for 2019-2024 on 23 April 2019. In developing the strategy the Trust had engaged with over 500 staff and patients over the last nine months, and had held nine dedicated engagement events for the public, 15 events for staff and two events of diverse groups of patients, staff and wider stakeholders. The Trust had also held meetings with GPs, patient groups, trade unions and clinical and managerial leadership teams. The strategy would be widely communicated to staff, stakeholders and patients. Feedback from the Board visits earlier that morning suggested that staff increasingly felt that the Trust was moving away from being reactive to having more of a sense of direction and a plan which was encouraging. The new strategy would provide further certainty. • Over 200 people had been put forward for the second St George's Hero Awards to be held on 16 May 2019, which would once again be supported and organised by the St George's Hospital Charity. The shortlisted nominees had now been announced and the Trust was delighted that TV personality, Lorraine Kelly, had agreed to compere and present the awards. • An eight year old girl had suffered a stroke whilst attending a dancing class. Seven months later, after being in PICU for three days and seven weeks on Nicholls Ward, as well as a period of intensive rehabilitation,	

		Action
	Issy has returned to dance classes. The CEO paid tribute to the patient and staff working in Children's services and PICU. Ann Beasley congratulated the Trust on its new clinical strategy for 2019-2024, noting that this was an excellent piece of work. The Trust Board noted the report.	
QUALITY AND PERFORMANCE		
2.1	**Quality and Safety Committee Report**	
	Sir Norman Williams, Committee Chair, highlighted the key messages from the meeting held on 21 March 2019. The Committee challenged the Executive to set out when the Trust would achieve the necessary improvements in responding to complaints in a timely way. It had been told that by September 2019 measures would be in place to ensure improvements in performance. Of the 83 actions identified in response to the Care Quality Commission (CQC) inspection, 1 Red and 5 Amber would not be delivered by 31 March 2019. These 6 actions would continue to be addressed as part of the Trust's ongoing quality improvement plan. The Trust had previously reported a Serious Incident involving a reported failure in ventilation on McEntee Ward. All members of staff had been screened and all results received to date had been reported as negative. As at 28 March 2019, there had been a total of 31 cases of *C. Difficile* against an annual threshold for 2018/19 of 30 cases. The Committee noted a report of legionella on one of the Trusts wards. The patient had been transferred as an inpatient from another hospital. The patient was reported as stable and further tests to identify the exact strain of legionella are underway. The response rate for Friends and Family Test (FFT) in the Emergency Department (ED) in February 2019 was reported as 20%. The FFT response rate for Maternity Services was 4%, compared with a national response rate in this area of 15%. The Committee discussed a number of ways in which the Trust could improve its performance. The Committee questioned the clarity of the quality section of the Annual Plan. The Committee Chair had sought assurance that the narrative was consistent with what would be reported in the Quality Account. The Committee questioned the risk rating for Strategic Risk 4 (SR4) and heard that the strategic risks were being reviewed for 2019/20 and links between SR4 and the strategic risks that recognise the importance of the wider external relationships would be made and the risk score reviewed. Sir Norman Williams also said that the Trust had a well-established transitional care service on the post-natal ward that supported a programme of work to prevent Term Admissions into Neonatal Units. The Trust performed well with a rate of term admissions into the neonatal unit in 2017/18 of 2.75% compared with the national target of <6%. The Committee commended the Trust's performance. The Chairman thanked Sir Norman Williams for his report. The CN asked the Board to note that in 2017/18 the Trust threshold for *C.Difficile* was 31 cases and the Trust reported 30 cases. In 2018/19 the threshold for *C.Difficile* was 30 cases and as at the 28 March the Trust has reported 31 cases. In relation to the response rate for Friends and Family Test (FFT) in Maternity Services, the CN commented that, as discussed earlier in the meeting, the Trust would issue four electronic tablets and hoped to see an improvement in feedback.	

		Action
	The Trust had 56 different LocSSIPs for non-theatre areas. Improving compliance is a priority however the Trust also needs to ensure it has the right audit tool for every single LocSSIPs. The CEO noted that whilst it was important for the Trust to achieve compliance with 25 and 40 working day complaint responses it was important not to put all the focus on the Trust's complaints team. The organisation needed to change the way it responds to complaints and consider how it acted to resolve complaints more quickly. The Board noted the report.	
2.2	**Integrated Quality and Performance Report (IQPR)**	
	The DDET gave an overview of the report. On the Balanced Scorecard, the activity summary was previously reported as red and at Month 11 was now amber. The Trust would deliver the expected level of activity for outpatients but it was 279 behind for its non-elective discharges for the year. As reported at the Finance and Investment Committee on 21 March 2019, the monthly activity return submitted to NHS Improvement (NHSI) had included positive performance against activity targets in elective and day case areas in February 2019. The Trust had started the roll out of text message reminders for the FFT with circa. 6,000 text reminders being issued each week. The CN reported the *C.Difficile* threshold for 2019/20 would be 48 cases. There were some changes in the way *C.Difficile* cases were going to be recorded. With reference to the Quality section, mortality and readmissions, the CMO reported on a high level of scrutiny and discussion at a recent meeting of the Mortality Monitoring Committee. Sir Norman Williams asked the Board to note that NEDs had requested to receive more detail about of mortality at weekends and that this be set out in a formal report. The CMO stated that such a report would be brought to the Quality and Safety Committee in May 2019. Tim Wright noted outpatient productivity (attendance per day) was reported as green on the Balanced Scorecard but on page 8 of the report there were several directorates reported as red. The DDET explained that the differences were due to data catch-up. The Balanced Scorecard rating is informed by the variance column on page 8 of the report. Overall the Trust had done 2.6% more first outpatient attendances per working day in 2018/19 year compared to 2017/18. The CEO noted that in 2019/20 the Trust would enter into a different financial arrangement that supported changes to the model of outpatients. This would require the Trust to change how it reported performance. The CFO reported that the Trust was beginning to see changes in the contractual arrangements which were moving away from a transactional-based funding mechanism to a block-based funding mechanism. The COO asked the Board to note the Trust had reported its referral to treatment (RTT) performance data for January 2019 for the Tooting site which was 85.5%. This was ahead of the Trust's internal trajectory but below the national target of 92%. The COO asked the Board to note there was a technical error when the January data was uploaded to NHS Digital and so there was an incorrect position shown publically. As part of the February position there would be a contract note confirming the error and the action that was being taken to correct this. The Trust had strengthened its own internal processes to ensure no such error can occur again. With reference to on the day cancellations for non-clinical reasons, the COO asked the Board to note there had been an increase in such cases. Whilst this was	

		Action
	disappointing, 97.3% of patients were rebooked within 28 days. The Trust had met six of the seven Cancer standards in the month of January 2019 and was continuing to achieve both the 14 day standard and 62 day standard. However, the Trust would not be complaint with the 62 day standard in February 2019. A number of operations were cancelled as a consequence of operational pressures and the COO asked the Board to note the Trust's apologies to those patients affected by these cancellations. The Chairman commented on the Trust's performance in relation to the emergency department (ED). The COO noted the continued challenge associated with ED performance, especially when the Department was receiving more than 30 attendances in an hour. The DHROD reported an improved position in relation to the Trust's vacancy rate. This continued to be below the target in the month of February, reporting 9.3% against a Trust target of 10%. The key focus for 2019/20 was on turnover as the Trust was losing a considerable number of its staff on an annual basis. The Trust would be reporting consultant appraisal figures from April 2019. The percentage of consultant appraisal currently stands at 83%. The Trust was looking at a reduction of Agency Spend of £15m in 2019/20. The Trust had reviewed medical pay rates and was looking to review the potential impact on activity should there be a reduction in agency spend. The Trust was also reviewing the level of spend on interims in the Trust. This included a line by line review of end dates and the rationale for any extensions. The Board noted the report.	
2.3	**Cardiac Surgery Update**	
	The CMO introduced the paper which provided an update on the work being undertaken to improve the cardiac surgery unit. The CMO explained that a 'dry run' CQC inspection (facilitated by NHSI) has been completed and gave the Trust some positive feedback around progress in leadership and governance in cardiac surgery. The quality summit on 14 March and the Independent Scrutiny Panel on 20 March had recognised that the Trust had made progress with governance in cardiac surgery. The Trust continued to monitor patient safety in cardiac surgery and remained confident that services were currently safe. Findings from the external mortality review of patient deaths between April 2013 and September 2018, which had been commissioned by NHSI in December 2018, continued. Its emerging findings would be triangulated with findings from the 'dry run' CQC inspection. Although the mortality review was a retrospective process, the Trust had been asked by NHSI to consider whether any findings or themes from the retrospective review are relevant to current patient safety. The 'dry run' CQC inspection and the external review had both highlighted the issue around clarity of documentation, note keeping and communication, particularly communication through notes. The Trust had put in place a series of contemporaneous rolling audits for note keeping and consent processes in cardiac surgery. The CMO explained that the findings from the 'dry run' CQC inspection and external review should give the Board assurance that the service was currently safe. There continued to be three extreme risks on the risk register. The Trust recognised that it has the same team in cardiac surgery as before and it could not be complacent about issues around team culture and behaviours.	

		Action
	The Trust Board noted the update on progress being made in Cardiac Surgery.	
QUALITY AND PERFORMANCE		
2.4	**Quality Improvement Academy Update**	
	The DDET introduced a paper that highlighted some of the larger elements of the Quality Improvement Academy's (QIA) current activities and the key themes that will inform its work over the coming year. The earlier discussion following the Board visits served to highlight just how much Quality Improvement (QI) work was going on in the Trust. Nurses, doctors and managers were now routinely using the Plan Do Study Act (PDSA) approach. The DDET had great hopes for the momentum that was building and with the support of the CN and CMO there was much that could be achieved in the year ahead. The staff survey results were a real catalyst for the QIA team. With a rising levels of demand and expectations from across the Trust, the team had created a high level transformation plan for 2019 and started engagement with senior leaders to set in place the conditions to extend the reach and impact of QI. At the end of March, the team would acquire additional resource from the current planned care programme and work was underway to agree where and how best to deploy the new team members. The CEO asked how quickly the QIA programme could progress whilst ensuring that progress was sustainable and change embedded. The Trust was working to learn lessons from the RTT recovery programme. Operational leadership was key and a multi-disciplinary approach essential. Imposing QI initiatives did not work and the vision for the next year was to improve the clarity of QI priorities at service level. The CMO agreed that imposing QI priorities or projects would not work. The paper demonstrated how much work had been done to get the organisation ready to undertake QI at scale. The vision for the future should be an increase in focus and clarity about what the Trust's QI priorities were, not only as an organisation but also department by department, care group by care group. There are structured ways through which the Trust could achieve that. For example, Getting it Right First Time (GIRFT) visits offered the opportunity to identify quality improvement priorities for the next year or even the next five years. In a years' time, it should be possible to ask any Board member or member of staff what the top three Trust QI priorities were and to get a consistent answer. Sir Norman Williams commented that he served on the programme board for Getting it Right First Time (GIRFT) and was familiar with the programme and it was a powerful tool. But it was also important that progress be sustained without an external group coming back to make sure people were improving. The Trust needed to demonstrate how it would sustain progress with QI initiatives without regular external scrutiny. The DDET reported that the Model Hospital Team had launched the GIRFT indicators in General Surgery. The Trust now had national benchmarking on a monthly basis against its GIRFT indicators and that could be used to report into the quality improvement dashboard. The CMO agreed with Sir Norman Williams that the Trust needed to own the GIRFT outputs, and commented that it should be possible to distil the GIRFT reports into a few key priorities visible to the Quality and Safety Committee and the Board. The DHROD reported on the launch of the Enhanced Leadership Programme which tied in with QI and ensured that new managers were aware of the QI focus. The CEO spoke of	

		Action
	the need to balance some of the efficiency that the GIRFT team brought alongside other quality outcome measures. The Acute Provider Collaborative had agreed to look at five specialties across the four trusts using GIRFT to drive change. The Board noted the intentions and progress of the Quality Improvement Academy to date.	
FINANCE		
3.1	**Finance and Investment Committee (FIC) Report**	
	Ann Beasley, Committee Chair, highlighted the key issues from the meeting held on 21 March 2019. Members of FIC reflected on how far the Trust had come over the last two years. The Trust had a better understanding of its financial position as well as of the strategic risks facing the organisation. The FIC had undertaken a deep dive into estates risks at its March 2019 meeting. This included a discussion of risks in relation to water safety. The mitigations in place for maintaining water safety were still fragile and were heavily dependent on individuals undertaking checks. The Committee had discussed RTT and noted the huge amount of work undertaken to return the Trust to national reporting for the Tooting site. It had been disappointing to be informed of a technical error when the January data was uploaded to NHS Digital however the fact that it was brought to the attention of the Committee and discussed in a respectful and challenging way said a lot about how the culture in the organisation had changed. Whilst the Trust had not achieved its activity plan for the year, it had developed a credible plan for 2019/20. The Committee had also agreed it would undertake its annual review of its effectiveness before the April 2019 meeting. The Trust Board noted the report.	
3.2	**Month 11 Finance Report** The CFO explained that the Trust was reporting a Pre-Provider Sustainability Fund (PSF) deficit of £51.8m at the end of February 2019 which is £22.9m adverse to plan. Within the position, income was adverse to plan by £10.1m, and expenditure was overspent by £12.8m. The Trust remained on track to achieve the forecast position.	
	Since the last report, the Trust had agreed a year end settlement with its main commissioners which gave the Trust a degree of security as it approached the year end. That agreement was consistent with the forecast position. The Trust continued to spend capital and was delivering in the way as forecast. The cash position remained challenging but was being closely managed. The Trust was not expecting any major issues or challenges over the next three days. The Board noted the Trust's financial performance to date.	
STRATEGY		
4.1	**Clinical Strategy Highlight Report**	
	The DS introduced the regular report which sets out the progress in developing the new Trust clinical strategy. A Board Seminar on the strategy had been held on 21 March 2019 and the Board would consider at its private meeting later today the full draft strategy. Subject to Board approval, the intention was to launch the new strategy on 23 April 2019. Communication	

		Action
	had been a key focus and work was underway to ensure that the strategy was communicated effectively to staff, patients, and key stakeholders. With the completion of the drafting of the strategy, there would be no further clinical strategy highlight reports presented to the Board. However, arrangements would be needed for reporting on implementation of the strategy. The Trust Board noted the progress reported and the identified issues and risks.	
4.2	**Corporate Objectives 2019/20**	
	The DS introduced the report which sets out the proposed corporate objectives for 2019/20. Since the initial discussions at Board in January 2019, further work had been undertaken to ensure the priorities were sufficiently focussed around a smaller number of key priorities aligned to the strategic objectives. The Trust Executive Committee had considered a revised set of objectives on 13 and 20 March 2019 and the Council of Governors had reviewed these at its meeting on 26 March 2019. Each Director and the CEO had signed up to the objectives for 2019/20. The objectives would be triangulated with the final revised Board Assurance Framework and Strategic Risks, once agreed. The CEO reported this was the first year the Trust had focused on a set of corporate objectives. The Trust also recognised the need to focus on fewer, and more strategic priorities. The Trust had launched a Clinical Governance review and the CEO noted that this should be incorporated into the corporate objectives. The Trust Board considered the proposed corporate objectives for 2019/20 and associated milestones and deliverables, and approved the objectives subject to the addition of the work in relation to the Clinical Governance Review.	**TB28.02.19/8** **DS**
GOVERNANCE		
5.1	**United Kingdom (UK) withdrawal from the European Union**	
	The CFO introduced the report which provided a summary of the key actions being taken to address issues that may result from a “no deal” exit from the European Union (EU). He added that the Trust was as prepared as it could be given the ongoing uncertainty. The Trust had not experienced any issues with supplies to date that could be attributed to Brexit and was monitoring the situation closely. Plans continue to be developed. To date no material risks had been identified, although the high level of uncertainty about what may happen made providing complete assurance difficult. Sir Norman Williams emphasised the potential workforce implications of Brexit, noting that there were a large number of other EU nationals working for the Trust, and that this was concentrated in some services. The DHROD responded, noting that the Trust was monitoring the turnover of EU staff closely. At present, the Trust was not seeing a higher level of turnover for other EU staff. Approximately 11% of Trust staff were from another EU country. In one or two areas, up to 40% of the staff were from other EU member states. The CFO stated workforce issues were likely to impact in three to nine months’ time. This was an area for ongoing monitoring regardless of the outcome. The Board noted the actions being taken.	
CLOSING ADMINISTRATION		
6.1	**Questions from the public**	

		Action
	The Chairman invited questions from the public. A member of the public asked a number of questions about the Trust's cardiac surgery service. In relation to the Hollywood review of behaviours within the unit which had not been implemented, she asked why the Trust had not re-briefed Ms Hollywood on the Trust's expectations, why she had not been asked to revise her report, and why the Trust had funded the review if it had not provided the resolution expected. She suggested that the reason the Trust had not taken forward the review was because it had not provided the response the Trust wanted. She further asked about what the Hollywood review had concluded regarding allegations of bullying within the unit. In addition, she asked why if the Hollywood review had not solved the behavioural issues within the unit the Trust was now employing the services of a mediator. She asked the Trust to confirm the costs of the ongoing High Court action. She also asked whether a succession plan had been put in place for the leadership of the unit given the recommendation in the Bewick report to put such a plan in place within two months. The Chairman thanked the member of public for her question and invited the CMO to provide a response. The CMO explained that the issues affecting the cardiac surgery unit dated back more than a decade. Resolving the dysfunction within the unit would take time, and the steps the Trust was taking to improve teamwork, build better relationships, introduce better governance, and enhance safety were all processes that by definition would not yield instant results. The behavioural issues within the unit had not been solved by Mr Livesey's appointment as Associate Medical Director for the service but he had made a huge contribution to the strengthening of governance, safety and of the team. The Trust had appointed an individual to work with and help develop the cardiac surgical team, and provide pastoral attention and support. It was entirely appropriate to provide this to the team. The Trust had been completely transparent about the cost impact of the issues affecting the cardiac surgery unit. By far the biggest cost impact was the reduction in workload and the resultant loss in income. There were also costs associated with the Trust's attempts to resolve the issues within the service and the Trust had likewise been transparent about this. It would not be appropriate for the Trust to comment publicly on issues regarding ongoing legal action. In relation to the leadership of and succession within the unit, the Chairman stated that the appointment of Mr Livesey was a key part of addressing the issues highlighted in the Bewick report, ensuring the unit had the leadership it needed to improve governance, safety and team working.	
6.2	**Any other risks or issues identified**	
	There were no new risks or issues to note.	
6.3	**Any Other Business**	
	No other business was raised.	
6.4	**Reflections on the meeting**	
	The Chairman invited Tim Wright to lead reflections on the meeting. He reported the meeting had been held in a much better room which had aided the Board's discussions. Feedback from the Board visits was a powerful piece of grounding for the Board. He suggested that the Board had greater confidence in its understanding of the Trust's financial position but said more work was needed in relation to quality where more clarity was needed on	

		Action
	some of the underlying causes of the issues affecting quality. The Balanced Scorecard in the IQPR was showing more green and this was encouraging. On culture change, Tim Wright observed that the Board had not explicitly talked about it that morning but it permeated all of the different discussions, and was particularly noticeable in relation to the conversations about quality improvement and queried whether the Trust could replicate some of the exemplars that it was starting to see to other areas and share good practice. Tim Wright commented that the Board was in a much improved place with regard to its understanding of estates risks and of the fragility of the mitigations in place to manage these. Addressing the issue of quality raised by Tim Wright, Sir Norman Williams commented that the Quality and Safety Committee had discussed its forward plan and would be reinstituting regular deep dives into areas of concern. The DCA had developed a plan for reviewing the Committee's effectiveness and along with the Clinical Governance Review it was hoped these measures would begin to offer more clarity on matters in relation to Quality and Safety. Stephen Collier suggested that the issues identified during the Board visits were in many cases systemic and the Board needed to be confident they were being addressed. He also observed that a lot of work was done in committee but that this was not always visible and suggested that the minutes of Board Committees should be included in the papers for Board meetings. The DHROD noted that the Trust was beginning to have conversations about cultural change and was developing plans for a change programme. The CEO asked the Board to consider how much it could step away from transactional business in order to spend at least 20 to 30% of its time on culture. The CN commented that the Trust was putting all its ward managers through a leadership programme and the second cohort had just been completed. The Chairman thanked the CN for her update and asked the CN to bring one of the leadership programme presentations to Board. The Chairman also welcomed what had been a very thoughtful discussion about how the Board should progress to the next stage of development. The Chairman agreed with comments made by Tim Wright in relation to feedback from Board visits but suggested that feedback from Board members could be more analytical rather than descriptive. The Chairman noted the Board progressed through the agenda rather expeditiously because so much work had been undertaken at Board Committee level. It is however the responsibility of the Board to demonstrate publically what has been discussed and agreed at Board Committee level. The Board could give consideration to including Board Committee minutes in the Board pack.	**TB28.02.19/9** **CN** **TB28.02.19/10** **DCA**
STAFF STORY		
The Chairman welcomed Dr Penny Neild, consultant gastroenterologist, who was invited to attend today's meeting to discuss her work on the Clinical Assessment Service (CAS). Dr Neild explained that she had attended a "Future of outpatients engagement meeting" in March 2017 which had highlighted the need for a fundamental change in approach which started with asking the patients what they wanted, what was going wrong for them, and what could be changed. A month later she had attended a Gastroenterology Council away day where she heard of the work of the gastroenterology team at the Royal Wolverhampton Hospital that introduced a Clinical Assessment Service (CAS) to streamline the patient's pathway in 2014. Having learnt of the success of the programme at Wolverhampton, the		

	Action
Trust decided to undertake a Retrospective Referrals Audit and from January and February 2017 a random sample of 99 referrals were selected. The Gastroenterologists reviewed the referrals as if they were undertaking a CAS and the outcome of the decision made was then compared against the patient's actual pathway. The results of the Audit indicated the majority of investigations selected in the CAS audit were the same as the investigations ordered in the face to face appointment. Of note was that 7 of the 99 patients did not attend (DNA) their face-to-face appointment and 15 patients were 'lost' without further follow up appointments booked. The average number of days from referral to first follow up appointment, after investigations, was 205 days (the range was between 13and 438). The results indicated that patients had to wait considerable time and attend several outpatient appointments before they got anything meaningful from the Trust. At the beginning of February 2018, the Trust had started a process of consultation with a range of stakeholders including GPs, patients and patient representatives. For Phase One, a process was tested with a sample of patients and the learning from that exercise was incorporated into a second phase of work in October 2018 when the programme acquired a pathway coordinator and later on a clinical nurse specialist. This made a huge difference to the efficiency of the service in terms of the number of patients that could be seen. The service was safe, no patients were lost, the patients had someone to talk to and as soon as investigations were completed they could be reviewed and acted on. Eight General Practices took part in phase two. Dr Neild reported patient and GP feedback and CAS findings so far and presented a summary of two case studies that compared the current pathway and the CAS pathway that illustrated the impact of the CAS pathway in terms reducing the number of attendances at outpatients and reducing the time from referral to diagnosis.	
STAFF STORY In April 2019 the Trust would issue a patient and GP survey and this would be followed up by a series of focus groups. The plan in Quarter 1 2019/20 was to receive business case approval, undertake an evaluation of the testing phase and develop a testing model for patients with access issues. In Quarter 4 2019/20 the plan was to roll out CAS across gastroenterology. Dr Neild set out the reasons for why CAS has worked so far that included leadership, support from the transformation team to help build relationships and reduce barriers to change and a collaborative multidisciplinary team with a 'can do' attitude. Models of care were built iteratively with an eye on what was needed for the next stage. The programme had involved detailed data collection for analysis and to reassure the team (and wider stakeholders) the programme was on the right track. Dr Neild set out the areas where the programme needs senior support, sponsorship and resources. Stephen Collier asked why patients were sent letters when there are other ways to contact them. Sir Norman Williams asked to know how the programme would educate colleagues, GPs and other stakeholders, and asked what lessons had been learnt to date. Dr Neild replied that GPs had been worried there would be more work for them as a result of the process, but this was not the case and people were beginning to see the benefits. The DDET expressed his thanks on behalf of the transformation team for what had been achieved by the Gastroenterology team. The CMO asked to know whether the lessons learnt could be applied to other specialties and if this was done at scale whether it could transform outpatient care and even some inpatient admission decisions. Dr Neild said she believed it could. The Chairman asked the executive whether support for the programme has been built into Trust's plans in 2019/20. The CFO confirmed there was resource to support this	

	Action
initiative. On behalf of the Board the Chairman thanked Dr Neild for her presentation.	

Meeting closed at 13.30 hours
Date of next meeting: Thursday 25 April 2019 at St George's Hospital

Trust Board Action Log Part 1 - April 2019

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB 31.01.2019/03	**BAF**	Further consideration to be given to the risk score and assurance statements relating to the partnership aspects of Strategic Risk 4 and that this would be brought back to Board through the Quality and Safety Committee and the next quarterly report to Board	25.04.2019	**CN**	On agenda.	**PROPOSED FOR CLOSURE**
TB28.02.2019/1	**Integrated Quality and Performance Report**	Sarah Wilton asked for an update on urology. The COO explained that he would provide an oral update on urology at the next Board meeting.	25.04.2019	**COO**	The COO agreed to take a report to TEC and FIC in May 2019. Subject to this report being agreed there will be no requirement to bring this back to Board.	**ACTION CLOSED**
TB28.02.19/7	**Patient Story**	It was agreed that the CN would investigate whether the issues highlighted in the patient story were isolated or raised wider concerns, and this would be presented to a future meeting of the Quality and Safety Committee.	25.04.2019	**CN**	This was discussed at the Quality & Safety Committee on 18 April 2019 and an update provided in the Committees report under agenda item 2.1	**PROPOSED FOR CLOSURE**
TB28.02.19/8	**Corporate Objectives 2019/20**	The Trust Board considered the proposed corporate objectives for 2019/20 and associated milestones and deliverables, and approved the objectives subject to the addition of the work in relation to the Clinical Governance Review. The Chairman stated that the inclusion of this should be reported to the Board at the next meeting.	25.04.2019	**DS**	See addendum to action log.	**PROPOSED FOR CLOSURE**
TB28.02.19/9	**Reflections on the meeting**	The Chairman asked the CN to bring one of the leadership programme presentations to Board.	30.05.2019	**CN**	To be reported on at Trust Board meeting on 30 May 2019	**OPEN**
TB28.02.19/10	**Reflections on the meeting**	The Board should give consideration to including Board Committee minutes in the Board pack	30.05.2019	**DCA**	To be reported on at Trust Board meeting on 30 May 2019 after the DCA has consulted with the Chairman and Trust Board Committee Chairs.	**OPEN**

Addendum: Action TB/28.02.19/8 - Corporate Objectives 2019/20

As discussed the detail of the additional corproate objectives for 2019/20

Treat the patient, treat the person	Q1 Milestones	Q2 Milestones	Q3 Milestones	Q4 Milestones	***SMART Measures of Success***
1.2 We will: map, standardise, support and improve our departmental-level governance of quality, safety and learning	Independent review of care group/department level safety governance and culture: report to CMO (end of April). Report and emerging action plan will be discussed at Trust Board in May.	Note: agreed milestones for Q2/3/4 in Q1 when action plan has been developed to support implementation.	Note: agreed milestones for Q2/3/4 in Q1 when action plan has been developed to support implementation.	Note: agreed milestones for Q2/3/4 in Q1 when action plan has been developed to support implementation.	***Note: SMART measures of success will be determine d following production of the action plan in Q1.***

Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**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 Update

Trust Board, Thursday 25 April

I am pleased to begin my report to the Trust Board by talking about the launch of our new five year strategy on Tuesday, 23 April.

Delivering outstanding care, every time:

Our new strategy – *Delivering outstanding care, every time* - launched this month sets out our ambition to deliver outstanding care, every time for patients, staff and the communities we serve.

The strategy we published on Tuesday this week is the end-result of a lot of hard work involving many people, both in and outside the organisation – for which I am extremely grateful.

I joined the organisation in May 2017, and developing a new strategy for the organisation has been a key priority for me since then, as it has for Gillian, our Chairman, and the Trust Board. It is also something I am asked about regularly by our staff, plus many of the external stakeholders I meet on a regular basis.

Our new strategy confirms that we will continue to deliver the same core services local people young and old have come to rely on. One of our stated priorities in the new strategy is to provide excellent local services, and this is something we are committed to delivering.

Our new strategy will, however, lead to a step change in how we deliver some of our more specialist services. Specifically, we will prioritise and channel investment into our **cancer, children's, neurosciences, and major trauma services**; whilst also supporting those teams central to delivery of these services, in particular diagnostics and critical care.

This strategy has been shaped by our staff, stakeholders and local people – and the energy and enthusiasm everybody has shown for making the organisation a better place to work and to be treated at has shone through.

Equally, we can't deliver what we need in isolation – which is why closer collaboration is also central to the way we work going forward.

Investing in our hospital estate:

I am pleased to say we have secured investment to address some of the challenges with our hospital estate at St George's.

Last year, we invested a significant amount of money into our IT infrastructure; enabling us to increase network reliability but, as important, roll-out iClip (Cerner Millennium) to all inpatient wards at St George's, with plans to extend the same software to Queen Mary's Hospital during 2019/20.

This year, the money we've secured will be used to improve our hospital estate at St George's, although the challenges we face are significant, and won't all be solved during the next 12 months, or in the short-term.

The bulk of the money will be invested into core infrastructure, including fire safety, water and electricity, plus theatre ventilation, which is a challenge for many of our teams.

The improvement works we need to carry out will result in some disruption, which our estates and facilities team will endeavour to keep to an absolute minimum. However, it will be important for us to clearly communicate the reasons for the works – and the temporary disruption they may cause – to our staff, plus patients and visitors coming to St George's.

Of course, we do not have a bottomless pit of money to spend – and we also need to deliver significant financial savings over the course of the next 12 months. We will continue to invest, but only in those areas where it really matters, like estates, and where the benefits to staff and patients are clear.

Patient experience:

This week is Patient Experience of Care Week, and I am pleased that on 1 April we changed the standard visiting hours across our hospitals, so that relatives can visit their loved ones any time between 8am-8pm.

The extension of visiting hours at both St George's and Queen Mary's is designed to improve the experience of patients, and it was a decision we took with the experience of our patients and their relatives in mind.

I know from personal experience with my dad that restricted visiting hours can be really difficult for relatives, as well as patients. I wanted to visit my dad in hospital at lunchtime to help with his eating; but was prevented from doing so, which wasn't good for anybody, not least the staff on duty.

As a result, I am delighted we have been forward thinking here at St George's, and put new visiting hours in place after talking to our staff and patients. The decision we've taken has been well received, and will make a big difference to the care our teams provide.

Our teams do a huge amount to improve patient experience, be it in the form of our Get Set 4 Surgery programme, which helps prepare people for surgery; or our New Beginnings project, which involves listening to women about their experiences of giving birth at St George's.

If we are going to provide outstanding care, every time it needs to be truly holistic; and I am really pleased at some of the examples of this in practice I see every day.

Celebrating our staff:

As always, our staff continue to shine, and are rightly being recognised for the work they do – both here at St George's, and in roles outside the organisation.

This month, Dr Gill Cluckie, Consultant Nurse for Stroke, was appointed as the new joint London Clinical Director for Stroke; whilst Dr Jeremy Isaacs, one of our Consultant Neurologists, has been appointed as Dementia Clinical Director for the Capital.

This is a significant achievement for both Dr Cluckie and Dr Isaacs, and shows just how highly regarded they are outside the organisation; as well as the potential within this organisation for our staff to influence the way in which care is delivered across the country.

The Channel 4 documentary series 24 Hours in A&E has been shortlisted for a BAFTA nomination, which is testament to the many staff and patients who feature, plus those teams – clinical and non-clinical - who work behind the scenes to make the series possible.

Finally, I am delighted that a seventh ward at St George's (Kent) has achieved gold in our ward accreditation scheme. The scheme is now well embedded, and enables us to track progress on our wards against a common set of standards, with gold set deliberately high – so it is a fantastic achievement for the team on Kent Ward, who look after patients who have a neurological condition.

Jacqueline Totterdell, Chief Executive

Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**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 April 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality and Safety Committee Report – April 2019

Matters for the Board's attention

The Quality and Safety Committee met on Thursday, 18 April 2019 and agreed to bring the following matters to the Board's attention:

1. Update on February Board Patient Story

The Committee duly considered a detailed report on the management of pain in response to the issues raised at the Board meeting in February, pertaining to a patient who was cared for on Champneys Ward as an outlier and had poor experience of pain control.

The Committee heard that the review into the case focused on four areas:

- Management of patients who are outliers
- Access to medication that is non-ward stock
- Support for ward staff in the management of acute pain
- Assurance of patients' pain management across the Trust

The Committee were assured by the steps taken since the incident and the responses given pertaining to the key issues. The Committee also noted that the use of e-prescribing had improved system and practices. In addition, the ward accreditation process provides further ongoing assurances with focus on evaluation of patients' pain following administration of analgesia.

2. Quality Improvement Plan (QIP) Dashboard

The Committee explored the reasons why the Trust had not met the performance targets in the following areas for March 2019 and what actions were being taken to improve the position:

- Percentage of estates emergency calls (priority 1) resolved within 6 hours
- Percentage of utilisation of central theatres pre-operative slots
- Percentage of patients in the emergency department with red flag sepsis receiving antibiotics within 1 hour

The Committee welcomed and endorsed the Quality Improvement Plan for 2019-20 noting that the quality objectives will include the top three quality priorities and clinical governance. The Committee also noted the proposed key performance indicator measures which are subject to further development. The Committee noted that this would be a holistic approach to management of quality performance which will be embedded and aligned to corporate objectives, quality account priorities and strategic priorities.

3. Integrated Quality and Performance Report (IQPR)

The Committee gave particular focus to the infection control performance report in the IQPR noting that the Trust had 1 case of MRSA for 2018/19 and 31 patients acquired *C.difficile*. The threshold for *C. difficile* was 30 cases. The Committee noted further improvements being made to avoid E. coli and MSSA infections.

The Committee also heard about the increase in grade three pressure ulcers which will be kept under close scrutiny. Conversely, the Committee noted the decrease in grade two pressure ulcers. The Committee will also monitor the number of emergency C-Section cases to gain assurances there are no underlying issues related to this current upward trend.

4. Close Report: CQC MUST and SHOULD Action Plan & Self-assessment against CQC Fundamentals of Care Standards

The Committee was disappointed that there remained four outstanding actions within the CQC Action Plan but agreed to close the action plan. The Committee will keep under scrutiny and monthly review the four outstanding actions all of which will be completed by September 2019.

The Committee reviewed the results from the core services self-assessments against the key CQC standards. The Committee were assured about the process and methodology and noted that the maternity service had rated itself *requires improvement* in the safe domain and the outpatient service had revised its well-led and caring rating to requires improvement. The Committee welcomed this level of introspection and noted that action plans were in place to drive improvements in each area with immediate actions already taken. The next stage of the process involves independent external reviews which will be triangulated with the internal self-assessments and form an overall view and judgement.

The Committee noted that this was a powerful process and a significant step forward in terms of process and practice but noted caution in terms of self-evaluation without external scrutiny.

5. Cardiac Surgery Update

The Committee also considered the Cardiac Surgery Update which is discussed later on the Board agenda.

6. Report from Patient Safety & Quality Group (PQSG)

The Committee received the summary from the PQSG. Of particular note was an update on the process being undertaken by SWL GP's to review patients and the potential clinical harm from delays in referral to treatment (final stage of clinical harm review process). Work continues on the process, but of the patients reviewed to date no harm was found to have been caused to these patients. The commissioners are considering bringing the review process to final closure. Once this has been done a final overview report to conclude the clinical harm review process will be brought to the Committee.

7. Mortality Monitoring Committee (MMC) Report

The Committee received and noted the mortality report which will be presented to the Board in due course.

8. Draft Quality Report (Accounts) 2018/19

The Committee endorsed the draft Quality Report for circulation to stakeholders for comment noting that further work was required to develop the document before final sign-off.

9. Deep Dive: FTT response rates Emergency Department, Maternity and Outpatients

The Committee welcomed the Heads of Nursing to discuss friends and family test (FTT) response rates. Response rates in Emergency Department, Maternity and Outpatients have been areas of concerns for the Board. The Committee were assured there were robust plans in place and heard about the decisive actions being taken to improve the response rates.

10. Medication Incident and Controlled Drugs – Review of Quarter One to Quarter Two 2018/19

The Committee received and noted the quarter 1-2 report on medication incidents and controlled drugs. The report flagged issues with timeliness of prisoners getting access to medication however it was recognised that the Trust had limited influence of practices of HMP Wandsworth but should review what more could be done to influence and support improvement in practice.

11. Review of Board Assurance Framework and Corporate Risk Register Risks

The Board Assurance Framework is on the Board agenda and the Committee agreed that risks interlinked with Strategic Risk 2 could be downgraded as a result of the actions taken to mitigate risk in Cardiac and referral to treatment (RTT).

12. Committee Effectiveness Survey Results & Forward Plan

The Committee considered its effectiveness survey results and approved the proposed forward plan. Actions will be put in place to address the key issues arising from the survey. The Committee recognised the actions required to improve effectiveness and will be monitoring itself against the actions agreed.

13. Risks for Escalation

The Committee heard about the following arising risks some of which are scheduled for wider discussion on Key Issues in Part 2 of the Board.

- Never Event in gynae day surgery
- Water Safety
- Cardiac Catheter Laboratories

Sir Norman Williams
Committee Chair

18 April 2019

Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No**	**2.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	**James Friend, Director of Delivery, Efficiency & Transformation**		
Report Author:	**Emma Hedges, Mable Wu, Kaye Glover**		
Presented for:	**Information and assurance about Quality and Performance for the year to Month 12.**		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access, performance and workforce objectives. The Trust is performing positively against a number of indicators, including a reduction in patient's length of stay, continued positive recommendation rate through Friends and Family survey from our inpatients, and sustained improvement in re-booking offers to our patients within 28 days who had an on the day cancellation. However existing challenges continue in particular Four Hour Operating Standard and patient flow. The Trust has maintained compliance against the Diagnostic access target, achieved five of the eight Cancer standards. In addition St George's Trust resumed National RTT reporting in January 2019, marking a significant step forward in the Trust's data quality journey. This follows a two and a half year reporting gap from June 2016.		
Recommendation:	The Board is requested to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	Safe Caring Responsive Effective Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:	The trust remains in Quality Special Measures based on the assessment of the Regulator NHS Improvement.		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance.		
Previously Considered by:	Finance & Investment Committee	**Date**	18/4/2019
Equality Impact Assessment:			
Appendices:			

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St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 25 April 2019
Reporting period – March 2019

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

March 2019

Daycase and Elective Surgery operations

Actual
5,028

Target 5,209

Discharges before 11am

Actual 18%

Target 30%

Four Hour Emergency Standard

Actual
83%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
96%

Target 95%

Outpatient First Appointment

Actual 16,610

Target 16,843

Feb 2019

Referral to Treatment Standard – Incomplete pathways

Actual
85.2%

Target
92%

Balanced Scorecard Approach

St George's University Hospitals NHS
NHS Foundation Trust

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Theatre productivity (cases per session)	Outpatient productivity (attendances per day)	Bed productivity (length of stay)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control A	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer G	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Key

A Current Month
Previous Month

Executive Summary – March 2019

St George's University Hospitals NHS
NHS Foundation Trust

Our Outcomes

- The Emergency Department saw more than a 5% increase in footfall, treating an additional 26 patients per day with the increases coming in patients self-presenting. Compared to the same month in 2018 there has been a 10% increase in emergency attendances. In March, over 800 patients were streamed back to Primary Care, with the percentage of all attending patients directed elsewhere for assessment and treatment increasing by 33% compared to the same month last year. Non-elective length of stay has reduced however the number of stranded and super stranded patients has increased over the past quarter.

Finance and Productivity

- Elective and Daycase activity is currently showing below plan year to date however there will be a level of post month data catch up.
- The number of Elective procedures per working day has seen a positive increase compared to the same period last year, treating on average 15 more patients per working day.

Our Patients

- We reported three cases of Clostridium Difficile infection in March, totalling 31 cases for the year. This is above our 2018/19 threshold of 30 cases.
- We reported a total of two MSSA bacteraemia incidents in the month of March, totalling 27 cases for the year. which has exceeded our internal threshold for 2018/19 of 25 cases.

Process

- Performance against the Four Hour Operating Standard in March was 83.1%, which was below the monthly improvement trajectory of 90%.
- The Trust met five of the seven Cancer standards in the month of March, continuing to achieve the 14 day standard, however 62 day performance fell to 77.8% with six tumour groups under 85%.
- 95.9% of patients with on the day cancellations were re-booked within 28 days and the number of cancellations have reduced by 43% compared to the same period last year.
- Performance against Incomplete Pathway Completeness currently stands at 85.2% which is above our locally agreed trajectory of 84%.

Our People

- The Trust Vacancy rate continues to be below the threshold in the month of March reporting 9.6% against a Trust threshold of 10%.
- The Trust sickness level has remained above target of 3%, however a decrease is seen for the consecutive month reporting 3.4% in March.
- Mandatory and Statutory Training figures for March were recorded at 90%.
- Non-medical appraisal rates remain below target with a performance of 70.4% against a 90% target.

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Theatre productivity (cases per session)	Outpatient productivity (attendances per day)	Bed productivity (length of stay)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control A	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer G	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Our Finance and Productivity Perspective

Activity Summary

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	
		Mar-18	Mar-19	Variance	Plan Mar-19	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	13,774	15,040	9.19%	14,400	4.44%	164,510	169,331	2.93%	169,536	-0.12%
Inpatient	Elective & Daycase	4,428	5,028	13.55%	5,209	-3.47%	54,135	58,368	7.82%	60,789	-3.98%
	Non Elective	4,298	4,115	-4.26%	4,239	-2.93%	46,916	47,738	1.75%	50,341	-5.17%
Outpatient	OP Attendances	51,146	53,765	5.12%	56,583	-4.98%	634,265	668,520	5.40%	665,316	0.48%

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

Source: SLAM

Our Finance and Productivity Perspective

Theatre – Touch Time Utilisation

Theatre Utilisation

Main List Specialty	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Number of Patients in the last month
Cardiothoracic	64%	79%	81%	75%	74%	69%	70%	70%	73%	72%	72%	80%	74%	62
ENT	77%	75%	81%	77%	80%	84%	76%	77%	82%	78%	80%	76%	74%	129
General Surgery	77%	79%	78%	80%	82%	79%	82%	80%	82%	84%	78%	78%	82%	229
Gynaecology	82%	77%	77%	77%	83%	81%	77%	83%	87%	81%	79%	88%	74%	112
Neurosurgery	83%	76%	87%	80%	74%	84%	78%	76%	81%	80%	82%	78%	75%	156
Oral and Maxillo Facial Surgery	62%	58%	71%	73%	89%	75%	82%	63%	84%	78%	84%	67%	91%	25
Paediatric Dentistry	57%	62%	53%	50%	53%	58%	55%	56%	60%	62%	65%	68%	65%	31
Paediatric Surgery	74%	78%	82%	80%	81%	78%	75%	74%	72%	75%	76%	82%	74%	102
Plastic Surgery	69%	73%	74%	73%	77%	75%	75%	77%	74%	78%	74%	75%	69%	232
Renal Medicine & Surgery	79%	67%	76%	71%	72%	78%	61%	67%	82%	60%	66%	67%	83%	6
Trauma & Orthopaedics	80%	87%	76%	85%	84%	79%	82%	90%	85%	90%	81%	83%	90%	128
Urology	79%	77%	84%	78%	88%	84%	84%	85%	86%	81%	86%	82%	80%	190
Vascular Surgery	77%	77%	77%	76%	72%	68%	74%	76%	70%	74%	76%	82%	75%	48
Grand Total	**77%**	**77%**	**80%**	**78%**	**79%**	**79%**	**78%**	**79%**	**80%**	**80%**	**79%**	**79%**	**77%**	**1,450**

Theatre Average Cases per Session

Main List Specialty	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Cardiothoracic	1.5	1.6	1.6	1.8	1.8	1.5	1.3	1.4	1.5	1.5	1.5	1.7	1.4	
ENT	1.6	1.8	1.9	1.8	1.7	1.8	1.7	1.7	1.7	1.6	1.9	1.6	1.6	
General Surgery	1.9	1.9	1.9	1.8	1.8	1.7	1.7	1.8	1.7	1.6	1.8	1.7	1.6	
Gynaecology	2.5	2.4	2.3	2.3	2.7	2.6	2.5	2.6	2.5	2.9	2.7	2.6	2.3	
Neurosurgery	1.2	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.2	1.1	1.0	1.1	
Oral and Maxillo Facial Surgery	3.3	3.0	3.6	3.0	4.0	3.7	3.9	3.1	3.8	3.8	3.7	3.1	4.0	
Paediatric Dentistry	4.3	4.3	3.7	4.2	4.0	3.8	4.1	3.9	4.5	4.7	4.4	4.3	4.1	
Paediatric Surgery	2.7	2.4	2.6	2.4	2.6	2.6	2.7	2.6	2.7	2.7	2.6	2.5	2.6	
Plastic Surgery	2.2	2.2	2.0	2.0	2.0	2.2	2.2	2.1	2.0	2.0	1.9	2.0	2.1	
Renal Medicine & Surgery	1.3	1.8	1.5	1.7	1.4	1.4	1.3	1.6	1.5	1.4	1.2	1.8	1.5	
Trauma & Orthopaedics	1.5	1.6	1.4	1.6	1.6	1.5	1.6	1.9	1.9	1.8	1.9	1.9	1.9	
Urology	2.0	2.1	2.1	2.1	2.0	2.1	2.1	2.1	2.0	2.1	2.0	2.0	2.0	
Vascular Surgery	1.2	1.2	1.3	1.0	1.1	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	
Grand Total	1.8	1.8	1.8	1.8	1.8	1.8	1.7	1.8	1.8	1.8	1.8	1.8	1.7	

Below target | Above target | No target set

What the information tells us

- Touch time utilisation and the number of patients operated on in each theatre session have remained steady over the past 12 months
- Utilisation in all specialties have reduced their session utilisation rate in the reporting period with the exception of General Surgery, Oral & Max Fax, Renal and T&O
- Along with reduced utilisation, the average number of cases per session has also reduced overall and again has seen little improvement over the last 12 months and remains under target for those specialties where targets have been set.
- T&O average cases per session have seen a positive step change in the last 6 months.
- General Surgery average cases per session has dropped in March and currently sits below the lower confidence limit

Actions and Quality Improvement Projects

- Clinicians continue to 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 look at the list planning process.
- Actions from 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.
- 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%.
- Pathway Coordinators continue to review bookings targets and on the days issues in their Daily Huddles

Our Finance and Productivity Perspective

Number of Elective and Daycase Patients treated per Working Day

Months	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2017-18	2018-19	Variance	Discharges for month
Cardiology & Cardiac Surgery	15.5	14.8	16.3	17.0	15.5	15.4	15.7	14.0	16.8	13.8	14.7	17.2	16.2	16.3	15.6	-4.2%	340
Clinical Haematology	2.9	1.8	2.1	2.2	1.7	1.4	2.2	1.7	1.5	1.8	1.0	1.3	1.4	2.2	1.7	-22.6%	29
Diabetes/Endocrinology	0.8	2.0	2.3	1.5	1.7	1.9	2.0	2.0	1.8	1.2	2.0	1.6	1.8	1.6	1.8	11.2%	38
Endo & Gen Med	50.9	55.0	60.9	61.0	55.6	55.7	56.3	54.6	59.2	49.7	57.3	56.4	61.6	53.4	56.9	6.6%	1,294
ENT	7.4	6.1	8.8	8.7	9.0	7.8	9.1	8.9	7.8	7.1	9.5	7.9	7.9	9.0	8.2	-8.9%	166
General Surgery	10.6	9.4	9.6	10.6	8.8	8.8	11.1	9.9	10.7	10.4	10.7	10.5	12.8	9.8	10.3	4.7%	268
Gynae & Obs	11.1	9.9	9.5	10.3	11.3	10.5	10.2	11.4	11.2	8.8	11.0	10.8	10.4	10.2	10.4	2.1%	218
Max Fax & Dental	5.7	6.4	6.8	6.4	6.7	6.2	7.4	6.4	6.4	5.5	6.7	7.2	5.4	6.0	6.5	7.4%	113
Neuro Surgery	9.5	9.4	8.7	9.4	9.1	8.0	10.0	8.9	10.1	8.9	8.2	9.3	10.5	8.7	9.2	6.1%	221
Neurology	22.2	25.2	24.2	27.9	25.9	24.0	25.6	30.0	28.8	24.2	28.7	34.3	31.0	23.9	27.5	14.8%	650
Oncology	1.8	1.7	1.9	1.8	1.8	1.7	1.6	1.8	1.2	1.5	2.8	2.7	1.8	2.6	1.8	-28.2%	37
Paediatric Medicine	7.2	10.1	10.1	8.5	10.0	9.5	9.6	12.0	10.3	10.9	10.5	12.5	11.9	9.1	10.5	15.7%	250
Paediatric Surgery	8.8	8.5	8.0	8.5	8.3	8.6	9.9	9.2	10.7	8.4	9.6	10.0	10.0	8.7	9.1	4.8%	210
Pain Clinic	6.7	5.7	6.0	5.5	4.5	4.4	5.3	5.3	6.2	5.2	5.1	5.3	5.3	5.0	5.3	5.5%	112
Plastic Surgery	14.6	16.1	18.7	17.7	17.4	19.1	18.8	17.1	18.3	15.9	17.1	17.4	16.5	13.9	17.5	25.8%	347
Renal Medicine	3.7	5.3	5.4	5.7	4.5	5.3	5.4	4.7	3.8	4.4	3.2	5.2	3.7	4.5	4.7	4.9%	78
Trauma & Orthopaedics	8.4	7.4	7.0	6.8	7.7	6.5	6.5	6.4	8.5	6.0	7.7	8.5	6.4	7.2	7.1	-1.1%	134
Urology	10.4	11.6	11.2	13.2	13.0	11.6	13.4	14.5	14.0	12.9	13.4	14.8	13.2	11.8	13.1	11.0%	277
Thoracic Surgery	2.9	2.6	3.0	3.3	3.5	2.5	2.4	2.5	2.9	2.7	2.3	3.2	3.1	3.0	2.8	-6.4%	65
Vascular Surgery	6.0	5.4	6.0	4.3	4.8	4.4	4.7	5.1	4.6	4.3	5.1	3.9	4.4	5.0	4.7	-5.0%	92
Other	3.7	4.0	6.5	6.2	6.4	6.4	4.8	5.3	5.6	5.5	6.5	6.6	4.2	3.8	5.7	51.1%	89
Grand Total	210.9	217.9	233.0	236.4	227.3	219.8	231.5	231.9	240.6	209.4	233.1	246.3	239.4	215.7	230.5	6.9%	5,028

Daycase as a percentage of all Elective Activity	68.7%	73.1%	75.1%	74.4%	80.1%	77.2%	75.3%	76.6%	77.0%	75.0%	77.7%	77.1%	74.8%

Below target | Above target | No target set

What the information tells us

- Neurosurgery and General Surgery are above their upper limit in March 2019 however, as the average cases per session has remained constant, the additional activity is a result of additional sessions.
- Urology has shown a consistent improvement over the previous 12 months.

Note: Daycase and Inpatient Elective daily activity is now merged

Actions and Quality Improvement Projects

- 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,
- 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.
- SNTC Division finance has completed service specific one pagers in conjunction to identify actions required to support SLA achievement.

Our Finance and Productivity Perspective

Outpatient Productivity

First Outpatient Attendances (average per working day)

Directorate	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	First Outpatient Attendances per working day 2017-18	2018-19	Variance	Trend
Cardiology, Cardiothoracic & Vascular Services	60	59	62	66	57	54	58	59	67	51	59	58	59	66	59	-10.5%	
Childrens Services	40	41	50	49	42	42	50	45	51	38	50	47	46	47	46	-1.2%	
Neuro	86	87	83	83	73	67	81	84	88	74	94	81	75	82	81	-1.6%	
Renal & Oncology	22	25	27	30	24	25	23	27	28	23	26	25	24	23	25	9.3%	
Specialist Medicine	148	139	153	157	142	129	144	142	150	126	148	147	144	144	143	-0.5%	
Surgery	245	265	271	300	264	253	270	279	275	257	268	264	278	256	270	5.5%	
Womens Services	69	82	85	92	89	85	89	86	90	78	88	92	82	80	87	8.7%	
T&O	54	55	56	60	62	50	55	52	55	48	53	54	51	50	54	7.9%	
Other	32	37	38	43	38	34	36	37	34	36	39	33	32	32	36	14.3%	
Total	**756**	**790**	**827**	**880**	**791**	**737**	**805**	**812**	**838**	**731**	**826**	801	791	**780**	**802**	2.8%	
											Forecast	**804**	**815**				

Follow Up Outpatient Attendances (average per working day)

Directorate	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	FollowUp Outpatient Attendances per working day 2017-18	2018-19	Variance	Trend
Cardiothoracic & Vascular Services	98	121	116	113	107	100	117	107	124	104	113	106	96	110	110	0.0%	
Childrens Services	70	72	81	73	77	76	87	81	90	73	83	84	70	78	79	0.7%	
Neuro	107	114	113	113	109	105	122	117	123	104	124	118	101	102	114	11.5%	
Renal & Oncology	191	205	217	228	229	219	248	245	243	229	238	223	230	209	230	9.9%	
Specialist Medicine	499	500	520	501	508	477	533	509	529	481	528	537	526	482	512	6.4%	
Surgery	332	354	374	357	349	336	357	352	362	331	382	350	335	351	353	0.6%	
Womens Services	46	50	58	52	64	58	78	69	76	64	69	65	52	53	63	19.1%	
T&O	76	84	81	82	86	77	82	85	93	76	86	85	76	80	83	3.2%	
Other	74	99	98	94	89	86	97	92	91	77	91	92	87	80	91	13.5%	
Total	**1,493**	**1,598**	**1,659**	**1,613**	**1,618**	**1,534**	**1,721**	**1,656**	**1,730**	**1,539**	**1,713**	**1,661**	**1,574**	**1,545**	**1,635**	5.8%	

What the information tells us

- Outpatient activity for the period April 2018 – March 2019 is above plan by 0.5%, Children's and Women's Division and Medical Specialties are driving the over performance in both First and Follow up.
- Across the Directorates, First Outpatient attendances averaged 791 per working day and is below the SLA target for the month, however this is expected to increase once coding has been completed. The RAG rating applied is based on the SLA plan per working day which saw an increase in activity compared to the same period last year.
- Though we have increased the number of daily number of Outpatient First Attendances by 2.8%, we have increased our Follow Up attendance by 5.8% which would indicate our First to Follow Up ratio is not improving.

Actions and Quality Improvement Projects

- Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.

Our Finance and Productivity Perspective

Outpatient Productivity

First and Follow Up DNA Rates (by month)

Directorate	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	DNA patients in the last month	Patients not attending rate 2017-18	Patients not attending rate 2018-19	Variance	Trend
Cardiothoracic & Vascular Services	10.3%	10.8%	10.2%	9.4%	12.2%	10.2%	9.4%	11.5%	10.9%	10.5%	10.9%	10.3%	10.1%	306	8.8%	10.5%	⇧ 1.7%	
Childrens Services	13.3%	16.0%	14.1%	12.9%	14.2%	13.1%	10.0%	11.3%	10.1%	10.9%	10.9%	10.9%	10.2%	318	10.4%	12.0%	⇧ 1.6%	
Neuro	9.2%	10.8%	10.9%	8.5%	9.5%	9.4%	10.0%	10.6%	9.6%	10.2%	10.3%	10.6%	11.0%	440	8.4%	10.1%	⇧ 1.7%	
Renal & Oncology	10.6%	10.6%	11.0%	8.1%	11.1%	11.0%	10.5%	10.4%	11.0%	10.2%	9.7%	10.1%	9.4%	333	10.8%	10.3%	⇩ -0.5%	
Specialist Medicine	11.7%	14.3%	13.1%	11.3%	11.4%	11.8%	11.6%	12.6%	13.1%	11.5%	12.3%	11.2%	10.8%	1,484	13.0%	12.1%	⇩ -0.9%	
Surgery	10.7%	12.1%	11.7%	9.0%	10.9%	10.9%	10.2%	12.1%	11.6%	10.8%	10.4%	10.5%	10.4%	1,431	10.9%	10.9%	⇩ 0.0%	
Womens Services	8.4%	8.6%	8.7%	7.3%	8.4%	9.8%	8.2%	8.7%	8.2%	7.4%	6.6%	7.4%	6.8%	517	9.9%	8.0%	⇩ -1.9%	
T&O	12.0%	11.8%	13.7%	8.4%	9.2%	11.0%	10.7%	10.4%	11.6%	10.9%	10.6%	7.9%	9.1%	296	9.3%	10.4%	⇧ 1.1%	
Other	14.0%	10.0%	9.5%	11.6%	12.9%	13.8%	12.5%	14.4%	15.4%	14.2%	12.9%	12.9%	14.3%	1,307	10.0%	12.9%	⇧ 2.9%	
Total	**11.5%**	**12.6%**	**12.0%**	**10.1%**	**10.9%**	**11.3%**	**10.6%**	**10.5%**	**10.5%**	**10.9%**	**10.8%**	**10.5%**	**10.6%**	**6,432**	**10.2%**	**10.9%**	⇧ 0.7%	

First and Follow Up Ratio

Directorate	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	First to FollowUp Ratio 2017-18	First to FollowUp Ratio 2018-19	Variance	Trend
Cardiothoracic & Vascular Services	1.63	2.06	1.87	1.72	1.86	1.85	2.01	1.81	1.85	2.04	1.92	1.83	1.63	1.68	1.90	⇧ 13.0%	
Childrens Services	1.76	1.75	1.60	1.47	1.86	1.82	1.74	1.80	1.77	1.89	1.66	1.79	1.52	1.69	1.74	⇧ 2.9%	
Neuro	1.24	1.31	1.36	1.36	1.49	1.57	1.51	1.39	1.40	1.40	1.32	1.46	1.35	1.24	1.41	⇧ 13.5%	
Renal & Oncology	8.67	8.38	8.08	7.64	9.75	8.89	10.77	9.08	8.68	10.13	9.15	8.92	9.58	9.02	9.06	⇧ 0.4%	
Specialist Medicine	3.38	3.60	3.40	3.19	3.59	3.71	3.70	3.58	3.53	3.81	3.57	3.65	3.65	3.35	3.57	⇧ 6.6%	
Surgery	1.35	1.34	1.38	1.19	1.32	1.33	1.32	1.26	1.32	1.29	1.43	1.33	1.21	1.37	1.32	⇩ -4.0%	
Womens Services	0.67	0.61	0.68	0.56	0.72	0.69	0.88	0.80	0.84	0.82	0.78	0.71	0.63	0.67	0.74	⇧ 10.9%	
T&O	1.40	1.51	1.44	1.38	1.38	1.55	1.49	1.63	1.69	1.59	1.62	1.57	1.49	1.60	1.53	⇩ -4.8%	
Other	2.33	2.64	2.54	2.20	2.31	2.52	2.70	2.49	2.69	2.16	2.33	2.79	2.72	2.52	2.46	⇩ -2.5%	
Total	**1.98**	**2.02**	**2.01**	**1.83**	**2.04**	**2.08**	**2.14**	**2.04**	**2.06**	**2.10**	**2.07**	**2.07**	**1.99**	**1.98**	**2.04**	⇧ 3.0%	

What the information tells us

- Whilst on a full year basis a higher proportion of patients have not attended, the improvements made recently have seen a 0.9% reduction compared to the same time last year. For the month of March 10.6% of patients did not attend, this on average is 310 patients per working day.
- Impact of seeing more follow up patients is new to follow up ratio increased, showing a 3% increase compared to 2017/18
- DNA Rate for March is 10.6% showing a 0.9% decrease compared to the same month last year, however, due to the spike in April and May this shows we have finished the year 0.7% higher than last year.

Actions and Quality Improvement Projects

- Further appointment types currently excluded from one way text message will go live by 19th April 2019.
- The two way text facility will launch across all requested appointment types on 29th April 2019.

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Our Finance and Productivity Perspective

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

Directorate	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	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	2.7	2.6	2.7	2.6	2.6	2.5	2.5	2.7	2.9	2.8	2.8	2,759	3.0	2.7	-10%	
Cardiothoracic	9.0	9.0	8.7	7.8	8.5	8.9	8.6	8.8	7.7	8.8	7.6	9.7	9.2	242	8.8	8.6	-2%	
Childrens & Women	2.5	2.5	2.5	2.4	2.5	2.4	2.4	2.3	2.4	2.4	2.4	2.9	2.5	1,761	3.5	2.5	-30%	
Neurosciences	10.6	8.9	10.6	11.6	9.4	9.6	6.6	8.8	9.6	9.8	10.8	13.5	9.7	263	9.4	9.9	5%	
Senior Health	8.4	11.3	10.2	11.8	7.4	12.0	7.8	7.6	8.7	11.4	12.5	11.1	10.2	108	11.5	10.2	-12%	
Specialist Medicine	7.6	6.1	9.3	7.3	6.4	8.7	6.8	6.4	7.6	7.5	8.3	6.8	7.1	230	7.7	7.4	-5%	
Surgery & Trauma	4.3	4.6	4.0	4.6	3.7	5.0	4.4	4.6	5.1	4.2	5.3	5.0	3.6	915	4.5	4.5	0.2%	
Therapeutics	13.2	9.8	9.8	3.6	19.2	8.3	15.7	12.0	9.8	21.1	12.3	25.3	10.6	28	11.8	13.1	12%	
Grand Total	**4.0**	**4.0**	**3.9**	**3.9**	**3.7**	**4.0**	**3.6**	**3.6**	**3.7**	**3.8**	**4.0**	**4.3**	**3.7**	**6,306**	**4.5**	**3.9**	-14%	

What the information tells us

- Over the last twelve months patients admitted to the hospital via an emergency pathway spend on average 3.9 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.
- In the month of March length of stay decreased with patients staying on average 3.7 days. Compared with the previous month, all areas reduced length of stay with the exception of specialist medicine who reported a slight increase in March.
- Children's & Women's, Acute Medicine and Senior Health have seen a significant decrease in patient length of stay, and the Trust have seen overall reduction compared to last year improving bed workflow and reducing the number of patients waiting for a hospital bed to become available from the Emergency Department.

Actions and Quality Improvement Projects

- The Inpatient Clinical teams have identified a range of patient experience, quality and productivity opportunities to evolve the process embedded within iClip which will be prioritised in line with other IT developments.
- The Trust are working with Cerner to develop the required logic to support the Red to Green initiative.
- One off clinical capacity is being sought to return the stranded patient volumes to levels where there is confidence that patients are being enabled to leave hospital in a timely manner and others admitted likewise.

Our Finance and Productivity Perspective

Length of Stay

Elective Length of Stay (Excluding Daycase)

														Average length of Stay			
Directorate	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Discharges in the last month	2017-18	2018-19	Variance	Trend
Cardiothoracic	4.8	4.1	4.0	4.4	4.1	4.4	2.9	3.8	3.3	3.7	3.5	4.2	3.6	206	4.6	3.9	-16%	
Childrens & Women	2.1	2.3	3.2	2.7	2.2	2.1	3.1	2.5	2.4	2.1	3.8	2.7	3.0	76	2.7	2.6	-2%	
Neurosciences	12.7	8.7	7.3	12.8	7.1	8.9	10.0	8.0	9.3	10.6	10.2	8.4	5.9	167	10.1	9.2	-9%	
Surgery & Trauma	3.2	3.8	4.1	3.7	3.3	4.3	3.4	3.7	3.5	4.6	4.5	3.9	3.5	448	3.9	3.9	-1%	
Grand Total	**5.2**	**4.6**	**4.6**	**5.5**	**4.1**	**4.8**	**4.7**	**4.4**	**4.6**	**5.3**	**5.4**	**4.7**	**4.0**	**897**	**5.1**	**4.8**	-5%	

What the information tells us

- Over the last twelve months patients admitted to the hospital via an elective pathway spend on average 4.8 days in a hospital bed and a year on year comparison shows improved progress across all directorates.
- March saw a further reduction in length of stay compared to February 2019 meaning patients can be discharged home earlier following their procedure.
- Latest Model Hospital data indicates that around four beds of capacity could be released at any one time were the Trust to match peer group Daycase rates, with 1,200 fewer patients needing to stay in hospital overnight each year.
- The Theatres Teams are also working to ensure that patients with increased likelihood of being able to go home on the day of their operation are placed at the start of the Theatre list to maximise the probability that they do not need to be admitted

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Theatre productivity (cases per session)	Outpatient productivity (attendances per day)	Bed productivity (length of stay)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control A	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer G	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Our Patient Perspective — Quality

Patient Safety

Indicator Description	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Number of Never Events in Month	0	2	1	0	0	0	0	0	2	0	0	1	0	0	
Number of SIs where Medication is a significant factor	0	1	0	0	0	0	0	0	1	1	0	0	0	0	
Number of Serious Incidents	8 / mth	5	4	5	2	4	1	3	5	6	6	6	6	4	
Serious Incidents - per 1000 bed days	N/A	0.19	0.17	0.21	0.09	0.17	0.04	0.13	0.20	0.26	0.26	0.25	0.27	0.16	
Safety Thermometer - % of patients with harm free care (all harm)	95%	94.3%	93.1%	95.3%	96.5%	94.9%	95.7%	96.3%	95.1%	95.0%	95.6%	95.9%	96.5%	96.0%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.5%	97.8%	98.0%	98.7%	98.5%	98.2%	99.0%	98.3%	97.7%	97.6%	98.4%	98.6%	98.3%	
Percentage of patients who have a VTE risk assessment	95%	96.0%	95.9%	95.8%	96.0%	96.9%	96.4%	96.2%	96.0%	96.2%	95.5%	95.9%	95.7%		
Number of Patient Falls	N/A	157	138	117	155	143	136	141	181	173	148	128	147	135	
Falls (Moderate and Above Severity)	N/A	2	3	1	1	1	1	0	1	3	1	3	1	2	
Number of patient falls- per 1000 bed days	N/A	6.05	5.77	5.01	6.70	6.11	5.91	6.26	7.40	7.50	6.32	5.29	6.52	5.32	
Acquired Category 2 Pressure Ulcers	N/A	12	2	6	10	20	15	9	12	25	13	10	16	6	
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.46	0.08	0.26	0.43	0.85	0.65	0.40	0.49	1.08	0.56	0.41	0.71	0.24	
Avoidable Category 3 & 4 Pressure Ulcers	0	0	5	0	2	2	3	1	0	0	1	0	3	3	
Avoidable Category 3 & 4 Pressure Ulcers per 1000 bed days	0	0	0.21	0	0.09	0.09	0.13	0.04	0	0	0.04	0	0.13	0.12	
Acquired Category 3 Pressure Ulcers		6	11	4	6	5	3	2	1	3	7	7	4	11	
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

What the information tells us

- Four Serious Incidents (SIs) were reported in March, with a total of 52 SIs for the year.
- The number of falls reported in March was 135, of the falls reported one patient sustained severe harm and one patient sustained moderate harm.
- A decrease in acquired category two pressure ulcers has been seen in March with 11 patients acquired a category 3 or unstageable pressure ulcer, three of these were found to be avoidable. Ten of the Pressure ulcers occurred within the Medical Division with over half occurring on 3 wards (Amyand, Allingham and Rodney Smith).

Actions and Quality Improvement Projects

- 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 targeted Falls education and training..
- The Tissue Viability Nurses have provided daily teaching across these three areas and supported the ward teams in the reviewing of the practice on the ward. This has included making suggestions on how the staff undertake and document wound assessments.
- The Tissue Viability Team is currently reviewing the assessment documentation and care plan on iClip following completion of the RCAs to ensure that it is more user friendly and a care plan is automatically triggered on at risk patients.

Our Patient Perspective — Quality

Infection Control

Indicator Description	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD Actual	YTD Threshold	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	
Cdiff Incidences (in month)	30	2	6	1	3	3	2	2	3	2	3	2	1	3	31	30	
MSSA	25	1	2	2	1	1	2	1	4	2	5	3	2	2	27	25	
E-Coli	60	5	1	9	6	4	3	4	2	4	3	1	4	6	47	60	

What the information tells us

- In the month of March the Trust reported three cases, totalling 31 cases for the year, which is just above the threshold trajectory for period April 18 – March 19.
- The Trust reported a total of two MSSA bacteraemia incidents in the month of March which has exceeded our internal threshold for 2018/19.
- The Trust has reported 47 cases of E coli in 2018-19, six of which occurred in March.

Note: 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 reported a total of two incidents in the month of March which has exceeded our internal threshold for 2018/19.

Actions and Quality Improvement Projects

- The infection control team committee are reviewing the option to complete RCA for MSSA bacteraemia to identify good practice and opportunities for further improvement.
- All C Diff cases have undergone a Root Cause Analysis (RCA). No lapses in care have been identified to date, however a review of all C.diff cases in 2018/19 is being carried out to look for themes that may identify an opportunity to work with system partners to improve outcomes for patients.

Mortality and Readmissions

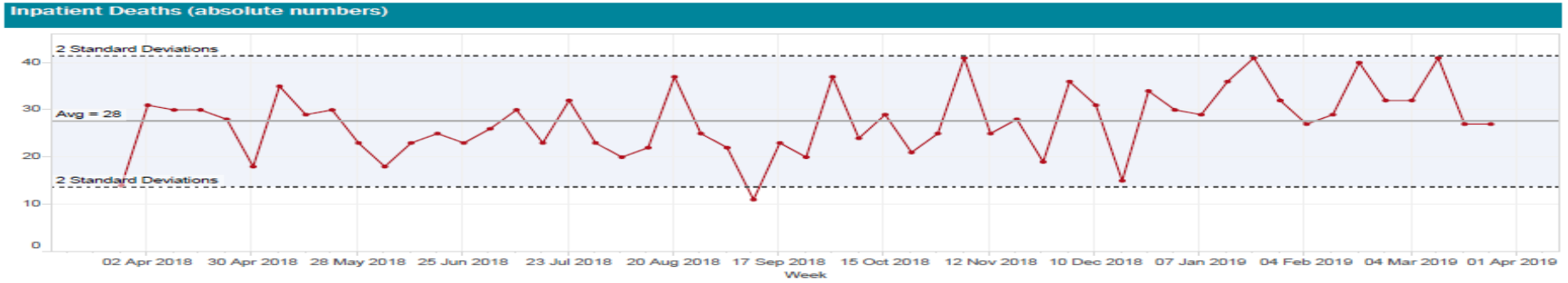
Indicator Description	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-17 to Nov-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	97.3	93.8	106.3	94.9	86.7	79.5	69.8	80.3	73.0	64.2	76.9	74.5	84.7	
Hospital Standardised Mortality Ratio Weekend Emergency	107.9	123.7	121.5	113.8	78.2	97.6	79.5	72.2	62.7	82.4	113.3	79.1	96.8	
Hospital Standardised Mortality Ratio Weekday Emergency	95.3	84.9	95.6	79.7	87.1	82.5	67.6	78.1	68.4	60.1	64.9	78.2	80	

Indicator Description	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Summary Hospital Mortality Indicator (SHMI)	0.83	0.83	0.83	0.83	0.82	0.82	0.82	0.82	0.82	0.84	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	10.6%	8.8%	8.7%	8.7%	8.50%	8.20%	8.20%	7.00%	8.90%	8.30%	7.60%	8.20%	

Please note SHMI data is reflective of the period October 2017 to September 2018 based on a rolling 12 month period (published 14th February 2019).
HSMR data reflective of period December 2017 –October 2018 based on a monthly published position (published 14th February 2019).
Mortality Green Rag Rating is reflective of periods where the Trust are better than expected, non-Rag Rating is where the Trist are in line with expected rates.

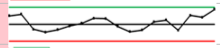
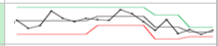
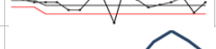
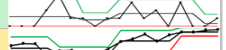
What the information tells us

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.



Our Patient Perspective — Quality

Maternity

Definitions	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Total number of women giving birth- (per calendar day)	14 per day	13	14	14	13	13	13	15	13	14	13	14	13	13	
% of all deliveries where caesarean section occurred	<28%	25.3%	26.3%	28.1%	28.0%	25.1%	23.2%	23.8%	26.8%	27.5%	23.7%	29.2%	28.5%	31.4%	
% deliveries with Emergency C Section (including no Labour)	<8%	8.0%	8.4%	7.8%	9.7%	6.6%	6.2%	6.5%	6.8%	8.3%	7.0%	9.3%	9.4%	10.8%	
% Time Carmen Suite closed	0%									0	0	0	0		
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	3.4%	3.8%	3.5%	3.5%	5.1%	4.5%	3.3%	2.0%	3.6%	1.5%	2.1%	1.4%	2.0%	
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.1%	1.9%	2.8%	1.7%	2.4%	3.6%	1.8%	2.0%	2.6%	2.7%	2.6%	1.9%	3.0%	
Number of term babies (> 34 weeks), with unplanned admission to NNU		7	7	12	12	2	17	11	8	9	10	12	6	10	
Supernumerary Midwife in Labour Ward	>95%								95.2%	98.3%	100%	98%	96%		
Number of babies still born at term (37 weeks+)	<3	0	0	1	1	1	0	0	0	1	0	1	0	3	
Number of babies still born at term (24 to 36 weeks and 6 days)	<3	4	1	0	0	0	3	1	3	0	1	2	2	2	
Number of babies born alive who die within (7 days of birth)	<3	1	1	0	1	1	3	1	2	0	3	0	0	0	
% women booked by 12 weeks and 6 days	90%	66.1%	57.7%	61.4%	67.9%	75.0%	77.8%	82.6%	75.6%	81.9%	84.7%	84.9%	86.8%	87.4%	

What the information tells us

- The total caesarean section rate (CSR) has also increased in the month and is just within the upper control limit
- The percentage of women booked in March by 12+6 weeks of pregnancy was at the highest mark all year, also booking well over 500 women in the month. The service has consistently improved this metric over the past 12 months
- The number of 3rd or 4th degree tears has fallen consistently over the past 12 months

Actions and Quality Improvement Projects

- Stillbirths are being reviewed by the maternity governance team to understand the ones where the babies were not expected to survive, and a particular focus on those cases where reduced fetal movements, fetal growth restriction (FGR), and gestational diabetes were thought to be a factor. This will draw attention to any improvements that can be made in the care of women.
- The service continues to monitor staffing across the service with a plan for responsive recruitment.
- The service will look at the individual Caesarean section rate (CSR) categories to better understand factors contributing to an increase. For example, locums and new consultants' cover of labour ward was higher than usual because of rota gaps and this may be linked with increased emergency CSR. Furthermore, there was a parallel increase in induction of labour and this subset of patients have a higher emergency CSR. These will be closely monitored on an ongoing basis.

Our Patient Perspective — Quality

Patient Voice

Indicator Description	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Emergency Department FFT - % positive responses	90%	81.4%	84.0%	85.0%	85.5%	83.7%	84.6%	83.5%	84.2%	79.2%	84.2%	82.8%	78.5%	81.6%	
Inpatient FFT - % positive responses	95%	96.3%	97.2%	97.3%	97.1%	96.7%	96.6%	96.3%	97.0%	95.5%	96.4%	96.5%	96.0%	96.9%	
Maternity FFT - Antenatal - % positive responses	90%	95.8%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%						
Maternity FFT - Delivery - % positive responses	90%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	90.9%	95.6%	95.7%	91.7%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%		100.0%	100.0%	
Community FFT - % positive responses	90%	98.3%	97.1%	98.5%	98.3%	98.0%	98.4%	99.5%	95.6%	97.4%	96.1%	96.3%	94.9%	98.9%	
Outpatient FFT - % positive responses	90%	98.4%	97.3%	97.3%	97.4%	97.4%	97.1%	96.3%	94.9%	97.3%	95.6%	96.1%	92.3%	90.7%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		94	96	85	79	120	96	93	90	88	78	92	84	101	
PALS Received		259	264	317	292	337	294	335	416	353	252	369	334	284	

What the information tells us

- ED Friends and Family Test (FFT) – In the month of March 81.6% of patients attending the Emergency Department would recommend the service to family and friends reporting an increase compared to the previous month, the response rate remains below our target of 20%.
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96.9% in March providing reasonable assurance on the quality of patient experience
- Outpatient FFT recommend rate has fallen to 90.7% however this may be a result of the increase in response rates which has risen from 1.5% in February to 5.0% in March
- We continue to deliver above target against our Outpatient recommend rate.
- Maternity and Community FFT remain above local threshold with work continuing to improve the number of patients responding which is currently below target.
- There were over 100 complaints received in March 2019 which is the highest number of complaints received in the past eight months.

Actions and Quality Improvement Projects

- Patients can now access the FFT on our website. In addition to the monthly reports of performance to ward areas a weekly report to matrons/ward managers is now in place. This gives the number of discharges versus the number of FFT responses completed and clearly identifies areas that need to improve. Text messaging the FFT after appointment has started in a number of clinics.
- A deep dive review has taken place for ED, Maternity and Outpatients in order to understand the challenges in improving the response rate. This has revealed the need for multiple solutions for specific areas and the teams will be implementing this over the next few months following presentation of the review at Quality and Safety Committee
- Complaints and PALS: The weekly Commell is being used to maintain organisational focus on meeting both timeliness and quality standards for complaint responses. A restructure of the central complaints team is in the consultation stage which closes in late April. The Med Card division are using additional resource for a period of time to support with complex complaints. Surgery Neurosciences Therapies and Cancer division has improved performance across most of its directorates. 64

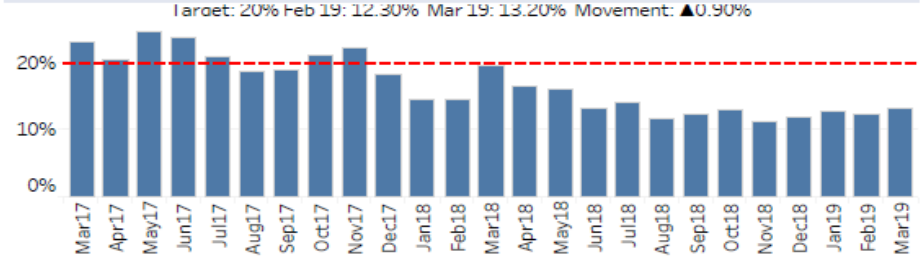
Our Patient Perspective — Quality

Patient Voice

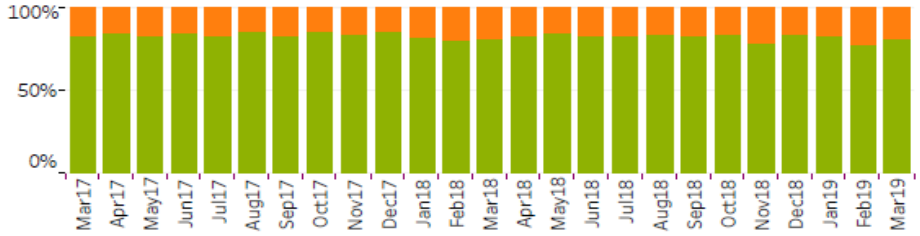
CARING – Friends and Family Test

--- Target ¢ MetricMeasure Percentage Neutral

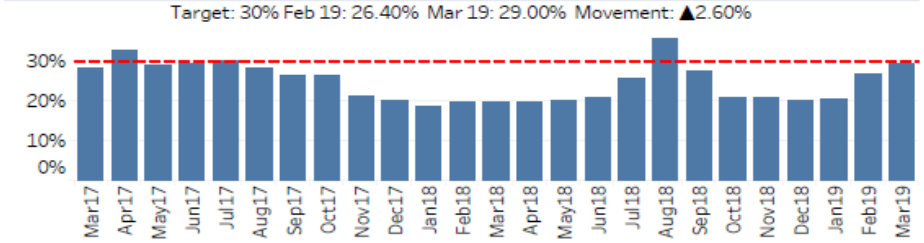
A&E Friends & Family Response Rate



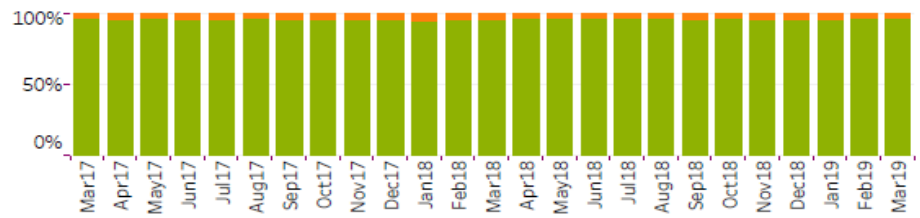
A&E Friends & Family Recommend Rate
The expected target is 90%



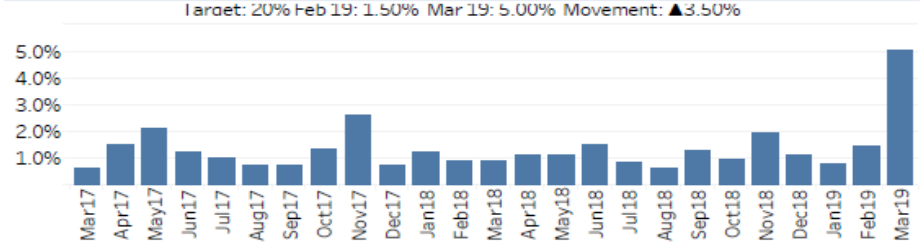
IP Friends & Family Response Rate



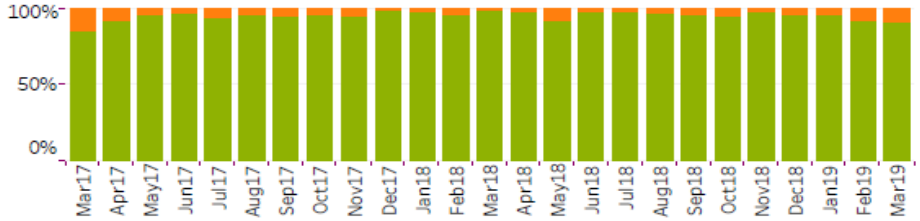
IP Friends & Family Recommend Rate
The expected target is 95%



OP Friends & Family Response Rate



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



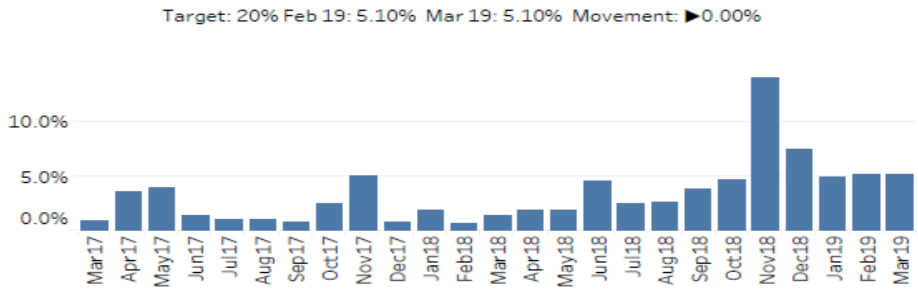
Our Patient Perspective — Quality

St George's University Hospitals NHS
NHS Foundation Trust

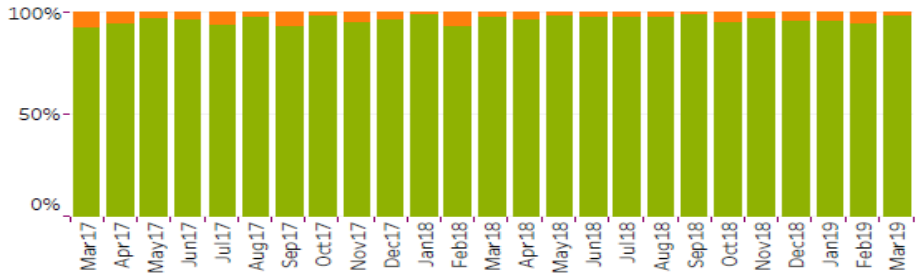
Patient Voice

--- Target ¢ MetricMeasure Percentage Neutral

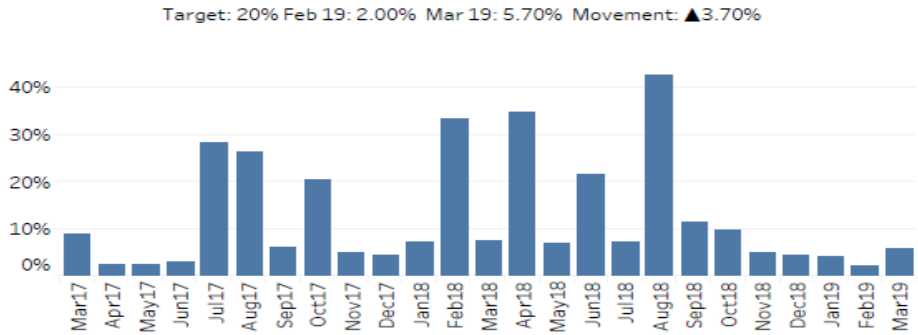
Community Friends & Family Response Rate



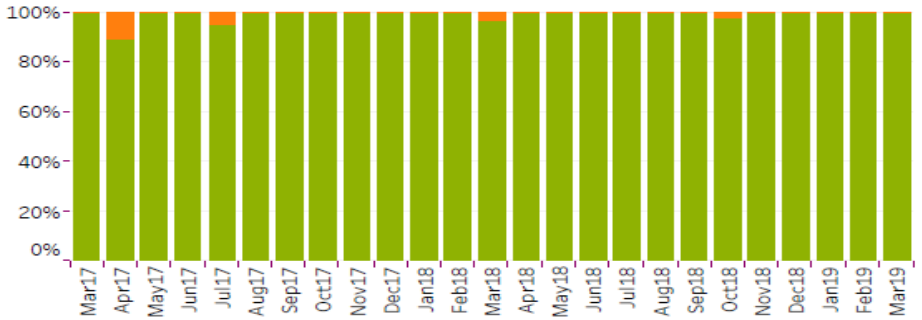
Community Friends & Family Recommend Rate
The expected target is 90%



Maternity (Birth) Friends & Family Response Rate



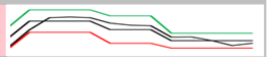
Maternity (Birth) Friends & Family Recommend Rate
The expected target is 90%



OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Theatre productivity (cases per session)	Outpatient productivity (attendances per day)	Bed productivity (length of stay)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control A	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer G	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Our Process Perspective — Delivery

Emergency Flow

Indicator Description	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
4 Hour Operating Standard	95%	81.6%	88.4%	93.3%	93.6%	93.3%	91.1%	90.3%	90.1%	85.5%	85.6%	84.2%	82.2%	83.1%	
Patients Waiting in ED for over 12 hours following DTA	0	2	1	1	0	1	0	1	0	1	2	0	0	1	
Admitted patients with a length of stay 7 Days or Greater		291	303	265	278	271	272	266	287	294	291	315	321	315	
Ambulance Turnaround - % under 15 minutes	100%	41.0%	45.0%	45.7%	43.6%	42.0%	42.3%	46.4%	42.5%	37.4%	37.0%	33.9%	33.0%		
Ambulance Turnaround - % under 15 minutes (London Average)	100%	41.1%	45.2%	45.7%	47.4%	46.7%	48.1%	52.6%	47.4%	46.5%	44.7%	41.6%	43.1%		
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	105	92	65	72	67	85	109	111	138	135	145	87		
Ambulance Turnaround - % under 30 minutes	100%	94.5%	95.3%	96.8%	96.3%	96.2%	95.5%	94.1%	94.5%	93.0%	93.6%	92.3%	95.1%		
Ambulance Turnaround - % under 30 minutes (London Average)	100%	87.5%	88.8%	91.9%	93.7%	93.1%	92.2%	92.5%	92.2%	91.5%	90.5%	88.2%	90.3%		
Ambulance Turnaround - number over 60 minutes	0	10	1	0	0	0	2	3	0	3	1	13	6		

What the information tells us

- The Emergency Department saw more than a 5% increase in footfall, treating an additional 26 patients per day with the increases coming in patients self-presenting. Compared to the same month in 2018 there has been a 10% increase in emergency attendances.
- The daily average of stranded and super stranded patients have increased in recent weeks.
- Performance against the Four Hour Operating Standard in March was 83.1%, which was below the monthly improvement trajectory of 90%. The improvement trajectory will require the delivery of improved performance in both admitted and non-admitted pathways

Actions and Quality Improvement Projects

- In March, over 800 patients were streamed back to Primary Care, with the percentage of all attending patients directed elsewhere for assessment and treatment increasing by 33% compared to the same period last year. Commissioner colleagues are looking to work more closely with individual GP practices to understand the root causes of this growth
- Divisions are reviewing stranded and super stranded patients in escalation review meetings and we continue to work with sector colleagues to further improve processes to enable and facilitate discharge.
- We have enacted an Emergency Care Enhanced Support Plan with effect from 5th February 2019 to remain in place until end March 2019. A daily midday meeting has been established to track key metrics against targets which we know to be indicators of good flow within the organisation; (e.g. no. patients in the ED (target <70), time to treatment (>60% within 60mins), AMU bed occupancy (<80%), Trust-wide bed occupancy (<92.5%) and no. of patients with a Section 5 with a date that has passed (<25 patients). The output of the daily meeting includes focused actions to be carried out, with the aim of delivering real time improvements in flow and performance on a daily basis.
- MADE Event (Multi-Agency-Discharge-Event) planned in April with Local Health and Social Care System Partners

Our Process Perspective — Delivery

Referral To Treatment

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RTT Incomplete Performance	92%	84.5%	85.2%													
RTT Incomplete Trajectory		83%	84%	84%	84.3%	84.6%	84.9%	85.3%	85.5%	85.8%	86.1%	86.5%	86.8%	87.2%	87.7%	88.1%
Total waits greater than 18 weeks (inc 52Wk waiters)		5,921	5,929													
Total waits greater than 18 weeks Trajectory				6,400	6,263	6,142	6,020	5,859	5,779	5,657	5,536	5,376	5,255	5,095	4,894	4,734
Total waits greater than 52 weeks	0	118	116													
Total waits greater than 52 weeks Trajectory				31	23	16	9	5	5	5	0	0	0	0	0	0
RTT Incomplete Performance - Admitted		65.50%	65.50%													
Total waits greater than 18 weeks - Admitted		1,563	1,563													
Total waits greater than 52 weeks - Admitted	0	62	63													
RTT Incomplete Performance -Non Admitted		87.72%	87.70%													
Total waits greater than 18 weeks - Non Admitted		4,358	4,366													
Total waits greater than 52 weeks - Non Admitted	0	56	53													

What the information tells us

- The Trust remains ahead of trajectory for RTT incomplete performance.
- The Trust continues to reduce the volume of patients waiting over 52 weeks on an incomplete pathway.
- Outsourcing of General Surgery elective activity throughout 2019 has resulted in a large reduction in the number of reportable 52 week breaches from the end of March 2019. As at 12 April 2019, there are no patients outside the General Surgery Care Group waiting over 52 weeks.

Actions and Quality Improvement Projects

- The Trust recommenced reporting of RTT data for January 2019, following a gap in reporting since May 2016. After the release of the January 2019 data, the Trust identified that a technical issue had resulted in around 10,000 incomplete pathways being excluded from the reported position for January 2019 . The trust has corrected the issue for the February 2019 data submission and will resubmit January 2019 data as part of the revision publication in July 2019.
- To reduce the number of patients waiting over 52 weeks for surgery, we have increased the number of outsourced General Surgery patients up to the end of March 2019.
- We continue daily monitoring of all patients waiting over 52 weeks for first definitive treatment.
- We continue to reduce the number of patients unbooked for first outpatient appointment.
- We have agreed an activity plan and RTT trajectory to be deliverer throughout FY 2019/20. This will deliver 88.1% performance by March 2019

Our Process Perspective — Delivery

Referral To Treatment by Specialty

Specialty	Admitted		Non Admitted							
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
General Surgery	419	29.8%	656	73.6%	608	467	1,075	56.6%	142	50
Urology	264	65.9%	1,064	88.0%	1,110	218	1,328	83.6%	12	0
Trauma & Orthopaedics	275	63.3%	2,381	87.7%	2,263	393	2,656	85.2%	12	0
Ear, Nose & Throat (ENT)	414	50.7%	2,063	85.2%	1,967	510	2,477	79.4%	40	0
Ophthalmology	0	-	0	-	0	0	0	-	0	0
Oral Surgery	4	50.0%	305	95.7%	294	15	309	95.1%	0	0
Neurosurgery	176	63.1%	1,898	82.9%	1,685	389	2,074	81.2%	12	0
Plastic Surgery	375	51.5%	1,067	82.9%	1,078	364	1,442	74.8%	29	7
Cardiothoracic Surgery	3	100.0%	3	66.7%	5	1	6	83.3%	0	0
General Medicine	0	-	16	93.8%	15	1	16	93.8%	0	0
Gastroenterology	553	95.1%	1,589	86.2%	1,895	247	2,142	88.5%	8	0
Cardiology	740	75.7%	2,337	86.7%	2,586	491	3,077	84.0%	0	0
Dermatology	0	-	1,982	87.3%	1,731	251	1,982	87.3%	5	0
Thoracic Medicine	0	-	1,506	91.1%	1,372	134	1,506	91.1%	0	0
Neurology	55	85.5%	2,332	92.5%	2,205	182	2,387	92.4%	3	0
Rheumatology	2	100.0%	906	84.7%	769	139	908	84.7%	1	0
Geriatric Medicine	0	-	93	98.9%	92	1	93	98.9%	0	0
Gynaecology	242	47.5%	2,106	96.2%	2,141	207	2,348	91.2%	8	0
Other	1,008	71.9%	13,203	87.6%	12,292	1,919	14,211	86.5%	180	59*
Total	**4,530**	**65.5%**	**35,507**	**87.7%**	**34,108**	**5,929**	**40,037**	**85.2%**	**452**	**116**

*58 bariatric surgery (General Surgery), 1 vascular

Our Process Perspective — Delivery

Diagnostics

Indicator Description	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
6 Week Diagnostic Performance	1%	0.2%	0.2%	0.2%	0.3%	0.3%	0.2%	0.4%	0.2%	0.5%	0.6%	0.5%	0.3%	0.5%	
6 Week Diagnostic Breaches	N/A	17	15	14	25	24	15	30	18	39	37	41	24	40	
6 Week Diagnostic Waiting List Size	N/A	7,075	7,956	7,735	7,809	7,236	6,946	7,617	7,593	7,322	6,652	7,649	7,754	7,622	

Indicator Description	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
MRI	1%	0.1%	0.1%	0.0%	0.4%	0.0%	0.3%	0.1%	0.2%	0.3%	0.6%	0.4%	0.6%	0.1%	
CT	1%	0.3%	0.1%	0.0%	0.3%	0.0%	0.0%	0.0%	0.2%	0.1%	0.7%	0.6%	0.0%	0.0%	
Non Obstetric Ultrasound	1%	0.0%	0.0%	0.0%	0.3%	0.0%	0.1%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Audiology Assessments	1%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.4%	4.3%	
Electrophysiology	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%	
Peripheral Neurophysiology	1%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	
Sleep Studies	1%	0.6%	0.0%	0.0%	0.0%	1.1%	1.5%	0.0%	0.0%	7.7%	2.4%	1.1%	0.8%	2.7%	
Urodynamics	1%	9.1%	5.0%	23.9%	6.3%	26.5%	0.0%	13.9%	14.6%	10.2%	8.5%	16.3%	14.0%	0.0%	
Colonoscopy	1%	0.7%	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	0.7%	3.0%	0.0%	2.9%	1.0%	0.0%	
Flexi Sigmoidoscopy	1%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cystoscopy	1%	0.0%	1.0%	0.8%	3.0%	1.8%	4.4%	2.6%	3.0%	4.5%	5.4%	3.2%	0.0%	1.9%	
Gastroscopy	1%	1.8%	1.0%	0.0%	0.0%	1.8%	0.0%	0.3%	0.0%	0.0%	0.6%	1.4%	0.6%	1.8%	

What the information tells us

- The Trust has continued to achieve performance in March reporting a total of 40 patients waiting longer than 6 weeks, 0.5% of the total waiting list.
- Compliance has not been achieved within four modalities, Echocardiography, Sleep Studies, Cystoscopy and Gastroscopy.
- Performance within Urodynamics is now compliant reporting zero breaches for the month.

Actions and Quality Improvement Projects

- Performance and recovery plans continue to be monitored through the weekly performance meetings.

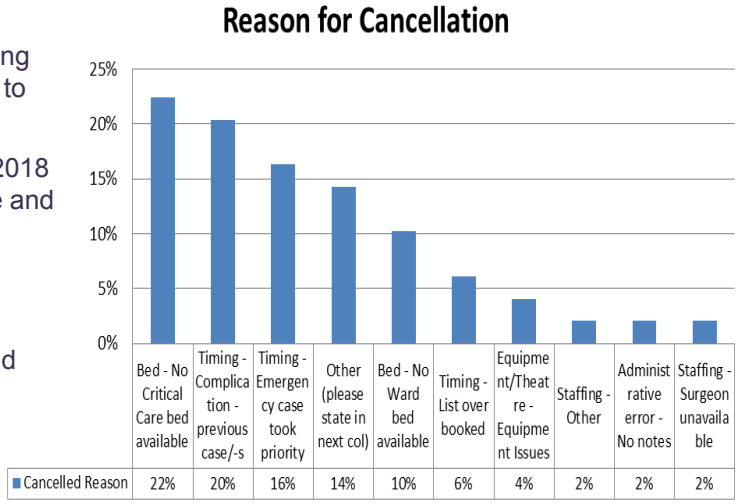
Our Process Perspective — Delivery

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Number of on the Day Cancellations		86	64	87	42	54	44	55	52	53	60	86	73	49	
Number of on the Day cancellations re-booked within 28 Days		76	60	80	33	51	39	48	50	52	58	86	71	47	
% of Patients re-booked within 28 Days	100%	88.4%	93.8%	92.0%	78.6%	94.4%	88.6%	87.3%	96.2%	98.1%	96.7%	100.0%	97.3%	95.9%	

What the information tells us

- Reducing cancellations has been a key focus within the improvement work streams supporting the theatre productivity programme, and we have seen a significant improvement compared to the same period last year, therefore improving patient experience.
- The increase in the re-booking performance has continued to be maintained since October 2018 after introducing daily huddles where the Patient Pathway Co-ordinators proactively manage and review patients that have previously been cancelled.
- In March, 95.9% of patients were re-booked within 28 days and the number of cancellations have reduced by 43% compared to the same period last year.
- Reasons for on the day cancellations include Trauma cases taking priority, complications and ITU bed capacity.

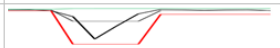
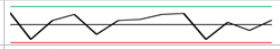
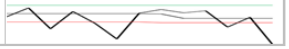


Actions and Quality Improvement Projects

- Continue to roll out Patient Pathway Co-ordinators booking Pre-Operative Assessments for Day Surgery, as well as Inpatient cases improving patient experience and slot utilisation. This has already significantly improved the average utilistaion rates from 50% in December to 73% in February and achieving 90% in the first week of March for Pre Op Assessment slots.
- Following successful implementation of the Text Reminder Service within Day Surgery Pre-Assessment, Inpatient Surgery Pre-Assessment expansion is being explored
- Call to every patients before surgery continues to work well, next steps are to create a list of patients that are fit (via improved POA process) and available at short notice (via improved triaging processes) to fill gaps of any short notice cancellations
- At times of high non-elective activity, ensure that elective patients are reviewed, including their bed requirements, in advance of the day of surgery

Our Process Perspective — Delivery

Cancer

Indicator Description	Target	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	96.7%	96.8%	93.1%	93.3%	83.0%	93.1%	95.0%	95.5%	96.3%	95.9%	96.6%	94.4%	93.3%	1,189	
Cancer 14 Day Standard Breast Symptomatic	93%	96.5%	96.8%	94.4%	79.4%	22.2%	55.2%	86.4%	97.9%	97.1%	95.4%	96.9%	97.4%	94.6%	223	
Cancer 31 Day Diagnosis to Treatment	96%	99.3%	96.5%	98.4%	99.0%	97.0%	98.4%	98.5%	99.0%	99.1%	96.5%	98.2%	97.4%	98.4%	192	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	100.0%	95.5%	100.0%	95.7%	94.1%	95.0%	96.6%	100%	96.9%	96.6%	94.6%	97.9%	94.4%	36	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83	
Cancer 62 Day Referral to Treatment Standard	85%	80.8%	88.1%	92.3%	85.9%	89.6%	85.7%	85.7%	80.6%	87.8%	88.1%	94.8%	86.2%	77.8%	63	
Cancer 62 Day Referral to Treatment Standard Reallocated Position	85%													80.5%	66.5	
Cancer 62 Day Referral to Treatment Screening	90%	89.1%	95.2%	80.8%	92.7%	84.6%	73.8%	91.6%	94.1%	91.8%	93.2%	82.0%	88.7%	70.5%	22	

What the information tells us

- The Trust met five of the seven Cancer standards in the month of March, continuing to achieve the 14 day standard, however 62 day performance fell to 77.8% with six tumour groups under 85%.
- A number of patients chose to delay treatment, while also complex pathways and capacity issues were identified.

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

Month	Target	Actual Performance	Internal Performance
Sep-18	85%	80.6%	85.0%
Oct-18	85%	87.8%	92.5%
Nov-18	85%	88.1%	100.0%
Dec-18	85%	94.8%	100.0%
Jan-19	85%	86.2%	96.0%
Feb-19	85%	70.5%	81.6%

Actions and Quality Improvement Projects

- 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 George's 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.

Our Process Perspective — Delivery

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	No of Patients
Brain	93%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	-	100.0%	-	100.0%	100.0%	100.0%	2
Breast	93%	96.5%	93.9%	94.8%	91.9%	61.2%	87.4%	97.5%	94.5%	99.4%	97.4%	98.8%	97.4%	98.6%	208
Children's	93%	100.0%	100.0%	80.0%	100.0%	100.0%	90.9%	-	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	1
Gynaecology	93%	96.8%	94.3%	94.9%	91.9%	86.1%	91.7%	90.8%	81.9%	87.8%	87.5%	95.9%	69.5%	65.3%	98
Haematology	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	21
Head & Neck	93%	97.6%	100.0%	100.0%	97.5%	92.3%	93.0%	95.6%	99.3%	99.8%	98.1%	96.0%	98.5%	100.0%	121
Lower Gastrointestinal	93%	100.0%	97.8%	94.1%	90.3%	67.5%	94.7%	98.9%	94.3%	98.1%	95.8%	94.5%	97.2%	92.1%	242
Lung	93%	100.0%	100.0%	100.0%	96.3%	90.9%	97.6%	94.7%	95.2%	100.0%	100.0%	100.0%	93.3%	100.0%	38
Skin	93%	94.8%	95.9%	94.1%	93.8%	92.7%	93.3%	92.9%	97.4%	96.6%	97.4%	97.6%	97.1%	95.9%	271
Upper Gastrointestinal	93%	97.3%	95.3%	85.2%	88.1%	89.9%	96.6%	93.9%	96.7%	98.8%	95.4%	94.1%	91.8%	90.9%	66
Urology	93%	95.1%	98.2%	81.3%	92.9%	96.5%	95.2%	93.1%	96.8%	92.4%	93.4%	96.6%	94.5%	94.2%	121

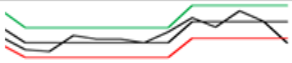
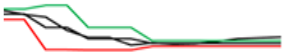
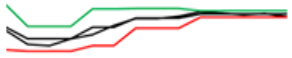
62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	No of Patients
Brain	85%	-	-	-	-	-	-	-	-	-	100.0%	100.0%	-	-	0
Breast	85%	100.0%	88.9%	94.1%	84.6%	91.7%	90.9%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	82.4%	17
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	77.8%	0.0%	100.0%	80.0%	100.0%	75.0%	100.0%	80.0%	90.0%	100.0%	83.3%	88.9%	50.0%	3
Haematology	85%	83.3%	81.8%	100.0%	63.6%	100.0%	100.0%	88.9%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	4.5
Head & Neck	85%	83.3%	80.0%	100.0%	90.0%	75.0%	72.7%	81.8%	80.0%	100.0%	86.7%	87.5%	46.2%	85.7%	3.5
Lower Gastrointestinal	85%	75.0%	100.0%	100.0%	100.0%	100.0%	71.4%	83.3%	66.7%	88.9%	100.0%	100.0%	100.0%	81.8%	5.5
Lung	85%	57.1%	100.0%	100.0%	87.5%	83.3%	71.4%	66.7%	28.6%	50.0%	70.0%	72.7%	80.0%	75.0%	8
Skin	85%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	84.6%	92.3%	100.0%	100.0%	92.3%	100.0%	1.5
Sarcoma	85%	100.0%	-	-	-	-	-	-	-	-	-	-	-	-	0
Upper Gastrointestinal	85%	57.1%	66.7%	87.5%	33.3%	80.0%	100.0%	78.9%	50.0%	54.5%	100.0%	100.0%	0.0%	50.0%	1
Urology	85%	70.0%	96.7%	80.5%	84.6%	84.9%	85.7%	88.2%	92.9%	88.9%	77.8%	95.0%	89.5%	71.1%	19
Other	85%	-	-	-	-	-	-	100.0%	-	100.0%	100.0%	-	0.0%	-	0

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Theatre productivity (cases per session)	Outpatient productivity (attendances per day)	Bed productivity (length of stay)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control A	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer G	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Our People Perspective — Workforce

Workforce

Indicator Description	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Trust Level Sickness Rate	3%	3.6%	3.2%	3.2%	3.6%	3.5%	3.5%	3.4%	3.7%	4.1%	3.8%	4.3%	4.0%	3.4%	
Trust Vacancy Rate	10%	13.3%	12.6%	11.3%	11.0%	10.6%	10.2%	10.4%	9.3%	8.9%	9.4%	9.4%	9.3%	9.6%	
Trust Turnover Rate* Excludes Junior Doctors	13%	17.2%	16.9%	17.0%	17.3%	17.4%	17.1%	16.6%	16.6%	16.9%	16.9%	17.1%	17.1%	17.5%	
Total Funded Establishment		9,497	9,469	9,318	9,242	9,239	9,160	9,180	9,165	9,171	9,196	9,229	9,238	9,248	
IPR Appraisal Rate - Medical Staff	90%	72.2%	81.1%	81.3%	79.9%	77.7%	Not currently provided								
IPR Appraisal Rate - Non Medical Staff	90%	61.6%	61.2%	63.4%	64.6%	67.6%	69.7%	69.7%	69.7%	71.8%	71.5%	70.9%	71.3%	70.4%	
% of Staff who have completed MAST training (in the last 12 months)		87%	87%	87%	87%	89%	88%	88%	88%	89%	89%	89%	89%	90%	
Ward Staffing Unfilled Duty Hours	10%	8.9%	6.5%	5.1%	4.9%	5.8%	5.5%	6.7%	6.6%	5.1%	6.1%	6.6%	6.7%	7.2%	

* Excludes Junior doctors

What the information tells us

- The Trust Vacancy rate continues to be below the threshold in the month of March reporting 9.6% against a Trust threshold of 10%
- The Trust sickness level has remained above target of 3%, however a decrease is seen for the consecutive month reporting 3.4% in March.
- Mandatory and Statutory Training figures for March were recorded at 90%.
- Medical Appraisals rates are being reviewed and will not be reported this month.
- Non-medical appraisal rates remain below target with a performance of 70.4% against a 90% target.

Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No**	**2.3**
Report Title:	**Cardiac Surgery Update**		
Lead Director	**Dr Richard Jennings, Chief Medical Officer**		
Report Authors:	**Matt Jarratt, General Manager, Cardiac, Vascular and Thoracic Surgery, Chris Wood, Project Manager Cardiac Surgery**		
Presented for:	**Assurance and discussion**		
Executive Summary:	This paper provides an update to the Trust Board on the steps being taken to improve the cardiac surgery service following the NICOR safety alert (March 2018) and the findings of the independent review (Professor Bewick, July 2018). Since the last update to the Trust Board (March 2019) the following key developments have taken place: • Interviews for case management Clinical Nurse Specialist (CNS) posts have taken place, and appointments have been made. • An external consultant (who started on 20 March) continues to provide support to the cardiac surgery team. • Work to the current locum consultant post permanent and substantive has begun, with the advertisement about to go out. • A Programme Lead and Administrator have been appointed to oversee the turnaround programme. • The Independent Mortality Review Panel has continued to meet. • Letters are being sent to all the next-of-kin of the deceased patients whose care is being reviewed by the Independent Mortality Review Panel. • The Trust is in communication with HM Senior Coroner for Inner West London to ensure she remains appropriately informed and updated with regard to the work of the Panel.		
Recommendation:	The Trust Board is asked to note the update on progress being made in Cardiac Surgery.		
Supports			
Trust Strategic Objective:	• Treat the patient, treat the person • Right care, right place, right time • Champion Team St George's		
CQC Theme:	• Safe, Well Led		
Single Oversight Framework Theme:	• Quality of Care, Leadership and Improvement Capability		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		
Previously Considered by:		**Date**	

CARDIAC SURGERY UPDATE
Trust Board, 25 April 2019

1. PURPOSE

To update Trust Board on progress being made with Cardiac Surgery since the last presentation to Trust Board (March 2019).

2. EXTERNAL ASSURANCES

2.1. Meetings of the independent Mortality Review Panel

2.1.1. The independent mortality review panel has continued to review patients.

2.1.2. Two letters will be sent to all next of kin: a 'being open' letter which introduces the fact that the review is taking place and that the care of the deceased patient associated with the addressee is being reviewed; and subsequently an 'outcome' letter which will notify the next of kin of the findings of the panel.

2.1.3. A dedicated phone line and e-mail address is in place (staffed by senior nursing staff), to provide a single point of contact for next of kin (available Mon-Fri in working hours).

2.1.4. The Trust is in communication with HM Senior Coroner for Inner West London to ensure she remains appropriately informed and updated with regard to the work of the Panel.

2.2. At the South London Steering Group Planning Workshop on 02/04/19 cardiac services, including cardiac surgery, were among the four specialist areas discussed with regard to further networking and collaboration between providers. The meeting was attended by the CMOs of SGUH, GSTT and KCH.

3. INTERNAL DEVELOPMENTS

Within the last four weeks, the following key service developments have taken place.

3.1. Pre-operative Assessment and case management. Interviews have taken place for the additional nursing appointments (B7 and B8a) to enable the Case Management Team to be put in place, with offers of employment successfully made to both posts. The administrative team is being reorganised to support the Case Management team.

3.2. Culture and behaviour. An external HR consultant has started work, as part of our culture and leadership improvement (OD) strategy for the service.

3.3. Additional substantive consultant recruitment. The existing locum consultant position (currently filled) is being made a substantive post. Provided that recruitment is successful, this will strengthen the on-call rota.

3.4. Project Manager Chris Wood MBE has commenced in the new post of Project Manager for Cardiac Surgery, with a dedicated administrative assistant.

4. INTERNAL ASSESSMENT

4.1. The safety of the service continues to be closely monitored by the Trust and a daily safety dashboard is considered by the Chief Medical Officer and Chief Nurse. The Trust is confident that the safety of the service is currently being maintained, but this continues to require a high level of oversight by a significant number of senior individuals within the Trust.

5. IMPLICATIONS

There continue to be three extreme risks on the risk register for this service, with another due to be added in the next week:

1 Losses incurred through reduced income as a result of decreased activity, and direct costs incurred through turnaround programme. (Original risk score 25, current score 20).The risk score has not been reduced within the last month.
2 Drop off in referrals and significant loss of patient and referrer confidence in the service caused by high media profile of current challenges. This impacts on the longer-term viability of the service (Original risk score 20, current score 15). The risk score has not been reduced within the last month.
3 Adverse impact on patient safety within the service, and poor adherence to Trust values on poor behaviours from within cardiac surgery team, anaesthetics, theatre staff and other key groups (Original risk score 20, current score 15).

In addition, there continues to be a risk in regard to junior medical staffing. This is being managed through active recruitment and the use of bank and, where necessary, agency staff. The rota is complete and there are no gaps at any point currently. As such, the risk is controlled.

6. RECOMMENDATION

The Trust Board is asked to discuss and take assurance from the update on progress being made in Cardiac Surgery.

Date: 25 April 2019

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Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No.**	**2.4**
Report Title:	**Transformation Quarter Four Report**		
Lead Director	**James Friend. Director of Delivery, Efficiency and Transformation**		
Report Author:	**James Friend. Director of Delivery, Efficiency and Transformation**		
Presented for:	**Information**		
Executive Summary:	This is the fourth quarterly report for 2018/19 setting out to the Trust Board the approach, progress and impact of the Transformation work completed at the end of 2018/19 and the work continuing into 2019/20. Overall, the main Transformation programmes fully delivered their change objectives for 2018/19. This was achieved alongside a £750k reduction in team costs for the year. As has been previously reported to the Trust Board, interdependencies on IT change capacity and operational management capacity remain the most significant factors setting the pace of deliverable change and improvement.		
Recommendations:	The Trust Board is asked to note the report.		
Supports			
Trust Strategic Objectives:	**Right Care, Right Place, Right Time** 9. Patient choice • *Aim: Ensure patients have access to high quality outpatient care, including by standardising outpatient pathways, supported by ICT, ensuring all activity is captured and reported.* • *Aim: Offer patients greater choice in how they access acute specialties with alternative to face-to-face appointments.* **Build a Better St. George's** 12. Strategy and engagement • *Aim: We will develop an organisational and clinical strategy that asserts St. George's position as a provider of local and world –reading specialist services.* • *Aim: We will work with our partners and stakeholders to seek their views, so we address the challenges we face together.* 13. Governance • *Aim: More engagement and involvement of patients, front line staff and partner organisations.*		
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:	None directly in this paper.		
Legal/Regulatory:	N/A		
Resources:	None requested in this paper.		
Previously considered	Trust Executive Committee (as Monthly Reports)	Date:	February, March and April 2019.
Appendices:	Appendix One – Key Performance Indicators: 2018/19		

Transformation Quarter 4 Board Report: January to March 2019

1. Purpose of Document

1.1. This report has been written to provide a summary of the activity and impact of the Transformation work across the Trust during the last quarter of 2018/19.

1.2. This report sets out the way in which Transformation activity is being integrated into the operational areas for 2019/20 to ensure that the risk of silo working is mitigated.

2. Overall Progress

2.1. During 2018-19, nearly 600,000 patients benefitted from the transformation initiatives that reached implementation or live testing. The majority of these were helped to attend their Outpatient appointments through text reminders but a further eleven initiatives were delivered ranging from being helped away from the ED Front Door to the most appropriate environment for their urgent care assessment and treatment to 'mothers-to-be' being booked onto Continuity of Carer pathways from antenatal to postnatal care.

2.2. Headline benefits analysis for 2018-19 shows that the £3.4m planned CQUIN and CIP dividends have been delivered, and the overall Transformation Cost Centre has achieved its forecast spend, some £300k lower than the post £450k CIP budget that was set.

2.3. During March, the focus was on completing a number of PDSA ("Plan Do Study Act") post implementation review posters to support the handing back of projects to the operational teams ahead of the reshaping of Transformation resource towards supporting Quality Improvement work through the Academy in 2019-20. A number of previous example posters were on display at the February Board.

2.4. The Trust has said goodbye to Laura Copas who has led the Outpatient (and latterly Planned Care) Transformation work for the last two years. Laura brought key strengths around managing the partnership working with primary care and commissioner colleagues as well as an enthusiastic approach to coaching, team leadership and improvement methodology theory. The capabilities that she fostered within the team now have the opportunity to take on Laura's mantle.

2.5. Two of our project managers were seconded in to supporting operational roles during the quarter; Maria Peries was seconded to MedCard to support the management of operational patient flow and Lila Piling has been directly supporting the Pre-Operative Assessment team while a replacement nurse lead was being recruited. Such arrangements help the Transformation team to actively coach operational colleagues in change and improvement techniques on a day to day basis.

2.6. In January we welcomed back our Business Intelligence guru, Mable Wu, on a part time basis to support the evolution of the Quality Improvement Dashboard, to lead the Performance Visibility Team, to coach her colleagues in measuring the quality and use of resources benefits of transformation changes and to provide one off internal consultancy support for clinical and operational teams.

2.7. In line with the Trust's Improvement Methodology, Terms of Reference documents have been drafted for each transformation initiative commissioned to run into 2019-20 and these are being reviewed by each respective clinically led Steering Group. This will ensure that any work is aligned with the operational teams and that there is no risk of silo working. There is indication that around £2m of potential productivity benefits for 2019-20 can be targeted, depending on the associated IT implementation plan timetable. Access to any capital investment for initiatives such as Ambulatory

Emergency Care (referred to as Same-Day Emergency Care in the NHS Long Term Plan) would give the opportunity to increase this productivity benefit.

3. Medical Staff eRoster Project

3.1. In March the Chief Medical Officer and Director of Workforce jointly wrote to all medical staff with an outline of the project and asking for their support and engagement with the roll-out. This commenced the communications and engagement plan. Regular updates are provided to divisional and directorate teams and introduction and orientation meetings are being held with Care Group Leads and General Managers.

3.2. All General Managers for the first 26 services to go-live have been written to, starting the data gathering process. There are now three Implementation Managers working with services to manage the build, training and deployment and the project is on target for all Junior Doctors to be on eRoster by the end of October 2019.

3.3. The roll-out of eRoster (Activity Manager) for Consultants will start in November 2019 although work has started with ENT as an early adopter of this software.

3.4. A software demonstration and Q&A session is also planned for 15 May for consultant colleagues.

4. Maternity

4.1. The first Continuity of Carer to be submitted to NHS England vis the Local Maternity System has shown that St George's Maternity unit have reached a fantastic 28% for bookings for March 2019 where the same midwife team follow the family from their initial discussions and scans all the way to their post-natal care. This includes those women booking under the Willow Team and two new Birth Centre Teams who will provide care for women booking from various 'out of area' postcodes. In addition, women booking for home birth continue to have Continuity of Care with the Rainbow Team. A number of women have delivered their babies under the care of the Willow Team this month. Operational conversations are on-going with regard to transferring some clinic appointments to community locations.

4.2. The New Beginnings team attended the Patient Experience Network Awards in Birmingham and were finalists in the 'Using Insight for Improvement – Integrated Care' section. The day provided an opportunity to share the New Beginnings work with a large audience as well as gaining valuable ideas from others about ways to gather patient experience feedback. The project has also been nominated for a Trust Award in the Innovation category. Work continues on the change ideas discussed at the co-design meetings, with a trial of new paper knickers currently underway.

4.3. Work towards the 2019 CNST Incentive scheme submission continued. The Maternity Dashboard was circulated by the Clinical Director and comments are being reviewed ahead of the next iteration.

5. Unplanned & Admitted Patient Care (Flow)

5.1. The Transformation work around the Unplanned and Admitted Patient Care is undergoing a full review, refresh and relaunch for 2019/20.

Workstream 1: ED Front Door

5.2. The ED Front Door Workstream closed at the end of March after delivery of its planned improvements, including:

- charity funding bid secured to refurbish the front door area and install new signage
- revised escalation procedure to initiate immediate 'queue-busting' tactics
- intelligent data dashboards to provide better visibility of streaming volume and patterns

- revised pathway to out-of-hours GPs to simplify and standardise processes
- streaming trolley checklist developed to ensure consistency and easy access to equipment
- working together with Voluntary Services to increase volunteer presence at the ED front door to 5-days a week, helping to offer our patients a welcoming and safe entry into the ED.

5.3. Financially the workstream has supported ED income by working with IT to reduce streaming pathway coding mistakes that cost the Trust up to £20,000 each month. The workstream also achieved 100% of the £443,000 award for the Front Door Streaming CQUIN after successfully increasing streaming rates, helping to prevent ED crowding and supporting the Transformation Principle of getting our patients to the right place for their assessment, for their treatment and for their care.

Workstream 2: ED Processes

5.4. The ED Processes Workstream also closed at the end of the financial year having delivered multiple efficiency savings across the department. Highlights of this workstream included the launch of flu point-of-care testing in the ED, a project funded by £5,000 won in the Trust's Quality Week Dragons' Den competition and co-led by Transformation and an ED Consultant, with support from South West London Pathology. This project reduced flu test result turnaround time from a minimum of 90 minutes to just 18 minutes thanks to a state-of-the-art diagnostic analyser situated in the ED. Rapid results also allowed prospective cohorting – admitting patients directly to designated 'Flu A' and 'Flu B' wards to prevent cross-infection, reduce length of stay and keep our patients and staff safe. St George's is the first Trust in the UK to launch flu point-of-care testing in the ED and the project gained a nomination for the HSJ award in Acute Sector Innovation.

5.5. Other achievements included the procurement and installation of 20 new ophthalmoscopes. This project doubled the number of ophthalmoscopes in the ED to ensure that every assessment area or cubicle had within-arm's-reach access, after it was highlighted on the 6-monthly ED Efficiency Survey as a key cause of delay. In February 2019, the new ophthalmoscopes were installed, saving the estimated 400 minutes per day that clinicians had previously spent searching for missing or broken devices.

5.6. The workstream also supported IT with the ED Paperlight implementation – a move from paper notes to electronic notes which will improve information sharing, data quality and reduce manual administration – and helped to identify opportunities to improve IT-related efficiency for the IT Consolidation Project.

5.7. From 2016/17 to 2017/18, based on clinically identified opportunities for improvement, the Trust moved from national bottom quartile Emergency medicine productivity (Cost per Weighted Activity Unit) to top quartile (NHS Improvement Model Hospital data). The clinical teams have identified further opportunities for improvement within the Urgent Care Centre environment as an area of focus for the start of 2019/20.

Inpatient Processes

5.8. The phlebotomy pilot has now been completed for quicker and earlier turnaround of bloods for AMU and Cavell. This pilot showed that the turnaround times for pathology have improved significantly whilst discharges were also increased in our short stay unit leading to reduced Length of stay. Project abstract has been accepted by the Society of Acute Medicine (SAM). There is ongoing support to the operational team to provide visibility of inpatient phlebotomy service provision on a day to day basis to ensure patients are receiving timely phlebotomy access.

5.9. The rollout of Minimum Standards and High Performing Teams in the wave 1 wards continue to progress well with a series of weekly meetings being held to drive improvements for teams and their patients. Amyand ward is piloting running board round using electronic white board. In addition to this, MDT meetings have been re-organised to allow for better planning and improve patient care and flow. "Train the Trainer" approach is being developed order to expedite the

minimum standards & HPT rollout to other wards. The foundation for improvement using this methodology has been built.

5.10. The workstream is implementing Red2Green across the wards before the end of Q2 2019, using a solution built within Cerner iClip. The Red2Green approach is a visual management system to assist in the identification of wasted time in a patient's journey. In order to streamline the way the trust works, approval to retire predicted discharge date (PDD) has been sought. It is planned that the implementation of Red2Green and PDD retirement will happen by the end of September 2019.

Discharge Processes

5.11. Merton CLCH and LBM single referral pathway is now live with 25 Wards live and communications sessions completed for over 100 staff. The opportunities from the Wandsworth pilot of the Bluebird Assessment at Home service are being assessed using an agreed evaluation framework, supported by the transformation team.

5.12. Immediate actions are underway for the Transfer of Care Bureau improvement focusing on attendance, roles, responsibilities and current information systems, with the view to clarify and simplify process where possible. Work continues with the longer term plan to redesign the Transfer of Care function at a larger scale.

Planning for 2019-20

5.13. The revised Flow Transformation Programme for 2019/20 will continue to centre on delivering the three principles of transformation:

- Making the right thing to do for our patients be the easiest thing to be done by our clinicians
- Aligning our clinical capacity with our pathway demand
- Getting our patients to the most appropriate environment for their assessment, for their treatment and for their care

5.14. The clinical leadership team are identifying which initiatives are best managed as operational performance recovery and which may require Transformational support. Conversations are continuing, primarily with the MedCard Division, as to how to create the operational performance conditions to prepare for longer term transformation. This is in line with the necessary requirement to "Perform before you Transform" so that the foundations are in place for sustained success and that the areas of true investment value creation opportunity can be fully understood.

5.15. Overall, our clinicians are challenging each other only to not discharge patients when they are not in a condition in which they would be admitting them. This ambition relies on having confidence that the surrounding healthcare system from diagnostic access, outpatient booking and out of hospital care will effectively meet the needs of each patient.

5.16. Same Day Emergency Care (Ambulatory Care), both for patients arriving at the trust and for patients able to leave hospital and return the following day to continue their treatment or care, has been identified as the key opportunity to meet this ambition and programme resources will be weighted in this area.

6. Planned Care

6.1. The main clinical pathway projects within the Planned Care Transformation portfolio have been handed back to the operational teams including through the completion of a series of Post Implementation Review PDSA posters using the Trust's Improvement Methodology. This includes Intermediate Tier - Dermatology Implementation, Teledermatology, Virtual Consultations, Clinical Assessment Service and Pre-operative Assessment.

6.2. For the full year 2018-19, 26,186 non-face to face ("Virtual") outpatient attendances have been recorded reaching the full CQUIN target and representing a growth of 46% from the previous year.

This is in the context of the IT workflow solutions not yet having been rolled out (which was the original expectation) and the systems and processes being used not yet reaching the Transformation principle of making the right thing to do for the patient be the easiest thing to be done by the clinician.

6.3. As commissioned by the operational team, Transformation support continues within the Digital Outpatients area, including:

- Hybrid Mail - Nearly 1,000 test letter proofs of our outpatient follow up letters have now been received within the test environment and have also completed successful proof of concept testing within our live environment.
- Check-in-kiosks - Over 1,000 patients per week are now routinely using the check in kiosks and utilisation continues to climb to 20% this month (previously utilisation was only 8%). Work to optimize the check in kiosks on the Tooting site is now largely complete. There are 15 kiosks now deployed across 10 areas. Planning support has been provided to the operational teams for the wider deployment of check in booths, with the intention to install kiosks to a further 13 outpatient areas (including at QMH).
- Text Messaging - More than 20,000 messages per week are regularly sent and in the last week of March this reached 26,000. This includes 18,000 appointment reminders (including Radiology), more than 6,000 Friends and Family survey request messages and 1,500 two way text reminders offering our patients the opportunity to confirm or change their appointment. A review of appointment types currently excluded from appointment reminders is underway by all service managers. The Trust DNA rate has dropped in recent months, coinciding with the go live of text reminders, it now stands at 10.0% and is expected to drop into single figures as reminder volumes are increased further in April. The conversion to two way reminders has also had a smaller additional positive effect. Reminders for some elective admissions went live in March, initially with the surgical admissions lounge and once this trial proves effective this can be scaled-up across other areas.

7. Quality Improvement Academy

7.1. After a successful period building awareness and interest in quality improvement, the team has focused on creating a clear plan for the new operational year. There has been a continued promotion of quality improvement conversations particularly as part of the Trust strategy development process and facilitation of CQC readiness assessment workshops.

7.2. With a rising level of demand and expectations from across the Trust, the team has created a high level plan for 2019 and actively started engagement with senior leaders to set in place the conditions to extend the reach and impact of QI. At the end of March, the team acquired additional coaching resource from the previous planned care programme and work is now underway to agree where and how best to deploy the new team members.

7.3. In preparation for the next CQC inspection visits, the team has facilitated a series of QIP engagement / planning workshops across eight care pathways.

8. Recommendation

The Trust Board is asked to note the report.

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

Date: 18 April 2019

Appendix One – Key Performance Indicators: 2018/19

	Metric	Baseline (17/18)	Target	Actual											
				April 18	May 18	June 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar19
1	Proportion of Outpatient Attendances that are Non- Face to Face	0.6%	By year end: 1st Attendances = 20%	0.4%	0.6%	0.4%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%	0.6%
		3.2%	By year end: Follow-up Attendances = 50%	4.1%	4.9%	4.9%	5.8%	5.2%	6.5%	5.7%	5.8%	6.3%	5.1%	5.7%	4.3%
		2.3%	Overall, based on Follow-up to First Attendance Ratio of 2:1 = 40%	2.8%	3.4%	3.2%	4.0%	3.6%	4.4%	3.9%	4.0%	4.3%	3.5%	3.8%	2.9%
2	Outpatient DNA Rate	10.6%	8.0%	12.7%	12.0%	10.1%	10.8%	11.3%	10.5%	10.5%	10.5%	10.9%	11.0%	10.6%	10.5%
3	Admitted Pathway Four Hour Operating Standard	64.3%	April: 69.0% May: 76.7% June & July: 87.1% August: 81.9% September: 87.1% October: 79.3% November: 81.9% December: 74.1% January 2019: 74.1% February 2019: 71.6% March 2019: 87.1%	67.9%	82.2%	81.5%	76.6%	74.7%	70.9%	70.3%	61.5%	62.5%	51.4%	50.2%	54.7%
4	SAFER –Downstream Ward Transfers before Noon – St James's Wing Wards & Heberden	29.3%	33% (23.9% of Patients Admitted through ED Attend between 6am and 11am; 31.2% between 6am and Noon)	25.6%	26.1%	26.3%	25.8%	28.4%	24.9%	20.4%	25.3%	22.7%	25.8%	24.1%	22.9%
5	Number of Women booked on to a Midwifery Continuity of Care Pathway	0	20% of bookings by March 2019					2	17	18	36	42	43	34 / 516 (7%)	109 / 435 (25%)

Red – Worse than baseline, Amber at baseline or better, but not at target, green at target or better.

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St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 April 2019	**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 April 2019.		
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 – April 2019

The Committee met on 18 April and in addition to the regular items on strategic risks, operational performance and financial performance, it considered a paper on Estates' risks in relation to Water Supply, the latest position on financial planning for next year, an update on costing that outlined the expected impact of the Costing Transformation Programme, an update on the Trust's longer-term financial plan, and the latest progress on the Improving Healthcare Together project.

It was a good meeting, in which all attendees participated in a mature discussion of issues, based on reliable data. Indeed reflections at the end, from the Chair of Southern Healthcare Foundation Trust, shadowing the Committee Chair during the meeting, observed a high quality of papers and a good level of Trust between committee members. In particular, the roles of non-executive and executive colleagues were clear and distinct. The Committee took assurance from the fact that most indicators were consistent with expectations at the end of the financial year 2018/19, albeit not necessarily where hoped at the beginning of the financial year.

Among reflections of the Trust's performance in 2018/19 was that some metrics are no longer as useful, such as discharges before 11am, and other metrics continue to show excellent progress from the Trust, namely the Agency expenditure value of £17.1m, very slightly over the Trust's internal cap of £17.0m and well under the external (NHS Improvement) target of £20.6m.

Among many positives, the committee welcomed the discussion of the path for the Trust to exit financial special measures (FSM) in the coming 6-9 months.

The Committee wishes to bring the following items to the Board's attention:

1.1 Estates Risks- the Director of Estates & Facilities (DE&F) gave an on risks related to water safety.

1.4 Finance Risks- the Chief Financial Officer (CFO) introduced a paper on financial risk that addressed the changes in the risk environment as the Trust has now moved into the new financial year of 2019/20. The new functional risks required have led to a change in the quantity and description of strategic risks reported to the committee. The Committee discussed the implications of potential 'system control totals' on the Trust in the coming financial year.

1.5 Activity- the Director of Delivery, Efficiency & Transformation (DDET) updated the Committee on the positive performance against activity targets in elective and daycase areas in March which was not fully captured in the Integrated Quality & Performance Report. He noted that updated performance was 5,375 operations against a target of 5,209. The Committee welcomed this information.

1.6 Emergency Department (ED) update - the DDET noted the continued challenge with Emergency Flow performance (83.1% in March) but outlined some of the other important metrics as part of a storyboard being worked up for 2018/19. He noted that attendances are up 3% year on year and 1,600 more patients have been admitted within 4 hours. He also observed some of the issues that may have caused some of the changes in attendance patterns, including a directory of service from NHS 111 that streams patients to the ED that would be more suitable for primary care support.

1.7 The Committee also discussed metrics that are potentially not as useful as guides for the committee to assess performance. Firstly, the 'discharges before 11am' metric, currently set at 30%, is now not always appropriate as it may lead to services delaying discharge until the following morning when the previous afternoon would be better for patients and other performance metrics. Secondly, the DNA outpatient target may have been set at a too optimistic level and the DDET agreed that this will be reviewed in 2019/20.

1.8 RTT- the Chief Operating Officer (COO) updated the Committee on Referral to Treatment (RTT) targets in February. Performance of 85.2% against the 92% Incomplete Pathway target was within agreed trajectory. He also observed the reduction in 52 week waiters, with 27 patients currently waiting above a year at year end, below the trajectory of 31 agreed.

1.9 Cancer- the COO updated the Committee on the challenges of performance against the 62 day cancer target in February owing to cancellations on the day following bed pressures. He observed that March performance is better, and that at year-end the target is expected to be met. He also noted that all targets are expected to be met at year end, except the Screening target of 90%, which is still expected to be above 85%, despite sector-wide capacity issues.

1.10 Agency Performance- the Director of HR & Organisational Development (DHROD) updated the committee on the agency expenditure value of £17.1m, very slightly over the Trust's internal cap of £17.0m and well under the external (NHS Improvement) target of £20.6m. The committee welcomed this good news.

1.11 Financial Performance & Forecast- the Deputy CFO noted performance in 2018/19 to be reported in the draft accounts was a pre-PSF deficit of £52.0m, which was in line with the best case forecast first reported to the committee in August 2018. The committee again welcomed this good news, showing that the Trust understands and can predict financial performance, albeit adverse to the original plan.

1.12 Cash & Associated Issues- the Director of Financial Operations (DFO) updated on the latest cash position of the Trust. The Committee were comforted to see good cash management taking place.

1.13 Costing Update- the Director of Financial Planning (DFP) updated on the Costing Transformation Programme and the implications for the coming months.

1.14 Annual Planning Update – the CFO introduced an update on the annual plan for 2019/20 and progress made on the longer term (5 year) financial plan. He observed the work still to be undertaken in 2019/20 mainly focussed on the development of more 'Green CIPs'.

1.15 Improving Healthcare Together – The Director of Strategy updated the committee on the latest progress with the Improving Healthcare Together project and governance arrangements for the next round of feedback from the Trust in May. The committee noted the paper.

1.16 Committee Effectiveness – the CFO noted that this exercise would be reviewed at next Committee meeting.

1.17 Procurement Report – the CFO introduced the latest update from the procurement team and the committee welcomed the format used. The CFO noted the work currently underway on a (SWL) sector-wide approach to procurement.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 18 April 2019 for information and assurance.

Ann Beasley
Finance & Investment Committee Chair,
April 2019

Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No.**	**3.2**
Report Title:	**M12 Finance Report**		
Lead Director/ Manager:	**Andrew Grimshaw, Chief Financial Officer**		
Report Author:	**Michael Armour, Financial Strategy, Strategic Development** **Tom Shearer, Strategic Finance Manager, Finance Directorate**		
Presented for:	**Update**		
Executive Summary:	Overall the Trust is reporting a Pre-PSF deficit to date of £52m at the end of Month 12 (March), which is £23m adverse to plan. This position is in line with the Trusts year end forecast.		
Recommendation:	The Trust Board notes the Trust's financial performance for 18/19.		
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	Date	18/04/19
Appendices:	N/A		

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St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 12 (March 2019)

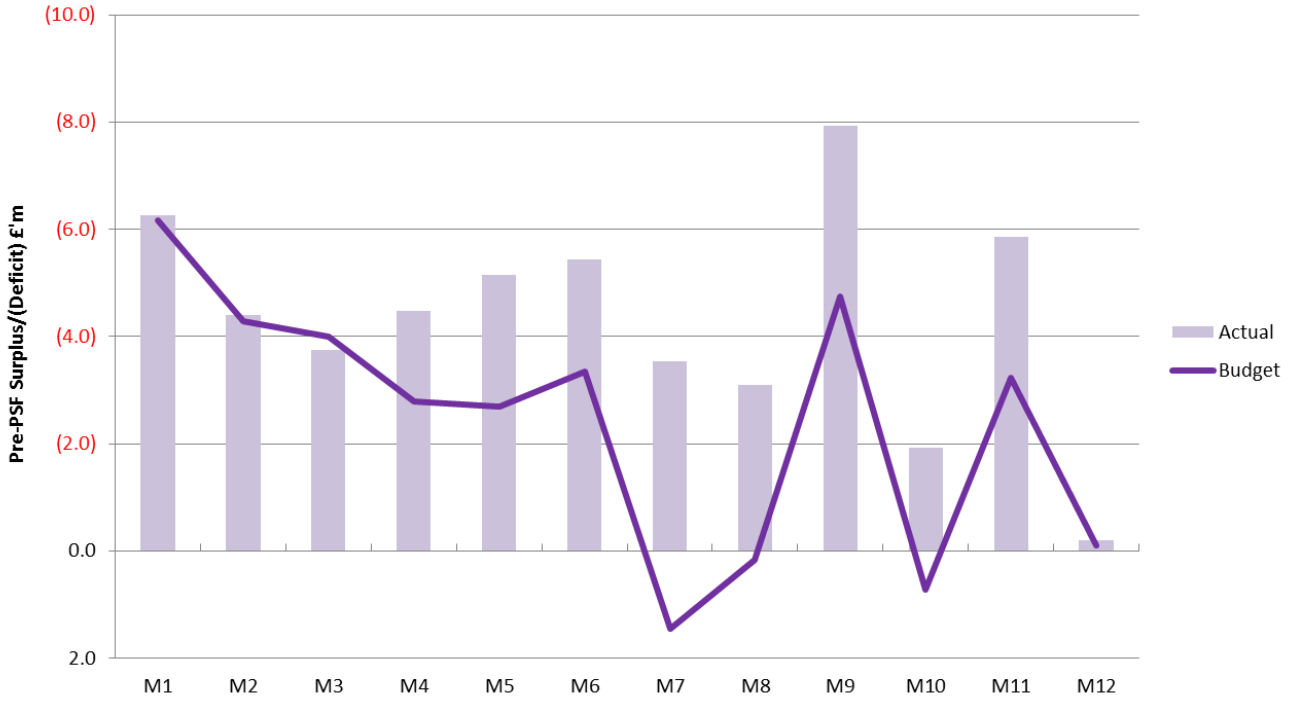
Chief Financial Officer

25th April 2019

1. 2018/19 Financial Outturn Performance

Externally reported position | Reconciliation to internal plan

			M12 Budget (£m)	M12 Actual (£m)	M12 Variance (£m)	M12 Variance %	Annual Budget (£m)	Annual Actual (£m)	Annual Variance (£m)	Annual Variance %	Internal vs External Plan Adjustments (£m)	Annual Variance vs Internal Plan (£m)
Pre-PSF	Income	SLA Income	56.2	70.4	14.2	25.3%	660.9	666.1	5.1	0.8%	(17.4)	(12.3)
		Other Income	13.7	24.1	10.3	75.3%	161.4	170.7	9.3	5.7%	(4.3)	4.9
	Income Total		**69.9**	**94.5**	**24.5**	**35.1%**	**822.3**	**836.7**	**14.4**	**1.8%**	**(21.8)**	**(7.4)**
	Expenditure	Pay	(41.9)	(64.0)	(22.2)	(52.9%)	(509.7)	(535.1)	(25.4)	(5.0%)	20.7	(4.7)
		Non Pay	(25.2)	(27.8)	(2.6)	(10.2%)	(307.6)	(320.1)	(12.5)	(4.1%)	1.1	(11.5)
	Expenditure Total		**(67.1)**	**(91.8)**	**(24.7)**	**(36.9%)**	**(817.3)**	**(855.2)**	**(37.9)**	**(4.6%)**	**21.8**	**(16.1)**
	Post Ebitda		(2.9)	(2.8)	0.1	3.4%	(34.0)	(33.5)	0.5	1.4%	0.0	0.5
Pre-PSF Total			**(0.1)**	**(0.2)**	**(0.1)**	**(110.7%)**	**(29.0)**	**(52.0)**	**(23.0)**	**(79.4%)**	**(0.0)**	**(23.0)**
PSF			1.5	5.0	3.5	240.3%	12.6	6.9	(5.7)	(45.3%)	0.0	(5.7)
Grand Total			**1.4**	**4.8**	**3.4**	**249.1%**	**(16.4)**	**(45.1)**	**(28.8)**	**(175.6%)**	**(0.0)**	**(28.8)**



Trust Overview

Overall the Trust is reporting a Pre-PSF deficit of £52.0m at the end of Month 12, which is £23.0m behind plan. This is in line with the agreed forecast with NHSI.

PSF income of £5m was awarded to the Trust in M12, taking total PSF received to £6.9m.

For consistency, narrative variances below are provided against the internal plan. These vary from the external position by category. Whilst the external plan is static, the internal plan is updated throughout the year (for example, AfC pay award impact not reflected in external plan, as per NHSI instruction, but adjusted for internally for management reporting purposes).

- **SLA Income** is £12.3m under plan. The main areas of note are Elective with an adverse variance (£9.7m) and Beddays (£2.3m).
- **Other income** is £4.9m over plan, which is primarily RTA owing to increased invoicing (£2.7m) and VAT reclaims following external review (£2.2m).
- **Pay** is £4.7m overspent. Medical staffing overspends of £7.4m are partially offset by non-medical staffing underspends of £2.7m due to vacancies.
- **Non-pay** is £11.5m overspent, mainly owing to increased pass-through devices income (£5.3m), non pass-through drugs (£2.9m), additional consumable costs (£1.8m) and additional IT costs (£1.5m).
- **PSF Income** agreed with NHSI is £6.9m in 2018/19. This is £5.7m adverse to plan.

2. Balance Sheet as at Year End 2018/19

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**377.2**	**400.0**	**390.5**	**-9.5**
Stock	**6.4**	5.6	7.8	2.2
Debtors	**112.3**	101.7	101.9	0.2
Cash	**3.5**	3.0	3.2	0.2
Creditors	**-118.4**	-113.4	-122.4	-9.0
Capital creditors	**-15.4**	-3.6	-4.3	-0.7
PDC div creditor	**0.0**	-1.9	0.0	1.9
Int payable creditor	**-0.7**	-1.2	-1.2	0.0
Provisions< 1 year	**-0.2**	-0.2	-0.5	-0.3
Borrowings< 1 year	**-57.7**	-27.7	-57.6	-29.9
Net current assets/-liabilities	**-70.2**	**-37.7**	**-73.1**	**-35.4**
Provisions> 1 year	**-1.0**	-0.6	-1.0	-0.4
Borrowings> 1 year	**-241.6**	-314.5	-284.3	30.2
Long-term liabilities	**-242.6**	**-315.1**	**-285.3**	**29.8**
Net assets	**64.4**	**47.2**	**32.1**	**-15.1**
Taxpayer's equity				
Public Dividend Capital	**133.2**	133.1	133.4	0.3
Retained Earnings	**-167.9**	-185.0	-213.4	-28.4
Revaluation Reserve	**97.9**	97.9	110.9	13.0
Other reserves	**1.2**	1.2	1.2	0.0
Total taxpayer's equity	**64.4**	**47.2**	**32.1**	**-15.1**

Year End 2018/19 Balance Sheet Movement

- Fixed assets are £9.5m lower than plan due to lower capital spend than plan .
- Stock is £2.2m higher than plan due mainly to increase in Pharmacy and Cardiac stock.
- Overall debtors are £0.2m higher than plan.
- Creditors are £9m higher than plan.
- Capital creditors are £0.7m higher than plan.
- 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 £51.9m YTD for deficit financing which is more than plan. The Trust will drawdown £6.4m in April.
- No capital loan was received in 2018/19.
- The deficit financing borrowings are subject to an interest rate 3.5% since November 17.

3. Year End 2018/19 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	-17.1	-45.4	-28.3
Depreciation	23.5	23.8	0.3
Interest payable	10.9	10.8	-0.1
PDC dividend	0.8	0.0	-0.8
Other non-cash items	-0.2	-0.2	0.0
Operating deficit	**17.9**	**-11.0**	**-28.9**
Change in stock	0.7	-1.2	-1.9
Change in debtors	12.6	13.8	1.2
Change in creditors	-7.0	0.5	7.5
Net change in working capital	**6.3**	**13.1**	**6.8**
Capital spend (excl leases)	-57.3	-34.9	22.4
Interest paid	-10.4	-10.4	0.0
PDC dividend paid	1.1	0.0	-1.1
Other	-0.4	0.4	0.8
Investing activities	**-67.0**	**-44.9**	**22.1**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	21.8	51.9	30.1
Capital loans	29.7	0.0	-29.7
Loan/finance lease repayments	-9.2	-9.4	-0.2
Cash balance 31.3.19	**3.0**	**3.2**	**0.2**

Year End 2018/19 Cash Movement

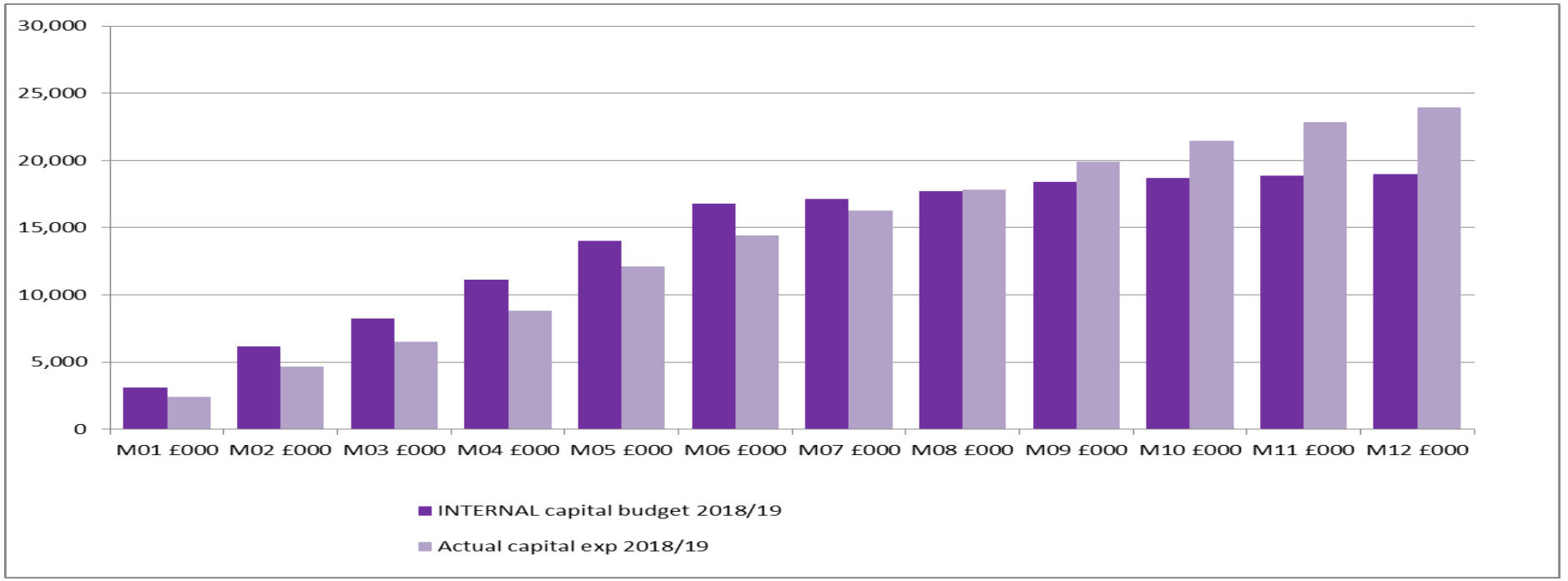
- The cumulative M12 I&E deficit is £45.4m, £28.3m adverse to plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £45.4m, depreciation (£23.8m) does not impact cash. The charges for interest payable (£10.8m) 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 £11m.
- The operating deficit variance from plan of £28.9m.
- Working capital is better than plan by £6.8m. The favourable variance on debt comprises £3m adverse variance on invoiced debt and a £4.2m favourable variance on accrued debt. The £7.5m adverse variance on creditors relates mainly to the timing of payments for other NHS bodies. The Trust has borrowed £51.9m YTD which is in higher than the YTD plan by £30.1m in order to fund the current year deficit. The Trust had a draw down of £2.5m loan in March. The borrowings are subject to an interest rate of 3.5% for the amounts drawn since November 17.

March Cash position

- The Trust achieved a cash balance of £3.2m on 31 March 2019, £0.2m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 17 week cash flow submitted last month.

4. 2018/19 Capital Budget and Expenditure

INTERNAL capital budget 2018/19 (excl bid - not approved) and YTD exp



- The Trust's internally funded capital expenditure budget for 2018/19 is £18.9m.
- The Trust has incurred capital expenditure of £24.9m in this year. This comprises £19.1m against the YTD internal capital budget of £18.9m and £5.9m expenditure incurred 'at risk' on the projects for which the Trust has submitted a bid for capital funding to NHSI. Therefore the capital programme is over spent by approx £5.9m at M12 overall.
- **The total amount spent and committed for Capital at Risk is £5.9m, therefore the Trust has now reached the limit approved of £6m.**
- The main component of the year to date under spend on internal capital relates to the biggest project – the Lanesborough Wing stand-by generators project (Infra Renewal category) which is under spent by approx £347k as at M12. The medical equipment project and SWLP project has underspent this year 2018-19.

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Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No**	**4.1**
Report Title:	**2018/19 Corporate Objectives – Quarter 4 report**		
Lead Director	**Suzanne Marsello, Director of Strategy**		
Report Author:	**Sarah Brewer, Head of Business Planning**		
Presented for:	**Assurance**		
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 in Q4 and end of year position.		
Recommendation:	The Trust Board is asked to asked to: • Consider the report, and in particular the proposed action for the outstanding priorities not met in 2018/19 • 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:	TEC	**Date:**	17th April
Appendices:			

2018/19 Corporate Objectives
Quarter Four Report

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 Q4

2.1 Corporate objectives for Q4 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 previously agreed by Trust Board.

2.2 11 objectives have been rated green, 14 amber, and 13 red. 11 had no applicable milestones for Q4.

Organisational Objective	Green	Amber	Red	N/a (for quarter)	Update outstanding	Consolidated Quarterly Position	Year End Position (and change on previous Q)
Treat the patient, treat the person	2	3	4	0	0		↔
Right care, right place, right time	3	4	3	2	0		↔
Balance the books, invest in our future	1	1	1	1	0		↑
Build a better St. George's	2	4	2	4	0		↔
Champion Team St. George's	1	1	0	3	0		↔
Develop tomorrow's treatments today	1	1	2	1	0		↓
OVERALL	**11**	**14**	**13**	**11**	**0**		↔

3.0 Risks and mitigating actions

3.1 The Q4 position represents an improvement from Q3, when 15 objectives were rated red, 15 amber and 12 green, but not sufficient improvement to change the overall RAG rating for the year.

3.2 It should be noted that many of the individual priorities within the overarching objectives did meet their quarterly milestones across each quarter (These are 1.1, 3.3, 7.3, 9.2, 10.2, 12.1, 13.3, 16.2 – 16.4).

3.3 The objectives which have not been delivered in Q4 as planned which continue to pose a risk into 2019/20 are:

a) Training on the Mental Capacity Act
b) Delivery of NHSI-agreed ED performance
c) Reduction of the deficit
d) Corporate risk management
e) Ensuring a safe environment with plans to achieve relevant statutory standards and managing risk associated identified on the BAF
f) Installation of a new MRI scanner

3.5 All deliverables not met year to date as at Q4 are set out in Annex A, along with a progress update, mitigation and assessment of the extent to which not meeting the objective poses a material risk. This also sets out proposed action for these in 2019/20 and indicates whether they are included as part of the 2019/20 objectives or will be 'business as usual' activities.

4.0 Recommendations

4.1 The Trust Board is asked to:

- Consider the report, and in particular the proposed action for the outstanding priorities not met in 2018/19.

- Approve the report.

Annex A – Deliverables not met at Year End

Objective	Deliverables not delivered & causing amber or red RAG rating	Progress update	Mitigation	Material risk? (Link to BAF)	Further action required in 2019/20
Treat the patient, treat the person					
1.2 Ensure that the environment is safe and appropriate for the treatment of our patients, with plans to achieve relevant standards as our baseline	Quarterly Review to be undertaken of all PAM matters in March	Partially delivered **-P**AM review to Board in December. It was agree to hold a Board development session to support the Board in their understanding and decision making re PAM matters. This session will take place in Q1 2019/20	Board development session to support the Board in their understanding and decision making re PAM matters in Q1 2019/20	Not a material risk given that work to deliver is underway	This is included in the corporate objectives for 2019/20
2.1 Improve End of Life Care (EoLC) for patients and their families across the Trust	Development and implementation of EoLC training programme	Not delivered - Training plan in place, but delivery has been delayed as e-learning package not yet developed	Training plan in place for face to face training on EOLC to staff. elearning for staff to be implemented in May 2019.	Not a material risk to the trust at this stage, as the work to deliver is underway in Q1 2019/20	This is will be BAU training
3.1 Improve our compliance with Mental Capacity Act Assessment (MCAA)	Develop Level 3 training	Not delivered- Level 3 training not implemented . Level 1 and 2 training in place. Level 3 training plan to be developed in Q1 2019/20 following the commencement of additional resource into the MCA/DoLs team.	Note that L3 not yet mandated nationally, and not in our contract.	**Potentially a material risk** to the trust, given CQC focus in this area.	This is included as a corporate objective in 2019/20
3.2 Improve the safe, effective and appropriate use of restraints (e.g. bed rails) throughout the Trust	Ensure staff are trained in relation to the MCA, as per objective above (other deliverables relating to this objective have been delivered).	As above	As above	**Potentially a material risk** to the trust, given CQC focus in this area.	This is included as a corporate objective in 2019/20

5.1 Ensure safe and secure handling of medicines focusing on room and fridge temperature monitoring solution for medicines	Seek IDG approval for required investments, contingent on funding allocation from prioritised capital programme.	Not delivered - funding request not progressed. This is due to scoping work done in Q2 which identified that the proposed solution (electronic continuous monitoring system) was not the most suitable solution. An alternative monitoring system of recording fridge temperatures and compliance monitoring was put in place and is fit for purpose.	Continuing with current system of recording fridge temperatures and compliance monitoring.	Not a material risk to the Trust and the current system is fit for purpose from CQC perspective.	This will be BAU Q1 2019/ and any future review of temperature control requirements across the estate will for part of the wider estates capital programme.
5.2 Continue to improve discharge medication turnaround times for patients to improve the patient experience and patient flow through the Trust	Tender to external partners for monitored dosage systems (other objectives delivered)	Tender drafted but not yet published.	Tender has been delayed due to re-scoping of the tender to include SWL trusts	Not a material risk to the trust at this stage, as the work to deliver is underway and other activity relating to this objective is on track	This will need to continue into Q1 of 2019/20 due to delay to tender and the BAU contract management
Right care, right place, right time					
6.1 Enhance processes within ED to improve emergency care performance and patient care and experience	Meet NHSI agreed ED performance of 92%.	88.34% performance in Q4.	UEC transformation programme will support improved performance in ED	**A material risk** to annual objective of meeting target performance agreed with NHSI	This is included as a corporate objective in 2019/20
7.2 Develop boundary-less flow to minimise LOS for patient requiring on-going treatment or care, and create the flexibility with hospital to maintain a steady state during periods of increased demand	Launch of Smartboard in Cavell, Nye Bevan and AAA (other Q4 milestones in this objective have been developed)	Smartboard not delivered, awaiting new version from supplier: implement in Q1 2019/20	Operational work-around in place	Not a material risk as effective workarounds have been implemented and delivery of the solution is expected in Q1 2019/20	This will be BAU post Q1 2019/20
7.4 Estates will draw	Approval and	Work has commenced on scoping the estates	Estates strategy to follow	Not a material risk to the	This is included as

up and assist with physical plans/options to support emerging operations plans/strategy	ratification of Estates Strategy to be undertaken at Board in March dependent on clinical strategy production. Including a timescale and final requests.	strategy which is now to be delivered in 2019/20 now that the clinical strategy has been delivered	agreement of clinical service strategy.	trust at this stage, as the work to deliver is underway in alignment with the clinical strategy and other supporting strategies.	a corporate objective in 2019/20
8.1 Increase theatre productivity	Completion and opening of refurbished theatre/s	Not delivered due to a change in the plan for theatre refurbishments.	Whilst the quarterly milestones have not been achieved, the overall aim of increasing theatre productivity has been achieved, particularly in Q4. This is measured by the average case per session (ACPS) and the average available opportunity available which define more clearly the productivity of theatres. Our inpatient opportunity is now at 12%, which when compared against our peers puts us in the upper percentile.	Not a material risk due to the improvement made in theatre productivity and the opportunities for greater improvement in day surgery which will be the focus for 2019/20	This will be BAU in 2019/20
8.2 – Reduce cancellations on the day of surgery	100% cancellations rebooked within 28 days**.**	This target has been missed by a small margin- the figures for March are still to be ratified. 100% was achieved in January and 97.3% in February.	Continued efforts to achieve 100% target. (the February target was missed due to 2 patients not being re-booked within 28 days due to ICU capacity)	Not a material risk given the performance trajectory	This will be BAU in 2019/20
9.1 Ensure patients have access to high quality outpatient care, including by	Auto upload of key documents into Cerner functionality achieved	Not fully delivered as document suitable for auto upload are still being identified	The Head of Process Redesign (Transformation) continues to work directly with IT to identify documents to be	Not a material risk to the trust at this stage, as the work to deliver is underway.	This will be BAU in 2019/20 as an on-going role to keep documents

standardising outpatient pathways, supported by ICT, ensuring all activity is captured and reported.			uploaded as and when they are available and relevant.		uploaded
9.3 – Ensure that patients have easy access to the hospital to check appointment enquires through phone and e-mail system	Fully scoped project plan to be delivered	This was due in Q3 and was not delivered	This is to be included in digital priorities in 2019/20	Not a material risk	This is included as a corporate objective in 2019/20
10.1 Return Tooting campus to national reporting of the 18 week RTT standard and work to reduce waiting times against all national standards	Cerner roll-out at QMH to facilitate return to reporting at QMH campus in 19/20 Zero 52 week waiters**.** E-Triage - backlog reduction of 75% of all referrals waiting longer that 5 days from April baseline RTT incomplete aggregate performance achievement - 82%	Delay to Cerner roll-out at QMH due to technical issues with the contractor - now will be in Q1/Q2 2019/20 27 52 week waits at end of Q4 (against an internal target of 32) Aggregate performance is 81.92%	Tooting site has returned to reporting and improvements against all waiting times being achieved – cancer and diagnostics targets being consistently met	Not a material risk as improvement against all waiting times standards have been achieved.	This will be BAU in 2019/20
Balance the books, invest in our future					
11.1 We will continue to reduce our deficit and aim to break even in 2019	Meet target monthly deficit. Produce an affordable 5 year Workforce strategy fully aligned to Clinical Strategy	Not delivered, for reasons set out in detail in papers to FIC throughout Q3/Q4	Mitigating actions set out in papers to FIC throughout Q3/Q4	**A material risk**, end of year targets unlikely to be met. Deficit is likely to be £51.6m This is higher than the deficit target set by NHSI, but represents a reduction on the deficit of	This is included as a corporate objective in 2019/20

	Deliver CIP targets. Manage to budget.			£53.0m reported in 2017/18.	
11.2 We will deliver organisational efficiencies – from the way we buy drugs to how we use our clinical IT systems	Develop a clinical IT strategy (Roll-over from Q3)	IT strategy not delivered	Proposal to develop now clinical strategy approved	Not a material risk	This is a priority for 2019/20 and forms part of the programme of work to develop supporting strategies for the new clinical strategy
11.3 We will develop a financial model to help us identify and prioritise future investment requirements	Completion of draft long term financial model.	This has not been developed	As per national guidance, a 5 year financial plan is to be developed in 2019/20 in collaboration with the SWL HCP	**A material risk** to the sustainability of the Trust if a long term financial model is not developed	This is included as a corporate objective in 2019/20
11.4 Estates will produce a timely and accurate delivery of CIPs including service contract negotiations and agreement of possible land sales	Land sales agreed for Doddington and possible Maybury Street Car Park land dependent on car park and land redevelopment scheme. Initial review of sales and outcome of negotiations with PFI provider by February	Doddington sale has been agreed but will complete Q1 2019/20. A decision on other sales will need to be part of the estates strategy An external review of assurance on Atkinson Morley Wing has been carried out and similar exercise in QMH – the first phase is completed second phase will take up to 6 months to complete	Doddington sale forcecast to complete in Q1 2019/20 with other sales reviewed as part of the estates strategy Recruitment to business management team to progress in Q1 which will provide additional capacity in the team	Not a material risk at this stage, Estates as work is progressing as part of the development of the estates strategy.	This is included as a corporate objective in 2019/20
Build a better St George's					
12.2 – We will work with our partners and stakeholders to seek their views, so we address the challenges	We will carry out an annual stakeholder engagement survey in order for us to track changes in	Stakeholder engagement survey has not commenced – this will be done in Q2 2019/20	Although no formal survey has been undertaken, the breadth of engagement as part of the development of the clinical strategy has	Not a material risk due to the level of engagement already undertaken during the development of the clinical strategy.	This will be BAU in 2019/20

we face together	perception over time. The first survey will be carried out by March 2019, so enabling us to establish a baseline for tracking future stakeholder opinion.		provided some useful early insight which can be used		
13.1 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.	Board forward work plan developed and is on the April Board agenda for the Board's consideration. Mapping of groups below Board sub-Committees largely complete. Future state to be developed by end May 2019. New TEC Terms of Reference are on hold pending the development of the Accountability Framework which is being led by the CFO. The TEC ToR need to reflect this accountability framework.	Board forward plan is now complete subject to Board review. TEC continues to operate to current ToR and schedule.	Not a material risk	Will be BAU from Q1 2019/20 - Agree future state of governance groups below Trust Board sub-Committee in Q1 2019/20. Agree final TEC ToR and submit to Board for approval in Q1 2019/20
13.2 More engagement and involvement of patients, front line staff and partner organisations	Launch of new Trust corporate branding for use across all communications and reporting channels	Rebranding exercise underway, but not yet complete	Launch of new brand expected April 2019	Not a material risk	This will be BAU in 2019/.20
13.4 Ensure the appropriate governance measures are in place to learn from incidents and complaints	Quarterly audit of actions agreed within SI reports / complaints responses.	Partially delivered - Audit takes place for never events and SIs agreed with commissioners, but not all.	Audit process to audit greater proportion of SIs to be agreed in Q1 as part of the review of divisional governance review.	Not a material risk	This is included as a corporate objective in 2019/20
13.5 Continue to	Sufficient progress	Although a proportion of extreme risks have	Audit report conducted into	**Material risk** to the	This will be BAU in

monitor compliance with the risk management policy and improve risk registers at every level	to show that extreme risks have reduced.	been reduced within the Trust such as ICT these have been replaced by new risks such as Cardiac Surgery.	risk management and presented to Audit Committee all.	organisation	2019/20 as part of the review of the BAF and reporting to the RME
14.2 Renew local area network on Tooting site	Wiring installed Work commenced on cabinets	Progress has been delayed –will be completed Q1 2019/20	Core wiring due to be complete end of April. Second phase project (cabinets) due to commence May.	Not a material risk as work will be completed in the near future.	This is included as a corporate objective in 2019/20
14.4 Roll out iClip to Queen Mary's Hospital Roehampton	Go live in outpatients and inpatients at QMH.	Delayed due to technical problems with the contractor	This will now take place in Q 2019/20	Not a material risk to the trust at this stage, as the work to deliver is a priority for 2019/20 and forms one of the corporate priorities into 2019/20	This is included as a corporate objective in 2019/20
15.1 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	Outstanding milestone (from Q2) - 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	This has not impacted on the aim of increasing theatre productivity in 2018/19 (see notes on 8.1) Risk survey now undertaken. Capital bids have been granted which will be focussed on the BAF risks for the next 12 months	Not a material risk given that the survey has now been completed which will allow investment to be focussed on the BAF risk.	This is included as a corporate objective in 2019/20
15.2 We will ensure a safe environment with plans to achieve	Prepare the Annual Report for the coming year and	The report has been delayed by a month due to management capacity within E&F. This will be presented to the Board in May	The report will be presented to the Board in May. Board development session to	**Potentially a material risk** for trust to consider although the additional	This is included as a corporate objective in

relevant statutory standards as our baseline	give state of the Estate address in March to Board		be held in Q1 2019/20	capital funding recently announced will support the Trust to be able to address identified risk.	2019/20
15.3 Undertake a market review of substantive contracts including the FM contract. Instigate the implementation of a potential measured equipment service governing in the first instance Medical Equipment and large Diagnostic equipment	Appoint and commence overall management contract with preferred supplier.	Soft FM tender is complete and contract awarded (agreed at the March Board)	Managed Equipment Service Contract – scoping of the specification will commence in Q1 2019/20 and will require alignment of all MES contracts currently held by different directorates in the Trust to have a central MES.	Not a material risk at this stage as work is progressing.	This is included as a corporate objective in 2019/20
Champion team St George's					
16.1 Improve staff engagement	Staff Appreciation Awards (all other milestones delivered)	Invites issued for event in May 2019	Event will take place in May	Not a material risk to the trust at this stage, as the work to deliver is underway.	This is included as a corporate objective in 2019/20
16.6 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	Newsletter published October / November Quarterly Divisional Meeting held in March 2019	Milestones delayed due to capacity constraints Quarterly meeting not held but estates KPIs are now reported at weekly comms cell (relating to reactive maintenance and will be refreshed as part of the Divisional performance reviews)	Business Management Function being appointed which will bring more capacity to the team Dedicated Communications person to be appointed	Not a material risk to the trust due to progress made and plans going forward.	This is included as a corporate objective in 2019/20

works and reactive maintenance.					
Develop tomorrow's treatments today					
17.1 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 and will be part of the education strategy	Interviewed for new Director of Medical Education and agreed the appointment would be for 1 year and the focus will be on the development of multi-disciplinary education strategy	Not a material risk to the trust at this stage, as things will progress as part of the education strategy	This is included as a corporate objective in 2019/20
18.1 – We will embed research into clinical practice, to further foster a 'bench to bedside' culture within our organisation	Allocate internal research funding PAs for consultants	This has not progressed: this will be an integral part of the new research strategy which will be delivered in Q2 2019/20	This will progress as part of the development of the future research strategy	Not a material risk to the Trust as work to develop the research strategy is underway	This is included as a corporate objective in 2019/20
18.2 – We will innovate and ensure our patients have access to the latest treatments and surgical procedures	Implement technology into practice	All specialities implemented except Urolift	Urolift will be implemented in Q1/2 2019/20	Not material risk given progress already made	This will be BAU in 2019/20
18.3 We will use the latest technology to improve outcomes for patients and make it easier for staff to provide care safely and effectively	Implement Cerner at QMH Install new MRI scanner at St. George's	Delay to Cerner implementation at QMH due to technical issues with contractor Solution to procure new MRI scanner not yet agreed	Cerner to be implemented in QMH as part of the capital plan for 2019.20 The Trust is exploring ways to replace the MRI scanner in 2019/20 as part of the overall capital programme	**Potentially a material risk** of further delays to installation of MRI scanner and the impact on quality of service delivery	This is included as a corporate objective in 2019/20

Annex B - approach to RAG-rating

1. The RAG ratings for Q4 derived as follows. Each objective is shown as:

- Green for Q4 if all its Q4 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 early April).
- Amber for Q4 if some of the associated Q4 milestones have been delivered, and some not, or if the milestones are partially delivered.
- Red if the milestones for Q4 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).

3. The RAG rating for the year-to-date position shows whether there is any slippage against what we set out to do year-to-date. In most cases this will mean the RAG-rating is the same as for the Q4 position, but if the Q4 position is 'green' and we have still not delivered on a milestone from an earlier quarter, this is taken into account in the YTD position.

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Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No.**	**5.1**
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:	**Information**		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 4 April 2019, including commenting on assurance to the Board on key risks allocated to the Committee.		
Recommendation:	The Board is requested to receive this report.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

1. Committee Chair's Overview

We continue to have good attendance at the Committee from support functions and from the operational divisions. I would again thank all who made the time to attend, particularly given the experience they bring and their insight and willingness to contribute.

The areas of focus at this month's meeting have been: a review of the Trust's position on Freedom to Speak Up against recently-issued national guidance; a review of the latest report from our Guardian of Safe Working; the workforce implications of the proposed CIP programme for 19-20; and, critically, a long discussion of the factors underpinning the disappointing result of the recent staff survey.

2. Key points:-

Board Assurance

As part of our focus on providing the Board with assurance on matters related to workforce, we are undertaking a year-end review of our Terms of Reference and the Committee's own assessment of its functioning. The questionnaire on Committee functioning has been circulated to members and the results should be available by early May.

Strategic Themes

Theme 1 - Engagement

We reviewed the results of the staff survey, undertaken at the turn of the year as part of the wider NHS Staff Survey. There are some positives in the results. First an increased response rate, 54% up from 51% last year; second, the recognition of the work that Chairman, Chief Executive and the senior team are doing on values, and their work to help improve St George's; and third, some teams were singled out for their contribution to the Trust.

But these positives are crowded out by the overall results. Two elements in particular disappoint: first, that after much internal effort over recent months to improve our culture and levels of engagement, the result suggests that we are in broadly the same place we were a year ago; and second, the verbatim comments that we reviewed bear a striking similarity to those we looked at a year ago – the inference being that for some staff very little has changed in the way they are treated by their managers.

We spent considerable time at the Committee reviewing the verbatim comments and identifying themes and possible actions to address. The key themes identified by the HR team (and specific comments) were as follows:-

Bullying & harassment	(33)	all negative
Trust values	(31)	mixed, some positive, some negative
Ethnicity, race & Brexit	(15)	generally negative
Engagement	(7)	generally negative

The Committee discussion focussed on two elements in particular; first, what was driving the comments made; and secondly, the relative success or not of the engagement and leadership development programmes that had been undertaken over the previous 18 months. This was a wide-ranging, engaged and open discussion which helped identify areas for further attention.

Clearly it is for the Trust executive to determine how best to address the issues identified, but I hope that the discussion at the Committee helps identify areas for focus. Certainly there was no sense that this was an insuperable position, but equally a recognition that the type of

cultural change needed would in some areas be a long hard haul. A number of Committee members were keen to support the HR team outside the Committee meetings.

Theme 2 – Leadership and Progression

There were no specific agenda items for discussion under this heading.

Theme 3 - Workforce Planning

A final budget has now been prepared for the 19-20 financial year. Within this is a staffing plan which starts from the actual position as at March 2019. It is good to see the level of close working that has been developed between HR and finance, and the realistic approach to staff budgeting. This has also highlighted a number of areas where a pay spend reduction could be achieved, and these are being addressed within the CIP process.

The Trust is about to announce its Clinical Strategy, and preparation work is being undertaken within HR to enable the Trust's executive to bring forward a Workforce Strategy to support that. This will be a subject for future months.

We reviewed a number of workforce statistics, noting that: the vacancy rate had decreased to 9.28% (down almost 4% on a year ago); sickness had fallen back to 4.02% (but still above target); and staff turnover had increased to 17.13%. We regard the turnover figure as high, although relative to other local Trusts it compares favourably and it is 0.15% lower than 12 months ago. MAST compliance stood at 89.25%, reflecting the steady increase seen over the last 12 months.

Theme 4 – Compliance

Freedom to Speak Up - we reviewed a paper prepared by Karyn Richards-Wright setting out recent national guidance, and agreed with the recommendation that the Trust should consolidate its various policies in this area into a single 'Raising Concerns' policy.

Safe Working – we received an update paper from Serena Hayward, the Trust's Guardian of Safe Working. A copy is included in the papers for the Trust Board, so I will not repeat the content – other than to note that there has been a further reduction in the number of exception reports being raised. Although we could not get complete assurance on this, the strong inference from the discussion at the Committee was that this reflects an underlying reality rather than an increasing reluctance to report.

Other – we sought and received assurance from Harbhajan Brar that he was not aware of any areas where there had been or was any non-compliances by the Trust.

Stephen J Collier

16 April 2019

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Meeting Title:	**Trust Board**		
Date:	25 April 2019	**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 17 April 2019.		
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 Report – April 2019

Matters for the Board's attention

1. **2018/19 Internal Audit Progress Report**

   Since the Committee met in January 2019, six internal audit reviews had been completed. The Committee noted that the review into Consultants Job Planning received limited assurance but welcomed the reasonable assurance rating for the following:

   - Car Parking (Tooting)
   - Board Assurance Framework
   - Patient Engagement
   - Data Security and Protection Toolkit

   The sixth report relates to the review on Bullying and Harassment which is currently in draft format awaiting the delayed management response. The Committee will consider this report at its next meeting and reminded the executive of the importance of these areas, particularly in light of the responses to the recent annual Staff Survey.

2. **Internal Audit Recommendation Tracker**

   Good progress had been made on closing down internal audit recommendations. There are 25 open recommendations of which six are overdue. This is good progress from the 52 actions which were open in January 2019.

   There is only one high priority recommendation on the tracker which is not yet due and relates to Consultants Job Planning.

3. **Final Internal Audit Reports**

   The Committee considered the five aforementioned (item 1 above) internal audit review reports. The Committee heard that the review on Car Parking (Tooting) was very useful and the outputs of this review will support the Trust to effectively manage and monitor car parking arrangements across the Trust and its various sites. The useful intelligence from the review will also support the Trust in transport planning especially around demand and capacity. The Committee received assurance that previously reported car parking funds shortfalls (circa £3k) were related to coding issues and these issues had been redressed with the year-end position being only £300 off target.

   The Committee were assured by the progress made in improving the position on Data Security and Protection Toolkit but noted that with new processes coming into force for 2019/20 there will be further work to be done.

   Similarly the Committee were pleased to note the reasonable assurance rating of the patient engagement review. Patient engagement work is continuing to evolve and this review will be revisited again in the next 12-18 months. The Committee agreed that the scope of the future audit would be developed with engagement from patient representatives.

   Whilst the Committee recognised the good work done to develop the board assurance framework which is on-going, and welcomed the reasonable assurance rating, it stressed to the executive the need to continue to develop and improve risk management across the Trust, to develop a consistent approach to risk management and monitoring in the

divisions and to ensure that this is escalated through the relevant Board committees. The Committee agreed that risk management would remain a key feature of the internal audit plan and asked executives to provide an update on the on-going work around risk management across the Trust and provide assurance that strategic risks are being adequately triangulated both within and beyond the Board.

The Committee was disappointed to learn of the limited assurance rating of the internal audit review into Consultants Job Planning. The Committee was assured by the executives that medical workforce is a key focus for the Trust and the senior team and that the issues raised in the report are being given full attention and will be completed in full within the agreed timescales. The Committee will keep progress against the actions from the audit under close review and will receive an update at each of its next two meetings.

4. **Draft Head of Internal Audit Opinion 2018-19**

The Committee welcomed the draft report and the reasonable assurance rating for the period 2018-19 which reflected the significant work carried out by the Trust to improve its controls and practice.

5. **Internal Audit Plan 2019-2020**

The Committee asked the executive to continue to review and refine the annual plan and in particular to give consideration to how to include reviews of cross cutting areas and themes within the Trust's strategy and corporate objectives, to assess how effective the organisation is at learning (from SI'S, never events, complaints, internal and external reviews, inspections and audits) and embedding good practice and implementing recommendations/outputs from clinical and quality audits. The Committee approved the internal audit plan for 2019-20 recognising it is a dynamic document which should be reviewed by the executive periodically to ensure that it continues to reflect the needs of the organisation. The Committee will review the plan in October.

6. **External Audit & Year-end Preparations**

The Committee met the external auditor partner for a confidential and private meeting before the start of the full audit committee.

The Committee welcomed the report that the 2018-19 external audit was progressing well and welcomed the news that the review of the Trust's annual report 2017-18 reflected some good areas of practice and those areas for improvement will be embedded in the 2019-20 report.

The Committee also noted the update on the plans for delivering the Annual Report, Financial Accounts and Quality Reports 2018-19 and noted the draft reports.

7. **Internal Governance & Compliance**

The Committee received the reports on loses and special payment and breaches and waivers and noted the good progress made in both areas.

8. **Counter fraud**

The Committee received and discussed the Counter Fraud Annual Report 2018/19 and Counter Fraud Work Plan 2019-20. The Committee heard of the plans to improve engagement and involvement on counter fraud across the Trust. The Committee thanked Pauline Lewis, who has retired after 37 years of service to the organisation, for her service to the Trust.

The Committee also endorsed the Chair's signature of the Counter Fraud self-review report for 2018-19.

9. **Freedom to Speak Up & Whistleblowing Report**

The Committee noted the update on Freedom to Speak Up & Whistleblowing, but was concerned, particularly in light of the Staff Survey feedback, to reinforce the importance of ensuring that the policy is updated, approved and communicated quickly to provide improved clarity and effectiveness across the Trust.

10. **Internal Audit Tender 2020-2023**

The Committee considered the proposed approach to retendering internal audit services and approved the proposed tender document for the procurement of a provider of internal audit services from April 2020 onwards. It agreed the plans for scoring the bids received and awarding the contract and noted the timeline for the procurement and the award of contract.

11. **Compliance with Trust Constitution and Code of Governance**

As part of ensuring the Trust has robust governance arrangements in place the Committee considered the two schedules of assurance. The first looked at the Trust's compliance with key elements of its Constitution and the second considered the how the Trust practically complies with the NHS Foundation Trust's Code of Governance. The Committee welcomed the clear and thorough review, noting that barring a few minor matters to update in the Trust's Constitution there was strong evidence the Trust was compliant with its constitution and with the FT Code of Governance.

12. **Review of the Committee's Cycle of Business 2019-20**

The Committee reviewed and agreed the work programme which details the business which will be considered by the Committee in 2019-20 subject to some minor adjustments.

Recommendation

13. The Board is asked to:
    - Note the update on the key issues considered by the Audit Committee at its meeting on 17 April 2019.

Sarah Wilton
Audit Committee Chair, NED
April 2019

Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No.**	**6.2**
Report Title:	**Fit and Proper Persons (FPP) Annual Update Report**		
Lead Director/ Manager:	**Harbhajan Brar, Director of Human Resources and Organisational Development**		
Report Author:	**Harbhajan Brar, Director of Human Resources and Organisational Development**		
Presented for:	**Assurance/Update**		
Executive Summary:	The Board has requested that the Director of Human Resources and Organisational Development provide an annual update on FPP compliance against Regulation 5. The purpose of this paper is to give the Board on-going assurance that the Trust remains fully compliant with Regulation 5. Fit and Proper Persons: Directors.		
Recommendation:	The Board is asked to note the current assurance around the Fit and Proper Persons assessment.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-Led)		
Implications			
Risk:	Failure to meet the FFP requirements could result in further regulatory actions being taken against the Trust		
Legal/Regulatory:	The requirement to meeting the FFP test is outlined in Regulation 5: Fit and Proper Persons		
Resources:	No additional resources required		
Previously Considered by:	Trust Board and Trust Executive Committee	**Date:**	Quarterly - Dec 18
Equality Impact Assessment:	Not undertaken. Policy applied to every Board member		
Appendices:	Appendix A - Exec and Non Exec FPPR compliance list		

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

Trust Board – 25th April 2019

1.0 PURPOSE

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

2.0 BACKGROUND

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

2.2 All the breaches identified arising out of the Section 29A Warning Notice and subsequent enforcement undertakings agreed with NHSI were addressed and audited.

3. CQC Inspection

3.1 The St George's University Hospitals NHS Foundation Trust CQC report was published in July 2018 and they confirmed that the "Fit and Proper Person checks of directors were in place" (See p14 CQC Trust Inspection Report – July 2018).

4. Future Developments – Kark Review

4.1 In July 2018 Tom Kark was tasked by the government to review how effective the Fit and Proper Person's Test (FPPT) is "… in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors."

4.2 Kark found that the FPPT has "few fans" in the way that it is currently applied: it does not do what it holds itself out to do and does not ensure that directors are fit and proper for the post they hold. Nor does it stop the unfit or misbehaved from moving around the system.

4.3 In the FPPT context, it's not competence that causes difficulties for NHS employers; it's dealing with difficult issues around whether a director is of "good character" and whether they may have been involved in some way in "serious mismanagement" or "serious misconduct".

4.4 The Kark report has seven recommendations, of which the government has accepted the first two:

i. **All directors (executive, non-executive and interim) should meet specified standards of competence.**

ii. **Creation of a central database to hold information about directors' qualifications and history.**

iii. Creation of a mandatory reference requirement for each director.

iv. Extension of the Fit and Proper Persons Requirement to all commissioners and other appropriate arms-length bodies.

v. Creation of a body ("Health Directors Standards Council") with powers to disbar directors for serious misconduct.

vi. Amending the FPPT to remove the reference to directors 'being privy to' mismanagement.

vii. Further work to be done to ascertain whether the FPPT needs to be amended in the field of social care.

4.5 In addition, Health Minister, Stephen Barclay has indicated that he wants to widen the fit and proper test for NHS directors to include a legal duty to act on victimisation, so they can be removed from their post if they fail to stop harassment or discrimination.

5. Recommendation

It is recommended that:-

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

5.2 All Executive and Non-Executive Directors will be asked to sign the Fit and Proper Persons Test Declaration Form (Annex B) on an annual basis.

Annex A

Name	Fit and Proper Persons Test - Declaration Form	Employment History	References	Professional Registration	Expire/Revalidation Date	Essential Qualifications/ Copies	Occupational Health	Right to Work	Identity Check	DBS/Criminal Conviction Checks	Search of Insolvency and Bankruptcy Register	Search of Disqualified Directors	Social Media Search	Complete		FPPR Met
Jacqueline Totterdell	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Avey Bhatia	✓	✓	✓	✓	20/11/2020	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Richard Jennnings	✓	✓	✓	✓	09/06/2019	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Harbhajan Brar	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Andrew Grimshaw	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
James Friend	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Ellis Pullinger	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Suzanne Marsello	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Kevin Howells	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Stephen Jones	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Gillian Norton	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Norman Williams	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Ann Beasley	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Jenny Higham	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Sarah Wilton	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Stephen Collier	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Tim Wright	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓

Annex B

St George's University Hospitals NHS
NHS Foundation Trust

Fit and Proper Persons Test

Declaration Form

Objective

The Fit and Proper Persons Regulation came into force in March 2015. The aim of the regulation is to ensure that all board level appointments of NHS Foundation Trusts have a process in place to ensure those individuals appointed are fit and proper to carry out their role. The test applies when a new director is appointed. This is known as Regulation 5. Regulation 5 is in addition to the existing general obligation for health service providers to ensure they employ individuals who are fit for the role and to demonstrate that 'nominated individuals' have necessary qualifications, skills and experience. This self-declaration form is to be completed by all new Directors.

Requirements

The requirements of the fit and proper persons test are set out below:

1. the individual is of good character,
2. the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
3. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
4. the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
5. none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

Declaration

I understand the requirements of the Fit and Proper Persons Test listed above and I can confirm that I am not aware of any issues that would raise any concerns regarding my appointment. If I become aware of any issues that may raise concerns or that the Trust will need to consider, I will immediately inform the Trust of the relevant details.

Are there any issues that you would like to disclose:

Yes: ☐ No: ☐

Signed: .....

Date: .....

Role: .....

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Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No**	**6.3**
Report Title:	**Board Assurance Framework (BAF) – Quarter 4 Review**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Alison Benincasa, Quality Improvement Director**		
Freedom of Information Act (FOIA) Status:	**Unrestricted**		
Presented for:	**Decision/Assurance/Discussion**		

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 4 assurance rating and statements from the committees of the Board.

Assurance rating

The assurance rating has changed for the following strategic risks:

- SR16 has changed from partial assurance to significant assurance in response to Board approval of the Trust Clinical Strategy in March 2019

There have been no further changes to the assurance ratings for the strategic risks. However specific areas in SR2 and SR10 have positive assurances:

- SR2: The Quality and Safety Committee noted improved assurance on the visibility of data for referral to treatment times and the steps taken to stabilise safety and governance in cardiac surgery.

- SR10: The Workforce and Education Committee noted improving assurance on control of risks associated with access to training for staff as evidenced in the staff survey and MAST performance.

Nine risks have a 'partial' assurance rating; seven risks have a 'limited' assurance rating and one risk has 'significant' assurance rating (see appendix 2 for definitions).

Risk scores

The risk score has changed for the following strategic risks:

- SR2 has been reduced to 12 (from 15). The decision was made following discussion in Committee that there is now a significant level of assurance and visibility on the quality of data for referral to treatment times and for the steps taken to stabilise the safety and governance for cardiac surgery. However, the Committee recognises the on-going work required and that the 4 hour performance target remains an issue of concern.

- SR8 has been reduced to 10 (from 12). The decision was made following

	discussion in Committee to reflect the risks with a direct impact on developing a positive and supportive culture. The Committee received limited assurance from the staff survey that while some improvements have been seen there still remains much work to do to fully embed a positive and supportive culture. • SR16 has been reduced to 3 (from 6) to reflect the approval of the Trust Strategy at March Board. This risk is now recommended for closure and a new risk related to the delivery of the Clinical Strategy will be described for 2019-20. There has been no change to the risk scores for other strategic risks. **Strategic Risks for the Board – SR9;SR16;SR14;SR17** The Board is asked to agree the assurance level for these risks based on the assurances from reports to the Board. When considering the risk score for these risks the Board's attention is drawn to: • There has been no change to the external partnership element of SR4 since the discussion at the Quality and Risk Committee in relation to quarter 3 (this risk is cross referenced to SR17). The QSC previously discussed emerging risks from developments in the external environment and the STP and how these might impact on the risk score for partnership risks. • Board approval of the Trust Clinical Strategy in March 2019 with reference to SR16.
	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**	04 April 2019 18 April 2019 18 April 2019
Equality Impact	N/A		

Assessment:	
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.

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Appendix 1

Board Assurance Framework
Quarter 4 2018/19

BOARD ASSURANCE FRAMEWORK OVERVIEW										QUARTER 4
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating Q1	Q2	Q3	Q4	Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
Treat the patient, treat the person	*Moderate*	*SR1*	We are unable to develop new roles, changes in skill mix and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could result in care which is below the minimum standard.					*This risk score is unchanged. Workforce remains a significant area of risk. Uncertainty remains around the retention of EU workers. Whilst data shows we are not losing EU staff, this situation needs to be kept under constant review. There are still on-going junior doctor rota gaps. Whilst work has commenced to develop a long term workforce strategy, this risk remains extreme until further assurances that plans will start to see a shift in skill mix/the development of new roles. The Committee continues to consider that it has insufficient 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.					*The risk score has reduced from 15 to 12. The Committee has received a level of assurance and visibility on the quality of data for referral to treatment times and for the steps taken to stabilise the safety and governance for cardiac surgery. However, the Committee recognises the on-going work required and that the 4 hour performance target remains an issue of concern*	Chief Operating Officer	Quality Committee	12↓
	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.					*The risk score is unchanged. The Committee has noted the formal close of the CQC action plan in response to the CQC inspection 2018 with ongoing exception reporting of 4 outstanding actions. 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.					*The risk score is unchanged. The Committee noted that there has been no change to the external partnership element of this strategic risk since the last Committee discussion in quarter 3.*	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.					*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. There has been no material change in Q4*	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					*The risk score is unchanged. The new organisational structure has stabilised the Control Environment in most areas although some portfolios and spans of control are being revisited. Information and Communication aspects around the Model Hospital and benchmarked opportunities, particularly in planned care data quality, to drive demand and capacity planning for infrastructure and workforce prioritisation require further development.*	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.					*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.					*The risk score has reduced from 12 to 10 to reflect the greater weight given to the risks with a direct impact on developing a positive and supportive culture particularly in relation to access to training. The Committee received limited assurance from the staff survey that while some improvements have been seen there still remains much work to do.*	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.					*The risk score and assurance rating are unchanged. Assurance from the annual staff communications survey was reported to TEC in June 2018. The next annual communications survey will take place in Q1 2019/20 and this will provide further assurance. In March 2019, the Trust secured funding for the development of a new Trust Intranet, with the SGH Charity funding two thirds of the project which will be implemented during 2019/20 and will help significantly improve communications with staff. In Q4 2018/19, however, the limitations of the current Intranet continued to impact on the effectiveness of our communication with staff.*	(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.					*The risk score remains remain unchanged. The Workforce and Education Committee noted improving assurance on control of risks associated with access to training for staff as evidenced in the staff survey and MAST performance, although not consistent across all modules.*	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.					*The risk score remains unchanged. The Committee noted that further work to develop senior leadership is underway.*	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.					*The risk score is unchanged. The roll out of ICIP at St George's provides an improved level of assurance on the control of risks associated with the multiple healthcare record systems and provision of discharge summaries, however assurance remains limited on the overall 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.					*The risk score is unchanged and remains on extreme risk of 20. Assurance remains limited on the overall control of this risk.*	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.					*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. Working capital borrowing to fund the higher than planned forecast deficit in 18/19 has been agreed with NHSI.*	Chief Executive	Board	16
	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 clinical service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.					*The risk score has reduced from 6 to 3. The Clinical Strategy was approved by the Trust Board in March 2019. The assurance rating has improved from partial to significant. This risk as described is now considered closed.*	(CEO) Director of Strategy	Board	3
	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.					*The risk score is unchanged. Quarterly highlight reports to the Board meeting (part B) provide 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.					*The risk score is unchanged.*	Medical Director	Quality Committee	8

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Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No**	**6.3**
Report Title:	**Proposed changes to the Board Assurance Framework (BAF)**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control**		
Freedom of Information Act (FOIA) Status:	**Unrestricted**		
Presented for:	**Approval, Discussion and Steer**		
Executive Summary:	In October 2017 the Board agreed the strategic risks to the Trust's strategic objectives and assigned an executive lead and assuring committee for each risk. This paper presents to the board revised proposed strategic risks for 2019/20 for discussion and approval. Also attached is a proposal for the management of strategic risks through the assuring committees. Adopting this process will allow consistency in reporting as well as the detail around individual risks, gaps in control, assurance and actions being taken to address the gaps. This will ensure that the assuring committees see the detail of the constitute risks that feed into the strategic risk.		
Recommendation:	The Board is asked: 1. To discuss the 2019/20 proposed risks and approve. 2. To consider the proposal for management of strategic risks through assuring committees		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	N/A		
Appendices:	Proposed Strategic Risks 2019/20 Process for the Management of Strategic Risks		

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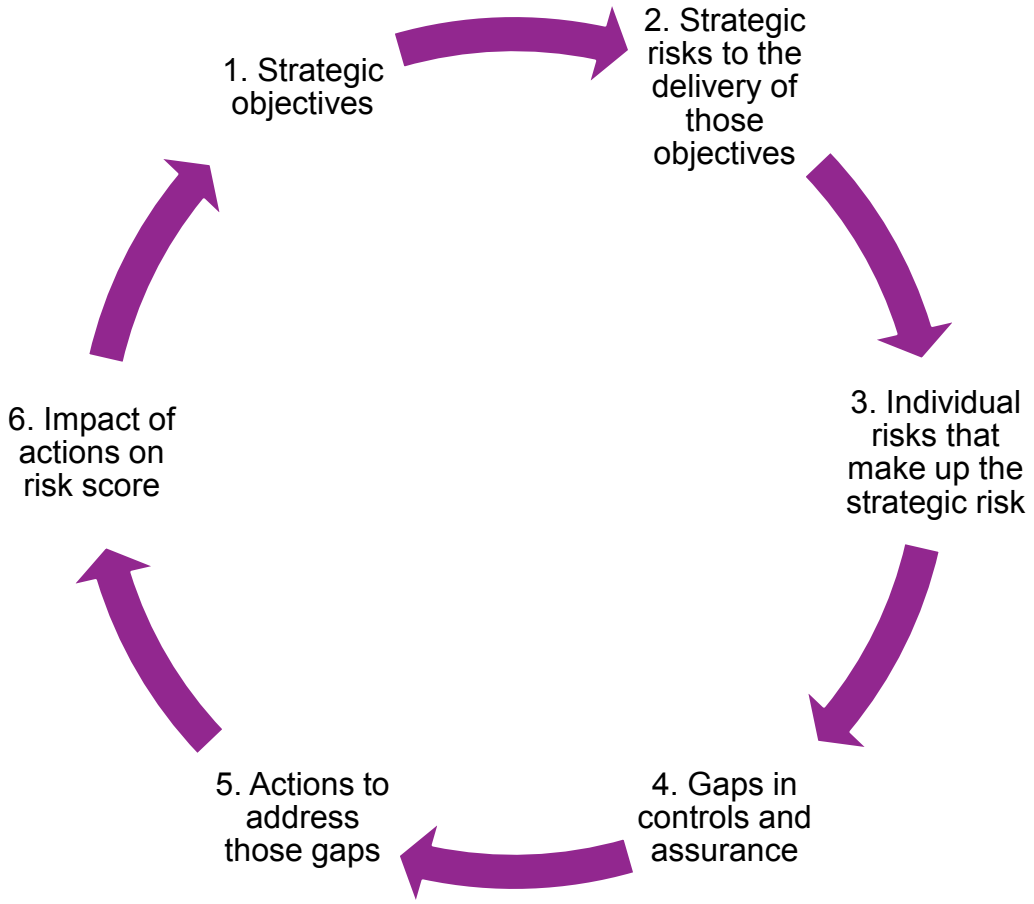
Proposed Management of Strategic Risks through Board Assurance Committees

Trust Board 25th April 2019

Avey Bhatia Chief Nurse & Director of Infection Prevention and Control
Andrew Grimshaw Chief Financial Officer

The Management of Strategic Risks



- The strategic risks (2) have been derived from the strategic objectives (1). In effect the actions necessary to address the strategic risk should deliver the strategic objectives.
- Looking at this the other way, we should not have a strategic risk that is not aligned to strategic objectives or referenced through the corporate objectives. If we do then it can be argued the corporate objectives are not complete.
- Strategic risks in themselves are what can be termed **"umbrella"** risks. That is they are quite broad in nature. For example, achieve financial balance. In effect many individual issues make up the risk (3).
- In order to mitigate the risk any gaps in control and assurance need to be identified (4) and actions plans developed to deliver the mitigation (5). The expected impact on the risk score should be identified (6), which in turn should support the delivery of the strategic objective.
- The Board sets the strategic and corporate objectives and agrees the strategic risk. The executive directors own individual risks, assessment of gaps and action plans. With the impact on the risk scores being reported through the RME to TEC, the assurance committees re the strategic risk and the Board via the BAF.
- This section outlines how this process could work.

Risk Process: Worked Example (Finance)

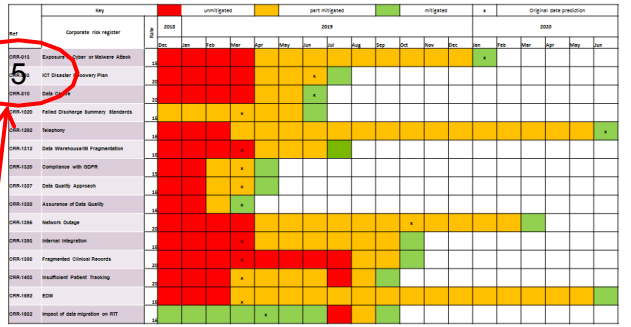
Strategic Objective:
Balance the books
invest in our future

1

2

3

Risk areas managed by the Finance Department	Strategic Risks (2019/20)			
	We are in financial balance	Our cost structures are understood and defined	Investment requirements and potential funding are defined	Improve management of commercial relationships
Maintaining an effective control environment (Ops)	Y			
Managing I&E in line with budget (Rep)	Y			
Identifying and delivering CIPs (DFI)	Y	Y		
Maintaining an effective procurement env (Ops)				Y
Maintaining a five year forward view (Plan)	Y			
We understand our cost structures. (Plan)		Y		
A five year investment plan is in place (Ops).			Y	
Processes exist to deliver agreed investment (ops).			Y	
Future cash requirements are understood (ops).	Y			
Processes exist to manage cash and working capital (Ops)	Y			
Manage commercial relations with non-NHS orgs procuring services from the Trust (Plan)				Y
Prepare the Trust for a possible no-deal EU Exit (CFO)				Y
System control totals: The impact of STG from other SWL organisations failing to meet their individual control totals (Ops)	Y			
Managing within a block contract (Ops)	Y			



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Organisational objective:	Balance the books, invest in our future.
Strategic risk:	Balance to financial balance
Functional risk:	Identifying and delivering CIPs
Risk owner	Chief Finance Officer supported by the Director of Efficiency and Transformation and the Director of Finance (Reporting)

Risk scoring	Likelihood	Impact	Overall risk
Gross risk	4	4	16
Net risk	3	4	12
Target risk	2	4	8

	Controls and Mitigation that should be in place	Lead	Frequency of review	Reported where?	Is the control/ mitigation effective?	Action	Due by
1	All CIPs are supported by detailed milestone implementation plans.	DoF(P)	Weekly	TRIG		Milestones to be reviewed as part of CIP planning 18/19 to ensure clear and quantifiable milestones to allow monitoring ahead of delivery timescales.	
2	All CIPs are embedded in budgets.	DoF(P)	Weekly	TRIG		100% 'green' schemes required by March 18, with 50% required by Feb 18. All green schemes to be embedded within budgets.	Mar-18
3	All CIPs are owned by the responsible manager/budget holder.	DoF(P)	Weekly	TRIG			
4	Benchmarking is used to drive CIP plans.	DoF(P)	Weekly/ Monthly	TRIG/ Costing steering group		Operational benchmarking to be used as part of transformation programmes of work. SLR/PLICS data to be utilised to identify areas of comparable inefficiency via the costing steering group, and IDG.	Mar-18
5	CIP governance is clearly defined and in place	DoF(P)	Weekly	TRIG			

1. The strategic objective.
2. Four strategic risks have been identified that could challenge the delivery of this objective.
3. For each of these strategic risks a range of individual risks have been identified.
4. For each of the individual risk an assessment of the gaps in control and assurance has been undertaken and actions developed to address them.
5. A target risk improvement plan has been developed to illustrate the mitigation (or not) of the individual risk, the strategic risks and hence the delivery of strategic objective.

(examples used on this slide for illustration purposes only).

The process

1. **Strategic objectives**. These have been agreed by the Trust Board.
2. **Strategic risks**. Have been agreed by the Trust Board together with an executive director and board assurance committee reporting line.
3. For each strategic risk set a range of **individual risks**. Executive leads now need to undertake this work.
4. For each of the individual risks an **assessment of the gaps in control and assurance** needs to be undertaken, together with the actions needed to address them. This work needs to be completed by executive leads. The illustration provided on the previous page needs some further work to ensure the process used aligns with the functionality of Datix to ensure simple operation and maintenance. Developing the assessment of gaps in control and assurance will;
    1. Need to be updated in Datix. This link is key to ensure effective oversight, consistent reporting and compliance.
    2. Help to inform the objectives for relevant managers and departments. For example, within Finance the actions needed to address the risks informs departmental and individual objective setting. This helps to align actions to manage strategic risks with day to day activities.
    3. Informed reports to the Risk Management Executive. The individual risks are those that should be discussed at the RME. All other risks raised at RME can be viewed through the lens of the strategic risks. As noted earlier, if the corporate objectives are comprehensive then material risks outside of these should be rare. However, this process also allows any new material risks identified to be escalated to the Board Assurance Framework.
    4. Be available for review by the relevant assurance committee to test the robustness of plans to address strategic risks. The expectation is this would be reviewed in detail by exception when actions to mitigate the strategic risks were either not seen as robust or were failing to deliver in line with plan.
    5. Help ensure the wider risk register can be linked to these risks to avail the duplication of risks within the Trust process. For example, do we hold individual risks regarding every budget that overspends or do we hold a single risk regarding supporting effective budget management?
5. A **target risk improvement** is maintained to provide easy overview. This can be used to inform reporting to the relevant assurance committee, with more detail provided on an exception basis of any areas of concern or note. The illustration provided on the previous page is from ICT.

Appendix 1

PROPOSED STRATEGIC RISK 2019/20					
Strategic Objective	**Risk appetite**	**Strategic Risk**		**Executive Lead**	**Assuring Committee**
Treat the patient, treat the person	***Low***	***SR1***	**There is a risk that we do not create an environment and embed an apporoach to Quality Improvement which minimise the occurrence of harm to our patients**	Chief Nurse	Quality & Safety Committee
	Low	***SR2***	**There is a risk that our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care.**	Chief Medical Officer	Quality & Safety Committee
Right care, right place, right time	***Low***	***SR3***	**There is a risk that our patients wait too long for treatment**	Chief Operating Officer	Quality & Safety Committee
	Low	***SR4***	**There is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated**	Chief Information Officer	Finance and Investment Committee
	Moderate	***SR5***	**There is a risk that we fail to make progress in delivering our clinical services strategy**	CEO (Director of Strategy)	Board
	Moderate	***SR6***	**There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities.**	CEO (Director of Strategy)	Board
Balance the books, invest in our future	***Low***	***SR7***	**There is a risk that we do not develop plans to achieve unsupported financial balance within X years.**	Chief Financial Officer	Finance and Investment Committee
	Low	***SR8***	**There is a risk that the Trust is unable to source sufficient capital funds to support investment in areas of material risk.**	Chief Financial Officer	Finance and Investment Committee
Build a better St George's	***Low***	***SR9***	**There is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy.**	Director of Estates & Facilities	Finance and Investment Committee
	Low	***SR10***	**There is a risk that we do not improve our estate to provide a safe environment for our patients and staff**	Director of Estates & Facilities	Finance and Investment Committee
Champion team St George's	***Low***	***SR11***	**There is a risk that we are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care.**	Director of HR and OD	Workforce and Education Committee (WEC)
	Low	***SR12***	**There is a risk that we are not seen as a diverse and inclusive employer by our staff**	Director of HR and OD	Workforce and Education Committee (WEC)
	Low	***SR13***	**There is a risk that we are unable to addreess the underlying culture of harassment and bullying.**	Director of HR and OD	Workforce and Education Committee (WEC)
	Low	***SR14***	**There is a risk that we are unable to recruit, train and sustain (retain) an engaged and effective workforce.**	Director of HR and OD	Workforce and Education Committee (WEC)
	Low	***SR15***	**There is a risk that we are unable to develop new and innovative roles/ways of work to deliver our rust clinical strategy**	Director of HR and OD	Workforce and Education Committee (WEC)
Develop tomorrow's treatments today	***High***	***SR16***	**There is a risk that we cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.**	Chief Medical Officer	Quality & Safety Committee

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Meeting Title:	**Trust Board**		
Date:	**25 April 2019**	**Agenda No.**	**6.4**
Report Title:	**Trust Board Business Cycle (April 2019 to March 2020)**		
Lead Director/ Manager:	**Stephen Jones, Director of Corporate Affairs**		
Report Author:	**Michael Weaver, Interim Head of Corporate Governance**		
Presented for:	**Approval**		
Executive Summary:	As a matter of good governance and practice it is important that the Board gives consideration to how it allocates its time, not only within a given meeting but over the period of the business year. The Trust Board Business Cycle, included in this report, provides a systematic and robust framework to enable the Board to work effectively and ensure that its work is well planned in advance and aligned with the work of its Committees. In addition, in order to support effective decision making and planning, a protocol for reserving matters private meeting of the Trust Board meeting held in has been developed and reflects exemptions set out in the Freedom of Information Act (2000). The Board cycle of business has been developed with input from the Executive team, and aligns with the work of Board sub-Committees.		
Recommendation:	The Board is asked to review and approve: • The proposed cycle of business for the Board's public meetings.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and improvement capability (well-led) – Effective boards and governance.		
Implications			
Risk:	As set out in the paper.		
Legal/Regulatory:	The purpose of this report is to invite the Board to consider and approve an updated cycle of business for its scheduled meetings in the Financial Year 2019/2020.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix 1. Trust Board in Public (Part One) Board Business Cycle (April 2019 to March 2020)		

Trust Board Business Cycle (April 2019 to March 2020)

Trust Board, 25 April 2019

1. Purpose

1.1. This paper sets out a proposed cycle of business for the Board's public meetings in 2019/20 and a protocol for informing decisions over the matters to be considered by the Board in private. It has been developed with input from the Executive team and aligns with the cycles of business of the Board sub-Committees. The Board is asked to review and approve the cycle of business and protocol for reserving matters for private meetings.

2. Background: Governance of NHS organisations

2.1. Those who are charged with the governance of NHS organisations have an increased need for good-quality, timely information - to set strategic direction, to oversee progress towards strategic goals and to monitor operational performance[1]. Every member of the Board needs sufficient information at a high enough level to be confident that the organisation is well run, but not so much information that it becomes difficult to tell what is important. The past decade has seen ever-increasing interest in the effectiveness of governance across all sectors, prompted not only by high-profile business failures but also in the public sector by concerns about integrity, independence, accountability and recognition of the growing complexity of effective public service provision.

2.2. The foundations of good practice were laid down in the Cadbury Report in 1992 and developed by Greenbury, Hampel, Turnbull and more Higgs (2003). Alongside the Nolan principles of public life, the recommendations of these reports have been extended to public bodies, including through the Good Governance Standard for Public services in 2004. Good practice for NHS foundation trusts is also set out in the NHS Foundation Trust Code of Governance (2014).

2.3. Good governance is underpinned by intelligent information, which enables the Board to:

- Set an appropriately challenging, but achievable, strategic direction.
- Identify the strategic issues that require discussion or decision, and distinguish these issues from operational detail.
- Provide constructive challenge.
- Make sure that taxpayers are receiving value for money.
- Identify trends in performance.
- Enable comparisons with the performance of similar organisations.
- Understand the needs, views and experiences of users and non-users from all backgrounds and communities.
- Make sure that users are receiving a high-quality service.
- Anticipate potential impact of key policy, technology and socioeconomic developments.
- Assure itself that the organisation complies with regulatory requirements and standards.

[1] The intelligent Board, Dr Foster Intelligence, 2006

2.4. Using information intelligently means that boards need to distinguish between:

- Issues that need to be reported routinely to the board at a certain level of detail
- Issues that need to be reported only if there is demonstrably a problem, for example, where performance significantly diverges from that achieved by peer trusts.
- Issues that change relatively slowly and that should therefore be looked at on a quarterly or six-monthly basis.

3. The Board agenda

3.1. Board agendas currently follow a set format, structured around themes of quality and safety, performance, strategy, finance, workforce and governance. Each meeting contains both strategic and operational items, at different points in the annual board cycle different aspects could receive greater emphasis according to the availability and relevance of data on some issues, for example, quarterly or annually; priorities and issues for the Trust; importance of focusing in depth on certain business critical services from time to time; key events, including the development of the business plan, approval of the accounts, and submissions to NHS Improvement.

3.2. The Board cycle of business for 2019/20 has been developed to help the Board fulfill its roles of setting strategy, monitoring performance, holding the organisation to account, and establishing and modeling the culture for the Trust.

3.3. The NHS Foundation Trust Code of Governance requires the Trust to be headed by an effective Board of Directors and sets out a number of requirements for the Board, including:

- Provide leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed
- Set the Trust's strategic aims at least annually, ensuring that the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and periodically reviewing progress and management performance.
- Ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its health care delivery.
- Regularly review the performance of the Trust against regulatory and contractual obligations, and approved plans and objectives.
- Ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.
- Ensure compliance of the Trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.
- Ensure the quality and safety of health care services, education, training and research delivered by the Trust and apply the principles and standards of clinical governance
- Set the Trust's vision, values and standards of conduct and ensure that its obligations to its members are understood, clearly communicated and met.
- Ensure that the Trust functions effectively, efficiently and economically
- Meets frequently enough to discharge its responsibilities.

3.4. To support the Board's effectiveness, all information provided to the Board should:

- Be clearly, simply presented, including graphic overviews, analysis and brief commentary.
- Be updated in a timely manner.
- Direct the board's attention to significant risks, issues and exceptions.
- Provide a level of detail appropriate to the board's role.

3.5. The key tests of the success of any information resource for the Board will be the extent to which it:

- Prompts relevant and constructive challenge.
- Supports informed decision-making.
- Is effective in providing early warning of potential problems (e.g. quality, performance, finance, workforce, governance)
- Develops all directors' understanding of the organisation and its performance.

3.6. The Board cycle of business for 2019/20 has been developed to support the Board in meeting the requirements of good governance in general and the specific regulatory and other requirements on the Trust. It has been developed with the input of Executive Directors and aligns with the cycles of business of the Board sub-Committees.

4. Recommendation

4.1. The Board is asked to note and approve:

- The proposed cycle of business for the Board's public meetings.

Michael Weaver
Interim Head of Corporate Governance
15 April 2019

Appendix 1: Public (Part 1) Board Forward Plan 2019-20

Public (Part 1) Board Forward Plan 2019-20 Scheduled, Standing Agenda Item	Lead	Author(s)	Committee	25/04/2019	30/05/2019	27/06/2019	25/07/2019	29/08/2019	26/09/2019	31/10/2019	28/11/2019	19/12/2019	20/01/2019	27/02/2019	26/03/2019
Board Walkabout															
Feedback from Board Walkabout	All	CN	Board	S	S	S	S	S	S	S	S	S	S	S	S
Opening administration															
Welcome, Introductions and Apologies for Absence	All	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Declaration / Register of Interests	All	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Minutes of Previous Meeting (accuracy)	Chair	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Matters Arising (Tracker) and Action Log	Chair	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Chief Executive's Report	CEO	ADC and DCA	TEC	S	S	S	S	S	S	S	S	S	S	S	S
Workforce and Education															
Workforce and Education Committee Report	NED	Committee Chair	WEC	S		S		S		S		S		S	
Freedom to Speak Up Guardian Report	DHROD	FTSU	WEC	Q4			Q1			Q2			Q3		
Workforce Race Equality Standard (WRES) Annual Report	DHROD	DHROD	Board												A
WRES Action Plan	DHROD	DHROD	WEC		Q4		Q1			Q2			Q3		
NHS National Staff Survey	DHROD	HRA	Board											A	
Gender Pay Gap	DHROD	WIM	WEC											A	
Ethnicity Pay Gap	DHROD	WIM	WEC											A	
Guardian of Safe working	CMO	SH	Board											A	
Revalidation & Medical Appraisal Annual Report and Statement of Compliance	CMO	HR	TEC						A						
Fit and Proper Person Test (Update Reports/Annual Report)	DHROD	DHROD	TEC	√	A										
Annual Report on Nurse Revalidation	CN	HR	TEC						A						

Public (Part 1) Board Forward Plan 2019-20 **Scheduled, Standing Agenda Item**	**Lead**	**Author(s)**	**Committee**	**25/04/2019**	**30/05/2019**	**27/06/2019**	**25/07/2019**	**29/08/2019**	**26/09/2019**	**31/10/2019**	**28/11/2019**	**19/12/2019**	**20/01/2019**	**27/02/2019**	**26/03/2019**
Finance															
Finance and Investment Committee Report	NED	Committee Chair	FIC	S	S	S	S	S	S	S	S	S	S	S	S
Finance Report	CFO	CFO and HoFR	FIC	S	S	S	S	S	S	S	S	S	S	S	S
Annual Carter Report Progress Update	CFO	CFO and HoFR	TEC											A	
Approval of Annual Budget (including Pay, Non-Pay, Capital and Cost Improvement Plan)	CFO	CFO and HoFR	FIC												A
Quality and Performance															
Quality and Safety Committee Report	NED	Committee Chair	QSC	S	S	S	S	S	S	S	S	S	S	S	S
Integrated Quality and Performance Report	DDET	PDM and DPM	FIC and QSC	S	S	S	S	S	S	S	S	S	S	S	S
Cardiac Surgery Update	CMO	GMCVT and AMD CS	QSC	S	S	S	S	S	S	S	S	S	S	S	S
Serious Incidents	CN	CN	QSC		Q4		Q1			Q2			Q3		
Mortality Monitoring Committee Report and Learning from Deaths	CMO	MMC and CEA	TEC		Q4		Q1			Q2			Q3		
Safer Staffing Report	CN	CN	QSC		Q4		Q1			Q2			Q3		
Transformation and Quality Improvement Report	DDET	DDET	TEC	Q4			Q1			Q2			Q3		
Infection Prevention and Control Annual Report	CN	CMM/DIPC	QSC						A						
Annual Mental Capacity Act and Deprivation of Liberty Safeguards Report	CN	MCA DoL and Stet Adults	QSC					A							
Annual Complaints Report (patient experience)	CN	CN	QSC						A						

Public (Part 1) Board Forward Plan 2019-20 Scheduled, Standing Agenda Item	Lead	Author(s)	Committee	25/04/2019	30/05/2019	27/06/2019	25/07/2019	29/08/2019	26/09/2019	31/10/2019	28/11/2019	19/12/2019	20/01/2019	27/02/2019	26/03/2019
Quality and Performance															
Annual Health and Safety Report (including Fire Safety and Water Safety)	DEF	DEF	TEC								A				
Medicines Management Annual Report	CN	Chief Pharmacist	QSC								A				
Duty of Candour Annual Report	CN	CN	QSC								A				
National In-patient Survey	CN	CN	QSC								A				
Winter Plan/Local Escalation Plan	COO	HoSO	TEC								A				
Annual Report for Security Management	DEF	DEF	TEC		A										
Safeguarding Adults Annual Report	CN	CN	QSC			A									
Safeguarding Children Annual Report	CN	CN	QSC				A								
Learning Disability Services Annual Report	CN	CN	QSC						A						
Looked After Children Annual Report	CN	CN	QSC				A								
Annual Audit of End of Life Care	CN	CN	QSC				A								
Strategy															
Corporate Objectives (Quarterly Updates)	DS	HoS and HoBP	TEC	Q4			Q1			Q2			Q3		
Strategy Implementation Plan - Progress Report	DS	HoS and HoBP	TEC		√					√					
Research Strategy and Annual Report	CMO	AMDR and JRES	QSC		A										
Trust Communications Strategy	ADC	ADC	TEC												A
Outpatients Strategy	DS	DS	TEC		√										
NHSI Narrative Annual Plan	DS	HoBP	TEC	A											

Public (Part 1) Board Forward Plan 2019-20 Scheduled, Standing Agenda Item	Lead	Author(s)	Committee	25/04/2019	30/05/2019	27/06/2019	25/07/2019	29/08/2019	26/09/2019	31/10/2019	28/11/2019	19/12/2019	20/01/2019	27/02/2019	26/03/2019
Governance															
Information Governance Toolkit and The Data Security and Protection Toolkit	CFO	CIO	IGC		A										
Audit Committee Report	NED	Committee Chair	AC	S	S		S			S			S		
Board Assurance Framework	CN	CN	QSC	Q4			Q1			Q2			Q3		
Corporate Risk Register	CN	CN	TEC		Q4		Q1			Q2			Q3		
Annual Review of Risk Management Strategy & Policy	DCA	Secretariat	TEC and AC											√	
Information Governance Annual Report	CFO	CIO	TEC and AC											√	
GDPR: Implementation	CFO	CIO	TEC		Q4		Q1			Q2			Q3		
St George's Hospital Charity Report	DS	CEO Charity	TEC		Q4		Q1			Q2			Q3		
Report on use of the Trust Seal	DCA	Secretariat	TEC	Q4			Q1			Q2			Q3		
Remuneration Committee Report	DHROD	DHROD	TEC		Q4		Q1			Q2			Q3		
NHS Premises Assurance Model (NHS PAM)	DEF	DEF	TEC		Q4		Q1			Q2			Q3		
Annual Report and Accounts including Quality Account and Remuneration Report	CEO	CFO and DCA	AC		A										
Annual Governance Statement	DCA	Secretariat	TEC		A										
Annual Audit Letter	CMO	CMO	AC							A					
Annual Self-Assessment of Compliance with Foundation Trust Licence	DCA	Secretariat	TEC		A										
Emergency Preparedness, Resilience and Response (EPRR) – Annual EPRR Assurance Submission	COO	EPM	TEC										A		
Freedom of Information Annual Report	DCA	Secretariat	TEC			A									
Re-subscription to Codes (Etiquette, Openness, NHS Constitution.)	DCA	Secretariat	TEC											A	

Public (Part 1) Board Forward Plan 2019-20 **Scheduled, Standing Agenda Item**	**Lead**	**Author(s)**	**Committee**	**25/04/2019**	**30/05/2019**	**27/06/2019**	**25/07/2019**	**29/08/2019**	**26/09/2019**	**31/10/2019**	**28/11/2019**	**19/12/2019**	**20/01/2019**	**27/02/2019**	**26/03/2019**
Governance															
Use of Trust Seal	DCA	Secretariat	TEC and AC					√						√	
Approve Amendments to Standing Orders, Scheme of Reservation & Delegation, SFIs and Detailed Scheme of Delegation	DCA	Secretariat	TEC and AC											A	
Board development plan	DCA	Secretariat	TEC											A	
Review Trust Board Business Cycle	DCA	Secretariat	TEC	A										A	
Review Committee Structure & Board Committee Terms of Reference	DCA	Secretariat	TEC											A	
To agree schedule of meeting dates for following (financial) year	DCA	Secretariat	TEC											A	
Closing administration															
Questions from the public	Chair	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Summary of Actions	DCA	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Any new risks or issues identified	All	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Items for the next meeting	All	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Any other business	All	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Board Evaluation - Reflection on the meeting	All	Secretariat	Board	S	S	S	S	S	S	S	S	S	S	S	S
Patient / Staff Story	CN	CN	Board	S	S	S	S	S	S	S	S	S	S	S	S

Key:

S = Standing Items; A = Annually; Q= Quarterly (Q1-4)

Lead/Author: *All = All Board Members; Chair = Trust Chair; CEO = Chief Executive Officer; CMO = Chief Medical Officer; CN: Chief Nurse Director of Corporate Affairs; CFO = Chief Financial Officer; COO = Chief Operating Officer; DDET = Director of Delivery, Efficiency and Transformation; DEF = Director of Estates and Facilities; DHROD; Director of Human Resources & Organisational Development; CIO = Chief Information Officer; HoFR - Head of Financial Resources; DS = Director of Strategy; HoS = Head of Strategy; HoBP = Head of Business Planning; Deputy Director of Efficiency & Transformation; HoBP = Head of Business Planning; EPM = Emergency Preparedness Manager; ADC = Associate Director of Communications; NED = Non-Executive Directors; CIO = Chief Information Officer; SIRO = Senior Independent Responsible Officer*

Committee*: TEC = Trust Executive Committee; FIC = Finance & Investment Committee; QSC = Quality and Safety Committee; WEC = Workforce & Education Committee; TB= Trust Board; IGG = Informatics Governing Group; COG = Council of Governors*

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