St George's University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 26 September 2019, 10:00-13:30**
Venue: **Room 2.6 Hunter Wing, St George's University of London**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the site**	**Board Members**	Note	Oral
ALUES AWARD					
	B	**Staff Values Award Presentation**	**Chairman**	-	Oral
1.0 OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Chairman**	Note	Oral
	1.2	**Declarations of interest**	**All**	Inform	Report
	1.3	**Minutes of meeting on 25 July 2019**	**Chairman**	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
10:35	**1.5** **1.5.1**	**CEO's Report** **Trust Executive Committee Terms of Reference**	**Chief Executive Officer**	Inform *Note*	Report *Report*
2.0 QUALITY & PERFORMANCE					
10:40	**2.1** **2.1.1**	**Quality and Safety Committee Report** **Mental Capacity Act and Deprivation of Liberty Standards (Annual Report 18-19)**	**Committee Chairman** **Chief Nurse**	Assure	Report
11:00	**2.2**	**Integrated Quality & Performance Report**	**Chief Transformation Officer**	Review	Report
11:15	**2.3**	**Cardiac Surgery Update**	**Chief Medical Officer**	Assure	Report
11:25	**2.4**	**Quality Improvement Academy Quarterly Report**	**Chief Transformation Officer**	Assure	Report
3.0 WORKFORCE					
11:35	**3.1** **3.1.1**	**Workforce & Education Committee Report** **Workforce & Education Committee Terms of Reference**	**Committee Chairman**	Assure *Approve*	Report *Report*
11:45	**3.2**	**Staff Engagement Plan 2010/2021**	**Chief People Officer**	Approve	Report
12:00	**3.3**	**A Framework of Quality Assurance for ROs and Revalidation – Annual Report**	**Chief Medical Officer**	Approve	Report
4.0 FINANCE					
12:10	**4.1**	**Finance and Investment Committee Report**	**Committee Chairman**	Assure	Report
12:20	**4.2**	**FIC (Estates) Report**	**Committee Chairman**	Assure	Report

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Time	Item	Subject	Lead	Action	Format
12:30	**4.3**	**Finance Report (Month 05)**	Director of Financial Planning	Update	Report
5.0 GOVERNANCE					
12:40	**5.1**	**Audit Committee Report**	**Committee Chairman**	Assure	Report
	5.1.1	**Use of Trust Seal 2018-19**	**Chief Corporate Affairs Officer**	*Assure*	*Report*
	5.1.2	**Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions**	**Chief Corporate Affairs Officer**	*Approve*	*Report*
6.0 CLOSING ADMINISTRATION					
13:00	**6.1**	**Questions from the public**	**Chairman**	Note	Oral
	6.2	**Any new risks or issues identified**	**All**	Note	
	6.3	**Any Other Business**		Note	
	6.4	**Reflections on the meeting**		Note	
7.0 PATIENT/STAFF STORY					
13:10	**7.1**	**Paediatric Patient Journey**	**Susannah Stevenson, Patient's Mother**	-	Oral
13:25 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".

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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 2019-20 (Thursdays)									
28.03.19	25.04.19	30.05.19 (QMH)	27.06.19	25.07.19	29.08.19	26.09.19	31.10.19 (QMH)	28.11.19	19.12.19
30.01.20	27.02.20	26.03.20							

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Sir Norman Williams	Non-Executive Director/Senior Independent Director	NED
Sarah Wilton	Non-Executive Director	NED
Avey Bhatia	Chief Nurse & Director of Infection, Prevention & Control	CN
In Attendance		
Ellis Pullinger	Chief Operating Officer	COO
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Sally Herne	Quality Improvement Director – NHS Improvement	QID
Andy Stephens	Director of Financial Planning – deputising for CFO	DFP
Secretariat		
Tamara Croud	Interim Assistant Trust Secretary	IATS
Apologies		
Tim Wright	Non-Executive Director	NED
Andrew Grimshaw	Chief Finance Officer	CFO
Jacqueline Totterdell	Chief Executive Officer	CEO
Richard Jennings	Chief Medical Officer	CMO
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

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Meeting Title:	**TRUST BOARD**		
Date:	**26 September 2019**	**Agenda No.**	**1.2**
Report Title:	**Board Member Declarations of Interest**		
Lead Director/ Manager:	**Stephen Jones, Chief Corporate Affairs Officer**		
Report Author:	**Stephen Jones, Chief Corporate Affairs Officer**		
Presented for:	**For Information**		
Executive Summary:	The updated Register of Board Members' interests is attached as Appendix A. It was agreed, in March 2019, 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. This update also coincides with our launch of the Declare system, the new online portal where Board members can make their declarations online quickly and easily. Members of the public will also be able to see what declarations our staff, including Board members, have made. The system is due to launch on 1 October 2019 and in readiness for this members have been asked to advise the Project Manager of any updates to their interest as these will be pre-loaded on to the system ahead of the formal launch date.		
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		

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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	
Gillian Norton	Chairman	Chairman of Epsom and St Helier Hospitals	October 2019	Present	Remunerated
Gillian Norton	Chairman	Chair of Trustees of Richmond upon Thames Voluntary Fund	September 2019	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	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: Cielo Healthcare (Milwaukee, USA)	2015	Present	

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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, 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	
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	

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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: Eden Futures (supported living provider)	2016	Present	
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)	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	

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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)	Honorary Consultant: Imperial College London	November 2011	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	

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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
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

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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	Non-Executive Director Private Healthcare Information Network (PHIN)	2015	Present	Approx. 1 day per month.- remunerated
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

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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	Remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Non-Executive Director, and Audit and Risk Committee Chair - Hampden Members' Agencies Limited	2008	Present	Remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Trustee and Vice Chair - Paul's Cancer Support Centre	1995	Present	Non remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Magistrate – South West London Magistrates Court and Central London Family Court	2005	Present	Non remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Co-opted Member – Wimbledon and Putney Commons Conservators Audit and Risk Committee	2019 (January)	Present	Non remunerated

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
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	

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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	
Jacqueline Totterdell	Chair	Chair of the Clinical Research Network (CRN) South London Partnership Board	2019	Present	
Avinderjit (Avey) Bhatia	Chief Nurse and Director of Infection Prevention and Control	None			
Harbhajan Brar	Chief of People	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	Chief Medical Officer	None			

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Chief Transformation Officer	Trustee, Carrie's Home Foundation	2018	Present	Non-remunerated
James Friend	Chief Transformation Officer	Trustee, Westcott Sports Club	2018	Present	Non-remunerated
James Friend	Chief Transformation Officer	Council Liaison Officer, Mole Valley Conservative Association	2017	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Hut Management Committee, Westcott	2012	Present	Non-remunerated
James Friend	Chief Transformation Officer	District Councillor Westcott, Mole Valley District Council	2008	Present	Leader of the Opposition

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Chief Transformation Officer	Church Warden, St John's The Evangelist, Wotton	2004	Present	Non-remunerated
James Friend	Chief Transformation Officer	Volunteer, Radio Wey	1994	Present	Non-remunerated
James Friend	Chief Transformation Officer	Associate Member, Association of Corporate Treasurers	1998	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Westcott Cricket Club	1996	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Chartered Institute of Bankers	1996	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member, National Trust	1992	Present	Non-remunerated
Stephen Jones	Chief Corporate Affairs Officer	Wife is a senior manager at NHS England	5 March 2018	Present	
Suzanne Marsello	Chief Strategy Officer	None			
Ellis Pullinger	Chief Operating Officer	None			

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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 25 July 2019, 10:00 – 13:30
Room 2.6, Hunter Wing St George's University of London

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
Sarah Wilton	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer/Deputy Chief Executive Officer	CFO/DCEO
Dr Richard Jennings	Chief Medical Officer	CMO
IN ATTENDANCE		
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Emilie Perry	Deputy Director of Operations – Children, Women, Diagnostics and Therapies (deputising for COO)	DDO-CWDT
APOLOGIES		
Ellis Pullinger	Chief Operating Officer	COO
Sally Herne	NHSI Improvement Director	NHSI-ID
SECRETARIAT		
Tamara Croud	Interim Assistant Trust Secretary (Minutes)	IATS

Feedback from Board Visits
Board members visited a range of services across Lanesborough Wing which experienced particular challenges during the July 2019 heat wave. Board members were accompanied by members of the Estates and Facilities team who recorded key issues raised during the visits to ensure that steps were taken promptly to address them. 3rd Floor Lanesborough: Chairman and CEO The CEO reported that whilst the wards were very hot, staff understood the challenges and were sanguine about the situation, noting that the heat wave would only last a few days. Staff appreciated the level of engagement from senior management, the provision of additional iced water, ice creams and the relaxation of the dress code allowing staff to wear scrubs. Speaking to patients, it was

Feedback from Board Visits

evident that they also understood the challenges in the heat wave and appreciated everything the Trust had done.

4th Floor Lanesborough Wing: Prof. Jenny Higham and CFO/DCEO
Jenny Higham reported staff felt that the challenges were being addressed, noting that the current inconveniences could be tolerated in the short-term. Staff also appreciated the enhanced visibility from the senior team and Board members. The CFO/DCEO reported that higher levels of reliance on fans and air conditioning units had resulted in power outages which presented additional issues for the Trust and those interdependencies were not to be underestimated.

5th Floor: Sir Norman Williams and CMO
The CMO reported that whilst some parts of the floor were more comfortable than others, the open corridors and staff areas were very uncomfortable. Some patients were unable to self-mange fluid intake so staff had devised effective systems so that patients did not get dehydrated. The team flagged the challenge with the air flow in one of the single rooms used to manage isolated patients on Pinckney Ward and the need to address this. Staff were also cognisant of the challenges with managing patients who had mental health challenges in the extreme heat on Frederick Hewitt Ward.

Resuscitation Training and Delivery Suite: Sarah Wilton and CN
The CN reported that there was variability in temperature with areas such as the drug room and theatres very cool. Whilst it was hot in areas such as the delivery suite, staff were doing everything they could to keep patients comfortable. Other issues raised by staff included the challenge of getting to grips with the new iClip system, staffing and the state of the ladies' changing room. The Resuscitation Team advised that despite additional resources and more online training, it was unlikely the Trust would attain the statutory mandatory training target for resuscitation until the end of the year as opposed to the September 2019 as originally planned.

General Intensive Care Unit (GICU) and Clinical Health Records: Ann Beasley and CSO
The CSO reported that the Estates Team would look into issue with regulating the air conditioning unit in GICU. Ann Beasley commented that it was encouraging to see good leadership that considered what services could be run during the heat wave. The Clinical Health Records environment was extremely hot and the Estates Team would follow-up on issues with ordering fans for the team.

PICU and Neonatal: Stephen Collier and CPO
Stephen Collier reported that following conversations with three sets of patients it was evident that people were positive about the way the Trust had managed the challenges with the heat wave. It was also evident there had been a cultural change, with staff taking ownership of rostering in these areas. The CPO reported that PICU were very proud to have achieved Gold ward accreditation. The environment was welcoming and positive and management flexibility around uniform was very much appreciated during the heat wave. The team were very proactive about staffing and had taken control of self-rostering. An issue related to bank staffing would be addressed by the CPO. Another general issue raised by the team was around the lack of space for paediatric patients' parents to stay which was being temporarily addressed with the use of space in Ronald MacDonald House.

Emergency Department: Tim Wright and CTO
Tim Wright reported that although the ED was very busy the passion and care was evident and stood out. The estates team were also committed to addressing any issues. Whilst the teams are using iClip it did take time to log on and it would be useful to look into speeding this up and also useful to introduce express iClip training for bank staff. The air conditioning system is very old and it was not possible to get more out of it. The team huddle was a very good example of the implementation of new ways of working.

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		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and noted the apologies as set out above.	
1.2	**Declarations of Interest** The Board noted the register of Board members' interests. Sir Norman Williams advised that he had recently been appointed as Chair of the Independent Reconfiguration Panel from 1 October 2019. This new role would give rise to conflict of interest that could not be managed and, as a result, Sir Norman would resign from his role as a Non-Executive Director at the Trust on 30 September 2019. The Chairman noted that the Board was very disappointed to see Sir Norman Williams leave and noted the huge contribution he had made to the Trust since joining the Board in April 2016.	
1.3	**Minutes of the meetings held on 27 June 2019** The minutes of the meeting held on 27 June 2019 were agreed as an accurate record subject to correcting a typographical error in the spelling of Tim Wright's name under the Board visits feedback section on page three.	
1.4	**Action Log and Matters Arising** The Board reviewed the action log and agreed that actions TB28.02.19/9 (Leadership programme presentation), TB25.04.19/02 (Changes to the BAF) and TB27.06.19/04 (Quality Improvement Academy) would be closed for the reasons stated.	
1.5	**Chief Executive Officer's Update** The CEO highlighted the key elements of her report, noting congratulations to the Chief Strategy Officer on being asked to join the expert panel convened by South West London and St George's Mental Health NHS Trust, Richard Mycroft for taking on the role of Lead Governor, and Terence Joe on his appointment as the new Head of Patient Experience and Partnership. The Board received and noted the CEO's report.	
2.0	**QUALITY AND PERFORMANCE**	
2.1	**Quality and Safety Committee Report** Sir Norman Williams, Chair of the Committee, presented the report of the meeting held on 18 July 2019. The Trust's clinical negligence claims profile was the feature of a comprehensive deep dive and the Committee was pleased to see a detailed breakdown of the pattern of claims and the ways in which the Trust currently sought to learn from them. The Committee heard that a large volume of benchmarking data had just been shared with the Trust through the Get It Right the First Time (GIRFT) programme and this would enable the Trust to effectively benchmark on activity, patient cohort and specialism, and the Committee looked forward to this. The Committee also noted that the new NHS Patient Safety Strategy would have significant implications for the way in which the Trust sought to learn from claims.	

		Action
	The Committee had been reassured that the correct and immediate steps were taken in light of the recent 'never event' related to retained swab. The Committee would receive a full report on lessons learnt and actions taken to eliminate further incidents. Ann Beasley commented that it would be useful to know if there were any correlating factors between this never event and previous never events to enable better understanding of any reoccurring trends which could get to the root cause and support prevention. The CN advised that a meeting attended by around 130 theatre staff was held shortly after the incident and key solutions such as the provision of additional training on the surgery checklist, empowering staff to take the time to carry out the relevant checks, and cross checking of swab trays had been identified as steps that could support improvements. The CMO reported that it was important to look at learning from other organisations when considering how best to improve systems and practices which reduce or eliminate the possibility of human error and the Trust had some work to do to reflect on this. The teams concerned were high performing so when something went wrong it was important to understand the full picture. Sir Norman Williams noted that there were around 360 never events each year across the NHS as a whole, the pressure faced in these areas could not be underestimated and it was important to put measures in place to support teams. It was also important to carry out effective training at regular intervals to ensure that systems and practice were sufficiently embedded. The CEO noted that retained swab never events had happened on a number of occasions and it was important to understand what was giving rise to this, including any cultural issues. Addressing the issue meant going beyond the usual processes and changing hearts and minds. Sir Norman Williams offered that it may be useful to implement the stop the line card systems implemented by car manufacturers. The Committee considered the proposed submission for a rebate from the Clinical Negligence Schemes for Trusts (CNST) for Maternity Services and had been satisfied that the service had met the 10 safety standards and could provide robust evidence. As a result, the Committee commended the report to the Board and recommended that it approved the submission. The Committee was assured that the cervical screening backlog was being addressed and was reassured that the processes for blood transfusion had been reviewed and strengthened from the quarterly report on South West London Pathology. The Committee noted the good progress on the referral to treatment performance at the Tooting site in the first quarterly report and noted that plans were progressing to begin reporting at Queen Mary's Hospital. The learning from deaths quarter one report highlighted the possible presence of some soft signals that there may be challenges with the sufficient senior reviews at weekends and the Committee heard that this was part of the on-going work around seven day working of which consultant job planning was a key element. For the avoidance of doubt, he noted that there were no mortality concerns at weekend. The Committee also raised concerns about the Board Assurance Framework risk pertaining to the four hour standard in the Emergency Department, noting that as articulated the risk should have a higher risk score. The CMO also reported that the Lead Medical Examiner interviews would take place on 8 August in response to the query flagged by the Committee. The Board noted the report.	

		Action
2.2	**Integrated Quality and Performance Report (IQPR)** The CTO gave an overview of the IQPR at Month 3 (June 2019). Day case and elective activity performance had improved and the Trust was ahead of plan on outpatients receiving first appointments. Theatre productivity had improved significantly but the Trust needed to manage its activity within the block contracts and ensure it was having the right conversations with local commissioners to ensure it was properly reimbursed for activity. There was also improvement in patient safety and infection control performance metrics and cancer had moved forward. The new accountability framework was now operational and performance challenge sessions with Divisions which had been held recently had highlighted a step change in performance oversight. This provided greater transparency in key areas. The DDO-CWDT reported that the June performance data on 62-day and 2-week cancer targets would show an improvement as a result of the continued operational focus. The referral to treatment (RTT) external review report would be completed soon and would provide a recommendation about whether or not it was possible to roll-out RRT reporting at the Queen Mary's Hospital site as planned in the autumn, subject to Board approval. The Emergency Department (ED) remained challenged and focus was being given to the following three areas as part of the improvement plan to turnaround performance: • Strengthening the leadership in the ED with the re-establishment of the two-hourly huddles with escalation as required and focusing on the workforce to ensure rotas were robust. • Focus was being given to patients with long lengths of stay in particular stranded and super stranded patients. The weekly meetings led by Divisional Directors of Nursing and Governance continued to focus on cross agency pathway management. Therapies teams were also working hard to see all referrals on the same day by proactively diverting resources to meet demand. • Improving Divisional support, for example by enhancing the daily divisional silver role. The inter-professional standards had been re-launched in order to achieve the 30 minute speciality referral standard paired with timely transfer of patients to ambulatory care areas where appropriate. The CSO reported that the Emergency Care System Support Group was conducting a focused review of mental health and frail patients which would feed into the emergency department action plan. Ann Beasley noted that the Finance and Investment Committee had discussed ED performance. Whilst it recognised the effort to sort out the issues, the Committee was frustrated with the inconsistency in performance. The Chairman noted that it was good to see that plans were in place to address the ED issues, but stated that it was time to see those actions translate into sustained improvements in performance. Sarah Wilton asked for more information on what was being done system-wide around admission prevention. The CEO reported that the Trust was one of four London Trusts that were away from plan on ED performance and, as such, there was increased scrutiny from NHS Improvement. The Trust had agreed with commissioners to conduct an external review of all pathways across the system with the view of developing a holistic plan to address the root causes of the performance shortfall. The Chairman noted that the ED target must be delivered and actions needed to be implemented. Sarah Wilton commented that any new plans should build on previous work and not override previous actions plan. The CEO agreed and reported that the review would include	

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	reviewing previous plans to ensure that it was built on previous work, with the view that the new plan would deliver the systematic change required to achieve consistent high performance in ED. The CTO reported that the improvement action plan was intended to address the immediate actions required to begin the turnaround ED and did not seek to address the long-term issues as this was the focus of the external review. Whilst it was important that the Trust did not lose sight of the challenge with the primary care pathway and capacity, the Chairman commented that the Board needed to be cognisant that a significant part of the challenge in ED related to internal practice and processes which needed to be addressed. The CN reported that the infection control and prevention report in month 4 would include details of the approach to reviewing Escherichia Coli (E. Coli) and Methicillin-sensitive Staphylococcus aureus (MSSA). Sir Norman Williams requested that the information on the percentage of day cases be reinstated in the IQPR as it was important that the Board monitored this metric; the CTO advised that this would be reinstated. The CPO advised that increased focus was being given to reducing the number of agency staff in the Trust and this was picked up in the divisional performance challenge sessions. It was expected that many roles would be substantively filled by September. Sarah Wilton reminded the Board of the request to include more external benchmarking data against key metrics. The Board noted the report.	
2.3	**Cardiac Surgery Update** The CMO presented an update on the steps being taken to improve the cardiac surgery service and outlined the key points of the report. The Trust was pleased that Cheryl Ramsay had started work as Interim Programme Manager on 1 July 2019 and noted that she would support the Trust's engagement with the Independent External Mortality Review and wider work to improve the service. Of the 210 patient deaths between 2013 and 2018 which were being considered by the Independent External Mortality Review, the panel had contacted the relatives of 181 of these and both NHS Improvement and NHS England agreed that the Trust had done everything it could to contact the relatives of patients whose deaths were within scope of the review. The development of electronic referral forms would improve processes in cardiac surgery and at the Quality Summit held on 24 July the Care Quality Commission advised that there were no concerns about the safety of the service. Work continued with partners to develop a high quality networked cardiac surgery service across South London. The Board noted the report and took assurance from the update.	
2.4	**Transformation Quarter 1 Update** The CTO reported that during Quarter 1 good progress had been made against the transformation programme. Key workstreams included centralisation and automation of patient letters, improving the focus on the Quality Improvement Academy, and enhanced working to get the *'St George's'* way embedded. Over 400 people across the Trust had been	

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	engaged in quality improvement projects. Many of the transformation projects related to patient involvement and engagement. The transformation team had also worked closely with teams to develop business cases for the emergency pathway. Ann Beasley noted that it was evident there were some good projects progressing and queried how the Trust would measure their impact and outcome. The CTO reported that the effective measurement of impact and outcome was a key workstream for the Trust. The IQPR included quality improvement (QI) metrics which enabled the Trust to begin tracking and measuring the impact of key QI and transformation projects. However, more work was needed and this would be picked up at the Board development session on leadership and QI on 29 August. The CEO noted that the Trust would know that these transformation projects were making a difference when it was evident that staff felt empowered to make changes for the benefit of patients and themselves and this would also signal the required cultural shift. The Board now needed to reflect on how it demonstrated the QI approaches in how it engages and speaks about QI. This would also be discussed at the Board development session. In response to a query from Stephen Collier, the CPO reported that the introduction of *Allocate* for junior doctor rostering had been delayed because a phased approach had to be taken as a result of the need for additional validation of rostering data in some areas. The CFO commented that it was important to get people to take responsibility for data and the importance of improving the organisational systems but it was equally important to get the balance right. The Board noted the report	
2.5	**Learning from Deaths Quarterly Report** The Board received and noted the quarter one report from the Mortality Monitoring Committee (MMC) on learning from deaths which had been discussed at the Quality and Safety Committee on 18 July 2019. The CMO outlined the key elements within the report including that the MMC had reviewed 94.6% (384) of deaths which was in excess of the 70% target. There was, however, an opportunity to get further triangulation and learning embedded and this was being pursued. The Trust's mortality rating was 0.3% which was significantly less that the national average of 3%. The review into deaths highlighted that the quality and quantity of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) conversations had improved but there was still more work to be done. Ann Beasley noted that 1.3% of the deaths reviewed found that there was poor care and queried the process for following this up with the relevant teams. The CMO advised that results from the review were provided to relevant teams but more work was needed on closing the loop, namely, going back and reviewing that learning has been embedded to avoid further instances. It should also be noted that when the Serious Incident Panel reviewed cases any issues of poor care were flagged immediately. The Chairman noted that the missing element seemed to be how the Trust followed up on feedback from learning from deaths with teams and that this may be closed as a result of the processes being implemented following the clinical governance review. The Board also noted that the CMO may temporarily take over chairing of the MMC when Dr Nigel Kennea steps down until a substantive replacement was found. The Board noted the report.	

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2.6	**Safeguarding Children Annual Report** The Board received and noted the Annual Safeguarding Children Report which had been discussed at the Quality and Safety Committee (QSC) on 18 July 2019. The CN outlined the key elements within the report including that a key area for improvement included staff safeguarding supervision which would be discussed at QSC in six months. The Chairman noted that the QSC had been substantially assured by this report. The Board noted the report.	
3.0	**FINANCE**	
3.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on 18 July 2019. The Committee had a robust discussion about the Board Assurance Framework risks for both finance and information technology and found that the new format with clearer visibility on the supporting risks and actions was helpful. The Committee recognised the fragility of the financial position despite being on plan in month. There was pressure on the pay budget and the cost improvement programme (CIPs) with further schemes to be identified. The Committee was also cognisant of the impact of having a block contract and the need to manage this effectively. The Committee received and discussed a report on procurement which had improved significantly and was helping to improve efficiency. The Board noted the report.	
3.2	**Finance and Investment Committee (Estates) Report (FIC(E))** Tim Wright, Non-Executive Director lead for estates, provided an update on the meeting held on 18 July 2019. The Committee now had a complete picture of the estates issues as a result of the new governance processes in place and were assured by the way the estates team were addressing these issues. The scale of the task and the costs implications should not be underestimated and there was still concern about the ability of the Trust to deliver at the required pace given the tight resources. The Committee would be looking at the longer-term plans and actions. Clinical teams were very aware of the water safety issues and were engaging with the Estates Team to ensure that any potential risks areas were addressed quickly. Tim Wright noted that at present focus is on meeting regulatory requirements, addressing urgent issues and developing the long term estates strategy. The Board noted the report.	
3.3	**Month 03 Finance Report** The CFO reported that at Month 3 the Trust was on plan but there were significant challenges. Income was above target and expenditure was favourable against budget but the financial position was very pressured. CIPs were currently on track with many of the schemes scheduled to deliver at the latter part of the financial year. From the high-level forecast at month three, there was an overspend on pay in some areas. The Trust was closely managing the block contract. There were emerging issues around	

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	the national supply chain and an issue related to estates which would incur additional costs. The Trust's capital budget was on plan. The Board noted the report.	
4.0	**Strategy**	
4.1	**Corporate Objectives (Q1) Report** The CSO provided an overview of the exception report for delivering the corporate objectives at quarter one (Q1). Of the 18 objectives, eight had been rated green, seven amber, two red and one had no milestones for Q1. There were now key metrics for measuring success against objective one. In response to Ann Beasley's comments about the lack of progress on the diversity and inclusion objective, the CPO reported that progress had been hindered by capacity issues which are currently being managed with additional resources being sourced. Sarah Wilton queried the delay to the listening events which were considered a useful source of information and the CPO reported that there was already a good level of understanding about the key issues. The Chairman noted that there was a degree of anxiety around the progress being made on the workforce objectives. The CPO reported that these objectives were key priorities but there had been significant resourcing issues and he would discuss these further at the Board development session in August. The Board noted and approved the report.	
4.2	**Corporate Support Strategies** The Board received and noted the update on progress to develop the supporting strategies and that each Board Committee would receive progress reports on relevant supporting strategies.	
4.3	**Outpatients Strategy** The CSO reported that the outpatient strategy was a key part of the Trust's overarching strategy and it linked to the NHS Long Term Plan and national priorities to transform outpatient services. The strategy had been developed following engagement with staff, patients and other stakeholders. The implementation plans were being developed to include wider programmes of work across the South West London but there had been good progress on digitalisation. The plan for the current year focused on workforce, estates and digitalisation. The DDO-CWDT reported that key workstreams had focused on patient pathways and estates and getting the workforce model right. Tim Wright noted that the prominence of IT leapt out from the proposed strategy and queried whether the Trust was missing a step by not having an ICT strategy which covered the financial implications and interdependencies of long-term ICT systems. It would also be useful to understand where other digital leaders had implemented similar systems. Sarah Wilton commented that the strategy did not highlight the role of the Integrated Care System (ICS) or GPs. The strategy also had one significant weakness in that there were no significant peer analysis/comparators. Stephen Collier noted that the strategy was coherent with the exception of the information around the three supporting pillars and asked who the leads	

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	were and about the key priorities. The CSO advised that the detailed digital strategy would be presented to Finance and Investment Committee which would provide further clarity. Whilst the outpatients' strategy spoke to the national transformation programme, the ICS did not have a system-wide solution and therefore the paper focused on addressing the Trust's outpatient challenges. The implementation plan was a separate operational document which detailed how the outpatients team would focus on getting the basics right. The CTO added that the work around planned care transformation was part of the work currently being done by the outpatients' team. The Trust was benchmarking with some global digital exemplars such as Oxford and it was noteworthy the Trust was not as far behind system leaders with good examples including the implementation of Cerner. The Trust had been very clear with commissioners that this workstream related to planned care and getting patients the right care in the right place. The Trust was working with system partners on national benchmarking and technology development. The DDO-CWDT reported that the detailed plan by speciality was being developed with the focus being on improving the patient pathway. The Chairman reflected that some of the NEDs were not sighted on the digital strategy and asked the executive team to think about how to ensure the full Board was engaged and understood the key elements before it was presented for approval. The Chairman reflected that the Board needed to hear more about what underpinned the strategy and agreed to work with the CSO to develop what needed to come back to the Board. The Board agreed that it could not approve the outpatients' strategy, but did agree the underlying vision expressed.	
5.0	**Governance**	
5.1	**Clinical Negligence Scheme for Trusts (CNST) – Maternity Services** The Board reviewed the self-assessment against the ten CNST safety standards in relation to maternity services as part of the process for applying for a rebate from NHS Resolution. The Board noted that this had been reviewed by the Quality and Safety Committee as observed earlier in the meeting. The CN advised that reference to the Trust Board receiving reports was incorrect and should instead state that the Quality and Safety Committee would receive these reports. The Board approved submission to NHS Resolution and gave the Chief Executive delegated authority to sign the declaration on behalf of the Board.	
5.2	**Board Assurance Framework** The Board conducted a detailed review of the Board Assurance Framework (BAF). The CN reported that unlike other risks areas which had been scrutinised at relevant Board Committees the workforce and organisational development risks had not yet been scrutinised by the Workforce and Education Committee (WEC) which was due to meet on 8 August 2019. The strategic risks had been aligned to the corporate risks. Work continued to strengthen the assurance ratings process and create greater consistency and structure. In reviewing the report, the Board was asked to consider whether or not it was content with the proposed assurance ratings.	

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	The Chairman noted that the BAF report and progress had taken a big step forward but recognised there were still elements of work being undertaken and there had been very good discussions and debates about relevant risks at the Finance and Investment and Quality and Safety Committees in July. The Chairman also flagged concerns from the NEDs about SR11-15. Ann Beasley commented that the risk rating for SR12 was low at nine and the CPO advised that this would be reviewed by WEC in August. Key actions related to SR12 were being progressed at pace and WEC would consider a separate paper on diversity and inclusion which outlined the actions that would be taken to mitigate the risk. Sarah Wilton noted that the risk rating for SR11 was also too low, with other Board members concurring. Stephen Collier noted that SR14 should reflect the developing risk around headroom. The Chairman summarised that the Board had concerns about scoring, assurance rating and the text contained in strategic risks 11, 12 and 13. The CPO advised that WEC would review these risks and in relation to SR14 and the key actions around retention plans would be included in the descriptor. The CFO noted that given that risks score for SR8 and 9 in relation to capital SR12 should be rated as a score of 16. The CPO noted that he would review the risk scoring for SR14 reflecting on the interdependences with other risks. The CN reported that the SR5 and SR6 had been developed in conjunction with the CSO. SR6 was scored a risk rating of nine based on all the work the Trust is doing around SWL and with external partners. Sir Norman Williams expressed anxiety around this rating given the Board had limited assurance around the different moving parts in the external environment and the NHS landscape. In addition, reflecting on the contributing risks scores, the rating for SR5 should be increased to 16. The Chairman, with many Board members concurring, noted that there was a key underpinning risk not included under SR6 which related to the relationships within the system. This risk needed to be scored higher to reflect this uncertainty around where the Trust fits into an uncertain environment. A discussion on where the ownership for changing risks rating ensued and it was clarified that whilst the Risk Management Executive played a key role in ensuring that there was a clear structure and approach for risk management and risk rating, the responsibility for affixing the appropriate risk rating for BAF risks lay with the Board and the CN should ensure the Risk Management Strategy was updated to reflect this. The Chairman summarised the actions as follows: • **The Workforce & Education Committee (WEC) would review the workforce and organisational risks to ensure they adequately articulated the key elements of risks and were appropriately rated giving consideration to the wider BAF and other interdependent risks;** • **The Board approved the risks and ratings in relation finance and quality; and** • **Further work would be carried out to increase the rating for strategic risk 5 and the CN and Chairman would work on the description of strategic risk 6 with the view of increasing the risk rating to 12.**	**WEC** **Chairman CN**
5.3	**St George's Hospital Charity Report** The Board received and noted the quarter one report from the St George's	

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	Hospital Charity. The CEO reported that the Trust had secured charitable funding from the Charity to develop its intranet which would provide support to staff and make a huge difference in how teams work.	
5.4	**Horizon Scanning Report: Emerging Policy, Regulatory, Statutory and Governance Issues (Q1)** The CCAO presented the quarter one horizon scanning report, which was the first of a new series of quarterly updates on emerging political, legislative, policy and regulatory issues that have relevance to the Trust and was intended to support the Board in providing a regular and systematic review of key developments. The Board welcomed the report and noted that it was very useful to receive a report that provided a comprehensive overview of emerging issues which could impact directly or indirectly on the Trust.	
5.5	**Workforce & Education Committee Terms of Reference Review** The Board approved the Workforce and Education Committee terms of reference subject to inserting an additional reference to the Committee's role in overseeing diversity and inclusion in the section on the Committee's purpose. It was also noted that now that Board Directors' job titles had been updated, these would need to be updated in the terms of reference.	
6.0	**CLOSING ADMINISTRATION**	
6.1	**Questions from the public** The Chairman invited questions from the public. Trust Governor, Mia Bayles, reflected that the Board may find it useful to introduce the flash card system mentioned in the discussions about never events. It was noted that this would indeed be given due consideration. The CN reported that all wards and theatre areas had white boards in response to a comment from Hazel Ingram, Patient Participation and Engagement Representative.	
6.2	**Any other risks or issues identified** There were no other risks or issues identified that were not already considered by the Board as part of the discussions in the Board Assurance Framework.	
6.3	**Any Other Business** There were no matters of any other business raised for discussion.	
6.4	**Reflections on the meeting** The Chairman invited the Sir Norman Williams to offer reflections on the meeting. Sir Norman William commented that the meeting and the quality of the discussions were good. The quality of the papers, however, was variable and needed to improve. In particular, the executive summaries needed further attention to ensure responsible Directors teased out the key points that the Board needed to consider; too often executive summaries	

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	appeared to be an afterthought. The feedback from Board visits were very instructive and it was important to keep the emphasis on staff and patients. It was also important that the feedback collated was reviewed to ensure actions were taken forward. It was good to see the level of challenge in the discussions about the integrated quality and performance reports but it would be useful to have had more challenge from the executive directors. There needed to be more work on effective measurement of the impact and outcomes of transformation and QI projects. The question of how learning was embedded across the Trust needed sustained attention and further work is needed in this area. The NEDs were not assured by the outpatients' strategy given the absence of an implementation plan in the document. Whilst it was fully understood that some reports needed robust discussion by the full Board, it may be useful to utilise the Board Committees to sharpen the discussion and not repeat previous debates, for example on the CNST maternity report. The horizon scanning report was very good, and Sir Norman commented that he felt that more time should have been allocated to this and that there was not enough discussion and reflection on the key implications for the Trust.	
7.0	**VALUES AWARDS, PATIENT & STAFF STORIES**	
7.1	**Values Award** The Board welcomed Karen Langley, Patient Pathway Coordinator in Gynaecology, who was nominated for a Living Our Values Award by a patient she supported. The Board thanked Karen for her contribution to the Trust, supporting the patient and demonstrating the Trust's values. The Chairman presented the award.	
7.2	**Staff Stories: Ward and Department Manager Leadership Development Programme and Quality Improvement Projects** The Board welcomed Robert Bleasdale, Deputy Chief Nurse (DCN), Donna Morgan, Senior Sister, Champneys Ward on the Renal Unit (DM) and Ma Rube Simba, Staff Nurse, Kent Ward in Neurology (MRS). The DCN provided an overview of the ward and department manager leadership development programme which spanned eight study days and included seven taught modules covering leading the ward, self as leader, leading at the Trust, working with others and leading the service. To complete the course participants needed to complete a quality improvement project and present the results at the end of the course, subject themselves to a 360 degree feedback review, and complete the two-day passport to management course. DM introduced her quality improvement project on advanced care planning for renal patients noting that the driver for the project was the established research which showed that through structured discussions with patients and their families the Trust could help people live well right to the end of their life. MRS outlined her project which resulted in the development of a protocol which described the roles and responsibilities of a Nurse in-charge/Charge Nurse when running a shift. Both MRS and DM outlined the value they both attained from completing the leadership programme and how they had used their learning to support not only their team but also other teams across the Trust and externally.	

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		Action
	The Board noted the presentation and posters and thanked MRS and DM for their passion and focus.	
Date of next meeting: Thursday 26 September 2019 at Room H2.6, Hunter Wing, St George's, University of London		

Trust Board Action Log Part 1 - September 2019

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB27.06.19/01	**Integrated Quality and Performance Report (IQPR) (Month 02)**	It was agreed that the CMO and DHROD would look into reviewing quality of appraisals and report to the Workforce and Engagement Committee.	19/12/2019	CMO & CoP		**NOT DUE**
TB27.06.19/02	**Clinical Governance Review**	The CMO agreed to present a formal report to the Board on the metrics which will be used to measure impact of implementing the recommendations in the clinical review.	31/10/2019	CMO		**NOT DUE**
TB27.06.19/03	**Clinical Governance Review**	It was important to maintain the balance between pace and realism and CMO should include an update on implementation of the action plan in the next report to the Board.	31/10/2019	CMO		**NOT DUE**
TB25.07.19/01	**Board Assurance Framework (Quarter 1(19-20) Review)**	The Workforce & Education Committee (WEC) would review the workforce and organisational risks to ensure they adequately articulated the key elements of risks and were appropriately rated giving consideration to the wider BAF and other interdependent risks; and Further work would be carried out to increase the rating for strategic risk 5 and the CN and Chairman would work on the description of strategic risk 6 with the view of increasing the risk rating to 12.	31/10/2019	WEC/CN/Chairman	These actions have been completed and will be reflected in the next iteration of the BAF presented to the Board in October.	**NOT DUE**

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Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Chris Rolfe, Associate Director of Communications		
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		
Equality Impact Assessment	N/A		
Previously Considered by:	N/A	**Date:**	N/A

St George's University Hospitals NHS
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Chief Executive's report to the Trust Board – September 2019

Developments in our external environment

I want to begin my report to the Trust Board by talking about the appointment of Gillian Norton, our Chairman, as the new Chairman in Common for both St George's and Epsom and St Helier University Hospitals NHS Trust.

NHS Improvement announced Gillian's appointment last week, and she will formally take up the position of Chairman for Epsom and St Helier from 1 October. She takes over from Laurence Newman, who retires on 30 September at the end of his term of office.

On a personal level, I am delighted for Gillian. The positive impact she has had here at St George's should not be under-estimated, and I have learned a huge amount from her. Like Laurence before her, I am also sure she will do a fantastic job at Epsom and St Helier, in addition to her existing commitments here at St George's.

Of course, Gillian is not the only Chairman in Common in London, or indeed nationally; but I am confident that, for us, this new arrangement will only help and benefit patients, staff, and the communities our different Trusts serve.

In reality, St George's and Epsom and St Helier already work closely in a number of ways – for example, approximately 60 of our consultants routinely work across both Trusts, and multiple sites; and many of our services (such as renal) look after the same patients, albeit for different needs and at different stages of their treatment.

As two organisations working together so closely, I am confident we can continue to learn a huge amount from each other, not least because the challenges we face – such as high demand for our services, and an ageing population – are arguably better tackled as two providers working in tandem. In short, I am excited about the potential for closer collaboration, which was a key driver in our five year strategy published in April this year.

Delivering on our vision and strategy

Since the last Trust Board meeting in July, we have made further progress in delivering our new vision and strategy – particularly our strategic priority to build **stronger foundations**.

A number of examples stand out. At the end of September, we completed the roll-out of iClip (Cerner Millennium) to Queen Mary's Hospital in Roehampton. We completed the roll-out of iClip at St George's last year, so to have extended the system to Queen Mary's is a huge step forward.

Of course, this represents significant change for a number of staff; however, the feedback from staff at Queen Mary's so far has been positive and it means that, for the first time, we have one core patient administration system across the Trust that all staff are using, and inputting patient information into. This is better for patients, and staff, who historically have had to work with multiple systems.

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I am also pleased to say that we are continuing to reduce the number of people waiting longer than they should for planned care. At the end of July, only 6 patients were waiting more than 52 weeks for treatment. This is still six too many, but given that in previous years the number of patients waiting more than a year has been in the hundreds, we should be positive about the progress we have made.

I am also pleased with the progress we have made in complaints handling in recent months. The response rate and timeliness of our complaint responses has improved dramatically, which is a great start. However, the quality of our responses is equally important, and this is something we are stressing to teams, and providing them with support for. The very best organisations place huge value in complaints, and the importance of learning from them – and this is something we should aspire to as an organisation.

Unfortunately, we are finding it much harder to deliver emergency care performance consistently at present. I know how hard staff are working, but we need to get a firmer grip on the various issues that impact on performance; and get a better understanding of why waiting times fluctuate so much more than they should. Emergency care performance is a challenge for all Trusts, but I know there is more we can do to deliver improvements, and in a sustainable way.

Celebrating our staff

As always, our staff continue to deliver fantastic outcomes for our patients, a number of which are deserving of mention.

One of our patients, Anthony Lelliott, had his hand saved by our surgeons after an accident at work. His story was the subject of media headlines across the nation, and even as far afield as New Zealand! Some stories really strike a chord, and Antony's story – and the multi-disciplinary team here at St George's who looked after him – was one such example.

I often talk about our ward accreditation programme, but I am really proud of this initiative, and how it is helping to drive up standards across the organisation. In recent weeks, the Surgical Admissions Lounge, Paediatric Intensive Care Unit and Nye Bevan ward at St George's have all secured gold for the first time – which is a massive achievement, and something we are keen to celebrate, not least as an incentive for other areas!

Our staff do so much for patients beyond the provision of hospital care. Last weekend, our organ donation team held their annual Tree of Life ceremony, which recognises the courage of those patients at St George's, and their families, who donate organs. I wasn't able to attend the event this year, but I know it was an emotional and uplifting occasion, as it always is. Huge credit for the many staff involved in putting this fantastic event together.

Key appointments/administration

There have been a number of significant appointments since the last Trust Board meeting in July.

First of all, however, I would like to say a personal thanks to Professor Sir Norman Williams, who leaves his Non-Executive role at St George's this week to take up a new position as

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Chair of the Independent Reconfiguration Panel. Sir Norman has been a key part of the Trust's improvement journey in recent years, and I know this is something Gillian will want to touch on later in the meeting as well.

In terms of new appointments, I am delighted that Dr Jane Evans will be taking on the role of Divisional Chair for our Medicine and Cardiovascular Sciences from the start of next month. Jane is highly capable, and has worked at St George's for a number of years, so she will be a fantastic addition to the senior team.

As part of our work to strengthen our governance processes, the Trust Executive Committee had introduced a new structure, monthly rhythm and ways of working. Reflecting this, earlier this month we agreed a new terms of reference for the Committee, which is attached to this paper for the Board's review.

Finally, I am looking forward to our Annual Members' Meeting, which follows the Trust Board meeting on Thursday 26 September. This year, we are trialling a marketplace event for the first time ahead of the formal meeting, including health checks provided by our cardiology and diabetes teams. I am sure the new format will be a success but, as important, provide local people and stakeholders with another opportunity to hear about the progress we are making, and answer any questions they may have.

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Meeting Title:	Trust Executive Committee		
Date:	26 September 2019	**Agenda No**	**1.5.1**
Report Title:	Trust Executive Committee Terms of Reference		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Assurance		
Executive Summary:	Wide-ranging changes to the Trust Executive Committee were introduced in July 2019 as part of the establishment of the new Trust Accountability Framework. To support TEC's new format, new Terms of Reference have been developed. These set out: • the purpose of TEC and its duties • the composition of the group (Executive Directors and Divisional Chairs) and regular attendees • the quorum for the group (six members, including at least three Executive Directors) • the groups reporting into TEC, all of which should provide reports to TEC as part of the new reporting structure • the reporting of key issues discussed, decisions taken and actions agreed to the Trust Board • the need to review the terms of reference on an annual basis		
Recommendation:	The Board is asked to note the terms of reference for the Trust Executive Committee.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Without appropriate terms of reference for its Committees, there is a risk that the Trust may not have effective decision-making structures which could result in either poor decisions or a delay in decision-making.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality Impact Assessment	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	Trust Executive Committee Terms of Reference		

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TRUST EXECUTIVE COMMITTEE

Terms of Reference

1. NAME OF GROUP

The Committee shall be known as the Trust Executive Committee (TEC).

2. AUTHORITY

Establishment: The Trust Executive Committee has been established as an executive management Committee of the Trust Board.

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

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

Cessation: The Trust Executive Committee is a standing group within the governance structure and can only be disbanded on the authority of the Trust Board.

3. PURPOSE OF THE GROUP

The Trust Executive Committee is the most senior executive decision-making body of the Trust and is responsible for the effective operational management of the Trust. It will advise and is responsible to the Trust Board on all matters relating to Trust operations. Its role is to focus on the most significant strategic issues requiring decisions or consideration by the management of the Trust, with a particular focus on final review and approval. The purpose of the Committee is to:

i. Oversee and ensure the effective implementation and delivery of the Trust strategy, as agreed by the Trust Board
ii. Oversee organisational performance and agree actions to improve performance where appropriate
iii. Make management decisions on issues within the remit of the Trust Executive Committee
iv. Oversee the effectiveness of operational governance and risk management processes
v. Escalate issues to the Trust Board as appropriate, and examine issues referred to it by the Trust Board and the assurance Committees

4. DUTIES OF THE GROUP

The Trust Executive Committee will discharge the following duties:

i. Review Trust-wide organisational performance, including quality and safety, finance, access standards, and workforce and act
ii. Consider the Trust's draft annual business plan, ahead of agreement by the Trust Board
iii. Prioritise and take decisions in relation to the use of resources
iv. Take decisions on investment in line with the financial approval limits set out in the Trust's Scheme of Delegation and scrutinise investment decisions prior to consideration by the Trust Board where required
v. Agree entries on the Board Assurance Framework, and review the supporting strategic risks on the corporate risk register, prior to their consideration by the Trust Board
vi. Review the performance of each of the Trust's divisions (clinical and corporate)
vii. Receive reports from and scrutinise the work of each corporate area

viii. Review the work and effectiveness of the groups reporting into the Trust Executive Committee, including reviewing annually their terms of reference, and request items on their agendas requiring further consideration of issues as necessary.
ix. Review regular, periodic and occasional papers to be presented by the executive team to the Trust Board
x. Examine any issues referred to it by the Trust Board or the assurance Committees of the Board
xi. Identify and agree issues to refer to the Care Quality Commission and NHS England and NHS Improvement, and other bodies as appropriate

5. CHAIRPERSON

The Chief Executive will chair this group. In his/her absence, the Deputy Chief Executive will typically take the chair. In the absence of both the Chief Executive and Deputy Chief Executive, an individual to be nominated by the Chief Executive will take the chair.

6. COMPOSITION OF THE GROUP
MEMBERSHIP

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

Title	Role in the group
Chief Executive	Chair
Deputy Chief Executive and Chief Finance Officer	Deputy Chair
Chief Medical Officer	Member
Chief Nurse and Director of Infection Prevention and Control	Member
Chief Operating Officer	Member
Chief People Officer	Member
Chief Corporate Affairs Officer	Member
Chief Strategy Officer	Member
Chief Transformation Officer	Member
Divisional Chair, Children, Women's, Diagnostics and Therapies (CWDT) Division	Member
Divisional Chair, Medicines and Cardiovascular (MedCard) Division	Member
Divisional Chair, Surgery, Neurosciences, Cancer and Theatres (SNCT) Division	Member

Members of the Committee should make every effort to attend all meetings of the Committee. All members, both Board Directors and Divisional Chairs, are expected to attend a minimum of 75% of all TEC meetings. Deputies can attend the group with the permission of the Committee chairperson, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

ATTENDEES

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

Title	Role in the group / committee	Attendance guide
Divisional Director of Operations, CWDT	Regular Attendee	E.g. Dependant on the agenda / as and when required / every meeting

Title	Role in the group / committee	Attendance guide
Divisional Director of Operations, MedCard	Regular Attendee	Every meeting
Divisional Director of Operations, SNCT	Regular Attendee	Every meeting
Chief Information Officer	Regular Attendee	Every meeting
Associate Director of Communications	Regular Attendee	Every meeting
Director of Quality Governance	Occasional Attendee	Dependent on agenda
Deputy Chief Finance Officer	Occasional Attendee	Dependent on agenda

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

7. QUORACY

Number: The minimum number of members for a meeting to be quorate is six members, including at least three Board Directors (either voting or non-voting). Attendance by a nominated deputy will not count towards the quorum.

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

8. DECLARATION OF INTERESTS

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

9. MEETING FREQUENCY

Meetings of the Trust Executive Committee shall be held weekly according to the following schedule:

Week	Focus of meeting
1	Divisional and Corporate Reports (including priority issues, reports from sub-groups of TEC, reports from corporate areas)
2	Programme Board (including reports from each of the established workstreams, issues of importance)
3	Pre-Trust Board (including all regular and periodic executive reports to the Trust Board, issues of importance)
4	Divisional Performance Reviews (including Integrated divisional quality and performance reports, issues of importance)
5 (if applicable)	Additional reports for consideration, TEC workshops

10. MEETING ARRANGEMENTS / SECRETARIAL

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i. An annual schedule of meetings of the Trust Executive Committee shall be established prior to the start of each financial year;
ii. Secretarial support (including minute taking duties) will be provided to the group by the Corporate Governance team, overseen by the Chief Corporate Affairs Officer. In the eventuality that this support is not available, the chair should be notified before the meeting in order to ensure that alternative arrangements can be made.
iii. The agenda for the meeting will be agreed and compiled through discussion between the chair and Chief Corporate Affairs Officer.
iv. All papers and reports to be presented at the Trust Executive Committee must be submitted to the identified secretarial support for the group at least 3 working days prior to the meeting (the Friday before the meeting).
v. The agenda and supporting papers for the meeting will be forwarded to each member and planned attendees a minimum of 3 working days in advance of the meeting taking place.

11. RELATIONSHIP WITH OTHER GROUPS/COMMITTEES

The groups reporting to the Trust Executive Committee are:

- Business Continuity Steering Group
- Divisional Management Boards
- Estates Management Group
- Financial Systems Management Group
- Informatics Governance Group
- Investment and Disinvestment Group
- Major Incident Steering Group
- Patient Safety and Quality Group
- People Management Group
- Risk Management Executive

Each of the groups outlined above will report to the Trust Executive Committee through a report provided by the chair of that group to the Week 1 Committee meeting. A standing item will be included on the agenda for the Trust Executive Committee in Week 1 for chairs of these reports, which, at minimum, should include a summary of the issues considered by the group, actions agreed, and any issues to be escalated to the Trust Executive Committee.

12. REPORTING

The Trust Executive Committee is accountable and will report to the Trust Board.

The chair of the Committee will prepare a summary report to the Trust Board ahead of each meeting of the Board setting out key issues discussed, actions agreed and any issues to be referred or escalated to the Board. This may, from time to time, require separate reports to be prepared for the public (Part 1) and private (Part 2) Board meetings, as directed by the chair of the Committee.

13. AGENDA

STANDING AGENDA ITEMS

i. Apologies;
ii. Declarations of Interest;
iii. Minutes of the Previous Meeting;
iv. Action Log and Matters Arising;

v. Key Issues
vi. New Risks, Issues and Matters for Escalation to the Board;
vii. Issues to Report to the CQC;
viii. Any Other Business
ix. Reflection on Meeting Effectiveness

FORWARD CYCLE OF BUSINESS

A forward plan for the items and reports to be received by the Committee shall be prepared ahead of each new financial year.

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

14. REVIEW OF TERMS OF REFERENCE

These Terms of Reference shall be subject to an annual, scheduled review as scheduled on the forward cycle of business. This review should consider the performance of the Trust Executive Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. An annual Committee effectiveness survey will be prepared for the chair of the Committee by the Chief Corporate Affairs Officer.

These Terms of Reference were last reviewed on 4 September 2019.

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APPENDIX 1

TRUST EXECUTIVE COMMITTEE FORWARD CYCLE OF BUSINESS

2019/20: MEETINGS

Wednesday the	Trust Board	week number		Duration of T
03-Jul		1	Corporate and divisional reports	2 hrs
10-Jul		2	Change Board	2hrs
17-Jul		3	Formal TEC (pre-Board)	2 hrs
24-Jul	**25-Jul**	4	Performance reviews	3 hrs
31-Jul		Fallow		2 hrs
07-Aug		1	Corporate and divisional reports	2 hrs
14-Aug		2	Change Board	2 hrs
21-Aug		3	Formal TEC (pre-Board)	2 hrs
28-Aug	**29-Aug**	4	Performance reviews	3 hrs
04-Sep		1	Corporate and divisional reports	2 hrs
11-Sep		2	Change Board	2hrs
18-Sep		3	Formal TEC (pre-Board)	2 hrs
25-Sep	**26-Sep**	4	Performance reviews	3 hrs
02-Oct		Fallow		2 hrs
09-Oct		1	Corporate and divisional reports	2 hrs
16-Oct		2	Change Board	2 hrs
23-Oct		3	Formal TEC (pre-Board)	2 hrs
30-Oct	**31-Oct**	4	Performance reviews	3 hrs
06-Nov		1	Corporate and divisional reports	2 hrs
13-Nov		2	Change Board	2hrs
20-Nov		3	Formal TEC (pre-Board)	2 hrs
27-Nov	**28-Nov**	4	Performance reviews	3 hrs
04-Dec		1	Corporate and divisional reports	2 hrs
11-Dec		2	Change Board	2 hrs
18-Dec	**19-Dec**	3	Formal TEC (pre-Board)	2 hrs
25-Dec		4	Performance reviews	3 hrs
01-Jan		Fallow		2 hrs
08-Jan		1	Corporate and divisional reports	2 hrs
15-Jan		2	Change Board	2hrs
22-Jan		3	Formal TEC (pre-Board)	2 hrs
29-Jan	**30-Jan**	4	Performance reviews	3 hrs
05-Feb		1	Corporate and divisional reports	2 hrs
12-Feb		2	Change Board	2 hrs
19-Feb		3	Formal TEC (pre-Board)	2 hrs
26-Feb	**27-Feb**	4	Performance reviews	3 hrs
04-Mar		1	Corporate and divisional reports	2 hrs
11-Mar		2	Change Board	2hrs
18-Mar		3	Formal TEC (pre-Board)	2 hrs
25-Mar	**27-Mar**	4	Performance reviews	3 hrs
01-Apr		1	Corporate and divisional reports	2 hrs
08-Apr		2	Change Board	2hrs

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2.1

Meeting Title:	**Trust Board**		
Date:	**Thursday 26 September 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 meetings in August and September 2019.		
Recommendation:	The Board is asked to note this report.		
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		

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Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on Thursday, 22 August and 19 September 2019 and agreed to bring the following matters to the Board's attention:

1. Deep Dives

The Committee's deep dives in August and September focused on Thematic Serious Incident Analyses conducted by the Trust. These reviews were identified and agreed in conjunction with our commissioners and are part of a series of reviews looking at themes, root causes or contributory factors in completed serious incident investigations.

The Committee's discussions are summarised below and follow-up and lessons learned reports will be programmed in the Committee's forward plan.

1.1. Thematic Serious Incidents Analysis: Radiology/Imaging (August)

This review focused on eleven serious incidents in the radiology/imaging service. Four key themes for improvement including interpretation of imaging, reporting/alerting speciality about unexpected results, results by requesting speciality and insufficient communication between clinicians and radiology were identified.

The Committee were reassured by the steps taken to address these issues including the introduction of generic emails (rather than to individual's email addresses) to share imaging results with multidisciplinary teams, introduction of daily reviews of imaging results in the emergency department and the introduction of an audit programme to review compliance with actions. The Committee queried the robustness of the mechanisms to ensure the embedding of the actions and ensuring that where patients are outside the Trust's catchment imaging/radiology results were effectively shared with appropriate parties. The Committee were reassured there would be a robust audit programme and from those results the Trust would be able to gain assurance (or not) that the actions to address the key themes are embedded and effective. The Committee were also pleased to note that imaging/radiology teams routinely contact GPs to advise of results for patients outside the Trust's catchment.

1.2. Thematic Serious Incidents Analysis: Communications (September)

This review looked at 30 serious incidents and identified that communications was either a root cause or contributory factor in 27 cases. There were a few emerging themes from the review including treatment escalation plans, clarity and lack of follow-up in patient pathway and policy adherence. These themes are being addressed through a number of workstreams including the development of an accessible policies hub, improved documentation with introduction of iClip (trust-wide), the quality improvement programme for outpatients and the introduction of the critical care outreach team. The fundamental issue however is related to the breakdown of communication in handover and ward rounds. There are areas in the Trust were standard templates are used for ward rounds and handover but it is recognised that there needs to be standardisation across the Trust (as far as possible) and this work will be driven through a quality improvement initiative. The Committee endorsed the plan to conduct a baseline audit of ward rounds and handovers in pilot areas and then re audit following localised developed handover template implementation to review effectiveness.

2. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance. On review of the month 04 IQPR, the Committee welcomed the report that the Trust would conduct additional audits to ascertain if there were any underlying issues that were driving the reduction in compliance with appropriate response to early warning scores for adults. The Committee were also

pleased to hear about the very good progress made against responding to complaints and that focus was now on sustaining this good performance and embedding learning from complaints. The performance was further demonstrated in the Complaints Performance report which was presented to the Committee in September and reported below.

In month 05, the number of VTE risk assessments being carried out had reduced significantly which the Committee heard was related to a change in national guidance on inclusion criteria. This is being addressed and with the use of iClip to capture this data it is expected this will improve. There is some targeted work in Maternity and the Clinical Decision Unit (CDU) to support this.

The Committee also explored how the Trust had managed the pressure in the emergency department on 16 September and noted that the Trust had managed the high demand sufficiently to ensure that it could deescalate OPEL 3 status 48 hours later as a result of close working and collaboration across the hospital.

3. Exception Report: Care Quality Commission Outstanding Actions

The Committee noted that the Care Quality Commission (CQC) action related to achieving mandatory training targets remained outstanding as a result of not being able to achieve 85% on resuscitation training. The Committee heard that despite additional resources, training and electronic training materials being put in place attainment of the target remained challenged. The committee was informed that the Trust Executive Committee had requested a trajectory till December and that this was being produced. The surgery division has given assurances that there is sufficient capacity and variability in delivering the training to achieve compliance by December 2019.

4. Nurse Staffing Report (Planned vs Actual)

The Committee considered the nurse staffing reports and noted that the overall fill rate for July was 93.72% and 94.6% in August. These fill rates were in the normal limits with any exceptions effectively managed ensuring there were no safety issues.

5. Cardiac Surgery Update

The Committee considered the monthly Cardiac Surgery Updates which is discussed later on the Board agenda.

6. Annual Reports

6.1. Learning Disabilities Services

The Committee considered the annual report from the learning disabilities services and noted, with pleasure, that despite a 9.2% increase in activity the service had only received one complaint in the last year. In addition, outstandingly in the last five years there had been no avoidable deaths or serious untoward incidents in the Trust related to patients with learning disabilities. The service is truly an exemplar service given the size of the team and level of activity.

6.2. Infection Prevention and Control Annual Report 2018-19

The Board will receive the annual Infection Prevention and Control 2018-19 at its October meeting and the Committee welcomed the report noting that there were no arising issues the Committee had not previously considered. The Committee where assured by the content of the report and plans to drive improvement.

6.3. Duty of Candour Annual Report 2018-19

Again, the Committee was pleased to receive the duty of candour report noting that the Trust was 100% complaint with completing duty of candour but it was recognised that there was more work to complete duty of candour within 20 workings days.

6.4. National Inpatient Survey 2018

The Committee considered the results of the national inpatient survey which was undertaken with a sample of patients that had been inpatients at the Trust in July 2018. 460 patients out of 1250 eligible patients responded to the survey. The results reflect that the Trust had made improvements in some areas with further work required around discharge, quality of food and sleeping areas with opposite sex. The Committee also noted that the Patient Engagement and Participation Group will have a role to play in developing actions to drive improvements in these quality areas.

7. Quality Improvement Academy Quarterly Report

The Committee considered the quarterly report from the quality improvement academy and noted the good work being undertaken. Whilst the report had improved the Committee urged the development of a dashboard to better enable tracking of the programmes of work and the need for an even more coordinated and integrated approach.

8. Cost Improvement Programme (CIP) Approval Revised Quality Impact Assessment (QIA)

The Committee noted and was assured by the progress made to enhance the CIP/QIA processes in the Trust.

9. Referral to Treatment (RTT)

In August, prior to consideration by the Board the Committee considered the proposals to return to referral to treatment reporting at the Queen Mary's Hospital site. The Committee endorsed the plans for returning to RTT reporting and the deployment of iClip having noted the good progress made against the project workstreams and the external assurance on readiness to go live.

The Committee also considered an interim report on the Clinical Harm Review Programme and noted that the programme had been formally closed by the commissioners and the Trust. The final report is expected in October / November 2019 and will be presented to the committee.

In September, the Committee heard that the Trust had returned to RTT reporting at the QMH site and iClip had been deployed following approval by the Board and the Trust Executive Committee. Quarterly reports will be presented to the Committee on RTT performance. The committee expressed its gratitude to everyone involved and especially the IT department who went over and beyond during the weekend of deployment.

10. Complaints Performance

The Committee received the report on Complaints Performance for April-June 2019. It is evident that the establishment of a more senior team and weekly complaints CommCell meetings are driving significant improvements. The total complaints response performance in August was 99% against the 95% target and from current data it is forecast that Trust would achieve 100% in September 2019. The committee were pleased to note the significant improvements and sought assurance on sustainability.

11. Infection Prevention and Control Briefing

In response to a previous action the Committee received a detailed briefing on clostridium difficile (CDI) and legionella. The Committee noted that the Trust had taken all necessary mitigations in relation to managing legionella but noted that the Trust needed to remain vigilant.

The Committee were also apprised of the recent cases of CDI on Dalby Ward and enterovirus incidents that were part of the report circulated to the Board and that all steps have been taken to manage these issues effectively.

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

The Committee received the summaries from the PQSG meetings held in July and August. The Committee received an update on the Trust's processes/practice for decontamination of the nasoendoscopes. The Trust will have introduced single use disposable scopes for high volume clinical settings by the end-September. This will further enhance the current compliant processes.

The Committee also noted that the Critical Care Outreach Team will be launched on a phase basis with full service available in February 2020. The first phase will be available early November providing 24/7 outreach services supported by a multi professional team.

13. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Registers which focused on the four strategic risks which fall within its remit. In light of the challenges in the Trust's emergency department, as discussed above, the Committee asked that the risk ratings be reviewed and increased for the corporate risks pertain to patient safety in ED and the Trust's reputation which fall under strategic risk three. This will be reviewed by the Committee in October ahead of the Board discussion of the full BAF.

Sir Norman Williams
Committee Chair
20 September 2019

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2.1

Meeting Title:	Trust Board		
Date:	26 September 2019	**Agenda No**	**2.1.1**
Report Title:	Mental Capacity Act and Deprivation of Liberty – Annual Report (2018/19)		
Lead Director/ Manager:	Avey Bhatia – Chief Nurse and Director of Infection Prevention and Control Robert Bleasdale – Deputy Chief Nurse		
Report Author:	James Godber, MCA and DoLs practitioner David Flood, Named Nurse for Safeguarding Adults,		
Presented for:	Assurance		
Executive Summary:	The report highlights some of the key achievements of, and areas of challenge relating to effective application of the Mental Capacity Act (MCA) across The Trust. There were 336 MCA related referrals in 2018/19, a 45% increase on the previous year, resulting in 127 applications to the local authority. Patient facing staff working with adults are now auto – enrolled on high quality, scenario based training and rates of compliance are high (Level 1 – above 90% and Level 2 above 70%). Steps have been taken to improve assurance relating to staff knowledge and practice in relation to the MCA, but more work is required, and this has been incorporated into the Trust Quality Improvement Plan for MCA for 2019/20. Resource to support staff knowledge including a dedicated intranet site for the MCA and Deprivation of Liberty Safeguards (DoLS) and a full time practitioner to directly support complex cases has provided a foundation for the development of further tools and initiatives to support the consistency and quality of practice and documentation in relation to the MCA. Currently an additional post holder is in place funded by NHSI for 6 months, and Corporate Nursing intends to submit a business case for further funding. This will support further development of the agenda and resources, including the development of a Champions programme and Trust wide documentation relating to Capacity assessment and Best Interests Decisions. The MCA is one of the Trust's Key Priorities for 2019/20 and this is supported by a development plan and trust steering group along with oversight on progress from the Safeguarding Committee, Patient Quality and Safety Group and, via the Integrated Performance and Quality report, the Trust Board and Subcommittees. Looking ahead, Revised legislation relating to key aspects of the Mental Capacity Act and the introduction of the Liberty Protection Safeguards poses a new challenge for NHS healthcare providers as roles, duties and responsibilities previously under the control of the local authorities are now likely to be owned by Trusts and CCGs, with multi-factorial resource, reputational and legal implications.		

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Recommendation:	The Board is asked to receive and note the report which was discussed at the Quality and Safety Committee in July.		
Supports			
Trust Strategic Objective:	- Treat the patient – treat the person - Right care, right place, right time		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:			
Implications			
Risk:			
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duties in this area		
Resources:	The Annual Report references the currently available resources.		
Equality Impact Assessment	N/A		
Previously Considered by:	Patient Safety and Quality Group Quality & Safety Committee	**Date:**	17th July 2019 19 July 2019
Appendices:	Nil		

MCA and DoLS Annual Report 2018-19

1.0 Introduction:

The Mental Capacity Act 2005 (MCA) derives from Human Rights legislation and provides a statutory framework to empower and protect people of 16 years and above who may not be able to make their own decisions. It also provides a clear process detailing when and how decisions can made on behalf of others, and enables people to plan ahead and protect their approach to decision making in case they lose capacity in the future.

Deprivation of Liberty Safeguards (DoLS) is an amendment to the MCA that provides a system of legal safeguards covering the patient and the relevant organisation if someone who lacks capacity is being kept in a particular setting in their best interests for the purposes of delivering care or treatment.

Given that The Act sets out powers, duties and responsibilities at a legislative level, there are personal and organisation risks of not applying the MCA correctly when delivering acts of care and treatment. Perhaps more importantly, an organisation embeds the MCA into all aspects of routine practice, is far more likely to keep the people it cares for at the very centre of decision that affect them.

Following the CQCs findings of variable / poor application of the MCA at St George's University Hospitals in 2016, an MCA practitioner role was piloted and, in October 2017, made substantive. Key aims and objectives were developed relating to training, audit, and awareness raising and resource development. This report details progress across these key areas. It should be emphasised that practice at St George's in relation to the MCA has been recognised as having a broad scope, and that development of this practice is increasingly recognised as a long term programme of behavioural change requiring support from multiple stakeholders.

2.0 Governance and Structure:

The MCA/DoLs practitioner reports to the Lead Nurse for Adult Safeguarding and is a key member of the Safeguarding Team.

The continued implementation of the MCA across the Trust and supporting systems to evidence and embed application is one of the Trust Quality Priorities for 2019/20. In support of this a development plan and a steering group has been established which meets every 2 months to progress the actions and develop a Trust MCA strategy.

The progress of the Quality Improvement plan is monitored through the Trust Safeguarding Committee. The Safeguarding Committee chaired by the Chief Nurse meets every 2 months and includes representation from the Adult Safeguarding Lead from the CCG.

In addition to the reporting on progress against the QIP, activity figures and training compliance through the Safeguarding Committee, a report is submitted to the patient Safety and Quality Group every 6 months. Additional metrics relating to the workstream are being monitored in 2019/20 through the Integrated Performance and Quality report to the Trust Board and Subcommittees.

Organisational resources supporting good governance around the MCA include the Mental Capacity Act and DoLS Policy and The Restrictions and Restraints Policy, alongside a number of tools for staff to use operationally to work through complex cases.

Nationally, the recently completed NICE guidance on Decision Making and Mental Capacity provides a new and comprehensive framework against which levels of practice can be judged. Other key documents in this respect include the Mental Capacity Act code of Practice itself (currently being revised), the Royal College of Surgeons Guidance on Consent and GMC guidance on consent (currently being reviewed).

3.0 MCA Training:

3.1 Introduction of mandatory and statutory training programmes specifically covering the MCA and DoLS Training:

There has been a significant change in training provision in the last 12 months. In order to improve the quality and availability of training, two e-learning packages were launched covering essential (Level 1, launched 27/04/2018) and intermediate (Level 2, launched 20/12/2018) levels of knowledge. All patient facing staff working with adults and children over 16 years of age have been enrolled onto one of these two modules and must complete them as part of their mandatory and statutory training requirements.

Both levels of training include scenario based learning and case studies, with Level 2 using video content showing Trust staff and professional actors using the MCA in a clinical context . Unsolicited feedback on training content has been positive, as evidenced by the quotes below from individuals who have undertaken the Level 2 training:

"I have just completed the new eMAST MCA and DOLs module, and wanted to comment that it is the best eMAST module I have completed at St George's by a long way…. thank you so much for showcasing a community example and stressing how acute and community teams should work together".

Clinical Team Leader, Wandsworth Community Neuro Team.

"Just wanted to say that that is a brilliant MCA/DOLs training resource. Has it been put forward / recognised for wider use (eg National?). It should be……"

Stroke Consultant, St George's Hospital

3.2 Face to Face Training:

Face to face training also continued with approximately 60 face to sessions delivered over the 2018/19 financial year, to an estimated 500 staff. These sessions were typically delivered to Key areas where additional needs are identified; on request of Practice Educators or other Clinical educational co-ordinators; or to 'difficult to reach' groups. Examples include training delivered to St George's staff working at HMP Wandsworth; training provided to Postgraduate medical trainees working at St George's; Medical and nursing staff rotating through the emergency department; HCAs on the Foundations of Psychological Care Course; and therapists working in areas patients with where dementia and neurological disturbance is prevalent.

Other training activity has involved collaborative working with other specialties and disciplines. This has included presenting at: the Grand Round at St George's in May 2018, the trust-wide End of Life Care Study Day in November 2018 and a critical care study day at St George's in March 2019 (attended by therapy practitioners from across England and Wales).

3.3 Headline Training Figures:

Following the launch of Level 1 (essential) MCA / DoLS training as an e-learning module in April 2018 , the level of compliance has increased over the course of the 2018-19 financial year and reaching 88.5% in March 2019 (see fig. 1.1). For reference, at the time of writing (Aug 2019) the latest compliance figures showed 92.1% compliance.

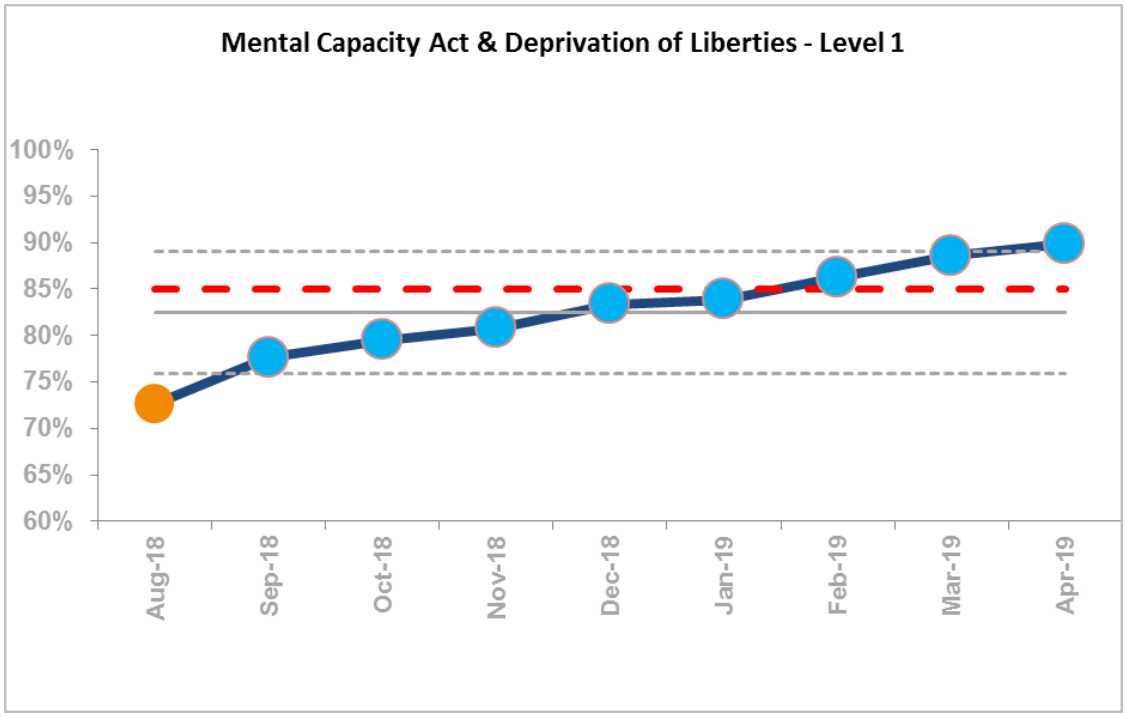

Fig 1.1 Overview of Level of Training Compliance for Level 1 MCA training April 2018-March 2019

For Level 2 MCA /DoLS training (intermediate), launched December 2018, compliance in March 2019 stood at 40.9%. For reference, at the time of writing, the last available figure, for August 2019, showed compliance for Level 2 at 73.0%, with an approximate increase of 10% per month since launch (see fig1.2).

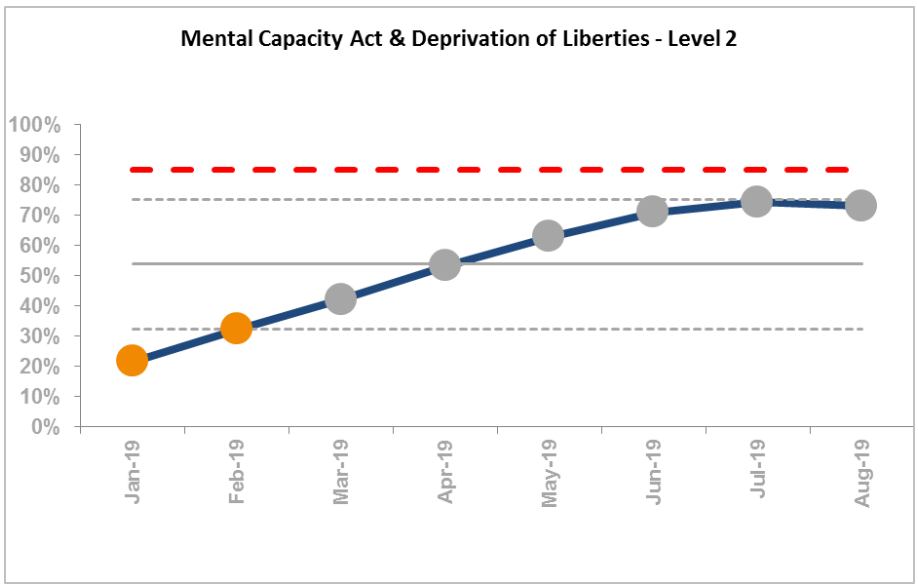

Fig 1.2 Overall level of training compliance for Level 2 MCA training January 2019 – August 2019.

Next steps (planned within the current financial year 2019/20):

Level 3 Training Development:

The planning and development of level 3 training (Advanced) is scheduled for the current financial year. The intent is to include an element of live simulation based training to build on and apply the information and knowledge covered in level 2. This training will be aimed at key senior individuals in the Trust across divisions, and MCA Champions (see below) who will support a best practice approach to the MCA across the Trust. It had been hoped that this module could be developed sooner, but the timeframe for development has been changed for the following reasons:

1. The resources and support required to effectively support development of this module were not sufficient given competing operational pressures.

2. There was perceived benefit in allowing time for Level 1 and 2 training to be undertaken and absorbed by staff before a module targeting more advanced knowledge and practice was released.
3. Level 3 would be aimed at training key individuals to respond to / support others to effectively apply the MCA in complex cases. However, some of the key systems and structures to embed best practice are still in development (e.g. development of the MCA Champions role and trust-wide templates for capacity assessment). Integrating these systems into the development of advanced training was preferred.
4. Contingency was in place to allow the delay of Level 3 MCA Training, as all patient facing staff identified as potentially needing level 3 have been auto enrolled on level 2 training until Level 3 becomes available.

Preparing for changes to the Deprivation of Liberty Safeguards (DoLS):

Training across all levels will need to be updated to reflect pending changes to the DoLS scheme as part of the Mental Capacity Amendment Act (see risks to delivery and service). Depending on the available resources, in the first instance, the development of a standalone brief introductory training module raising awareness about the Liberty Protection Safeguards (LPS), may be needed. Ultimately though, training across levels 1, 2 and 3 will need to be reviewed and revised to incorporate the changes to practice that result from the new legislation once this is fully understood.

Plan and agree improved output and outcome measurement for MCA training (assurance):

At present, both Level 1 and 2 e-learning modules include assessment components that must be passed to show compliance. Depending on resources, it would be desirable to develop additional capability in terms of training assurance (e.g. feedback in relation to bespoke face to face sessions; better capture by profession of attendance at bespoke or tailored education sessions).

4.0 MCA Audit

4.1 Background Context

Auditing practice in relation to the MCA has been a challenging task nationally.

The MCA code of practice does not offer a comprehensively concrete and replicable way of measuring good practice in the healthcare setting and case law interpreting the MCA is constantly evolving.

CQC guidance for assessors on evidence of good practice in relation to the MCA provides indicators relating to the presence of policies, assurance, training and practice in relation to capacity assessment and best interests decision making but arguably leaves how to achieve this open to interpretation and may be highly dependent on the assessors knowledge of an act that is frequently misconstrued.

NICE guidance on Decision Making and Mental Capacity (released November 2018) places an increased focus on the quality and extent of training staff, and supporting people to make their own decisions. It urges the development of processes and tools to help people apply the MCA, and breaks down capacity assessment and best interests decision making into person centred, component parts. It is certainly a helpful step away from the sometimes abstract elements of the act but cannot, by itself, provide clear direction on how to measure if a consistent and multi-disciplinary approach to training, documentation, and the integration of practice relating to the MCA into local systems and processes is taking place.

We knew from previous audit and CQC feedback that, whilst there are some areas of good practice in relation to the MCA, the standard of practice was not consistent, there were examples of poor application of the MCA in relation to the use of restrictions and restraints, and at times, evidence of appropriate consultation with the patient was missing.

The challenge during 2018-19, against this backdrop, was to further build an approach to 'taking the temperature' with regards to how the MCA is applied, and simultaneously begin the longer term process of developing an agreed approach for more in depth assurance

process that grows in parallel with the systems and processes and resources being developed to support application of the MCA.

4.2 Audit activity and findings

Two main areas of focus were selected with assurance in mind: Staff knowledge (theoretical, evidenced via discussion) and staff practice (as evidenced in medical and nursing notes).

Staff Knowledge:

As part of a wider MCA dashboard, corporate nursing started to audit staff knowledge via the ward accreditation process. A question directly about the MCA has been integrated into ward accreditation assessment questions. It is scenario based and requires the staff to discuss how they would apply the MCA in response to a clinical situation. From January 2019, trends showing the performance of staff in relation to this question can be viewed over time. An MCA question is also asked as part of back to the floor audits, administered by matrons covering their respective wards.

Results from the ward accreditation audits are shown below (fig 1.3). They show good to excellent performance on the question asked. However, it is just a single question and the sample size may be too small at this stage to provide a reliable picture of MDT practice, (particularly as the majority of questions were directed at nurses as opposed to other professionals). An example of the type of question asked is given below:

"A patient wishes to discharge themselves against medical advice and you are worried about their safety. You feel they may lack capacity to make such a decision. What should you do?"

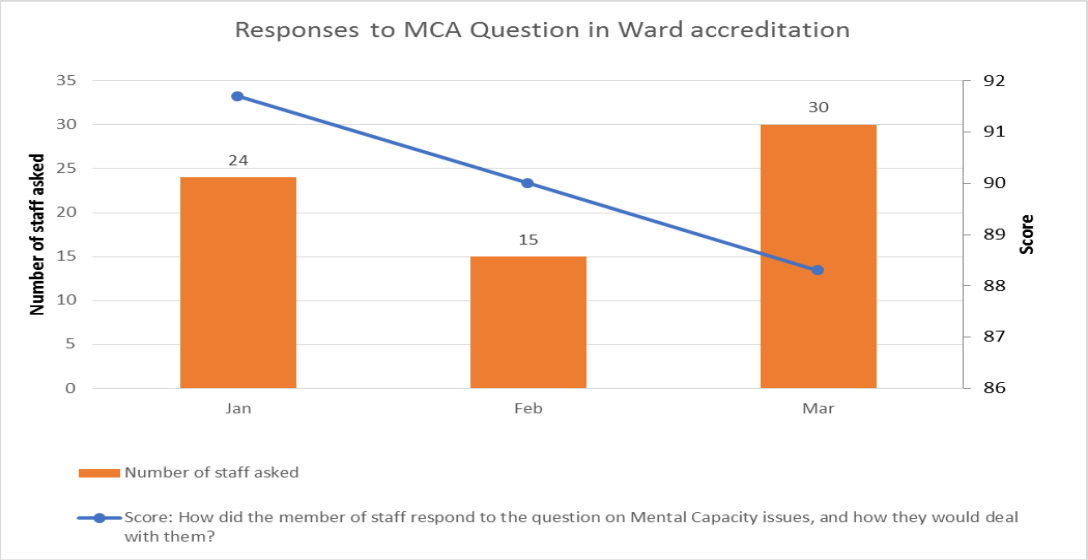

Fig 1.3: Responses to MCA question in ward accreditation

Staff Practice:

Deep dive audits: These were undertaken in April, May, June and July across The Wolfson and Mary Seacole ward at Queen Mary's Hospital, The Acute Medical Unit, and Gray and Cavell wards. The aim of these audits was to capture the extent to which the MCA is applied in decisions where serious medical / surgical interventions or changes in discharge destination or arrangements were at stake. The audit was designed to involve MDT members from across disciplines in the screening and audit process, and aimed to provide a barometer of practice, but also education and information to team members who might then take a lead in supporting others to deliver best practice in relation to the MCA.

Neither of these outcomes was achieved effectively. The reasons for these were multi-factorial but included:

- Variable ability of members of the MDT to support the process due to operational pressures.

- The labour intensive nature of the audit process.

- Difficulty drawing clear interpretations from the findings due to small sample size.

- (With hindsight) the methodological flaws inherent in looking at the application of the mental capacity act during the course of a 'live' admission rather than reflecting in its use over the course of a complete episode (i.e. sometimes difficult to judge if an absence of evidence re: the MCA represented process being neglected, or simply actions pending).

MCA Practice evidenced via Ward Accreditation Visits :

In addition to the staff knowledge question relating to the mental capacity assessment, two questions relating to applied practice were also present, with a focus on the use of restrictions and restraints in patient's lacking capacity to consent to related elements of their care. Again, these questions were also asked as part of back to the floor audits, administered by matrons covering their respective wards. Again, from January 2019, trends showing the performance of staff in relation to these questions during accreditation visits can be viewed over time (see figs 1.4 and 1.5 below).

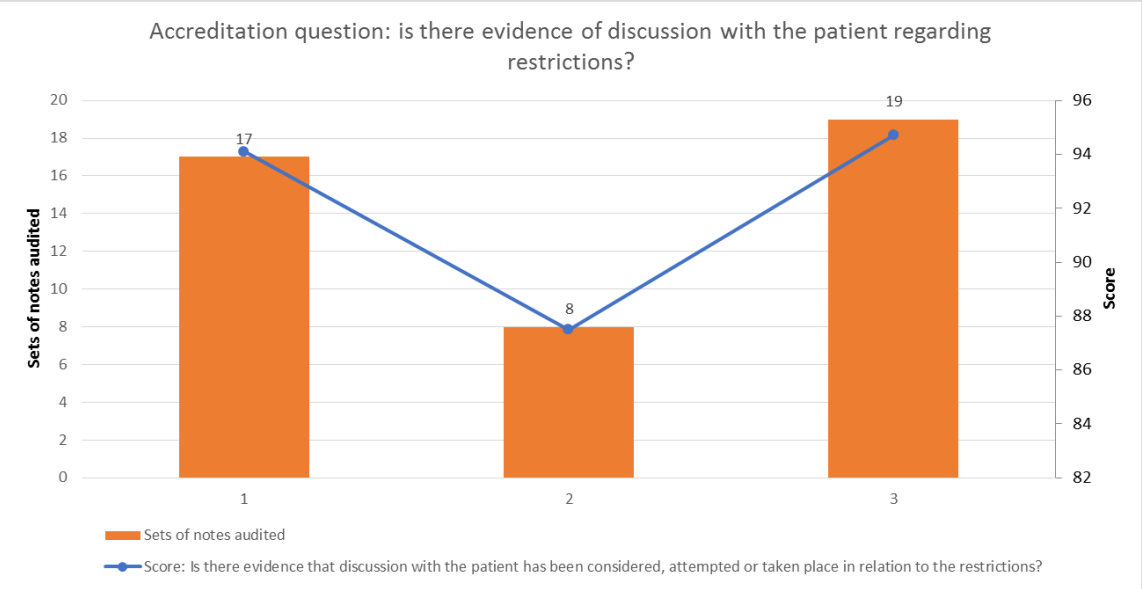

Fig 1.4. Responses to MCA question 1 in ward accreditation relating to the use of restrictions

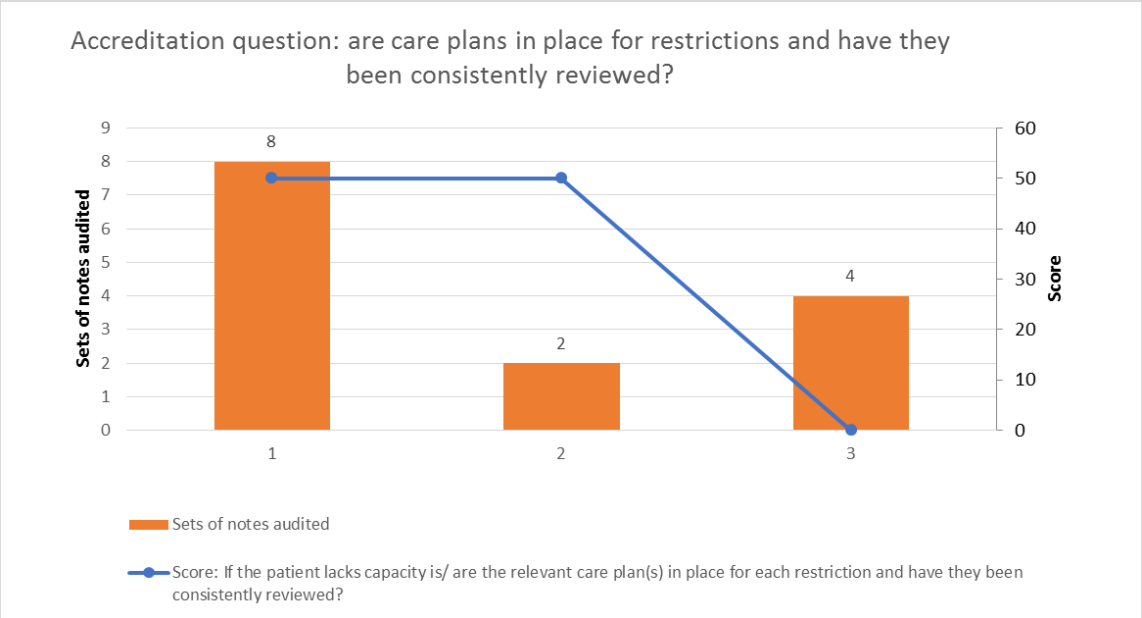

Fig 1.5 Responses to MCA question 2 in ward accreditation relating to the use of restrictions

These results suggest good evidence of discussion with patients about the use of restrictions but a possible problem with completion of the appropriate care plan documentation for restrictions and restraints. Small sample sizes imply caution needed against drawing strong conclusions in either case.

Additionally, restriction and restraint functionality had only been embedded into The Trust's electronic record keeping system in December 2018. Some initial difficulties adapting to the new system were anticipated. However, the MCA Practitioner and Falls co-ordinator worked collaboratively to take a closer look at use of the new documentation nonetheless. This was done between February and April 2019 by undertaking unannounced spot checks auditing how staff were coping with and using the new assessment and framework. The aims of this audit were to provide context on restriction and restraint use, gather feedback to inform future training and changes to documentation, and to seek assurance in relation to the current systems and approach underpinning the use of restrictions and restraint.

The areas reviewed covered high risk areas in where patient's with cognitive and communication disturbance are usually more prevalent, including: Thomas Young (stroke and neurorehabilitation), General ICU including HDU area (intensive medicine) & Brodie and McKissock (neurology / neurosurgery) wards. Themes found included good awareness of

staff of the need to document restrictions and restraints, with staff typically able to rationalise why the restrictions were in place in a patient's best interests. Nurses in charge had good awareness and oversight on what restrictions and restraints were in place and on what patients for the entire ward.

Areas for improvement found included:

- An inconsistent approach to documentation.

- Reduced understanding of the relationship between capacity and best interests decision making.

- Reduced integration of 1:1 supervision and the use of sedation into IClip documentation

- The presence of duplication and associated administrative time burden on patient facing endemic in the design of the current IClip electronic documentation.

A finalised report with recommendations around training, policy review, local practice and further changes to electronic record systems is pending.

4.3 Next Steps:

- Given the national difficulty effectively auditing the MCA, St George's has started to work collaboratively with other healthcare providers within the South West London STP to agree, develop and refine an augmented approach to auditing the MCA that is meaningful, achievable and able to provide a larger data sample to inform qualitative and quantitative measures of assurance. Initial outputs are expected in quarter 3.
- A Trust wide audit of staff knowledge is planned, based on clinical scenarios, to be conducted quarterly with the results being monitored through the steering group, IQPR and reported through the divisions.
- In the medium term, the development of a process of more in depth audit of the application of the MCA for patient's in high risk groups (e.g. those with dementia, delirium, neurological illness) that links with the creation of new trust-wide documentation (see section 5.0 of this report), and is supported across the trust

divisionally via the Steering group and by those working as newly created MCA Champions.

- Further work with patient partnership groups such as Healthwatch is planned, to support the development of content for audit tools, training programmes, guidance and documentation relating to the MCA.
- Continuation of existing audit mechanisms in place via ward accreditation assessments and Back to the Floor Programmes.

5.0 MCA Awareness Raising and Resource Development

Awareness raising is predominantly provided through face to face training, e-learning programmes and via MCA Practitioner role, accessible via bleep, email and phone, for direct support with complex cases. The following has also been present or developed with the aim of improving awareness and understanding of the MCA:

- September 2018: The establishment of a bi-monthly MCA steering Group, chaired by the Deputy Chief Nurse, to facilitate moving the MCA / DoLS agenda forward Trust-wide.
- November 2018: The presence of a manned MCA consultation desk with posters, and supporting literature for staff at the Trust Quality Improvement week November in November 2018.
- The maintenance and development of a Trust Intranet site dedicated to the Mental Capacity Act and Deprivation of liberty safeguards: to support staff to understand and apply The Act. http://stg1wordpress01/wordpress/mcadols/

It is also of note that a plan to pilot standardised pro-formas for documentation of capacity assessments and best interests decisions did not occur as planned during this 2018-19, due to the competing commitments of the majority of stakeholders (including the MCA Practitioner). Additionally, whilst documents were created and have been the subject of limited review and editing by clinical staff, the Trust's move away from paper documentation has prompted a change of approach (see below).

Next steps (planned within the current financial year):

- Working with the Clinical Documentation Change Team and patient facing clinicians to develop a standardised, Trust wide approach to documentation in relation to the mental capacity act. Initial outputs will link to the production of electronic pro-formas for documenting capacity assessments and best interests decisions with the aim of guiding clinicians in appropriately recording evidence of The Act being applied.

- Develop an MCA Champions role: The development of a network of MCA Champions established across professions and divisions, beginning with the development of a role description, competency framework and quarterly training programme. The aim of developing this network is to widen the availability of expertise in relation to applying the MCA beyond the small existing central resource.

- Produce physical and electronic versions of Quick reference cards for staff to help staff understand and recall key elements of the MCA and how it applies to their patient interactions.
- Produce posters for dissemination to all wards providing key information about the MCA resource in the trust, and key contact names and details.
- Commence review of the application of paperwork and practice linked to the restrictions and restraint policy.

6.0 MCA and DoLS referrals

There are clear duties under the Mental Capacity Act (2005) that staff have to all patients. When a patient lack s capacity, decisions made for them, must have regard for the principles laid out in The MCA. Not doing so carries the risk of litigation, loss of reputation and infringement of human rights. In addition, the hospital, as a 'managing authority' has a responsibility to ensure that all those patients who could potentially meet the criteria of deprivation have the appropriate safeguards triggered (Deprivation of Liberty Safeguards) are referred to the 'supervisory authority' (the appropriate local authority) for independent assessments and that any such assessment or authorisation is reported to the Care Quality Commission.

During 2018/19 there has been 336 referrals relating to the Mental Capacity act and DoLS, a 45% increase on the 2017-18 figure of 232 (see fig 1.6 overleaf) . Of the 336 referrals received by team at St George's, 127 of these resulted in an urgent DoLS being put in pace and a request being sent to the local authority to grant a Standard Authorisation.

Subjectively, the complexity of cases has increased compared to the previous year (which may reflect increased awareness of the MCA relationship to complex decisions secondary to the increased training and education resource). These often complex cases can include decisions relating to possible movements from a person's home to a nursing home, potentially lifesaving surgical and medical procedures and cases where restrictions or restraints are being used to deliver treatment. See fig 1.7, below and overleaf, for an example of a complex referral.

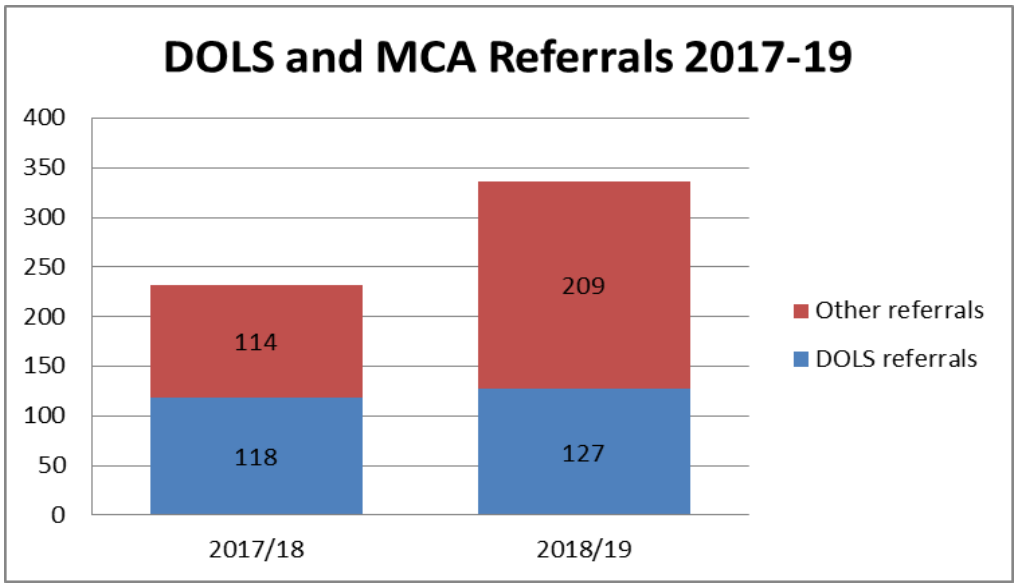

Fig 1.6 DoLS and MCA Referrals Compared 2017/18 and 2018/19

Brief overview of a Complex Case referral (anonymised):

Following admission to St George's with personality changes, a 28 year old with English as a second language is admitted with personality changes, falls and visual difficulties. Having been asked to leave the flat they were living in due to changes in behaviour, the patient is now homeless.

The patient is found to have HIV and a brain tumour (explaining the personality changes) and multiple specialists are involved in her care. Previously an independent woman, she deteriorates over the course of her admission to the extent where she is highly dependent very unlikely to be able to live independently without improvements in her level of function.
The patient's family all live abroad and the patient is keen that they do not find out about the HIV status as it has substantial negative cultural connotations. The patient requires neurosurgery to treat the tumour and improve the otherwise very poor prognosis, but the surgery is risky (including a risk of death) and there is a realistic prospect that whilst it may result in an extension to life it will not improve level of disability and could worsen it, causing blindness and immobility, without improving her cognition. The safety of surgery is also linked to HIV status with professionals caught between a desire to intervene before symptoms worsen further and concerns that proceeding with surgery without further assessments and possible delay further increases the risk of a poor outcome. As the admission progresses the patient's ability to understand the situation deteriorates to the extent where the team have serious doubts about the patient's ability to meaningfully contribute towards deciding on how to proceed. The patient's family simply want her to be better but are not able to support the decision making process as they don't seem to understand the complexity of the case. The patient is increasingly refusing interventions associated with medical care and assessments relating to fitness for surgery. The ward team call the MCA practitioner for support.

Fig 1.7 Case study giving example of complex referral.

8.0 Collaborative Working

During 2018/19 the MCA Practitioner was involved in multiple partnership working projects including:

- Presenting a questionnaire to a Healthwatch Special Interests Group asking patient groups about their experiences of communication with healthcare professionals and what could be improved - and integrating feedback and key findings into training and education packages.

- Working closely with the Speech and Language Therapy Team at St George's to champion their involvement in supporting vulnerable patient's to be at the centre of decisions affecting their care.

- Working with clinical excellence networks under the Royal College of Speech and Language Therapists to deliver training to Speech therapists across the UK on issues relating to Mental Capacity.

- Being asked to present at the National Mental Capacity Forum based on the work done by the team at St George's.

- Authoring a chapter in a recently published training resource for Speech therapists focusing on mental Capacity.

- On-going membership of / attendance at the London-wide MCA and DoLS network.

- Setting up and co-ordinating a group of South West London healthcare professionals to collectively develop an approach to auditing the application of the Mental Capacity Act.

9.0 Risks to delivery and service

1. Managing change from the Deprivation of Liberty Safeguards to the Liberty Protection Safeguards (LPS):

The LPS scheme will replace DoLS having received royal assent in Spring 2019, with implementation currently planned for late 2020. As part of the LPS scheme, many of the responsibilities previously owned by the local authority will pass on, in an amended form, to NHS Trusts. The new roles, duties and responsibilities that accompany this transfer will need to be accompanied by appropriate resources, training and awareness raising to help The Trust apply the revised legal framework in accordance with the law.

In addition, St George's takes a risk based approach to DoLS, based on legal advice. Whilst this has hopefully helped teams focus on operational needs, and kept much of the

administrative burden associated with DoLS away from front line clinicians, it may also have had the unintended consequence of:

- De-skilling clinicians and reducing awareness of the need for DoLS - a concern in the context of new responsibilities that are likely to sit with staff at St George's under the LPS scheme.

- Impacting on the understanding of the implications of the LPS and potential work load and resource requirements. If we review only current referral activity, rather than carefully scrutinising the viability of continuing a risk based approach to Liberty Protection Safeguards based on a completely new code of practice, this could lead to an inadequate ability to meet the obligations laid out under LPS, and the higher risk of litigation and reputational damage that would ensue.

2. Whilst there is representation at the MCA steering group from divisions, there continues to be inconsistent support from divisional colleagues due to existing demands. Additionally the MCA practitioner continues to experience poor levels of understanding and engagement from medical staff, with some seeing the MCA as an additional aspect to their role rather than fundamental in providing care to patients.

3. It is recognised that there has been an increase in contacts and formal DoLs applications from St Georges. The Trust currently has one MCA/DoLs practitioner who also leads on the service development aspects detailed in the report. NHSI have provided special measures money to support an additional post for 6 months to allow additional capacity in the team to work on the quality improvement plan**.** Currently no further funding has been identified following the end of the secondment and a business case is being submitted to seek further funding. This is particularly important as additional time will be required to understand the implications of the LPS.

4. There is currently a lack of project management support to drive key aspects of the development plan in respect of MCA and DoLs. Whilst it is appreciated the temporary additional posts will facilitate the releasing of time, aspects of the improvement plan would be better served with project support to allow the subject matter experts to work with clinical teams.

10. Conclusion

This year has seen an evolving response to the challenges of embedding the MCA into clinical practice across St George's. Lessons learned from the attempts to provide a 'quick fix' to the gaps in staff knowledge and practice in the previous year are evident: The production of a development plan, creation of a Trust wide MCA steering group with divisional representation, and centralised oversight and monitoring of progress suggest increased commitment to a longer term programme of behavioural change, though improved medical representation and further development of divisional involvement in this programme are still needed.

With a predominant focus on training resource development over the year in question, approximately 80% of staff requiring MCA training have now undertaken high quality training. Applied practice in the area of restrictions and restraints has also been augmented by the introduction of MCA compliant documentation on IClip.

Subjectively, awareness of the MCA appears to have improved and referrals have increased significantly, but assurance and audit tools need further development to provide reliable data and staff need more support to document in a way that shows good practice in relation to the MCA. The changing legislation (from DoLS to LPS) brings challenges and resource implications that will require a co-ordinated, appropriately resourced and thought through approach.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No**	**2.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	James Friend, Chief Transformation Officer		
Report Author:	Emma Hedges, Mable Wu		
Presented for:	Information and assurance about Quality and Performance for Month 5		
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 significant increased elective activity with a reduction in patient's elective length of stay, with sustained improvement in the number of on the day cancellations. The Trust remained ahead of trajectory for RTT incomplete performance in Jul-19 and achieved all seven Cancer Standards. Our Patient Safety metrics were all within expected process limits for the reporting period and the Quality Improvement Key Programmes show steady progress. However existing challenges continue in particular Four Hour Operating Standard. Quality Improvement metrics will be added in Q3 and Q4. Reporting on Mental Capacity Act Knowledge compliance will be reported in Month 6. Please note that the report is under development working to incorporate NHSI recommendations.		
Recommendation:	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	Safe; Caring; Responsive; Effective and 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.		
Equality Impact Assessment:	N/A		
Previously Considered by:	Finance & Investment Committee Quality & Safety Committee	**Date**	19/09/2019
Appendices:			

St George's University Hospitals NHS
NHS Foundation Trust

NHS
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Integrated Quality & Performance Report for Trust Board

Meeting Date – 26 September 2019
Reporting period – August 2019

Our Outcomes

NHS
St George's University Hospitals
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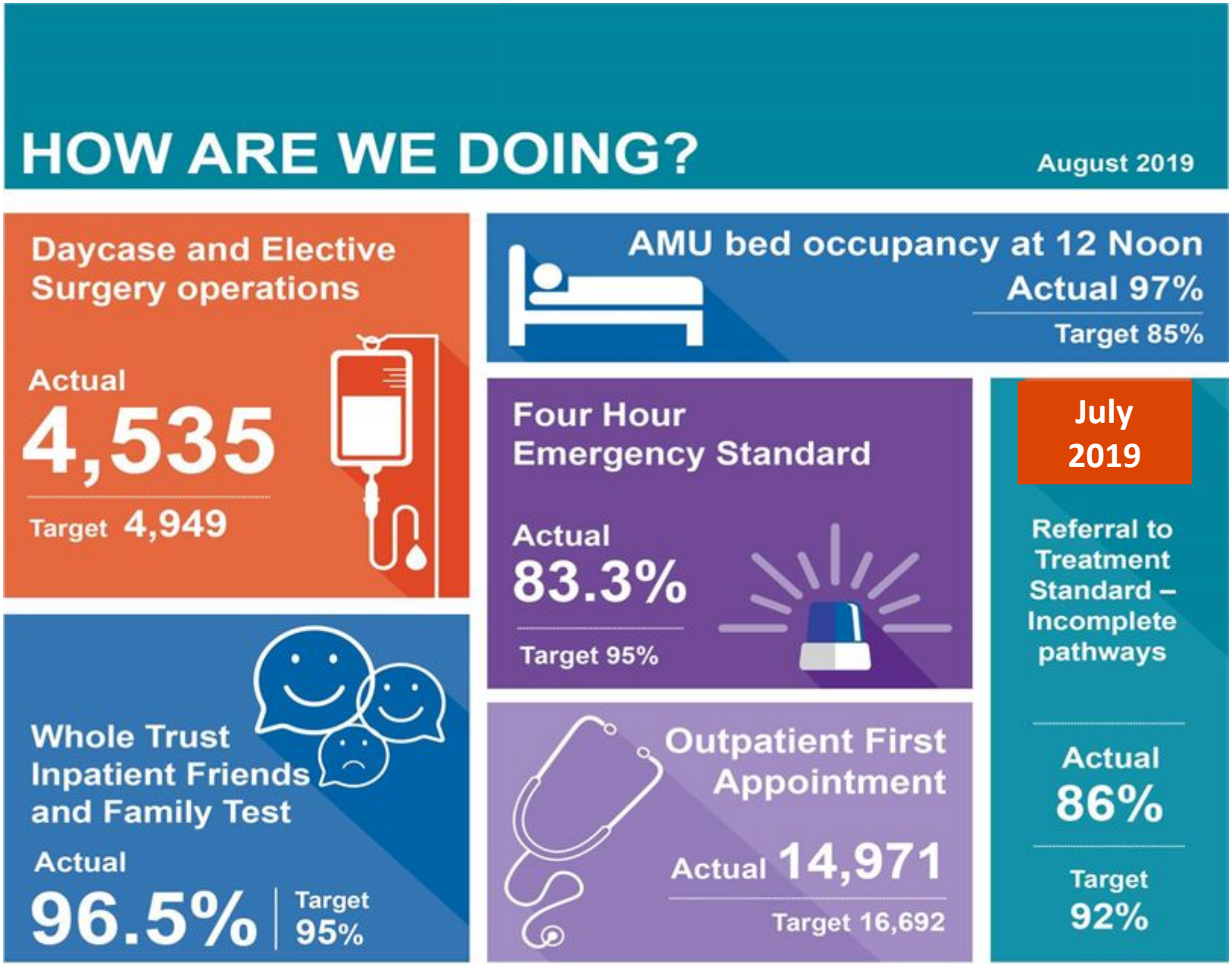
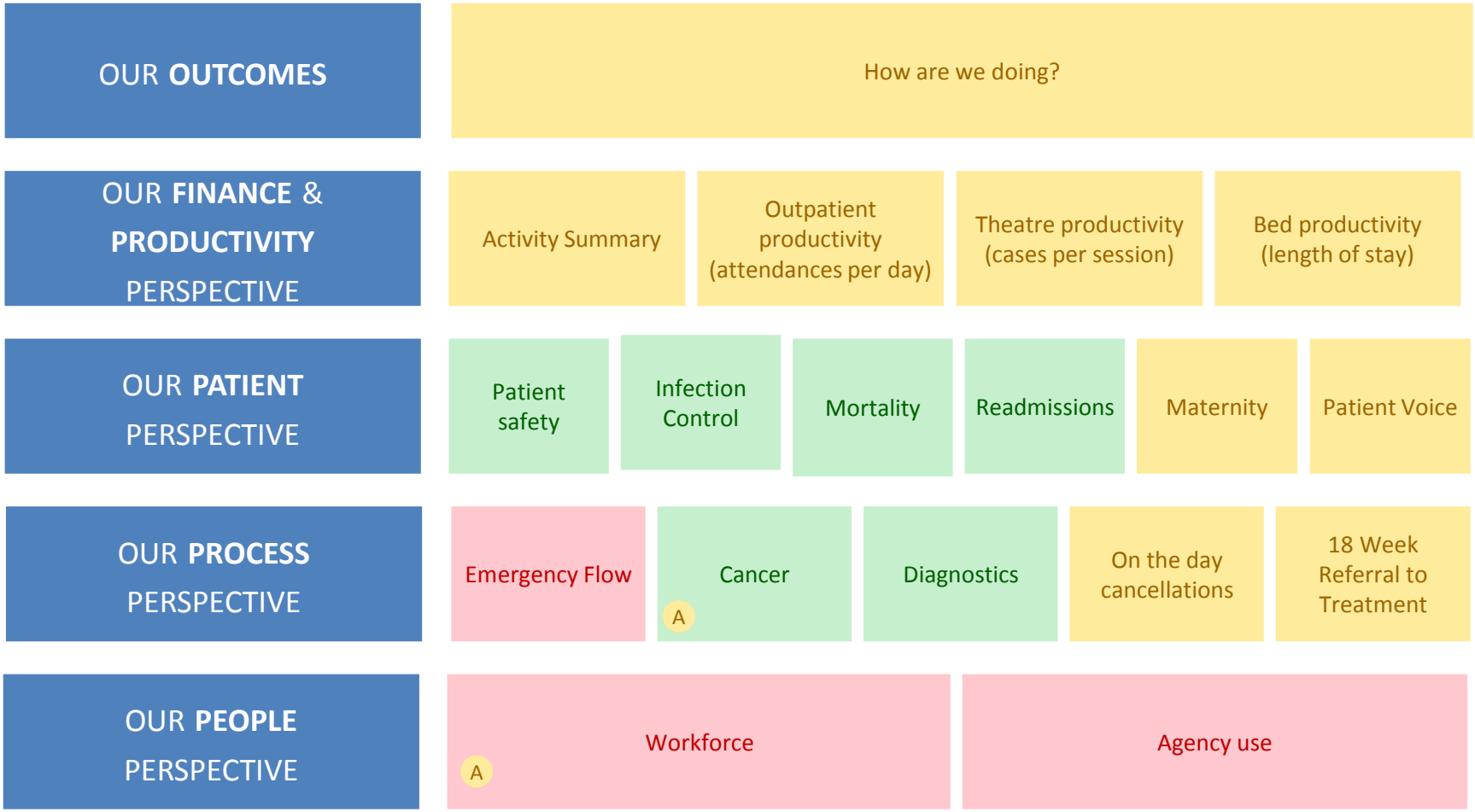


Balanced Scorecard Approach

St George's University Hospitals NHS Foundation Trust

2.2



3

Executive Summary – August 2019

St George's University Hospitals NHS Foundation Trust

Our Finance and Productivity Perspective

- Outpatient Activity at Trust level, although decreased in the month of August as expected due to seasonality, remained within their normal process limits and showed no sign of special cause variation.
- Elective and Daycase activity is currently slightly below plan year to date however this is due to a decrease in activity in the reporting month and is expected to catch up.
- The Trust continues to deliver more Elective procedures per working day whilst reducing the length of stay for these patients.

Our Patient Perspective

- Training for QIP programmes has fallen however this is a result of the Junior Doctor intake. The decline has been less severe this August period as compared to previous August periods.
- There has been an increase in DATIX reporting for July and August. The August increase is predominantly related to cleaning concerns which are being monitored and addressed daily.
- Complaints has met all of its compliance targets for the first time.
- Percentage of patients who have a VTE risk assessment appears to have deteriorated significantly however this is a result of a change in National guidance and a larger cohort is now being captured. All other Patient Safety metrics are within expected process limits.

Our Process Perspective

- Performance against the Four Hour Operating Standard in August was 83.3% and performance dropped below the lower control limit showing a special cause variation.
- The Trust achieved all seven Cancer standards in the July. The Trust returned to compliance against the 14 day standard achieving above 93% in all tumour groups. Monthly performance remain above the mean in the process charts showing no significant variation in the past thirteen months.
- In July, the Trust reported 86% for 18 week wait incomplete RTT performance which is above the monthly recovery trajectory of 85.3%. The National target is 92%.
- In August, Trust performance remained compliant against the six week diagnostic standard, and performance remained under the lower process control limit, with a total of 74 patients waiting greater than six weeks and a performance of 0.96%. The number of patients on the Trusts diagnostic waiting list remains within the upper and lower control limits.
- The rebooking process has maintained recent improvement and reduced the variability in the number of patients re-booked within the 28 day standard with on average, 98% rebooked within 28 days for the previous six months. In August, 100% of patients were re-booked within 28 days.

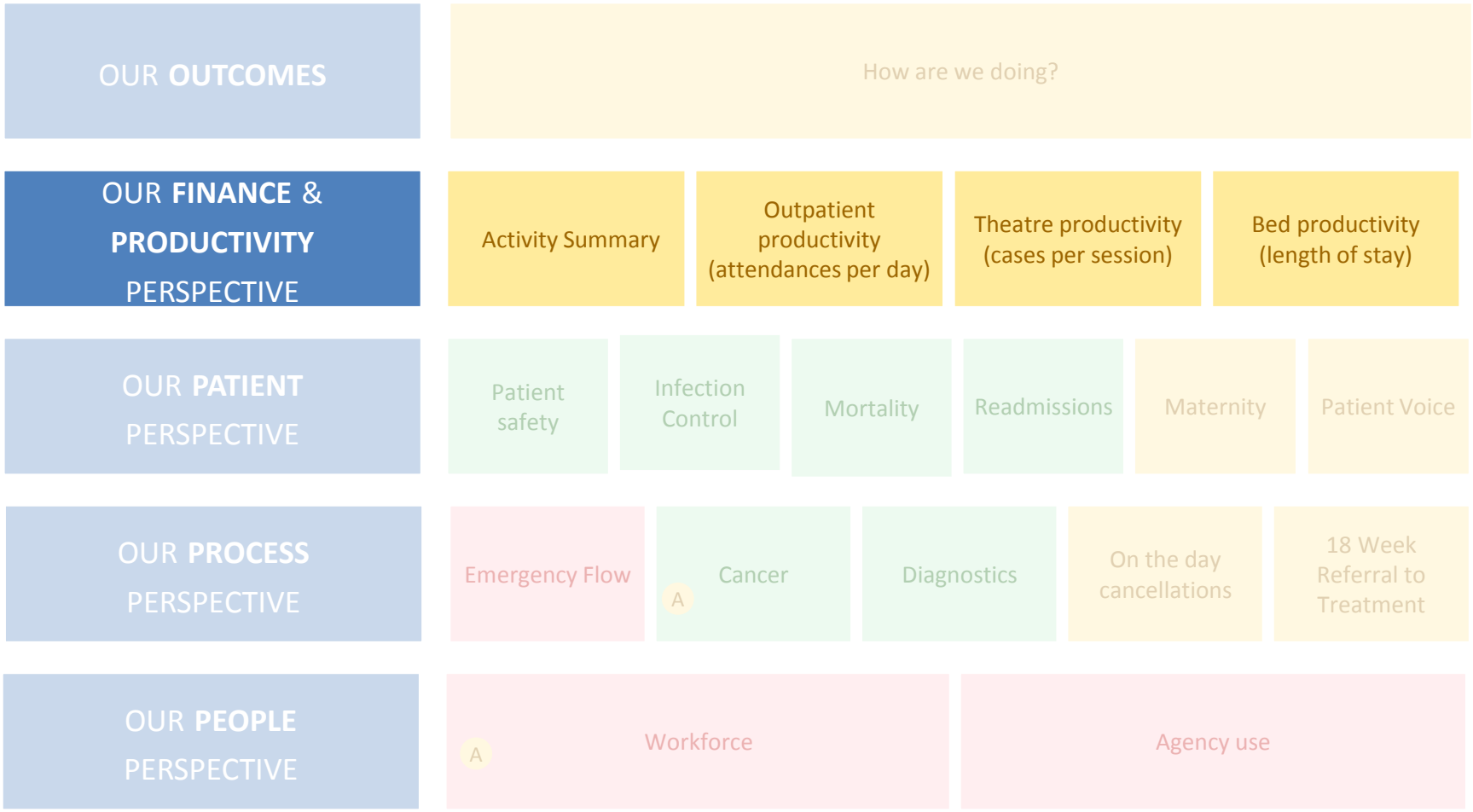
Our People Perspective

- Mandatory and Statutory Training figures for August were recorded at 90.2% with a mean of 86.2%.There has been consistent improvement month on month of this figure.
- The Trusts Total Funded Establishment and Trust Vacancy rate both remain below the lower control limit however have both seen a steady increase over the past four months.
- The Trust's total pay for August was £44.37m. This is £0.79m favourable to a plan of £45.16m.
- The Trust's 2019/20 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

2.2



Our Finance & Productivity Perspective

5

Activity against our Plan

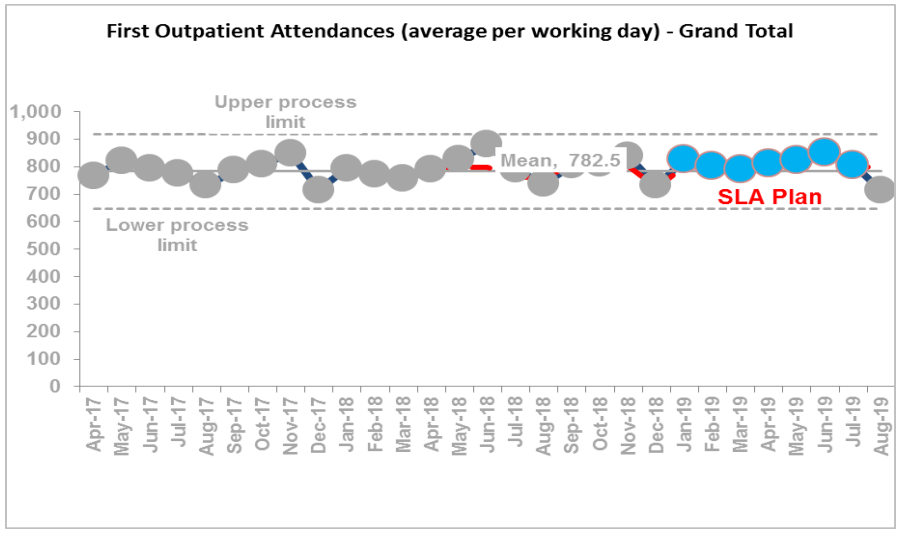
		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Aug-18	Aug-19	Variance	Plan Aug-19	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	13,267	13,729	3.48%	14,375	-4.49%	69,972	71,382	2.02%	70,947	0.61%
Inpatient	Non Elective	3,964	3,871	-2.35%	4,003	-3.30%	19,793	19,997	1.03%	19,849	0.75%
	Elective & Daycase	4,836	4,535	-6.22%	4,949	-8.37%	24,051	25,149	4.57%	25,284	-0.53%
Outpatient	OP Attendances	51,233	54,360	6.10%	54,831	-0.86%	276,283	275,325	-0.35%	284,762	-3.31%

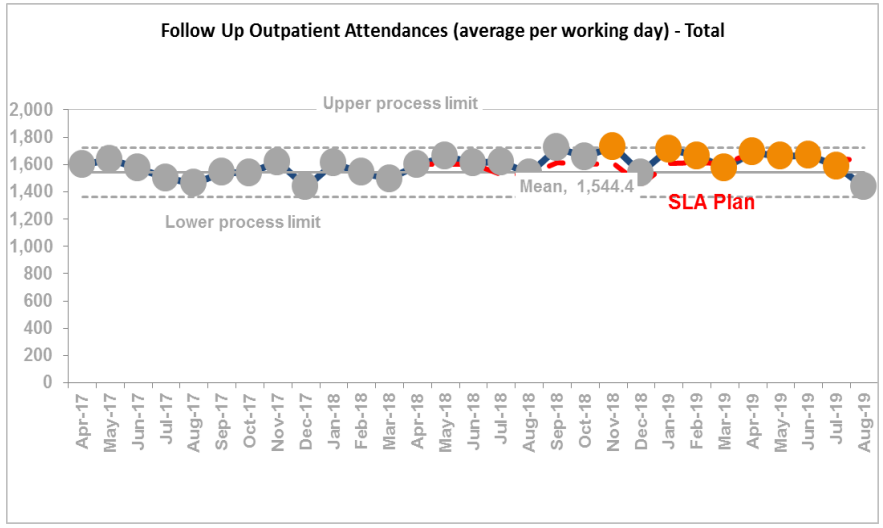
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

Note: Figures quoted are as at 01/09/2019, and do not include an estimation for activity not yet recorded (eg. un-cashed clinics). The expected performance vs. plan by Point of Delivery (POD) post catch up is:

ED – No change
Elective and Daycase – Slight over-performance against plan (~1%)
Non-elective – Over-performance against plan (~3%)
Outpatients – Underperformance against plan (~2%)

Outpatient Productivity





What the information tells us

- Outpatient first and follow up activity saw an expected reduction in the month of August, however remains within the upper and lower control limits at Trust level.
- Renal & Oncology continue to have Outpatient first activity consistently above their mean whereas Women's Services have fallen below their lower process limit for a consecutive month. All other services show common cause variation and stay within the expected process limits. We do expect activity to see an increase when cashing up is completed for the month.
- At Trust level follow-up activity has remained within its process limits with a dip below the mean in August due to seasonal variation.
- Women's Services have seen activity for the number of patients attending a follow appointment fall beneath the mean for a consecutive month.
- Cardiothoracic and Surgery have both had seven months with their follow-up activities below the mean indicating a special cause variation, with Trauma & Orthopaedic activity showing to be on a downward trend.

Actions and Quality Improvement Projects

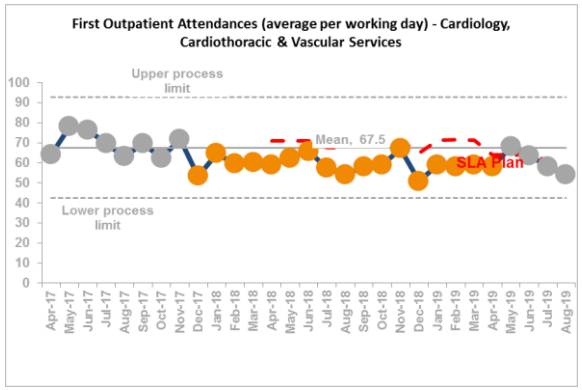
- Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.
- Women's services are meeting weekly to ensure that referrals are being triaged and appointments booked in a timely manner,
- Model Hospital data is being reviewed to identify opportunities.
- The Trust is working in partnership with other hospitals across South West London to redesign six specific outpatient pathways.

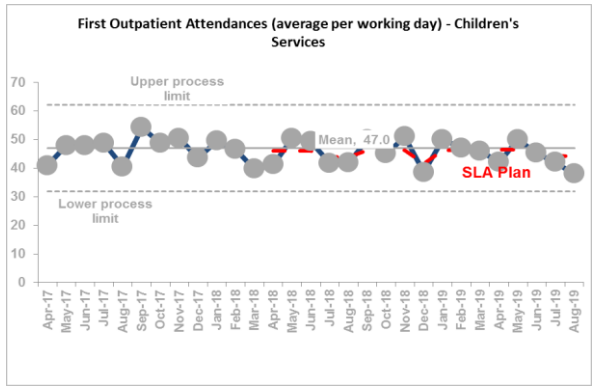
Number of First Outpatient attendances per Working Day

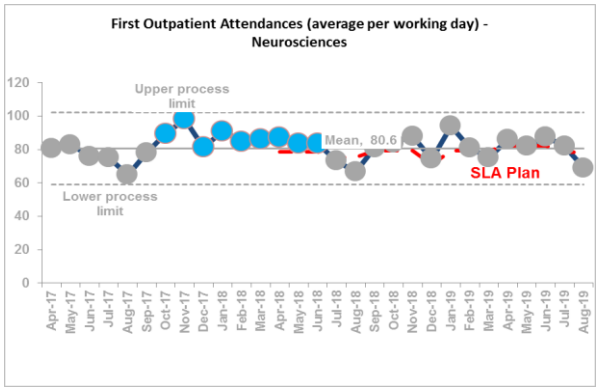
St George's University Hospitals NHS Foundation Trust

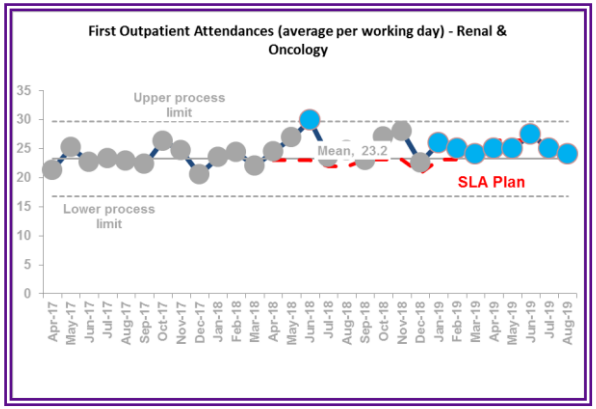
2.2

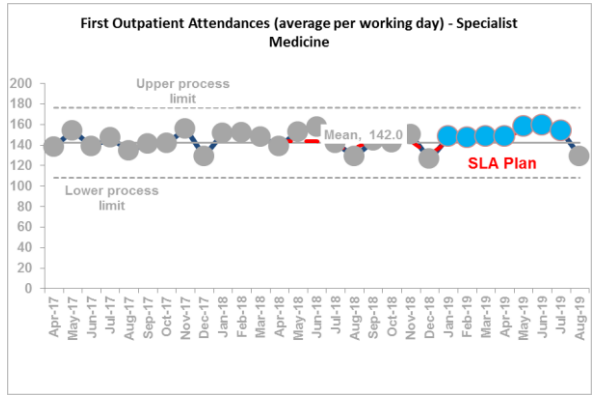
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

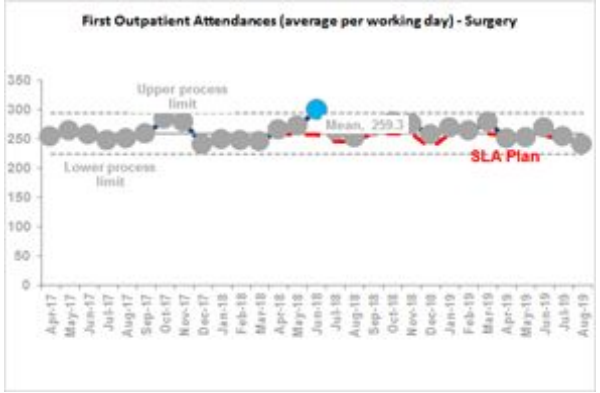


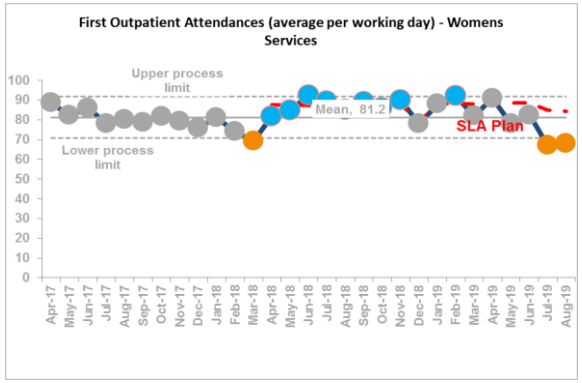


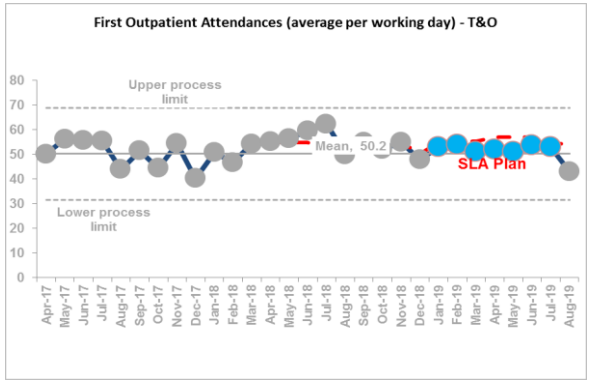








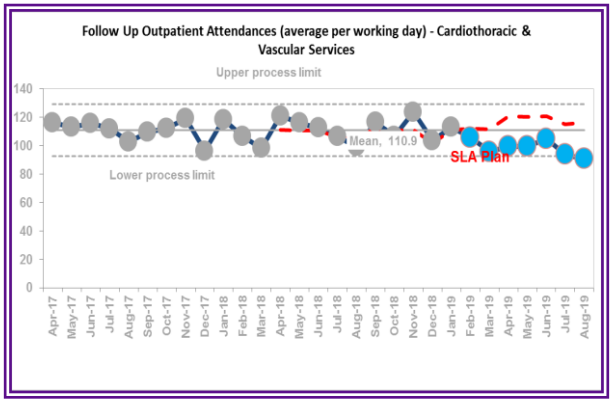


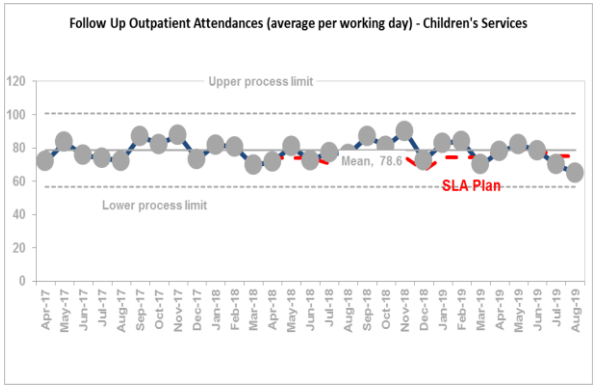


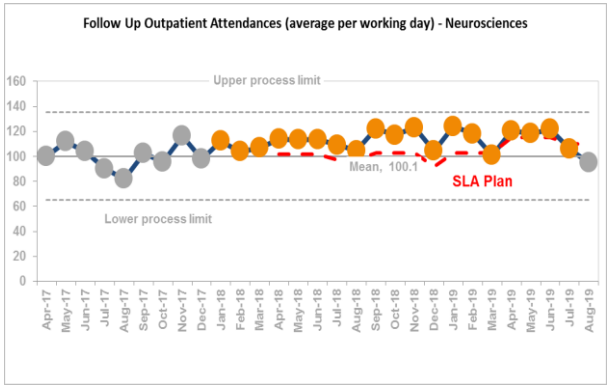
Number of Follow Up Outpatient attendances per Working Day

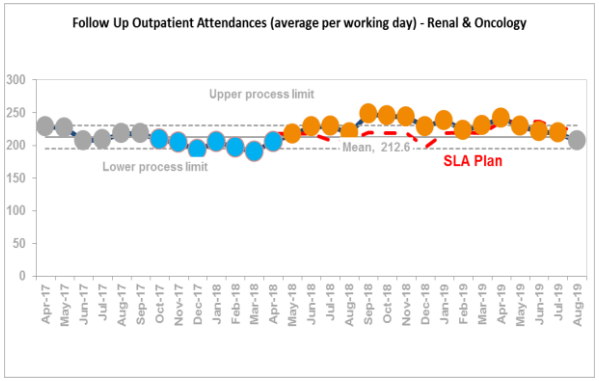
St George's University Hospitals NHS Foundation Trust

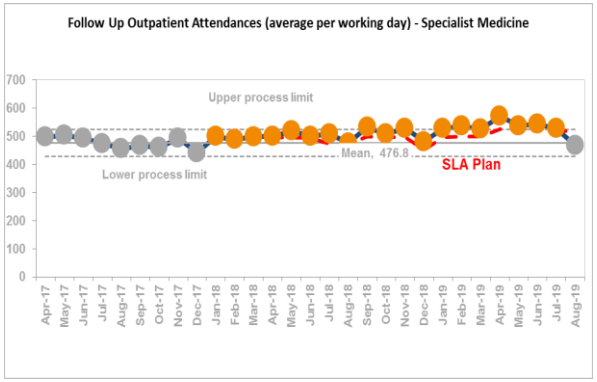
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

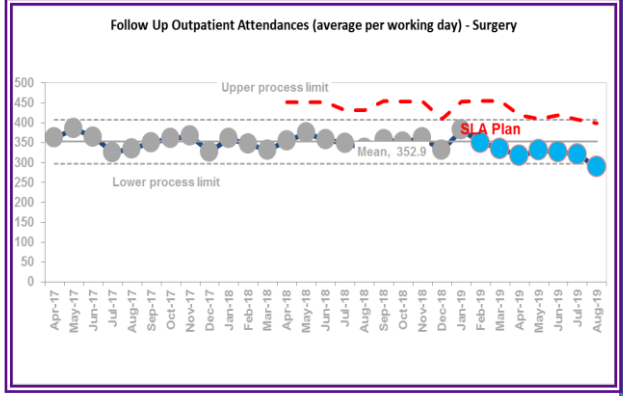


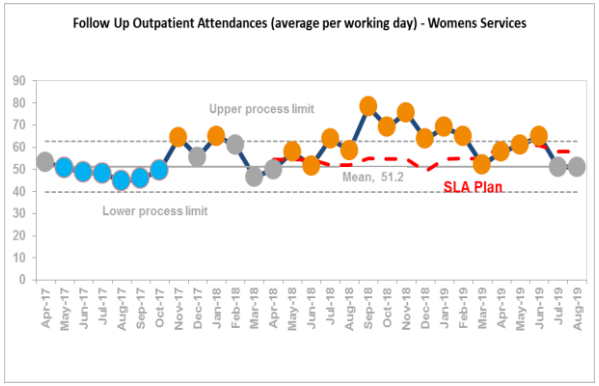


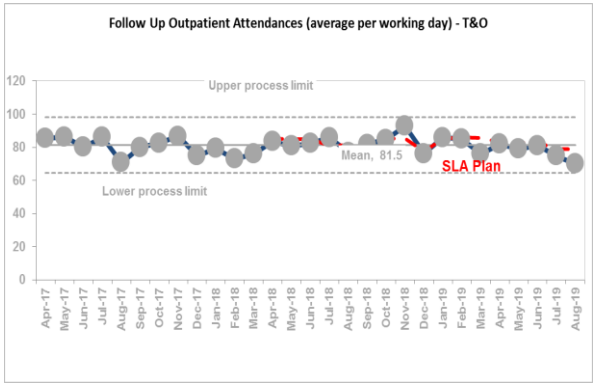




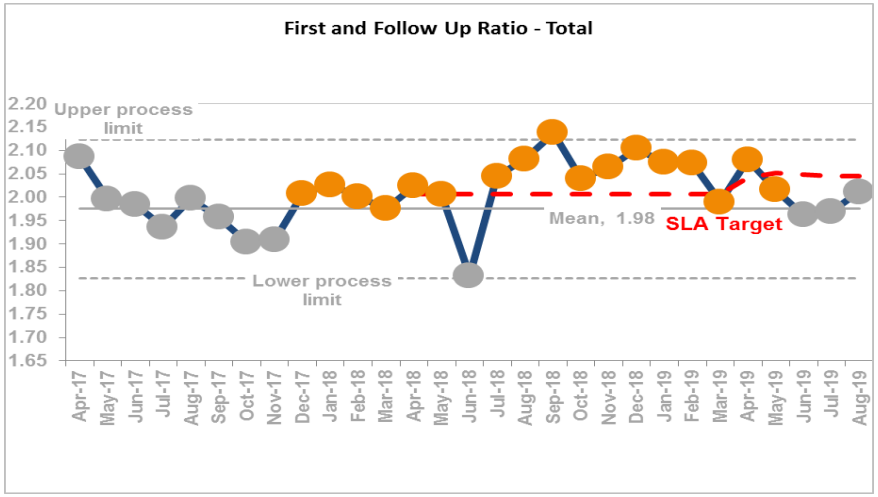


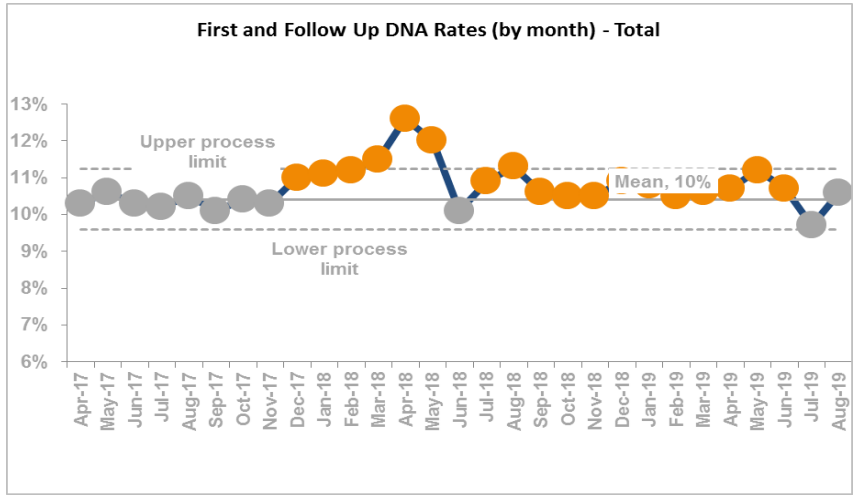






Outpatient Productivity





What the information tells us

- The Trusts First to Follow-up ratio is within its expected process limits and shows common cause variation.
- Surgery and Trauma & Orthopaedic Services both continue to have First and follow up ratios consistently below their mean for at least the past seven months which reflects the recent reduction in follow-up activity.
- The Trust DNA rate is within its process limits and shows common cause variation.
- Women's services and Renal & Oncology have consistently been below its means whereas Neurosciences and Other (Acute Medicine, Therapies and Diagnostics) have all been consistently above their means for over a year.
- The number of patient DNA's in August have seen an increase within Children's Services and Specialty Medicine moving above the mean.

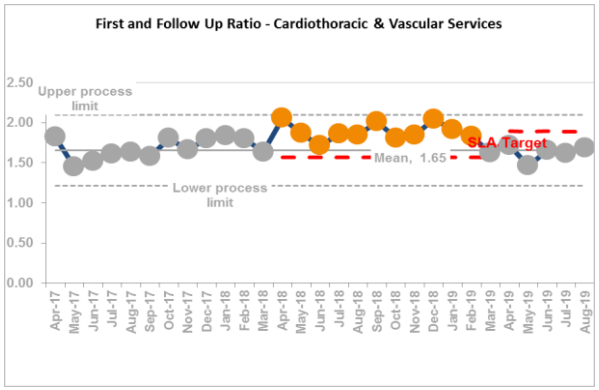
Actions and Quality Improvement Projects

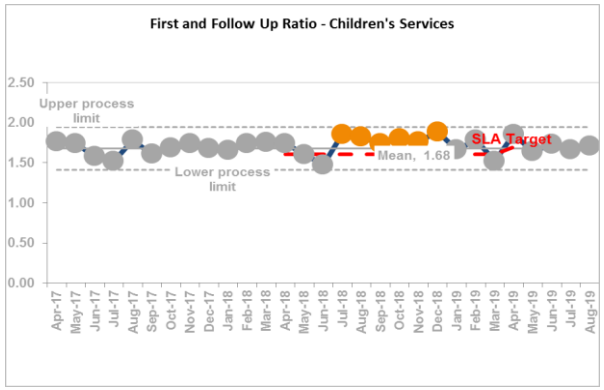
- Divisions are currently scoping opportunities to implement virtual follow-up appointments and open access to support reducing follow-up attendances and improve new to follow-up ratios across the services.
- Additional appointment types have been added to the two way text reminder service in Dermatology, Plastics, Trauma & Orthopaedics, Haematology, Audiology, Audiology Medicine and Ear Nose & Throat.
- Two way text reminder roll out continues.
- Neurosciences have seen a recent increase due to moving away from partial booking system for all new referrals. Service will be auditing the number of DNA's to understand non-attendance.

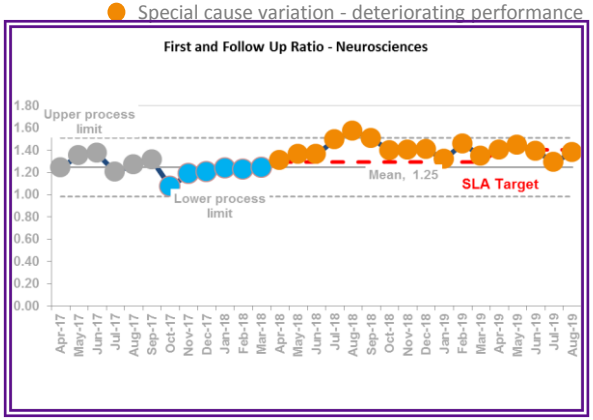
New to Follow Up Ratios

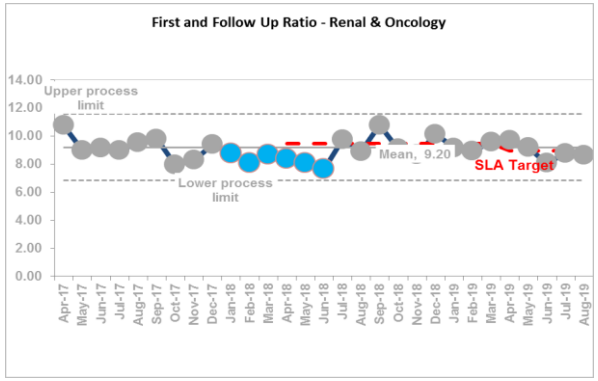
St George's University Hospitals NHS Foundation Trust

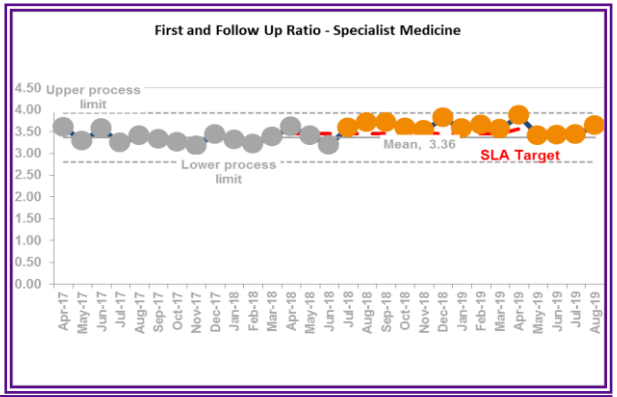
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

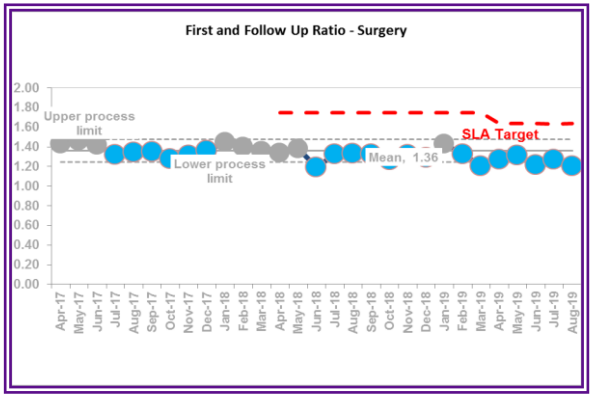


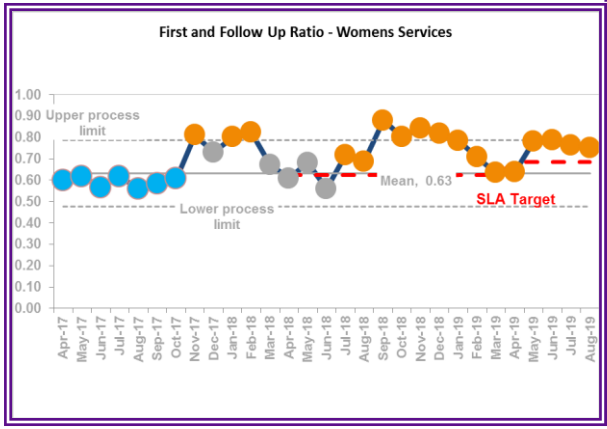


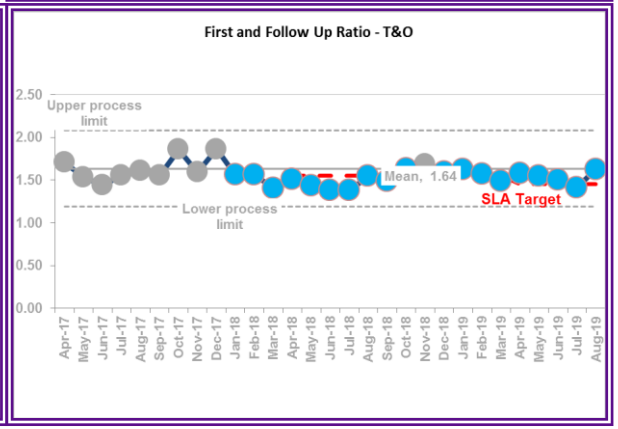








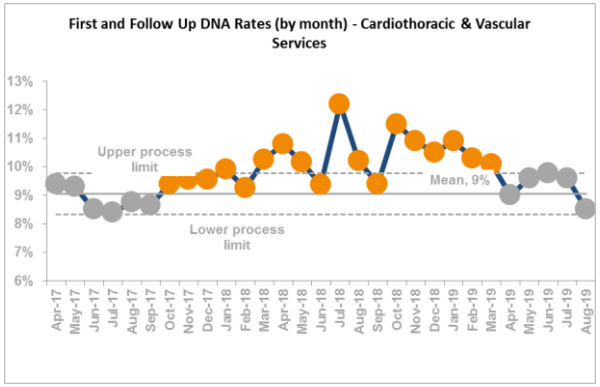


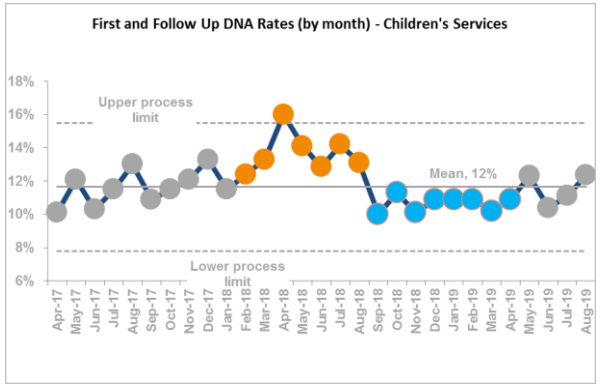


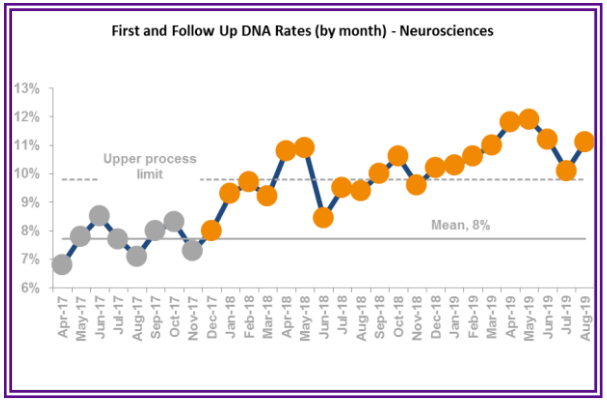
Percentage of patients that did not attend their appointment

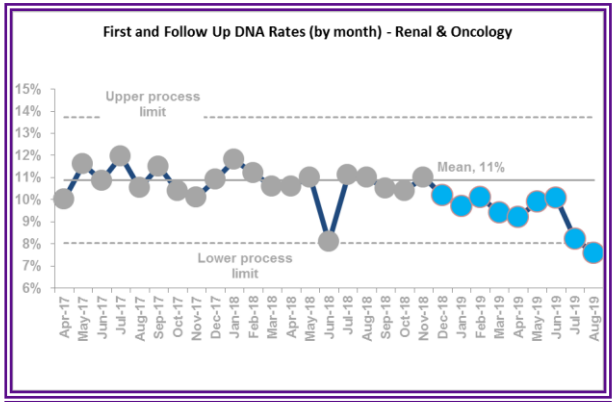
St George's University Hospitals NHS Foundation Trust

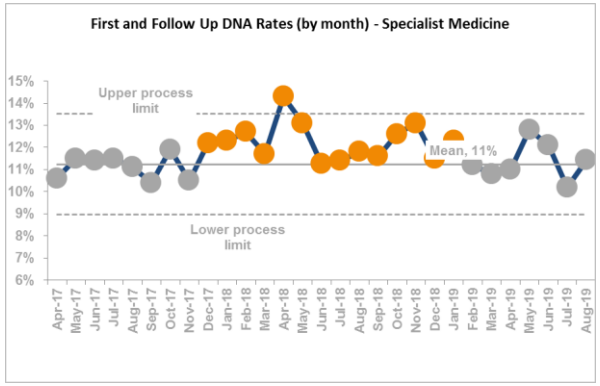
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

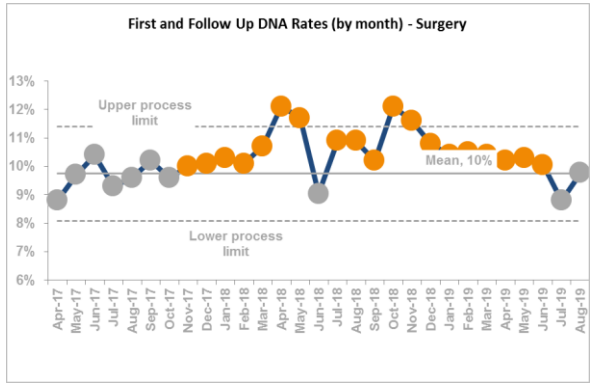


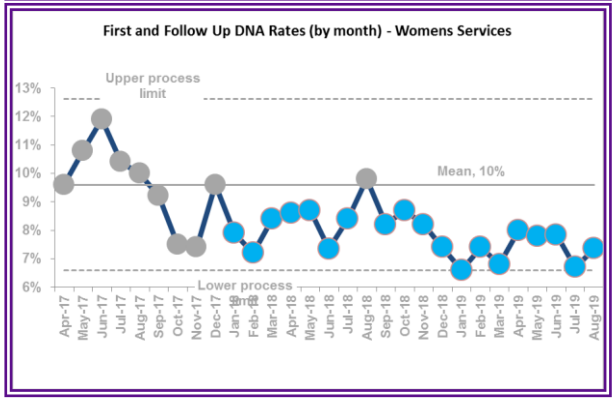


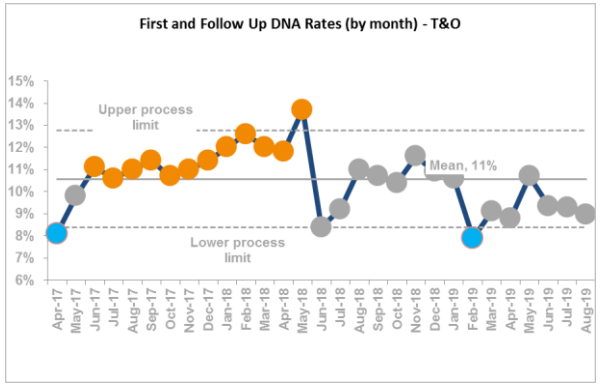


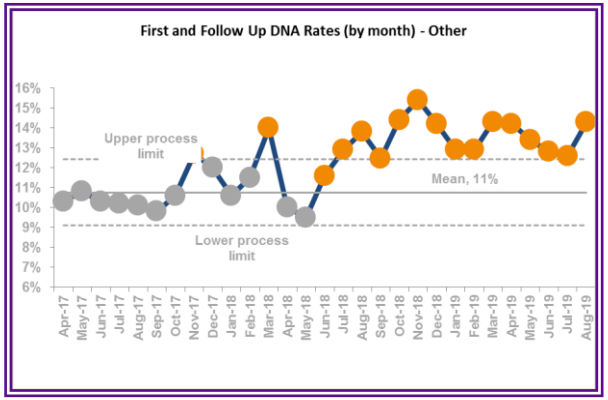




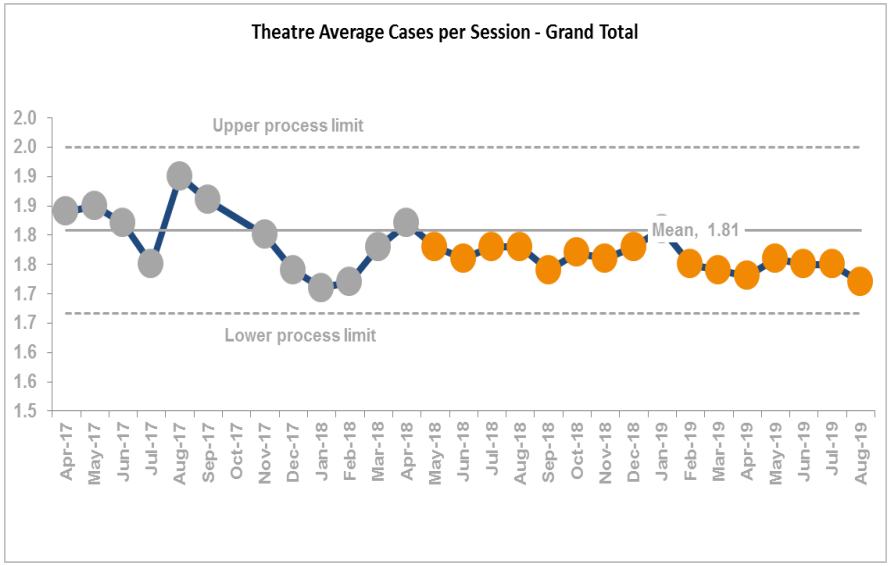


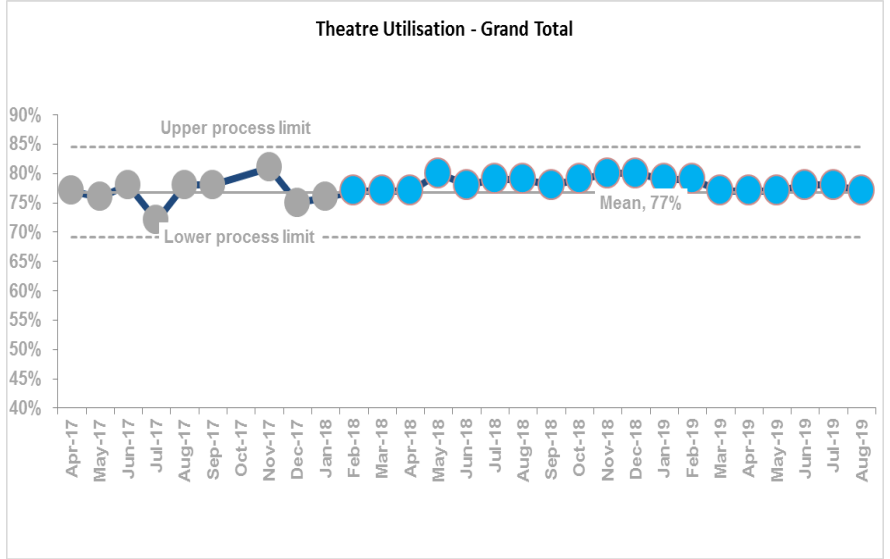






Theatre – Touch time utilisation





What the information tells us

- The Trust's Cases per Session remains within its normal process limits however for the past seven months, it has been consistently below its mean and below the same period last year.
- Ear, Nose & Throat have increased throughput in the month of August moving above the upper control limit, with Vascular Surgery also seeing an increase in the number of cases per session for the past three months but remaining within the control limits. Whereas Neurosurgery and General Surgery has fallen below its mean since the beginning of this calendar year. Trauma and Orthopaedics had sustained run above its mean for nine months but in July and August fell below its means however it is within its expected control limits. All other specialties are within expected range
- The Trust's Theatre utilisation remains above its mean at 77% however it remains consistently below 85%.
- Cardiothoracic's utilisation is consistently below its mean. Ear, Nose and Throat Services return to performance above the upper control limit.

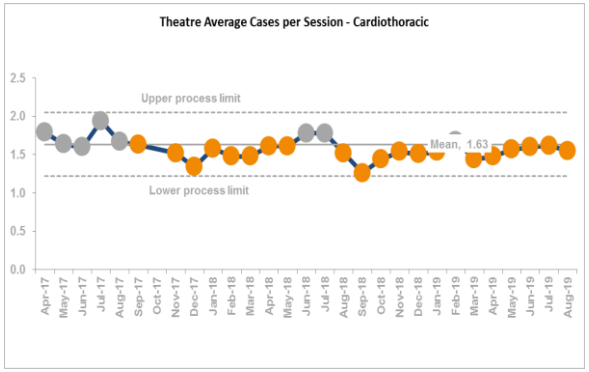
Actions and Quality Improvement Projects

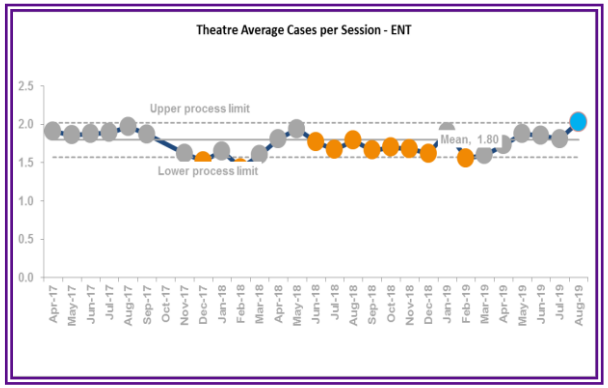
- The Theatre Steering Group has been launched to focus on making sure we are maximising the resources we have so we can support our staff to treat patients
- The Theatre Steering Group has been launched to focus on making sure we are maximising the resources we have so we can support our staff to treat patients
- The POA Steering Group is in place and looking to centralise IP and DSU areas into one area to make it an easy as possible for our patients to be assessed for surgery, and make the best use of our resources
- A new scheduling tool called 'INSIGHT' is having a soft launch w/c 23rd September, the tool will provide consultant specific data, to support with better list compilation to ensure we are efficiently using theatre resource .

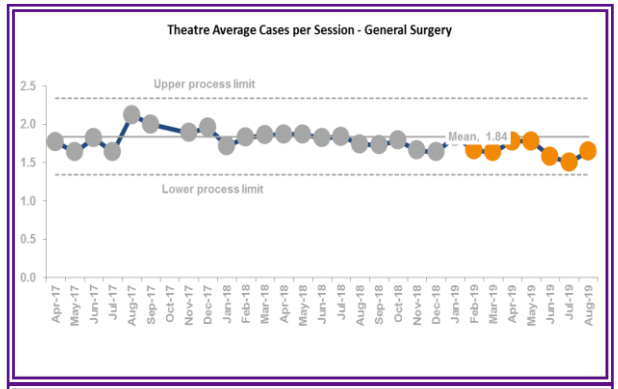
Theatre productivity – cases per session

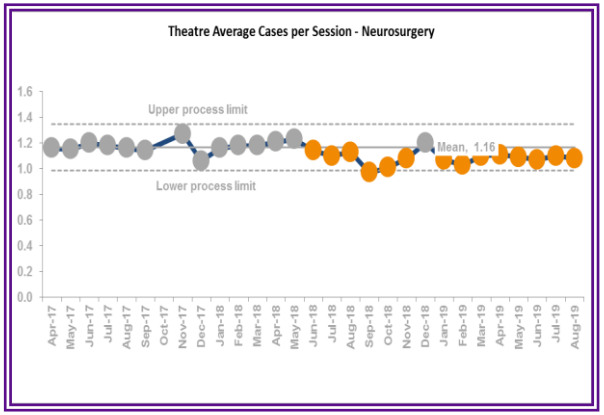
St George's University Hospitals NHS Foundation Trust

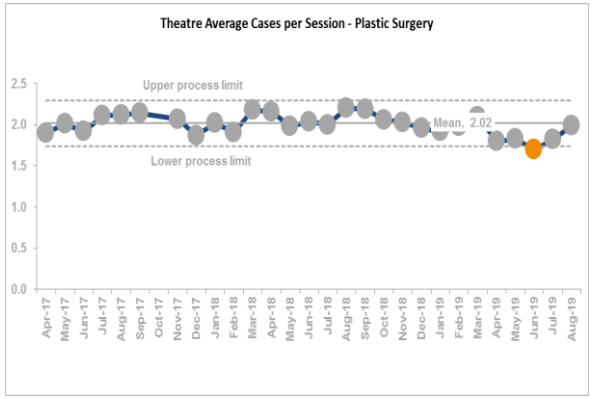
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

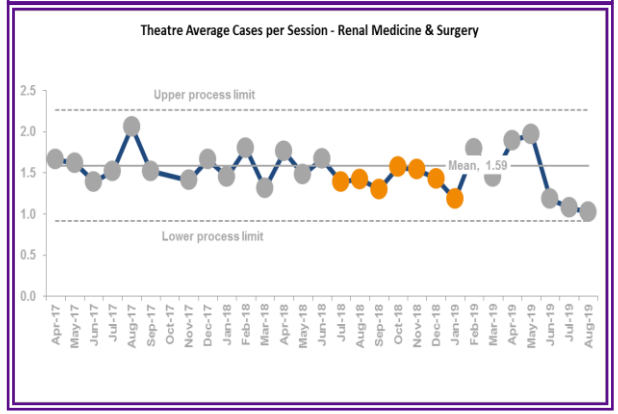


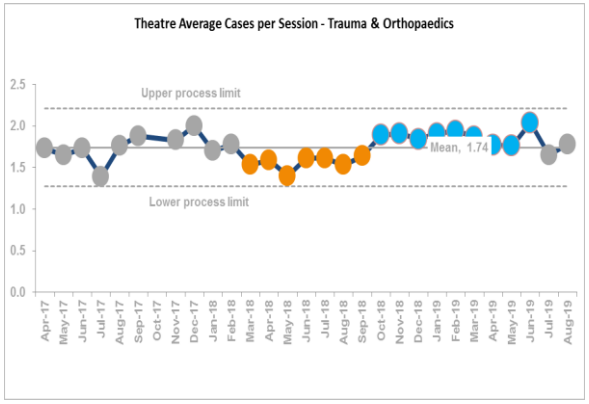


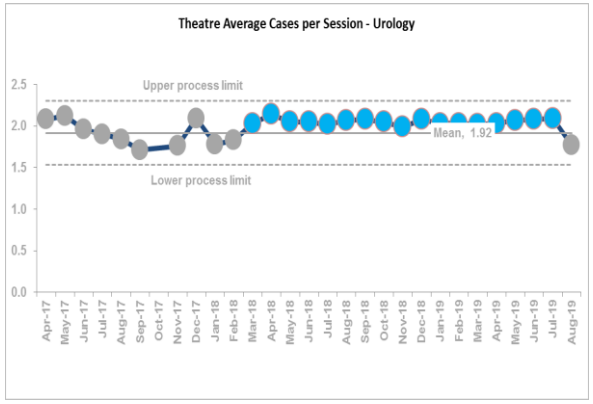


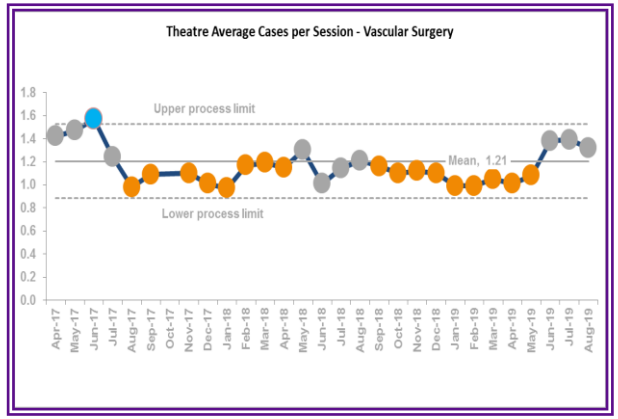








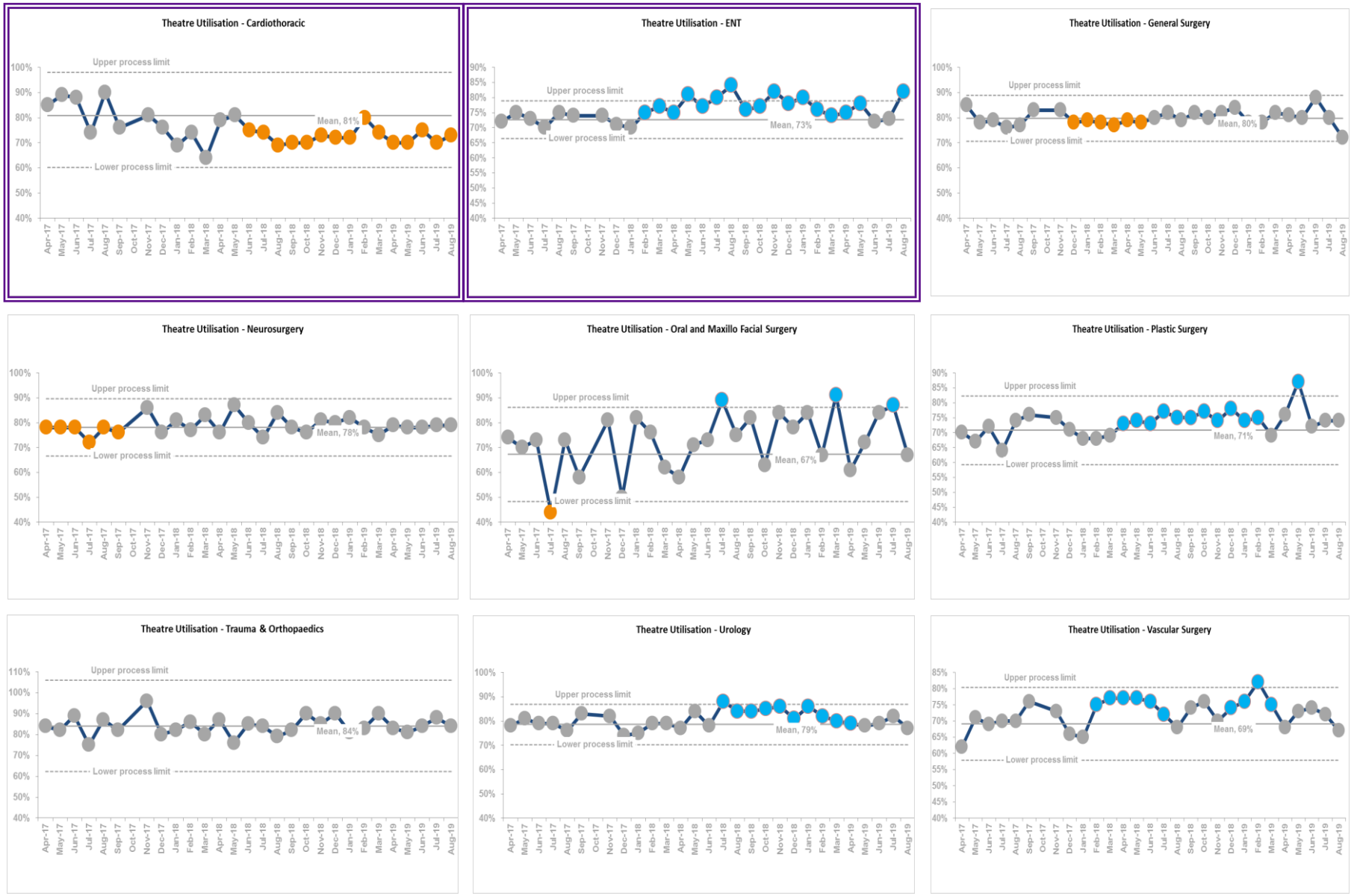




Theatre productivity – Utilisation

St George's University Hospitals NHS Foundation Trust

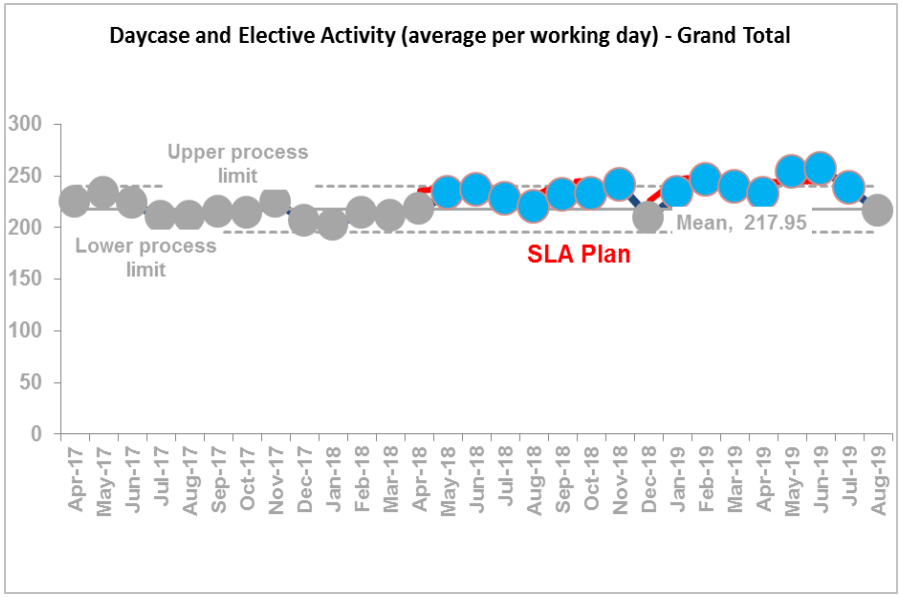
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

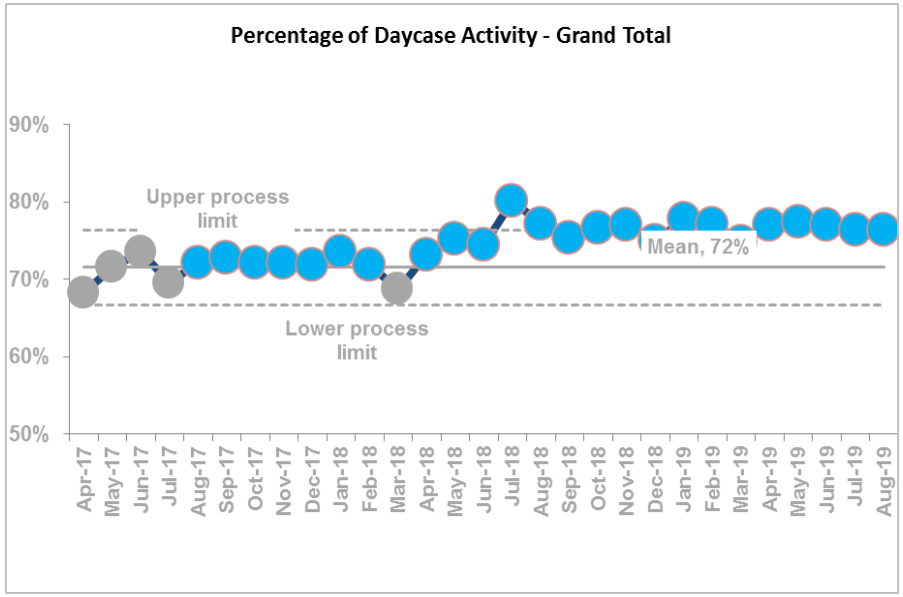


Number of Elective and Daycase Patients treated per Working Day

St George's University Hospitals NHS Foundation Trust

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance





What the information tells us

- August 2019 data has fallen slightly below average however along with the seasonal variability there will be be an element of data catch up and activity numbers are likely to increase once coding is complete. The year to date activity is on target with SLA plan.
- Neurology and Plastic Surgery are both performing above their means.
- Cardiology & Cardiac Surgery, General Surgery and Trauma & Orthopaedics specialties are showing special cause variation as these specialties are below their lower process limits.
- Ear Nose and Throat have been consistently below their mean for the past seven months
- All of the other specialties are within their expected process limits.

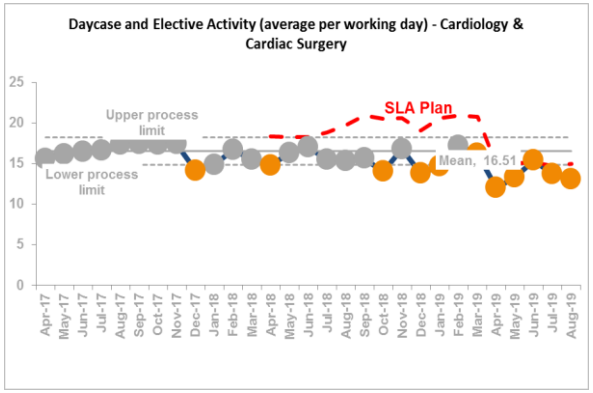
Actions and Quality Improvement Projects

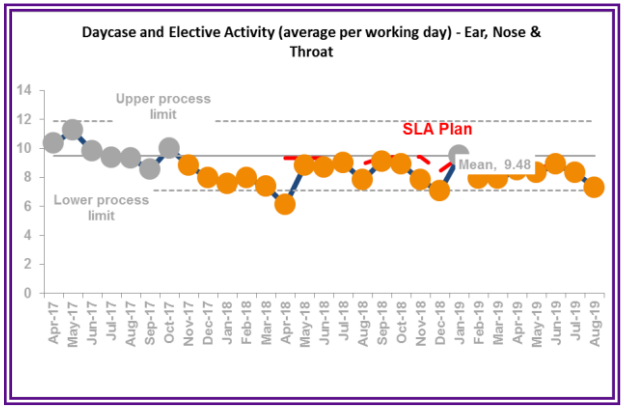
- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions. This is linked to a weekly task and finish group.
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases and utilisation.
- SNTC Division finance has completed service specific one pagers in conjunction to identify actions required to support SLA achievement.

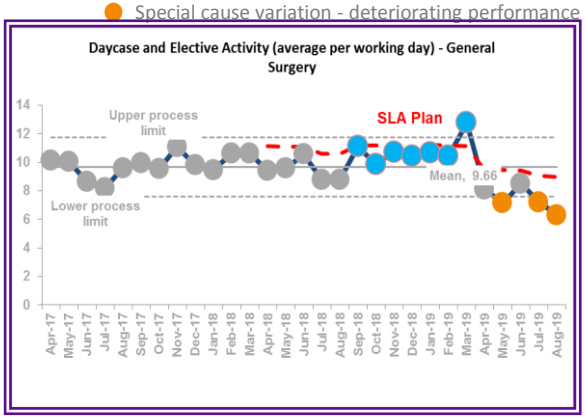
Number of Elective and Daycase Patients treated per Working Day

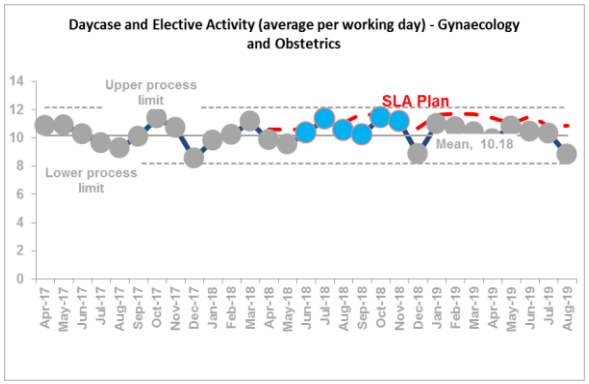
St George's University Hospitals NHS Foundation Trust

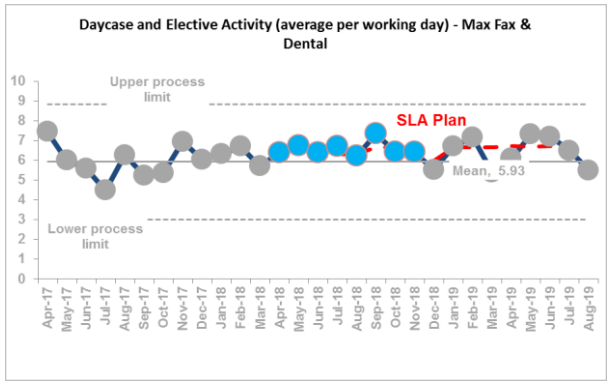
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

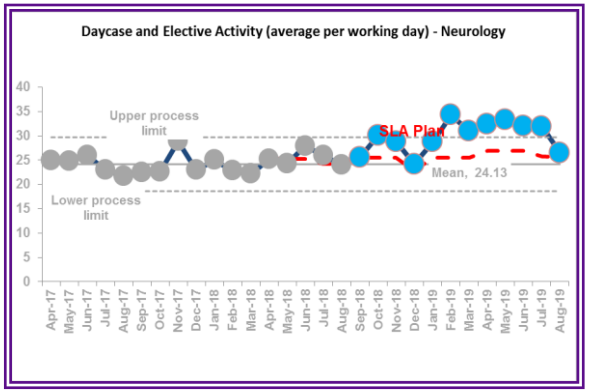


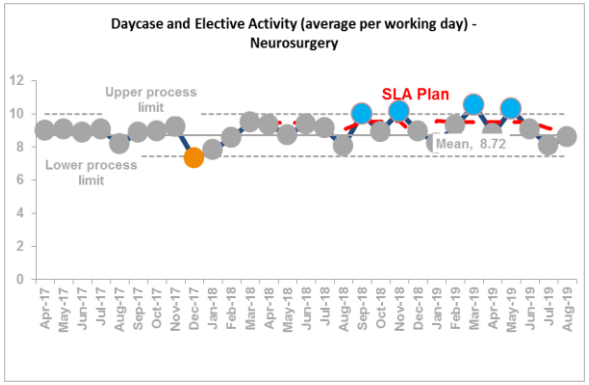


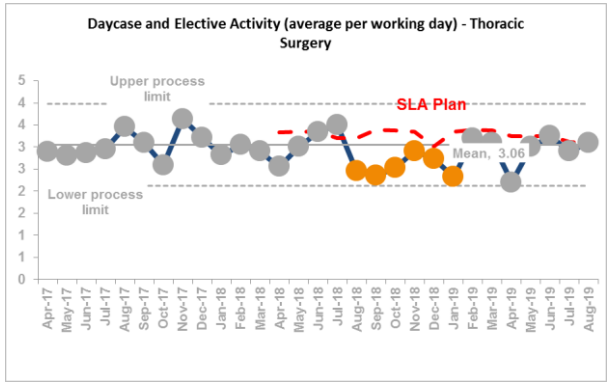


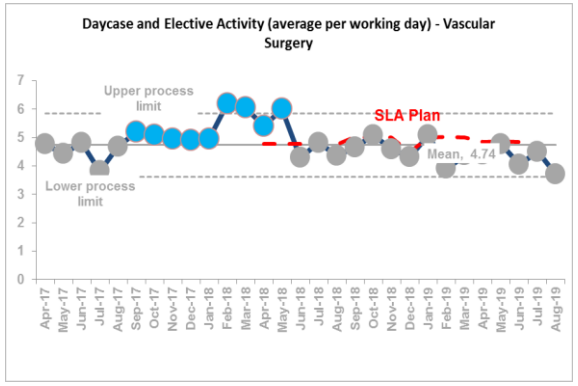








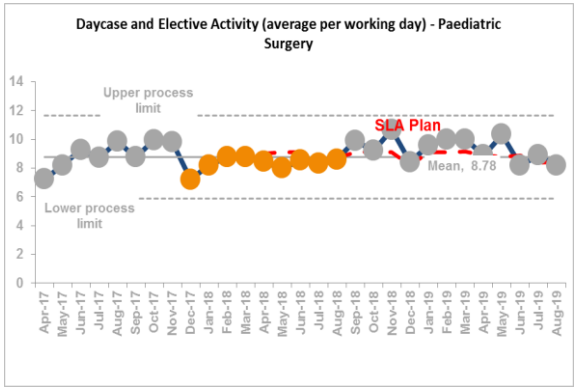


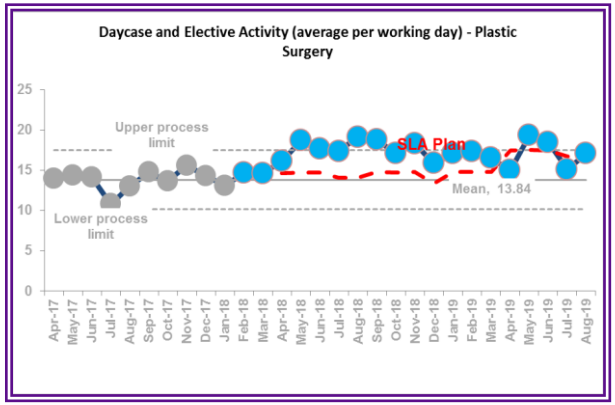


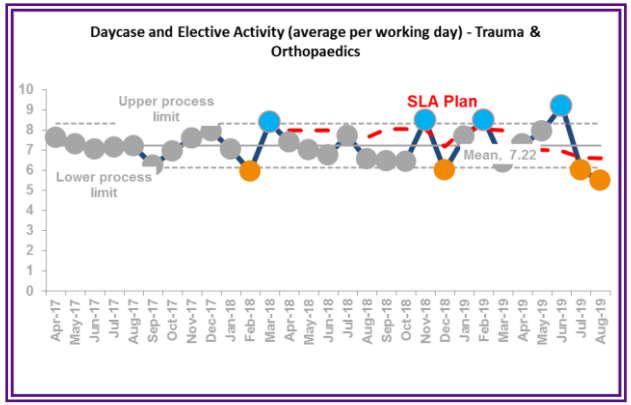
Number of Elective and Daycase Patients treated per Working Day

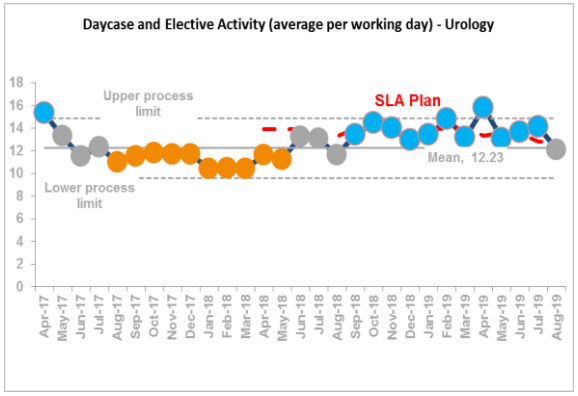
St George's University Hospitals NHS Foundation Trust

- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



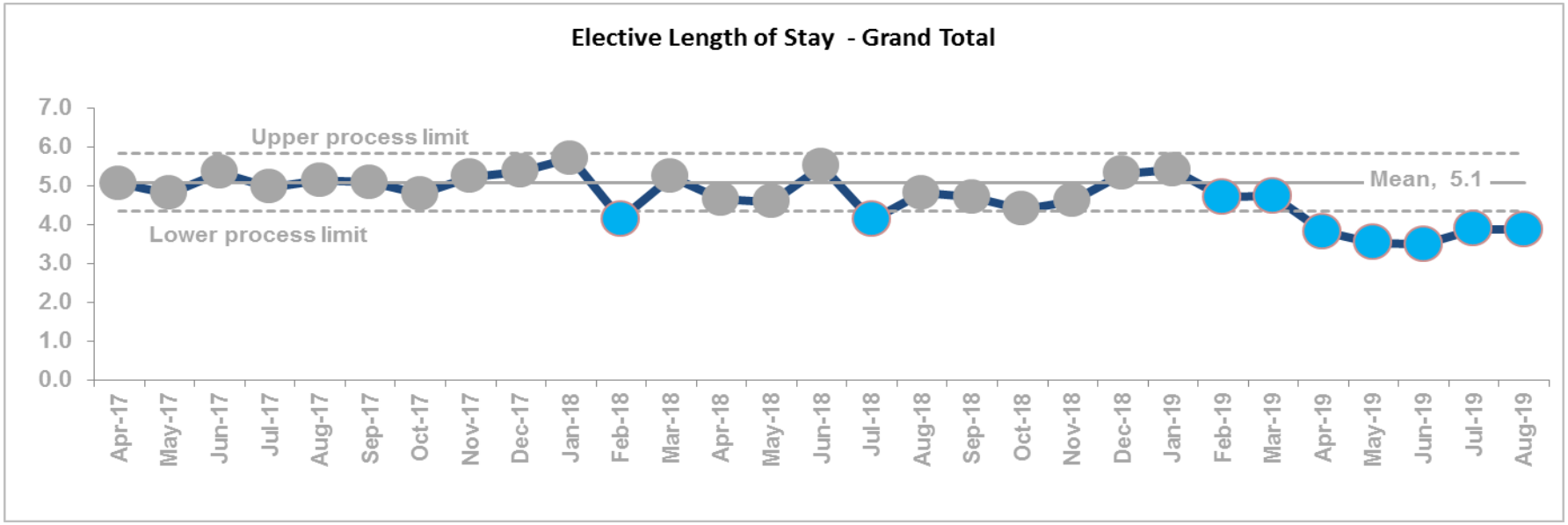






Our Finance & Productivity Perspective

Elective Length of Stay (excluding daycase)



What the information tells us

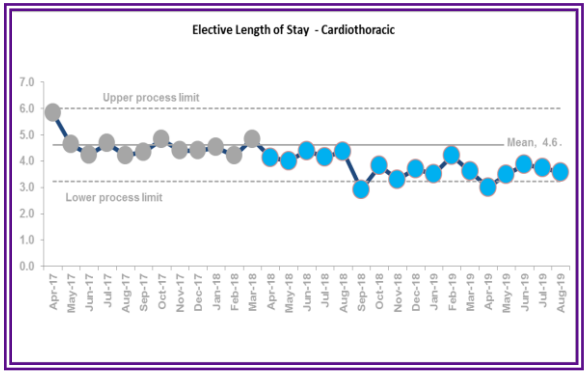
- The Trust's Elective overall elective length of stay is below its lower limit for the previous five months and has been consistently below its mean for the past seven months
- Cardiothoracic Length of Stay remains consistently below its mean
- Surgery and Trauma have reduced their length of stay month on month consistently for the previous seven months and is at its lower process limit.

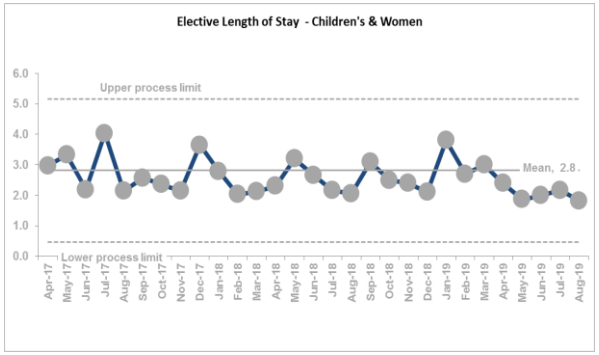
Elective Length of Stay (excluding daycase)

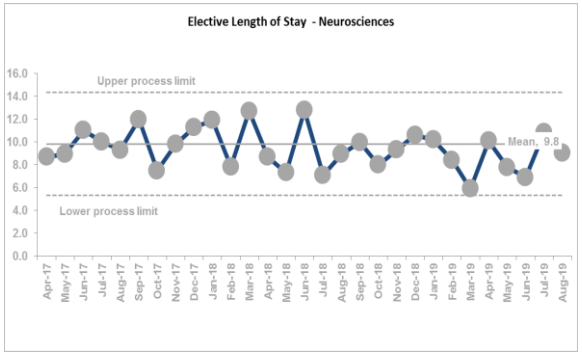
St George's University Hospitals NHS Foundation Trust

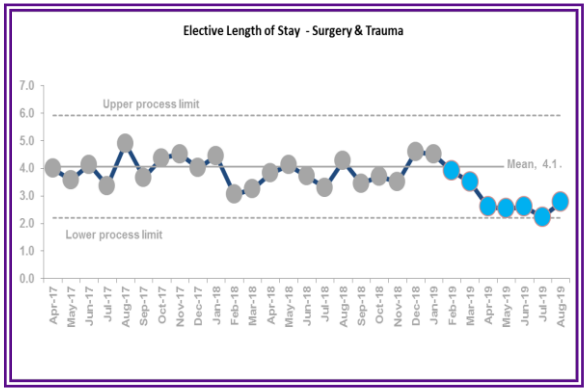
2.2

- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance





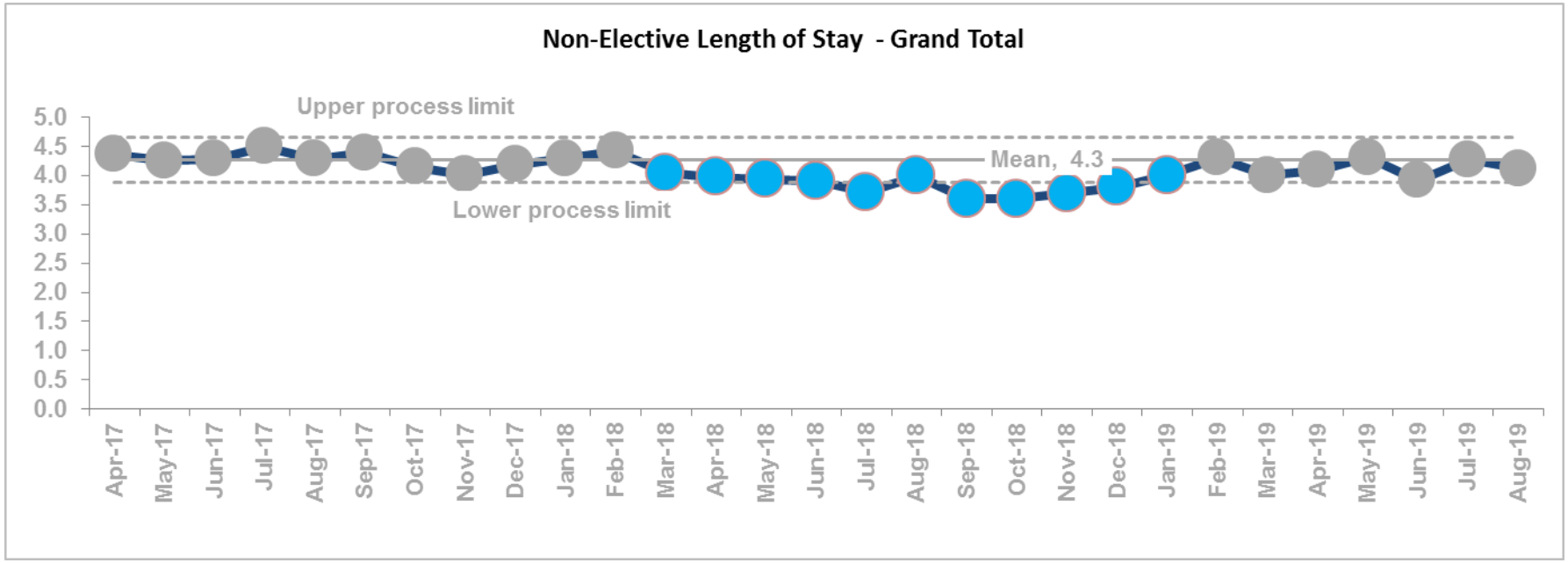




Our Finance & Productivity Perspective

Non Elective Length of Stay

St George's University Hospitals NHS Foundation Trust



What the information tells us

- The Trust's Non-Elective length of stay is within the expected process limits.
- Acute Medicine's Non-Elective length of stay has again remains above the mean for a consecutive month and is nearing the upper control limit.
- Specialist Medicine have dropped back to within normal process control limits after exceeding the upper limit in May 2019 and June 2019.
- Cardiothoracic have also fallen back into expected control limits having previously been above the mean for the past six months.
- Children's and Women's directorate was consistently below its mean however have recently shown special cause variation with length of stay being above the mean.
- All other directorates' variation are due to common cause

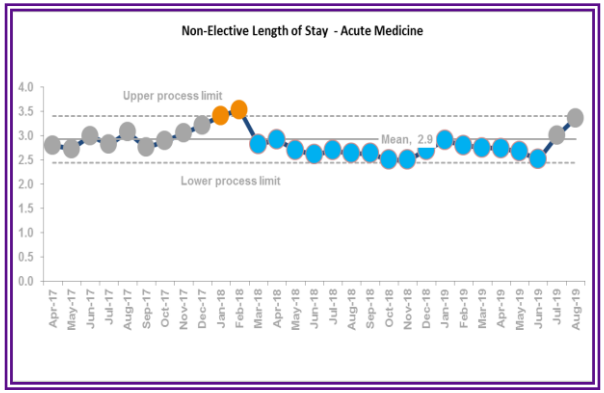
Actions and Quality Improvement Projects

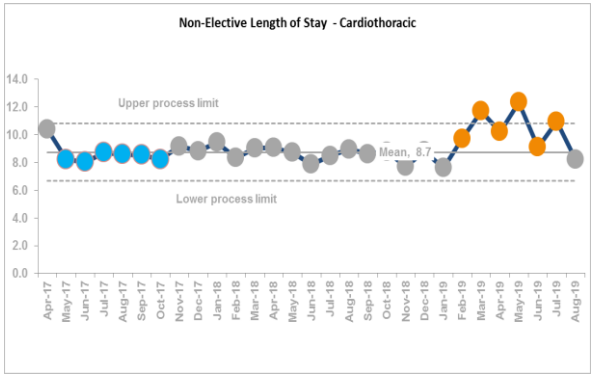
- The Emergency Department and Inpatient Clinical teams have identified a range of patient experience, quality and productivity opportunities to evolve the processes embedded within iClip and these need to be the immediate priority.
- Support Ward teams to deliver SAFER consistently.
- A return to a concerted focus on long and extended length of stay patients is being implemented by the Medcard Division.

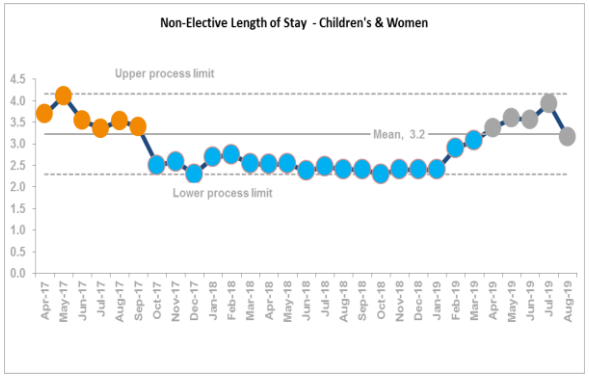
Non Elective Length of Stay

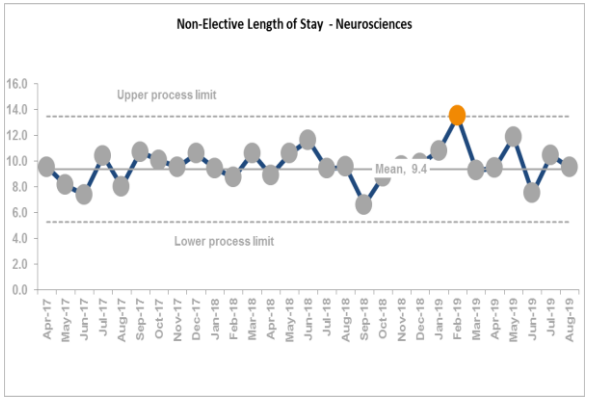
St George's University Hospitals NHS Foundation Trust

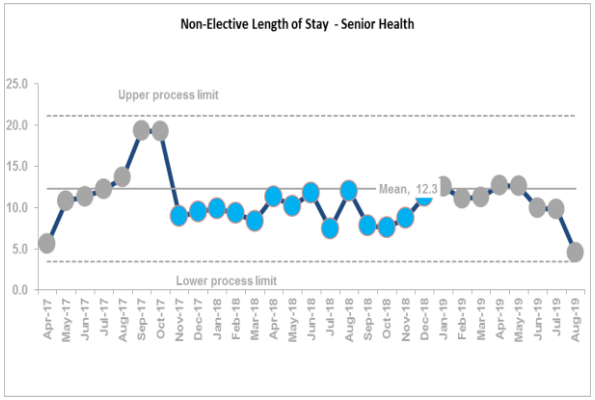
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

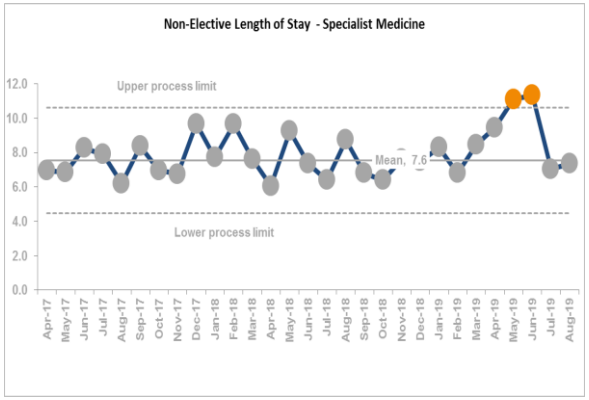


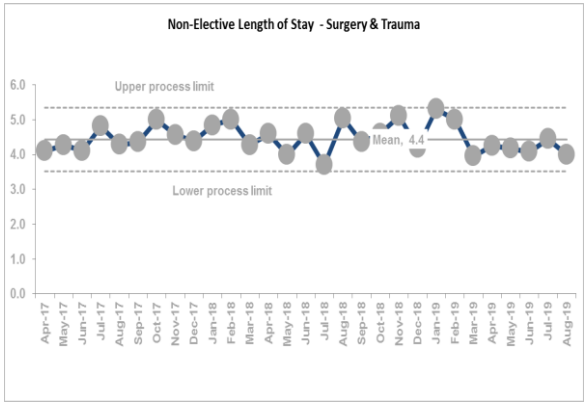


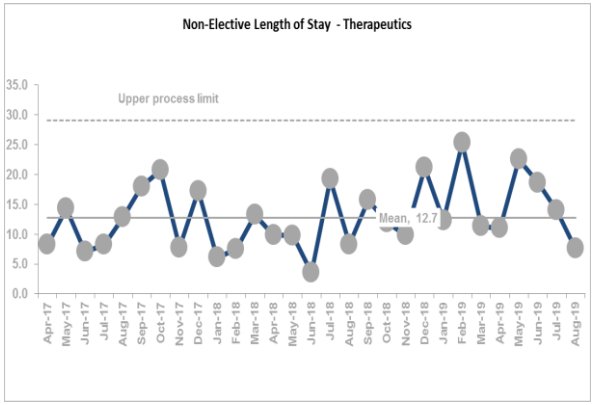










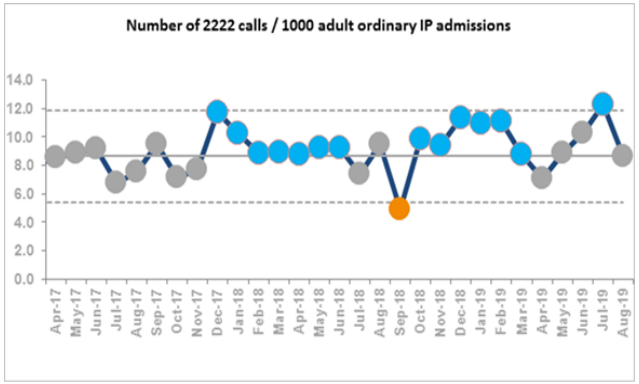


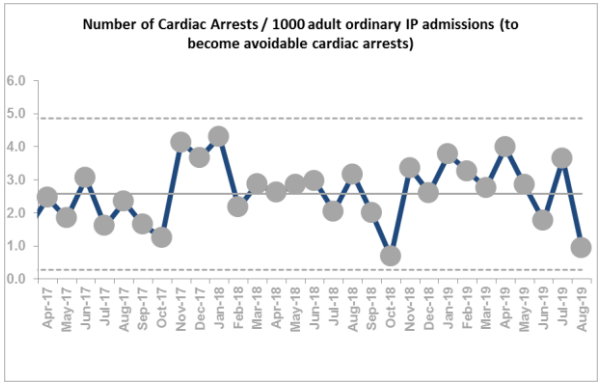
Balance Scorecard

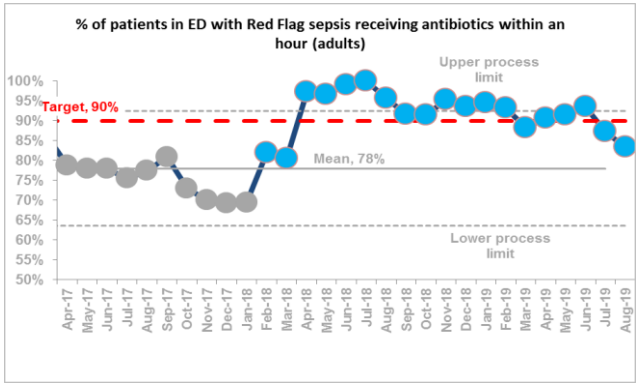
St George's University Hospitals NHS Foundation Trust

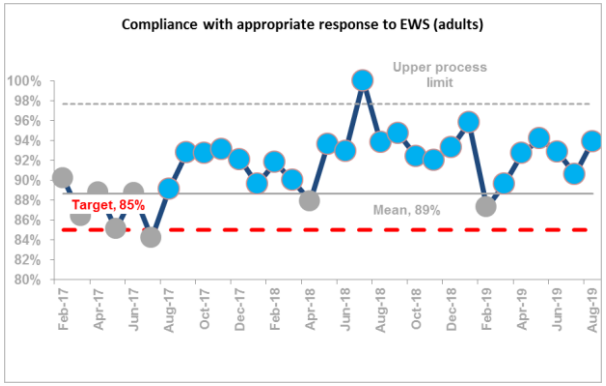
OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient productivity (attendances per day)	Theatre productivity (cases per session)	Bed productivity (length of stay)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control	Mortality	Readmissions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

Quality Priorities – Treatment Escalation Plan









What the information tells us

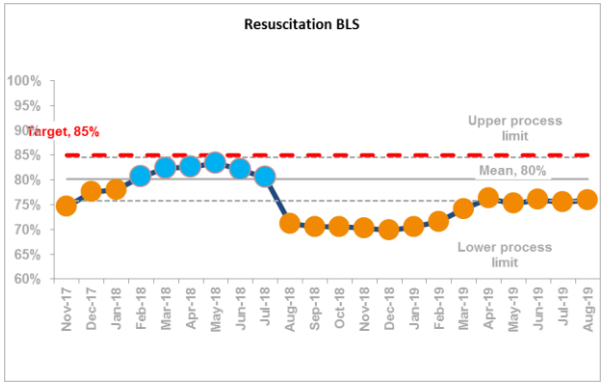
- The rate of 2222 calls and number of Cardiac Arrests are within control limits
- The Trust has fallen below its target of 90% of adult patients in the Emergency Department with Red Flag Sepsis receiving antibiotics within an hour

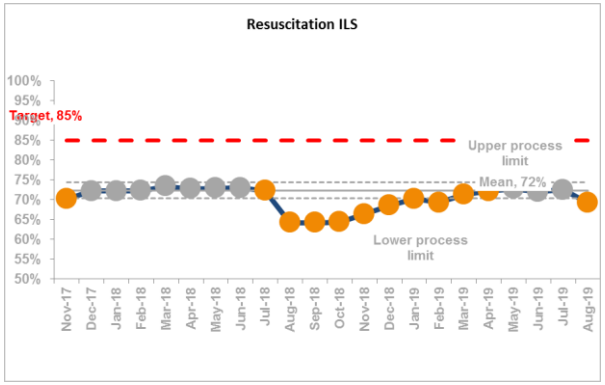
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

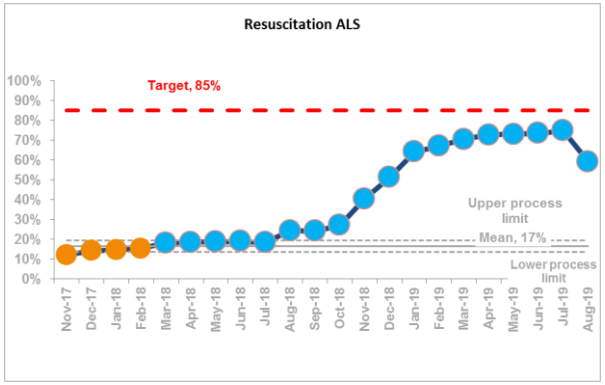
Actions and Quality Improvement Projects

- Emergency Department congestion has been identified as the cause of the fall of performance for worsening performance. The team are working with the FLOW programme to decongest the Emergency Department.
- Information Technology (IT) is working towards TEP being on iCLIP; this is currently in the test domain. Audit measures have been agreed with IT in readiness for electronic audit facility anticipated by end of Q3.

Quality Priorities –Deteriorating Patients







What the information tells us

- Additional resuscitation BLS (Basic Life Support) training has been commissioned but delivery of this performance target by 30 September 2019 is at risk. Resuscitation ILS and ALS (Intermediate and Advanced Life Support) training performance is also benefitting from additional training capacity as outlined above
- Training performance has fallen in August however this is due to the intake of Junior Doctors. The fall has not been as sharp as in previous August periods

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

Actions and Quality Improvement Projects

Deteriorating Patients

- Successful Trust wide rollout of National Early Warning Score 2 (NEWS2) in late March 2019
- Improved divisional engagement with Deteriorating Adults Group from nursing with responsibility for driving improvements across the Trust
- Developing management level and monthly audit data with IT for NEWS2 in iCLIP in readiness for electronic audit facility anticipated by end of Q3
- Critical Care Outreach project group established and interim Matron appointed with phased implementation due from Q3

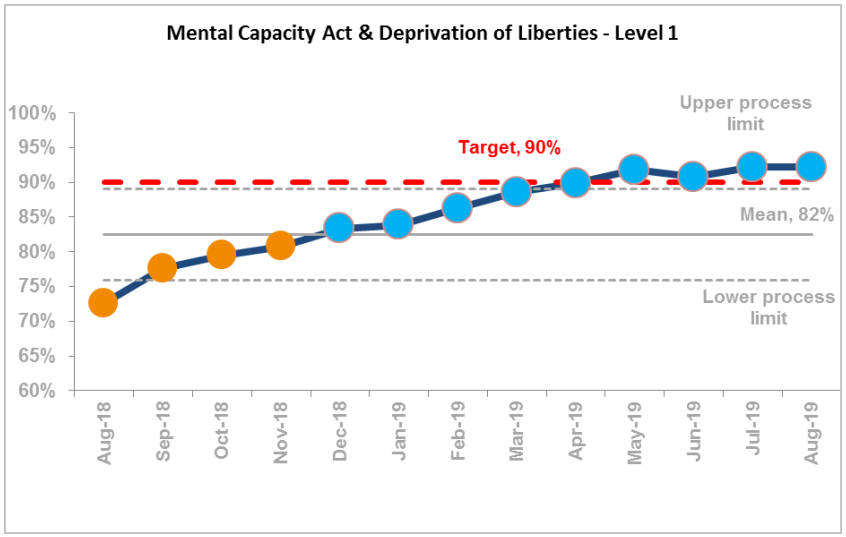
Resuscitation

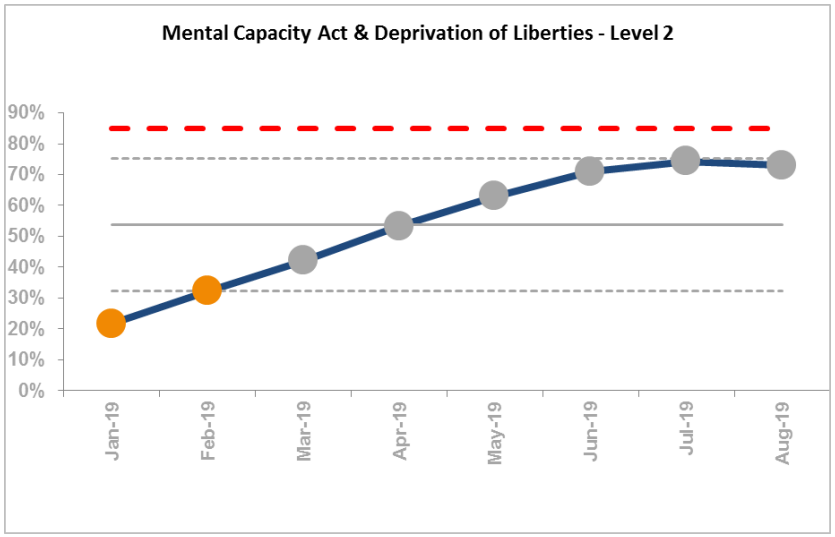
- Additional champions recruited to deliver training.
- DNA list sent to divisional management teams to review and action.
- Additional staffing: 1.5 WTE seconded staff (in place) + 2 WTE to fill established vacancies releasing 12-18 additional training places for each course
- eILS has been introduced (removes the recertification course); a half day course; reduces DNA rate; creates capacity for additional BLS sessions
- Consultant only BLS session - blended approach to learning; video, then face-to-face session, 30 minutes duration.
- MAST training records of junior doctors from the previous employer currently being checked to update Totara.
- Training monitored weekly at Trust Communication Cell

Quality Priorities – Mental Capacity Act & Deprivation of Liberties

St George's University Hospitals NHS Foundation Trust

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance





What the information tells us

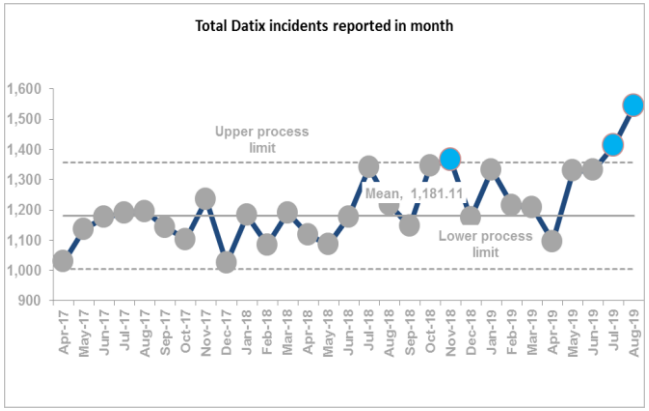
- Mental Capacity Act and Deprivation of Liberties – Level 1 training has exceeded the performance trajectory.
- Level 2 training is showing consistent improved performance month on month however, similar to other training programmes, the completion rate has fallen due to the intake of Junior Doctors

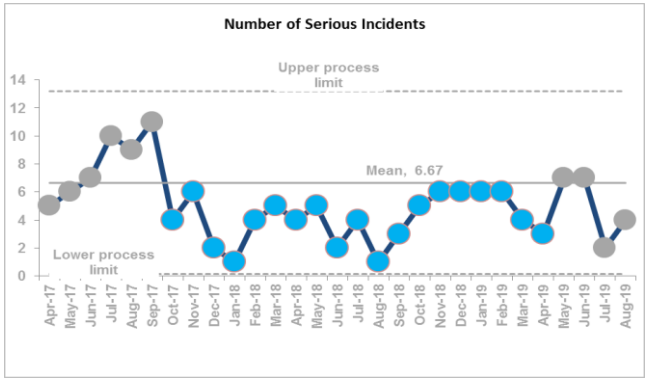
Actions and Quality Improvement Projects

- The Trust, along with SW London sector, has developed a draft standardised audit tool which is now under consultation. Taking a sector approach will enable to Trust to benchmark practice with similar Trusts and create a community of practice.
- Audit question framework developed to provide small scale pulse check of staff awareness. Outcomes to be reported for October Trust Board and are currently being reported at ward level
- Trust wide staff knowledge survey to be developed and completed quarterly.
- Electronic templates in iClip for documentation of MCA and Best Interests decisions are being reviewed for testing in Q3.

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%									100.0%	92.0%	100.0%	data two months in arrears	
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	39%	47%	64%	66%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days					





What the information tells us

- There continues to be no breaches of the 60 day time scale for SI investigations.
- There has been an increase in DATIX reporting for July and August. The August increase is predominantly related to cleaning concerns which are being monitored and addressed daily

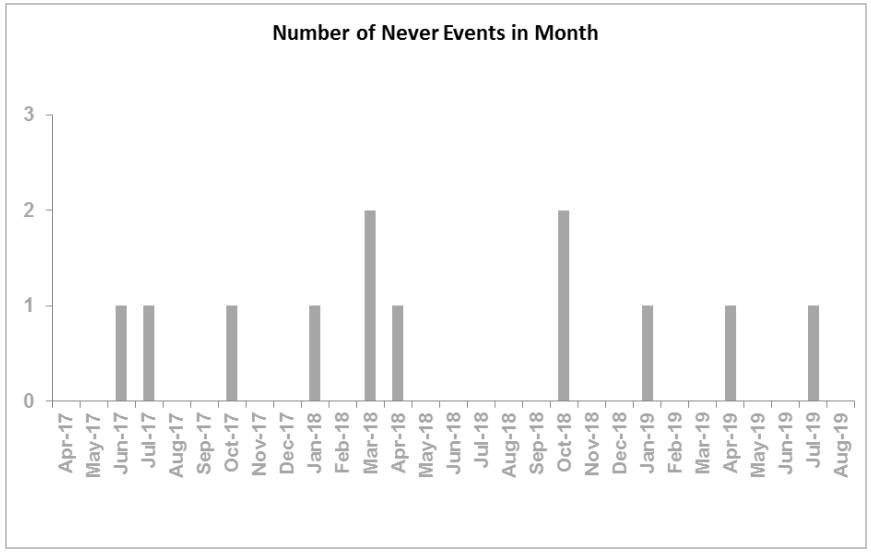
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

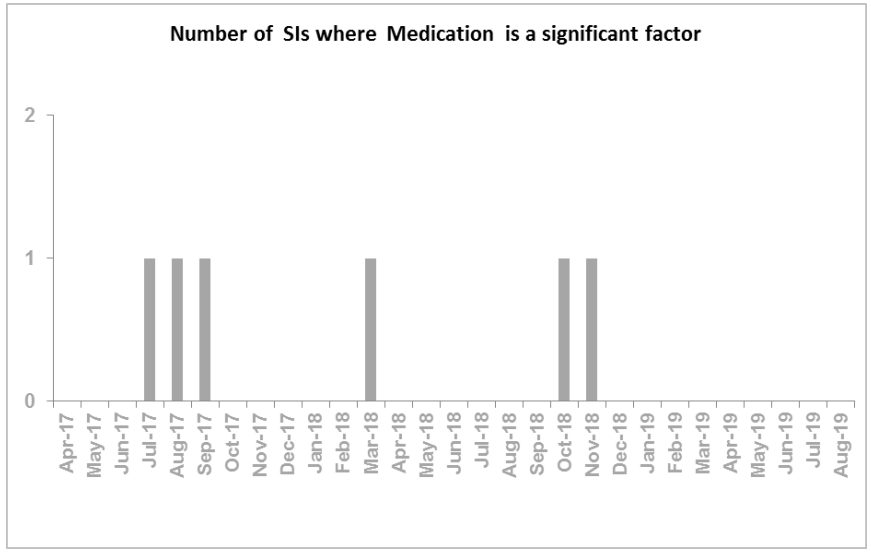
Actions and Quality Improvement Projects

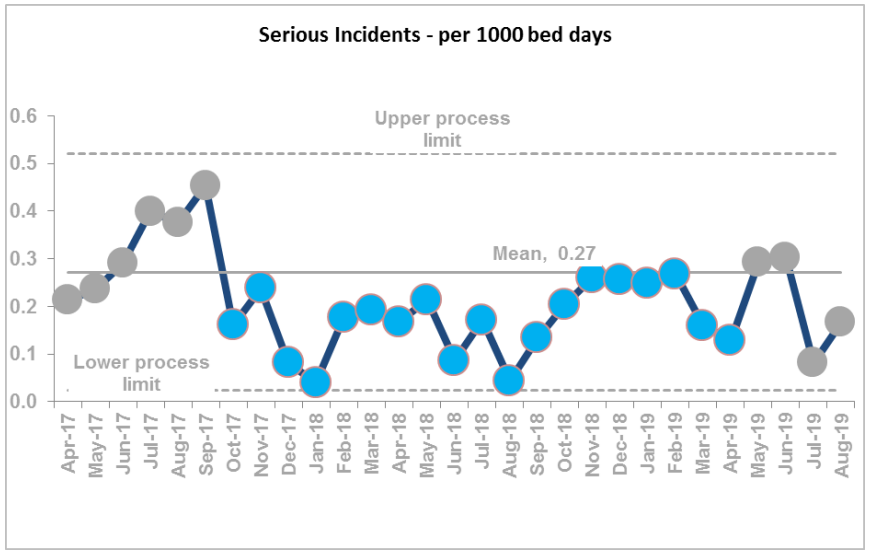
- Incidents – The number of Datix incidents will be reported by severity and per 1000 bed days from Q3 which will allow for benchmarking against other Trusts and tracking of the harm profile.

Quality Priorities – Learning from Incidents

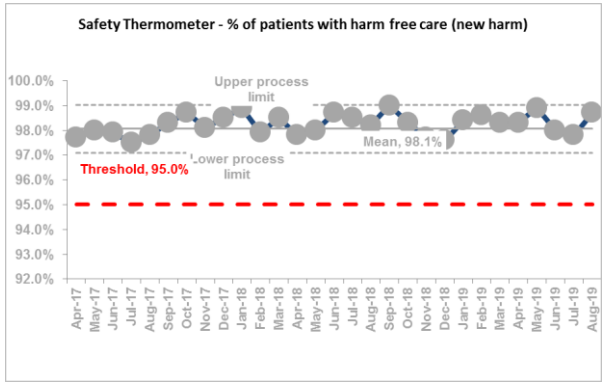
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

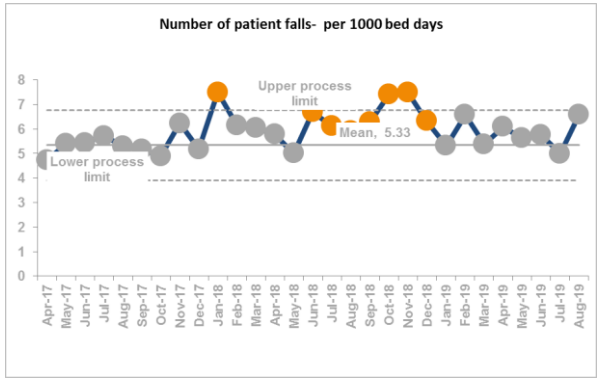


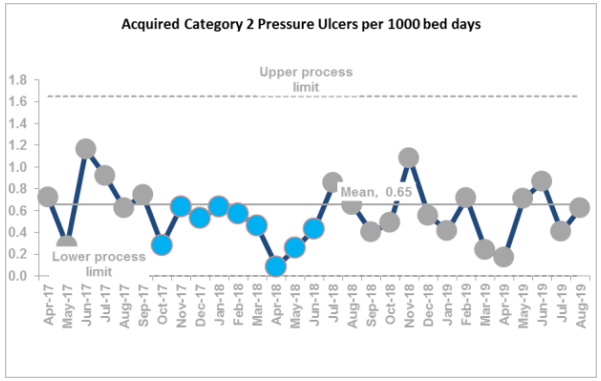




Patient Safety







What the information tells us

- There has been a step change in the percentage of patients with VTE assessments. This is due to a change in guidance and now includes areas such as maternity and CDU.
- All other metrics show variation due to common cause.

Actions and Quality Improvement Projects

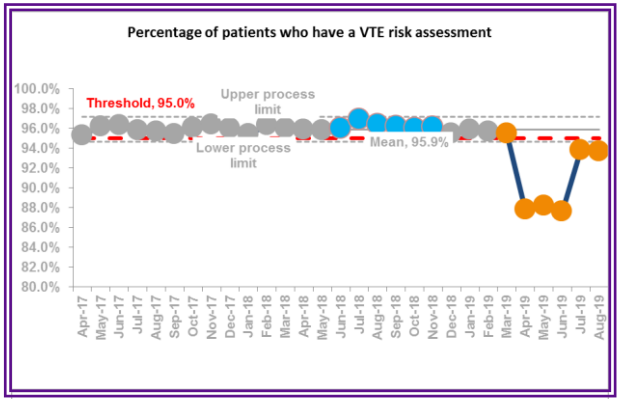
- The ward accreditation is fully embedded and there are no inpatient areas which require improvement
- The Trust is working to deliver the Falls CQUIN, specifically focussing on lying and standing for patients over 65 in line with NICE guidance

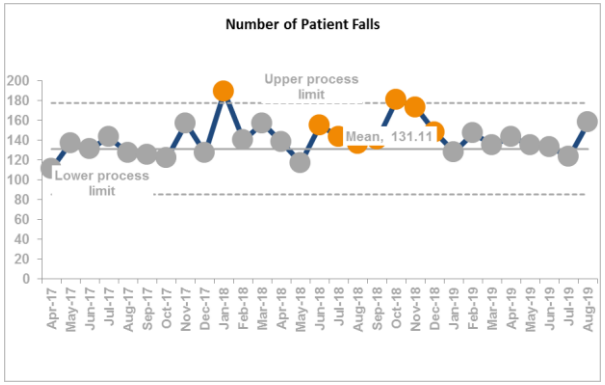
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

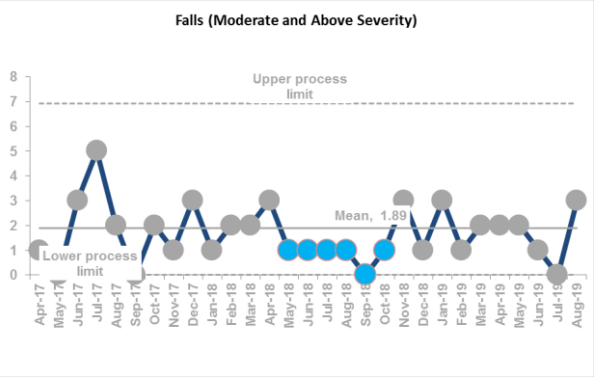
Patient Safety

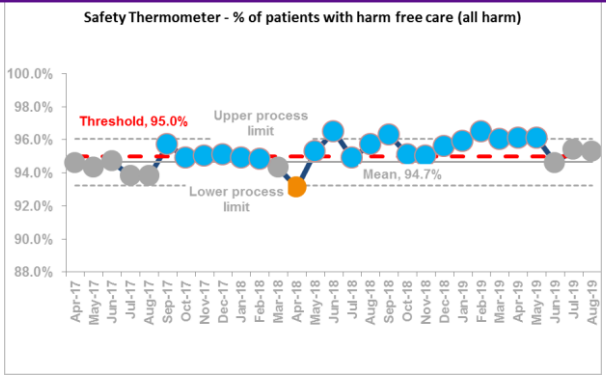
St George's University Hospitals NHS Foundation Trust

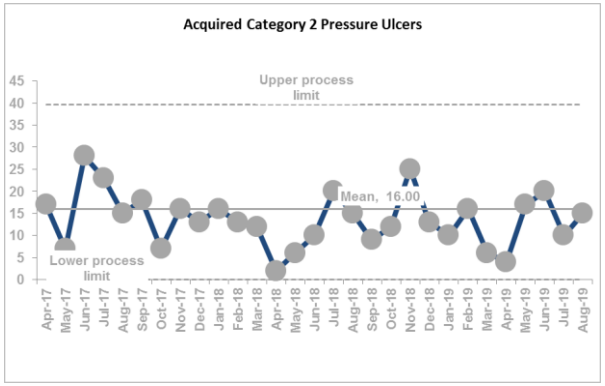
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

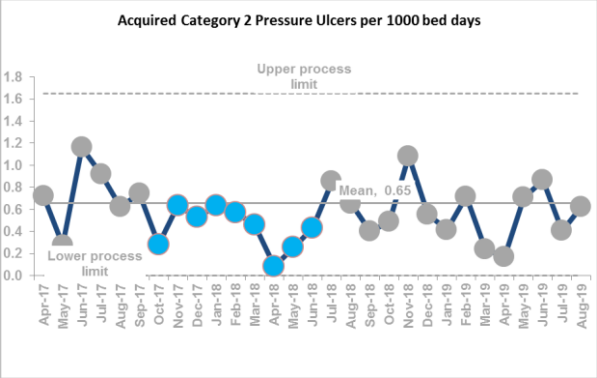


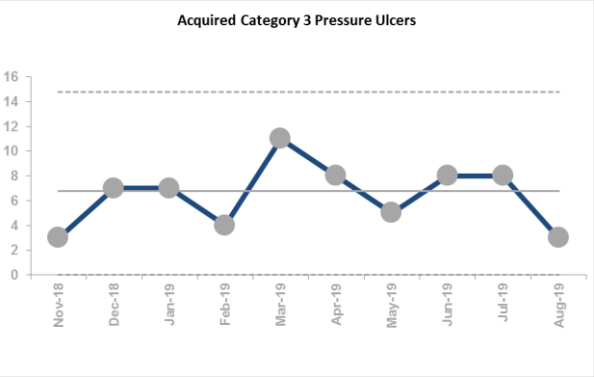


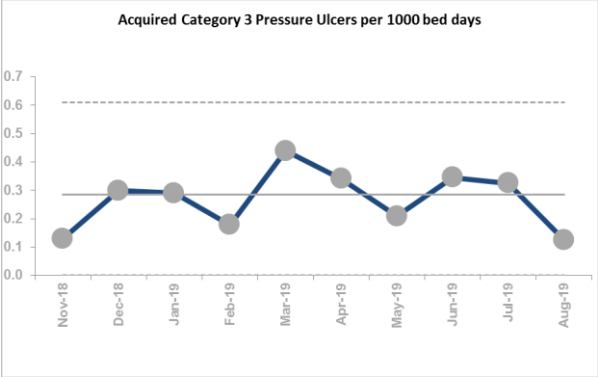












Infection Control

Indicator Description	Threshold	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD Actual
MRSA Incidences (in month)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Cdiff Hospital acquired infections	48	2	2	3	2	3	2	1	3	4	4	3	4	4	19
Cdiff Community Associated infections										0	0	2	0	1	3
MSSA	25	2	1	4	2	5	3	2	2	4	6	1	0	3	14
E-Coli	60	3	4	2	4	3	1	4	6	4	7	5	7	7	30

What the information tells us

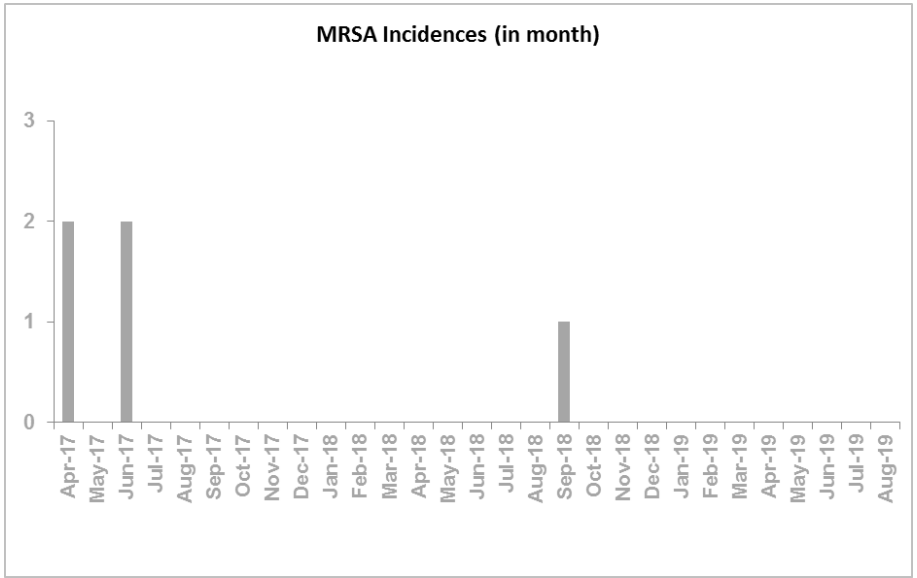
- The Trust MRSA position remains at zero year to date.
- The Cdiff YTD position is 22 with 19 Hospital Acquired infections and 3 Community Associated infections. The number of Ecoli cases reported remains within the control limits
- E-Coli and MSSA infection rates show common variation.

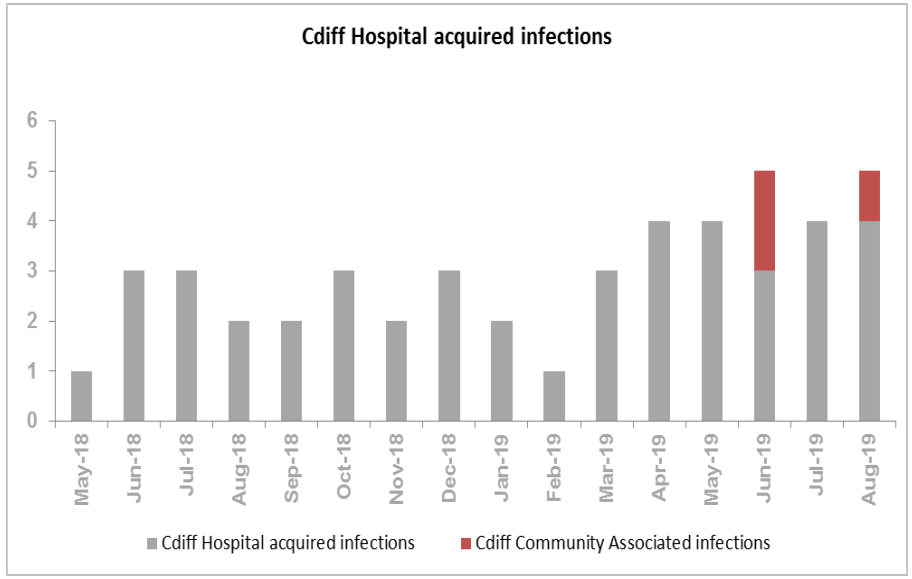
Actions and Quality Improvement Projects

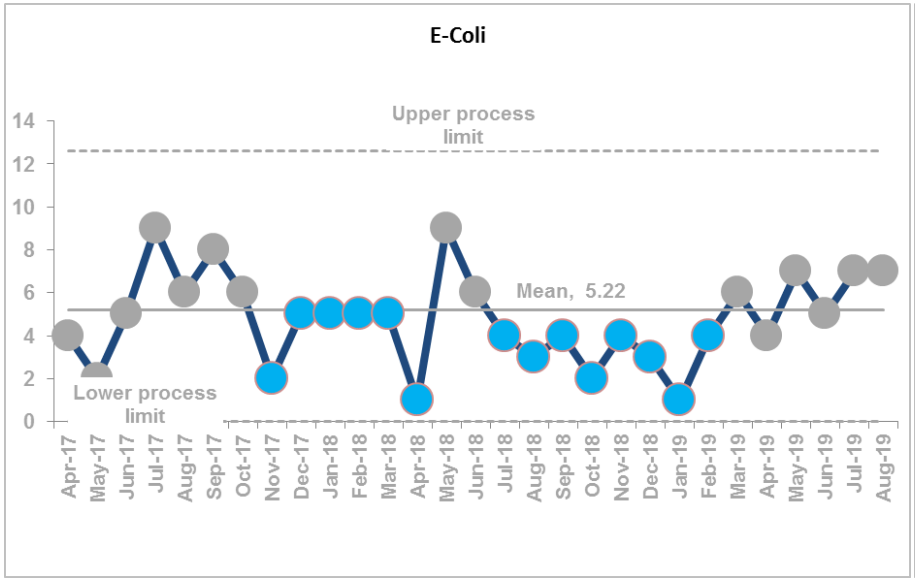
- All Cdiff cases have undergone a Root Cause Analysis (RCA).
- All MSSA cases are now to undertake a RCA to establish any causes and opportunities for learning and change in practice, and is reported through the infection control committee.
- A project group has been established across SWL STP to reduce the number of E-Coll infections. The first area of priority is catheter associated infections, however St Georges numbers are lower than peers in SWL

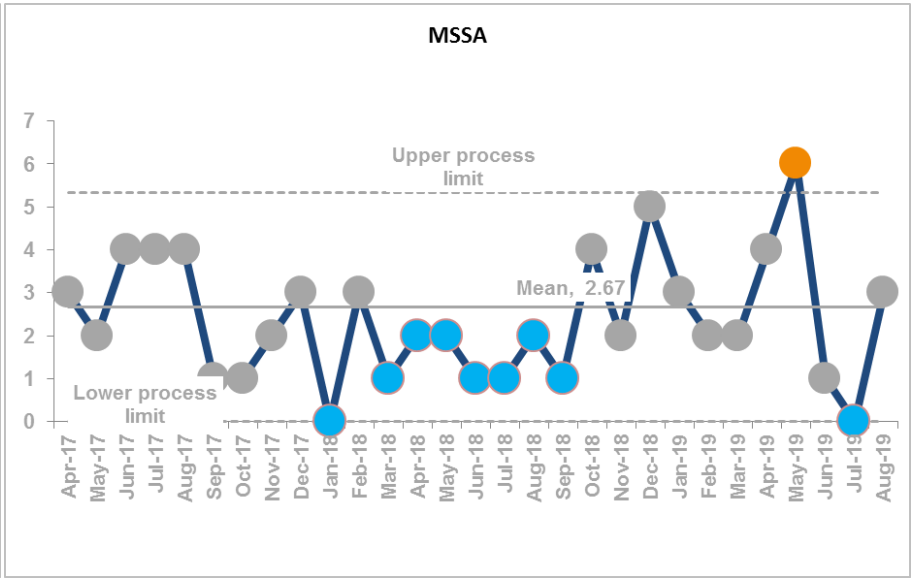
Infection Control

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance









Mortality and Readmissions

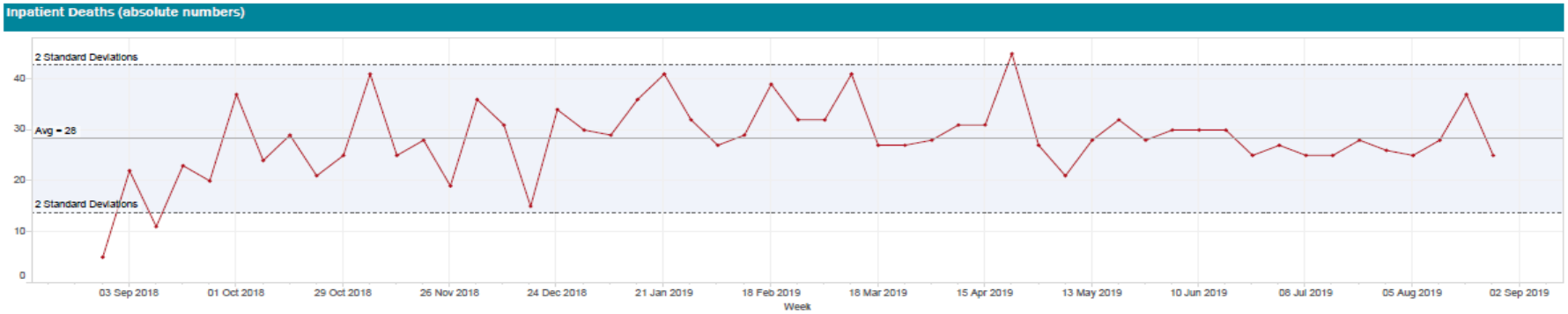
Indicator Description	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Jun 2018 to May 2019
Hospital Standardised Mortality Ratio (HSMR)	86.7	79.5	69.8	80.3	73.0	64.2	76.9	74.5	77.6	78.1	79.4	79.4	91.9	82.3
Hospital Standardised Mortality Ratio Weekend Emergency	78.2	97.6	79.5	72.2	62.7	82.4	113.3	79.1	74.6	85.2	82.9	82.9	91.3	86.7
Hospital Standardised Mortality Ratio Weekday Emergency	87.1	82.5	67.6	78.1	68.4	60.1	64.9	78.2	79.4	74.1	76.3	76.3	91.5	80.1

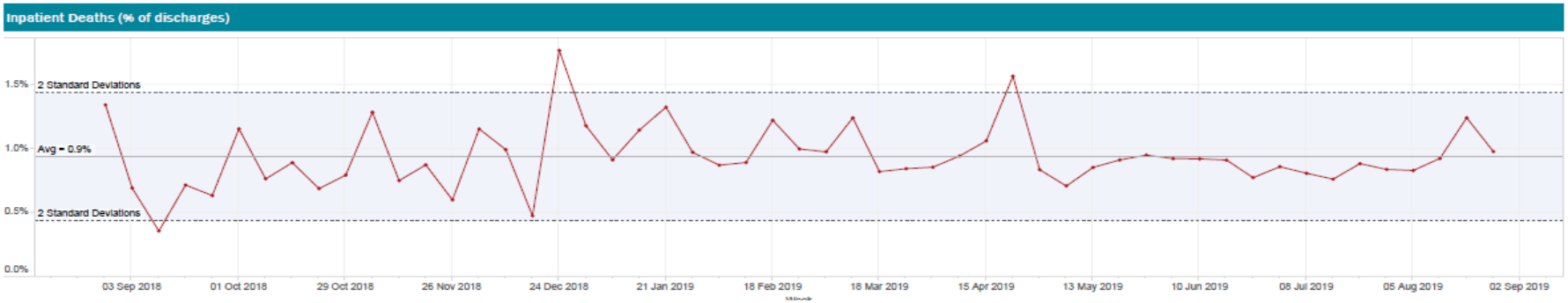
Indicator Description	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Summary Hospital Mortality Indicator (SHMI)	0.82	0.82	0.82	0.82	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.81
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.20%	8.20%	7.00%	8.90%	8.30%	7.60%	8.20%	7.20%	8.20%	7.90%	8.00%	7.90%

Please note SHMI data is based on a rolling 12 month period (published Aug 2019).
HSMR data reflective of period June 2018 – May 2019 based on a monthly published position (published Aug 2019).

What the information tells us

Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns and deaths as a percentage of discharges has increased above standard variation. 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.

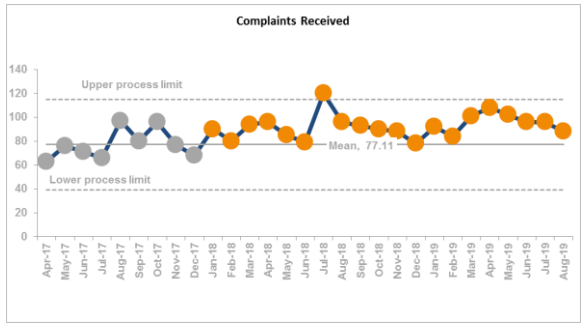


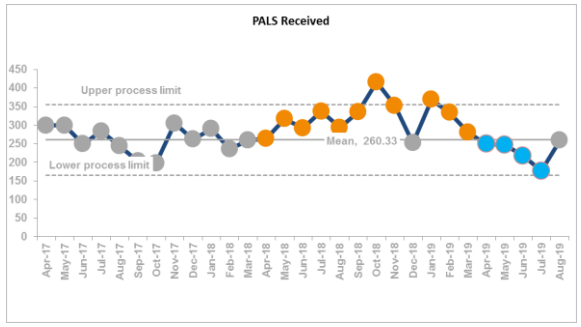


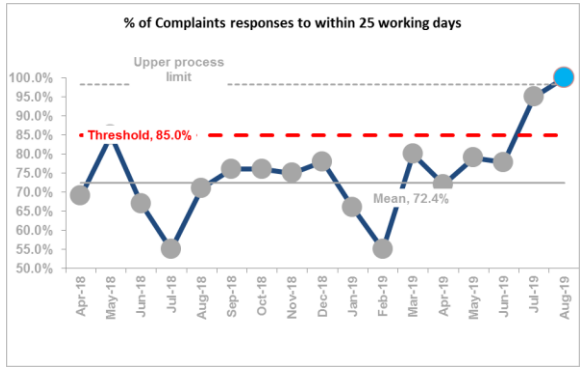
Complaints

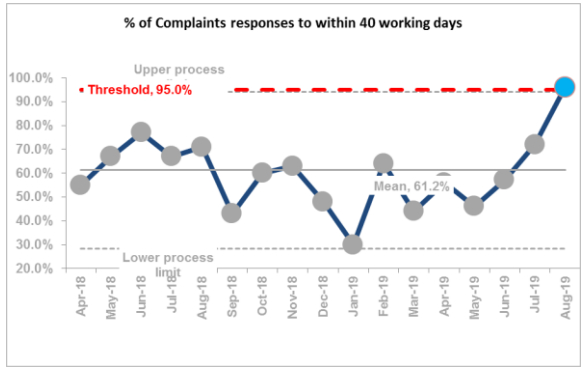
St George's University Hospitals NHS Foundation Trust

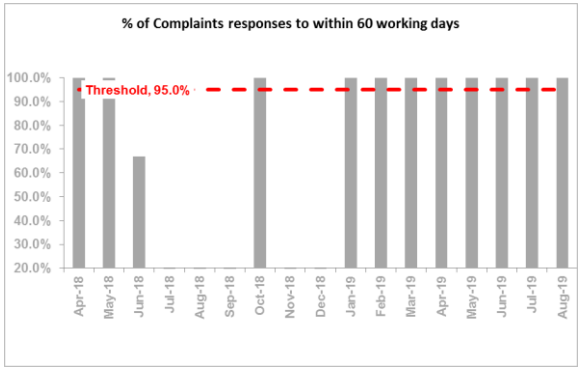
Indicator Description	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0
% of Complaints responses to within 25 working days	85%	71%	76%	76%	75%	78%	66%	55%	80%	72%	79%	78%	95%	100%
% of Complaints responses to within 40 working days	95%	71%	43%	60%	63%	48%	30%	64%	44%	56%	46%	57%	72.0%	96%
% of Complaints responses to within 60 working days	95%	None Due	None Due	100%	None Due	None Due	100%	100%	100%	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0			0	0	0	0	0	0	1	0	0	0	0











- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

What the information tells us

- The number of complaints received is consistently above the 2017/18 average
- Response compliance for 25 working day complaints has reached 100%
- Response compliance for 40 working day has reached 100%
- Response compliance for 60 working day complaints continues to deliver against the performance target

Actions and Quality Improvement Projects

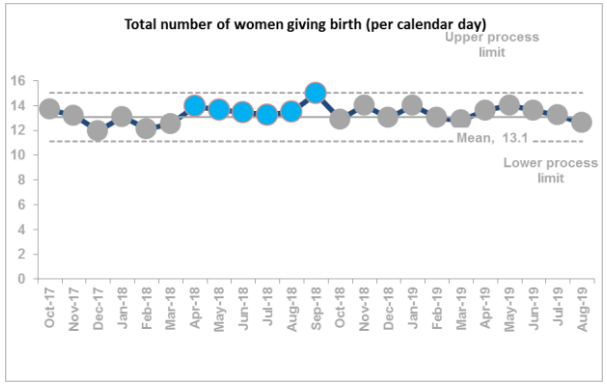
From 15 July 2019 we have commenced a daily complaints comcell led by the Chief Nurse.

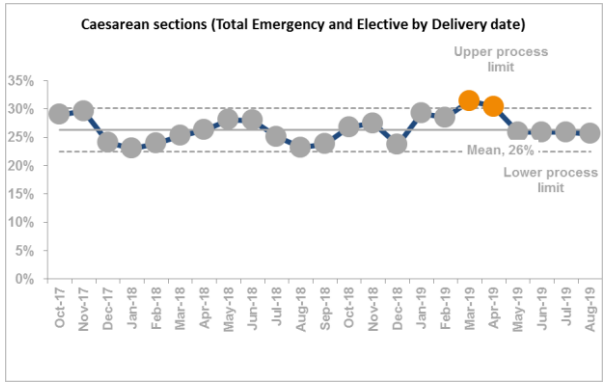
The change in process has had a positive impact on complaints performance with measures showing a marked improvement

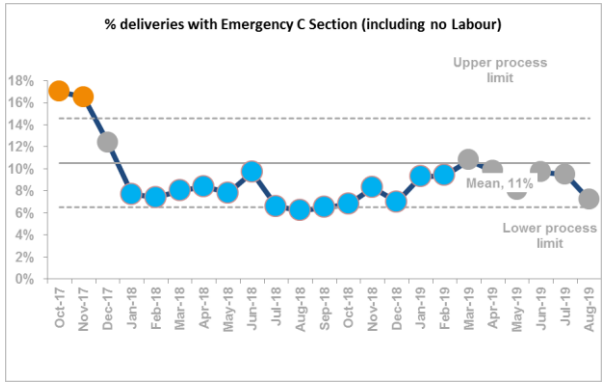
Maternity

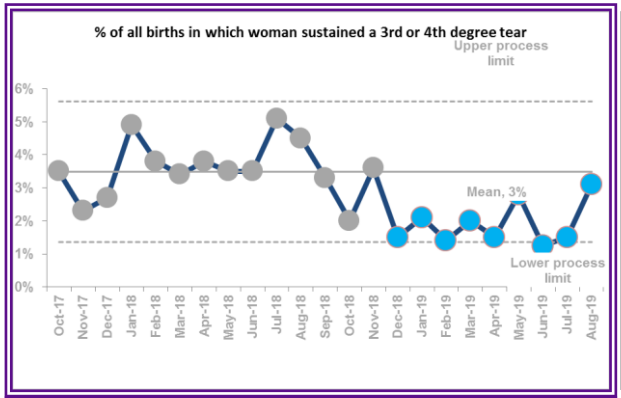
St George's University Hospitals NHS Foundation Trust

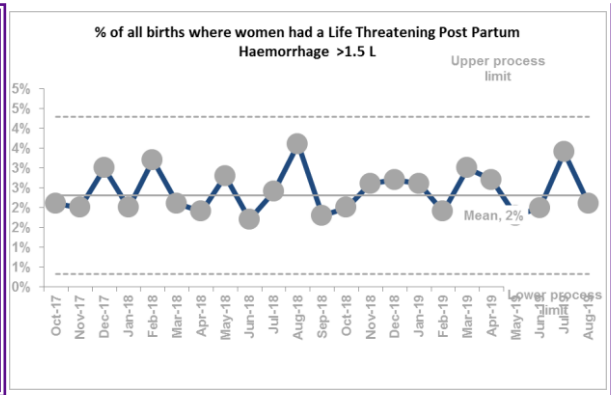
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

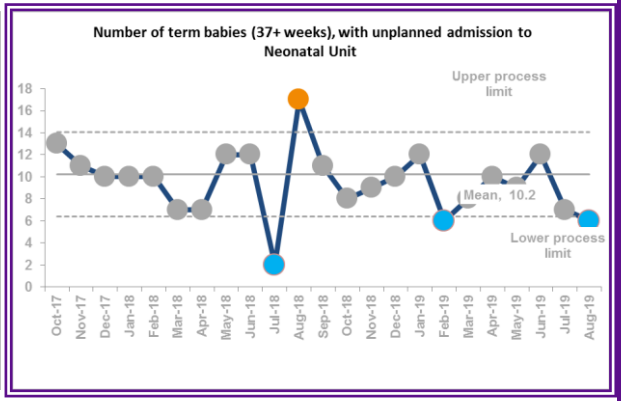


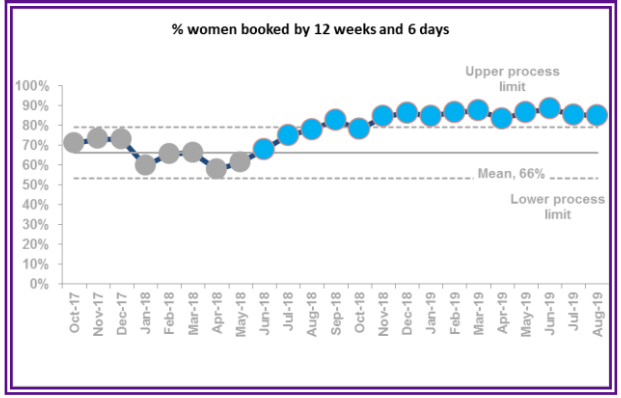












2.2

Our Patient Perspective

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Maternity

St George's University Hospitals NHS Foundation Trust

2.2

Definitions	Format	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Total number of women giving birth (per calendar day)	Number	14 per day	13	15	13	14	13	14	13	13	14	14	14	13	13
Caesarean sections (Total Emergency and Elective by Delivery date)	%	<28%	23.2%	23.8%	26.8%	27.5%	23.7%	29.2%	28.5%	31.4%	30.4%	25.9%	25.9%	25.9%	25.6%
% deliveries with Emergency C Section (including no Labour)	%	<8%	6.2%	6.5%	6.8%	8.3%	7.0%	9.3%	9.4%	10.8%	9.8%	8.1%	9.7%	9.5%	7.2%
% Time Carmen Suite closed	%	0%				0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%	6.7%	0.0%	4.8%
% of all births in which woman sustained a 3rd or 4th degree tear	%	<5%	4.5%	3.3%	2.0%	3.6%	1.5%	2.1%	1.4%	2.0%	1.5%	2.8%	1.2%	1.5%	3.1%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	%	<4%	3.6%	1.8%	2.0%	2.6%	2.7%	2.6%	1.9%	3.0%	2.7%	1.8%	2.0%	3.4%	2.1%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit	Number		17	11	8	9	10	12	6	8	10	9	12	7	6
Supernumerary Midwife in Labour Ward	%	>95%			95.2%	98.3%	100.0%	98.4%	96.4%	95.2%	96.7%	98.4%	98.3%	100.0%	96.8%
% women booked by 12 weeks and 6 days	%	90%	77.8%	82.6%	78.0%	84.4%	86.2%	84.7%	86.6%	87.3%	83.3%	86.6%	88.4%	85.3%	84.9%

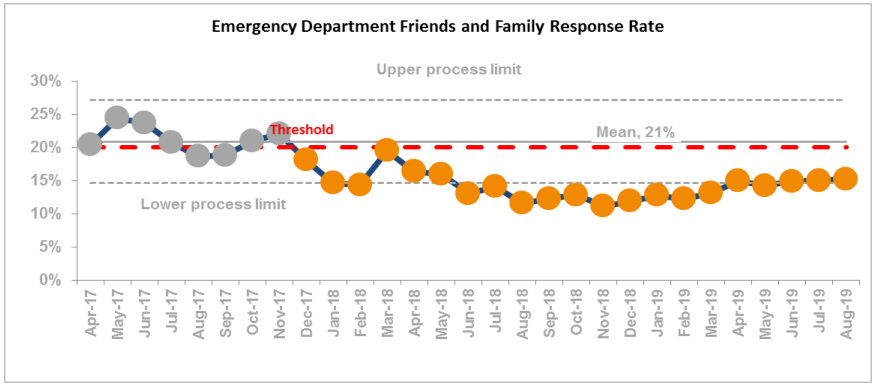
What the information tells us

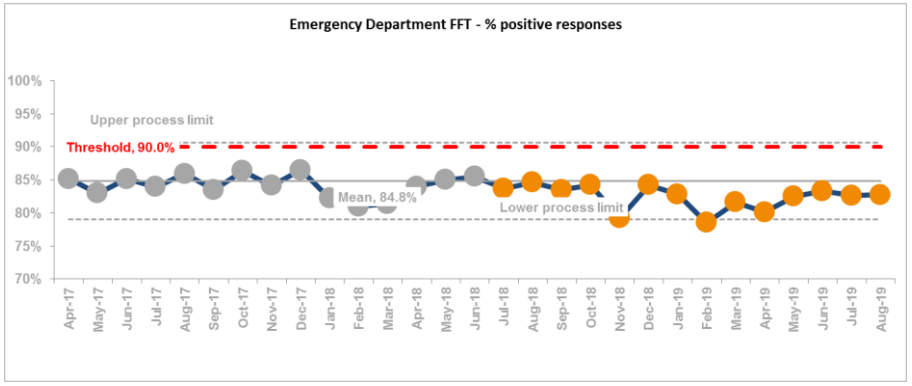
- The number of babies with unplanned admissions to the neonatal unit fell was below the lower process limit for August
- The number of births dropped in August, but remained within process control limits. A renewed focus has been given to booking women soon after their referral, to keep numbers up.
- The emergency caesarean rate dropped in month and the overall caesarean rate remained stable as do the other morbidity measures of Post Partum Haemorrhage (PPH) and tears.

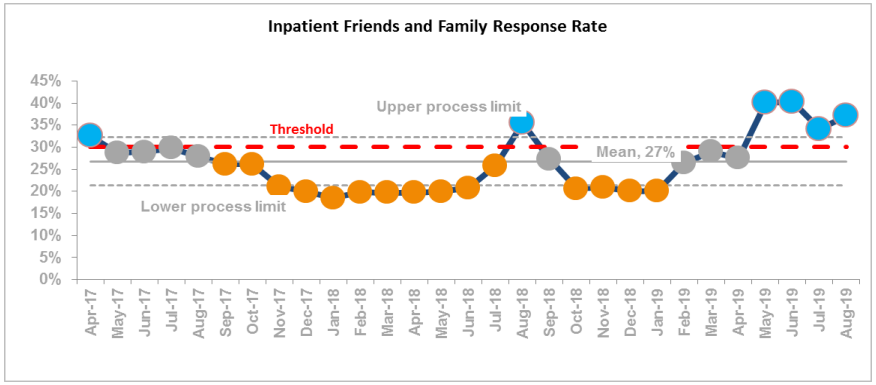
Actions and Quality Improvement Projects

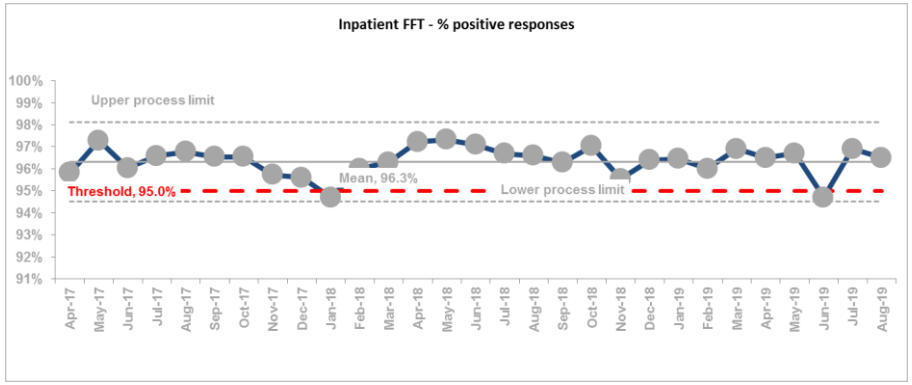
- The MatNeo safety project looking at reducing term admissions to Neonatal Unit is making progress, with team training running in September with maternity and neonatal staff
- The impact of episcissors continues to be monitored.

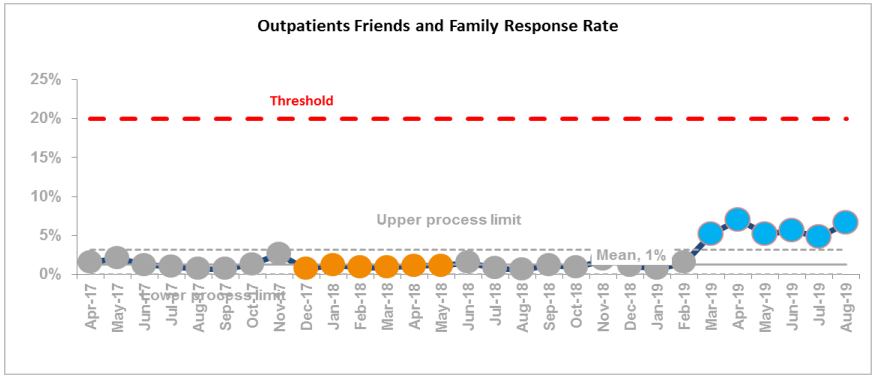
Friends and Family Test

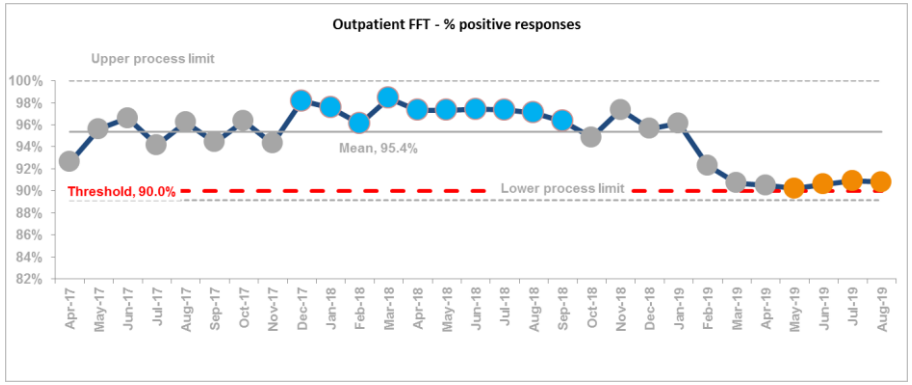




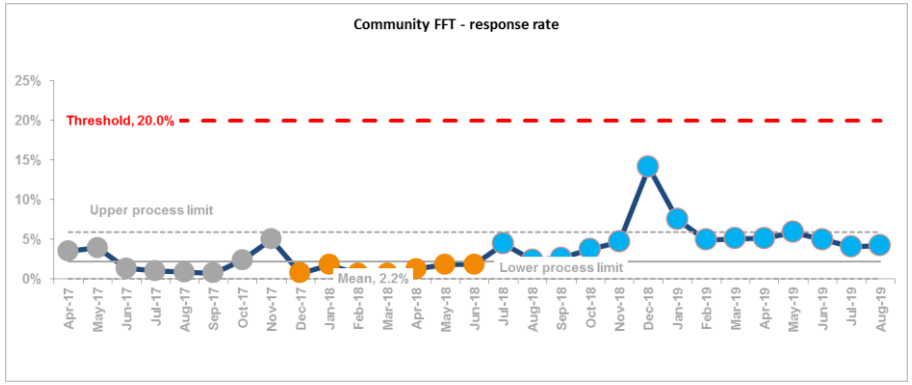


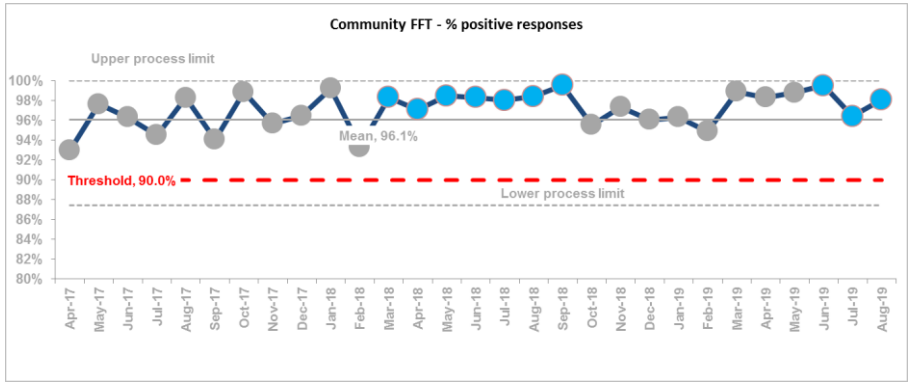


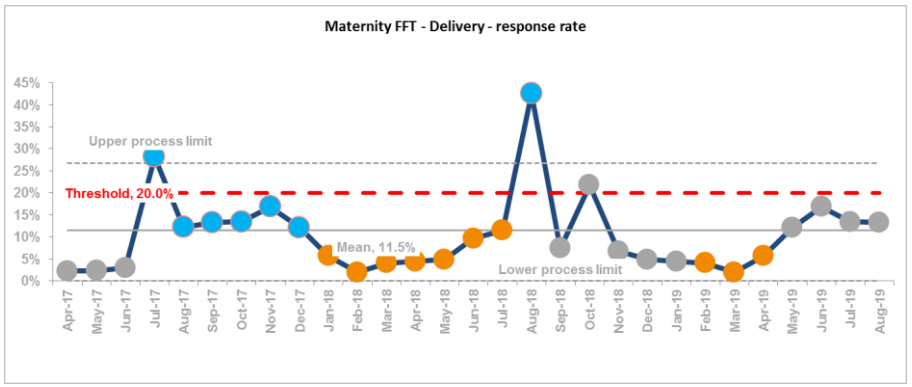


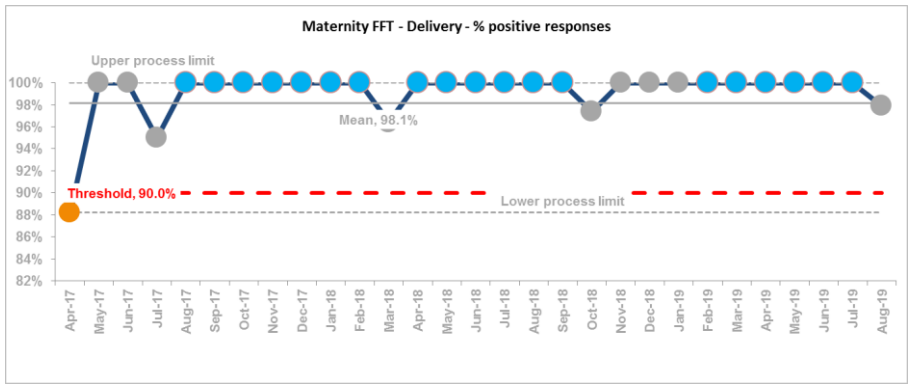


Friends and Family Test









Friends & Family Survey

Indicator Description	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Emergency Department FFT - % positive responses	90%	84.6%	83.5%	84.2%	79.2%	84.2%	82.8%	78.5%	81.6%	80.1%	82.5%	83.3%	82.6%	82.7%
Inpatient FFT - % positive responses	95%	96.6%	96.3%	97.0%	95.5%	96.4%	96.5%	96.0%	96.9%	96.5%	96.7%	94.7%	96.9%	96.5%
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%	100.0%	0.0%	0.0%				100.0%	90.0%	85.7%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	98.7%	100.0%	100.0%	90.9%	95.6%	95.7%	91.7%	96.4%	94.6%	98.0%	100.0%	98.3%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	100.0%	0.0%	0.0%	100.0%	0.0%	100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%
Community FFT - % positive responses	90%	98.4%	99.5%	95.6%	97.4%	96.1%	96.3%	94.9%	98.9%	98.3%	98.8%	99.5%	96.4%	98.1%
Outpatient FFT - % positive responses	90%	97.1%	96.3%	94.9%	97.3%	95.6%	96.1%	92.3%	90.7%	90.5%	90.2%	90.6%	90.9%	90.8%

What the information tells us

- ED Friends and Family Test (FFT) – In the month of August 82.7% of patients attending the Emergency Department would recommend the service to family and friends. The response rate has remained at 15% in the month of August, below our target of 20%.
- Inpatient Friends and Family Test (FFT) has increased to 96.9% an improvement on last month position of 94.7%.
- We continue to deliver above target against our outpatient recommend rate with July performance of 90.9%. However the response rate remains below the Trust target, whilst it is recognised this has improved to consistently above 5%.
- Maternity and Community FFT are above local thresholds in July and work continues to ensure patient responses improves. The London average response rate for community is 4.4% and England is 3.9%.

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 outpatient clinics.
- Review of London trusts that consistently achieve high response rates for ED and Maternity to be shared with services so that they can review practice.
- Changes to the FFT data capture and requirements are awaiting nationally for implementation by the end of the year.

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

2.2

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

Our Process Perspective

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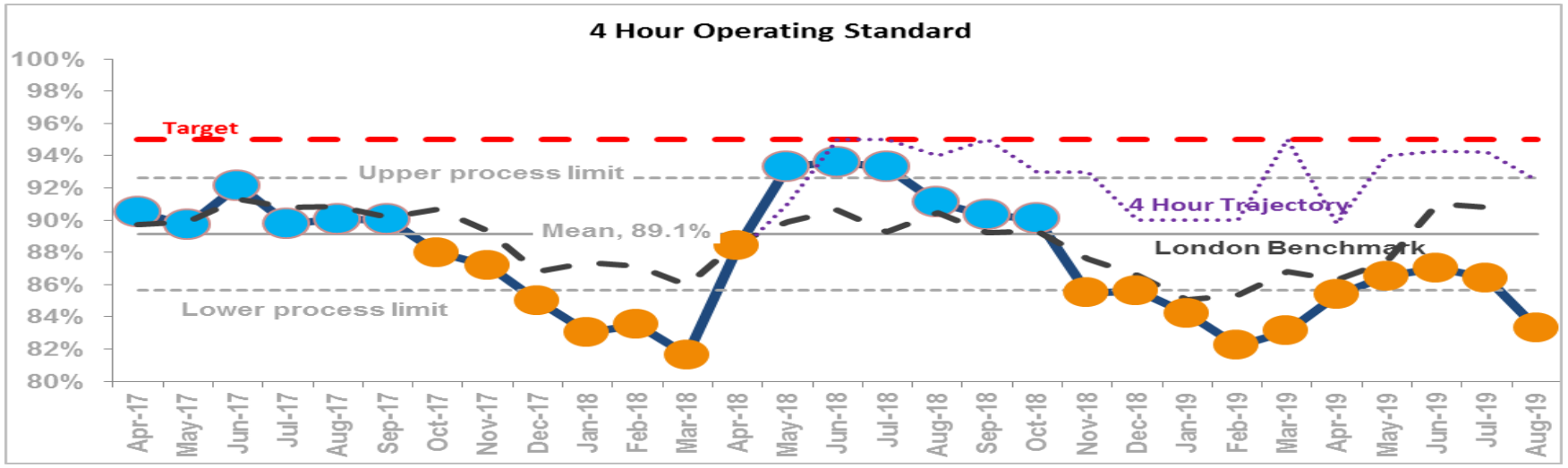
Emergency Flow



What the information above tells us:

- The number of patients either discharged, admitted or transferred within four hours of arrival has seen a decrease from 86.4% in July to 83.3% in August, with performance moving below the lower control limits.
- Performance is currently below the monthly improvement trajectory of 92.5% for August in order to achieve a year end position of 90%.

The information on the following slides shows us:

- Attendances between April and July this year have been significantly higher than the attendance plan and shows variability on a daily basis. In the month of August attendance numbers have dropped as expected due to seasonality however compared to the same period last year is 3% higher.
- Both admitted and non-admitted performance continues to be below its lower process limit.
- The AMU occupancy at midday is above the targeted 85% seeing an increase in August but within the upper control limit.
- The G&A bed occupancy has increased to a level not seen in the last two August's and remains above the mean.
- The number of patients staying in a hospital bed greater than 7,14 and 21 days is above the mean for a consecutive month.
- Ambulance handover times have seen a slight reduction in performance in July with 30 minute performance falling below the lower control limit however remains above London average.

Actions and Quality Improvement Projects

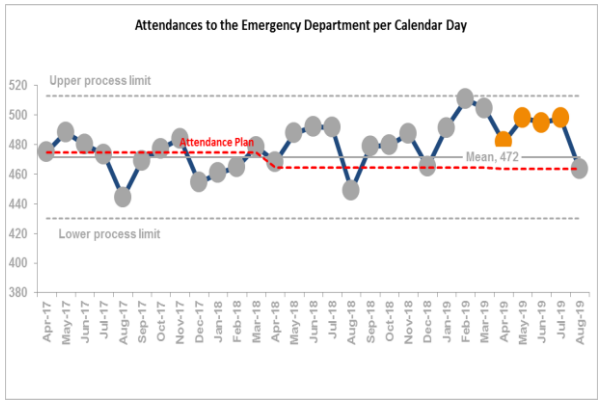
Specifically, in the last month we have undertaken the following and a Trust to improve ED Flow:

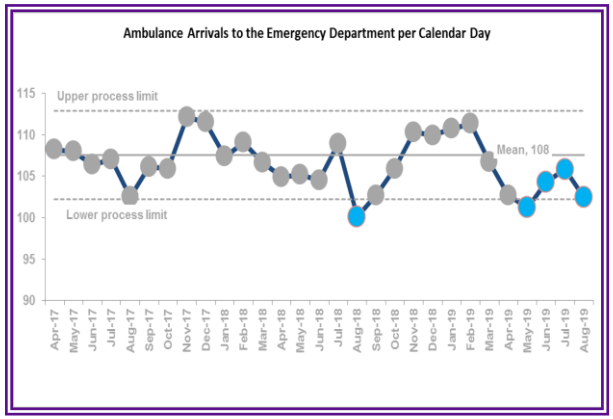
1. Following the re-launch of the inter-professional standards monitoring of the metrics to identify challenges has commenced
2. Agreement from TEC to open Rodney Smith ward to 28 beds from 1st October 2019 in preparation of winter pressures
3. Initial evaluation of ED rotas and amendments made. Detailed review underway
4. Continue to establish Transfer of Care to be completed by end of September 2019
5. Continue to embed SAFER on every ward to be completed by end of October 2019

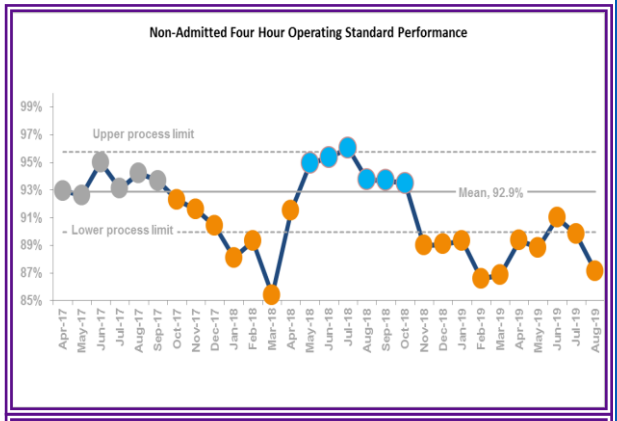
Emergency Flow

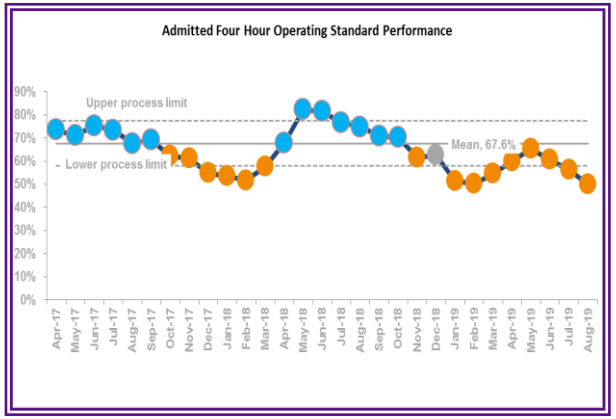
St George's University Hospitals NHS Foundation Trust

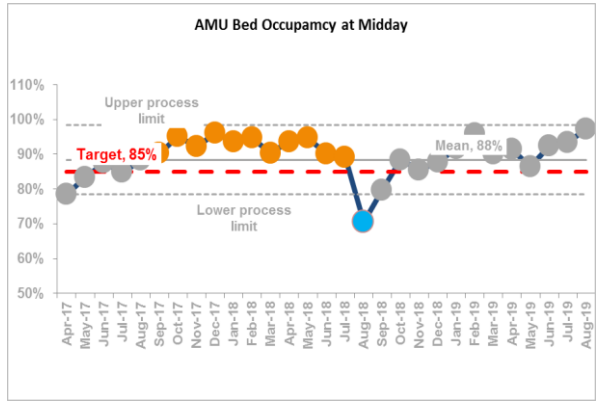
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

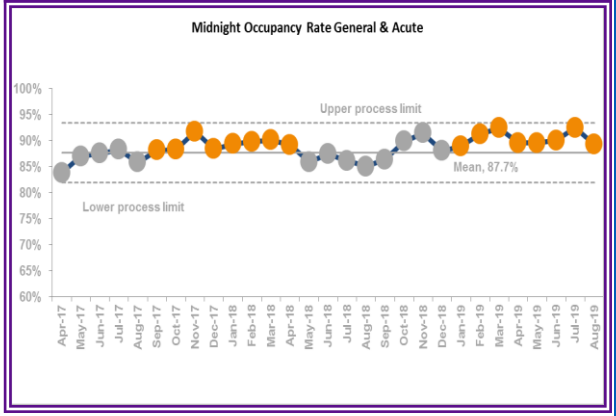


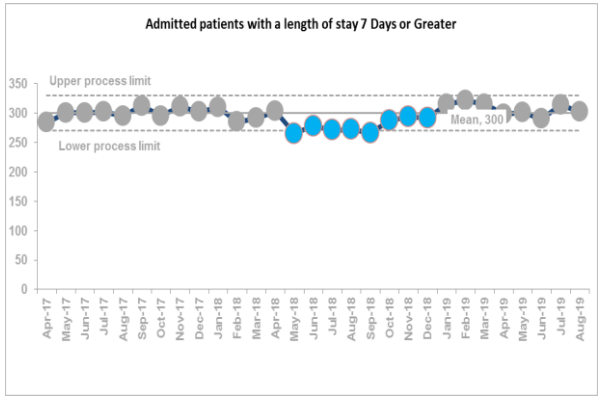


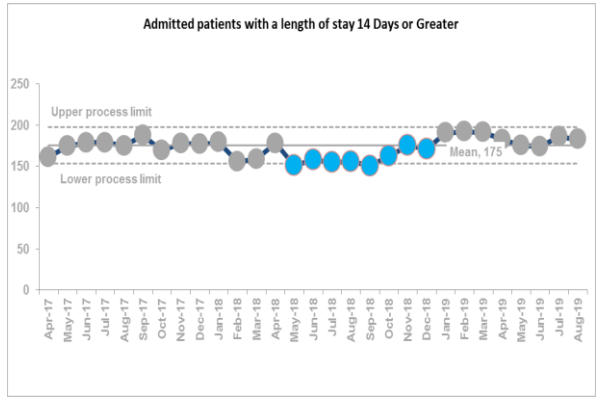


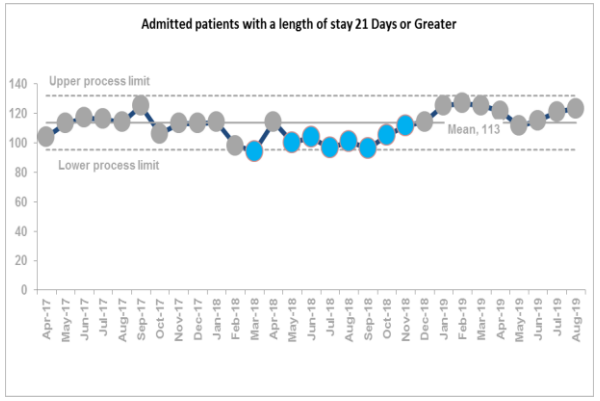






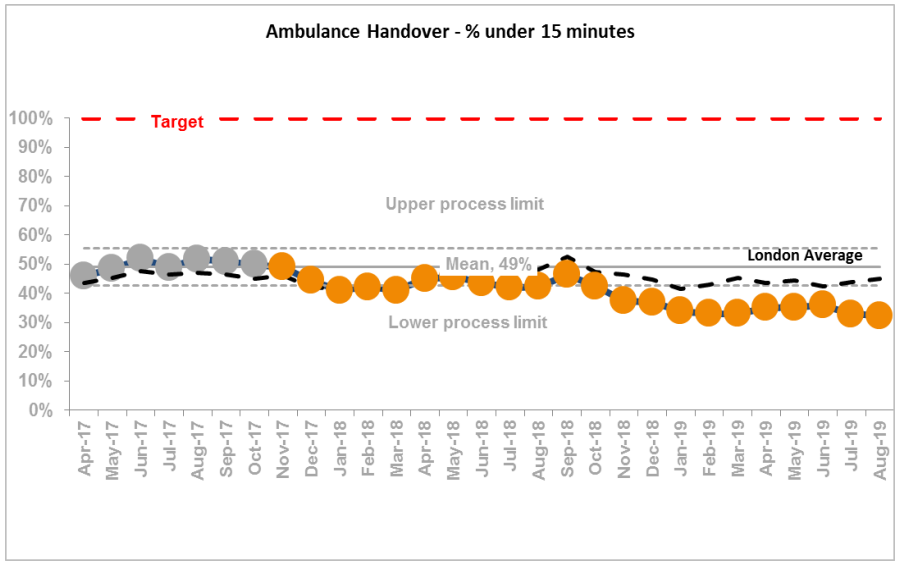


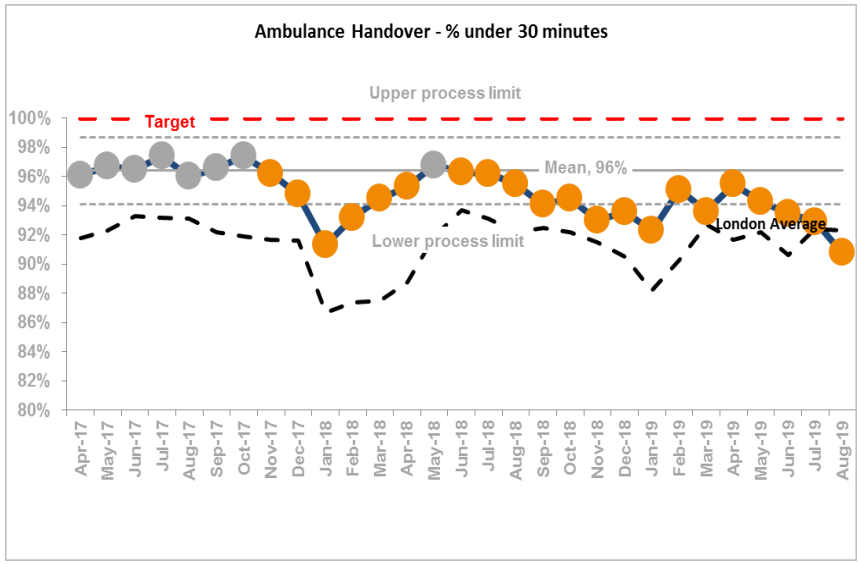


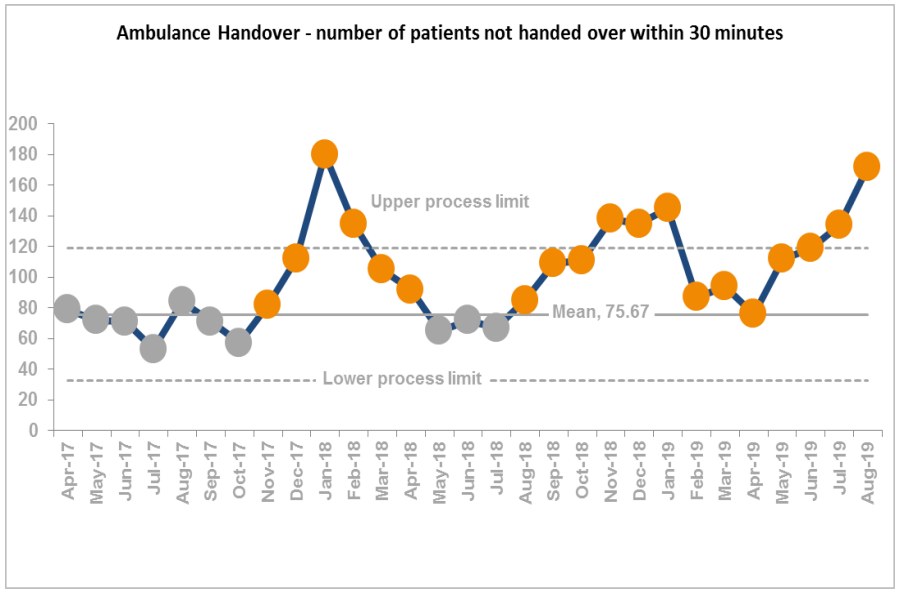


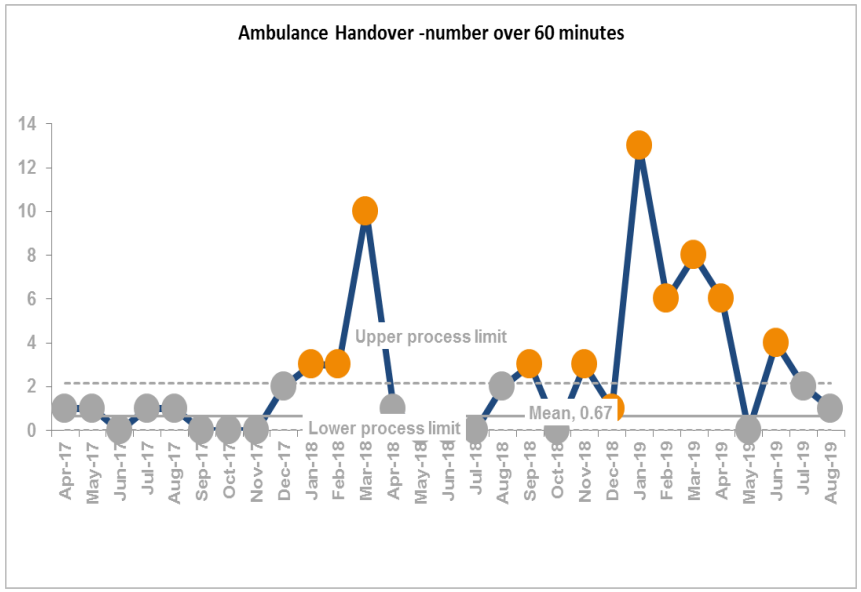
Emergency Flow

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance









Referral to Treatment

St George's University Hospitals NHS Foundation Trust

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%	86.1%	85.8%	86.6%	86.0%	86.1%								
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%
RTT Total Incomplete Waiting Lize Size		40,016	40,037	39,674	41,013	42,671	41,658	41,259								
RTT Total Incomplete Waiting Lize Size Trajectory					39,890	39,880	39,870	39,860	39,850	39,840	39,830	39,820	39,810	39,800	39,790	39,780
Total waits greater than 18 weeks (inc 52Wk waiters)		5,921	5,929	5,515	5,812	5,717	5,820	5,739								
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	27	22	16	7	5								
Total waits greater than 52 weeks Trajectory				31	23	16	9	5	5	5	0	0	0	0	0	0
RTT Incomplete Performance - Admitted		65.5%	65.5%	66.6%	65.3%	68.8%	68.7%	66.3%								
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428	1,511	1,459	1,494	1523								
Total waits greater than 52 weeks - Admitted	0	62	63	18	7	8	4	1								
RTT Incomplete Performance -Non Admitted		87.7%	87.7%	88.5%	88.3%	88.8%	88.3%	88.5%								
Total waits greater than 18 weeks - Non Admitted		4,358	4,366	4,087	4,301	4,258	4,326	4216								
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15	8	3	4								

What the information tells us

- The above table relates to St George's (Tooting site only) Referral To Treatment (RTT) performance.
- The total waiting list has continued to reduce following increases in April and May 2019. The Trust remains behind trajectory for Total PTL size however the margin the Trust remains behind trajectory has reduced from 4.45% in June to 3.46% in July 2019 .
- As a result of cleaning the Patient Tracking List (PTL), and reducing the number of patients reported on incomplete RTT pathways, the Trust were able to marginally improve performance which has remains ahead of trajectory.
- The Trust reported five 52 week breaches in July-19. June-19 trajectory was five.

Actions and Quality Improvement Projects

- Currently validating August-19 month end performance ahead of submission 18th September-19. Due to Queen Mary's Hospital (QMH) Patient Administration System (PAS) migration, the Trust will only have 10 working days to validate August month end as opposed to the normal 13 working days. This will be monitored closely through to the 10th working day (Friday 13th September 2019).
- Continued daily monitoring of all patients waiting over 52 weeks for first definitive treatment. The Trust are now tracking a six month forward look to ensure the Trust remains ahead of trajectory.
- Undertake a review of all un-outcomed historic activity (admitted and non admitted) to ensure monthly submission is an accurate reflection of activity undertaken – this includes historic surgical dates
- On-going weekly review and monitoring of data quality metrics including duplicate encounters and code 11 outcomes (continuation of pathway following a ward discharge – these pathways should not routinely be on an RTT pathway).
- Currently reviewing plans pre and post migration to ensure SGH and QMH have all the support required for September reporting. The Trust will show an increase in PTL size that is not currently build into the Trusts trajectory.

Referral to Treatment

Specialty	Admitted		Non Admitted		Incomplete Pathway					
	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	217	34.6%	722	76.7%	629	310	939	67.0%	51	2
Urology	328	60.4%	997	88.9%	1,084	241	1,325	81.8%	12	0
Trauma & Orthopaedics	143	56.6%	2,367	89.9%	2,208	302	2,510	88.0%	4	0
Ear, Nose & Throat (ENT)	450	44.0%	2,028	88.2%	1,986	492	2,478	80.1%	12	0
Ophthalmology	0	-	0	-	0	0	0		0	0
Oral Surgery	16	68.8%	526	91.4%	492	50	542	90.8%	0	0
Neurosurgery	157	75.2%	2,076	82.5%	1,831	402	2,233	82.0%	9	0
Plastic Surgery	479	63.3%	937	85.5%	1,104	312	1,416	78.0%	22	0
Cardiothoracic Surgery	2	100.0%	1	100.0%	3	0	3	100.0%	0	0
General Medicine	0	-	37	94.6%	35	2	37	94.6%	0	0
Gastroenterology	420	92.9%	1,588	92.3%	1,855	153	2,008	92.4%	6	0
Cardiology	869	72.3%	2,721	85.2%	2,945	645	3,590	82.0%	5	0
Dermatology	4	75.0%	2,461	93.5%	2,305	160	2,465	93.5%	3	0
Thoracic Medicine	0	-	1,736	87.3%	1,515	221	1,736	87.3%	1	0
Neurology	33	84.8%	2,301	90.8%	2,118	216	2,334	90.7%	1	0
Rheumatology	0	-	918	82.4%	756	162	918	82.4%	4	0
Geriatric Medicine	1	100.0%	88	94.3%	84	5	89	94.4%	0	0
Gynaecology	336	59.8%	2,060	95.6%	2,171	225	2,396	90.6%	6	0
Other (next slide)	1,061	71.3%	13,179	88.4%	12,399	1,841	14,240	87.1%	49	3
Total	**4,516**	**66.3%**	**36,743**	**88.5%**	**35,520**	**5,739**	**41,259**	**86.1%**	**185**	**5**

- There are a number of specialties reported under speciality 'Other'. This follows guidance set out in the documentation, "Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care" – produced by NHS England. The following slide outlines 'Other' specialties by treatment function group (TFG) and associated performance.
- All five 52 week breach patients reported in July were General Surgery – this is in line with Trust Trajectory.
- Patients highlighted on the following slide have been grouped by Treatment Function Group (TFG). Where a service is listed on the following slide under the same speciality name as above – these are different patients. For example General Surgery on the following slide are Colorectal, Upper GI and Breast patients, General Surgery on this slide are purely General Surgery

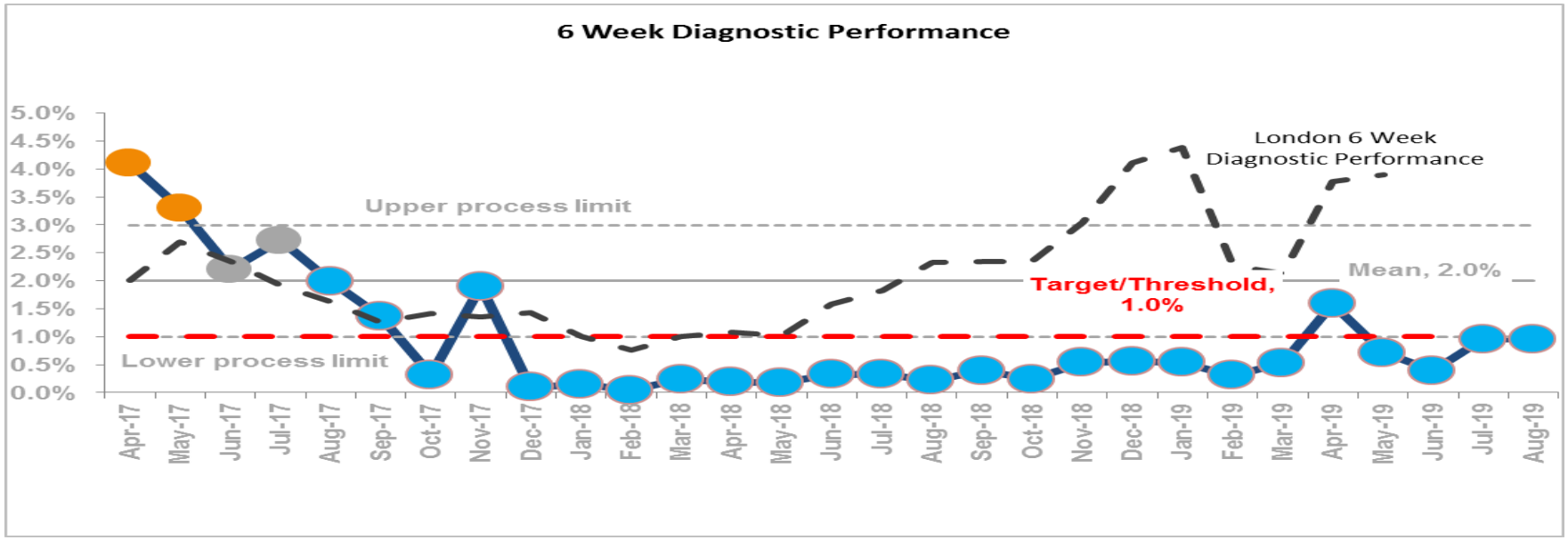
Referral to Treatment

St George's University Hospitals NHS Foundation Trust

2.2

Specialty	Admitted		Non Admitted		Incomplete Pathways					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
Audiology	1	0.0%	1,550	89.9%	1,393	158	1,551	89.8%	0	0
Cardiac Surgery	44	97.7%	44	100.0%	87	1	88	98.9%	0	0
Chest Medicine	0	-	2	100.0%	2	0	2	100.0%	0	0
Clinical Genetics	0	-	1,467	78.5%	1,151	316	1,467	78.5%	1	0
Clinical Haematology	40	100.0%	714	97.5%	736	18	754	97.6%	0	0
Clinical Infection Unit	0	-	53	96.2%	51	2	53	96.2%	0	0
Dental	67	82.1%	584	95.7%	614	37	651	94.3%	0	0
Dermatology	0	-	234	95.3%	223	11	234	95.3%	0	0
Diabetes/Endocrinology	3	66.7%	779	90.6%	708	74	782	90.5%	1	0
ENT	94	30.9%	195	78.5%	182	107	289	63.0%	5	0
Gastroenterology	1	100.0%	450	90.7%	409	42	451	90.7%	0	0
General Surgery	246	74.4%	2,029	79.1%	1,789	487	2,276	78.6%	29	3
Gynaecology	1	100.0%	161	100.0%	162	0	162	100.0%	0	0
Interventional Radiology	23	82.6%	23	82.6%	38	8	46	82.6%	1	0
Maxillofacial	85	65.9%	1,070	87.0%	987	168	1,155	85.5%	3	0
Oncology	6	100.0%	132	99.2%	137	1	138	99.3%	0	0
Paediatric Medicine	37	46.0%	1,607	91.9%	1,494	150	1,644	90.9%	0	0
Paediatric Surgery	149	68.5%	507	92.7%	572	84	656	87.2%	2	0
Pain Clinic	41	46.3%	519	94.2%	508	52	560	90.7%	0	0
Pathology	0	-	20	100.0%	20	0	20	100.0%	0	0
Plastic Surgery	2	0.0%	100	84.0%	84	18	102	82.4%	0	0
Radiology	16	81.3%	19	89.5%	30	5	35	85.7%	1	0
Renal Medicine	34	94.1%	326	98.5%	352	7	359	98.1%	0	0
Theatres	0	-	28	50.0%	14	14	28	50.0%	2	0
Thoracic Surgery	15	80.0%	81	87.7%	83	13	96	86.5%	0	0
Trauma & Orthopaedics	25	68.0%	46	93.5%	60	11	71	84.5%	1	0
Unassigned	0	-	2	100.0%	2	0	2	100.0%	0	0
Vascular Surgery	131	83.2%	437	92.0%	511	57	568	90.0%	0	0
Grand Total	1,061	71.3%	13,179	88.4%	12,399	1,841	14,240	87.1%	46	3

Diagnostics



What the information tells us

- In August, Trust performance remained compliant against the six week diagnostic standard, and performance remained under the lower process control limit, with a total of 74 patients waiting greater than six weeks and a performance of 0.96%.
- The number of patients on the Trusts diagnostic waiting list remains within the upper and lower control limits.
- Compliance has not been achieved within six modalities.
- Echocardiography and Gastroscopy performance are within the expected control limits, reducing the number of patients waiting greater than six weeks in the month of August, however still above national target.
- Non Obstetric Ultrasound has not achieved target for the first time July 2017 reporting 1.02% and although still within expected control limits has moved above the mean.

Actions and Quality Improvement Projects

Cystoscopy

- There has been an increase in the number of TWR referrals requiring cystoscopy which has impacted on routine referrals.
- Capacity will become available as the new TWR pathway is rolled out which will introduce biomarker testing which will reduce TWR cystoscopy
- There is a plan to train CNS to undertake benign cystoscopy– two in training

Paediatric Endoscopy

- Re-allocation of four theatre sessions in September dedicated to Gastroscopy to decrease the number of patients waiting. Working alongside Theatre's and Specialty Medicine to secure additional substantive capacity going forward.

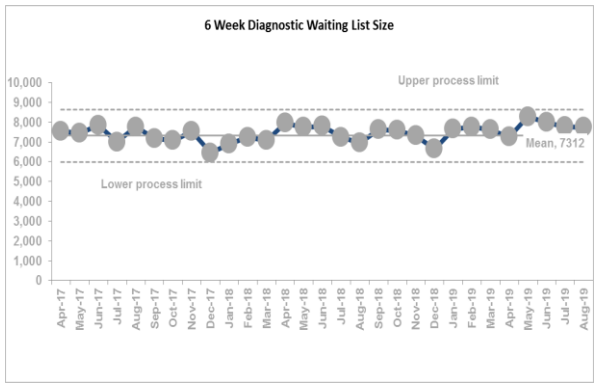
Non Obstetric Ultrasound

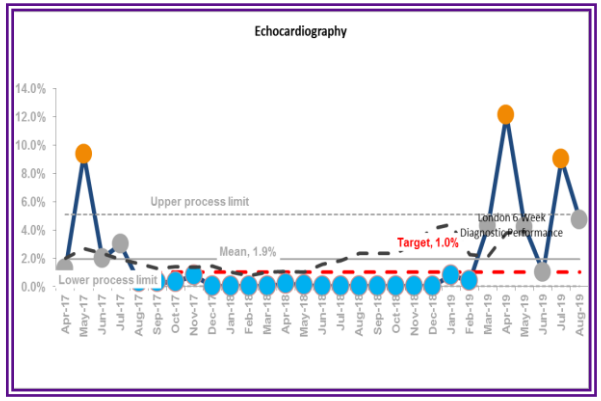
- All patients currently waiting greater than six weeks have an appointment booked in September. Additional sessions will be provided in September to recover performance and reduce backlog.

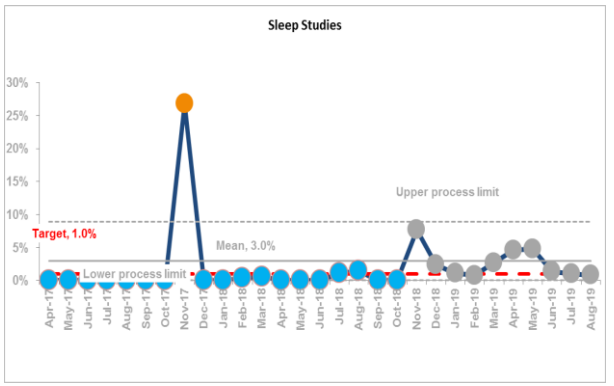
Diagnostics

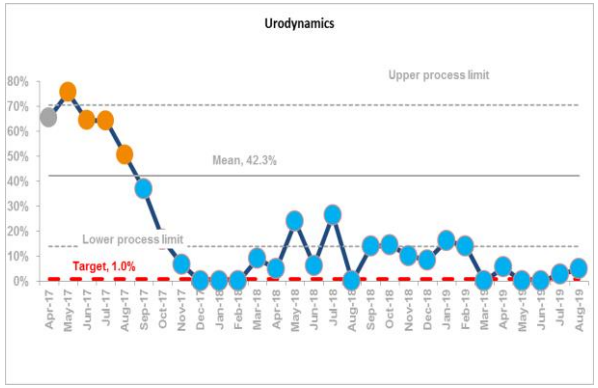
NHS
St George's University Hospitals
NHS Foundation Trust

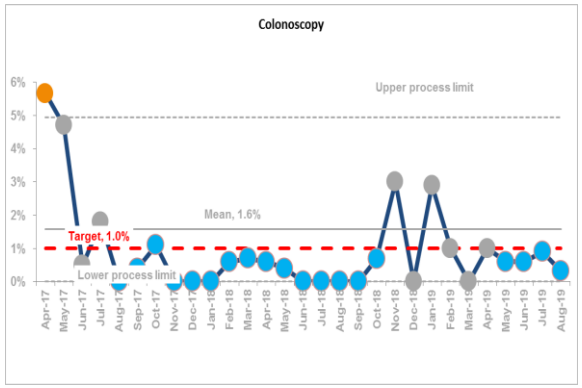
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

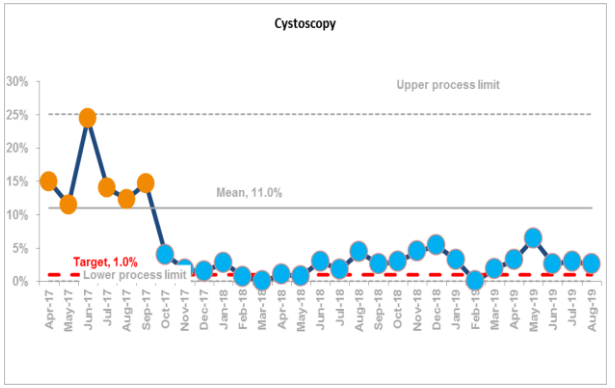


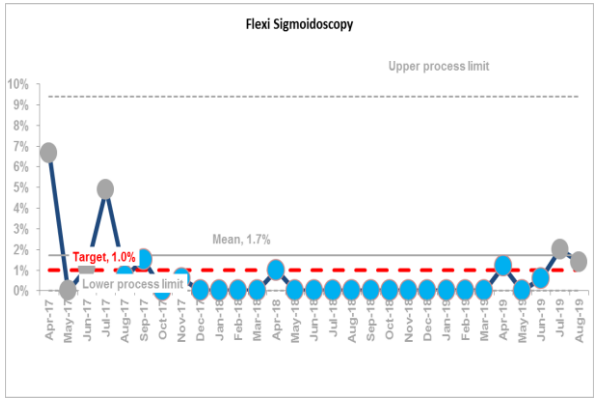


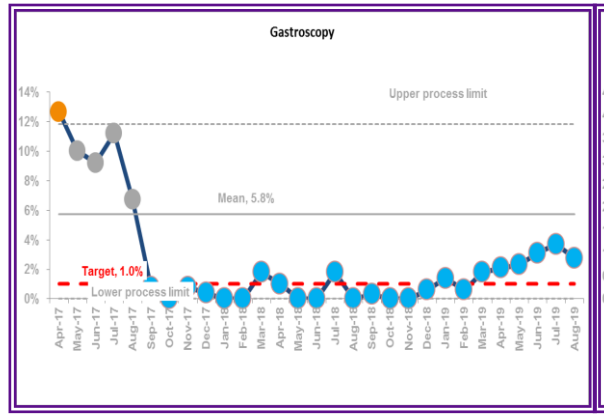


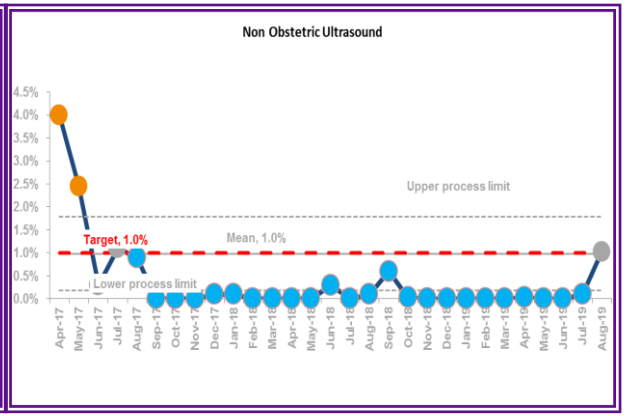






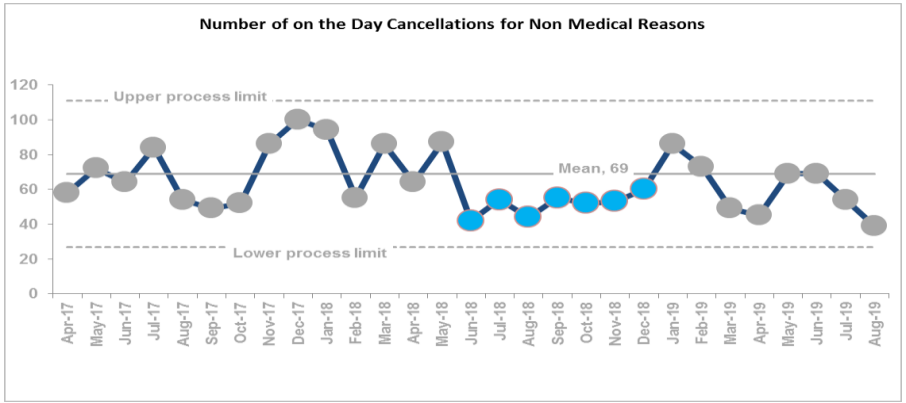


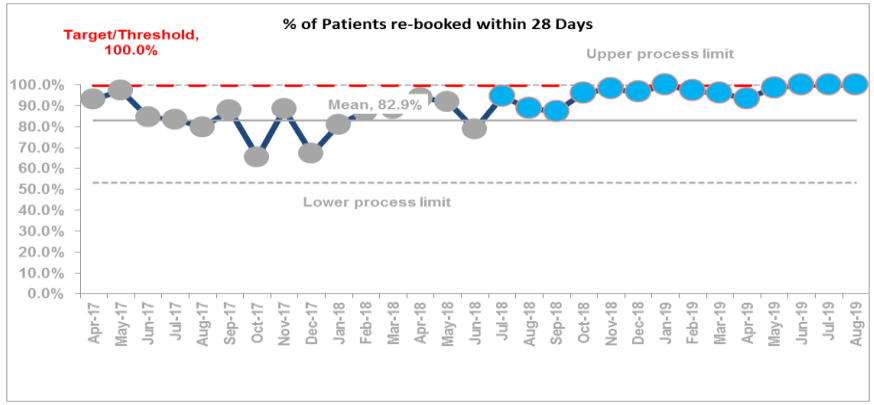




Our Process Perspective

On the Day Cancellations for Non Clinical Reasons





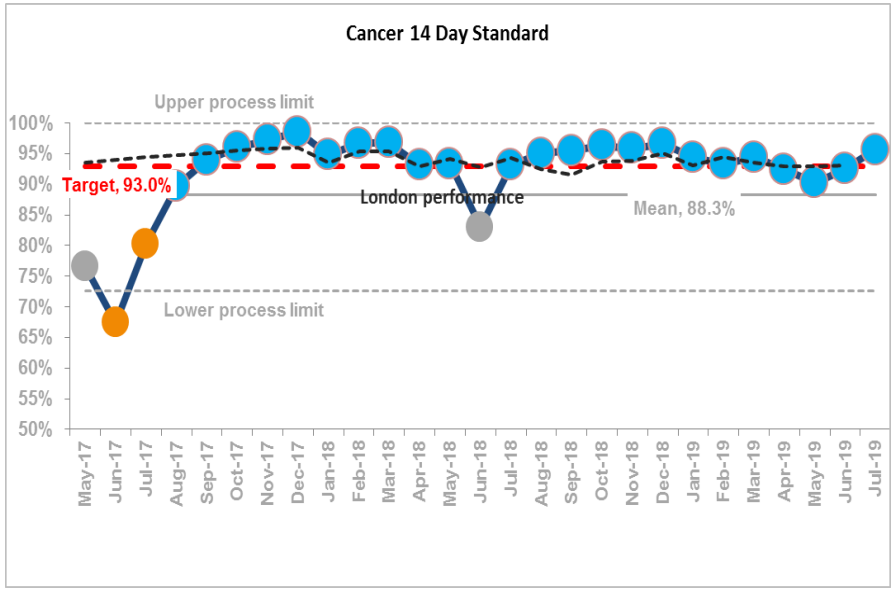
What the information tells us

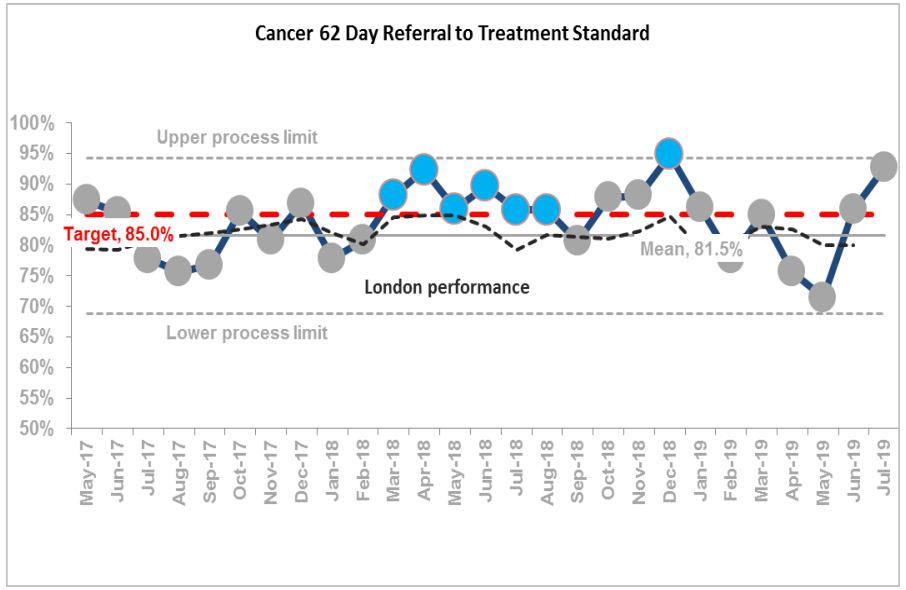
- There has been some variability in On the Day cancellations however performance remains within expected levels staying within the upper and lower control limits and has seen a reduction within the last three months cancelling a total of 38 on the day cancellations in the month of August.
- The rebooking process has maintained recent improvement and reduced the variability in the number of patients re-booked within the 28 day standard with on average, 98% rebooked within 28 days for the previous six months. In August, 100% of patients were re-booked within 28 days.
- The main reason for on the day cancellations in August were due to the number of Trauma cases taking priority (15 cases cancelled), mainly affecting Plastic Surgery and Cardiology. Timing issues with a number of lists over booked were the reason for nine cases being cancelled on the day with the highest proportion within Neuro Surgery.

Actions and Quality Improvement Projects

- Two way text reminders being rolled out for IP and DSU surgery dates, this will also include a firmer message to encourage patients to attend
- Netcall is being discussed, and we will look to roll out as part of the PPC office moves, this will ensure more of our calls are answered so patients calling to cancel/reschedule surgery dates can get through to someone quickly (51% of calls are currently answered)
- The Trust Directory is being updated to ensure the correct numbers for the PPCs are listed to support switchboard putting patients through to the right person
- Partial Bookings are being sent out to all patients added to the IP, and DSU waitlist, which asks patients if they are available at short notice (1 day, to 1 week before TCI) so we have a pool of patients to pull from when other patients cancel at short notice (for DSU, 65% of our total cancellation are patients cancelling at short notice)
- New Pre Operative Assessment (POA) targets have launched which ask PPCs to ensure all patients on the admitted DSU PTL have a POA booked, and 100% of patients 20 weeks + on the IP admitted PTL have a POA booked, this will ensure the PPCs have an adequate pool of 'fit' patients to pull from (this will also support short notice bookings)
- Information is now being entered on Theatreman (IP scheduling system) which highlights if a patient is on a cancer pathway, and their breach date, to mitigate the risk of these patients being cancelled because of bed flow challenges
- The PPC team are designing a 'Friends and Family test' for scheduling which will help us understand why patients cancel, so we can look to put actions in place to stop DNA's/short notice cancellations
- Non clinical on the day cancellations are discussed daily at the PPC huddle to ensure patients are dated within 28 days

Cancer





What the information tells us

- The Trust has achieved all seven cancer standards for the month of July, returning to compliance against the 14 Day Standard and remaining compliant against the 62 Day Standard.
- Within the 14 Day Standard, all tumour groups achieved above the 93% national target, performance remains within the upper and lower control limits.
- The number of patients awaiting treatment greater than 62 days from referral has continued to increase above the mean with a performance of 92.7% in the month of July 2019 against the target of 85%.
- As shown by the wide upper and lower process limits, Cancer 62 day screening performance has been varied over the past thirteen months reporting, however has maintained compliance reporting 97.4% in the month of July with performance showing above the mean for the third consecutive month.

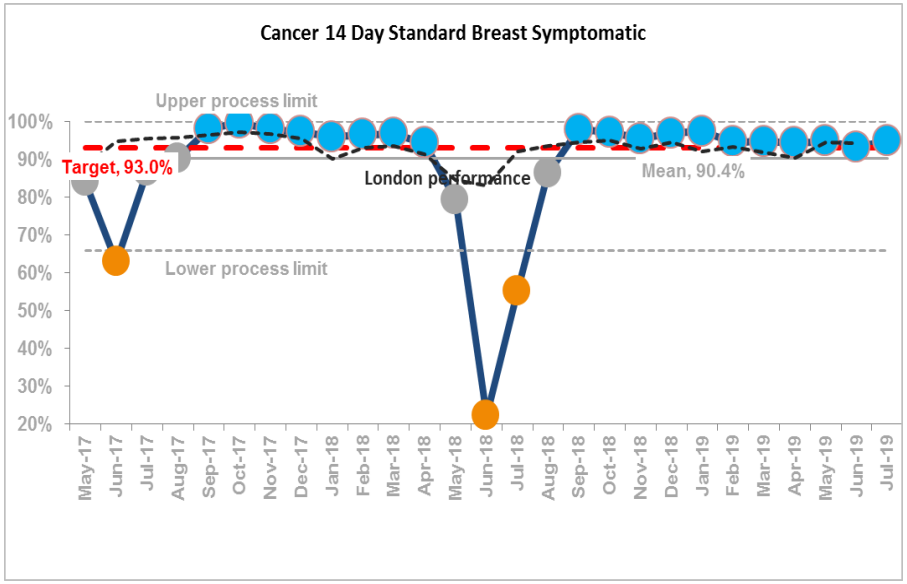
Actions and Quality Improvement Projects

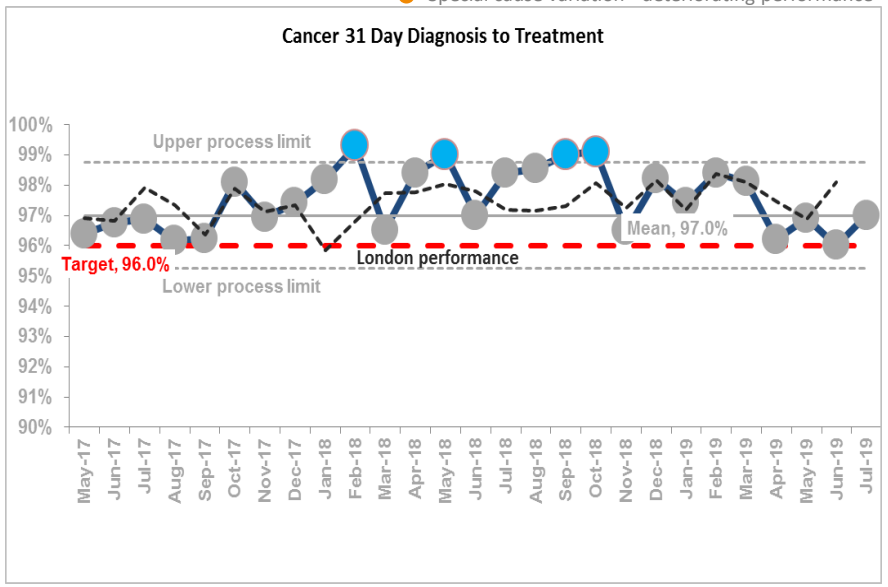
The recovery action plan has three key parts in it:

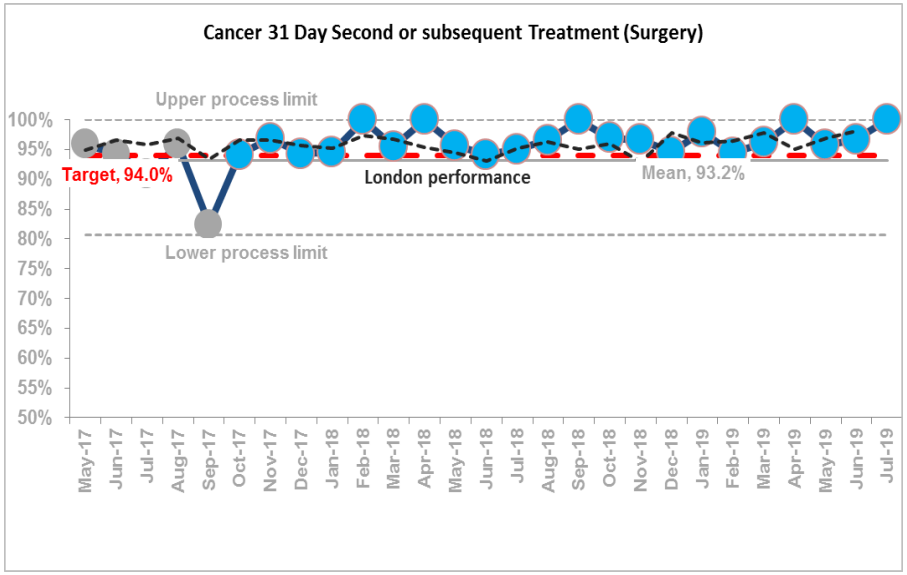
- TWR Clinic polling on ERS set at 12 days with robust management of ASI list has seen reduction in numbers. Further work needs to be done at service level to ensure the right capacity is in place to meet the demand of new polling ranges. Plans for services to review further demand and capacity planning to meet this requirement.
- Continued targeted support to three specific services (Gynaecology, Upper and Lower GI). For Upper and Lower GI, access to endoscopy is the focus with changes to the administrative function plus additional Straight to test capacity identified in Lower GI Service with plans to increase total slots by September 2019. For Gynaecology, short term capacity planning six weeks in advance (both clinic and diagnostic capacity) is the focus. Gynaecology has introduced robust breach management via a weekly huddle and senior management engagement.
- 62 day focus has been on closer integration between Cancer and theatre teams to ensure that all opportunities to treat patients are maximised- including cancer theatres huddle and 642 attendance. Additional walk in slots for pre-assessment identified and slots ring fenced for services. Training & Development of internal and external staff as well as good service engagement.

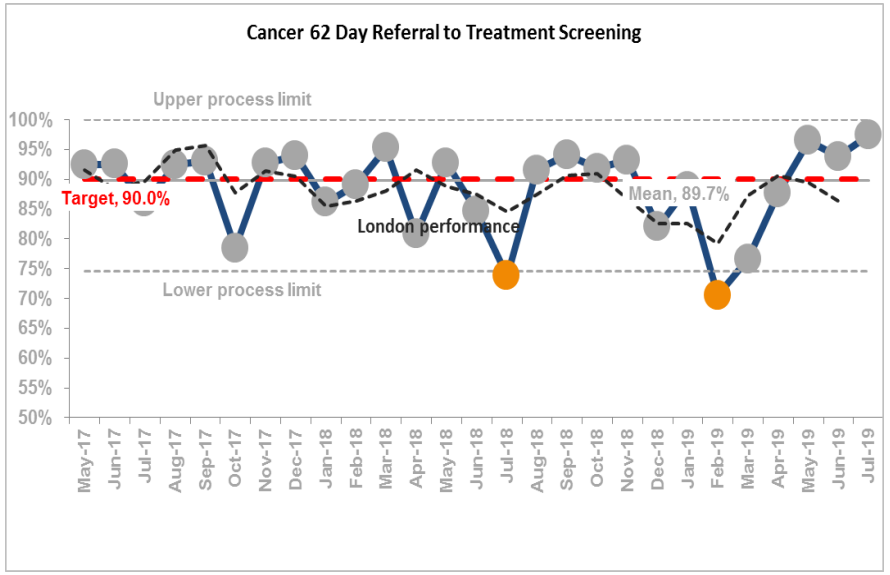
Cancer

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance









Cancer

St George's University Hospitals NHS Foundation Trust

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	No of Patients
Brain	93%	100.0%	100.0%	-	100.0%	-	100.0%	100.0%	100.0%	-	100.0%	-	100.0%	-	0
Breast	93%	87.4%	97.5%	94.5%	99.4%	97.4%	98.8%	97.4%	98.6%	97.9%	99.5%	96.3%	96.9%	95.4%	241
Children's	93%	90.9%	-	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	4
Gynaecology	93%	91.7%	90.8%	81.9%	87.8%	87.5%	95.9%	69.5%	65.3%	80.0%	75.0%	59.3%	78.0%	95.5%	132
Haematology	93%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	21
Head & Neck	93%	93.0%	95.6%	99.3%	99.8%	98.1%	96.0%	98.5%	100.0%	99.3%	98.0%	97.8%	100.0%	98.9%	182
Lower Gastrointestinal	93%	94.7%	98.9%	94.3%	98.1%	95.8%	94.5%	97.2%	92.1%	94.5%	85.6%	91.1%	87.9%	93.7%	301
Lung	93%	97.6%	94.7%	95.2%	100.0%	100.0%	100.0%	93.3%	100.0%	96.9%	100.0%	95.6%	96.8%	95.7%	47
Skin	93%	93.3%	92.9%	97.4%	96.6%	97.4%	97.6%	97.1%	95.9%	97.6%	96.9%	95.5%	94.8%	96.0%	481
Upper Gastrointestinal	93%	96.6%	93.9%	96.7%	98.8%	95.4%	94.1%	91.8%	90.9%	83.5%	87.9%	70.2%	90.9%	95.1%	102
Urology	93%	95.2%	93.1%	96.8%	92.4%	93.4%	96.6%	94.5%	94.2%	92.2%	90.1%	95.4%	92.1%	93.8%	145

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	No of Patients
Brain	85%	-	-	-	-	100.0%	100.0%	-	-	-	-	-	-	-	0
Breast	85%	90.9%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	82.4%	90.9%	83.3%	80.0%	87.5%	73.3%	7.5
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	75.0%	100.0%	80.0%	90.0%	100.0%	83.3%	88.9%	50.0%	100.0%	66.7%	66.7%	100.0%	100.0%	1
Haematology	85%	100.0%	88.9%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	30.0%	33.3%	77.8%	100.0%	2.5
Head & Neck	85%	72.7%	81.8%	80.0%	100.0%	86.7%	87.5%	46.2%	85.7%	80.0%	77.8%	40.0%	28.6%	80.0%	2.5
Lower Gastrointestinal	85%	71.4%	83.3%	66.7%	88.9%	100.0%	100.0%	100.0%	81.8%	66.7%	41.7%	100.0%	69.2%	83.3%	6
Lung	85%	71.4%	66.7%	28.6%	50.0%	70.0%	72.7%	80.0%	75.0%	70.0%	71.4%	100.0%	100.0%	91.7%	6.0
Skin	85%	100.0%	100.0%	84.6%	92.3%	100.0%	100.0%	92.3%	100.0%	89.7%	100.0%	75.8%	95.7%	100.0%	12.5
Upper Gastrointestinal	85%	100.0%	78.9%	50.0%	54.5%	100.0%	100.0%	0.0%	50.0%	60.0%	100.0%	20.0%	75.0%	100.0%	2.5
Urology	85%	85.7%	88.2%	92.9%	88.9%	77.8%	95.0%	89.5%	71.1%	88.9%	83.0%	75.8%	93.9%	100.0%	14
Other	85%	-	100.0%	-	100.0%	100.0%	-	0.0%	-	100.0%	-	-	100.0%	-	0

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

2.2

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

Our People Perspective

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Workforce

What the information tells us

- Mandatory and Statutory Training figures for August were recorded at 90.2% with a mean of 86.2%.There has been consistent improvement month on month of this figure.
- Medical appraisal rates are now being reported by the new appraisal system and currently stands at 85.7%.
- Non-medical appraisal performance, remaining below target with a performance of 71.3% against a 90% target. However, as can be seen by the tight upper and lower process limits for the previous six months, the process is stable and will not likely reach 90% without external action.
- The Trusts Total Funded Establishment and Trust Vacancy rate both remain below the lower control limit however have both seen a steady increase over the past four months.

Actions and Quality Improvement Projects

In August, the monthly agency target set was £1.25m. The total agency cost is worse than the target by £0.54m. HR Managers will be meeting with DDO's to discuss remedial actions.

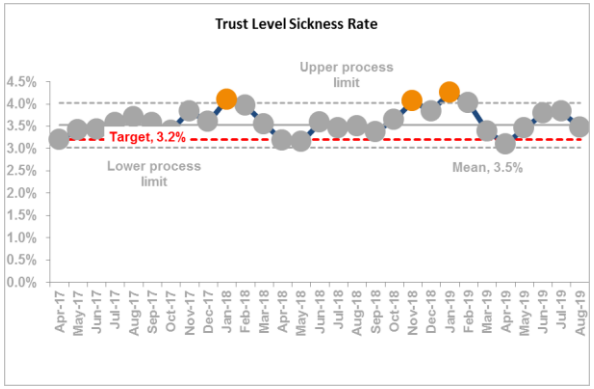
Indicator Description	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Trust Level Sickness Rate	3.2%	3.5%	3.4%	3.7%	4.1%	3.8%	4.3%	4.0%	3.4%	3.1%	3.5%	3.8%	3.8%	3.5%
Trust Vacancy Rate	10%	10.2%	10.4%	9.3%	8.9%	9.4%	9.4%	9.3%	9.6%	9.1%	10.3%	10.5%	11.9%	12.8%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.1%	16.6%	16.6%	16.9%	16.9%	17.1%	17.1%	17.5%	17.1%	17.4%	17.4%	17.5%	17.7%
Total Funded Establishment		9,160	9,180	9,165	9,171	9,196	9,229	9,238	9,248	9,112	9,241	9,251	9,365	9,432
IPR Appraisal Rate - Medical Staff	90%	Data Unavailable									85.4%	84.5%	84.4%	85.7%
IPR Appraisal Rate - Non Medical Staff	90%	69.7%	69.7%	69.7%	71.8%	71.5%	70.9%	71.3%	70.4%	71.6%	72.5%	73.6%	73.3%	71.3%
Overall MAST Compliance %	85%	89.3%	88.2%	88.3%	88.3%	89.1%	89.3%	89.1%	89.4%	89.8%	90.6%	91.2%	91.2%	90.2%
Ward Staffing Unfilled Duty Hours	10%	5.5%	6.7%	6.6%	5.1%	6.1%	6.6%	6.7%	7.2%	5.7%	5.9%	6.1%	6.3%	5.4%

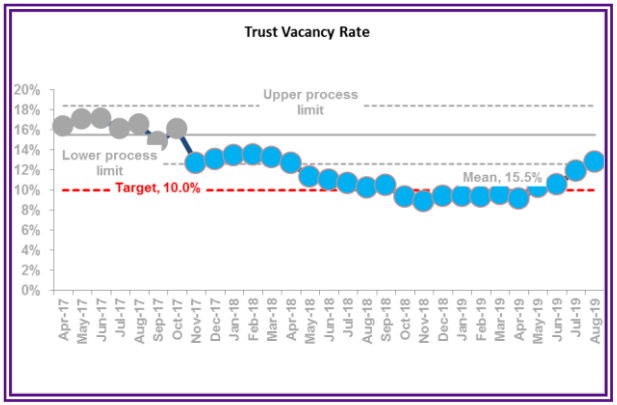
Workforce

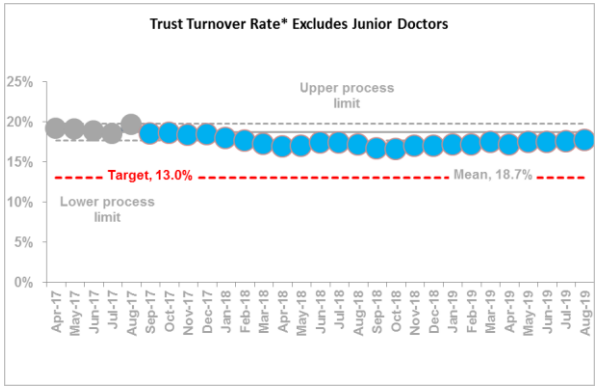
St George's University Hospitals NHS Foundation Trust

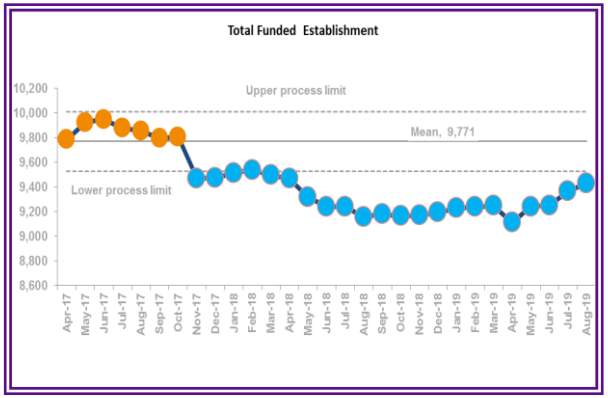
2.2

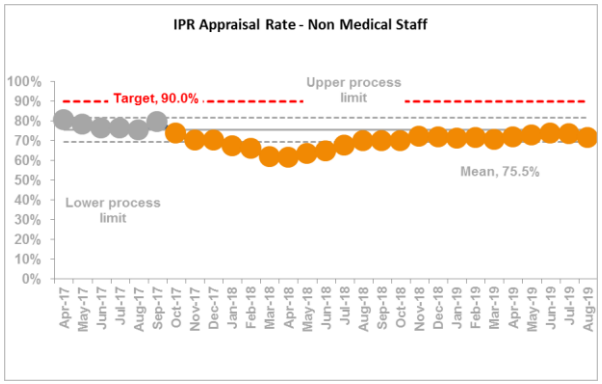
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

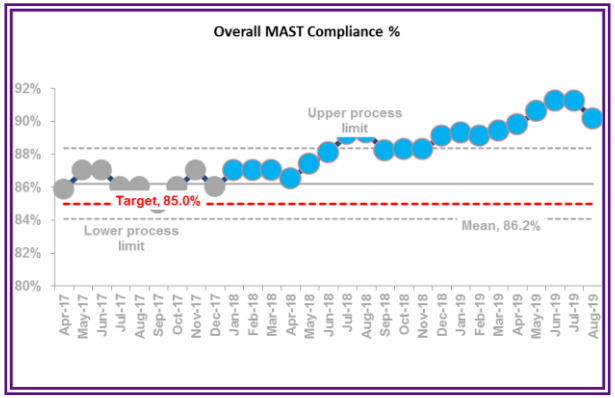


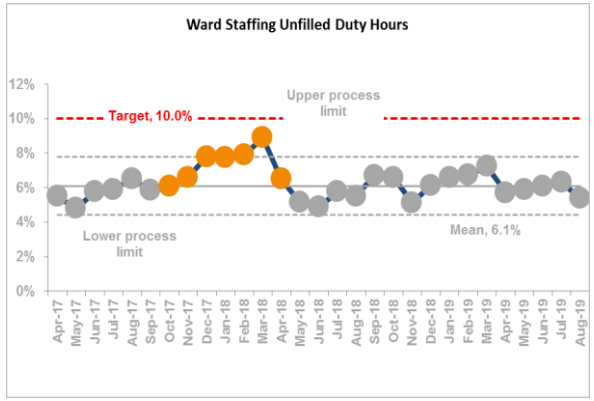












Our People Perspective

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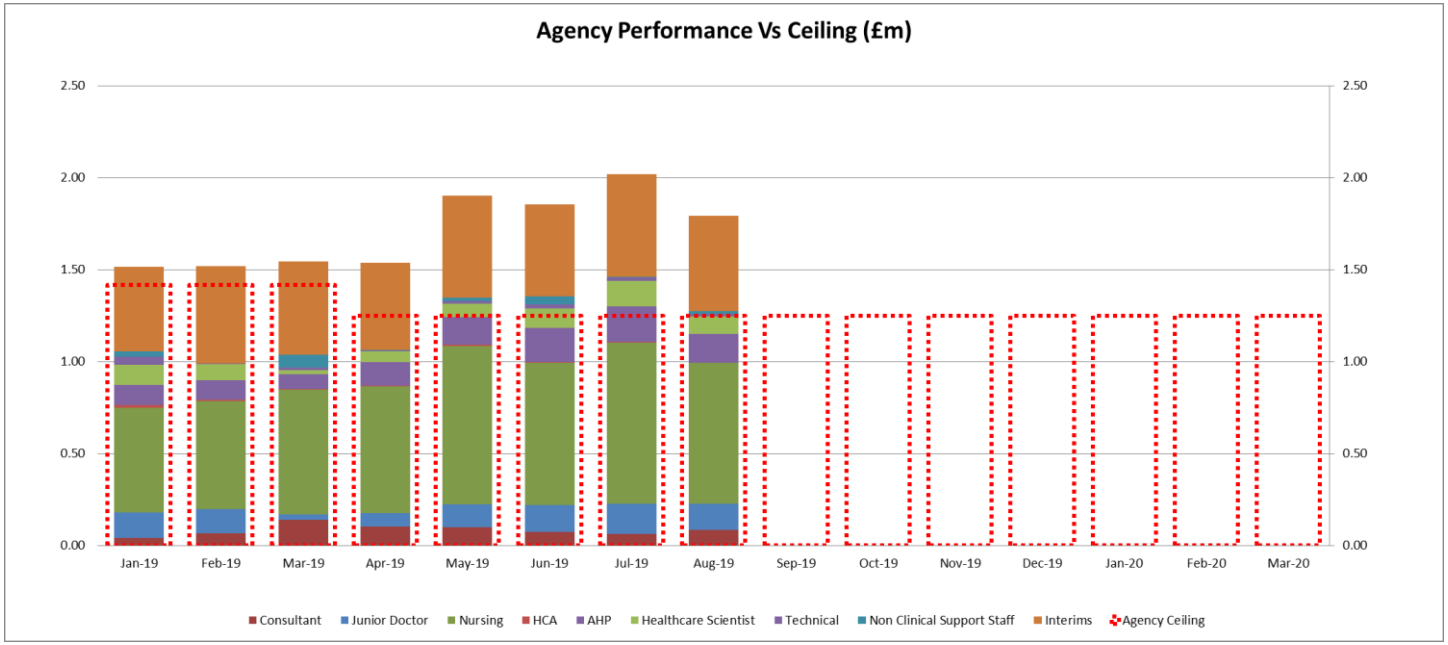
Agency use



- The Trust's total pay for August was £44.37m. This is £0.79m favourable to a plan of £45.16m.
- The Trust's 2019/20 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.
- Agency cost in August was £1.79m or 4.1% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs.
- For August, the monthly target set was £1.25m. The total agency cost is worse than the target by £0.54m.
- Agency cost is £0.22m lower compared to July. There have been decreases mainly in Nursing (£0.11m), Healthcare Scientist (£0.04m) and AHP (£0.03m).
- The biggest areas of overspend were Interims (£0.22m), Nursing (£0.18m), Junior Doctor (£0.07m) and AHP (£0.05m).

***restated to reflect the underlying agency spend**

Agency use

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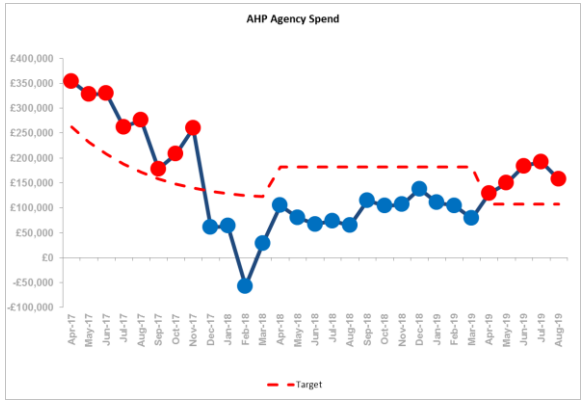
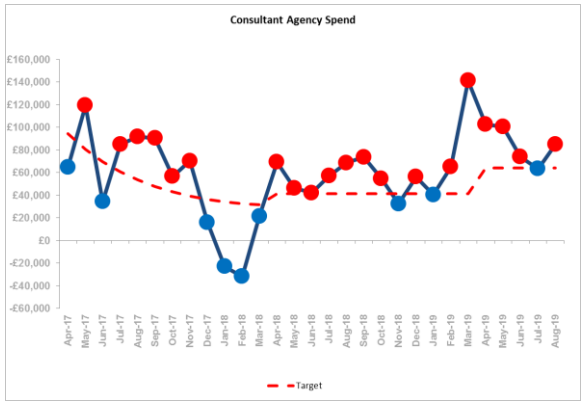
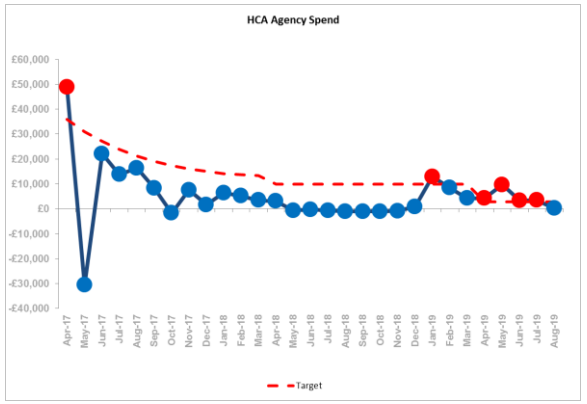
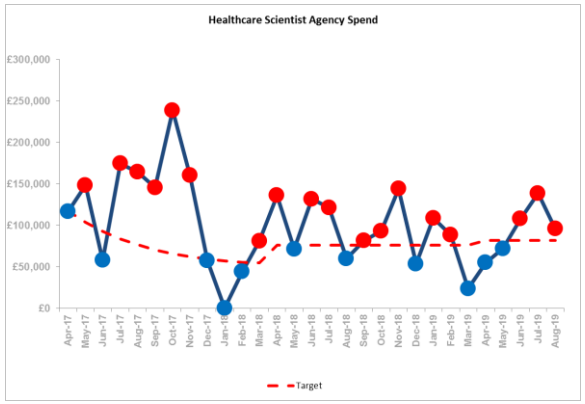
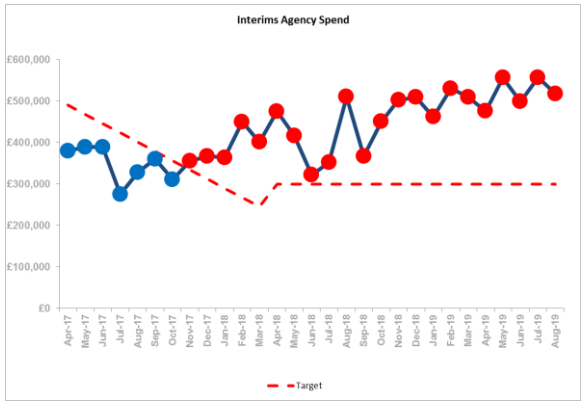
Above cap

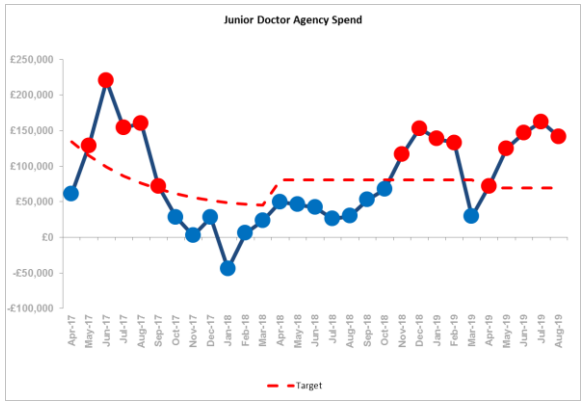


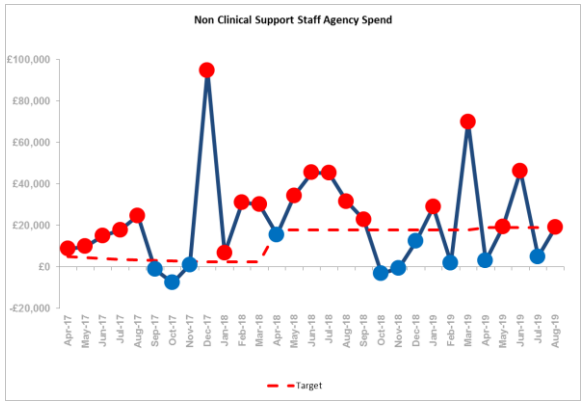


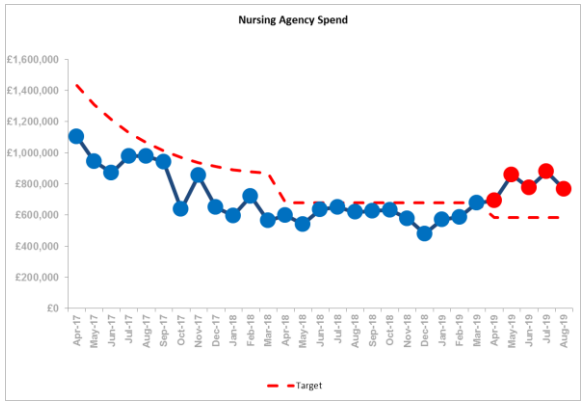


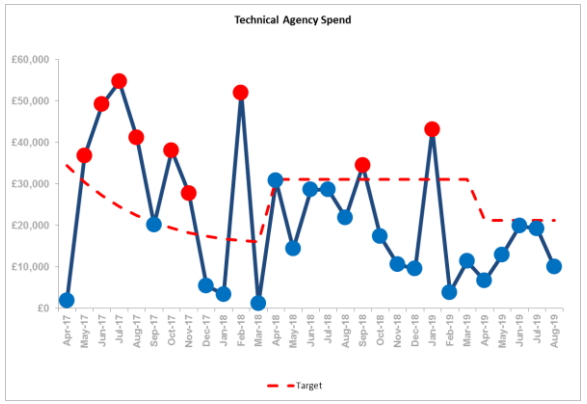








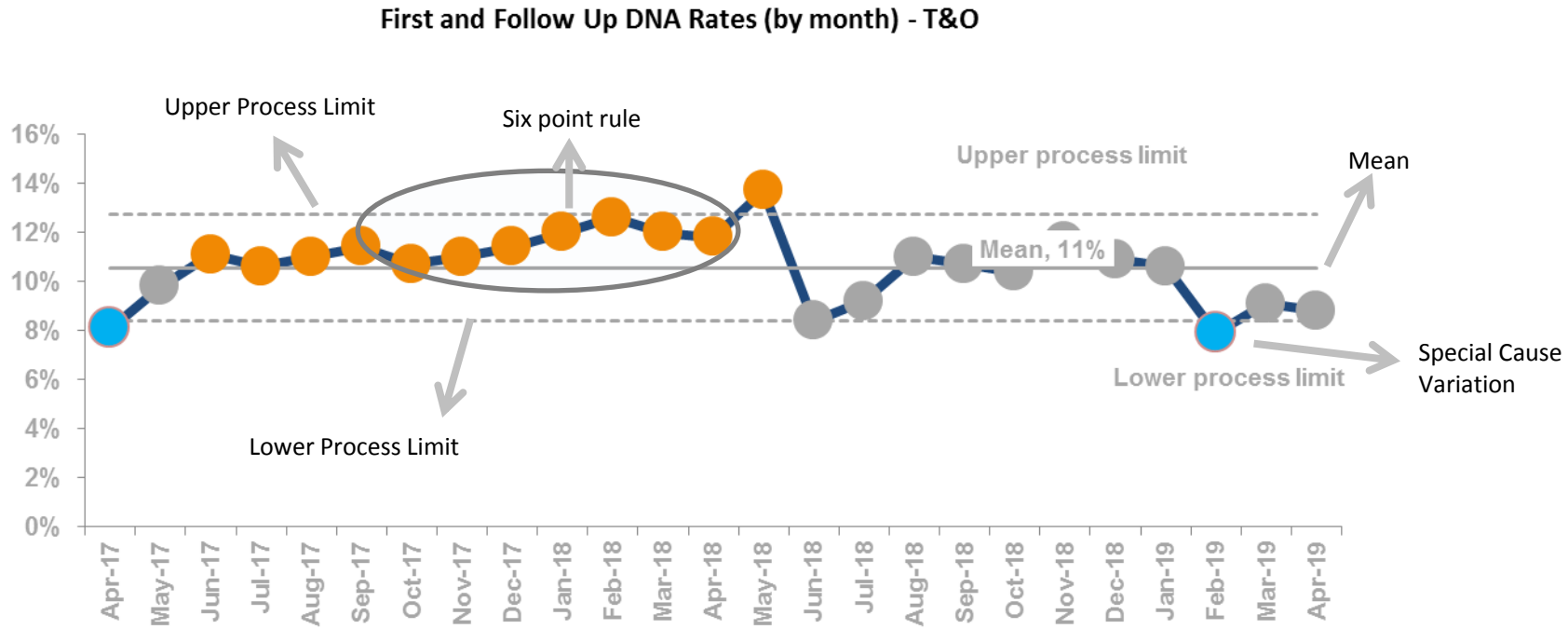




Appendix

- Interpreting SPC (Statistical Process Control) Charts
- First Outpatient Attendances Data Table
- Follow-up Attendances Data Table
- First to Follow-up Ratio Data Table
- First and Follow-ups Did Not Attend Rate Data Table
- Elective and Daycase Data Table
- Theatre Utilisation Data Table
- Theatre Cases per Session Data Table
- Elective Length of Stay Data Table
- Non Elective Length of Stay Data Table
- Patient Quality Data Table
- Patient Safety Data Table
- Emergency Flow Data Table
- Diagnostic Data Table
- On the Day Cancellations Data Table
- Cancer Performance Data Table

Interpreting SPC (Statistical Process Control) Charts



SPC Chart – A time series graph to effectively monitor performance over time with three reference lines; Mean, Upper Process Limit and Lower Process Limit. The variance in the data determines the process limits. The charts can be used to identify unusual patterns in the data and special cause variation is the term used when a rule is triggered and advises the user how to react to different types of variation.

Special Cause Variation – A special cause variation in the chart will happen if

- The performance falls above the upper control limit or below the lower control limit
- 6 or more consecutive points above or below the mean
- Any unusual trends within the control limits

Data tables

First Outpatient Attendances (average per working day)

Directorate	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Attendances in the last month	First Outpatient Attendances per working day: 2018-19 YTD	2019-20 YTD	Variance	Variance
Cardiology, Cardiothoracic & Vascular Service	54	58	59	67	51	59	58	59	58	68	64	58	54	1,134	60	60	1	1.2%
Children's Services	42	50	45	51	38	50	47	46	42	50	45	42	38	799	45	43	-1	-3.2%
Neurosciences	67	81	84	88	74	94	81	75	86	82	88	82	69	1,440	79	81	3	3.3%
Renal & Oncology	25	23	27	28	23	26	25	24	25	25	27	25	24	501	26	25	-1	-2.3%
Specialist Medicine	129	144	142	150	126	148	147	148	148	158	159	154	129	2,710	144	150	6	4.1%
Surgery	253	270	279	275	257	268	264	278	250	252	269	253	240	5,043	271	253	-18	-6.6%
Womens Services	85	89	86	90	78	88	92	82	91	78	82	67	68	1,423	87	77	-9	-10.8%
T&O	50	55	52	55	48	53	54	51	52	51	54	53	43	901	57	51	-6	-10.8%
Other	34	36	37	34	36	39	33	32	60	60	62	59	49	1,020	38	58	20	51.6%
Total	**737**	**805**	**812**	**838**	**731**	**826**	**801**	**791**	**812**	**823**	**850**	**806**	**713**	**14,971**	**805**	**801**	**-4**	**-0.5%**

Follow-up Outpatient Attendances (average per working day)

Directorate	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Attendances in the last month	FollowUp Outpatient Attendances per working day: 2018-19 YTD	2019-20 YTD	Variance	Variance
Cardiothoracic & Vascular Services	100	117	107	124	104	113	106	96	100	100	105	94	91	1,921	111	98	-13	-12.0%
Children's Services	76	87	81	90	73	83	84	70	78	82	78	70	65	1,356	76	75	-1	-1.5%
Neurosciences	105	122	117	123	104	124	118	101	121	118	122	106	95	1,999	111	112	1	1.3%
Renal & Oncology	219	248	245	243	229	238	223	230	242	229	221	219	207	4,341	220	224	4	1.7%
Specialist Medicine	477	533	509	529	481	528	537	526	573	538	544	528	469	9,858	501	530	29	5.8%
Surgery	336	357	352	362	331	382	350	335	317	331	327	321	289	6,067	354	317	-37	-10.5%
Womens Services	58	78	69	76	64	69	65	52	58	61	65	51	51	1,068	56	57	1	1.5%
T&O	77	82	85	93	76	86	85	76	82	79	81	75	70	1,469	82	77	-5	-5.5%
Other	86	97	92	91	77	91	92	87	119	121	125	124	97	2,029	93	117	24	25.9%
Total	**1,534**	**1,721**	**1,656**	**1,730**	**1,539**	**1,713**	**1,661**	**1,574**	**1,689**	**1,659**	**1,668**	**1,587**	**1,434**	**30,108**	**1,605**	**1,607**	**3**	**0.2%**

First to Follow-up Ratio

Directorate	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	First to FollowUp Ratio: 2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic & Vascular Services	1.85	2.01	1.81	1.85	2.04	1.92	1.83	1.63	1.72	1.46	1.65	1.62	1.69	1.87	1.63	-12.9%
Children's Services	1.82	1.74	1.80	1.77	1.89	1.66	1.79	1.52	1.85	1.64	1.73	1.67	1.71	1.70	1.72	1.2%
Neurosciences	1.57	1.51	1.39	1.40	1.40	1.32	1.46	1.35	1.40	1.44	1.39	1.29	1.38	1.42	1.38	-2.6%
Renal & Oncology	8.89	10.77	9.08	8.68	10.13	9.15	8.92	9.58	9.68	9.17	8.06	8.76	8.63	8.55	8.86	3.6%
Specialist Medicine	3.71	3.70	3.58	3.53	3.81	3.57	3.65	3.55	3.87	3.41	3.41	3.43	3.64	3.50	3.55	1.5%
Surgery	1.33	1.32	1.26	1.32	1.29	1.43	1.33	1.21	1.27	1.31	1.21	1.27	1.20	1.31	1.25	-4.4%
Womens Services	0.69	0.88	0.80	0.84	0.82	0.78	0.71	0.63	0.64	0.78	0.79	0.76	0.75	0.65	0.74	14.3%
T&O	1.55	1.49	1.63	1.69	1.59	1.62	1.57	1.49	1.58	1.55	1.51	1.42	1.63	1.45	1.54	5.8%
Other	2.52	2.70	2.49	2.69	2.16	2.33	2.79	2.72	1.98	2.02	2.03	2.10	1.98	2.44	2.02	-17.2%
Total	**2.08**	**2.14**	**2.04**	**2.06**	**2.10**	**2.07**	**2.07**	**1.99**	**2.08**	**2.02**	**1.96**	**1.97**	**2.01**	**2.00**	**2.01**	**0.5%**

Data tables

First and Follow-up DNA Rate

Directorate	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	DNA's in the last month	Patients not attending rate 2018-19 YTD	Patients not attending rate 2019-20 YTD	Variance
Cardiothoracic & Vascular Services	10.2%	9.4%	11.5%	10.9%	10.5%	10.9%	10.3%	10.1%	9.0%	9.6%	9.8%	9.6%	8.5%	219	10.6%	9.5%	-1.1%
Children's Services	13.1%	10.0%	11.3%	10.1%	10.9%	10.9%	10.9%	10.2%	10.9%	12.3%	10.4%	11.1%	12.4%	313	14.3%	11.2%	-3.1%
Neurosciences	9.4%	10.0%	10.6%	9.6%	10.2%	10.3%	10.6%	11.0%	11.8%	11.9%	11.2%	10.1%	11.1%	420	9.9%	11.2%	1.3%
Renal & Oncology	11.0%	10.5%	10.4%	11.0%	10.2%	9.7%	10.1%	9.4%	9.2%	9.9%	10.1%	8.2%	7.6%	251	10.2%	9.3%	-0.9%
Specialist Medicine	11.8%	11.6%	12.6%	13.1%	11.5%	12.3%	11.2%	10.8%	11.0%	12.8%	12.1%	10.2%	11.4%	1,437	12.5%	11.5%	-1.0%
Surgery	10.9%	10.2%	12.1%	11.6%	10.8%	10.4%	10.5%	10.4%	10.2%	10.3%	10.0%	8.8%	9.8%	1,295	10.9%	9.8%	-1.1%
Womens Services	9.8%	8.2%	8.7%	8.2%	7.4%	6.6%	7.4%	6.8%	8.0%	7.8%	7.8%	6.7%	7.4%	516	8.3%	7.6%	-0.7%
T&O	11.0%	10.7%	10.4%	11.6%	10.9%	10.6%	7.9%	9.1%	8.8%	10.7%	9.4%	9.3%	9.0%	244	10.8%	9.5%	-1.2%
Other	13.8%	12.5%	14.4%	15.4%	14.2%	12.9%	12.9%	14.3%	14.2%	13.4%	12.8%	12.6%	14.3%	1,395	11.0%	13.3%	2.3%
Total	**11.3%**	**10.6%**	**10.5%**	**10.5%**	**10.9%**	**10.8%**	**10.5%**	**10.6%**	**10.7%**	**11.2%**	**10.7%**	**9.7%**	**10.6%**	**6,090**	**11.4%**	**10.6%**	-0.8%

Elective & Daycase activity (average per working day)

Months	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2018-19 YTD	2019-20 YTD	Variance	Discharges for month
Cardiology & Cardiac Surgery	15.4	15.7	14.0	16.8	13.8	14.7	17.2	16.2	12.0	13.3	15.4	13.7	13.1	15.9	13.6	-14.4%	275
Clinical Haematology	1.4	2.2	1.7	1.5	1.8	1.0	1.3	1.4	0.8	0.8	0.7	1.4	1.2	2.0	0.9	-52.5%	25
Diabetes & Endocrinology	1.9	2.0	2.0	1.8	1.2	2.0	1.6	1.8	1.8	2.7	1.9	1.6	1.5	1.9	2.0	6.3%	32
Endoscopy & Gen Med	55.7	56.3	54.6	59.2	49.7	57.3	56.4	61.6	57.4	68.5	70.8	65.3	60.4	58.1	65.5	12.7%	1,268
Ear, Nose & Throat	7.8	9.1	8.9	7.8	7.1	9.5	7.9	7.9	8.5	8.3	8.9	8.3	7.3	8.1	8.5	4.5%	154
General Surgery	8.8	11.1	9.9	10.7	10.4	10.7	10.5	12.8	8.1	7.1	8.5	7.2	6.3	9.6	7.7	-19.2%	133
Gynaecology and Obstetrics	10.5	10.2	11.4	11.2	8.8	11.0	10.8	10.4	9.9	10.8	10.5	10.3	8.8	10.3	10.4	1.1%	185
Max Fax & Dental	6.2	7.4	6.4	6.4	5.5	6.7	7.2	5.4	6.1	7.3	7.2	6.5	5.5	6.6	6.8	3.3%	115
Neurosurgery	8.0	10.0	8.9	10.1	8.9	8.2	9.3	10.5	8.8	10.3	9.1	8.1	8.6	9.1	9.1	-0.9%	180
Neurology	24.0	25.6	30.0	28.8	24.2	28.7	34.3	31.0	32.4	33.3	32.1	31.9	26.5	25.8	32.4	25.7%	556
Oncology	1.7	1.6	1.8	1.2	1.5	2.8	2.7	1.8	4.0	3.4	3.6	3.8	3.9	1.8	3.7	107.1%	83
Paediatric Medicine	9.5	9.6	12.0	10.3	10.9	10.5	12.5	11.9	12.9	12.3	12.6	11.2	9.2	9.7	12.3	26.7%	194
Paediatric Surgery	8.6	9.9	9.2	10.7	8.4	9.6	10.0	10.0	8.9	10.3	8.2	8.9	8.2	8.3	9.1	9.1%	173
Pain Clinic	4.4	5.3	5.3	6.2	5.2	5.1	5.3	5.3	4.5	3.1	5.2	3.3	1.9	5.4	4.0	-25.3%	40
Plastic Surgery	19.1	18.8	17.1	18.3	15.9	17.1	17.4	16.5	15.0	19.3	18.5	15.1	17.1	17.5	17.0	-2.7%	359
Renal Medicine	5.3	5.4	4.7	3.8	4.4	3.2	5.2	3.7	4.3	6.5	5.1	4.3	3.8	5.2	5.0	-3.5%	81
Trauma & Orthopaedics	6.5	6.5	6.4	8.5	6.0	7.7	8.5	6.4	7.3	8.0	9.2	6.0	5.5	7.2	7.6	5.4%	115
Urology	11.6	13.4	14.5	14.0	12.9	13.4	14.8	13.2	15.8	13.0	13.7	14.1	12.1	12.3	14.1	15.2%	255
Thoracic Surgery	2.5	2.4	2.5	2.9	2.7	2.3	3.2	3.1	2.2	3.0	3.3	2.9	3.1	3.1	2.8	-8.3%	66
Vascular Surgery	4.4	4.7	5.1	4.6	4.3	5.1	3.9	4.4	4.4	4.8	4.1	4.5	3.7	5.1	4.4	-13.6%	78
Other	6.4	4.8	5.3	5.6	5.5	6.5	6.6	4.2	7.5	7.4	8.6	9.3	8.0	5.8	8.2	42.4%	168
Grand Total	**219.8**	**231.5**	**231.9**	**240.6**	**209.4**	**233.1**	**246.3**	**239.4**	**232.3**	**253.7**	**256.7**	**237.8**	**215.9**	228.6	245.1	7.2%	4,535

Daycase as a percentage of all Elective Activity	77.2%	75.3%	76.6%	77.0%	75.0%	77.7%	77.1%	74.8%	77.0%	77.4%	77.0%	76.3%	76.3%

Data tables

Theatre Utilisation

Main List Specialty	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Number of Patients in the last month
Cardiothoracic	69%	70%	70%	73%	72%	72%	80%	74%	70%	70%	75%	70%	73%	80
ENT	84%	76%	77%	82%	78%	80%	76%	74%	75%	78%	72%	73%	82%	143
General Surgery	79%	82%	80%	82%	84%	78%	78%	82%	81%	80%	88%	80%	72%	101
Gynaecology	81%	77%	83%	87%	81%	79%	88%	74%	81%	71%	78%	84%	81%	111
Neurosurgery	84%	78%	76%	81%	80%	82%	78%	75%	79%	78%	78%	79%	79%	152
Oral and Maxillo Facial Surgery	75%	82%	63%	84%	78%	84%	67%	91%	61%	72%	84%	87%	67%	31
Paediatric Dentistry	58%	55%	56%	60%	62%	65%	68%	65%	58%	80%	64%	59%	74%	23
Paediatric Surgery	78%	75%	74%	72%	75%	76%	82%	74%	77%	79%	79%	80%	78%	89
Plastic Surgery	75%	75%	77%	74%	78%	74%	75%	69%	76%	87%	72%	74%	74%	150
Renal Medicine & Surgery	78%	61%	67%	82%	60%	66%	67%	83%	66%	88%	69%	79%	77%	6
Trauma & Orthopaedics	79%	82%	90%	85%	90%	81%	83%	90%	83%	81%	84%	88%	84%	127
Urology	84%	84%	85%	86%	81%	86%	82%	80%	79%	78%	79%	82%	77%	174
Vascular Surgery	68%	74%	76%	70%	74%	76%	82%	75%	68%	73%	74%	72%	67%	72
Grand Total	**79%**	**78%**	**79%**	**80%**	**80%**	**79%**	**79%**	**77%**	**77%**	**77%**	**78%**	**78%**	**77%**	**1,259**

Theatre Average Cases per Session

Main List Specialty	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Cardiothoracic	1.5	1.3	1.4	1.5	1.5	1.5	1.7	1.4	1.5	1.6	1.6	1.6	1.6
ENT	1.8	1.7	1.7	1.7	1.6	1.9	1.6	1.6	1.7	1.9	1.9	1.8	2.0
General Surgery	1.7	1.7	1.8	1.7	1.6	1.8	1.7	1.6	1.8	1.8	1.6	1.5	1.7
Gynaecology	2.6	2.5	2.6	2.5	2.9	2.7	2.6	2.3	2.5	2.2	2.4	2.5	2.4
Neurosurgery	1.1	1.0	1.0	1.1	1.2	1.1	1.0	1.1	1.1	1.1	1.1	1.1	1.1
Oral and Maxillo Facial Surgery	3.7	3.9	3.1	3.8	3.8	3.7	3.1	4.0	2.7	3.1	3.4	3.2	3.0
Paediatric Dentistry	3.8	4.1	3.9	4.5	4.7	4.4	4.3	4.1	3.9	4.9	4.2	3.8	3.8
Paediatric Surgery	2.6	2.7	2.6	2.7	2.7	2.6	2.5	2.6	2.4	2.7	2.2	2.5	2.2
Plastic Surgery	2.2	2.2	2.1	2.0	2.0	1.9	2.0	2.1	1.8	1.8	1.7	1.8	2.0
Renal Medicine & Surgery	1.4	1.3	1.6	1.5	1.4	1.2	1.8	1.5	1.9	2.0	1.2	1.1	1.0
Trauma & Orthopaedics	1.5	1.6	1.9	1.9	1.8	1.9	1.9	1.9	1.8	1.8	2.0	1.7	1.8
Urology	2.1	2.1	2.1	2.0	2.1	2.0	2.0	2.0	2.0	2.1	2.1	2.1	1.8
Vascular Surgery	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.0	1.1	1.4	1.4	1.3
Grand Total	1.8	1.7	1.8	1.8	1.8	1.8	1.8	1.7	1.7	1.8	1.8	1.8	1.7

Data tables

Elective Length of Stay

Directorate	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Discharges in the last month	Average length of Stay 2018-19 YTD	Average length of Stay 2019-20 YTD	Variance
Cardiothoracic	4.4	2.9	3.8	3.3	3.7	3.5	4.2	3.6	3.0	3.5	3.9	3.7	3.6	212	4.2	3.5	-15.4%
Children's & Women	2.1	3.1	2.5	2.4	2.1	3.8	2.7	3.0	2.4	1.9	2.0	2.2	1.8	103	2.6	2.1	-18.4%
Neurosciences	8.9	10.0	8.0	9.3	10.6	10.2	8.4	5.9	10.1	7.8	6.9	10.8	9.0	161	9.0	8.9	-0.7%
Surgery & Trauma	4.3	3.4	3.7	3.5	4.6	4.5	3.9	3.5	2.6	2.5	2.6	2.2	2.8	507	3.7	2.5	-33.4%
Grand Total	**4.8**	**4.7**	**4.4**	**4.6**	**5.3**	**5.4**	**4.7**	**4.7**	**3.8**	**3.5**	**3.5**	**3.9**	**3.9**	**983**	**4.7**	**3.7**	-22.0%

Non-Elective Length of Stay

Directorate	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Discharges in the last month	Average length of Stay 2018-19 YTD	Average length of Stay 2019-20 YTD	Variance
Acute Medicine	2.6	2.6	2.5	2.5	2.7	2.9	2.8	2.8	2.7	2.7	2.5	3.0	3.4	2,360	2.7	2.9	5.4%
Cardiothoracic	8.9	8.6	8.8	7.7	8.8	7.6	9.7	11.7	10.2	12.3	9.1	10.9	8.2	185	8.6	10.2	18.0%
Children's & Women	2.4	2.4	2.3	2.4	2.4	2.4	2.9	3.1	3.4	3.6	3.6	3.9	3.2	668	2.5	3.5	43.1%
Neurosciences	9.6	6.6	8.8	9.6	9.8	10.8	13.5	9.3	9.5	11.9	7.5	10.5	9.5	224	10.0	9.8	-2.5%
Senior Health	12.0	7.8	7.6	8.7	11.4	12.5	11.1	11.2	12.7	12.6	9.9	9.8	4.6	56	10.5	9.9	-6.1%
Specialist Medicine	8.7	6.8	6.4	7.6	7.5	8.3	6.8	8.5	9.5	11.1	11.3	7.0	7.4	136	7.6	9.3	22.4%
Surgery & Trauma	5.0	4.4	4.6	5.1	4.2	5.3	5.0	4.0	4.3	4.2	4.1	4.4	4.0	843	4.4	4.2	-4.4%
Therapeutics	8.3	15.7	12.0	9.8	21.1	12.3	25.3	11.3	11.0	22.5	18.6	14.0	7.6	27	10.1	14.7	45.6%
Grand Total	**4.0**	**3.6**	**3.6**	**3.7**	**3.8**	**4.0**	**4.3**	**4.0**	**4.1**	**4.3**	**3.9**	**4.3**	**4.1**	**4,499**	**3.9**	**4.1**	6.0%

Data tables

Patient Safety

Indicator Description	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Number of Never Events in Month	0	0	0	2	0	0	1	0	0	1	0	0	1	0
Number of SIs where Medication is a significant factor	0	0	0	1	1	0	0	0	0	0	0	0	0	0
Number of Serious Incidents	=<8 month	1	3	5	6	6	6	6	4	3	7	7	2	4
Serious Incidents - per 1000 bed days	N/A	0.04	0.13	0.20	0.26	0.26	0.25	0.27	0.16	0.13	0.29	0.30	0.08	0.17
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.7%	96.3%	95.1%	95.0%	95.6%	95.9%	96.5%	96.0%	96.1%	96.1%	94.6%	95.4%	95.3%
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.2%	99.0%	98.3%	97.7%	97.6%	98.4%	98.6%	98.3%	98.3%	98.9%	98.0%	97.8%	98.7%
Percentage of patients who have a VTE risk assessment	95%	96.4%	96.2%	96.0%	96.2%	95.5%	95.9%	95.7%	95.5%	87.8%	88.2%	87.6%	93.8%	93.7%
Number of Patient Falls	N/A	136	141	181	173	148	128	147	135	143	135	133	123	158
Falls (Moderate and Above Severity)	N/A	1	0	1	3	1	3	1	2	2	2	1	0	3
Number of patient falls- per 1000 bed days	N/A	5.91	6.26	7.40	7.50	6.32	5.31	6.57	5.38	6.08	5.63	5.75	4.99	6.58
Acquired Category 2 Pressure Ulcers	N/A	15	9	12	25	13	10	16	6	4	17	20	10	15
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.65	0.40	0.49	1.08	0.56	0.42	0.72	0.24	0.17	0.71	0.86	0.41	0.63
Acquired Category 3 Pressure Ulcers		3	2	1	3	7	7	4	11	8	5	8	8	3
Acquired Category 3 Pressure Ulcers per 1000 bed days		0.13	0.09	0.04	0.13	0.30	0.29	0.18	0.44	0.34	0.21	0.35	0.32	0.13
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Data tables

Quality Priorities

Indicator Description	Threshold/Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Number of 2222 calls / 1000 adult ordinary IP admissions		9.5	4.9	9.8	9.4	11.3	11.0	11.1	8.8	7.1	8.9	10.2	12.3	8.6
Number of Cardiac Arrests / 1000 adult ordinary IP admissions (to become avoidable cardiac arrests)		3.2	2.0	0.7	3.4	2.6	3.8	3.3	2.8	4.0	2.8	1.8	3.6	0.9
% of patients in ED with Red Flag sepsis receiving antibiotics within an hour (adults)	90%	95.7%	91.6%	91.4%	95.3%	93.5%	94.5%	93.2%	88.3%	90.6%	91.4%	93.5%	87.2%	83.4%
Compliance with appropriate response to EWS (adults)	85%	93.8%	94.7%	92.4%	92.0%	93.3%	95.8%	87.3%	89.6%	92.7%	94.2%	92.9%	90.6%	93.9%
Resuscitation BLS	85%	71.1%	70.5%	70.5%	70.3%	69.8%	70.5%	71.5%	74.1%	76.2%	75.2%	76.0%	75.5%	75.9%
Resuscitation ILS	85%	64.2%	64.2%	64.3%	66.3%	68.5%	70.2%	69.3%	71.3%	72.1%	72.7%	72.0%	72.5%	69.2%
Resuscitation ALS	85%	24.4%	24.2%	27.1%	40.4%	51.2%	64.2%	67.0%	70.4%	72.7%	73.0%	73.5%	74.8%	59.1%

Indicator Description	Threshold/Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	72.6%	77.6%	79.5%	80.8%	83.4%	83.9%	86.3%	88.6%	89.8%	91.8%	90.8%	92.2%	92.1%
Mental Capacity Act & Deprivation of Liberties - Level 2	85%						21.7%	32.2%	42.0%	53.2%	62.9%	70.9%	74.3%	73.0%
Total Datix incidents reported in month		1,217	1,147	1,345	1,366	1,174	1,333	1,215	1,208	1,096	1,329	1,332	1,413	1,544
Monthly % of incidents low and no harm										Delayed Not yet available				
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%									100.0%	92.0%	100.0%	data two months in arrears	
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	39%	47%	64%	66%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days					

Data tables

Emergency Flow

Indicator Description	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
4 Hour Operating Standard	95%	91.1%	90.3%	90.1%	85.5%	85.6%	84.2%	82.2%	83.1%	85.4%	86.5%	87.0%	86.4%	83.3%
Patients Waiting in ED for over 12 hours following DTA	0	0	1	0	1	2	0	0	1	1	0	1	2	3
Admitted patients with a length of stay 7 Days or Greater		272	266	287	294	291	315	321	315	298	301	290	314	302
Ambulance Handover - % under 15 minutes	100%	42.3%	46.4%	42.5%	37.4%	37.0%	33.9%	33.0%	33.0%	35.1%	35.2%	36.0%	32.9%	32.4%
Ambulance Handover - % under 15 minutes (London Average)	100%	48.1%	52.6%	47.4%	46.5%	44.7%	41.6%	43.1%	45.4%	43.5%	44.4%	42.3%	43.9%	45.0%
Ambulance Handover - number of patients not handed over within 30 minutes	0	85	109	111	138	135	145	87	94	76	112	119	134	172
Ambulance Handover - % under 30 minutes	100%	95.5%	94.1%	94.5%	93.0%	93.6%	92.3%	95.1%	93.6%	95.5%	94.3%	93.5%	92.9%	90.8%
Ambulance Handover - % under 30 minutes (London Average)	100%	92.2%	92.5%	92.2%	91.5%	90.5%	88.2%	90.3%	92.7%	91.7%	92.2%	90.6%	92.4%	92.3%
Ambulance Handover - number over 60 minutes	0	2	3	0	3	1	13	6	8	6	0	4	2	1

Diagnostics

Indicator Description	Threshold	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
6 Week Diagnostic Performance	1%	0.2%	0.4%	0.2%	0.5%	0.6%	0.5%	0.3%	0.5%	1.6%	0.7%	0.4%	0.95%	0.96%
6 Week Diagnostic Breaches	N/A	15	30	18	39	37	41	24	40	115	59	31	74	74
6 Week Diagnostic Waiting List Size	N/A	6,946	7,617	7,593	7,322	6,652	7,649	7,754	7,622	7,247	8,274	7,992	7,772	7,737

Indicator Description	Threshold	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
MRI	1%	0.3%	0.1%	0.2%	0.3%	0.6%	0.4%	0.6%	0.1%	0.3%	0.3%	0.0%	0.0%	0.0%
CT	1%	0.0%	0.0%	0.2%	0.1%	0.7%	0.6%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
Non Obstetric Ultrasound	1%	0.1%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	1.0%
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%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%
Audiology Assessments	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%
Echocardiography	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.4%	4.3%	12.1%	4.2%	1.0%	9.0%	4.7%
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%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%
Sleep Studies	1%	1.5%	0.0%	0.0%	7.7%	2.4%	1.1%	0.8%	2.7%	4.6%	4.8%	1.4%	1.0%	0.9%
Urodynamics	1%	0.0%	13.9%	14.6%	10.2%	8.5%	16.3%	14.0%	0.0%	5.7%	0.0%	0.0%	2.9%	4.9%
Colonoscopy	1%	0.0%	0.0%	0.7%	3.0%	0.0%	2.9%	1.0%	0.0%	1.0%	0.6%	0.6%	0.9%	0.3%
Flexi Sigmoidoscopy	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	0.6%	2.0%	1.4%
Cystoscopy	1%	4.4%	2.6%	3.0%	4.5%	5.4%	3.2%	0.0%	1.9%	3.2%	6.4%	2.6%	3.0%	2.6%
Gastroscopy	1%	0.0%	0.3%	0.0%	0.0%	0.6%	1.4%	0.6%	1.8%	2.1%	2.3%	3.1%	3.7%	2.8%

Data tables

On the Day Cancellations

Indicator Description	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Number of on the Day Cancellations		44	55	52	53	60	86	73	49	45	69	69	54	38
Number of on the Day cancellations re-booked within 28 Days		39	48	50	52	58	86	71	47	42	68	69	54	38
% of Patients re-booked within 28 Days	100%	88.6%	87.3%	96.2%	98.1%	96.7%	100.0%	97.3%	95.9%	93.3%	98.6%	100.0%	100.0%	100.0%

Cancer

Indicator Description	Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	No of Patients
Cancer 14 Day Standard	93%	93.1%	95.0%	95.5%	96.3%	95.9%	96.6%	94.4%	93.3%	94.4%	92.4%	90.2%	92.5%	95.6%	1,656
Cancer 14 Day Standard Breast Symptomatic	93%	55.2%	86.4%	97.9%	97.1%	95.4%	96.9%	97.4%	94.6%	94.7%	94.4%	94.9%	93.2%	94.9%	214
Cancer 31 Day Diagnosis to Treatment	96%	98.4%	98.5%	99.0%	99.1%	96.5%	98.2%	97.4%	98.4%	98.1%	96.2%	96.9%	96.0%	97.0%	198
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	95.0%	96.6%	100.0%	96.9%	96.6%	94.6%	97.9%	94.4%	96.2%	100.0%	95.7%	96.7%	100.0%	31
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	105
Cancer 62 Day Referral to Treatment Standard	85%	85.7%	85.7%	80.6%	87.8%	88.1%	94.8%	86.2%	77.8%	85.0%	75.6%	71.4%	85.8%	92.7%	54.5
Cancer 62 Day Referral to Treatment Screening	90%	73.8%	91.6%	94.1%	91.8%	93.2%	82.0%	88.7%	70.5%	76.6%	87.7%	96.5%	93.8%	97.4%	19

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Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No**	**2.3**
Report Title:	**Cardiac Surgery Services Update**		
Lead Director	Richard Jennings, Chief Medical Officer		
Report Authors:	Steve Livesey, Associate Medical Director of Cardiac Surgery & Cardiac Surgery Care Group Lead Cheryl Ramsay, Cardiac Surgery Programme Lead		
Presented for:	Assurance		
Executive Summary:	This report provides an update to Trust Board on the steps being taken to improve the cardiac surgery service following the NICOR safety alerts and the findings of the independent report by Professor Bewick (July 2018). Since the last update to the Trust Board in July 2019, the following key developments have taken place: • All 210 cases have now been reviewed by the External Mortality Review Panel - the last meeting was held on 31 July 2019; • The Next of Kin (NoK) contact process has been completed. Of the 210 cases that were reviewed by the External Mortality Review Panel, 195 Being Open Letters have been posted to NoK (= 93%) – as at 23 August 2019; • Contingency planning is being undertaken with NHS England / NHS Improvement to plan for different possible sequelae to the publication of the External Mortality Review Panel Report, including those that might in theory impact upon service provision; • The Single Item Quality Surveillance Group Meeting (was called the Quality Summit Meeting) held on 21 August 2019 was a positive meeting. The next meeting will be held on 16 September 2019; • There is currently one extreme risk on the Cardiac Surgery risk register, this is: 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).		
Recommendation:	The Trust Board is asked to discuss and take assurance from 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		

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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.		
Equality Impact Assessment	N/A		
Previously Considered by:		**Date**	

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Trust Board Meeting - CARDIAC SURGERY UPDATE

1.0 PURPOSE

1.1 To update the Trust Board on the progress being made with Cardiac Surgery since the presentation to the Trust Board in July 2019.

2.0 EXTERNAL ASSURANCES

2.1 Meetings of the Independent Mortality Review Panel

2.1.1 The last Independent Mortality Review Panel meeting was held on 31 July 2019. The Panel reviewed 210 cases.

2.1.2 In the Programme Board Meeting, chaired by Sir David Sloman, on 8 August 2019, it was agreed that the Trust had done everything practicably possible to send Being Open Letters to all families that could have been contacted, and it was deemed that the Trust's communication was complete.

1.2 Contingency Planning

2.2.1 Contingency planning is being undertaken with NHS England / NHS Improvement to plan for different possible sequelae to the publication of the External Mortality Review Panel Report, including those that might in theory impact upon service provision.

3 INTERNAL DEVELOPMENTS

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

3.1 The Cardiac Surgery Steering Group met on 12 August 2019, and amongst other things, reviewed and approved a Cardiac Surgery Operational & Clinical Standard Operating Procedures (SOPs) Audit Schedule for 2019 / 2020 and reviewed The Cardiac Surgery Risk Register.

3.2 The Next of Kin (NoK) contact process has been completed. Of the 210 cases that were reviewed by the External Mortality Review Panel, 195 Being Open Letters have been posted to NoK (= 93%) – as at 23 August 2019.

3.3 The Cardiac Surgery Case Management Team, which is a multi- disciplinary group, will be operating from a single site office as of 1 October 2019.

3.4 The Single Item Quality Surveillance Group Meeting (was called the Quality Summit Meeting) held on 21 August 2019 was a positive meeting. The next meeting will be held on 16 September 2019.

4.0 INTERNAL ASSESSMENT

4.1 The safety of the service continues to be closely monitored by the Trust with the dashboard being circulated and considered by the Chief Medical Officer and Chief Nurse as well, in addition to, the local cardiac surgery service. 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.

5.0 RISK REGISTER

5.1 The Cardiac Surgery Risk Register was reviewed by the Cardiac Surgery Steering Group in a meeting held on the 12 August 2019 (the risks and mitigations have been updated on DATIX, the Trust's Risk Management System).

5.1.1 There is currently one extreme risk on the Cardiac Surgery risk register, this is:

- 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).

5.1.2 The risk below was an extreme risk in July 2019, however it has now been mitigated to a "high risk":

- 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 12 – mitigation includes, only the Associate Medical Director for Cardiac Surgery & Care Group Lead operates on high risk cardiac cases, all cardiac surgery patients are overseen via daily MDT Meetings etc).

5.1.3 The risks below were extreme risks in July 2019, however they have been mitigated to "moderate risks", these are:

- Service Continuity - there is a risk that some Consultant Cardiac Surgeons, as a result of the External Mortality Review Report being published, may feel that they are not able to work, which will in turn impact the Cardiac Surgery service (Original risk score 15, current score 8).

- Losses incurred through reduced income as a result of decreased activity, and direct costs incurred through the programme (Original risk score 25, current score 8). The Trust's Risk Management Executive Meeting in August 2019 directed that this risk be downgraded and should be closed once the actions are complete.

There continues to be a risk in regards to junior medical staffing, which is currently being managed through active recruitment and the use of bank and, where necessary, agency staff. The rota is complete and the Trust is not experiencing gaps. The specialty has also been successful in actively recruiting into Registrar and SHO slots. As such, the risk is controlled.

6.0 RECOMMENDATION

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

Date: 12 September 2019

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NHS Foundation Trust

2.4

Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No.**	2.4
Report Title:	Quality Improvement Academy		
Lead Director	James Friend. Director of Delivery, Efficiency and Transformation		
Report Authors:	Martin Haynes, Improvement Methodology Director Dr. Mark Hamilton, Associate Medical Director		
Presented for:	Noting.		
Executive Summary:	The past quarter has included launch of the culture, leadership and organisation development workstream (led by the CEO), including workshops with both senior leaders and the Trust Executive Committee team to support development of the Divisional Leadership Accountability Framework. This work will help establish the conditions for improvement and define future leadership development needs and the values and behaviours that resonate with our organisation. A further workshop with the Trust Board gave the opportunity to understand and explore how the St George's Way framework will shape the way we work in the future. At the same time the Flow Coaching Academy team launched their first 'Big Room' coaching workshops. Detailed reviews of the GIRFT & Health Improvement Network programmes have also given us a clear understanding for the future support needs for the clinical/management teams. This paper also highlights some of the larger elements of the QIA's activities over the past quarter.		
Recommendations:	The Board is asked to note the intentions and progress of the Academy to date.		
Supports			
Trust Strategic Objectives:	Right Care, Right place, Right Time Balance the Books, Invest in the Future Build a Better St George's Champion Team St George's Develop Tomorrow's Treatments Today		

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CQC Themes:	Safe and Effective - Well Led		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources		
Implications			
Risk:	None in this paper.		
Legal / Regulatory:	N/A		
Resources:	None requested in this paper.		
Equality Impact Assessment	N/A		
Previously considered	At Trust Executive Committee, as part of Monthly Transformation Report	Date:	September 2019
Appendices:			

Quality Improvement Academy Update for Trust Board 26/9/19

Report Structure

- **Executive Summary** – major themes / activities over the past quarter
- **Creating conditions for change** – work with senior leaders to enable a culture of improvement across the trust
- **Building capability and capacity to lead change** – training and engagement activities that build skills and understanding to lead improvement activities
- **Coaching the organisation through change** – examples of current improvement activity across the trust
- **Building Infrastructure to Sustain Improvement** – how we are embedding improvement principles, frameworks and tools into the way we work at St George's

Executive Summary

- Launched TEC Accountability Framework which is helping improve structure and rigour of meetings and better enabling TEC members to identify and manage key exceptions
- Launch of leadership, culture and organisation development workstream, led by our CEO.
- Completed detailed review of GIRFT & Health Improvement Network programmes
- Completed workshops with senior leaders and members of the TEC team focused development of divisional leadership accountability framework
- Held workshop with Trust Board team to explore and understand how the St George's Way framework will support our organisation development, leadership and improvement objectives
- The Flow Coach Academy team launched its first 'Big Room' coaching workshops and has commenced planning for launch of our own academy in 2020
- Integrated QI training as part of the junior doctors trust induction process
- We continue to promote use of Post Implementation Reviews / After Action Reviews to support continuous learning as part of improvement project activities or key events which adversely impact operational performance/patient care

Creating conditions for change

Culture & Organisation Development

Launch of culture, leadership and organisation development workstream, lead by our CEO. It's focus will be:

- Use the **St George's Way** to determine the expectations and development of our leadership community
- Determine and deliver an **Organisational Development** strategy that supports St George's to become a successful, high performing Trust, that responds and adapts quickly to change by working with its staff
- To develop, with our staff, a set of **values and behaviours** that resonate with our organisation, and sets the blue print for our culture including undertaking a Cultural Diagnostic

Divisional Leadership Accountability Framework

Work has already started to evolve the Divisional Leadership Accountability Framework, including workshops with senior leaders & the TEC team

The next quarter will commence with a series of staff engagement workshops and development of the organisation development plan.

Creating Conditions for Change

Selected Activity Summary

- Launched TEC Accountability Framework
- Completed board workshop to explore understanding and implementation of St George's Way framework across SGUH
- Delivered Senior Leaders workshop focused on development of divisional leadership role accountability framework
    - This was followed by a supporting TEC workshop where the team reviewed feedback from the Senior Leaders workshop and further refined expectations of these key roles
- CPO held first People Management Group which will support development and implementation of our Organisation Development plans

Key actions for next Quarter

- Develop and test new behaviour / role accountability framework for key divisional leadership roles (starting with Divisional Chair, DDO & DDNG)
- Develop and agree 24 month combined QIA & organisation development business plan
- Develop and launch our third Quality Improvement week to promote understanding and learning across the trust
- Identify and engage c10 key leaders from our talent pool to visit Orlando Health in Florida (Dec 19) to learn more about the full potential of quality improvement and become key influencers and drivers of change in our clinical divisions
- QIA leads to support divisional teams to plan and focus improvement activities aligned with their operational and quality priorities

Building capability & capacity to lead change

St George's University Hospitals NHS
NHS Foundation Trust

2.4

Selected Activity Summary

- Delivered improvement workshops / presentations to the following teams:
  - Clinical neuropsychology and clinical health psychology team
  - 50 junior doctors who joined the trust in Sept 2019
  - Staff attending the 4 day Enhanced Leadership Development workshops
  - Paediatric clinical governance group
- Dedicated coaching and development sessions with initial group of ward teams leading roll-out of Treatment Escalation Plans

Activity for Next Quarter

- Develop training / coaching programme to support organisation development plans
- QIA Improvement leads to develop divisional QI training/development plans

474 Total number of staff who have attended one of more of our formal improvement training workshops*

45 Doctors, clinicians & managers attended specialist IHI QI workshops

c120 Doctors, clinicians, managers, commissioners, GPs & patients facilitated through 3 Acute Provider Collaborative workshops to develop new care pathways across SWL

* Since launch of formal training in Sept 2018

Coaching the Organisation Through Change

This section highlights examples of current improvement activity across the trust

Getting It Right First Time

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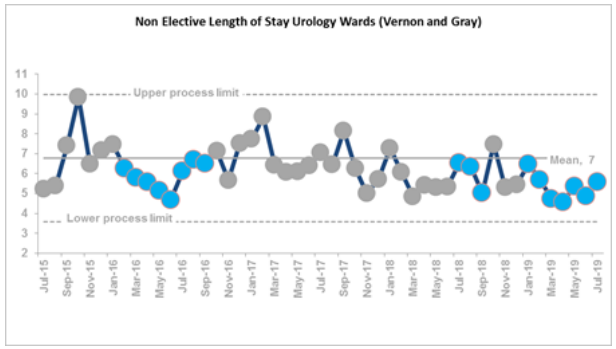
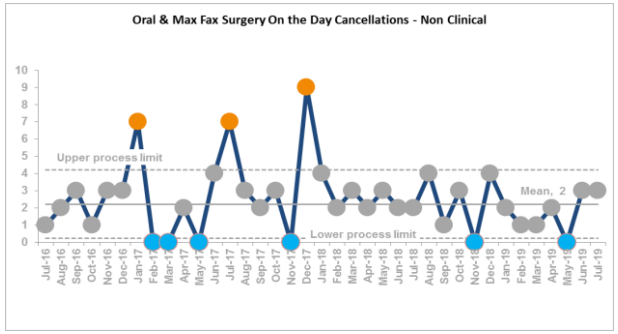




Selected Activity Summary

- Confirmed spine team achieved £425k/annum through improvement procurement
- Vernon & Gray wards implemented consultant of the week to help reduce length of stay
- Introduction of dedicated paediatric list in oral & maxillofacial to help reduce on the day cancellations

GIRFT Activity Summary

Division	Specialty	Deep Dive	Total	Complete	In progress	* Consider later	**Not applicable / not to be taken forward	***action plans in development
MedCard	Vascular surgery	01/11/2016	54	28	9	14	3	0
	Cardiothoracic surgery	04/09/2017	31	3	2	0	1	25
	Renal	05/03/2019	Awaiting implementation meeting to confirm recommendations					
	Endocrinology	11/04/2019	Awaiting implementation meeting to confirm recommendations					
	Geriatric Medicine	02/05/2019	12	0	12	0	0	0
	Diabetes	18/06/2019	Awaiting implementation meeting to confirm recommendations					
	Gastroenterology	26/07/2019	Awaiting implementation meeting to confirm recommendations					
	Acute & General Medicine	TBC	Awaiting Deep Dive					
Surgery	Orthopaedics	04/11/2013	30	10	12	8	0	0
	Urology	20/09/2016	30	10	9	11	0	0
	Spinal Surgery	16/01/2017	25	0	4	1	0	20
	Oral & Maxillofacial	12/07/2017	23	1	10	10	2	0
	ENT	21/11/2017	7	1	6	0	0	0
	General Surgery	05/03/2018	32	2	8	0	0	22
	Hospital Dentistry	01/08/2018	9	0	0	0	0	9
	Anaesthetics / POM	04/03/2019	Awaiting implementation meeting to confirm recommendations					
	Stroke (regional event)	19/06/2019	Awaiting implementation meeting to confirm recommendations					
	Neurosciences (regional event)	21/06/2019	Awaiting data pack from Regional Event					
CWDTCC	Obs and Gynae	04/07/2017	6	2	3	1	0	0
	Paediatric Surgery	15/02/2018	9	0	0	0	0	9
	Intensive / Critical Care	09/11/2018	8	0	0	0	0	8
	Radiology	07/12/2018	19	5	10	3	1	0
	Breast Surgery	07/06/2019	Awaiting implementation meeting to confirm recommendations					
	Grand Total		295	62	85	48	7	93
				21%	29%	16%	2%	32%

Activity for Next Quarter

- Implementation meetings scheduled for: Anaesthetics, Endocrinology Diabetes, Renal and Gastroenterology
- Agree model to embed local GIRFT reporting within divisions
- Understand implications of London GIRFT team restructure and support available to SGUH

Health Improvement Network Projects

HIN Activity Summary

Selected Activity Summary

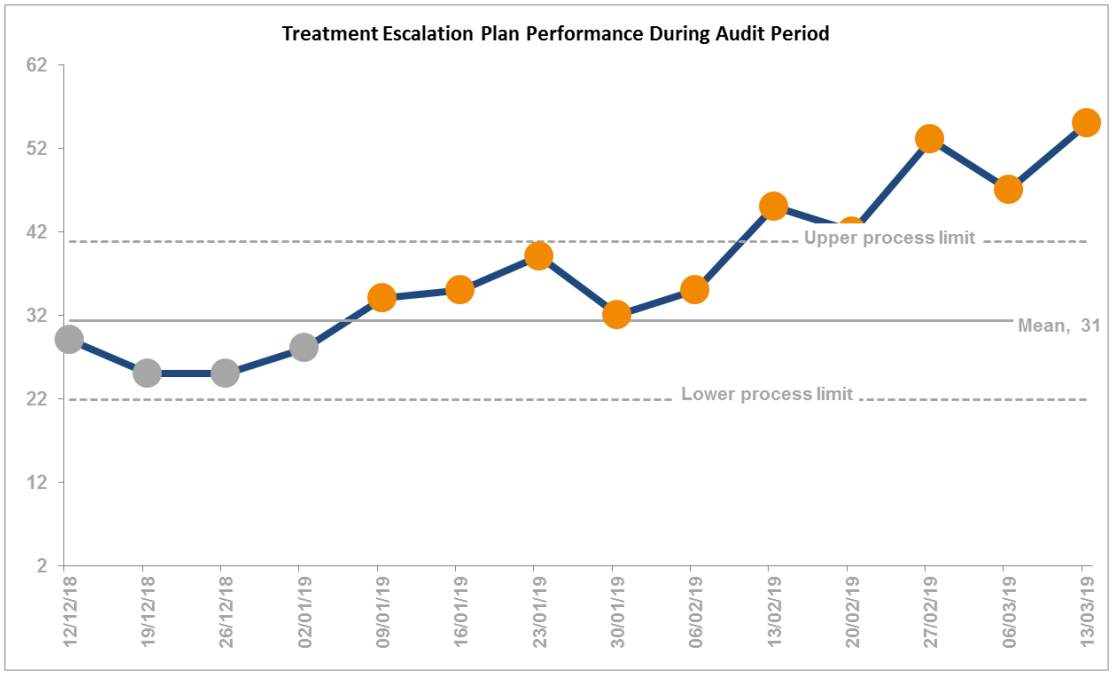
- Review of Episcissors shows reduced use of product as the clinical lead does not see a real benefit & they are unlikely to purchase further products
- Troponin testing review completed, but we do not qualify for HIN subsidy as we were using the product prior to its HIN launch

Activity for Next Quarter

- Progress HeartFlow implementation following appointment of new manager within team
- Support PLGF launch and complete post implementation review poster
- Complete final post implementation review for Episcissors and provide formal feedback to HIN

Product Name	Clinical theme / Specialty	Patient Impact Scale	Appetite / agreement & capacity to proceed	Status	RAG
SecurAcath	Multiple	~ 900 PICC placements	Agreed	Implemented / in-use	Green
NIC (Non Injectable Connector)	TBC	unknown	Unknown	Unknown	Green
EndoCuff Vision	Gastroenterology / Endoscopy	limited use at present	Agreed	Implemented / not in use	Green
Episcissors	Maternity	150 patient uses per year	Agreed	Implemented / in use	Green
Troponin High Sensitivity assay	ED / Cardiology	9736 chest pain patient arrivals at ED (18/19)	Agreed	Implemented / in use	Green
Urolift	Urology	25 patients per year	Agreed	Unknown	Green
Frozen Faecal Microbiota Transplantation	Gastroenterology / Endoscopy	4 patients per year	Agreed	Initial discussions	Green
gammaCore	Neurology / Mental Health	20 patients per year	Agreed	Project In progress	Green
HeartFlow	Cardiology / CT Radiology		Agreed	Project In progress	Red
Pre-eclampsia PLGF Test	Maternity	~ 100 patients per year	Agreed	Project In progress	Green
DrDoctor modules and Patient Knows Best (PKB)	Digital Outpatients	TBC	TBC	TBC	Red

Corporate Priorities: Treatment Escalation Plans



Selected Activity Summary

- Continuing roll-out of TEPs with Marnham, Senior Health, MAU, HFU & ED teams as the key innovators/early adopters
- TEP now part of trust induction process and TEP QI plan available for each division

Activity for Next Quarter

- Launch TEP in iCLIP
- Commence “TEP Talks” communication campaign
- QIA team to agree support needs with divisional teams to embed TEPs in everyday processes, including active nursing & medical leads, use of TEP Toolkit and learning boards
- Develop and test implementation options for Deteriorating Adult project

Flow Coaching 'Big Rooms'

Pre-Op Team at Launch of First 'Big Room' Coaching Workshop

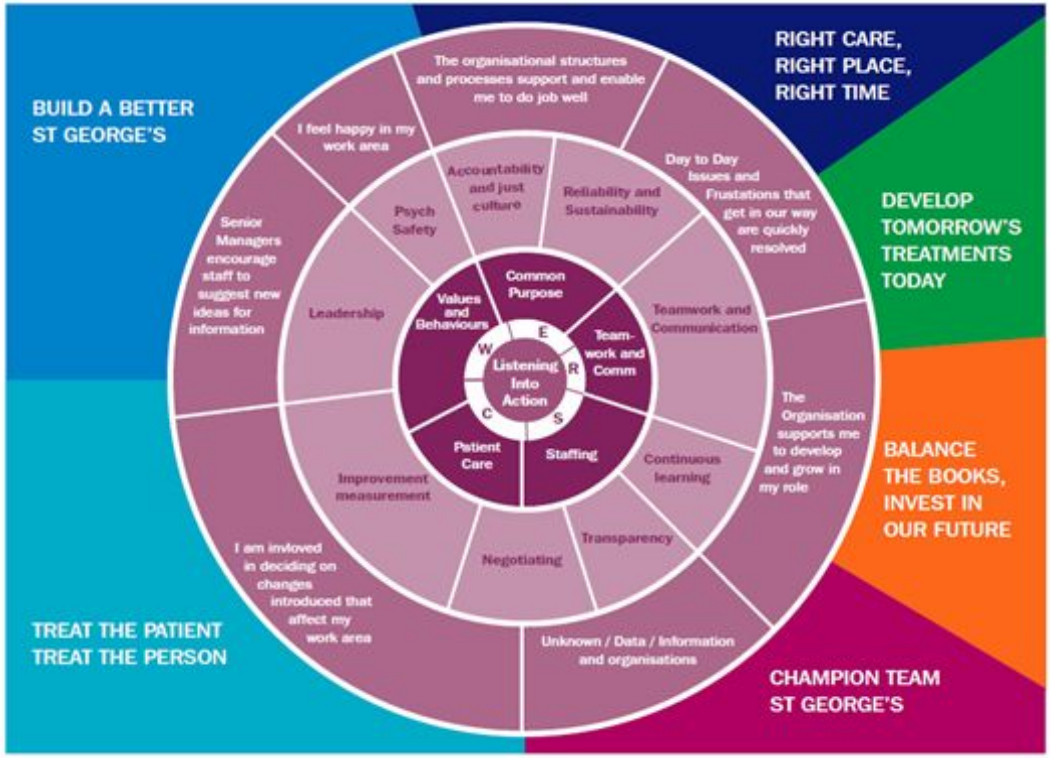
Selected Activity Summary

- Launched 2 (of 4) Flow Coaching Big Room workshops covering gastroenterology and pre-op pathways
- Commenced planning for launch of our own academy in 2020

Activity for Next Quarter

- Launch of 3rd and 4th Flow Coaching Big Room workshops (hand service & paediatric trauma)
- Flow Coaches to attend their 6th of 11 planned Flow Coaching training workshops in Sheffield
- Continue planning for launch of SGUH's Flow Coaching Academy in 2020

Development of Mary Seacole Ward Team



The Mary Seacole ward team has cleverly joined up elements of the trust's improvement methodology, and our strategic goals to address variance in levels of performance and poor staff satisfaction. Led by Bernie Kennedy, Head of Community Therapies (and one of our specialist improvement coaches) the team started with a Listening into Action review and have used the St George's Way framework and other cultural / technical improvement tools to build a more cohesive and effective team.

Bernie says "It's not always been an easy ride. Sometimes it's been very uncomfortable, we've been in the wrong gears sometimes, and it's been a bit bumpy, but we are moving forwards and can see a horizon!

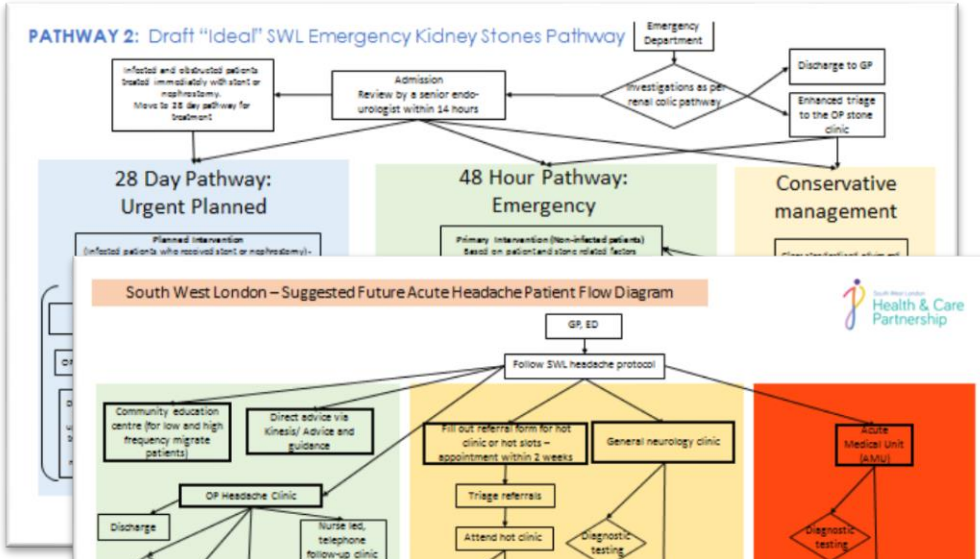
Acute Provider Collaborative

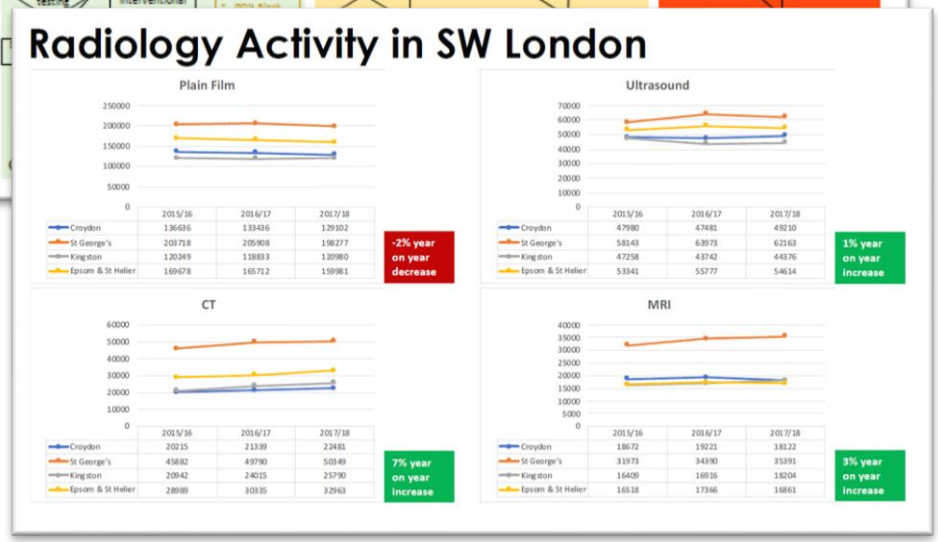
Selected Activity Summary

- Facilitated three APC pathway development/vision workshops with c120 colleagues from across SWL, covering:
  - Emergency Kidney Stones
  - (Neurology) Headache Pathway, and
  - Radiology
- Continued support of project teams as they implement changes across Earwax/Micro-suction pathway

Activity for Next Quarter

- Support SGUH to pilot audiologist-led earwax removal clinic, enabling release of consultant time to focus on underlying diagnostic/treatment priorities
- Support second round implementation workshops for earwax, kidney stones, headache & radiology teams
- Facilitate Mothers & Babies introductory/vision workshop





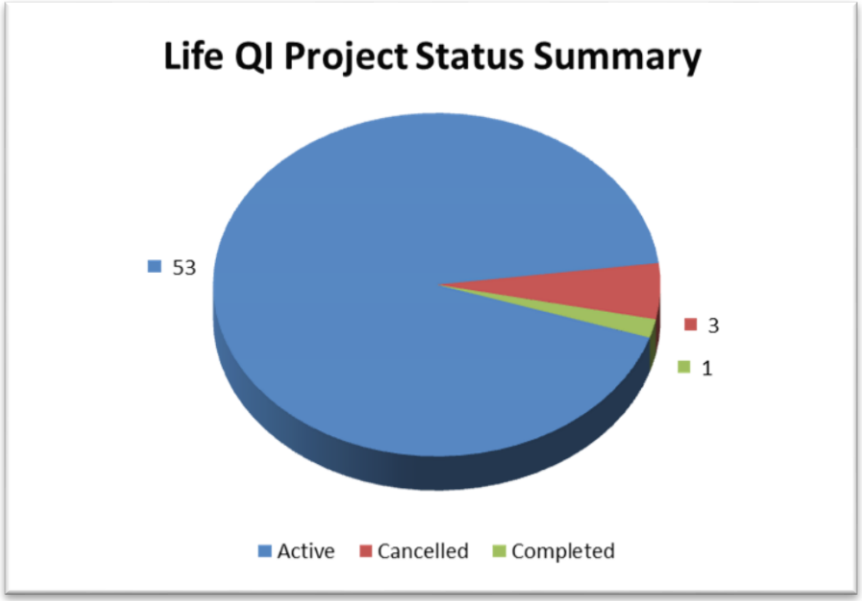
LifeQI Projects

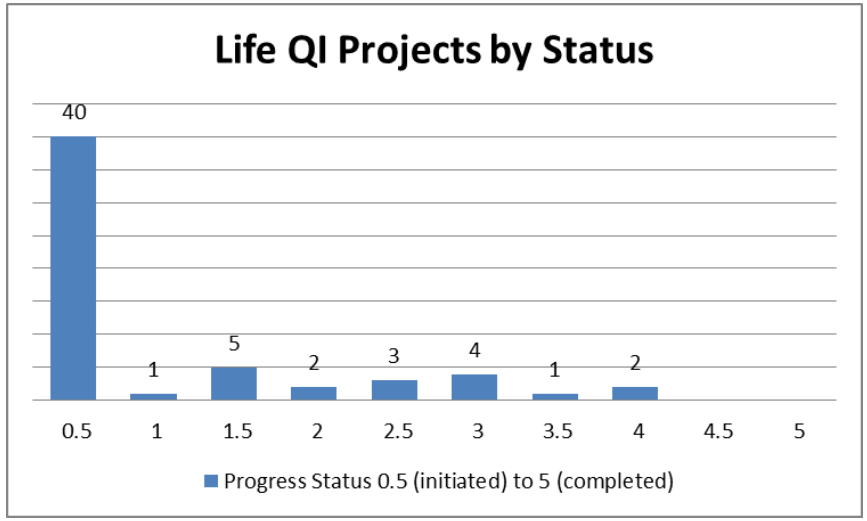
Selected Activity Summary

- We now have 166 verified users on Life QI system and are encouraging all staff attending training workshops to make the system our default improvement project management tool

Activity for Next Quarter

- Extend use of Life QI to improve visibility of QI project activity and enable targeted coaching support based upon project status scores
- Support project teams understanding and use of the Life QI system, particularly the use of driver diagrams / SPC charts to identify & manage PDSA opportunities
- Encourage teams to actively update project status





Building Infrastructure to Sustain Improvement

This section highlights work that improves staff access to quality improvement tools, techniques and ongoing learning

Embedding improvement & continuous learning into the way we work

St George's University Hospitals NHS
NHS Foundation Trust

2.4

Selected Activity Summary

- Quality improvement training now an integral part of the Enhanced Leadership Development Training programme
- Facilitated lessons learned review following loss IT systems after major power outage
- Supported Financial Improvement Director in development of TEC programme board reporting framework
- Human Factors training framework established to enable structured learning for theatre teams
- Developed a structure for an “Improvement Hub” to be launched as part of the trust’s updated intranet project
- Created a direct link to the clinical audit team whose manager is now part of the central QI team

Activity for Next Quarter

- Extend use of ‘learning boards’ as part of Treatment Escalation Plans project
- Develop partnership with trust BI team to provide integrated QI/analytical support & coaching offer (initially focused around GIRFT programme)

It’s great to see that Jane Evans, who attended one of our first Quality Improvement training workshops has been appointed MedCard’s new Divisional Chair. She is a real advocate for QI and it’s good to see that the St George’s Way and improvement themes are now actively included as part of her job description

St George's University Hospitals NHS
NHS Foundation Trust

3.1

Meeting Title:	Trust Board Meeting		
Date:	26 September 2019	**Agenda No.**	**3.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Harbhajan Brar, Chief People Officer		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Assurance		
Executive Summary:	This paper sets out the key risks and issues reviewed by the Committee at its meeting on 8 August 2019, including commenting on assurance to the Board on key risks allocated to the Committee.		
Recommendation:	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Champion Team St George's		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and improvement capability (well led)		
Implications			
Risk:	As set out in the paper.		
Legal / Regulatory:	N/A		
Resources:	N/A		
Previously considered by:	N/A	**Date:**	N/A
Equality Impact Assessment:	N/A		
Appendices	Appendix 1: London Hospital Comparators		

St George's University Hospitals NHS
NHS Foundation Trust

1. Committee Chair's Overview

This was the first meeting of the Committee under its new Terms of Reference (TORs), and with the re-direction of certain more operationally-oriented matters to the new People Management Group (PMG). We were therefore feeling our way forward in this new environment, although the indications are that this shift to a more assurance-focussed approach will work well and complement the operational delivery focus that is being further developed within the executive. The first meeting of the PMG will take place at the beginning of September.

We had reasonable attendance at the Committee and I would thank all who made the time to attend, particularly given the experience they bring and their contribution to the assurance provided to the Committee. There were a couple of notable absences from the meeting, and I have dropped those individuals a line reminding them that if they cannot be present we encourage them to send an alternate.

The areas of focus at this month's meeting were: review of the Trust level risks allocated to the Committee; a discussion of the ways of working to be adopted by the Committee under the new TORs and the proposed work plan to apply over the rest of the year; final approval of the new 'Raising Concerns' policy; review of the draft response to NHS England from the Trust in relation to the Trust's appraisal and revalidation of medical practitioners; and observations on a draft six-point Staff Engagement action plan.

One additional key point that was identified at the meeting was the need for the Trust to update its Statement of Purpose, once the withdrawal from community services is completed. That change will also track into a number of other Trust statements and policies.

2. Key points:-

Board Assurance

The Committee has five Trust level risks[1] allocated to it by the Board as part of the Board Assurance Framework, and the Committee's assessment of these risks was discussed in detail. The Committee concluded that it would recommend to the Board that risk ratings should be updated as follows:

SR12 – **Diversity and Inclusion**, the risk rating should be raised from 9 to 12, reflecting the lack of progress over the last year or so;

SR14 – **Recruitment and Retention**, the risk rating should be reduced from 16 to 12, reflecting progress being seen (though within this a new risk factor be added – the impact of tax charges on NHS Pensions, as a disincentive to Consultants to undertake additional sessions).

The Committee also discussed the growing uncertainty around the implications of **Brexit** and it was agreed that this risk would be assessed on a Trust wide basis by the Trust's Risk Management Executive.

The Committee reviewed and approved a proposed response to Health Education England in relation to the management of appraisal of medical practitioners within the Trust. The Board will be asked to approve the final Statement of Compliance, and the Committee recommends that it does so **(see item 3.3 on the Board's agenda).**

The Committee reviewed and approved the final draft of the Freedom to Speak Up policy, and recommends this to the Board for adoption. In addition, we think it would be helpful in maintaining profile of this area for the Freedom to Speak Up Guardian to report quarterly to the Board, attending in person.

[1] SR 11 – cultural shift (staff feel engaged, able to raise concerns) ;SR12 diversity and inclusion; SR13 failure to address culture of bullying and harassment; SR14 recruit and retain the right workforce; and SR15 unable to deliver new and innovative roles and ways of working.

The Committee received an interesting report on the Trust's performance against other London Trusts – and a copy of a table which summarised a number of performance metrics is added as an Appendix to this Report. It will be seen that the Trust is an outlier on sickness and staff appraisal.

Strategic Themes

Theme 1 - Engagement

Staff Engagement Plan 2019-21 – we reviewed and endorsed the second draft of the plan, which had been amended so as to create a particular focus in six key areas (see item 3.2 on the Board agenda). The Committee noted that change to the Trust's culture is a continuing and longer-term process. It was also observed that as the number of adverse responses to the Staff Survey continued to decline, it was becoming more difficult to assess their statistical significance – although it was clear that the adverse comments are an indicator of staff concern. The Engagement Plan will now be further developed by management.

As a result of continuing sickness of the Trust lead, there was no **WRES** update available. This is now a matter of real concern to the Committee as the Trust's objective of managing down this area of risk (SR12) is being materially compromised by the failure of direction in this important area. We were informed that alternative resource is being sourced from another Trust, but the absence of our own solution remains of concern. As a consequence, the Committee has made the recommendation it has on the risk rating of this risk.

Theme 2 – Leadership and Progression

There were no specific papers referencing this theme. However, we had a report that the implementation of the Coaching Strategy continues and the benefits of mediation in employment issues is being emphasised. In addition, eight in-house mediators are being trained to ensure that workplace conflicts are dealt with before they escalate.

Theme 3 - Workforce Planning and Strategy

We reviewed a number of **workforce statistics**, noting that although most metrics had been generally moving in the right direction, there had been some adverse movements over the summer: the vacancy rate had increased to 10.54% (still well down over a year ago); Trust sickness absence had increased to 3.79% (just above target) ; and staff turnover remained static at 15.85%. Appraisal rates continue to be improved: Non-medical appraisal compliance has increased 2% to 73.6%, whilst medical appraisal has been moved up to 84% overall with consultants at over 89%.

We had a short discussion of the bank and agency fill rates being achieved by the Trust. We have agreed that Harbhajan will bring forward more up to date information and data, and also report on trends in the level of unfilled shifts. We remain concerned at the trend on agency spend, and will be undertaking a more detailed review at our next meeting. In the meantime, we were assured that the executive was focussed on this and would be applying more grip here.

Theme 4 – Compliance.

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

21 August 2019

St George's University Hospitals NHS
NHS Foundation Trust

Appendix – London Hospital Comparators

Indicators	Chelsea and Westminster Hospital NHS Foundation Trust	Great Ormond Street Hospital for Children NHS Foundation Trust	Imperial College Healthcare NHS Trust	London North West Healthcare NHS Trust	Royal Free London NHS Foundation Trust	South London and Maudsley NHS Foundation Trust	St George's University Hospitals NHS Foundation Trust	The Royal Marsden NHS Foundation Trust	University College London Hospitals NHS Foundation Trust
Headcount	6177	5014	10834	8,591	9642	4879	8932	4357	9259
Whole Time Equivalent	5686.07	4686.3	9657.27	7,983	8956.71	4535.01	8361.52	3982.9	8612.01
Turnover (%)*	19.1%	14.8%	11.32%	10.2%	16.4%	18.1%	14.9%	14.5%	13.8%
Overall sickness rate (%)*	2.7%	2.4%	3.11%	3.3%	3.3%	2.9%	3.5%	3.5%	3.4%
Appraisal (%)*	87.3%	85.0%	87.30%	84.0%	77.0%	86.4%	70.4%	88.6%	81.5%
Statutory and mandatory training performance (%)*	91.0%	93.0%	92.1%	87.0%	74.0%	84.6%	89.5%	90.0%	93.3%
Recruitment time to fill (days)*	8.24	67.00	36	40.60	78.44	60.90	55.90	56.30	68.00
Vacancies (FTE)*	620.00	80.10	1512.00	925.20	1136.07	795.28	887.27	379.5	848.23
Vacancies (%)*	9.8%	1.7%	13.54%	9.4%	11.4%	14.9%	9.6%	8.6%	9.8%
Diversity profile*:									
BME (%) of workforce,FTE : % of all employees who have an ethnic origin other than 'white' as at 31 March 2018	44.4%	29.0%	49.95%	70.3%	49.7%	45.9%	44.4%	32.6%	46.1%
Disability (%) of workforce, FTE	1.7%	2.0%	1.41%	1.7%	1.8%	4.3%	2.0%	3.1%	1.6%
Gender female (%) of workforce, FTE	75.8%	77.0%	72.13%	75.9%	71.9%	70.0%	71.7%	77.7%	71.1%

- Compares data for London Teaching Trusts who have opted to share their information
- Sickness is a rolling 12 month figure for April 18 – Mar 19
- Turnover is a rolling 12 month figure and excludes fixed term contracts and junior doctors
- All other indicators are based on a snapshot as at 31st March 2019

St George's University Hospitals NHS
NHS Foundation Trust

3.1

Meeting Title:	Trust Board		
Date:	26 September 2019	**Agenda No**	**3.1.1**
Report Title:	Workforce and Education Committee Terms of Reference		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approval		
Executive Summary:	The Board approved the new terms of reference for the Workforce and Education Committee at its meeting in July 2019. At the Committee meeting on 8 August 2019, the Committee agreed to recommend to the Board some minor changes to the terms of reference. These were: • To set out that secretariat support to the Committee will be provided by the Corporate Affairs team; • To include in the terms of reference the new governance structure for people issues following the establishment of the new People Management Group. The Committee is scheduled to finalise its forward plan for the remainder of 2019/20 at its meeting on 10 October 2019.		
Recommendation:	The Board is asked to approve the minor changes to reference for the Workforce and Education Committee.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Without appropriate terms of reference for its Committees, there is a risk that the Trust may not have effective decision-making structures which could result in either poor decisions or a delay in decision-making.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Board Workforce and Education Committee	**Date**	25 July 2019 13 June 2019
Appendices:	Workforce and Education Committee Terms of Reference		

St George's University Hospitals NHS
NHS Foundation Trust

WORKFORCE AND EDUCATION COMMMITTEE

Terms of Reference

1. NAME OF GROUP

The Committee shall be known as the Workforce and Education Committee (WEC).

2. AUTHORITY

Establishment: The Workforce and Education Committee has been established as a sub-Committee of the Trust Board.

Powers: The Workforce and Education Committee is authorised by the Board of Directors to:

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

Cessation: The Workforce and Education Committee is a standing group within the governance structure and can only be disbanded on the authority of the Trust Board.

3. PURPOSE OF THE GROUP

The Workforce and Education Committee's purpose, as aligned to the Trust's strategic objectives, is to oversee the development of an empowered workforce that is both modern and flexible, with a culture that supports people to deliver to their best. The Trust's ambition is to be an employer of choice in south west London, working in partnership across the local health economy ensuring that the Trust has the right workforce to deliver its strategy. The Committee provides the Board with assurance that there are robust mechanisms in place to ensure:

i. Robust oversight of the delivery of the Trust's strategic aims in relation to its workforce
ii. Detailed consideration is given to the development and implementation of the Trust's workforce and education strategies
iii. Effective oversight and monitoring of workforce planning
iv. Effective oversight of the delivery of the Trust's diversity and inclusion strategy, and monitoring of performance in relation to the Workforce Race Equality Standard and the gender pay gap
v. Adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies
vi. The impact of workforce performance on the Trust's overall performance is closely monitored
vii. Staff well-being and development is monitored effectively
viii. Appropriate governance arrangements are in place in relation to workforce and education issues and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

4. DUTIES OF THE GROUP

The Workforce and Education Committee will discharge the following duties that have been delegated by the Board of Directors:

(a) Workforce and education strategy

i. To monitor and provide assurance to the Trust Board on the delivery of the workforce and education components of the Trust clinical strategy 2019-24
ii. To oversee and provide assurance to the Trust Board on the development of new strategies in relation to workforce and education, aligned to and in support of the Trust clinical strategy 2019-24
iii. To consider the strategic implications of cross-system working and integration on the development of the Trust's workforce strategy

(b) Workforce planning

i. Review and provide challenge in relation to the development of the draft annual workforce plan
ii. Oversee the delivery of the workforce plan in year
iii. Improve the efficiency and productivity of the Trust workforce
iv. Review the workforce aspects of the Trust's Cost Improvement Programme
v. Oversee Trust-wide use of agency staff and provide assurance in relation to meeting the agency cap set annually by NHS Improvement

(c) Staff engagement

i. Provide oversight of plans to improve engagement by the Trust with its staff, with the aim of securing increasing levels of staff engagement
ii. Review the results of the annual NHS staff survey and oversee the development and implementation of actions plans to address issues identified

(d) Diversity and inclusion

i. To oversee the implementation of the Trust's diversity and inclusion strategy
ii. To review the Trust's performance in relation to the Workforce Race Equality Standard
iii. To review the Trust's performance in relation to the gender pay gap and the ethnicity pay gap

(e) Staff well-being

i. Oversee performance on staff appraisal rates (clinical and non-clinical)
ii. Oversee performance in relation to mandatory and other training
iii. Receive regular reports from the Partnership Forum
iv. Receive regular confidential reports on disciplinary matters, including in relation to Maintaining High Professional Standards cases, ensuring that due process is followed

(f) Risk

i. On behalf of the Trust Board, the Committee shall regularly scrutinise the Trust's significant risks in relation to workforce and education issues, satisfying itself of the adequacy of the controls in place to mitigate the risks. This includes scrutinising the Board Assurance Framework risks allocated to the Committee.

(g) General governance

i. To consider matters referred to the Workforce and Education Committee by the Trust Board or by the groups which report into it
ii. Every year, to set an annual work plan and conduct a review of the Committee's effectiveness (including achievement of the work plan and a review of the Committee's terms of reference) and report this to the Board

iii. To ensure that all relevant policies and procedures that fall under the Committee's areas of interest are in place and up to date.
iv. As required, to review any relevant Trust strategies relevant to the Committee's terms of reference prior to approval by the Board (if required) and monitor their implementation and progress.

5. CHAIRPERSON

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

The Chief People Officer (CPO) will be the Executive Lead for the Workforce and Education Committee

6. COMPOSITION OF THE GROUP

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

Name	Title	Role in the group
Stephen Collier	Non-Executive Director	Committee Chair
Sarah Wilton	Non-Executive Director	Member
Tim Wright	Non-Executive Director	Member
Harbhajan Brar	Chief People Officer	Member
Avey Bhatia	Chief Nurse and Director of Infection Prevention and Control	Member
Richard Jennings	Chief Medical Officer	Member

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

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

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

Title	Role in the group / committee	Attendance guide
Chief Corporate Affairs Officer	Regular Attendee	Every meeting
Divisional Director of Operations – CWDT	Regular Attendee	Every meeting
Divisional Director of Operations - MedCard	Regular Attendee	Every meeting
Divisional Director of Operations – SNCT	Regular Attendee	Every meeting
Associate Medical Director – Workforce	Regular Attendee	Every meeting
Deputy Director of Human Resources	Regular Attendee	Every meeting
Associate Director of	Regular Attendee	Every meeting

Title	Role in the group / committee	Attendance guide
Workforce		
Workforce Intelligence Manager	Regular Attendee	Every meeting
Listening into Action Lead	Regular Attendee	Every meeting

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

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

Governors shall be invited to attend the meeting as observers.

7. QUORACY

Number: The minimum number of members for a meeting to be quorate is three members, including at least one Executive Director and two Non-Executive Director (one of whom shall be the Committee Chair or, in his/ her absence another Non-Executive Director Committee member nominated to Chair the meeting).

As an *ex-officio* member of the Committee, the Trust Chairman shall count towards the quorum for the Committee.

Attendance by a nominated deputy will not count towards the quorum.

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

8. DECLARATION OF INTERESTS

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

9. MEETING FREQUENCY

Meetings of the Workforce and Education Committee shall be held six times per year, typically every other month. The frequency of meetings may be changed only with the agreement of the Trust Board.

10. MEETING ARRANGEMENTS / SECRETARIAL

i. An annual schedule of meetings of the Workforce and Education Committee shall be established prior to the start of each financial year;
ii. The Chief Corporate Affairs Officer will oversee the provision of secretariat support for the Workforce and Education Committee, and the Secretary to the Committee will be a member of the Corporate Governance team, which will work closely with the Executive Lead and Non-Executive Committee Chair. This will include taking accurate minutes, producing an action log and issuing follow up actions, ensuring that the planning for and

outcomes of Committee meetings are shared appropriately. Alternative arrangements for secretariat support may be agreed by the Committee.

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

iv. All papers and reports to be presented at the Workforce and Education Committee must be submitted to the identified secretarial support for the group at least 5 working days prior to the meeting, unless otherwise agreed with the Committee Chair.

v. The agenda and supporting papers for the meeting will be forwarded to each member and planned attendees a minimum of 4 working days in advance of the meeting taking place.

11. RELATIONSHIP WITH OTHER GROUPS/COMMITTEES

The Committee will report to the Trust Board.

The People Management Group (PMG), which is chaired by the Chief People Officer, is a sub-group of the Trust Executive Committee. The PMG will provide assurance to the Workforce and Education Committee on the issues within the Committee's remit. A diagram of the groups reporting to the Board on workforce and education issues is attached at Appendix 1.

12. REPORT TO THE TRUST BOARD

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

13. AGENDA

STANDING AGENDA ITEMS

i. Apologies;
ii. Declarations of interest;
iii. Minutes of the Previous Meeting;
iv. Matters Arising and Action Log;
v. Board Assurance Framework – Review of Risks allocated to the Committee;
vi. Review of any new Risks identified;
vii. Items for escalation or control issues to the Trust Board or Audit Committee;
viii. Forward plan
ix. Reflections on meeting

14. FORWARD CYCLE OF BUSINESS

A forward plan for the items and reports to be received by the Committee will be agreed by the Committee. This should be referred to when setting the agenda for each meeting of this Committee. The forward cycle of business will be reviewed, along with these Terms of Reference, on an annual basis prior to the start of the financial year.

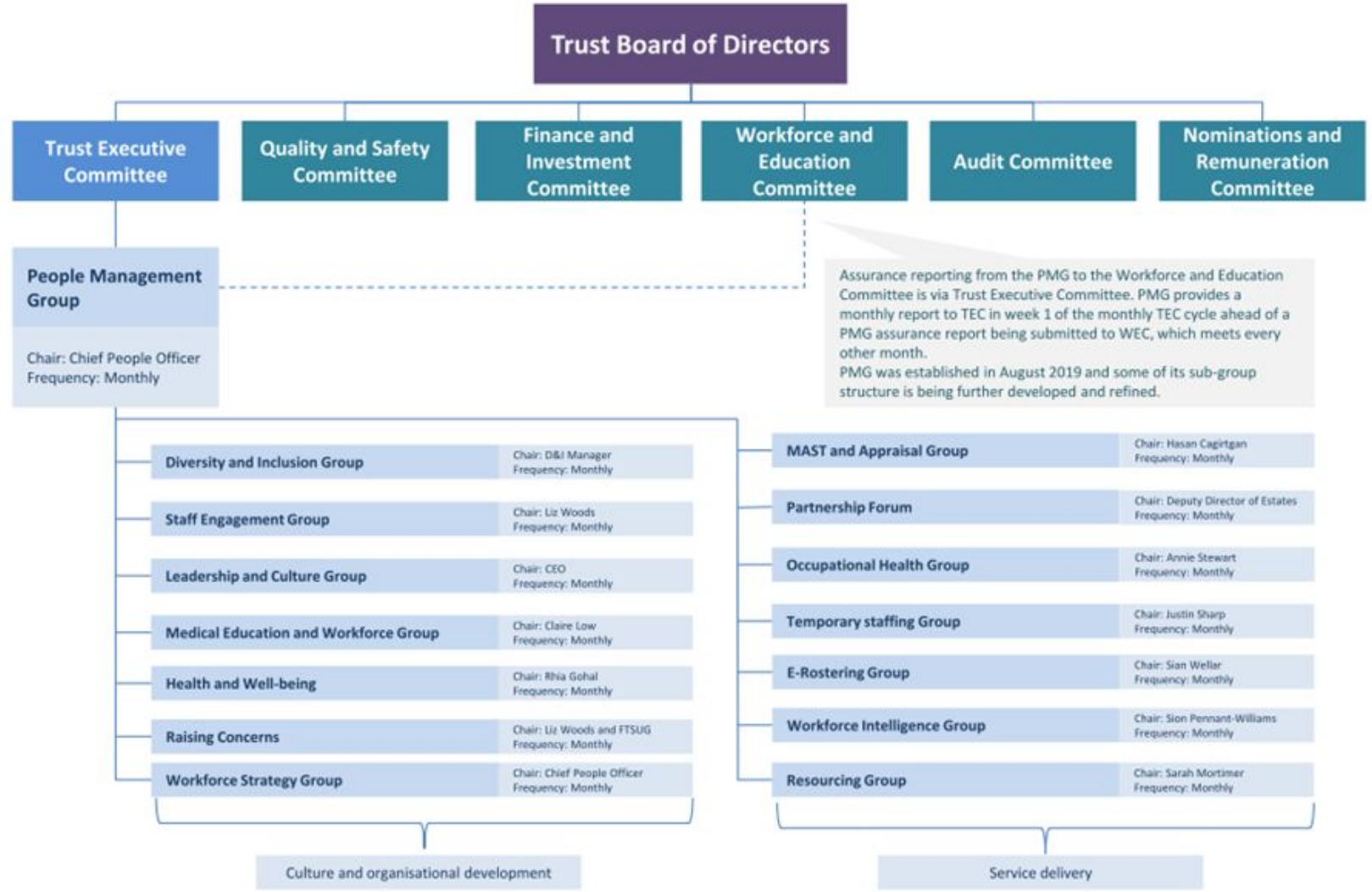
15. REVIEW OF TERMS OF REFERENCE

These Terms of Reference shall be subject to an annual review prior to the start of each financial year. This review should consider the performance of the Workforce and Education Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business.

These Terms of Reference were last reviewed by the Committee on 8 August 2019 and were previously approved by the Trust Board on 25 July 2019.

St George's University Hospitals NHS
NHS Foundation Trust

APPENDIX 1: PEOPLE GOVERNANCE STRUCTURE



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St George's University Hospitals NHS
NHS Foundation Trust

3.2

Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No**	**3.2**
Report Title:	**Staff Engagement Plan 2019-2020**		
Lead Director/ Manager:	Harbhajan Brar, Chief People Officer		
Report Authors:	Harbhajan Brar, Chief People Officer Liz Woods, Staff Engagement Lead		
Presented for:	Approval/Ratification		
Context	The Trust Board at its meeting in June 2019 (Part 2) considered a draft 2019-2021 Staff Engagement Plan. The Trust Board asked for the draft plan to be developed further, taking into consideration the key areas of concern that staff had raised via the 2018 staff survey. Trust Board members were keen to see a plan that was both effective and ambitious and one that helps to achieve sustainable cultural change. The draft 2019-2020 Staff Engagement plan was rewritten. It has had input from members of the Trust Executive and the Trust's Staff Engagement steering group. The draft plan was also shared with members of WEC, who provided comments and feedback. It is also being shared with the Partnership Forum at its next meeting in September for further comment. Our normal governance arrangements, whereby this report would first be considered at TEC and then formally tabled at WEC, before going to Trust Board cannot apply, as the next WEC does not meet until October 10th.		
Recommendation:	The Board is asked to: 1. Approve the attached Staff Engagement Plan 2. Note planned activities within the Staff Engagement Plan 2019-2020 3. Note that monitoring and reporting framework will be via the PMG 4. Note that quarterly updates on progress are provided to TEC, WEC and the Trust Board		
Supports			
Trust Strategic Objective:	Champion Team St George's		
CQC Theme:	Safety, Effectiveness, Responsive, Caring and Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led) Operational performance		
Implications			
Risk:	Failure to deliver the Staff Engagement Plan may result in the desired cultural shift not being achieved; loss of confidence by staff in the organisation; and perceived failure of leadership to engage staff		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality Impact Assessment	N/A		
Previously Considered by:	TEC	**Date** N/A	September 2019

St George's University Hospitals NHS
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Staff Engagement Plan v2 2019/20

1. Purpose

1.1 The purpose of this paper is to introduce a revised (draft) Staff Engagement Plan for 2019 – 2020. The revised plan takes into account the comments from the Trust Board in that the plan:

- Directly and comprehensively addresses the key concerns from staff in the feedback that our staff provided via the free text comments in the 2018 staff survey
- Focuses on limited (but important) areas that should have the greatest impact on changing the culture of the organisation and;
- Focuses in particular on, 'leadership'

1.2 Much thought has also been given to the 'ask', that the plan be 'more ambitious', in order to achieve the 'cultural change' that the Board had previously agreed was a necessary requirement, if we are to deliver our vision - 'Outstanding Care, Every Time'.

1.3 For the purpose of this paper, culture is defined as the 'self-sustaining pattern of behaviour(s) that determines how we do things around the Trust'.

1.4 Within this paper it is recognised that changing culture will take time and trying to do this at pace, without getting some of the basics right, can often have a negative and detrimental effect.

1.5 Changing an organisation's culture is one of the most difficult leadership challenges, primarily because an organisation's culture comprises an interlocking set of goals, roles, processes, values, communications practices, attitudes and assumptions.

1.6 This is one of the main reasons that we are proposing to implement a one year staff engagement plan, which starts with 'getting some of the basics (fundamentals) right'.

1.7 The purpose of this paper is facilitate a Trust Executive Committee (TEC) discussion as to whether the pitch and approach of this plan is right prior to Trust Board approval in September 2019.

1.8 The day-to-day operational management/governance of the plan will rest with the newly formed People Management Group (PMG) which will be tasked to provide updates and assurance on progress to the Board.

2. Context

2.1 The corporate objective 2019-20 of *Champion Team St George's* is set to deliver a significant shift in the St George's culture through:

- Listening, responding to and engaging our staff
- Developing outstanding leaders and effective teams
- Taking a zero tolerance approach to bullying and harassment
- Working to deliver our Diversity and Inclusion Strategy
- Empowering our staff to make real change

- Refreshing and living our Trust Values

3. Our Staff Engagement Plan 2019-2020

3.1 We want to see the culture of the organisation begin to slowly change in a way that is sustainable.

3.2 We want to get the basics right for our staff as that is what they are asking for in their response to staff survey and at all staff meetings.

3.3 This plan will help to drive the start of a cultural change programme that is fully aligned to the Champion Team St George's strategic objective.

3.4 The plan focuses on the six priority areas that staff themselves have identified in their feedback to the Trust via the full staff survey and again through the quarterly friends and family surveys.

1. Listening, responding to and engaging our staff

What we will do	Activity	Led by	Measured by
Every member of staff will have regular team briefings, so they are fully sighted as to what is happening across Queen Mary's Hospital, St George's Hospital and our community sites	We will use tools such as 'Go Engage' to identify where these are happening regularly and address accordingly where they are not	Jacqueline McCullough	Numbers of team briefings taking place
Every member of staff will have an annual appraisal and regular one to ones with their manager that are designed to support and develop them	Our target is 90%; we will routinely canvass staff to tell us if they haven't had an appraisal and rectify this via their line management	Sarah James	Sustaining a 90% appraisal target
Every member of staff will have the opportunity to 'voice their views' and we will do this by holding regular 'all staff' meetings and ensuring that we act on what our staff have to say by providing regular feedback	Twice yearly all staff meetings with feedback loops in various formats TeamTalks Introduce a Director's 'Question Time'	Liz Woods	Numbers of meetings, types of meetings, feedback from these

2. Taking a zero tolerance approach to bullying and harassment

What we will do	Activity	Led by	Measured by
Every member of staff will know that as a Trust we have adopted a 'zero tolerance' approach towards bullying and harassment, whether it be from our patients, our colleagues or our managers and every member of staff will know how to report any such incidents and will be supported accordingly	Our current poster campaign will contribute towards this This will be profiled through team briefings and Trust communications	Jacqueline McCullough	Awareness levels monitored qualitatively and quantitatively
What we will do	**Activity**	**Led by**	**Measured by**
Every member of staff will know that we have put into place revised policies and procedures (Raising Concerns) to tackle concerns about poor care, unsafe practices and poor management, that will enable staff to feel confident that the Trust will take action whenever they raise concerns	Promotion of our 'raising concerns' process via Champions network, Induction, LIAiSE etc. with quarterly reporting to the Board	Karyn Richards-Wright Liz Woods	Numbers of referrals, feedback from staff raising concerns, themes and trends

3. Working to deliver our Diversity and Inclusion Strategy

What we will do	Activity	Led by	Measured by
Every member of staff will know that as a Trust we formally recognise that a disproportionate number of our black and minority ethnic staff go into formal disciplinaries and that this is unacceptable. Our staff will know and need to be assured that we are putting into place mechanisms that will enable us to fully understand, track and report the reasons for all formal disciplinary actions, to ensure that they are non-discriminatory	We will use the NHS tools to review all cases before they formally go into the formal disciplinary process	Celia Oke	Numbers of black and minority ethnic staff going into formal disciplinaries, feedback from staff, quarterly reporting to WEC via PMG Data from WRES
We formally recognise that there is an adverse impact (disproportionality) on the number of black and minority ethnic staff who are appointed to senior roles and so we will train additional black and minority ethnic staff to sit in on senior	Training of additional BAME staff to sit in on senior recruitment panels	Celia Oke	Numbers of recruitment panels with black and minority ethnic representation, numbers of black and minority ethnic

recruitment panels, to ensure that the panels are more representative of the communities we serve, as research shows that this leads to fairer recruitment outcomes			staff appointed to senior roles
Every member of staff will know that as a Trust we want to set up and support a number of (inclusive) staff led Diversity and Inclusion (D&I) networks/ groups, that support our BAME, Female, LGBT and staff with disabilities	These were established in early 2019 and will be reinvigorated in Autumn 2019	Celia Oke Trust Executive Champions	Numbers of network members and attendances, frequency of network meetings

4. Developing outstanding leaders and effective teams

What we will do	Activity	Led by	Measured by
We recognise that we need to up-skill our managers to enable them to better manage their staff and teams so we are putting in place a number of organisational development initiatives to support this cultural journey	All managers to attend Passport to management training Quality Improvement projects High Performing Teams Leadership development programmes Master classes Senior manager development programmes Appraising staff	Sarah James	Numbers attending training, feedback from staff about how they are managed

5. Empowering our staff to make real change

What we will do	Activity	Led by	Measured by
Every member of staff to feel empowered to make a real difference in their work areas, and to support this we will continue to roll out our Quality Improvement teaching and coaching programmes (as part of the St George's way)	Work in progress	Martin Haynes Quality Improvement programmes	Numbers of teams engaging with Quality Improvement programmes, qualitative feedback and outcomes from improvement programmes

6. Refreshing and living our Trust Values

What we will do	Activity	Led by	Measured by
Every member of staff is important to us and as such **we will continue to recognise all their wonderful achievements through our values awards and other recognition events**	Values Awards Greatix Thank you cards Long service awards St George's Heroes	Liz Woods	Numbers of nominations and awards presented, feedback from annual long service awards, attendance at and feedback from St George's Heroes
We will develop, a revised set of values and behaviours that better resonate with our organisation and our staff, and ones that set the blue print for our culture, empowering our staff to challenge, without fear of reprisal, repercussion or recrimination, anyone who does not live the Trust values	PMG work stream to refresh the values	Jacqueline Totterdell	Simplification of values and articulation of accepted behaviours, Values and Behaviours Charter

3.5 As a Trust Executive, we will commit to hold to account those managers who fail to get these basics right.

4. Monitoring and reporting framework

4.1 The main performance metrics to measure the impact of our Staff Engagement Plan will be the quarterly Friends and Family Test and the annual NHS Staff Survey. We will also use the new Go Engage tool to measure the impact of our engagement initiatives.

4.2 Once we have agreed that these are the right six areas to focus on, we will then develop a number of additional metrics to measure individual initiatives, as well as assign lead managers to own and oversee the delivery of the Staff Engagement Plan.

St George's University Hospitals NHS
NHS Foundation Trust

3.3

Meeting Title:	Trust Board		
Date:	26 September 2019	**Agenda No**	**3.3**
Report Title:	A Framework of Quality Assurance for ROs and Revalidation – Annual Report		
Lead Director/ Manager:	Dr Richard Jennings, Chief Medical Officer		
Report Authors:	Ms. Karen Daly, Responsible Officer and Associate Medical Director Claire Low, Medical HR Manager Nicola McDonald, Revalidation support officer		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval		
Executive Summary:	As a Designated Body, St George's University Hospitals NHS Foundation Trust and its Responsible Officer (RO) have statutory responsibilities that are monitored by NHS England. These responsibilities include the oversight of annual appraisal of the medical employees of the trust and the monitoring of their fitness to practice. This report contains the "Framework of QA for ROs, Annex D – a mandatory NHSE document which informs the Trust Board and supports the Statement of Compliance which requires signing and returning to NHSE. **Key messages** In April 2019 medical revalidation entered its seventh year. Following the phased implementation of revalidation submissions across England (20% doctors in year 1 and 40% each in year 2 and 3), the majority of licensed doctors were revalidated by March 2016 and the numbers of recommendations to the GMC are now climbing to a peak per month (27 in July 2019). In the last year we have made significant improvements to our systems for supporting medical appraisal and monitoring compliance. Further developments with regard to Quality assurance of appraisal with the primary aim of improving the value of appraisal to Doctors will be implemented in the coming year. The report describes achievements and action plans.		
Recommendations:	WEC is asked to approve the attached "Framework for Quality Assurance for Responsible Officers" before it is submitted to the Trust Board in September. - The Board will be asked to accept this standardised annual report, which follows an annual audit submitted to NHS England in June 2019, covering the period 1 April 2018 to 31 March 2019. - The Board will be asked to approve the "Statement of Compliance" confirming that St George's University Hospitals NHS Foundation Trust is in compliance with The Medical Profession (Responsible Officers)		

	Regulations 2010 (as amended in 2013). - The CEO will be asked to sign the attached statement of compliance for return to NHSE by the end of September.		
Supports			
Trust Strategic Objective:	1. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. 2. Refresh the Trust's strategy, to develop a sustainable service model with a clear and consistent message. 3. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safety, Effectiveness, Responsive, Caring and Well Lead		
Single Oversight Framework Theme:	Medical workforce support and development		
Implications			
Risk:	Failure to improve our systems will contribute to poor medical engagement and failure to retain medical staff. There will be limited alignment of medical staff development with Trust strategy and objectives.		
Legal/Regulatory:	If we do not improve our appraisal systems there is a risk that recommendations to GMC for revalidation are not robust and we will also invite scrutiny from NHSE. This leaves the Trust open to regulatory challenge and potential legal challenge.		
Resources:	Resources have been restricted by the structures put in place by the Trust historically to support the implementation of Medical Appraisal. Improvements will require an increase in resource which is planned through business processes.		
Previously Considered by:	Workforce and Education Committee	**Date**	08/08/2018
Equality Impact Assessment:	N/A		
Appendices:	• AoA comparator report 2018-19		

3.3

Dr Mike Prentice
Revalidation Lead
NHS England
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LS2 7UE

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18 July 2019

Our Ref: 896
Publications Approval 000740

Ms Karen Daly
Responsible Officer
St George's University Hospital NHS Foundation Trust

Dear Ms Daly

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 896 - St George's University Hospital NHS Foundation Trust

I am writing to thank you for submitting a return to the NHS England 18/19 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report setting out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The 2018/19 slimmed down version of the AOA was designed to concentrate primarily on the quantitative measures of previous AOAs, the number of doctors with a prescribed connection and their appraisal rates. In this the sixth year of the AOA, I am pleased to report a continuing upward trend in the overall appraisal rate. This is extremely reassuring and I would like to thank you once again for your continued work. There is emerging evidence that creating the right environment for doctors to reflect on their clinical practice through appraisal is one which enables them to thrive and develop professionally. This benefits the patients that they look after and allows doctors to have confidence in their professional practice.

As well as revising the AOA, a review of reporting the other important aspects of the responsible officer function (monitoring of practice, responding to concerns, and identity/language checks) have moved to the annual Board report. The Board report, combined with the annual Statement of Compliance, has been re-designed to support a conversation within the designated body to review all the responsible officer's obligations and to agree an action plan for areas where further development is identified.
Assurance of the totality of the designated body's work on the responsible officer's duties will therefore be provided to the higher level responsible officer through both completion of the AOA and the statement of compliance, as signed off by the designated body's Board or equivalent management body.

Board-level accountability for the quality and effectiveness of appraisal rates is extremely important and this report, along with the resulting action plan, should be presented to your board, or an equivalent management body. It is also good practice to include the report in an NHS organisation's Quality Account.

If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Dr Vin Diwakar
Your local revalidation team's lead contact	Maxine Hastings
Your local revalidation team's contact details	england.revalidation-london@nhs.net

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2019. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing the required assurance to your higher level RO, and to NHS England.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Doctor Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer
cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 862 returns from designated bodies (DBs) to the 2018/19 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2019

The following information is presented as per your own AOA submission.

Name of designated body:	St George's University Hospital NHS Foundation Trust
Name of responsible officer:	Ms Karen Daly
Sector:	Acute hospital/secondary care non-foundation trust
Prescribed connection to:	NHS England (Regional Team - London)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Maxine Hastings at england.revalidation-london@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2018/19 for the full indicator definitions if required.

2018/19 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 52	All sectors: Total DBs: 862
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	52 (100.0%)	851 (98.7%)

2018/19 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: DBs in sector: 52	All sectors: Total DBs: 862
2.1	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2019**	No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
2.1.1	Consultants	634	17065	53177
2.1.2	Staff grade, associate specialist, specialty doctor	7	4420	12543
2.1.3	Doctors on Performers Lists	0	0	47422
2.1.4	Doctors with practising privileges	0	3	1870
2.1.5	Temporary or short-term contract holders	258	5824	22314
2.1.6	Other doctors with a prescribed connection to this designated body	0	285	7128
2.1.7	**Total number of doctors with a prescribed connection**	899	27597	144454

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 52	All sectors: Total DBs: 862
		Completed appraisals (1)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had a completed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	571 (90.1%)	94.1%	93.7%
2.1.2	Staff grade, associate specialist, specialty doctor	4 (57.1%)	85.4%	88.2%
2.1.3	Doctors on Performers Lists	N/A	N/A	95.2%
2.1.4	Doctors with practising privileges	N/A	100.0%	92.7%
2.1.5	Temporary or short-term contract holders	175 (67.8%)	79.6%	81.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	91.6%	87.9%
2.1.7	**Total number of doctors who had a completed annual appraisal**	750 (83.4%)	89.6%	91.5%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 52	All sectors: Total DBs: 862
		Approved incomplete or missed appraisal (2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Approved incomplete or missed appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	18 (2.8%)	3.4%	4.2%
2.1.2	Staff grade, associate specialist, specialty doctor	2 (28.6%)	9.8%	8.6%
2.1.3	Doctors on Performers Lists	N/A	N/A	4.2%
2.1.4	Doctors with practising privileges	N/A	0.0%	5.1%
2.1.5	Temporary or short-term contract holders	53 (20.5%)	14.2%	13.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	4.9%	10.5%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	73 (8.1%)	6.7%	6.4%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 52	All sectors: Total DBs: 862
		Unapproved incomplete or missed appraisal (3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Unapproved incomplete or missed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	45 (7.1%)	2.5%	2.2%
2.1.2	Staff grade, associate specialist, specialty doctor	1 (14.3%)	4.8%	3.2%
2.1.3	Doctors on Performers Lists	N/A	N/A	0.6%
2.1.4	Doctors with practising privileges	N/A	0.0%	2.2%
2.1.5	Temporary or short-term contract holders	30 (11.6%)	6.3%	4.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	3.5%	1.6%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	76 (8.5%)	3.7%	2.1%

2018/19 AOA indicator SECTION 3:		Your organisation's response
3.1	The last Annual Board report was signed off on:	28/09/2018 00:00:00
	The last Statement of Compliance was signed off on:	28/09/2018 00:00:00

2018/19 AOA indicator SECTION 4: Comments		Your organisation's response
4.1		

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of St George's University Hospitals NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 05/06/2019 Action from last year: No action required Comments: 83.4% of appraisals in 2018/19 were completed in accordance with category 1 of the AOA. This is an increase from last year's AOA which showed 75.6% compliance. Consultant appraisal rates were 90% which is 4% less than the average for same sector DBs. This is improved from 83% last year. The AOA also showed an increase in the total number of connections from 857 to 899. Action for next year: Improve the overall % of completed appraisals, particularly in our non-Consultant groups. The Appraisal Leads will work with their divisions to support appraisal. Appraisal rate review is a part of the regular divisional performance review.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: No action from last year Comments: Ms Karen Daly completed RO training in November 2015 and commenced as RO in May 2016. Action for next year: No action required.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: To procure an electronic appraisal system and to recruit 3 medical appraisal leads. Comments: We have a web based Revalidation Management System(RMS) in use and favourably reviewed by Appraisees. The RO is supported by one WTE Revalidation Support Officer. The RO has written a job description/person specification for the Divisional Medical Appraisal Leads that will be advertised in September. Action for next year: Appoint Medical Appraisal Leads and provide training.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: No action from last year

Comments: The Revalidation Support Officer regularly cross references the GMC Connect database with new starter and leaver reports.

Action for next year: Maintain accurate connections.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: To review and publish the Medical Appraisal Policy

Comments: The Medical Appraisal Policy review was previously put on hold pending the introduction of the new electronic appraisal system. The updated policy has now been drafted will go through authorisation before being published/circulated.

In the meantime, new starters are provided with guidance on medical appraisal and revalidation and clinical leads are updated via Medical Board and Care Group Lead Forums etc.

Action for next year: Publish/circulate updated medical appraisal policy.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: No action from last year

Comments: The system for appraisal and revalidation recommendations has been improved significantly since the NHSE visit in 2016 and now is the time to request a peer review to identify areas for improvement.

Action for next year: Commission peer review.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: No action from last year

Comments: All doctors with a prescribed connection are supported with appraisal and revalidation and have access to the same governance systems. On request, the Revalidation Support Officer will complete a medical practice information transfer form for those who work at St George's but are connected to another organisation i.e. for their annual appraisal.

Action for next year: No action required.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: No action from last year

Comments: All doctors are required to declare their full scope of work in their appraisal and should seek confirmation from all organisations in which they work of any complaints and significant events they have been named in (or that they have not been named) to include as supporting information for reflection.

Action for next year: The Appraisal and Revalidation Group will triangulate information about doctors from difference sources. Our appraisal leads will support appraisers to challenge supporting information (or lack of).

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: No action from last year

Comments: The appointment of Medical Appraisal Leads will enable us to implement an enhanced quality assurance process which will lead to improvements to appraisal inputs in general.

Action for next year: Improve quality of medical appraisal inputs.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: To review and publish the Medical Appraisal Policy

Comments: The Medical Appraisal Policy review was previously put on hold pending the introduction of the new electronic appraisal system. The updated policy has now been drafted and will go through authorisation process before being published/circulated.

Action for next year: Publish/circulate updated medical appraisal policy.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: No action from last year

Comments: The Trust delivered a "New Appraiser" Workshop in March 2019 and currently has an adequate number of appraisers overall. However, there is no clear process for allocation of appraiser to doctor, as well as a lack of knowledge of the minimum number of appraisals an appraiser should carry out each year (5).

Action for next year: Rationalisation of appraiser group, removing those without sufficient activity.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: To implement a quality assurance process to include recruitment of Medical Appraisal Leads and appraiser feedback and calibration events.

Comments: The Medical Appraisal Leads will support the quality assurance process and calibration events. The new electronic appraisal system requests feedback from each doctor after their appraisal has been submitted. We need to include this in the quality assurance process and ensure any concerns are highlighted. We also need to provide this feedback annually to appraisers to be included within their own appraisal.

Action for next year: Implement an enhanced quality assurance process and introduce appraiser forums.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: No action from last year

Comments: See above.

Action for next year: Report to WEC quarterly.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: No action required

Comments: The number of revalidation recommendations between April 2018 and March 2019 totalled 211.

The majority of these were submitted on time. A small number were submitted late due to administration error i.e. revalidation on a weekend.

The number of recommendations to revalidate totalled 139.

The number of recommendations to defer totalled 72.

There were no recommendations of Non-Engagement.

Action for next year: Ensure recommendations are submitted on time and investigate reasons behind the high deferral rate.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: No action from last year

Comments: The Revalidation Support Officer will inform each doctor of what recommendation has been submitted. In the majority of cases where a deferral is necessary, the Revalidation Support Officer will communicate this to the doctor beforehand. Either way, the doctors will be given a clear action plan and timeframe to achieve by the next due date. The RO contacts the doctor directly in cases where they are deferred because they are subject to an ongoing process.

Action for next year: No action required

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: No action from last year Comments: There are structured governance systems in place at local, divisional and wider Trust level. Action for next year: A recent external report (April 2019) has highlighted some inconsistencies in process and conduct of our systems for Clinical Governance. There is a clear action plan arising which is to be implemented in the coming year.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: No action from last year Comments: Our RMS enables incidents and significant events known to the RO to be flagged on the appraisal page for inclusion in the next appraisal. Action for next year: The Appraisal and Revalidation group will develop processes to improve the quantity and quality of information available to Doctors as inputs for their appraisals.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: No action from last year Comments: The Responding to Concerns meeting takes place weekly and considers all concerns raised internally and externally. The Divisions are encouraged to submit concerns to the group for discussion and for the purpose of assuring a consistent approach across the Trust. The group agrees proportionate approach which may range from an informal local process to an MHPS investigation. We ensure that appropriate support including Occupational Health and staff support is available for all Doctors in difficulty Action for next year: share the purpose of the RtC more widely and encourage escalation for benchmarking purposes.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: No action from last year

Comments: Significant concerns about Medical Staff at St George's are managed under the Maintaining High Professional Standards policy the disciplinary policy for Medical and Dental Staff. In addition to this policy, there is a weekly Responding to concerns meeting attended by the Chief Medical Officer, the Director of HR, Responsible Officer, Medical HR Manager and Divisional HR Manager (where appropriate) whereby all cases are reviewed and those in a formal process are monitored to ensure sufficient progress. The RO meets regularly with Liaison Officers from the GMC and PPAS. The progress of MHPS cases is reported to Trust Board.

Action for next year: Our MHPS policy is undergoing external review and there will be a formal review of all historic cases for the purpose of improving our processes.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: No action from last year

Comments: Where doctor works for multi-organisations, information is transferred from RO to RO using a MPIT form.

Action for next year: No action required

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

Comments: See action from section 4.

Action for next year: No action required

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Comments: The Medical Staffing Team carry out the 6 NHS Employment Check Standards that outline the type and level of checks employers must carry out before recruiting staff into NHS positions. Action for next year: No action required

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of last year's actions

- There has been an increase in appraisal compliance rates since last year, despite an increased number of connections
- The volume of recommendations due has increased since last year

Actions still outstanding

- *Recruitment of Medical Appraisal Leads* – JD/PD ready and will be advertised in September for a short period.
- *Review of Medical Appraisal Policy* – This has been drafted and will go through authorisation process in order to be published on the intranet within the next few month

New Actions:

- Organise training for Medical Appraisal Leads
- Implement a quality assurance process for appraisals
- Implement a quality assurance process for appraisers
- Implement local appraiser calibration events
- Review appraiser database
- Develop processes to improve the quantity and quality of information available for appraisal inputs

Overall conclusion:

The Trust has successfully implemented an electronic appraisal system that has been well received by doctors and the Revalidation Support Officer. We now look forward to finalising the Medical Appraisal Policy and appointing our Medical Appraisal Leads who will support the RO in achieving higher appraisal rates as well as improving the quality of appraisal.

Section 7 – Statement of Compliance:

The Board of St George's University Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: St George's University Hospitals NHS Foundation Trust.

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

St George's University Hospitals NHS
NHS Foundation Trust

4.1

Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee (Core) 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 22nd August 2019 and 19th September 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		

St George's University Hospitals NHS
NHS Foundation Trust

Finance and Investment Committee (Core) – August & September 2019

The Committee met on 22 August & 19 September and in addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on 5 year Financial Planning, a Cath Lab business case, and an SWLP report.

Committee members discussed the BAF risks on finance and IT. A review of financial risk suggested a change was appropriate in one of the functional risks on budgetary control, and IT risk discussion mainly focussed on the QMH IClip deployment and the risks that should change following implementation. Brexit risk was also discussed and the committee agreed to take input from other committees while maintaining overall oversight at FIC (Core). The Committee also noted encouraging performance on metrics reported in the IQPR (including RTT, Diagnostics and Cancer Targets). Emergency Flow was the exception, where no assurance was given at present (while TEC oversees a new action plan to address performance). Agency Expenditure was noted as higher than trend and July's year on year increase was noted. The committee discussed actions being taken to bring costs down. The Committee observed the Trust's position with respect of the block contract and outlined upcoming steps on QIPP with SWL commissioners. The underlying position and financial forecast were reviewed which both show actions are required in order to deliver this year's plan and be in a sustainable financial position for the start of 2020/21. **The Committee wishes to bring the following items to the Board's attention:**

1.1 Finance Risks- at the August the Chief Financial Officer (CFO) gave an update on financial risks. He noted the intention to increase the functional risk 'Managing Income & Expenditure in line with budget' and the Committee agreed that Brexit risk was to take input from other committees whilst FIC (Core) retained the risk responsibility.

1.2 ICT Risks- the Chief Information Officer (CIO) introduced papers on ICT risk and assurance on the deployment of QMH iClip at the August meeting. The Committee welcomed the assurance provided and recommended that the Board approves returning to QMH RTT reporting and the go live of iClip on the QMH site. At the September meeting the committee noted the positive indicators following go-live at QMH the preceding weekend.

1.3 Activity- in August the Deputy CFO updated the Committee on the positive performance against activity targets in elective, non-elective and outpatient procedures in July. The Committee welcomed this information, although it was noted that the financial implications are affected by the SLA block contract. This pattern continued into September's meeting with August's performance.

1.4 Cancer update - the Chief Operating Officer (COO) noted the improvement in Cancer performance with 6 of the 7 standards met in June and the 7th (14 day compliance) only missing by 0.5%. In July all standards were met. He also noted the requirements in order to deliver the targets by year end, following two challenging months for 62-day performance in April and May. The Committee was encouraged by this information.

1.5 RTT Update- the COO updated the Committee on Referral to Treatment (RTT) targets. Performance of 86.0% in June and 86.1% in July against the 92% Incomplete Pathway target was ahead of agreed trajectory and August is expected to in line with trajectory as well. He also noted the 52 week performance as being on trajectory in June and July, while August

may have 6 52 week waiters compared to a target of 5. The Committee noted the expectation that QMH patient data being added to the PTL would improve RTT performance.

1.6 Emergency Department (ED) update - the COO noted the deterioration in Emergency Flow performance (86.4% in July and 83.3% in August). He noted that he could currently provide no assurance on ED performance and noted the work being done by TEC and externally to put a plan in place to support improved performance. The Committee reflected that consistency of ED performance was the challenge the Trust must focus on.

1.7 Agency Performance- in August's meeting the Chief People Officer (CPO) outlined some of the challenge in Agency expenditure in July and the action being taken, in particular with interims and ward nursing, to improve performance. The Committee noted work underway to review annual leave usage in ward areas.

1.8 Financial Performance- the CFO noted performance to date at month 5 was in line with plan showing a £30.3m Pre-PSF/FRF/MRET deficit. The Committee discussed the impact of the block contract in specialist and non-specialist areas, with the latter forming part of discussion with commissioners on QIPP. In addition, observation was made of the challenge with the Trust's underlying position, which is not improving at the required level. The committee also noted the continued strong cash management.

1.9 Financial Forecast- the CFO provided an update for the committee on the trust's financial forecast. In September the CFO noted the process being undertaken with executive leads to focus on different aspects of pay expenditure to improve the current run rate and deliver the financial plan. The Committee noted the action plans required to mitigate the financial risk expected at year end.

1.10 5 year planning – the Deputy CFO noted latest deadlines for the SWL sector and nationally with respect to 5 year planning at the August meeting. At the September committee, members agreed the Trust's approach ahead of the draft September submission to the STP.

1.11 Cath Labs Full Business Case – the Director of Financial Planning introduced the Cath Labs Business case. The Committee recommended the case to Trust Board following discussions about the impact on car parking, and noted the good quality of the case.

1.12 SWLP report - The Committee was updated on SWLP performance for Quarter 1. SWLP is broadly on plan, with discussion at the committee focussed on LIMS implementation, a new Head of Finance in post and the new 'cost per case model' in development.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Core) for information and assurance.

Ann Beasley
Finance & Investment Committee Chair,
August & September 2019

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No**	**4.2**
Report Title:	**Finance and Investment Committee (Estates) Report**		
Lead Director/ Manager:	Tim Wright, Lead Non-Executive Director, Estates and Ann Beasley, Finance & Investment Committee Chair,		
Report Author:	Tim Wright, Lead Non-Executive Director, Estates and Ann Beasley, Finance & Investment Committee Chair,		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 22 August 2019 & 19 September 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		

St George's University Hospitals NHS
NHS Foundation Trust

Finance and Investment Committee (Estates) – August & September 2019

This Part 2 FIC meeting has been set up on a monthly basis to provide more comprehensive assurance on Estates risks in the Trust.

Both the August and September meetings were constructive and helpful at which members received updates from the Assistant Directors (ADs) of Estates on their respective domains. In addition, the committee received a number of papers including an external review of Estates Governance, an update on the Premises Assurance Model (PAM), a post project evaluation of the Dalby Ward refurbishment, and a BAF risks update. Committee members praised the good quality of papers produced and indicated that they would be content to receive more summarised documentation in future months now that all detailed AE reports have been reviewed and actions plans for all domains are progressing.

The Committee welcomed a first update from the Capital Projects and Medical Physics leads as well as further updates from other Estates areas. When reviewing the 5 Associate Director (AD) domains, progress to mobilise the Procure22 contract was noted and the Cardiac Cath Lab project, a re-audit of Water Safety and the bedding in of the new Mitie (cleaning) contract were discussed. The Committee once again thanked the Estates teams for all their efforts, in particularly outside of standard working hours.

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

1.1 External Governance Review – in August the Committee received in draft a detailed report from Rider Levett Bucknall on Estates Governance. The Committee accepted the broad thrust of the report and were grateful of the overall summary it provided. It was recognised that the majority of recommendations the report contained were now in hand and it was agreed that Estates would discuss with the authors the most suitable form of the final report.

1.2 Risk Review - the Chief Financial Officer (CFO) provided an update on Estates BAF risks in September noting that while the fundamental position on risks are unchanged, there is now more clarity on when risks are likely to change in terms of ratings.

1.3 AD Report - Capital Projects – the Committee received papers outlining progress on Capital projects. Recent changes in staffing of that team were noted and the difficulty of recruiting Project Managers at Band 7 discussed. It is important that adequate resource is in place to respond to Procure22 contractor requirements and the CFO confirmed that authority has been given to do what is necessary to meet essential recruitment requirements. Some minor delays to the Cath Lab project due to peripheral works are of concern but clinical teams are fully engaged in planning and impacts under control.

1.4 AD Report - Estates –. Progress has been made in a number of areas including work underway using Computer Aided Design (CAD) to produce drawings and system schematics that will in future be maintained in-house. A re-audit of water safety reported in September is expected to show the Trust improving from a 'no assurance' rating at the last audit. The committee also discussed 'black start' testing and agreed that this was not appropriate until there was full understanding of all areas of the Estate. The September meeting included emphasis from members that movement to a longer term approach was now required on water safety whilst dealing with issues as they arise.

1.5 AD Report - Facilities – In August the Committee discussed progress on the new cleaning and catering contract with Mitie which was experiencing transition issues as new arrangements bedded in. In September the CFO noted that the increased oversight from the department is paying off following a difficult original implementation. There is now increased

stability within the department and CFO praised the quick mobilisation of the management team at the Trust and at Mitie to improve the situation.

1.6 AD Report- Health & Safety –The main focus is on Fire Safety and good progress is being made on the Fire Safety Action Plan including the production of fire compartmentalisation drawings using CAD. Recent HSE Improvement Notice recommendations are being addressed and on track to be closed out within the prescribed timeframe. Entenox leak issues in Maternity have been resolved and improvements to ventilation will be addressed within the capital programme.

1.7 AD Report- Medical Physics & Clinical Engineering – the Committee received its first report from the AD - Medical Physics & Clinical Engineering. Incidents under investigation or completed this month were discussed. The need to increase wifi capacity was noted as was the role of the hospital charity in funding the provision of additional medical equipment.

1.8 PAM update- The Committee noted an update on the Premises Assurance Model following an action at the previous committee. The Committee noted a number of actions due in September which were expected to be met.

1.9 Dalby Ward: Post Project Evaluation – The CFO introduced a paper on the Dalby ward refurbishment post project evaluation. The Committee welcomed this update and noted that many of the expected benefits were now being realised. The report highlighted the importance of the current capital programme to remediate the basic infrastructure across the estate so that further improvements can be achieved.

1.10 Authorising Engineer Update Report – The CFO introduced a paper on the AE report summary. The Committee discussed the need to recruit Approved Persons (APs) urgently in some Estates areas and noted that a full staffing plan is to be presented to TEC for approval in September.

1.11 Fire Strategy Implementation Plan - The Committee received a Fire Strategy Implementation Plan update from the Assistant Director of Health & Safety, Fire and Security. The Committee noted that a template is now in place and that surveys would need to be completed before an action plan can be drawn up.

1.12 Ventilation HSE Improvement Notice – The Committee noted that work is focussed on meeting August milestones and was assured that plans to meet the November deadline to implement a suitably informed risk-based, planned preventative maintenance (PPM) programme are on track.

1.13 Estates Strategy - The Committee recognised that progress is being made and that some aspects will need to be progressed quickly to underpin other Trust developments such as the development of an Emergency Floor. The emerging strategy will look to sensibly sequence improvements to align with strategic priorities of the Trust.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Estates) on 22 August 2019 & 19 September 2019 for information and assurance.

Tim Wright & Ann Beasley
Lead Non-Executive Director, Estates & Finance & Investment Committee Chair, August & September 2019

St George's University Hospitals NHS
NHS Foundation Trust

4.3

Meeting Title:	**TRUST BOARD**		
Date:	**26 September 2019**	**Agenda No.**	**4.3**
Report Title:	**M05 Finance Report 2019/20**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer Represented by Andy Stephens, Director of Financial Planning		
Report Author:	Tom Shearer, Deputy Chief Financial Officer Michael Armour, Reporting Accountant		
Presented for:	Update		
Executive Summary:	The Trust has reported a deficit to date in M5 of £30.3m which is equal to the Pre-PSF/FRF/MRET plan. Within the position, income is adverse to plan by £0.1m, and expenditure is underspent by £0.1m. CIP performance to date is £8.5m which is in line with plan. The Trust has recognised £10.7m of PSF/FRF/MRET funding YTD to Month 5 in line with plan. The Trust also recognised £0.5m of prior year PSF.		
Recommendation:	The Trust Board is asked to note the Trust's financial performance to M5.		
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		
Equality & Diversity	There are no equality and diversity implications arising from the contents of this report.		
Previously Considered by:	Finance & Investment Committee (Core)	Date	19/9/19
Appendices:	N/A		

TB Sep 19

4.3

Financial Report Month 05 (August 2019)

Chief Finance Officer

26th September 2019

Executive Summary – Month 05 (August)

St George's University Hospitals NHS
NHS Foundation Trust

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF/MRET/FRF deficit of £30.3m** at the end of August, which is **on plan**. Within the position, income is adverse to plan by £0.1m, and expenditure is underspent by £0.1m. **M5 YTD PSF/MRET/FRF income of £10.7m** in the plan has **been achieved** in the Year-to-date position. **£2.8m of this is MRET which is expected to be received in all scenarios, and the remaining £8.0m has been achieved** as the Trust is delivering the Pre-PSF/MRET/FRF plan. **£0.5m of Prior Year PSF** is included in the position following a re-allocation of the General PSF after finalisation of annual accounts.	On plan	On plan
Income	Income is reported at £0.1m adverse to plan year to date. SLA income is £2.3m over plan, mainly due to decreased Challenges and excluded Drugs and Devices which are offset in non-pay. Non-SLA income is £2.4m adverse to plan, which is mainly owing to shortfalls in Pharmacy and Pathology income, both of which are offset by lower costs.	£0.1m Adv to plan	£0.5m Adv to plan
Expenditure	Expenditure is £0.1m favourable to plan year to date in August. This is caused by Non Pay adverse variance of £0.9m which is caused by . Pay is £0.8m favourable to plan, mainly driven by non-clinical underspends.	£0.1m Fav to plan	£0.5m Fav to plan
CIP	The Trust planned to deliver £8.5m of CIPs by the end of August. To date, £8.5m of CIPs have been delivered; which is on plan. Income actions of £1.7m and Expenditure reductions of £6.8m have impacted on the position. A £3.0m gap remains in Green schemes identified against the £45.8m target.	On plan	On plan
Capital	Capital expenditure of £19.2m has been incurred year to date. This is to plan. The current month YTD position is £19.2m and the previous month YTD position is £15.8m.	£19.2m To plan	£15.8m To plan
Cash	At the end of Month 5, the Trust's cash balance was £3.1m. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.	£0.1m Fav to plan	£0.4m Fav to plan
Use of Resources (UOR)	At the end of August, the Trust's UOR score was 4 as per plan.	UOR score 4	UOR score 4

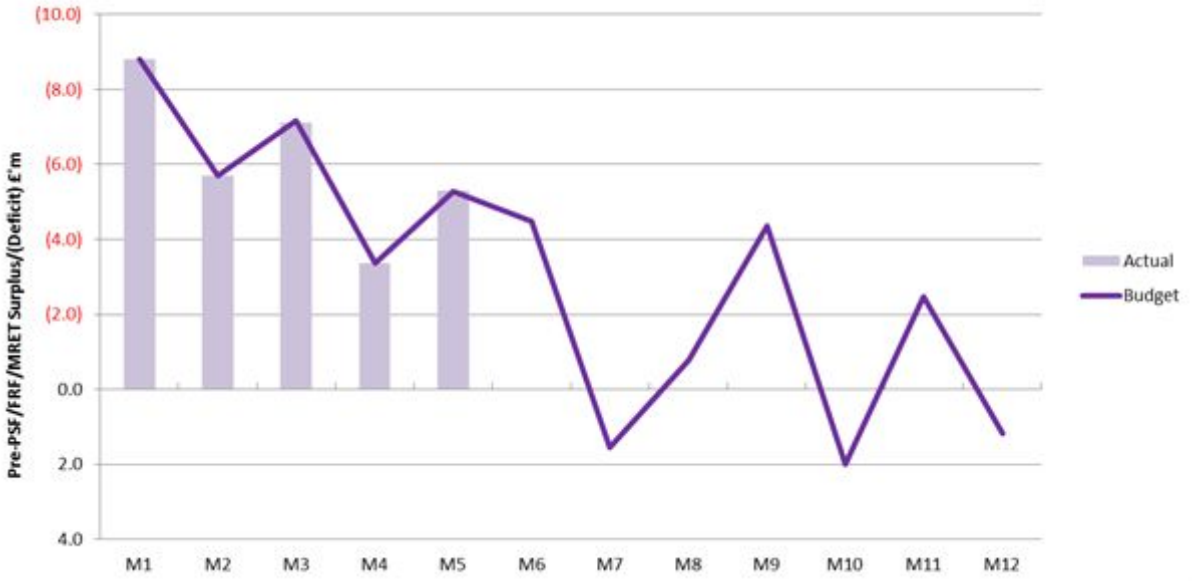
St George's University Hospitals NHS
NHS Foundation Trust

Contents

1. Month 05 Financial Performance

St George's University Hospitals NHS
NHS Foundation Trust

			Full Year Budget (£m)	M5 Budget (£m)	M5 Actual (£m)	M5 Variance (£m)	M5 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF/FRF/MRET	Income	SLA Income	679.9	55.6	56.4	0.8	1.4%	279.7	282.1	2.3	0.8%
		Other Income	157.5	13.4	13.0	(0.4)	(2.9%)	66.2	63.8	(2.4)	(3.7%)
	Income Total		**837.3**	**69.0**	**69.4**	**0.4**	**0.6%**	**346.0**	**345.9**	**(0.1)**	**(0.0%)**
	Expenditure	Pay	(532.6)	(45.2)	(44.4)	0.8	1.8%	(229.7)	(228.9)	0.8	0.3%
		Non Pay	(306.6)	(26.1)	(27.3)	(1.2)	(4.7%)	(131.6)	(132.5)	(0.9)	(0.7%)
	Expenditure Total		**(839.2)**	**(71.3)**	**(71.7)**	**(0.4)**	**(0.6%)**	**(361.3)**	**(361.4)**	**(0.1)**	**(0.0%)**
	Post Ebitda		(35.8)	(3.0)	(3.0)	(0.0)	(0.1%)	(15.0)	(14.8)	0.2	1.4%
Pre-PSF/FRF/MRET Total			**(37.7)**	**(5.3)**	**(5.3)**	**(0.0)**	**(0.4%)**	**(30.3)**	**(30.3)**	**0.0**	**0.0%**
PSF/FRF/MRET			34.7	2.4	2.4	0.0	0.0 %	10.7	10.7	0.0	0.0 %
Total			**(3.0)**	**(2.9)**	**(2.9)**	**(0.0)**	**(0.7%)**	**(19.6)**	**(19.6)**	**0.0**	**0.0%**
Prior Year PSF			0.0	0.0	0.0	0.0	0.0 %	0.0	0.5	0.5	0.0 %
Grand Total			**(3.0)**	**(2.9)**	**(2.9)**	**(0.0)**	**(0.7%)**	**(19.6)**	**(19.1)**	**0.5**	**2.6%**

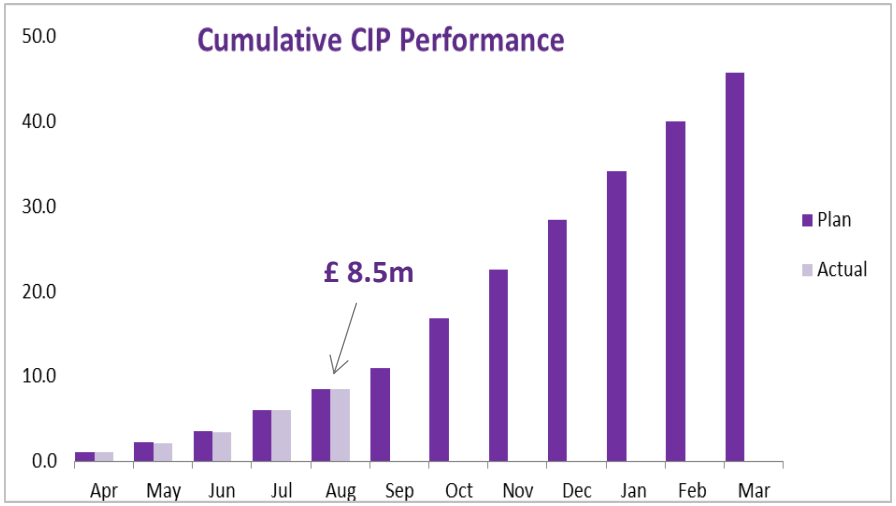


Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £30.3m at the end of Month 05, which is on plan.
- **SLA Income** is £2.3m ahead of plan, after adjustment for block contract values. There remains a large level of estimation within the M5 income position due to delays in coding in some specialties.
- **Other income** is £2.4m under plan, which is owing to Pharmacy services income, and Pathology income, both of which are offset by reduced cost.
- **Pay** is on £0.8m underspent due to Non-Clinical pay underspend caused by vacancies.
- **Non-pay** is £0.9m overspent, mainly related to pass-through income.
- **PSF/FRF/MRET Income** is on plan at M05 YTD, at £10.7m. The Trust has met the pre-PSF control total target of a £30.3m deficit.
- **Prior Year PSF** of £0.5m is included in the position. This is the trust's element of the Post Accounts PSF adjustment for 2018/19.
- **CIP delivery** of £8.5m is on plan. Delivery to plan is:
  - Pay £0.1m favourable
  - Non-pay on plan
  - Income £0.1m adverse

4.3

2. CIP Performance M05



YTD (£ m)			
Category	**Plan**	**Act**	**Variance**
Income	1.7	1.7	(0.1)
Pay	4.3	4.4	0.1
Non Pay	2.4	2.4	(0.0)
Total	**8.5**	**8.5**	**(0.0)**

2019/20 (£ m)			
Category	**Plan**	**Green Schemes**	**Variance**
Income	9.4	7.0	(2.3)
Pay	23.4	18.9	(4.6)
Non Pay	13.0	16.9	3.9
Total	**45.8**	**42.8**	**(3.0)**

CIP Delivery and Variance

- CIP delivery at the end of M5 is on track compared to plan
- Green schemes now total £42.8m, which is 93% of the target

CIPs at Risk / Under Delivery

- The CIP delivery profile steps up at M7, by when the £3.0m gap to 100% Green will need to be closed, to assure delivery of the target in full.

CIP Pipeline / Mitigations

- TEC has taken the decision to hold £3m of budgeted cost pressures as a CIP, until this can be replaced by pipeline schemes, this is included in the current Green plan total of £42.8m
- In addition, all divisions have been asked to identify further CIP schemes that relate to discretionary spend.
- There are £5.4m of amber and red schemes which divisions are focused on translating to a green rating. In addition there are £20.7m of pipeline schemes that need to be followed through to Green or removed.
- Following the recent Use of Resources assessment, a further review of Model Hospital and other benchmarking data is being undertaken to support divisions identify and act upon further productivity and financial efficiency opportunities, when compared to peers, in support of their CIP recovery plans.
- A detailed review of all CIP schemes will be undertaken to support the M6 financial forecast.

3. Balance Sheet as at Month 05

St George's University Hospitals NHS
NHS Foundation Trust

	Mar-19 Audited Account (£m)	Revised Y/E Plan 31.3.2020	YTD Revised Plan (£m)	YTD Actual (£m)	YTD Variance to Plan (£m)
Fixed assets	**390.5**	**408.8**	**393.2**	**399.5**	**6.3**
Stock	**7.8**	6.5	5.4	7.8	2.4
Debtors	**101.9**	84.2	87.3	91.5	4.2
Cash	**3.2**	3.0	3.0	3.1	0.1
Creditors	**-122.4**	-86.5	-104.3	-112.6	-8.3
Capital creditors	**-4.3**	-3.6	-2.6	-15.5	-12.9
PDC div creditor	**0.0**	0.0	0.0	0.0	0.0
Int payable creditor	**-1.2**	-1.2	-1.2	-2.9	-1.7
Provisions< 1 year	**-0.5**	-0.4	-0.4	-0.4	0.0
Borrowings< 1 year	**-57.6**	-82.5	-86.7	-72.6	14.1
Net current assets/-liabilities	**-73.1**	**-80.5**	**-99.5**	**-101.6**	**-2.1**
Provisions> 1 year	**-1.0**	0.0	0.0	-1.0	-1.0
Borrowings> 1 year	**-284.3**	-299.3	-281.6	-284.1	-2.5
Long-term liabilities	**-285.3**	**-299.3**	**-281.6**	**-285.1**	**-3.5**
Net assets	**32.1**	**29.0**	**12.1**	**12.8**	**0.7**
Taxpayer's equity					
Public Dividend Capital	**133.4**	133.4	133.4	133.4	0.0
Retained Earnings	**-213.4**	-216.5	-233.4	-232.7	0.7
Revaluation Reserve	**110.9**	110.9	110.9	110.9	0.0
Other reserves	**1.2**	1.2	1.2	1.2	0.0
Total taxpayer's equity	**32.1**	**29.0**	**12.1**	**12.8**	**0.7**

M05 YTD Balance Sheet

- Fixed assets are £6.3m higher than plan. This includes depreciation charges and capital spend to month 5.
- Stock is £2.4m higher than plan, mainly due to an increase in the pharmacy area.
- Debtors is £4.2m higher than plan in month and has reduced by £10.4m from March 2019. Target reduction of £18m by year end is being actively pursued.
- The cash position is £0.1m higher than planned. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.
- Creditors are £8.3m higher than plan in month, however they have been reduced by £9.8m since March 2019.
- Capital creditors are £12.9m higher than the plan. These are accruals for commitments to August.
- £13.6m of capital loan was received as at August subject to an interest rate of 1.55%. The Trust has requested drawdown of capital loan in September of £2.1m with the same interest rate as in July.
- The Trust requested and received working capital loan of £11.6m in April and May to fund the current year deficit as per submitted plan. No loan was drawn down since then, including in August and September.
- The deficit financing borrowings are subject to an interest rate of 3.5%.

4. Month 5 YTD Analysis of Cash Movement

St George's University Hospitals NHS
NHS Foundation Trust

	Revised YTD Plan £m	YTD Actual £m	YTD Variance £m
Opening Cash balance	**3.2**	**3.2**	**-0.0**
Income and expenditure deficit	-20.0	-19.3	0.7
Depreciation	10.2	10.2	0.0
Interest payable	5.1	5.1	0.0
PDC dividend	0.0	0.0	0.0
Other non-cash items	-0.1	-0.1	0.0
Operating deficit	**-4.8**	**-4.1**	**0.7**
Change in stock	-2.5	-0.1	2.4
Change in debtors	6.6	10.8	4.2
Change in creditors	-18.1	-9.8	8.3
Net change in working capital	**-14.0**	**0.9**	**14.9**
Capital spend (excl leases)	-17.4	-7.4	10.0
Interest paid	-3.3	-3.3	0.0
PDC dividend paid	0.0	0.0	0.0
Other	0.0	-0.2	-0.2
Investing activities	**-20.7**	**-10.9**	**9.8**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	27.5	11.6	-15.9
Capital loans	13.6	13.6	0.0
Loan/finance lease repayments	-1.8	-11.2	-9.4
Cash balance 31.08.19	**3.0**	**3.1**	**0.1**

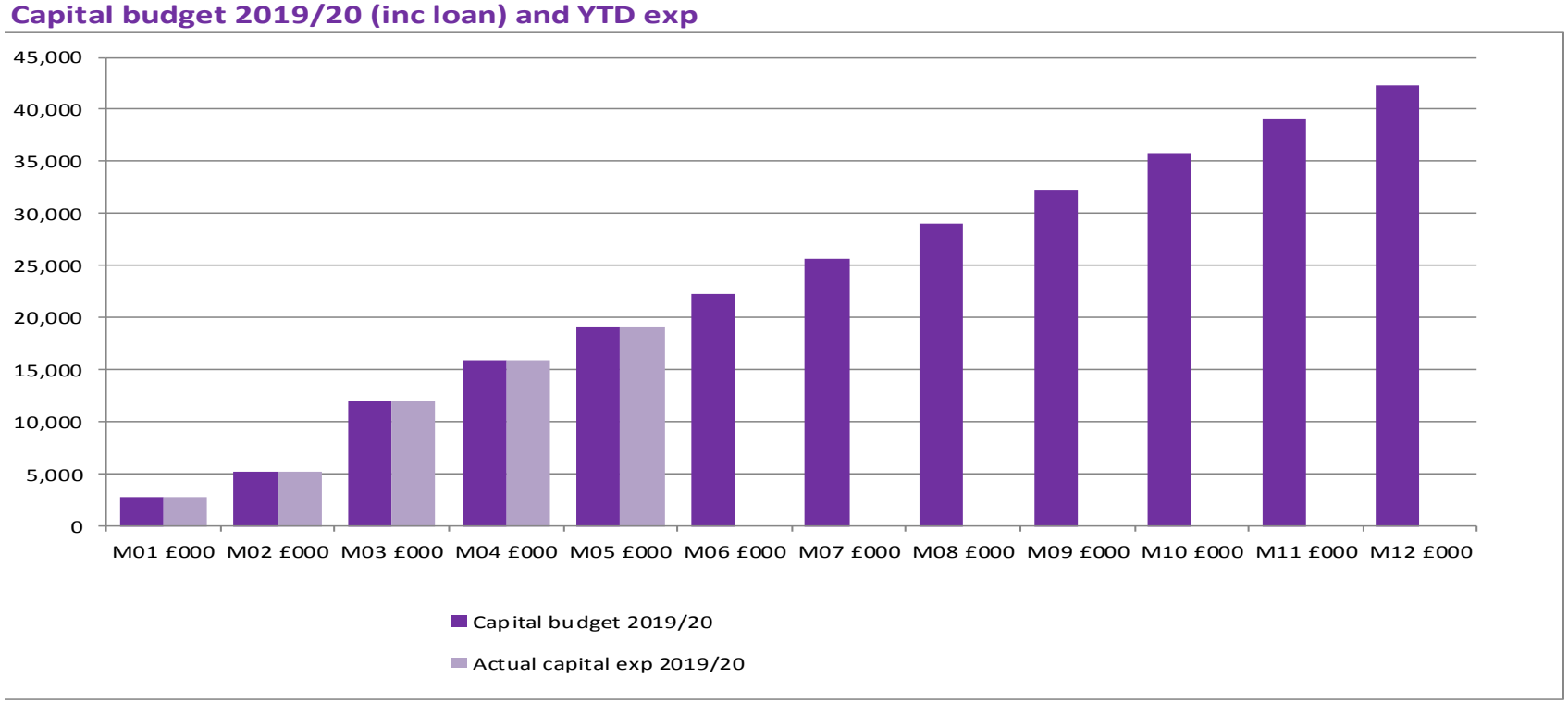
M01-M5 YTD cash movement

- The cumulative M5 I&E deficit is £19.3m, £0.7m lower than 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 £19.3m, depreciation (£10.2m) does not impact cash. The charges for interest payable (£5.1m) and 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 £4.1m.
- The operating deficit variance from plan is £0.5m.
- Working capital is better than plan by £14.9m. This favourable variance comprises of £4.2m better on debtors and £8.3m better on creditors. The change of stock level is £2.4m better than the plan.
- The Trust has borrowed £11.6m to fund the YTD deficit.
- The Trust has received £13.6m for capital loan. The working capital borrowing is £15.9 lower than the YTD plan. The Trust has requested a drawdown of capital loan in August of £2.1m with an interest rate of 1.55%. Although the Trust can borrow up to £27.5m, however due to the phasing of the I&E at month 5, we have not requested any loans since June. The Trust would have had to repay any excess as the maximum loan cannot exceed £12.8 at the yearend.

August cash position

- The Trust achieved a cash balance of £3.1m on 31 August 2019, 0.1m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 15 week cash flow submitted last month.

5. Capital budget and expenditure at M05



- The Trust's funded capital expenditure budget for 2019/20 is £40.3m.
- The Trust has incurred capital expenditure of £19.171m in the first five months of the year. This spend is against a capital plan of £19.171m but the spend includes a spend to plan accrual of £8.668m for commitments.

6. Finance and Use of Resources Risk Rating

St George's University Hospitals NHS
NHS Foundation Trust

Use of resource risk rating summary	Plan (M05 YTD)	Actual (M05 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	1
Agency rating	1	2
SCORE BEFORE OVERRIDES		3
SCORE AFTER OVERRIDES		4

Basis of the scoring mechanism

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

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of August, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in the first 3 categories, owing to adverse cash and I&E performance.
- The "agency rating" score of 2 is owing to additional agency costs that have meant the Trust has exceeded its agency ceiling to date (otherwise a '1' would have been scored).
- The distance from plan score is worked out as the actual % YTD I&E deficit (5.50%) minus planned % YTD I&E deficit (5.50%). This value is 0.00% which generates a score of 1.

Overrides

- The Trust's score is based on the average of the 5 metrics which generates a score of 3.
- However a number of overrides exist which may change this score.
- As the Trust is currently in financial special measures, the Trust score deteriorates to a 4 automatically.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No**	**5.1**
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 01 August 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		

5.1

St George's University Hospitals NHS
NHS Foundation Trust

Audit Committee Report – August 2019

Matters for the Board's attention

1. External Audit – Annual Letter

The Committee received the final report from the external auditors following the completion of the annual audit of the Trust's financial accounts, annual report and quality accounts with no issues to report.

2. Internal Audit Report

The Committee considered the following reports from the internal auditor:

- Progress Report against the Internal Audit Plan 2019/20
- Internal Audit Review Recommendation Tracker
- Final Internal Audit Report on review on Infection Prevention and Control

The Committee welcomed the news that good progress was being made against the internal audit programme for 2019/20. The Committee will consider an updated version of the plan having asked the Trust Executive Committee review plan to ensure that it was fit for purpose and responsive to the current risk environment. The Committee also suggested that the Trust Executive Committee consider how and when to incorporate reviews of the Trust's major projects management framework and current work and enhanced governance structures around estates and facilities.

The Committee were pleased to note that the Infection Prevention Control systems received a reasonable assurance rating and were reassured that the recommendations were being progressed through the relevant sub-groups.

Whilst it was evident that good progress was made in completing actions from internal auditors with only five outstanding actions on the tracker compared to 12 previously reported the Committee raised concerns about the delay of the review of Consultants Appraisal and Revalidation and asked the Trust Executive Committee to ensure that there is sufficient resources to complete this internal audit.

3. Internal Compliance and Assurance

The Committee received and discussed the following reports pertaining to the Trust's internal governance mechanisms.

3.1. Board Assurance Framework

The Committee considered a report which outlined how the Audit Committee receives assurance that the Trust has robust risk management processes and effective management of Board Assurance Framework risks. The Committee noted that more work was needed to codify the role of the Audit Committee and other Board Committees and any process should clearly map the end-to-end process for reviewing risks. The Committee accordingly agreed to defer its review of the risk management processes until the Risk Management Executive and Trust Executive Committee had completed the parallel streams of work to enhance risk management across the Trust.

3.2. Clinical Audit Programme

The Committee considered the report which outlined the programme of clinical audits being undertaken in the Trust. The programme includes 125 clinical audits and whilst the Committee welcomed the greater transparency on the programme and processes it raised concerns about the level of clinical input across the Trust. The Committee, minded of the importance of clinical audits in driving improvement in outcomes for patients flagged the necessity for all clinicians to routinely submit data/cases to these audits. The Committee also asked that the Quality & Safety Committee play a role in scrutinising the outcome from the audits.

3.3. Raising Concerns and Freedom to Speak Up Guardian

The Committee received a comprehensive report on Raising Concerns and reviewed the revised policy. The Committee flagged areas that required further clarity in policy document but welcomed and was assured by the enhanced processes and the plans to launch the new policy which gives greater clarity and guidance for staff on raising concerns. The Committee also noted the additional documents including posters and flow charts to support staff and raise awareness.

The Committee also heard about the progress being made closing the five Freedom to Speak Up Guardian Cases and that the Board would receive a report in October 2019.

The Committee welcomed the news that the Trust would bring in additional resources which would enable the delayed audit into diversity and inclusion to take place in quarter three.

3.4. Counter Fraud

The Committee received the report from the Counter Fraud team noting that the level of awareness of counter fraud issues across the Trust had increased as of result of the increased training being provided and continued support from the internal auditors. Consequently, the Committee noted the increase in the number of cases being reported which is a good indicator of the work being done. The Committee noted that training will be provided to the Board in due course. The Committee welcomed the enhanced reporting and asked for greater analysis of key trends in future reports.

3.5. Information Governance Compliance Update and Annual Report

The Committee noted the high degree of work undertaken by the Trust to improve its information governance systems and data management processes. The Committee heard that the General Data Protection Regulations are now part of the business as usual and that work is ongoing to map across how information is processes across the Trust. Work is now focused on ensuring the Trust complies with the data protection toolkit for 2019/20.

3.6. Standing Orders (SO), Reservation and Delegation of Powers (RDP) and Standing Financial Instructions (SFIs) Review

The Committee commended the comprehensive work done to review the Standing Orders (SO), Reservation and Delegation of Powers (RDP) and Standing Financial Instructions (SFIs). The Committee asked for some minor areas of clarification and drafting changes subject to which recommend that the Board approve the documents. ***See Board agenda item 5.1.2.***

3.7. Trust Policies

The Committee received and is assured by the process and the level of work undertaken to manage the Trust's policies. The report provided greater transparency and demonstrated the level of work to improve the position and it was evident that there is a robust governance process through the Trust Executive Committee which is monitoring the out-of-date policies.

The Committee also reviewed the Managing Conflicts of Interest Policy, noting there had been not substantive changes to the policy which is based on the NHS England model policy and therefore approved the policy.

3.8. Use of Trust Seal

The Committee was assured by robustness of the process for the use of the Trust seal and noted the use thereof in 2018/19 and the first quarter of 2019/20. ***See Board agenda item 5.1.1.***

Losses and Compensation Payments & Breaches and Waivers

The Committee noted the improvement in the management of losses and compensation payments and breaches and waivers. In both instances there has been improvement in the value and number.

4. Emerging Issues

The Committee were advised on two emerging issues under matters on any other business related to ICT Access Review and July Pension Payroll which the Chief Financial Officer will appraise the Board of in Part 2.

Recommendation

The Board is asked to note the update on the key issues considered by the Audit Committee at its meeting on 01 August 2019.

Sarah Wilton
Audit Committee Chair, NED
August 2019

St George's University Hospitals NHS
NHS Foundation Trust

5-

Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No**	5.1.1
Report Title:	**Use of the Trust Seal**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Information		
Executive Summary:	The use of the Trust seal is required to be reported to the Trust Board on an annual basis. The report details its use during 2018/19. Following the historic control issue regarding the signing of construction contracts reported to the Audit Committee in January 2019, the Seal has been used on a number of occasions in late 2018/19 and Q1 2019/20 to address these issues. As the majority of the 21 occasions in 2019/20 where the Trust Seal has been used was a consequence of this, the report sets out the use of the Seal in Q1 2019/20 as well as the use of the Seal in 2018/19. The attached report was considered and noted by the Audit Committee at its meeting on 1 August.		
Recommendation:	The Board is asked to note the use of the Trust seal in 2018/19 and Q1 2019/20.		
Supports			
Trust Strategic Objective:	Build a better St George's		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and Improvement Capability		
Implications			
Risk:	There is a risk that the Trust is seen as not having robust governance systems.		
Legal/Regulatory:	As set out in paper.		
Resources:	There are no specific resource implications.		
Equality Impact Assessment	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	N/A		

5.1

5.1

Use of the Trust Seal, 2018/19 and Q1 2019/20

Stephen Jones, Chief Corporate Affairs Officer
1 August 2019

1. Overview

St George's University Hospitals NHS
NHS Foundation Trust

1. Purpose

The use of the Trust seal must be reported to the Audit Committee on an annual basis. This report sets out the use of the Trust seal in the year 2018/19.

2. Background

The Trust Standing Orders (SO.8) set out the rules governing the use of the Trust seal. Among other provisions governing the custody of the seal and the sealing and signature of documents, the Standing Orders require the Trust to maintain a register in which every use of the seal is recorded.

The Standing Orders provide that the Trust Seal should be affixed in the presence of the Chief Executive, and Chair where appropriate, or two senior managers duly authorised by the Chief Executive, and also not from the originating department.

A Register of Sealing must be maintained and a record of the sealing of every document must be kept.

Use of the Trust Seal must be reported to the Board.

3. Use of the Trust Seal in 2018/19

The Trust Seal was used on a total of 4 occasions in 2018/19. The table in section 2 (page 3) sets out the dates on which the Trust Seal was used, the purpose for which the Trust Seal was affixed, and the signatories and witnesses to its use.

4. Use of the Trust Seal in 2019/20 – Year-to-date

It was reported to the Committee in January 2019 that an historic control issue had been identified with the signing of estates contracts in previous years, which required attention and application of the Trust seal. In the year-to-date, the Trust Seal has been used on a total of 21 occasions and the vast majority of the occasions on which the Seal has been used in 2019/20 to date have been for the purposes of addressing these historic control issues. There is a separate item on the Committee's agenda for its meeting on 1 August regarding these historic control issues.

5. Recommendation

The Committee is asked to note the use of the Trust Seal in 2018/19 and the use of the Seal to date in 2019/20.

St George's University Hospitals NHS
NHS Foundation Trust

2. Use of the Trust Seal in 2018/19

Ref	Date	Title	Reason	Signatories	Witnesses
691	30 July 2018	School Nursing Contract	2x Deeds of Variation between London Borough of Wandsworth and St George's University Hospitals NHS FT	Deirdre Baker (Head of Finance), Stephen Jones (DCA)*	Ila Modhwadia (EA - Chair & CEO)
692	8 October 2018	Queen Mary Hospital Former Alcohol Treatment Centre	Occupation of this space for the relocation of the Childrens Therapies team from 166 Roehampton Lane when this unit closed. This lease adds this space to the overall lease of occupation for QMH for SGH	Andrew Grimshaw (CFO), Kevin Howell (DEF), Jenni Doman ((D-EF), Lesley Burr (IDFS)*	Joshua Roles (EA - Chair & CEO)
693	8 October 2018	Lease of Tooting Blood Centre Annex	This lease was for the Finance department relocation from 120 The Broadway to the Jasmine Annexe in the Tooting Blood Centre Annexe building.	Andrew Grimshaw (CFO), Kevin Howell (DEF), Jenni Doman ((D-EF), Lesley Burr (IDFS)*	Joshua Roles (EA- Chair & CEO)
694	19 November 2018	Dear Park Road Lease	This lease is a further lease of occupation for the Radiological Protection team; clinical equipment maintenance and training department as the previous lease had expired.	Andrew Grimshaw (CFO), Kevin Howell (DEF), Jenni Doman ((D-EF), Stephen Jones (DCA)*	Joshua Roles (EA- Chair & CEO)

** Delegated authority from the Chief Executive in accordance with the Standing Order SO.8*

St George's University Hospitals NHS
NHS Foundation Trust

2. Use of the Trust Seal in 2019/20 – Year-to-date (1)

Ref	Date	Title	Reason	Signatories	Witnesses
695	29 May 2019	Ambulatory Care Refurbishment Project	Expansion and relocation of the Ambulatory Care clinic Richmond Ward St James Wing. The construction dates ran from November - March 2018	Kevin Howell (DEF), Stephen Jones (DCA)*	Andrew Grimshaw (CFO), Jenni Doman (AD-EF), Joshua Roles (EA – Chair & CEO)
696	29 May 2019	Blood Transfusion Office Relocation	The project involved the fit-out of the building leased from NHS Blood Transfusion Service into office accommodation, providing over 100 desk spaces to accommodate the relocation of the Finance team from 120 the Broadway back to St George's site.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
697	29 May 2019	Moorfields Eye Hospital Refurbishment	Complete refurbishment of Trust space leased to Moorfield's Eye Hospital (Theatres and Duke Elder ward on 5th floor Lanesborough wing). The construction programme ran from February – December 2018.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
698	29 May 2019	CT Scanner (St James' Wing)	'JCT 2016 Design & Build contract' pertaining to the construction element of the CT scanner replacement in St James Wing ED. This included the construction, mechanical and electrical works and associated preliminaries; the contracted works being £60,050.00, and was delivered as a design and build turnkey solution by Siemens Health. The contract was administered by McNaughts.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
699	29 May 2019	Lanesborough HV/LV Generator Project	Replacement and upgrade of HV ring switches & distribution switchgear; replacement of HV-LV Transformers; replacement and upgrade of Standby Generator Sets; replacement and upgrade of LV main switch panels.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
700	24 April 2019	SWL + St George's MH Trust Willow Annex + Grosvenor Wing	To install and fit out an office block for 240 members of staff displaced by the demolition of Clare and Knightsbridge Wings. Failure to proceed would result in inadequate space for corporate offices (IT, Finance, procurement etc). The construction programme ran from January – March 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
701	1 May 2019	Moorfields Second Deed of Variation Lease	Adjustment to the lease. As there has been considerable delays to the completion of the project (Duke Elder Eye Unit) which have resulted in operational performance and income being affected.	Jacqueline Totterdell (CEO), Andrew Grimshaw (CFO)	Joshua Roles (EA-Chair & CEO)

** Delegated authority from the Chief Executive in accordance with the Standing Order SO.8*

2. Use of the Trust Seal in 2019/20 – Year-to-date (2)

St George's University Hospitals NHS
NHS Foundation Trust

Ref	Date	Title	Reason	Signatories	Witnesses
702	1 May 2019	Expansion of Emergency Department	Minor Works to increase the footprint of the existing seminar room, to include an adjacent office, and to supply new mechanical ventilation to support, to allow for teaching requirements in ED. The project was funded by SFT monies from SGUL and from a charitable gift. The construction programme ran from January – March 2018.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
703	29 May 2019	Trevor Howell Day Care Chemo Chair Extension	The existing oncology day case ward was not fit for purpose and was unable to manage the daily workflow. The scheme increased the space allocation for patients and the number of treatment chairs from 14 to 16. The construction dates ran from April – December 2016.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
704	29 May 2019	Mortuary Expansion Phase II	Phase Two of mortuary expansion project, undertaken following Human Tissue Authority (HTA) inspection and subsequent report in August 2015. Works provided new freezer space for long-term storage; greater than thirty-days, and contaminated community storage, as indicated in the proposed statutory requirements from the HTA in 2017. The construction programme ran from August-October 2016.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
705	29 May 2019	Bronte Annex Demolition and Associated Works	To isolate the remaining building services (eg water) and demolish Bronte Annexe. This building was deemed unfit for purpose. The demolition programme ran from November – December 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
706	29 May 2019	Packaged Sub-Station Installation Project Contract	The Project consisted of: • A new electrical sub-station and a new transformer externally by St. James Wing. • A new electrical HV/LV panel to provide additional electrical capacity for the Theatres refurbishment projects (Theatres 3 and 4, Theatres 7 and Theatres 1 and 2 (St. James Wing). • Retrospectively re-wiring past projects to ensure full compliance with HTMs. The construction programme ran from June- September 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)

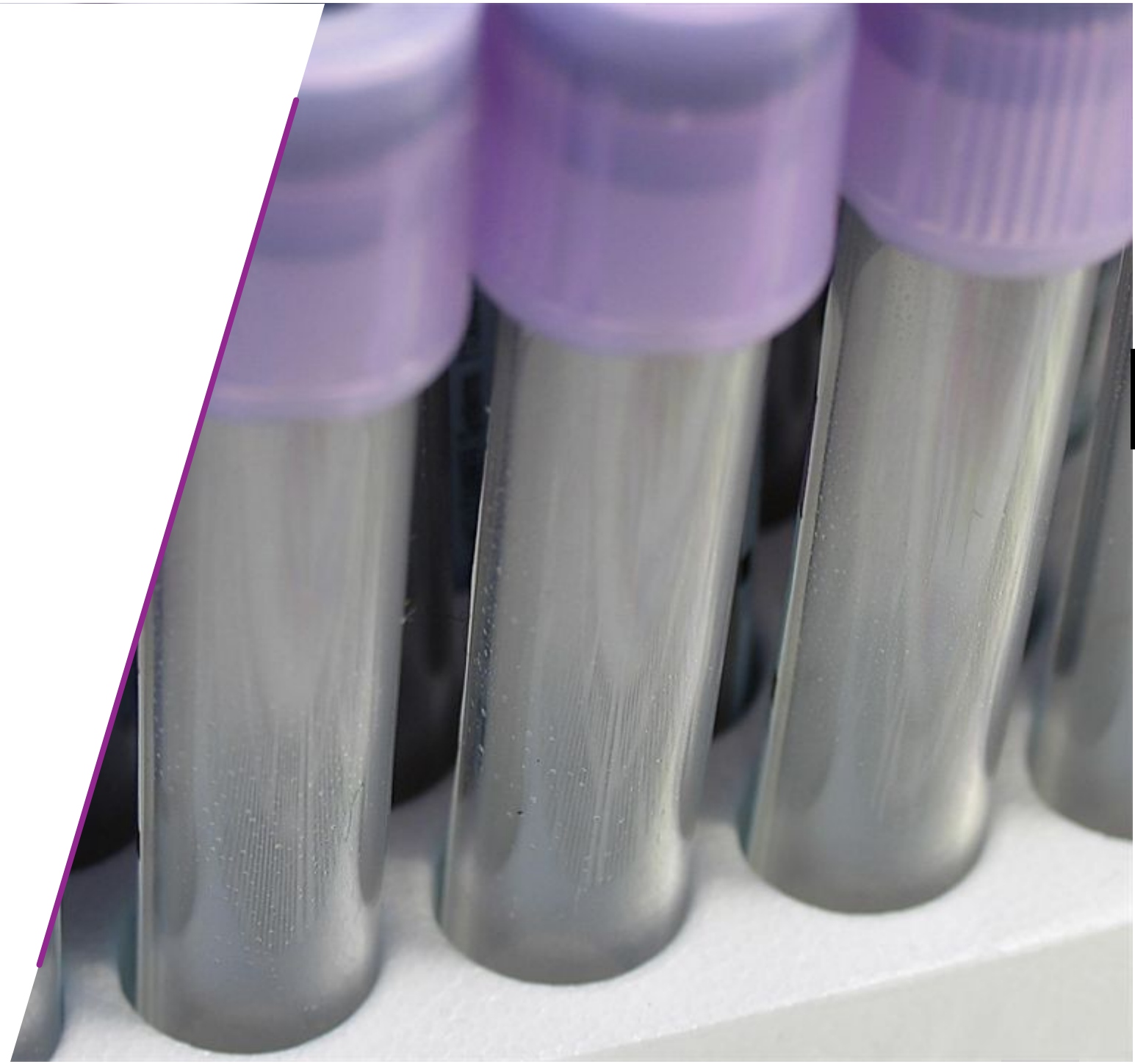
St George's University Hospitals NHS
NHS Foundation Trust

2. Use of the Trust Seal in 2019/20 – Year-to-date (3)

Ref	Date	Title	Reason	Signatories	Witnesses
707	29 May 2019	Neuro Rehabilitation Unit: Transfer from Wolfson to Lanesborough Wing	Transfer of existing clinical service from Wolfson site in Wimbledon, following public consultation on service provision and subsequent sale of land. New clinical service provided on the St George's site in Lanesborough Wing, as well as the rehabilitation services at Queen Mary, Roehampton. The construction programme ran from December 2011 – March 2012.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
708	29 May 2019	Champneys Ward Upgrade	Part refurbishment of existing hospital ward accommodation to provide suitable clinical service provision for renal patient's services; including dialysis stations, following the CQC 2016 inspection. Works included new mechanical ventilation, flooring, lighting, ceilings, decoration and RO plant for dialysis. The construction programme ran from September - November 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
709	29 May 2019	Medical Physics Relocation Project	Strip out of Bed Management Team offices and creation of a Medical Physics workshop to replace accommodation vacated as a result of the plan to demolish Knightsbridge Wing. The construction programme ran from January – March 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
710	29 May 2019	Upgrade of Theatres 5 + 6	The project included a complete refurbishment of Theatres 5 and 6 in St. James Wing to bring them it up to current standards with individual Ultra Clean Ventilation in both Theatres and provide modern theatres with up-to-date technology. The construction dates ran from April to September 2016.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
711	29 May 2019	Surgical Assessment Unit (SAU)	The Nye Bevan Unit project was a project to deliver a new emergency surgical assessment facility on the ground floor of St James Wing co-located with the ED department. The new facility comprises eight short-stay beds, eight trolleys, two clinics and one minor treatment room. It required the relocation of the Chapel / Multifaith facility, Fracture clinic Admin, Audiology, Chest Clinic Consultants, QMR Medical Records and Quality team. The construction programme ran from October – June 2016.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)

2. Use of the Trust Seal in 2019/20 – Year-to-date (4)

Ref	Date	Title	Reason	Signatories	Witnesses
712	29 May 2019	Venous Access Project	The existing venous access room needed to be relocated urgently as part of the renal service relocation out of Knightsbridge Wing. The project involved conversion of a disused X-ray room in SJW X-ray to create a new venous access room with two patient bays and preparation area. The construction dares ran from November – February 2017	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
713	29 May 2019	Modular Office Accomodation	To install and fit out an office block for 240 members of staff displaced by the demolition of Clare and Knightsbridge Wings. Failure to proceed would result in inadequate space for corporate offices (IT, Finance, procurement etc). The construction programme ran from January – March 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
714	29 May 2019	Clinisys Laboratory Information Management SWL Pathology	Extending the scope of the existing contract to include other elements of IT provision for the service model – Clinical Portal and Integration engine.	Jacqueline Totterdell (CEO), Andrew Grimshaw (CFO)	Stephen Jones (DCA), Tim Planche (SWLP), Joshua Roles (EA – Chair & CEO)
715	29 May 2019	SWL Lift Deed of Surrender for St John's Therapy Centre	St George's no longer manage the podiatry services at St Johns. Lease is now managed between CHP and the service provider.	Jacqueline Totterdell (CEO), Stephen Jones (DCA)	Joshua Roles (EA – Chair & CEO)



excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 September 2019	**Agenda No**	**5.1.2**
Report Title:	**Review of Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer Andrew Grimshaw, Chief Finance Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Review		
Executive Summary:	The Standing Orders, Reservation and Delegation of Powers, and Standing Financial Instructions (SOs, RDP, and SFIs) are key components of the Trust's corporate governance structure and processes. The Audit Committee is the Committee of the Board responsible for reviewing and providing assurance to the Board that these are robust and up-to-date. The Audit Committee considered these following a review in the Spring and Summer 2019 and considered proposed revisions at its meeting on 1 August 2019. Subject to minor amendments, the Committee approved these to go to Board for approval.		
Recommendation:	The Board is asked to: ▪ Review the proposed amendments to the revised Standing Orders, Reservation and Delegation of Powers, and Standing Financial Instructions ▪ Agree to the proposed changes ▪ Note the plans for communicating the updated SOs, RDP and SFIs across the organisation		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future Build a better St George's		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and Use of Resources Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	A clear and up-to-date set of Standing Orders, Scheme of Delegation and Authority and Standing Financial Instructions are core to the good governance of the Trust. Failure to maintain this risks lack of clarity in our core governance processes.		
Legal/Regulatory:	The SOs and SFIs must comply with current legislation and be consistent with the Trust's legal status as a public benefit corporation.		
Resources:	N/A		

5.1

St George's University Hospitals NHS
NHS Foundation Trust

Equality Impact Assessment	N/A		
Previously Considered by:	Audit Committee Trust Executive Committee	**Date**	1 August 2019 18 September 2019
Appendices:	Standing Orders, Reservation and Delegation of Powers, and Standing Financial Instructions, 2019/20 (track changed version)		

St George's University Hospitals NHS
NHS Foundation Trust

Standing Orders, Reservation and Delegation of Powers, and Standing Financial Orders
Trust Board, 26 September 2019

1.0 PURPOSE

1.1 The Standing Orders, Reservation and Delegation of Powers, and Standing Financial Instructions are key components of the Trust's corporate governance structure and processes. This paper sets out proposed amendments to the SOs and SFIs following a full internal review. The Board is asked to consider and agree to the proposed amendments.

2.0 BACKGROUND

2.1 The Audit Committee last considered the Trust's Standing Orders, Scheme of Delegation and Authority and Standing Financial Instructions at its meeting on 10 January 2019. At that meeting the Committee agreed that the existing SOs, RDP and SFIs remained sufficiently robust and fit for purpose, pending a further review the outcome of which would be brought to the Audit Committee for consideration at this meeting in August 2019. Subject to minor amendments, the Audit Committee agreed to recommend to the Board that these be approved.

3.0 REVIEW OF THE SOs AND SFIs

3.1 An internal review of the SOs and RDP led by the Chief Corporate Affairs Officer and of the SFIs lead by the Chief Finance Officer has been undertaken. A review by external legal experts had initially been planned but was deemed unnecessary in light of the outcome of the internal review, which has proposed only a limited number of amendments, and the budget constraints within the Trust.

3.2 The key changes recommended to the Committee are:

a) To update references to legislation and guidance to ensure that the most recent statutory, regulatory and national policy is referenced in the document. This incudes, for example, adding references to the Health and Social Care Act 2012, the Bribery Act 2010, the Equality Act 2010, the Data Protection Act 2018, and the 2017 NHS England guidance on *Managing Conflicts of Interest in the NHS* which superseded the previous 1993 Department of Health Circular, *Standards of Business Conduct for NHS Staff.*

b) To further update the references to the declaration and management of interests in order to ensure these were consistent with the Trust's Constitution and the Trust's Policy on Managing Interests in the NHS and the 2017 NHS England Guidance;

c) To update the section of the Standing Orders dealing with the Committees that are established by the Trust Board to include the Quality and Safety Committee, the Finance and Investment Committee, the Workforce and Education Committee and Trust Executive Committee. Previously, these had not been reflected in the SOs, although the Commercial Board was referenced, and this is now proposed for deletion given that it was disbanded some time ago. Reflecting this, changes are proposed to the Reservation and Delegation of Powers to ensure that where these Committees are referenced, the references are in

line with their purpose as set out in their respective terms of reference, as agreed by the Board.

d) To update the Reservation and Delegation of Powers to make clear the processes by which Trust-wide policies are approved. Previously these provided that authority for approving such policies was delegated to the Policy Ratification Group. This Group was disbanded over three years ago and was not replaced. The change proposes that authority is delegated to the Trust Executive Committee which shall make appropriate arrangements for the approval of Trust-wide policies and guidance as required, unless Board approval is required or the matter is reserved under the SOs and SFIs to the Board or one of its sub-Committees;

e) To add further rigour to the arrangements for sealing documents and the reporting thereof to the Board;

f) To include a number of updates to outdated terminology, including replacing references to the NHS Litigation Authority with NHS Resolution;

g) To reflect current practice with regards to delegations assigned to members of the executive team (e.g. maintenance and oversight of the risk register is undertaken by the Chief Nurse);

h) To reference the new titles of certain Executive Directors following the changes made following the June 2019 Board meeting.

i) To add clarity to the references to “members”, making clear that such references are to members of the Board of Directors, rather than members of the Foundation Trust.

3.3 The Audit Committee considered the above amendments at its meeting on 1 August 2019 and agreed to recommend these to the Board subject to the following amendments to the text, all of which have been actioned and are reflected in the attached document:

- To set out the role of the newly established position of Deputy Chief Executive in the Reservation and Delegation of Powers (page 37). This has been included in the updated section, with the role-specific elements mirroring the role description as approved by the Nomination and Remuneration Committee in February 2019.

- To cross check the explanation of the role of the Audit Committee as expressed in the SFIs with the amended Audit Committee terms of reference (page 65). This has been completed, and the wording around the role of the Audit Committee has been cross checked with the latest version of the terms of reference, with amendments made as necessary.

- To update the hyperlink in the guidance on Reverse e-Auction (page 63). A new hyperlink has been inserted.

3.4 The Audit Committee also asked for clarification as to whether the Trust currently had in place liability insurance for Directors as provided for under the SOs, RDP and SFIs. Directors’ liability is covered under NHS Resolution’s Liabilities to Thurd Parties Scheme. The Trust is a

member of both the Clinical Negligence Scheme for Trusts (for clinical claims) and Liabilities to Third Parties (for non-clinical claims).

3.5 A track changed version of the document setting out the changes proposed is set out in Appendix 1.

3.6 The suggested changes ensure that the SFOs, RDP and SFIs remain fit for purpose until the next Annual Review.

4.0 COMMUNICATIONS PLAN

4.1 Given the importance of the SOs, RDP and SFIs as key components of the Trust's corporate governance structure and processes, we have developed a communication plan to ensure that the updated document is communicated effectively across the organisation. All Executive and Non-Executive Directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions. The key elements of the communication plan are:

a) Publication of the SOs, RDP and SFIs on the Policy Hub;

b) Communication via the regular policy update in eG St George's;

c) A news story in eG St George's to bring some of the provisions to life in a more meaningful way for staff.

d) A 2-3 page summary document will be published setting out for staff the key elements of the SOs, RDP and SFIs about which they need to be aware.

4.2 The new Scheme of Delegation will be implemented as part of the project to upgrade our financial system. We are currently upgrading the Trusts financial system – Agresso to the latest version. Communications have gone out regarding this. As part of the final phase of the project we will updating the system with the new scheme of delegation. Therefore the new scheme of delegation will go live at the beginning of quarter four, January 2020. Communications will be going out regarding this before this so all staff are aware of the impact of the changes to the approval levels.

4.3 Some minor formatting issues with the document will be addressed prior to publication. These are not material in nature.

5.0 RECOMMENDATION

5.1 The Board is asked to:

- Review the proposed amendments to the revised Standing Orders, Reservation and Delegation of Powers, and Standing Financial Instructions
- Agree the proposed changes
- Note the plans for communicating the updated SOs, RDP and SFIs across the organisation

St George's University Hospitals NHS
NHS Foundation Trust

Standing orders, reservation and delegation of powers and standing financial instructions 20198-201920

5.1

Profile	
Version:	1.8
Author:	Chief Corporate Affairs Officer
Executive/Divisional sponsor:	Chief Corporate Affairs Officer
Applies to:	All Trust staff
Date issued:	
Review date:	August 2020
Approval	
Approval person/Committee:	Board
Date:	

St George's University Hospitals NHS
NHS Foundation Trust

Document History			
Version	**Date**	**Review date**	**Reason for change**
1.2	March 2010	March 2011	Routine review
1.4	June 2012	June 2013	Amendments to reflect changes to board sub-committee structure and executive team
1.5	May 2014	May 2015	Routine review and update Schedule A Limits per Scheme of Delegation
1.6	September 2015		Lowering of financial authorisation limits in Schedule A for budget holders. Minor changes to reflect Foundation Trust status New clause on borrowing drawdowns.
1.7	March 2018	March 2018	Routine review and update of SFIs and SOs. Increase of financial authorisation limits in Schedule A as approved by the audit committee and implemented in March 2018. SOs updated to reflect the organisation's new governance structure following its authorisation as an NHS Foundation Trust in February 2015.
1.8	July 2019	September 2019	Internal review of SOs and SFIs. Key changes: - Update references to legislation and guidance - Update references to the management of declarations of interest to bring them into line with the 2017 NHS England guidance - Include reference to the full range of sub-Committees of the Board - Insert reference to the Deputy CEO role in line with the role description as agreed by the Nomination and Remuneration Committee in February 2019 - Update the process by which Trust-wide policies are approved - Add further rigour to the process for using the Trust Seal - Update out-dated terminology - Reflect current practice in delegations to Executives - Reference new Executive job titles

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or ~~Director of~~ Chief Corporate Affairs Officer).

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, National Health Service Act 2006 (as amended), Health and Social Care Act 2012 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means St George's University Hospitals NHS Foundation Trust.

1.2.3 **"Board"** means the Chairman, officer and non-officer members of the Trust collectively as a body.

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.5 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.6 **"Chairman of the Board (or Trust)"** is the person appointed by the Trust's Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

1.2.7 **"Chief Executive"** means the chief officer of the Trust.

1.2.8 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.9 **"Committee"** means a committee or sub-committee of the Board created and appointed by the ~~Trust~~Board.

1.2.10 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

1.2.11 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.13 **"Director of Finance"** means the Chief Financial Officer of the Trust.

1.2.14 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.
(A separate organisation, the St Georges Charitable Foundation (renamed in 2007 the St George's Hospital Charity) was established in April 2001 to administer the charitable funds raised by St Georges. It took over the funds held by the St George's Hospital Special Trustees Charitable Fund of which the Trust was Trustee. As such the Trust now has no charitable funds and therefore there are no governance requirements. – see SO 4.8.3)

1.2.15 **"Member"** means officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chairman. The term, as used in this document, does not refer to the membership of the Foundation Trust.

1.2.16 **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.2.17 **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

1.2.18 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.19 **"Non -officer Member"** means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

1.2.20 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.21 **"Officer Member**" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

1.2.22 **"Quality and Safety Committee"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which the Trust has responsibility.

1.2.23 **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance. In the absence of a Trust Secretary, this reference should be read as the ~~Director of~~ Chief Corporate Affairs Officer.

1.2.24 **"SFIs"** means Standing Financial Instructions.

1.2.25 **"SOs"** means Standing Orders.

1.2.25 **"Vice-Chairman"** means the non-officer member appointed by the Board to take on the Chairman's duties if the Chairman is absent for any reason.

St George's University Hospitals NHS
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SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

St George's University Hospitals NHS Foundation Trust is a statutory body which came into existence in 2015.

(1) The principal place of business of the Trust is Blackshaw Road, Tooting, London SW17 0QT. The Trust also operates services from Queen Mary's Hospital, Roehampton Lane, London SW15 5PN, St John's Therapy Centre, 162 St John's Hill, London SW11 1SW, the Nelson Health Centre, Kingston Road, London SW20 8DB, and HMP Wandsworth, London SW18 3HS.

(2) NHS Foundation Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995 and the Health Act 1999 and the National Health Service Act 2006 and the Health and Social Care Act 2012.

(3) The functions of the Trust are conferred by this legislation.

(4) As a statutory body, the Trust has specified powers to contract in its own name.

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

(6) The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

(1) In addition to the statutory requirements, the NHS Improvement and the Care Quality Commission may, within their powers under relevant legislation, issue guidance to Trusts.

(2) The Foundation Trust Code of Governance requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The Code, as well as the Trust's Constitution, also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code and the Trust's Constitution make various requirements concerning possible conflicts of interest of Board members and how these should be handled.

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS. Further requirements in relation to openness are set out in the Trust's Constitution.

1.3 The Trust Constitution and Delegation of Powers

(1) The Constitution of the Trust sets out the organisation's principal purpose, powers and governance arrangements. These provisions include the composition, duties and working arrangements of the Council of Governors and the Board of Directors, and provisions relating to the membership of the Trust and the Annual Members' Meeting. Under the Constitution, the Trust also has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. The Constitution incorporates the Standing Orders for the Council of Governors (Annex 6: Standing Orders for the Practice and Procedure of the Council of Governors), and the Standing Orders for the Board of Directors (Annex 7: Standing Orders for the Practice and Procedure of the Board of Directors). The Standing Orders for both the Council of Governors and the Board of Directors provide for each to establish and adopt additional protocols and procedures for their respective operation and for the economic, effective and efficient operation of good governance of the Trust generally. These additional protocols and procedures are set out in the Standing Orders detailed in this document. Should any conflict exist between the provisions of these Standing Orders and those of the Constitution, it is the Constitution that takes precedence.

(2) Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit. Delegated Powers are set out in Section C of this document. This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2. COUNCIL OF GOVERNORS

2.1 Composition, election and tenure of the Council of Governors

The Constitution of the Trust sets out provisions relating to the composition of the Council of Governors (paragraph 12 and Annex 3), the rules governing the election of governors (paragraph 13 and Annex 4), the tenure of governors (paragraph 14), and rules governing disqualification and removal of governors (paragraph 15). The provisions set out below do not replicate this information and set out only those provisions relating to the practice and procedure of the Council of Governors as stated in the Constitution.

2.2 Duties of governors

(1) The general duties of the Council of Governors are:

(a) To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and

(b) To represent the interests of the members of the Trust as a whole and the interests of the public.

(2) The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

2.3 Meetings of the Council of Governors

(3) Admission of the public and the press. All meetings of the Council of Governors are to be open to members of the public unless two thirds of the members of the Council of Governors present decide otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or other special reasons. The Chairman may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

(4) Calling and notice of meetings:

(a) The Council of Governors is to meet a minimum of four (4) times in each financial year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days' written notice of the date and place of every meeting of the Council of Governors to all governors. Notice will also be published on the Trust's website and in the Trust's membership newsletter if applicable.

(b) Meetings of the Council of Governors may be called by the Secretary, the Chairman, or by five (5) governors (including at least two (2) elected governors and two (2) appointed governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all governors as soon as possible after receipt of such a request and will call a meeting on at least fourteen, but not more than twenty eight, days' notice. Notice by post, delivery in person, fax or email shall constitute written notice.

(5) Chair of the meeting: In accordance with paragraph 17 of the Trust's Constitution, the Chairman of the Board of Directors or, in his/her absence, the deputy chairman of the Board of Directors, shall preside at meetings of the Council of Governors. If the Chairman and deputy chairman are absent, or are disqualified from participating, then the governors shall choose by majority which public governor present shall preside for that part of the meeting.

(6) Quorum: No business shall be transacted at a meeting of the Council of Governors unless at least one third of the Council of Governors is present, a majority of whom must be public governors.

(7) Voting:

(a) Questions arising at a meeting of the Council of Governors shall be decided by a majority of votes. In case of an equality of votes the person presiding at or chairing the meeting shall have a casting vote.

(b) Members of the Council of Governors may participate in meetings by telephone, teleconference, video or computer link, and participation in a meeting in this manner shall be deemed to constitute a presence in person at the meeting. In such cases, if a person attends the meeting by telephone, teleconference, video or computer link, then such person shall be able to cast their vote verbally (such verbal vote to be recorded in the minutes).

(8) Committees: The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees to assist the Council of

Governors in carrying out its functions. The Council of Governors may appoint governors and may invite directors and other persons to attend and advise committees. The Council of Governors may, through the Secretary, request that external advisors assist them or any committee they appoint in carrying out its duties. Such committees established by the Council of Governors may meet in private for reasons of commercial confidentiality or other special reason if the members of the committee so decide.

(9) Confidentiality: In the event of the Council of Governors, or any committee established by the governors, meeting in private for all or part of a meeting, governors shall not disclose outside of the Council of Governors meetings the contents of the papers, discussions or minutes of the items taken in private.

2.4 Disclosure of interests

(1) Governors shall declare any pecuniary, personal or family interest, whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors. A family interest will include but is not limited to those of a governor's spouse or partner. Any governors appointed subsequently shall declare such interests on appointment or election. Such interests include:

(a) Directorships, including non-executive directorships held in private companies, public limited companies or public benefit corporations (with the exception of those of dormant companies);

(b) Ownership or part-ownership of private companies, businesses or consultancies known as being likely or possibly seeking to do business with the NHS;

(c) Majority or controlling shareholdings in organisations known as being likely or possibly seeking to do business with the NHS;

(d) A position of trust or fiduciary duty in a charity or voluntary organisation in the field of health and social care;

(e) Any connection with a voluntary or other organisation contracting for NHS services; or

(f) Any commercial interest in the decision before the meeting.

(2) The following shall not be treated as interests:

(a) An employment contract with the Trust held by a staff governor;

(b) An employment contract with a local authority held by a local authority governor;

(c) An employment contract with a partnership organisation held by a partnership governor.

2.5 Declaring interests

(1) At the time governors' interests are declared, they shall be recorded in the Council of Governors' minutes and entered on a register of interests of governors to be

maintained by the Secretary. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

(2) During the course of a Council of Governors meeting, if a conflict of interest is established, the governor concerned shall disclose the fact, and withdraw from the meeting and play no part in the relevant discussion or decision.

(3) If a governor has any doubt as about the relevance of an interest, he/she should discuss it with the Chairman or Secretary who shall advise him/her on whether or not to disclose the interest.

2.6 Code of Conduct

(1) All members of the Council of Governors are required to comply with any Code of Conduct for governors adopted from time to time by the Council of Governors or the Board of Directors.

3. BOARD OF DIRECTORS

3.1 General duty of the Board of Directors

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.

3.2 Appointments to the Board of Directors

(1) Appointment of the Chairman and Non-Executive Directors: The governors at a general meeting of the Council of Governors shall, subject to other provisions of the Constitution, appoint or remove the Chairman of the Trust and the other Non-Executive Directors. Any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with any procedures the Board of Directors may approve from time to time.

(2) Appointment of the Chief Executive and other Executive Directors: The Chief Executive is appointed by the Non-Executive Directors subject to the approval of the Council of Governors. A committee consisting of the Chairman, the Chief Executive and other Non-Executive Directors shall appoint the other Executive Directors.

(3) Appointment and powers of the Deputy Chairman: The governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors to be Deputy Chairman of the Board of Directors. If the Chairman is unable to discharge his/her functions as Chairman of the Trust for whatever reason, the Deputy Chairman of the Board of Directors shall be Acting Chairman of the Trust.

(4) The Board of Directors comprises:

(a) a Non-Executive Chairman;

(b) Six other Non-Executive Directors, one of whom is the Deputy Chairman; and

(c) Four Executive Directors, which must include the Chief Executive (who is also the Accounting Officer), the Chief Financial Officer, the Medical Director, and the Chief Nurse.

(5) The Board may appoint additional Directors as non-voting members of the Board.

3.3 Removal of members of the Board of Directors

(1) Removal of Chairman and Non-Executive Directors: Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

(2) Removal of the Chief Executive: The Non-Executive Directors may remove the Chief Executive.

(3) Executive Directors: A ~~panel~~ Committee consisting of the Chairman, the Chief Executive and the other Non-Executive Directors may remove other Executive Directors.

3.4 Role of Members of the Board of Directors

The Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) **Chief Financial Officer**

The Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to ~~its members~~ members of the Board and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) **Non-Executive Members**

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise collective authority when acting as members of, or when chairing, a committee of the Trust which has delegated powers.

(5) **Chairman**

The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive

powers. The Chairman must comply with the terms of appointment, the provisions of the Trust's Constitution, and with these Standing Orders.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that the Board discusses key and appropriate issues in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

3.5 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

3.6 Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers that it has delegated to officers and other bodies are contained in the Scheme of Delegation.

3.7 Meetings of the Board

(1) **Calling and notice of meetings**:

(a) Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days' written notice of the date and place of every meeting of the Board of Directors to all directors.

(b) Meetings of the Board of Directors may be called by the Secretary, the Chairman, or by two or more directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all directors as soon as possible after receipt of such a request and shall call a meeting on at least fourteen but not more than twenty eight days' notice.

(2) **Chair of the meeting**:

(a) At any meeting of the Board of Directors, the Chairman of the Board of Directors, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he/she is present, shall preside. If the Chairman and Deputy Chairman are absent, then the Non-Executive Directors present shall choose which Non-Executive Director present shall preside.

(b) If the Chairman is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chairman, if present shall preside. If the Chairman and Deputy Chairman are absent, or are disqualified from participating, then the

remaining Non-Executive Directors present shall choose which Non-Executive Director shall preside.

(3) **Frequency of meetings:** Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

(4) **Notice of business to be transacted:**

(a) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be circulated electronically to every member so as to be available to members at least six clear calendar days before the meeting. The notice shall be approved by the Chairman or by an officer authorised by the Chairman to approve on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(b) In the case of a meeting called by Board members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(c) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.7(10).

(d) A Board member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman and Secretary at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

(e) Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)) and published on the Trust's website.

(5) **Agenda and supporting papers:** The Agenda will be sent to members 6 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be circulated no later than three clear days before the meeting, save in emergency or, where the Chairman proposes and at least half of the Board members in attendance agree, the papers presented require immediate consideration. A copy of the agenda will be provided to the Council of Governors in line with the requirements of the Trust's Constitution.

(6) **Quorum**:

(a) No business shall be transacted at a meeting unless at least one third of the directors is present including not less than one non-executive director and one executive director.

(b) An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

(c) If the Chairman or other Board member has been disqualified from participating in the discussion on any matter and / or from voting on any resolution by reason of a conflict of interest, that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and / or the passing of a resolution on any matter, that matter may not be discussed further or voted

upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

(7) **Voting**:

(a) Questions arising at a meeting of the Board of Directors shall be decided by a majority of votes. In the case of an equality of votes the person presiding at or chairing the meeting shall have the casting vote.

(b) Save as provided in Standing Order 3.8 (Suspension of Standing Orders) and 3.9 (Variation and amendment of Standing Orders), every question put to a vote at a meeting shall be determined by a majority of the votes of Board members present and voting on the question.

(c) At the discretion of the Chairman, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(d) If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(e) If a Board member so requests, their vote shall be recorded by name.

(f) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

(g) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(h) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

(8) **Petitions:** Where a petition has been received by the Trust the Chairman shall include the petition as an item for the agenda of the next meeting.

(9) **Notice of motion**:

(a) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

(b) The notice shall be delivered at least 15 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

(10) **Emergency motions**: Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting',

a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

(11) **Motions – Procedure at and during a meeting**:

a) Who may propose: The Chairman of the meeting or any Board member present may propose a motion. Another Board member must also second it.

b) Contents of motions: The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

c) **Amendments to motions:** A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

d) **Rights of reply to motions**:

i. Amendments: The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

ii. Substantive / original motion: The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

e) **Withdrawing a motion:** A motion, or an amendment to a motion, may be withdrawn.

f) **Motions once under debate**: When a motion is under debate, no motion may be moved other than:

i. an amendment to the motion;
ii. the adjournment of the discussion, or the meeting;
iii. that the meeting proceed to the next business;
iv. that the question should be now put;
v. the appointment of an 'ad hoc' committee to deal with a specific item of business;
vi. that a member/director be not further heard;
vii. a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

(12) **Motion to Rescind a Resolution**:

(a) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Board member who gives it and also the signature of three other Board members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(b) When any such motion has been dealt with by the Trust Board it shall not be competent for any ~~director/~~Board member other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

(13) **Chairman's ruling**: The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

(14) **Record of attendance**: The names of the Chairman and ~~Directors/~~Board members present at the meeting shall be recorded.

3.8 Suspension of Standing Orders

(a) Except where this would contravene any statutory provision or the rules relating to the Quorum (SO 3.7(6)), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(b) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and Board members of the Trust.

(c) No formal business may be transacted while Standing Orders are suspended.

(d) The Audit Committee shall review every decision to suspend Standing Orders.

3.9 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 3.7(9);

- upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision.

3.10 Minutes of Board meetings

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.11 Admission of public and the press

(a) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all meetings of the Trust Board, but shall be required to withdraw upon instruction of the Trust Board as follows:

- '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', Section 1 (2), Public Bodies (Admission to Meetings) Act l960
- Guidance should be sought from the NHS Foundation Trust's Freedom of Information Lead to ensure the correct procedure is followed on matters to be included in the exclusion.

(b) **General disturbances**

The Chairman (or Vice-Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

- 'That, in the interests of public order, the meeting adjourns for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence', 'Private' or minutes headed 'Confidential' or 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the ~~Trust~~Board.

3.12 Observers at Board meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES OF THE BOARD OF DIRECTORS

4.1 Appointment of Committees

(a) Subject to the provisions of the Trust's Constitution, the Board of Directors may delegate any of its powers to a committee whose membership is composed entirely of directors or to an executive director.

(b) The Board of Directors shall have various committees which will advise it, including an ~~a~~Audit ~~c~~Committee, a ~~Board of Directors n~~Nominations and Remuneration C~~c~~ommittee ~~and a Board of Directors remuneration committee~~. For the avoidance of doubt, a nominations committee shall only perform an advisory role to the Board of Directors in relation to a selection process and it shall not be responsible for making any appointments.

(c) Each such committee, and any sub-committee, shall have such terms of reference and powers as the Board of Directors shall determine from time to time. The Trust shall determine the membership of such committees and sub-committees and shall, if it requires, receive and consider reports of such committees.

4.2 Joint Committees

(i) Joint committees may be appointed by the Trust by joining together with one or more other Trusts consisting of, wholly or partly, the Chairman and Board members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

Any committee or joint committee appointed under this Standing Order may, subject to the requirements of the Trust's Constitution or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who

are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term "Chairman" is to be read as a reference to the Chairman of ~~other~~ the committee as the context permits, and the term "member" is to be read as a reference to a member of ~~other~~ the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or provision set out in the Trust's Constitution. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Board members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Constitution of the Trust. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with any provision set out in the Trust's Constitution and with the Foundation Trust Code of Governance.

4.8 Committees established by the Trust Board

The committees, sub-committees, and joint-committees established by the Board are:

4.8.1 **Audit Committee**

In line with the requirements of the Trust's Constitution (at paragraph 40), an Audit Committee will be established, comprised of Non-Executive Directors. It will ~~and constituted to~~ provide the Trust Board with an independent and objective review of ~~review on its~~ financial and corporate governance, assurances processes and riak management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. ~~systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on~~

~~a periodic basis.~~ It shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance. The Committee shall also review the integrity of the financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board. The duties of the Committee are to:

(i) Review the establishment and maintenance of an effective system of integrated governance, internal control and risk management;
(ii) Ensure there is an effective internal audit function that meets mandatory standards and provides independent assurance to the Committee;
(iii) Review the findings of the external auditors and consider the implications and management's response to their work;
(iv) Ensure the systems for financial reporting to the Board are subject to review as to the completeness and accuracy of the information provided to the Board;
(v) Ensure the Trust has in place effective measures to comply with requirements of the Bribery Act 2010 and a means by which suspected acts of fraud, corruption and bribery can be reported;
(vi) Review arrangements that allow staff to raise, in confidence, concerns;

~~The Foundation Trust Code of Governance requires a minimum of three non-executive directors be appointed, of which one must have significant, recent and relevant financial experience.~~

4.8.2 **Nominations and Remuneration Committee**

In line with the requirements of the ~~–~~Trust's Constitution, a Nominations and Remuneration Committee will be established and constituted.

The Trust's Constitution (at paragraph 35.2) requires~~d~~ the Committee be comprised exclusively of Non-Executive Directors who are independent of management.

The purpose of the Committee will be to advise the Trust Board about appropriate remuneration, allowances and terms of service for the Chief Executive and other Executive Directors including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms.

4.8.3 **Quality and Safety Committee**

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

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

4.8.4 **Finance and Investment Committee**

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

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

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4.8.5 **Workforce and Education Committee**

The Board has established a Workforce and Education Committee. The purpose of the Committee, as aligned with the Trust's strategic objectives, is to oversee the development of an empowered workforce that is both modern and flexible, with a culture that supports people to deliver to their best. The Committee is established to provide the Board with assurance that there are robust mechanisms in place to ensure:

(i) Robust oversight of the delivery of the Trust's strategic aims in relation to its workforce;
(ii) Detailed consideration is given to the development and delivery of the Trust's workforce and education strategies;
(iii) Effective oversight of the delivery of the Trust's diversity and inclusion strategy, and monitoring of performance in relation to the Workforce Race Equality Standard and the gender pay gap

(iv) Effective oversight and monitoring of workforce planning;
(v) Adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies;
(vi) The impact of workforce performance on the Trust's overall performance is closely monitored;
(vii) Staff well-being and development is monitored effectively;
(viii) Appropriate governance arrangements are in place in relation to workforce and education issues.

4.8.6 **Trust Executive Committee**

The Board has established the Trust Executive Committee, which serves as the most senior Executive decision-making forum in the Trust.

~~4.8.3 **Trust and Charitable Funds Committee**~~

~~A separate organisation, the St George's Charitable Foundation (renamed in 2007 the St George's Hospital Charity) was established in April 2001 to administer the charitable funds raised by Trust. It took over the funds held by the St George's Hospital Special Trustees Charitable Fund of which the Trust was Trustee. As such the Trust now has no charitable funds and therefore there are no governance requirements on the Trust Board in relation to the Charity.~~

4.8.4 **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 In accordance with the Trust's Constitution, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of Trusts to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:

(i) by another Trust;

(ii) jointly with any one or more of the following: NHS Foundation Trusts, NHS Trusts, or Clinical Commissioning Groups;

(iii) by arrangement with the appropriate Trust or Clinical Commissioning Group, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with the Trust's Constitution. The Board, in respect of its sub-committees, shall approve the constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall

determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or regulatory requirements. Outside these statutory and regulatory requirements the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the Audit Committee for action or ratification. All employees of the Trust have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board, or Committees or groups to which authority is delegated, will from time to time agree and approve Policy statements and / or procedures that will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute, or in the minutes of the Committee or group to which authority for approving such statements or procedures is delegated, and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the ~~'Standards of Business Conduct' and~~ 'Managing Conflicts of Interests' policies for the Trust staff;
- the staff 'Disciplinary Procedure and Rules' and 'Appeals Procedure' adopted by the Trust, both of which shall have effect as if incorporated in these Standing Orders.

- Anti-fraud and anti-bribery policy.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the ~~the~~ Trust's Constitution and the following statutory requirements, guidance and any other regulatory requirement:

- All relevant legislation relating to the NHS, including but not limited to the National Health Service Act 2006 (as amended) and the Health and Social Care Act 2012
- Caldicott Guardian 2006~~;~~
- Data Protection Act 2018
- Anti-Bribery Act 2010
- Anti-Money Laundering Act 2018
- Freedom to Speak Up Guardian
- Guardian of Safe Working
- Equality Act 2010~~;~~
- NHS Foundation Trust Code of Governance
- Freedom of Information Act 2000~~.~~

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 **Requirements for Declaring Interests and applicability to Board Members**

(a) The Trust's Constitution requires directors to declare any pecuniary, personal or family interest, whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors. A family interest will include those of a director's spouse or partner. Any directors appointed subsequently shall declare such interests on appointment.

(b) Such interests include:

i. Directorships, including Non-Executive Directorships held in private companies or public limited companies or public benefit corporations (with the exception of those of dormant companies);

ii. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

iii. Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

iv. A position of trust or fiduciary duty in a charity or voluntary organisation in the field of health and social care;

v. Any connection with a voluntary or other organisation contracting for NHS services;

vi. Research funding/grants that may be received by an individual or their department;

vii. Interests in pooled funds that are under separate management.

viii. Any other commercial interest in the decision before the meeting.

(c) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust Secretary as soon as practicable.

(d) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a Board member of the Trust.

7.1.2 **Definition of terms used in interpreting 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing including purchase orders.

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither he/she nor any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

Any remuneration, compensation or allowance payable to the Chairman or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.1.3 **Declaring interests**

(a) At the time directors' interests are declared, they should be recorded in the Board of Directors' minutes and entered on a register of interests of directors to be maintained by the Secretary. Any changes in interests should be declared at the next Board of Directors' meeting following the change occurring.

(b) During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned shall disclose the fact, and withdraw from the meeting and play no part in the relevant discussion or decision.

(c) If a director has any doubt about the relevance of an interest, he/she should discuss it with the Chairman or Secretary who shall advise him/her on whether or not to disclose the interest.

7.1.4 **Publication of declared interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report, in line with any specific guidance set out by NHS Improvement. The information should be kept up to date for inclusion in succeeding annual reports.

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.1(b)) which have been declared by both executive

and non-executive Trust Board members. This responsibility is delegated to the Trust Secretary.

7.2.2 These details will be kept up to date as interests are declared~~by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated~~.

7.2.3 The Register will be available to the public ~~and the Trust Secretary will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it~~in line with the requirements of the Trust's Constitution (Section 37).

7.3 Standards of Business Conduct

7.3.1 **Trust Policy and National Guidance**

All Trust staff and Board members must comply with the Trust's Constitution in relation to conflicts of interest and with the Foundation Trust Code of Governance (see SO 6.2).

7.3.2 **Interest of Officers in Contracts**

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.3.3 **Canvassing of and Recommendations by Board Members in Relation to Appointments**

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.3.4 **Relatives of Members or Officers**

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any Board member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

ii) The Chairman and every Board member and officer of the Trust shall disclose to the Trust Board any relationship between himself/herself and a candidate of whose candidature that Board member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Board member or holder of any office under the Trust.

iv) Where the relationship to a Board member of the Trust is disclosed, the Standing Order headed 'Disability of Chairman and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager (Trust Secretary) by him/her in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of the Chief Executive, and Chair, where appropriate, or two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them, where this is necessary. Use of the Trust Seal shall be reported to the Board, unless otherwise delegated to a Committee under the Reservation and Delegation of Powers and Scheme of Delegation.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her (Trust Secretary), shall enter a record of the sealing of every document. The register shall record the date on which the Seal was used, the purpose for which it was used, and those officers who signed and witnessed its use.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

(a) MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 **Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board

may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C – RESERVATION and DELEGATION of POWERS

DUTIES AND RESPONSIBILITIES RESERVED TO THE COUNCIL OF GOVERNORS

1. **Performance of the Board of Directors**
   The Council of Governors is responsible for holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. ~~The Foundation Trust Code of Governance makes clear that t~~This includes ensuring that the Trust does not breach the conditions of its licence.

2. **Appointments and removal of Non-Executive Directors**
   The Council of Governors is responsible for the appointment of the Chairman of the Board of Directors and the other Non-Executive Directors including a Deputy Chairman. The power to remove the Chairman or another Non-Executive Director rests with the Council of Governors, and such removal requires the approval of three-quarters of the members of the Council of Governors.

3. **Appointment and removal of external auditors**
   The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

4. **Amendment of changes to the Trust's Constitution**
   The Trust may make amendments to its Constitution only if more than half of the members of the Council of Governors of the Trust voting approve the amendments (with more than half of the Board of Directors also voting to approve the amendment).

5. **Approval of mergers etc.**
   The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

6. **Approval of significant transactions**
   The Trust may enter into a significant transaction only if half of the members of the Council of Governors of the Trust voting approve entering into the transaction. A significant transaction is defined in the Trust's Constitution (paragraph 46.3).

DUTIES AND RESPONSIBILITIES RESERVED TO THE BOARD OF DIRECTORS

The Board of Directors is collectively responsible for the performance of the Trust and is subject to a general duty:
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.

The Board of Directors has six key functions:

- ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;
- appoint, appraise and remunerate senior executives;
- ~~ratify~~ set the strategic direction of the organisation ~~within the overall policies and priorities of the Government and the NHS~~in the context of the national and NHS policy framework and local system priorities, define its annual and longer term strategic objectives and agree plans to achieve them;
- oversee the delivery of planned results by monitoring performance against objectives and

ensuring corrective action is taken when necessary;
- ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

The NHS Foundation Trust Code of Governance identifies the following duties of the Board, to:

- provide entrepreneurial leadership of the NHS foundation trust within a framework of prudent and effective controls, which enables risk to be assessed and managed;
- be responsible for ensuring compliance by the Trust with its licence, constitution, mandatory guidance, relevant statutory requirements and contractual obligations
- develop a clear vision for the Trust
- set the Trust's strategic aims at least annually, taking into consideration the views of the Council of Governors
- ensure that necessary financial and human resources are in place for the Trust to meet its priorities and objectives
- ensure the quality and safety of health care services, education, training and research delivered by the Trust
- ensure the Trust functions effectively, efficiently and economically
- set the Trust's vision, values and standards of conduct and ensure that its obligations to its members are understood, clearly communicated and met
- act in the best interests of the Trust and avoid conflicts of interest.

The Board has reserved the following responsibilities for itself:

1. General Enabling Provision

- The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. (SOs 3.6)

~~**DUTIES AND RESPONSIBILITIES RESERVED TO THE BOARD**~~

2. Regulations and Control

- Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.
- Suspend Standing Orders. (SOs 3.8)
- Vary or amend the Standing Orders. (SOs 3.9)
- Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2
- Approve Board-level governance structures. (SO 4, SFIs 33.1)
- Where appropriate, approve proposals from the Quality and Safety, for ensuring quality and developing clinical governance in services provided by the Trust.
- Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks (where discretion is allowed) on the recommendation of the Chief Financial Officer. Decisions to self-insure should be reviewed on a periodic basis. (SFIs 33.2)
- Approve a scheme of delegation of powers from the Board to committees. (SOs 4.1, 4.5, SFIs 10.2.2)
- Approve terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. (SOs 4.1, 4.4)
- Receive reports from committees including those that the Trust is required by its Constitution or regulation to establish and to take appropriate action. (SOs 4.4)
- Consider recommendations from the Trust's committees where the committees do not have executive powers.
- Require and receive the declaration of Board members' interests that may

conflict with those of the Trust and determining the extent to which that Board member may remain involved with the matter under consideration. (SOs 7.1)

- Require a register of declaration of officers' interests that may conflict with those of the Trust. (SOs 6.2, 7.2, 7.3 and SFIs 21.2.6, 30)

3. Appointments/ Dismissal

- Appoint and dismiss committees (and individual members) that are directly accountable to the Board. (SOs 4.1)
- Appoint~~ment~~ a Nominations and Remuneration Committee (SOs 4.8.2 & SFIs 20.1)
- Receive recommendations from the Nominations and Remunerations Committee regarding the discipline and, if necessary, dismissal of Executive Directors (SOs 4.8.2).
- Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Nominations and Remuneration Committee. (SFIs 20.1.4)

~~**DUTIES AND RESPONSIBILITIES RESERVED TO THE BOARD**~~

4. Strategy, Plans and Budgets

- Define the strategic aims and objectives of the Trust.
- Approve the budget strategy of the Trust, including the capital programme. (SFIs 10.2.1)
- Authorise the Chief Executive and Chief Financial Officer (and their deputies in their absence) to make short-term borrowings on behalf of the Trust. (SFIs 22.1.2)
- Approve business cases in accordance with the financial threshold set out in Schedule A Summary Financial Limits
- Approve Outline Business Cases (OBC), Strategic Outline Cases (SOC) and Final Business Cases, in accordance with delegated limits, set out in Schedule A. (SFIs 13.7.2)
- Approve proposals for acquisition, disposal or change of use of land and/or buildings, subject to the Trust delegated limits defined by the Department of Health.
- Recommend approved PFI proposals in accordance with the financial thresholds set out in Schedule A. (SFIs 17.13, 24.2.1)
- Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature in accordance with the financial thresholds set out in Schedule A. (SFIs 17.13, 24.2.1)
- Approve proposals in individual cases for the write-off of losses or making of special payments above for losses and special payments and within limits delegated by the Department of Health and set out in Schedule A.
- Receive reports on approved proposals for action on litigation against or on behalf of the Trust. (SOs 4.8.4)
- Receive reports on reviewed use of NHS Resolution risk pooling schemes (LPST/CNST/RPST), and approve recommendations. (SFIs 33.2)

5. Policy Determination

- Approval of Trust-wide policy~~ies~~ documents is delegated to the ~~Policy Ratification Group~~Trust Executive Committee, which will make appropriate arrangements for the approval of Trust-wide policies and guidance, as required, unless Board approval is statutorily required or the matter is reserved to the Board or its Committees under these Standing Orders and Standing Financial Instructions.

6. Audit

- Appoint an Audit Committee (SOs 4.8.1).
- Receive recommendations from the Audit Committee on appropriate actions arising from Internal and External Audit reports and recommendations.
- Receive the annual Audit Issues Memorandum from the external

auditor and agree the proposed actions, taking account of the advice, where appropriate, from the Audit Committee.

~~**DUTIES AND RESPONSIBILITIES RESERVED TO THE BOARD**~~

7. Annual Reports and Accounts

- Receipt and approval of the Trust's Annual Report and Annual Accounts. (SFIs 14). The Annual Report and Accounts, and any report of the auditor on them, must be presented to the Council of Governors at a general meeting of the Council of Governors and to the members of the Trust at the Annual Members' Meeting.

8. Monitoring

- Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated.
- Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements.

9. Emergency Powers

- The powers which the Board has retained to itself within the Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members. (SOs 5.2)

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
ALL EMPLOYEES	The Trust's Standing Financial Instructions require all staff to: • Comply with national guidance contained in ~~HSG 1993/5 "Standards of Business Conduct for NHS Staff".~~NHS England's Managing Conflicts of Interest in the NHS, which came into force on 1 June 2017 • Inform the Chief Financial Officer of money due from transactions which they initiate/deal with. (SFIs 16.2.3). • Immediately report any discovery or suspicion of loss of any kind to the Local Counter Fraud Specialist, who will inform the Chief Financial Officer. (SFIs 26.2.2) The Standing Orders (7.4) require all staff to: • Comply with national guidance contained in NHS England's Managing Conflicts of Interest in the NHS, which came into force on 1 June 2017~~HSG 1993/5 "Standards of Business Conduct for NHS Staff".~~ • Comply with Standing Orders and Standing Financial Instructions (SFIs). • Comply with Trust's Policy on ~~Standards of Business Conduct.~~Managing Conflicts of Interest in the NHS, which incorporates the national policy which came into effect on 1 June 2017.
ALL MEMBERS OF THE BOARD AND EMPLOYEES	All employees of the Trust, including the Board Members: Have a duty to disclose any non-compliance with the Trust's Standing Financial Instructions to the Chief Financial Officer as soon as possible. (SFIs 10.1.6) Are responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures. (SFIs 10.2.6) Must disclose non-compliance with Standing Orders to the Chief Executive as soon as possible. (SOs 5.6)
AUDIT COMMITTEE CHAIRMAN	The Audit Committee Chairman must bring to the attention of the Board, as soon as possible, where there is evidence of ultra vires transactions or improper acts. (SFIs 11.1.2) Submit a regular report to the Board, including recommendations on appropriate actions arising from Internal and External Audit reports and recommendations

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
BOARD CHAIRMAN	The Foundation Trust Code of Governance identifies the Chairman's role as to: • provide leadership to the Board of Directors; • lead on setting the agenda for the Board of Directors and the Council of Governors and ensure adequate time is available for discussion of all agenda items, in particular strategic risks; • ensure the Board of Directors and Council of Governors work together effectively; • ensure that directors and governors receive accurate, timely and clear information which enables them to perform their duties effectively, including by taking steps to ensure that governors have the skills and knowledge they require to undertake their role; • promote effective and open communication with patients, service users, members, staff, the public and other stakeholders; • promote a culture of openness and debate by facilitating the effective contribution of non-executive directors, in particular and ensuring constructive relations between executive and non-executive directors. The Trust's Standing Orders identify the following duties and responsibilities of the Board Chairman: • Final authority in interpretation of Standing Orders (SOs 1.1). • Chair meetings of the Council of Governors (SOs 2.3(5)) • Chair all meetings of the Board of Directors and associated responsibilities. (SOs 3.4, 3.7(2)) • Give final ruling in questions of order, relevance and regularity of meetings. (SOs 3.7(13)) • Have a second or casting vote. (SOs 3.7(7)(a))
BOARD CHAIRMAN / CHIEF EXECUTIVE	• Authorise use of the Trust seal. (SOs 8.2) • The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members. (SOs 5.2).
BUDGET HOLDERS	Standing Financial Instructions (13.4.2) requires budget holders to ensure: • no overspend or reduction of income that cannot be met from virement is incurred; • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the Chief Financial Officer other than those provided for within available resources and manpower establishment.
DELEGATED TO INDIVIDUALS	**DUTIES AND RESPONSIBILITIES**
CHIEF EXECUTIVE	The NHS Foundation Trust Accounting Officer Memorandum

	(2015)requires the Chief Executive to: • Be accountable as the Trust's NHS Accounting Officer to Parliament for stewardship of Trust resources. (7) • Have responsibility for the overall organisation, management and staffing of the Trust and for its procedures in financial and other matters. • Sign a statement in the Accounts outlining responsibilities as the Accountable Officer. (10) • Sign a statement in the Accounts outlining responsibilities in respect of Internal Control. (10) • Ensure the Trust has effective management systems that safeguard public funds and assist the Trust Chairman to implement the requirements of corporate governance including ensuring managers (12 and 13); • have a clear view of their objectives and the means to assess progress in meeting these objectives; • are assigned well defined responsibilities for making the best use of resources; • have the information, training and access to the expert advice they need to exercise their responsibilities effectively. • Ensure that expenditure by the Trust complies with Parliamentary requirements and avoids waste and extravagance. (16) • If the Chief Executive considers the Board or Chairman is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire. (19) • If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that the Chief Executive is overruled it is normally sufficient to ensure that the Chief Executive's advice and the overruling of it are clearly apparent in relevant Board papers. In such cases, and in those described in paragraph 24, the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting. (21) The Chief Executive is responsible for: • Taking the lead on the evaluation of the executive directors. Advising the Board and the Council and for recording and submitting objections to decisions. The other duties of the Chief Executive as Accountable Officer are laid out in the ~~The~~ NHS Foundation Trust Accounting Officer Memorandum (2015).

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
CHIEF EXECUTIVE (CONTINUED)	The Trust's Standing Financial Instructions identify the following Duties and Responsibilities of the Chief Executive: • Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control. (SFIs 10.2.3) • Agree decisions to involve police in cases of misappropriation and other irregularities not involving fraud or corruption. (SFIs 11.2.1[c])

	• Delegate budget to budget holders, and advise the Chief Financial Officer. (SFIs 13.3.1) • Identify and implement cost improvements and income generation activities in line with the Annual Plan and Budget Strategy. (SFIs 13.4.3) • No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive. (SFIs 17.8.6[iii]) • Will appoint a manager to maintain a list of approved firms. (SFIs 17.8.8) • No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive. (SFIs 17.9.4) • Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services, in accordance with limits set out in Schedule A. (SFIs 18.1.1) • Delegate overall responsibility for control of stores (subject to Chief Financial Officer responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (SFIs 25.2) The Trust's Standing Orders identify the following Duties and Responsibilities of the Chief Executive: • The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion. (SO 5.4)
DEPUTY CHIEF EXECUTIVE	The Chief Executive Officer may delegate functions to the Deputy Chief Executive as appropriate. These include: • Delivery: Integrating target setting, delivery and performance management across the full range of the agenda; quality, performance, workforce and finance. • Organisational development: Coordinating development requirements are identified and agreed, and effective plans developed and implemented. • Support the identification and delivery of transformation plans. • Supporting the flow of information to the Trust Executive Committee to ensure it has effective and timely oversight of key issues. • Support the integration and coordination of risk identification and management into operational reporting and planning. • Coordinate internal planning, linking strategy, tactical performance and improvement.

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DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER	The NHS Foundation Trust Accounting Officer Memorandum (2015) identifies the following joint duties and responsibilities for the Chief Executive and Chief Financial Officer: • Ensure the accounts of the Trust are prepared in accordance with principles and in the format directed by the Secretary of State. The Accounts must disclose a true and fair view of the Trust's financial

	performance for the period and its assets and liabilities at the balance sheet date. (9) • Sign the accounts on behalf of the Board. (9) • Chief Executive, supported by Chief Financial Officer, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness. (18)
CHIEF PHARMACIST	• Responsible for control of pharmaceutical stocks and security arrangements. (SFIs 25.2.1, 25.2.2, 25.2.6)
DEPARTMENTAL MANAGERS	• Inform staff of their responsibilities and duties for the administration of the property of patients. (SFIs 28.6) • Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission. (SFIs 28.2) • As advised by the Chief Financial Officer, provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of. (SFIs 28.3)
DIRECTOR OF ESTATES AND FACILITIES	• Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within "Estatecode". The technical audit of these contracts shall be the responsibility of the relevant Director. (SFIs 21.2.7) • Capital programme (SFIs 24.1.1 & 2): a. establish and Chair a Capital Programme Group, with appropriate membership; b. ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans

DELEGATED TO INDIVIDUALS	**DUTIES AND RESPONSIBILITIES**
DIRECTOR OF ESTATES AND FACILITIES (CONTINUED)	c. responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost, in line with limits set out in Schedule A; d. ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; e. ensure that a business case is produced where applicable in accordance with Schedule A Summary of Financial Limits for Scheme of Delegation f. approve changes in capital budgets, in accordance with limits set out in Schedule A. • Responsible for control of stocks of fuel oil and coal. (SFIs 25.2.1)
CHIEF FINANCIAL OFFICER	• Operational responsibility for effective and sound financial management and information. (Accountable Officer Memorandum)

	• Compile and submit to the Board an annual plan and budget strategy, which takes into account financial targets and forecast limits of available resources. (SFIs 13.1.1) The annual plan and budget strategy will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan. • Approval of all financial procedures. (SFIs 10.1.3) • Advise on interpretation or application of Standing Financial Instructions. (SFIs 10.1.4) • To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions. (SFIs 10.2.4) • (SFIs 10.2.5) Responsible for: o Implementing the Trust's financial policies and co-ordinating corrective action; o Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; o Ensuring that sufficient records are maintained to explain the Trust's transactions and financial position; o Providing financial advice to members of the Board and staff; o Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.

DELEGATED TO INDIVIDUALS	**DUTIES AND RESPONSIBILITIES**
CHIEF FINANCIAL OFFICER (CONTINUED)	• Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply. (SFIs 10.2.7) • Monitor and ensure compliance with the Council of Governors and Board Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist. (SFIs 11.5) • Submit budgets to the Board for approval; Monitor performance against budget; submit to the Board financial estimates and forecasts. (SFIs 13.1.2 & 13.1.3) • Ensure adequate training is delivered on an ongoing basis to budget holders. (SFIs 13.1.6) • Devise and maintain systems of budgetary control. (SFIs 13.4.1) • Preparation of annual accounts and reports. (SFIs 14.1) • Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (SFIs 15.1) (The Board approves the appointment of bankers). • Tendering and contract procedure. • Waive formal tendering procedures, or delegate responsibility as appropriate, within limits set out in Schedule A. (SFIs 17.7.3) • Report waivers of tendering procedures to the Audit Committee. (SFIs 17.7.3) • Where a supplier is chosen that is not NHS Supply Chain (see info@supplychain.nhs.uk) the reason shall be recorded in writing to the Chief Executive. (SFIs 17.7.5) • Shall ensure that appropriate checks are carried out as to the

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
~~CHIEF FINANCIAL OFFICER (CONTINUED)~~	technical and financial capability of those firms that are invited to tender or quote. (SFIs 17.8.9) • The Chief Financial Officer shall nominate an officer who shall oversee and manage contracts on behalf of the Trust. (SFIs 17.14) • Ensure that regular appropriate statements are provided to the Board detailing actual and forecast income from the SLA. (SFIs 18.4) • Payroll (SFIs 20.4.1 and 20.4.2): o specifying timetables for submission of properly authorised time records and other notifications; o final determination of pay and allowances, as advised by the Human Resources Department; o ensuring that payments are made on agreed dates; o agreeing method of payment; o issuing instructions (as listed in SFI 10.4.2). • Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies. (SFIs 20.4.4) • Determine, and set out, level of delegation of expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. (SFIs 21.1) • Set out procedures on the seeking of professional advice regarding the supply of goods and services. (SFIs 21.1.3) • Shall be responsible for ensuring the prompt payment of accounts and claims. (SFIs 21.2.2) • Responsible for ensuring policies and procedures are in place for the appropriate procurement of and payment for goods and services provided to the Trust (SFIs 21.2.3) • Propose prepayment arrangements to the Finance, Performance and Investment approval. (SFIs 21.2.4) • Approve the form of official orders. (SFIs 21.2.5) • Propose procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act, for approval by the Finance and Investment Committee. (SFIs 21.3) • Advise the Board on investments and performance of investments held and prepare detailed procedural instructions on the operation of investments held. (SFIs 22.2.2 & 22.2.3)
CHIEF FINANCIAL OFFICER (CONTINUED)	• Ensure that the Trust has in place processes to manage the business case approval process for capital schemes. (SFIs 24.1.2) • Ensure the Trust's compliance with current tax legislation. (SFIs 24.1.4) • Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure. (SFIs 24.1.5) • Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes. (SFIs 24.1.7) • Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector. (SFIs 24.2.1) • Maintenance of asset registers. (SFIs 24.3.1) • Responsible for systems of control over stores and receipt of

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
	goods. (SFIs 25.2) • Set out procedures and systems to regulate the stores. (SFIs 25.2) • Responsible for preparation and implementation of stocktaking arrangements. (SFIs 25.2) • Approve alternative arrangements where a complete system of stores control is not justified. (SFIs 25.2) • Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items. (SFIs 25.2) • Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers. (SFIs 26.1.1) • Prepare procedures for recording and accounting for losses, special payments and informing the police in cases of suspected arson or theft. (SFIs 26.2.1) • Where a criminal offence is suspected, the Chief Financial Officer must inform the Chief Executive if theft or arson is involved. In cases of fraud and corruption the Chief Financial Officer must inform the Local Counter Fraud Specialist and Counter Fraud and Security Management Service (CFSMS) Regional Team in line with Trust Policies. (SFIs 26.2.2) • Notify CFSMS (Counter Fraud and Security Management Service) and External Audit of all frauds. (SFIs 26.2.2) • Notify the Audit Committee and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial). (SFIs 26.2.3) • Ensure losses are recovered where appropriate, by using the Trust's insurance arrangements. (Responsibility delegated to Legal Services Manager). (SFIs 26.2.6) • Maintain the losses and special payments register. (SFIs 26.2.7) • Responsible for accuracy and security of computerised financial data. (SFIs 27.1) • Where computer systems have an impact on corporate financial systems satisfy himself that (SFIs 27.5): a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c) Chief Financial Officer and staff have access to such data; d) Such computer audit reviews will be carried out as considered necessary. • Where the Board decides to use the risk pooling schemes administered by ~~the~~ NHS ~~Litigation Authority~~ Resolution the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements. (SFIs 33.4) • Where the Board decides not to use the risk pooling schemes administered by the NHS ~~Litigation Authority~~ Resolution for any one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
	reimbursed. (SFIs 33.4) • Ensure documented procedures cover management of claims and payments below the delegated limit, as set out in Schedule A. (SFIs 33.4) • Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. (SFIs 27.3) • Seek periodic assurances from the provider that adequate controls are in operation. (SFIs 27.3) • Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place. (SFIs 27.4). • Be responsible for the receipt, endorsement and safe custody of tenders received. (SFIs 17.8.2) • Maintain a register to show each set of competitive tender invitations despatched. (SFIs 17.8.3)
~~DIRECTOR OF HUMAN RESOURCES~~CHIEF PEOPLE OFFICER	• The ~~Director of Human Resources and Organisational Development~~ Chief People Officer shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. (SFIs 17.15) • Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and deal with variations to, or termination of, contracts of employment. (SFIs 20.5)
EXECUTIVE DIRECTORS	The NHS Foundation Trust Accounting Officer Memorandum (2015) requires Executive Directors to: • achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. • follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office (NAO).
EXECUTIVE DIRECTORS AND ALL SENIOR STAFF	Responsible for security of Trust assets including notifying discrepancies to the Chief Financial Officer, and reporting losses in accordance with Trust procedure. (SFIs 24.4.4)
NOMINATED MANAGERS* (AUTHORISED SIGNATORIES)	Nominated Managers are required to: • Submit time records in line with timetable. (SFIs 20.4.3) • Complete time records and other notifications in required form. (SFIs 20.4.3) • Submit termination forms for employees leaving the Trust's employment, in prescribed form and on time. (SFIs 20.4.3) • Implement and maintain security arrangements and custody of keys (SFIs 25.2) • Operate a system for slow moving and obsolete stock, and report to the Chief Financial Officer evidence of significant overstocking. (SFIs 25.2)
NON EXECUTIVE	The NHS Foundation Trust Code of Governance identifies that: Non-Executive Directors should constructively challenge and help develop proposals on strategy and scrutinise the performance of

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DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
DIRECTORS	management in meeting agreed goals and objectives, and monitor the reporting of performance.
REQUISITIONERS	Comply with the Trust policy for Procurement of goods and services. (SFIs 21.2.1)
~~DIRECTOR OF~~ CHIEF CORPORATE AFFAIRS OFFICER	The ~~Director of~~ Chief Corporate Affairs Officer shall: • ~~Be responsible for the receipt, endorsement and safe custody of tenders received. (SFIs 17.8.2)~~ • ~~Maintain a register to show each set of competitive tender invitations despatched. (SFIs 17.8.3)~~ • Publish and maintain a Freedom of Information Scheme. (SFIs 27.2.2) • Ensure all staff are made aware of the Trust policy on Managing Conflicts of Interest in the NHS, which includes the acceptance of gifts and other benefits in kind by staff. (SFIs 30) • Ensure retention of documents, in accordance with the extant Department of Health policy on the retention of records (SFIs 32) • Maintain a complete and accurate ~~Risk Register and Controls~~ Board Assurance Framework. (SFIs 33.1) • Maintain Register(s) of Interests., for Board members and other Senior Officers of the Trust. (SO 7.2)
CHIEF NURSE	• Maintain a complete and accurate Risk Register
AUDIT COMMITTEE ~~AUDIT COMMITTEE (CONTINUED)~~	The Audit Committee is established as a permanent sub-committee of the Trust Board and is accountable to the Trust Board. The role of the Audit Committee is to: • review and independently scrutinise the ~~St George's University Hospitals NHS Foundation~~ Trust's systems of ~~clinical~~ governance, internal control and risk management thereby ensuring, through proper process and challenge, that integrated governance principles are embedded and practised across all ~~St George's~~ Trust activities and that they support the achievement of the Trust's objectives. • review key internal and external financial, clinical, fraud and corruption and other policies, reports and assurance functions thereby providing independent assurance on them to the Board ~~of St George's~~. • to review the integrity of financial statements prepared on the Trust's behalf. • undertake all other statutory duties of an NHS FT Audit Committee. • Submit a regular report to the Board, including recommendations on appropriate actions arising from Internal and External Audit reports and recommendations. The Foundation Trust Code of Governance requires that the Audit Committee: • Approve the procedure for the declaration of interests and the declaration of hospitality. • Ensure there are proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns (eg raising concerns at work, Freedom to Speak Up and Whistle-blowing).

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
~~AUDIT COMMITTEE (CONTINUED)~~	The Standing Financial Instructions require that the Audit Committee: • Ensure an adequate internal audit service is provided (the Audit Committee (SFIs 11.1.1, 11.1.3 & 11.2.1): Approve the appointment of the Internal Auditors, and monitor the effectiveness of the Internal Auditors. Agree the Internal Audit annual workplan. • Ensure cost-effective External Audit provision (11.4) • Agree the External Auditors annual Workplan • Receive reports from the External Auditors and monitor progress with implementation of recommendations by the Trust • Make recommendations to the Board on appropriate actions arising from internal and external audit reports and recommendations; • Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; • Monitor compliance with Standing Orders, Standing Financial Instructions, and Scheme of Delegation. • Review schedules of losses and compensations and make recommendations to the Board, for items in line with thresholds set out in Schedule A. • Approve special payments in accordance with the financial thresholds set out in Schedule A. • Review the annual financial statements and Annual Report prior to submission to the Board, making recommendations where appropriate. • Provide independent and objective view on internal control and probity. • Approve write-off of losses (within limits delegated by the Department of Health) and subject to limits delegated to Chief Executive and Chief Financial Officer, and report to the Board accordingly. See Schedule A. (SFIs 26.2.4) • The Audit Committee Chairman must bring to the attention of the Board, as soon as possible, where there is evidence of ultra vires transactions or improper acts. (SFIs 11.1.2) The Standing Orders require the Audit Committee to: • Review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board) and to waive Standing Financial Instructions (SOs 3.13). • Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention (SOs 5.6) • Review proposals in individual cases for the write-off of losses or making of special payments as set out in Schedule A.
~~COMMERCIAL BOARD~~	~~The Committee has been established as a subcommittee of the Trust Board, to add value to the trust's commercial activities.~~ ~~The aim of the committee is to assist in the development of the trust's marketing and commercial strategies, in line with the trust's overall corporate strategy and priorities.~~ ~~The Committee will consider all aspects of business development, but will focus on the use of marketing to drive increased NHS income and commercial developments to drive increased non-NHS income. Key~~

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
	~~success indicators will include:~~ ~~• private patient income vs NHS income~~ ~~• maximised income from assets~~ ~~• NHS income through market share / market growth~~ ~~The Committee will support and add value to the executive management consideration of post-project reviews to ensure commercial and / or marketing learning – not assurance – and value for money gained from existing commercial contracts.~~
TRUST EXECUTIVE COMMITTEE	The Trust Executive Committee had been established to: • Comprise the Directors of the Trust and Divisional Chairs and others as set out in the Terms of Reference for the Committee; • be the executive decision making body the Trust, supported by a Cross Divisional Management Team; • provide assistance to the Chief Executive in the performance of his duties as Accountable Officer, including: development and implementation of strategy and day to day operational management of the Trust • make appropriate arrangements for the approval of Trust-wide policies and guidance, as required, unless Board approval is statutorily required or the matter is reserved to the Board or its Committees under these Standing Orders and Standing Financial Instructions
FINANCE AND INVESTMENT COMMITTEE	The Committee has been established to assist the trust maximize its healthcare provision subject to its financial constraints. In its thinking, the Committee considers patient safety to be of paramount importance. It achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensure: • detailed consideration is given to the trust's financial, investment and associated performance issues to ensure that the trust uses public funds wisely; and • by ensuring that adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies e.g. the Department of Health and NHSI and achievement of the trust's strategic aims and objectives; • management of operational performance against national targets and corporate objectives. The Committee will have a role in the trust's performance management framework, receiving recommendations for intervention as part of the agreed escalation process when required. The Committee will: • Monitor the Trust's financial position on a monthly basis, with particular regard to achievement of its statutory break-even duty, delivery of cost improvement plans, controls over income recognition and collection controls over expenditure and investment income and the management of financial resources and the adequacy of forecasting and reporting. • Review the Trust's medium and long term financial strategy and make recommendations to the Board. • Review controls over the establishment within the Trust. • Approve in-year changes to the Trust's Capital Programme, up to

DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
	thresholds in Schedule A. • Approve prepayment arrangements proposed by the Chief Financial Officer (SFI 21.2.4) • Approve procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act, recommended by the Chief Financial Officer (SFI 21.3)
WORKFORCE AND EDUCATION COMMITTEE	The ~~HR and~~ Workforce and Education Committee has been established as a sub-committee of the Trust Board to oversee the development of an empowered workforce that is both modern and flexible, with a culture that supports people to deliver to their best. The Committee is established to provide the Board with assurance that there are robust mechanisms in place to ensure: ~~• Provide assurance to the Board that there are processes and plans in place to ensure that the Trust key objective 'to Champion Team St George's' is achieved.~~ ~~• Informed by the local and national agenda, to provide guidance and reference in the development of the workforce strategy to support the trust's longer term strategy and an annual workforce plan to support the trust's Integrated Business Plan. Be assured that the trust has robust appraisal systems and workforce plans in place that enable the trust to provide excellent clinical care and excellence in research and education.~~ • Robust oversight of the delivery of the Trust's strategic aims in relation to its workforce; • Detailed consideration is given to the development and delivery of the Trust's workforce and education strategies; • Effective oversight and monitoring of workforce planning; • Adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies; • The impact of workforce performance on the Trust's overall performance is closely monitored; • Staff well-being and development is monitored effectively; • Appropriate governance arrangements are in place in relation to workforce and education issues.
NOMINATIONS AND REMUNERATION COMMITTEE	The Nominations and Remuneration Committee has been established as a sub -committee of the Trust Board (SFIs 20.1.2, 20.1.3. Membership includes all Non-Executive Directors of the Trust. The Committee will: • Approve appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees not covered by National pay policies, including: o All aspects of salary (including any performance-related elements/bonuses); o Provisions for other benefits, including pensions and cars. • Appoint and monitor and evaluate the performance of Executive members of the Board. • Ensure that plans are in place for orderly succession of appointments to Executive Director posts and of other Directors who report to Executive Directors • Approve recommendations regarding arrangements for termination of employment and other contractual terms.

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DELEGATED TO INDIVIDUALS	DUTIES AND RESPONSIBILITIES
QUALITY AND SAFETY COMMITTEE	The Quality and Safety Committee has been established as a Committee of the Trust Board. It functions as the Trust's umbrella clinical and quality governance committee. It enables the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to enable it to deliver a quality service according to each of the dimensions of quality set out in *High Quality Care for All* and enshrined in the Health and Social Care Act 2012. Membership includes three Non-Executive Directors, the Medical Director and the Chief Nurse. The Committee's role is to provide assurance to the Board in relation to: • Safety – achieving high and improving levels of patient and staff safety and identifying, prioritising and managing risk arising from the delivery of clinical care. • Clinical Effectiveness – consistently achieving good clinical outcomes and high levels of productivity through evidence-based clinical practice. • Patient Experience – promoting safety and excellence to deliver an excellent patient experience as measured by direct interaction with, and feedback from, those using the Trust's services.

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5.1

SCHEDULE A – SUMMARY FINANCIAL LIMITS FOR SCHEME OF DELEGATION approved by Audit Committee on 11 January 2018

1 LIMITS - QUOTATION & TENDERING

Non-construction contracts £ ex VAT		**Construction contracts £ex VAT**	
£ 0 -£10,000	1 written quotation	£ 0 - £10,000	1 written quotation
£10,001 - £50,000	3 written quotations	£10,001-£50,000	3 written quotations
£50,001 - £111,676*	TRUST Tender required	£50,001-£4,322,012*	TRUST Tender required
>£1111,676*	OJEU Tender required	>£4,322,012	OJEU Tender required

*OJEU limits effective 1st January 2014 – 31st December 2014.

2 AUTHORISATION LIMITS – CONTRACTS

Level	**Expenditure £ ex VAT**	**Non-NHS income £**	**NHS Income £**
Head of Procurement	0 – 250,000		
Director of Finance, Performance & Informatics / Nominated Deputy	250,001 - 1,000,000	0 - 1,000,000	0 - 10,000,000
Chief Executive	1,000,001 - 3,000,000	1,000,001 - 3,000,000	10,000,000+
Trust Board	3,000,001 - TDL*	3,000,001 - TDL*	

(i) All contracts (as opposed to purchase orders) must be signed according to the above thresholds
(ii) Only those recorded above are empowered to sign a contract on behalf of the Trust.
(iii) Contract value is defined as the aggregate value ex VAT over the full contract term.
eg The relevant value for a 5 year expenditure contract costing £60,000 pa would be £300,000 and therefore would require sign-off by the Finance Director

3 EXPENDITURE AUTHORISATION LIMITS – REQUISITIONS, INVOICES AND PURCHASE ORDERS

	Requisitions & invoices £ ex VAT	**Purchase orders £ ex VAT**
AFC band 6/7 or equivalent	0 – 1,000	
AFC band 8A or equivalent	1,001– 2,000	
AFC band 8B or equivalent	2,001 – 10,000	
Head of Procurement		0 – 101,000(OJEU)
Div Dir of Ops*/Asst Director	10,001 – 75,000	
Finance Director	75,001 -1,000,000	100,001 – 1,000,000
Chief Executive	1,000,001 - 3,000,000	1,000,001 - 3,000,000
Trust Board	3,000,001 - TDL*	3,000,001 - TDL*

4 AUTHORISATION LIMITS – OTHER

	Write-offs & special pymts (Note 1) £	**Business cases Revenue £ pa**	**Business cases Capital £ £**	**Capital increase (Note 2) £**
Div Dir Ops*/Asst Director Dir of Finance, Perf & Info	0 – 10,000			
Investment, Divestment & Disinvestment Group (IDDG)		0 - 250000	0 - 250000	0 - 250000
Executive Management Team		250,001-3,000,000	250,001-3,000,000	250,001-2,000,000
Capital Programme Group Audit Committee (Note 1)	10,000 - TDL**			
Finance Committee		3,000,001-5,000,000	3,000,001-5,000,000	2,000,001-5,000,000
Trust Board		5,000,001 - TDL	5,000,001 - TDL	5,000,001-TDL

Note 1: Chairman of the Audit Committee or his/her nominated deputy has the power to approve write-offs or special payments on behalf of the Committee in urgent situations where recourse to the Audit Committee is not practicable or would result in further loss The Chairman of the Audit Committee must report such cases to the Audit Committee at the earliest opportunity.
Note 2: Increases in an individual capital project budget over the budget approved by the Trust Board at the commencement of th financial year as long as the total of planned capital expenditure for the year is not exceeded.
Note 3 = TDL Trust Delegated Limit as defined by Department of Health.

* Divisional Directors of Operations fulfill these responsibilities on behalf of their Divisional Chairs.

St George's University Hospitals NHS
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5.1

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

10.1.3 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations ~~including Community Services Wandsworth integrated with St. George's Healthcare NHS Trust with effect from 1st October 2010~~ and ~~other~~ any Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes and policies. The Chief Financial Officer must approve all financial procedures and policies.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Financial Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that may result in dismissal and, where appropriate, criminal proceedings against you.**

10.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.

10.2 Responsibilities and delegation

10.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board has resolved that the Board may only exercise certain powers and decisions in formal session. These are set out in Section C 'Decisions Reserved to the Board'. All other powers have been delegated to such other committees as the Trust has established.

10.2.3 **The Chief Executive and Chief Financial Officer**

The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Council of Governors, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's System of Internal Control.

10.2.4 It is a duty of the Chief Financial Officer to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.5 **The Chief Financial Officer**

The Chief Financial Officer is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) complying with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be subject to these instructions. It is the responsibility of the Chief Financial Officer to ensure that such persons are made aware of this.

10.2.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Financial Officer.

11. AUDIT

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2018), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

~~(d)~~(e) Reviewing compliance with the Constitution, Licence and Code of Governnace;

~~(e) reviewing schedules of losses and compensations and making recommendations to the Board;~~

~~(f) reviewing schedules of debtors/creditors balances over 6 months and £5,000 old and explanations/action plans and all write offs;~~

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

(g) Reviewing arrangements that allow staff of the Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties

of financial reporting and control, clinical quality, patient safety or other matters;

~~(g)~~(h) Ensuring the Trust has in place adequate mesures to comply with the requirements of the Bribery Act 2010 and a means by which suspected acts of fraud, corruption or bribery can be reported.

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. (To the Chief Financial Officer in the first instance.)

11.1.3 It is the responsibility of the Audit Committee to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.2 Audit Committee

11.2.1 The Audit Committee is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS Internal Audit Standards 2011;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption, is the responsibility of the Chief Executive;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The Chief Financial Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

11.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

11.3.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

11.3.4 The Chief Internal Auditor shall be accountable to the Audit Committee. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.4 External Audit

11.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost -efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the Trust Chief Executive and Chief Financial Officer shall monitor and ensure compliance with all relevant guidance and legislation

11.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

11.5.3 The Local Counter Fraud Specialist shall report to the Trust Chief Financial Officer and shall work with staff in NHS ~~Counter Fraud Authority~~ Protect and the Area Anti-Fraud Manager of NHS Protect in accordance with the Department of Health Fraud and Corruption Manual.

11.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

11.6.4 The Chief Executive has overall responsibility for controlling and co-ordinating security. However, key tasks are delegated to the Director of Estates and Facilities and the appointed Local Security Management Specialist.

12. RESOURCE LIMIT CONTROL

Not applicable to NHS Foundation Trusts.

13. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1 Preparation and Approval of Plans and Budgets

13.1.1 The Chief Financial Officer will compile and submit to the Board an Annual Plan that takes into account financial targets and forecast limits of available resources. The Annual Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

13.1.2 Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

13.1.3 The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

13.1.4 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

13.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

13.1.6 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

13.3 Budgetary Delegation

13.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

13.3.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

13.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

13.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Financial Officer.

13.4 Budgetary Control and Reporting

13.4.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

13.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Financial Officer;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive or their chosen delegated authority, other than those provided for within the available resources and manpower establishment as approved by the Board.

13.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

13.5 Capital Expenditure

13.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 24).

13.6 Monitoring Returns

13.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

13.7 Business cases

13.7.1 The Chief Executive will set up a Business case review process to be led by the Chief Financial Officer.

13.7.2 Business cases must be approved by the Board in accordance with the financial thresholds set out in Schedule A Summary of Financial Limits for the Scheme of Delegation.~~.~~

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Chief Financial Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to NHSI and the Department of Health for each financial year in accordance with the timetable prescribed by NHSI.

14.2 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts, along with any report of the auditor on them, must be presented to the Council of Governors and to the members of the Trust at the Annual Members' Meeting, and be made available to the public.

14.3 The Trust will publish an annual report, in accordance with the provisions set out in the Trust's Constitution, and present it to the Council of Governors and to the

members of the Trust at the Annual Members' Meeting . The document will comply with the Department of Health's Group Accounting Manual (GAM).

15. BANK AND OPG ACCOUNTS

15.1 General

15.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

15.1.2 The Board shall approve the banking arrangements.

15.2 Bank and GBS accounts

15.2.1 The Chief Financial Officer is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) ensuring a month-end deposit balance of a minimum of £3m, in accordance with guidance from NHSI.

(e) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(f) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts that must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

15.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

15.4 Tendering and Review

15.4.1 The Chief Financial Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

15.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

16.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

16.2 Fees and Charges

16.2.1 The Trust shall follow the Department of Health's advice in the "Costing" Manual in setting prices for NHS service agreements.

16.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

16.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

16.3 Debt Recovery

16.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

16.3.2 Income not received should be dealt with in accordance with losses procedures.

16.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Chief Financial Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

17. TENDERING AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

17.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions

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17.3 Trust Procurement Policy

The T~~t~~rust will have in place and maintain an up to date Procurement Policy and Tendering procedures to be read as part of these standing orders.

17.4 Trust Tender Limits

LIMITS – QUOTATION & TENDERING

Non-construction contracts £ ex VAT		Construction contracts £ ex VAT	
£0 to £10,000	One written quote	£0 to £10,000	One written quote
£10,001 to £50,000	Three written quotes	£10,001 to £50,000	Three written quotes
£50,001 - £111,767	Trust Tender	£50,001 - £ 4,322,012	Trust Tender
> £101,000	OJEU tender required	> £3,900,000	OJEU tender required

Aggregation

Under EU rules aggregation must be applied to any purchase that is subject to the EU directives. When determining if a contract is over the EU threshold and therefore subject to the EU Rules you must aggregate the value of all individual requirements expected to be awarded at the same time for goods or services of the same type across The Trust.

Where there is a continuing requirement, recurring contracts or orders of the same type for the same item/ services let over a period, must be aggregated irrespective of existing commitments.

You should not disaggregate purchases simply to avoid the application of the EU rules. Neither should you aggregate purchases just to bring them within the scope of the rules.

Aggregation is compulsory for application of the EU thresholds. However, the aggregation rules do not necessarily mean that there can only be one contract.

Several contracts could be awarded, but each one should be treated as if the rules applied to them individually.

17.5 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to https://www.gov.uk/guidance/eauctions. ~~www.ogc.gov.uk.~~

17.6 Capital Investment Manual and other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and "Estate code" in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The use of management consultants by the NHS and Department of Health.".

17.7 Formal Competitive Tendering

17.7.1 **General Applicability**

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from, provided by, or recommended by the Department of Health) or NHSI;
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

17.7.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

17.7.3 **Exceptions and instances where formal tendering need not be applied**

Any procurement over the current OJEU tendering limit may not be waived. Where a genuine emergency exists the Chief Executive must seek legal advice and Board approval for an OJEU tender waiver.

The Trust's Formal tendering or quotation procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed limits set out in Schedule A;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 25;

The Trust's Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where Framework agreements from collaborative Procurement hubs or OGC are in place.

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering or quotation procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering, or quotations, is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

SFI waivers for the Trust tendering procedure may only be signed by the Chief Executive or The Trust Chief Financial Officer. All waivers

regarding Trust tendering procedures or OJEU Tenders must be reported monthly to Audit Committee.

Waivers relating to the Trust quotation process may be signed by the Chief Financial Officer or their delegated representative. These Waivers do not have to be reported to Audit Committee, but a full record of such Waivers must be kept for inspection by the Finance Department.

17.7.4 **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. 17.1 and 17.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

17.7.5 **List of Approved Firms**

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Chief Financial Officer it is desirable to seek tenders from firms not on the approved lists (please refer to: **info@supplychain.nhs.uk)**, the reason shall be recorded in writing to the Chief Executive (see SFI 17.6.8 List of Approved Firms).

17.7.6 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance without Departmental of Health approval.

17.7.7 **Items that subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

17.8 Contracting/Tendering Procedure

17.8.1 **Invitation to tender**

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard

Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

17.8.2 **Receipt and safe custody of tenders**

The Chief Executive or his nominated representative (the Trust Secretary) will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

17.8.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(ii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iii) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Chief Financial Officer or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(v) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Trust Secretary will count as a Director for the purposes of opening tenders.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Chief Executive, or a person authorised by him (Trust Secretary), to show for each set of competitive tender invitations despatched:

- the name of all firms or individuals invited;
- the names of firms or individuals from which tenders have been received;
- the date the tenders were opened;

- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 17.6.5 below).

17.8.4 **Admissibility**

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

17.8.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

17.8.6 **Acceptance of formal tenders (See overlap with SFI No. 17.7)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

17.8.7 **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

17.8.8 **List of approved firms (see SFI No. 17.5.5)**

(a) **Responsibility for maintaining list**

A manager nominated by the Chief Executive (Head of Procurement) shall on behalf of the Trust maintain lists of approved firms from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction.

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, ~~and~~ the Disabled Persons (Employment) Act 1944, and Equality Act 2010 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any

relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Chief Financial Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

17.8.9 **Exceptions to using approved contractors**

If in the opinions of the Chief Executive and the Chief Financial Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

17.9 Quotations: Competitive and non-competitive

17.9.1 **General Position on quotations**
Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income does not exceed, or is reasonably expected not exceed £50,000. Schedule A Summary Financial Limits for the Scheme of Delegation sets out the numbers of quotations required dependent on the value of business.

17.9.2 **Competitive Quotations**

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust in accordance with Schedule A.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record. All quotations must be on company headed paper as read only documents.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record, in line with Trust procurement procedures.

17.9.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

17.9.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Financial Officer.

17.10 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows (and confirmed in Schedule A attached to the Scheme of Delegation):

Designated budget holders	up to	£40,000
Assistant Director	up to	£250,000
Board Director	up to	£500,000
Finance Director	up to	£1,000,000
Chairman or Chief Executive	up to	£3,000,000
Trust Board	over	£3,000,000

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes. A full evaluation report must be presented by the Procurement Department to the appropriate authorising manager. Full details of the evaluation process are set out in the Trust's Procurement Policy and Tendering Procedure.

The value stated is the total value of the contract over the contract term so that if a contract is a £1m pa contract with a two year term the contract value is £2m, and can therefore be authorised by the Chair or Chief Executive. If the £1m contract has a five year term, the contract value is £5m, and must therefore be authorised by the Board.

17.11 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use the NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer.

17.12 Authority to sign Contracts with suppliers.

Only the Chief Executive or the Chief Financial Officer or their delegated representative has the authority to sign contracts of ANY value with Suppliers. The authority limits set out above are for the authorisation of Purchase orders or Tenders and is not the Authority to sign a contract.

17.13 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.14 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, "Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Financial Officer shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

17.15 Personnel and Agency or Temporary Staff Contracts

The ~~Director of Human Resources and Organisational Development~~ Chief People Officer shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.16 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

17.17 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £100, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DHSC guidance has been issued but subject to compliance with such guidance.

17.18 In-house Services

17.18.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.18.2 In all cases where the Board determines that in- house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Financial Officer representative. For services having a likely annual expenditure exceeding £250,000 a non-officer member should be a member of the evaluation team.

17.18.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.18.4 The evaluation team shall make recommendations to the Board.

17.18.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.18.6 Where a service is currently provided out of house and is to be brought in-house, the Chief executive should nominate an officer to oversee, manage, and assess the process. Any transfer will be agreed by the Chief Executive.

17.19 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

17.20 PROCUREMENT ETHICS & STANDARDS

17.20.1 Ethical behaviour in purchasing is particularly important for Public Sector bodies due to the extra scrutiny involved with the expenditure of public funds. The integrity and professionalism of individual members of staff, and The Trust as a whole should be maintained at all times.

The guiding principles of ethical behaviour in Procurement are as follows:

- the conduct of The Trust's employees should not foster the suspicion of any conflict between their official duty and their personal interest
- the action of The Trust should not give the impression that they have or may have been influenced by a gift or consideration to show favour or disfavour to any person or organisation
- dealings with suppliers must at all times be honest and fair
- ethical behaviour must be promoted and supported by appropriate systems, such as the procedure set out in this policy and by the governance as set out in Standing Orders and Rules of Procedure
- information provided by suppliers should be regarded and treated as confidential
- buyers keep sufficient records to establish an audit trail to demonstrate that appropriate standards have been observed on each purchase

17.20.2 It is an offence under the ~~Prevention of Corruption Act 1916~~ Bribery Act 2010 for staff to accept any gifts or consideration as an incentive or reward for doing anything in an official capacity, or showing favour or disfavour to any person in an official capacity.

17.20.1 All staff in contact with suppliers are vulnerable to accusations of fraud and corruption as they are in contact with the commercial world where it may be normal practice to offer gifts and hospitality.

17.20.2 It is vital that The Trust's staff **are**, and are **seen to be,** above reproach in their actions and must ensure that their personal judgement and integrity cannot reasonably be seen to be compromised by the acceptance of benefits of any kind from a third party.

17.20.3 The following lists a number of irregular situations that must be avoided:

- send drawings, specifications, prototypes or samples of one supplier to another
- divulge prices of one supplier to another
- invent lower bids to force prices down
- refusing to use a supplier's product on the basis of clinical or personal preference, when trials have not been conducted to back up preference and prove use of new supplier represents a clinical risk.
- refusing to undertake clinical trials on new products/suppliers.
- exaggerate quantities above known requirements
- call for unnecessarily short delivery times
- state time as 'of essence to the contract' unnecessarily
- promise that a contract has a longer term than is warranted or practicable
- permit some suppliers to re-quote while others are denied this facility
- give false information under any circumstances
- use a dominant position to take unfair advantage of a small supplier
- allow personal bias or prejudice to influence purchasing decisions
- take 'prompt payment' or other discount when they are not 'current' or not earned or relevant
- solicit or accept from suppliers any 'personal favours'
- accept bribes of any kind
- develop personal relationships with sales staff, which could affect decisions
- any existing relationships should be declared prior to the tender exercise
- allow staff to hold undeclared financial interests in suppliers
- make alterations to tender documents; - if changes are required correction fluid must not be used and a record of all alterations must be kept with details copied to the supplier
- allow gaps in records

18. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

18.1 Service Level Agreements (SLAs)

18.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within the Local Business Plan (LBP) and wherever possible, be based upon integrated care

pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

18.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18.3 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, has delegated to the Chief Financial Officer the need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

19. COMMISSIONING

This section is not applicable to this Trust.

20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

20.1 Remuneration and Benefits (see overlap with SO No. 4)

20.1.1 In accordance with the Trust's Constitution and Standing Orders, the Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

20.1.2 The Committee will:

(a) agree and advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) agree and authorise the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) agree, authorise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

20.1.3 The Committee shall report in writing to the Board the basis for its decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and other Non-Executive Directors.

20.2 Funded Establishment

20.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

20.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

20.3 Staff Appointments

20.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either of a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment.

20.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

20.4 Processing Payroll

20.4.1 The Chief Financial Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.4.2 The Chief Financial Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act 2018 and General Data Protection Regulation;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) segregation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Payroll department must be informed immediately.

20.4.4 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.5 Contracts of Employment

20.5.1 The Board shall delegate responsibility to the ~~Director of Human Resources and Organisational Development~~Chief People Officer.

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Financial Officer will determine the level of delegation to budget managers.

21.1.2 The Chief Financial Officer will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

21.1.3 The Chief Financial Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

21.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

21.2.2 **System of Payment and Payment Verification**

The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance national guidance or with contract terms, whichever is later.

21.2.3 The Chief Financial Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the appropriate cost of capital discount rate as advised by the Chief Financial Officer, Performance and Informatics).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

(d) The Chief Financial Officer will proposed prepayments for approval by the Finance and Investment Committee.

21.2.5 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Financial Officer;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

21.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in ~~HSG 93(5) "Standards of Business Conduct for NHS Staff"~~NHS England's Managing Conflicts of Interest in the NHS);

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Financial Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer;

(l) petty cash records are maintained in a form as determined by the Chief Financial Officer.

21.2.7 The Director of Estates and Facilities shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Estatecode. The technical audit of these contracts shall be the responsibility of the relevant Director.

21.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

21.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures recommended by the Chief Financial Officer, and approved by the Finance and Investment Committee, which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

22. BORROWING

22.1.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on, and any requirement to repay Public Dividend Capital (PDC) and any proposed new borrowing, within the rules and limits set by the Department of Health and the Finance and Investment Committee. The Chief Financial Officer is also responsible for reporting on a monthly basis to the Board concerning the Trust's ability to service debt and make repayments of borrowings and all loans and overdrafts using the applicable Department of Health metrics.

22.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short-term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer.

22.1.3 The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

22.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health.

22.1.5 Any short- term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

22.1.6 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and the loan agreements approved by the Trust Board in advance of any draw downs.

22.1.7 The draw down arrangements for loans and facilities approved by the board shall be as follows unless separate arrangements are required by the lender and these separate arrangements are approved by the board:

(i) The Trust may only draw down borrowings under loans or facilities approved by the board.
(ii) All drawdowns of borrowings ("utilisation requests") must be signed/counter-signed by at least two of the following officers - the Chief Financial Officer, the Deputy Director of Finance and an Associate Director of Finance.
(iii) The board shall be notified at the next meeting following the date of the drawdown that the drawdown has taken place, the reasons for the drawdown, and the terms of the loan to which the drawdown relates including the term, the interest rate(s) and repayment period. This notification should normally form part of the monthly finance report to the board.
(iv) The board shall be notified of the cumulative value of drawdowns and the undrawn balance of the loans. This notification should normally form part of the monthly finance report to the board.

22.2 INVESTMENTS

22.2.1 Temporary cash surpluses must only be invested with the National Loans Fund in periods where the Trust is in Financial Special Measures. When financial special measures are not in place, surplus cash made be invested in 'safe harbour' investments. Such safe harbour investments are considered sufficiently low risk so as to not require review by the Board.

22.2.2 The Chief Financial Officer has the authority to approve cash investments for a maximum period of 12 months. Cash investments for longer periods must be approved by the Finance and Investment Committee.

22.2.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

23. FINANCIAL FRAMEWORK

23.1 The Chief Financial Officer should ensure that members of the Board are aware of the Single Oversight Framework. This document contains directions which the Trust must follow. It also contains directions to NHS national and commissioning bodies regarding resource and capital allocation and funding to Trusts.

24. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

24.1 Capital Investment

24.1.1 The Director of Estates and Facilities:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

24.1.2 For every capital expenditure proposal the Director of Estates and Facilities shall ensure:

(a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

(c) Business cases must be approved by the Board in accordance with Schedule A Summary Financial Limits of the Scheme of Delegation.

24.1.3 For capital schemes where the contracts stipulate stage payments, the Director of Estates and Facilities will issue procedures for their management, incorporating the recommendations of “Estatecode”.

24.1.4 The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

24.1.5 The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

24.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive, with advice from the Director of Estates and Facilities, shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.8);

(c) approval to accept a successful tender (see overlap with SFI No. 17.8).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

24.1.7 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account Department of Health Guidance on Delegated Limits for Capital Investment.

24.2 Private Finance (see overlap with SFI No. 17.13)

24.2.1 The Trust should test for PFI when considering capital procurement. When the Trust proposes to use finance that is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

24.3 Asset Registers

24.3.1 The Chief Financial Officer is responsible for the maintenance of registers of assets, and will advise on the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

24.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Group *Accounting Manual* as issued by the Department of Health.

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

24.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the *Capital Accounting Manual* issued by the Department of Health.

24.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Group *Accounting Manual* issued by the Department of Health.

24.3.8 The Chief Financial Officer of the Trust shall calculate and pay capital charges as specified in the Group *Accounting Manual* issued by the Department of Health.

24.4 Security of Assets

24.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

24.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Executive Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Executive Board members and employees in accordance with the procedure for reporting losses.

24.4.6 Where practical, assets should be marked as Trust property.

25. STORES AND RECEIPT OF GOODS

25.1 General position

25.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee (Head of Procurement) by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

25.2.3 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

25.2.4 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

25.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 26 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

25.3 Goods supplied by NHS Logistics

25.3.1 For goods supplied via the NHS Logistics central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer who shall satisfy himself that the goods have been received before accepting the recharge.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 **Procedures**

The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

26.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

26.2 Losses and Special Payments

26.2.1 **Procedures**

The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

26.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Local Counter Fraud Specialist, who will then inform the Chief Financial Officer. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Financial Officer must inform the Local Counter Fraud Specialist and the Area Manager NHS ~~Counter Fraud Authority~~Protect.

The Chief Financial Officer must notify ~~the CFSMS~~ NHS Protect and the External Auditor of all frauds.

26.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

(a) the Audit Committee,

(b) the External Auditor.

26.2.4 Within limits delegated to it by the Department of Health, the Board has delegated responsibility to the Audit Committee to approve the writing-off of losses above £10,000. Approval of write-off of £10,000 and below is delegated to the Chief Executive or Chief Financial Officer, as set out in Schedule A.

26.2.5 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

26.2.6 For any loss, the Chief Financial Officer should ensure losses are recovered where appropriate, by using the Trust's insurance arrangements, having delegated responsibility delegated to Legal Services Manager.

25.2.7 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.8 No special payments exceeding Trust delegated limits shall be made without the prior approval of the Department of Health.

26.2.9 All losses and special payments must be reported to the Audit Committee at every meeting.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the Chief Financial Officer

27.1.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act ~~1998~~2018~~, as altered by the General Data Protection Regulation~~;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Financial Officer may consider necessary are being carried out.

27.1.2 The Chief Financial Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and

thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

27.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

27.2.2 The Trust Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that is made publicly available.

27.3 Contracts for Computer Services with other health bodies or outside agencies

The Chief Financial Officer, Performance and Informatics shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Operating Officer shall periodically seek assurances that adequate controls are in operation.

27.4 Risk Assessment

The Chief Financial Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

27.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Financial Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

28. PATIENTS' PROPERTY

28.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

28.2 The Chief Nurse and Divisional Director of Operations are responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The Chief Operating Officer, with advice from the Chief Financial Officer, must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to minimise the risk of loss to the patient.

28.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

28.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

29. FUNDS HELD ON TRUST

Not applicable. The Trust does not ~~to St George's, as at present there are no~~ hold funds ~~held~~ on Trust. These ~~as all funds~~ were transferred to St George's Charitable Foundation in 2001 – renamed in 2007 St George's Hospital Charity.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO ~~STANDARDS OF BUSINESS CONDUCT~~ MANAGING CONFLICTS OF INTEREST IN THE NHS (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the ~~Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff'~~ NHS England's Managing Conflicts of Interest in the NHS and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Foundation Trusts.

32. RETENTION OF RECORDS

32.1 The Trust Secretary shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

32.2 The records held in archives shall be capable of retrieval by authorised persons.

32.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Trust Secretary, with authorisation from the Chief Executive. Detail shall be maintained of records so destroyed.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Nurse and ~~Trust Secretary~~ Chief Corporate Affairs Officer shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board Committees responsible for each risk on the Board Assurance Framework and reported to the Board as appropriate.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements for reviewing the Risk Management programme.

The existence, integration and evaluation of the above elements will assist the Chief Executive in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

33.2 Insurance: Risk Pooling Schemes administered by NHS ~~LA~~Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by ~~the~~ NHS ~~Litigation Authority~~ Resolution or self-insure for some or all of the
risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

33.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trusts may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a Public **Private Partnership or legacy Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

33.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by ~~the~~ NHS ~~Litigation Authority~~ Resolution the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by ~~the~~ NHS ~~Litigation Authority~~ Resolution for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Financial Officer will draw up formal documented

procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.