Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting
Thursday 28 May 2020

Agenda and papers

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St George's University Hospitals NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 28 May 2020, 09:00-11:35**
Venue: **WebEx and For Internal Staff Room 52, 1st Floor Grosvenor Wing**

Time	Item	Subject	Lead	Action	Format
1.0 OPENING ADMINISTRATION					
09:00	1.1	Welcome and apologies	Chairman	Note	Oral
	1.2	Declarations of interest	All	Assure	Oral
	1.3	Minutes of meeting – 30 April 2020	Chairman	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
09:05	1.5	Chief Executive Officer's Report	Chief Executive	Inform	Report
2.0 COVID-19					
09:10	2.1	Covid-19 Overview	Chief Executive/ Acting Chief Nurse	Assure	Report
3.0 QUALITY & PERFORMANCE					
09:35	3.1	Quality and Safety Committee Report	Committee Chairman	Assure	Report
	3.1.1	Committee Annual Review & Revised Terms of Reference			
09:45	3.2	Integrated Quality & Performance Report	Chief Operating Officer	Assure	Report
10:00	3.3	Learning from Deaths Report, Q4 2019/20	Chief Medical Officer	Assure	Report
4.0 WORKFORCE					
10:10	4.1	Guardian of Safe Working	Chief Medical Officer	Assure	Report
5.0 FINANCE					
10:20	5.1	Finance and Investment Committee Report	Committee Chair	Assure	Report
	5.1.1	Committee Annual Review & Revised Terms of Reference			
10:30	5.2	Finance Report (Month 01)	Acting Chief Finance Officer	Update	Report
6.0 RISK, GOVERNANCE & COMPLIANCE					
10:40	6.1	Audit Committee Report	Committee Chair	Assure	Report
	6.1.1	Committee Annual Review & Revised Terms of Reference			
10:50	6.2	St George's Hospital Charity Report	Chief Strategy Officer	Inform	Report
11:00	6.3	Provider Licence Annual Self-Certification	Chief Corporate Affairs Officer	Approve	Report
11:10	6.4	Board Assurance Framework Report, Q4 2019/20	Chief Corporate Affairs Officer	Approve	Report
11:20	6.5	Board Annual Forward Plan	Chief Corporate Affairs Officer	Approve	Report

Time	Item	Subject	Lead	Action	Format
7.0 CLOSING ADMINISTRATION					
11:30	**7.1**	**Questions from Governors/Public**	**Chairman**	Note	Oral
	7.2	**Any new risks or issues identified**	**All**	Note	
	7.3	**Any Other Business**		Note	
11:35	**CLOSE**				

Thursday, 25 June 2020, 09:00-11:00
WebEx and For Internal Staff Room 52, 1st Floor Grosvenor Wing

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St George's University Hospitals NHS Foundation Trust

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.

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Vice Chairman	NED
Elizabeth Bishop	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Prof. Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
Tim Wright	Non-Executive Director	NED
Andrew Grimshaw	Deputy Chief Executive Officer	DCEO
Avey Bhatia	Chief Operating Officer	COO
Robert Bleasdale	Acting Chief Nurse & Director of Infection, Prevention & Control	ACN
Richard Jennings	Chief Medical Officer	CMO
Tom Shearer	Acting Chief Financial Officer	ACFO
In Attendance		
TBC	Deputy Chief People Officer	DCPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Secretariat		
Tamara Croud	Head of Corporate Governance/Board Secretary	HOCG-BS
Apologies		
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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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 30 April 2020
Room 52, 1st Floor Grosvenor Wing, St George's Hospital, Tooting & WebEx

Name	Title	Initials
PRESENT ***(*attendees joining the meeting via videoconferencing)***		
Gillian Norton*	Chairman	Chairman
Jacqueline Totterdell*	Chief Executive Officer	CEO
Ann Beasley*	Non-Executive Director	NED
Elizabeth Bishop*	Non-Executive Director	NED
Stephen Collier*	Non-Executive Director	NED
Prof Jenny Higham*	Non-Executive Director	NED
Prof Parveen Kumar*	Non-Executive Director	NED
Dr Pui-Ling Li*	Associate Non-Executive Director	ANED
Tim Wright*	Non-Executive Director	NED
Avey Bhatia	Chief Operating Officer	COO
Robert Bleasdale	Acting Chief Nurse and Director of Infection Prevention & Control	ACN/DIPC
Dr Richard Jennings	Chief Medical Officer	CMO
Tom Shearer*	Acting Chief Finance Officer	ACFO
IN ATTENDANCE		
Harbhajan Brar	Chief People Officer	CPO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Humaira Ashraf*	Deputy Chief People Officer – Culture & OD	DCPO-C
Elizabeth Nyawade	Deputy Chief People Officer – Human Resources	DCPO-HR
SECRETARIAT		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG
APOLOGIES		
Andrew Grimshaw	Deputy Chief Executive Officer	DCEO
James Friend	Chief Transformation Officer	CTO

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and recorded hers and the Board's appreciation of and support for the staff and the executive leadership	

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		Action
	during what was an unprecedented time for the Trust and the NHS more widely whilst the nation continued to face the Covid-19 pandemic. The demands on the Trust were evolving but were no less intense and this continued to put significant pressure on the Trust and its staff at all levels.	
1.2	**Declarations of Interest** The Board noted that Ann Beasley had been appointed as a member of the NHS Providers Board in her role as Chair of South West London & St Georges Mental Health NHS Trust.	
1.3	**Minutes of the meetings held on 26 March 2020** The minutes of the meeting held on 26 March 2020 were approved as an accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log. It was noted that the CEO would circulate executive and senior leadership resilience plan related to action item TB26.03.20/01 to non-executive directors once it had been finalised. In relation to action TB19.12.19/08, it was reported that the Board would receive a report on the freedom to speak up guardian in May 2020 and noted that staff were still utilising the function and the Trust was ensuring that people were aware of the measures in place for staff to raise and escalate concerns and issues during the Covid-19 pandemic.	
1.5	**Chief Executive's Report** The CEO reported that it was increasingly clear that the NHS would be managing Covid-19 related issues for at least the next 12-18 months. While the Trust, and the NHS more broadly, had created the capacity to cope with the initial surge of Covid-19 cases, it was likely that the nation would experience further peaks and troughs in the numbers of people infected by the illness over a protracted period. As a result, the Trust would need to remain agile in responding to these and remain focused at all times on maintaining patient safety. Reflecting on the discussions in the media about the impact of Covid-19 on people from the Black, Asian and Minority Ethnic (BAME) backgrounds, the Trust was proactively engaging with staff to ensure that it was able to support this group of staff, which made up 48% of all staff at the Trust. The Board expressed its sincere condolences to the family and friends of Kenneth Lambatan, Clinical Research Nurse in Cardiology who had passed away earlier in the week with Covid-19. The CEO reported that the Trust continued to engage with families of patients' whose deaths under the care of the cardiac surgery service had been examined by the independent external mortality review, the report of which had been published the previous month alongside the report of the independent scrutiny panel on cardiac surgery. The Trust remained committed to making the further improvements to the service identified in the	

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		Action
	reports, following the progress documented by the Care Quality Commission in its inspection report in December 2019. The Board noted the report and that the Trust had received a letter from Sir David Sloman, Regional Director for London, formally confirming that NHS England and NHS Improvement had endorsed the recommendation from the Care Quality Commission that the Trust be taken out of '*quality special measures*'. This represented a significant milestone for the Trust.	
2.0	**NOVEL CORONAVIRUS (Covid-19)**	
2.1	**Update on Novel Coronavirus (Covid-19)** The Board was provided with an update on the Trust's management of and response to the Covid-19 pandemic. The following key points were reported: • The Trust had experienced a peak of Covid-19 cases in early April 2020 with numbers steadily reducing since then. The Trust now had more capacity within the organisation than originally projected and was looking at how it could safely step services back up and it was working closely with local and national partners to encourage people to make use of hospitals for emergency and urgent services. The Trust, along with other NHS organisations, had experienced a significant decrease in emergency activity, with the a fall of almost 60% in attendances to the emergency department compared with the same period the year before. In particular, there had been a significant fall in the number of heart attack and stroke patients presenting. Going forward the Trust needed to remain flexible and agile and respond to likely future fluctuations in Covid-19 cases whilst caring for patients and retaining some of the innovative approaches that the Trust had put in place in recent weeks. • The Trust was getting ready to increase its testing of asymptomatic staff and patients. The Trust was already testing all symptomatic staff; a total of 999 staff had already been tested, 450 of whom had tested positive. South West London Pathology, which was based at the Trust, had processed a total of 14,619 tests. Focus was being given to ensuring there were robust operational procedures and mechanisms in place. Pui-Ling Li queried what measures the Trust had in place to ensure that that people did not have to come into the main site to get tested and what was being done for those who needed to rely on public transport. It was reported that the Trust had clear protocols in place for testing people outside the main hospital buildings which included the use of the St George's Pod. The Trust also had provisions in place to test key front line symptomatic staff and their families at home. NHS England and NHS Improvement had recently published guidance requiring all elective patients to be screened for Covid-19 prior to admission regardless of whether they displayed symptoms in order to limit nosocomial infection. • The Trust had good stocks of personal protective equipment which was being provided centrally with the exception of visors and eye protection and the Trust had found alternate sources which had been quality assured for the hospital's use. The Trust was adhering to government guidelines on the use of PPE throughout the hospital. While all staff were	

		Action
	supplied with the correct level of PPE the Trust needed to improve its communication with staff so they understood what level of PPE they required to deliver services outside Covid-19 areas. Stocks of PPE were delivered to wards each day. In response to a question from Elizabeth Bishop, it was reported that the Trust had weekly calls with union representatives and to date they had not raised concerns from Trust staff about PPE. • The Trust had robust ethical decision making protocols in place for patients being triaged in and out of critical care units. These processes could be used in the event that demand for ventilation outstripped capacity. Fortunately the Trust did not need to make use of these protocols. Further work was, however, being done to develop these protocols and the Clinical Ethics Committee was being engaged in the process. • During the early stages of Covid-19 the Trust had managed to provide training to over 1,400 redeployed staff, delivered over 1,600 nurse refresher courses and retrained 260 healthcare support workers. In addition whilst the Trust had projected a 20% staff sickness during the peak of the crisis it had only reached a maximum of 12.8% and currently the staff absence related to Covid-19 was below 5%. Prof. Higham noted that St. George's University of London had dedicated its laboratory-based research programme to support the national Covid-19 research priorities, with patients and volunteer staff already entered on to clinical trials. The Board noted the significant work the St George's Hospital Charity had undertaken to support the Trust and its staff during the Covid-19 pandemic and the successful campaign which had, to date, raised over £300,000 in its Covid-19 appeal. The Board noted the report.	
3.0	**QUALITY AND PERFORMANCE**	
3.1	**Quality and Safety Committee Report** Professor Parveen Kumar, Chair of the Committee, presented the report of the meeting held on 23 April 2020, which set out the key matters raised and discussed. In addition to receiving detailed reports on Covid-19 the Committee also endorsed the action plan to address the '*should do*' recommendations from the 2019 Care Quality Commission inspection. The Committee had also received reports on serious incidents, cardiac surgery, and had considered the strategic risks on the Board Assurance Framework assigned to it by the Board. The bulk of the Committee's discussions had, naturally, focused on Covid-19 and the steps being taken to ensure both Covid-19 and non-Covid patients received safe care. The Trust had begun a structured process to assess the clinical impact on existing patients whose care pathway had been disrupted by the increased focus on Covid-19 and on potential patients who would have been expected to have accessed the Trust's services but had not done so. All 44 care group leads had been asked to conduct a structured review and to	

		Action
	list out, by diagnostic group, patients known to the Trust whose care may have been compromised by the focus of Covid-19 and to identify any patients who may potentially come to harm because they were not accessing the Trust services. The information from this review would inform the development of the clinical safety strategy for managing the Covid-19 pandemic in the Trust. The first priority of the strategy would focus on how the Trust supported those patients known to the Trust to receive the care they need. The second priority involved working with South West London partners to develop a communications strategy to ensure that people understood that hospital services were open and accessible to those needing care and treatment. The next phase of the work involved mapping the length of time these patients had been waiting for care and the degree of clinical harm that could be caused if the Trust did not restart or scale back up these services immediately. It also involved identifying how quickly the Trust needed to act to prevent the potential clinical harm occurring. Key considerations included possible future peaks of Covid-19 and enhanced infection prevention and control mechanisms. Prof. Higham and Prof. Kumar reinforced the need for clear communication to individuals about the measures the Trust had in place to safely care for non-Covid-19 patients and ensuring information about appointments include details about safety precautions taken across the estate to protect them. In response to a question from Ann Beasley, it was reported that of the 42 cases of *clostridium difficile* which had been analysed in conjunction with local commissioners at month 9, there were only eight cases in which lapses of care had been identified and there were no common recurring themes except in two or three cases where the Trust had inappropriately sampled patients known to be colonised with *c. difficile.* The detailed analysis of these cases would be included in the annual infection prevention and control report. The Board noted the report.	
3.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 12 (March 2020), which had been scrutinised at both the Finance and Investment and the Quality and Safety Committees. Outside the matters raised in the reports from the Board Committees and in the earlier update on Covid-19, the Board noted that the Trust would see an increase in mortality rates in quarter four related to Covid-19 patients. It was also noted that whilst the Trust had missed its internal agency spend target of £15m its performance was below the NHS £25m trajectory, and the Trust had ended the year with a £18.5m agency spend. The Trust would continue with the £15m target in 2020/21 subject to Covid-19 requirements. The Board received and noted the report.	
3.3	**Cardiac Surgery Report** The Board received and noted the Cardiac Surgery report. As a result of the changes to the provision of services at the Trust due to Covid-19, there had	

		Action
	been no cardiac surgery operations in month and staff had been redeployed to support caring of patients with Covid-19. The Trust's cardiac surgery inpatients had been transferred to Bart's Healthcare NHS Trust. As referenced in the CEO's report, the Trust had continued with its engagement with bereaved families following the publication of the independent external mortality review in March 2020. Over forty families had contacted the Trust to date and half of those had expressed a desire to meet the Trust to discuss their family members' case. The Trust was committed to meeting any family who wished to do so. In light of the Covid-19 pandemic and the social distancing restrictions, the Trust was offering virtual meetings where families wished and for those who wanted to meet in person the Trust would do so as soon as the restrictions permitted. The Board noted the report and agreed that in light of the independent assurance regarding the safely of and improvements to the service set out in the report – and in particular from the Care Quality Commission and the National Institute for Cardiovascular Outcomes Research – it would receive quarterly reports on the service going forward which would provide an analysis of trends and outcomes alongside ongoing assurance regarding the safety of the service and the implementation of the recommendations of the independent reports.	
4.0	**FINANCE**	
4.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on 23 April 2020. The Committee reiterated its disappointment that the Trust had missed achieving the control total agreed with NHS England and NHS Improvement at the start of the year but was nonetheless pleased that the Trust had attained the re-forecasted year-end position and that there had been no further slippage in this. In the wake of Covid-19 the Committee considered how best to maintain the level of grip and financial control that had recently been implemented and would closely monitor this risk going forward. The Committee also noted its appreciation and thanks to the procurement, estates and ICT teams which had been very responsive during the Covid-19 crisis. The Board noted the report.	
4.2	**Month 12 Finance Report** The Board noted the Month 12 finance report. The Trust ended the financial year 2019/20 with a deficit of £13.3m, which included a £1.3m adjustment for Covid-19 expenditure and provisions for annual leave. The Trust had spent capital in line with its forecast of £55m, with £1.7m additional spend related to Covid-19. Cash was on plan at £3m at year-end. The Board noted the report.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from the public** There were no questions raised by Governors or members of the public.	

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		Action
5.2	**Any other risks or issues identified** There were no other risks or issues identified.	
5.3	**Any Other Business** The Board noted that this would be Harbhajan Brar's last meeting of the Board. The Board thanked him for his service to the Trust as Chief People Officer over the past three years and wished him well in his new role.	
	Date of next meeting: Thursday, 28 May 2020, Room 52 and videoconference	

Trust Board Action Log Part 1 - May 2020						
Action Ref	**Section**	**Action**	**Due**	**Lead**	**Commentary**	**Status**
TB26.03.20/01	**Novel Coronavirus (COVID-19)**	The Chairman asked that a resilience plan for the Executive team be developed and shared with the Board.	30/04/2020	CEO/DCEO	**At the April 2020 meeting the CEO reported that there the executive team had developed a robust resilience plan which outlined the measures that would be taken in the event that an executive director would not be able to carry out their role. The document identified provisions for the CEO and Deputy CEO and senior leaders that would be able to act into the role of one of the executive directors. It also set out arrangements for deputising for the Trust Chairman. It was agreed the CEO would circulate this outside the meeting and therefore this action could be closed.**	**PROPOSED FOR CLOSURE**
TB26.09.19/04	**Mental Capacity Act and Deprivation of Liberty Standards (Annual Report 18-19)**	**Developing Annual Reports for other performance areas:** The Board agreed that it would be useful to complete annual reports for certain other performance areas such as treatment escalation plans and that proposals on which areas would benefit from this approach would be presented to the Quality and Safety Committee for consideration.	~~26/03/2020~~ 28/05/2020	CN/CTO	**In September 2019 the CTO recommended and the Board agreed that it would be useful for the Trust to complete separate annual reports for other performance areas such as treatment escalation plans. Whilst this was a valuable exercise the current demands on NHS resources additional reporting required in response to the COVID-19 pandemic, it is unlikely the Trust would be able to complete this action as envisaged. It is proposed that a place marker entered in the Board's 2021/20 workplan to revisit this item later in the year where proposals on which areas might warrant dedicated annual reports will be set out.**	**PROPOSED FOR CLOSURE**
TB19.12.19/09	**Finance and Investment Committee (Estates) Report (FIC(E))**	The Board noted the report and asked that the Health and Safety inspection report be presented to the Committee as a matter of urgency.	~~26/03/2020~~ 28/05/2020	ACEO	**UPDATE: This action would be copied onto the Finance & Investment Committee Action Log and the Board would receive an update in the FIC's Report to the Board in due course**. *Previous Update: ACEO reported that the Health & Safety Report Action Plan would be discussed at the FICE meeting and a report provided to Board.*	**PROPOSED FOR CLOSURE**
TB30.01.20/04	**Seven Day Services Implementation Update**	The Board noted the report and asked that the programme of work be integrated into the development of the annual plan for 2020-21, with the Trust Executive Committee providing oversight and scrutiny of progress.	~~26/03/2020~~ 28/05/2020	CMO	**UPDATE: The COVID-19 pandemic has resulted in the deferral of implementation of seven day services clinical standards until September 2020 and therefore this item has been incorporated into the QSC Workplan for August 2020 and the Board workplan for September 2020.** *Previous Update: Deferred to accommodate focused March agenda and developing national health crisis.*	**PROPOSED FOR CLOSURE**
TB19.12.19/07	**Freedom to Speak Up Guardian Report**	The Board agreed that the executive team would ensure that the organisation understands the need to engage with the FTSU process in a timely way and provide a method for the FTSUG to escalate non-engagement.	~~26/03/2020~~ 28/05/2020	TEC	**UPDATE: This will be included in the update from the Freedom to Speak Up Guardian at its June 2020 Meeting.** *Previous Update: Deferred to accommodate focused March agenda and developing national health crisis.*	**PROPOSED FOR CLOSURE**
TB19.12.19/08	**Freedom to Speak Up Guardian Report**	The Board also agreed that arrangements for executive sponsorship of the Freedom to Speak Up function should be reviewed.	~~26/03/2020~~ 28/05/2020	CEO	**UPDATE: This has been completed with the support of NHS Improvement and the executive oversight of FTSU has now moved to the CCAO.** Previous Update: Deferred to accommodate focused March agenda and developing national health crisis.	**PROPOSED FOR CLOSURE**
TB28.11.19/05	**Annual Research Report**	The Board noted the annual research report and agreed that the next iteration would include comparative data to demonstrate where the Trust sits in relation to other organisations.	Q1 2020/21	CMO	**The Annual research report has been included in the Board's 2020/21 Workplan and the CMO will ensure that this data is incorporated in the report. The next annual report would come to the Board in September 2020. The QSC would adopt this action on behalf of the Board.**	**PROPOSED FOR CLOSURE**
TB30.01.20/02	**Integrated Quality and Performance Report (IQPR)**	**Non-Medical Appraisals Deep Dive at WEC:** The Board agreed that the Workforce and Education Committee (WEC) would conduct a deep dive into non-medical staff appraisals and the executive team could learn from the work carried out in the estates team to improve the department's appraisal rates.	28/05/2020	CPO	**The Board stood down WEC in response to the COVID-19 pandemic. The Committee would start to meet from June 2020 and this action has been moved to the WEC action log.**	**PROPOSED FOR CLOSURE**
TB27.02.20/02	**Outpatients Strategy**	The Board approved the strategy subject to a robust business case being undertaken and the Board given the opportunity to scrutinise the financial investment envelop and the key risks and next steps.	28/05/2020	COO	**The development of the outpatients business case has been paused whilst the Trust responds to the COVID-19 pandemic. The Board would be asked to review any business case which falls within its remit in line with the Standing Financial Instructions. This action has been copied to the FIC action log. The Committee would provide the relevant assurances to the Board about the robustness of the business case.**	**PROPOSED FOR CLOSURE**
TB26.03.20/02	**Quality & Safety Committee Report**	The Board agreed that executive team should ensure that both the short and long term risks associated with COVID-19 and its impact and implications for other service provision should be considered by the relevant executive workstreams responsible for managing the Trust's response to the pandemic.	28/05/2020	DCEO	**UPDATE: This work has been completed and reflected in agenda item 6.4 below**. *Previous Update: Not yet due. The Quality Safety Committee discussed this risk rating at its meeting on 23 April 2020 and the executive team have been tasked with looking at BAF risk which would be considered at the May 2020 Board meeting.*	**PROPOSED FOR CLOSURE**

TB26.03.20/03	**Quality & Safety Committee Report**	The Board noted the report and agreed that a risk related to COVID-19 should be reflected in the Board Assurance Framework.	28/05/2020	CCAO	**UPDATE: This work has been completed and reflected in agenda item 6.4 below**. *Previous Update: Not yet due. The Quality Safety Committee discussed this risk rating at its meeting on 23 April 2020 and the executive team have been tasked with looking at BAF risk which would be considered at the May 2020 Board meeting.*	**PROPOSED FOR CLOSURE**
TB19.12.19/01	**Action Log & Matters Arising**	**Plans for Providing Effective Assurance at Committees (Corporate Objectives):** The Board agreed that plans for reporting on and providing effective assurance through Committees to the Board on corporate objectives would be picked up as part of the process for agreeing the objectives for 2020/21.	~~26/03/2020~~ 28/05/2020	CSO/CCAO	**This is being revisited in light of the changes to the operational governance structures (described in the CEO's report at item 1.5) and an update will be brought to the next meeting in June 2020.**	**OPEN**
TB28.11.19/01	**Medication Incidents and Controlled Drugs Q1-2 Report**	The CMO agreed that the next iteration of the medicine incident and controlled drugs report would include relevant benchmarking data.	~~28/05/2020~~ 20/06/2020	CMO	**This report would be presented to QSC and Board in June 2020 and would include benchmarking data. This action would be copied to the QSC action log.**	**OPEN**
TB30.01.20/05	**Patient Story: Sickle Cell Patients in the Emergency Department**	The Board thanked Ms Vitalis for sharing her story and agreed that a follow-up report would be presented to the Board setting out the actions that had been taken to ensure that her poor experiences would not be repeated either for herself or for others.	30/06/2020	CN	Not yet due.	**NOT DUE**
TB27.02.20/01	**Learning from Deaths Quarter Three 2019/20 Report**	The Board noted the report and it was agreed that an item on the Medical Examiner system would be included in the Board development programme in the first half of 2020/21.	30/06/2020	CMO	Not yet due.	**NOT DUE**

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Meeting Title:	Trust Board		
Date:	28 May 2020	**Agenda No.**	**1.5**
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting. It is also important for the Trust Board to note – as set out in this report - that the executive has recently made changes to the Trust's governance structures, including replacing the Trust Executive Committee with the Trust Management Group.		
Recommendation:	The Board is asked to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

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Chief Executive's report to the Trust Board – May 2020

Introduction

Since my last report to the Trust Board, I am pleased to say that the first Covid-19 peak has now passed – although we remain vigilant, and ready for future increases and spikes in activity.

The slowdown in patients presenting with Covid-19 has allowed us to pause briefly, and assess the impact of recent weeks - on staff and patient services - and the challenges and opportunities that lie ahead.

I continue to be impressed by the way in which the organisation has responded. It has not been plain sailing, and we have learned a huge amount – however, our staff have looked after patients (and their relatives) with incredible kindness and compassion.

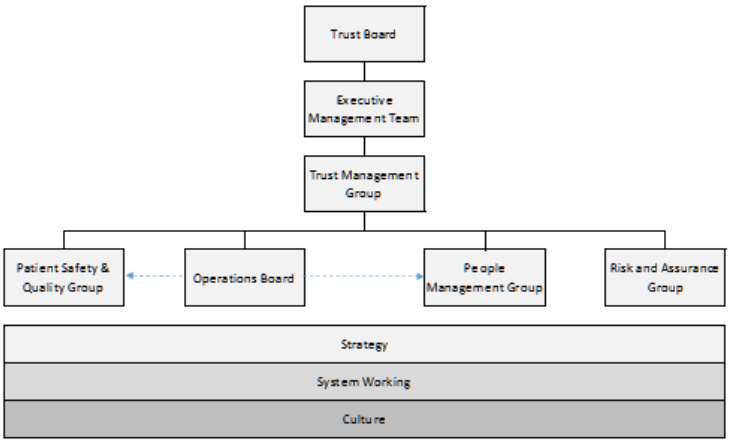
They have also provided safe, high quality patient care – despite the pressures, and uncertainties that surround Covid-19, including how it affects different communities and vulnerable groups.

During May, members of Team St George's – both Trust staff and those employed by partner Mitie - have sadly passed away, in some cases as a result of Covid-19. This has been deeply distressing for immediate colleagues, and the wider organisation. Our thoughts are with the friends and families of those colleagues.

Taking stock

With the first Covid-19 peak having passed, we have taken the opportunity to revisit our operational governance structures, and realign some of our management processes and meetings, to ensure they are truly fit for purpose and enable the organisation to respond in an agile way to current demands and future challenges.

A high level overview of our meeting structure is set out in the graphic below:



As part of this, we have established a new Operations Management Group, chaired by Avey Bhatia, our Chief Operating Officer. This will help bring a renewed focus to operational management and performance, with – crucially - senior clinical representation from our divisional teams. This group will have oversight of the Trust's performance against all of the operating standards in the NHS Constitution, including the four-hour emergency standard, the two week cancer standard and the 18 week referral to treatment time standard. The group will also provide oversight of financial issues.

The new Operations Management Group links closely with the pre-existing Patient Safety and Quality and People Management groups – with a new Risk and Assurance Group helping to identify and track issues of significance or concern across the equal priorities of quality, finance and performance and matters of regulatory compliance.

These groups will now report into a newly constituted Trust Management Group (TMG), comprising Executive Directors, Divisional Chairs and certain other staff. It replaces the Trust Executive Committee, and will be responsible for leading delivery of the Trust's objectives, leading the delivery of the required quality and performance standards, ensure resources are used efficiently and effectively, and provide oversight of all aspects of the Trust's operation, both clinical and non-clinical.

System and strategy work will also feed into the TMG, as will the important work we are doing to improve the culture of the organisation. The TMG will be accountable to the Executive team, led by myself as CEO, which will retain the accountability line to the Trust Board. The new structures are set out in Appendix 1.

We have quickly recognised that Covid-19 is going to fundamentally change the way we work going forward – so the groups above are underpinned by a renewed focus on strategy, culture, and system working, all of which are central to our ability to thrive in the future.

Our services – and key considerations

Our hospitals and community services are still functioning in very different ways as a result of Covid-19; and this will remain the case for months and potentially years to come. But we are seeing some signs of a return to previous behaviours, particularly in relation to how patients access and use our services.

Bed occupancy is gradually increasing – at the time of writing, it stands at 65%, but we expect this to rise fairly rapidly, particularly as more and more people return to something close to normal life following the relaxation of the national lockdown.

ED attendances are creeping back up, but our emergency care performance is tracking consistently above 95% - which, despite the drop in attendances, is still a significant achievement, and credit is due to our emergency care and medicine teams for the way they have managed and organised care over the past few weeks.

Providers across south west London are all keen to re-start elective activity as soon as possible, and we are working closely to ensure this is done in a consistent and organised way – and communicated clearly.

However, we also have a duty to manage patient expectations – re-starting elective activity is far more complex than stopping it, and we will only take this step when we are confident that patients will be kept safe, and not exposed unnecessarily to increased risk of infection.

The one area that continues to thrive as a result of Covid-19 is outpatients. Over 75% of outpatient activity is currently being undertaken virtually – and this continues to be welcomed by both patients and staff. Of course, we should not consider outpatients 'fixed', and the service has faced challenges in recent years – but the response from the team overseeing the service has been fantastic.

Our staff

Our staff have coped admirably with the incredible pressures of recent weeks, but it is also very clear that the next stage – recovery, and re-starting activity in new and different ways – is going to be even harder.

We have been clear with staff that we will not be returning to the old and established way of doing things. Many teams have welcomed this – and seen age old barriers and obstacles lifted overnight – whilst, for others, it is more challenging, with working lives turned upside down.

Both reactions are natural, and understandable – but, in all cases, we need to support staff; and help them process what has happened in recent weeks, and what is means both for our future as an organisation, and theirs as individuals. Our culture champions are working hard to support this work, and it is something I personally see as absolutely crucial that we focus on now, and going forward.

We are working hard to meet with and listen to staff, both virtually and – where possible – in person. We have held four listening events for staff to discuss issues affecting Black, Asian, and Minority Ethnic colleagues – and this has surfaced some deeply worrying behaviours, which I addressed in a message to staff last week. However, tackling the behaviours we've identified is a daily challenge, and one we mustn't shy away from.

Charitable support

Finally, I would like to praise again, as I did last month, the incredible support we've had from local charities, and local communities, particularly in recent weeks. We have also continued to benefit from the support of charities based at St George's – including First Touch, plus St George's Hospital Charity.

St George's Hospital Charity launched a dedicated Coronavirus Appeal in mid-March, and this has already raised nearly £350,000, which is staggering, and shows the high-esteem in which our staff and the services they provide are held.

We are incredibly grateful to the charity, both for their fundraising efforts and practical, hands on support which is really appreciated by staff. The Board will consider a standalone report by the St George's Charity at its meeting.

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NHS
St George's University Hospitals
NHS Foundation Trust

Key appointments and administration

Harbhajan Brar, our Chief People Officer, moved to a new role at Imperial College last week. Harbhajan has been our human resources and organisational development lead for the past three years, and we wish him well in his new role.

We are recruting a permanent successor for Harbhajan, but in the meantime, Elizabeth Nyawade and Humaira Ashraf - our two Deputy Chief People Officers - will provide interim cover until a substantive appointment to the executive director role is made.

Elizabeth will be Acting Chief People Officer for Workforce, whilst Humaira will be Acting Chief People Officer for Organisational Development and Culture.

We have also appointed Andrew Asbury as our new Director of Estates and Facilities. Andrew takes up his post on Monday 25 May. Jan Bradley will also join us in August as our new Director of Midwifery.

2.1

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NHS
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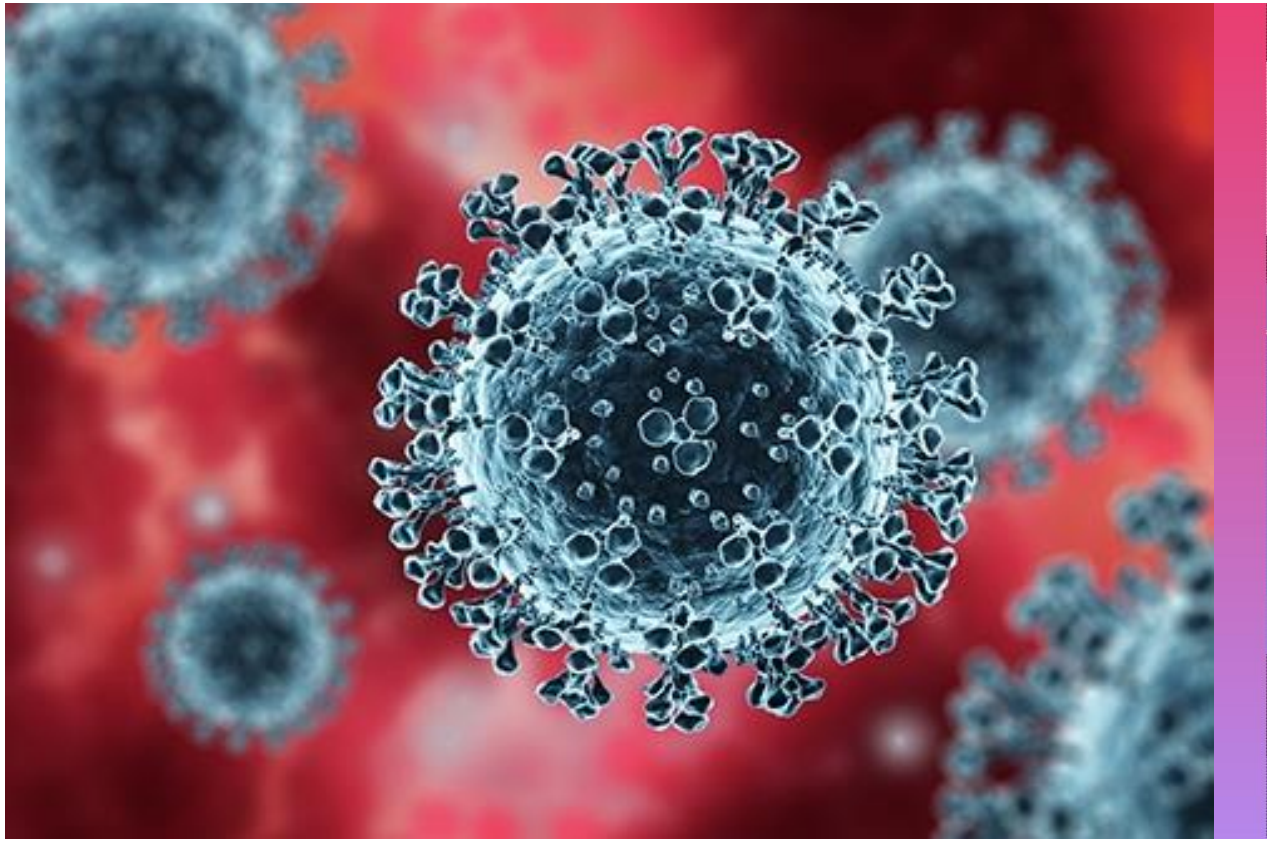
NHS Foundation Trust

Covid-19 Summary

Trust Board

Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control



21 May 2020

2.1

Meeting Title:	**Trust Board**		
Date:	28 May 2020	Agenda No	2.1
Report Title:	Covid-19 Update & Safety Dashboard		
Lead Director/Manager:	Robert Bleasdale, Chief Nurse/Director of Infection Prevention and Control		
Report Author:	Robert Bleasdale, Chief Nurse/Director of Infection Prevention and Control		
Presented for:	Note		
Recommendation:	**The Board is asked to note contents of the presentation for information.**		
	Supports		
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care; Leadership and Improvement Capability		
	Implications		
Risk:	The Trust has in place a risk register for the management of Covid-19 which is highlighted in this report		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence.		
Resources:	N/A		
Previously Considered by:	N/A	Date	
Equality Impact Assessment:	No direct implications		
Appendices:	Appendix 1: Quality & Safety Dashboard		

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Executive Summary

- Since the last update, the Trust has continued to operate with more capacity than demand for COVID 19 patients needing our care and support in ITU and general medical beds. In addition, we have continued to run a range of retained services, such as: trauma, maternity, neonatal, cancer, stroke, heart attack, medical and surgical take, paediatrics, imaging and pathology.

- Demand for COVID 19 inpatient beds peaked on 2nd April and for ITU peaked on the 12th April. Since then we have plateaued at a lower level of COVID 19 demand and this is forecast to continue.

- The existing work streams used to manage the Trust Covid response will now be incorporated into a new meeting structure, which will include an operations group which will be responsible for the oversight of Trust performance and resumption of services, in line with new national guidance. We will continue to work collaboratively with partners across SW London and NHS London to achieve this.

- The Trust has implemented new operating guidance for the management of urgent elective surgical patients. This process has seen the establishment of dedicated 'green' covid protected areas with patients being screened prior to admission.

- In order to minimise transmission of Covid dedicated admission pathways have been implemented based on a patients symptoms and test results following testing within the emergency department.

- Following the publication of the London Infection Prevention guidelines and national operating framework the operational group with the support of infection prevention and control are working to ensure these are fully implemented, including the establishment of a working group to implement social distancing measures within the workplace.

- A self assessment against the national standards for infection prevention and control is currently being completed using the national Board Assurance Framework document, which will be presented at the Quality and Safety Committee in June.

- The draft definitions for nosocomial transmission will be applied to St Georges cases and a review completed to establish any learning, including contact tracing for positive cases within the hospital.

- A Safety dashboard has been created to monitor the care within ITU and waiting times following the temporary suspension of services. This has been matched to the 7 key themes from the quality and safety strategy and will be reviewed monthly in line with the IQPR through the Quality and Safety Committee. It is anticipated the metrics will evolve as we resume services and should we have any further surges in Covid admissions.

- The CMO is leading a group to prioritise and coordinate the resumption of clinical services using a risk based approach, which reports to the Operational Group.

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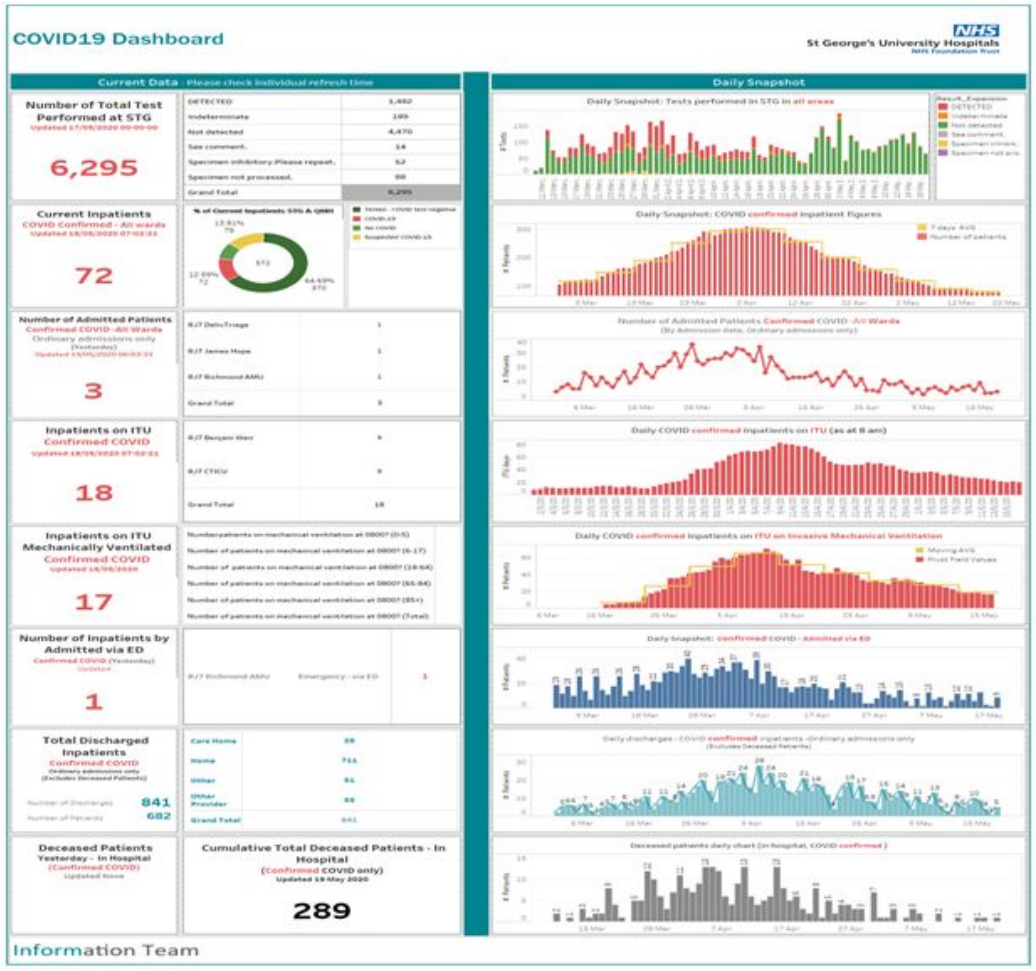
COVID 19 Demand and Activity at 19th May 2020



- We have passed our first peak and stepped down to a plateau of demand in relation to COVID 19.
- COVID 19 inpatients reduced again this week to 72, down from a peak of 304 on 2nd April.
- COVID 19 inpatients on ITU reduced again at 18, down from a peak of 83 on 12th April.
- A total of 6,295 COVID 19 tests on patients have been completed, with 1,482 identified as positive.
- A total of 841 discharges for patients with confirmed COVID 19, of which there have been 289 diagnosed COVID 19 deaths.
- There are currently 572 (65%) inpatient G&A beds in use and 317 (35%) closed. Bed occupancy naturally increasing at c.5% a week currently
- Our forecast for the next 7 days of May 2020 is that we will continue on the current plateau, with demand for COVID 19 ITU further reducing in the range of 15-30 beds and medical COVID 19 of 45 -90 beds (see page 3 and 4).
- As the current social distancing measures are eased, we will continue to track the impact closely on forecast demand, 7-14 days in advance.

COVID 19 Update

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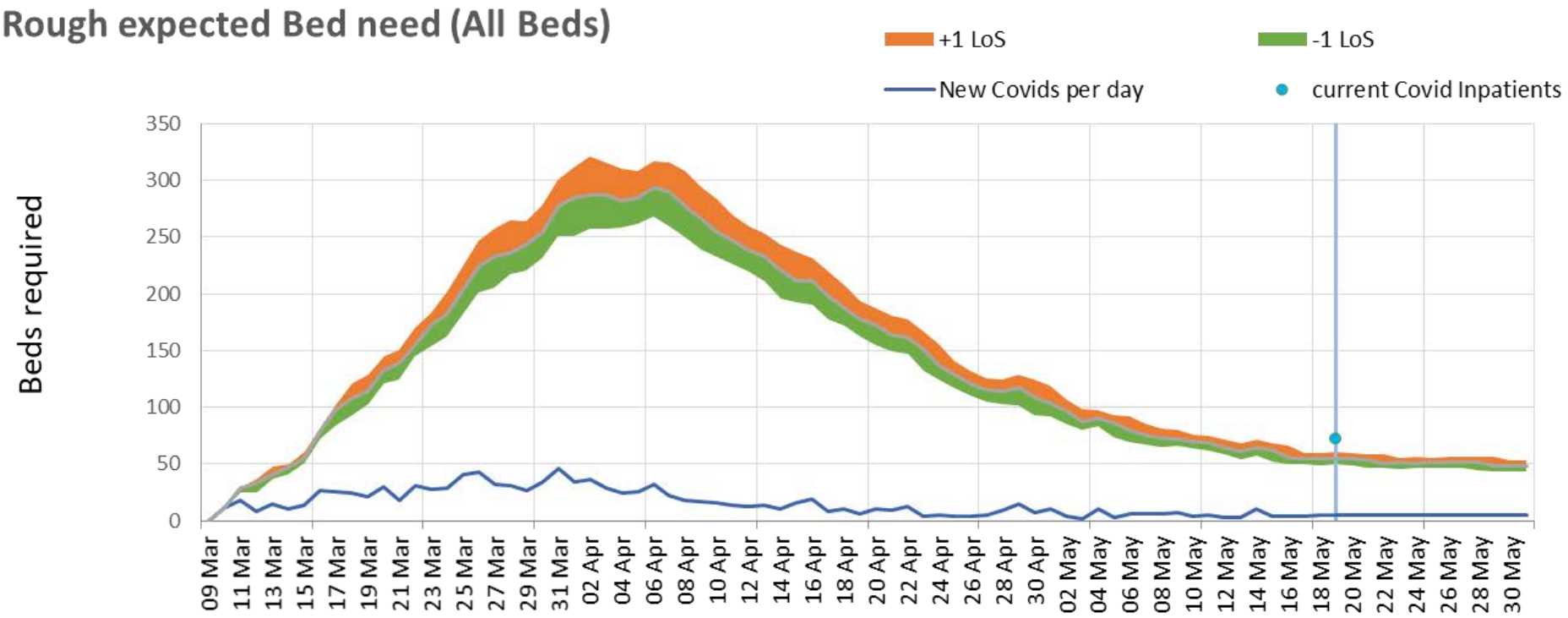
SGH Bed Base

Estimated Covid Bed Base range as at 19th May 2020



Based on current position, we forecast ~50 beds for Covid+ patients. As at 19th May we are using 72 beds (**blue dot**).

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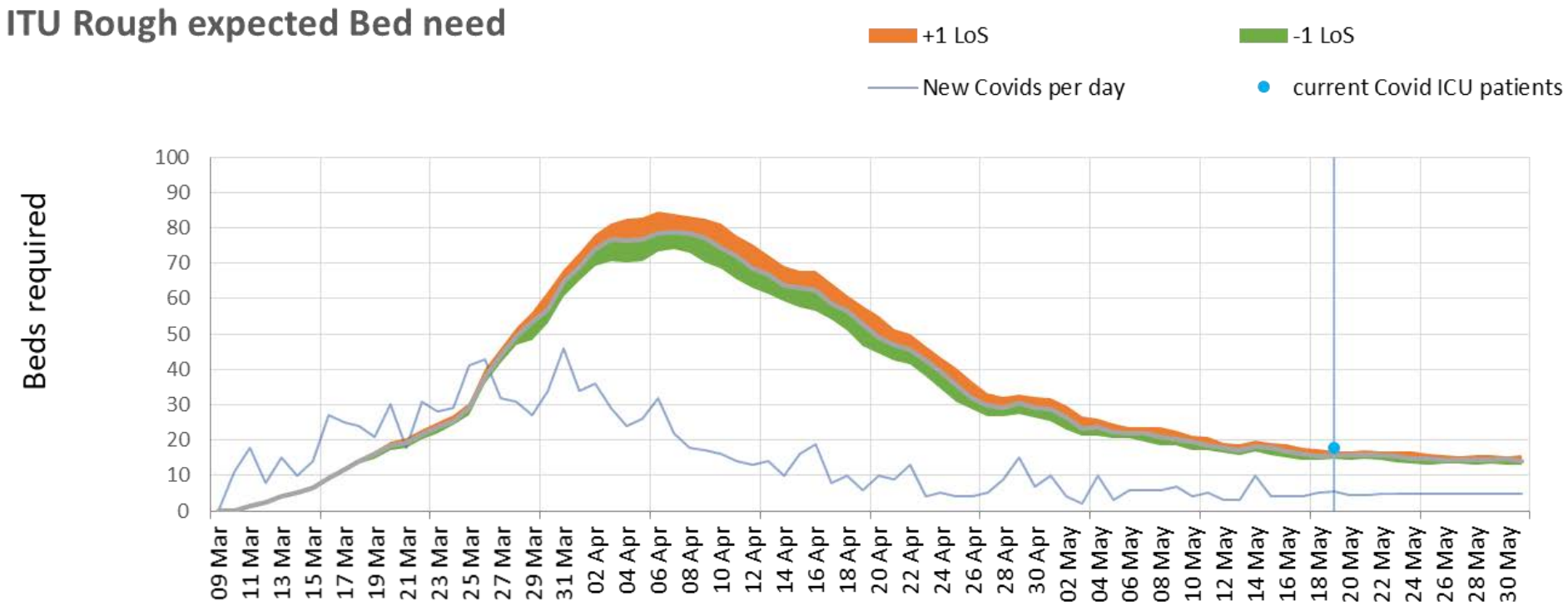
SGH Bed Base

Estimated Covid ITU Bed Base range as at 19th May 2020



We are forecasting COVID ITU demand of ~15 beds. At 19th May we were using 18 ITU beds.

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Testing position and Capacity

- To date, the total number of St George's staff tested in the Bence-Jones Testing Facility for Covid-19 is 927. Of the 927 staff tested, 431 tested positive. 722 of the staff were clinical, 150 non clinical and remaining 55 staff members did not have their job titles registered.
- SWL Pathology, based at St George's has processed 708 of the 927 tests, as the first 219 tests were sent to Collindale.
- Staff testing at St George's POD now includes staff (and household members) from CLCH, Your Healthcare, SWLStGs, Primary Care and Pharmacy Staff.
- The CCG co-ordinates the referral of staff from the above units to St George's POD.
- Following a decision from NHSE/I in April, all non-elective hospital admissions are now being screened for Covid-19, regardless of whether or not they have any suggestive signs or symptoms. This is to facilitate early detection of mild or pre-symptomatic cases and prevent nosocomial transmission.
- The expansion of testing to all emergency admissions, coupled with a pilot of sampling of asymptomatic staff across SWLStGs and community services resulted in a significant demand in the lab
- Unfortunately due to insufficient reagents to maintain the level of activity tests for ESTH and RNOH are now being processed at an alternative lab.
- Next Steps:
  - SWLP working through the operational group to implement serology testing at St Georges POD
  - Conducting a capacity and demand review based on the new national and London IPC guidance which was published on 15/05/2020 which details suggested testing regime for elective, non elective and day case patients.

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Infection Prevention and Control Measures and Elective Surgery

Urgent Planned Care Wards
The planning for an urgent Planned Care Ward (UPCW) to separate emergency and urgent elective care and create a 'clean' or 'GREEN' areas of the hospital is underway. The UPCW will facilitate new clinical pathways for elective level 2 cancer, benign surgical patients and urgent surgical patients. Exclusion criteria will apply, for example patients with a tracheostomy.

Reducing the risk of infection
The new clinical pathways will be supported by full pre-operative assessment, scheduled Covid-19 testing and a period of shielding prior to admission and post discharge to:

- mitigate the risk of nosocomial infection with Covid-19 to patients coming to St George's Hospital for urgent planned surgical care
- reassure staff and patients of the risk reduction re exposure to Covid-19 for urgent planned care patients and their families

There will be dedicated staff on the UPCW, including dedicated nurses, therapist, pharmacist, junior medical staff, hostess and domestic – no temporary staff will be used

Theatres and recovery areas
Theatres have been designated RED and GREEN and full PPE will be required for all theatre procedures. Patients on UPCW pathways will utilise GREEN theatres only

Intensive Care
A separate facility within ITU will be the designated GREEN facility.

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Infection Prevention and Control Measures and Urgent & Emergency Care

Identification and Management in ED

On arrival to the emergency department patients are immediately identified as either:

- Asymptomatic
- Symptomatic for Covid19
- Known Covid19 positive

Patients who are symptomatic or known positive are nursed in separate designated areas
All patients that require admission from the ED are swabbed and tested for Covid19
PPE in place for staff within ED

Reducing the risk of infection

Agreed risk stratified approach to patients according to Covid symptoms and test awaited/positive/negative results in place.
Wards have been designated to accommodate the following patient groups:

- Symptoms of Covid – high risk – results awaited
- Asymptomatic of Covid – low risk – results awaited
- Covid positive on test results
- Covid negative on test, but symptoms and clinical presentation suggestive of Covid
- Covid negative on tests and symptoms unlikely

Where patients are cared for awaiting test results additional measures have been put in place to minimise the risk of infection

- Reduction of beds within bays to maintain 2m distance between patients
- Enhanced cleaning of touch points and toilets
- Curtains to be pulled between patients if possible to act as a barrier
- Face masks in use for symptomatic patients where this does not compromise clinical care

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Infection Prevention and Control Measures

Reducing the risk of transmission

- Supporting policy for the procedures for the management of patient pathways currently being finalised which in addition to the previous criteria will also include:
  - Screening questions for all patients which should be completed daily
  - Screening questions for all staff working in green areas, which should be completed daily in addition to temperature checks
  - Dedicated transportation arrangements for those patients shielding or most at risk

Social Distancing

- Trust working group established to review the national recommendations regarding social distancing and infection control measures for the work place
- Immediate communication measure instigated to support this

Nosocomial Transmission

- Whilst there has been no national definition provided currently the infection prevention team will be applying the following criteria to Trust cases.
- Following application of these definition a review of cases will be completed to establish any immediate learning, whilst a formal RCA process is instigated.
  - **Hospital onset, indeterminate hospital-associated infection**: Covid positive sample taken >48 hours and <=7 days after admission
  - **Hospital onset, probable hospital associated Covid infection:** Covid positive sample taken >7 days and <=14 days after admission
  - **Hospital onset, healthcare acquired Covid infection:** Covid positive sample taken >14 days after admission *(this is the measure most likely to only be detecting hospital versus community acquired infection)*

An assessment against the national standards and NHSE/I recommendations is underway using the provided IPC Board Assurance Framework and will be presented to the Quality and Safety Committee in June 2020.

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Patient Safety Dashboard

The Trust has taken a risk assessed approach to restructure its clinical services in response to Covid-19 to ensure the safe and effective provision of clinical pathways.

Given the risk that rapid untested service change may impact on the quality and safety of patient care, a Covid-19 specific performance dashboard has been developed to enable focus and on-going monitoring of 34 key metrics across the seven priority areas outlined below within the Trust's Quality and Safety Strategy 2019-24:

- Priority 1: Minimise avoidable harm
- Priority 2: Improve patient outcomes
- Priority 3: Excellent patient experience
- Priority 4: Improved staff experience
- Priority 5: Equitable patient access and quality
- Priority 6: Embed quality, safety and learning culture
- Priority 7: Provision and development of pioneering treatments

The dashboard is still under development and is likely to evolve in line with national guidance and as services resume.

As the dashboard is populated over time the analysis of the information presented may become more meaningful in terms of indicating key areas of concern for Covid-19 patients and/ or its impact or emerging themes requiring further review. However, this dashboard needs to be set against the Trusts Integrated Quality and Performance report to provide an accurate reflection of quality and safety across the Trust's services.

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Appendix 1: Work stream summary

Work stream	Priorities/ key actions since last meeting	Lead
Surge and Sustain	• Developed the plan for the retained expansion of ITU capacity to enable recommencement of services and manage and anticipated Covid demand, in line with IPC principles. • Expansion of Testing capacity to support community providers and testing of all emergency admissions • Established admission pathways for emergency admissions to enable segregation until results are processed.	COO
Safely Standing Down	• A new care pathway for the management of urgent surgical patients has been agreed and implemented, which creates a 'clean non-COVID ward' environment to mitigate the risk of nosocomial transmission to patients who need this urgent planned surgery at the St. George's, Tooting site.	CTO/ COO/ CMO
Workforce	• Held staff listening sessions with BAME staff in the development of a staff risk assessment, which has been launched 18th May 2020. • Establish working group to progress recommendations from "Our plan to rebuild" specifically regarding social distancing • Providing psychological support to frontline teams and linking this to our communications and well-being plans. • Developing a workforce modelling capability to forecast the staff needed for various demand scenarios in the second phase.	CPO
Support Activities	• Delivered the stock and PPE needed to safely manage the Trusts COVID 19 response in the first phase. • Building the stock levels needed to support our phase 2 response, with a focus on gowns and protective masks. • Provide mutual aid to other partners in SWL • Expansion of fit testing to identified staff	DCFO
Ethics and Palliative Care	• Agreed and implemented Treatment Escalation Plans to support new ways of working required by our COVID 19 response. • Agreed the 'decision making framework' to triage patients to and from ITU • Developing the COVID elements of the Quality and Safety dashboard to provide assurance regards standards of care and clinical outcomes	CMO
Support to Staff	• Extended staff testing for COVID 19 to all staff groups that have the symptoms on site and through the Chessington drive-in centre • Upgrade of iPad systems to facilitate video messaging for patients • Launch of staff team awards/ recognision • Support International Nurses Day and International Day of the Midwife	CCA
Returning to Normal	• Planning the Trusts response to the second phase, for COVID and non-COVID 19 patients, in line with NHS London and NHS SW London's pandemic response strategy.	COO

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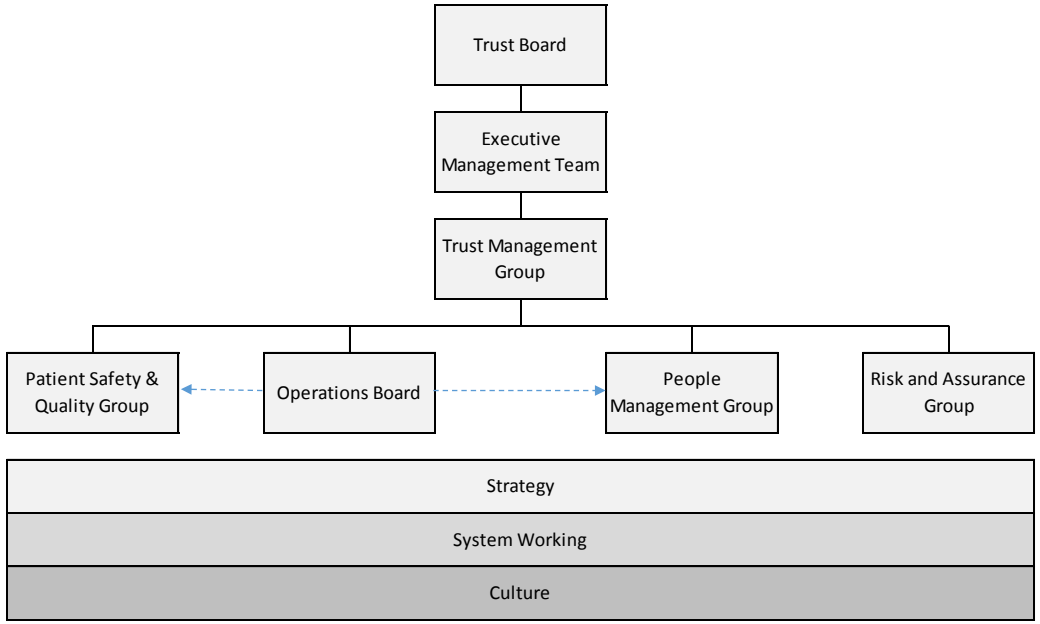
Appendix 2: New operational governance structure

Following the successful management of the initial phase of the Trust Covid response it is agreed that to support the resumption of services in line with new operating guidance the work streams used previously will now be incorporated into a new framework of meetings which report through to the Trust Executive. Within this structure, the Patient Safety and Quality Group would remain the key operational group responsible for managing quality and safety issues and reporting, via the Trust Management Group and Executive team, to the Quality and Safety Committee of the Board.



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St George's University Hospitals NHS Foundation Trust

3.1

Meeting Title:	**Trust Board**		
Date:	**Thursday, 28 May 2020**	**Agenda No**	**3.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Prof. Dame Parveen Kumar, Chairman of the Quality and Safety Committee**		
Report Author:	**Prof. Dame Parveen Kumar, Chairman of the Quality and Safety Committee**		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting in May 2020.		
Recommendation:	**The Board is asked to:** • **Note the update in the report; and** • **Receive the Annual Committee Report;** • **Approve the proposed changes to Committee's Terms of Reference; and** • **Endorse the Committee's 2020/21 Work plan**		
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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St George's University Hospitals NHS Foundation Trust

Quality and Safety Committee Report

3.1

Matters for the Board's attention

The Quality and Safety Committee met on 21 May 2020 and agreed to bring the following matters to the Board's attention:

1. Novel Coronavirus (Covid-19)

The Committee received a comprehensive report on Covid-19. The report included updates on demand and activity, effective pathway management and resuming clinical services safely, enhanced infection prevention and control measures and testing of patients and staff.

On examination of the quality and safety dashboard the Committee was assured that the numbers of cases were on a downward trajectory. The Committee heard about the plans to resume clinical services and in order to start treating non-Covid patients safely in the hospital the Trust was developing robust standard operating procedures to ensure the risk of infection was minimised, through the implementation of dedicated pathways.

The Trust had completed a review of the patients currently waiting to use its services and had developed the clinical safety strategy to ensure a risk managed process for the resumption of services. This includes the need for patients undergoing elective care to isolate prior to presentation, and undergo Covid19 testing prior to their procedure.

The Trust was also working closely with South West London partners to encourage people to attend their appointments and access the Trust services if required.

Whilst much work was underway to develop the Trust's infection prevention and control measures the Committee heard about the current provisions in place to ensure that there were designated areas for Covid and non-Covid patients coming in to the hospital for elective surgical procedures, urgent and emergency care and general infection prevention and control measures related to personal and protective equipment, social distancing and criteria for nosocomial transmissions.

The Committee, at its next meeting, would consider the detailed self-assessment of the Trust's enhanced infection prevention and control measures against the national standards for infection prevention and control for Covid19.

The Committee also considered and endorsed the Trust's risk based approach to undertaking staff fit testing for FFP3 masks, acknowledging that the use of different types and models of FFP3 equipment added a different level of challenge for the Trust.

The Committee were assured the Trust was taking the right approach but encouraged the management team to ensure that sufficient focus was given to ensure that the Trust was fully compliant with national guidance by the end of June 2020 and noted that the Trust was already a week ahead of its trajectory to be fully complaint.

The Committee also noted that now that the trajectory of patients with Covid19 was reducing the Trust was very aware that staff need additional support and care as they process the impact of operating in a heightened environment and staff were being encouraged to take annual leave and look after their mental health and wellbeing.

The Committee were also apprised of the work of the Clinical Ethics Committee noting that there was a tool in place to support effective decision making should the need arrive.

Fortunately, during the peak the Trust and the wider NHS had sufficient respiratory resources to care for all patients and this decision making support tool was not used. The Clinical Ethics Committee and the Chief Medical Officer was now working on refining and finalising the framework in the event that there were future peaks of Covid-19. The Trust was seeking legal advice to ensure that the framework for withdrawing care was within legal boundaries and adheres to national standards and guidance. The Committee was also assured to learn that the Trust had at the peak of Covid cases a rota of senior clinicians to be called upon if required to participate in effective decision making on a case by case basis and this pool of people would be maintained in the event of future rises in cases.

The Board would have noted much of the same updates as discussed above but the Committee wanted the Board to be mindful of the level of complexity of delivering safe hospital services and shielding non-Covid patients will add to how the Trust's infection prevention and control mechanisms and systems operate.

2. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance at month 01 (2020/21). At month 01 the Trust's treatment escalation plan (TEP) were now available for completion electronically as part of the patient record. As a result of this the improved position of 40% of inpatient and 60% of covid-19 patients have a TEP in place with numbers increasing daily was noted.

The number of Datix reports had decreased in month, with most rated as low or no harm. The committee heard how a review of the incident pattern for month one had been completed to ensure that there had not been a significant change in reporting due to the operational impact of Covid19. Whilst there had been a reduction in Datix incidents a review showed that the reduction correlated to areas where services had stopped or reduced, such as breast screening and endoscopy. There was also a reduction noted in areas where there had been reduced occupancy, but an increase, was noted in intensive care units (ITU) areas where the service had expanded the bed base. It was noted that there was no concerning trends or soft signals or that there were any underlying safety issues.

The Trust also experienced an increase in the number of category two pressure ulcers which on early review is considered to relate to tissue viability nurses being redeployed to intensive care units, and other staff members were temporarily responsible for assessing pressure ulcers. The redeployment of the tissue viability nurses to support ITU has prevented the validation of correct categorisation of skin damage, and based on historical data it is anticipated that some of these cases have incorrectly been recorded as pressure ulcers.

The Committee was pleased to learn that whilst the complaints performance had dipped in month 01, there was a plan to increase performance in month 02 which was currently delivering.

The Trust's response rates for friends and family had increased significantly for the Emergency Department (ED) to 22.6% against the target of 20% with 93.9% of respondents indicating that they would recommendation the Trust services to their friends and family. The Committee recognised that whilst the ED survey was conducted by text, there were challenges in other areas with conducting the survey's whilst achieving social distancing and infection control measures.

3. Safe Staffing Report

The Trust's overall fill rate (registered nurses and healthcare assistances combined) was 83% in April 2020 compared to 93.85% in February 2020. However in April 2020, nursing staff had more time to spend on patient related activities in comparison to previous months mainly due to low occupancy in the wards as evidenced through the increase in Care Hours Per Patient Day. The Committee noted that all red flags raised in month had been safely mitigated.

4. Serious Incident Reporting

The Committee noted that four serious incidents had been declared in April 2020 and two investigations closed.

5. Learning from Deaths Report (Quarter 4)

The Committee also discussed the learning for deaths which is also presented below under agenda item 3.3. The Committee noted that many of the deaths in the quarter related to Covid-19 patients. The Committee would also conduct a deep dive into mortality with a focus on how the organisations processes mortality alerts and signals into the organisation as part of its programme of work during 2020/21.

6. Draft Quality Report 2019/20

The Committee received and endorsed the draft version of the Trust's quality report which would be issued to stakeholders for comments. In light of the national health crisis NHS Improvement/England had written to trusts to defer the Quality Report (Account) beyond the date specified in the regulations, and for external audit/assurance of the report to be ceased. The Trust, however, was at an advanced stage in the process and would produce the document which following consideration by the Audit Committee would be presented for approval by the Board on 25 June 2020. The Committee also noted that because the document was not required to undergo the scrutiny of the external audit, for this reason the document would be taken to ensure adequate internal assurance were made around the content and the assurance statements within the document appropriately caveated.

7. Patient Safety & Quality Group (PSQG) Report

The Committee received and noted the report from the April 2020 meeting of the Patient Safety and Quality Group. The Trust continues to make good progress on completing the assessment of NICE guidelines and the Committee noted that 17 new guidance documents in relation to Covid-19 had been received and 10 had been subjected to the required assessments, with a trajectory requested for review of those elements outstanding. The Group was actively managing divisional progress on implementing serious incident action plans and any areas that were not performing had been asked to provide a trajectory of when actions would be completed.

8. Cardiac Surgery Report

The Board would consider the cardiac surgery report later on the agenda but the Committee noted that following the publication of the independent mortality review in March 2020 the Trust continued to engage with family members. The Trust cardiac surgery service performed only one operation in March 2020 as a result of Covid-19.

9. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register which focussed on the four strategic risks (SR) which fall within its remit and endorsed the partial assurance rating contained within the quarter four BAF presented for consideration by the Board below under agenda item, 6.4.

Committee Annual Report and Deep Dive Programme

The Committee considered its draft annual report attached in Appendix 1 for the Board's endorsement. The Committee also reviewed its Terms of Reference and propose the Board adopts the revised version which have been revised to bring these into line with the new template and the majority of changes are minor, intending to improve drafting and tidy up aspects of the terms of reference. The duties of the Committee have been reworked in order to clarify its responsibilities and simplify how these are set out. No substantive changes have been made to the role or scope of work of the Committee. The Committee was also pleased to approve a robust deep dive programme which addressed many of the key quality and safety issues the Committee would like to give focus to, including the two must do actions from the Care Quality Commission, divisional reviews and key risks mapped across the board assurance framework.

The Board is also asked to endorse the Committee's work plan for 2020/21.

Recommendation

The Board is asked to:

- **Note the update in the report; and**
- **Receive the Annual Committee Report; and**
- **Approve the proposed changes to Committee's Terms of Reference; and**
- **Endorse the Committee's 2020/21 Work plan.**

Dame Parveen Kumar
Committee Chair
May 2020

ANNUAL BOARD COMMITTEE REPORT

QUALITY & SAFTY COMMITTEE

1 April 2019 – 31 March 2020

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Quality and Safety Committee: 2019/2020 Annual Report

1 Introduction

The Quality and Safety Committee is the principal Committee of the Board responsible for overseeing and providing assurance to the Board on patient safety, clinical effectiveness, clinical and quality governance and patient experience.

This report sets out the work of the Committee during the reporting period 1 April 2019 to 31 March 2020. The Committee submits a report to the Board after each meeting setting out the key discussions of the Committee, areas of assurance and matters for escalation to the Board. The purpose of this annual report is to provide a wider perspective on the work of the Committee over the past year and in so doing provide assurance to the Board that the Committee has discharged its role in line with its approved terms of reference.

2 Committee purpose and duties

The Committee's purpose and duties are set out in its terms of reference as approved by the Board on 22 February 2018. These set out that the Committee should:

- function as the Trust's umbrella clinical and quality governance committee;
- provide the Board with assurance that high standards of care are provided by the Trust;
- provide the Board with assurance that there are adequate and appropriate governance structures, processes and controls in place to enable the Trust to deliver quality services in the following domains:
  - **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.

The Committee supports the Board in monitoring and managing four strategic risks on the Board Assurance Framework:

- Strategic Risk 1: The Trust does not create an environment and embed an approach to quality improvement which minimises the occurrence of harm to our patients;
- Strategic Risk 2: The Trust's clinical governance structures and how it implements them are neither clear nor robust and inhibit our ability to provide outstanding care;
- Strategic Risk 3: The Trust's patients wait too long for treatment;
- Strategic Risk 16: The Trust cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that the Trust lose

research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.

In line with good governance practice, the Committee's terms of reference have been reviewed and a revised draft terms of reference is set out at Appendix 4.

3 Membership and Committee Meeting Attendance

3.1 Members and Attendees

During the reporting period (April 2019 – March 2020) the following individuals were members of, or regular attendees at, the Committee:

Members/ Attendees	Role		Period
Dame Parveen Kumar	Chair	Non-Executive Director	January – March 2020
Prof. Jenny Higham	Member	Non-Executive Director	April 2019 – March 2020
Elizabeth Bishop	Member	Non-Executive Director	February – March 2020
Pui-Ling Li	Member	Associate Non-Executive Director	January – March 2020
Avey Bhatia	Member	Chief Nurse/ Director of Infection Prevention & Control	April 2019 – January 2020
		Acting Chief Operating Officer	February – March 2020
Dr Richard Jennings	Member	Chief Medical Officer	April 2019 – March 2020
Robert Bleasdale	Member	Chief Nurse/Director of Infection Prevention & Control	February – March 2020
	Attendee	Deputy Chief Nurse	April 2019 – January 2020
Gillian Norton	Ex Officio Member	Trust Chairman	April 2019 – March 2020
Jacqueline Totterdell	Attendee	Chief Executive Officer	April 2019 – March 2020
Stephen Jones	Attendee	Chief Corporate Affairs Officer	April 2019 – March 2020
Alison Benincasa	Attendee	Director of Quality Governance and Compliance	April 2019 – March 2020
Sally Herne	Attendee	NHS Improvement Quality Improvement Director	April 2019 – March 2020

The following individuals left the Committee during the reporting period:

Members/ Attendees	Role		Period
Tim Wright	Interim Chair	Non-Executive Director	October 2019 – February 2020
	Member		April – September 2019
Sir Norman Williams	Chair	Non-Executive Director	April – September 2019
Ellis Pullinger	Member	Chief Operating Officer	April 2019 – January 2020
Sarah Wilton	Member	Non-Executive Director	April 2019 – January 2020

In addition to members of the Trust's Council of Governors the following individuals regularly attend and observe the Committee:

Observers	Role	Period
Elizabeth Berner	Healthwatch Representative	April 2019 – March 2020
Sarah Cook	Healthwatch Representative	April 2019 – March 2020

3.2 Committee Meeting Attendance

In 2019/20, the quorum for each meeting of the Committee was three members which needed to include one non-executive director and one executive director (either the Chief Nurse or the Chief Medical Officer).

The Committee held a total of 12 meetings in the reporting period and the attendance of members are recorded below. All meetings were quorate.

Members/ Attendees	Role	Attendance
Dame Parveen Kumar	Chair	3/3
Prof. Jenny Higham	Member	10/12
Avey Bhatia	Member	10/12
Elizabeth Bishop	Member	2/2
Pui-Ling Li	Member	2/3
Gillian Norton	Trust Chairman	XX
Dr Richard Jennings	Member	10/12
Robert Bleasdale	Member	2/2
*Sir Norman Williams**	*Chair*	*5/5*
*Ellis Pullinger**	*Member*	*9/11*
*Sarah Wilton**	*Member*	*7/9*
*Tim Wright**	*Member (and interim Chair)*	*9/10*

**No longer members of the Committee*

The attendance of regular attendees at the Committee across the 12 meetings held in the reporting period are recorded below. These individuals were not members of the Committee and did no form part of the quorum.

Members/ Attendees	Role	Attendance
Jacqueline Totterdell	Attendee	4/12
Stephen Jones	Attendee	7/12
Alison Benincasa	Attendee	9/12
Sally Herne	Attendee	8/12
Robert Bleasdale*	Attendee	9/10

** Became a member of the Committee as Acting Chief Nurse in February 2020*

In addition to the individuals who attended the meeting to present specific agenda items the following regular attended the meeting as observers:

Members/ Attendees	Role	Attendance
Sarah Cook	Healthwatch	3
Elizabeth Berner	Healthwatch	7
John Hallmark	Governor	6
Bassey Williams	Governor	1
Khaled Simmons	Governor	2
Alfredo Benedicto	Governor	3
Mia Bayles	Governor	1
Hilary Harland	Governor	1

4 Committee activity and focus

The Committee develops a forward programme of work (see Appendix 6) at the start of each financial year which is intended to ensure it fulfils its purpose and duties as set out in the Committee's agreed terms of reference. The matters discussed and considered at the Committee during the period (April 2019 – March 2020) are set out in Appendix 3 mapped across the key duties as recorded in the approved terms of reference.

Each meeting of the Committee had a full agenda and the Committee submitted monthly reports to the Board following each meeting. The key areas of focus for the Committee in 2019/20 are outlined below. This draws on the matters set out within the monthly report to the Board during 2019/20.

4.1 Deep dives

As part of its annual work programme, the Committee holds regular deep dives across a range of quality and safety issues within its remit where it considers further assurance may be necessary. During 2019/20, the Committee conducted a total of eight deep dive reviews into the following areas:

- Maternity Services
- 12 Hour Trolley Breaches
- x3 Serious Incidents Thematic Analysis in Radiology, Cardiology and Communications
- End of Life Care
- Learning from Claims
- Friends and Family Tests: Emergency Department, Outpatients and Maternity

The Committee received assurances about the Trust's processes to manage claims and reassured that learning from claims was being embedded through programmes and initiatives supported and delivered by the legal team to divisions and care groups. Similarly the Committee was assured by the progress the Trust had made in improving the Trust's End of Life care protocols and process which resulted in the removal of the Care Quality Commission warning notice on the service. The Committee recognised the progress made on friends and family test surveys being completed in the services reviewed but whilst there had been a step change in these services the Committee continues to closely scrutinise performance through the integrated quality and performance report each month.

The serious incident analysis related to radiology, communications and cardiology gave rise to concerns from the Committee about the robustness of the clinical governance systems in place at care group level and the implications of effective communication between services. Whilst the Committee were reassured that the relevant teams had undertaken the recommendations from serious incident thematic analysis it continues to be concern about the degree to which the Trust had embedded actions to prevent further recurrence of similar incidents. The Committee plans to conduct a deep dive review in 2020/21 which is timetabled into its deep dive programme in Appendix 5. 12 hour trolley breaches remain a key issue for the Trust and the Committee were struck by the challenges system wide related to the sufficiency of mental health beds available to patients. The Committee would revisit 12 hour trolley breaches in 2020/21 to ensure that the actions take were having the adequate impact and reviews performance as part of the IQPR each month.

During 2019/20, the Committee expressed concerns about the quality and timeliness of some of the deep dives in its programme. As a result, the Committee reviewed its approach to conducting deep dives and agreed a set of triggers for holding such reviews. These triggers included: on-going non-achievement or highly volatile performance against a core standard; the occurrence of a series of never events in the same service or in different

services with shared characteristics; significant regulatory breach; key drivers in incidents or complaints; lack of change in risk scores relating to Board Assurance Framework or corporate risks; and monitoring of progress in service improvement following CQC inspection rating. The Committee's work programme in 2020/21 will include a set of deep dive reviews informed by these criteria. Alongside this, guidance has been prepared for staff presenting deep dives in order to ensure that the Committee receives the information required as an assurance Committee of the Board. The Committee will closely monitor the quality and timeliness of actions that arise from deep dives undertaken over the coming year.

4.2 Strategic risk

The Committee closely monitored the four strategic risks on the Board Assurance Framework for which it is responsible for scrutinising and providing assurance to the Board and considered a range of additional and emergent risks relevant to quality and safety.

The Committee monitored, sought assurances and supported mitigation of risks related to water safety, cardiac catheter laboratories, compliance with NICE guidance assessments, implementation of the seven day standards, and impact of delays in the national procurement on cervical screening.

The Committee was pleased to note the improvement in timely completion of assessment on NICE guidelines. On behalf the Board, the Committee also reviewed the Trust's compliance with seven day standards noting the challenges with meeting some of the key standards by April 2020. In light of Covid-19 pandemic NHS Improvement and NHS England have delayed the deadline for achieving full compliance and the Committee will continue to consider the Trust preparedness and compliance with the standards.

The Committee's concerns about water safety helped to inform the Board's decision to establish a short-term group to focus on estates and this additional scrutiny lead to a focused improvement programme of work which lead to the external assurance rating of the Trust's water safety.

The Committee also received reports of serious incidents and never events. These reports had come to the Committee on an *ad hoc* basis but in recognition of the importance of closely scrutinising these issues the Committee put in place a new structure of monthly reports on serious incidents and never events and agreed a process for considering biannual thematic reviews. These reports have afforded the Committee the opportunity to have an oversight of the number of serious incidents including never events and the learning following the closure investigations into the incidents. This greater transparency enhances the Committee's performance and Board-level oversight of serious incidents and never events.

4.3 Compliance and clinical governance

A core element of the Committee's focus in 2019/20 was monitoring of the Trust's completion of the outstanding actions from the 2016 Care Quality Commission Inspection. Whilst the Committee was disappointed that the Trust could not close the final action related to meeting the target for life saving and resuscitation training, and the pace of progress with this during the year, it was however pleased to have closed the other seven outstanding CQC actions. The Committee also reviewed and endorsed the must do actions in response to the Trust's 2019 inspection, the report of which was published in December 2019. The CQC's recommendation to NHS Improvement that the Trust be taken out of quality special measures was indicative of the work that had been undertaken to address previous CQC recommendations and the broader strengthening of clinical and corporate governance systems across the Trust.

The strengthening of clinical governance was another area of focus for the Committee in 2019/20, following the commissioning of a series of external clinical governance reviews by the Board in the previous year. The Committee considered and reviewed the outcomes of the phase 1 and phase 2 reviews prior to their consideration by the Board and closely monitored the implementation of the actions and recommendations of these reviews during the year. Whilst it was disappointed at the progress in implementing the actions, the Committee were confident that the correct structures had been identified to begin to drive key improvements especially in relation the multi-disciplinary team and mortality monitoring meetings which underpin clinical governance systems across the Trust. These themes were also scrutinised by the Committee and as part of the follow-up deep dive into the serious incident thematic analysis into radiology, communication and cardiology.

The Committee has continued to closely scrutinise the actions being taken to improve the quality, safety and operation of the Trust's cardiac surgery service, following the mortality alerts received in May 2017 and April 2018. During 2019/20, the Committee received monthly reports on cardiac surgery and received regular updates on the progress of the independent external mortality review commissioned by NHS Improvement in December 2018. The Committee considered a range of metrics regarding the safety and quality of the service and was assured by the progress achieved in improving the governance and safety of the service, which was independently verified by the findings of the CQC's inspection report published in December 2019. The Committee will continue to review the performance cardiac surgery service and will monitor key quality and safety metrics.

The Committee receives quarterly reports on learning from deaths and medicines management. The Trust's management of medicines was regarded as robust but the Committee had concerns about the use of e-prescribing across the Trust and tasked management to keep this under close scrutiny. On mortality, the Committee was assured that the Trust was not an outlier in relation to its mortality rating and in fact was below the national average.

4.4 Annual reporting

As part of the Committee's annual cycle it received nine annual reports and were assured by the performance of infection prevention and control, safeguarding, learning disabilities services, looked after children services, duty of candour and complaints. The Committee also approved the draft of the quality accounts/report and the quality priorities. The Committee were very pleased by the improved performance of complaints and impressed by the quality of service delivered by the learning disabilities team.

4.5 Strategy

In April 2019, the Trust published its new clinical strategy 2019-24. To assist in the delivery of the clinical strategy, a number of supporting strategies have been developed. Among these were the Quality and Safety Strategy and the Research Strategy. The Committee took a close interest in and carefully scrutinised the development of both strategies and, following this, recommended their approval to the Board. Looking forward, the Committee will monitor the implementation of the strategies and will provide assurance to the Board on this, including escalating any concerns.

5 Committee Effectiveness

The Committee conducted a review of its effectiveness and the report is attached in Appendix 6. Overall, the results of the review suggest that the Committee is working broadly effectively, albeit with areas in which it can improve. All respondents stated that the Committee was either “very effective” or somewhat effective. The Committee recognised however there was further room to develop, improve and mature. Reflecting on the extent to which steps could be taken to improve the effectiveness of the Committee felt that “a moderate amount” steps could be taken to improve the Committee’s effectiveness. See figure 1 and 2.

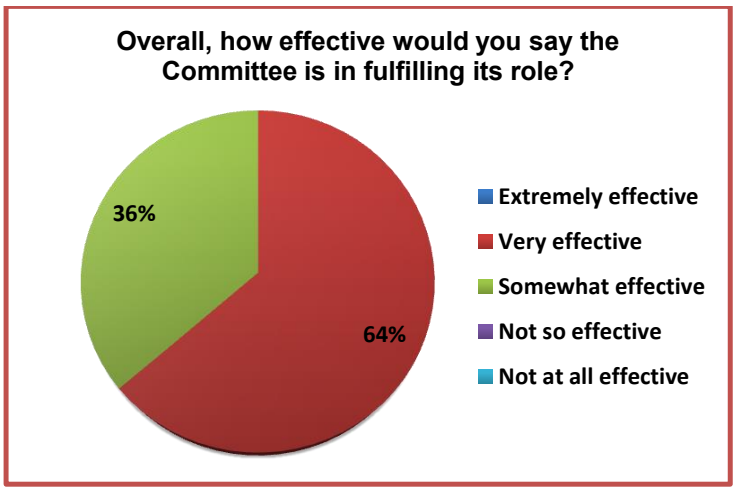


Figure 1

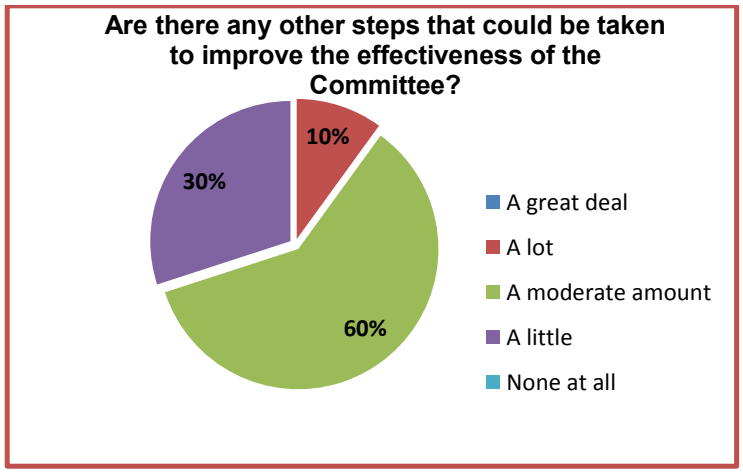


Figure 2

The Committee agreed the following actions to improve the work of the Committee:

Action	Progress
Develop robust Committee workplan which covers the key matters which fall within the Committee's remit. The Committee workplan should include a robust deep dive programme, patient experience, transformation, and annual review of the quality and safety strategy, CQC full action plans, review of divisional performance against quality indicator, research and development, placeholders for reviewing business cases with for quality and safety implications and regular review of compliance with NICE and HSE.	See Appendix 5
The workplan should also be framed from the BAF risk allocated to the Committee.	Will be completed once BAF signed-off by Board
A mechanism should be put in place for the Committee to receive explicit feedback and assurance from the relevant governance forums	See Appendix 5
Develop a robust programme of deep dives, and plan these in for the year ahead leaving some space in the forward plan for newly emergent issues that require / warrant a deep dive so that the Committee can respond to new issues.	See Appendix 5
Develop and implement robust report drafting guidance and template for assurance reporting, which is being picked up as part of the Board report writing improvement project. Improve circulation of reports in a timely way. There should be particular attention paid to develop a series of report which reflects how learning has been embedded especially in relation to serious incidents, complaints, never events and deep dive reports.	In progress as part of wider Board reporting systems. Also see Appendix 5
Revise the format of the Committee's report to the Board to ensure that there was clarity on level of assurance and key areas of risk, recognising that this piece of work is already underway with the objective of rolling out the new format at the start of the new financial year.	In progress as part of wider Board reporting systems.
Add a placeholder on the Committee's agenda for raising emerging risks and provide the opportunity for the Committee to decide what matters it would like to explore further.	Will be standing item on Committee agendas

6 Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2020/21 is attached, alongside the work plan that had previously been agreed for 2019/20 and on which this reporting year is based. During the reporting period, the Committee raised concerns about the number of items it was required to consider. The nature of the Committee's work means that it does cover a broad scope of matters on behalf of the Board. The proposed work plan for 2020/21 at Appendix 5 sets out the matters for consideration by the Committee. This seeks to build in the feedback on the previous forward work plan and seeks, where possible, to streamline this and focus the Committee on the key issues. During the Covid-19 pandemic the Committee will need to adopt a flexible approach to its forward plan in light of the operational pressures that flow from the management of the impact of the pandemic on the Trust. Over the coming months, while it will work to the agreed plan, it may be necessary to adjust this (subject to these operational pressures) to focus on areas of immediate priority.

The Committee's terms of reference have been reviewed and updated to reflect the current operation of the Committee (see Appendix 4). The terms of reference have been reviewed

with a view to clarifying the simplifying the duties of the Committee so that the Committee is supported to use its time and focus on the key issues on which it needs to provide assurance to the Board.

The Board previously agreed the Committee's terms of reference in February 2018. The key changes proposed to the terms of reference and which the Board is asked to agree include:

- Additional clarity on the role of the Committee as an assurance Committee of the Board on all matters related to quality, safety and clinical governance;
- A revised and streamlined description of the Committee's duties which brings the terms of reference into line with the operation of the Committee and changes to the forward plan of business for the Committee;
- Amendments to the membership of and attendance at the Committee to reflect current arrangements

7 Conclusion and Assurance Statement

During 2019/20, the Committee worked hard to deliver its duties and in doing so had started to strengthen its own operation and effectiveness, recognising that there was more than needs to be done. The Committee can assure the Board that there were many areas of good practice in the Trust and there was evidence (as demonstrated in the December 2019 CQC Inspection Report) that the Trust overall provides a good quality and safe services. The Trust has been on a journey and there are area of the Trust that can demonstrate strong governance mechanisms and leadership and other parts that still have some improvements to make. The Committee will, in particular, maintain its focus on the implementation of the clinical governance reviews and on monitoring the actions identified by the CQC. The Committee also recognised that the improved transparency and escalation of quality and safety issues to the Committee was testament to improvements in culture, on which the Board was focusing in particular over the coming year. In 2020/21, the Committee will maintain its focus on providing the Board with assurance on the Trust's improvements in quality and safety and in monitoring the progress required to ensure the in year Quality and Safety strategy objectives are delivered and the Trust makes progress in realising its ambition to provide outstanding care, every time.

8 Appendix 1: Approved Terms of Reference - 2018

Quality & Safety Committee

Terms of Reference

1. NAME

Quality & Safety Committee (QSC)
This Committee was previously known as the Quality Committee and before that the Quality & Risk Committee.

2. AUTHORITY

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

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

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

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

3. PURPOSE OF THE GROUP

The QSC 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.

It particularly supports the following Trust strategic objectives:

i. The patient, treat the person
ii. Right care right place, right time
iii. Development tomorrow's treatments today

4. DUTIES OF THE GROUP

The QSC will discharge the following duties as delegated by the Trust Board:

Performance against Quality Measures

i. To undertake a thorough review of the Trust's performance against quality and safety measures, undertaking deep dive reviews on any areas of concern.

ii. To monitor performance against the Quality Improvement Plan and consider any changes to the plan in light of new priorities or other factors.

iii. To scrutinise the Trust's arrangements for responding to the Enforcement Actions and Licence Conditions which gave rise to the Trust being placed in Quality Special Measures. Monitor the progress against the Trust's plans to return to a position of regulatory compliance in respect of Quality.

iv. To receive a regular report from the Trust's Clinical Governance Committee.

Evidence-Based Clinical Practice

i. To receive assurance on action taken to improve mortality rates as part of the Trust's mortality review process.

ii. To ensure there is a well-functioning and effective process for considering and implementing guidance from the National Institute for Health and Clinical Excellence (NICE) and National Service Frameworks, recommendations from the National Confidential Enquiry national audits and responding to National Patient Safety Agency (NPSA) Alerts.

iii. To receive assurance in respect of the delivery of any action plans arising from reviews or investigations into safety and or quality by healthcare regulators, inspectorates, accrediting bodies or Royal Colleges.

Compliance

i. To monitor compliance with the Care Quality Commission's (CQC) fundamental standards and oversee any remedial action required.

ii. To undertake an annual "deep-dive" review into the work of each Division to review performance against:
- Fundamental Standards
- Quality Indicators

iii. To receive regular reports on the Trust's infection control arrangements and receive assurance on remedial measures taken to handle any outbreak of infection.

iv. To receive regular reports on the Trust's compliance with Safeguarding requirements and matters concerning Deprivation of Liberty and Mental Capacity Act.

v. To receive recommendations on the Trust's annual Quality Account priorities and monitor their in-year progress.

vi. To monitor any relevant submissions to NHS Improvement.

Audit

i. To receive the annual Clinical Audit Programme and ensure that it is in line with the audit needs of the Trust prior to commending it for approval by the Board. Monitor its in-year progress including actions taken to address audit concerns.

ii. To make recommendations concerning the annual programme of Internal Audit work to the extent that it applies to matters within the remit of the QSC and consider the major findings of quality related internal audit reports (including the management response).

Research and Development

i. To ensure the Trust has an effective Research and Development strategy in place and produces an annual Research and Development Report to the Trust Board.

ii. To review governance arrangements for Research and Development activity within the Trust including clinical ethics.

Learning when Things Go Wrong

i. To review the risks allocated to the QSC from the Board Assurance Framework and receive assurance that actions are in place to effectively manage and control the risks identified.

ii. To ensure there are clearly defined and well understood processes for escalating safety and quality issues and meeting the Trust's obligations in respect of duty of candour with patients and families.

iii. To undertake regular "deep dive" reviews into Serious Incidents (SIs) and Complaints to receive assurance that changes in Trust practice have been made and sustained, and that the lessons learned have been widely disseminated throughout the Trust.

iv. To consider regular reports identifying the trends and themes arising from claims, litigation, incidents (including SIs) and complaints and the management actions being taken to reduce risks and learn lessons.

Patient Experience

i. To review the Trust's arrangements for managing complaints and Patent Advice & Liaison Service contacts.

ii. To ensure the Trust has an effective system for patient feedback (including Friends and Family Test, patient environment and amenities) and patient involvement.

iii. To undertake a review of the findings of any national patient surveys including any relevant action plans.

iv. To consider and review any issues relating to equality and diversity which may impact on patient experience or care.

General Governance

i. To consider matters referred to the QSC by the Board or by the groups which report to it

ii. Every year, to set an annual Work Plan and conduct a review of the Committee's effectiveness (including the achievement of the Work Plan and a review of the Committee terms of reference) and report this to the Board

iii. To ensure a system is in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.

iv. As required, to review any relevant Trust strategies relevant to the Committee's terms of reference (e.g. those associated with clinical quality, clinical effectiveness, health and safety, patient experience) prior to approval by the Board and monitor their implementation and progress.

v. To consider the arrangements for the assessment by the Medical Director and Chief Nurse on the safety and quality impact of the schemes within the Trust's Cost Improvement and Transformation Programme.

vi. On behalf of the Finance & Investment Committee, to consider the clinical and safety aspects of all business cases worth more than £1m prior to their consideration by the Trust Board.

5. COMMITTEE CHAIR AND COMMITTEE EXECUTIVE LEAD

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

The Medical Director and the Chief Nurse & Director of Infection Prevention Control will be the Executive Leads for QSC.

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
Sir Norman Williams	Non-Executive Director	Committee Chair
Jenny Higham	Non-Executive Director	Member
Sarah Wilton	Non-Executive Director	Member
Richard Jennings	Chief Medical Officer	Member*
Avey Bhatia	Chief Nurse & Director of Infection Prevention Control	Member
Ellis Pullinger	Chief Operating Officer	Member

16052019: Tamara Croud (IATS) – changed Andy Rhodes to Richard Jennings ahead of full review.

ATTENDANCE

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

Name	Title	Attendance Guide
Jacqueline Totterdell	Chief Executive	Every Meeting
Stephen Jones	Director of Corporate Affairs	Every Meeting
Elizabeth Palmer	Director for Quality Governance	Every Meeting
Gillian Norton	Chairman	Every Meeting
Alison Benincasa	Quality Improvement Director	Every Meeting
Sally Herne	NHSI Quality Improvement Director	Every Meeting
Mark Hamilton	Associate Medical Director (*Caldicott Guardian, General Data Protection Regulations, Patient Confidentiality)*	As required
Nigel Kennea	Associate Medical Director *(learning from patient deaths)*	As required
Renate Wendler	Associate Medical Director *(learning when things go wrong)*	As required
Vin Kumar	Acting Chief Pharmacist *(Medicines Optimisation and Controlled Drugs)*	As required
Kate Hutt	Clinical Audit & Effectiveness Manager *(Clinical Audit Plan)*	As required
Matthew Laundy	Consultant (Antimicrobial Resistance)	As required
Jeremy Isaacs	Consultant Neurologist and Dementia Clinical Lead *(Dementia)*	As required

PRESENT

Representatives from the Council of Governors Representatives
Healthwatch Representatives

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.

7. QUORACY

The quorum for any meeting of the QSC shall be the attendance of a minimum of three members of which one shall be a Non-Executive Director and one shall be either the Medical Director or the Chief Nurse.

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.

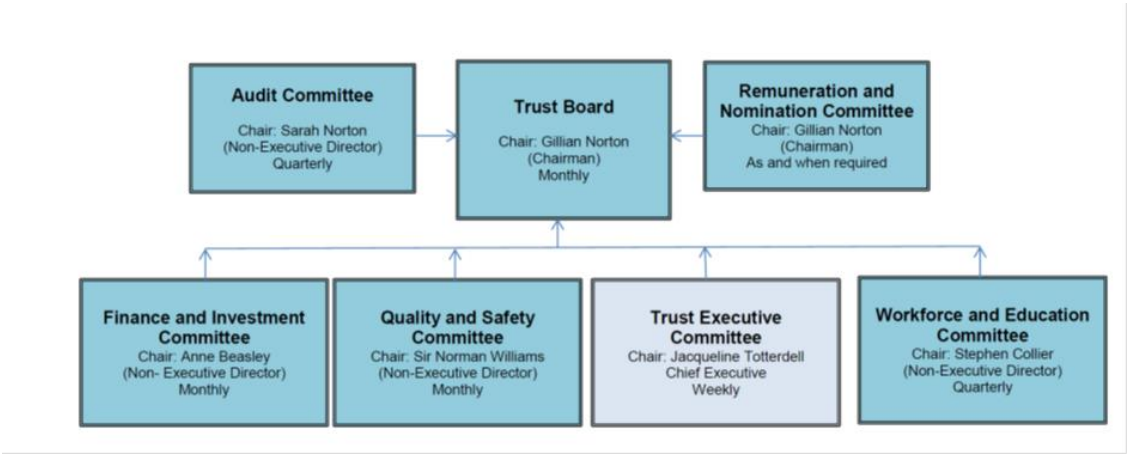
8. DECLARATION OF INTERESTS

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 QSC shall be held monthly, one week before the Board.

10. RELATIONSHIP WITH OTHER COMMITTEES



11. MEETING ARRANGEMENTS / SECRETARIAL

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

12. AGENDA AND FORWARD CYCLE OF BUSINESS

Standing Agenda Items

i. Apologies;
ii. Minutes/Action Notes of the Previous Meeting;
iii. Matters Arising and Action Log;
iv. Declarations of Interest;
v. Review of any Risks identified;
vi. Items for Escalation;
vii. Reflection on Meeting Effectiveness
viii. Other standing items that will appear at every meeting of the group to be added to this list as appropriate.

Forward Cycle of Business

A forward plan for the items and reports to be received by the Committee is included at Appendix 1 of this Terms of Reference. This should be referred to when setting the agenda for ach iteration of this group.

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.

13. 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 at Appendix 1. This review should consider the performance of the QSC including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business.

9 Appendix 2: Committee Workplan 2019-2020

Month	Frequency	Lead	Authors	Committees	18/04/2019	23/05/2019	20/06/2019	18/07/2019	22/08/2019	19/09/2019	24/10/2019	21/11/2019	12/12/2019	23/01/2019	20/02/2019	19/03/2019
SAFETY & QUALITY IMPROVEMENT																
Integrated Quality and Performance Report (including Quality Improvement Dashboard)	Monthly	CN	PDM and DPM		√	√	√	√	√	√	√	√	√	√	√	√
Trust CQC compliance – Self Assessment	6 monthly	CN	QID		√						√					
Core Service KLOE Assessment	Annual and as required	CN	QID				Medical Care (incl. Older People)	Critical Care	Urgent & Emergency Care	Surgical (incl. Gynaecology			Outpatients Services (incl. Diagnostics)	Maternity Service	Services for Children and Young People	End of Life Care
CQC Action Plan – including 'Must do' and 'Should do'	Monthly	CN	QID		√	√	√	√	√	√	√	√	√	√	√	√
Safeguarding Adults - Annual Report	Annual	CN	HoS				√									
Safeguarding Children and Young People – Annual Report	Annual	CN	HoS					√								
Learning Disability Services - Annual Report	Annual								√							
Mental Capacity Act Report	Annual							√								
Looked After Children Annual Report	Annual	CN	CLSN			√										
Infection Control Report (Including Antimicrobial Stewardship) (**Annual**/6-Monthly Update)	6 Monthly and Annual	CN							√ Annual						√ 6 Month	
Nurse Staffing Report (Planned Vs Actual)	Monthly	CN	DCN			√	√	√	√	√	√	√	√	√	√	√
Mortality Monitoring Committee and Learning from Patient Deaths	Quarterly	CMO			√			√			√			√		
SWL Pathology - Quality Report	Quarterly	COO	Tim Planche				√	√		√			√			√
Quality Improvement Academy	Quarterly	CN	QID				√			√			√			√
Radiation Protection	Annual											√				
Nurse Establishment Review	Annual	CN	DCN				√ (this went to board)									
Gosport Action Plan		CN	CN					√								
CIP approval and QIA review	Quarterly	CN	DFI			√			√			√			√	
Deep Dive – **Subject TBC**	Monthly	CN			Friends & Family Test		Maternity	Clinical Claims	√	√	√	√	√	√	√	√
EFFECTIVENESS																
Clinical Audit Annual Plan	Annual	CN														√
NICE compliance	6 Monthly	CN	CEAM			√						√				
CAS Alerts	Annual													√		
Policy compliance tracker	Quarterly	DCA	Secretariat				√	√		√			√			√
Research Strategy and Annual Report	Annual	CMO						√								
Medicine Management and Controlled Drugs report	6 monthly				√						√					
HTA Designated Individual report	Annual				√	√				√						
Caldicott Guardian Report	Annual	CMO								√						
Clinical Ethics Committee report	Annual	CMO														√
Never Event Assurance/Gap analysis	6 Monthly	CN			√						√					
Referral to Treatment Quarterly Reports	Quarterly	COO						√ (Q1)			√ (Q2)			√ (Q3)		
EXPERIENCE																
Patient Experience and Engagement Report	Biannual	CN	HoPE				√						√			
National Patient Surveys incl: Cancer(TBC)/Maternity(TBC last one Jan 18)/ED(expected circa Sept)	Annual	CN							Inpatient				Children & Young People			
Complaints, Litigation, Incidents, PALS and Lessons Learned Thematic Report (CLIPI)	6 Monthly	DCA	HoLS							√						√
Complaints Annual Report	Annual	DCA	HoPE									√				
PLACE Audit	Annual	CN	QID							√						
Annual Quality Priorities	Annual	CN	QGD											√ Draft	√ Annual	
Annual Quality Statement	Annual	CN	QGD			√ Annual									√ Draft	
Duty of Candour Annual Report	Annual	CMO								√						
Enter and View report (Health Watch)	Annual															√
STRATEGY & RISK																
Quality Strategy		CN	CN						√					√		
Litigation Report	Annual	DCA	HoLS											√		
Board Assurance Framework & Corporate Risk Register	Monthly				√	√	√	√	√	√	√	√	√	√	√	√
Health and Safety	Bimonthly	CFO/CN				√			√		√		√		√	
GOVERNANCE & OTHER MATTERS																
Annual Review of Quality Committee Effectiveness (Approve Process/**Report**)	Annual	DCA/CN	Secretariat												√ Process	√ Annual
Annual Review of Terms of Reference	Annual	DCA/CN	Secretariat						√							
Annual Review of Committee Work Programme	Annual	DCA/CN	Secretariat						√							√

10 Appendix 3: Items Considered by the Quality & Safety Committee - April 2019 – March 2020

Performance against Quality Measures	Compliance	Learning when Things Go Wrong	Patient Experience	General Governance	Evidence-Based Clinical Practice	Audit	Research and Development
Monthly Integrated Quality & Performance Report	Infection Prevention and Control Briefing: Legionella, Clostridium Difficile	Quarterly Learning from Deaths Report	Patient Partnership and Experience Group Update	Clinical Governance Review Reports (Phase 1 and 2)	Bi-Annual NICE Compliance Report	Internal Audit: Patient Experience	Research & Development Annual Report
Quarterly Quality Improvement Academy Report	Human Tissue Authority: Designated Persons Report	Deep Dive: Serious Incidents Thematic Analysis - Radiology	National Adult Inpatient Survey	Update on Trust-wide Policies: Patient Care	Quarterly Learning from Deaths Report	Internal Audit: Board Assurance Framework	Research Strategy 2019-2024
Head and Neck	Annual Infection Prevention and Control Report 2018-19	Deep Dive: Serious Incidents Thematic Analysis - Communication	National Children and Young People Survey	Quarterly Cost Improvement Plan & Quality Impact Assessment	Deep Dive End of Life Care	Clinical Audit Programme Report	
Maternity Services	Annual Mental Capacity Act and Deprivation of Liberty Services Act	Deep Dive: Serious Incidents Thematic Analysis - Cardiology	National Maternity Services Survey	CNST Maternity Services	Weekend Mortality Report		
Learning Disability Services Annual Report	Quality Priorities 2019/20 and forward plan for 2020/21	Deep Dive: Learning from Claims	National Urgent and Emergency Care Survey	South West London Pathology Report	Learning from Gosport Report & Action Plan		
Quality Strategy 2019-2024	Annual Safeguarding Adults Report	Duty of Candour	Annual Complaints Report	Committee Effectiveness Review 2019/20			
Midwifery (Maternity) Services Review and Action Plan	Annual Safeguarding Children Report	Monthly Serious Reports (from December 19)	Deep Dive: Friends and Family Test - Emergency Department, Outpatients, Maternity Services	Novel Corona Virus – Covid-19 Updates			
Monthly Cardiac Surgery	Infection Prevention and Control Briefing: Recent Infection Control Issues	Complaints: Performance Report					

Performance against Quality Measures	Compliance	Learning when Things Go Wrong	Patient Experience	General Governance	Evidence-Based Clinical Practice	Audit	Research and Development
Quarterly Referral to Treatment Report	Annual Learning Disability Services Report	Clinical Harm (Referral to Treatment) Review and Closure Reports					
12-Hour Trolley Breaches	Care Quality Commission: Must and Should & Exception Report: Outstanding	Learning from Incidents (October 2018) & Never Events					
Bewick Recommendations Report	Quarterly Medicine Management Report						
Monthly Nurse Safe Staffing	Care Quality Commission: Draft 2019 Inspection Report & Must Do Action Plan						
Quality Improvement Plan	Care Quality Commission: Self-Assessment against Fundamental Standards						
Monthly Patient Safety and Quality Group Reports	Seven Day Service Report: Progress on Implementation and NHS Improvement Submission						

Other Appendices not embedded

11 Appendix 4: Revised Terms of Reference

12 Appendix 5: 2020/21 Draft Committee Workplan

13 Appendix 6: Committee Effectiveness Review

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Quality and Safety Committee Terms of Reference

Approved by the Trust Board TBC

Approval and review dates

Profile	
Document name	Quality and Safety Committee Terms of Reference
Version	2.0
Executive Sponsor	Chief Medical Officer; Chief Nurse and DIPC
Author	Chief Corporate Affairs Officer
Approval	
Approval group	Trust Board of Directors
Date of approval	TBC
Date for next review	April 2021

Quality and Safety Committee Terms of Reference

1. Name of Group

The Quality and Safety Committee.

2. Authority

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

Powers: The Quality and Safety Committee is authorised by the Board of Directors to:

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

Cessation: This is a standing Committee of the Board and may only be disbanded or its remit amended on the authority of the Board.

3. Purpose of the Group

The Quality and Safety Committee is established as the Trust's primary forum for providing assurance to the Board on all aspects of quality, safety and clinical governance. The role of the Committee is to provide assurance to the Board in relation to:

- all aspects of the quality of care, safety of services, standards of care provided to patients, patient outcomes and effectiveness, and patient experience;
- the effectiveness of clinical governance systems, structures and processes;
- the effective management of risks related to quality, safety and clinical governance including the oversight of strategic risks on the Board Assurance Framework assigned by the Board to the Committee;
- regulatory standards in relation to quality and safety;
- research and development;
- oversight of the implementation of the Trust's quality and safety and research strategies.

The Committee plays a key role in supporting the Trust in delivering on its strategic ambition of providing outstanding care every time to its patients, staff and the communities it serves.

In fulfilling its role, the Committee will actively demonstrate the Trust's values, providing an appropriate balance of challenge and support.

4. Duties of the Group

The key duties of the Quality and Safety Committee include:

(a) Clinical performance and effectiveness:

i. Regularly scrutinise the Trust's performance against key quality and safety measures, including those set out in the Integrated Quality and Performance Report. This will include the quality aspects of performance metrics, infection control, complaints handling, mortality and morbidity monitoring, serious incidents and never events.
ii. Oversee and ensure there are effective system for monitoring clinical outcomes and clinical effectiveness; with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.
iii. Receiving assurance in relation to the delivery of any action plans arising from reviews or investigations into safety and or quality internally by the Trust or externally by healthcare regulators, inspectorates, accrediting bodies or Royal Colleges.

(b) Patient experience:

i. Oversee and seek assurance that the Trust has in place effective systems for delivering a high quality experience for all of its patients and users, and their family and carers. This will include monitoring the findings of relevant national patient surveys and action plans and considering any issues relating to equality and diversity which may impact on patient experience or care.
ii. Oversee the processes by which the Trust seeks to involve and engage patients and carers in the design and delivery of care.
iii. Ensure robust systems and processes are in place to deliver effective clinical governance across the Trust. This includes overseeing the delivery of any improvement actions identified by the Trust or by external reviews.

(c) Compliance:

i. Seek assurance that the Trust is compliant with the requirements of its registration with the Care Quality Commission. This will include overseeing any remedial action that may be required and the monitoring of progress against any must and should do actions identified by the CQC in its inspections of the Trust.
ii. Receive recommendations in relation to the Trust's annual quality priorities and monitor progress against their delivery
iii. Receive and scrutinise annual reports related to quality and safety including but not limited to complaints, infection prevention and control, Mental Capacity Act and Deprivation of Liberty, Safeguarding, duty of candour etc.
iv. Monitor and provide assurance in relation to the production of the Trust's annual Quality Account prior to submission to NHS England and NHS Improvement

(d) Learning when things go wrong:

i. Receive regular reports on serious incidents, including regular thematic analysis of serious incidents.
ii. Oversee and seek assurance that the Trust has in place robust processes to ensure effective identification and dissemination of learning from incidents, complaints and litigation. This will include identification of any themes and trends.
iii. Oversee the mechanisms for ensuring the appropriate discharge of the duty of candour.

(e) Audit:

i. Receive the annual Clinical Audit Programme and monitor its delivery.
ii. Receive relevant reports from the Trust's internal auditors relating to patient safety and quality and identify any issues for consideration as part of the annual internal audit programme.

(f) Research, development and clinical ethics:

i. Review governance arrangements for research and development activity within the Trust including clinical ethics.
ii. Receive periodic assurance reports on the Trust's research programme.
iii. Oversee the delivery of the Trust's research strategy.

(g) Strategy, Risk and Governance:

i. Undertake deep dives in relation to areas of material concern in relation to quality, safety and clinical governance, particularly where performance is persistently below expectations and conduct further interrogation in any area which gives rise to quality and safety concerns.
ii. Oversee the implementation of the Trust's quality and safety strategy.
iii. Oversee and monitor the management of the strategic risks on the Board Assurance Framework assigned to the Committee by the Board and relevant risks on the Corporate Risk Register.
iv. Receive assurance that that the Trust is compliant with relevant Trust-wide policies and procedures related to the Committee's role and purpose.
v. Consider the arrangements for the assessment by the Chief Medical Officer and Chief Nurse relating to the quality and safety impacts of schemes within the Trust's Cost Improvement Plans and transformation programme.
vi. On behalf of the Finance and Investment Committee, consider the clinical and safety aspects of all business cases worth more than £1m prior to their consideration by the Trust Board.

5. Chairperson and Executive Lead(s)

A Non-Executive Director will chair the Quality and Safety Committee.

The Chief Medical Officer and Chief Nurse are the Executive Leads for the Quality and Safety Committee.

6. Composition of the Group

Membership: The membership of the Committee shall comprise three Non-Executive Directors, the Associate Non-Executive Director, the Executive leads and the Chief Operating Officer.

The current membership of the Committee is:

Name	Title	Role in the group
Prof. Dame Parveen Kumar	Non-Executive Director	Committee Chair
Elizabeth Bishop	Non-Executive Director	Member
Jenny Higham	Non-Executive Director	Member
Pui-Ling Li	Associate Non-Executive Director	Member
Avey Bhatia	Chief Operating Officer	Member
Robert Bleasdale	Chief Nurse and Director of infection Prevention and Control	Member
Richard Jennings	Chief Medical Officer	Member

Members are expected to make every effort to attend all meetings and a register of attendance shall be maintained.

7. Regular and Other Attendees

The following individuals are not members of the Committee but will instead attendance the Committee on a regular basis:

- Chief Corporate Affairs Officer
- Deputy Chief Nurse
- Director of Quality Governance and Compliance

At the discretion of the Committee Chair, the Committee may also request other members of the Executive team and other relevant members of staff to attend meetings of the Committee or to attend for specific agenda items.

The following may also attend the Committee's meetings as observers:

- Healthwatch representatives
- Trust Governors (up to a maximum of three)

Deputies can attend the Committee 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.

8. Quoracy

The quorum for any meeting of the Quality and Safety Committee shall be three members, of of which must be a Non-Executive Director and one must be either the Chief Medical Officer or the Chief Nurse. Regular or other attendees do 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 endorsed either at the subsequent quorate meeting or on email circulation by sufficient number of Committee members to ensure the decision is valid.

In the absence of the Committee Chair, the Committee should nominate another Non-Executive Director to chair the Committee's meeting(s).

9. Declaration of Interests

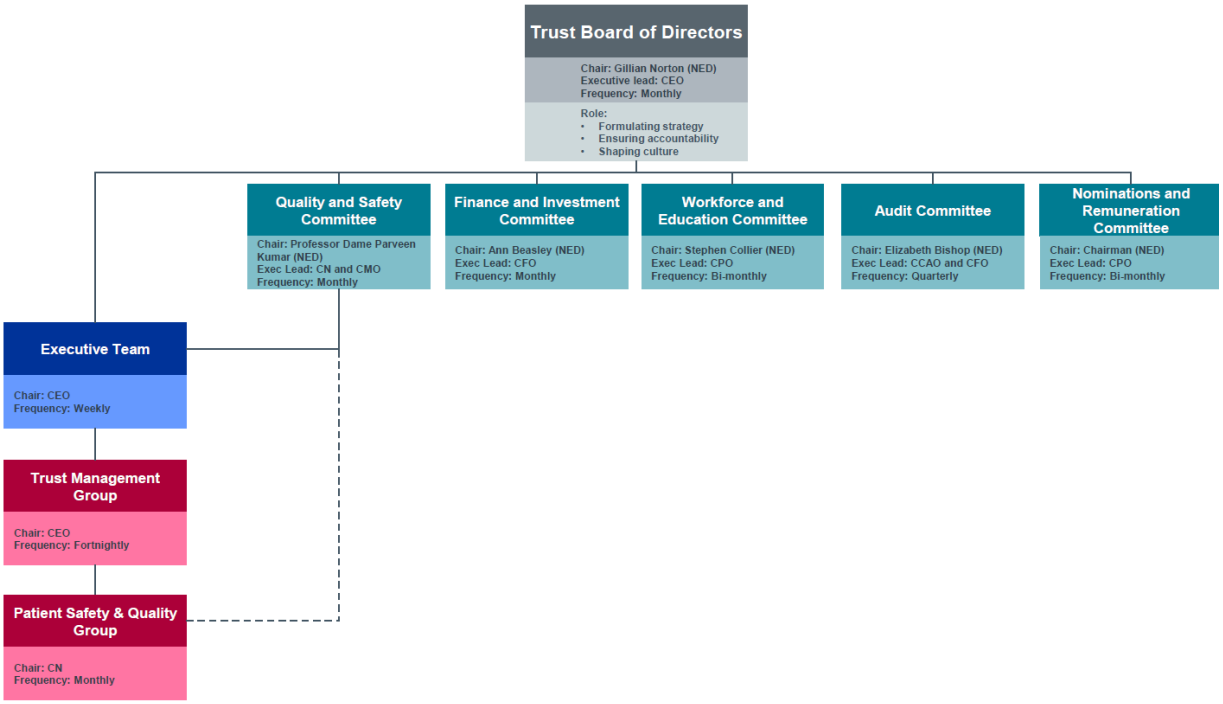
All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

10. Meeting Frequency

The Quality and Safety Committee shall meet monthly, typically on the penultimate Thursday of each month. The frequency of meetings may be changed only with the agreement of the Trust Board.

11. Relationship with other groups and committees

The Committee will report to the Trust Board.



The Quality and Safety Committee will receive regular reports from the Trust's Patient Safety and Quality Group which includes regular updates on key quality and safety issues included but not limited to:

- Radiation Protection
- Gosport Action Plan
- SWL Pathology - Quality Report
- Trust CQC compliance – Self Assessment
- NICE compliance
- CAS Alerts
- PLACE Audit
- Enter and View report (Health Watch)
- Complaints: In year Performance and Lessons
- Health & Safety

The Committee will also receive regular reports from the following forums which report into the Patient Safety and Quality Group:

- Clinical Ethics Committee (at least bi-annual)
- Mortality Monitoring Committee (at least quarterly)

Reporting of these groups to the Quality and Safety Committee will be via the Trust Management Group and Executive Team.

12. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Quality and Safety Committee shall be established at the start of each financial year;
ii. The Corporate Governance team will provide secretariat support to the Committee. This will include taking accurate minutes of each meeting, producing and managing timely delivery of items on the action log, ensuring that the planning for and outcomes of Committee meetings are shared appropriately.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Leads.
iv. All papers and reports to be presented at the Quality and Safety Committee must be submitted as final Executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days ahead of the meeting.

13. Agendas

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair and Executive Lead(s).

14. Annual cycle of business

An Annual cycle of items and reports to be received by the Committee will be agreed by the Committee. The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

15. Report to the 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.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

16. Review of Committee Effectiveness and Terms of Reference

The Committee will conduct a review of its effectiveness each year, the results of which will be reported to the Board.

The Committee's Terms of Reference shall be subject to an annual review. This review should consider the performance of the Quality and Safety Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Board.

Quality and Safety Committee Forward Work Plan 2020/21

Month	Frequency	Lead	Authors	23/04/2020	21/05/2020	18/06/2020	23/07/2020	20/08/2020	17/09/2020	22/10/2020	19/11/2020	17/12/2020	21/01/2021	18/02/2021	18/03/2021
COVID-19															
COVID-19 - Overview and Safety Dashboard (inc. workstream updates)	Monthly	CN/CMO	Various	√	√	√	√	√	√	√	√	√	√	√	√
Clinical Safety Strategy during COVID-19 pandemic	Monthly	CMO	CMO	√	√	√									
DEEP DIVE															
Deep Dives (clinical issues, areas and themes) - Programme of topics to be agreed by Committee in May 2020	Monthly	CN	Various			√	√	√	√	√	√	√	√	√	√
SAFETY & QUALITY IMPROVEMENT															
Integrated Quality and Performance Report (including Quality Improvement Dashboard)	Monthly	CN	PDM and DPM	√	√	√	√	√	√	√	√	√	√	√	√
Serious Incidents Report (including never events)	Monthly	CMO	CMO	√	√	√	√	√	√	√	√	√	√	√	√
Serious Incidents: Thematic Analysis	Bi-Annually	CMO	CMO					√						√	
Update on CQC Action Plan (Must/Should Do)	Quarterly	CN	DQGC	√			√			√			√		
Patient Safety & Quality Group Report	Monthly	CN	DQGC	√	√	√	√	√	√	√	√	√	√	√	√
Cardiac Surgery Report	Quarterly	CMO	CMO	√			√			√			√		
Mortality Monitoring Committee and Learning from Patient Deaths	Quarterly	CMO	CMO		**√ Q4**			**√ Q1**			**√ Q2**			**√ Q3**	
Nurse Staffing Report (Planned Vs Actual)	Bi-Monthly	CN	DCN		√		√		√		√		√		√
Infection Control Report (Including Antimicrobial Stewardship)	6 Monthly	CN	David Shakespeare											**√ 6 Month**	
Quality Improvement and Transformation Programme Update	Bi-Annually	CN	DQGC						√						√
Maternity Service Action Plan Update	Quarterly	CN	DDO-CWDT			√			√			√			√
Head and Neck Services	As required	CMO	DC-SNTC				√					√			
EFFECTIVENESS															
Clinical Governnace Reviews - Phase 1/2/3	x3 / year	CMO	CMO			√				√				√	
Clinical Audit Annual Plan	Annual	CN	CEAM												√
Trust-wide Policy Updates: Patient Care	Bi-Annually	CCAO	Secretariat					√					√		
Medicine Management and Controlled Drugs Report	6 monthly	CMO	Vin Kumar		√							√			
Clinical Ethics Committee and Key Ethical Decisions	As required/Annual	CMO	CMO	**√ (COVID)**	**√ (COVID)**	**√ (COVID)**			√			√			√
Seven Days Services Compliance (NHS Returns)	Adhoc	CMO	CMO					√						√	
EXPERIENCE															
Patient Experience and Engagement Report	Biannual	CN	HoPE					√							√
National Patient Survey (Published 2020/21)	Annual	CN	Various				**Adult Inpatient**						**Maternity Services**		

Month	Frequency	Lead	Authors	23/04/2020	21/05/2020	18/06/2020	23/07/2020	20/08/2020	17/09/2020	22/10/2020	19/11/2020	17/12/2020	21/01/2021	18/02/2021	18/03/2021
STRATEGY, GOVERNANCE & RISK															
Board Assurance Framework & Corporate Risk Register	Monthly	CCAO	CCAO	√	√	√	√	√	√	√	√	√	√	√	√
Quality Strategy Implementation Updates	Quarterly	CN	CN				√			√			√		
Quality Priorities (report on performance / proposed new priorities)	As required	CN	DQGC										√	√	
Research & Development Strategy Implementation	Quarterly	CMO	Dan Forton			√			√			√			√
CQC Statement of Purpose	Annual	CN	DQGC								√				
ANNUAL TRUST REPORTING/REVIEWS															
Quality Accounts/Report (1st Draft/Final Draft) (NHS Returns)	Annual	CN	DQGC		**√ Draft**	**√ Final**									
Complaints Annnual Report	Annual	CN	HoPE					**√ Annual**							
Duty of Candour Annual Report	Annual	CMO	DCN/CIL							**√ Annual**					
Caldicott Guardian Annual Report	Annual	CMO	CMO								**√ Annual**				
Nurse Establishment Annual Review	Annual	CN	DCN		**√ Annual**										
Safeguarding Adults - Annual Report	Annual	CN	HoS			**√ Annual**									
Safeguarding Children and Young People – Annual Report	Annual	CN	HoS			**√ Annual**									
Learning Disability Services - Annual Report	Annual	CN	Padraic Costello						**√ Annual**						
Mental Capacity Act Report/Deprivation of Liberty Annual Report	Annual	CN	MCA/DOLsP				**√ Annual**								
Infection Control Report Annual Report	6 Monthly/Annual	CN	David Shakespeare					**√ Annual**							
Clinical Neglience Scheme for Trusts: Renewal for Maternity Services	Annual	CN	CN				**√ Annual**								
Human Tissue Authority Report (Designated Individual) (NHS Returns)	Annual	CMO	CMO							√					
Research & Development Annual Report	Annual	CMO	Dan Forton						**√ Annual**						
COMMITTEE GOVERNANCE & OTHER MATTERS															
Annual Review of Committee Effectiveness (Approve Process/**Report**)	Annual	CCAO/CN	Secretariat									**√ Process**		**√ Annual**	
Annual Review of Terms of Reference	Annual	CCAO/CN	Secretariat											√	
Annual Review of Committee Work Programme	Annual	CCAO/CN	Secretariat	√											√
Annual Committee Review Report to Board	Annual	CCAO/CN	Secretariat	√											√

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Quality & Safety Committee Effectiveness Review 2019/20

Survey results and action plan

Stephen Jones
Chief Corporate Affairs Officer

Tamara Croud
Board Secretary

20 February 2020

1. Introduction

Purpose, context , summary and recommendation

1. Purpose

This paper presents the results of the Quality & Safety Committee review of effectiveness for 2019/20 which was undertaken since the last meeting of the Committee in January 2020, and highlights potential action points for consideration based on the feedback received through the survey.

2. Background and context

All Committees of the Board are required to undertake reviews of their effectiveness on an annual basis.

The Committee agreed plans for undertaking the effectiveness review at its meeting on 12 December 2019. The survey was conducted between 28 January 2020 and 11 February 2020. Responses to the survey were provided via an online survey tool.

Conclusion/Summary:

In a number of areas, the survey suggested the Committee was working well but many members reflected there was more work to do to improve reporting to the Committee, assurance provided to the Board and scrutiny of risks. Comments also suggest that having a robust workplan would go some way to improve the effectiveness of the Committee.

In terms of the proposed measures to improve the quality of papers, a wider piece of work is currently underway across all Board Committees to strengthen reporting and draw out assurance more clearly, as well as to introduce a consistent approach in Committee reports to the Board.

3. Recommendation

The Committee is asked to note the results from the Committee Effectiveness Review 2019/20 and the proposed actions to further improve the effectiveness of the Committee.

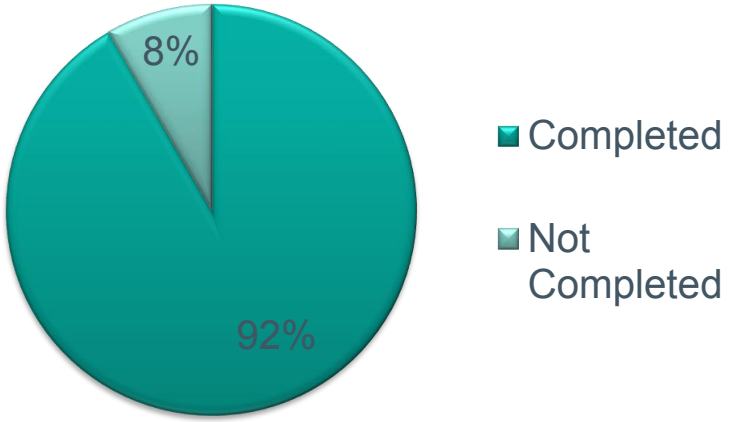
2. Engagement

The following groups were invited participated in the survey:
- Committee members
- Trust Chairman
- Executive leads for the Committee (CN and CMO)
- Other Executive Directors
- Regular attendees at the Committee

There was positive engagement with the review; 11 of the 12 individuals asked to respond did so, providing a response rate of 92%. This was a 6% rise in engagement compared with the 2018/19 effectiveness survey.

Respondent	Numbers
Committee Member	5
Regular attendee of the Committee (as listed in the Committee's terms of reference)	4
Other Non-Executive or Executive Director	1
Other Non-Executive or Executive Director	1

Committee effectiveness review 2019/20: Response rate



3. Key findings from Quality & Safety Committee Effectiveness Review 2019/20

Views on overall effectiveness and scope for improvement

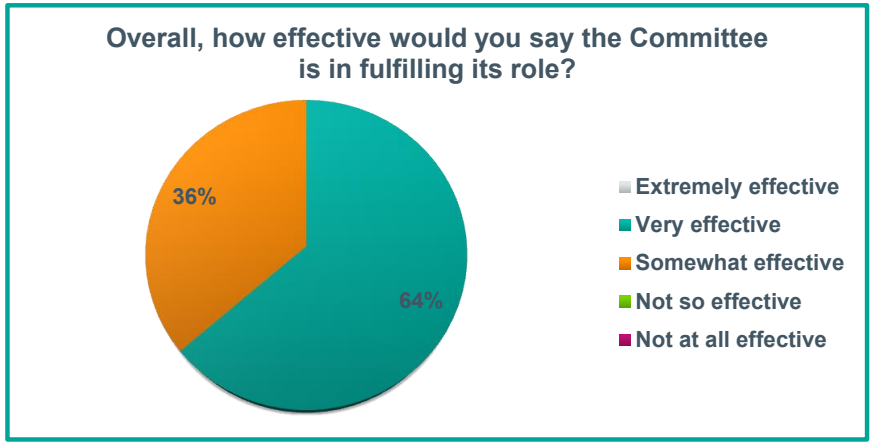
The full survey results of the Committee effectiveness review 2019/20 are set out in Appendix 1. This sets out the results for each question along with all of free text comments received.

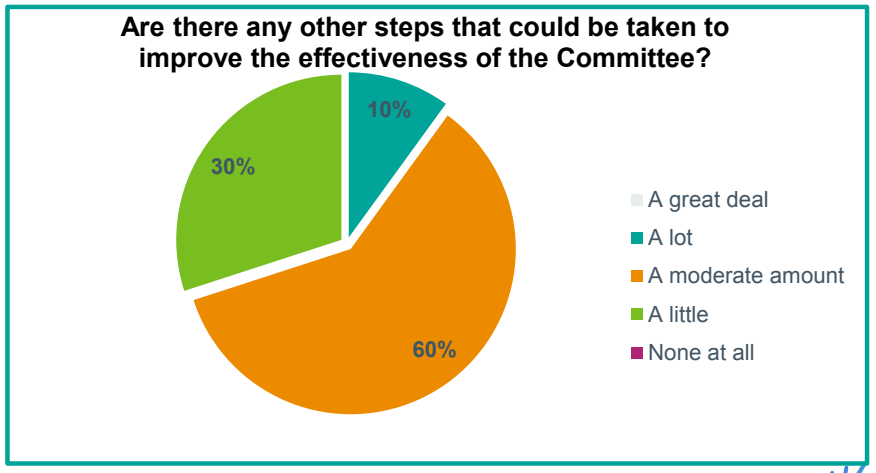
Overall, the results of the review suggest that the Committee is working broadly effectively, albeit with areas in which it can improve. All respondents stated that the Committee was either “very effective” (7 responses) or somewhat effective (4 responses). No respondents stated that the Committee was ineffective.

At the same time, none of the respondents said that the Committee was extremely effective, indicating that there is scope for the Committee to further develop, improve and mature.

Reflecting on the extent to which steps could be taken to improve the effectiveness of the Committee, none of the respondents stated that “a great deal” was necessary to improve the Committee’s effectiveness. 30% of respondents said “a little” steps were necessary to improve the Committee’s effectiveness. The largest proportion of respondents, 60%, felt that “a moderate amount” could be done whilst 10% felt a lot of steps could be taken to improve the Committee’s effectiveness.

Based on the results, improving the functioning of the need some focused work in some rather than wholesale change.





4. Key findings from Quality & Safety Committee Effectiveness Review 2019/20

Views on what's going well

The survey identified a number of areas where respondents, overall, fed back positive messages:

- **Terms of Reference:** Respondents (100%) 'agree' or 'strongly agree' that the Committee had in place and approved terms of reference and that Committee members and regular attendees under the remit of the Committee. 73% of respondents agreed that the Committee had in place an agreed forward plan. A majority (81%) of respondents also felt that the Committee had a clear understanding of governance groups that directly report into and how this aligns to quality and safety report to the Trust Executive.

- **Membership and attendance:** Respondents agreed that the Committee had the appropriate membership to carry out its duties. 82% of respondents were satisfied with the range, frequency, number of executives and other participants attending the Committee. Most respondents (91%) agreed that the Committee had the range of skills and knowledge to carry out its remit and similarly 82% thought that the Committee possessed the wider skills to be full effective.

- **Quality of papers:** On the whole, most (72%) of the respondents agreed that the agenda and programme of work for the Committee cover the assurance needs of the Board. 100% of respondents felt that the Committee had the opportunity to examine specific quality and safety issues in detail on areas of concern.

- **Meetings:** Circa 90% of respondents agreed that the meetings were chaired effectively committee provided insight and strong constructive challenge to the organisation.

- **Reporting and escalation:** All respondents 'agree' or 'strongly agree' that the Committee discuss matters for reporting and escalation to the Board. Most (90%) respondents noted that the Committee provided a clear report setting out the issues considered.

- **Review of Quality & Safety Issues** Respondents felt that the Committee provided effective assurance of the Board on performance against quality and safety measures. 81% of respondents 'agree' or 'strongly agree' that the Committee systematically scrutinised and challenged the risks allocated to it on the Board Assurance Framework. In a similar vein respondents felt that there was a clear understanding of the broader risks around quality and safety facing the organisation. The Committee received regular briefings on emerging risk. The majority of respondents (90%) agree or strongly agree that the Committee effectively monitor the CQC Action Plan. Most of the respondents felt that the Committee effectively reviewed compliance and performance on safeguarding, infection control, and deprivation of liberty.

5. Key findings from Quality & Safety Committee Effectiveness Review 2019/20

Views on areas for development

The survey highlighted a number of areas in which there was mixed feedback, with some respondents providing very positive feedback and others suggesting these were areas in which significant improvement was needed:

- **Committee Programme of Work:** The Committee terms of reference care due to be reviewed by the Committee in March and then presented to the Board for approval. Respondents provided free text comments which suggest the Committee's forward plan was not fit for purpose which led to meeting agendas being overloaded. This leads to items being regularly deferred putting pressure on future meetings. Whilst the respondents understood the quality and safety reporting lines they felt there was no effective mechanism for ensuring that the Committee received assurance from these forums. Respondents reflected that there was room to improve the work programme of the Committee by focusing on effectiveness, patient experience, divisional reviews and greater assurance reports for deep dive reviews. Less than half (45%) the respondents '*agree'* that papers were clear, concise, provided enough information and submitted and circulated in a timely way. Free text comments suggest that there was room to improve how the Committee seeks assurance and receives evidence that actions have been suitably implemented and embedded.

- **Induction:** Free text comments from respondents highlighted the need to review how to make best use of the attendees. The level of challenge from between non-executive directors and executive directors could be improved. Only 27% of respondents could clearly agree that there was effective induction and training programme in place for new member. Many respondents could not recall there being one in place and/or did not have an induction, albeit that the membership of the Committee has, until very recently, been broadly stable for some time.

- **Reporting & Escalation:** Free text comments from respondents highlighted the need to improve how the Committee reflects its level of assurance on key matters discussed in its report to the Board. The process for escalating risk to the Audit Committee could be improved.

- **Quality and Safety Issues:** Respondents reflected that it would be useful to have the BAF risk drive the workplan. Free text commentary also suggests that it would be useful for the Committee to receive the full Board Assurance Framework, periodically. The briefing of emerging risks needed to be more consistent. The Committee focuses on the priority outstanding or high-level CQC Action plans but does not routinely scrutinise wider actions from the CQC. Whilst 72% of respondents felt there was effective monitoring of Serious Incidents processes free text reflect that the Committee only recently started receiving serious incident reports. Similarly the respondents felt there was a lack of focus on patient experience with most of the focus on the Patient Partnership & Engagement Group or friend and family test. Respondents signal dissatisfaction with the arrangements in place for reviewing and overseeing implementation of recommendation from external sources such as NICE and HSE. Only 45% of respondents agreed or strongly agreed that the Committee does not effectively review research and development. Similarly only 36% of respondents felt that the Committee considers arrangement of assessing quality and safety impact of CIP and transformation programmes. As similarly low level of responds recall reviewing business cases for business cases for quality and safety implications.

6. Potential actions to address feedback from effectiveness review

The areas for further development highlight potential areas in which the Committee may want to focus in improving its effectiveness in the year ahead:

- Develop robust Committee workplan which covers the key matters which fall within the Committee's remit. The Committee workplan should include a robust deep dive programme, patient experience, transformation, and annual review of the quality and safety strategy, CQC full action plans, review of divisional performance against quality indicator, research and development, placeholders for reviewing business cases with for quality and safety implications and regular review of compliance with NICE and HSE.
- The workplan should also be framed from the BAF risk allocated to the Committee.
- A mechanism should be put in place for the Committee to receive explicit feedback and assurance from the relevant governance forums
- Develop a robust programme of deep dives, and plan these in for the year ahead leaving some space in the forward plan for newly emergent issues that require / warrant a deep dive so that the Committee can respond to new issues.
- Develop and implement robust report drafting guidance and template for assurance reporting, which is being picked up as part of the Board report writing improvement project. Improve circulation of reports in a timely way. There should be particular attention paid to develop a serious of report which reflects how learning has been embedded especially in relation to serious incidents, complaints, never events and deep dive reports.
- Revise the format of the Committee's report to the Board to ensure that there was clarity on level of assurance and key areas of risk, recognising that this piece of work is already underway with the objective of rolling out the new format at the start of the new financial year.
- Add a placeholder on the Committee's agenda for raising emerging risks and provide the opportunity for the Committee to decide what matters it would like to explore further.

Conclusion/Summary:

In a number of areas, the survey suggested the Committee was working well but respondents reflected there was more work to do to improve reporting to the Committee, assurance provided to the Board and scrutiny of risks. Comments also suggest that having a robust workplan would go some way to improve the effectiveness of the Committee.

In terms of the proposed measures to improve the quality of papers, a wider piece of work is currently underway across all Board Committees to strengthen reporting and draw out assurance more clearly, as well as to introduce a consistent approach in Committee reports to the Board.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

3.2

Meeting Title:	**Trust Board**		
Date:	28 May 2020	**Agenda No**	**3.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	Avey Bhatia, Chief Operating Officer James Friend, Chief Transformation Officer		
Report Author:	Emma Hedges, Mable Wu, Kaye Glover		
Presented for:	Information and assurance about Quality and Performance for Month 1		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, quality, patient access and performance. **Our Finance & Productivity** COVID-19 has impacted the activity levels at the Trust. Elective and Outpatient activity has been reduced in order to ensure the Trust can manage patients in a safe environment. Theatre capacity has been retained for essential services only and outpatient activity has been reduced in line with social distancing guidance. Virtual and telephone outpatient clinics have continued. Activity across all PODS has been significantly reduced with 51% less outpatient attendances in April 2020 compared to April 2019. Elective and daycase activity has reduced by 81% compared to the same period; ED attendances have also fallen by 60% compared to the same period. **Our Patient Perspective** The Trust has launched electronic Treatment Escalation Plans across the Trust which allows patients and staff to be aware of the limits of treatment in the event of patient deterioration. Deteriorating patients is one of the Trust's Quality Priorities in 2020/21. The metrics in this report will be reviewed and revised in line with our updated Quality Priorities as per the Quality Accounts. There has been a significant increase in Category 2 and 3 Pressure ulcers in April. Category 3 and above pressure ulcers have undergone Root Cause Analysis and the learning is being disseminated at ward level. Emergency Department Friends & Family (FFT) positive response rate reached its highest in over two years with 93.9% of responders stating that they would recommend the service to family and friends. The ED response rate also exceeded its target of 20% with a 22.6% response rate. FFT surveys completed on tablet computers remains suspended during the current COVID-19 incident which has impacted response rates in other areas. **Our Process Perspective** The Trust's four hour operating standard performance in April was 88.3% with emergency flow improving on a daily basis in May. Emergency flow The Trust met two of the seven cancer standards for March 2020. All urgent two week referrals are being triaged by consultants. The cancer patients are being actively tracked and reviewed by multi-disciplinary teams (MDTs) and are being prioritised as per NHS England guidance. Due to the suspension of routine interventions, the Trust's six week diagnostic		

	performance deteriorated to 63.6% against a National Target of 1% in April. March 2020's RTT performance was 79.3% against the Trust trajectory of 88.1% with 32 patients waiting longer than 52 weeks. Similar to the six week diagnostic performance, the position is expected to deteriorate however the overall waiting list size is expected to decrease as referrals have fallen by circa 80%. **Our Workforce Perspective** The Trust sickness rate has increased again in April to 5.6% against a long term average of 3.5%.		
Recommendation:	The Committee is requested to note the report		
Supports			
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:			
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Previously Considered by:	Trust Executive Finance & Investment Committee Quality & Safety Committee	**Date**	20/5/2020 21/5/2020 21/5/2020
Equality Impact Assessment:			
Appendices:			

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

3.2

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 28 May 2020

15th May 2020

Our Outcomes

How Are We Doing?

April 2020

Daycase and Elective Surgery operations

Actual: 884

Target: 5,149

AMU bed occupancy at 12 Noon

Actual: 47.9% Target: 85%

Four Hour Emergency Standard

Actual: 88.3%

Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 100%

Target 95%

Outpatient First Attendance

Actual 6,683

Plan 16,892

March 2020

Referral to Treatment Standard - Incomplete pathways

Actual: 79.3%

Target: 92%

Target for Daycase and Elective Surgery Operations and Outpatient First Attendance is based on pre COVID-19 SLA plan

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE & PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control R	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations R	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce		Agency Use		Estates Health and Safety	

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID plan

Executive Summary – April 2020

Our Finance and Productivity Perspective

- COVID-19 has continued to have a significant impact in activity in April across all services with Elective and Outpatient activity 81% and 51% respectively lower than the same period last year.
- Similarly, Emergency Department attendances and Non-elective admissions are also 59% and 43% lower than the same month last year.
- The Trust has retained enough theatre capacity to maintain essential services whilst closing all other theatres to support COVID-19 Surge plans
- The Trust is also continuing to see outpatients in virtual or safe environments.

Our Patient Perspective

- The Trust began collecting Treatment Escalation Plans data on appropriate inpatients on the 23rd March 2020, this allows patients and staff to be aware of the limits of treatment in the event of the patient deteriorating. Uptake has steadily increased since records began showing special cause variation.
- Safety Thermometer is no longer being completed, it has been cancelled indefinitely at national level resulting in no more Harm Free Data. The Trust is in discussions its replacement once things return to normal.
- There was a marked deterioration in the number of Grade 2 and 3 Pressures ulcers with a 68% and 100% increase respectively, likely due to COVID-19
- The number of Complaints and PALs received fell in April, and the response rate for 25 and 40 days were below target.
- The number of births in April remained below the plan and the drop in birth numbers is consistent with those reported across the sector.
- The percentage of positive responses for Friends and Family Test have increased across all services Due to COVID-19 NHSE asked Trusts to suspend patient surveys since a number of our surveys are completed on tablet computers as a consequence the cohort of patients surveyed is much lower than normal.

Our Process Perspective

- Emergency Department attendances in the calendar month of April significantly decreased seeing the number of patients attending the Emergency Department fall below the lower control limit for the consecutive month. The Trust have seen on average less than 200 patients attending the department on the Tooting Site per day over the month, and of these, the number discharged, admitted or transferred within four hours of arrival was 88.3%.
- In April, COVID-19 adversely impacted the Trust's six week diagnostic standard performance with routine elective work on hold. In total 63.6% of patients on the diagnostic waiting list were waiting longer than six weeks at the end of April.
- March 2020 incomplete Referral To Treatment (RTT) performance was 79.3% against the Trust trajectory of 88.1%. The Trust 52 week breach position deteriorated in March with 32 patients waiting longer than 52 weeks for treatment. This is a direct result of stopping routine elective surgery . The RTT performance is expected to deteriorate as a result of COVID-19 lockdown though patients are being seen where possible.

Our People Perspective

- Sickness rate has increased by 0.5% in the month of April reporting a rate of 5.6%.
- Appraisal rates for Non Medical staff fell to 67.9% in April against a target of 90%. Appraisal rates for Medical staff was not reported.
- The Trust's total pay for April was £49.00m. This is £0.57m adverse to a plan of £48.42m.

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
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Key

Current Month

A Previous Month

Our Finance & Productivity Perspective

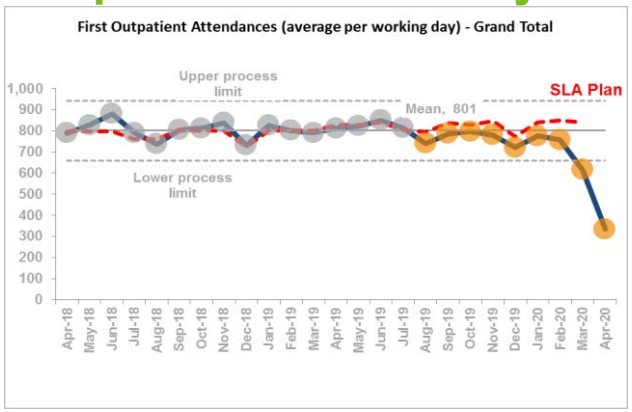
Activity against our Plan

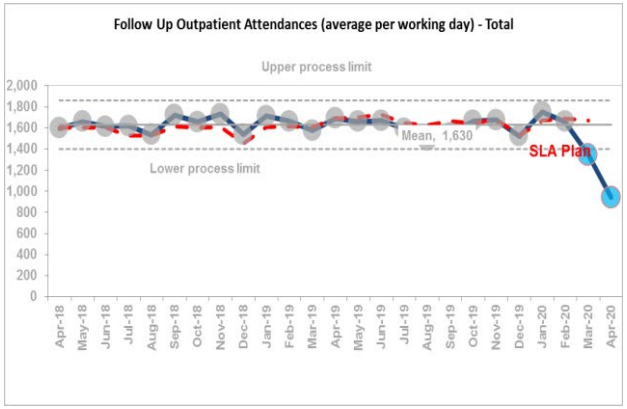
		Apr-19	Apr-20	Variance	Plan Apr-20	Variance	YTD 19/20	YTD 20/21	Variance	Plan YTD	Variance
ED	ED Attendances	13,845	5,582	-59.68%	14,299	-60.96%	13,845	5,582	-59.68%	14,299	-60.96%
Inpatient	Non Elective	3,298	1,892	-42.63%	3,162	-40.16%	3,298	1,892	-42.63%	3,162	-40.16%
	Elective & Daycase	4,678	884	-81.10%	5,149	-82.83%	4,678	884	-81.10%	5,149	-82.83%
Outpatient	OP Attendances	54,360	26,575	-51.11%	55,154	-51.82%	54,360	26,575	-51.11%	55,154	-51.82%

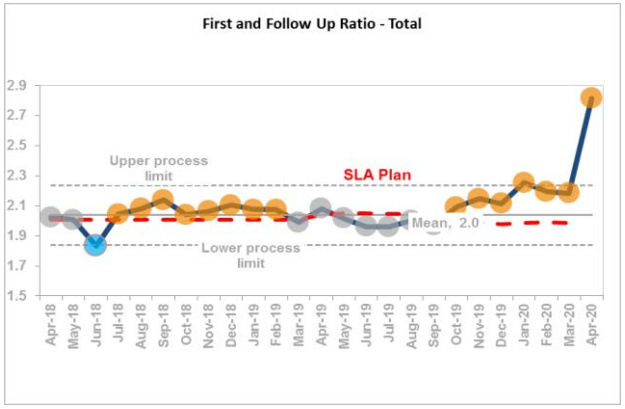
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

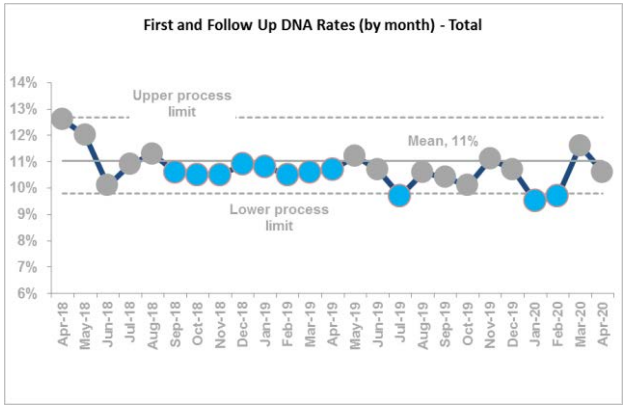
Note: Figures quoted are as at 09/05/2020, and do not include an estimate for activity not yet recorded (eg. un-cashed clinics).
Plan for 2020/21 is based on pre COVID-19 SLA plan

Outpatient Productivity









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

What the information tells us

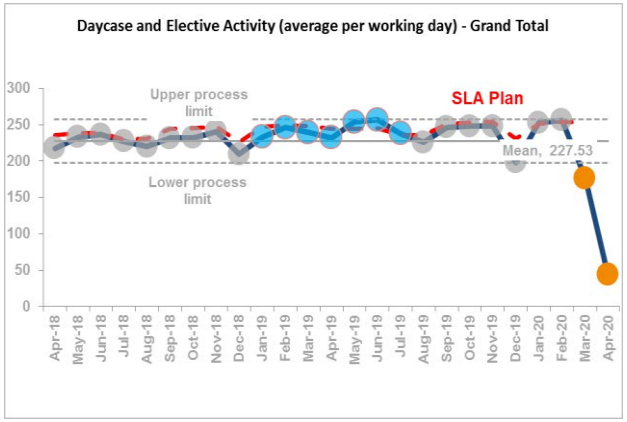
- Outpatient first activity has been below the lower control limit for a consecutive month. The number of attendances per day was 59% lower than the same period last year. All specialties are reporting activity in April below the lower control limit with the exception of Children's Services who remains within the upper and lower control.
- At Trust level, follow-up activity has significantly fallen and performed below the lower control limits in March and April. Compared to the same month last year activity per day is 44% lower. All specialties have fallen below the lower control limits with Neurology, Specialised Medicine and Women's services seeing the largest drop in activity per day.
- With the drop in the overall number of new and follow up appointments the number of patients that did not attend has significant dropped by 41% compared to March. The Trust DNA rate in April was 10.6%.

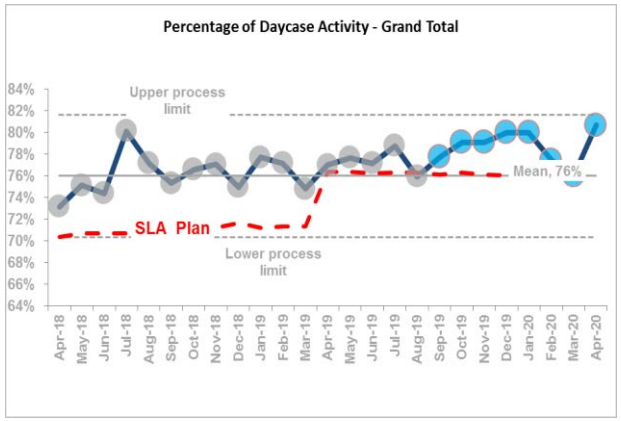
Actions and Quality Improvement Projects

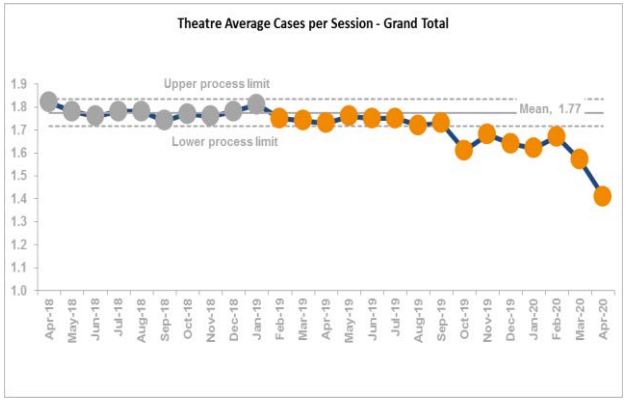
A Safely Standing Down workstream was set up on 24 March 2020. The workstream centres on review and reprioritisation of activity in light of the current COVID-19 pandemic. The aim of the workstream is to minimise the number of patients on site within a risk assessed approach to prioritisation, as per National Guidance.

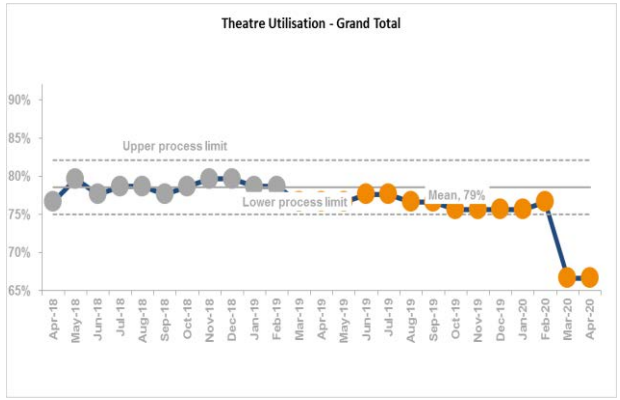
The workstream has successfully migrated outpatient activity to virtual settings across the Trust to reduce footfall on the Tooting site. There remains an element of catch up in terms of recording patient outcomes for April for virtual clinics.

Elective Activity & Theatre Productivity









Actions and Quality Improvement Projects

A minimal theatre schedule was implemented to offer only urgent and emergency treatments across all specialties. This was due to availability of kit and staff as well as safety for patients. This schedule has been under constant review and has been amended as the demands have changed.

All lists have been booked through a clinically led prioritisation process - twice a day for emergency lists, and once a week for urgent cancer lists.

More elective lists have been run in recent weeks as staff and capacity returned to anaesthetics and theatres. This is continually under review as guidelines and the situation changes.

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

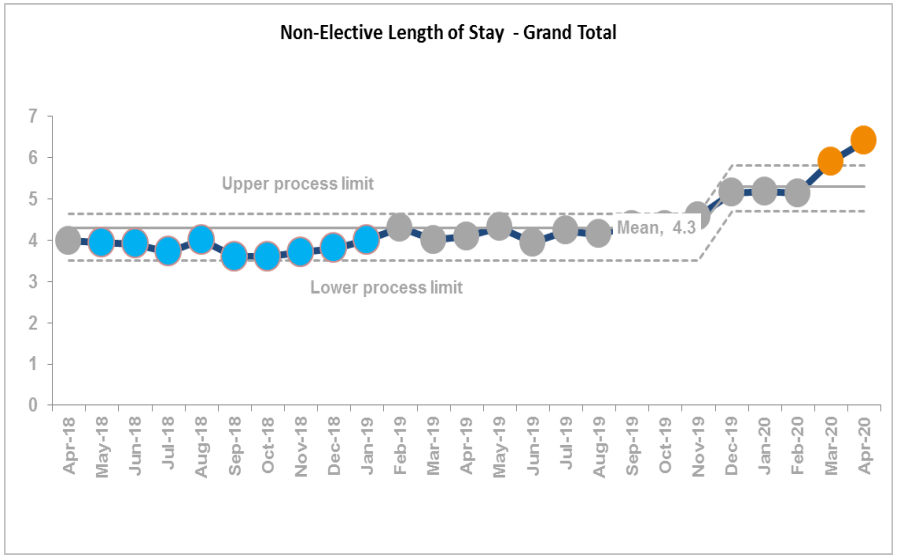
What the information tells us

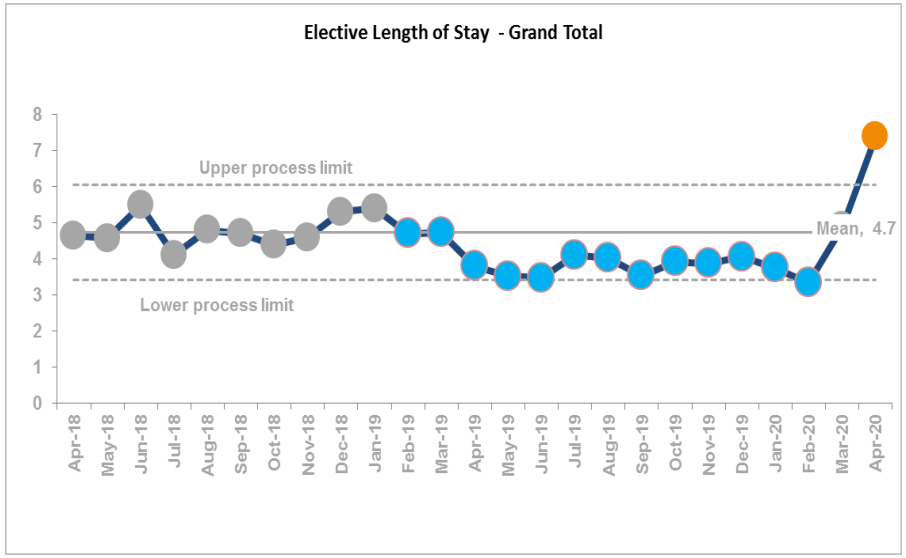
- Activity data for elective treatments for April fell below the lower control limits for a consecutive month with a significant number of elective activity cancelled. Compared to April last year there has been a drop 81% drop in elective activity.
- All service have seen a fall in activity below the lower control limits with the exception of Haematology where activity remains within the upper and lower control limits and Oncology where activity remains above the upper control limit.
- Trust level theatre utilisation and theatre cases per session has fallen as expected with the number of theatres reduced to manage current challenges.

3.2

Our Finance & Productivity Perspective

Length of Stay





What the information tells us

- The number of non-elective admissions have reduced in April by 37% compared to the same period last year following a decrease in demand impacting the profile of non-elective length of stay which has seen an increase at Trust level. All services with the exception of Neurology, Specialty Medicine and Therapeutics are above the upper control limits.
- Elective length of stay has moved above the upper control control limits, although length of stay has increased the number of elective procedures and admissions have reduced overall.
- The Trust's increase in Length of Stay is attributable to:
    - High number of COVID inpatients, these patients have an average LOS of 15 days
    - Decrease in short LOS patients as routine operations have ceased; short stay wards were converted to COVID wards
    - Decrease in zero LOS patients as lock down has had a significant impact in ED attendances
    - Decrease in long stayers as the Trust has worked with system partners to expedite discharges, please refer to the Emergency Flow slide

Actions and Quality Improvement Projects

An acute post-COVD clinic will be set up to enable earlier patient discharge for COVID patients

The Trust continues to meet with system partners daily to ensure patient discharges are not blocked. As lockdown eases, the discharge teams are focussing on maintaining the pressure and focus on ensuring patients are discharged in a timely manner

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
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OUR **PEOPLE** PERSPECTIVE	Workforce		Agency Use		Estates Health and Safety	

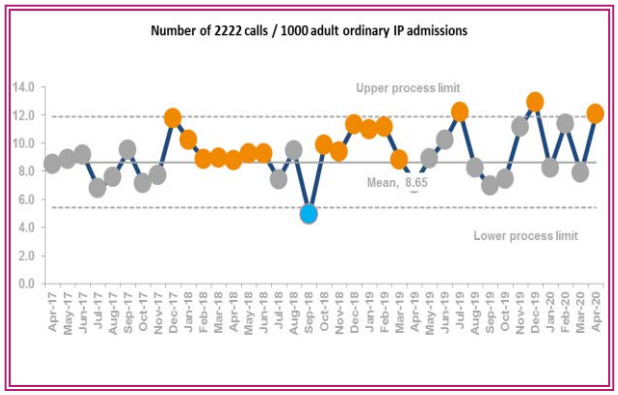
Key

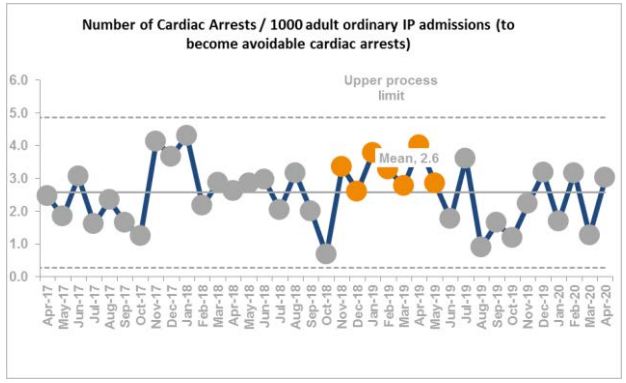
Current Month

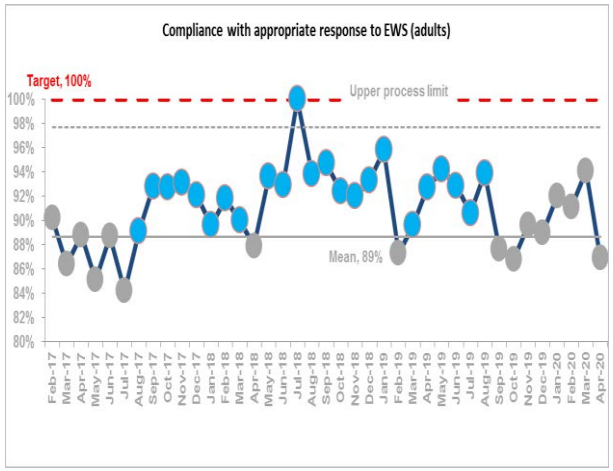
A Previous Month

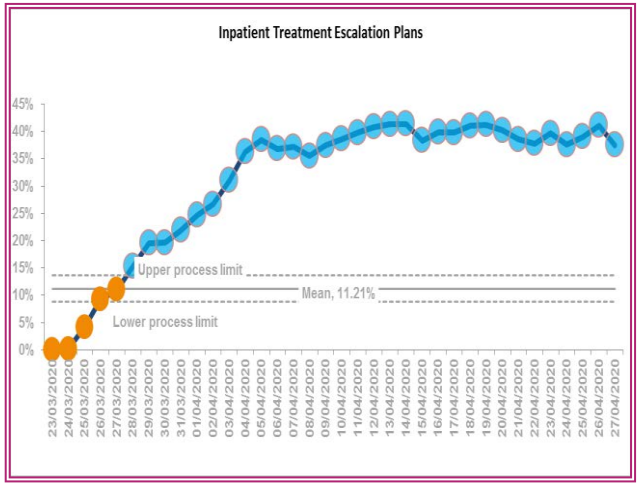
Our Patient Perspective

Quality Priorities – Treatment Escalation Plan









What the information tells us

- The number of 2222 performance deteriorated this month showing special cause variation.
- Compliance with appropriate response to Early Warning Score (EWS) fell from 94% in March to 86.9% this month and continues to show common cause variation. The cohort of EWS patients can be seen in the Appendix
- As at 23 March 2020, the trust began collecting Treatment Escalation Plans data on all adult inpatients, this allows patients and staff to be aware of the limits of treatment in the event of the patient deterioration. Uptake has steadily increased since introduction.

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

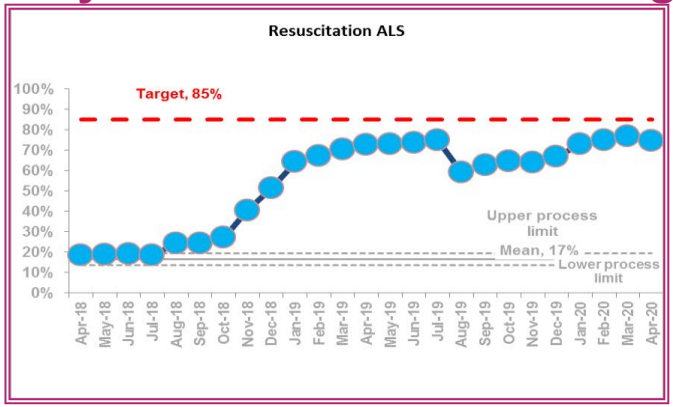
Actions and Quality Improvement Projects

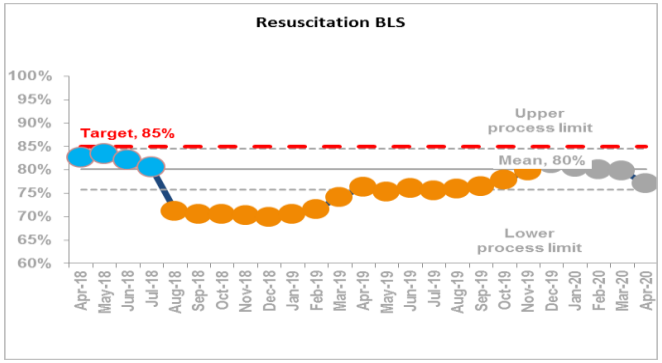
- Treatment Escalation Plans (TEP) are now live in iClip
- Trust wide communication to request TEPs are put in place for all adult inpatients within 24 hours of admission

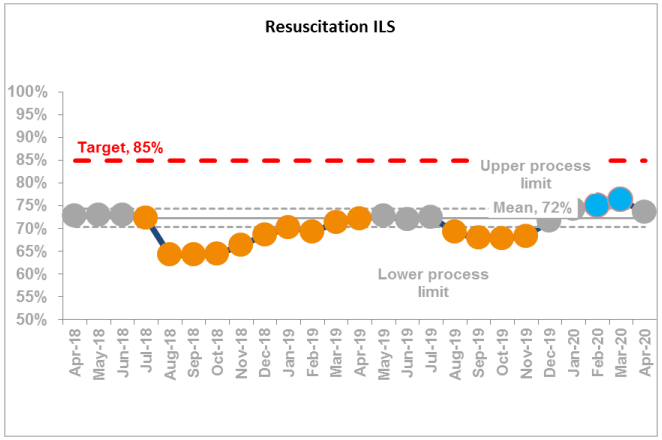
3.2

Our Patient Perspective

Quality Priorities – Deteriorating Patients







- ALS (Advanced Life Support) training performance shows continued improved performance but has not met the 85% performance target.
- BLS (Basic Life Support) training performance is within the process control limits.
- ILS (Intermediate Life Support) has increased and is now above the mean and showing special cause variation, both continue to underperform against the 85% target. .

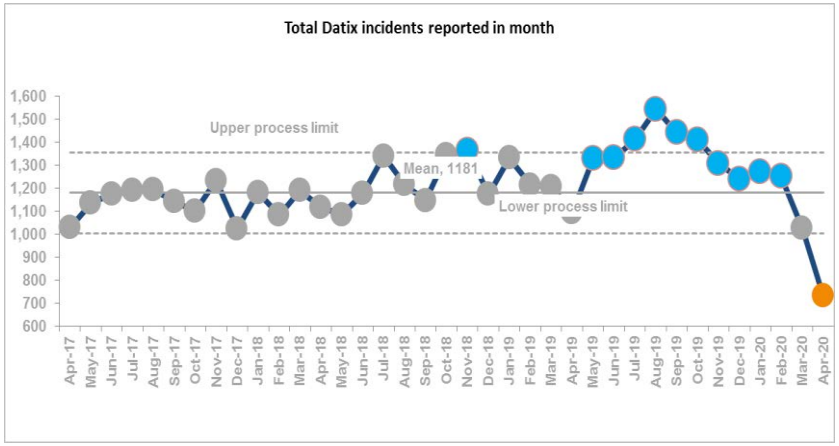
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

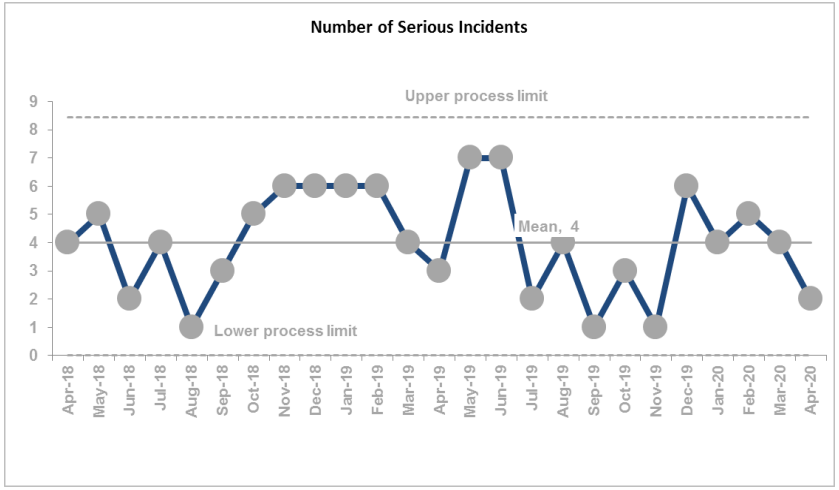
Actions and Quality Improvement Projects

- From mid-March 2020 the focussed provision of ALS and ILS training has been scaled back due to the need for the resuscitation training team members to return to practice in critical care. BLS continues to be targeted at staff where training is not up to date and in addition for practitioners returning to practice in response to COVID-19.

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Total Datix incidents reported in month		1,096	1,329	1,332	1,413	1,544	1,442	1,410	1,309	1,241	1,271	1,252	1,026	734
Monthly percentage of Incidents of Low and No Harm		97.0%	97.0%	99.0%	97.0%	98.0%	97.0%	97.0%	96.0%	96.0%	96.0%	96.0%	93.0%	data one months in arrears
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%	97.0%	93.0%	97.0%	97.0%	98.0%	86.0%	84.0%	67.0%	data two months in arrears	





What the information tells us

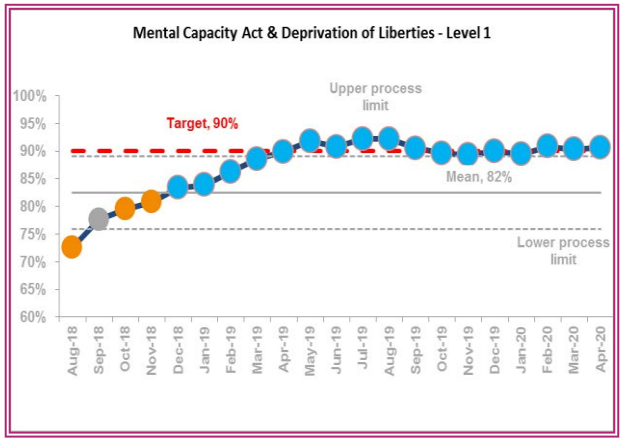
- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- There was a reduction in the number of adverse incidents reported in April 2020, with 93% of those resulting in no and low harm.
- There were no reported Never Events in April 2020.

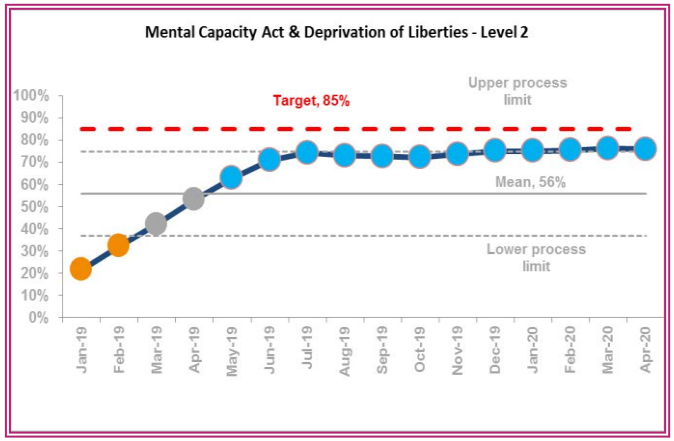
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

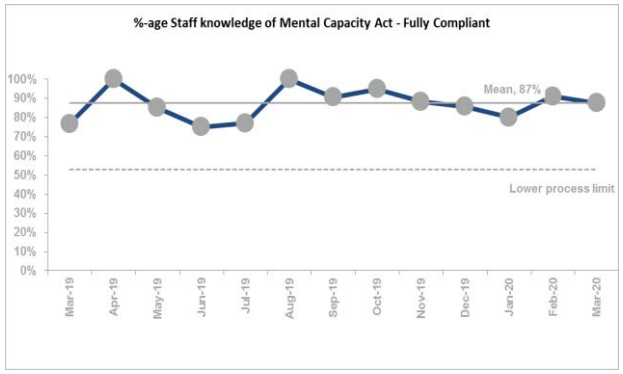
Actions and Quality Improvement Projects

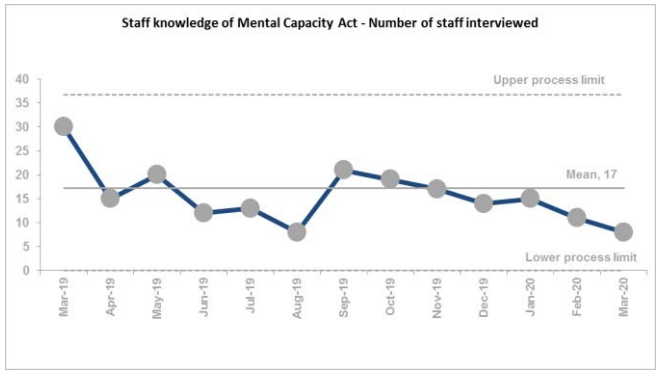
- Incidents – A review of the adverse incidents reported in April 2020 is being undertaken. There are a number of factors that may have contributed to the reduction in the number that were reported including COVID-19 and change in in the normal activity / services being provided during this period. This will be reported to the Patient Safety and Quality Group (PSQG).

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









What the information tells us

- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 remains within target
- Level 2 training performance has plateaued. Overall level 2 compliance currently stands at 76.4%
- Metrics taken from the ward accreditation system shows the number of staff interviewed and their level of knowledge was not recorded due to COVID-19

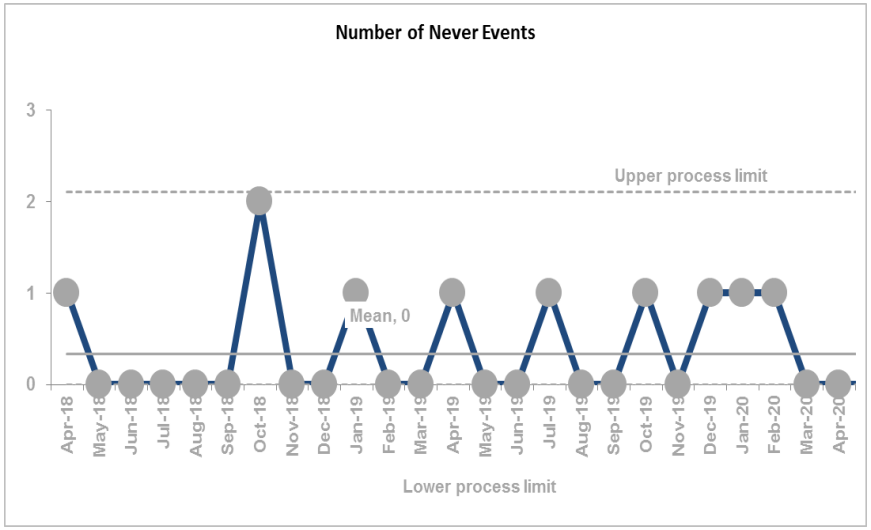
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

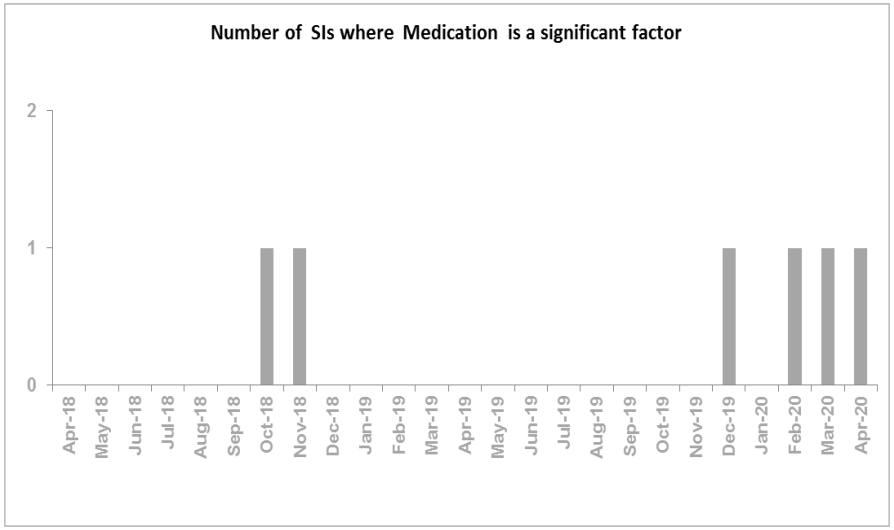
Actions and Quality Improvement Projects

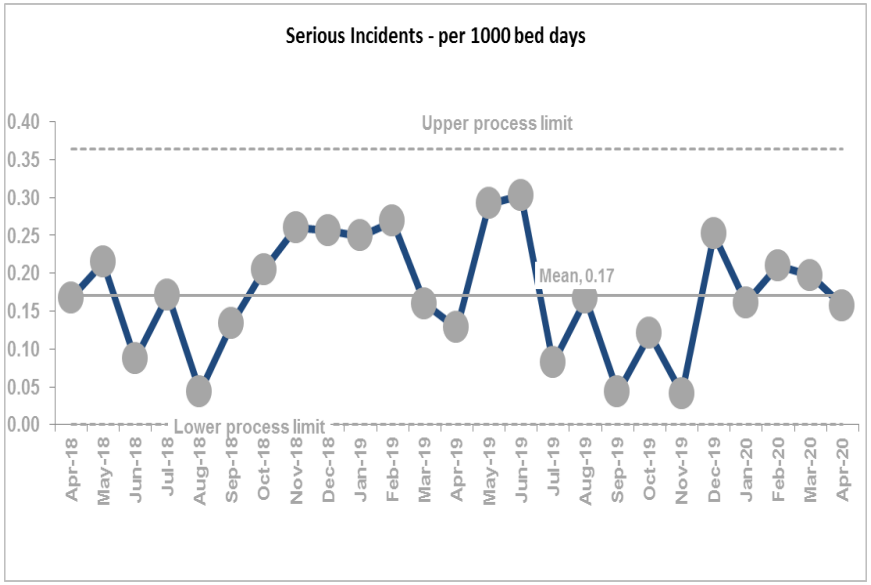
- Mental Capacity Act & Deprivation of Liberties lead commenced in post on 17 February 2020.
- Band 7 MCA Practitioner starts in post on 18 May 2020.
- Further revisions to ICLIP MCA templates being submitted following medical / surgical review. Aim of these forms is to standardise recording and enable efficient audit processes but need to be user friendly to maximise uptake.
- Quarterly staff knowledge audit delayed / currently suspended due to current COVID 19 outbreak. The aim of this audit, developed in partnership with South West London partners, is to enable the Trust to benchmark and review level of staff knowledge against an expert agreed pass mark and in relation to other local healthcare organisations.
- Currently working with medical consent lead and audit team to undertake audit of consent and develop tools to optimise audit process for this area.

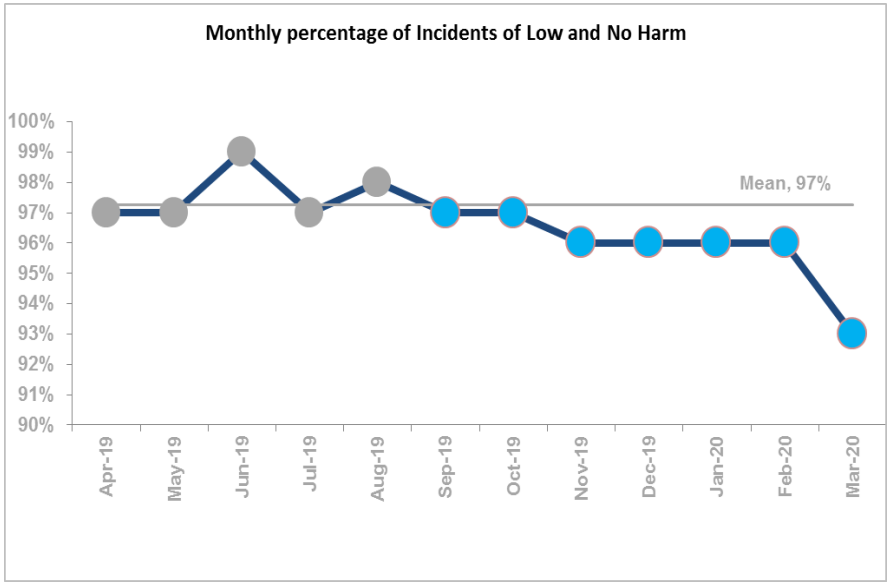
Quality Priorities – Learning from Incidents

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







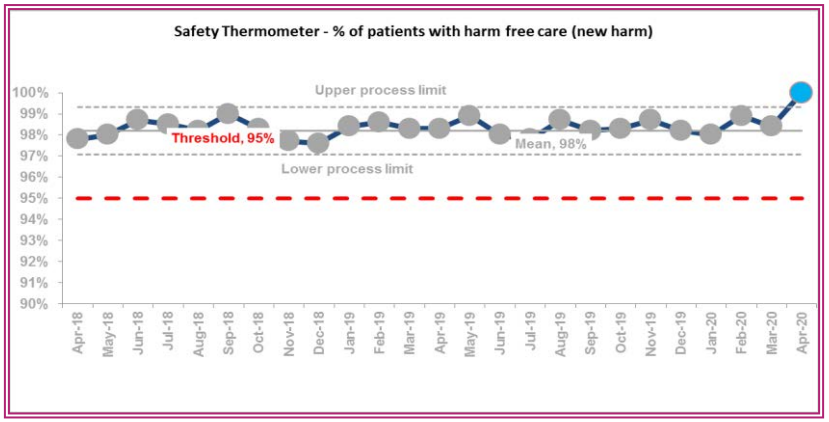


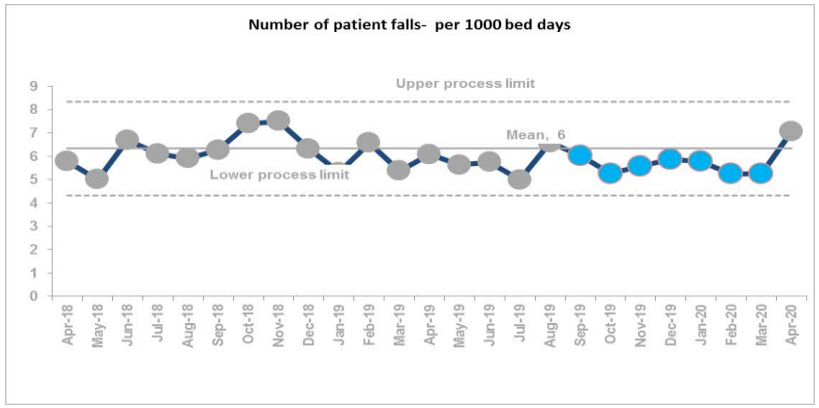
Data is 1 month in retrospect

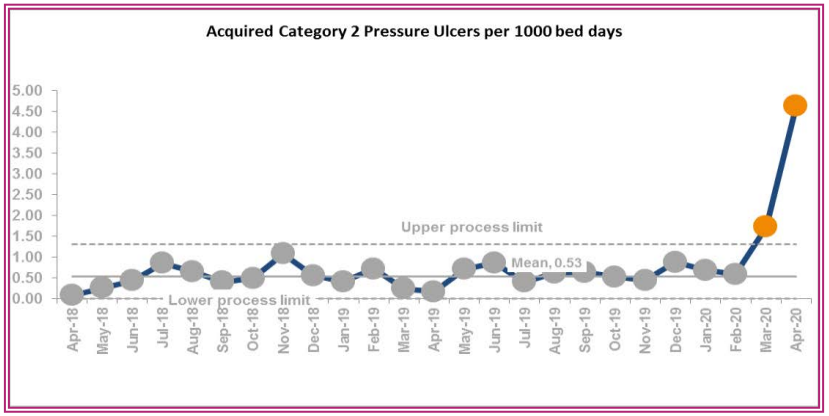
3.2

Our Patient Perspective

Patient Safety







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

What the information tells us

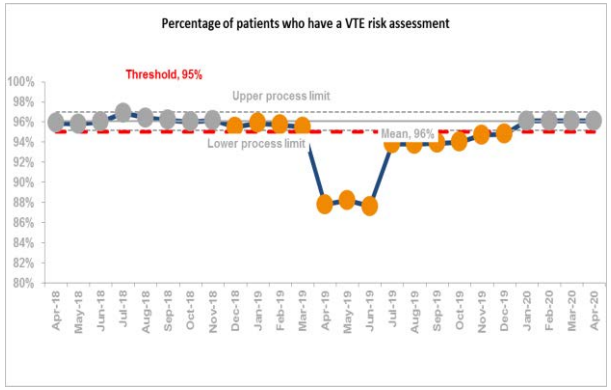
- The Trust is meeting its VTE standards and is above the upper process control limit. As outlined in the actions below, the patient cohort has been updated in line with NICE guidance.
- Safety thermometer– percentage of patients with harm free care increased to 100%.
- There was a marked deterioration in the number of Grade 2 and 3 Pressures ulcers with performance showing special cause variation

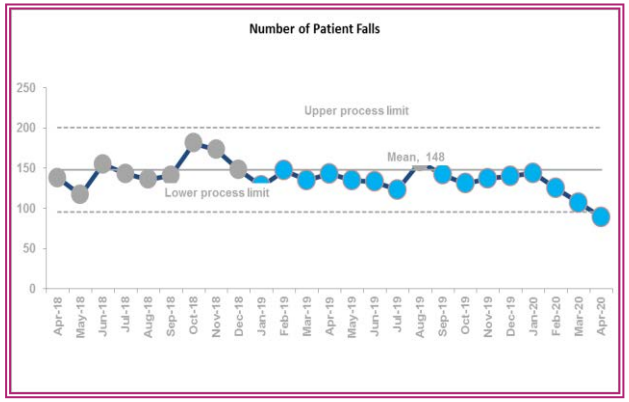
Actions and Quality Improvement Projects

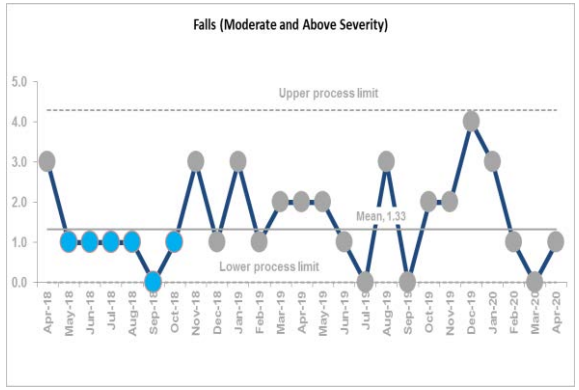
- All patients who have a length of stay less than 14 hours and all non-inpatient areas are now excluded from the VTE risk assessment compliance figures as per NICE guidelines. Results from Q3 for VTE risk assessment compliance were 96.1%, this is a huge improvement that was due to the streamlining and rationalising of the inclusion and exclusion criteria for the report. The Trust met the target for the last quarter and the Hospital Thrombosis Group continue to monitor results.
- Category 3 and above pressure ulcers have undergone Root Cause Analysis (RCA) to identify any key learning. RCA results previously discussed in a cross divisional meeting has been changed to local discussions at ward level due to COVID19 pandemic. This will be reviewed going forward to ensure shared learning is widely disseminated.

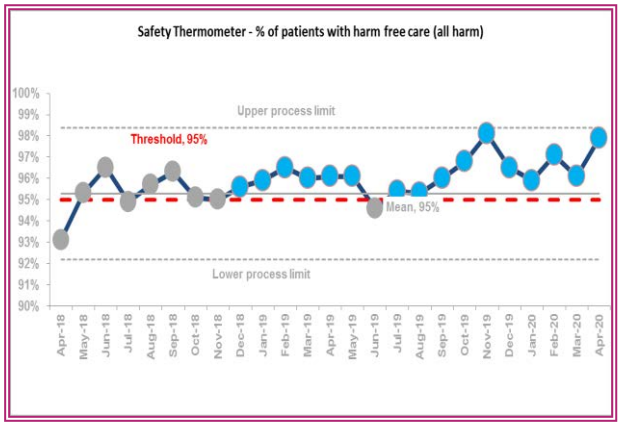
Patient Safety

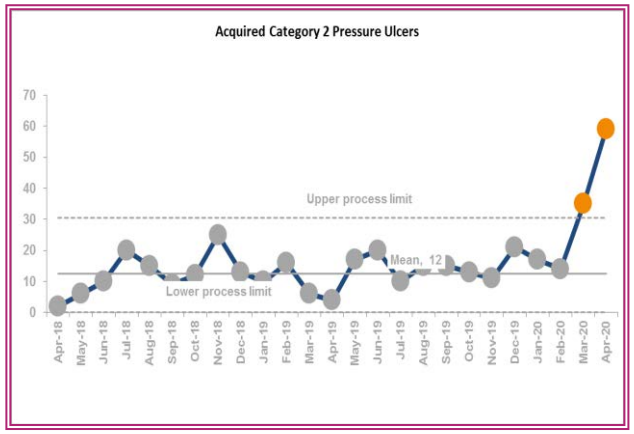
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

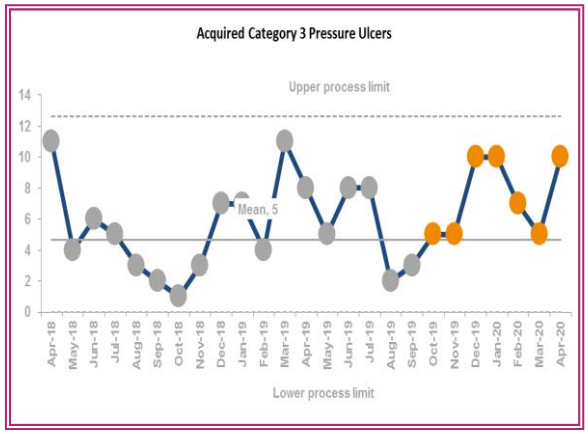










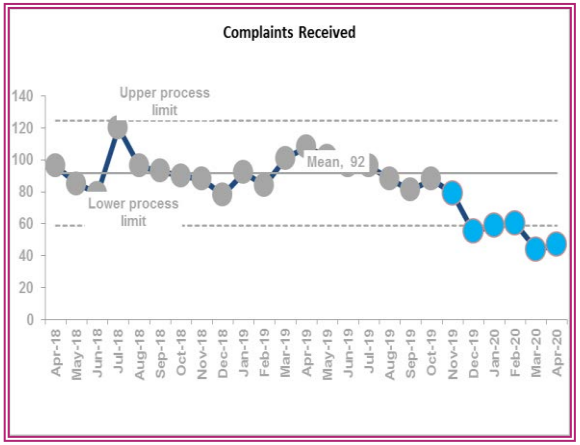


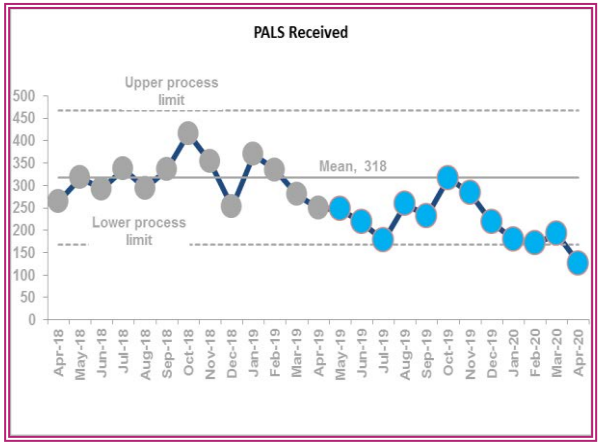
3.2

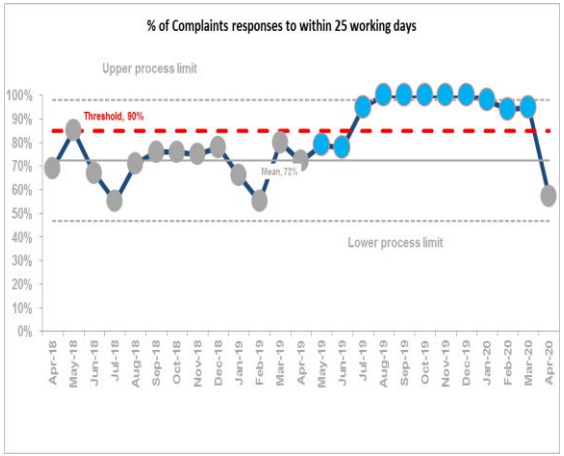
Our Patient Perspective

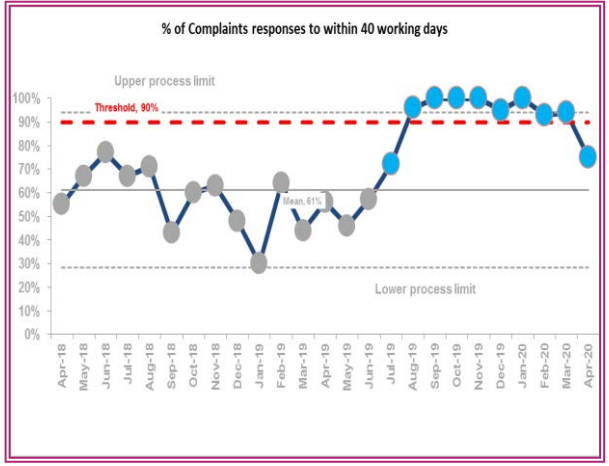
Complaints

Indicator Description	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Complaints Received		108	102	96	96	88	81	88	79	55	59	60	44	47
% of Complaints responses to within 25 working days	85%	72%	79%	78%	95%	100%	100%	100%	100%	100%	98%	94%	95%	57%
% of Complaints responses to within 40 working days	90%	56%	46%	57%	72%	96%	100%	100%	100%	95%	100%	93%	94%	57.0%
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PALS Received		249	247	218	177	259	232	316	283	218	180	171	192	126









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

What the information tells us

- Reduced performance was seen across all response categories for this reporting
- The number of PALs enquiries has decreased

Actions and Quality Improvement Projects

The daily complaints CommCell continues to refocus attention on complaint investigation and ensure performance is restored across all response categories

Infection Control

Indicator Description	Threshold 2020-2021	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	0	0	1	0	1	0	1	0	0	0
Cdiff Hospital acquired infections	TBC	4	4	5	4	4	6	3	2	2	5	3	1	1	1
Cdiff Community Associated infections		0	0	1	1	1	0	1	2	0	0	0	2	0	
MSSA	TBC	4	6	1	0	3	2	2	3	5	6	3	2	3	3
E-Coli	TBC	5	7	5	7	7	8	6	4	9	5	7	4	3	3

What the information tells us

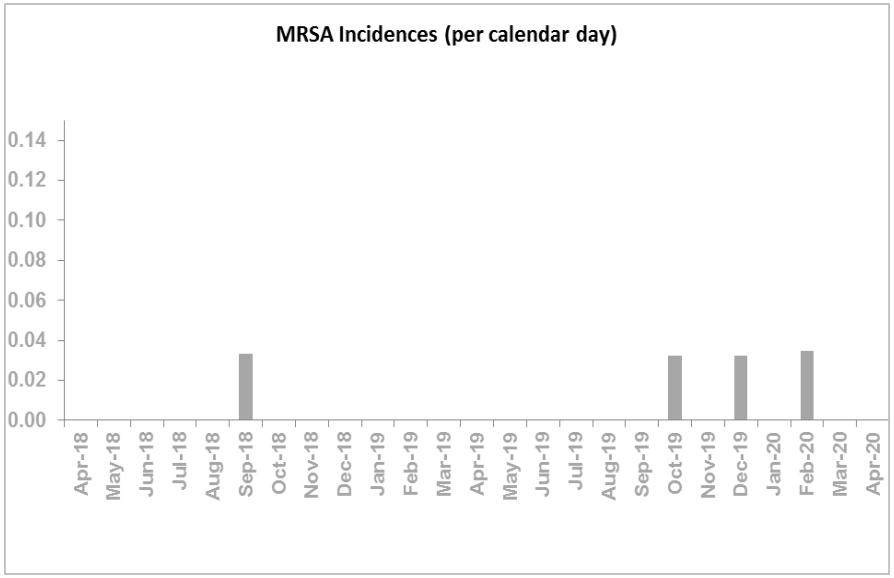
- The Trust reported no MRSA incidents in April 2020. There is a zero target for 2020/21.
- In April there was one Cdiff incident which was Hospital Acquired..
- The number of Ecoli and MSSA cases reported remains within control limits with three incidents for each infection respectively.

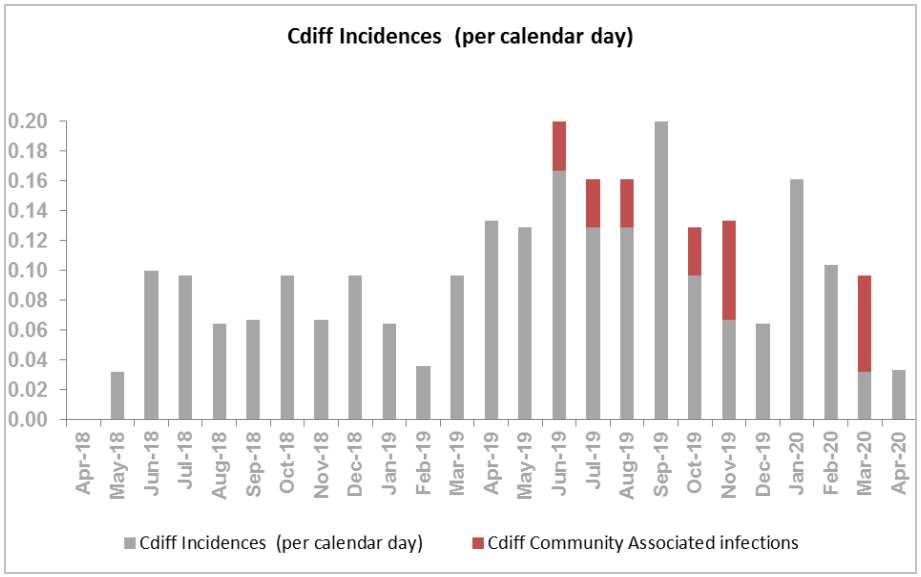
Actions and Quality Improvement Projects

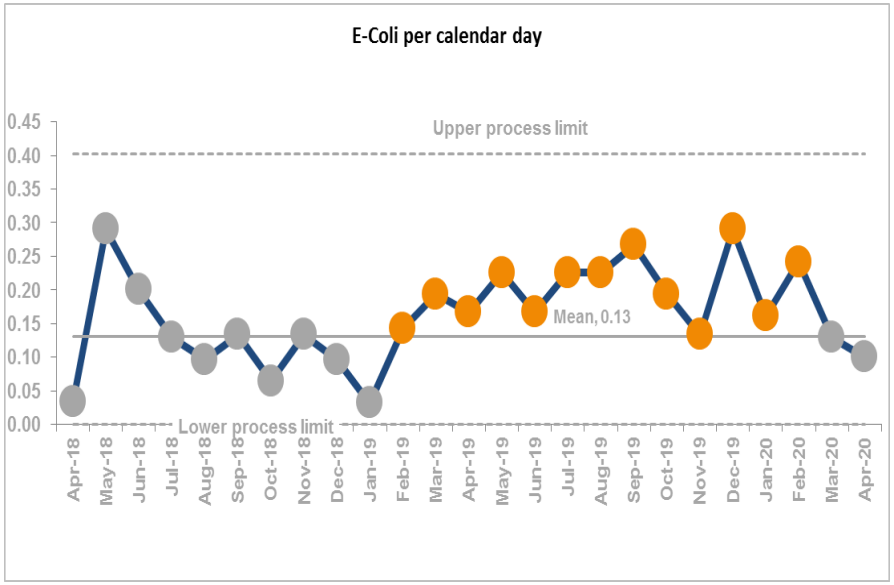
- The Trust continues with infection control measures with more emphasis on care of invasive lines and Aseptic Non Touch Technique
- Back to the floor by the Matrons and lead nurses focusing on line management and documentation on visual inspection of phlebitis (VIP) score
- Infection control and cleaning standards measured through the ward accreditation process.
- Areas where Hospital Acquired Infections have occurred are placed under a higher frequency surveillance and audit programme.
- A data quality exercise has resulted in an increase in the number of Ecoli and Cdiff incidents. A review is being conducted.

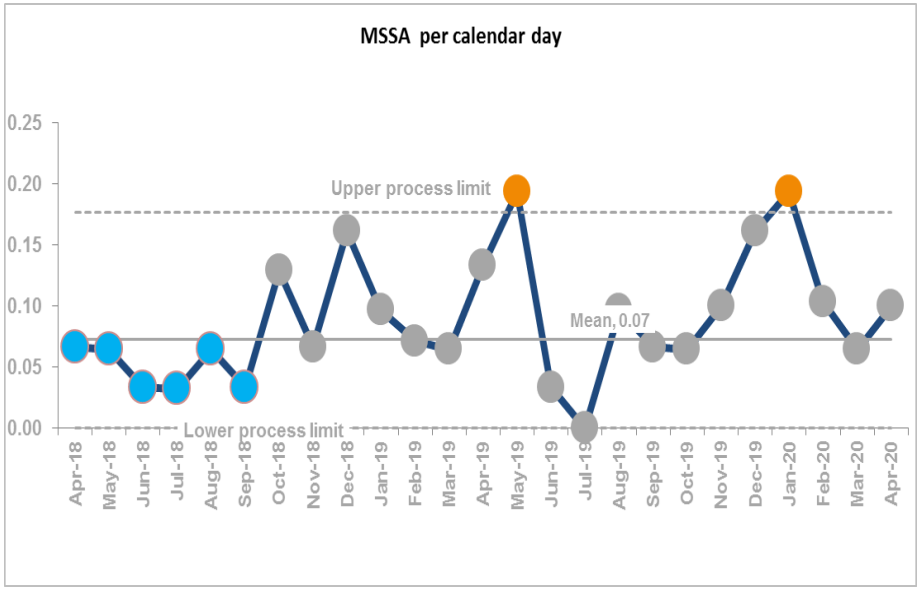
Infection Control

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









Mortality and Readmissions

Indicator Description	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb 2019 to Jan 2020
Hospital Standardised Mortality Ratio (HSMR)	79.4	91.9	89.5	105.5	87.9	92.1	88.5	95	101.6	91.4	90.2	93.1
Hospital Standardised Mortality Ratio Weekend Emergency	82.9	91.3	73.5	113	77.2	93.8	107.3	80.6	100.1	87.6	112.3	92.8
Hospital Standardised Mortality Ratio Weekday Emergency	76.3	91.5	92.5	100.4	90.8	96.2	80.4	102.9	102.9	90.8	90.1	93.2

Indicator Description	Apr18-Mar19	May18-Apr19	Jun18-May19	Jul18-June19	Aug18 to Jul19	Sep18-Aug19	Oct18-Sep19	Nov18-Oct19	Dec18-Nov 19
Summary Hospital Mortality Indicator (SHMI)	0.82	0.82	0.81	0.83	0.83	0.83	0.85	0.85	0.85

Indicator Description	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	9.6%	9.3%	10.6%	8.7%	7.3%

Note: **HSMR data reflective of period Feb 2019 – Jan 2020 based on a monthly published position.**
SHMI data is based on a rolling 12 month period and reflective of period December 2018 to November 2019 published (April 2020).Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways.

What the information tells us

Both of the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over performance and also under performance

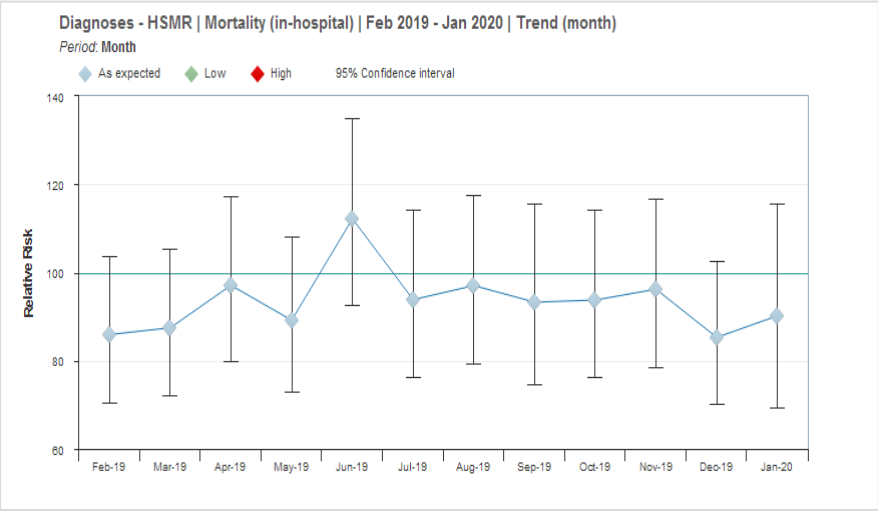
Actions and Quality Improvement Projects

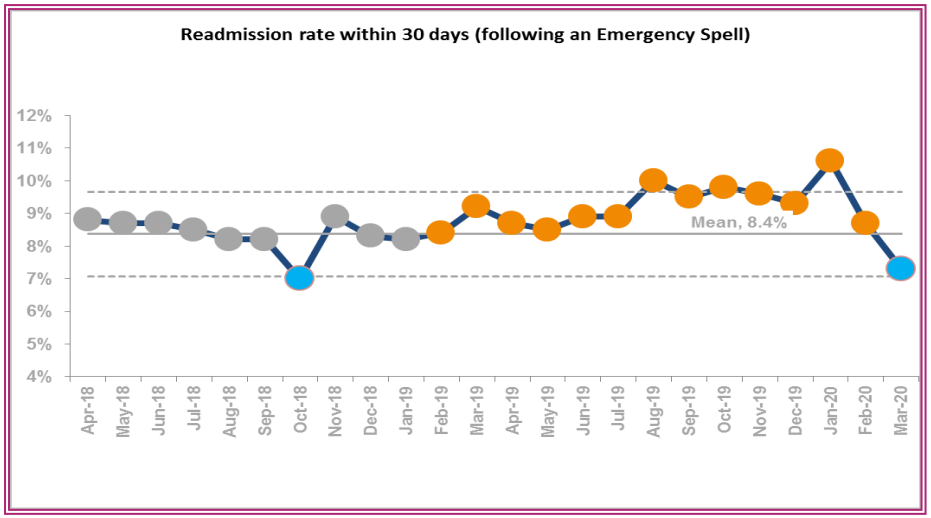
We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Committee (MMC).
In April the outcome of an investigation in relation to the Reduction of fracture of bone (upper/lower limb)', covering the period December 2018 to November 2019, was reported to the committee. The investigation found that all deaths had already been reviewed by at least one of the Mortality Review Team, Trauma Governance Group or CTICU. In the large majority of cases no avoidability or concerns were noted and the deaths were found to be expected given the severity of illness and/or injury. Where there were any concerns these had been reported prospectively to the Risk Team for consideration of investigation. In one case an SI had been declared and fully investigated finding a medication prescribing error which did not contribute to the patient's death. The Mortality Monitoring Committee was satisfied that this signal had been appropriately investigated and found no concerns or areas for action.

Mortality and Readmissions (Hospital Standardized Mortality Rate)

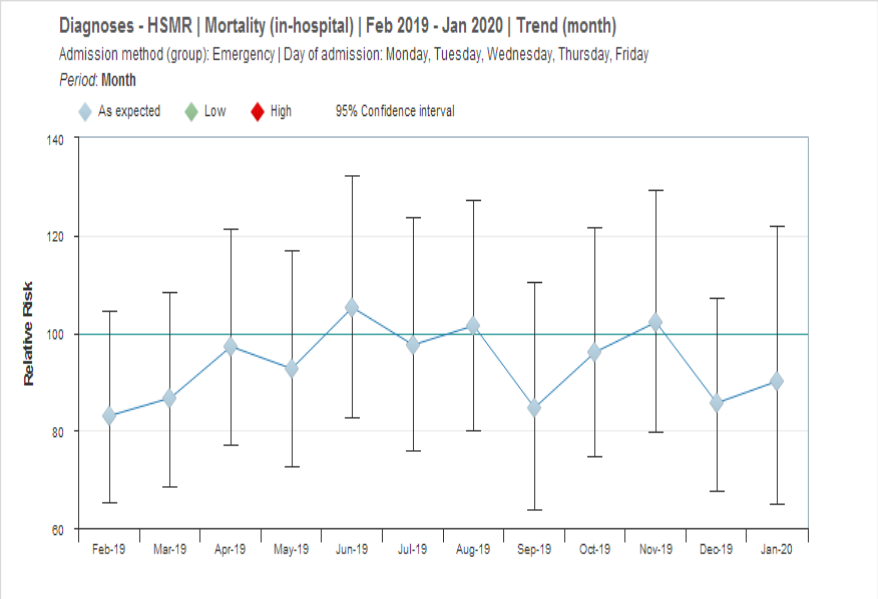
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

HSMR

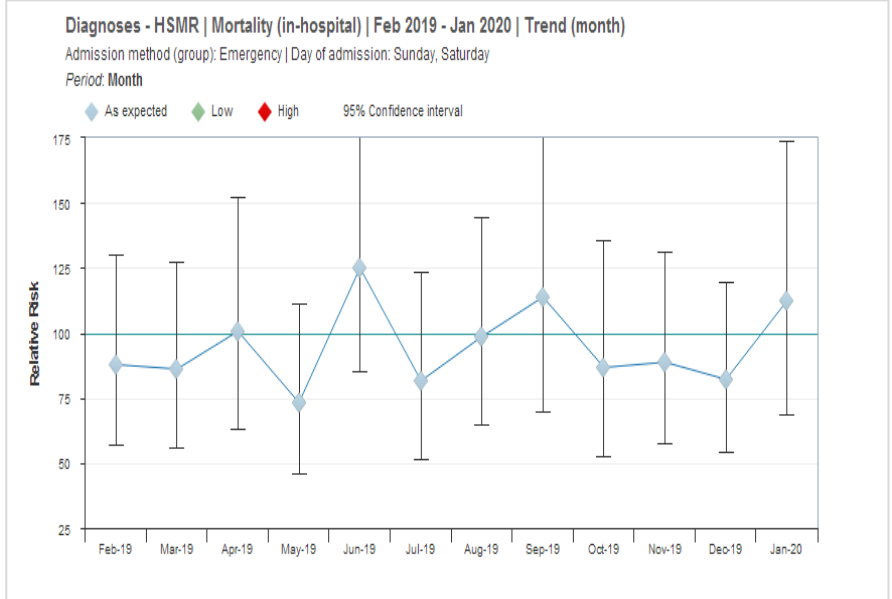




HSMR Weekday



HSMR Weekend

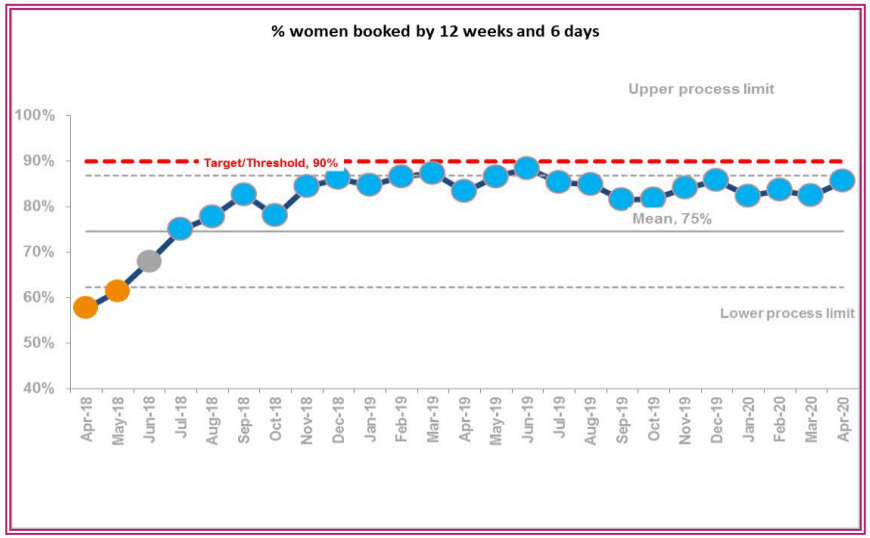


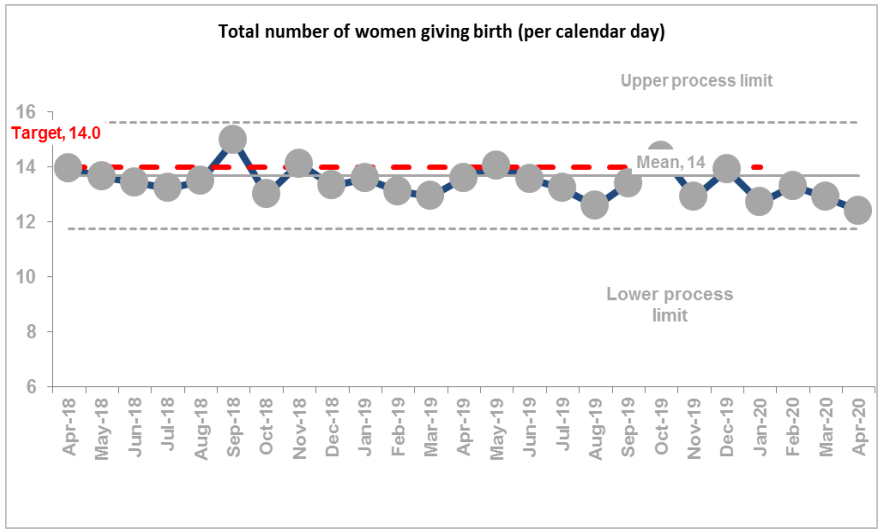
3.2

Our Patient Perspective

Maternity

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





What the information tells us

- The number of births in April remained below the target as they have since the beginning of the year. This drop in birth numbers is consistent with those reported across the sector and is not a loss of market share.
- The number of women booked within12 weeks and 6 days improved to 85.6% and the number of women booked within 9 weeks and 6 days also increased to 64.9%. Most of these booking appointments were completed by phone.

Actions and Quality Improvement Projects

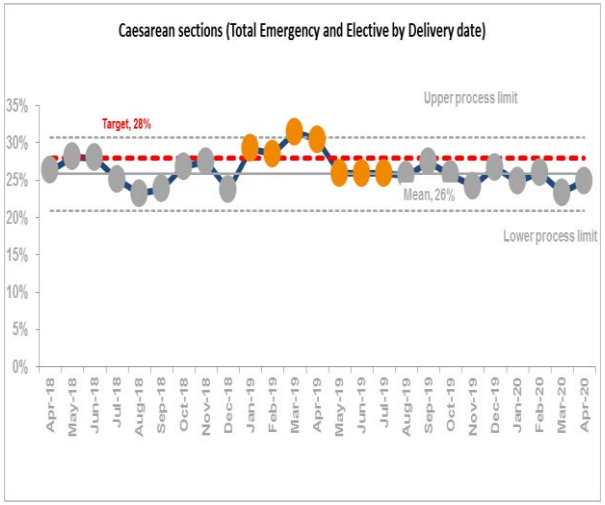
Virtual clinics have been rolled out across the antenatal and postnatal pathways and the team are working with IT to address issues around documentation. Telephone bookings have been possible due to improved estates with rooms allocated at The Nelson. Staff and women's feedback on this new way of working will be evaluated and retention of the rooms would help build this service. One issue already emerging nationally is that women are less likely to disclose abuse during virtual appointments and a working group is developing guidelines on this.

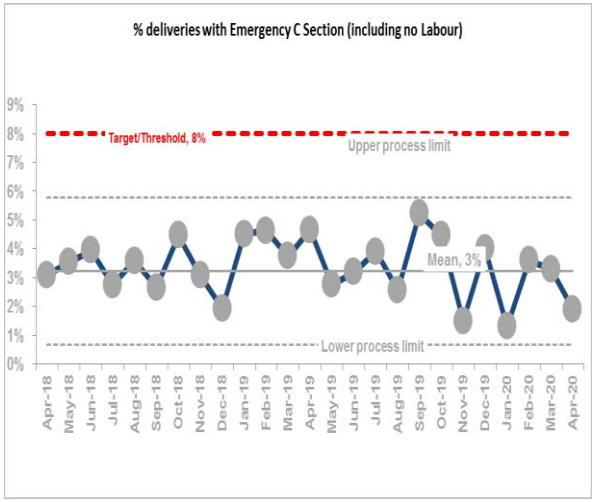
The home birth service was suspended at the COVID-19 outbreak due to both staff sickness and London Ambulance Service (LAS) availability. During this time women booked for a home birth were cared for in the Birth Centre and we received positive feedback from these women. Due to improved LAS response times and a refreshed homebirth team we reinstated our home birth service on 11th May

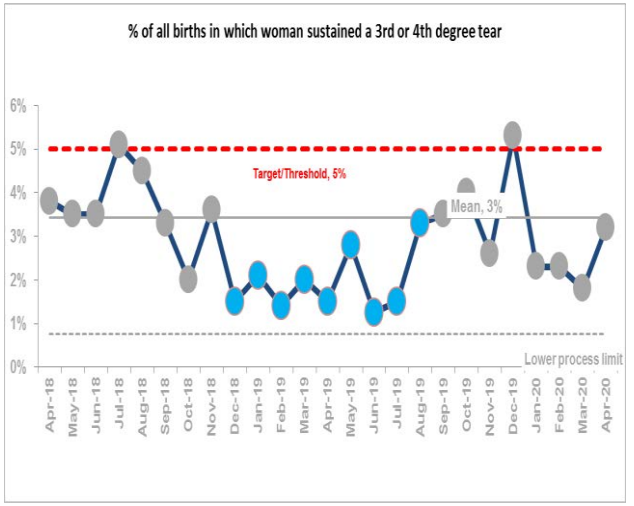
The supervisor on Labour Ward was supernumerary on every shift for the first time in April and this helped to support staff working under difficult conditions.

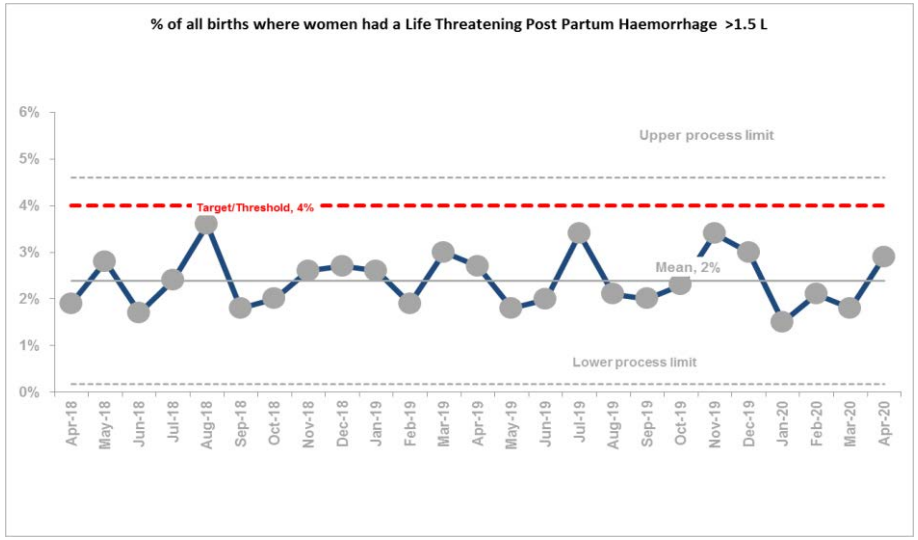
Maternity

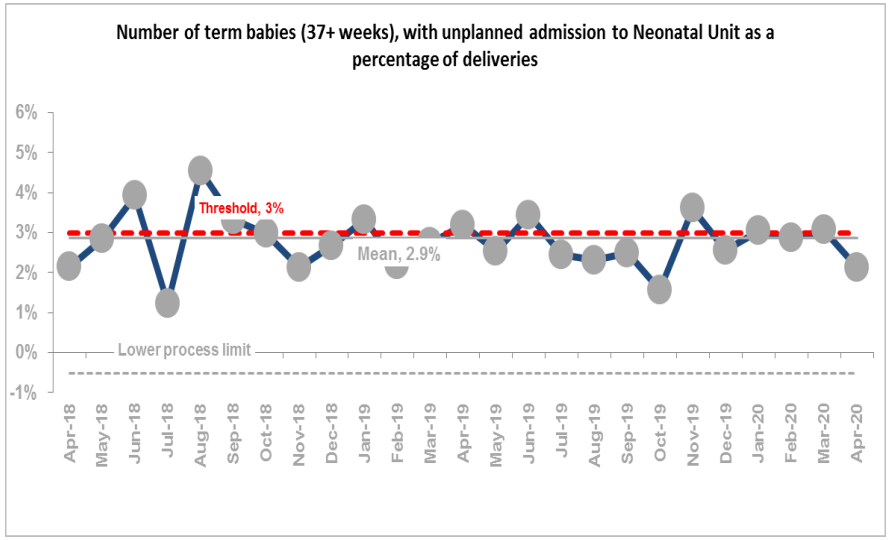
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance











3.2

Friends & Family Survey

Indicator Description	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Emergency Department FFT - % positive responses	90%	80.1%	82.5%	83.3%	82.6%	82.7%	80.5%	81.5%	79.0%	80.3%	84.2%	86.2%	87.8%	93.9%
Inpatient FFT - % positive responses	95%	96.5%	96.7%	94.7%	96.9%	96.5%	96.6%	96.0%	96.5%	96.9%	96.8%	96.6%	97.2%	100.0%
Maternity FFT - Antenatal - % positive responses	90%	100.0%	90.0%	85.7%	100.0%		100.0%			100.0%	100.0%		100.0%	100.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	95.2%	100.0%	100.0%	94.1%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	96.4%	94.6%	98.0%	100.0%	98.3%	95.2%	100.0%	97.3%	88.0%	90.7%	96.9%	100.0%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	90.0%	100.0%	
Community FFT - % positive responses	90%	98.3%	98.8%	99.5%	96.4%	98.1%	98.8%	99.3%	98.1%	97.7%	100.0%	98.6%	100.0%	
Outpatient FFT - % positive responses	90%	90.5%	90.2%	90.6%	90.9%	90.8%	90.1%	89.6%	90.7%	90.3%	89.9%	89.9%	91.7%	98.2%

What the information tells us

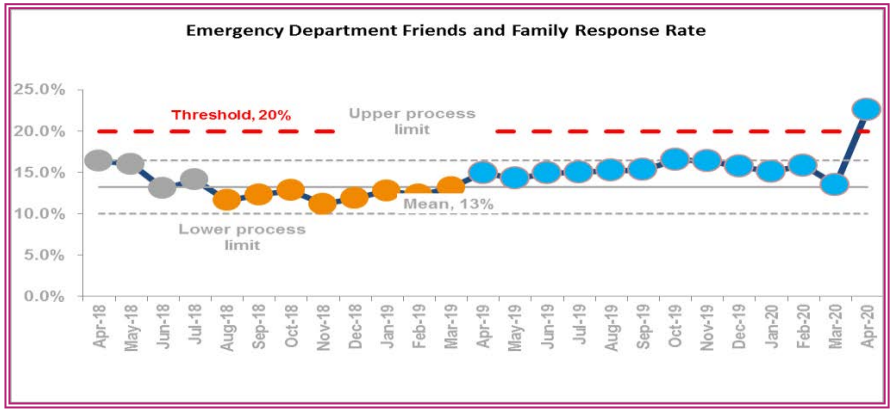
- Due to COVID-19 NHSE asked Trusts to suspend patient surveys to lower contamination risks since a number of our surveys were completed on tablet computers. As a consequence the cohort of patients surveyed is much lower than normal.
- There were no responses for the birth services and Community in April as this advice was conveyed to staff.
- Future plans will likely involve a move to text message for all areas (outpatients have restarted as they use this method)
- The percentage of positive responses across all services has improved this month against the lower cohort of patients surveyed
- Our Emergency Department rate was 93.9% of patients attending the emergency department would recommend the service to family and friends. This is the highest performance for over two years.
- Our Outpatient recommended rate was 98.2% against a target of 90%. The response rate remains below target at 0.2%.

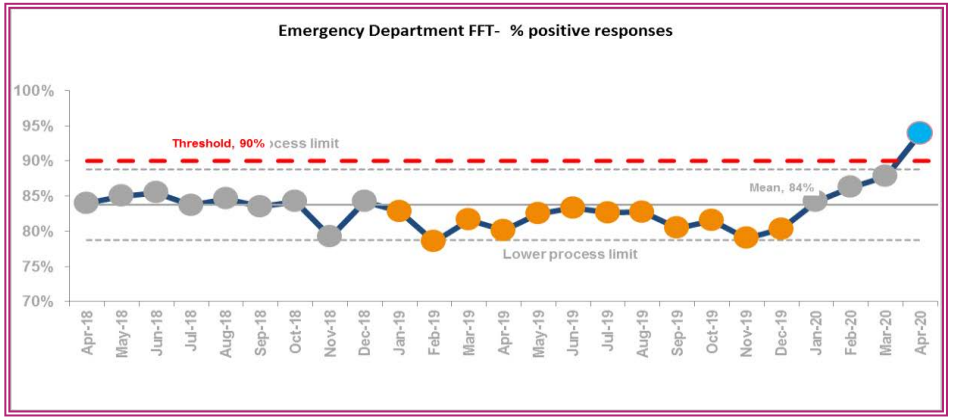
Actions and Quality Improvement Projects

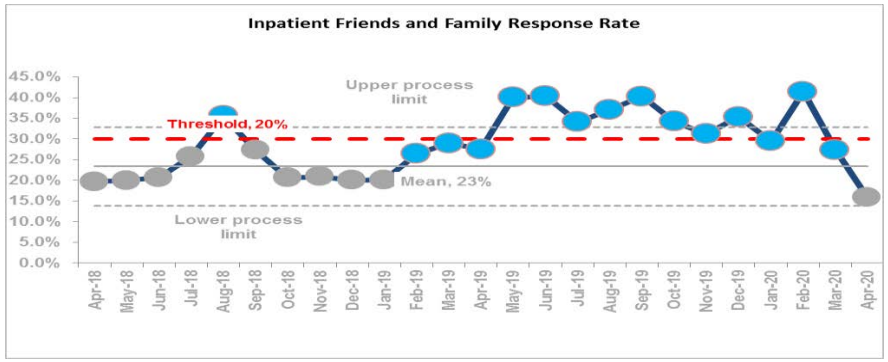
- Changes in Friends and Family (FFT) guidance was due to be implemented in April 2020. The guidance encourages patients to provide feedback throughout their care episode. In preparation for this and in line with guidance, the wording of the questions and changes to the Trust systems are being developed for launch at a future date to be confirmed
- The FFT surveys completed on tablet computers continue to be suspended. There are plans in place to convert tablet surveys to SMS surveys for outpatient areas.
- Further plans are under development to safely capture patient feedback across all service areas.

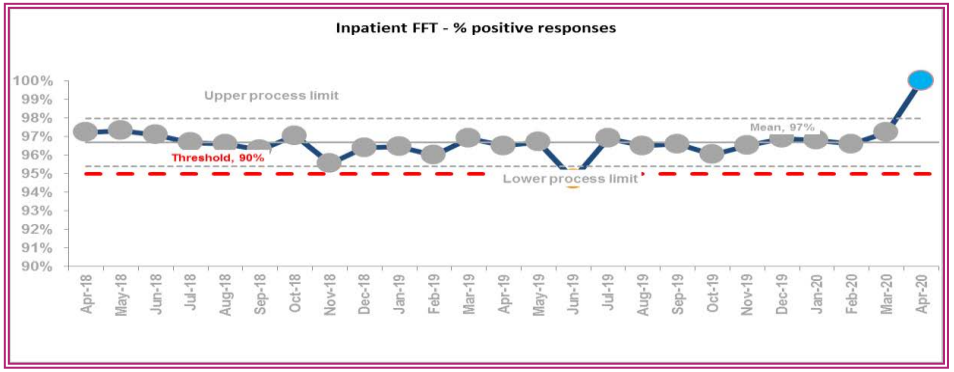
Friends and Family Test

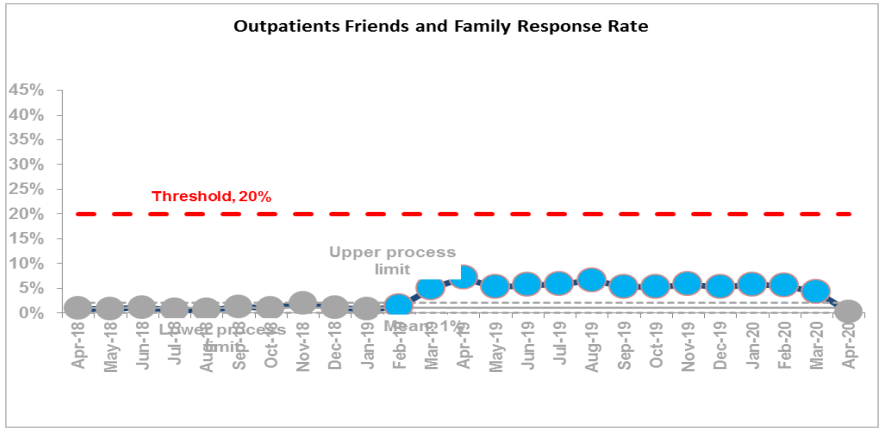
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

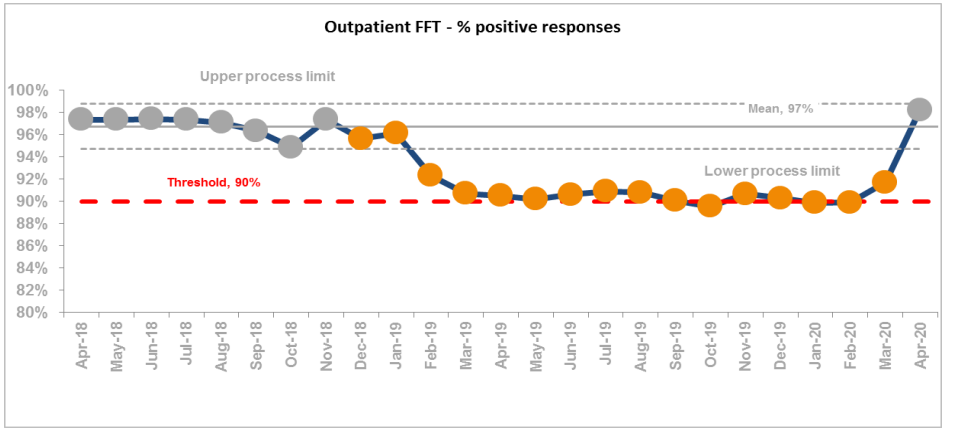










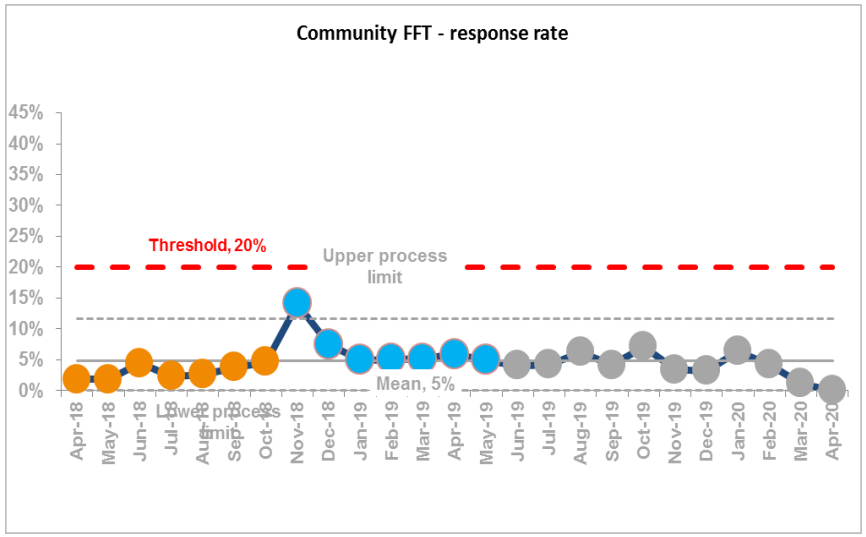


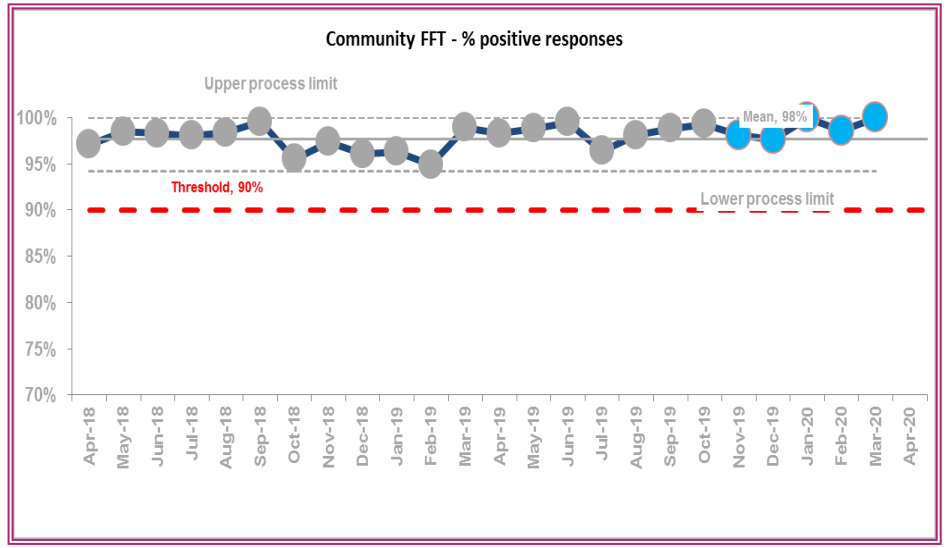
3.2

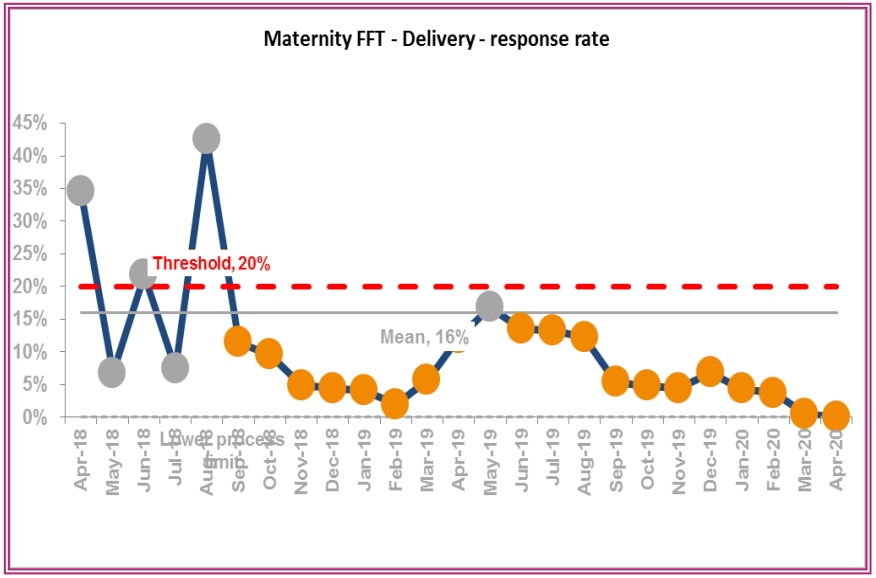
Our Patient Perspective

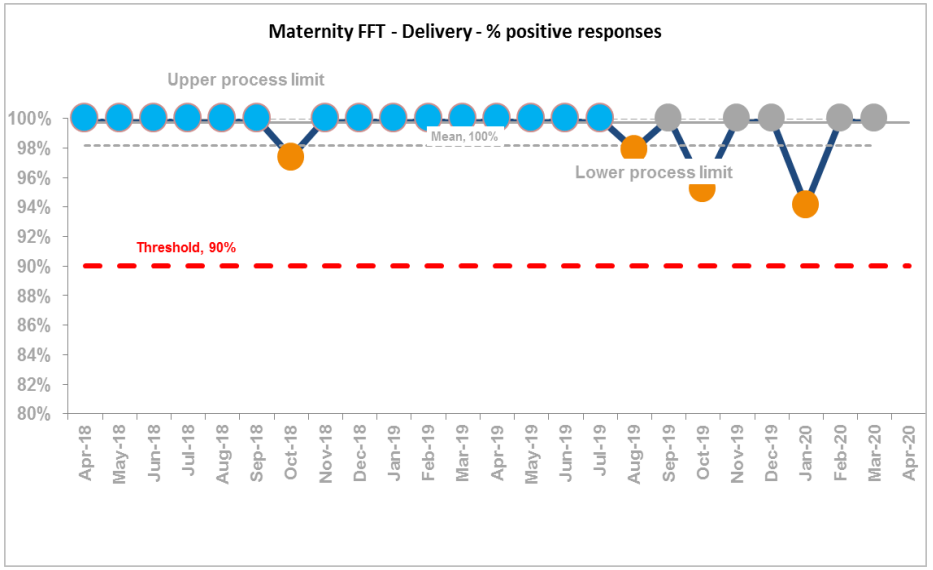
Friends and Family Test

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









Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?						
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery	
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control R	Mortality	Readmissions	Maternity	Patient Voice	
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations R	18 Week Referral to Treatment		
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency Use	Estates Health and Safety				

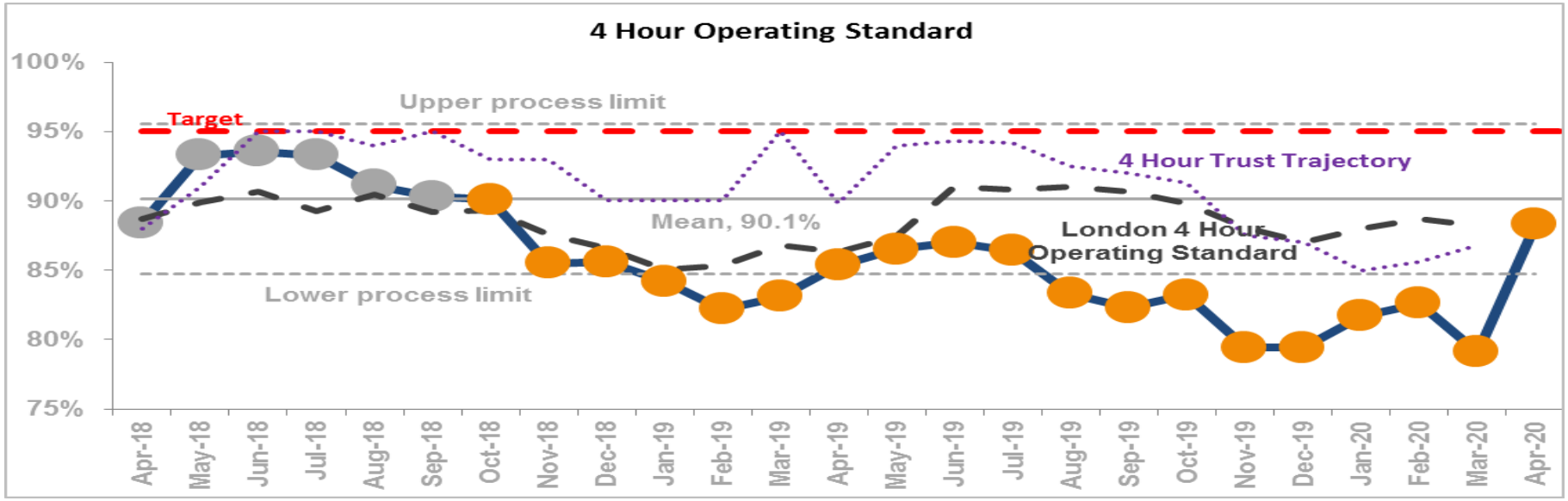
Our Process Perspective

Key

Current Month

A Previous Month

Emergency Flow



What the information tells us:

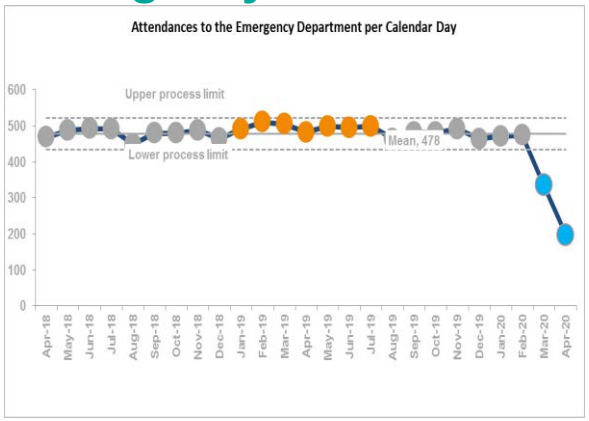
- Attendances in the calendar month of April significantly decreased seeing the number of patients attending the Emergency Department fall below the lower control limit for the consecutive month. The Trust have seen on average less than 200 patients attending the department on the Tooting Site per day over the month, and of these, the number discharged, admitted or transferred within four hours of arrival was 88.3%.
- Compared to the same month last year the Trust has seen a drop of 50% in the number of adult attendances and a drop in Paediatrics attendances by 65%
- Bed occupancy for both Trust (general and acute beds) and AMU has reduced, this is in line with Trust actions plans in relation to creating bed capacity in response to an expected COVID-19 surge.
- The number of patients who have been in a hospital bed longer than 7, 14 and 21 days, saw a continuous daily decrease throughout April with the average performance moving below the lower control limits in all areas. Internal and external teams supporting our inpatients to return home and daily escalation calls to review patients that are medically optimised remains a focus with early May performance seeing a continued trend.

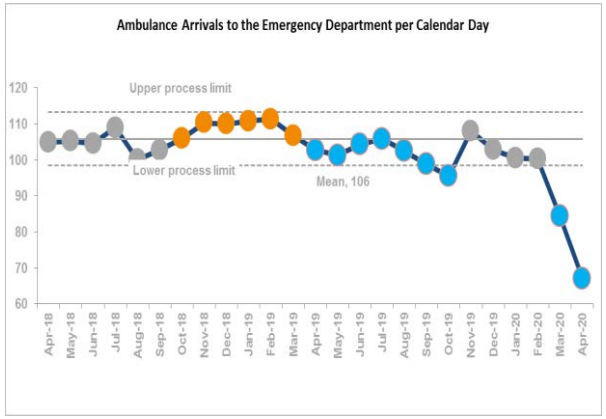
Actions and Quality Improvement Projects

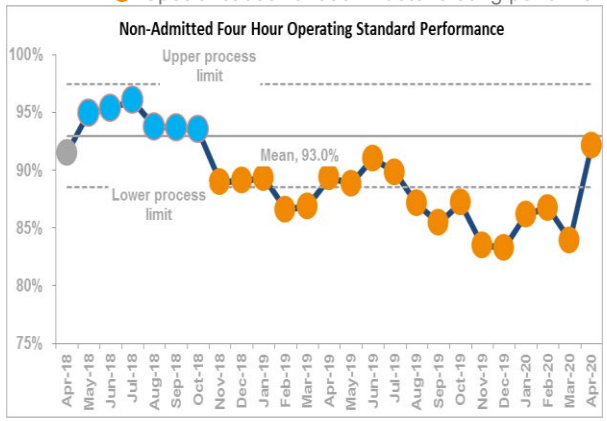
- **Collaborative Working**: Unscheduled care, safety & performance meetings between ED & AMU senior teams three times a week to review breaches and identify solutions. Joint flow & safety huddles between ED & AMU four times daily over 24hr period to provide understanding of capacity & flow issues providing ability to support ED with patient flow.
- **Emergency Care Processes**: Emergency Care attendances have reduced significantly as a result of patients supporting social distancing and using healthcare services differently. Whilst the attendances have reduced the acuity is higher than normal due to COVID-19. ED has reconfigured to meet changing demands. These changes include splitting into Red/Green areas to protect patients and flexing capacity. AMU & NBU have changed working practices providing support for red & green seated CDU's to support flow from ED. Speciality pathways have been redesigned and implemented at pace to support the National Pandemic and challenge in acuity.
- **Urgent Care Centre Waits and Direct Access:** UCC direct pathways have been implemented at pace to ensure timely turnaround of non-COVID patients, this has been cross Divisional joint working. All pathways risk assessed and standard operating procedures agreed.
- **Mental Health:** Alternative mental health pathways put in place to support this patient cohort and again attendances are reduced and redirected where appropriate, following action taken by South West London & St. George's Mental Health Trust and London Ambulance Service.

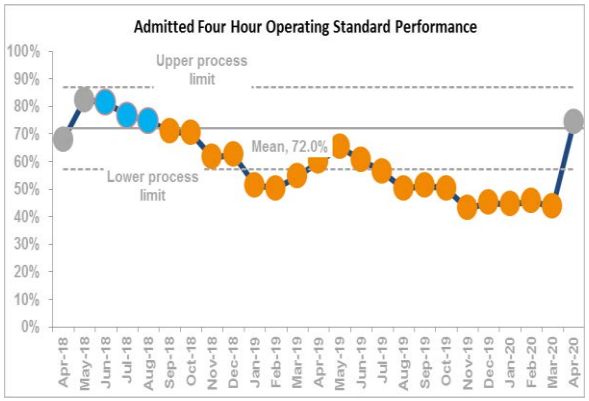
Emergency Flow

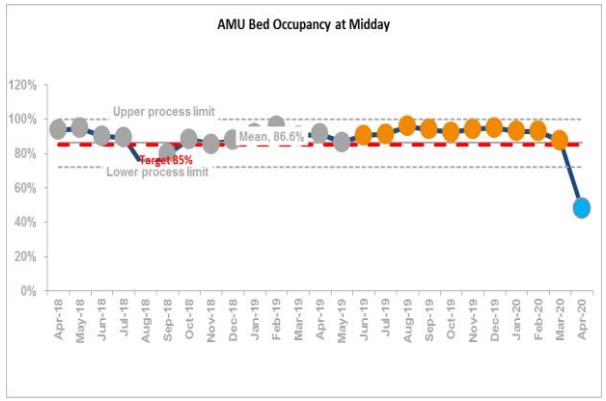
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

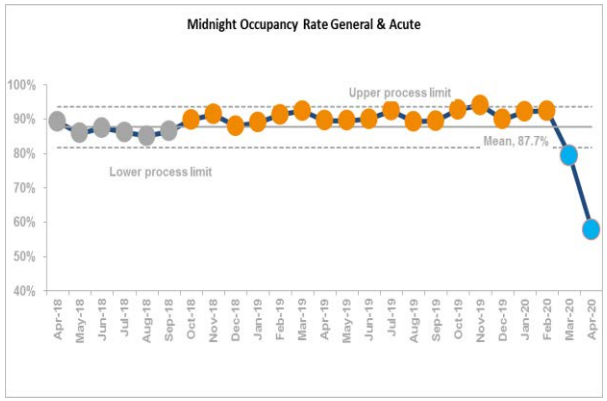


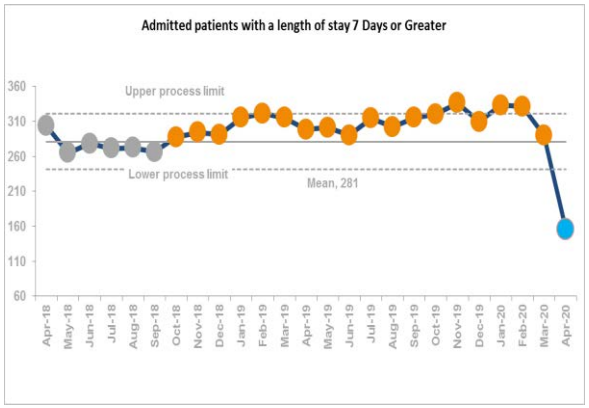


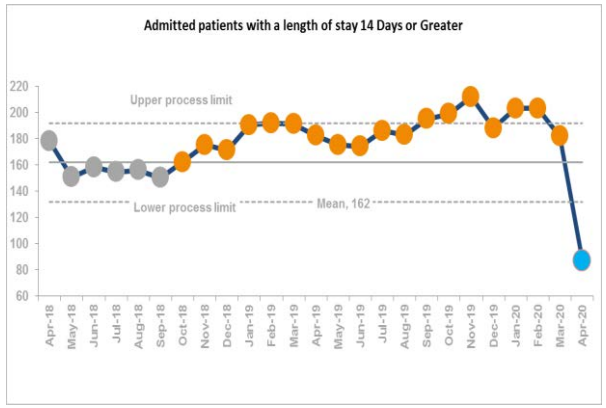


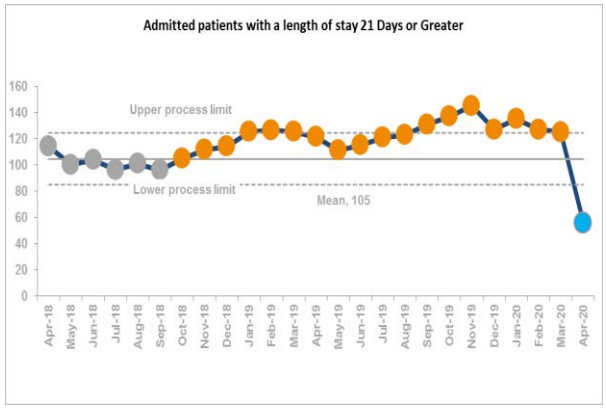




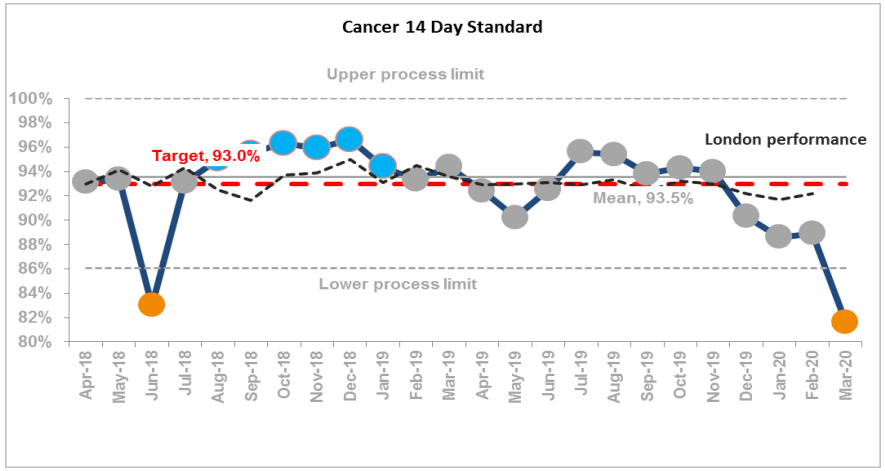


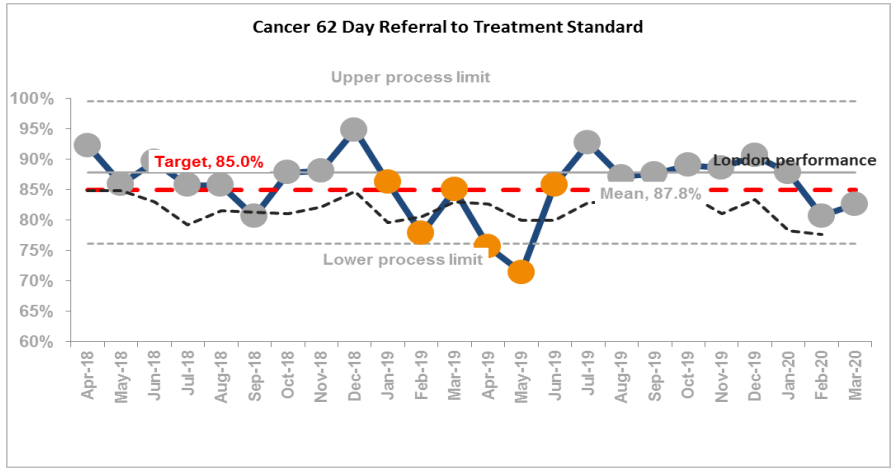






Cancer





What the information tells us

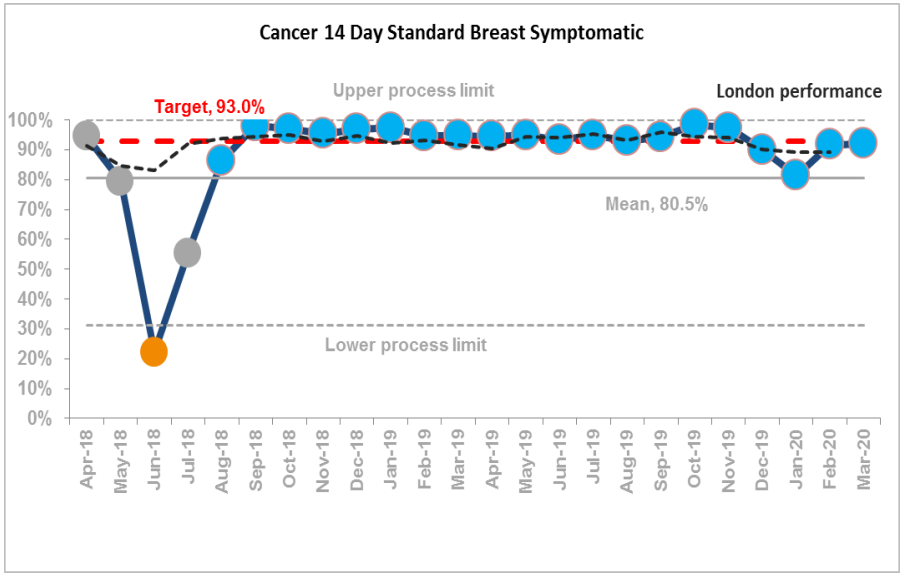
- The Trust met two of the seven cancer standards for the month of March, both 14 day standard and 62 day standard performance was under target.
- Within the 14 Day Standard, performance for the month was at 81.6% and moved below the lower control limit. Six tumour groups were non-compliant against the 93% national target, these were Gynaecology, Head & Neck, Lower Gastrointestinal, Lung, Skin and Upper Gastrointestinal.
- Performance against 62 days remained within the upper and lower control limits however has fallen below the mean for a consecutive month. Performance for the month was 82.6% - five tumour groups reported non-compliant Breast, Haematology, Head & Neck, Lower Gastrointestinal and Urology. There were a 10 breaches, three of which were due to changed treatment plans due to COVID.
- Cancer 31 Day Diagnosis to Treatment performance was below target and has fallen below the lower control limit
- Cancer 62 Day Referral to Treatment Screening remains below target and is within its upper and lower control limit.

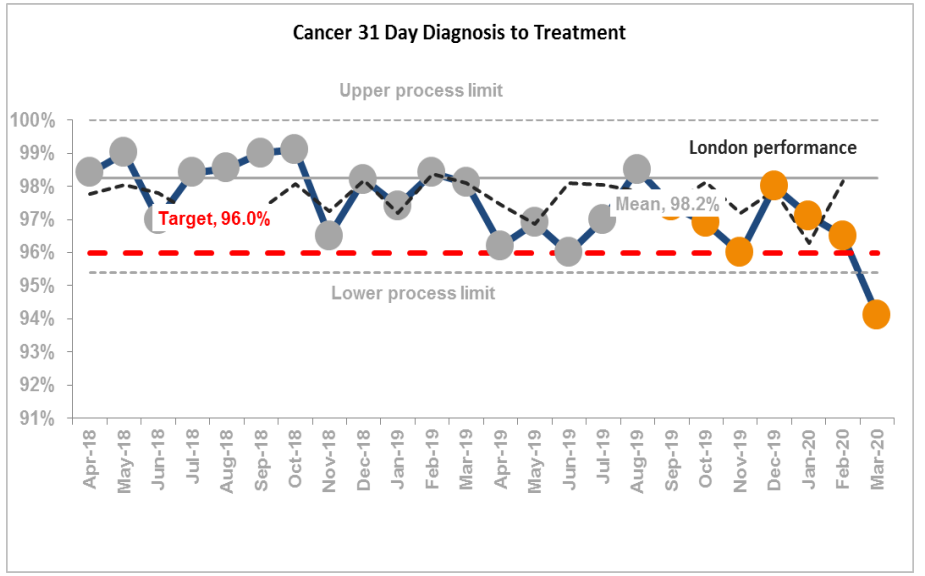
Actions and Quality Improvement Projects

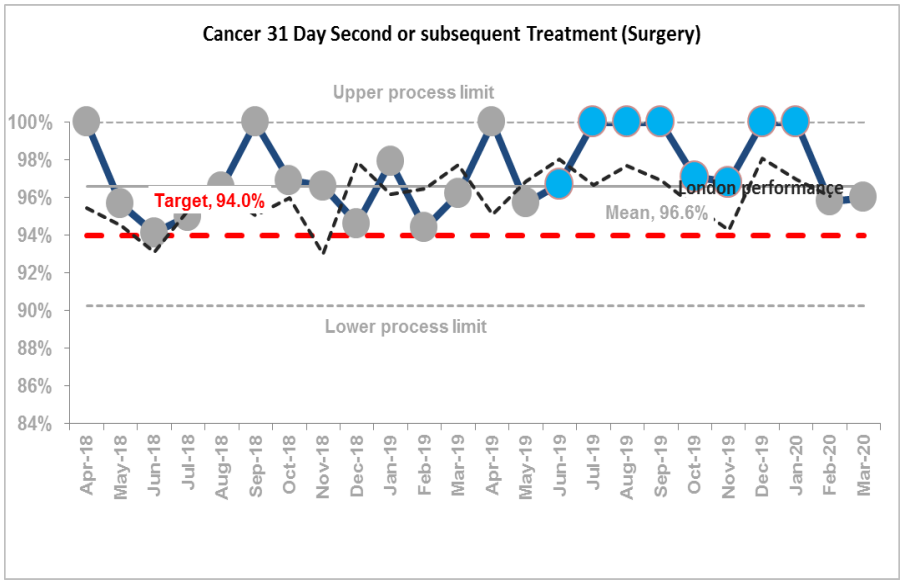
- All cancer patients continue to be tracked and reviewed through MDTs.
- All TWR referrals are being triaged by consultants and where necessary face to face appointments and diagnostics are continuing. All patients referred in March have now either had a virtual consultation, face to face appointment or been referred back to GP with advice (only low risk patients). Evidence of some non compliance driven by patient choice (self isolating and not wishing to attend) as well as longer waits for some face to face slots as doctors redeployed; appropriate clinical review is in place to mitigate risk.
- Patients on TWR, subsequent and screening pathways continue to be prioritised as per NHSE guidance.
- All patients who require surgery within four weeks (Cat 1A/1B and 2) are being tracked on a separate Patient Tracking List (PTL) and having surgery at the Trust or referred to the RMP Hub. Two cancer lists (5 sessions each day) are running at St George's, Monday to Friday with the Green surgical pathway. This process has enabled all priority 1A/1B and 2 patients to be treated within the national timescales and there are no Priority 2 patients waiting more than two weeks for treatment
- Priority 3 (can be treated within 10/12 weeks and nationally agreed to be on hold until recently) patients are being tracked on a separate PTL with review dates being agreed by consultants/MDTs to ensure there is adequate safety netting in place. There are currently about 85 Priority 3 patients waiting for treatment and so will impact significantly on future 62 day performance.

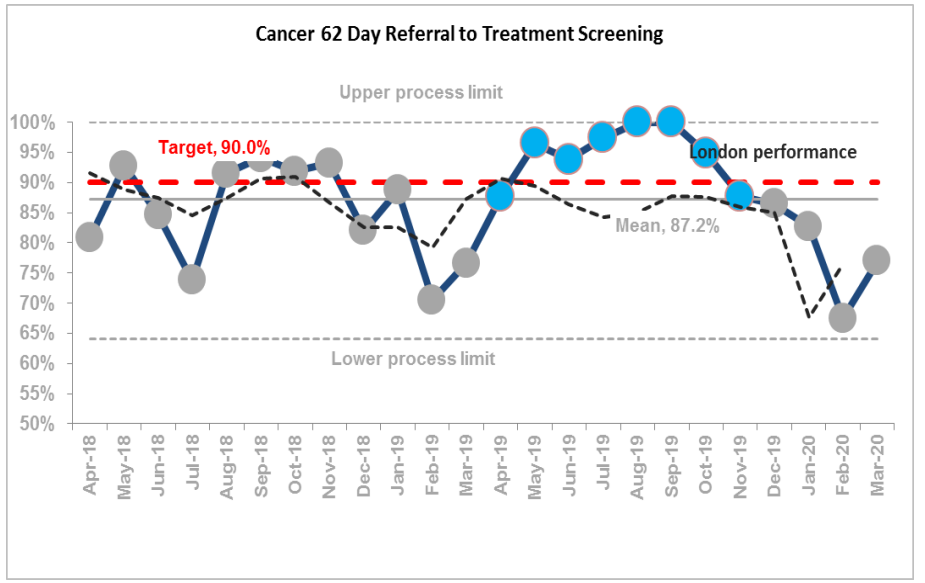
Cancer

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









Cancer

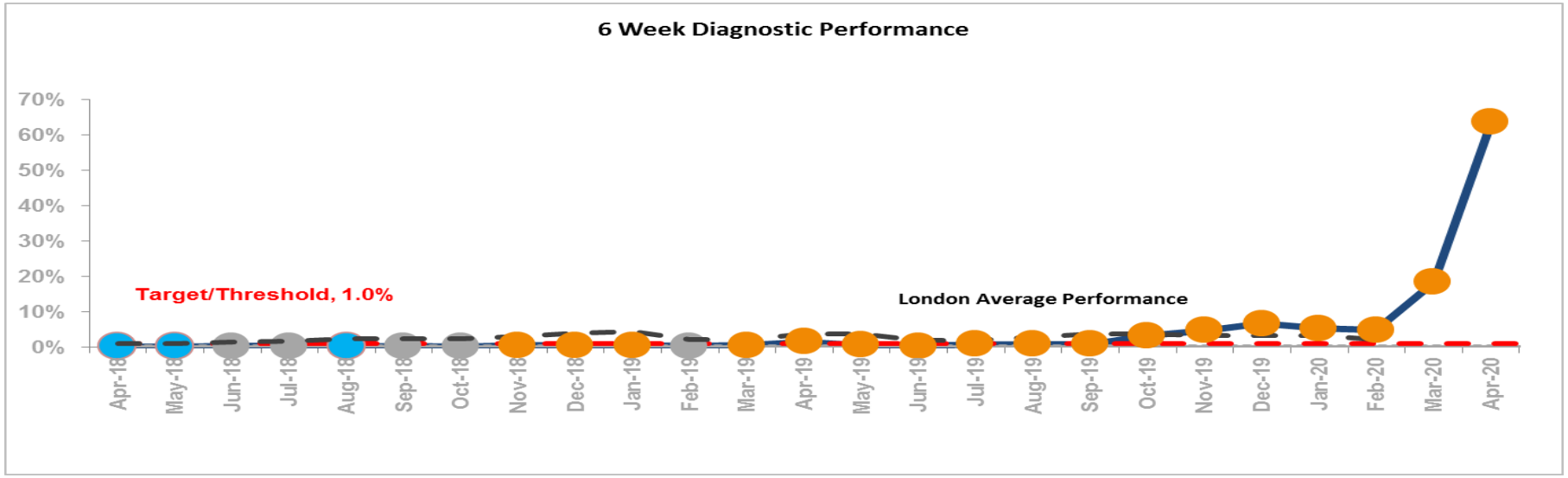
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	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	No of Patients
Brain	93%	-	100.0%	-	100.0%	-	100.0%	100.0%	-	-	-	100.0%	-	-	0
Breast	93%	97.9%	99.5%	96.3%	96.9%	95.4%	94.9%	95.9%	100.0%	97.0%	95.6%	84.7%	95.6%	93.3%	135
Children's	93%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	85.7%	100.0%	100.0%	4
Gynaecology	93%	80.0%	75.0%	59.3%	78.0%	95.5%	97.2%	95.4%	97.6%	99.2%	99.0%	94.4%	95.9%	86.9%	99
Haematology	93%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	86.7%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	16
Head & Neck	93%	99.3%	98.0%	97.8%	100.0%	98.9%	96.4%	96.6%	99.0%	96.6%	89.4%	95.2%	95.5%	90.8%	131
Lower Gastrointestinal	93%	94.5%	85.6%	91.1%	87.9%	93.7%	93.1%	92.8%	89.7%	91.5%	80.3%	81.8%	69.9%	63.8%	312
Lung	93%	96.9%	100.0%	95.6%	96.8%	95.7%	100.0%	97.1%	97.7%	100.0%	84.1%	80.6%	90.9%	85.7%	35
Skin	93%	97.6%	96.9%	95.5%	94.8%	96.0%	98.0%	91.8%	95.9%	91.0%	94.8%	94.7%	93.3%	84.1%	295
Upper Gastrointestinal	93%	83.5%	87.9%	70.2%	90.9%	95.1%	88.9%	87.2%	82.5%	88.1%	82.7%	75.3%	84.4%	75.5%	98
Urology	93%	92.2%	90.1%	95.4%	92.1%	93.8%	93.0%	97.0%	88.4%	95.6%	92.9%	93.6%	93.6%	93.9%	132

62 Day Standard Performance by Tumour Site - Target 85%

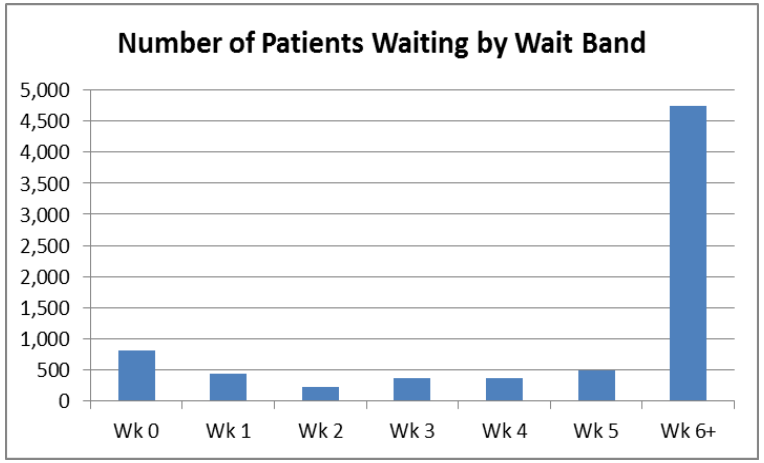
Tumour Site	Target	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	90.9%	83.3%	80.0%	87.5%	73.3%	88.6%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	58.8%	8.5
Children's	85%	-	-	-	-	-	100.0%	-	-	-	-	100.0%	100.0%	-	0
Gynaecology	85%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%	60.0%	100.0%	80.0%	66.7%	100.0%	100.0%	1
Haematology	85%	100.0%	30.0%	33.3%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	85.7%	66.7%	33.3%	1.5
Head & Neck	85%	80.0%	77.8%	40.0%	28.6%	80.0%	80.0%	75.0%	76.5%	76.9%	68.2%	89.5%	73.7%	81.0%	10.5
Lower Gastrointestinal	85%	66.7%	41.7%	100.0%	69.2%	83.3%	63.6%	90.0%	100.0%	87.5%	83.3%	60.0%	71.4%	75.0%	4
Lung	85%	70.0%	71.4%	100.0%	100.0%	91.7%	89.5%	60.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	1.5
Skin	85%	89.7%	100.0%	75.8%	95.7%	100.0%	100.0%	78.9%	100.0%	89.5%	100.0%	91.7%	100.0%	100.0%	14
Upper Gastrointestinal	85%	60.0%	100.0%	20.0%	75.0%	100.0%	53.8%	66.7%	80.0%	50.0%	100.0%	0.0%	40.0%	-	0.0
Urology	85%	88.9%	83.0%	75.8%	93.9%	100.0%	94.4%	100.0%	83.8%	87.8%	100.0%	85.0%	84.0%	81.5%	13.5
Other	85%	100.0%	-	-	100.0%	-	-	-	100.0%	-	100.0%	100.0%	0.0%	100.0%	1

Diagnostics



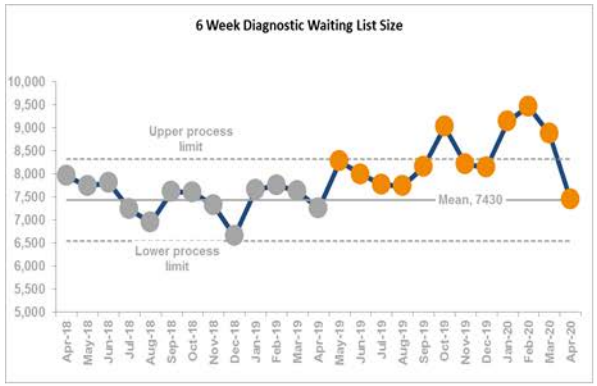
What the information tells us

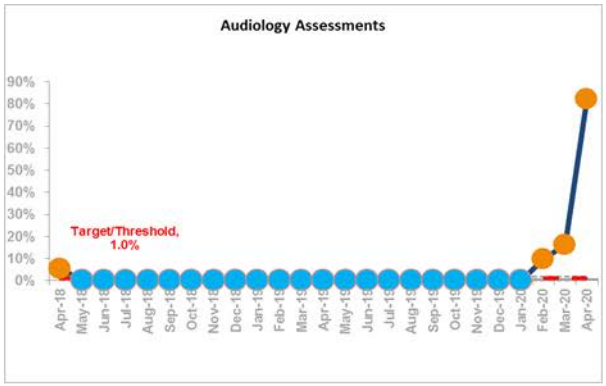
- In April, the Trust did not achieve the six week diagnostic standard with an adverse performance of 63.6%. The total number of patients waiting greater than six weeks was 4,738, a significant increase compared to March.
- As part of the standing down work stream, in relation to COVID planning, and in line with The Royal College of Radiologists national guidance, a significant number of routine diagnostics have been postponed, increasing the waits across all modalities.
- A weekly review is being undertaken of any urgent referrals waiting > 6 weeks. The services are reporting that these are due to either patient choice, due to CV19, or triage and downgrading to routine by the Consultant.

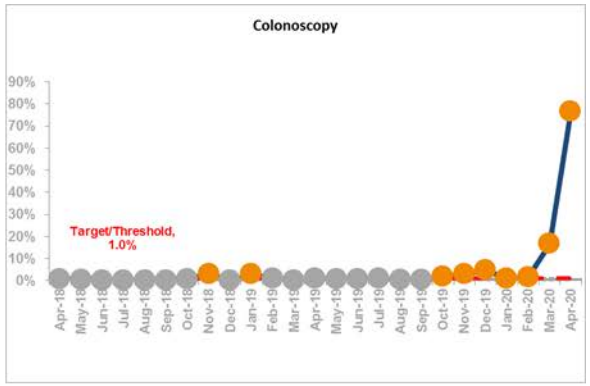


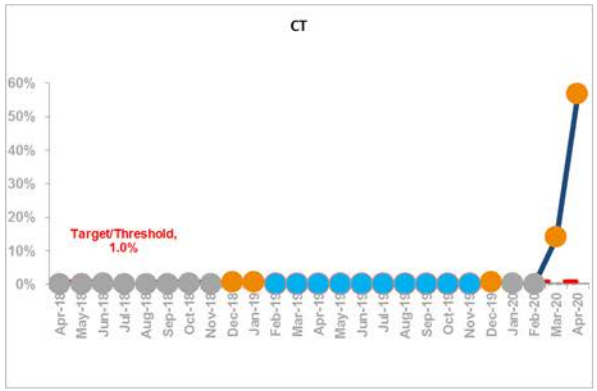
Diagnostics

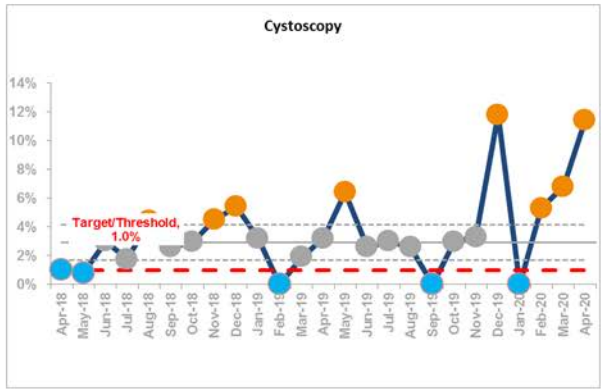
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

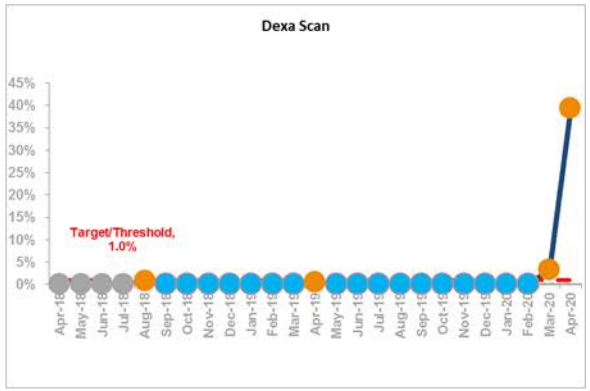


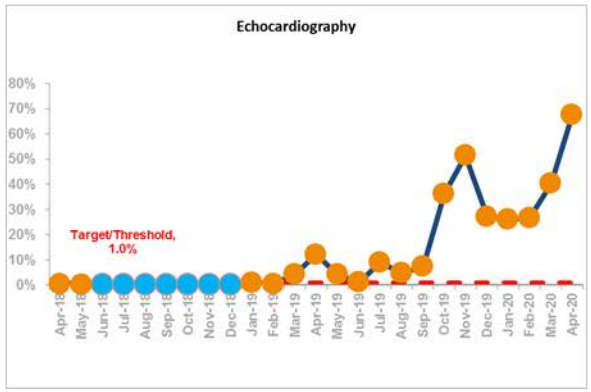


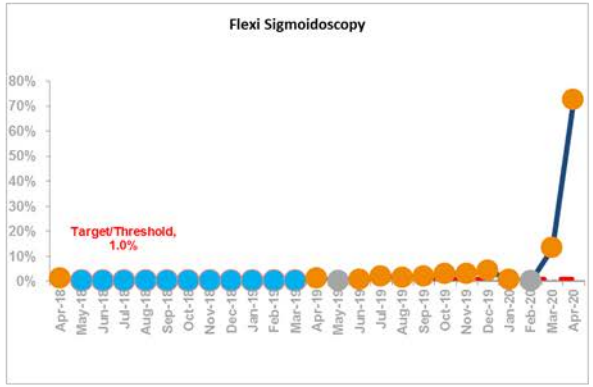


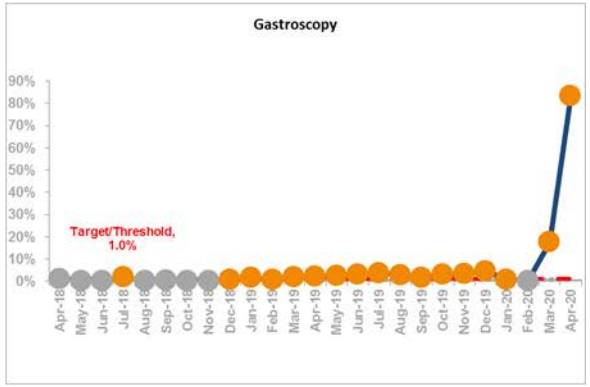










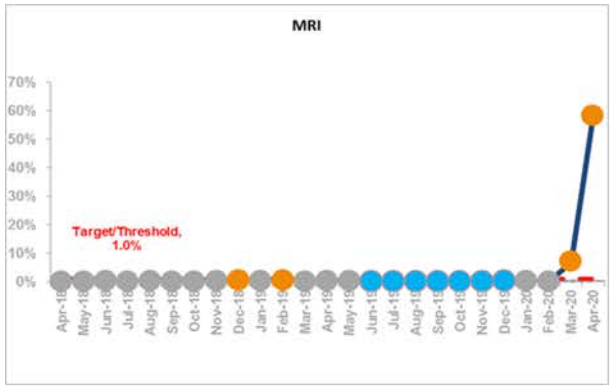


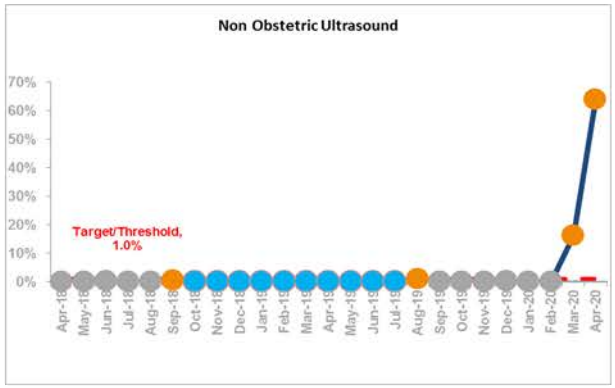
3.2

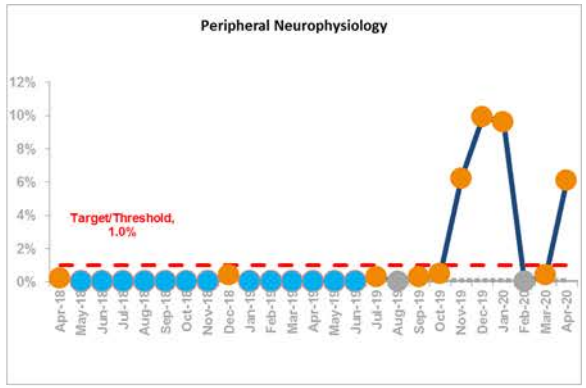
Our Process Perspective

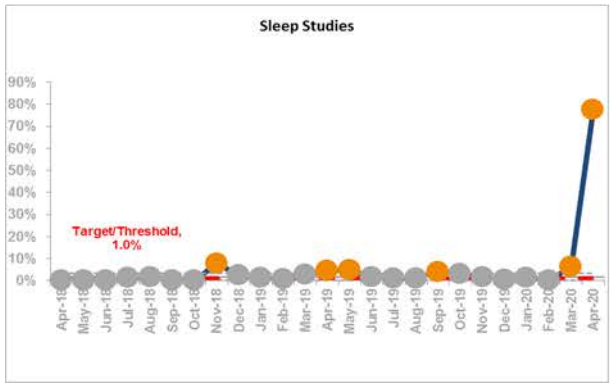
Diagnostics

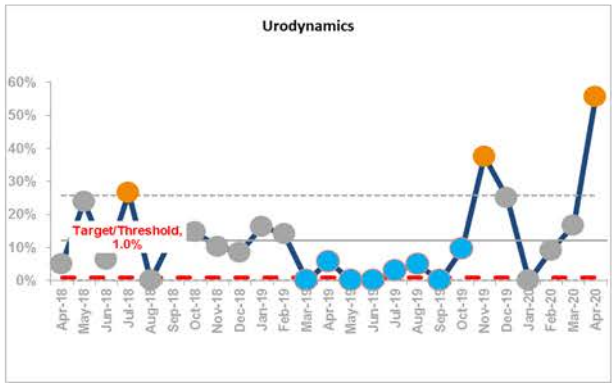
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



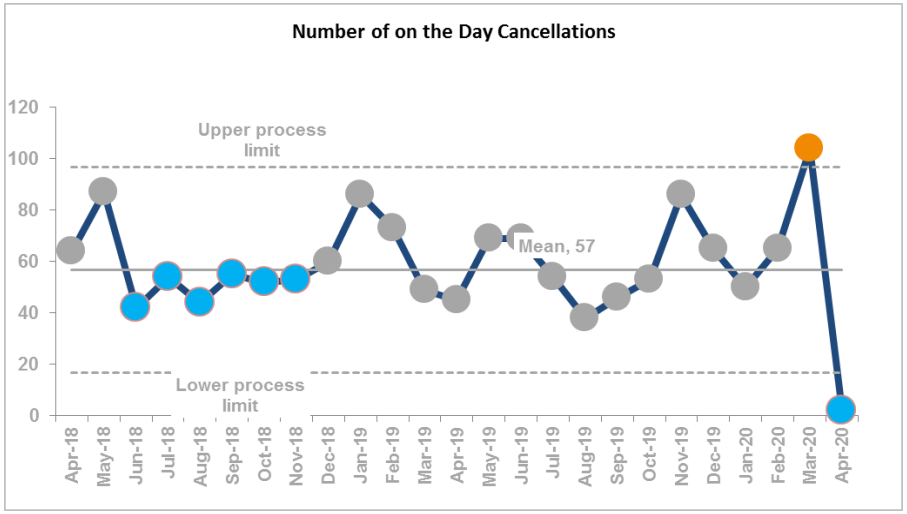


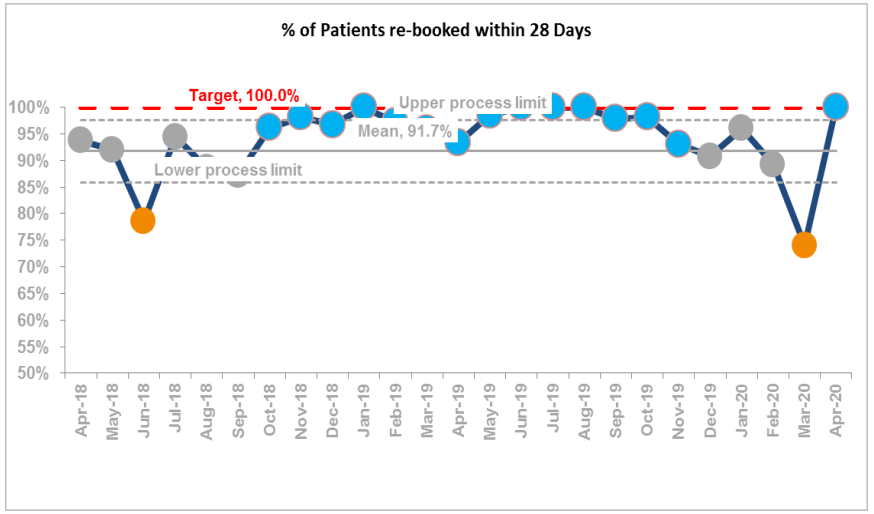






On the Day Cancellations for Non Clinical Reasons





What the information tells us

- Due to the fall in elective activity from March where all routine elective activity was cancelled many patients were informed of cancellation in advance of their procedure date. In April two patients were cancelled on the day for non clinical reasons of which both patients were re-booked within 28 days.

Actions and Quality Improvement Projects

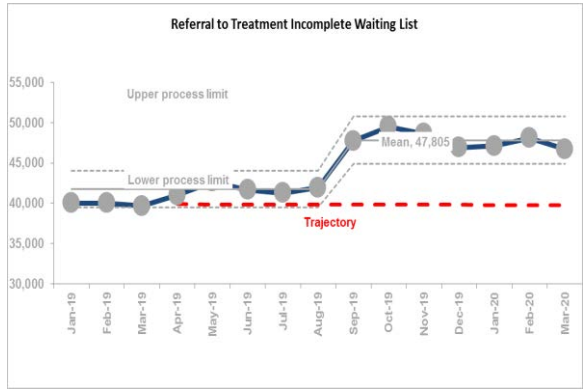
- Theatre capacity is reviewed constantly to ensure that it meets the required demands and is using staff, kit and theatres as fully as possible.
- Clinical prioritisation is happening twice daily for urgent emergency patients and weekly for urgent cancer cases.

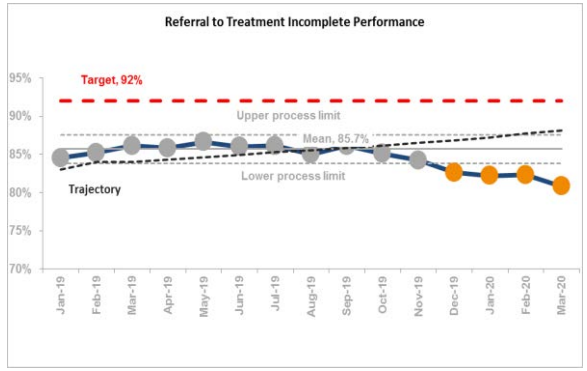
Referral to Treatment

Indicator Description	Target	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 Trust Incomplete Performance	92%	86.1%	85.8%	86.6%	86.0%	86.1%	85.0%	86.1%	85.1%	84.2%	82.6%	82.2%	82.3%	79.3%
RTT Trust Incomplete Performance Trajectory for 19/20		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		39,674	41,013	42,671	41,658	41,259	41,945	47,714	49,495	48,640	46,918	47,089	48,061	47,048
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)		5,515	5,812	5,717	5,820	5,739	6,305	6,651	7,353	7,701	8,183	8,382	8,498	9,755
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	27	22	16	7	5	6	6	1	7	9	10	11	32
Total waits greater than 52 weeks Trajectory		31	23	16	9	5	5	5	0	0	0	0	0	0
RTT Incomplete Performance - Admitted		66.6%	65.3%	68.8%	68.7%	66.3%	63.7%	65.9%	65.3%	63.7%	61.4%	60.5%	61.9%	57.2%
Total waits greater than 18 weeks - Admitted		1,428	1,511	1,459	1,494	1,523	1,655	1,643	1,686	1,719	1,876	1,950	1,891	2,186
Total waits greater than 52 weeks - Admitted	0	18	7	8	4	1	2	4	0	2	5	2	3	20
RTT Incomplete Performance -Non Admitted		88%	88.3%	88.8%	88.3%	88.5%	87.6%	88.3%	87.3%	86.4%	85.0%	84.7%	84.7%	82.0%
Total waits greater than 18 weeks - Non Admitted		4,087	4,301	4,258	4,326	4,216	4,650	5,008	5,667	5,982	6,107	6,432	6,607	7,569
Total waits greater than 52 weeks - Non Admitted	0	9	15	8	3	4	4	2	1	5	4	8	8	12

What the information tells us

- The Trust remains behind trajectory for incomplete Referral To Treatment (RTT) with a submitted performance of 79.3% in March 2020 against the Trust trajectory of 88.1%.
- The Total Patient Tracking List (PTL) size reported in March 2020 was 47,048 (inclusive of Queen Mary Hospital pathways) reducing by 2% compared to February. The Trust trajectory of PTL size was not adjusted to take into account the QMH patients migrated in September 2019. The Total PTL size will continue to decrease due to a reduction in the number of referrals received of c.80%.
- The Trust 52 week breach position deteriorated in March with 32 patients waiting greater than 52 weeks for treatment. This is a direct result of stopping routine elective surgery on Monday 16th March due to COVID-19.





Actions and Quality Improvement Projects

- The Trust is continuing to monitor all patients on the waiting list (admitted and non admitted pathways) including daily tracking of patients over and approaching 52 weeks..
- It is anticipated the number of 52 week breaches will increase daily due to restrictions in outpatients and elective interventions.
- The overall waiting list size will decrease in size by between 4-5% per month whilst referral numbers remain lower than normal.
- Daily reporting on uncashed clinic appointments to ensure accuracy of Data Quality for incomplete RTT performance.

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	312	42.9%	772	83.3%	777	307	1,084	71.7%	35	5
Urology	285	51.2%	1,519	91.7%	1,539	265	1,804	85.3%	25	3
Trauma & Orthopaedics	205	54.1%	1,930	85.6%	1,763	372	2,135	82.6%	15	0
Ear, Nose & Throat (ENT)	576	26.4%	2,537	85.2%	2,313	800	3,113	74.3%	83	4
Ophthalmology	0	-	561	82.4%	462	99	561	82.4%	1	0
Oral Surgery	3	66.7%	295	65.4%	195	103	298	65.4%	3	0
Neurosurgery	240	64.2%	2,455	73.4%	1,957	738	2,695	72.6%	30	1
Plastic Surgery	543	41.8%	871	87.6%	990	424	1,414	70.0%	72	7
Cardiothoracic Surgery	0	-	0	-	0	0	0	-	0	0
General Medicine	0	-	32	81.3%	26	6	32	81.3%	0	0
Gastroenterology	743	83.4%	2,067	78.8%	2,249	561	2,810	80.0%	31	0
Cardiology	896	62.9%	2,927	79.5%	2,890	933	3,823	75.6%	47	0
Dermatology	2	50.0%	3,069	79.3%	2,434	637	3,071	79.3%	23	0
Thoracic Medicine	15	100.0%	1,593	85.4%	1,375	233	1,608	85.5%	5	0
Neurology	14	92.9%	2,617	86.0%	2,264	367	2,631	86.1%	5	0
Rheumatology	0	-	1,119	78.6%	879	240	1,119	78.6%	7	0
Geriatric Medicine	1	0.0%	89	93.3%	83	7	90	92.2%	1	0
Gynaecology	171	34.5%	2,407	84.8%	2,100	478	2,578	81.5%	10	1
Other	1,106	65.8%	15,076	81.4%	12,997	3,185	16,182	80.3%	135	11
Total	**5,112**	**57.2%**	**41,936**	**82.0%**	**37,293**	**9,755**	**47,048**	79.3%	**528**	**32**

- 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.

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control R	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations R	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce		Agency Use		Estates Health and Safety	

Our People Perspective

Key

Current Month

A Previous Month

Workforce

Indicator Description	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Trust Level Sickness Rate	3.2%	3.1%	3.5%	3.8%	3.8%	3.5%	3.4%	3.7%	3.8%	4.0%	3.9%	4.0%	5.1%	5.6%
Trust Vacancy Rate	10%	9.1%	10.3%	10.5%	11.9%	12.8%	12.8%	9.3%	9.9%	11.2%	10.8%	10.7%	10.6%	10.5%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.1%	17.4%	17.4%	17.5%	17.7%	17.7%	17.8%	17.6%	17.6%	17.4%	17.3%	16.9%	16.7%
Total Funded Establishment		9,112	9,241	9,251	9,365	9,432	9,534	9,280	9,294	9,403	9,383	9,369	9,369	9,373
IPR Appraisal Rate - Medical Staff	90%	ata Unavailab	85.4%	84.5%	84.4%	85.7%	81.5%	83.9%	81.5%	83.6%	84.9%	81.7%	80.0%	
IPR Appraisal Rate - Non Medical Staff	90%	71.6%	72.5%	73.6%	73.3%	71.3%	70.4%	70.9%	72.3%	72.3%	72.0%	72.4%	69.6%	67.9%
Overall MAST Compliance %	85%	89.8%	90.6%	91.1%	91.2%	91.3%	90.6%	89.7%	89.7%	90.0%	89.7%	90.6%	90.7%	90.2%
Ward Staffing Unfilled Duty Hours	10%	5.7%	5.9%	6.1%	6.3%	5.4%	6.5%	6.1%	3.8%	5.3%	5.4%	6.2%		

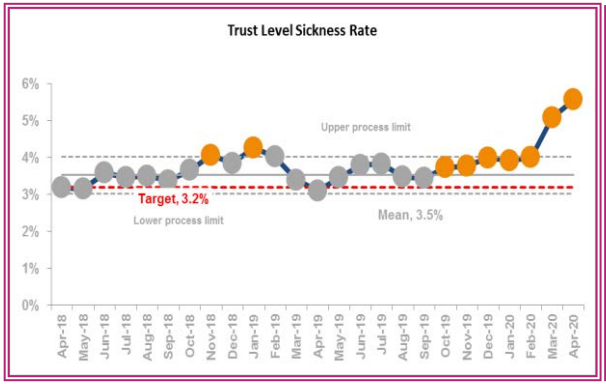
What the information tells us

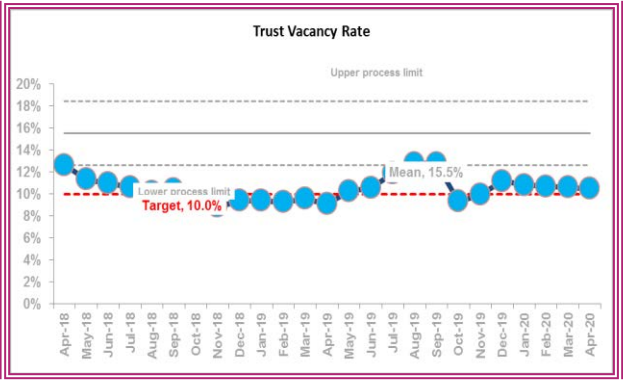
- Sickness rate has increased by 0.5% in the month of April reporting a rate of 5.6%
- Appraisal rates for Non Medical staff fell to 67.9% in April against a target of 90%. Appraisal rates for Medical staff was not reported

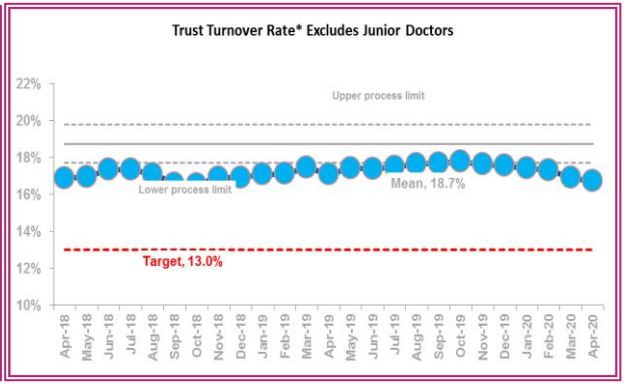
Actions and Quality Improvement Project
Due to COVID-19, workforce initiatives have been focussed on ensuring adequate staffing and support is in place.

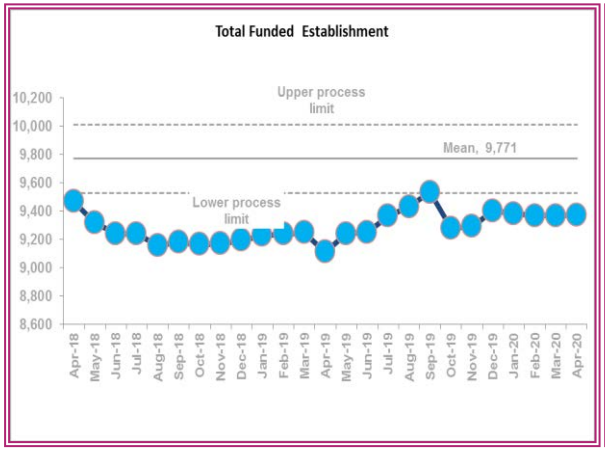
Workforce

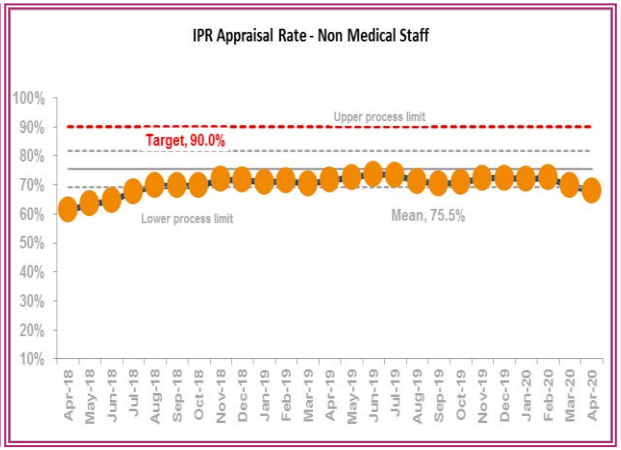
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

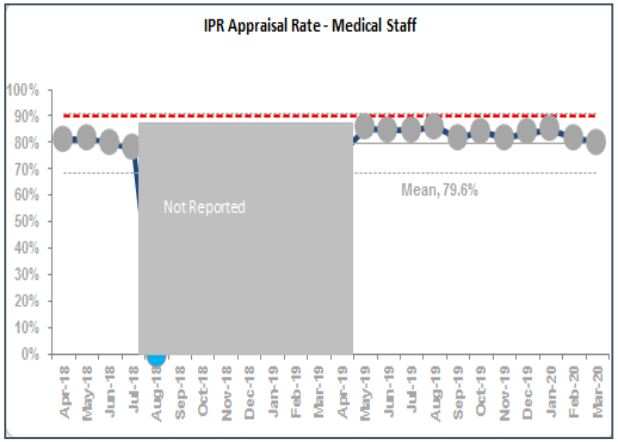




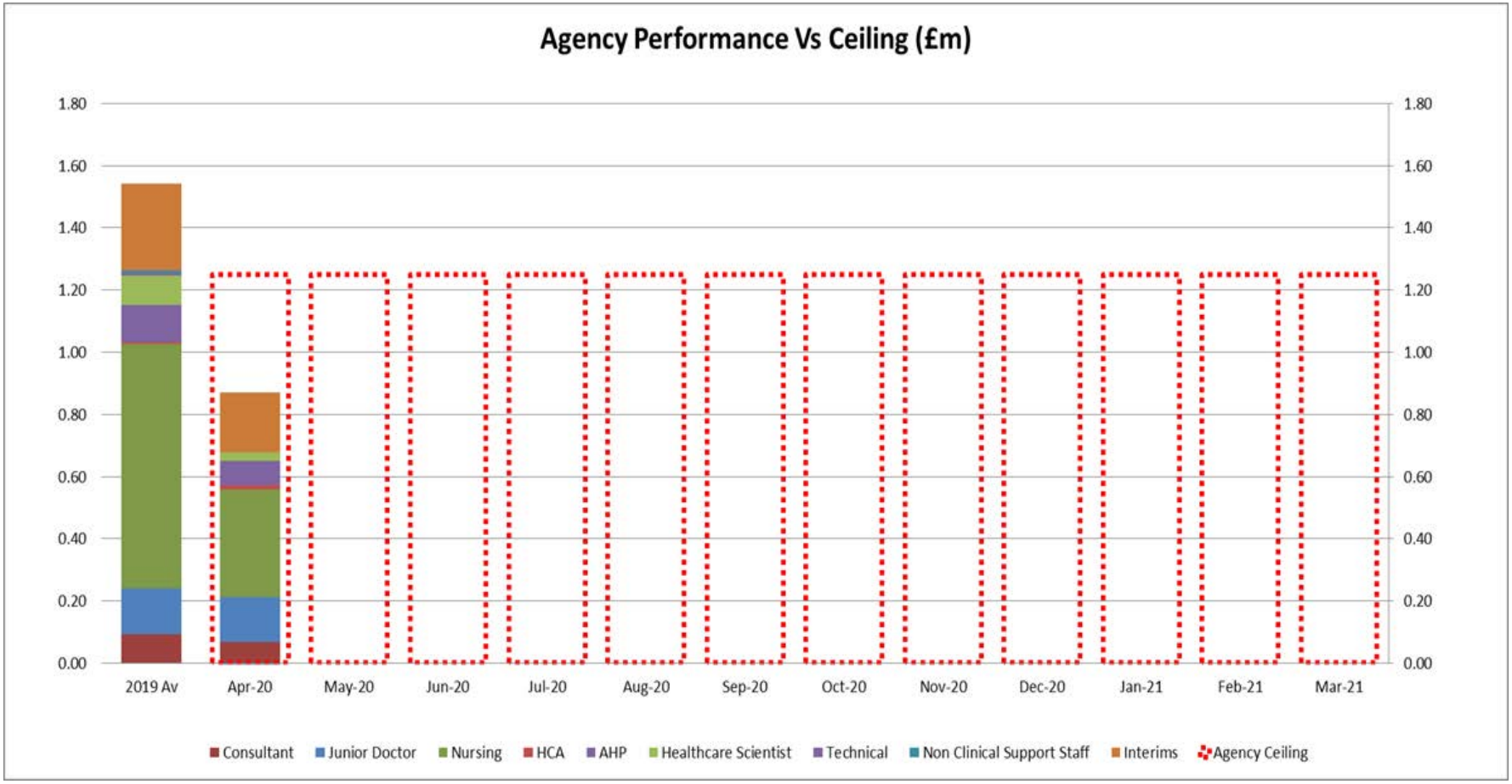






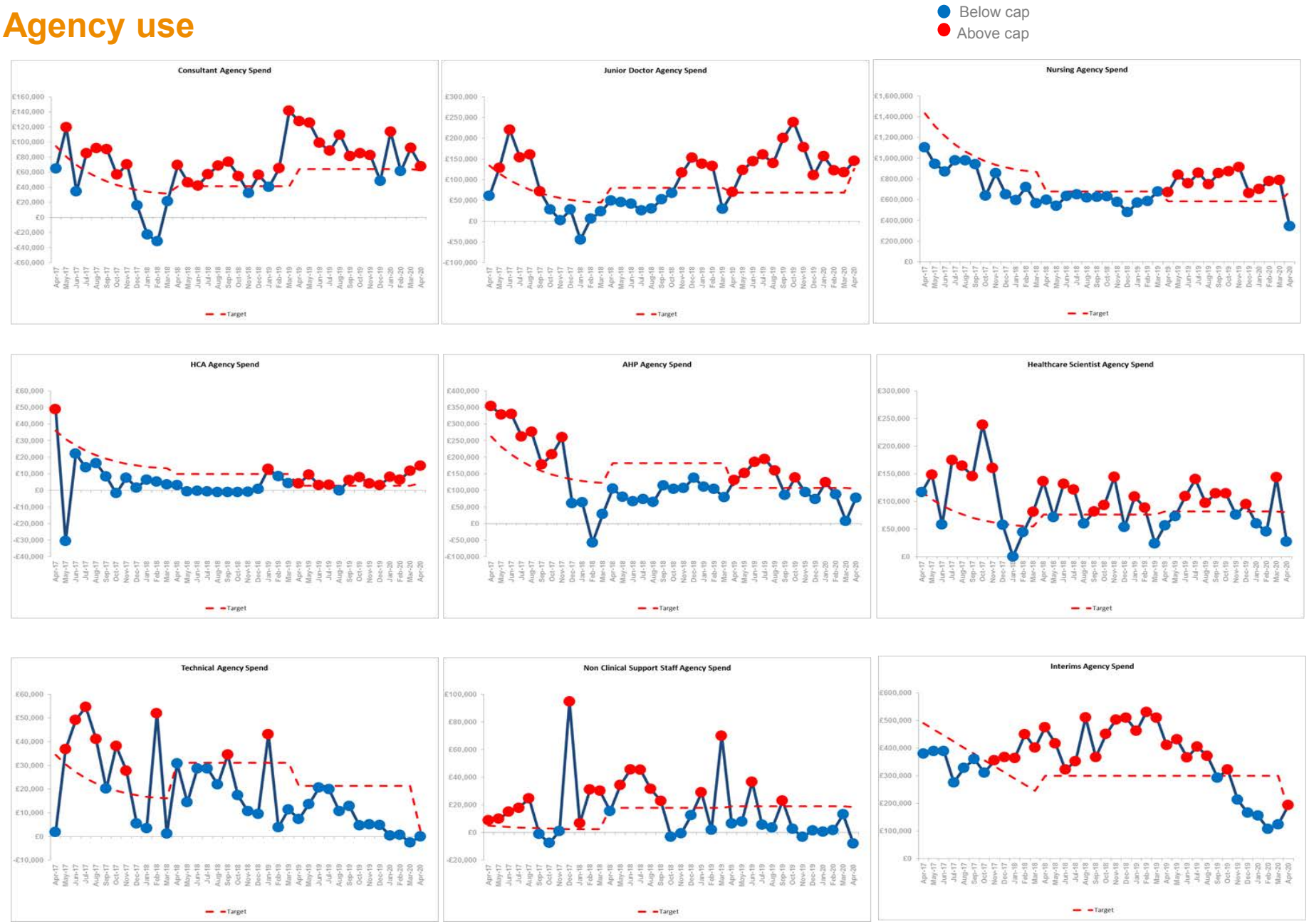


Agency use

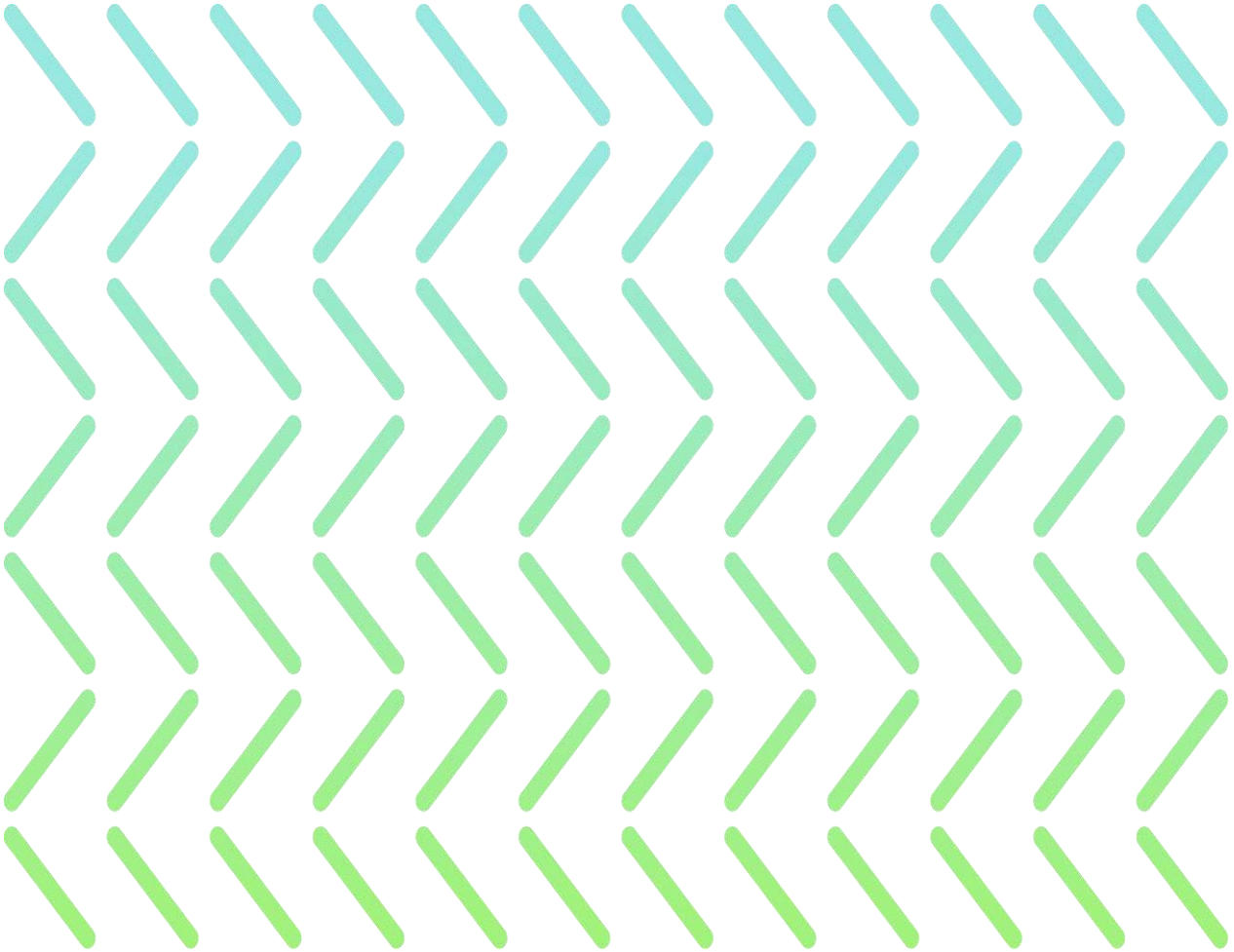


- The Trust's total pay for April was £49.00m. This is £0.57m adverse to a plan of £48.42m.
- The Trust's 2020/21 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.
- Agency cost was £0.86m or 1.8% of the total pay costs. For 2019/20, the average agency cost was 3.3% of total pay costs.
- For April, the monthly target set is £1.25m. The total agency cost is better than the target by £0.39m.
- The biggest areas of overspend were Interims (£0.02m) and Junior Doctor (£0.02m). The biggest areas of underspend were Nursing (£0.33m)
- Agency spend is low across the Trust due to staff redeployment as a result of COVID -19

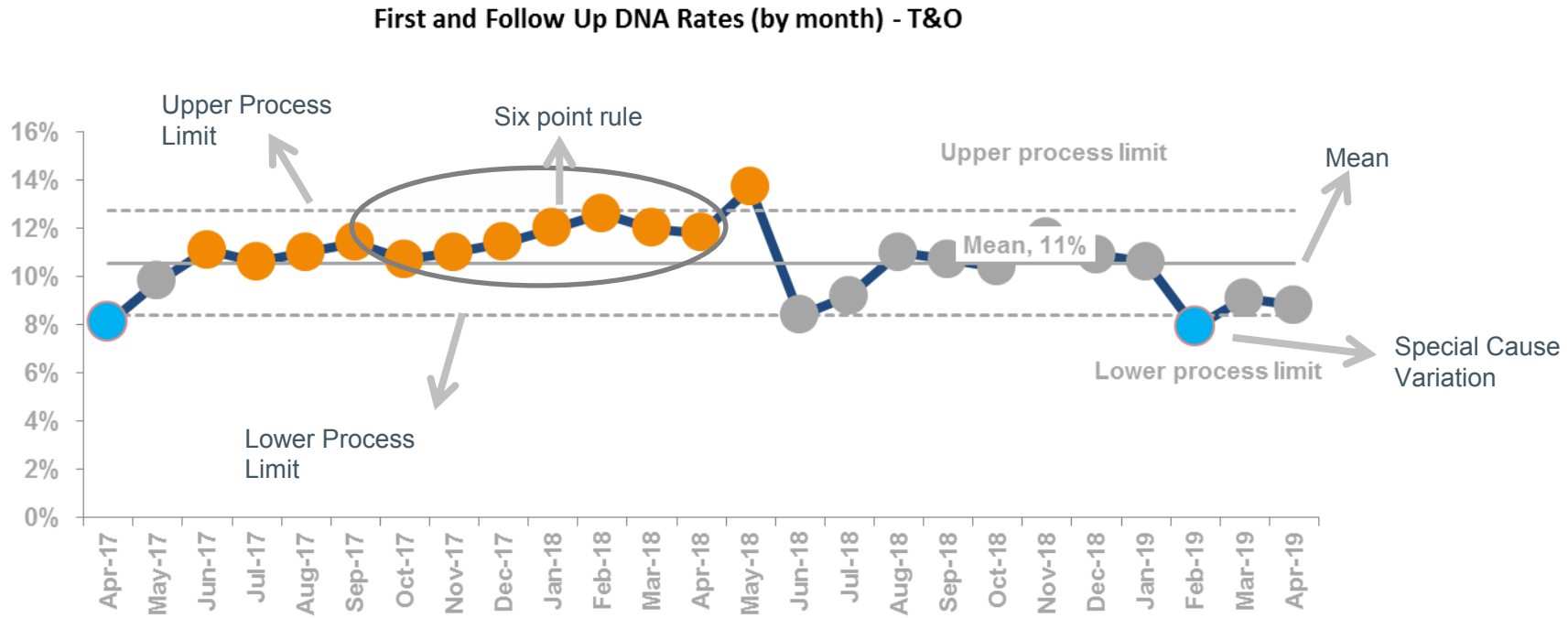
Agency use


Below cap
Above cap
Consultant Agency Spend
Junior Doctor Agency Spend
Nursing Agency Spend
HCA Agency Spend
AHP Agency Spend
Healthcare Scientist Agency Spend
Technical Agency Spend
Non Clinical Support Staff Agency Spend
Interims Agency Spend
Target

Appendix
Additional Information



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

Maternity

Definitions	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Total number of women giving birth (per calendar day)	14 per day	13.6	14.0	13.6	13.2	12.6	13.4	14.4	12.9	14	13	13	13	12
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	30.4%	25.9%	25.9%	25.9%	25.6%	27.4%	25.7%	24.2%	26.7%	24.8%	26.0%	23.3%	24.9%
% deliveries with Emergency C Section (including no Labour)	<8%	4.7%	2.8%	3.2%	3.9%	2.6%	5.2%	4.5%	1.5%	4.0%	1.3%	3.6%	3.3%	1.9%
% Time Carmen Suite closed	0%	5.0%	0.0%	6.7%	0.0%	4.8%	1.7%	19.4%	11.7%	8.1%	1.6%	22.5%	27.4%	10.0%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	1.5%	2.8%	1.2%	1.5%	3.3%	3.5%	4.0%	2.6%	5.3%	2.3%	2.3%	1.8%	3.2%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.7%	1.8%	2.0%	3.4%	2.1%	2.0%	2.3%	3.4%	3.0%	1.5%	2.1%	1.8%	2.9%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		13	11	14	10	9	10	7	14	11	12	11	13	9
Supernumerary Midwife in Labour Ward	>95%	96.7%	98.4%	98.3%	100.0%	96.8%	96.7%	96.8%	96.7%	96.8%	96.8%	94.8%	93.5%	100.0%
% women booked by 12 weeks and 6 days	90%	83.3%	86.6%	88.4%	85.3%	84.9%	81.5%	81.7%	84.1%	85.7%	82.3%	83.6%	82.4%	85.6%

Early Warning Score

Indicator Description	Threshold/ Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Compliance with appropriate response to EWS (adults)	100%	92.7%	94.2%	92.9%	90.6%	93.9%	87.6%	86.8%	89.6%	89.0%	92.0%	91.1%	94.1%	86.9%
Number of EWS Patients Adults)		381	518	393	448	360	380	356	534	420	400	460	289	290

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3.3

Meeting Title:	**Trust Board**		
Date:	28 May 2020	**Agenda No**	3.3
Report Title:	Learning from Deaths Report, Q4 2019/20		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Kate Hutt, Head of Medical Examiner's Office & Mortality Review Service Dr Manav Sohal, Clinical Governance Lead Cardiology Clinical Academic Group Dr Nigel Kennea, Lead Medical Examiner		
FOIA Status:	Unrestricted		
Presented for:	Discussion Update		
Executive Summary:	The paper provides an overview of the work of the Mortality Monitoring Committee (MMC) and Learning from Deaths in Q4 2019/20. The report notes areas for action in relation to implementation of the Learning from Deaths framework and establishing effective links to the Medical Examiner system. In order to demonstrate learning from mortality governance, recent investigation and improvement work within cardiology, in response to a Dr Foster Alert, is summarised. With regard to the recent peak of Covid-19 cases, this paper shows initial data on the Trust's Covid-19 deaths as provided by the Medical Examiner's Office. The period extends beyond Q4 2019/20 into Q1 2020/21.		
Recommendation:	The Board is asked to: • Note the update on the work of the Mortality and Monitoring Committee in Q4 2019/20; • Note the updated Learning from Deaths data and the development work planned. • Note the implementation of the Medical Examiner system in the Trust and enhancements to the service in light of Covid-19.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective; Well Led		
NHS Oversight Framework Theme:	Safe; Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Development work around mortality governance and the Learning from Deaths agenda has been delayed due to the required response to Covid-19. Work to clearly define and implement Care group, Trust (Learning from Deaths) and ME processes, and their interconnectivity, has not been completed. This needs to be finalised to ensure governance is effectively managed and opportunities for learning are not missed. Prospective review of mortality has significantly decreased with transfer of previously key personnel into the new ME service and with attention redirected to Covid-19 response.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:			
Previously Considered by:	Quality and Safety Committee	**Date**	21 May 2020
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

Learning from Deaths Report, Q4 2019/20

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Trust Board with an update on the work of the Mortality Monitoring Committee (MMC), and the current position of mortality reviews completed in line with the Learning from Deaths framework. An update on the delivery of requirements of the framework and the introduction of the Medical Examiner (ME) service is also detailed.

In order to demonstrate effective governance and learning through mortality monitoring and investigation a summary of recent cardiology work in this area is highlighted. This work was led by the Clinical Governance Lead for the Cardiology Clinical Academic Group.

The report highlights initial data summarising the peak in mortality resulting from COVID 19 and how the Medical Examiner Office responded to the pandemic.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK AND NATIONAL STRATEGY

2.1 **Learning from Deaths – Ongoing Development**

The new Trust Lead for Learning from Deaths, Mr Ashar Wadoodi took up post at the end of March. This is a new role, responsible for the implementation of the National Quality Board's framework for Learning from Deaths within the Trust, ensuring that opportunities to learn from cases and prevent repeat causes of harm are maximised. This role will interact closely with Care Group Governance Leads, and provide an essential link to the Medical Examiner service.

With the support of the Chief Medical Officer, the Learning from Deaths Lead will develop structures and processes to work very closely with Care Group Governance/Morbidity and Mortality Leads to strengthen governance and learning. Over the next quarter it will be important to define which deaths are to be reviewed, taking into account guidance from the NHS National Patient Safety Team around which Covid-19 deaths should be subject to structured judgement review. Furthermore reliable processes for identification, allocation of reviews and reporting will need to be defined and implemented. The level of resource within the mortality review team is reduced from previous levels where six PAs were previously allocated. Through most of this quarter the level of resource was between 1 and 2 PAs and at the end of the period stood at 3 PAs. It will be necessary to review this and agree an appropriate level of resource to enable the needs of the programme to be met.

As part of the action plan arising from the mortality governance review the strategy and aims of the Mortality Monitoring Committee are currently being reviewed. At the meeting in March members agreed that an extraordinary meeting would be held to take this forward and to begin formulating new terms of reference; however, in the current circumstances this work has been paused and the committee is focusing on essential priorities. These include monitoring our mortality outcomes at diagnosis and procedure group level and overseeing investigations of mortality outlier alerts.

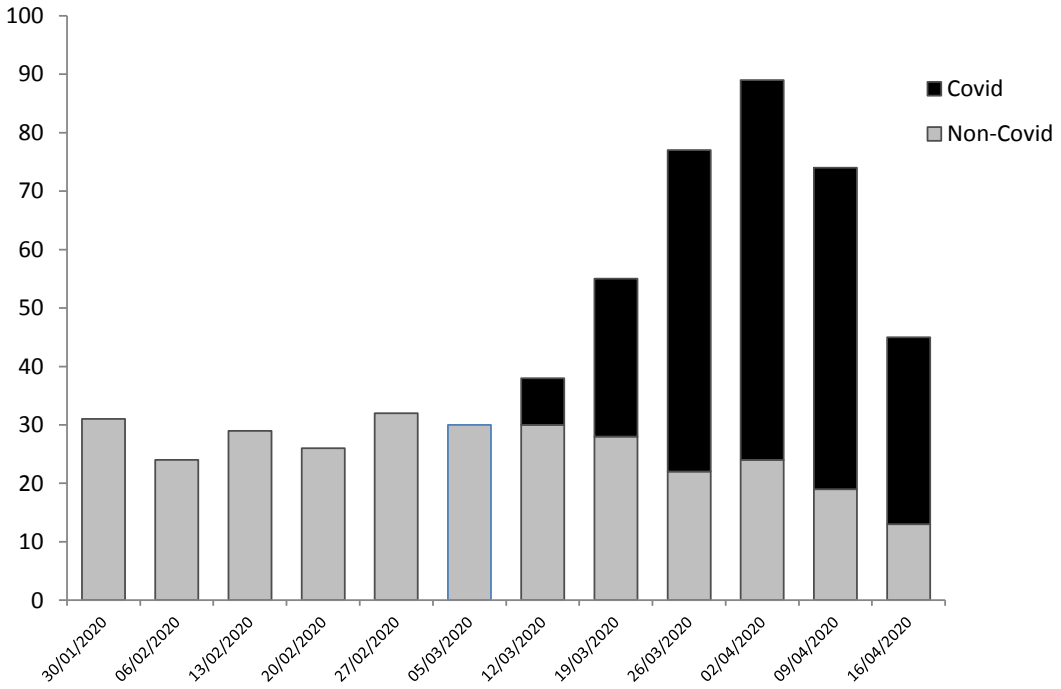
A second meeting of Care Group Governance leads took place at the beginning of March. The meeting focussed on the establishing a community of practice, which will help shape and support the delivery of effective local Mortality and Morbidity meetings, which will in turn contribute to the wider understanding of and learning from mortality across the trust. The resource needed to support and standardise mortality work across the specialties was also discussed, and it was welcomed that a number of administration posts are being introduced to work across the care groups in support of this.

2.2 **Medical Examiner Service**

Expansion of the Medical Examiner service continued in January, as additional MEs, recruited in December began to take up post. During January and February the service gradually moved towards scrutinising all deaths.

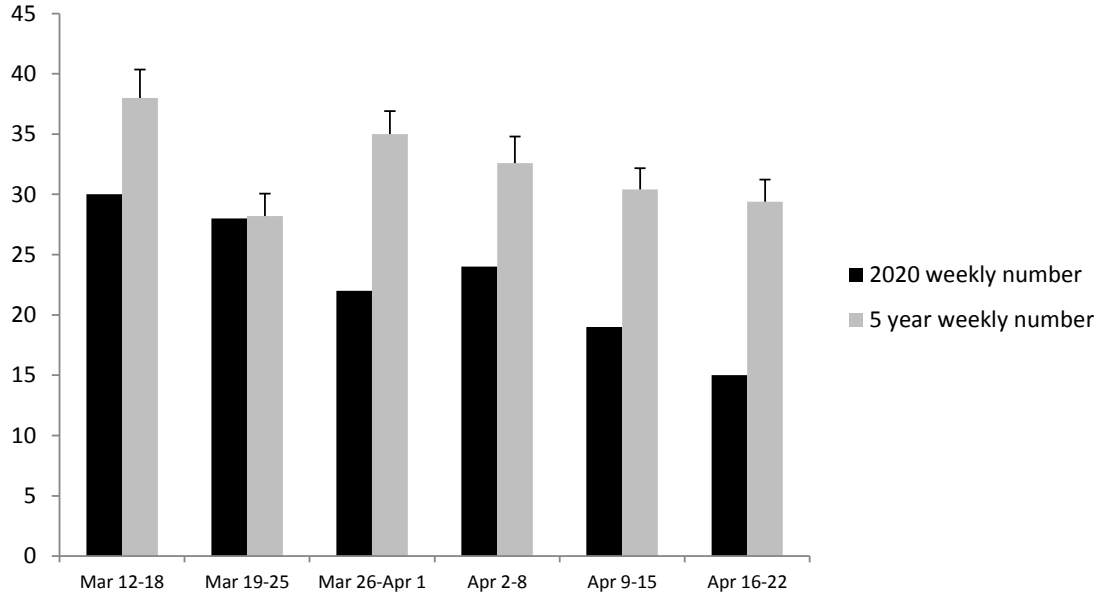
In anticipation of excess deaths in relation to covid and as a number of the appointed MEs work in essential services such as anaesthetics and critical care, early in March it became necessary to increase our ME capacity. A number of consultant colleagues whose clinical commitments had reduced due to changes in outpatient and elective activity, volunteered to complete the mandatory ME training and join the team. During the mortality peak there were at least two MEs present during each shift. This support has been vital for clinical teams in a number of ways. Senior leadership has ensured that changes to national guidance around certification and documentation were interpreted correctly, and applied consistently with training and support of clinical teams. Usually death certification and cremation papers are completed by junior doctors and having guidance and expertise of a consultant available has supported learning and provided professional care at an exceptional time.

The ME service has worked directly with the Bereavement Service, Mortuary, Registrars of Births and Deaths and the Coroner to ensure timely and accurate documentation for affected families. The ME team have collated and began to analyse the mortality data related to Covid-19 and all-cause mortality over this period. The Trust's first Covid-19 death was on 12/3/20 and data for the first 6 weeks following this (and preceding weeks) is shown below. In this period there were 242 deaths with Covid-19 with 2/3 (n=181) deaths in men. A high proportion of patients that died with Covid-19 were diabetic (34%) and/or hypertensive (48%).



There has been a reduction in non-Covid19 deaths in the March and April in comparison to previous years which may be of any of three main reasons, namely that:

1. Some of the patients with Covid19 may have died in this period anyway;
2. Some patients have died outside of hospital;
3. That there are fewer deaths from certain activities (i.e. trauma), or reduction in referral into our hospital from other hospitals for conditions with high mortality (i.e. cardiology, neurosurgery, vascular, trauma). These possibilities would warrant further investigation.



The ME service will remain responsive to the needs of the bereaved, and it is likely that Consultants supporting the service for the 'Covid19' period may be allowed back to support their clinical service in the next period.

The service will work with regional and national ME teams to ensure St George's presents accurate data and that financial implications of the Coronavirus Act (i.e. no Crem 5 income) do not disadvantage our service. At present the national team has not provided guidance about how the loss of this income stream will be balanced nationally.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 During this quarter fewer reviews were completed due to the reduced level of resource. As the process of defining which cases should be reviewed under the Learning from Deaths agenda is ongoing, only cases identified by the ME as requiring SJR were reviewed. These comprise of deaths of patients with learning disabilities (n=2), severe mental health diagnosis (n=6) and those where the ME has detected a potential issue with care (n=10).

Section 4.1 provides an overview of local scrutiny of deaths in patients with LD that have occurred during this report period.

3.2 **Overview of January to March 2020**

Between January and March 2020 there were 485 deaths. Members of the Mortality Review Team (MRT) reviewed 18 deaths, representing 3.7% of deaths. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

The structured judgement review methodology requires reviewers to identify problems in healthcare and to assess whether or not these have caused harm. Of the 18 cases reviewed this quarter problems were identified in 3 (16.7%) cases. Harm was thought to have been caused in only one of these cases and this related to assessment and treatment. This case was referred to the MRT reviewer to the clinical team for local scrutiny.

A judgement regarding avoidability of death is made for all reviews. Sixteen of 18 deaths reviewed were assessed as definitely not avoidable and no deaths were judged to be more than likely avoidable.

Avoidability of death judgement score: Q4 2019/20	Total
6 = Definitely not avoidable	**16**
5 = Slight evidence of avoidability	**1**
4 = Possibly avoidable but not very likely (less than 50:50)	**1**
3 = Probably avoidable (more than 50:50)	**0**
2 = Strong evidence of avoidability	**0**
1 = Definitely avoidable	**0**
TOTAL	**18**

An assessment of overall care should be provided for each death and this was completed for 17 of those reviewed this quarter. In 13 cases patients were felt to have received care that was either 'good' or 'excellent', with 3 rated as 'excellent' and 10 as 'good'. Care was rated as 'adequate' in the remaining cases and no 'poor care' was observed.

4.0 THEMES AND LEARNING

The following summary highlights a recent investigation of mortality signals in cardiology and the associated learning derived as a result. Also included is a focus on the deaths of patients with learning disabilities.

4.1 A summary of the Cardiology review of recent Dr Foster Alerts for Acute Myocardial Infarction and PTCA

A new signal was picked up in November 2019 suggesting a higher than expected mortality for cases coded as Acute Myocardial Infarction (AMI) at St. George's. Between September 2018 and August 2019, there were 95 deaths against 74.2 expected. There was also a SHMI signal for this diagnosis.

The Variable Life Adjusted Display (VLAD) plot for AMI touched the lower control limit twice between September 2018 and November 2018. Having been the subject of an alert for the same diagnosis in March 2017 that resulted in changes to the delivery of the acute interventional cardiology service, the more recent alert was investigated to better understand if the data triggering the alert was accurate and, if so, was it the result of one (or more) systemic issue(s).
Analysis of the 95 deaths has identified the following salient points:

- 24 were cases of out of hospital cardiac arrest.
- 22 cases were not treated in the cath lab due to severe frailty/comorbidities/perceived futility. Review of these cases by the Governance Lead for the Cardiology Clinical Academic Group (CCAG) has established that the decisions to adopt a non-invasive approach were appropriate in all cases.
- 2 patients died following high risk cardiac surgery (with appropriate documentation of relevant MDT discussions).
- 2 patients died in circumstances that meant there was a delay in them getting to the cath lab due to other PPCI patients being treated concomitantly.
- 1 patient died after high risk PCI to that was complicated by vessel rupture. The patient went for salvage surgery but did not survive. The patient had been appropriately discussed at MDT.
- 2 patients were incorrectly coded.

Of the 95 deaths, 88 were reviewed by the Mortality Review Team (MRT) and 82 were judged as definitely NOT avoidable. Of the remaining cases, there was felt to be slight evidence of avoidability in 5 cases, one death was declared as a Serious Incident (SI) and 7 were not reviewed. The 7 cases that were not reviewed by the MRT were reviewed by the Cardiology Lead for Governance and presented to the Mortality Monitoring Committee. The deaths were all judged to be definitely not avoidable. A deep dive into the 5 cases with slight evidence of avoidability and the death declared as a SI – incident reference DW115695 2019/491 - identified learning points that have resulted in change to practice/process. These changes will be audited. The changes include:

- A full protocol for ensuring agitated patients have a team member on each side of the table at all times is now in place. A wider review of how to manage agitated patients in need of urgent/emergency patients is currently being undertaken (in conjunction with our anaesthetic colleagues).
- Adoption of an interventional consultant of the week. This individual is tasked with seeing the cardiology inpatients felt likely to need intervention. They then meet with the cath lab coordinator to ensure scheduling is based on clinical urgency. This is currently being audited.

Following the review of all 95 deaths, the CCAG offered to the MMC the following observations:

- *We are reassured that the most recent VLAD plot for SHMI in the AMI group shows a generally stable trend with no deviation to the lower line of control.*
- *Complex cases requiring surgical input are discussed at a daily MDT.*
- *Case note review has also demonstrated good documentation of consensus decision-making when evaluating patients for high risk PCI (in non PPCI settings).*
- *Patients on CTICU are reviewed daily by the non-invasive cardiology consultant of the week who liaises with the intervention/EP teams as appropriate. Job plans have been changed to achieve this.*
- *The Clinical Lead for the CCAG reviews the VLAD plots with individual PCI operators on a 3-monthly basis and has no concerns at this time.*
- *We are satisfied that futile cases are not being intervened on.*
- *We will remain vigilant with regards to the AMI and PCI mortality signals as we wish to understand how our mortality data fits in with national trends.*

  Moving forward, we will look to see how our SHMI data compares with other heart attack centres and will seek to understand if any differences are due to the high proportion of cases presenting as out of hospital arrests or if there are points we can learn from our peers.

4.2 Learning disabilities

All deaths that occur in patients with learning disabilities are submitted to the national Learning Disabilities Mortality Review Programme (LeDeR). The LeDeR reviews are co-ordinated by the CCG and we have established effective liaison with these colleagues. We work together closely to share our local independent mortality reviews and in turn receive redacted copies of the LeDeR review. It is anticipated that in 2020/21 regular reports from the LD team will be presented to MMC, identifying aspects of best practice and highlighting any areas for local learning and improvement.

The mortality review team continue to carry out timely local review using our standard methodology. The table below summarises the deaths of patients with learning disabilities (LD) from the beginning of 2018/19 to the end of Q4 2019/20. In total there have been 25 deaths, with reviews completed for each. No avoidability was identified.

This quarter there have been 2 LD deaths. No problems in healthcare were identified and the deaths were judged to be definitely not avoidable. Overall care was judged to be good in both cases.

LD DEATHS Avoidability of death judgement score	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
TOTAL DEATHS	1	3	3	2	3	7	4	2
LOCAL REVIEWS COMPLETED	1	3	3	2	3	7	4	2
6 = Definitely not avoidable	1	3	3	2	3	7	4	2
5 = Slight evidence of avoidability	0	0	0	0	0	0	0	0
4 = Possibly avoidable but not very likely (< 50:50)	0	0	0	0	0	0	0	0
3 = Probably avoidable (> 50:50)	0	0	0	0	0	0	0	0
2 = Strong evidence of avoidability	0	0	0	0	0	0	0	0
1 = Definitely avoidable	0	0	0	0	0	0	0	0

5.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

5.1 Summary Hospital-level Mortality Indicator (SHMI) [source: NHS Digital]
The latest SHMI data, covering discharges from December 2018 to November 2019, was published on 9th April 2020. The Trust's overall mortality is categorised as lower than expected at 0.85; we are one of 12 trusts nationwide in this category. The SHMI for St George's site is lower than expected at 0.85. A site specific measure for Queen Mary's is not reported due to low numbers.

NHS Digital provides a SHMI value for a number of diagnosis groups, as detailed below. For these groups VLAD (variable life adjusted display) charts, which show the difference between the expected number of deaths and observed deaths over time, are also available. The latest information is summarised in the table below and shows that our mortality is either lower than, or in line with what would be expected for all the diagnosis groups analysed.

Diagnosis Group	SHMI value	SHMI banding
Cancer of bronchus; lung	0.58	Lower than expected
Secondary malignancies	0.71	Lower than expected
Pneumonia (excluding TB/STD)	0.80	Lower than expected
Urinary tract infections	0.80	As expected
Gastrointestinal haemorrhage	0.88	As expected
Septicaemia (except in labour), shock	1.05	As expected
Fluid and electrolyte disorders	0.78	As expected
Acute myocardial infarction	1.19	As expected
Acute bronchitis	0.79	As expected
Fracture of neck of femur (hip)	0.94	As expected

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

HSMR analysis: February 2019 – January 2020	Score	Banding
HSMR (all admission methods)	93.1	Lower than expected
HSMR: Weekday emergency admissions	93.2	Lower than expected
HSMR: Weekend emergency admissions	92.8	As expected

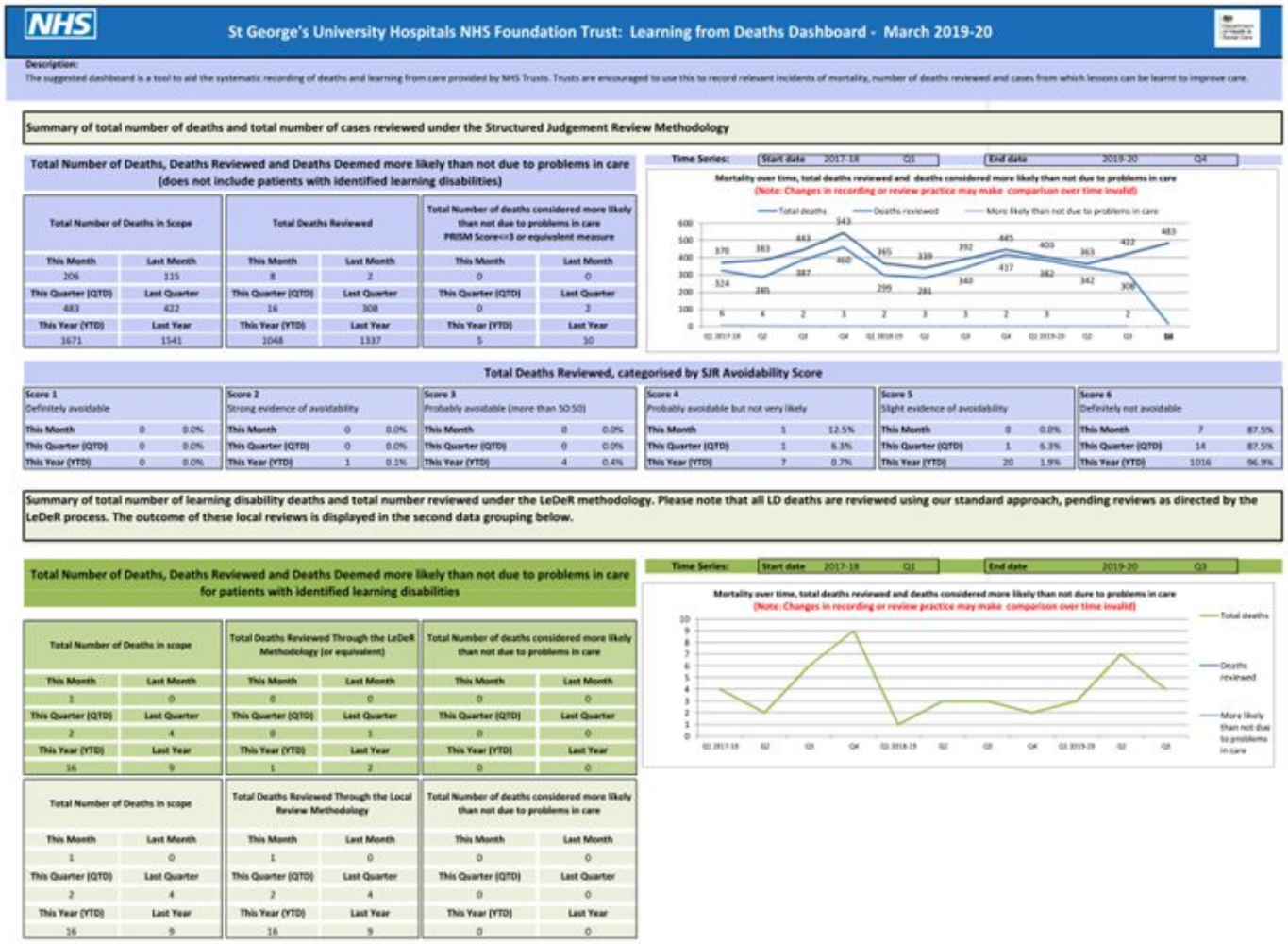
In addition to considering the high level data above, which is also reported in the Integrated Quality Performance Report, risk-adjusted mortality at both diagnosis and procedure group level is evaluated.

An investigation of the procedure group 'Reduction of fracture of bone (upper/lower limb)' covering the period December 2018 to November 2019, has recently been completed and was reported to the MMC in April 2020. During the 12 month period there were 11 deaths observed against an expected number of 5.1. The 11 deaths were of patients from 5 different diagnosis groups.

The investigation found that all deaths had already been reviewed by at least one of the Mortality Review Team, Trauma Governance Group or CTICU. In the large majority of cases no avoidability or concerns were noted and the deaths were found to be expected given the severity of illness and/or injury. Where there were any concerns these had been reported prospectively to the Risk Team for consideration of investigation. In one case a SI had been declared and fully investigated finding that a medication prescribing error which did not contribute to the patient's death (incident reference DW113974 2018/28336).

The Mortality Monitoring Committee was satisfied that this signal had been appropriately investigated and found no concerns or areas for action.

Appendix 1: National Quality Board Dashboard – data to 31st March 2020



NHS

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - March 2019-20

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

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
206	115	8	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
483	422	16	308	0	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1671	1541	1048	1337	5	10

Time Series: Start date 2017-18 Q1 End date 2019-20 Q4

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care
(Note: Changes in recording or review practice may make comparison over time invalid)

Total deaths; Deaths reviewed; More likely than not due to problems in care

Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	12.5%	This Month	0	0.0%	This Month	7	87.5%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	6.3%	This Quarter (QTD)	1	6.3%	This Quarter (QTD)	14	87.5%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.1%	This Year (YTD)	4	0.4%	This Year (YTD)	7	0.7%	This Year (YTD)	20	1.9%	This Year (YTD)	1016	96.9%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping below.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	4	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
16	9	1	2	0	0

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	4	2	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
16	9	16	9	0	0

Time Series: Start date 2017-18 Q1 End date 2019-20 Q3

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care
(Note: Changes in recording or review practice may make comparison over time invalid)

Total deaths; Deaths reviewed; More likely than not due to problems in care

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4.1

Meeting Title:	Trust Board		
Date:	28 May 2020	**Agenda Item:**	2.1
Report Title:	Guardian of Safe Working Hours (GOSWH) Report – for the period 09/11/2019 – 27/03/2020		
Lead Director/ Manager:	Dr Richard Jennings		
Report Author:	Dr Serena Haywood, Guardian of Safe Working Hours		
Presented for:	Assurance		
Executive Summary:	The Covid-19 pandemic has affected all work of junior doctors in the Trust in an evolving picture. Covid-19 planning involves rotas, redeployment, training, exception reporting and wellbeing. The data for training posts includes general practitioners (GPs) in training, but does not include trust doctors or clinical fellows. Trust doctors and clinical fellows work alongside doctors in training on the junior doctor rota, but are not employed on the Doctor in Training contract. Rota gaps data for the period covered by this report is not available due to Covid-19. All rotas are currently being remodelled. There were 98 exception reports with all but 6 related to working hours. Most are reported in medicine particularly respiratory, reflecting winter pressures during this period. The GOSWH is looking to spend the Health Education £60,000 wellbeing money on a rest space, but has not yet been able to source the appropriate physical space within the Trust. No fines were issued this quarter. One Immediate Safety Concern was raised in acute medicine and a plan made towards a resolution. The GOSWH is awaiting a survey result from the respiratory trainees who have reported being discouraged from submitting exception reports The Director of Medical Education (DME) post vacancy has been filled since 01 April 2020 and regular meetings between the DME and the GOSWH are planned.		
Recommendation:	The Trust Board is asked to receive and note the Guardian of Safe Working Hours report.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well led Safe		

Single Oversight Framework Theme:	Quality of Care	
	Implications	
Risk:	• Failure to ensure that doctors are safely rostered, and enabled to work hours that are safe, risks patient safety and the safety of the doctor. • Failure to ensure that doctors are safely rostered, and enabled to work hours that are safe, risks overtime payments and fines being levied.	
Legal/Regulatory:	Compliance with the *Terms and Conditions of Service for NHS Doctors and Dentists in Training (England)* (2016)	
Resources:	• Funding for overtime payments, fines and service charges arising from work schedule reviews • Additional Programmed Activities (PA) allocation in consultant job plans for time taken to personalise work schedules, resolve exception reports and perform work schedule reviews • Administrative support for the role of Guardian	
Equality and Diversity:	N/A	
Previously Considered by:	N/A	This report would usually have been considered by the Workforce and Education Committee, but the May 2020 WEC meeting was cancelled due to the Covid-19 pandemic.
Appendices:	Exception reports in detail Current Medical Vacancies – Not available Update criteria for fines	

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Guardian of Safe Working Hours (GOSWH) Report

Quarter 4 2019/20

1.0 PURPOSE AND BACKGROUND

This paper provides assurance to the Board on the progress being made to ensure that junior (trainee) doctors' working hours are safe, and to highlight all fines and work schedule reviews relating to safe working hours. This report also includes information on all rota gaps on all shifts.

The Guardian of Safe Working Hours (GOSWH) is a senior appointment made jointly by the Trust and junior doctors. The GOSWH ensures that issues of compliance with safe working hours are addressed by the doctor and/or Trust and provides assurance to the Board that doctors' working hours are safe.

As the Trust is the Lead Employer Organisation for General Practice training across South London, the GOSWH will receive reports for all of the doctors under its employment from the GOSWH's host organisations.

The GOSWH reports to the Board through the Workforce and Education Committee of the Board, as follows:

i. The Workforce and Education Committee will receive a *Guardian of Safe Working Hours Report* no less than once per quarter on all work schedule reviews relating to safe working hours. This report will also include data on all rota gaps on all shifts. The report will also be provided to the Local Negotiating Committee (LNC).
ii. A consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps, will be included in a statement in the Trust's Quality Account, which must be signed off by the Trust chief executive. This report will also be provided to the LNC.
iii. Where the GOSWH has escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, for decision and action, and where these have not been addressed at departmental level and the issue remains unresolved, the GOSWH will submit an exceptional report to the next meeting of the Board.
iv. The Board is responsible for providing annual reports to external bodies, including Health Education South London, Care Quality Commission, General Medical Council and General Dental Council.

There may be circumstances where the GOSWH identifies that certain posts have issues that cannot be remedied locally, and require a system-wide solution. Where such issues are identified, the GOSWH will inform the Board. The Board will raise the system-wide issue with partner organisations (e.g. Health Education England, NHS England, NHS Improvement) to find a solution. The GOSWH also reports regularly to the General Medical Council (GMC) via local liaison.

The GOSWH is accountable to the Board. Where there are concerns regarding the performance of the GOSWH, the BMA or other recognised trade union, or the Junior Doctors Forum will raise those concerns with the Trust Chief Medical Officer. These concerns can be escalated to the senior independent director on the Board where they are not properly addressed or resolved. The Senior Independent director is a Non-executive director appointed by the Board, to whom concerns regarding the performance of the Guardian of Safe Working Hours can be escalated where they are not properly resolved through the usual channels.

2.0 COVID-19 PLANNING AND ANTICIPATED PROBLEMS

a) Rota – The Trust's Workstream Group are currently meeting. The GOSWH has been in conversation with the chair and the chair of the Local Negotiating Committee (LNC) to ensure that the rotas fall within the *Working Time Directive* wherever possible. The e-rostering

programme will be used where possible. Exception reporting will therefore be for exceptions to the new rota not the old work schedules. Trainees were asked to consider volunteering for the Covid-19 acute hospital, NHS Nightingale, but, as of May 2020, NHS Nightingale has been suspended and this is no longer a factor.

b) Redeployment - The guidance from Health Education England, NHS England and the General Medical Council (GMC) is that doctors should be supported in training for any new roles or for returning to roles. Doctors in training volunteered early to deploy into acute areas and have now been formally redeployed by education leads of the Trust via the Workstream Group.

c) Wellbeing – during this time, rest and wellbeing are a particular challenge. The Estates team have provided comprehensive Trust-wide rest and support facilities. The Trust has repurposed four rooms for staff wellbeing during the Covid-19 pandemic, and these are available for junior doctors to use. Individual wellbeing support in terms of food and a supportive discussion is being offered by the Medical Examiners team as doctors come to discuss deaths. Departments including paediatrics have well-being offered in handovers, individual sessions an webinars with the RCPCH.

d) Pay - Pay will not drop below the agreed pay scale of the Doctor in Training contract. Any extra hours above the agreed new rota can be exception reported and signed off by the GOSWH to ensure swift payment. Annual leave will be honoured, wherever possible.

e) Teaching - The Director of Medical Education (DME) is sending regular updates to ensure the trainees feel supported in this uncertain time. Training for surgeons in particular is a concern as elective surgery is currently frozen. Strategies are in development nationally. Appraisals and training sign offs had been frozen but with the introduction of more videoconferencing has now begun via the Annual Review of Competency Progression (ARCP).

f) Personal Protective Equipment (PPE) - PPE is available throughout the Trust and the trainees are encouraged to report any shortages.

g) Junior Doctors' Forum (JDF) - The GOSWH is holding weekly drop-ins with the DME and Chief Medical Officer (CMO) (if available); the LNC Chair has also been invited to attend. The trainees have chosen a number of areas of focus for these meetings, and these have included interactive discussions with the Infection Prevention and Control team, the consultant psychologist and others involved in maintaining staff wellbeing. The trainees are now all able to use a messaging service and can be contacted for changes to rotas and any other essential information and wellbeing. For example, medical students are collecting donated food to deliver to the Doctors' mess.

3.0 ANALYSIS OF REPORTS AND FINES

3.1. Fines

There were no fines issued this quarter.

3.2. Exception Reports

A total of 98 exception reports were submitted the majority in relation to working hours/conditions in this quarter, with six due to missed training or education opportunities. Missed breaks were not separately reported, but were often mentioned in working time breaches. Most exceptions were in medicine, which is consistent with previous experience during the months of winter pressures.

In the fourth quarter of 2018/19, there were 87 exception reports; reporting has therefore increased compared with a year ago.

All but four exception reports were eligible for review.

St George's is the Lead Employer of GP trainees across South London. One exception episode was reported by GP trainees.

The GOSWH will close incomplete exception reports on the Allocate software with a note to the trainee to ensure that they claim any outstanding overtime payment if they have been unable to take Time-off in Lieu (TOIL) within a month.

The 2019 update to the Doctor in Training contract asks that TOIL is completed within 48 hours. This is an on-going problem for trainees as there is limited time to take TOIL. They are therefore paid overtime.

3.3 Exception Report Breakdown

Division	Number of exceptions	Breakdown
Medicine and Cardiovascular	**63**	**41 Acute Medicine including AMU**
		0 Gastroenterology
		2 Nephrology
		6 Endocrinology
		0 Neurology
		13 Respiratory
		0 Cardiology
		0 ED
		1 Haematology
		0 Care of the elderly
Children's, Women's, Diagnostics and Therapeutics	**9**	**0 Obstetrics and gynaecology**
		9 Paediatrics
		0 Neonatal medicine
		0 Paediatric surgery
Surgery, Theatres, Neurosciences and Cancer	**25**	**18 General surgery**
		0 Vascular surgery
		0 Plastic Surgery
		2 Urology
		5 ENT
		0 Renal transplantation
		0 Neurosurgery
		0 Trauma and orthopaedics
		0 Cardiothoracic surgery
Community	**0**	**QMH rehab**
		Psychiatry
		The Priory

Appendix A contains full details of the exception reports made.

3.4 Immediate Safety Concern (concerns raised by trainee)

No Work Schedule Reviews were carried out, as this one report related to staffing and not a specific rota issue

11/02/2020 - Raised by an ST4 trainee in General Medicine.

Concerns raised:

1. *Only they and one other doctor were available during the day to see 24 patients.*
2. *The other doctor is also new.*
3. *The locum consultant said they would find help as the doctor felt overloaded, but the doctor felt that the ward was using medical students to cover doctor gap. An F1 was found from another ward to support.*
4. *The ward was minimally staffed for weeks on end and this situation could occur on a regular basis making taking annual leave and attending training difficult.*

The response from the trainee's Educational Supervisor and also the Training Programme Director (TPD) was that the department was aware that some wards are short staffed and they were working to address this. An email had been sent to the various medical teams: the first thing done was to give extra specialty days back to the junior doctors, and a meeting was due to take place on 11/03/2020 with the different teams to try to improve the rotas for August, but this meeting was deferred due to Covid-19. This meeting includes junior doctor representation. New rotas will be ready by the end of May 2020 and hopefully some of these issues can be addressed. This will be revisited after the Covid-19 pandemic.

3.5 Details of specific exception reports by specialty

Respiratory

Several exception reports were raised in regards to the large number of outlining patients for the Respiratory team. This is a common occurrence during times of winter pressures. The TPD responded, noting that there is a daily e-mail that is circulated to all the teams with a list of outlining patients, which reduces the risk that any patient will be inadvertently overlooked.

In addition, trainees reported being unable to take annual and study leave and feel unable to exception report and say that it is being discouraged. The respiratory consultants were unaware of this issue and were surprised to hear that this concern had been raised.

Action:

- The respiratory department was undertaking a survey to explore details of these concerns for details in order to take specific action and will review as a department.

3.6 Senior Health

An exception submitted on 26 Feb 2020; *"The ward should have a minimum of three junior doctors. Today with have 2 junior doctors. There is a locum consultant but he will not be doing a ward round as he has seen the whole ward over the past 2 days. We also have a medical student to help but she is not a fully trained doctor. This will leave 24 patients and 2 outliers for 2 junior doctors to see. This low staffing has occurred due to a training day. The ward is generally run on minimal staffing so any training/sickness leaves the ward understaffed. This is a recurrent problem and is making obtaining specialist training very difficult as I have to spend most days covering a low or understaffed*

ward. It also makes additional tasks such as ward lumbar punctures difficult as there is insufficient staffing to cover the ward while these tasks are done."

The response from Senior Health was:

- On the particular day mentioned the ward was short by one doctor, however a consultant was available.
- It was a (Core Medical Trainee) training day and one of the doctors who were due to be working on the ward had gone on the training day; the departmental processes regarding study leave applications for training days will be reviewed.
- A meeting was arranged with the doctor who raised the concern to make sure TOIL is given and to try to prevent this happening in the future.

3.7 Acute Medical Unit (AMU)

1. One trainee reported that there was a "*hostile environment"* for trainees for work involving non-medical staff. Nothing had been fed back in the most recent Local Faculty Group (Jan 2019) but this had been also raised previously.

Action:

- This feedback has been discussed at an AMU consultant meeting and is being taken seriously.
- This feedback will be discussed at the AMU Senior Leaders Meeting - deferred until after Covid-19.
- The Junior Doctor Representative conducted a survey of all juniors on AMU (both those who are resident and those who rotate through). The findings of which were presented back to the AMU Local Faculty Group. No further reports of the AMU being a hostile environment were made.
- The Junior Doctor Representative was specifically asked for her thoughts about the about the perception of AMU as a hostile environment. She stated that this was not something she recognised.

2. Acute clerking experience has been reported as limited due to the pattern of junior doctor rotations (i.e. subspecialty in year 1) and varying days of AMU block dedicated to clerking, rather than standard days.

Action:

- Work is being done by the Medical Training Directors to look at the rotations.
- The AMU 'block' rota is being reviewed.

3. Teaching missed whilst on AMU

Action:

- The Clinical Lead will speak to the Rota Coordinator to ensure trainees are not missing training.

- There has also been at least one time that CMT and Foundation training days have happened on the same day, which had a negative impact on the department and a few people had to be asked not to attend to maintain safe staffing levels. This is a more difficult problem to solve.

3.8 Renal

The reported problem is that there are 2.8 whole-time equivalents (WTEs) on the on-call rota, which has been designed for 6 WTEs, so the doctors in training are often picking up additional work. Cover on the ward in the daytime is inconsistent and there can be only one F2 on the ward.

Action:

- The Clinical Lead has been contacted and a review is awaited - likely to be after the Covid-19 pandemic.

3.9 Palliative Care and Oncology

It is reported that trainees can be pulled from Oncology and are not getting time in Palliative Care. F2s report often not being part of ward rounds and feeling an imbalance in the work with Physician Associates who cannot prescribe, so the F2s are left with the prescribing and smaller jobs.

Action:

- There is a meeting set up with Palliative Care and Oncology to discuss.
- More information is being gathered via a survey.

3.10 Paediatrics

There were two reports in relation to prolonged evening handover and two reports about inability to attend teaching due to Emergency Department pressures. The GOSWH met with the Department Lead and College Tutor to look at ensuring handovers run to time and that time is found for teaching. They were engaging with trainees to make sure handover was prompt and that time was made for training. No further reports have been submitted since the end of 2019.

3.11 Rota gaps

This information is not currently available, nor currently relevant due to the reconfiguration of the workforce in response to Covid-19.

3.12 Junior Doctor Forum

The Junior Doctor Forum (JDF) continues to meet monthly. Attendance remains high. The GOSWH is supporting a renewed survey of the British Medical Association (BMA) Fatigue Charter compliance. Preliminary findings suggest that rest, fresh food and reliable Information Technology (IT) remain the most expressed needs.

The position of the Doctors' Mess was also seen as less inaccessible to those in Atkinson Morley and St James' Wings and so rest areas not used overnight are being explored. Fine money and Wellbeing money has been committed to refitting the shower and developing a rest area in the Doctors' Mess.

3.13 New Terms and Conditions and rota implications

All rotas are currently being brought into compliance by the deadline, as discussed in the previous report.

4.0 IMPLICATIONS

4.1 Risks

The response to Covid-19 and the impact on working life, personal health and wellbeing is currently the main concern for all trainees. At this point in the pandemic, the impact of the crisis in the UK healthcare sector is not yet fully known. The GOSWH will report back to the WEC and the Board in a full report in the next quarter and is available for ad-hoc updates, if required.

Other issues:

1. Reluctance of some trainees to exception report has become a significant problem raised by the trainees themselves. The GMC survey has currently been suspended and specific examples are being sought. The impact on morale and safe working needs to be fully explored

2. Working outside of work schedules in Acute Medicine, including missing training, requires further detail that has not been able to be explored due to the response to Covid-19. The risk to safe working remains an issue when normal rotas are returned to.

4.2 Legal Regulatory

The GOSWH follows the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (update 2019)

4.3 Resources -cost pressures from fines

Funding overtime payments to doctors in training represents a cost pressure. Following work schedule reviews, additional staff may be required to bring working hours into safe limits and to bring their hours into line with their work schedules. If actual working hours cannot be brought into line with work schedules, then basic pay for staff may need to increase. This would represent a further cost pressure. Lastly, fines may be levied if unsafe working practices continue.

5.0 NEXT STEPS

5.1 Supporting trainees to exception report

The Guardian will be helping consultants to help trainees to make exception reports.

5.2 Specialities

See relevant sections.

6.0 RECOMMENDATIONS

The Board is asked to note this report and take note of the various risks to safe working hours and trainee wellbeing in relation to the Covid-19 pandemic. The Trust is being flexible and planning ahead as much as it can and involving the GOSWH in decision making, but the full impact is not yet known. The GOSWH is available for strategic advice and reflecting the concerns of the trainees who are on the frontline of acute work and are instrumental in the health and wellbeing of the patients of St George's University Hospitals.

Appendix A - Summary of exception reports by specialty

Please note that comments are a random sample of those submitted in exception reports during this quarter. All reports will have been discussed with educational supervisors with a resolution (although this is not always recorded). The trainee is encourage to report again in the situation has not resolved.

General Surgery (Upper & Lower GI surgery, vascular excluding Transplant surgery)

- F1 General surgery – 18 reports.
- F2 Urology – 2 reports
- F1 ENT – 5 reports

Comments included;

- *"Reduced staff on the ward"*
- *"Only prescriber on ward, significant prescribing burden, including weekend prescriptions that had not been done"*
- *"2 hours over time due to ongoing demands on the ward"*
- *"Awaiting implementation of new hours and revised contracted hours"*

General Medicine (Acute Medicine, Cardiology, Senior Health, Gastroenterology, Respiratory Medicine).

- F1 General medicine and AMU – 30 reports, including missed teaching and missed breaks
- F2 General Medicine and AMU – 3 reports
- ST4 – 8 reports
- FY2 Nephrology – 2 reports
- FY1 Respiratory – 5 reports
- CT2 Respiratory – 8 reports
- F1 ENT – 6 reports
- CT2 Hematology – 1 report

Comments included;

- *"Throughout this week I came in early and left late to prep the list which we had been told my registrars had to be a specific way. Unfortunately the list had not been updated accurately the previous week and so a lot of changes needed to be made. There was also lots of outliers who although looked after my locum, we attempted to help where we could to ensure everyone left at an appropriate time. Getting in 45 minutes early enables me to prep the list for changes that were made overnight especially key when new patients were admitted into the ward. Without adding their issues, PMH and investigations so far to the list would have meant there were no information for the ward round leading to prolonged round and a less clear plan for the day. Furthermore, one of our SHOs is non clinical at the moment and the other is often away for half a day due to her clinics making sharing jobs more difficult. The registrars were aware of the issues this week. They had specifically told us a layout for the list and understood why we were staying late. Of the juniors all stayed late each day with some also coming in early to prep the list appropriately."*

- *"Got in early to prep the list as Monday mornings are notorious for there being large changes in the list to need to make for the weekend. Had to update the list and out on all the details of a new patient that arrived overnight. Day was busy with 2f1s on the ward and a CT covering both. All regs were in clinic .in the late evening had 3 very unwell patients, one with new onset vomiting and raised potassium, another who the team were worried could deteriorate*

overnight and another with an hb of 60. Unfortunately the h@n team were also incredibly busy and so the whole team stayed back to get the patients the suitable care they needed."

- *"I arrived early to prep the list as over the weekend often patients change and this can lead to a disrupted ward round and less time to do jobs in the day. Throughout the day there was 1 less trainee available as 2 were allocated to outliers. Getting jobs finished, the list prepped and patients who were unwell to a level which was safe took longer than expected. Hospital at night team took over some jobs but expressed they were very busy. I worked an extra 3h 15m."*

- *"The registrars were still in when we left. They were sympathetic to us staying later everyone in the team is stating late at the moment an Working as hard as they can"*

- *"The registrar performing marrows on Tuesday morning also can never attend the Tuesday lunchtime teaching session at this starts at 12.30. Steps taken to resolve matters - Handed - over wherever possible."*

Paediatrics

- ST1 – 8 reports
- SpR – 1 report

Comments

- *"Handover post-nights overran due to volume of patients/workload. Unable to take breaks during shift and missed teaching due to clinical workload."*

- *"Unable to attend teaching due to being switched to surgical shift where ward round occurs during scheduled teaching."*

- *"Covering both surgical and neurosurgical SHO roles with no other support due to planned sickness. Unable to complete tasks in time allocated. Asked for help from other paediatric doctors with smaller workloads. Consultants aware of issue."*

- *"Staffing shortage (1 SHO, no F1, and no SpR) identified at beginning of the day, consultant kindly helped all day but also left similar time with work taken home."*

- *"Stayed 30 mins late for handover - started at 2030 when night team arrived (on time) almost always takes an hour to handover (also had to wait for oncology and ED to handover, as usually happens) Also had no break that day."*

Appendix B - Current Trainee Vacancies

This is currently in process in response to the changes for Covid-19.

Appendix C - Terms and Conditions update 2019, including breaches incurring a financial penalty

14. The guardian of safe working hours will review all exception reports copied to them by doctors to identify whether a breach has occurred which incurs a financial penalty, as set out in paragraphs 15-16 below.

15. Where such concerns are shown to be correct in relation to:

a. A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or

b. A breach of the maximum 13 hour shift length; or

c. A breach of maximum of 72 hours worked across any consecutive 168 hour period

d. where 11 hours rest in a 24 hour period has not been achieved (excluding on-call shifts); or

e. where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or

f. where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved

The doctor will be paid for the additional hours at the penalty rates set out in Annex A, and the guardian of safe working hours will levy a fine on the department employing the doctor for those additional hours worked, at the rates set out in Annex A.

16. Where a concern is raised that breaks have been missed on at least 25% of occasions across a four week reference period, and the concern is validated and shown to be correct, the guardian of safe working hours will levy a fine at the rate of twice the relevant hourly rate for the time in which the break was not taken.

17. Additionally, to ensure that no further breaches occur, a work schedule review may be required

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Meeting Title:	**Trust Board**		
Date:	28 May 2020	**Agenda No**	**5.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 21st May 2020.		
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		

5.1

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Finance and Investment Committee – May 2020

The Committee met on 21 May. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on the 2020/21 Financial Plan, the Renal Dialysis Tender and an update to the Committee Terms of Reference.

Committee members discussed the BAF risks on finance and ICT in respect of the COVID-19 virus, although noting no change in overall risk scoring at present. The Committee noted performance in Activity, Diagnostics, Cancer, RTT and Emergency Flow which have been affected to varying degrees by the pandemic. The Committee discussed current financial performance, cash management and capital expenditure, as the Trust reports the first month of the new financial year. Implications for the annual plan in 2020/21 were also discussed, in view of what was experienced in month 1. **The Committee wishes to bring the following items to the Board's attention:**

5.1

1.1 Finance & ICT Risks – the Acting Chief Financial Officer (ACFO) and the Chief Information Officer (CIO) gave updates on their respective BAF risks. They noted no change in risk scoring. Discussions on financial risk continue to focus on the underlying financial position, which remains a paused risk while the trust is under the temporary funding arrangements of COVID-19. ICT discussions focussed on the strain on the network from, in particular, the use of audio-visual technology, for example in outpatient settings.

1.2 Estates Report – the Deputy Director of Estates & Facilities (DDE&F) introduced the paper on Estates. The Committee discussed staff morale in the Mitie team, the latest on the Procure-22 (P22) contract and the impact of staff from changes to parking rules that may be put in place in June.

1.3 Activity Update – the Chief Operations Officer (COO) updated the committee on the Trust's performance against activity targets for first month fully affected by the COVID-19 pandemic (April). She noted that against plan or previous year, volumes of elective and daycase activity is lower by c80% and outpatients by c50%, following guidance released from the government to cancel non-essential patient care. She observed that virtual outpatient appointments are more prevalent and that chemotherapy appointments continue to be provided, relocated to the Day Surgery Unit.

1.4 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in February of 79.3% was below the incomplete target trajectory of 88.1%, and the number of 52 week waits of 32 was more than the trajectory of 0. The size of the waiting list (including QMH patients) was 47,048 patients. The COO noted performance in April, where 129 52-week waits had been observed (11 owing to patient choice from COVID, 113 through a consultant decision related to COVID, and 5 for non-COVID related reasons). She also noted the reduction in referrals from primary care which is evidenced by the waiting list not growing, although the backlog of patients (those waiting over 18 weeks) has grown by 3,506 since February.

1.5 Cancer Performance – the COO noted that the Trust met 2 of the 7 Cancer performance targets in March, noting challenges in patient choice and capacity in Diagnostics from previous months that continue to have an impact. She also noted good work done to get Cancer Surgery started at St Anthony's Hospital.

1.6 Diagnostics Performance – the COO noted the continued pause in all non-urgent diagnostics owing to COVID-19. Diagnostics performance was therefore challenged in April, with 63.6% of patients having a Diagnostic wait of over 6 weeks compared with a target of 1%, and a longest wait of 17 weeks.

1.7 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 88.3% in April, following a reduction in A&E attendances to below 200 per calendar day owing to COVID-19. The COO noted that year to date performance was now 92.29%, and that in the last 3 weeks the Trust was the top performing in London, and 11th of 123 in the country.

She also observed that performance did not include the (currently closed) QMH minor injuries unit, so only type 1 activity was counted, which made performance more impressive.

1.8 Financial Performance – the ACFO noted performance in month 1 of breakeven, following a £3.7m top-up accrual to offset the deficit position as per central guidance. He noted that £3.3m of COVID costs had been incurred, with a £3.4m shortfall in block income and £3.0m of underspends due to significantly reduced 'business as usual' activity owing to COVID. He also noted that the cash balance at the end of April was £50.3m against a plan of £3.0m owing to receipts of both the April and May block values, and that capital expenditure was over the £55.0m plan by £1.6m owing to COVID costs as yet unconfirmed by NHSI/E. The committee discussed the provision of expenditure required to 'catch-up' on activity not undertaken owing to COVID.

1.9 2020/21 Planning Update (COVID-19) – the ACFO introduced the Committee to the paper providing an update on the financial plan for 2020/21, where a gap of £42.7m in terms of income shortfall has been observed. A review of financial reporting will be required in quarter 1 as COVID cost, 'business as usual' underspend and block income shortfalls affect the financial performance of the Trust. He also noted that the Trust's capital plan was at risk based on current estimates of the shortfall of STP CDEL compared to South West London plans. The Committee discussed the implications of these shortfalls on the Trust's revenue and capital plans.

1.10 Renal Dialysis Tender – the Associate Director of Procurement (ADP) introduced a document outlining the outcome of the Satellite Renal Dialysis Services Tender, following work undertaken jointly by the Trust and Epsom & St Helier University Hospitals NHS Trust. The Committee discussed the risks associated with moving to a new provider and the experiences from the recent re-tendering of the Trust's catering and cleaning contract which could provide lessons to learn. **The Committee agreed to recommend the outcome of the paper to the Trust Board, subject to receiving positive feedback from clinicians involved as well as reviewing the recent re-tendering of the catering and cleaning contract for any lessons to learn.**

2.0 Recommendation

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

Ann Beasley
Finance & Investment Committee Chair,
May 2020

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Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

5.1

Finance and Investment Committee – 2019/20

The Committee met on a monthly basis in 2019/20. This included 11 months of 'FIC Estates' meetings which were set up on a monthly basis to provide more comprehensive assurance on Estates risks in the Trust. Items of discussion were the standing items on Estates, ICT and financial strategic risk, operational performance and financial performance, as well as other items including the New Financial Plan for 2020/21, Costing and PLICS, Procurement and SWLP updates, Policies, Strategies and Technical Updates and the various tendering and business case decisions requiring the committee's recommendation.

Meetings were constructive and included rigorous challenge from committee members. All attendees participated in a mature discussion of issues, based on reliable data. A number of reflections at the end of each meeting were focussed on the high quality of papers produced, healthy level of non-executive challenge and openness of executives in describing the challenges that remain in delivering the relevant KPIs.

As the financial year closed, discussions focussed on the COVID-19 pandemic, where staff have responded exceptionally in the most challenging of circumstances. The operational and financial implications are being worked through to give the committee a good understanding of the impact, and will continue to be monitored as the nation moves out of the peak period, and the Trust is able to focus attention on elective activity.

The Committee brought the following items to the Board's attention during the year:

1.1 Finance Risks- the Committee was regularly updated on the changing nature of financial risk during the year. The Trust's major challenges remained the delivery of CIP and a balanced budget, which was the focus of much discussion. The latter risk was categorised as a '25' in most recent analysis, although these risk assessments have now been 'paused' while COVID-19 has impacted on the Trust's financial performance.

1.2 Estates Risks- the Committee received Estates risk updates during the year through the FIC Estates meeting. Discussions focussed on the key areas of risk such as Water Safety, Fire Safety, Ventilation and Health & Safety and the level of understanding provided to the committee gave members assurance that matters were being addressed effectively and in a timely way by the time the committee had met for the final time in March 2020. The department was commended by the newly unified committee in April for their excellent response to COVID-19.

1.3 ICT Risks- ICT risk updates were received which detailed the actions being undertaken to address risks, the most severe of which relate to having a single data centre and the current ICT disaster recovery plan. The IClip roll-out at QMH has addressed a number of patient record risks that existed at the start of the year, and attention has now focussed on the impact of COVID-19 on ICT risk.

1.4 Activity- the Committee was updated on the performance against activity targets throughout the year. It was noted that Outpatient activity underperformed throughout the year whereas Non-Elective activity overperformed. Financially, these variances were mitigated by the setting of a block contract for the majority of the commissioners associated with these two points of care delivery.

1.5 Emergency Department (ED) update – the Committee has seen challenge in ED performance in 2019/20 where the various contributory factors have been reviewed and actions taken. The department begins the new financial year with lower attendances and

occupancy. COVID-19 has had a significant impact on performance from the middle of March to the middle of April but has now started to stabilise and improve. The COO has now recommenced the Emergency Care Delivery Board.

1.6 Referral to Treatment (RTT) - the Trust has reported RTT for the whole of 2019/20 following a gap of non-reporting from May 2016 to January 2019 and began reporting QMH data following iClip implementation at that site in September 2019. The three metrics of 52-week waits, waiting list size and incomplete waiting list % were all prioritised by the committee during the year, and trajectories set in the latter part of the year were not met (and only partially owing to the COVID-19 pandemic). Delivery on these metrics will be a challenge to the Trust even as restrictions on elective activity are lifted in the coming months.

1.7 Cancer Performance- in recent months Cancer performance has been challenged in the two-week and 62 day metrics for a number of reasons. Actions have been agreed to address these. The Trust has met 3 of the 7 cancer targets in February 2020 which was expected owing to capacity challenges over Christmas and the New Year.

1.8 Diagnostics- the 1% Diagnostic target has seen challenges in the second half of 2019/20, mainly owing to capacity issues in the Echocardiography area. An action plan was in place to resolve this by May 2020, however further challenge owing to the commencement of COVID-19 has led to all non-urgent diagnostic testing being paused.

1.9 Agency Performance- the agency expenditure value was £18.5m at year end, higher than the Trust's internal cap of £15.0m and under the external (NHS Improvement) target of £20.6m.

1.10 Financial Performance & Forecast- performance in 2019/20 to be reported in the draft accounts was a pre-PSF/FRF/MRET deficit of £48.0m, which was in line with the best case forecast first reported to the committee in October 2019. The Committee was very disappointed that the Trust did not achieve the control total of a £37.7m pre-PSF/FRF/MRET deficit that was agreed at the start of the year.

1.11 Costing Updates- these were received quarterly to the committee and the most recent update in January 2020 noted the improvement of the reference cost index to 1.01 in 2018/19 (i.e. the Trust's cost base was 1% above average) from a high of 1.06 in 2016/17.

1.12 Annual Planning Updates – the annual plan was produced for final review at the Committee in March and April, following the developing situation with COVID-19. The Trust is expected to have a plan to breakeven, although a gap remains at present which is being explored with the regional NHSI/E team. A subgroup of the committee approved this updated plan on behalf of the Trust Board ahead of April 1st. As guidance continues to be provided, the Committee will receive further updates.

1.13 Business cases and tendering decisions – a number of business case and tendering decisions were brought to the committee in 2019/20, to approve or recommend to the Trust Board. These included SWL Procurement, the MRI business case, SWL PACS Procurement and the Cath Labs Full Business Case.

1.14 Technical & Policy updates – the committee remains up to date on all policies following approvals in February 2020. Technical updates are given on a 6-monthly basis.

1.15 SWLP Report – the committee receives a quarterly update on the financial performance of South West London Pathology. At Q3, SWLP was expected to deliver its financial plan in 2019/20.

1.16 Procurement Report – the Committee has received welcome updates on the procurement team in 2019/20. The main highlight was the agreed business case for SWL Procurement, which will start in 2020/21.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee in 2019/20 for information and assurance.

Ann Beasley
Finance & Investment Committee Chair,
April 2020

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5.1

Meeting Title:	**Trust Board**		
Date:	28 May 2020	**Agenda No**	5.1.1b
Report Title:	**Finance and Investment Committee Terms of Reference Review**		
Lead:	Tom Shearer, Acting Chief Finance Officer Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approve		
Executive Summary:	In line with good governance practice, Board Committees should review their terms of reference on an annual basis. The Board agreed the current Terms of Reference for the Finance and Investment Committee in October 2018. A review of the Committee's Terms of Reference has been undertaken and minor amendments are proposed: • Changes to the format to incorporate them into the new template for Committee Terms of Reference; • Replace References to the Single Oversight Framework with the new NHS Oversight Framework; • Draw out explicitly the role of the Committee in relation to reviewing operational performance; • Set out the role of the Committee in relation to estates and information technology, particularly following the reintegration of estates issues within the core FIC work plan; • Removing the requirement for Divisional Directors of Operations to attend the Committee as routine; • Removing the requirement for the Trust's NHSI Financial Improvement Director to attend the Committee. The proposed revisions to the Terms of Reference are at Appendix 1. Substantive amendments which rework or add new elements to the ToR are set out in green text. Substantive areas for removal are marked in red text.		
Recommendation:	The Committee is asked to review and approve the proposed updates to the Committee's Terms of Reference.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-led		
NHS Oversight Framework Theme:	Finance and Use of Resources 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		

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	in either poor decisions or a delay in decision-making.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Finance & Investment Committee	**Date**	21/05/2020
Appendices:	Appendix 1: Proposed revisions to the Committee's Terms of Reference		

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5.1

Finance and Investment Committee Terms of Reference

Approved by the Trust Board TBC

Approval and review dates

Profile	
Document name	Finance and Investment Committee Terms of Reference
Version	1.2
Executive Sponsor	Chief Finance Officer
Author	Chief Corporate Affairs Officer
Approval	
Approval group	Trust Board of Directors
Date of approval	TBC
Date for next review	April 2021

Finance and Investment Committee Terms of Reference

1. Name of Group

The Finance and Investment Committee.

2. Authority

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

Powers: The Finance and Investment Committee is authorised by the Board of Directors to:

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

Cessation: This is a standing Committee of the Board which may only be disbanded or its remit amended on the authority of the Board.

3. Purpose of the Group

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

i. detailed consideration is given to the Trust's financial, investment and associated performance issues to ensure that the Trust uses public funds wisely; and
ii. by ensuring that adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies and achievement of the Trust's strategic aims and objectives;
iii. detailed consideration is given to operational performance, and the impact of this on the Trust's financial position;
iv. effective oversight of assurance in relation to key risks relating to the Trust's estates and information technology infrastructure;
v. effective oversight of the implementation of the information technology and estates strategies.

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

4. Duties of the Group

The Finance and Investment Committee will discharge the following duties on behalf of the Board of Directors:

(a) Finance and Business Planning:

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

(b) Financial Strategy and Management:

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

(c) Contract Management:

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

(d) Procurement:

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

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

On behalf of the Board:

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

(f) Capex:

i. Consider any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.

ii. Review the Medical Equipment Strategy and assurances around the Medical Equipment Replacement programme.
iii. Consider any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy and recommend to the Board.
iv. Review the Trust's arrangements for facilities management.

(g) Operational performance:

i. Undertake detailed consideration of and seek assurance in relation to the operational performance of the Trust, in particular in relation to the operational standards set out in the NHS Constitution

(h) Transformation and Cost Improvement:

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

(i) Strategy and Risk:

i. Monitor the implementation of the Trust's Information Technology and Estates strategies
ii. On behalf of the Board, the Committee shall regularly scrutinise the Trust's significant risks in relation to finance, estates and information technology satisfying itself of the adequacy of the controls in place to mitigate the risks. This will include seeking assurance in relation to the safe operation of the Trust's estate and the robustness of estates governance.

(j) General Governance:

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

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. Chairperson

A Non-Executive Director will chair the Finance and Investment Commitee and his/her absence, another Non-Executive member of the Committee to be nominated by the remaining Committee members will take the chair.

The Chief Financial Officer is the Executive Lead for the Finance and Investment Committee.

6. Composition of the Group

Membership: The membership of the Committee shall comprise three Non-Executive Directors, the Associate Non-Executive Director, the Executive leads and the Chief Operating Officer.

The current membership of the Committee is:

Name	Title	Role in the group
Ann Beasley	Non-Executive Director	Committee Chair
Elizabeth Bishop	Non-Executive Director	Member
Stephen Collier	Non-Executive Director	Member
Andrew Grimshaw	Chief Finance Officer & Deputy Chief Executive	Member
Robert Bleasdale	Chief Nurse and Director of infection Prevention and Control	Member
Richard Jennings	Chief Medical Officer	Member

Members are expected to make every effort to attend all meetings and a register of attendance shall be maintained.

7. Attendance

The following are regular attendees at the Committee:

- Deputy Chief Finance Officer
- Director of Financial Planning
- Director of Estates and Facilities
- Chief Information Officer
- Chief Corporate Affairs Officer
- Chief People Officer
- Chief Strategy Officer
- Chief Operating Officer
- Chief Transformation Officer
- Head of Financial Reporting

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

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

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

At the discretion of the Committee Chair, the Committee may also request other members of the Executive team and other relevant members of staff to attend meetings of the Committee or to attend for specific agenda items.

Governors shall be invited to attend the meeting as observers (up to three).

8. Quoracy

The quorum for the Committee shall be the attendance of a minimum of three members, including at least one Executive and two Non-Executive members. Regular or other attendees do 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.

9. Declaration of Interests

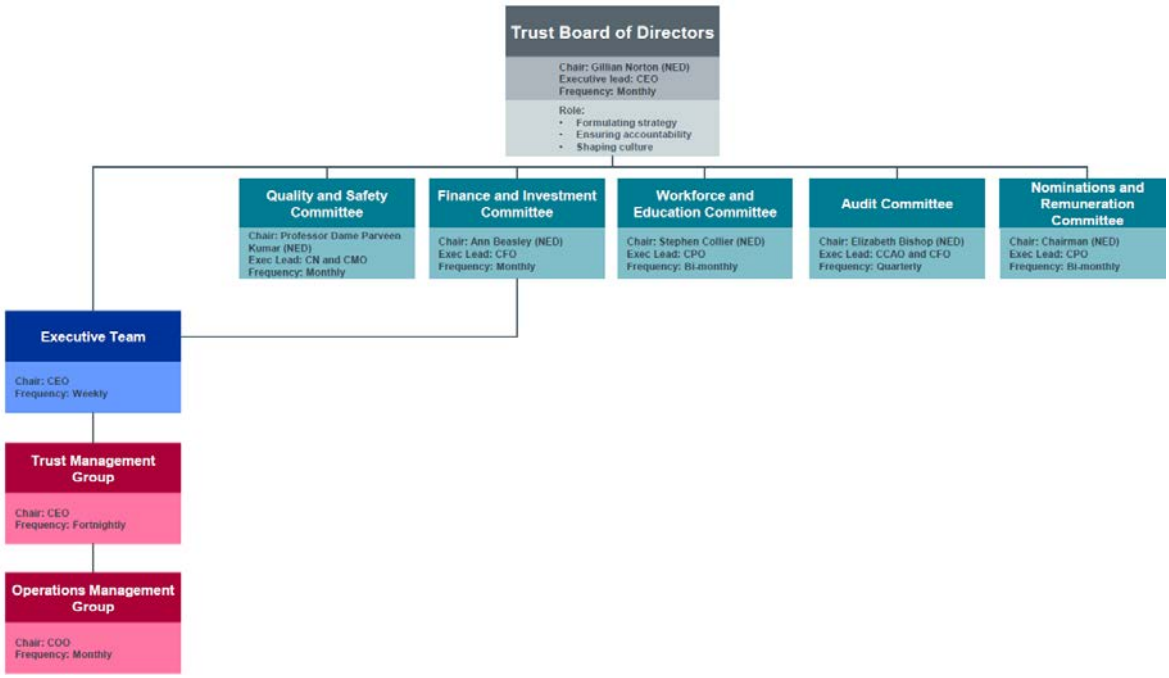
All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

10. Meeting Frequency

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

11. Relationship with other groups and committees

The Committee will report to the Trust Board.



12. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Finance and Investment Committee shall be established prior to the start of each financial year;
ii. The Chief Finance Officer will oversee the provision of secretariat support for the Committee. 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.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Lead.
iv. All papers and reports to be presented at the Committee must be submitted as final Executive approved reports on the Friday before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days ahead of the meeting.

13. Report to the 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.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

14. Annual cycle of business

An Annual cycle of items and reports to be received by the Committee will be agreed by the Committee. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

15. Review of Committee Effectiveness and Terms of Reference

The Committee will conduct a review of its effectiveness each year, the results of which will be reported to the Board.

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Board.

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5.2

Meeting Title:	**TRUST BOARD**		
Date:	**28th May 2020**	**Agenda No.**	**5.2**
Report Title:	**M1 Finance Report 2020/21**		
Lead Director/ Manager:	Tom Shearer		
Report Author:	Michael Armour		
Presented for:	Update		
Executive Summary:	The Trust has been requested to report a breakeven financial position at M1 by NHSE. This has been achieved through an income "top up" accrual to offset any deficit position, as per central guidance. The reported position at M1 includes £3.3m of COVID costs and £3.7m of Income Top Up. The underlying position, therefore, is a £0.4m deficit. This is made up of £3.4m shortfall in block income vs Trust budgeted costs, as set out in the Trusts interim plan for 20/21, offset by £3m of underspends due to significantly reduced BAU activity due to COVID.		
Recommendation:	The Trust Board notes the Trust's financial performance in M1.		
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:	Finance & Investment Committee	Date	21/05/2020
Appendices:	N/A		

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Financial Report Month 01 (April 2020)

5.2

Trust Board

Chief Finance Officer

28th May 2020

Executive Summary

Month 01 Financial Position

- The Trust has been requested to report a breakeven financial position at M1 by NHSE. This has been achieved through an income "top up" accrual to offset the deficit position, as per central guidance.
- The reported position at M1 includes £3.3m of COVID costs and £3.7m of Income Top Up. The underlying position, therefore, is a £0.4m deficit.
- This £0.4m deficit is made up of £3.4m shortfall in block income vs Trust budgeted costs, as set out in the Trusts interim plan for 20/21, offset by £3m of underspends due to significantly reduced BAU activity due to COVID.
- The Trust has spent £6m of capital in month 1, including £1.6m associated with COVID 19. The £1.6m COVID costs are current reported as an overspend. The £4.4m remaining capital spend is in line with the £55m capital plan (including £5m leases), of which £20m is internally funding. A material funding risk remains of the £30m capital requiring emergency loans.
- The Trusts cash balance at M1 was £50.5m. This is significantly higher than the £3m usually held by the Trust due to two months block payment being received in M1. The Trust is actively trying to ensure suppliers are paid in good time at the current time.

Month 01 Financial Performance

Month 1 financial position

- The table below shows the reported financial position of breakeven, in line with plan.
- It also pulls out 2 exception items; COVID costs of £3.3m, and an income 'Top Up' accrual of £3.7m.
- The final 2 columns shows the Trusts financial position, excluding these 2 exceptional items.

		Including COVID					Excluding COVID and Income Top Up	
		Full Year Budget (£m)	M1 Budget (£m)	M1 Actual (£m)	M1 Variance (£m)	COVID Cost (£m)	Income Top Up Accrual (£m)	M1 Actual (£m)	M1 Variance (£m)
Income	SLA Income	785.5	65.5	65.7	0.2	0.0	3.7	62.1	(3.5)
	Other Income	164.9	13.7	13.1	(0.7)	0.0	0.0	13.1	(0.7)
Income Total		**950.3**	**79.2**	**78.8**	**(0.4)**	**0.0**	**3.7**	**75.1**	**(4.1)**
Expenditure	Pay	(581.0)	(48.4)	(49.0)	(0.6)	(2.2)	0.0	(46.8)	1.7
	Non Pay	(330.2)	(27.6)	(26.5)	1.0	(1.0)	0.0	(25.5)	2.1
Expenditure Total		**(911.2)**	**(76.0)**	**(75.5)**	**0.4**	**(3.3)**	**0.0**	**(72.3)**	**3.7**
Post Ebitda		(39.1)	(3.3)	(3.3)	0.0	0.0	0.0	(3.3)	0.0
Grand Total		**(0.0)**	**0.0**	**0.0**	**0.0**	**(3.3)**	**3.7**	**(0.4)**	**(0.4)**

- Guidance from NHSE&I states that the Trust should report a breakeven position in April, which is achieved by an income top up accrual to balance the position.
- The financial impact of COVID on the Trust from additional expenditure is £3.3m.
- The income top up value in April is £3.7m, which brings the position to breakeven
- Excluding COVID costs, and excluding the income top-up accrual, the Trusts position would be £0.4m adverse to plan. This is due to the expected income 'Top Up' of £3.4m being offset by £3m of underspends due to not undertaking BAU activity due to COVID.

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Balance Sheet as at April-20

Balance Sheet	Mar-20 (£m)	M01 April-20 FY20-21 YTD Actual (£m)	Increase /Decrease from March-20
Fixed assets	**426.9**	**430.7**	**3.8**
Stock	**11.9**	11.9	0.0
Debtors	**93.7**	66.4	(27.3)
Cash	**3.5**	50.5	47.0
			0.0
Creditors	**(94.0)**	(124.6)	(30.6)
PDC div creditor	**0.0**	0.0	0.0
Int payable creditor	**(0.1)**	(1.5)	(1.4)
			0.0
Provisions< 1 year	**(0.3)**	(0.3)	0.0
Borrowings< 1 year	**(322.5)**	(321.7)	0.8
Net current assets/-liabilities	**(330.3)**	**(334.5)**	**(4.2)**
Provisions> 1 year	**(2.5)**	(2.5)	0.0
Borrowings> 1 year	**(69.9)**	(69.8)	0.1
Long-term liabilities	**(72.4)**	(72.3)	0.1
Net assets	**24.2**	**23.9**	**(0.3)**
Taxpayer's equity			
Public Dividend Capital	**135.7**	135.7	0.0
Retained Earnings	**(226.5)**	(226.8)	(0.3)
Revaluation Reserve	**113.8**	113.8	0.0
Other reserves	**1.2**	1.2	0.0
Total taxpayer's equity	**24.2**	**23.9**	**(0.3)**

M01 FY20-21 YTD Balance Sheet

- Fixed assets increased by £3.8m since March-20 this includes depreciation and capital accruals.
- There is no movement in stock compared to Mar-20.
- Debtors has reduced by £27.3m since March 2020. Target reduction of £18m by year end is being actively pursued.
- The cash position is £47m higher than March-20. This is due to receipt on Month 2 contract payment received in April-20. Cash resources are usually tightly managed at the month end to meet the required £3.0m minimum cash target.
- Creditors increased by £30.6m from March-20, due to increase in accruals and deferred income as a result of funding received in advance.
- DH intends to convert some of the capital and revenue support loan to PDC by the end of financial year.

5.2

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YTD Analysis of Cash Movement

	M01 YTD FY 20-21 Actual £m
Opening Cash balance	**3.4**
Income and expenditure deficit	(0.3)
Depreciation	2.3
Interest payable	1.1
PDC dividend	0.0
Other non-cash items	0.0
Operating surplus/(deficit)	**3.1**
Change in stock	0.0
Change in debtors	34.2
Change in creditors	26.8
Change in provisions	0.1
Net change in working capital	**61.1**
Capital spend (excl leases)	(16.6)
Interest paid	(1.0)
PDC dividend paid/refund	0.0
Interest Received	0.0
Investing activities	**(17.6)**
PDC Capital	0.0
WCF Loan received	0.0
WCF Loan repaid	0.0
Capital Loan received	0.0
Capital Loan repaid	0.0
Other Loans/ PFI /finance lease repay	0.5
Financing activities	**0.5**
Cash balance 30.04.2020	**50.5**

M01 FY20-21 YTD cash movement

The cumulative M01 20-21 I&E deficit is £0.3m. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).

Within the I&E deficit of £0.3m, depreciation (£2.3m) does not impact cash. The charges for interest payable (£1.1m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of £3.1m.

Working capital is increased by £61.1m. There is no change in stock level.

April-20 cash position

The Trust achieved a cash balance of £50.5m on 30th April 2020, £47.5m higher than the £3m minimum cash balance required by NHSI. This is due to the receipt of Month 2 funding in April 2020.

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M1 Capital

COVID return for April 2020

- The table below shows capital spend in month of £6m. This includes £1.6m of costs associated with COVID 19. This COVID capital spend currently stands as an overspend, although bids for funding have been submitted to NHSI/E.

- The capital plan is currently being worked through in detail as part of the South West London prioritisation work, before this is finalised, as SWL capital plans stand materially higher than the centrally allocated CDEL.

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	**Internal Budget £000**	M01	**M01 YTD budget £000**	M01 YTD exp £000	*M01 YTD var £000*
Infrastructure renewal	**15,540**	742	**742**	742	*0*
P22	**6,300**	47	**47**	47	*0*
Major projects	**21,000**	811	**811**	811	*0*
IT	**1,500**	2,389	**1,736**	2,389	*-653*
Medical equipment	**5,160**	2,061	**1,119**	2,061	*-942*
SWLP	**500**	-	**-**	0	*0*
Leases	**5,000**	-	**-**	0	*0*
Total	**55,000**	6,050	**4,455**	6,050	*-1,595*

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 May 2020	**Agenda No**	**6.1**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Elizabeth Bishop, Chair of the Audit Committee		
Report Author:	Elizabeth Bishop, Chair of the Audit Committee		
Presented for:	Assurance/Approval		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 07 May 2020.		
Recommendation:	**The Board is asked to:** • **Note the update in the report; and** • **Receive the Annual Committee Report;** • **Approve the proposed changes to Committee's Terms of Reference; and** • **Endorse the Committee's 2020/21 Work plan**		
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		

6.1

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St George's University Hospitals NHS Foundation Trust

Audit Committee Report – May 2020

Matters for the Board's attention

The Audit Committee met on 07 May 2020 and agreed to bring the following matters to the Board's attention:

1. Annual Reporting and External Audit Reports

1.1. External Audit Report

The Committee received the External Auditors' progress report. The Committee noted that the Covid-19 pandemic had impacted on the audit process and NHS Improvement/England (NHSI/E) delayed the deadline for submission of the annual report and accounts from May 2020 to 25 June 2020 and trusts were no longer required to submit a quality report but could do so voluntarily. The Trust will be preparing a quality report.

In addition the Covid-19 would be treated as a material risk for all NHS trusts, the accounts may include a caveat around asset valuation as a result of the current uncertainties on the market and NHSI/E have asked all NHS trusts with a cumulative deficit to continue to make the disclosure as part of its going concern statements. In addition external auditors expected that the Trust's value for money assessment may be positively impacted by the Trust's overall performance during the financial year and the NHSI/E conversion of the all NHS trusts debt to public dividend capital.

1.2. Annual Report, Financial Accounts and Quality Accounts Plan and Annual Policies 2019/20

The Committee also considered and endorsed the internal reports which outlined the plan and timetable for completing the annual report, financial accounts and the quality accounts/report. The Committee were pleased to see the progress made on producing the early drafts of the documents and offered some drafting comments ahead of the final consideration and approval in June 2020. The Committee considered and were comfortable with the accounting judgements in the draft financial accounts and that the year-end statements were in line with reports presented to the Board each month with no surprises.

Whilst the Committee endorsed the Trust's decision to voluntarily produce the quality report given the advanced state of the draft, it raised concerns that the document would not receive external scrutiny by external auditors and the Committee asked the Quality and Safety Committee to consider the implications of not having external assurance and report to the Board. It should be noted that the external auditors have indicated it would not be possible to complete the external audit of the quality report by the June 2020 submission date.

2. Internal Audit Report

The Committee considered the following reports from the Internal Auditor:

- Draft Annual Head of Internal Auditors Report
- Internal Audit Review Progress Report and Recommendation Tracker
- Draft Internal Audit Plan 2020-21 and 2020-30 Audit Strategy
- Final Internal Audit Report:
  - Use of NHS Staff Survey (Reasonable Assurance)
  - Key Financial Controls (Substantial Assurance)
  - Declaration of Interest (Substantial Assurance)

The Committee welcomed the good progress made on the internal audit plan for 2019-20 and noted that only one internal audit review was deferred as a result of Covid-19. The draft Head of Internal Audit Opinion concluded that the Trust had **reasonable and effective risk management, control and governance processes in place**. The reasonable assurance rating was underpinned by the fact that of the 19 internal audit reviews completed in 2019/20, 10 were rated *reasonable assurance*, five *limited assurance* and four *substantial assurance*. Unlike in previous years none of the internal audit reviews received a *no assurance* rating. The Committee was very pleased to note the reasonable assurance ratings for the aforementioned internal reviews in particular that the key financial controls review had received better than reasonable assurance two years in a row.

The Committee asked the Workforce and Education Committee to also review the use of the NHS Staff Survey audit report.

The Committee were cognisant of the impact of Covid-19 on the internal audit programme 2020/21 and agreed to consider internal audit priorities at its next meeting.

3. Internal Compliance and Assurance

3.1. Revised Scheme of Delegation and Standing Financial Instructions

In line with the previous action from the Board, the Committee endorsed and approved the proposed changes to the Scheme of Delegation and Standing Financial Instructions to reflect recommendations from the estates review.

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

3.2. Counter Fraud Report

The Committee considered the annual Counter Fraud report, annual self-assessment for 2019/20 and the proposed work programme for 2020/21. Based on the counter fraud work conducted during the year the Committee endorsed the Trust's '*amber*' self-assessment rating against the standards for Providers: Fraud, Bribery and Corruption issued annually by the NHS Counter Fraud Authority (NHSCFA). The rating reflects the additional work the Trust needed to around processes and proactive prevention work and the Committee noted the 2020/21 work programme had been enhanced to ensure that the Trust could meet the highest standards. The Committee also note that Audit First would be supporting the Trust to develop and deliver its counter fraud work.

3.3. Aged Debts & Losses & Compensation Payments

The Committee noted that there had been a slight increase in the bad debt provision and that as a result of Covid-19 the Trust had not been able to complete the work to recoup outstanding debts in quarter four. The Committee where however pleased with the demonstrable impact of the additional controls and measures in place which had resulted in proactive debt management and improved losses and compensation processes.

3.4. Committee Annual Report, Revised Terms of Reference and Forward Plan

The Committee considered its draft annual report attached in Appendix 1 for the Board's endorsement. The Committee also reviewed its Terms of Reference and propose the Board adopts the revised version which includes largely minor changes to update outdated aspects and the following key changes:

- A reference to the role of the Committee in supporting the Trust in delivering its strategy.

- Explicitly drawing out the role of the Committee in relation to the Board Assurance Framework.
- A reference to the Committee living the Trust values.
- Clarification of how the Chairmanship of the Committee should be decided in the absence of the Chair.
- Clarification about the regular attendees at the Committee.

The Board is also asked to endorse the Committee's work plan for 2020/21.

Recommendation

The Board is asked to:

- **Note the update in the report; and**
- **Receive the Annual Committee Report; and**
- **Approve the proposed changes to Committee's Terms of Reference; and**
- **Endorse the Committee's 2020/21 Work plan.**

Elizabeth Bishop
Audit Committee Chair, NED
May 2020

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NHS
St George's University Hospitals
NHS Foundation Trust

6.1

ANNUAL BOARD COMMITTEE REPORT

AUDIT COMMITTEE

1 April 2019 – 31 March 2020

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Audit Committee: 2019/2020 Annual Report

1 Introduction

The Audit Committee has been established to ensure that that the Trust has effective mechanisms and systems of internal control. The Committee provides the Board of Directors with an independent review of the Trust's financial, corporate governance and risk management processes. It utilises, oversees and draws on the work of independent internal and external auditors to provide assurance that these systems are sound and being adhered across all areas of the Trust.

This report sets out the work of the Committee during the reporting period 1 April 2019 to 31 March 2020. The Committee submits a report to the Board after each meeting setting out the key discussions of the Committee, areas of assurance and matters for escalation to the Board. The purpose of this annual report is to provide a wider perspective on the work of the Committee over the past year and in so doing provide assurance to the Board that the Committee has discharged its role in line with its approved terms of reference.

2 Committee purpose and duties

The Committee's purpose and duties are set out in its terms of reference as approved by the Board on 25 October 2018. These set out that the Committee should:

- Provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.
- Oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.
- Review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.
- Review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.
- Ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors.
- Review the findings of the external auditors and consider the implications and management's response to their work.
- Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.

- Review financial reporting through the year and the financial statements and annual report before submission to the Board.

- Ensure there are robust and adequate counter fraud mechanisms and systems in place and routinely review updates on investigations and the Trust compliance with counter fraud and anti-bribery regulations.

- Ensure that there are robust systems to manage freedom to speak up.

- Ensure that there are overall sound corporate governance controls in place.

In line with good governance practice, the Committee's terms of reference have been reviewed and a revised draft terms of reference is set out at Appendix 4.

3 Committee Membership and Meeting Attendance

3.1 Members and Attendees

During the reporting period (April 2019 – March 2020) the following individuals were members of, or regular attendees at, the Committee:

Members/ Attendees	Role		Period
Sarah Wilton*	Chair	Non-Executive Director	April 2019 – January 2020
Elizabeth Bishop**	Chair	Non-Executive Director	February – March 2020
Ann Beasley	Member	Non-Executive Director	April 2019 – March 2020
Tim Wright	Member	Non-Executive Director	April 2019 – March 2020
Sir Norman Williams	Member	Non-Executive Director	April – September 2019
Pui-Ling Li**	Member	Associate Non-Executive Director	January – March 2020
Stephen Jones	Attendee	Chief Corporate Affairs Officer	April 2019 – March 2020
Andrew Grimshaw	Attendee	Chief Financial Officer	April 2019 – March 2020
Tom Shearer	Attendee	Acting Chief Financial Officer	January – March 2020

*Past members of the Committee ** New members of the Committee

In 2019/20, the membership of the Audit Committee included the chairs of the Finance and Investment Committee and the Quality and Safety Committee. The internal and external auditors attended each meeting of the Committee.

3.2 Committee Meeting Attendance

In 2019/20, the quorum for each meeting of the Committee was two members. For the avoidance of doubt only non-executive directors were members of the Committee.

The Committee held a total of five formal meetings and one informal workshop in the reporting period and the attendance of members are recorded below. All meetings were quorate.

Members/ Attendees	Role	Period
*Sarah Wilton**	*Chair*	*5/5*
Tim Wright	Member	5/5
Ann Beasley	Member	5/5
*Sir Norman Williams**	*Member*	*2/3*
Pui-Ling Li**	Member	0/1
Elizabeth Bishop***	Chair	1/1

**No longer members of the Committee*
*** Became an Associate Non-Executive Director at the Trust on 13 January 2020*
**** Attended as an observer at the January Committee meeting prior to becoming a Non-Executive Director at the Trust on 1 February 2020.*

The attendance of regular attendees at the Committee across the 5 meetings held in the reporting period are recorded below. In line with the requirements that audit committees should only comprise non-executive directors as members, these individuals were not members of the Committee and did not form part of the quorum.

Members/ Attendees	Role	Period
Stephen Jones	Attendee	5/5
Andrew Grimshaw	Attendee	3/5
Tom Shearer	Attendee	2/2

Other executive directors and senior leaders including the Chief People Officer, Chief Nurse, Chief Information Officer, Counter Fraud Lead also attended meetings of the Committee during the year to present specific reports or provide updates on internal audit reviews.

4 Committee activity and focus

The Committee develops a forward programme of work (see Appendix 2) at the start of each financial year which is intended to ensure it fulfils its purpose and duties as set out in the Committee's agreed terms of reference. The matters discussed and considered at the Committee during the period (April 2019 – March 2020) are set out in Appendix 3 mapped across the key duties as recorded in the approved terms of reference.

Each meeting of the Committee had a full agenda and the Committee submitted reports to the Board following each meeting. The key areas of focus for the Committee in 2019/20 are outlined below. This draws on the matters set out within the monthly report to the Board during 2019/20.

4.1 External Audit

The Committee members periodically held private meetings with the external auditors, Grant Thornton LLP, ahead of its meetings and during these meetings there were no issues of material concern raised. During the period the Committee received regular progress updates at each meeting from the external auditors on the preparations for and completion of the external audit of the Trust year-end financial statements, the annual report and the quality accounts during the period. In line with its 2019/20 work plan, the Committee welcomed the benchmarking report of the Trust's Annual Report, which set out helpful indicators of how the Trust's report compared with those of other organisations and learning that could be incorporated into the following year's report. The Committee reviewed the plans for

conducting the 2019/20 audit and agree to recommend to the Board the audit fee for the 2019/20 audit.

4.2 Internal Audit

The Committee members held private meetings with the internal auditors, TIAA, ahead of its meetings and during these meetings there were no issues of material concern raised. During the period the Committee considered 19 internal audit reviews with six reviews deferred or delayed because of the national emergency measures in place related to the Covid-19 pandemic.

Assurance Assessments	2019/20	2018/19
Substantial Assurance	4	2
Reasonable Assurance	10	12
Limited Assurance	5	7
No Assurance	0	1

The Committee was pleased that no reviews received a '*no assurance*' rating, four were rated *'substantial assurance'* and five had a '*limited assurance'* rating. The Committee's close scrutiny of the internal audit recommendation tracker, and the prior review of this by the Trust Executive Committee, resulted in the outstanding recommendations being proactively progressed, with the result that the number of outstanding actions had been significantly reduced compared with previous years.

The Committee was able to give assurance that the Trust had good financial internal controls which was reflected in the substantial assurance ratings for the Trust financial reporting and budgetary control and core finance systems. The Trust's serious incidents and declaration of interests systems also received *substantial assurance*.

The work of internal auditors also supported the Committee in ensuring that there was a robust policy in place for raising concerns, and issues raised in a special session with staff regarding bullying and harassment informed the development Trust's freedom to speak-up framework. The Committee had been concerned about the progress of the Trust's diversity and inclusion work and the internal audit conducted in quarter three, rated '*reasonable assurance'* was demonstrative of the work undertaken by the Trust to implement its diversity and action plan.

The Committee also commended the areas such as safeguarding adults, infection prevention and control, complaints, implementation of iClip project, General Data Protection Regulation (Data Protection) and use of staff survey which received a reasonable assurance rating during the period.

Other areas of concern following the internal audits conducted during this period which the Committee indicated it would keep under review included the outstanding recommendations for estates internal audit reviews, lack of progression of the Consultant Job Planning audit and progression of ICT audits and recommendations.

The contract for the provision of internal audit services to the Trust was re-tendered during the course of the year. A sub-group of the Committee was appointed to review tenders and

make a recommendation to the Committee and, based on this, this the Committee agreed to re-appoint TIAA as the Trust's internal auditors for the period April 2020 to March 2023.

4.3 Governance, Internal Control and Risk Management and Governance Manual

In addition to reviewing the outputs of the external and internal auditors, a core element of the Committee's focus in 2019/20 was monitoring the Trust's corporate governance, compliance and systems for internal control. To this end the Committee reviewed and recommended that the Board approved the revised Trust Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions. The Committee also considered and endorsed the progress on strengthening the internal controls and better transparency on the Trust's declaration of interests and trust-wide policies, management of research funding, information governance and clinical audit annual programme. In relation to declarations of interest, the Committee also approved revisions to the policy on behalf of the Board. On Trust-wide policies, the Committee was pleased with the progress that was made during the course of the year and with the new rigour that had been brought to this area. In addition, the Committee also considered the Trust's compliance against with the Trust Constitution and NHS Code of Governance, noting that the Trust was substantially compliance with both. It reviewed information governance arrangements received an annual report on this. In addition, the Committee considered a number of updates on the Board Assurance Framework and the Trust's risk management framework, expressing the need for more work to clarify the role of the Committee in the process. The Committee also noted that executive responsibility of the BAF would move to the Chief Corporate Affairs Officer from 1 April 2020.

4.4 Trust Annual Report and Accounts

In May 2019 the Committee held a special informal workshop to conduct a comprehensive review of the year-end reports including the quality report, annual report and annual accounts. At its subsequent formal meeting, the Committee endorsed the final drafts along with external auditor's opinions and assurance of the production and the true and accurate nature of the financial reports for 2018/19. The Committee signed off and endorsed the letters of representations for approval by the Board and endorsed the reported which were presented and approved with the annual report and accounts for 2018/19 to the Council of Governors in July 2019. The Committee noted the improvement in the process for publishing the annual report and accounts and the collaborative working between the Trust and external auditors. In January 2020, the Committee reviewed and agreed plans for the production of the 2019/20 annual report and accounts, the requirements and timelines for the submission of which have been impacted by the Covid-19 pandemic.

4.5 Financial Reporting and Accounts Review

The Committee received regular reports on aged debts, losses and compensation and breaches of waivers. The Committee was able to confirm that these internal controls and systems had significantly improved which have resulted in a significant reduction in values of age debts, losses and compensation and number of breaches and waivers.

4.6 Counter Fraud

The Trust's counter fraud reporting had improved during the year and the Committee gained assurance on the robustness of the processes in place. Internal Auditors had been providing support to the Trust's counter fraud team which resulted in increased training and awareness around the Trust. The Trust had subsequently engaged Audit First to continue to provide support to the small internal counter fraud team.

5 Committee Effectiveness

The Committee conducted a review of its effectiveness and the report is attached in Appendix 6. Overall, the results of the review suggest that the Committee is working broadly effectively, albeit with some areas in which it can improve. A clear majority of respondents (86%) stated that the Committee was “very effective”. The Committee recognised however there was further room to further improve the working of the Committee. Reflecting on the extent to which steps could be taken to improve the effectiveness of the Committee felt that a limited number of actions could be taken to improve the Committee’s effectiveness (see figure 1 and 2 below). These included executive leads attending Committee to respond to internal audits in their areas of responsibility, more systematic reporting of risk and control issues to the Committee from other Board Committees, clarifying the role of the Committee in the Trust’s risk management processes, ensuring the Committee made greater use of assurance mapping, and clarifying the distinct roles of the Audit Committee and Workforce and Education Committee regarding Freedom to Speak Up so as to avoid unnecessary duplication.

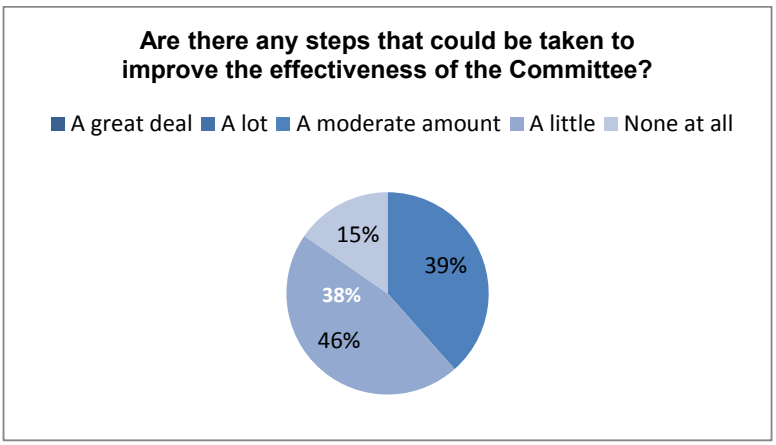


Figure 1

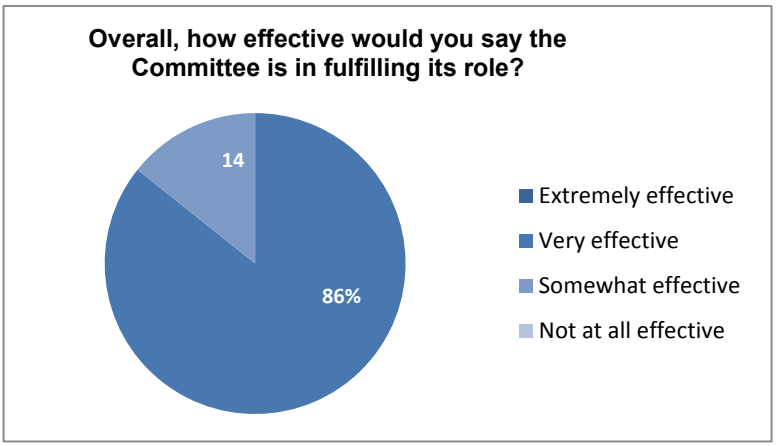


Figure 2

The Committee agreed the following actions to improve the work of the Committee:

Action	Status
Requirement for Executive leads to attend Committee for internal audits in their areas	Completed
Seek feedback on Audit Committee focused induction of incoming members and review plans as necessary	Being reviewed as part of wider governance work being conducted by the Chief Corporate Affairs Officer.
Introduce more systematic reporting from other Committees to the Audit Committees on new areas of risk or control issues	All Committee actions
Review risk management processes of the Committee following external review of Trust risk management policy and process	Programmed in the Committees Workplan 2020/21
Ensure Committee and Board make greater use of assurance mapping as part of 2020/21 approach to the BAF	Programmed in the Committees Workplan 2020/21
Clarify the distinct roles of the Audit Committee (AC) and Workforce & Education Committee (WEC) in relation to Freedom to Speak Up so as to avoid duplication of reporting	Completed – WEC will review the activity from FTSU and AC will review internal governance process.

6 Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2020/21 is attached (see Appendix 5). The nature of Committee means that key aspects of its work are driven by the work of the internal auditors, external auditors and counter fraud teams. The workplan for 2020/21 reflects the principles set out in the NHS Audit Committee Handbook and also reflects the required matters for the Committee's review. The Committee's concerns for greater assurance in relation to the Board Assurance Framework, Risk Management and Freedom to Speak Up Guardian are also reflected in the plan. The work plan has also been compressed to reduce the frequency of reports which are being scurtinised elsewhere, for example updates on Trust policies (all Board Committees now reviewing policies updates from their particular area), freedom to speak up in terms of the detailed content of concerns (activity being reviewed by Workforce and Education Committee so Audit Committee can focus on the internal controls systems).

The Committee's terms of reference have been reviewed and updated to reflect the current operation of the Committee (see Appendix 4). The only material addition to the terms of reference is clarifying its role in relation to risk management and freedom to speak up.

7 Conclusion and Assurance Statement

During 2019/20, the Committee worked hard to deliver its duties. Its effectiveness is reflected in the 82% effectives score from the Committee Effectiveness review. Through the work of the Committee the external auditors found no new areas unknown to the Trust that gave cause for concern and reflecting on the Head of Internal Audit Opinion the Committee can give an reasonable assurance rating on the Trust's internal controls, mechanisms and systems of corporate governance.

Appendix 1: Approved Terms of Reference - 2018

Audit Committee

Terms of Reference

1. NAME

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

2. AUTHORITY

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

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

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

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

3. PURPOSE OF THE GROUP

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

4. DUTIES OF THE GROUP

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

Governance, Internal Control and Risk Management

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

1. Review the risk and control related disclosure statements prior to endorsement by the Board; this shall include the Annual Governance Statement, Head of Internal Audit opinion, External Audit opinion and/or other appropriate independent assurances.

2. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.

3. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's corporate objectives.

4. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks; this shall include Clinical Audit programme overseen by the Trust's Quality & Safety Committee.

5. Review the adequacy and effectiveness of policies and procedures:

   a. by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern
   b. to ensure compliance with relevant regulatory, legal and conduct requirements.

Internal Audit

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

1. Review and approve the Internal Audit Strategy and annual Internal Audit Plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework).

2. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring co-ordination between the work of internal audit and external audit to optimise audit resources.

3. Conduct a regular review of the effectiveness of the internal audit function.

4. Periodically consider the provision, cost and independence of the Internal Audit service.

External Audit

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

1. Discuss and agree with the external auditor, before the audit commences the nature and scope of the external audit as set out in the annual plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.

2. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board;.

3. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).

4. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.

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

Financial Reporting and Accounts Review

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

1. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.

2. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.

3. Changes in, and compliance with, accounting policies, practices and estimation techniques.

4. The meaning and significance of the figures, notes and significant changes.

5. Areas where judgement has been exercised and any qualitative aspects of financial reporting.

6. Explanation of estimates or provisions having material effect.

7. The schedule of losses and special payments, ensuring these have received appropriate approval.

8. Any unadjusted (mis)statements.

9. Significant adjustments arising from the audit

.

10. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

11. The Letter of Representation.

In line with the Trust's Scheme of Delegation (sections 11.1 and 11.2) the Committee shall also monitor the integrity of the Trust's financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant

financial reporting judgements contained in them, to ensure the completeness and accuracy of information provided to the Board.

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

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

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

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

Raising Concerns

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

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

Governance Manual

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

Management

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

Annual Work Plan and Committee Effectiveness

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

5. COMMITTEE CHAIR AND COMMITTEE EXECUTIVE LEADS

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

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

6. COMPOSITION OF MEMBERSHIP

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

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

7. ATTENDANCE

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

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

Corporate Governance team

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

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

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

8. QUORACY

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

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

9. DECLARATION OF INTERESTS

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

10. MEETING FREQUENCY

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

11. RELATIONSHIP WITH OTHER COMMITTEES

12. MEETING ARRANGEMENTS / SECRETARIAL

i. An annual schedule of meetings of the Audit Committee shall be established prior to the start of each financial year;

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

13. REPORT TO THE TRUST BOARD

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

14. AGENDA AND FORWARD CYCLE OF BUSINESS

Standing Agenda Items

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

Annual Cycle of Business

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

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

15. REVIEW OF TERMS OF REFERENCE

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

Appendix 2: Audit Committee Workplan 2019-2020

ITEMS	Lead	Author(s)	Committee	17/04/2019	20/05/2019	01/08/2019 (11/07/19)	10/10/2019	16/01/2020
PRIVATE MEETINGS WITH AUDITORS								
Private meeting with Internal Auditors	NEDs Only	N/A	-			√		√
Private meeting with External Auditors				√			√	
OPENING ADMINISTRATION								
Welcome, Introductions and Apologies for Absence	All	Secretariat	-	√	√	√	√	√
Declarations of Interest	All	Secretariat	-	√	√	√	√	√
Minutes of Previous Meeting (accuracy)	Chair	Secretariat	-	√	√	√	√	√
Matters Arising (Tracker) and Action Log	Chair	Secretariat	-	√	√	√	√	√
ANNUAL REPORT, QUALITY REPORT AND ANNUAL ACCOUNTS								
Annual Report, Accounts & Quality Accounts Plans & Timetables	DCA/CFO	DCA/CFO	TEC	√				√
Accounting Policies	CFO	CFO	-					√
Financial Statements	CFO	CFO	TEC/FIC		√			
Draft Annual Governance Statement (AGS)	DCA/CFO	DCA/CFO	TEC/FIC	√				
Annual Report incl. Remuneration, AGS & Staff Reports (Final)	DCA/CFO	DCA/CFO	TEC		√			
Annual Accounts (Final)	CFO	CFO	TEC/FIC		√			
Quality Accounts (Final)	CN	DQG	QSC/COG		√			
EXTERNAL AUDIT								
External Audit Progress Report	EA	EA	-	√		√	√	√
Annual Audit Plan & Fees	EA	EA	-					√
Benchmarking Annual Report	EA	EA	-	√				
External Audit Findings (Final)	EA	EA	-		√			
Letter of Representation (Financial Audit) (Final)	CEO/CFO	CEO/CFO	-		√			
Reports to Council of Governors - Quality (Account) Report and Limited Assurance Opinion (Final)	EA	EA	-		√			
External Audit Annual Audit Letter	EA	EA	-			√		
INTERNAL AUDIT								
Internal Audit Progress Report	IA	IA	-	√	√	√	√	√
Final Internal Audit Review Reports	IA	IA	-	√	√	√	√	√
Internal Audit Recommendation Tracker	IA	IA	-	√	√	√	√	√
Draft Internal Audit Plan (For Review)	IA	IA	-					√
Internal Audit Plan (For **Approval**/Review)	IA	IA	-	√			√	
Draft Annual Report & Head of Internal Audit Opinion	IA	IA	-	√				
Final Annual Report & Head of Internal Audit Opinion	IA	IA	-		√			
Fraud Updates/Digest	IA	IA	-	√		√		
COUNTER FRAUD								
Counter Fraud Update Report	CFO	CFO	-	√		√	√	√
Counter Fraud Annual Report & Self-Assessment	CFO	CFO	-	√				
Counter Fraud Work Plan	CFO	CFO	-	√				
Review of Anti-Fraud/Anti-Bribery Policy (every three years)	CFO	CFO	-	Not due until Feb 2021				
FINANCE & PROCUREMENT								
Losses & Special Payments	CFO	CFO	-	√	√	√	√	√
Breaches & Waivers	CFO	CFO	-	√	√	√	√	√
Aged Debt	CFO	CFO	-			√	√	√
INFORMATION GOVERNANCE								
Information Governance Compliance Update & Annual Report	SIRO	CIO	IGG/TEC			√		
DSP Toolkit: Update (Data Quality/Security)	SIRO	CIO	IGG/TEC		√			√
RISK MANAGEMENT								
Annual Review of Risk Management Strategy & Policy	CN	DQG	Board					√
Board Assurance Framework Review	CN	DQG	Board			√		√
GOVERNANCE								
Review of Internal Audit Effectiveness	DCA	DCA	-				√	
Internal Audit Service Tender	DCA	DCA	-	√		√		
Standing Orders, Scheme of Delegation & Standing Financial Instructions	DCA/CFO	DCA/CFO	TEC					√
Trust Code of Conduct, Conflicts of Interest & Expenses	DCA	DCA	TEC					√
Review of Compliance with Trust Policies Protocols (Comprehensive Report, Progress Update (Verbal), Update Report (Paper))	DCA	DCA	TEC			√	√	√
Compliance with Provider Licence	DCA/CFO	DCA/CFO	TEC			√		
Clinical Audit Programme	CN	DQG	QSC			√		
Freedom to Speak Up & Whistleblowing Report	DHROD	DHROD	WEC	√	√	√	√	√
Use of Trust Seal	DCA	DCA	Board			√		√
Review of Committee Effectiveness	DCA	DCA	-					√
Review of Committee Terms of Reference	DCA	DCA	-	√				
Review of Committee Cycle of Business	DCA	DCA	-	√				
CLOSING ADMINISTRATION								
Report to the Board	Chair	DCA	-	√	√	√	√	√
Control issues identified in other Committees	Chair	DCA	-	√	√	√	√	√
Any new risks or issues identified	Chair	DCA	-	√	√	√	√	√
Items for the next meeting	All	Secretariat	-	√	√	√	√	√
Any other business	All	Secretariat	-	√	√	√	√	√
Reflection on the meeting	All	Secretariat	-	√	√	√	√	√
AGENDA ITEMS FROM ACTION LOGS								
LCRN Update - Research Funding *(AC11.1.18/58B)*	CFO	CFO	-		√			
Raising Concerns Policy at Work Policy *(AC.11.10.18/05)*	DHROD	DHROD	WEC			√		
Committee Effectivess Update - Use of Assurance Mapping to Target Risks and Induction tfor New Committee Members) (AC.1.01.2019/08)	CFO/DCA	DFO/DCA	-				√	

Appendix 3: Items Considered by the Audit Committee - April 2019 – March 2020

Governance, Internal Control and Risk Management and Governance Manual	Internal Audit/External Audit		Trust Annual Report and Accounts	Financial Reporting and Accounts Review	Counter Fraud/Bribery/Corruption Arrangements and Raising Concerns
Clinical Audit Annual Programme	Internal Audit Progress Updates	Safeguarding Adults	Draft/Final Annual Accounts (including financial statements)	Losses & Compensation	Counter Fraud Updates
Data Security Protection Toolkit	Internal Audit Recommendation Trackers	Diagnostic Test Reporting	Draft/Final Annual Report (including Annual Governance Statement, Remuneration and Staff Reports)	Aged Debts	Annual Counter Fraud Report
Review of Trust Policies	Learning from Incidents and Complaints	Financial Reporting Board Budget Setting	Draft/Final Annual Quality Account	Breaches and Waivers	Annual Counter Fraud Workplan & Risk Assessments
Risk Management and Board Assurance Framework Update	Diversity and Inclusion	Estates and Facilities	Letter of Representation (Financial Audit)	Accounting Policies	Annual Counter Fraud Compliance Self-Assessment
Declarations of Interest (Managing Conflict of Interest)	ICT Review of Data Quality - Roll out of iClip to QMH	Head of Internal Audit Opinion	Letter of Representation (Quality Account)		Counter Fraud Investigation Reports
Use of Trust Seal	General Data Protection Regulation compliance	Internal Audit Annual Plans	Report on Quality Report incl. Limited Assurance Opinion to Council of Governors		Freedom to Speak-Up Guardian Reports
Information Governance Compliance Update & Annual Report	ICT Review of Cyber Security	Client Briefings and Sector Updates and Newsletters	External Audit Findings		Revised Policy on Raising Concerns & Progress against Internal Audit Review of Bullying and Harassment
LCRN Update – Research Funding	Bullying & Harassment	Retender of Internal Audit Function	Report on the Audit of Financial Statements to Council of Governors		
Standing Orders, Standing Financial Instructions, Scheme of Delegation	Infection Prevention and Control	External Audit Progress Report and Sector Updates	Audit Committee Assurance Response to External Auditors (Letter to Committee Chair)		
Compliance with Trust Constitution and Code of Governance		External Auditors Annual Audit Plan & Fees			

Other Appendices not embedded:

Appendix 4: Revised Terms of Reference

Appendix 5: 2020/21 Audit Committee Workplan

Appendix 6: Committee Effectiveness Review

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Audit Committee Terms of Reference

Approved by the Trust Board (TBC)

6.1

Approval and review dates

Profile	
Document name	Audit Committee Terms of Reference
Version	1.1
Executive Sponsor	Chief Corporate Affairs Officer, Chief Finance Officer
Author	Chief Corporate Affairs Officer
Approval	
Approval group	Trust Board of Directors
Date of approval	TBC
Date for next review	April 2021

Audit Committee
Terms of Reference

1. Name of Group

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

2. Authority

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

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

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

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

3. Purpose of the Group

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

The Committee plays a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives. In exercising its duties the Committee supports the Trust in achieving its vision of delivering outstanding care, every time.

4. Duties of the Group

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

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

i. Review the risk and control related disclosures statements prior to endorsement by the Board. This shall include the Annual Governance Statement, Head of Internal Audit Opinion, External Audit Opinion and / or other appropriate independent assurances.
ii. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
iii. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's strategic and corporate objectives and provide assurance to the Board on the effectiveness of these.
iv. Oversee the robustness of the arrangements for providing the Board with assurance on the strategic risks identified in the Board Assurance Framework
v. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks. This shall include the clinical audit programme overseen by the Trust's Quality and Safety Committee.
vi. Review the adequacy and effectiveness of policies and procedures: (a) by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern, (b) to ensure compliance with relevant regulatory, legal and conduct requirements.

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

i. Reviewing and approving the Internal Audit strategy and annual Internal Audit plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework)
ii. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring coordination between the work of internal audit and external audit to optimise audit resources.
iii. Conduct a regular review of the effectiveness of the internal audit function.
iv. Periodically consider the provision, cost and independence of the internal audit service.

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

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

The Committee shall also work with the Council of Governors on the appointment or retention of the external auditors.

(d) Financial reporting and accounts review: The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to the completeness and accuracy of the information provided to the Board. The Committee shall review financial reporting through the year and the financial statements and annual report before submission to the Board,. Particularly focusing on:

i. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
ii. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
iii. Changes in, and compliance with, accounting policies, practices and estimation techniques.
iv. The meaning and significance of the figures, notes and significant changes.
v. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
vi. Explanation of estimates or provisions having material effect.
vii. The schedule of losses and special payments, ensuring these have received appropriate approval.
viii. Any unadjusted (mis)statements.
ix. Significant adjustments arising from the audit.
x. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
xi. The Letter of Representation.

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

(e) Counter Fraud, Bribery and Corruption Arrangements: The Committee shall ensure that the Trust has in place:

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

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

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

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

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

(g) General governance

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

(h) Management

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

(i) Annual work plan and Committee effectiveness

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

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. Chairperson

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

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

6. Composition of the Group

Membership: ~~This is a Non-Executive Director Committee and the following individuals will be the members.~~ The Committee membership comprises three Non-Executive Directors, one of whom is the Committee Chair, and one Associate Non-Executive Director. Only Non-Executive Directors (other than the Trust Chairman) may serve as members of the Audit Committee.

Name	Title	Role in the group
Elizabeth Bishop	Non-Executive Director	Committee Chair
Ann Beasley	Non-Executive Director	Member
Tim Wright	Non-Executive Director	Member
Pui-Ling Li	Associate Non-Executive Director	Member

Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting. In the absence of the Committee Chair, the Committee should nominate another member to Chair the Committee.

7. Attendance

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

~~In attendance – Trust~~	
~~Director of Corporate Affairs~~	~~DCA~~
~~Chief Financial Officer~~	~~CFO~~
~~Director of Financial Services~~	~~DFS~~
~~Head of Counter Fraud~~	~~HCF~~
~~Director of Quality Governance~~	~~DQG~~
~~Director of Human Resources & Organisational Development~~	~~DHROD~~
~~Chief Executive (for Annual Report, Annual Governance Statement, and Accounts approval)~~	~~CEO~~
~~In attendance - Audit~~	
~~External Audit Partner~~	~~EAP~~
~~External Audit Manager~~	~~EAM~~
~~Internal Audit Director~~	~~IA~~
~~Internal Audit Director~~	
~~Secretariat~~	
~~Corporate Governance team~~	

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

The following are regular attendees at the Committee:

- Chief Financial Officer
- Chief Corporate Affairs Officer
- External Auditors
- Internal Auditors

Other members of the Executive team may be required to attend the Committee at the Committee's request. This includes where there is an internal audit review with limited or no assurance, and where an internal control issue has been identified in that Director's portfolio.

At the discretion of the Committee Chair, other individuals may be invited to attend on an ad hoc basis or in support of specific agenda items. This would typically include:

- Local Counter Fraud Specialist
- Head of Technical Accounting – for the Annual Accounts
- Chief Nurse and / or Director of Quality Governance – for the Quality Account

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

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

8. Quoracy

The quorum for any meeting of the Audit Committee shall be the attendance of a minimum of two members. Regular or other attendees do 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.

9. Declaration of Interests

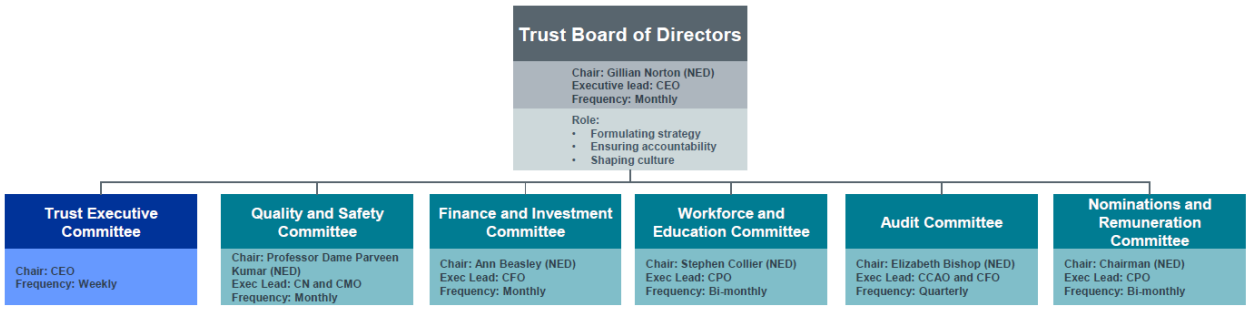
All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

10. Meeting Frequency

Meetings of the Committee shall be held five times per year, usually on the second Thursday of the month. The frequency of meetings may be changed only with the agreement of the Trust Board.

11. Relationship with other groups and committees

The Committee will report to the Trust Board.



12. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Audit Committee shall be established prior to the start of each financial year;
ii. The Director of Corporate Affairs will oversee the provision of secretariat support for the Audit Committee. 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.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Leads.
iv. All papers and reports to be presented at the Audit Committee must be submitted as final Executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days ahead of the meeting.

13. Report to the 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.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

14. Agenda

~~**Standing agenda items**~~

~~i. Apologies;~~
~~ii. Declarations of interest;~~
~~iii. Minutes of the Previous Meeting;~~
~~iv. Matters Arising and Action Log;~~
~~v. Reflections on meeting~~

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair.

15. Annual cycle of business

An Annual cycle of items and reports to be received by the Committee will be agreed by the Committee and is included at Appendix 1 of this terms of reference. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

16. Review of Terms of Reference

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Audit Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Board.

AUDIT COMMITTEE FORWARD WORKPLAN
01 April 2020 - 31 March 2020

ITEMS	Purpose	Lead	Author(s)	Committee	07/05/2020	11/06/2020	16/07/2020	08/10/2020	14/01/2021
PRIVATE MEETINGS WITH AUDITORS									
Private meeting with Internal Auditors	Discuss	NEDs Only	N/A	N/A			√		√
Private meeting with External Auditors	Discuss	NEDs Only	N/A	N/A		√		√	
ANNUAL REPORT, QUALITY REPORT AND ANNUAL ACCOUNTS									
Annual Report, Accounts & Quality Accounts Plans & Timetables	Note	CCAO/CFO	CCAO/CFO	TEC	√				√
Annual Accounts, Financial Statements, Going Concern Statement including NHS Debt Write-off (**Draft**/**Final**)	**Discuss**/ **Approve**	CFO	CFO	TEC/FIC	√	√			
Annual Report including Remuneration, Workforce Report, Annual Governance Statement etc. (**Draft**/**Final**)	**Discuss**/ **Approve**	CCAO/CFO	CCAO/CFO	TEC/FIC	√	√			
Annual Quality Accounts (**Draft**/**Final**)	**Discuss**/ **Approve**	CN	DQGC	QSC/CoG	√	√			
Accounting Policies	Approve	CFO	CFO	TEC					√
EXTERNAL AUDIT									
External Audit Progress Report	Discuss	EA	EA	N/A	√		√	√	√
Annual Audit Plan & Fees	Approve	EA	EA	N/A					√
Benchmarking Annual Report	Note	EA	EA	N/A	√				
External Audit Findings (Final)	Endorse	EA	EA	N/A		√			
Letter of Representation (Financial Audit) (Final)	Endorse	CEO/CFO	CEO/CFO	N/A		√			
Reports to Council of Governors - Quality (Account) Report and Limited Assurance Opinion (Final)	Endorse	EA	EA	N/A		√			
External Audit Annual Audit Letter	Receive/ Endorse	EA	EA	N/A			√		
INTERNAL AUDIT									
Internal Audit Progress Report	Note	IA	IA	TEC	√		√	√	√
Internal Audit Recommendation Tracker	Note	IA	IA	TEC	√		√	√	√
Final Internal Audit Review Reports	Note	IA	IA	TEC	√		√	√	√
Draft Internal Audit Plan (**Draft**/**Final**)	Discuss/ Approve	IA	IA	TEC			√		√
Draft Annual Report & Head of Internal Audit Opinion (**Draft**/**Final**)	Endorse	IA	IA	TEC	√	√			
Sector Updates and Digests (including Fraud)	Inform	IA	IA	TEC			√		
COUNTER FRAUD									
Counter Fraud Update Report	Discuss	CFO	CFL	TEC			√	√	√

AUDIT COMMITTEE FORWARD WORKPLAN
01 April 2020 - 31 March 2020

ITEMS	Purpose	Lead	Author(s)	Committee	07/05/2020	11/06/2020	16/07/2020	08/10/2020	14/01/2021
Counter Fraud Annual Report & Self-Assessment	Approve	CFO	CFL	TEC	√				
Counter Fraud Work Plan and Risk Assessment 2020/21	Approve	CFO	CFL	TEC	√				
Review of Anti-Fraud/Anti-Bribery Policy (every three years)	Approve	CFO	CFL	TEC					√
FINANCE & PROCUREMENT									
Losses & Special Payments	Discuss/ Endorse	CFO	CFO	TEC/FIC	√		√		√
Breaches & Waivers	Discuss/ Endorse	CFO	CFO	TEC/FIC		√		√	
Aged Debt	Discuss/ Endorse	CFO	CFO	TEC/FIC	√		√		√
INFORMATION GOVERNANCE									
Information Governance Compliance Update & Annual Report	Discuss/ Endorse	SIRO	CIO	IGG/TEC			√		
DSP Toolkit: Update (Data Quality/Security)	Discuss/ Endorse	SIRO	CIO	IGG/TEC			√		√
RISK MANAGEMENT									
Annual Review of Risk Management Strategy & Policy	Approve	CN	DQGC	Board			√		√
Review of Board Assurance Framework Internal Controls and Governance Mechanisms	Discuss/ Endorse	CCAO	CCAO	Board	√				√
CORPORATE GOVERNANCE/COMPLAINCE									
Review of Internal Auditors Effectiveness	Discuss	CCAO	CCAO	TEC				√	
Standing Orders, Scheme of Delegation & Standing Financial Instructions (Annual Complaince Review)	Review/ Approve	CCAO/CFO	CCAO/CFO	TEC					√
Annual Review of Trust Conflicts of Interest Complaince	Note	CCAO	CCAO	TEC			√		
Annual Review of Compliance with Trust Policies Protocols	Note	CCAO	CCAO	TEC				√	
Annual Review of Trust's Clinical Audit Programme	Note	CN	DQGC	QSC				√	
Freedom to Speak-up Internal Controls and Policies	Discuss/ Endorse	DHROD	DHROD	WEC			√		√
Use of Trust Seal	Note	CCAO	CCAO	Board			√		√
COMMITTEE GOVERNANCE									
Review of Committee Effectiveness	Discuss/ Endorse	CCAO	CCAO	N/A					√
Annual Committee Report to Board including Terms of Reference Update and Committee Forward Workplan	Discuss/ Endorse	CCAO	CCAO	Board	√				

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Audit Committee Effectiveness Review 2019/20

Survey results and action plan

6.1

Stephen Jones
Chief Corporate Affairs Officer

16 January 2020

1. Introduction

Purpose, context and engagement

1. Purpose

This paper presents the results of the Audit Committee review of effectiveness for 2019/20 which was undertaken since the last meeting of the Committee in October 2019, and highlights potential action points for consideration based on the feedback received through the survey.

2. Background and context

All Committees of the Board are required to undertake reviews of their effectiveness on an annual basis.

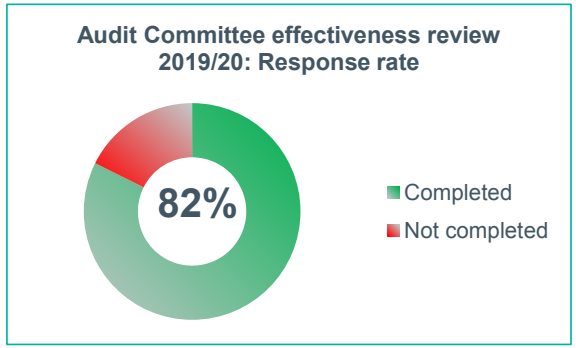
At its last meeting, the Audit Committee agreed plans for undertaking the effectiveness review. The survey was conducted between 3 and 14 January 2020. Responses to the survey were provided via an online survey tool.

3. Engagement

The following groups were invited participated in the survey:

- Committee members
- Trust Chairman
- Executive leads for the Committee (DCEO/CFO and CCAO)
- Other Executive Directors
- Regular attendees at the Committee
- Internal Auditors (one organisational response)
- External Auditors (one organisational response)

There was positive engagement with the review; 14 of the 17 individuals asked to respond did so, providing a response rate of 82%. This was a significant rise in engagement compared with the 2018/19 effectiveness survey which attracted six responses.



Respondent type	Number of respondents*
Non-Executives (Committee members)	4 (3)
Executive Directors	7
Regular attendees	1
Auditors	2

2. Key findings from Audit Committee Effectiveness Review 2019/20

Views on overall effectiveness and scope for improvement

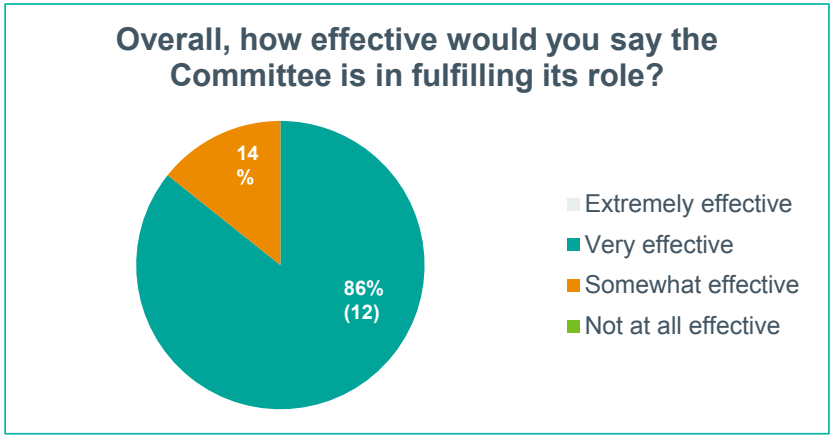
The full survey results of the Audit Committee effectiveness review 2019/20 are set out in appendix 1. This sets out the results for each question along with all of free text comments received.

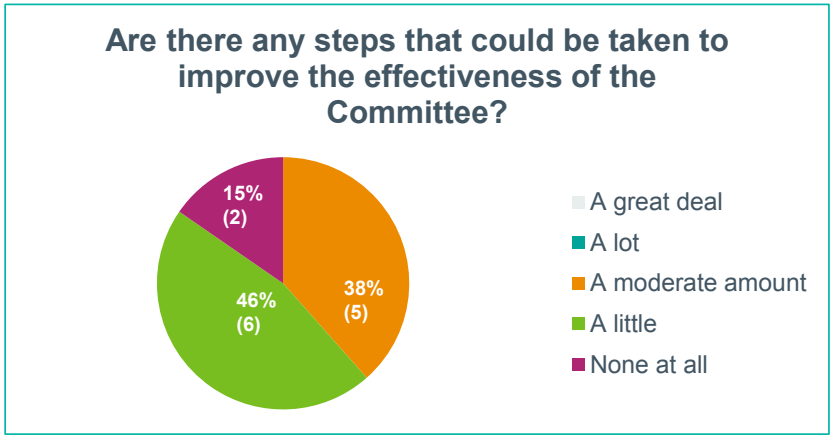
Overall, the results of the review suggest that the Committee is working effectively. All respondents stated that the Committee was either “very effective” (12 responses) or somewhat effective (2 responses). No respondents stated that the Committee was ineffective.

At the same time, none of the respondents said that the Committee was extremely effective, indicating that there is scope for the Committee to further develop, improve and mature.

Reflecting on the extent to which steps could be taken to improve the effectiveness of the Committee, none of the respondents stated that “a great deal” or “a lot” of steps were necessary to improve the Committee’s effectiveness. 46% of respondents thought “a little” could be done to improve the operation of the Committee and 38% felt that “a moderate amount” could be done. Just 15% felt that no steps could be taken to improve the effectiveness of the Committee.

Based on the results, improving the functioning of the Committee appears to be more in the realm of tweaks and adjustments in some areas rather than wholesale change.





2. Key findings from Audit Committee Effectiveness Review 2019/20

Views on what's going well

The survey identified a number of areas where respondents, overall, fed back positive messages:

- **Terms of Reference:** Responses indicated that the Committee had in place appropriate terms of reference that had been reviewed by both the Committee and Board, and that there was a clear forward programme of work in place that was fit for purpose. Respondents felt that Committee members and regular attendees understood the role and responsibilities of the Committee (100% of respondents either agreed or strongly agreed that there was clarity as to the Committee's role.

- **Membership and attendance:** 100% of respondents indicated that the Committee was well chaired (either strongly agreed, or agreed). 93% of respondents felt that the Committee had the skills it needed to ensure the Board received effective assurance from the Committee, with the same number finding the Committee and wider attendees had the skills necessary to help the Committee be fully effective.

- **Quality of papers:** 86% of respondents expressed a positive view about the clarity and quality of papers provided to the Audit Committee, 79% said papers were submitted and circulated in a timely way, and 93% stated that agendas and the forward plan covered the assurance needs of the Board. Overall, respondents suggested there was time to explore issues in sufficient depth (71%).

- **Challenge by the Committee:** 100% of respondents expressed the view that the Committee critically assesses the comprehensiveness and reliability of the assurances it receives (1 strongly agreed, 13 agreed) and 93% felt that the Committee provided insight and constructive challenge, though one comment suggested that the Committee could at times move into operational detail.

- **Reporting and escalation:** Overall, this was seen as a strength of the Committee, with 93% agreeing or strongly agreeing that the Committee discussed matters for escalation to the Board, and the same percentage stating that the Committee's report to the Board was clear and set out the level of assurance taken by the Committee.

- **Scrutiny of internal audit:** Respondents overwhelmingly expressed the view that the Committee effectively scrutinised internal audit – approving the audit plan, tracking recommendations, reviewing the findings of internal audits, and challenging where appropriate.

3. Key findings from Committee Effectiveness Review 2019/20

Views on areas for development

The survey highlighted a number of areas in which there was mixed feedback, with some respondents providing very positive feedback and others suggesting these were areas in which significant improvement was needed:

- **Membership and attendance:** While on the whole positive, free text comments in the survey emphasised the importance of the relevant Executive leads for internal audits attending for the Committee's consideration of these.
- **Induction:** 38% of respondents stated that there were effective induction arrangements in place for new members joining the Committee, with a further 54% expressing a neutral view. Free text comments in the survey suggested that there had been minimal turnover and as a result induction arrangements had not been directly experienced, though incoming Committee members would soon undertake that induction and may then be able to comment.
- **Reporting and escalation:** While this was generally seen as a strength of the Committee in terms of its reporting and escalating issues to the Board, there was a slightly more mixed picture in terms of the effectiveness with which new risks and control issues were escalated by other Committees to the Audit Committee for consideration. 1 respondent disagreed that this worked well, and 2 respondents expressed a neutral view. Likewise, one respondent disagreed that the Committee's reports to the Board were effective.
- **Risk:** The Committee's oversight of risk management was one area in which there was consistently more mixed feedback. Reflecting a theme from the 2018/19 effectiveness review, the view was expressed the Committee could make more use of assurance mapping. Three respondents also stated that the Committee did not effectively draw the Board's attention to its work on risk, or proactively commission additional assurance work where it had identified a risk which was not subject to sufficient review.
- **FTSU:** While 86% of respondents said that the Committee reviewed arrangements for freedom to speak up, the importance of the Committee maintaining a close focus on this was emphasised in free text comments, as was the view that more could always be done in this area. The need for greater clarity about the respective roles of the Audit Committee and Workforce and Education Committee – and the risks of duplication in reporting / lack of clarity as to purpose of reporting between the two Committees – was also highlighted in free text comments.
- **Wider control environment:** Again, while the overwhelming number of responses to the survey suggested that Committee had a sufficient understanding of the Trust's wider control environment, one respondent disagreed and emphasised in free text comments the need for more work in this area – particularly in relation to the operational control environment and clinical governance structures and processes.

5. Potential actions to address feedback from effectiveness review

The areas for further development highlight potential areas in which the Committee may want to focus in improving its effectiveness in the year ahead:

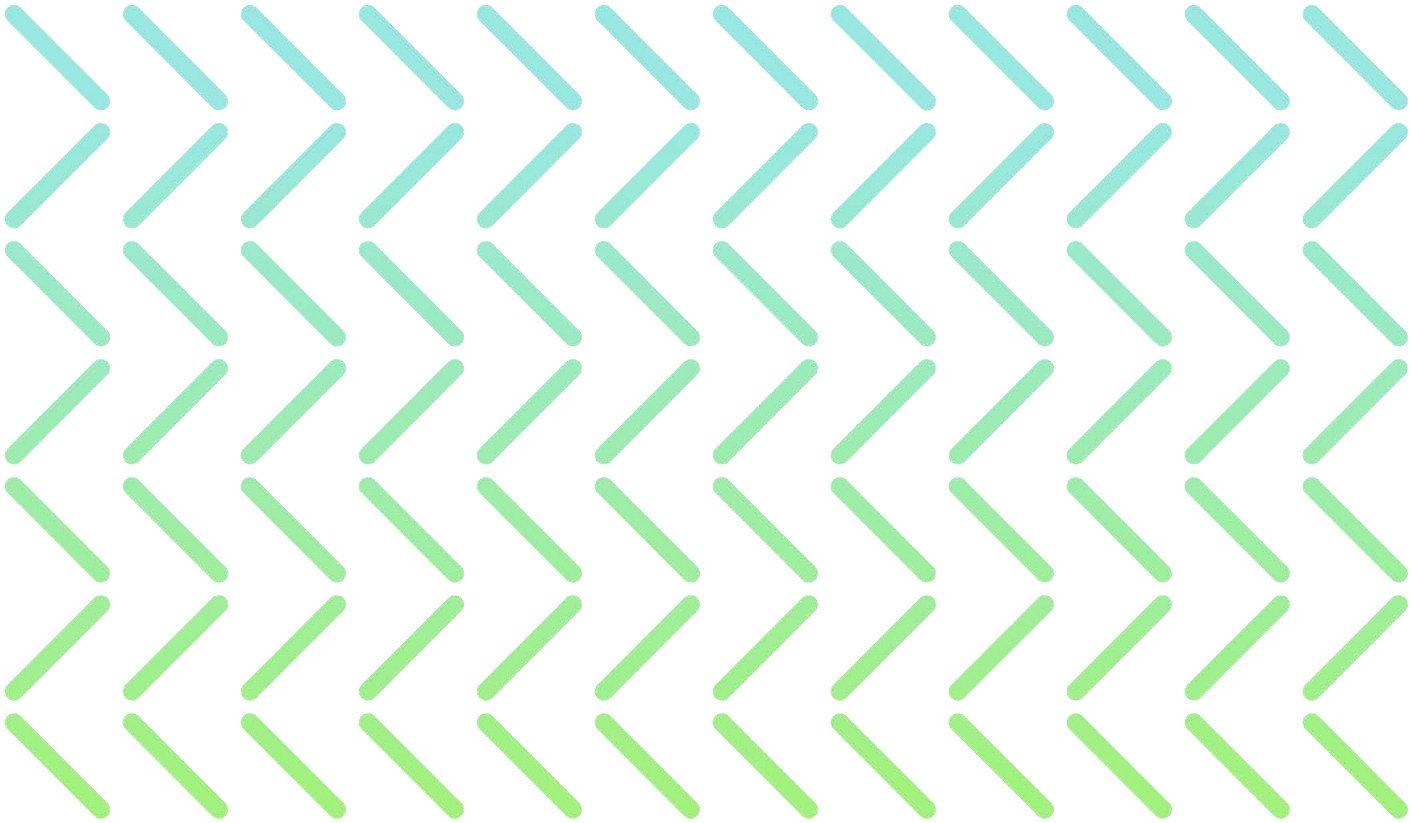
- Requirement for Executive leads to attend Committee for internal audits in their areas
- Seek feedback on Audit Committee focused induction of incoming members and review plans as necessary
- Introduce more systematic reporting from other Committees to the Audit Committees on new areas of risk or control issues
- Review risk management processes of the Committee following external review of Trust risk management policy and process
- Ensure Committee and Board make greater use of assurance mapping as part of 2020/21 approach to the BAF
- Clarify the distinct roles of the Audit Committee and Workforce Committee in relation to Freedom to Speak Up so as to avoid duplication of reporting

In a number of areas, the survey suggested the Committee was working well, but with responses agreeing rather than strongly agreeing that the Committee was working well. This again may provide scope for reflecting on how the Committee can further develop and improve going forwards.

For example, the following areas were highlighted as “good” rather than “great”:

- Committee forward work plan
- Time to explore items in sufficient depth at meetings
- Clarity and quality of papers
- Timely circulation of papers
- Comprehensiveness of the assurances received by the Committee
- Reporting to the Board on levels of assurance received
- Offering sufficient challenge to internal and external audit

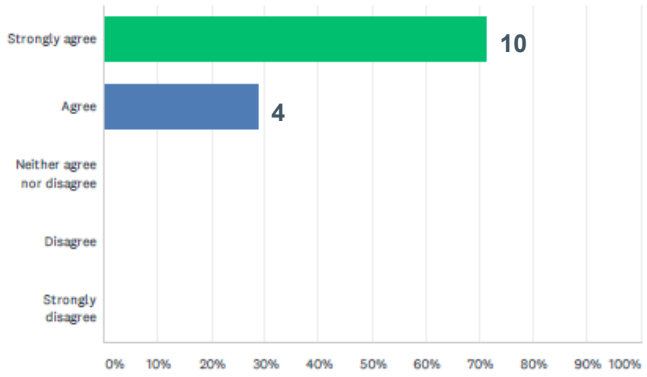
Appendix 1:
Full Audit Committee effectiveness review 2019/20 survey results



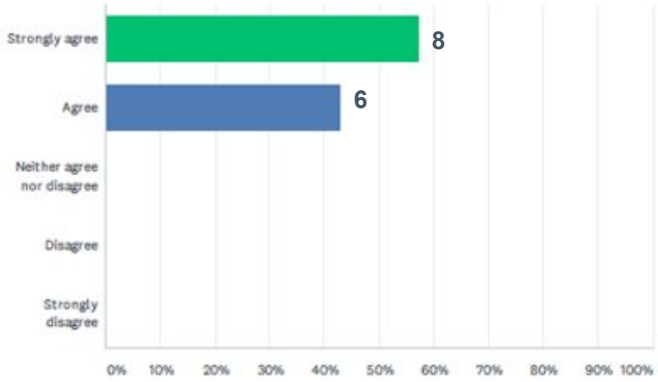
Appendix 1: Full survey results

Theme 1: Terms of Reference

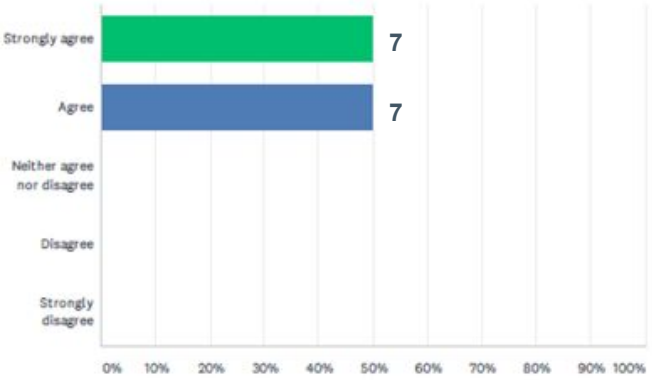
Q1: Does the Committee have Terms of Reference that have been approved by the Committee and by the Trust Board?



Q2: Do members and regular attendees have a clear understanding of the Committee's Terms of Reference and the role and responsibilities of the Committee?



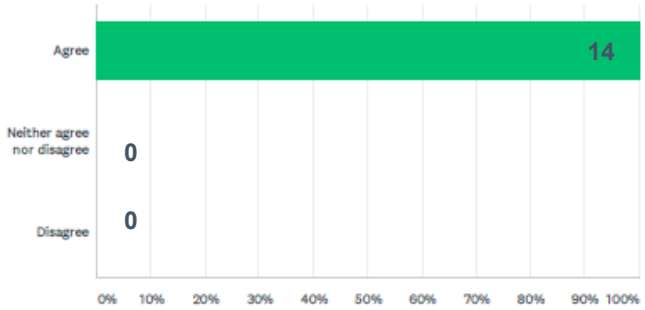
Q3: Does the Committee have in place an agreed business cycle / forward work plan that is fit for purpose?



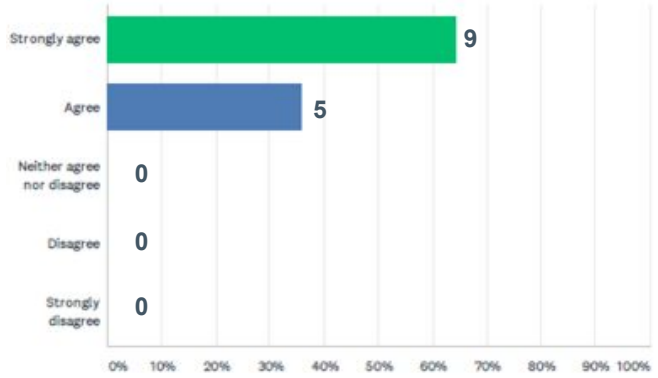
Appendix 1: Full survey results

Theme 2: Membership and attendance (1 of 3)

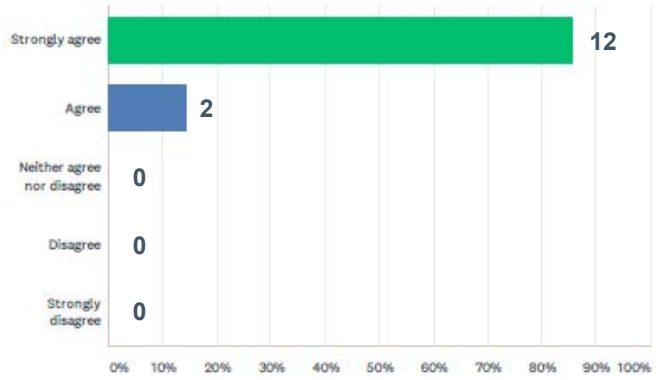
Q4: Does the Committee have a minimum of three members, including the Committee Chair, who are all non-executive directors of the Trust?



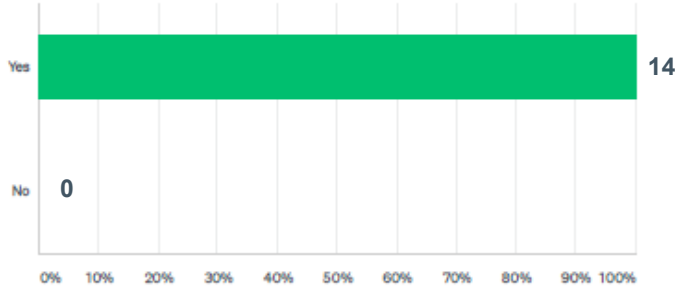
Q5: Is the Committee chaired by an individual who is appropriately independent?



Q6: Does at least one member of the Committee have recent and relevant financial experience sufficient to allow the Committee to competently analyse the financial statements and understand good financial management discipline?



Q7: Do the Chief Finance Officer, Chief Corporate Affairs Officer, Head of Internal Audit and External Auditor regularly attend meetings?



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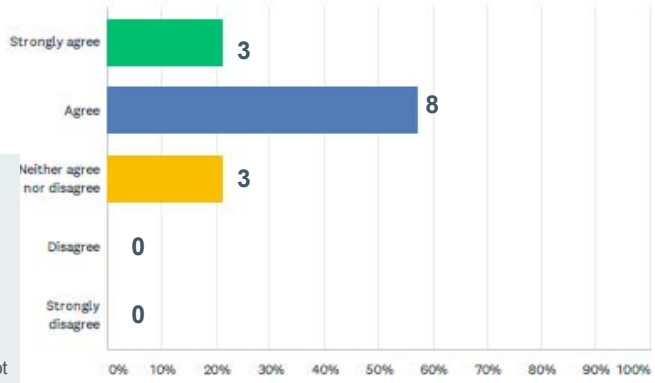
Appendix 1: Full survey results

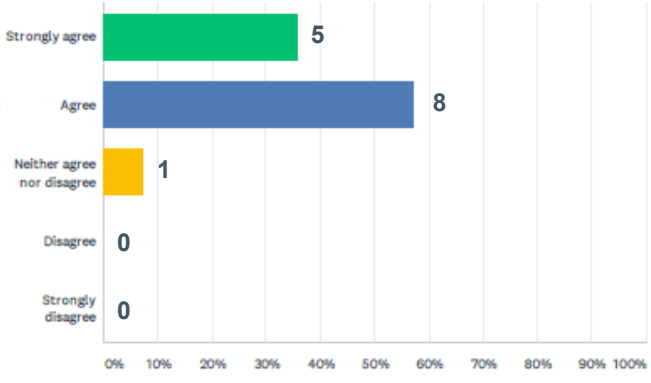
Theme 2: Membership and attendance (2 of 3)

Q8: Are you satisfied with the range, frequency and numbers of executives and other participants attending the Committee?



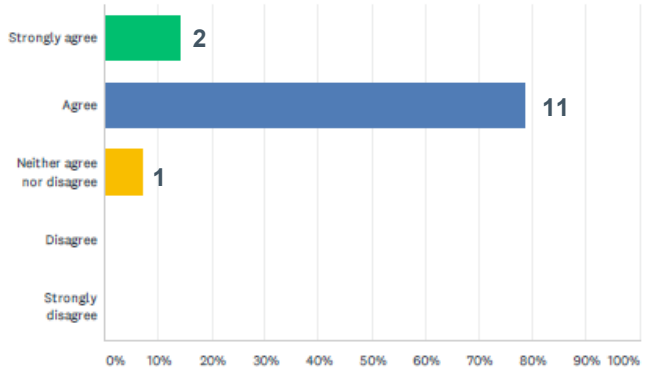
Comments:
- CFO and CCAO regular attendees. Some variability in others.
- Attendance by relevant executives for internal audits in their areas is important. This generally happens but there have been some occasions on which the lead executive has not attended.

Q9: Does the Committee collectively have the range of skills needed to ensure the Board receives the assurance it needs on governance, risk management, the control environment, and on the integrity of all elements of the Annual Report and Accounts?

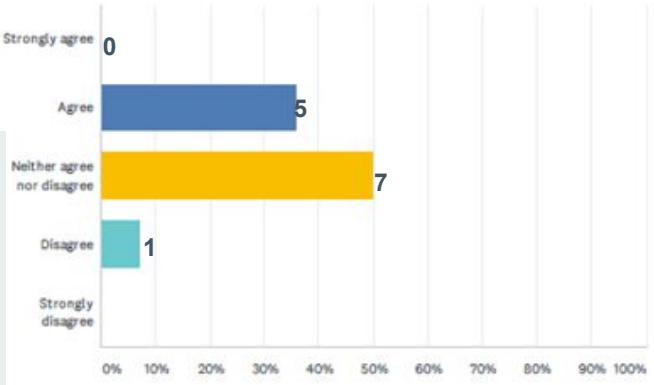


Comments:
- Yes and will opt in other subject matter experts as required

Q10: Does the Committee (through its members and those in regular attendance) possess the wider skills to be fully effective (e.g. in relation to the core business of the Trust, change management, operations, and strategically relevant issues)?



Q11: Does the Committee have effective induction and training arrangements for new members?

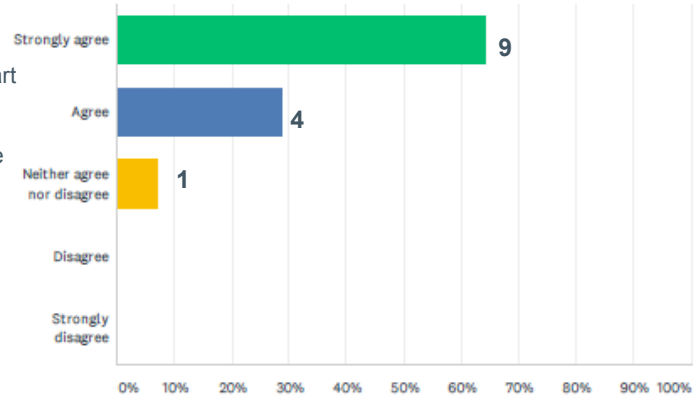


Comments:
- Only a small amount of turnover, but planned for incoming chair. Would need to think about induction for some of the execs into role of AC.
- I don't know
- As I'm not a listed attendee for the Committee I can't comment on this point through direct experience
- I don't know – I haven't had the experience of seeing new members being inducted or trained
- I believe we do – but the new chair can confirm on her arrival whether or not this training is effective
- I know effort has been put into this recently but I didn't receive a specific induction when I joined the Committee (2 or so years ago)

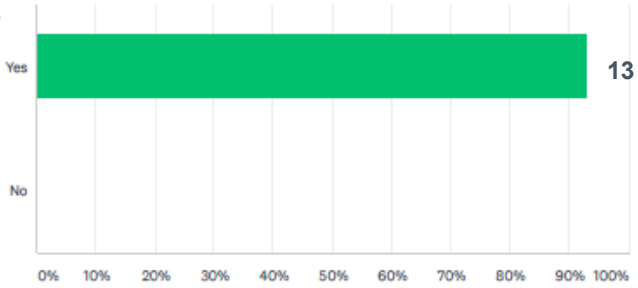
Appendix 1: Full survey results

Theme 2: Membership and attendance (3 of 3)

Q12: Do those attending the Committee declare material interest at the start of each meeting and is appropriate action taken when relevant matters are discussed?



Q13: Do members of the Committee periodically meet privately with the external auditors and internal auditors?



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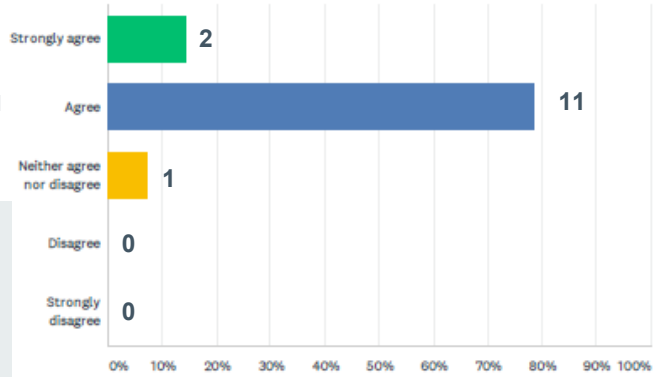
Appendix 1: Full survey results

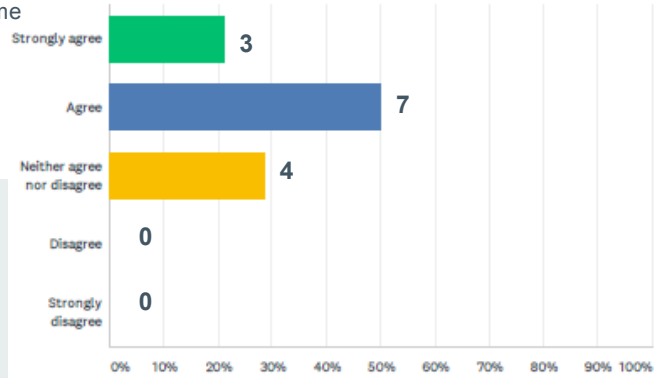
Theme 3: Agenda and papers

Q14: Do agendas and the forward programme of work for the Committee cover the assurance needs of the Board through a balance of appropriate agenda items?



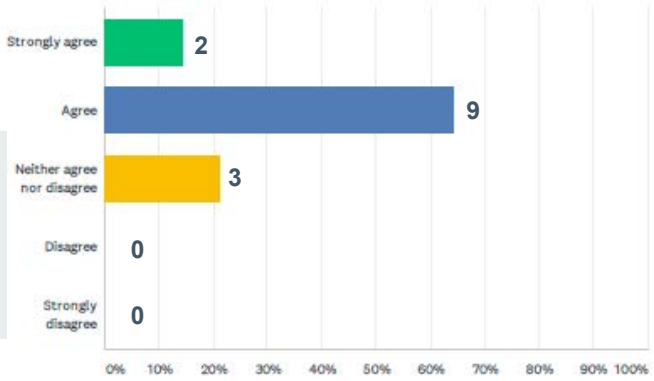
Comments:
- Agree fully – but link through to BAF not yet as clearly structured and evidenced as it might be. Lead on BAF (Chief Nurse) is developing this at present.

Q15: Is there sufficient time on the agenda to explore issues in appropriate depth?



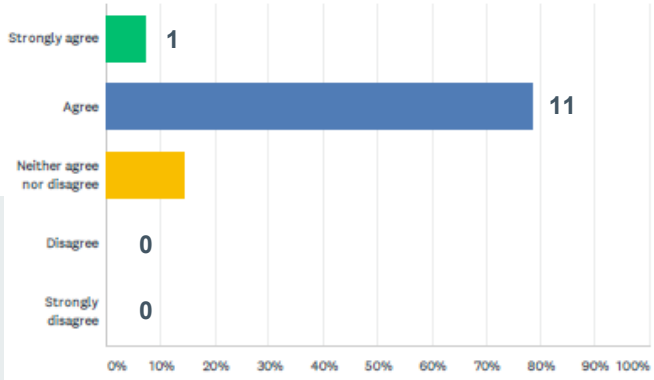
Comments:
- It's a balance and the Chair is effective in managing agenda time appropriately

Q16: Are papers for the Committee submitted and circulated in a timely way?



Comments:
- Usually they are, on occasion some papers arrive a little late

Q17: Are papers for the Committee clear, concise, provide enough information for the Committee to reach informed conclusions and provide appropriate assurance to the Board?

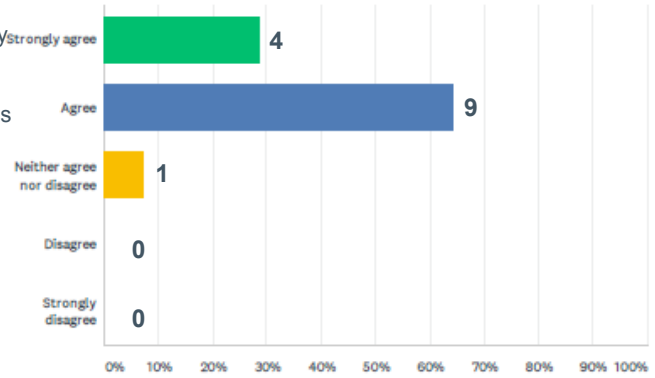


Comments:
- Papers for the Audit Committee are generally of good quality
- From limited experience of attending the Committee I would say yes

Appendix 1: Full survey results

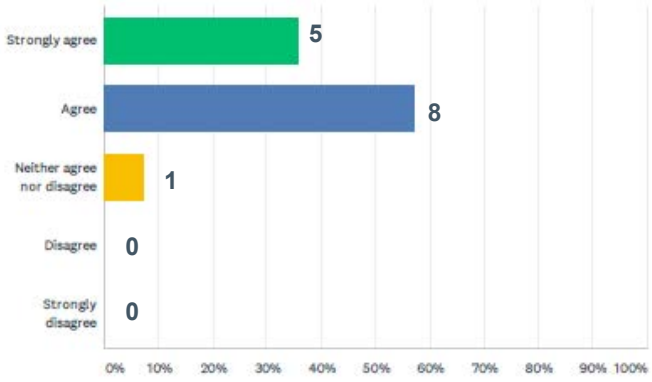
Theme 4: Meetings

Q18: Are meetings of the Committee chaired effectively (e.g. keeping the meeting to time, to agenda, to the point, enabling attendees to express their views, challenging inappropriate behaviours, summing up actions?



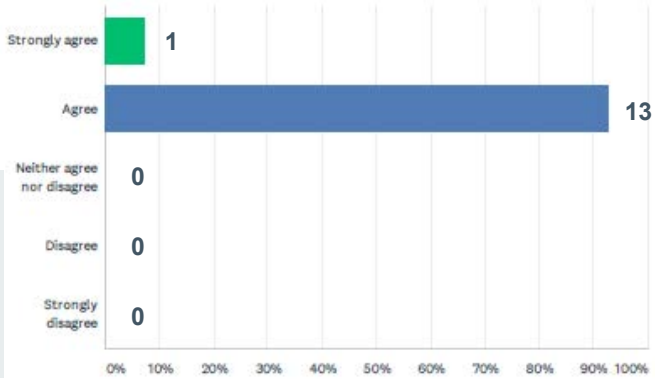
Q19: Does the Committee provide insight and strong, constructive challenge to the organisation where required?

Comments:
- The Committee offers challenge almost always in a constructive way
- At times can move into operational detail



Q20: Does the Committee critically review the comprehensiveness and reliability of the assurances it receives from across the Trust?

Comments:
- Always room for improvement in any organisation in this area



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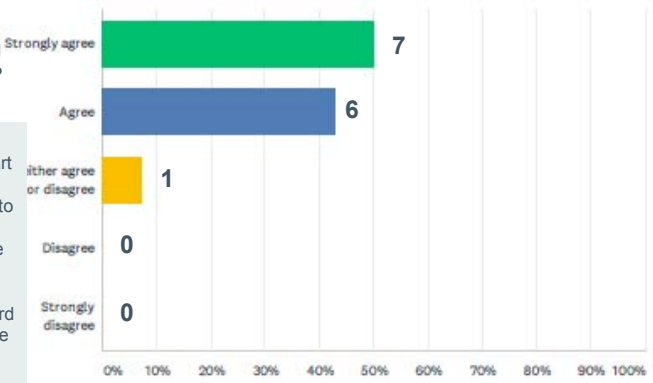
Appendix 1: Full survey results

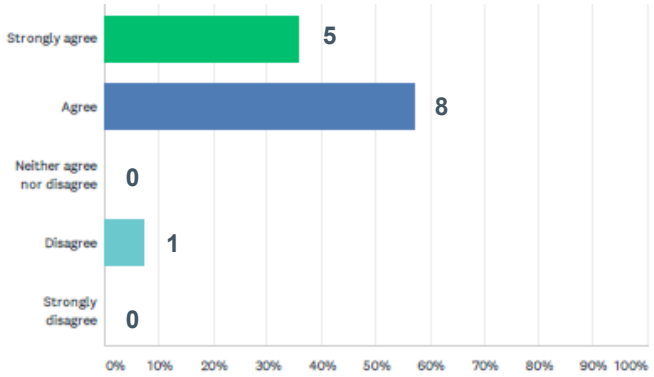
Theme 5: Reports and escalation

Q21: Does the Committee discuss matters for reporting and escalation to the Board?



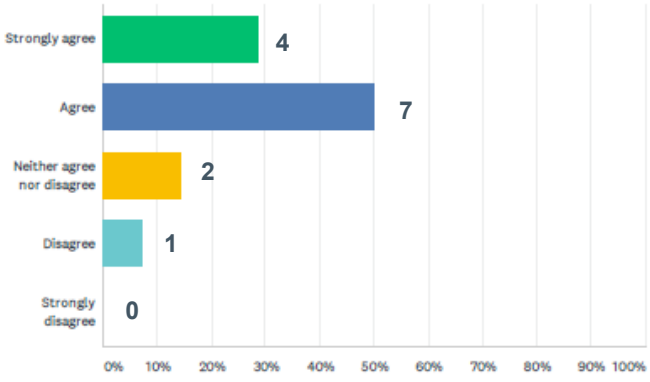
Comments:
- This is usually discussed as part of the closing administration at meetings. Items for escalation to the Board are set out in the Committee Chair's report to the Board
- Explicitly, the Chair reviews matters for escalation and Board reporting orally at the end of the meeting

Q22: Does the Committee provide the Board with a clear report setting out the issues considered and the level of assurance taken by the Committee?



Comments:
- Yes, although as part of the plans for developing and reporting from Committees to the Board in 2020-21, we are exploring a new model to set out more explicitly the areas where the Committee was assured, gaps, and escalation

Q23: Are new risks and control issues escalated by other Board Committees to the Audit Committee for consideration and does the Audit Committee escalate appropriate issues to the Board?

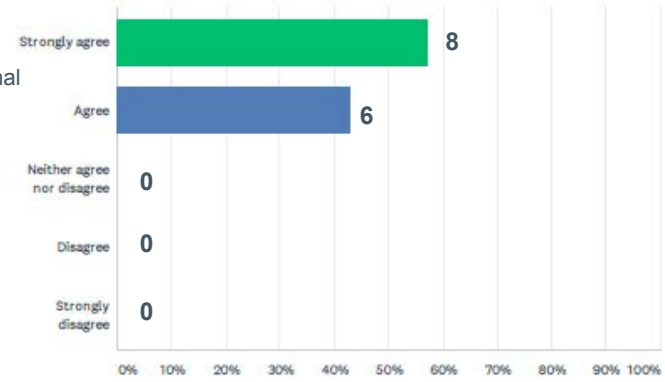


Comments:
- Yes, but clear tracking through to BAF, still under development, needs to be completed and implemented

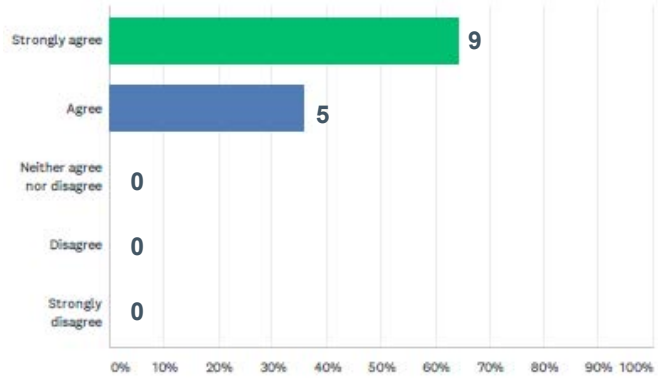
Appendix 1: Full survey results

Theme 6: Audit-specific issues (1 of 4)

Q24: Does the Committee review and approve the internal audit plan and internal audit strategy?

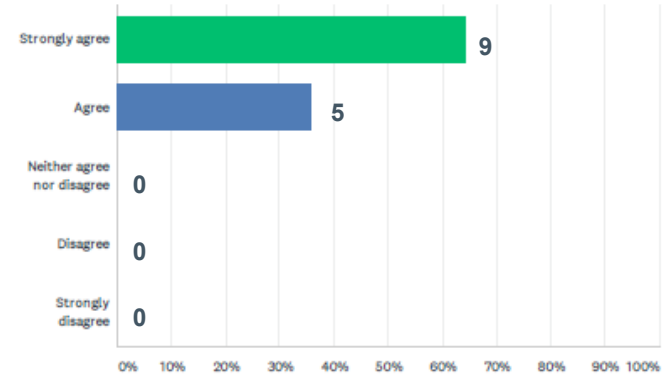


Q25: Does the Committee track all audit recommendations and hold the organisation to account for their implementation?

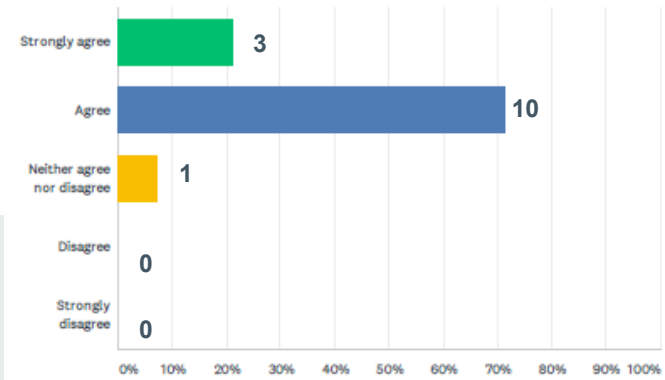


Comments:
- Yes, and grip of these has improved over the last year
- Regular review by TEC of completion of actions effectively reinforces timely completion between Audit Committee meetings

Q26: Does the Committee review the findings of the external auditors and consider the implications and the management's response to their work?



Q27: Does the Committee sufficiently consider and challenge the work of internal audit and external audit?



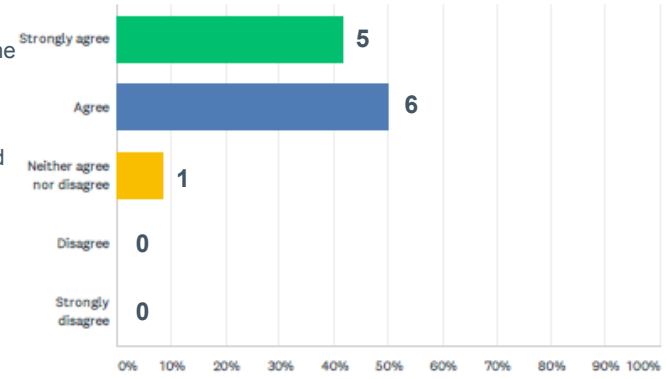
Comments:
- Generally yes, but there is scope for more

6.1

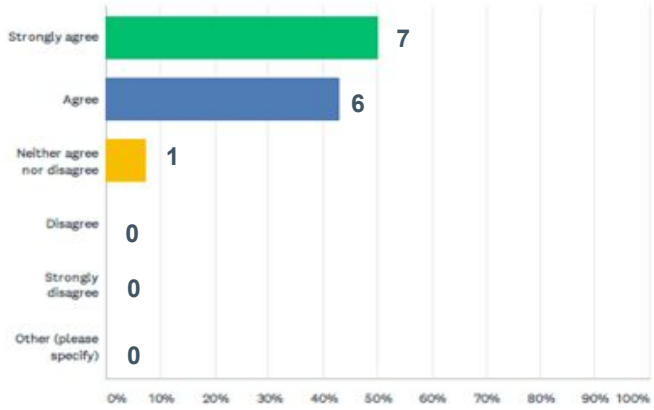
Appendix 1: Full survey results

Theme 6: Audit-specific issues (2 of 4)

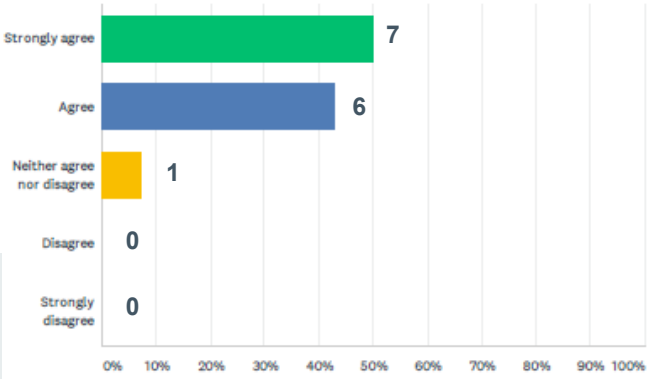
Q28: Does the Committee lead on the assessment of the Annual Governance Statement for the Board including the provision of advice on its preparation and scope?



Q29: Does the Committee give sufficient attention to financial management and reporting issues, including the consideration of key accounting policies, estimates and judgements and the quality of year-end financial statements?

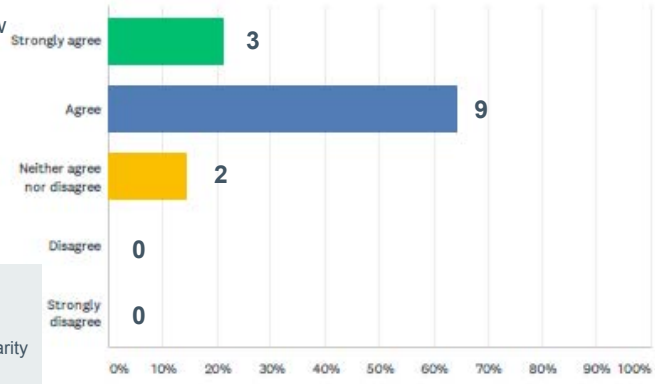


Q30: Does the Committee regularly review the adequacy of anti-fraud, anti-bribery and anti-corruption arrangements and receive an annual report from the Local Counte Fraud Specialist for the reporting year?



Comments:
- Yes, although there is scope for improving the reporting of counter fraud issues in line with the training provided to the Board

Q31: Does the Committee review arrangements that allow staff of the Trust and other individuals where relevant to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters?

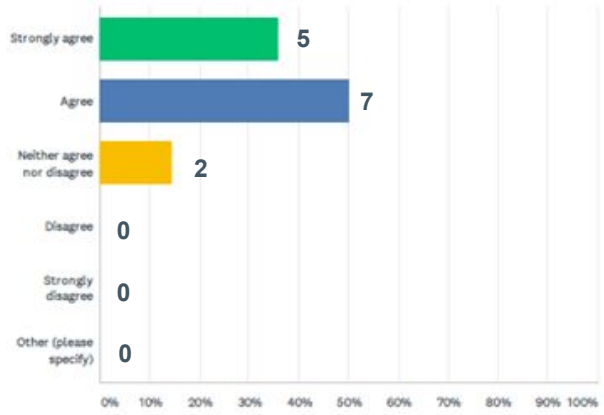


Comments:
- Could always do more in this area
- Yes, but in reviewing these arrangements there needs to be clarity between the role of the Audit Committee as the Committee providing assurance that the arrangements are robust, and the role of the Workforce and Education Committee,which also receives reporting on FTSU.
- The Committee has had a strong focus on the effectiveness of whistle blowing and freedom to speak up procedures in the last year or two, including completion of an internal audit - and will retain this focus until these processes are determined to be working entirely effectively by all relevant measures

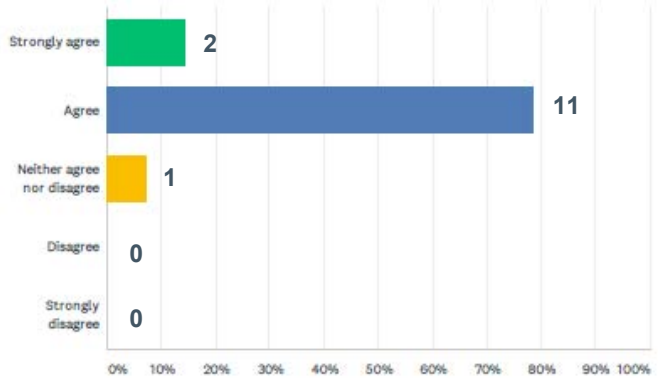
Appendix 1: Full survey results

Theme 6: Audit-specific issues (3 of 4)

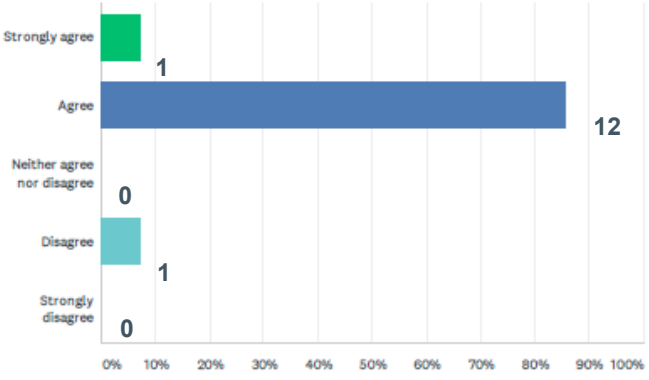
Q32: Does the Committee review the operation of the Standing Orders, Standing Financial Instructions, Schemes of Delegation, compliance with the Constitution and Code of Governance, and policies relating to managing declarations of interest?



Q33: Does the Committee review the establishment and maintenance of an effective system of governance, internal control, and risk management?

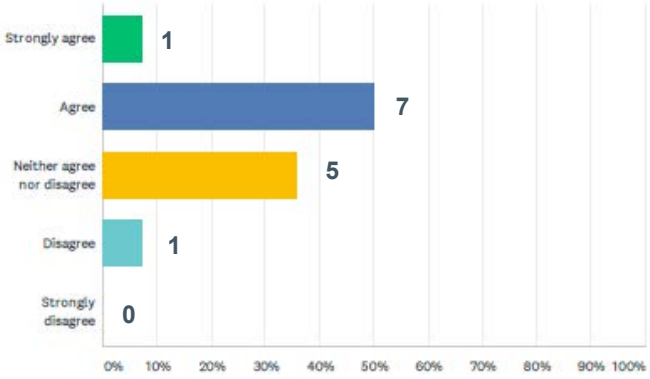


Q34: Does the Committee have a sufficient understanding of the organisation's overall control environment, including its governance and any outsourcing arrangements, and review its effectiveness regularly to provide assurance that arrangements are responding to risks within the organisation?



Q35: Does the Committee use assurance mapping to target areas of greatest risk in the Trust?

Comments:
- As noted above the structured mapping is under development

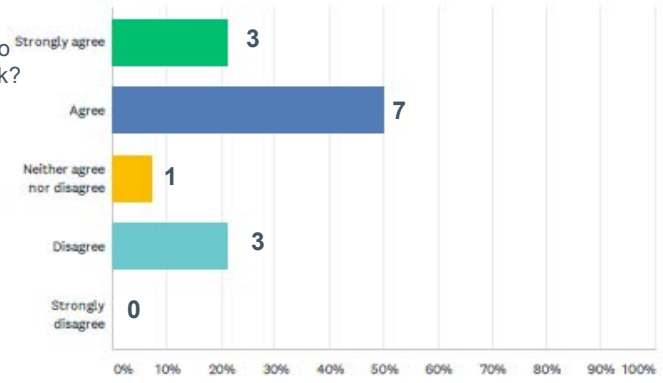


Comments:
- More work is needed in this area given the position of the Trust, esp the operational control environment
- Though governance at lower levels within the organisation has on occasion been difficult to fathom. A major review of clinical governance has recently been completed which will need careful consideration in its operation by AC

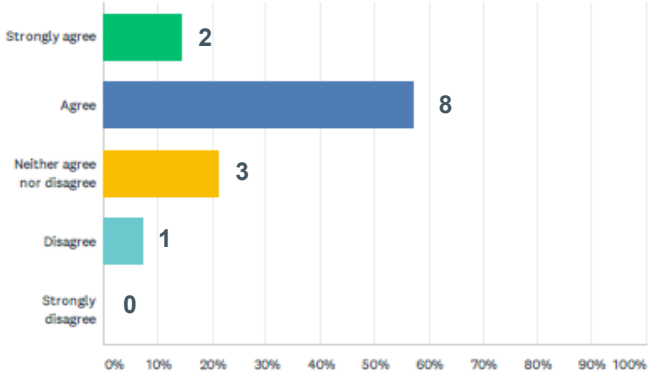
Appendix 1: Full survey results

Theme 6: Audit-specific issues (4 of 4)

Q36: Does the Committee draw the Board's attention to the results of its work on risk?



Q37: Does the Committee proactively commission additional assurance work where it has identified a risk or control issue which is not subject to sufficient review?

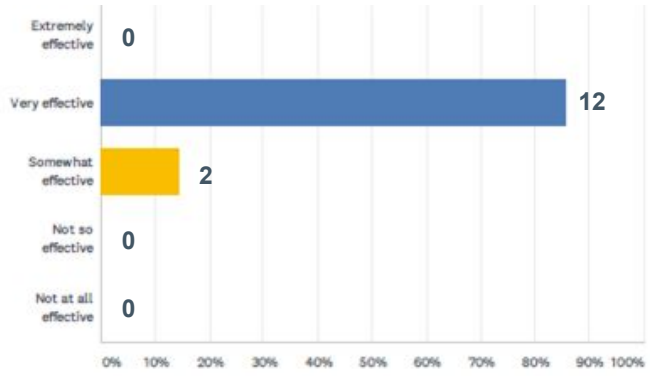


6.1

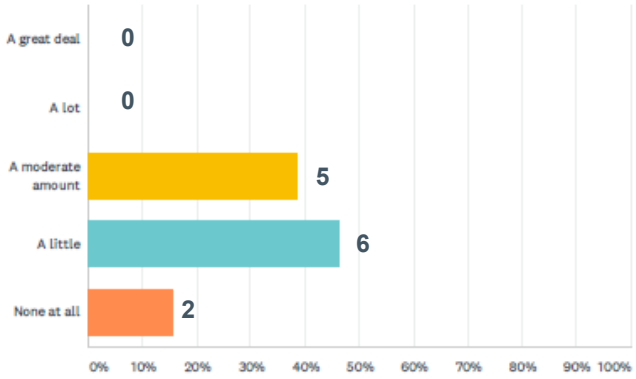
Appendix 1: Full survey results

Theme 7: Overall reflections

Q38: Overall, how effective would you say the Committee is in fulfilling its role?



Q39: Are there any other steps that could be taken to improve the effectiveness of the Committee



Comments:

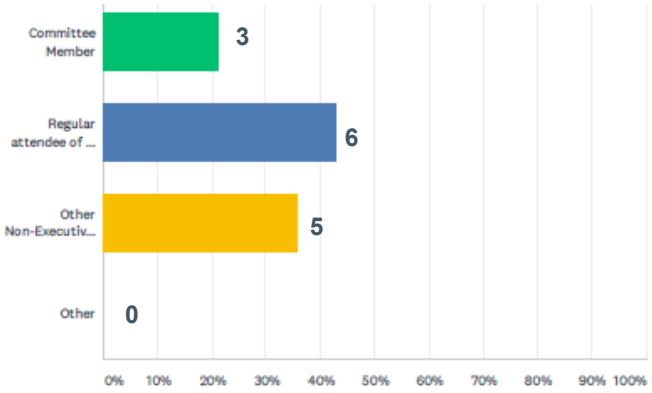
- The Audit Com should always challenge itself to do more/better. Aligning actions more closely against governance and control issues raised in reports (well led reports etc) might be worth looking at
- Generally, the Committee works well. There is effective challenge, testing of assurances, generally good quality papers, and well planned agendas. Its work on risk could be better defined and managed, and its role vis-a-vis the Workforce and Education Committee in respect of Freedom to Speak Up.
- Outcomes of recent Clinical Governance review ... implementation, oversight of operation and effectiveness review should be on AC 2020 work plan

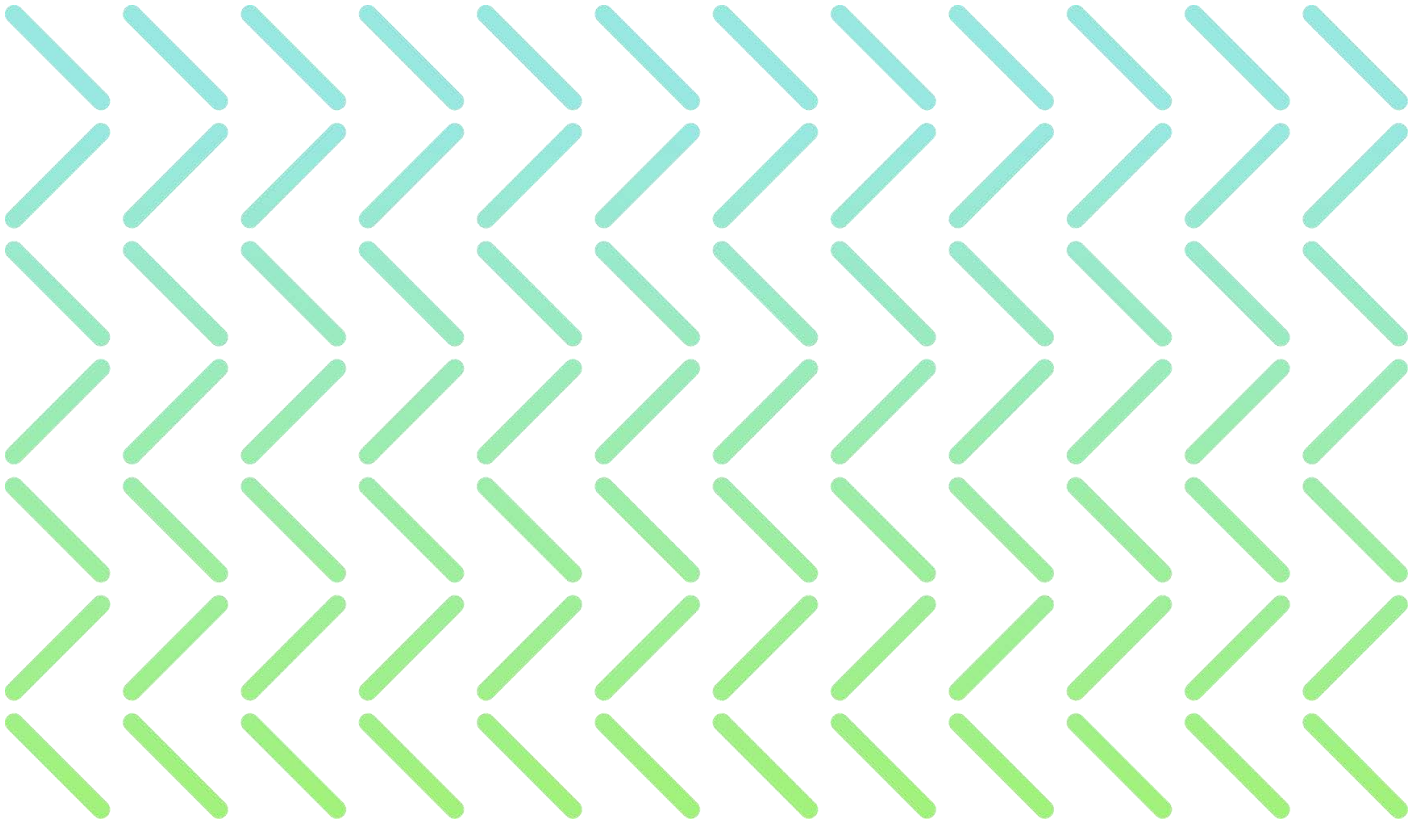
6.1

Appendix 1: Full survey results

Theme 8: Monitoring

Q40: What is your role in relation to the Committee?





Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	The Trust Board		
Date:	28 May 2020	**Agenda No**	**6.2**
Report Title:	**St. George's Hospital Charity: Six Monthly Update (Q3-4 2019/20)**		
Lead Director	Suzanne Marsello, Chief Strategy Officer (Director sponsor for St George's Charity)		
Report Author:	Amerjit Chohan, CEO, St George's Hospital Charity Vivien Gunn, Grants Manager, St George's Hospital Charity		
Presented for:	Approval Decision Ratification Assurance Discussion **Update** Steer Review Other (specify)		
Executive Summary:	At the April 2020 meeting the Charity's Finance Sub Committee received a draft report on Charitable Giving for the financial year 2019/20. During the year a total of £1.735m was spent, £996k being grant awards and £739k of restricted funds spend. The Charity's COVID-19 Appeal has been tremendously successful and has taken centre stage in this report. As of 7th May 2020 the Charity's income raised and pledged from the Appeal had raised circa £454,000. This is excluding the additional £98,000 the Charity has received from NHS Charities Together which takes the total raised to circa £552,000. The Charity has also received a large amount of generous donations. The Charity will be applying to NHS Charities Together for grant funding under its future schemes. The Charity is enormously grateful to all its supporters for the invaluable contribution they have made to its COVID-19 Appeal. The COVID-19 Appeal has been used to fund: Staff Wellbeing Hubs, Staff Care Packages, iPads to connect patients with families, Staff Team Thank You Awards, patient care supplies for wards, Personal Protective Equipment reusable gowns, staff appreciation support in the Year of the Midwife and of the Nurse and the COVID-19 Call for Applications funding scheme. This scheme allows Trust staff to apply for funding under various categories to support patients and staff. Additionally there is financial childcare support available and a contribution of £5,000 for funeral costs to the family of staff who have sadly died from COVID-19. Charity capital projects include the successful completion of Heberden and McEntee wards (total together £459,000), whilst other capital projects aim to be resumed once working practices allow. Fundraising for the Renal Appeal has halted for the time being due to the attention focussed on the COVID-19 Appeal. Total to date raised £97,000. The Charity approved 3 research projects in March 2020 for £398,000 and has secured a 7 year + research grant for £1,250,000 for the Advanced Ventricular Arrhythmia Training and Research (AVATAR) Programme which will be paid by yearly £150,000 instalments. The Charity will also be spending a legacy of £817,000 from Mr Hayler for research into neuro intensive care. Circa £42,000 was spent on funding medical equipment. The Charity very much looks forward to its continued close working with the		

6.2

	Trust.		
Recommendation:	The Trust Board is asked to: ➢ Note the report, and the investment that has been awarded by the Charity in support of Trust projects.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieve good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Well-Led**		
Single Oversight Framework Theme:	▪ Strategic Change		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date:**	20th May 2020
Appendices:	None		

6.2

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

St. George's Hospital Charity October 2019 to May 2020 Update

1.0 Purpose

1.1 The report is provided to give the Trust Board an update regarding the activities of the Charity since October 2019.

2.0 St George's Hospital Charity Activity Update

This report covers the period from October 2019, the time of the Charity's last report to the Trust, to May 2020. It will start with matters prior to the coronavirus pandemic and will then focus on the Charity's response to the crisis.

Business at the end of the financial year 19/20 was affected by COVID-19 as normal working patterns changed and Trust staff had to quickly change priorities to adapt to new requirements. At the April 2020 meeting the Charity's Finance Sub Committee received a draft report on Charitable Giving for the financial year 2019/20. During the year a total of £1.735m was spent, £996k being Grant awards and £739k of restricted funds spend. A number of grants totalling £149k were retracted.

Formal Board of Trustee meetings took place on 22 November 2019 and 20 March 2020.

2.1 Charity Capital Projects Update

The Charity is working with the Trust Capital Team with which it was meeting on a monthly basis prior to COVID-19. Of note:

- Thanks to a generous legacy the Charity funded the £209,000 refurbishment of McEntee Ward, the Trust's infection control ward which was completed in April 2020.
- The Charity was making good progress towards nearing the final plans for the refurbishment of the Forget-Me-Not-Suite in maternity. This is a separate suite of rooms for parents to be who have sadly faced the death of their new born baby. The Charity is immensely grateful to a couple who suffered such a loss who have been instrumental in raising funds for this refurbishment. The Charity hopes work on completing the refurbishment plans for this project will resume soon so that work can begin. Project budget circa £66,000.
- Similarly progress was being made prior to COVID 19 on finalising plans to use a longstanding grant for £60,000 to renovate the maternity reception on Level 1.
- Plans for the makeover of the parent's antenatal room on level 4 were also making progress and the Charity is looking forward to the project being resumed.
- The redevelopment plans of the Children's Garden located next to the Dragon's Centre have progressed. Almost half the required budget will be funded by a generous corporate donor with the balance to be hopefully confirmed from other sources soon.
- The Charity is delighted that the Functional Walking Course for the rehabilitation of amputees with prostheses at Queen Mary's Hospital, circa £41,000 project, was completed with an opening event originally planned for April 2020, but which has had to be postponed.
- The Heberden Ward refurbishment was completed towards the end of 2019 with Charity funding of £250,000.

2.2 The Renal Appeal

Prior to the COVID-19 crisis, the Renal Appeal campaign had raised circa £97,000. As a result of the pandemic, the public has been keen to support the COVID-19 Appeal so the Renal Appeal has been

less active. Once we return to some sort of normality, the renal campaign will be resumed notwithstanding the new challenges faced by charities to fundraise. The Charity looks forward to learning more about the Trust's future plans for the renovation and refurbishment of the Courtyard Clinic to create a state of the art renal facility.

2.3 Research

Thanks to generous legacies, the Charity approved circa £398,000 in March 2020 for 3 projects:

1) £149,078 -The Use of Multimodal MRI in Clinical Practice to aid Diagnosis and Prognosis for Brain Tumours
2) £148,486 - Development and Evaluation of HPV Molecular Testing Approaches in a New Age of Cervical Cancer Screening
3) £100,988 -Platinum STRESS Study (Platinum Chemotherapy Stress-Induced RNA Exosome Immune Signature Study)

Regrettably due to COVID-19 these projects will be delayed as is other research which the Charity also funds.

Of note the Charity was awarded a £1,250,000 grant by a charitable foundation for the Advanced Ventricular Arrhythmia Training and Research (AVATAR) Programme. This programme will run for a minimum of 7 years. The Charity will receive the grant of £150,000 per year with each annual payment conditional on satisfactory annual reporting of programme progress. The project objective is to improve the knowledge and understanding of ventricular arrhythmia pathophysiology and advance ablation techniques through research, establish strong foundations and enhance the skills of trainees in the management and ablation of ventricular arrhythmias.

The Charity has also received £817,000 from a legacy by Mr Hayler in memory of his late wife to be used for research into Neuro Intensive Care.

2.4 Medical Equipment Funding:

- £25,939 Ultrasound Machine to be used jointly by Amputee rehabilitation and Spasticity Team
- 50 x Blood Pressure Monitors for maternal medicine (£1,542) to manage complex pregnancies so that pregnant women can monitor and report their own blood pressure readings and so only need to come in for essential matters including baby scans.
- £15,200 for 2 x Ultrasound Systems for Haemodialysis Unit to assist needling the arteriovenous fistula and graft as part of improving clinical practice.

3.0 The Charity's COVID-19 Appeal

The Charity's COVID-19 Appeal has been tremendously successful as a result of the Charity adapting to working remotely, supporting the Appeal campaign across all social media channels, co-ordinating donations, organising volunteers and working with the Trust closely to listen and respond to what was required.

As of 7th May 2020 the Charity's income raised and pledged from the Appeal had raised circa £454,000. This is excluding the additional £98,000 the Charity has received from NHS Charities Together which takes the total raised to circa £552,000. The Charity has also received a large

number of generous donations. The Charity is incredibly thankful to the wider community for its amazing generous support.

Using donations and COVID-19 Appeal funds, the Charity has supported a number of programmes to support patients and staff by working with the Trust in very close partnership. This has played an important role in the success of the programmes to date. Programmes supported are:

3.1 COVID-19 Support Programmes

- 4 x Wellbeing Hubs to provide staff with an area to unwind and rest. The Charity equipped the Hyde Park Room, The Cardiac Gym, the Grosvenor Room and the Doctor's Mess. A fifth is desired at Queen Mary's Hospital although identifying a suitable space is proving difficult. The Charity appreciates the support of the Trust's Capital Team with which it worked to complete the hubs and the Trust's senior management team.
- The Wellbeing Hubs are supported by Project Wingman – a British Airways and other airlines initiative serving staff with refreshments chiefly in the Hyde Park Room.
- Staff Care Bags – the Charity with the help of wonderful volunteers has been organising staff Care Bags which have been distributed throughout the Trust, aiming to ensure that everyone is remembered and so feels appreciated. They contain food, drink and toiletries depending on what is donated. The Charity is supplementing donations by also purchasing supplies using Appeal Funds. The Charity has distributed over 5,000 care bags.
- iPads to connect patients with family and friends - the Charity has received many donations of iPads as well as purchasing additional ones (in total over 100). The Charity has worked with the Trust who have developed a corporate software solution to provide this communication facility to patients. The iPads are being distributed across COVID ICU and COVID wards in conjunction with other hospital areas who have requested them. The roll out of the iPads programme brings innovation to both patient care and communication.
- Team Thank You Awards – with the Trust the Charity launched this weekly initiative in May. This is proving enormously popular with staff invited to apply.17 teams have been awarded with Amazon Gift Vouchers in the first two weeks with circa 80 nominations received to date.
- The Charity is organising patient care supplies to the wards so that basic essentials such as toiletries are at hand for staff to draw on for patients.
- With a generous donation of £51,000 the Charity is purchasing 3,000 reusable PPE gowns.

3.2 Year of the Nurse and Midwife

The Charity has been lending its support to mark its appreciation of staff in this the Year of the Nurse and of the Midwife. This includes:

- International Day of the Midwife – the Charity participated in the selection panel for choosing 8 staff awards from over 100 nominations received. The Charity funded prizes and refreshments to mark the occasion which was held in the Hyde Park Room in staged visits by staff at required social distances.
- Using COVID Appeal funds, the Charity is funding £10 Gift Cards for a total of 4,800 nurses, healthcare assistants and midwives to mark the Year of the Nurse.

3.3 COVID-19 Call for Applications

In early May 2020 the Charity launched its COVID-19 Call for Applications under which staff can apply to the Charity for funding under various categories to support patients and staff. The grant application window will be open until June 19th 2020. Initial indications are that it has a strong uptake with a variety of requirements requested particularly to improve staff areas following the

Wellbeing Hubs initiative as well as requests to fund medical equipment and other equipment to aid remote working amongst staff as well as with patients.

3.4 Childcare Support

Separate to this the Charity is also working with the Trust Childcare Co-ordinator to assess applications for financial support with childcare for staff who have incurred exceptional additional costs due to the crisis and changing working patterns. This will also be open until June 19th 2020.

3.5 Funeral Costs Support

Sadly the Trust and one of its NHS contractor partners have suffered staff deaths due to COVID. The Charity is providing £5,000 to the family of each deceased person as a contribution to funeral costs. This is managed by the Trust.

3.6 The Charity's Arts Programme

The Arts Programme for patients has been reviewed due to the pandemic. This is being done in a number of ways:

- Expanding a pilot of virtual one-to-one artist sessions
- Planning St George's Music Week - a week of live online music performances
- A series of monologues, "Unmasked", sharing the experiences of staff
- A patient activity book has been commissioned

3.7 NHS Charities Together

The membership organisation for NHS Charities, NHS Charities Together, has raised over £100,000,000 to distribute to its members which it intends to do under various schemes being finalised. The Charity has received £98,000 already. Future funds awarded will be conditional on applying for grant awards. Grants schemes under which the Charity may formally apply for further funding will be:

- Stage 1: in addition to the 98,000 received by the Charity to date over and above the appeal funds raised, is a further £10,000,000 for which to apply with a focus on BME/Disabled Groups and Hidden Communities
- Stage 2: Integrated Community and Social Care Pathways Grants (voluntary, care & hospice sector – patients leave hospital more quickly and safely)
- Stage 3: Recovery and Post Pandemic Grants – to support mental health and recovery of NHS staff and volunteers

The Charity looks forward to working with the Trust to identify projects to fund under the above categories. Preliminary conversations between the Charity and the Trust have taken place.

Going forward the Charity looks forward to working hand in hand with the Trust so that everyone benefits from the huge amounts of funds raised by Captain Tom and others who have been part of the appeal managed by NHS Charities Together.

Meeting Title:	**Trust Board**		
Date:	28 May 2020	**Agenda No**	
Report Title:	**Annual Self-Certification of Compliance with Foundation Trust Licence**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approval		
Executive Summary:	Each year each NHS Foundation Trust must undertake a self-certification of compliance with its licence. The self-certification covers three licence conditions: • Systems for compliance with licence conditions and related obligations (Condition G6); • Availability of resources (Condition CoS7(3)); • NHS foundation trust governance arrangements (condition FT4(8)); • Training of Governors NHS Foundation Trusts are no longer required to submit their self-certifications to NHS England and NHS Improvement (NHSE&I). However, NHSE&I selects a number of Trusts to audit the self-certifications. St George's was selected for audit in 2018 and NHSI (as it was at the time) was content with its self-certification. As there have been no material changes in the process, the self-certification set out in this paper adopts the same overall approach as used by the Trust in 2018 and 2019. The self-certification must be published on the Trust's website by 30 June 2020.		
Recommendation:	The Board is asked to review and approve the self-certification against each of the licence conditions, including the proposed response in each area, to enable the Trust to complete the self-certification process.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five themes: Safe, Effective, Caring, Responsive and Well-led		
NHS Oversight Framework Theme:	Well-led		
Implications			
Risk:	As set out in the paper.		
Legal/Regulatory:	An assessment of compliance with licence conditions is required to be undertaken annually and to be approved by the Board.		
Resources:	There are no resource implications.		
Previously Considered by:	Trust Management Group	**Date**	20 May 2020
Equality Impact Assessment:	N/A		
Appendix:	Key Questions and Proposed Response		

Annual Self-Certification of Compliance with Foundation Trust Licence

Trust Board, 28 May 2020

1.0 PURPOSE

1.1 This paper sets out the Trust's proposed annual self-certification against its provider licence.

2.0 BACKGROUND

2.1 NHS England and NHS Improvement (NHSE&I) requires all NHS Foundation Trusts to undertake a self-certification on an annual basis against three licence conditions and one further activity, the training of governors. The purpose of the self-certification is to provide assurance that the Trust is compliant with the conditions of its licence. Compliance with the licence is routinely monitored through the NHS Oversight Framework but the annual self-certification is intended to provide additional assurance.

2.2 Providers were previously required to submit their self-assessments to NHSI via a dedicated portal. However, since 2018 this is no longer the case and NHSE&I instead selects a number of Trusts to ask for evidence that they have self-certified by providing the completed self-certification or relevant Board minutes and papers recording sign-off. In 2018, St George's was selected as one of the Trusts whose self-certification was audited. The Trust provided its self-certification and related documentation, as approved by the Board, and NHSI was satisfied that the process had been completed appropriately. As a result, the 2020 self-certification follows the same format and approach undertaken in recent years.

3.0 SELF-CERTIFICATION REQUIREMENTS

3.1 The Trust is required to self-certify the following conditions after the financial year end:

- That the Trust has taken all precautions to comply with the licence, NHS acts and NHS Constitution. This involves the Trust self-certifying that it has systems and processes that identify risks to compliance with the licence, NHS acts and NHS Constitution and that guard against those risks occurring (Condition G6).

- That the Trust has a reasonable expectation that required resources will be available to deliver designated services over the coming 12 months (Condition CoS7(3)). The Trust is required to self-certify against one of the following statements:

    - The required resource will be available for 12 months from the date of the statement;
    - The required resources will be available over the next 12 months, but specific factors may cast doubt on this; or
    - The required resources will not be available over the next 12 months.

  The required resources include: management resources, financial resources and facilities, personnel, physical and relevant asset guidance.

- That the Trust has appropriate governance structures and systems in place. There is no set approach for demonstrating this, but NHSE&I expects a compliant approach to

involve a review of the effectiveness of the Board and Committee structures, reporting lines and performance and risk management systems (Condition FT4(8)).

- That the Trust has provided adequate and appropriate training to its governors to enable them to carry out their roles.

3.2 For each condition or activity the Trust must either:

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

3.3 It is considered good practice to set out a brief statement explaining how the Trust considers it has complied, including any risks and mitigating actions. These will not be submitted to NHSE&I, though NHSE&I may review these should it select the Trust for audit purposes.

3.4 The deadline for submission of all self-certifications, except for FT4(8), is 31 May 2020. For FT4(8), the deadline is 30 June 2020, but there is no reason not to provide all responses at the same time. The self-certifications must be published on the Trust's website by 30 June 2020.

4.0 SELF-ASSESSMENT

4.1 The self-assessment set out at Appendix 1 proposes to the Board that the Trust is compliant with all three conditions, as well as the additional declaration in relation to the training of governors.

4.2 In relation to licence condition CoS7(3) (sufficient resources to deliver services over the coming 12 months), we propose to confirm that we are compliant, notwithstanding the fact that the Trust has remains in financial special measures and, at the point the budget was approved, had a projected income gap. This is on the basis that we anticipate that NHS England and NHS Improvement will fund this gap as part of its commitment to fund the Trust to break even. As a result, and despite risks to the financial position, we consider that the Trust can reasonably meet this licence condition. This is consistent with the approach taken in 2018 and 2019 where the Board agreed that the Trust should self-certify that it met this licence condition despite the Trust being in financial special measures and having a forecast deficit of £29m for 2018/19 and a forecast deficit of £3m in 2019/20. Previously, in 2017, the Trust reported that it was non-compliant with CoS7 as at that point in time it did not have in place an agreed annual plan. Given the fact that the Trust remains in financial special measures, the Board is asked to consider whether it is content to approve a self-certification of compliance in relation to this condition.

5.0 RECOMMENDATION

5.1 The Board is asked to review and approve the self-certification against each of the licence conditions, including the proposed response in each area, to enable the Trust to complete the self-certification process.

Stephen Jones
Chief Corporate Affairs Officer
28 May 2020

APPENDIX 1: SELF CERTIFICATION AGAINST LICENCE CONDITIONS 2019/20: CERTIFICATION DECLARATIONS AND STATEMENTS

Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
G6	Has the Trust taken appropriate steps to establish, review and maintain systems to identify and effectively manage risks?	*Confirmed*	*The Trust has taken appropriate steps to establish sound arrangements for risk management in the Trust. The Board has developed a Board Assurance Framework and process for assessing the strategic risks set out in the BAF. The BAF was updated in April 2019 following a review of the strategic risks and processes for overseeing the BAF. The BAF was formally reviewed by the Board on a quarterly basis during 2019/20. A further annual review of the BAF is currently being undertaken and the arrangements for regular review by the Board will continue in 2020/21.In addition, the full BAF will be presented to the Board in public in 2020/21, addressing feedback provided by the CQC in its 2019 inspection of the Trust.* *Strategic risks on the BAF are allocated to the Committees of the Board, with the exception of certain strategic risks that are reserved to the Board. The Board Committees review the risks allocated to them at each meeting and consider the risk scores, including any changes, and assurance statements to the Board. In 2019/20, the BAF was supported by the Chief Nurse and DIPC and by the Director of Quality Governance. For 2020/21, executive responsibility for the BAF has transferred to the Chief Corporate Affairs Officer.* *Risks on the Corporate Risk Register are scrutinised monthly by the Risk Management Executive, which undertakes this on behalf of the Trust Executive Committee which receives a report from RME. The risks on the Corporate Risk Register inform the risk scoring of the BAF. As part of the development of the updated BAF in 2019/20, the Trust made refinements to improve its risk management processes. An internal audit of the Trust's risk management processes was undertaken in 2019/20 and is scheduled to be considered by the Trust's Audit Committee in June 2020. The review has an indicative assurance rating of 'reasonable assurance'. The Trust is also undertaking further work to strengthen its risk management processes in 2020/21 and plans to review, with external input, service, departmental, divisional and corporate risk management processes.*

FT4(8)	Does the Trust have in place the governance systems necessary achieve the objectives set out in the licence condition?	*Confirmed*	*Following an external review of governance undertaken in 2017/18, the Trust made a number of changes to strengthen its Committee structures, reporting lines and risk management systems.* *The Trust has in place established Board and Committee structures. Committees review their effectiveness on an annual basis and these and these are used to identify areas for improvement. Every Committee of the Board conducts an annual review of its effectiveness. In 2019/20, Committee effectiveness reviews were conducted for the Quality and Safety Committee, Finance and Investment Committee, Audit Committee and the Workforce and Education Committee. These effectiveness reviews seek non-attributed feedback from members and regular attendees. All Committee in 2019/20 were judged to be effective, albeit specific actions to further improvement each Committee's effectiveness were identified and have been built in to each Committee's plans for 2020/21. Terms of reference for the Committees of the Board are agreed by the Board, and in 2019/20 the Board agreed changes to the Terms of Reference of the Workforce and Education Committee and Trust Executive Committee. The Terms of Reference of the Quality and Safety Committee, Finance and Investment Committee and Audit Committee are due to be considered by the Board at its meeting on 27 May 2020.* *There is an established risk management system (see statement above relating to condition G6). The Trust's performance is reviewed by the Board at each meeting, supported by the work of its sub-Committees.* *In 2019/20, the Trust conducted an in-depth review of its compliance with the NHS Foundation Trust Code of Governance and with its Constitution and reported on the results of this to the Audit Committee. The results demonstrated the Trust was substantially compliant with both.* *The progress the Trust has made in improving its governance systems and processes was evidenced in the latest inspection report by the CQC and the decision of NHS England and NHS Improvement, on the recommendation of the CQC, to take the Trust out of special measures for quality. This was a significant step for the Trust, which had previously been placed in special measures for quality in November 2016.*

CoS7(3)	Does the Trust have a reasonable expectation that it will have the required resources available to deliver designated services for the next 12 months?	*Confirmed*	*The Trust is subject to ongoing financial special measures, which were introduced in April 2017.* *Despite the suspension of the 2020/21 planning round as a consequence of Covid-19, the Trust has in place a Board-approved budget for 2020/21.As part of this, the Trust projects to break even in 2020/21. However, this is contingent on NHS England and NHS Improvement filling the income gap identified in the approved budget as part of its commitment to fund each Trust to break even. Covid-19 is expected to have significant financial implications, however NHS England and NHS Improvement have provided months 1 and 2 bloc contract payments at the start of the financial year and have committed to meet all reasonable and evidenced Covid-19 related expenditure by the Trust.* *The Trust recognises that aspects of its IT infrastructure and estate, in particular, need to be addressed but does not regard this as posing a risk to the resources available to deliver services in the next 12 months. On IT, significant work was undertaken in 2019/20 to reduce a significant number of IT risks facing the Trust. On estates, the Board has significantly increased its assurance regarding the Trust's position, the condition of the estate, and the actions being taken to address these. The Trust plans for 2020/21 include a capital programme of £50m and this will enable the Trust to address some of the most pressing estates issues.* *Management resources were maintained by appointments to the Board. A new position of Deputy Chief Executive was created and appointed to in May 2019 and a new Chief Operating Officer took up position in March 2020. Further senior appointments were made in 2019/20: three new Divisional Chairs to the Clinical Divisions were appointed and their roles were expanded and a new Divisional Director of Operations was appointment. Together this has strengthened divisional leadership. Two new Deputy Chief People Officers were also appointed in Q4 2019/20. A new Director of Estates and Facilities will join the Trust imminently and a recruitment campaign to appoint a new Chief People Officer is underway. The capability and continuity of the Board was also maintained through the appointment of two new Non-Executive Directors and an Associate Non-Executive Director and through the reappointment to new three-year year terms of office of two existing Non-Executive Directors and the reappointment of the Trust Chairman to a second term of office from April 2020.*

-	Has the Trust taken steps to ensure Governors are equipped with the skills and knowledge they require to fulfil their roles?	*Confirmed*	*The Trust has continued to provide a range of training and development opportunities for Governors to support them in their roles throughout 2019/20.* *In 2019/20, as part of the programme of Council meetings, Governors had briefings on patient partnership and engagement, Get It Right First Time and the Model Hospital, Information Technology, Volunteer Services, and staff engagement and the Trust's cultural change programme. Governors also received confidential briefings on steps being taken by the Trust to improve its cardiac surgery service, including updates from the Chief Executive and Chief Medical Officer on the progress of the independent mortality review into cardiac surgery at the Trust and a confidential briefing ahead of the publication of the independent reports. Alongside this, Governors were engaged and consulted in the development of the strategies developed by the Trust to support the delivery of its new clinical strategy 2019-24. This included sessions on the quality and safety strategy, research strategy, education strategy, digital strategy and the outpatients strategy.* *All Governors are notified of and encouraged to attend external events for Governors to increase their skills and knowledge and are supported to attend the NHS Providers Annual Conference for Governors (albeit there are limits in the number of delegates each Trust can put forward). In September 2019, the Trust hosted the NHS Providers London Governors Conference, and ten members of the Council of Governors attended. They received presentations from a number of external speakers, including the NHS England and NHS Improvement London Regional Director, on the current political, policy, financial and regulatory environment facing the NHS nationally as well as across London. Governors participated in a range of roundtable events and Q&A with presenters.* *Governors have been invited to take part in PLACE inspections at the Trust's Tooting and Roehampton sites. In addition, the Trust supports Governors to hold engagement sessions at the Trust's sites to engage with members and the public (Meet Your Governor Events) on a regular basis. In March 2020, the Trust supported Governors to hold constituency engagement events in the Trust's geographic constituencies in order to engage with members and the public and hear their views.* *In February 2020, following the most recent elections to the Council of Governors, the Trust held a briefing session for new Governors. This focused on the role of the Council and of*

			individual Governors in holding the NEDs individually and collectively to account for the performance of the Board and representing the interests of members and the public. It set out how the Council fitted within the governance structure of the Trust and the range of formal powers the Council exercises in relation to appointments and approval of significant transactions and the Constitution. This followed a programme of briefing events for prospective Governors ahead of the elections in which the Trust set out what being a Governor meant in practice. Upon commencement of their terms of office, Governors receive information about the Trust and are invited to meet the Corporate Affairs team to complete their Code of Conduct and discuss the sort of training and induction they require. Delivery of a full induction programme in March and April 2020 has, however, been limited as a result of the impact of Covid-19, but we are developing plans to support new Governors in their development virtually during the year. *Governors receive Parts 1 and 2 Board papers and are welcome to attend Part 2 of the Board as well as the Board Committees as observers. This ensures Governors have a wide range of information available to help them perform their roles effectively.* *The Council of Governors undertook a review of Council effectiveness in December 2019, which involved seeking unattributed feedback from Governors and Non-Executive Directors. Overall, this found that the Council was working effectively. However, it also identified a number of specific areas in which the Council could improve its effectiveness and this has been used to inform the development of the Council's work plan for 2020/21, which includes plans to hold a Council away day to focus on development (the timing and form of which may now be subject to social distancing rules).* *The Trust had planned to formally seek the views of the Council of Governors on the training Governors had received in 2019/20 at its meeting on 5 May 2020. Due to Covid-19, the meeting was cancelled and the views of Governors have instead been sought virtually, with Governors confirming their feedback by email. The Council has agreed the Trust should self-certify that this condition had been met. The Trust is committed to the training and development of its Governors and will continue to provide such support in 2020/21, virtually where necessary.*

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Meeting Title:	**Trust Board**		
Date:	28 May 2020	**Agenda No**	**6.4**
Report Title:	**Board Assurance Framework (BAF) – Quarter 4 2019/20 Assurance Rating and Full Board Assurance Framework**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Alison Benincasa, Director of Quality Governance and Compliance Maria Prete, Risk Manager		
Presented for:	Assurance		
Executive Summary:	This paper brings to the Board the summary page of the Board Assurance Framework (BAF) and the full BAF at the year-end position 2019/20. The summary sheet of the BAF (appendix 1) gives an overview of the risk profile of the Trust. The full BAF (appendix 2) provides the detail associated with the risks on the corporate risk register that contribute to the strategic risks. The BAF has been updated with the Quarter 4 2019/20 assurance ratings and statements from the Board Committees supported by a description of the assurances received. **Strategic Risks - Assurance Rating Quarter 4 2019/20:** In Quarter 4 2019/20 there has been no change to the overall assurance ratings for the sixteen strategic risks. Nine of the sixteen strategic risks have a 'partial' assurance rating and seven risks have a 'limited' assurance rating (see appendix 3 for definitions). Improvement in the assurance rating for SR4 did not materialise in Q4 as anticipated (IT). This was due to the impact of Covid-19 and the need to pause projects for example, roll out of the password standard to improve IT security, upgrade of Totara, patient records within iClip, data quality dashboard. The IT team focussed on increasing Service Desk provision, providing more laptops for home working with remote access licenses, provision of iPads and mobile phones for critical care teams. **Strategic Risk Scores – Changes in Quarter 4 2019/20:** The risk score has changed for one strategic risk as follows: • **SR3: Patients wait too long for treatment**: **Increased to 20 (from 16).** The increase is due to the new risks associated with COVID-19 and the impact of the pandemic on the provision of services during the initial COVID-19 peak and waiting lists for treatment and the number of those presenting to the emergency department. • **SR9: We are unable to deliver an estates strategy that supports the delivery of our clinical services strategy: Increased to 20 (from 16).** The increase is due to the impact of COVID-19 on the provision of clinical services across South West London and the implications for the development of the Trust's estates strategy. **Corporate Risk Register Risk Scores (risks contributing to the strategic risks) – Changes in Quarter 4 2019/20:** The table below identifies the changes made to the risks on the corporate risk register in Q4 2019/20:		

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Strategic Risk	Contributing Risk	Clinical/ Corporate Division	Change	Month change occurred
SR3	Covid-19	Corporate Nursing	New risk: Risk score 20	March 2020
SR4	Covid-19 remote working	ICT	New risk: Risk score 20	March 2020
SR9	Deliver the strategy (internally)	Estates and Facilities	Existing risk: Risk score	March 2020

	The Board is asked: 1. Note the changes in quarter 4 to the risk scores for contributing risks 2. Note the assurance ratings for quarter 4
Supports	
Trust Strategic Objective:	All
CQC Theme:	Well led
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability
Implications	
Risk:	The strategic risk profile
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence
Resources:	N/A
Previously Considered by:	Workforce and Education Committee — **Date** 18.02.2020 Quality and Safety Committee — 21.05.2020 Finance and Investment Committee – Finance — 21.05.2020 Finance and Investment Committee – Estates — 21.05.2020
Equality Impact Assessment:	N/A
Appendices:	Appendix 1. Summary Board Assurance Framework (BAF) – Quarter 4 2019/20 Appendix 2. Full Board Assurance Framework Appendix 3. Assurance ratings – definitions

Appendix 3 **Assurance ratings – definitions**

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

BOARD ASSURANCE FRAMEWORK OVERVIEW QUARTER 4 2019-2020											
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
				Q1	Q2	Q3	Q4				
1. Treat the patient, treat the person	*Low*	*SR1*	There is a risk that we do not create an environment and embed an approach to Quality Improvement which minimise the occurrence of harm to our patients					*The Committee has received assurance on the performance metrics within the IQPR, the implementation of the Critical Care Outreach service and use of Treatment Escalation Plans for adults. There has been sustained improvement in complaints response performance since July 2019 across all complaint categories. An update report was received at Quality and Safety Committee in January 2020 which outlined Quality Improvement activity in the Trust. The Quality and Safety Strategy 2019-24 was approved at Trust Board in January 2020. CQC inspection report was received in December 2019 and identified two regulatory requirements (MUST dos) related to consent and storage and accuracy of medical records. Improvement actions have commenced, however the delivery dates for improvement actions are under review due to the impact of Covid-19. Trust has received the audit report from TIAA, its internal auditors. The audit report gives substantial assurance for learning from incidents. Although the committee received assurance on progress in some areas the assurance rating is currently partial to reflect the need for further work and improvement.*	Chief Nurse	Quality & Safety Committee	12
	Low	*SR2*	There is a risk that our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care.					*The Committee has received assurance from the Cardiac Surgery update reports on progress. The CQC inspection report December 2019 noted improvements in governance processes for Cardiac Surgery Services. The external mortality review was published in March 2020 and the Board has received assurance regarding the actions being taken to improve the service. The Trust temporarily stopped undertaking cardiac surgery as part of a Pan-London Covid-19 agreement whereby cardiac surgery was diverted to Barts and Harefield to enable Trusts to free-up the resources and to optimise infection control arrangements for patients. Now that the Covid-19 peak has passed, the Trust is working towards the resumption of cardiac surgery in collaboration with neighbouring Trusts and the London region. In December 2019 Board supported the recommendation for additional investment to take forward the recommendations from the two external reviews; however the delivery dates for improvement actions are under review due to the impact of Covid-19. The assurance rating is currently partial to reflect the need for further work and that further assurance with reference to delivery is required.*	Chief Medical Officer	Quality & Safety Committee	15
2. Right care, right place, right time	*Low*	*SR3*	There is a risk that our patients wait too long for treatment					*The Committee has received assurance on the 4 hour operating standard and noted that performance was variable. Assurance was provided on the management of patient pathways at QMH following data migration to iClip. The review of the risk relating to an aging MRI scanner resulted in a reduction in the risk score from 20 to 12 based on the assurance provided as current mitigations were reported to be impact positively and planned works have commenced. Assurance relating to echocardiography diagnostic capacity for adults and paediatrics was provided. Progress towards the delivery of 7 day services clinical standard was provided but the standards were not met by 31 March 2020. The impact of Covid-19 saw a reduction in ED attendance and GP referrals in March 2020. A Clinical strategy (12 week forward view) was developed to focus on group A patients (the patients under our care) with a view to recommencing elective activity alongside emergency care provision. Assurance rating is currently partial to reflect the need for further work and improvement.*	Chief Operating Officer	Quality & Safety Committee	20
	Low	*SR4*	There is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated					*The Committee has received assurance on the successful risk mitigation of fragmented medical records as the implementation of iClip at QMH addresses the most material issue. This risk has now been closed. Assurance was also provided for three contributing risks resulting in reduced risk scores following the completion of planned mitigations. The committee noted the substantial progress and recognised the material individual risks that remain. Improvement was noted in these areas the overall assurance rating remains limited reflecting the need to complete the remainder of the planned works which had been impacted due to Covid-19.*	Chief Information Officer	Finance and Investment Committee	20
	Moderate	*SR5*	There is a risk that we fail to make progress in delivering our clinical services strategy					*<u>For Decision after discussion at Trust Board:</u> The Board has approved support strategies for research, workforce, education, quality, digital and outpatient strategies. Work on the Trusts' Estates Strategy requires review due to the impact of Covid-19 on the provision of services. The Board has received assurance of commissioners' support for the five year clinical services strategy. The Board has overview of the year 1 implementation plan. Year 2 implementation plans are being developed with directorates as part of the business planning process for 2020/21. This has now been delayed due to Covid-19. There may need to be some level of 're-set' on some of the plans however, the service changes that have been made due to Covid-19 may also provide an opportunity to implement some of the Trust's strategic priorities.*	CEO (Chief Strategy Officer)	Board	16
	Moderate	*SR6*	There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities.					*<u>For Decision after discussion at Trust Board:</u> The Board has received assurance that the Trust remains an active partner in the SWL Health and Care Partnership meetings focussed on developing the Integrated Care System and is engaged in the Acute Provider Collaborative. The Trust is an active contributor to the SWL Clinical Senate. The Board is reasonably assured that controls are adequate but indicates a partial assurance rating to reflect the need to assess the impact of Covid-19 in collaboration with partners across SWL.*	CEO (Chief Strategy Officer)	Board	9
3. Balance the books, invest in our future	*Low*	*SR7*	There is a risk that we do not develop plans to achieve unsupported financial balance within 3* years (*to be confirmed with regulators in conjunction with national planning guidance)					*The risk score was reviewed and increased to reflect the current financial forecast which indicates the original target deficit for 2019/20 will not be delivered. This has increased the challenge of returning to unsupported balance. The risks associated with the process aspects of this risk remain largely unchanged from Q1. The assurance rating remains limited.*	Chief Financial Officer	Finance and Investment Committee	25
	Low	*SR8*	There is a risk that the Trust is unable to source sufficient capital funds to support investment in areas of material risk					*The Committee has received assurance on the plans in place in relation to 2019/20 funding; for later years work is on-going. The assurance rating remains limited as a consequence and Capital bids have been submitted to NHS London to secure funding for capital spend as a result of the COVID 19 pandemic.*	Chief Financial Officer	Finance and Investment Committee	16
4. Build a better St George's	*Low*	*SR9*	There is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy					*The assurance rating remains limited as the Trusts' Estates Strategy requires review due to the impact of Covid-19 on the provision of services.*	Chief Finance Officer	Finance and Investment Committee	20
	Low	*SR10*	There is a risk that we do not improve our estate to provide a safe and compliant environment for our patients and staff					*The assurance rating remains limited, despite the progress made in some areas, due to the impact of Covid-19 and the requirement to review the provision of services across SW London.*	Chief Finance Officer	Finance and Investment Committee	20
5. Champion team St George's	*Low*	*SR11*	There is a risk that we are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care					*The Committee has received assurance on the progress achieved to date in the development of the 2019-2020 Staff Engagement Plan, implementation of the new engagement methodology Go-Engage and revised Raising Concerns at Work Policy. The assurance rating remains partial as the expected progress with reference to the Staff Engagement Strategy and implementation of the new engagement methodology did not materialise.*	Chief People Officer	Workforce and Education Committee	12
	Low	*SR12*	There is a risk that we are not seen as a diverse and inclusive employer by our staff					*The Committee has received assurance that additional resource has been brought in to the Trust to support the delivery of the D&I strategy and that the staff groups have been re-launched. The assurance rating remains partial, controls are generally adequate but the committee requires further assurance with reference to visibility of agreed performance metrics.*	Chief People Officer	Workforce and Education Committee	9
	Low	*SR13*	There is a risk that we are unable to sufficiently address issues of harassment and bullying					*The Committee has received assurance that the Raising Concerns Policy was revised and re-launched in the Trust. The assurance rating remains partial, controls are generally adequate but the committee requires further assurance with reference to visibility of agreed performance metrics.*	Chief People Officer	Workforce and Education Committee	12
	Low	*SR14*	There is a risk that we are unable to recruit, train and sustain (retain) an engaged and effective workforce					*The Committee has received assurance about the Trust vacancy rate. The assurance rating remains limited to reflect the concerns related to recruitment to some staff groups and the need for further work.*	Chief People Officer	Workforce and Education Committee	16
	Low	*SR15*	There is a risk that we are unable to develop new and innovative roles/ways of work to deliver our Trust clinical strategy					*The Committee has received assurance with the workforce strategy approved at Trust Board in December 2019. The assurance rating remains partial to reflect the need for further work in developing innovative and new ways of working.*	Chief People Officer	Workforce and Education Committee	12
6. Develop tomorrow's treatments today	*High*	*SR16*	There is a risk that we cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.					*The Committee has received assurance that there continues to be improvement in the numbers of patients recruited to clinical trials. The Research Strategy was approved by the Board in December 2019. The Trust is now highly active in research relating to Covid-19 clinical research studies open in the Trust. The assurance rating is currently partial to reflect the need to sustain the position.*	Chief Medical Officer	Quality & Safety Committee	9

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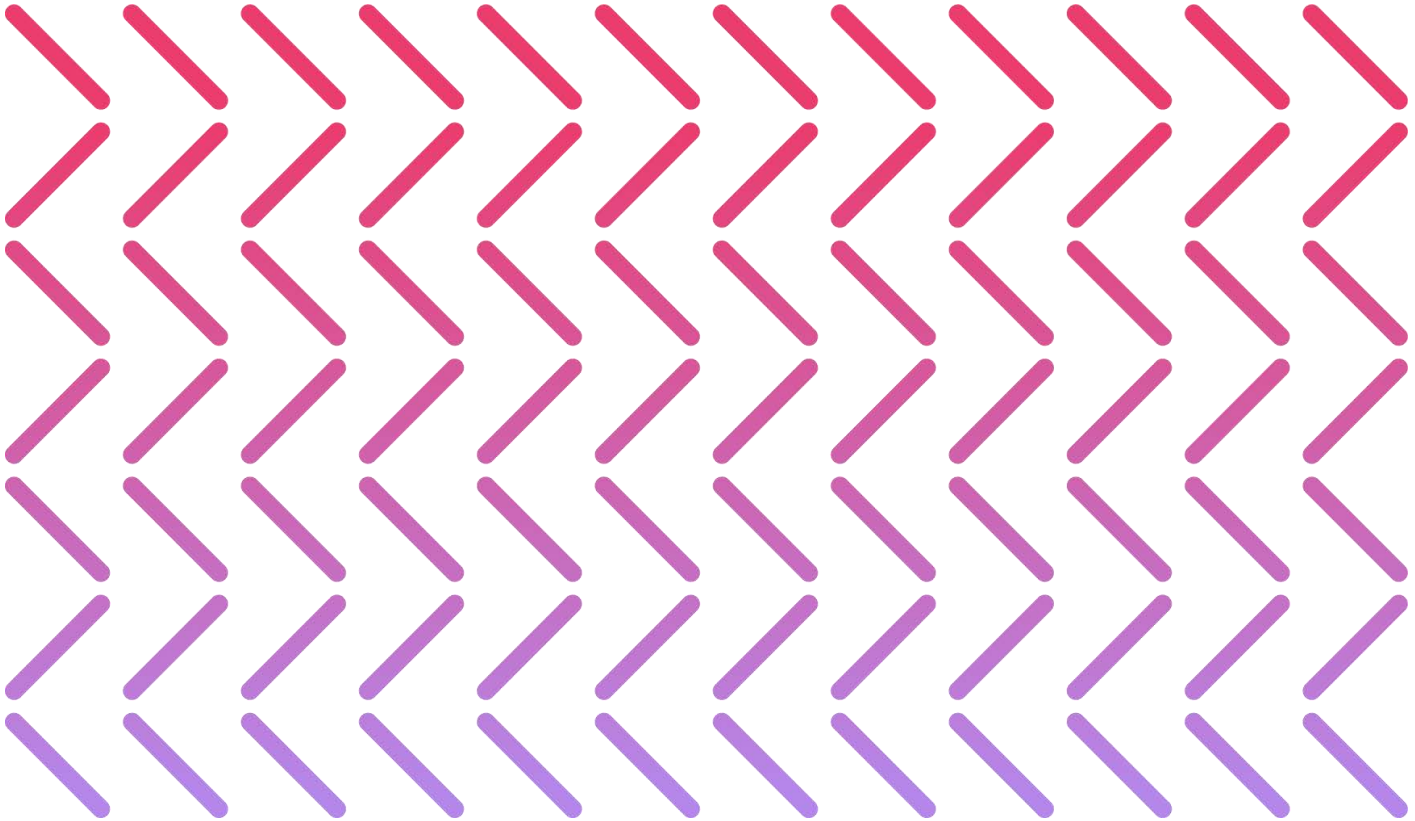
Board Assurance Framework Q4 2019/20

Trust Board
28 May 2020

Stephen Jones
Chief Corporate Affairs Officer

6.4

Individual risks contributing to strategic risks



6.4

Individual risks contributing to strategic risks

		* Overall SR score is based on the highest risk score		
Risk short form title	Description	Open Date	Initial Score*	Current Score Q4 19/20*
SR1 - There is a risk that we do not create an environment and embed an approach to quality improvement which minimises the occurrence of harm to our patients			20	12
Deteriorating patients	There is a risk that staff fail to recognise, escalate and respond appropriately to the signs of a deteriorating patient. This may happen because the Early Warning Score is inaccurately recorded or the escalation process is not applied correctly leading to a delay in treatment being started and a poor outcome for the patient	Dec 2016	20	8
Learning from incidents	Failing to learn from incidents may mean we fail to prevent incidents recurring in the future and causing avoidable harm to patients	Nov 2016	15	8
Learning from complaints	Failing to learn from complaints may mean we fail to make improvements to patient experience	Nov 2016	15	12
Developing and implementing a quality improvement methodology	Risk that we fail to develop and implement an effective and consistent methodology for quality improvement and miss opportunities to improve	Nov 2017	12	9
Compliance with the CQC regulatory framework	Failure to comply with the CQC regulatory framework and deliver actions in response to CQC inspections may prevent the Trust achieving an improved rating at our next inspection and exiting quality special measures	Jan 2017	20	12
Complaint response time	There is a risk that we fail to achieve a sustained improvement in the timeliness of complaint investigations and responses, this will impact on the experience of our patients and their confidence that we want to listen, learn and improve and we may lose the learning opportunities we get from complaints	Apr 2009	16	2
SR2 - There is a risk that our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care			20	15
Cardiac surgery service – patient safety impact	There is a risk that we may not make effective improvements to patient safety following the second NICOR mortality alert for cardiac surgery	Sep 2018	20	12
Cardiac surgery services - reputational impact	Reputational Impact of service challenges within Cardiac Surgery unit	Sep 2018	20	15
Acting on diagnostic findings	Risk of delays in treatment due to failure to ensure robust mechanisms are in place for the timely and appropriate follow up of all diagnostics tests, and critical test results such as blood tests , cell path and radiology. This may have an adverse impact upon patient care	Jul 2016	16	12
Improving the quality of clinical governance following external reviews	There is a risk that we may not improve the quality of clinical governance following the external reviews of mortality monitoring and MDT and clinical governance in a timely manner which may have an adverse impact on patient care	Sep 2019	12	12

Individual risks contributing to strategic risks

		* Overall SR score is based on the highest risk score		
Risk short form title	Description	Open Date	Initial Score*	Current Score Q4 19/20*
SR3 - There is a risk our patients wait too long for treatment.			20	20
Patient flow	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	Feb 2020	12 (TBC)	12 (TBC)
Emergency care 4hr operating standard - reputation	Risk to reputation arising from failure deliver and sustain the 95% Emergency Care Operating Standard	May 2015	20	12
Emergency care 4 hr operating standard – patient safety	Risk to patient safety arising from failure to deliver and sustain the 95% Emergency Care Operating Standard	Apr 2018	16	8
Single aging thirteen year old MRI scanner	Failure to produce speedy and high quality images due to old age of MRI scanner	Feb 2017	20	12
Management of patient pathways	Risk that patient pathways and waiting times are not accurately monitored or managed due to poor data quality and lack of management process	May 2014	20	6
ECHO Service Delivery (adult)	Risk of delay of planned ECHOs for patients who are on a 6 week diagnostic pathway (DM01) as provision of ECHO for inpatients is prioritised due to capacity and shortage of qualified staff	Oct 2019	20	16
Paediatric ECHO delivery	Inability to safely provide a paediatric ECHO service at St Georges Hospital due to the lack of a paediatric trained cardiac physiologist or a paediatric Cardiologist to oversee the delivery and interpretation of paediatric ECHO	Nov 2019	20	16
7 day services	Failure to be compliant with 4 of the Seven Day Services clinical standards	Dec 2019	12	12
Covid-19	There is a risk to patient and staff safety of exposure to Covid-19 virus arising from failure to identify and implement appropriate measures	Feb 2020	20	20

Individual risks contributing to strategic risks

		* Overall SR score is based on the highest risk score		
Risk short form title	Description	Open Date	Initial Score*	Current Score Q4 19/20*
SR4 - There is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated			25	20
Exposure to Cyber or Malware attack	Infrastructure - Risk of potential successful malware / cyber attack due to weakness in the ICT infrastructure. This could lead to loss of data and operational disruption	Apr 2016	20	**12**
Data Centre	Infrastructure - Potential loss of all on-site critical systems due to poor environmental condition affecting the data centre (Trust single data centre)	Mar 2013	20	**15**
ICT Disaster Recovery Plan	Infrastructure - Potential delay / failure of Trust being able to recover from an ICT disaster due to lack of ICT Disaster Recovery Plan	Feb 2011	20	20
Telephony	Infrastructure - Potential failure of the Trust's central telecoms system (ISDX) (1), radio tower system (DDI) (2), and/or VoIP platform (500 handsets) (3) due to aged telecoms infrastructure	Jul 2017	20	16
Network outage	Infrastructure - Risk of further major network outages due to out-dated, unreliable, and prone to failure network, as a result of a lack of investment and maintenance in the Trust's ICT Network Infrastructure	Dec 2017	25	20
Microsoft Licenses and Operating Systems	Service & Operation - Inability to implement new Microsoft licenses requirement and switch to new operating systems within due date, due to lack of investment	Jan 2019	15	**12**
Fragmented Clinical Records	Clinical information systems - Unavailability of all of the correct and up to date clinical information at point of care due to fragmented patient records as a consequence of: Cerner implementation, multiple clinical system running in parallel but separate from Cerner, Lack of ICT strategy, delay in scanning info onto EDM	Dec 2017	20	**12**
Internal Integration of clinical information systems	Clinical information systems - Lack of integration of trust clinical systems leading to transcription errors of clinical information, multiple processes, and sub optimal care for patient.	Dec 2017	16	**9**
Electronic document management (EDM) solution	Clinical information systems - potential inability to reinstate EDM software should there be a failure as software no longer supported by supplier and lack of trust server capacity for storage of legal copy.	Jul 2018	16	16
Insufficient Patient tracking	Clinical information systems - Unable to sufficiently track patients due to multiple clinical information systems and multiple processes. This would lead to mismanagement of RTT pathways	Dec 2017	20	10
QMH iCLIP Project impacting on RTT Reporting	Information - Delay in returning to RTT reporting due to time needed to migrate data from QMH PAS system Clinicom into Cerner Millennium. **CLOSED**	Sep 2018	16	**0**
Data quality process not implemented	Information - Poor data quality due to data quality process not implemented	Dec 2017	16	12
Data Warehouse/Information Management Fragmentation	Information - Risk of poor daily operational performance reporting due to difficulties to retrieve data stored on multiple storage	Aug 2017	20	**16**
Compliance with new GDPR	Service & Operation - Risk of accidental or unlawful destruction, loss, alteration, unauthorised disclosure of or access to personal data due to failure to incorporate / implement GDPR programme	Sep 2019	15	10
Potential loss of the CVIS system in Cardiac Cath Lab	Potential failure of the Cardiovascular Information System due to old age of system and no longer storage system out of capacity	Mar 2017	16	16
Lack of Digital Strategy	Lack of Digital Strategy may result in a potential failure to deliver all ICT strategic priorities of the Trust	Feb 2018	16	12
Facilities IT Systems	Should the security system fails, all areas of STG may become accessible to staff, patients, and visitors without access permissions,	Feb 2018	12	12
Exposure to Covid-19 virus	There is a need to increase remote working and change the way care is delivered which involves ICT skills, knowledge, hardware and systems, as enablers to help the trust get through the pandemic. This is changing the pace and focus of both business-as-usual activities and project activities for ICT	Mar 020	20	20

6.4

Individual risks contributing to strategic risks

		* Overall SR score is based on the highest risk score		
Risk short form title	Description	Open Date	Initial Score*	Current Score Q4 19/20*
SR5 - There is a risk that we fail to make progress in delivering our clinical services strategy			16	16
Capital availability to implement strategy	Risk that we do not have capital available to implement the strategy *(cross referenced to Finance risk: Five year investment plan)*	Jul 2019	16	16
Commissioners' support	Risk that the Trust does not have Commissioners' support to implement the strategy	Jul 2019	10	10
Capacity and capability to implement strategy	Risk that the Trust does not have capacity and capability to implement the strategy *(cross referenced to HR risk Recruit and retain sufficient workforce)*	Jul 2019	16	16
Other providers' strategies conflicting with Trust strategy	Risk that other providers' strategies are in conflict with the Trust's strategy and therefore unable to deliver	Jul 2019	15	15
SR6 - There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities			**9**	**9**
Workforce - Non viable clinical rotas	Risk of non-viable clinical rotas *(cross referenced to: HR risk Junior Doctor vacancies)*	Jul 2019	9	9
Increase demand on provided services	Risk that services continue to see current or increase demand on provided services	Jul 2019	9	9
Clinical pathways variation	Risk we do not eliminate variation across clinical pathways leading to poor patient experience	Jul 2019	9	9
Proposed new risk: Borough level clinical priorities	Risk of lack of Trust clinical and management capacity to engage with and deliver the clinical priorities for Merton and Wandsworth Borough as set out in their respective Health and Care plans	TBC	TBC	

6.4

Individual risks contributing to strategic risks

		* Overall SR score is based on the highest risk score		
Risk short form title	Description	Open Date	Initial Score*	Current Score Q4 19/20*
SR7 - There is a risk that we do not develop plans to achieve unsupported financial balance within 3 years. **to be confirmed with regulators in conjunction with national planning guidance**			20	25
Managing an effective financial control environment	Risk of not meeting statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers due to ineffective financial systems and processes	Oct 2016	20	20
Managing Income & Expenditure in line with budget	Risk the Trust is not able to manage income and expenditure against agreed budgets to delivery the financial plan.	Dec 2017	20	25
Maintaining a five year forward view	The Trust has insufficient capacity to develop a five year long term financial plan that is aligned to an agreed clinical strategy.	Dec 2017	16	9
Manage commercial relation with non-NHS organisations procuring services from the Trust	Risk that the Trust does not have sufficient capacity, or skills to manage commercial relationships with non-NHS organisations procuring services from the Trust.	May 2019	12	12
Future cash requirements are understood	Risk that future cash requirements are not understood	Dec 2017	20	15
Processes to manage cash and working capital	Risk that the Trust does not have up to date processes to manage cash and working capital	Dec 2017	20	12
Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London	Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London. It is unclear within planning guidance what the impact of other organisations within the South West London patch not hitting control totals will be on the organisations.	May 2019	9	9
Managing within new contract forms (block contracts)	There is a risk that the Trust could be financially impacted by a failure to manage performance inline with new contract models, specifically a block contract.	May 2019	9	9
Identifying and delivering CIPs for 2019/20	Risk that the Trust doesn't have sufficient capacity and capability to deliver CIPs at the level required to hit the financial plan.	Apr 2019	20	20
Maintaining an effective procurement environnent	Risk the Trust has insufficient capacity and capability to ensure best value is achieved on all procurement.	Oct 2016	15	9
Understanding cost structures	A risk that we do not understand our current cost and performance baseline and structures, or benchmark ourselves against others in this area to identify efficiencies and improvements.	Nov 2017	15	9
Unsupported finance and procurement system	A risk that the Trust has an unsupported finance and procurement system.	Oct 2019	8	8
SR8 - There is a risk that the Trust is unable to source sufficient capital funds to support investment in areas of material risk			20	15
Processes to deliver agreed investment	Risk that the Trust does not have processes to deliver agreed investment	Dec 2017	16	15
Five year investment plan	The Trusts deficit financial position doesn't currently provide sufficient internally generated capital to fund the required investment over a 5 year period. Alternative sources of financing have also yet to be identified in the absence of internally generated funds.	Dec 2017	20	16

Individual risks contributing to strategic risks

		* Overall SR score is based on the highest risk score		
Risk short form title	**Description**	**Open Date**	**Initial Score***	**Current Score Q4 19/20***
SR9 - There is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy			16	20
Developing a strategy	There is a risk that the Trust is unable to develop an Estates Strategy		6	6
Delivering the Strategy (internally)	There is a risk that the Trust is unable to deliver some elements of the Strategy. Examples of the factors would include an inability to secure funds to implement capital works		16	20
Delivering the Strategy (externally)	There is a risk that other organisations challenge some elements of the Strategy and seek to frustrate their implementation		12	12
SR10 - There is a risk that we do not improve our estate to provide a safe environment for our patients and staff			20	20
Systems and processes	Effective systems, processes including policies are in place		16	20
Governance	Clear governance exists within E&F, and through to the Trust Board		12	12
Capacity	There is sufficient capacity within E&F to undertake necessary work		16	16
Water safety	Water systems could pose a risk to staff, patients and visitors as they are not free from bacterial contaminants (e.g. legionella and pseudomonas)	May 2014	20	20
Cardiac Catheter Labs breakdown	Failure of Cath Lab equipment / infrastructure due to old age	Sep 2016	20	20
Ventilation systems	Ventilation systems could pose a risk to staff, patients, staff and visitors if they are not effectively operated and maintained.	Aug 2018	16	16
Potential overexposure of ionising radiation	There could be a risk of excessive exposure of radiation to staff, patients and visitors if radiation protection arrangements are not effectively operated and maintained	July 2019	9	9
Medical Equipment –maintenance and training	There is a risk of non compliance with the PPM policy and adhering to MHRA guidance on competence and training records if medical equipment is not maintained in line with our RBM approach and competence in its use is not recorded , impacting on patient safety	Mar 2016	12	12
Medical gases	Medical Gas systems could pose a risk to staff, patients, staff and visitors if they are not effectively operated and maintained.	Nov 2019	12	9
Health and Safety	There is an effective H&S culture in the Trust which ensures issues are identified and addresses promptly and effectively		16	16
Work is planned (Hard FM)	There is an appropriate balance between planned and reactive maintenance.		16	16
Fire safety systems	Weaknesses in fire safety systems could pose a risk to staff, patients and visitors , for example fire alarm systems, fire compartmentation and fire protection systems	Jun 2016	20	20
Electrical safety systems	Electrical systems are not maintained and/or are insufficient to manage the demand placed upon them and could pose a threat to staff, patients and visitors. This includes the safe operation and management of the systems as well as the services supported.	Aug 2017	16	16
Drainage and waste water systems	There could be a risk to patients, staff and visitors if drainage and waste water management systems are not effectively operated and maintained.		16	16
Buildings, plant and equipment maintenance	There could be a risk to, patients and visitors if Buildings, plant and equipment are not effectively operated and maintained.		12	12
Cleaning standards	There could be a risk to staff, patients and visitors if cleaning standards are not maintained.		12	12
Food safety	There could be a risk to staff, patients, staff and visitors if food safety standards are not maintained.		12	12

Individual risks contributing to strategic risks

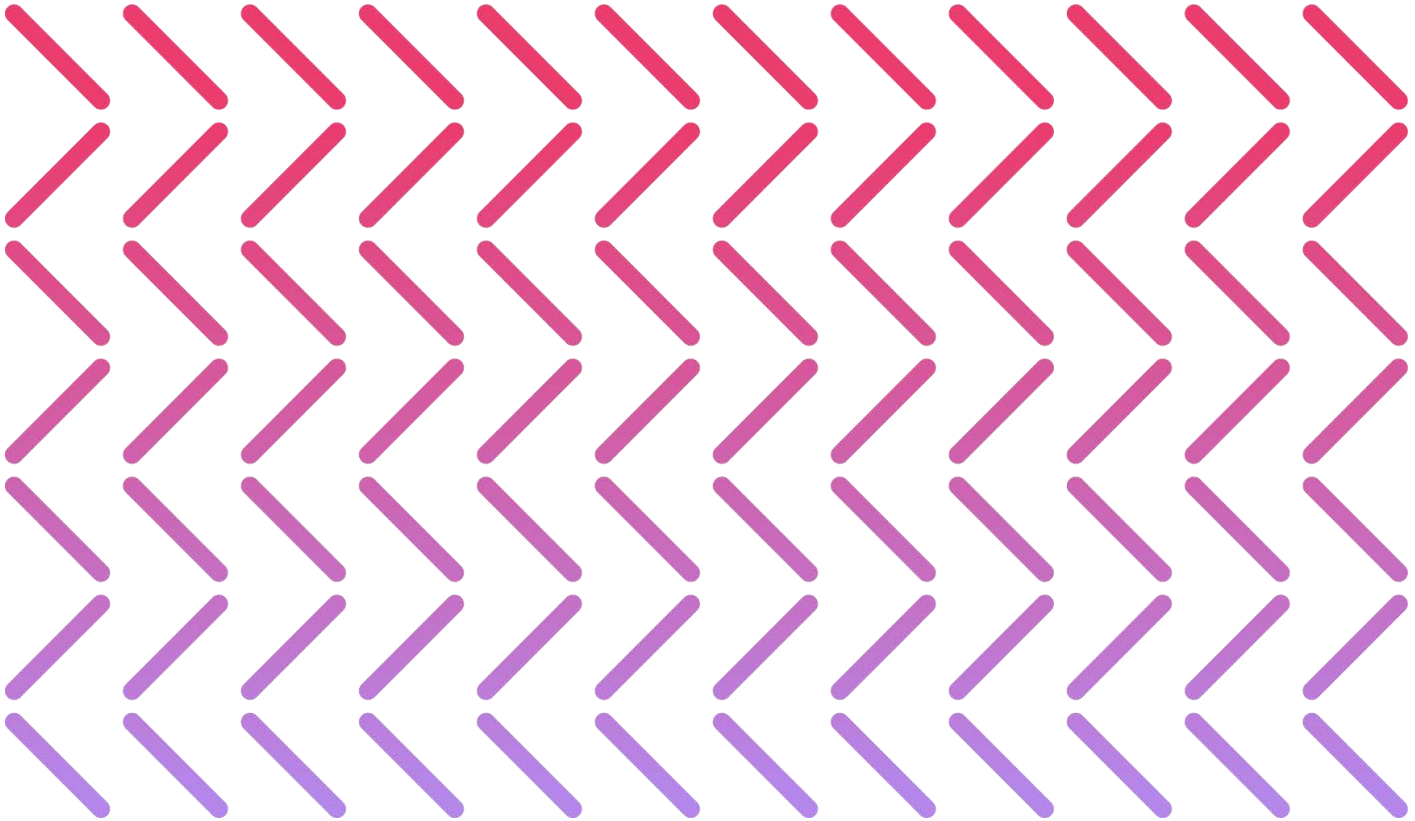
		* Overall SR score is based on the highest risk score		
Risk short form title	Description	Open Date	Initial Score*	Current Score Q4 19/20*
Strategic risk SR11 - There is a risk that we are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care			12	12
Engagement	There is a risk that we fail to effectively engagement with our staff	Jul 2019	12	12
Raising Concerns	There is a risk that our staff a) don't know how to raise concerns at work b) don't know who to raise concerns with c) are not confident the concerns will be properly address and d) don't feel safe in raising concerns	Jul 2019	12	9
Strategic risk SR12 - There is a risk that we are not seen as a diverse and inclusive employer by our staff			9	9
Diversity and Inclusion	There is a risk that we are unable to deliver our Diversity and Inclusion Strategy or that it does not have the required impact	Jul 2019	9	9
Strategic risk SR13 - There is a risk that we are unable to sufficiently address issues of harassment and bullying			12	12
Bullying and Harassment	There is a risk that our staff continue to report high levels of bullying and harassment compared with peers and that we have not taken adequate measures to address this	May 2010	12	12
Strategic risk SR14 - There is a risk that we are unable to recruit, train and sustain (retain) an engaged and effective workforce			16	16
Recruitment and Retention	There is a risk that we fail to recruit and retain sufficient and suitable workforce with the right skills to provide quality of care and service at appropriate cost	Oct 2015	16	16
Junior Doctors vacancies	There is a risk that we are unable to fill Junior Doctor rota vacancies, leading to rota gaps which may impact on patient safety	Oct 2018	16	16
BREXIT	There is a risk that we are unable to retain our EU staff post EU exit	Apr 2019	16	16
Impact on pension tax on the NHS	Pension tax impacting on the Trust. There are two elements to this risk. 1. Senior members of staff choose to leave the NHS as they have reached their Life Time Allowance (LTA) pension cap. 2. The impact of the annual allowance, where consultants are taking early retirement, reducing their hours, turning down additional work which is having an operation impact on the Trust. This leaves gaps in service cover	Jul 2019	16	16
High quality appraisals	There is a risk not all of our staff have a high quality appraisal	Nov 2017	9	9
Recognise good practice	A risk that we do not recognise success or good practice amongst our workforce	Nov 2017	9	9
Strategic risk SR15 - There is a risk that we are unable to develop new and innovative roles/ways of work to deliver our Trust clinical strategy			12	12
Workforce Strategy	There is a risk that we do not have a clear Workforce Strategy that supports the Trust's clinical ambition	Nov 2017	12	9
Organisational Development	There is a risk that we do not ensure that our senior managers are developed to have the right leadership skills to be able to deliver our vision of outstanding care every time	Nov 2017	12	12

Individual risks contributing to strategic risks

		* Overall SR score is based on the highest risk score		
Risk short form title	Description	Open Date	Initial Score*	Current Score Q4 19/20*
SR16 - There is a risk that we cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.			16	9
Recruitment to clinical research	Risk of failing to achieve sufficient Clinical Research recruitment, a significant shortfall in overall (CRN and Commercial) recruitment would result in a reduction in research funding and income.	Nov 2016	12	6
Research profile	There is a risk that insufficient focus is given to research in SGHT lead to a lack of investment in research, impacting on research delivery, income, reputation and ability to recruit and retain high calibre staff.	Nov 2016	12	9
MHRA accreditation of the research department	Risk of failing to retain MHRA accreditation for the research department due to poor infrastructure / compliance.	Dec 2017	16	8
Research partnership with St George's University	There is a risk that if research priorities are not aligned across SGUH and SGUL we will miss opportunities to translate academic research into improved patient outcomes.	Mar 2018	12	9

6.4

Risk reduction schedule



Risk Reduction Assurances and Rating

Key	Extreme Risk	High Risk	Moderate Risk	Mitigated Risk	Expected changes	o	Original timescale	x	Subsequent timescale

Short form of risk description	Risk Score March 2020	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Strategic risk SR1 - There is a risk that we do not create an environment and embed an approach to quality improvement which minimises the occurrence of harm to our patients													
Deteriorating patients	8			o									
Learning from incidents	8												
Learning from complaints	12												
Developing and implementing a quality improvement methodology	9												
Compliance with the CQC regulatory framework	12												
Complaint response time	2		o										
Strategic risk SR2 - There is a risk that our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care													
Cardiac surgery services – patient safety impact	12												
Cardiac surgery services - reputational impact	16												
Acting on diagnostic findings	12												
Improving the quality of clinical governance following external reviews	12												
Strategic risk SR3 - There is a risk our patients wait too long for treatment.													
Patient flow	12												
Emergency care 4hr operating standard – reputation impact	12												
Emergency care 4 hr operating standard – patient safety impact	8												
Single aging thirteen year old MRI scanner	12												
Management of patient pathways	6												
ECHO Service Delivery (adult)	16												
Paediatric ECHO delivery	16												
7 day services	12												
Covid-19	20												

Risk Reduction Assurances and Rating

Key	Extreme Risk	High Risk	Moderate Risk	Mitigated Risk	Expected changes	o	Original timescale	x	Subsequent timescale

Short form of risk description	Risk Score Mar 2020	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sept 20
Strategic risk SR4 - There is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated													
Exposure to Cyber or Malware attack	12						Project paused	Project paused					
Data Centre	15												
ICT Disaster Recovery Plan	20												
Telephony	16												
Network outage	20												
Microsoft Licenses and Operating Systems	12												
Fragmented Clinical Records	12												
Internal Integration of clinical information systems	9												
Electronic document management (EDM) solution	16												
Insufficient Patient tracking	10												
QMH iClip Project impacting on RTT Reporting	0	o	Risk closed										
Data quality process not implemented	12												
Data Warehouse/Information Management Fragmentation	16												
Compliance with new GDPR	10												
Potential loss of the CVIS system in Cardiac Cath Lab	16										Assumes project restarts		
Lack of Digital Strategy	12			o									
Facilities IT Systems	12												
Risk of exposure to Covid-19 virus	20												

6.4

Risk Reduction Assurances and Rating

Key		Extreme Risk		High Risk		Moderate Risk		Mitigated Risk		Expected changes	o	Original timescale	x	Subsequent timescale

Short form of risk description	Risk Score March 2020	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
SR5 - There is a risk that we fail to make progress in delivering our clinical services strategy													
Capital availability to implement strategy	16												
Commissioners' support	10												
Capacity and capability to implement strategy	16												
Other providers' strategies conflicting with Trust strategy	15												
SR6 - There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities													
Workforce - Non viable clinical rotas	9												
Increase demand on provided services	9												
Clinical pathways variation	9												
Proposed new risk: Borough level clinical priorities	TBC												

6.4

Risk Reduction Assurances and Rating

Key	Extreme Risk	High Risk	Moderate Risk	Mitigated Risk	Expected changes	o	Original timescale	x	Subsequent timescale

Short form of risk description	Risk Score March 2020	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
SR7 - There is a risk that we do not develop plans to achieve unsupported financial balance within 3 years. **to be confirmed with regulators in conjunction with national planning guidance**													
Managing an effective financial control environment	20												
Managing Income & Expenditure in line with budget	20												
Maintaining a five year forward view	9												
Manage commercial relation with non-NHS organisations procuring services from the Trust	12												
Future cash requirements are understood	15												
Processes to manage cash and working capital	12												
Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London	9												
Managing within new contract forms (block contracts)	9												
Identifying and delivering CIPs for 2020/21	20												
Maintaining an effective procurement environnent	9												
Understanding cost structures	9												
Unsupported finance and procurement system	8												
SR8 - There is a risk that the Trust is unable to source sufficient capital funds to support investment in areas of material risk													
Processes to deliver agreed investment	15												
Five year investment plan	16								12				

6.4

Risk Reduction Assurances and Rating

Key	Extreme Risk	High Risk	Moderate Risk	Mitigated Risk	Expected changes	o	Original timescale	x	Subsequent timescale

Short form of risk description	Risk Score March 2020	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
SR9 - There is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy													
Developing a strategy	6												
Delivering the Strategy (internally)	20												
Delivering the Strategy (externally)	12												
SR10 - There is a risk that we do not improve our estate to provide a safe environment for our patients and staff													
Systems and processes	20												
Governance	12												
Capacity	16												
Water safety	20												
Cardiac Catheter Labs breakdown	20												
Ventilation systems	16												
Potential overexposure of ionising radiation	9												
Medical Equipment –maintenance and training	12												
Medical gases	9												
Health and Safety	16												
Work is planned (Hard FM)	16												
Fire safety systems	20												
Electrical safety systems	16												
Drainage and waste water systems	16												
Buildings, plant and equipment maintenance	12												
Cleaning standards	12												
Food safety	12												

Risk Reduction Assurances and Rating

Key	Extreme Risk	High Risk	Moderate Risk	Mitigated Risk	Expected changes	o	Original timescale	x	Subsequent timescale

Short form of risk description	Risk Score March 2020	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Strategic risk SR11 - There is a risk that we are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care													
Engagement	12												
Raising Concerns	9												
Strategic risk SR12 - There is a risk that we are not seen as a diverse and inclusive employer by our staff													
Diversity and Inclusion	9												
Strategic risk SR13 - There is a risk that we are unable to sufficiently address issues of harassment and bullying													
Bullying and Harassment	12												
Strategic risk SR14 - There is a risk that we are unable to recruit, train and sustain (retain) an engaged and effective workforce													
Recruitment and Retention	16												
Junior Doctors vacancies	16												
BREXIT	16												
Impact on pension tax on the NHS	16							6					
High quality appraisals	9												
Recognise good practice	9												
Strategic risk SR15 - There is a risk that we are unable to develop new and innovative roles/ways of work to deliver our Trust clinical strategy													
Workforce Strategy	9												
Organisational Development	12												

6.4

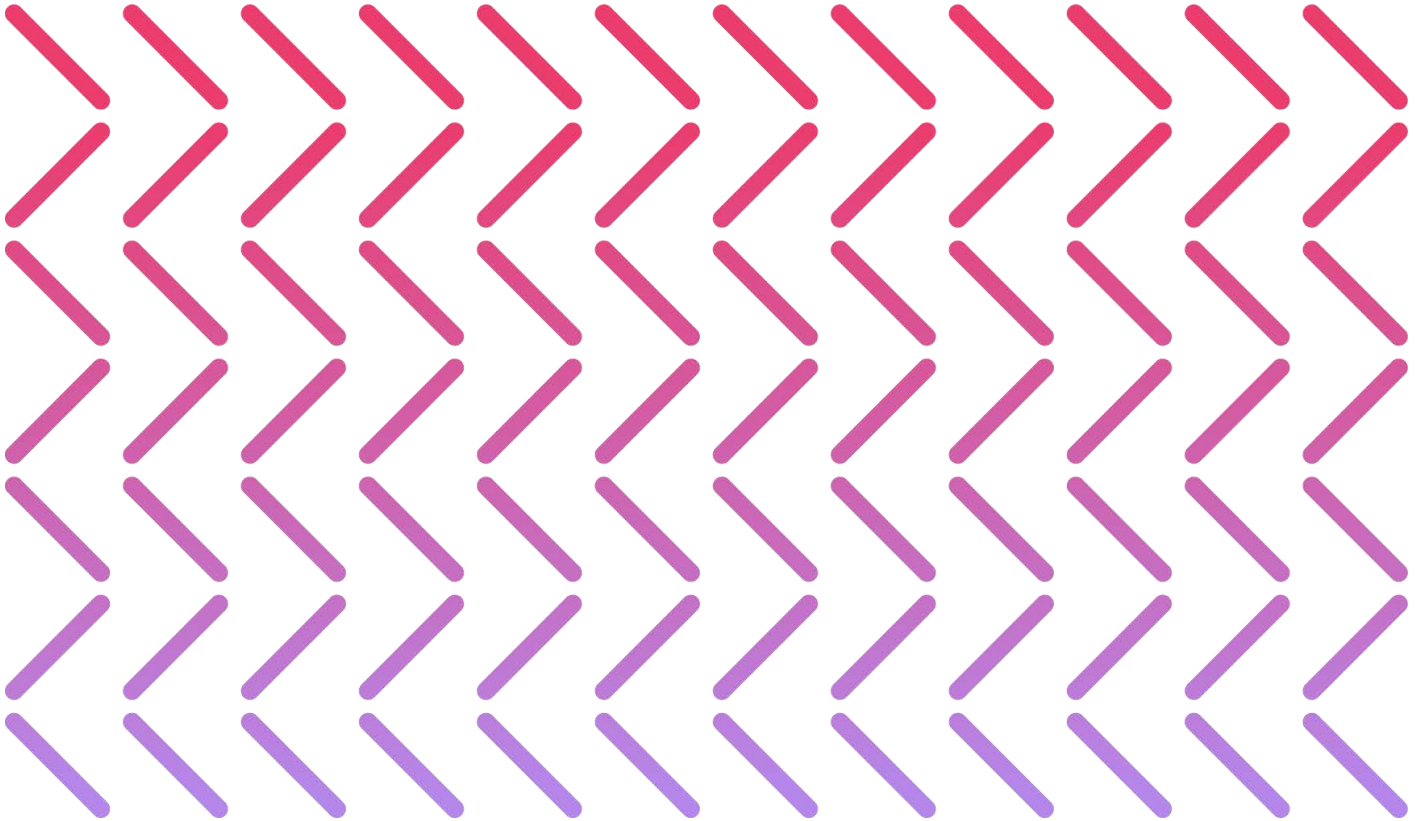
Risk Reduction Assurances and Rating

Key		Extreme Risk		High Risk		Moderate Risk		Mitigated Risk		Expected changes	o	Original timescale	x	Subsequent timescale

Short form of risk description	Risk Score March 2020	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
SR16 - There is a risk that we cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.													
Recruitment to clinical research	6												
Research profile	9												
MHRA accreditation of the research department	8												
Research partnership with St George's University	9												

6.4

Risk Reduction Assurances and Rating



6.4

Risk Reduction Assurances and Rating

Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
Strategic risk SR1 - There is a risk that we do not create an environment and embed an approach to quality improvement which minimises the occurrence of harm to our patients	**Low**	• **Impact of Covid-19** – A programme approach to support rapid service change was implemented supported by a governance and risk assurance framework • **Deteriorating patients -** Assurance is provided by the Integrated Quality and Performance Report (IQPR); The *Minimum Standards of Observations Policy* was updated and approved by PSQG in October 2019. Critical Care Outreach team in place since December 2019. A full complement of medical staff for the Critical Care Outreach Team was expected to be in place by March 2020, but this was not achieved due to an on-going problem with the national shortage of ICU doctors; at present this is mitigated by the number of doctors redeployed from other services for Covid-19, but will be a more overt risk when services return to normal. The Critical Care Outreach team in partnership with IT have implemented a whole Trust view of patients with NEWS scores greater than 5, which enables the team to be more pro-active and each ward or department has an identified NEWS champion. Electronic Treatment Escalation Plans (TEP) have been made available on iClip (March 2020) and the proportion of adult inpatients with an electronic TEP will be monitored. A decision making support tool for TEPs was disseminated to consultants (April 2020). • **Complaint response time –** Sustained improvement in performance since July 2019 until March 2020 across all complaint categories evidenced in the IQPR. In April 2020 local performance targets were not met due to focus on re-structuring hospital services. Revised process put in place and performance back on track in May 2020. • **QI methodology –** A report was received at Trust Board in September 2019 which outlined the launch of the culture, leadership and organisation development work stream (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. Quality Improvement week was held in December 2019 providing information on improvement projects, and clinical audit programmes. An update report was received at Quality and safety Committee in January 2020 which outlined QI activity in the Trust. The Quality and Safety Strategy was approved at Trust Board in January 2020 • **Compliance with CQC regulatory framework -** Outstanding action related to delivering 85% compliance against all resus mandatory training modules as part of CQC 2018 action plan was not delivered as planned by 31 December 2019. Revised delivery of compliance of ALS and BLS end of June 2020. Action to be incorporated into the CQC inspection 2019 action plan. CQC inspection report received in December 2019 identified two regulatory requirements (MUST dos) related to consent and storage and accuracy of medical records. Trust response to regulatory requirements sent to CQC on 16 January 2020. Inspection report and Trust regulatory requirement action plan formally received at PSQG, QSC and Trust Board in January 2020. Trust wide action plan in response to the CQC 2019 inspection has been developed by the divisions and approved at divisional governance meetings and brought to the April PSQG • **Learning from Incidents –** Trust has received the audit report from TIAA. The audit report gives substantial assurance for learning from incidents. • **Learning from Complaints –** Trust has received the audit report from TIAA. The audit report gives reasonable assurance for the learning from complaints in view of processes in place to monitor action delivery. Recommended action plan in place and monitored at PSQG	**Partial**	**Partial**	**Partial**	**Partial**
Strategic risk SR2 - There is a risk that our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care	**Low**	• **The Cardiac Surgery Service** The CQC inspection of August 2018 confirmed that the Cardiac Surgery Service is safe. The CQC carried out a further inspection in July and September 2019 and the report, published on 18 December 2019, recognised the improvements that have been made to the service and that they were "*now assured that there was credible and effective leadership in the cardiac surgery service*." The CQC noted the further improvements in governance, particularly in relation to mortality and morbidity meetings and that "*there was a strong clinical governance lead, who was making a positive difference.*' The Trust Board met on 26 March 2020 and received the reports of both the Independent Mortality Review and Independent Scrutiny Panel. The Board received assurance that actions had been taken to address almost all the recommendations made by both reports. The report was published on the same day and there has been limited media coverage to date. The most recent data from the National Institute for Cardiovascular Outcomes Research (NICOR) for the period 1 April 2015 to 31 March 2018, received in October 2019, demonstrates that the Trust is no longer an outlier for cardiac surgery mortality. External oversight of the unit is being maintained by NHSE/I and a package of support measures is in place to ensure there is continued progress and improvement. The Trust's Cardiac Surgery Service Steering Group, Chaired by the Trust's CMO, continues to provide internal scrutiny and oversight. All post-operative deaths are still reviewed by the Trust's Serious Incident Decision Making Group (SIDM), and the decisions made by this group continue to be independently reviewed by an external cardiac surgery expert from outside the Trust. • **Impact of Covid-19 on cardiac surgery** – The Trust temporarily stopped undertaking cardiac surgery as part of a Pan-London agreement whereby cardiac surgery was diverted to Barts and Harefield to enable Trusts to free-up the resources and to optimise infection control arrangements for patients. Now that the Covid-19 peak has passed, the Trust is working towards the resumption of cardiac surgery in collaboration with neighbouring Trusts and the London region. • **Acting on diagnostic findings -** Progress has been made with the OrderComms Catalogue. The mitigation of this risk is dependent on completion of Cerner inpatient deployment, currently 96% deployed in the inpatient area (Neonatal area to be completed). Outpatients and QMH to follow. • **Improving the quality of clinical governance following external reviews** – A paper was presented to Trust Board in December 2019 outlining the investment required and rationale to take forward the recommendations from the two external reviews. The recommendations in the paper including investment for additional resource circa £0.75M was supported. A desktop assessment of documentation (meetings ToRs, Agendas and minutes) has commenced as part of the third external review, to look at quality and safety monitoring and reporting to the Patient Safety and Quality Group and up to Quality and Safety Committee. Planned observational visits have been postponed due to Covid-19. The action plan following the two external reviews continues to be taken forward. • **Impact of Covid-19** – A programme approach to support rapid service change has been implemented supported by a governance and risk assurance framework	**Partial**	**Partial**	**Partial**	**Partial**

Risk Reduction Assurances and Rating

Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
Strategic risk SR3 - There is a risk our patients wait too long for treatment.	Low	• **Emergency care 4hr operating standard** - IQPR: the Trust continues to develop its Rapid Assessment Zone. Post- implementation review is scheduled to be undertaken. The Trust is also working on the Direct Access to Ambulatory Unit (Nye Bevan and AAA). ED attendance has been impacted by the COVID-19 emergencies and the low attendance for other emergencies. ED environment has been remodelled to provide safe triage and treatment of Covid-19 and non Covid patients • **Single aging thirteen year old MRI scanner** - A contingency plan is in place to continue service provision in the event of complete equipment failure. Outline business case approved at Trust Board in January 2020 to proceed to full business case. Planning permission has been applied for in January 2020 and expected back at the end of May. Tender for construction work went out mid March and is due back end of May. Provisional date for commencement of work is August 2020 and expected to be fully operational in February 2021. • **Management of patient pathways –** The Improvement Support Team (IST) (NHS England and NHS Improvement) undertook a Data Quality (DQ) assessment in November 2019. The final report was received and accepted in January 2020. The report highlighted nine recommendations for which an action plan is being developed. TIAA follow up of the DQ assessment has been deferred given the close proximity to the audit undertaken by the IST. The TIAA audit is currently being planned for the end of Q1 2020/2021. (IQPR) the March 2020 report indicates that the 52 week RTT performance has deteriorated. Work to reduce the volume of patients on the patient tracking list (PTL) was being undertaken but has now been impacted by Covid-19. The Safely Standing Down Other Activity programme in response to Covid-19 has restructured and changed services. Key performance indicators are currently being incorporated in to a Covid-19 dashboard to monitor patient pathways and patient safety. The trust is currently reviewing all vulnerable patients in line with Shielding Vulnerable Patients to ensure that individual plans of care are in place. A clinical strategy has been developed to support patient pathway management • **Delivery of ECHO** – Insourcing became operational from 18 January 2020. The waiting list will be reduced by 2500-3000 patients by June 2020, the wait list numbers are continuously monitored and insource capacity adjusted. The risk of patient harm has been considered and assessed by the Head of ECHO as low. • **Paediatric ECHO service** – There are three patient cohorts; 1. under 6 years, 2. over 6years and 3. Inpatients. For cohort 1 the adult paediatric physiologist and Consultant Paediatrician in Critical Care will continue with arranged clinics until February 2020, following which insourcing will take over. In cohort 2 the clinics have been suspended and will not recommence other than by the insourcing team who commenced on 18 January 2020. In cohort 3 there continues to be concern as the adult cardiac physiologist provides the ECHO service without supervision from a Consultant Paediatric Cardiologist. Engagement with the Evelina and Royal Brompton Trusts continues. • **7 day services clinical standards -** In January 2020 the Trust Board received a paper containing a detailed plan to improve our performance against the National 7 day services standards. The Board recognised that the trust would not meet every standard by April 2020. The Board paper described the series of actions that the trust will take that will increase the likelihood of compliance being achieved. The Board noted the report and asked that the programme of work be integrated into the development of the annual plan for 2020-21, with the Trust Executive Committee providing oversight and scrutiny of progress. Updates from each division about their progress against the standards was received by the Patient Safety and Quality Group in February 2020. An audit was planned in March 2020 to review all patients admitted under the general surgery team over one weekend to assess if the 7 days services criteria are being met at the weekend for General Surgery; however, due to the redeployment of staff due to Covid-19 this has been put on hold until normal services are resumed. NHSE/I has informed trusts that they have suspended the national submission process of provider self-assessments against the compliance with the 7 days services and will re-assess the situation towards the end of the year, nearer to the planned November 2020 submission • **Covid-19** The Trust is responding to the Public Health England advice on Infection Prevention and Control advice and PPE guidance. A number of executive led working groups have been established to restructure services in response to COVID-19. Isolation areas have been set up, Critical Care capacity has been increased in response to sector modelling. The Trust has restructured the operation of a number of OPD clinics and reviewed planned care in order to reduce footfall and protect patients and staff. Staff have been re-located to other areas according to their skills. Additionally, where appropriate, staff have been asked to work from home, supported by HR guidance. A staff counselling service has been established to support staff at the forefront of the operations. Daily updates and information are provided. Clinical strategy developed for next 12 weeks to focus on group A patients (the patients under our care) with a view to recommencing elective activity alongside emergency care provision. Further risk assessments have been undertaken to examine the risk of exposure to Covid-19 due to: lack of fit test for staff wearing FFP3 mask; lack of PPE and Trust capacity (physical, equipment and workforce	Partial	Partial	Partial	Partial

6.4

Risk Reduction Assurances and Rating

Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
Strategic risk SR4 - There is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated	Low	• **Cyber Security:** We have implemented some infrastructure improvements to improve Cybersecurity resilience which a recent penetration test ratified as effective to external threats, enabling a reduction in risk score. But there is some work to do on internal infrastructure, especially with regard to implementation of a password policy, to strengthen further. The password policy has been approved in principle by IGG and presented to TEC who asked for additional information. It is expected that the score can be reviewed and reduced once the new password standards are applied to the active directory accounts that enable staff to access multiple systems on the same username and password. Additional capital for cyber protection has been made available for spend before end of financial year – proposals being worked on to make best use of this. Password standards now being piloted within ICT and date set for roll out to trust – However trust roll out paused March 2019 due to Covid-19. • **Data Centre:** There have been some estates infrastructure issues impacting the data centre in relation to cooling and fire protection. This financial year, Estates have been replacing the air handling units to keep the area cool. There is additional remediation work required to fire protection before the score can be reduced. The score was reviewed to assess the progress of the remediation works. Three new Air Handling Units (AHU)/external chiller units have been installed and are fully commissioned, providing N+2 resilience and constant cooling to requisite air temperature (<24oC). For Fire protection, a quote was secured for design fees for preparation of RIBA Stage 3 report and budget cost for the M&E services for fire & electrical system upgrade. The score has been reduced in likelihood now the cooling is working, so 3x5= 15 which remains until further remediation completed. • **Disaster Recovery:** This remains an extreme risk as work continues to identify a 2nd data centre solution and understand the requirements of clinical services. ICT knows its core services and the cost of a cloud solution to reduce the VDI component of the risk but PACS and other systems sit on physical servers so remain a risk. The trust is considering a collaborative solution across SW London, although this may extend time frames for mitigating the risk once a design solution is in place. Covid-19 has forced ICT to review and update its current business continuity plans • **Telephony:** There are two components to this risk. Firstly an upgrade from the old to the new call manager system and secondly ISDX telephone maintainer. The new call manager system is installed but not commissioned due to supplier delay and the need to upgrade line capacity. The ISDX risk persists as the migration is more complex than we were led to believe and a new migration plan is being drawn up to take this into account. This has been hampered by supplier delay. So the score remains the same until these specific actions have completed. However, as additional mitigation, many administrative areas have now had VoIP telephony installed as planned, • **Network Outage:** Phased improvements are being put in place to mitigate the risk of a network outage. The data centre core has been replaced but the Atkinson Morley core is awaiting completion whilst the design proposals are re-assessed, to ensure that the network is future-proofed and meets demands for the next ten years. As the network components are replaced in phases, we would expect the risk to reduce. Capital money to support amended business case approved. Purchase orders placed for new infrastructure kit. There is also now a dependency on the Network project from the Back Up risk as the new back up solution requires some of the new infrastructure to be in place. Timeline modified based on new hardware purchasing. • **Microsoft Licences and Operating Systems:** This risk has 2 components, changes to Microsoft operating licenses and the replacement of legacy servers. The operating licenses have now been purchased so the likelihood score has decreased. Preparatory work is underway on the servers to liaise with system owners and do initial testing. This project has an 18-month timeline for full mitigation so timeline modified. 22% of the SQL and operating system estate is on the new supported platform and work continues to move other systems. A new issue with Agresso has been highlighted – this needs upgrade from current hosting on Windows 2003 server which is unsupported however the planned upgrade Autumn 2019 did not go live. Staff emails are still being migrated to Office 365 at rate of 200/night; Lanesborough Wing completed for both Win10 and Office 365. Continue:	Limited	Limited	Limited	Limited

Risk Reduction Assurances and Rating

Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
Continued: Strategic risk SR4 - There is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated	Low	**Continued:** • **Internal systems integration**: We have a residue of systems that are not integrated to iCLIP which will be prioritised and addressed via the ICT project team going forwards Any new systems being commissioned, are being designed to integrate with iCLIP. However the consequence score was reduced after the successful implementation of iCLIP at QMH, bringing integrated systems to Queen Mary's Hospital. • **Fragmented Medical Records**: Now that QMH has moved off its legacy Clinicom PAS to iCLIP, this risk score has been reduced as all patients will be using iCLIP for medical records numbers. The ICT project team is also working up projects to roll out clinical documentation and EPMA to outpatients, EPMA to ED and to complete the rollout of Surginet/Anaesthesia to theatres. This will mean that the bulk of the patient record will be in iCLIP. Alongside that, documents produced in other systems are being designed to be viewable from iCLIP rather than from EPR or EDM which will reduce the number of systems that clinical staff are expected to use. This risk will be evaluated post STG OP implementation and post theatres deployment, planned for 2020/21 – these projects have been paused whilst clinical staff focus on Covid-19 • **EDM:** A project is in flight to move EDM to a cloud-based storage solution which will improve performance speeds for users and part mitigate this risk. The legal copy from EDM was moved. The Prod copy is being moved across – current project plan. Post validation the source data can be deleted from trust servers, thereby reducing the risk score – potentially May. Training for Med Records staff will be arranged post-Covid-19 pandemic. A second phase of work will then aim to reduce the risk score further and to decommission EDM servers on site. • **Patient Tracking and the impact of the QMH to iCLIP project** data migration on the trust's RTT position were defined as two separate risks. These were reviewed by SMT in November after the RTT submission on 17th October to with the recommendation that the QMH risk can be closed and the patient tracking score remains static. RME closed this latter risk, leaving the more general patient tracking risk whose score remains the same with no changes in controls or mitigations. • **Data Quality Process** not implemented: This risk has been part mitigated by the introduction of monitoring processes for information standards compliance and controls in place to look at data quality issues. This is a continuous improvement process towards 'kite marking' of DQ dashboards, which was expected to be developed by end Q4 2019/20 but is delayed due to Covid-19. • **Data Warehouse Fragmentation:** Project work is underway to replace the QMH server and then a further six-month project will be required The work will now also encompass the research strategy which is in production currently. A phased introduction addresses current build which will be supervised by trust staff – and server specification being created.. Project kick off was held in January but the project is now delayed due to the focus on Covid-19. • **Compliance with GDPR:** The risk has been reduced from extreme to high at RME. Flows software has been purchased ,some training has been arranged, to assist with audit before score can be reduced. Calendar timeline adjusted to reflect implementation timeline which is now impacted by Covid-19.. • **CCAG-1214 -** Cardiology have raised a risk re their cardiovascular information system at end of life. . A new system has been procured but installation will be part of the refurbishment of the Cath Lab. ICT are involved in the Cath Lab project and will also support clinical system implementation as per the project timeline in 2020. This timeline will be adjusted once the Covid-19 pandemic has abated. • **IT1745 Lack of Digital Strategy** - a draft was presented at a Board away day in February and is now approved. The score was approved for reduction at the March IGG. • **IT1471- CORPORATE SYSTEMS/Facilities IT Systems –** ICT will support Facilities Dept. in the upgrade/replacement of their systems such as door security as these proposals are developed. • **CORP2051 – Risk of Exposure to Covid-19 Virus** – ICT have reviewed all projects and BAU activities, pausing some projects to release resources for Covid-19 focussed work such as increasing Service Desk provision, providing more laptops for home working with remote access licenses, mobile phones for critical care teams and training staff returning to STG to work	Limited	Limited	Limited	Limited

Risk Reduction Assurances and Rating

Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
SR5 - There is a risk that we fail to make progress in delivering our clinical services strategy	Moderate	Support Strategies - The research, workforce , education, quality, digital and outpatient strategies have all been approved by Trust Board. Work is progressing on the Trusts' estates Strategy. Implementation plans have been developed by each Division and will report progress through their Divisional Management Boards. Trust Board has overview of the implementation plan. They receive reports every 6 months on the progress . Year 2 implementation plans are being developed with directorates as part of the business planning process for 2020/21. This has now been delayed due to Covid-19. There may need to be some level of 're-set' on some of the plans however, the service changes that have been made due to Covid-19 may also provide an opportunity to implement some of the Trust's strategic priorities. The Trust has secured commissioners' support for the five year strategy and lack of commissioner support has not been an issue with regard to implementing year one. The outcome of public consultation on Improving Health Together will set the direction for the estates strategy across Epsom and St. Helier and the Trust. This risk will be reviewed at that point. The management capacity will be addressed within the recruitment risk by HR SWL STP attended by chief executives. The Trust attends key meeting & forums attended by commissioners and other providers. Assessing impact of Covid-19 – a full review of the impact of Covis-19 on progress and pace of delivery of the Trust's clinical strategy will be carried out in due course and associated plans amended to reflect findings	Limited	Limited	Limited	Limited
SR6 - There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities	Moderate	• The Acute Provider Collaborative meetings are chaired by the Trust CEO. The meeting has a focus on clinical pathway standardisation. • The Trust is represented at all SWL HCP meetings • The Acute Provider Collaborative meetings are attended at Director level • STP and Acute Provider Collaborative Forums allow general oversight of commissioner and provider plans to develop relationships outside the sector • The Trust is an active contributor to the SWL Clinical Senate Assessing the impact of Covid-19 – a full review of the impact of Covid-19 on addressing this risk and identify any mitigations that need to be put in place. This will need to be done in collaboration with partners across SWL	Partial	Partial	Partial	Partial

6.4

Risk Reduction Assurances and Rating

Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
Strategic risk SR7 - There is a risk that we do not develop plans to achieve unsupported financial balance within 3 years.** ***to be confirmed with regulators in conjunction with national planning guidance*	**Low**	• The COVID 19 pandemic resulted in usual financial governance arrangements being postponed (e.g. weekly Tuesday finance meetings) • Temporary governance arrangements have been put in place to ensure that all spend above £50k related to COVID 19, and not within budgets is signed of by a member of the executive team and the CFO. • Monthly reporting will review spend to ensure costs are stepped down where expected, and cost increases due to COVID are reasonable and justified. • The Trust has received indication that organisations will be funded at a level to break even if it can be evidences that spend levels are reasonable. • The Trust has been instructed by NHSE to report a breakeven position for M1 20/21.	Limited	Limited	Limited	Limited
Strategic risk SR8 - There is a risk that the Trust is unable to source sufficient capital funds to support investment in areas of material risk	**Low**	• CFO to plan central role in SWL capital prioritisation work to ensure Trust risks are adequately reflected. • Justification for additional sources of funding to be made to the NHS London based on critical safety issues. • Alternative sources of funding to continue to be explored where feasible (i.e. Leasing) • Capital bids to NHS London have been submitted to secure funding for capital spend as a result of the COVID 19 pandemic.	Limited	Limited	Limited	Limited

6.4

Risk Reduction Assurances and Rating

Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
Strategic risk SR9 - There is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy	**Low**	• The detailed risks within this Strategic Risk have been divided into two groups; Input issues (governance and control) and output issues (quality, standards and performance). This risk has been rated 20 across both groups A forecast has been developed for the INPUT risks which demonstrates improvements across the year. However, these are recent actions and modest assumptions have been made to date. A forecast has not been developed yet for the OUTPUT risks. Further work is required to determine the extent to which the actions identified across all the areas will "move the dial" on the risk scores. The completion of the work has been delayed due to Covid-19. A new due date will be discussed and agreed at SMT Due to Covid-19 delivery of services in South West London is now under review due to the impact that Covid -19	Limited	Limited	Limited	Limited
Strategic risk SR10 - There is a risk that we do not improve our estate to provide a safe environment for our patients and staff	**Low**	• The key driver of the score of 20 relates to the risk relating to delivery of the estate strategy, especially the ability to secure capital funding. The Trust will not generate sufficient funds internally, and access to other NHS funds is likely to remain uncertain • The Trusts ability to influence/ manage this risk will become clearer as this year (2019/20) progresses. This will remain under review. • **Systems an processes -** There is a lack of coordination between systems. A review of systems has commenced and a plan will be developed. Many core records (schematics and technical drawings) have not been maintained as new works have been undertaken. Work is underway to update schematics for all systems and ensure these are recorded and maintained.. A due date for completion will be provided in the near future • **Governance -** the governance structure is in place and the team on the feeding committee • **Capacity -** AE reports indicate a lack of capacity in many areas. Work will be undertaken over the next month to scope and identify solutions. Some short term actions are being scoped (use of interims, contractors and contracting out batches of work). As these are finalised further improvement in the risk score is expected. Proposal for additional resources is for review. • **Health and Safety -** All systems processes have now been reviewed and an action plan developed. Further work on understanding and embedding Health and Safety is required across the Trust • **Ventilation -** works on the ventilation systems are in progress and have been completed - The Trust has now met the conditions of the HMC improvement notice. HMC confirmed no further action will be taken. • Estates and Capital team have not been able to meet Estates and Capital programmes due to Covid-19 impact on staff and the need to change Estates infrastructure to meet demand for Surge capacity	Limited	Limited	Limited	Limited

Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
Strategic risk SR11 - There is a risk that we are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care	Low	• Revised staff engagement plan focuses on getting some of the basics right such as ensuring every member of staff receives a team brief, has had a staff appraisal, and is able to attend team meetings • Planning for the Go-Engage system to go live in April 2020. Go-Engage focuses on the 9 enablers of engagement and will be the platform used to re-launch our quarterly (Friends and Family) staff survey • The pilot for Go Engage was due Start in April 2020 was put on hold when COVID19 responsibilities took over. A new discussion will be need to be with the Division as part of their workforce plan to re-start work in the Division.	Partial	Partial	Partial	Partial
Strategic risk SR12 - There is a risk that we are not seen as a diverse and inclusive employer by our staff	Low	• Additional resource brought in to the Trust to support the delivery of the Diversity and Inclusion Strategy, to include diverse panel, further work around the number of BAME staff going into formal disciplinaries, reverse mentoring scheme • Staff groups re-launched supported by executive leadership	Partial	Partial	Partial	Partial
Strategic risk SR13 - There is a risk that we are unable to sufficiently address issues of harassment and bullying	Low	• Re-launched Raising Concerns at Work policy in August 2019. Staff engagement plan for 2019/20 has been agreed and being implemented	Partial	Partial	Partial	Partial
Strategic risk SR14 - Strategic risk SR14 - There is a risk that we are unable to recruit, train and sustain (retain) an engaged and effective workforce	Low	• In October 2019 The Trust won an award for nursing recruitment • Participated in the NHSI national Retention Programme reducing our nursing vacancies down to the just below the London average • Junior doctors supply continues to be an issue • Vacancy rate is reported to be at 10.47% . This could be impacted by the potential 'No deal' exit from EU • Upgrade of Totara is expected to be completed by end of June 2020. the system will enable on-line appraisals to support improved monitoring of appraisal performance targets. In addition it will enable us to review the quality of appraisals and review Trust wide training needs analysis • All student placements and non essential face-to-face training courses, including leadership programme, have been paused due to Covid-19	Limited	Limited	Limited	Limited
Strategic risk SR15 - There is a risk that we are unable to develop new and innovative roles/ways of work to deliver our Trust clinical strategy	Low	• Leadership development/ organisational development programme under development • Trust Workforce Strategy was formally signed off in December 2019. A number of sessions were held in January and February to finalise the implementation plan, but these have not been taken forward in a comprehensive way due to the COVID19 event.	Partial	Partial	Partial	Partial
Strategic risk SR16 - There is a risk that we cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.	High	• The research strategy 2019-24 which includes the new virtual research institute has been approved. • **Recruitment to clinical research** - There has been a boost in the Research profile which has seen a 100% increase in the recruitment of patients for Clinical Research over the last three years. • **MHRA compliance** – MHRA have carried out an inspection during September /October 2019. MHRA. Three critical findings were highlighted within the report. The service have developed an action plan to address the findings and have started the implementation of the MHRA recommendations • The Trust is now highly active in research relating to Covid-19 with 20 Covid -19 clinical research studies open in the Trust.	Partial	Partial	Partial	Partial

Risk Matrix
CxL=RS

CONSEQUENCE INDEX			LIKELIHOOD INDEX*		
5	Catastrophic	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure due to enforcement action; Total loss of public confidence	5	Almost Certain	No effective control; or ≥ 1 in 5 chance within 12 months
4	Major	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate	Moderate harm – medical treatment required up to 1 year; £100K - £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥ 1 in 100 chance within 12 months
2	Minor	Minor harm – first aid treatment required up to 1 month; £50K - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥ 1 in 1000 chance within 12 months
1	Insignificant	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Rare	Very good control; or <1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	28 May 2020	**Agenda No**	6.5
Report Title:	**Board Forward Plan 2020/21**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approve		
Executive Summary:	This paper sets out a proposed forward plan for the Board's public meetings in 2019/20. For 2020/21, the Board had planned to meet bi-monthly but due to COVID-19 agreed to meet on a monthly basis to provide support and oversight of key decision-making during a period of intense operational pressure. With the immediate operational pressures of COVID-19 easing, it is proposed that the Board would continue meeting monthly for the remainder of Q1 2020/21 but revert to its planned bi-monthly meeting rhythm from the start of Q2 2020/21. The attached Board forward plan 2020/21 reflects this, and maps the Board's work against this schedule. In the months where the Board does not meet formally, it is proposed that the Board would hold informal workshops and Board development sessions. A Board development plan for the remainder of 2020/21 will be brought to the Board for consideration at its meeting in June 2020. The key elements to highlight in the Board forward plan 2020/21 are: • The seven day services assurance submission to NHS England and NHS Improvement has been deferred as a result of COVID-19 and is now proposed for September following consideration by the Quality and Safety Committee. • The timing of the estates strategy is to be confirmed and a placeholder has been added to the forward plan. The Premises Assurance Model is provisionally scheduled for September. • Biannual stocktakes of the implementation of the Trust clinical strategy and supporting strategies are proposed. This would be supported by regular reviews of sub-strategies by the relevant Board Committees. Any material movements in implementation would be flagged to the Board via the Chief Executive's report. • The quarterly cycle of Board Assurance Framework reporting does not fit against a bimonthly rhythm of Board meetings and it is proposed that the BAF comes to the Board every other month. • Due to the timings of meetings, reports to the Board from the Workforce Committee would follow a month after the meeting.		
Recommendation:	The Board is asked to approve the Board forward plan 2020/21.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-led		

6.5

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)		
Implications			
Risk:	Without a clear forward plan, the Board and Committees may not function effectively, may not consider the full range of issues they are required to, and may not use their time to best effect.		
Legal/Regulatory:	NHS Boards are required to hold meetings in public. The NHS Foundation Trust Code of Governance expects Boards to have a clear plan of work for the coming year.		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	Appendix 1: Board forward plan 2020/21		

6.5

NOTES PROPOSED PUBLIC FORWARD PLAN - TRUST BOARD
BUSINESS AS USUAL - 2020-21

Public (Part 1) Board Forward Plan 2020-21	Frequency	Purpose	Board Lead	Author(s)	Committee	30/04/2020	28/05/2020	25/06/2020	30/07/2020	24/09/2020	26/11/2020	28/01/2021	25/03/2021
Board Walkabout													
Feedback from Board Walkabout	Monthly	Note	All	CN/DIPC	Board			√	√	√	√	√	√
Opening administration													
Welcome, Introductions and Apologies for Absence	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√
Declaration / Register of Interests	Monthly	Report	All	Secretariat	Board	√	√	√	√	√	√	√	√
Minutes of Previous Meeting (accuracy)	Monthly	Approve	Chair	Secretariat	Board	√	√	√	√	√	√	√	√
Matters Arising (Tracker) and Action Log	Monthly	Endorse	Chair	Secretariat	Board	√	√	√	√	√	√	√	√
Chief Executive's Report	Monthly	Note	CEO	ADC and CCAO	TMG	√	√	√	√	√	√	√	√
Board Committee Reports													
Audit Committee Report	Quarterly	Assure	NED	Committee Chair	AC		√	√	√			√	
Finance and Investment Committee Report	Monthly	Assure	NED	Committee Chair	FIC	√	√	√	√	√	√	√	√
Quality and Safety Committee Report	Monthly	Assure	NED	Committee Chair	QSC	√	√	√	√	√	√	√	√
Workforce and Education Committee Report	Bi-monthly	Assure	NED	CC	WEC			√		√	√	√	√
Quality, Safety, Patient Experience and Operational Performance													
Integrated Quality and Performance Report	Monthly	Assure	CFO	PDM and DPM	FIC and QSC	√	√	√	√	√	√	√	√
Cardiac Surgery Update	Quarterly	Assure	CMO	AMD-CS	QSC	√			√ Q1		√ Q2		√ Q3
Learning from Serious Incidents (Thematic Report) (Twice yearly)	Bi-Annual	Assure	CN/DIPC	Clinical Risk	PSQG/QSC					√			√
Learning from Deaths	Quarterly	Assure	CMO	CEA	TMG			√ Q4		√Q1	√ Q2		Q3
Quality Improvement & Transformation Quarterly Report	Bi-Annual	Assure	CTO	CTO	TMG				√			√	
Infection Prevention and Control Annual Report	Annual	Assure	CN/DIPC	CMM/DIPC	QSC						√		
Mental Capacity Act and Deprivation of Liberty Safeguards Report	Annual	Assure	CN/DIPC	MCA DoL and SG Adults	QSC					√			
Complaints Report (Annual)	Annual	Assure	CN/DIPC	CN/DIPC	QSC				√				
Medicines Management Annual Report	Annual	Assure	CN/DIPC	Chief Pharmacist	QSC							√	
National In-patient Survey	Annual	Assure	CN/DIPC		QSC							√	
Winter Plan/Local Escalation Plan	Annual	Assure	COO	HoSO	TMG							√	
Safeguarding Adults Annual Report	Annual	Assure	CN/DIPC	CN/DIPC	QSC				√				
Safeguarding Children Annual Report	Annual	Assure	CN/DIPC	CN/DIPC	QSC				√				
Learning Disability Services Annual Report	Annual	Assure	CN/DIPC	CN/DIPC	QSC					√			
Seven Day Services Assurance	Annual	Assure	CMO	CMO	QSC					√			
Organisation Development, Culture & Workforce													
Leadership & Culture Programme	Bi-Annual	Assure	CPO	CPO	TMG/WEC				√			√	
Freedom to Speak Up Guardian Report	Quarterly	Assure	CPO	FTSU	TMG/WEC			√		√		√	
Workforce Race Equality Standard (WRES) Annual Report	Annual	Endorse	CPO	DIM	TMG/WEC								√
Workforce Disability Equality Standard (WDES) Annual Report (New)	Annual	Endorse	CPO	DIM	TMG/WEC								√
NHS National Staff Survey	Annual	Assure	CPO	HRA	TMG/WEC								√
Gender Pay Gap	Annual	Assure	CPO	WIM	TMG/WEC								√
Ethnicity Pay Gap	Annual	Assure	CPO	WIM	TMG/WEC								√
Guardian of Safe Working *(Annual Report due April 2021)*	Annual	Assure	CMO	SH	TMG/WEC		√ Q4			√ Q1	√ Q2		√ Q3
Revalidation & Medical Appraisal Annual Report and Statement of Compliance	Annual	Assure	CMO	AMD	TMG/WEC					√			
Annual Report on Nurse Revalidation	Annual	Assure	CN/DIPC	HR	TMG/WEC					√			
Clinical Governance Systems for Doctors (New)	Annual	Assure	CMO	AMD	TMG/WEC							√	
Safe Staffing: Nurse Establishments	Annual	Approve	CN/DIPC	CN/DIPC	TMG/WEC/QSC			√					

6.5

NOTES PROPOSED PUBLIC FORWARD PLAN - TRUST BOARD
BUSINESS AS USUAL - 2020-21

Finance and Business Development/Planning													
Financial Performance Report	Monthly	Note	CFO	CFO and HoFR	FIC	√	√	√	√	√	√	√	√
Approval of Annual Budget (including Pay, Non-Pay, Capital and Cost Improvement Plan)	Annual	Approve	CFO	CFO and HoFR	FIC								√
Annual Plan (Narrative - Trust and System)	Annual	Approve	CSO	HoBP	TMG	√							√
Annual Report & Accounts and Quality Account	Annual	Approve	CFO/CCAO/CN	various	TMG/AC			√					
External Auditors Reports: Findings Report	Annual	Approve	CFO/CCAO/CN	External Auditors	TMG/AC			√					
External Auditors Reports: Opinion on Financial Statements	Annual	Approve	CFO/CCAO/CN	External Auditors	TMG/AC			√					
Letter of Representation (Accounts)	Annual	Approve	CFO/CCAO/CN	CFO	TMG/AC			√					
Letter of Representation (Quality Report)	Annual	Approve	CFO/CCAO/CN	CN/DIPC	TMG/AC			√					
Strategy, Partnership/System Working, Research and Horizon Scanning													
St George's Hospital Charity Report			CSO	CEO Charity	TMG		√				√		
Corporate Objectives (Bi-annual Updates)	Bi-Annual	Assure	CSO	HoS and HoBP	TMG					√			√
Estates Strategy	TBC	Approve	CMO	AMDR and JRES	TMG					√			
Trust Communications Strategy	Annual	Approve	CCAO	ADC	TMG						√		
Research Annual Report	Annual	Assure	CMO	JRES	TMG/QSC					√			
Horizon Scanning Report: Emerging Policy, Regulatory, Statutory and Governance Issues	Quarterly	Note	CCAO	CCAO	TMG				√		√		√
Horizon Scanning Report: Strategic-Local & Regional	Quarterly	Note	CSO	HoS and HoBP	TMG				√		√		√
Review of Supporting Strategies Implementation													
Trust Clinical Strategy	Annual	Assure	CSO	HoS/HoBP	TMG					√			√
Digital Strategy	Annual	Assure	CSO	HoS and HoBP	TMG					√			√
Education Strategy	Annual	Assure	CMO	AMD	TMG					√			√
Outpatients Strategy	Annual	Assure	COO	ADC	TMG					√			√
Workforce Strategy	Annual	Assure	CSO	CSO	TMG					√			√
Research Strategy	Annual	Assure	CMO	AMDR/JRES	TMG					√			√
Membership Engagement Strategy	Annual	Assure	CCAO	CCAO	TMG					√			√
Trust Corporate Governance, Complaince & Risk													
Risk:													
Board Assurance Framework	Quarterly	Assure	CCAO	DQGC	TMG/BC		√ Q4		√	√	√	√	√
Board Assurance Framework (Annual Review/Forward Plan)	Annual	Assure	CCAO	DQGC	TMG/BC		√						
Risk Management Strategy & Policy, Risk Appetite Statement	Annual	Approve	CCAO	Secretariat	TMG/AC					√			
Trust Governance:													
Use of the Trust Seal	Bi-Annual	Endorse	CCAO	Secretariat	TMG				√				
Amendments to Standing Orders, Scheme of Reservation & Delegation of Powers, SFIs	Annual	Approve	CCAO	Secretariat	TMG/AC							√	
Fit and Proper Person Test Process Procedures and Exception Reports	Annual	Assure	CPO	CPO	TMG/WEC			√					
Annual Anti-Bribery Stratement	Annual	Approve	CFO	CFL	TMG/AC								√
Corporate Complaince (Regulatory/Statutory):													
NHS Premises Assurance Model (NHS PAM)	Annual	Approve	CFO	DEF	TMG					√			
Self-Assessment of Compliance with Foundation Trust Licence	Annual	Approve	CCAO	Secretariat	TMG/AC		√						
Emergency Preparedness, Resilience and Response (EPRR) – Annual EPRR Assurance Submission	Annual	Approve	COO	EPM	TMG							√	
Clinical Negligence Scheme for Trusts (CNST) – Maternity Services	Annual	Approve	CN/DIPC	DDO=CWDT	TMG					√			
Board Governance													
Review Board Committee Annual Reports, Board Committee Terms of Reference	Annual	Approve	CCAO	Secretariat	TMG		√						√
Board Activity Forward Plan	Annual	Approve	CCAO	Secretariat	TMG		√						√
Board Meeting Schedule (to agree Board and Committee dates for next financial year)	Annual	Approve	CCAO	Secretariat	TMG					√			
Closing administration													
Questions from the public	Monthly	Note	Chair	Secretariat	Board	√	√	√	√	√	√	√	√
Summary of Actions	Monthly	Note	CCAO	Secretariat	Board	√	√	√	√	√	√	√	√
Any new risks or issues identified	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√
Items for the next meeting	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√
Any other business	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√
Board Evaluation - Reflection on the meeting	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√
Patient / Staff Story	Monthly	Note	CN/DIPC	CN/DIPC	Board			√	√	√	√	√	√

PROPOSED PRIVATE FORWARD PLAN - TRUST BOARD
BUSINESS AS USUAL - 2020-21

Public (Part 2) Board Forward Plan 2020-21	Frequency	Purpose	Board Lead	Author(s)	Committee	30/04/2020	28/05/2020	25/06/2020	30/07/2020	24/09/2020	26/11/2020	28/01/2021	25/03/2021
Opening administration													
Welcome, Introductions and Apologies for Absence	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√
Declaration / Register of Interests	Monthly	Report	All	Secretariat	Board	√	√	√	√	√	√	√	√
Minutes of Previous Meeting (accuracy)	Monthly	Approve	Chair	Secretariat	Board	√	√	√	√	√	√	√	√
Matters Arising (Tracker) and Action Log	Monthly	Endorse	Chair	Secretariat	Board	√	√	√	√	√	√	√	√
Key Issues	Monthly	Note	CEO	ADC/CCAO	TMG	√	√	√	√	√	√	√	√
Finance and Business Development/Planning													
Financial Forecaset	Monthly	Note	CFO	DCFO	FIC		√	√	√	√	√	√	√
Draft Annual Budget (including Pay, Non-Pay, Capital and Cost Improvement Plan)	Annual	Review	CFO	DCFO	FIC								√
Draft Annual Plan (Narrative - Trust and System)	Annual	Review	CSO	DCFO/HoBP	TMG								√
Draft Annual Financial Plan	Annual	Review	CFO	DCFO	FIC								√
Sustainable Transformation Programme Five Year Financial Plan	Annual	Review	CFO	DCFO	FIC								√
Outline & Final Business Cases	Adhoc	Approve	Variaus	Various	TMG/Various	*As required*							
Quality, Safety, Patient Experience and Operational Performance													
Indepth Service Reviews	Quarterly	Assure	CN/DIPC	DDO-CWDT	QSC				*As required*				
Learning from Serious Incidents (Thematic Report) (Twice yearly)	Bi-Annual	Assure	CN/DIPC	CRM	PSQG/QSC					√			√
Strategy, Partnership/System Working, Research and Horizon Scanning													
South West London Integrated Care System	Annual	Approve	CSO	HoS/HoBP	TMG				√		√		√
Post-COVID System Working	Monthly	Review	CEO	DCEO/CSO	TMG				*As required*				
Queen Mary Hospital	Annual	Review	CEO	DCEO/CSO	TMG						√TBC		
Specialised Commissioning South West London - Devolution of Budgets	Annual	Review	CEO	DCEO/CSO	TMG						√TBC		
Organisation Development, Culture & Workforce													
Maintaining High Professional Standards in the NHS	Monthly	Assure	CPO	CPO	Board	√	√	√	√	√	√	√	√
Trust Corporate Governance, Complaince & Risk													
Draft Board Assurance Framework (Annual Review/Forward Plan)	Quarterly	Assure	CCAO	DQGC	TMG/BC		√						
Board Governance													
Draft Board Development Plan	Annual	Approve	CCAO	Secretariat	TMG			√					√
Closing administration													
Summary of Actions	Monthly	Note	CCAO	Secretariat	Board	√	√	√	√	√	√	√	√
Any new risks or issues identified	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√
Items for the next meeting	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√
Any other business	Monthly	Note	All	Secretariat	Board	√	√	√	√	√	√	√	√