Trust Board Meeting

Date and Time: Thursday 4 May 2017, 10:00 – 12:15
Venue: Hyde Park Room, 1st Floor, Lanesborough Wing

10:00 – FEEDBACK FROM BOARD WALKABOUT

Time	Item	Subject	Action	Lead	Format
OPENING ADMINISTRATION					
10:20	**1.1**	**Welcome and Apologies**	-	Chairman	-
	1.2	**Minutes of Meeting held on 06.04.17**	Approve	Chairman	Paper
	1.3	**Action Log and Matters Arising**	Review	All	Paper
	1.4	**Update from Chair and CEO**	Inform	CEO	Oral
PATIENT SAFETY, QUALITY AND PERFORMANCE					
10:30	**2.1**	**Quality Improvement Plan Framework**	Assure	CN	Paper
	2.2	**Section 29a Progress Report**	Assure	CN	Paper
	2.3	**Performance & Quality Report**	Review	COO/CN	Paper
FINANCE					
11:00	**3.1**	**2016-17 Outturn Report**	Assure	DFPR/DFO	Paper
	3.2	**Report from Finance & Performance Committee**	Inform	Chair of Committee	Oral
WORKFORCE					
11:20	**4.1**	**Workforce Performance Report**	Inform	HRAB	Paper
	4.2	**Update on Leadership Strategy**	Approve	HRAB	Paper
GOVERNANCE & RISK					
11:40	**5.1**	**Corporate Risk Register**	Review	MD	Paper
	5.2	**IG Toolkit Submission**	Assure	CIO	Paper
	5.3	**Report on Use of Trust Seal 2016-17**	Review	Co Sec	Paper
12:00 - STAFF STORY Giovanni Gambaruto, Medical Devices Co-ordinator who did some sterling work to spend the capital budget before the year-end.					
CLOSING ADMINISTRATION					
12:10	**6.1**	**Questions from the Public**	-	Public	Oral
	6.2	**Summary of Actions**	-	Co Sec	Oral
	6.3	**Any New Risks or Issues**		All	-
	6.4	**Items for Future Meetings** i. Communications Strategy and Annual Plan (June 2017) ii. ICT Strategy (June 2017) iii. IPC Annual Report (June 2017) iv. ICT Plans (June 2017) v. Evaluation of Overseas Visitors and Migrant Cost Recovery Pilot (June 2017) vi. FOI Report (June 2017) vii. Review of Trust's Insurance Arrangements (June 2017) viii. Safeguarding Report (July 2017) ix. Charity to attend Board (July 2017) x. Learning from Avoidable Deaths (July 2017) xi. Update on Outpatients Programme and Business Case (July 2017) xii. Committee Terms of Reference & Annual Plans 2017-18		-	-
	6.5	**Any Other Business**	-	Chair	-
	6.6	**Reflection on Meeting**	-	All	Oral

12:15		**Close**			
Resolution to move to closed session In accordance with Section 1 (2) Public Bodies (Admissions to Meeting) Act 1960, the Board is invited to approve the following resolution: “That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”					

Date and Time of Next Meeting: Thursday 8 June 2017, 10:00 – 12:30

Trust Board
Purpose, Membership and Meetings

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 Those in Attendance		
Members (Voting)	**Designation**	**Abbreviation**
Gillian Norton	Chair	Chair
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	
Stephen Collier	Non-Executive Director	Name/NED
Jenny Higham	Non-Executive Director (University Rep)	
Sir Norman Williams	Non-Executive Director	
Sarah Wilton	Non-Executive Director	
Ann Johnson	Acting Chief Financial Officer	CFO
Avey Bhatia	Chief Nurse & DIPC	CN
Andrew Rhodes	Medical Director	MD
Thomas Saltiel	Associate Non-Executive Director	Name/NED
CEO Direct Reports		
Harbhajan Brar	Director of Human Resources and Organisational Development	DHROD
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
James Friend	Director of Delivery, Efficiency and Transformation	DDET
Larry Murphy	Chief Information Officer	CIO
Divisions		
Alison Benincasa	Divisional Chair, CSD	DC/CSD
Tunde Odutoye	Divisional Chair, SCTN	DC/SCNT
Lisa Pickering	Divisional Chair, MedCard	DC/MedCard
Justin Richards	Divisional Chair, CWDT	DC/CWDT
NHS Improvement		
Steve Leivers	Financial Improvement Director	FID
Marie-Noelle Orzel	Improvement Director	ID
Secretariat		
Fiona Barr	Trust Secretary and Head of Corporate Governance	Trust Sec

Trust Board Dates 2017-18 (Thursday's)		
08.06.17 10:00 – 13:00	06.07.17 10:00 – 13:00	10.08.17 10:00 – 13:00
07.09.17 10:00 – 13:00	05.10.17 10:00 – 13:00	09.11.17 10:00 – 13:00

07.12.17 10:00 – 13:00	11.01.18 10:00 – 13:00	08.02.18 10:00 – 13:00
08.03.18 10:00 – 13:00		

Minute of Trust Board Meeting in Public
6 April 2017 – From 10:00, Hyde Park Room, 2nd Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chair	GN
Simon Mackenzie	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Avey Bhatia	Chief Nurse	CN
Andrew Rhodes	Medical Director	MD
IN ATTENDANCE		
Thomas Saltiel	Associate Non-Executive Director	NED
Anna D'Alessandra	Director of Financial Planning & Performance	DFPR
Chris Evans	Chief Pharmacist (part)	CP
Robert Flanagan	Director Financial Operations	DFO
Mark Gammage	HR Advisor to the Board	HRAB
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Nigel Kennea	Associate Medical Director (part)	AMD
Larry Murphy	Chief Information Officer	CIO
Alison Benincasa	Divisional Chair, CSD	DC – CSD
Tunde Odutoye	Divisional Chair, SCTN	DC – SNTC
Lisa Pickering	Divisional Chair, CWDT	DC – CWDT
Justin Richards	Divisional Chair, MedCard	DC – MedCard
APOLOGIES		
Iain Lynam	Chief Restructuring Officer & Acting Financial Officer	CRO/CFO
Marie-Noelle Orzel	NHSI Quality Improvement Director	QID
SECRETARIAT		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec

PATIENT STORY Robert Bieber gave a very positive account of the care he had in the Trust over a long period of time. He had recently been admitted by ambulance with a suspected heart attack and was full of praise for Trust and ambulance service staff.	
1. OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed everyone to her first Trust Board meeting as Chairman. The apologies were as set out above.
Declarations of Interest	
1.2	The Chairman asked for declarations of interest. None were made.

Minutes of Meeting held on 09.03.17	
1.3	These were accepted as a true and accurate record of the meeting held on 09.03.17 save for an addition to minute 5.1 to read: *"It was agreed that there would be a Board workshop on risk to enable all members of the Board in identifying and agreeing strategic risks".* The Action Log would also be updated to this effect.
Matters Arising and Action Log	
1.4	The Board considered the Action Log and agreed that actions TB.09.02.17/14,15 & 17 and TB.09.03.17/19A, 19B, 20 & 21 which were proposed for closure could be closed.
1.5	The Board requested that appropriate action be taken by the COO to enable the closure of action TB.09.02.17/16. As TB.09.03.17/18 had not been adequately addressed by the COO in the Performance Report, this action was re-opened.
Update from Chair and CEO	
1.6	The CEO confirmed that the new CEO, Jacqueline Totterdell, would start from 01.05.17 and a successful appointment had been made to the role of CFO; negotiations were underway to agree a start date.
1.7	He advised that the Trust had been notified by NHS Improvement (NHSI) that it would be placed into Financial Special Measures. A key part of the recovery was the production of a credible Financial Recovery Plan and sustainable delivery against it and he was confident that the incoming CEO would put an executive team in place which would enable the Trust to get out of both Financial and Quality Special Measures.
1.8	The CEO reminded the Board that despite the difficulties with the Trust's performance, the care it delivered deserved praise and recognition. The Chairman agreed, saying that the staff she had met in her first few days were hugely committed and enthusiastic and were an integral part of the Trust's success.
2. PATIENT SAFETY, QUALITY AND PERFORMANCE	
Briefing on Learning from Patient Deaths	
2.1	Dr Nigel Kennea, Associate Medical Director and Intensive Care Consultant for newborn babies, joined the meeting to brief the Board on the National Quality Board's recently published: *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.* Following events in Mid Staffordshire and a recent review by the Care Quality Commission (CQC), learning from patient deaths was not always given sufficient priority and consequently valuable opportunities for improvements were being missed. The report also pointed out that there was more we could do to engage families and carers and to recognise their insights as a vital source of learning.
2.2	He advised that the standards expected of Trust Boards were set out at in the Appendix to the report but critically there was a requirement for a lead Executive and Non-Executive Director for learning from patient deaths. For St George's, this would be Prof Andrew Rhodes, the acting MD who would be the Lead Director with executive responsibility for the learning from patient deaths agenda and Sir Norman Williams as the NED with responsibility for oversight of progress.
2.3	The Board was assured that the Quality Committee would keep under regular review the process for identifying, reporting, investigating and learning from deaths in care and ensure that the Trust had a clear policy and approach and publication of the data and learning points from Q3 onwards. Already the Trust was well advanced in this field due to the work of Dr Kennea who was asked to speak at a national conference on Learning from Patient

	Deaths. He explained that the Trust's systems were reasonably mature in that they could identify patients in real time, including when and where they died, what the diagnosis was and who was responsible for their care. However, he advised that there was a need to invest in clinical and non-clinical resource to undertake the reviews and identify the lessons learned.
2.4	The Chairman thanked Dr Kennea noting that the point about resources had been heard and that she expected the Executive to work with him to address any requirements. She looked forward to the regular reporting of learning from patient deaths from January 2018 at the latest, though there was an internal target to do this by September 2018.
Quality Improvement Plan	
2.5	The Board was presented with a revised Quality Improvement Plan (QIP) which had been updated in format and content and aimed to put a greater focus on outcome that would be achieved rather than the tasks to be undertaken. The next step was to explain the purpose of the QIP in simple terms to staff and the Executive was working up plans to do this. There had been concern at the February 2017 Board meeting that some actions were slipping though as a result of concerted effort by a number of officers, many actions were back on track.
2.6	Whilst the Board welcomed the new approach, it asked for greater assurance on the actions being taken to address the Section 29A letters. It was agreed that this would be presented to the next meeting.
TB.06.04.17/23	**Provide a report on assurance with addressing the issues raised in the Section 29A letters.** **LEAD: CN**
2.7	The Board received the report and noted improvement on the delivery of the QIP. It looked forward to the further refinement of the plan and its outcomes.
Performance & Quality Report	
2.8	The COO presented the Performance Report setting out a number of steps which were being taken to improve performance in the Emergency Department and against the four hour standard which was below 95%. There were still a number of cases of delayed transfer of care though length of stay and overall bed occupancy were reducing, indicating a better flow through the hospital. He confirmed that "front door" processes, such as having senior decision makers available for triage and GP streaming, were in place and working.
2.9	He advised that changing the arrangements for additional payments to consultants had resulted in a reduction of activity in February and two main areas of concern were ENT and General Surgery. All Cancer standards were met in January and February with the exception of Two Week Wait performance which fell below target due to a high number of breaches within Endoscopy and Dermatology as a result of capacity pressures. There were recovery plans in place to improve performance in these areas as well as work with Commissioners to see what steps could be taken to manage demand differently. The NEDs queried why the number of GP referrals had reduced and if this trend would continue in 2017-18. The COO advised that Commissioner had actively taken steps to reduce GP referrals as part of plans to manage demand.
2.10	The Board received the report.
Report from Quality Committee	
2.11	Quality Committee Chairman Sir Norman Williams provided an oral report to the Board from the last Committee meeting noting the following:

	i. The CDiff rate was increasing and the Trust was likely to breach its threshold of 31 cases. The majority of cases were sporadic and had not resulted from lapses in care. ii. The Divisional Governance Report produced by STN&C was commended for being a concise and robust report. The Division had reported a significant improvement in compliance with the World Health Organisation checklist and Duty of Candour. iii. The frequency of serious incidents (SIs) was falling but there was now greater reporting though the Committee still wished to see a reduction in SIs. iv. The Committee was disappointed that there had been three Never Events following a long period in which none had been reported. v. The Trust was involved in a look back exercise requested by the Department of Health on the use of heater units in cardiac surgery. The Board was assured that all the high risk units had already been replaced. vi. Compliance with Duty of Candour had improved but the Committee had urged the Executive to strive for 100% compliance. vii. The Committee would receive a report on Safer Staffing at its next meeting. viii. The Committee still needed to see a plan for how the 2016-17 Quality Account would be produced.
Elective Care Data Quality Recovery Programme	
2.12	This paper provided an update on the elective care recovery programme, and the impact on delivery of the 18 week referral to treatment (RTT), diagnostic and cancer access standards. Whilst progress was being made, which would enable a return to national RTT reporting in 2018-19, there remained a huge amount to do – including addressing the backlog of clinic and discharge letters. Work is also on-going to identify those patients who may have come to harm as a result of long-waits.
2.13	The Board asked for further information about the cost of the RTT programme, and how this linked to delivery of the wider plan.
2.14	The Board concurred that it wished to have a proper report and discussion brought to the next Board meeting.
TB.06.04.17/24	**Provide a report to the Board on progress with the RTT project, noting progress made, timeline and milestones for achievement.** **LEAD: ECRPD, Diana Lacey**
Hospital Pharmacy Transformation Plan 2016 – 2020	
2.15	Chris Evans, Chief Pharmacist, attended for this item advising that the Hospital Pharmacy Transformation Plan (HPTP) would underpin the Trust Pharmacy and Medicines Optimisation strategy and business planning for 2017-18 and subsequent years. The HPTP would ensure that 80% of pharmacy staff resource is utilised for clinically focused patient facing medicines optimisation services by April 2020. This will include medicines reconciliation, medicines administration, prescribing of medicines, pharmacists working in out-patient and pre-admission clinics, medication safety and governance.
2.16	The paper set out the transformational work required for successful implementation and also advised of steps taken to share the HPTP with partners across London to support collaboration and economies of scale; the work would feed into the South West London Sustainability and Transformation Plan medicines optimisation agenda. Delivery of the HPTP would be reported by exception to the Patient Safety Quality Board.
2.17	The Board approved the Hospital Pharmacy Transformation Plan to be delivered by 2020.
3. FINANCE	

Month 11 Finance Report	
3.1	The Board noted a £2m improvement in the Trust's financial position, largely due to non-recurrent accounting benefits in Months 11 & 12, totalling around £8m. The Trust's year to date deficit was £72m and the forecast year-end outturn was a deficit of £74m against the £76m re-forecast deficit position at Month 9 (December).
3.2	Whilst there was an improvement in the overall year-end financial position, the underlying run rate was around £6-7m deficit per month and this had to be addressed. The Board was informed that it was extremely unlikely that the Trust would receive £5m in recycled penalties and fines through NHSI's best endeavours to recover these. The position on cash and capital was noted, including the expenditure of £34m of capital as predicted by year-end.
3.3	The Chair advised the Board whilst she would have expected to have seen next year's budget by this part of the annual cycle, this would be presented to the next meeting.
TB.06.04.17/25	**Present the 2017-18 budget to the Board meeting in May 2017.** **LEAD: CFO**
Report from Finance & Performance Committee	
3.4	The Chairman confirmed that Ann Beasley was the new Committee Chairman from 01.04.17. As many of the Board members were in attendance at the Committee and therefore fully apprised of the Committee's recent work, the Committee Chairman confirmed that the Committee's overriding focus had been on finalising the year-end position (reported above) and the work underway to produce the 2017-18 budget including assumptions around Cost Improvement Plans (CIPs). She noted that there was an expectation that the Demand & Capacity Model (DCM) developed by the COO would underpin the production of the budget, in particular resource and activity planning. To give the NEDs greater visibility on the financial position through the year, she requested that the Committee received forecast financial plan (setting out income, activity and CIP delivery) and performance against it by month. She also noted concern that the Trust had not yet agreed a budget for 2017-18.
Clare House – Demolition	
3.5	The Board formally ratified a decision taken at the Investment, Divestment & Dis-investment Group and approved internally at the Executive Management Group and the Finance & Performance Committee to approve the business case to demolish Clare House and associated decant costs, including modular buildings.
4. WORKFORCE	
Workforce Performance Report	
4.1	The HRAB presented the report and focused on improvements in compliance on appraisals and mandatory and statutory training (MAST): non-medical appraisal compliance had increased to74% (highest level since August 2015), and MAST compliance had reached the target of 85% for the first time this year. In addition, results from the Friends & Family Test showed improvements since Q2 (the last time the survey was conducted) on all measures although there was a considerable amount of effort and focus required to improve staff engagement to desired levels. To this end, the HRAB explained that the Trust had secured some Special Measures funding from NHSI to support staff engagement and he would report on how this money would be used at the next meeting.
4.2	The NEDs expressed concern at the level of staff turnover and requested that the Board received a formal report on the Staff Survey and actions being taken to address staff

	feedback at a future meeting. This was agreed.
TB.06.04.17/26	**Present a paper on staff engagement at the May 2017 Board meeting.** **LEAD: HRAB**
TB.06.04.17/27	**Present the results of the Staff Survey and the action plan to address feedback from staff at a future meeting of the Board.** **LEAD: HRAB**
Report from the Workforce and Education Committee	
4.3	The Chairman confirmed that Stephen Collier had taken over the chairmanship of this Committee and invited him to provide an update. He advised that he saw two key roles for the Committee moving forwards: to scrutinise the processes which supported the Trust's workforce and to forward plan changes in workforce and culture. Particularly important for the Committee were its scrutiny of the establishment (and plans to re-set the establishment baseline in line with the resource profiling set out in the DCM), tracking agency expenditure and working on actions to address staff concerns as set out in the annual Staff Survey. The Board supported these priorities.
5. GOVERNANCE & RISK	
Corporate Risk Register	
5.1	The report advised that the core operational risk exposure areas were: • Timely Access to Clinical Services/Patient Harm • Insufficient Resilience/Unstable Critical IT/Estates Infrastructure • Unsustainable Financial Position • Inadequate Governance/Reputation Loss.
5.2	The NEDs expressed concerns about resources to support risk management, noting that since the departure of the Director of Quality Governance, there had been a reduction in the resource available to support this important area. Despite straitened times, it was essential that the Trust had adequate resources in place to underpin its risk and governance arrangements. The Chief Nurse confirmed that interviews were planned for the Director of Quality Governance and she expected a successful outcome.
5.3	The Board was advised of work underway to produce a new Board Assurance Framework and the Chairman repeated her desire to have a Board workshop on risk and to involve the NEDs in the identification of strategic risks facing the Trust.
5.4	The Board received the report.
Report from Audit Committee	
5.5	The Chair of the Audit Committee focused on reports from Internal Audit which indicated limited assurance with the Trust's system of internal control (the Head of Internal Audit Opinion was likely to be one of Limited Assurance). She impressed upon the Executive of closing management actions that had been agreed through the Internal Audit process, and asked the CEO to lead the drive on this. She confirmed that reports on the annual audit of the accounts indicated that the audit was proceeding well. She also advised that she had asked the HRAB to provide a regular report on Whistleblowing to the Audit Committee. This was agreed.
6. CLOSING ADMINISTRATION	
Questions from Public	
6.1	The Chairman advised that the Board that Mrs Clare Edgley had submitted a question about a Swine Flu vaccination she had received whilst a member of staff at the Trust in

	2009. Mrs Edgley was present in the audience and repeated her question, advising that since then she had had a sleep disorder and various other symptoms and she wanted the Board's help in understanding if there was a link between the vaccination and her symptoms. She had tried to raise the matter through the complaints service and the Human Resources Department. The Chairman advised Mrs Edgley that Mark Gammage, the HR Advisor to the Board, would have a private meeting with her and had tried to contact her before the meeting to agree a convenient date and time.
6.2	Mrs Lesley Robertson, a patient representative, stated that she and her fellow patient representatives were on standby to provide the Trust with tangible support on initiatives to improve quality and support patient engagement and patient experience. They were a resource to be called on when the Trust was ready and were already looking forward to working with the Chief Nurse.
Any Other Business	
6.3	The Chairman closed the meeting by thanking Simone Mackenzie for his contribution to the Trust and the Board in his time as CEO. He had been the acting CEO in a difficult period for the Trust and on behalf of the Board, she thanked him for all his efforts. He responded by saying it had been a huge privilege to serve on the Board as CEO.
6.4	With no items of any other business, the Chairman closed the meeting.

Date and Time of Next Meeting: Thursday 4 May 2017, from 10:00

Trust Board Public - 04.05.17

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.03.11.16/03	**Mortality Statistics**	Undertake a deep dive into mortality statistics at the Quality Committee every six months.	~~QC.29.03.17~~ QC.23.05.17		MD ~~& CN~~	The Board received a briefing on Learning from Patients Deaths at it's meeting on 06.04.17. Therefore this item is closed.	Proposed for Closure
TB.05.01.17/08	**Overseas Visitors and Migrant Cost Recovery Pilot**	Board to receive an evaluation report on the pilot programme to recover costs in two clinical areas (maternity and an elective service) from overseas visitors and migrants who use NHS services but are not entitled to free care. Report to be received in June 2016.	TB.08.06.17		CRO	Not yet due.	Open
TB.05.01.17/11	**Leadership Development**	Present an updated report on leadership development to the March Board meeting (09.03.17).	~~TB.09.03.17~~	~~TB.06.04.17~~ TB.04.05.17	HRAB	On the Board agenda for 04.05.17.	Proposed for Closure
TB.05.01.17/12	**Claims and Insurance**	Present an update report to the March Board meeting (09.03.17) on the Trust's insurance arrangements following the review by an external insurance specialist.	~~TB.09.03.17~~	~~TB.06.04.17~~ TB.04.05.17	HoG	A verbal update wil be provided in the meeting on 04.05.17.	Open
TB.09.02.17/16	**Local Escalation Plan**	Updated Local Escalation Plan to be circulated to the Board following its approval by the CEO and Chair on behalf of the Board.				A verbal update wil be provided in the meeting on 04.05.17.	Open
TB.09.03.17/18	**Additional Payments**	Brief the Board on the implications of the changes to additional payments on income, activity and patient safety, by service line, at its next meeting.	~~Board.06.04.17~~	BoRD.04.05.17	COO	A verbal update will be provided in the meeting on 04.05.17.	Action Re-Opened
TB.09.03.17/19C	**Integrated Performance Report**	Over time, produce an Integrated Performance Report which triangulates metrics on finance, quality and performance, with qualitative and quantitative analysis, and an assessment of outturn by month and year end position.	Under Development		COO and CN	This report is subject to regular revision and review to improve the format and layout and provide the information that the Board will find useful to oversee and challenge performance. However until it fully triangulates information it is suggested that this action remains open.	Open
TB.09.03.17/22	**Board Workshop**	Organise Board workshop on risk to enable all members of the Board in identifying and agreeing strategic risks.	Board.06.04.17		Trust Sec	An outline paper on the new format for the BAF will be presented to Part 2 of the Board on 04.05.17, at which point there will be a workshop to discuss and identify new strategic risks with Board memebers.	Proposed for Closure
TB.06.04.17/23	**Section 29a Letters**	Provide a report on assurance with addressing the issues raised in the Section 29A letters.	Board.04.05.17		CN	On the Board agenda for 04.05.17.	Proposed for Closure
TB.06.04.17/24	**RTT**	Provide a report to the Board on progress with the RTT project, noting progress made, timeline and milestones for achievement.	Board.04.05.17		ECRPD	On the Private Board agenda for 04.05.17.	Proposed for Closure
TB.06.04.17/25	**Budget 2017-18**	Present the 2017-18 budget to the Board meeting in May 2017.	Board.04.05.17		CFO	On the Private Board agenda for 04.05.17	Proposed for Closure
TB.06.04.17/26	**Staff Engagement**	Present a paper on staff engagement at the May 2017 Board meeting.	Q1 2017-18		HRAB	Timing of item under discussion - though the EMT received a briefing on an outline approach to staff engagement on 24.04.17.	Open
TB.06.04.17/27	**Staff Survey**	Present the results of the Staff Survey and the action plan to address feedback from staff at a future meeting of the Board.	Q1 2017-18		HRAB	Timing of item under discussion. EMT received an outline approach to Staff Survery acton plan on 24.04.17.	Open

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Title: Quality Improvement Framework
Meeting: Trust Board
Date: 4th May 2017
Author: Chris Evans, QIP Project Manager
St George's University Hospital NHS Foundation Trust

Excellence in specialist and community healthcare

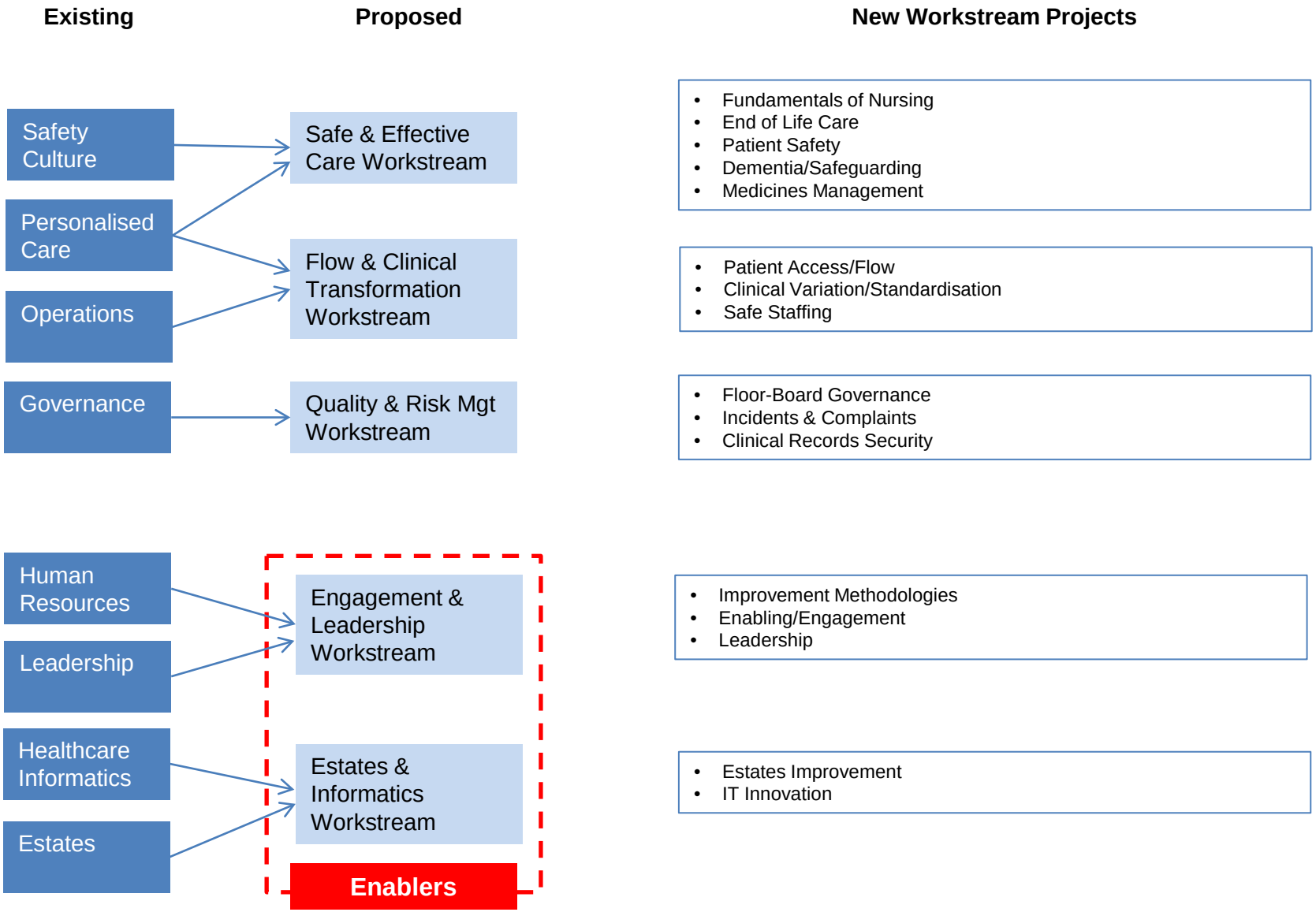
Introduction

This report provides an update of the revised quality improvement framework which is evolving with clinical engagement to develop the project plans and provides a brief position status for the QIP workstreams utilising the revised framework:

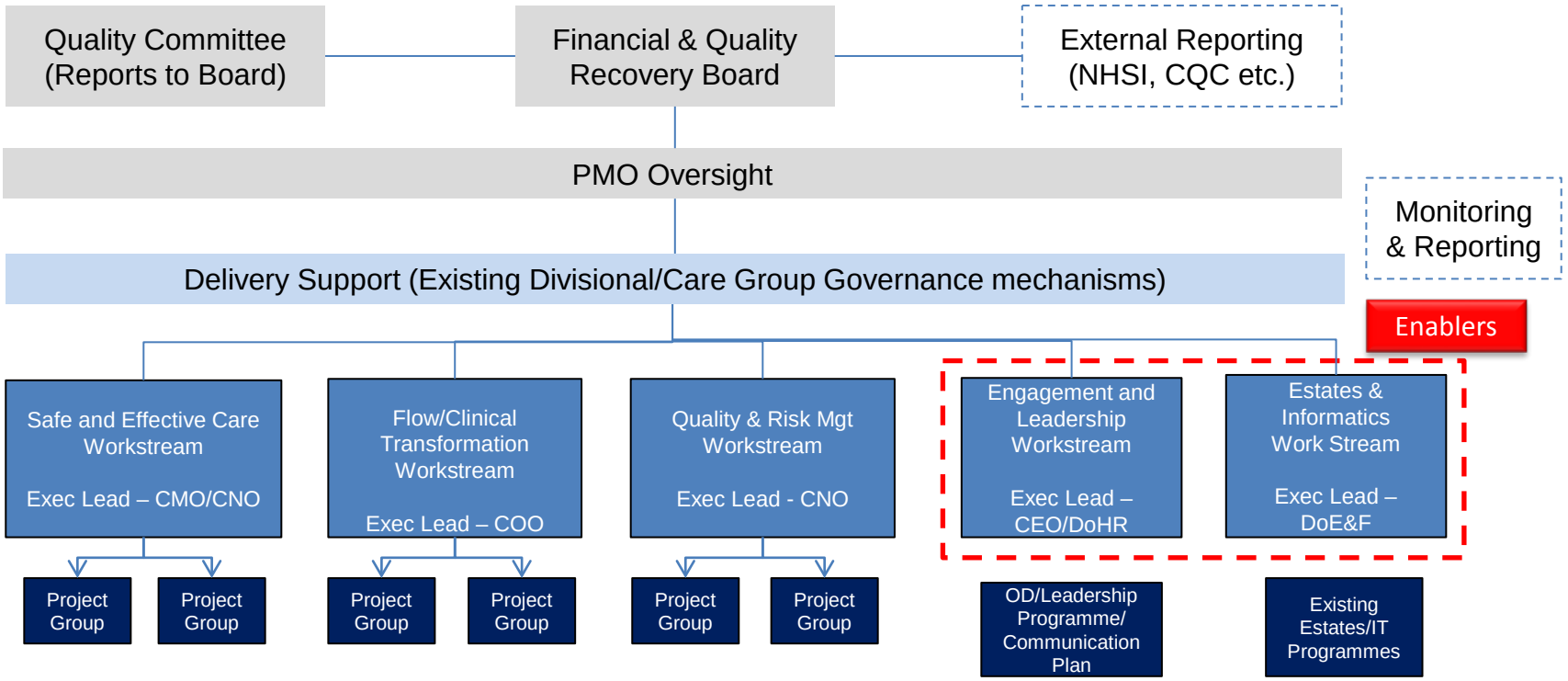
Key Points:

- Recap on the shift from QIP version one to the new QIP Framework. All of the **'must dos and should dos' will** be picked up in the new projects and are still being tracked to ensure nothing is missed within the transition
- Governance Structure for QIP oversight
- Report of current QIP status utilising new QIP Framework Workstreams and Projects

Re-framing existing Workstreams



Programme Structure



- Each of the three core improvement programmes will be comprised of a number of projects aligned to the work currently encompassed by the existing QIP, each with an assigned Project Lead who will undertake bi-weekly project meetings to support the Executive Workstream Leads
- Monthly Dashboard Metrics reporting will be implemented to set trajectories from an agreed baseline for each project
- As part of the move into new workstreams each project will be re-assessed in terms of date for project completion and current risk assessment and mitigation plans for delivery, with revised project completion dates being set in stone
- The workstreams are envisioned to be clinically owned and represent continually improvement with new projects being incorporated where quality issues are identified requiring input, and completed projects being removed and embedded as business-as-usual within the Trust

Board Reporting (Current Status)

In order to streamline reporting and ensure appropriate detail at the right level, a simplified Board Reporting mechanism is envisioned, the following details a snap-shot position for each of the revised workstreams and projects based on evidence and assurance from the existing QIP delivery. As each workstream and project is further developed and refined within the new framework these will be updated and form the basis for a new reporting mechanism to the Board.

Workstreams	Individual Projects	Recent Achievements	Risks	Mitigation
Safe & Effective Care	• Fundamentals of Nursing • End of Life Care • Patient Safety • Dementia/Safeguarding • Medicines Management	• Re-launched Pain Management Link Staff and audited compliance with policy. • Established an End of Life Care (EoLC) Steering Group, to implement a Three Year Strategy and implementation plan & Redesigned and implemented an EoLC pathway to replace the Liverpool Care Pathway. • Audited compliance with Infection Control standards, and KPIs in place for monitoring performance • New Dementia & Delirium Pathways implemented with audits for compliance with best practice being undertaken • Achieved 98% compliance with the BAPM standards & 100% compliance with medicines reconciliation	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**

KEY: Red Text Workstream/Projects designate at risk of completion by agreed date,
Green Text Workstream/Projects designate on track for achievement

Board Reporting (Cont.)

Workstreams	Individual Projects	Recent Achievements	Risks	Mitigation
Flow/Clinical Transformation	• Patient Access/Flow • Clinical Variation/ Standardisation • Safe Staffing	• Comprehensive programme of work in place but may require greater support to achieve the pace required • Implemented a new process for elective theatre planning to ensure optimum use of theatre capacity and forward planning, supported by daily operational performance meetings • MAST Training programme partially in place to support meeting the National Audit standards and Mapped out the current community service provision as part of the development of an Adult Community Health Strategy	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**

KEY: Red Text Workstream/Projects designate at risk of completion by agreed date,
Green Text Workstream/Projects designate on track for achievement

Board Reporting (Cont.)

Workstreams	Individual Projects	Recent Achievements	Risks	Mitigation
Quality & Risk Management	• Floor-Board Governance • Incidents & Complaints • Clinical Records Security	• External review has been commissioned to review corporate and clinical governance • Improved the process for ensuring compliance with Duty of Candour and established a web page dedicated to the dissemination of learning from incidents and complaints to aid leadership with feeding back to staff • Commenced roll-out of mobile working, with 320 XP Machines replaced and laptops deployed for mobile working pilot launch to improve staff access to clinical systems	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**

KEY: Red Text Workstream/Projects designate at risk of completion by agreed date,
Green Text Workstream/Projects designate on track for achievement

Board Reporting (Cont.)

Workstreams	Individual Projects	Recent Achievements	Risks	Mitigation
Engagement & Leadership	• Improvement Methodologies • Enabling/Engagement • Leadership	• Tendering of services for additional staff engagement, leadership development & governance review has successfully appointed Pinch Point, the Institute of Healthcare Improvement, and Deloittes to lead programmes • New leadership team coming into post which will provide the stability the needed by the organisation • Leadership strategy developed and being presented to board	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**

KEY: Red Text Workstream/Projects designate at risk of completion by agreed date,
Green Text Workstream/Projects designate on track for achievement

Board Reporting (Cont.)

Workstreams	Individual Projects	Achievements	Risks	Mitigation
Estates & Informatics	• Estates Improvement • IT Innovation	• Undertaken repairs to identified roof leaks and closed beds in those areas affected by water ingress, demolished the Wandle Unit and relocated staff along with the relocation of the Renal Ward in Knightsbridge Wing to an identified alternative site for Renal Outpatients • SLA between Moorfields and St Georges signed to ensure processes and procedures are in place for staff working across sites, along with the recruitment of an IT Manager to audit MAST stability and engage with corporate training	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**	**These are being identified through the Workstream Development Meeting with project leads (May 2017 completion)**

KEY: Red Text Workstream/Projects designate at risk of completion by agreed date,
Green Text Workstream/Projects designate on track for achievement

Next Steps

- Schedule of meetings with existing workstream programme leads, and with more widespread clinical staff (multi professional to review and develop workstream project areas over the coming weeks, scheduled to be complete by the end of May 2017

- As part of the above, each workstream project (as well as existing programmes where further work is required to meet standards) will develop an implementation Plan-on-a-Page and Driver Diagram to inform the areas of focus for delivery, scheduled to be complete by the end of May 2017

- Development of a Floor to Board reporting Matrix to support the implementation at an organisational level, allowing the QIP PMO to monitor where plans are working, as well as where support is required to further drive improvements, scheduled to be complete mid May 2017 to support the above areas of work

- Communications Plan being developed in conjunction with staff engagement work, with specific channels and targeted levels of information for different staff groups, scheduled to be in place by the beginning of May 2017

Meeting Title:	Trust Board		
Date:	4 April 2017	Agenda No:	**2.2**
Report Title:	Progress report on Section 29A Warning notice		
Executive Sponsor	Avey Bhatia – Chief Nurse and Director of Infection Prevention and control		
Report Authors:	Avey Bhatia – Chief Nurse and Director of Infection Prevention and control Christopher Evans – Quality Improvement Plan Lead		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	On the 26th August 2016 St George's University Hospital NHS Foundation Trust was served a warning notice under Section 29A of the Health and Social Care Act 2008. Following inspections undertaken by the CQC in June 2016 their view was that the quality of healthcare that we provided required significant improvements. The key areas of concerns identified : • Unsafe and unfit premises where healthcare is provided and staff are accommodated • Lack of formal mental capacity assessments and best interest decision making • Governance arrangements not effective in identifying and mitigating significant risks to patients • Data used in reporting and managing patients not robust or valid • Governance underpinning the effective integration of End of Life Care (EoLC) • Arrangements for ensuring directors are fit and proper were lacking In response to these concerns the Trust identified 21 actions that needed to be taken to provide safe care for our patients in an environment which supports this for both staff and patients and that meets with the standards expected by the CQC. The evidence for compliance has been reviewed (central compliance evidence repository) and where necessary this has been validated by directly reviewing practice. To date, progress has been made in delivery of the actions. However, the nature of some of the work means that full delivery of some of the actions will inevitably take a longer period to deliver (significant estates work) and/or achieve robust assurance that the required changes in practice have been fully embedded. In these cases interim actions have been taken to mitigate any immediate risk to patients or staff. As such the following areas of work are ongoing to ensure that the Trust can provide robust assurance of full delivery and compliance:		

	• Water safety management - agreed processes in place. However, on-going monitoring, testing and flushing is required. • Theatre refurbishment programme (16 theatres require full or partial refurbishment) – some theatres complete with others being completed as per estates plan. • Mental capacity assessments and evidence of best interest decision making particularly with regard to documentation – polices and practice reviewed with an educational role out plan. Whilst initial monitoring indicates improved compliance it is too early to provide full assurance of embedded and sustained practice. • Delivering of End of Life Care strategy milestones through to 2020 – strategy has been developed and in place. Processes in place to ensure monitoring of impact of strategy in practice. • Fit and proper person test – a review of the effectiveness of current processes is planned. Governance – improvements have been made to ensure effective management and learning from serious incidents an external Governance review has been commissioned to review all aspects of governance from floor to Board and further changes will be made in line with any recommendations. The Section 29A actions are only one part of the trust's overall quality improvement plan, with some areas having their own individual improvement programmes. The work to address the issues around Referral to treatment (RTT) processes which are currently non-compliant are ongoing and multifactorial. As such the board will be provided with a separate briefing.
Recommendation:	The board are asked to note the current status of work to achieve compliance with the section 29A warning notice and advise of any further action required
Supports	
Trust Strategic Objective:	Delivery of safe and effective care as assessed by the CQC
CQC Theme:	All CQC Domains
Single Oversight Framework Theme:	(i) Quality of Care (ii) Operational Performance (iii) Leadership and Improvement Capability
Implications	
Risk:	I. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care; and II. The Trust fails to comply with NHSI enforcement undertakings and the provider licence.
Legal/Regulatory:	Compliance with: (i) The Health and Social Care Act 2008 (Regulated Activities) Regulations (ii) 2014; (iii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015; (iv) Care Quality Commission (Registration) Regulations 2009; and (v) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission
Resources:	None

Previously Considered by:	Executive Management Team 24th April 2017		
Equality Impact Assessment:	N/A		
Appendices:			

Warning notice Section 29A of the Health and Social Care Act 2008 – progress report Trust Board April 2017

Introduction

Following inspections undertaken by the CQC in June 2016 the inspectors identified a number of significant concerns about the standards and quality of health care delivered. This resulted in a warning notice under Section 29A of the Health and Social Care Act 2008 being issued to St George's University Hospital NHS Foundation Trust in August 2017.

The areas of concerns focussed on the following key areas:

- Unsafe and unfit premises where healthcare is provided and staff are accommodated
- Lack of formal mental capacity assessments and best interest decision making
- Governance arrangements not effective in identifying and mitigating significant risks to patients
- Data used in reporting and managing patients not robust and valid
- Governance and integration of End of Life Care (EoLC)
- Arrangements for ensuring directors are fit and proper

The Trust sent a response to the CQC as requested on 30th November 2016 detailing the progress that had been made to date.

Progress against warning notice

In response to these concerns the Trust identified 21 actions that needed to be taken to provide safe care for our patients in an environment which supports this for both staff and patients and that meets with the standards expected by the CQC.

The table below shows progress against each of the 21 actions and provides an assurance RAG rating.

RED – Not assured
AMBER – Assured of progress to date but requires on-going monitoring and surveillance to ensure full compliance. An amber rating does NOT imply that that we failed to take sufficient action but rather that full delivery of the work plan requires more time due to scale of the issue or complexity involved in delivery. In this case the CQC will review the work plan, risk management approach, mitigation in place to ensure patient safety, timescales and achieving key milestones for delivery.
GREEN – Fully assured

The evidence for compliance has been assessed by interrogating the central compliance evidence repository (work plans, minutes of meetings, business cases, audit results, monitoring and surveillance results) and reviewed in practice where relevant.

Patient safety issue and compliance matter	Status	Comments / concerns	Assurance rating
1. Maintenance and refurbishment of Operating Theatres	On-going	There are a total of 16 theatres that require full or partial refurbishment. Theatres 5&6 have been completed and 2 further theatres are due to commence in June 2017. It takes approx. 5 months to fully refurb 2 theatres. The timescale for full refurbishment is 3-4 years. In the meantime significant maintenance and surveillance is in place to maintain patient safety and respond quickly to any risks that emerge. This has been RAG rated amber as significant work and investment is required over a number of years to deliver the theatre refurbishment plan	
2. Lack of capital investment in Lanesborough, St James's and Paul Calvert Theatres	On-going	Addressed via above action (No 1)	
3. Theatre air handling units in St James Wing failing	Complete	As per the action (No 1), above; In the meantime significant new plant, routine planned maintenance and surveillance is in place to maintain patient safety and respond quickly to any risks that emerge.	
4. Thermoregulation on Lanesborough Theatre 1	On-going	Addressed via above action (No 1), new plant, routine maintenance and automated surveillance is in place to maintain patient safety and respond quickly to any risks that emerge.	
5. Repair of Maternity Staff Room Roof in Lanesborough Wing	Complete	None. The cause of the original leak has been replaced and the drainage repaired. There have been no repeats of the original fault.	
6. Continued occupation of Wandle Unit after fire concerns identified	Complete	None. The original Wandle Annex has been demolished and replaced with a brand new modular building.	
7. Conclude renal unit patient moves from Buckland Ward, Knightsbridge Wing	Complete	None	
8. Assure fixed wire installation compliance across the SGUH site	On-going	The fixed wire test is ongoing and progressing well but is not fully complete at the time of this report. There is documented evidence of the testing schedule and that CQC accept the plan as evidence of addressing this area of compliance	
9. Water Safety Management – Legionella Contamination	On-going	The CQC wanted to review evidence of twice weekly flushing records to demonstrate the mitigation of risks to patients. These have been 100% compliant since September 2016. There have been two external expert assessments of our water safety programme (one from the HSE and one from an ex-HSE Inspector) and the reviews have made a number of recommendations which are being	

Patient safety issue and compliance matter	Status	Comments / concerns	Assurance rating
		actioned and monitored via the Water Safety Committee (WSC). A programme of work is in place which involves us undertaking regular tests on water samples using a risk based approach, treating appropriately if levels are high and then re-testing, use of tap filters as indicated, the ongoing removal of dead legs in the pipework and a replacement programme of sinks and taps. There remains further work to address particular issues in relation to supply between Grosvenor Wing and the Medical School and availability of accurate schematic drawings. Overall the risk to patients is adequately mitigated but relentless focus is required to keep this under control. This issue is kept under review by the Patient Safety Quality Board and Infection Prevention and Control Committee to which the WSC reports.	
10. Water Safety Management – Pseudomonas	On-going	This is particularly relevant to areas of augmented care for example renal dialysis and Intensive Care Units as it requires low use water outlets to be flushed every 24 hours. Ideally all low use outlets would be removed however bays or bed areas can be closed or simply not be occupied for a period of time so outlet usage can fluctuate from normal to low use. It is essential that we can demonstrate that these low use outlets are recognised and are being flushed in line with requirements. We have two consecutive months' data demonstrating 100% compliance and by end of April we will have three months. Work is underway to all agree a combined approach which is more efficient and sustainable for both Legionella and Pseudomonas.	
11. MCA Policy requires updating	Complete	None	
12. Awareness amongst staff of care interventions that might constitute restraint – bed rails and use of mittens to prevent removal of NG tubes	On-going	The key issue here is that **no** patient (whether they have capacity or not) have decisions made for them without informed consent or formal mental capacity assessment and best interest decisions being taken and clearly documented) Significant amount of work has been done to train and educate staff on understanding the Mental Capacity Act and its' application in practice. Training is available both face to face and via e learning. Risk assessments have been introduced for bed rails and	

Patient safety issue and compliance matter	Status	Comments / concerns	Assurance rating
		the use of mittens and are being completed. However, more work is required to ensure consistency across the 3 of the 4 wards identified as concerns by the CQC. Gwynne Holford (1 of the 4 wards) has taken an exemplar mufti professional approach in fully addressing this issue which has been led by the medical staff and supported by nursing and allied health professionals. This area will continue to be regularly tested in practice as well as comprehensive twice yearly audits on mental capacity assessments and deprivation of liberty safeguards.	
13. Recording of MCA and Best Interest Decisions	On-going	As above in action 12 significant progress has been made but consistency is still an issue. Comprehensive twice yearly audits will be undertaken as well as regular spot checks and assessment during internal compliance inspections.	
14. Fragmentation of Hospital and Community End of Life Care Teams	On-going	The objective for end of life care (EoLC) is that every patient has a dignified good death. There is only one change to get this right. The EoLC strategy was approved at Trust board in December 2016 together with a comprehensive implementation plan. The plan includes indicators and outcomes through to 2020. The plan includes milestones for delivery at corporate and divisional / directorate level and these are broken into deliverable, time specific measurable pieces of work. Delivery is monitored at the Community Services divisional performance reviews and the EoLC steering committee. To ensure seamless coordinated care there are now monthly meetings between acute and community staff. Access to training resources and services are equitable across community and acute. The Trust is also fully engaged with NHSI EoLC collaborative	
15. Risk Management process insufficient	On-going	Risk management systems and processes have been strengthened. However there remains concern about the Trusts overall clinical and corporate governance. An external review has been commissioned which is due to commence as soon as possible.	
16. Timeliness of reporting & investigating Sis, particularly in Surgery Division	Complete	This monitored at the weekly serious incident panel.	
17. RTT Waiting List Management	On-going	Significant programme of work underway but remains non-compliant and requires continued dedicated resource and focus to improve our processes, train our staff and manage the clinical	

Patient safety issue and compliance matter	Status	Comments / concerns	Assurance rating
		risk for our patients.	
18. Monitoring serial numbers for FP10 prescription pads, particularly in OPD	Complete	None	
19. Radiographers administering contrast media without authorised PGD in place	Complete	None	
20. Inadequate compliance with Fit & Proper Person Checks amongst board Members	On-going	System and processes are in place however due to the significant current transition of board members this remains an area that requires regular assessment to ensure ALL aspects for all directors are complete.	
21. Workforce Race Equality Standards (WRES) 2015 published without presentation to the Board	Complete	None	

Conclusion

Whilst progress has been made to improve the required standards of care and demonstrate compliance with the section 29A warning notice the work is ongoing to ensure sustained improvement and compliance. The CQC will carry out further inspections to assess the progress made to date and will also review our risk management approach and decision making for the ongoing work required. They will test compliance in practice and how mitigating actions are protecting our patients and staff. They will use this information to assess if the work done to date and the progress made demonstrate evidence of the Trust's commitment to ensuring the delivery of safe and effective care. is appropriate reasonable.

The Section 29A actions are only one part of the trust's overall quality improvement plan, with some areas having their own individual improvement programmes. The work to address the issues around Referral to treatment (RTT) processes which are currently non-compliant are ongoing and multifactorial. As such the board will be provided with a separate briefing.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality and Performance Report for Trust Board

Trust Board – 4th May 2017
Reporting period - March 2017

Excellence in specialist and community healthcare

Quality and Performance Executive Summary

In this month (page 4)

Are we safe? (pages 5-11)

In March the Trust reported 3 cases of C. Diff taking the year end position to 36 cases against a target of 31. The trust has had 2 MRSA bacteremia's reported for the year against a ceiling of 0. The second MRSA bacteremia that occurred in NICU in February 2017. There had been no MRSA bacteremia's acquired in NICU for at least 2 years prior to this. There has been 1 Never Event reported in February as a result of a retained swab post cardiac surgery, bringing the total of never events to 3 YTD, zero cases reported in March. Harm Free care (All Harms) has fallen below the national target this month, however new harms remain in line with the national average.

Are we effective? (pages 12-15)

The Trust continues to be better than the standard for weekday and weekend Hospital Standard Mortality ratio and also HSCIC. Total bed occupancy remains above the target of 85% , March observed an occupancy rate of 91.1% (midnight occupancy)for general and acute wards. Length of stay remains consistent. Readmissions data from Dr Foster shows that the trust is above the average of 7.2% (average based on region) observing a position of 9%. The higher rate is predominantly due to readmission following a non elective spell where we are currently performing at 12.7% against an expected of position of 9%, however the rate remains consistent and within upper and lower confidence limits

Are we caring? (pages 16-19)

The number of complaints received in February has decreased however we remain below the standard for 25 day response rate. This has been escalated through Divisions and challenged through Divisional Performance Reviews. There continues to be no same sex breaches reported year to date. Recommendation rates for Inpatients, A&E and outpatients remains above locally agreed target.

Are we responsive (pages 20-27)

Our performance against the 95% standard in A&E continues to perform below the national standard in March. We are working hard to improve this with a number of planned improvements to be implemented. Continued improvements are being made to improve treatment times for patients on a cancer pathway. All standards with the exception of Two week wait were met in February, recovery trajectories are in place for this. Diagnostic 6 week performance remains below national standard for the forth consecutive month, recovery actions are in place within areas of non compliant performance including cardiac MRI and endoscopy.

Are we well-led? Pages (28-32)

Our staff friends and family test scores are poor both for a place to work and as a place to be cared for. This is a concern. Staff sickness remains above the trust target of 3%. There has been an improvement in Trust core MAST topics that are above the target of 85% with the exception of Information Governance which is currently 83%. MAST performance remains a concern across infection control, Resuscitation and VTE. Divisions have been asked to produce trajectories for improved performance and training and education will be reviewing capacity to support this. Appraisal rates remain below target for both medical and non-medical appraisals and Divisions have been asked to focus on IPR and MAST which is monitored through Divisional Performance Reviews.

Trust Overview

Domain	Ref	Theme	Management priority (last month)	Management priority (this month)	Forecast	Briefings
Safe	1.1	Patient Safety Incident Reporting	On Track	On Track	Stable	There has been 1 Never Event reported in February, shared SI between STN&C/M&C divisions. The year end position for the Trust is 3 compared to 8 The previous year
	1.2	Patient Safety Harm free care	On Track	On Track	Stable	Harm Free care (All Harms) above target this month, new harms only remains above the target and national average.
	1.3	Infection control and cleanliness	Moderate	Significant	At risk	C-Difficile 36 cases year end position against a ceiling of 31. 2 cases of MRSA against target of ceiling of zero
Effective	2.1	Mortality Indicators	Excellent	Excellent	Stable	The Trust continues to be below the standard for weekday and weekend Hospital Standard Mortality ratio and also HSCIC
	2.2	Length of Stay	On Track	On Track	Stable	
Caring	3.1	Admitted Patient Experience	Excellent	Excellent	Stable	
	3.2	ED Patient Experience	Excellent	Excellent	Stable	
	3.5	Single Sex Breaches	Excellent	Excellent	Stable	
	3.6	Complaints	Significant	Significant	Stable	Performance remains stable, however below target
Responsiveness	4.1	ED Access	Significant	Significant	At Risk	ED operational target remains below the national and STP target, March performance 88.60% however our position remains good against the national picture and year end performance was 91.56%. Non-elective activity increased overall by 34.1% against Plan (5,296 versus Planned 3,950 episodes). Works carried out in ED to improve Assessment space will generate improvements within the ED environment and performance.
	4.2	Elective Care Access	Significant	Significant	At risk	This is mainly within a small collection of services: ENT, T&O, General Surgery with Recovery Plans in place. March performance for Admitted Elective cases increased by 15.7% compared to March 2016, with Day-Case performance increase up by 11.1% compared to March 2016.
	4.3	Cancer Access	Moderate	Moderate	Stable	All cancer standards met in February with the exception of Two week wait.
	4.4	Diagnostic Access	Significant	Significant	At Risk	6 week diagnostic performance remains below the target og 0.99% and recovery plans in place which include additional capacity
	4.5	Bed Capacity and Management	Moderate	Moderate	Stable	Bed occupancy remains constant with slight increase observed in March. The expansion of the Ambulatory Care model will further reduce occupancy and limit short-stay admissions over the next months.The continued presence of Medically-Fit patients is impacting on Bed Occupancy as well as causing financial impact through increased premium staffing required to manage approximately 80-90 patients daily with no requirement to be within the Trust.
	4.6	Cancelled Operations	Significant	Significant	At risk	Cancelled operations have recently been high due to alterations in clinical rotas. These are now rectified, and a reduction in cancelled operations have been seen from March 2017.
Well Led	5.2	Staff Experience	On Track	On Track	Stable	
	5.3	Workforce Indicators	Significant	Significant	At risk	Division have been requested to set trajectories for MAST and appraisal as we remain below target
	5.4	Safe Staffing	Moderate	Moderate	Improving	
Operational Dependencies	6.1	Activity Volumes	Moderate	Moderate	At Risk	Activity volumes are recalibrating as that activity not requiring to come to a tertiary centre is repatriated to other local Trusts, and GP referrals are following those pathways increasingly.
	6.2	Data Quality	Significant	Significant	At risk	Data Quality Project is improving overall validation, as well as delivery of training programme to improve the inputs within the PTLs, thus gradually improving the quality of data provided to management teams.

The trust is currently reviewing additional indicators for inclusion which will be incorporated in forthcoming reports

Scorecard Assessment Key

Management priority

Significant	An externally reported metric is below standard and therefore significant interventions are planned or in progress due to one or more factors
Moderate	An important internal metric is below agreed level and therefore moderate interventions are planned or in progress
Minor	Trends are adverse therefore some interventions are in place or in progress
On Track	All areas are on track
Excellent	Targets consistently met

Forecast

At Risk	Performance expected to worsen by next reporting period
Stable	Performance not expected to change significantly by next reporting period
Improving	Performance expected to improve by next reporting period

Statistical Process Control Charts

Performance against each indicator is shown as a Statistical Process Controls (SPC) chart. The purpose of these charts is to provide a simple view of performance over time, as well as an indicator of whether any variation in performance or activity is statistically important or not.
Each chart consists of four factors:

1) The run chart indicator, showing performance by month from April 2015 (blue line)
2) Average (mean) performance during the time period (green line)
3) Upper and lower control limits (UCL and LCL), which set out an expected range of variation for performance. Performance beyond these limits suggests a level of variation during the time period

In this month

	Mar-17	Compared to last Year	
		Same Month	YTD
The Trust received….			
 Referrals from GP	13,311	-1.1%	-4.9%
 Urgent Cancer Referrals Seen	1,159	-4.7%	0.32%
The Trust treated….			
 ED Attendances	14,625	-1.8%	1.5%
 Non Elective Admissions	4,624	8.7%	10.4%
 Outpatient First Attendances	15,680	13.5%	3.9%
 Day cases	3,463	11.1%	5.8%
 Elective Ordinary Admissions	1,546	15.7%	2.1%

SAFE Domain Scorecard

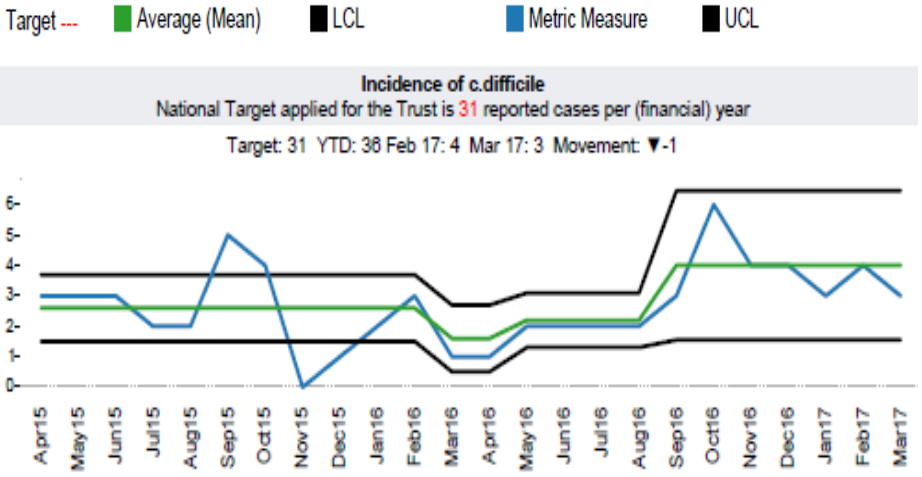
Executive Lead: Avey Bhatia, Chief Nurse

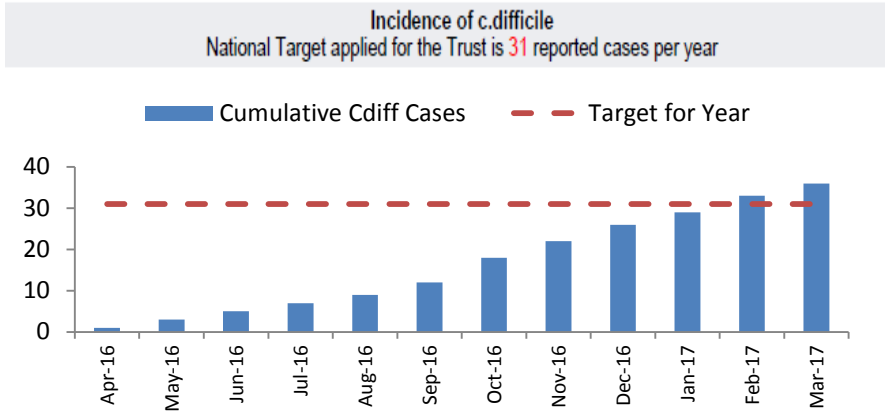
Theme	Indicator	Ref	Units	Period	Target	National or Local	Mth Rag Rating	Jan-17	Feb-17	Mar-17	Variance	YTD Total	Chart
Infection Control	Clostridium Difficile	76	Number	Mar-17	31	Local		3	4	3		36	Y
	MRSA bacteraemia cases	77	Number	Mar-17	0	National		0	1	0		2	N
	Incidences of E Coli	78	Number	Mar-17	N/A	N/A		6	3	11		68	Y
	Incidences of MSSA	56	Number	Mar-17	N/A	N/A		7	2	0		28	Y
	Cleaning & Decontamination Audit	238	%	Mar-17	95%	Local		96.4%	97.70%	95.43%		94.17%	Y
	Hand Hygeine Audit	233	%	Mar-17	95%	Local		97.0%	96.54%	95.27%		93.63%	Y
Incident Reporting	Total number of serious incidents reported	81	Number	Mar-17	N/A	N/A		8	7	8		94	Y
	Total number of Never Events	240	Number	Mar-17	0	National		0	1	0		3	Y
	Overdue CAS Alerts	115	Number	Mar-17	0	National		1	1	1		N/A	N
	Maternal Deaths	83	Number	Mar-17	0	National		0	0	0		0	N
	Medication errors causing serious harm	186	Number	Mar-17	0	National		1	0	0		8	Y
Harm Free Care	Number of falls per 1000 occupied bed days	1665	%	Mar-17	<3%	Local		1.20%	1.05%	1.10%		0.05%	Y
	Total number of patient falls	109	Number	Mar-17	N/A	N/A		161	137	154		1707	Y
	Attributable Grade 2 Pressure Ulcers per 1000 occupied days	242	%	Mar-17	N/A	N/A		0.09%	0.21%	0.14%		0.19%	Y
	Attributable Grade 3 & 4 Pressure Ulcers per 1000 occupied bed days	243	%	Mar-17	0.00%	Local		0.02%	0.02%	0%		0.01%	Y
	VTE Risk Assessments Completed	235	%	Mar-17	95%	National		96.75%	96.46%	96.25%		96.69%	Y
	Bed Rails Audit	236	%	Mar-17	95%	Local		92.99%	93.12%	88.98%		90.74%	Y
	Percentage of Harm Free Care		%	Mar-17	95%	National		95.53%	95.80%	94.35%		94.52%	Y
	Percentage of NEW Harm Free Care		%	Mar-17	95%	National		98.02%	97.59%	98.00%		97.97%	Y

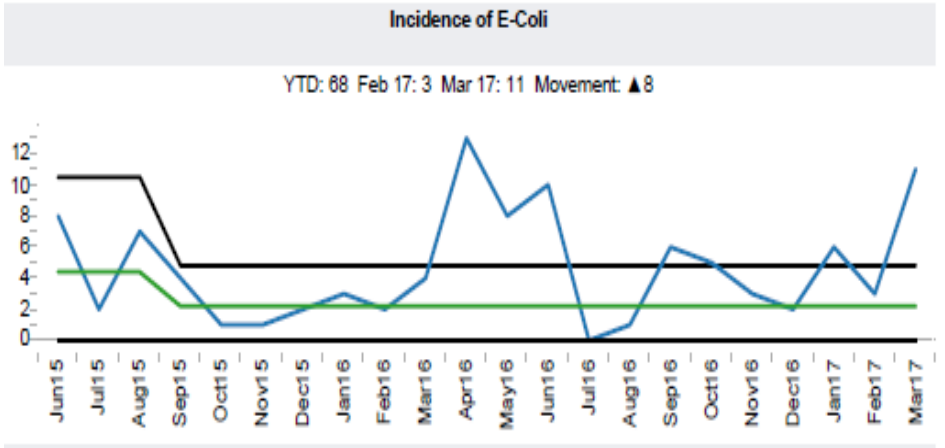
SAFE – Infection Control & Cleanliness

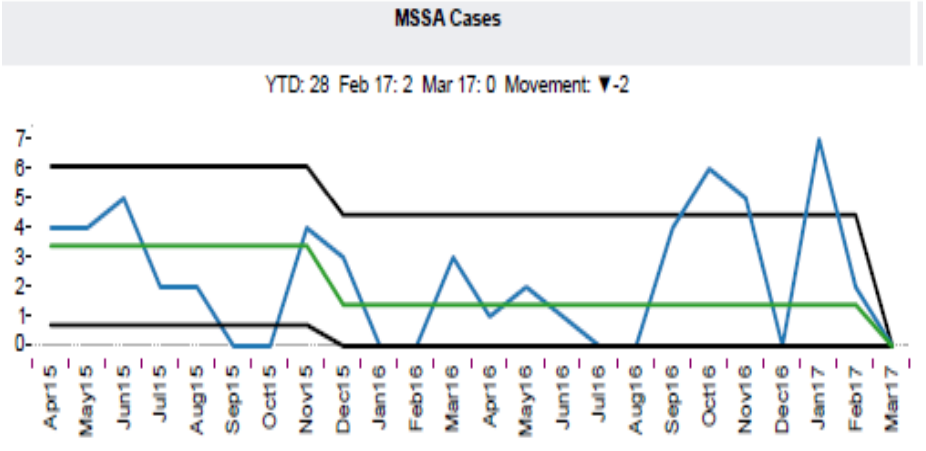
Briefing: The current number of Trust apportioned episodes for C.Diff is 36 against an end of year target of 31. A review and root cause analysis was completed for these cases which showed that few of these are likely to be adjudged as lapses in care and thus sanctions from the CCG would be unlikely. The results of this review have been shared with the CCG. The trust has had 2 MRSA bacteremia's at year end against a ceiling of 0. The second MRSA bacteremia that occurred in NICU in February 2017. There had been no MRSA bacteremia's acquired in NICU for at least 2 years prior to this and zero reported in March.

The ceiling for C.Diff and MRSA will remain the same for 2017/18. The Trust has had 2 cases of MRSA bacteremia in April 2017 and cases of C.Diff. An urgent review of these cases is being completed for presentation to the DIPC.





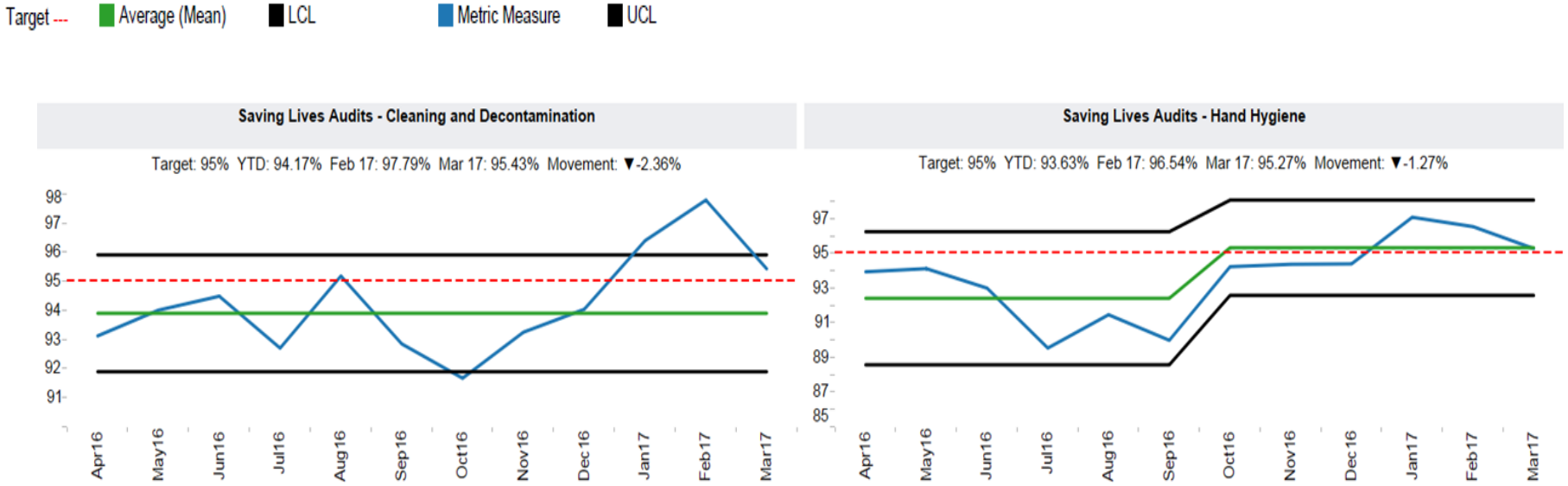




SAFE – Infection Control & Cleanliness

Briefing: For March the position for cleaning and decontamination is 95.43% against a target of 95% and Hand Hygiene 95.27%. An external review is expected to take place by NHSI and the CCG infection control leads to review standards of practice and compliance against the hygiene code.

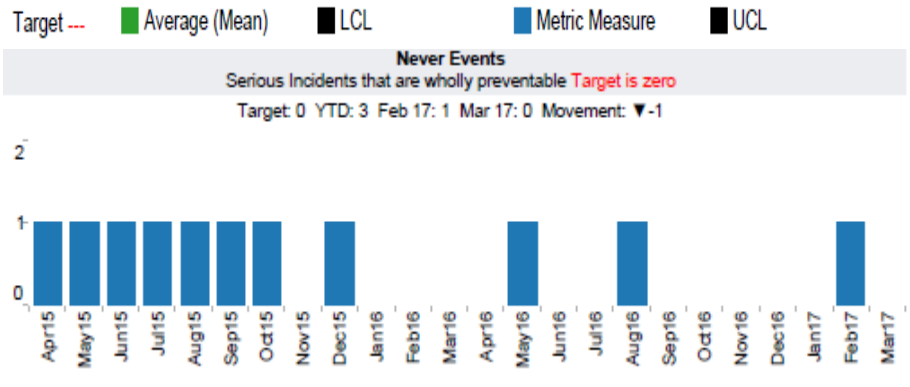
The infection Control team is currently recruiting a support nurse for 6 months to focus on Hand Hygiene compliance and education across professional groups.

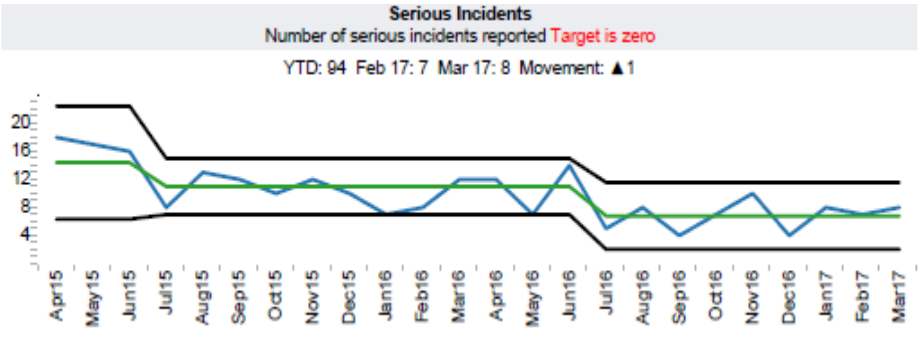


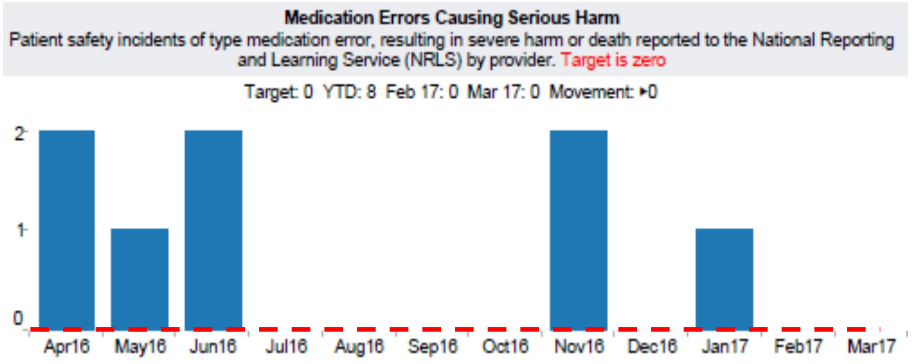
SAFE – Incident Reporting

Briefing:

There has been 1 Never Event reported in February as a result of a retained swab post cardiac surgery, bringing the total of Never Events to 3 for the year compared to a total of 8 reported in the previous year, zero cases were reported in March.

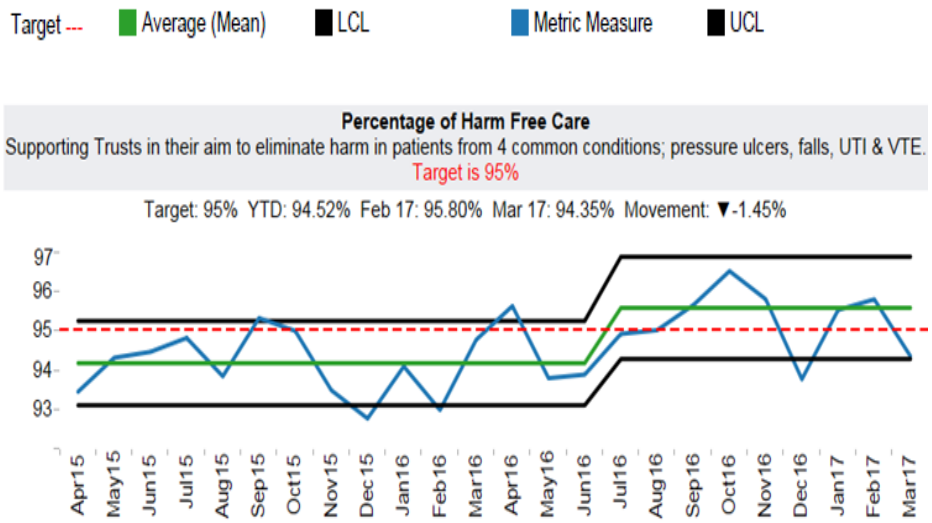


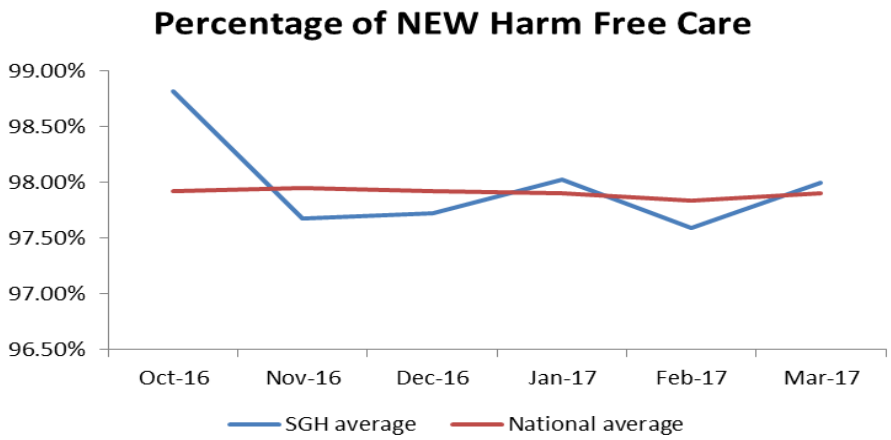




SAFE – Harm Free Care

Briefing:
March position is below target, reporting 94.35% against the target of 95% for all harms. However when reviewing compliance against new harms only, the percentage remains consistently above 95% and just above national average for the month of March
The trust has seen an increase in performance with this metric throughout the year, compared with previous year.





SAFE – Falls and Pressure Ulcers

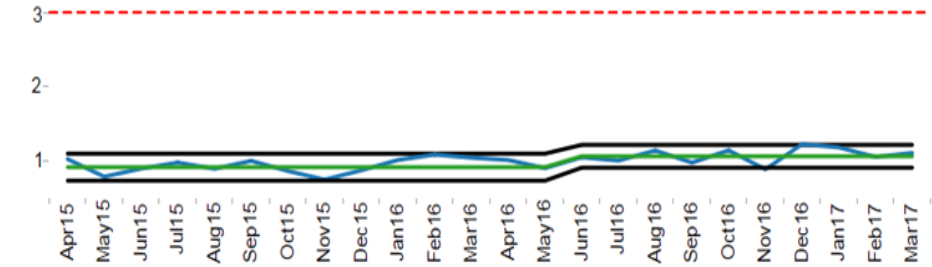
Briefing:

The falls position for the trust remains significantly below the national average. The trust has seen a decline in grade 2 pressure ulcers that are attributable, however there has been a recent rise between December and February in grade 3 and 4 ulcers that are avoidable. These are being investigated as Serious Incidents and the Tissue Viability team will be reviewing them as a cluster to establish any wider learning. There are three grade 3 and 4 pressure ulcers reported in March these were within community nursing / patients home and 2 within Cheselden ward. These have been declared as Serious Incidents for investigation and initial learning relates to poor compliance with the PUP care bundle and documentation.

Falls Per 1000 Occupied Bed Days

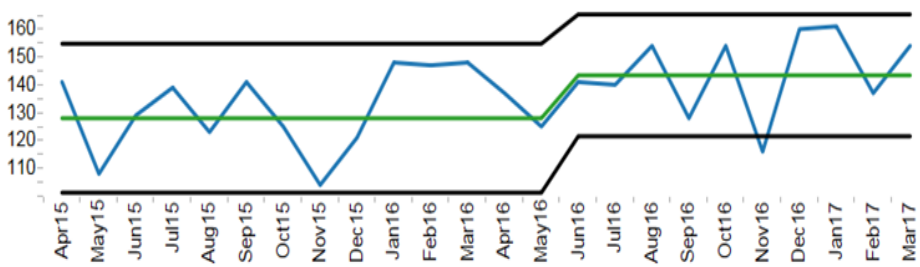
Number of Beds Occupied Per 1000 Bed Days Target is <3%

Target: <3% YTD: 0.99% Feb 17: 1.05% Mar 17: 1.10% Movement: ▲0.05%



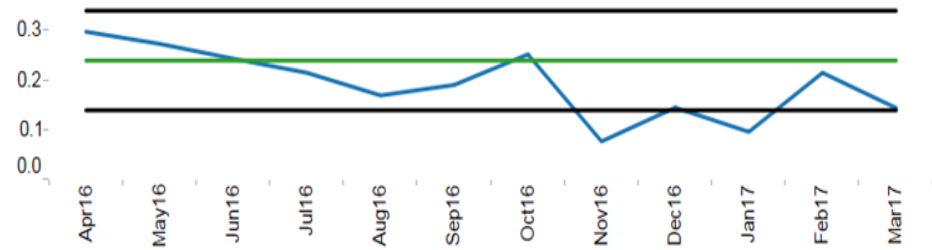
Total Patient Falls

YTD: 1707 Feb 17: 137 Mar 17: 154 Movement: ▲17



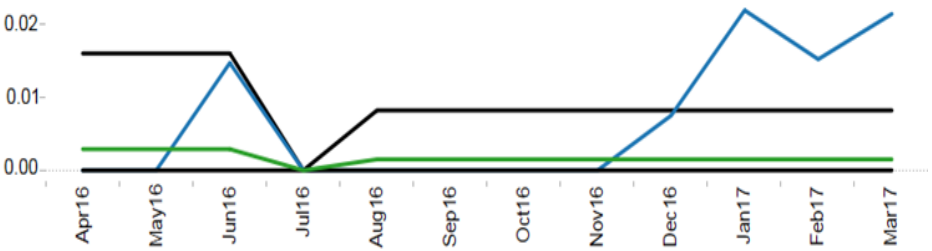
Attributable Grade 2 Pressure Ulcers per 1000 Occupied Bed Days

YTD: 0.19% Feb 17: 0.21% Mar 17: 0.14% Movement: ▼-0.07%



Attributable Grade 3 and 4 Pressure Ulcer per 1000 Occupied Bed Days

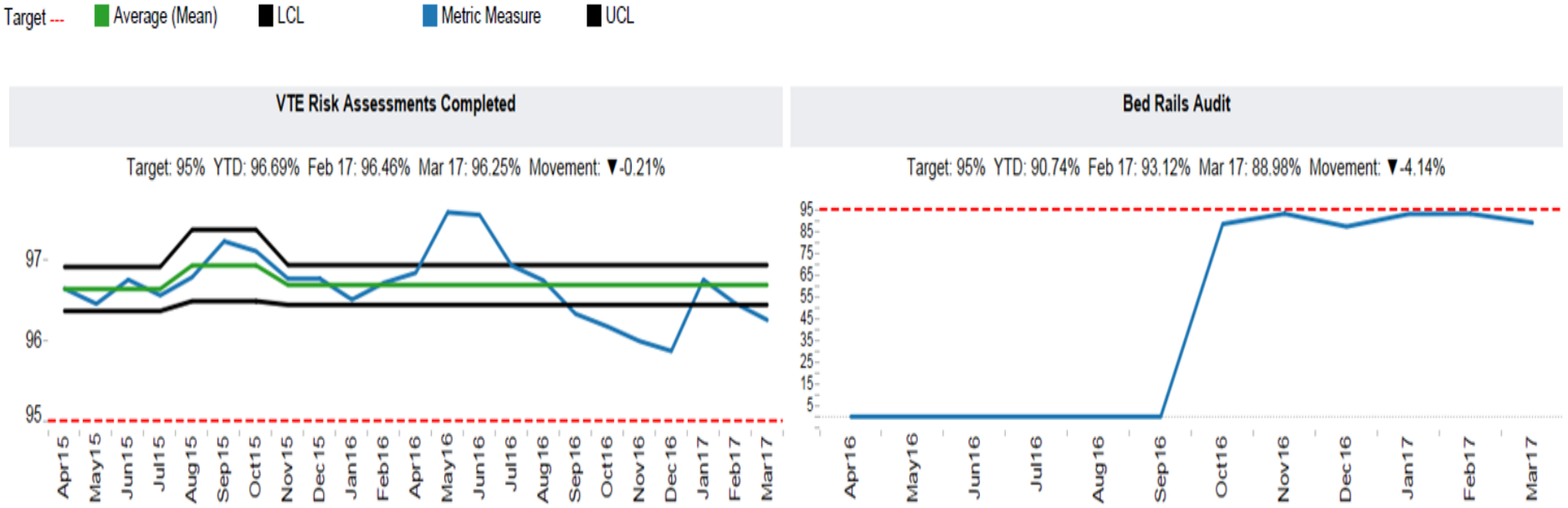
Target: 0% YTD: 0.01% Feb 17: 0.02% Mar 17: 0.02% Movement: ▸0.00%



SAFE – Harm Free Care

Briefing:

- VTE assessments continue to be performed above the national target of 95%, achieving 96.25% in March
- Bed rail audits were below the target of 95% in month. A review of the audit tool has been completed to ensure clarity of questions due to inaccurate completion of the tool. Ward Managers and Matrons for areas that have low compliance have been emailed with the results to ensure improvements with data collection and compliance with the audit. The bed rails audit has also been incorporated into the ward quality dashboard for monitoring at ward level and reporting through Divisional Meetings

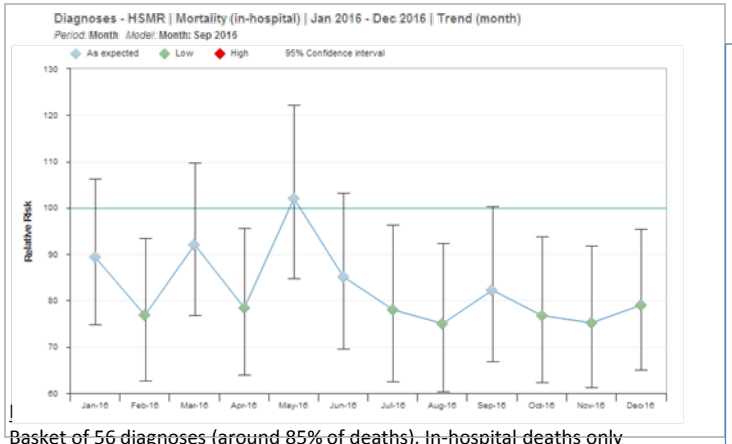


EFFECTIVE Domain Scorecard

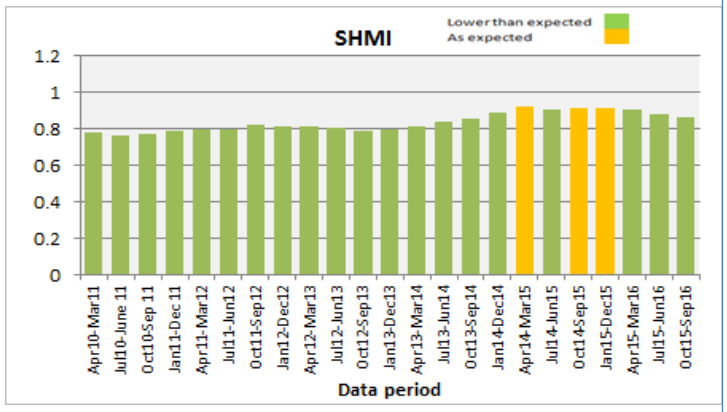
Executive Lead: Andy Rhodes, Medical Director

Theme	Indicator	Ref	Units	Period	Target	National or Local	Mth Rag Rating	Jan-17	Feb-17	Mar-17	Variance	YTD Total	Chart
Mortality Indicators	Hospital Standardised Mortality Ratio (HSMR)	114	%	Mar-17	100	National		84.1	83	82.5		N/A	N
	Hospital Standardised Mortality Ratio Weekday Emergency		%	Feb-17	100	National		82	79.9	TBC		N/A	N
	Hospital Standardised Mortality Ratio Weekend Emergency		%	Feb-17	100	National		86.4	85.6	TBC		N/A	N
	Summary Hospital Mortality Indicator (HSCIC)	113	%	Mar-17	100	National		0.9	0.9	0.9		N/A	N
Length of Stay	Length of Stay Elective	153	Number days	Mar-17	4	Local		4.4	3.8	3.9		N/A	Y
	Length of Stay Non Elective	154	Number days	Mar-17	5	Local		4.2	4	4.3		N/A	Y
Occupancy	Bed Occupancy General & Acute		%	Mar-17	<85%	Local		88.2%	92.4%	91.1%		N/A	Y
Re-admission	Emergency Re-admissions within 30 days following an elective spell at provider		%	Feb-17	TBC	Local		4.9%	5.0%	TBC		N/A	Y
	Emergency Re-admissions within 30 days following an non-elective spell at provider		%	Feb-17	TBC	Local		14.3%	14.3%	TBC		N/A	Y

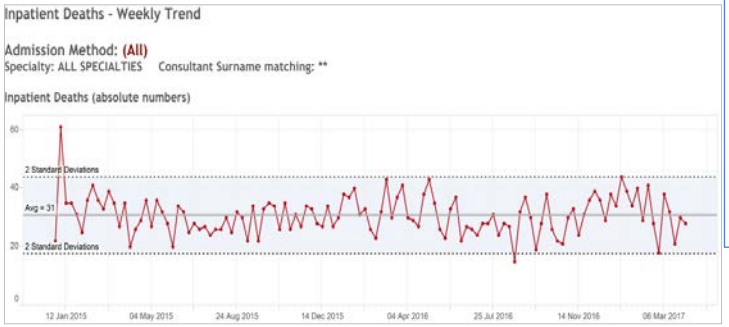
EFFECTIVE - Mortality



Basket of 56 diagnoses (around 85% of deaths). In-hospital deaths only
Adjusted for more factors, including palliative care



SHMI: summary hospital-level mortality indicator
All English acute non-specialist providers. All deaths in hospital and within 30 days of discharge



Risk-adjusted Mortality remains stable. HSMR remains better than expected: Jan 16 – Dec 16 = 82.5 with SHMI Oct 15 – Sep 16 = 0.86 – lower than expected. Raw mortality is monitored daily and remains stable within usual limits.

The committee has 'real-time' monitoring of deaths by date and by day of admission; the committee reviews all deaths following elective admission, and scrutinises all deaths in mortality signals that arise in analysis of Dr Foster data. Recent completed reviews include analysis of deaths following #NOF, crushing injury, atherosclerosis, septicaemia, and CABG (other). Reviews are triangulated with the SI process and one death from this month's reviews was investigated as an SI. There has been learning including the importance of documentation of pre-operative assessment, the challenges of discussing operative risks in extremely ill patients, and improved interaction with coding teams in cardiology and GICU to improve information. The mortality monitoring committee has independently screened 34% of all deaths for learning, and to identify areas to strengthen this year.

Learning from Deaths https://www.england.nhs.uk/ourwork/part-rel/nqb/ (published 15/3/17).

The framework stipulates that board should ensure their organisation: has board-level leaders (exec and non-exec) to take responsibility for 'learning from deaths'; has a systematic approach to identifying deaths requiring review and selecting other patients whose care they will review including vulnerable patients; adopts a robust and effective methodology for case record reviews of all selected deaths ensures case record reviews and investigations are carried out to a high quality; ensures that mortality reporting in relation to deaths, reviews, investigation and learning is regularly provided to the board (a dashboard has been provided to support reporting); ensures learning is acted on to sustainably change practice and improve care and reported in Quality Accounts (from June 2018); ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time to review and investigate deaths; offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to responding to a death;

A number of immediate priorities for the next two months have been identified, which include:

- A nominated non-executive director to provide oversight of progress;
- collect and publish quarterly information on deaths, including those deaths subjected to case record review and how many were judged to have been due to problems in care;
- training of Divisional staff in the use of the RCP structured judgement review (SJR) and the implementation of learning disability (LeDeR) review process;
- ensure that our policy on responding to deaths is clear and supports the organisation to deliver its duties and meet the new requirements;
- To review governance arrangements and processes. This is underway and as a key first step we are finalising arrangements to ensure there is a dedicated full-time resource (person) available to support the AMD for mortality to deliver this broad programme of work, both in collating the data, facilitating the reviews and dissemination of learning; this is currently being negotiated.

Through addressing these urgent actions we will develop a plan for implementation of all aspects of the guidance.

Deaths following time in hospital, England, October 2015 – September 2016

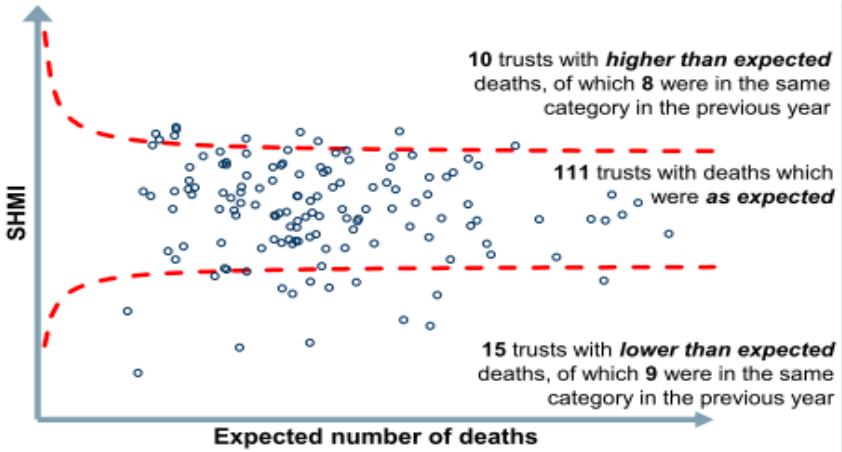
Quarterly statistics: Published 23rd March 2017

NHS Digital

This publication compares the actual number of deaths following time in hospital with the expected number of deaths, using the Summary Hospital-level Mortality Indicator (SHMI).

The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method of admission, current and underlying medical condition(s). It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

Between October 2015 and September 2016, there were approximately 8.9 million discharges, from which 286,000 deaths were recorded either while in hospital or within 30 days of discharge for the 136 hospital trusts covered. This includes deaths from other causes as well as deaths related to the reason for the hospital admission.



The 10 trusts with a ***higher than expected*** number of deaths were:

- **Blackpool Teaching Hospitals NHS FT**
- **Dorset County Hospital NHS FT**
- **George Eliot Hospital NHS Trust**
- Gloucestershire Hospitals NHS FT
- Pennine Acute Hospitals NHS Trust
- **South Tyneside NHS FT**
- **Southend University Hospital NHS FT**
- **Weston Area Health NHS Trust**
- **Wrightington, Wigan and Leigh NHS FT**
- **Wye Valley NHS Trust**

The 15 trusts with a ***lower than expected*** number of deaths were:

- **Barts Health NHS Trust**
- **Cambridge University Hospitals NHS FT**
- **Chelsea and Westminster Hospital NHS FT**
- **Guy's and St Thomas' NHS FT**
- Homerton University Hospital NHS FT
- **Imperial College Healthcare NHS Trust**
- Kingston Hospital NHS FT
- London North West Healthcare NHS Trust
- Poole Hospital NHS FT
- Salford Royal NHS FT
- St George's University Hospitals NHS FT
- **The Whittington Hospital NHS Trust**
- **Torbay and South Devon NHS FT**
- **University College London Hospitals NHS FT**
- **West Suffolk NHS FT**

Trusts in **bold** were also in the same category in the same period in the previous year. 'FT' means 'Foundation Trust'.

The SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust.

It is used along with other information to inform the decision making of trusts, regulators and commissioning organisations.

The SHMI is not a measure of quality of care. A *higher/lower than expected* number of deaths should not immediately be interpreted as indicating poor/good performance and instead should be viewed as a '**smoke alarm**' which requires further investigation.

The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts by their SHMI.

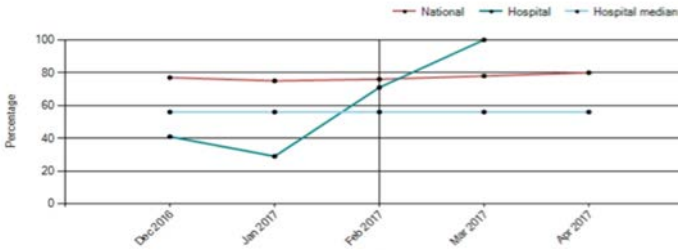
See the full release at http://digital.nhs.uk/pubs/shmioct15sep16 **0300 303 5678** **ISBN 978-1-78386-973-2**

Responsible Statistician: Sally Harrison **enquiries@nhsdigital.nhs.uk**

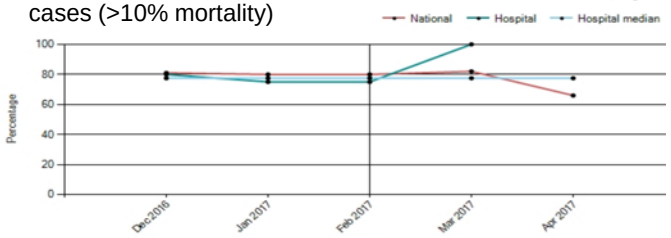
Audit performance- Feb-March 2017

Metric	CQC domain	Year 3 (Dec '16- Mar '17) Performance and comments
Case ascertainment- completion of audit data is assessed annually and RAG rated against HES data	Well led	Year 4 performance has improved from year 3. There has been a deterioration of this in March, which is being addressed by targeted reminders. IT infrastructure is crucial to data capture and an on-going risk.
Pre op documentation of risk of death Patients should have objective risk scoring, to guide intra-op and post op management	Effective	There has been consistent improvement in year 3, due to changing electronic booking form and building awareness. New functionality in NELA webtool will improve this further in coming months.
Access to theatres in appropriate timescale NCEPOD urgent classification cases- access in <6 hours, NCEPOD immediate- <2 hours	Responsive	Since Dec, 82% patients have been reaching theatre in appropriate timescale. Proposed changes in electronic booking system to further support this are currently pending implementation. RCA long waiters will then be easier.
Consultant surgeon and anaesthetist present in theatres if >5% predicted mortality	Effective	90% cases meet this standard. This is a consistently strong area of performance for St Georges.
Cases >10% predicted mortality) admitted to high dependency	Safe	GICU aim to take patients with risk of death >5%, 100% patients meeting admission internal standard. We are amongst the best performers nationally.
Length of stay	Not reported to CQC	Average LoS Dec to Mar is 19.7 days, median 13.3 days. Plans to introduce elderly care liaison provision may improve this.
Mortality	Effective	In hosp mortality Dec 16-Mar 17 is 13.7%. Average predicted risk of death was 19.4% This is higher than equivalent Y3 figure 10.8% - predicted mortality in Y3 was 16.6%

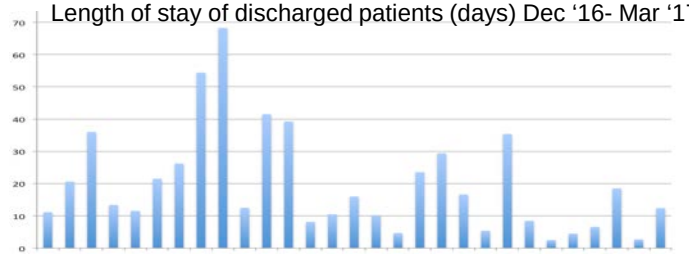
Pre op documentation of risk



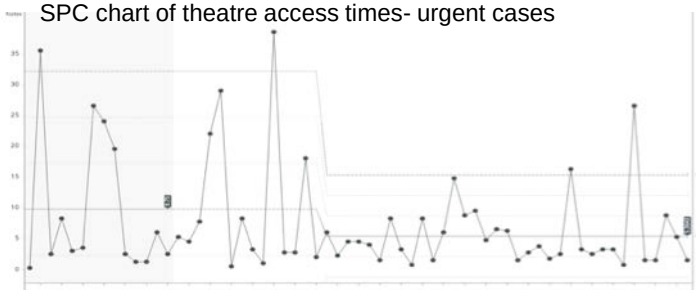
Consultant anaesthetist and surgeon present for high risk cases (>10% mortality)



Length of stay of discharged patients (days) Dec '16- Mar '17



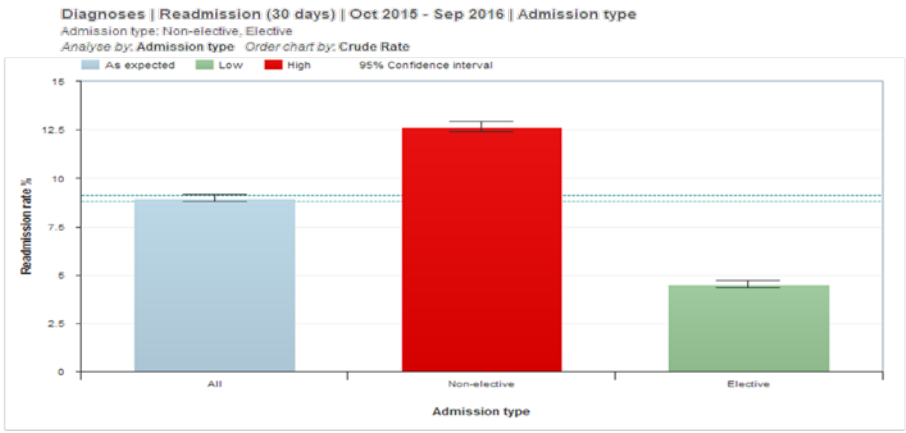
SPC chart of theatre access times- urgent cases

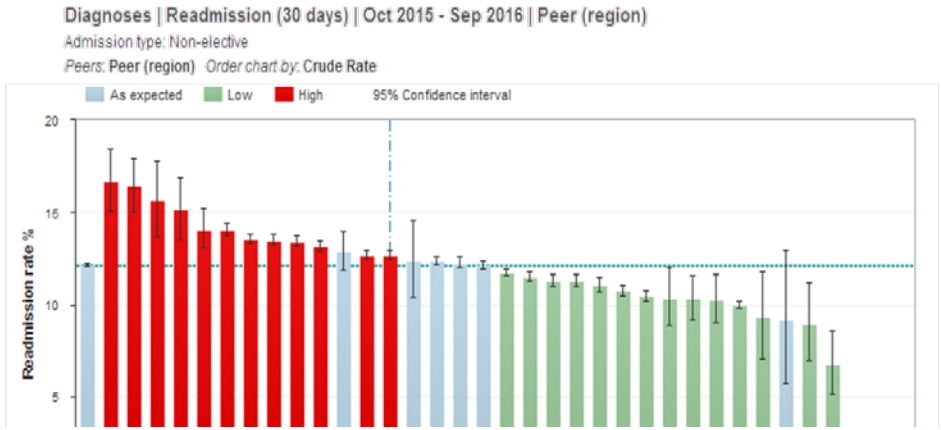


EFFECTIVE – Readmission Rates

Briefing: Data below summarises the Trusts re-admission rate within 30 days following either an emergency or elective spell in hospital. Data is shown over a 12 month period from October 2015 – September 2016 (as available on Dr Foster) The data shows over this period the re-admission rates at St Georges Hospital were above the average of 7.2% (average based on region) observing a position of 9%. The higher rate is predominantly due to readmission following a non elective spell where we are currently performing at 12.7% against an expected of position of 9%, however the rate remains consistent and within upper and lower confidence limits. Detailed analysis shows higher readmissions rates experienced are within the diagnoses groups of Cancer, Hematologic conditions, lung disease and mental health disorders. Readmission following an elective stay is below expected position at 4.5%.

Admission type	Month of discharge	Spells	Observed	Crude rate (%)	95% lower confidence limit	95% upper confidence limit
All		116181	10325	9.0	8.8	9.1
Non-elective Total		**63,602**	**7,970**	**12.7**	**12.4**	**12.9**
Non-elective		63,602	7,970	12.7	12.4	12.9
	Oct-15	5,425	666	12.4	11.5	13.3
	Nov-15	5,378	650	12.2	11.3	13.1
	Dec-15	4,933	563	11.6	10.7	12.5
	Jan-16	5,241	650	12.5	11.6	13.4
	Feb-16	5,467	678	12.6	11.7	13.5
	Mar-16	5,228	706	13.6	12.7	14.6
	Apr-16	5,162	658	12.9	12.0	13.8
	May-16	5,143	643	12.7	11.7	13.6
	Jun-16	5,500	692	12.7	11.9	13.6
	Jul-16	5,181	671	13.1	12.2	14.0
	Aug-16	5,385	660	12.4	11.5	13.3
	Sep-16	5,559	733	13.3	12.4	14.2
Elective Total		**52,579**	**2,355**	**4.5**	**4.3**	**4.7**
	Oct-15	4,469	208	4.7	4.1	5.3
	Nov-15	4,439	202	4.6	4.0	5.2
	Dec-15	4,113	201	4.9	4.3	5.6
	Jan-16	4,368	198	4.6	4.0	5.2
	Feb-16	4,504	184	4.1	3.5	4.7
	Mar-16	4,368	179	4.1	3.6	4.7
	Apr-16	4,244	192	4.6	3.9	5.2
	May-16	4,158	199	4.8	4.2	5.5
	Jun-16	4,542	180	4.0	3.4	4.6
	Jul-16	4,355	200	4.6	4.0	5.3
	Aug-16	4,423	208	4.7	4.1	5.4
	Sep-16	4,596	204	4.5	3.9	5.1

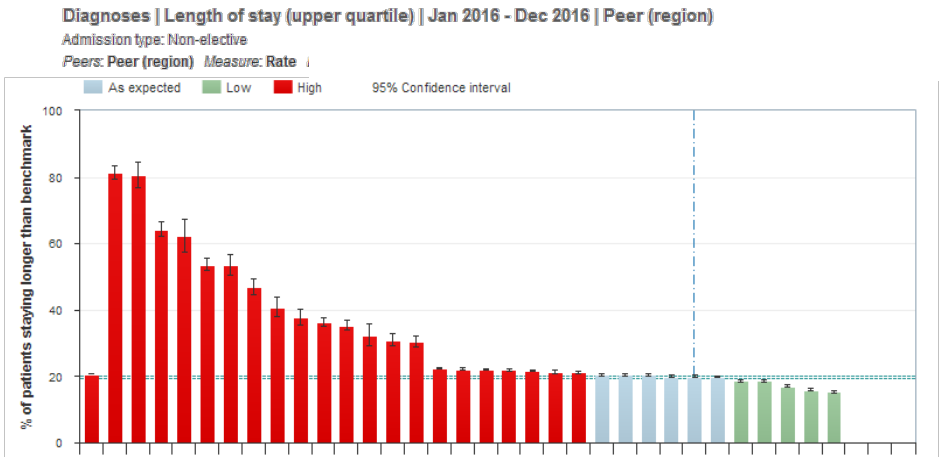


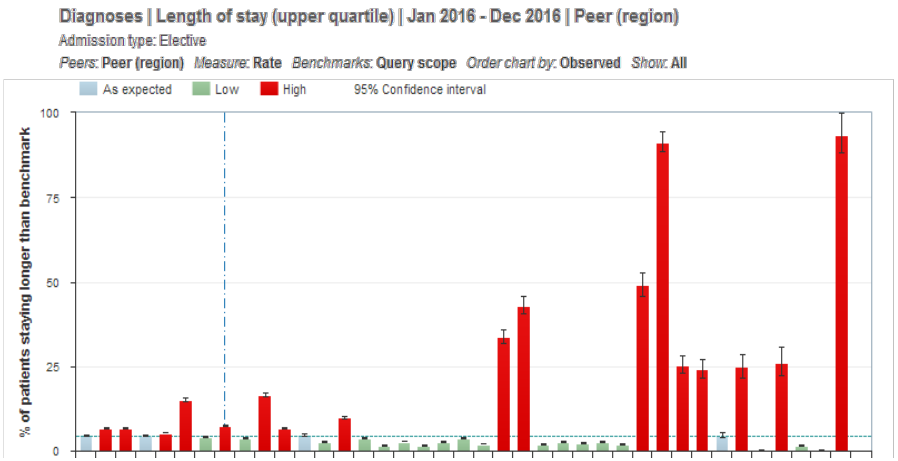


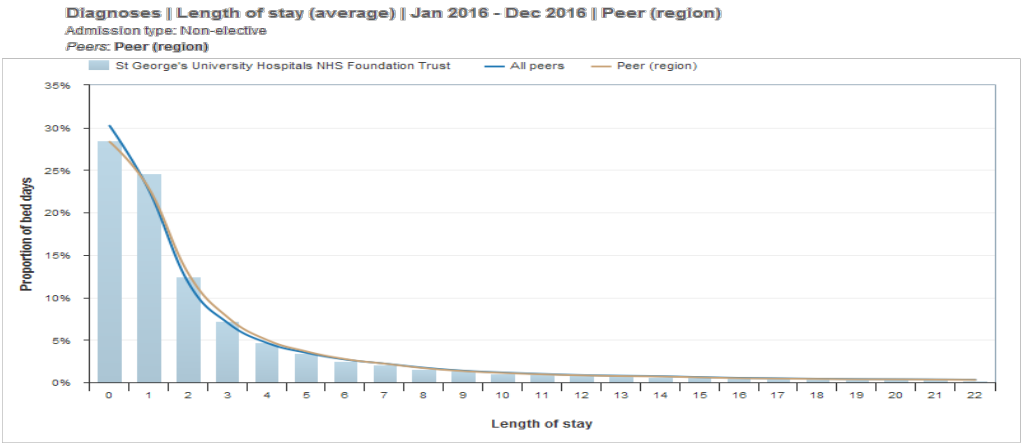
Data Source: Dr Foster Period Oct-15-Sep16

EFFECTIVE – Length of Stay

Briefing: Non Elective Stay – Mean length of stay (LOS) is 4.4 days for the period Jan–Dec 2016. This is as expected against Dr Foster benchmarking (taking into account high volume activity) and achieving well against peers. Mean LOS has seen a step change (↓) from April 2016 from 5 days to consistently reporting between 4-4.4 days on average) Analysis against upper quartile LOS shows that 20% of patients stay longer than benchmark, this is within expected range for non elective admissions and is below other providers.
Elective Stay – Mean LOS is 3.9 days for the month of March and has seen a slight decrease when compared to January and is comparable with our peers. However when benchmarked against upper quartile St George's is higher than expected showing that 7.4% of elective patients stay longer than benchmark against an expected rate of 6.3% and is above national average. Areas above expected range include pain management, total excision of bladder and cystectomy. Further analysis to be carried out to identify key areas.







Data Source: Dr Foster Period Oct-15-Sep16

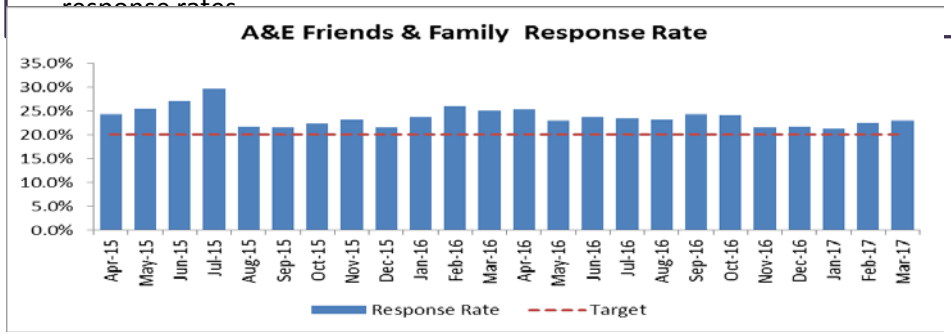
Executive Lead: Avey Bhatia, Chief Nurse

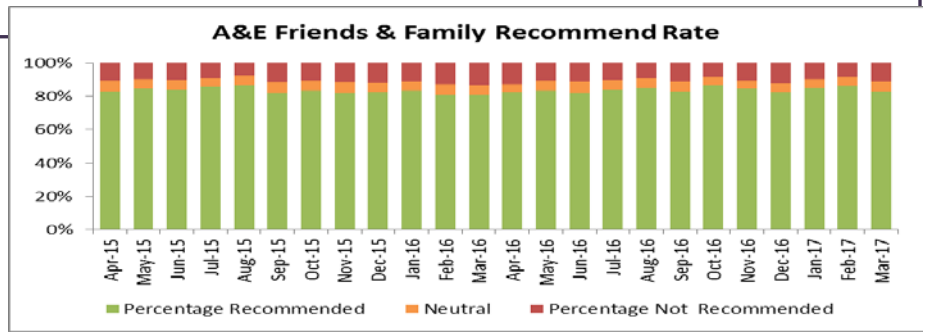
Theme	Indicator	Ref	Units	Period	Target	National or local	Mth Rag Rating	Jan-17	Feb-17	Mar-17	Variance	YTD Total	Chart
Mixed Sex Accomodation Breaches	Total Number of MSA breaches reported	91	Number	Mar-17	0	National		0	0	0		0	N
Friends & Family	FFT Response Rate A&E		%	Mar-17	20%	Local		21.30%	22.43%	22.91%		N/A	Y
	FFT Recommendation Rate A&E		%	Mar-17	90%	Local		85%	86.28%	82.75%		N/A	Y
	FFT Response Rate Inpatients		%	Mar-17	30%	Local		44.70%	26.20%	27.95%		N/A	Y
	FFT Recommendation Rate Inptients		%	Mar-17	95%	Local		96%	97%	97%		N/A	Y
	FFT Response Rate Outpatients		%	Mar-17	20%	Local		1.50%	1.30%	0.60%		N/A	Y
	FFT Recommendation Rate Outpatients		%	Mar-17	90%	Local		95.0%	93%	85%		N/A	Y
	FFT Response Rate Maternity		%	Mar-17	20%	Local		5.6%	5%	9%		N/A	Y
	FFT Recommendation Rate Maternity		%	Mar-17	90%	Local		87.0%	89%	97%		N/A	Y
	FFT Response Rate Community		%	Mar-17	20%	Local		2.7%	2%	0.8%		N/A	Y
	FFT Recommendation Rate Community		%	Mar-17	90%	Local		97.0%	96.2%	93%		N/A	Y
Complaints	Complaints responded to within 25 days	92	%	Feb-17	85%	Local		69.14%	72.86%			65.60%	Y
	Number of complaints with agreed extensions	112	%	Feb-17	100%	Local		92%	91.43%			87.30%	Y
	Total Number of complaints received	111	Number	Mar-17	N/A	N/A		85	73	81		903	Y
	Total number of PALS received	248	Number	Mar-17	N/A	N/A		363	346	294		3790	Y

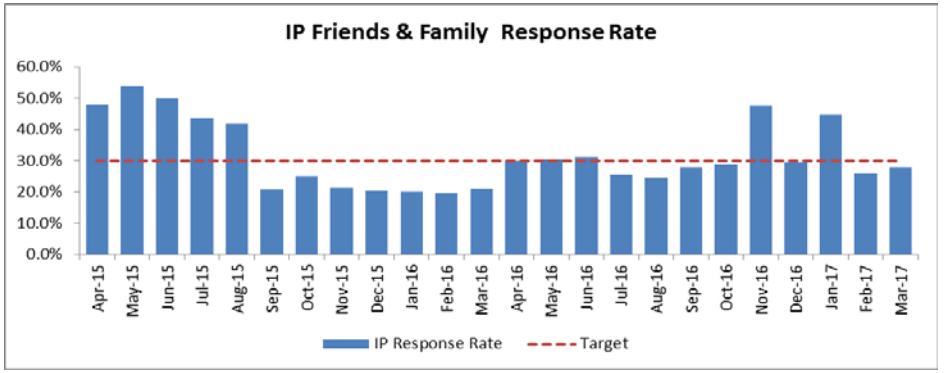
CARING – Friends and Family Test

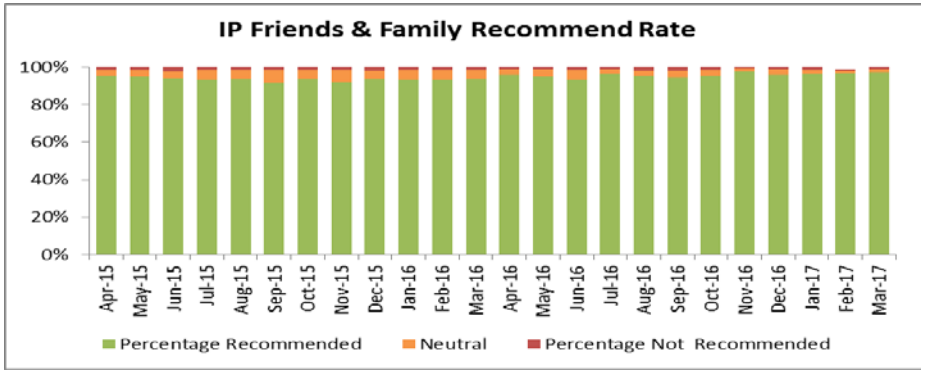
Briefing:

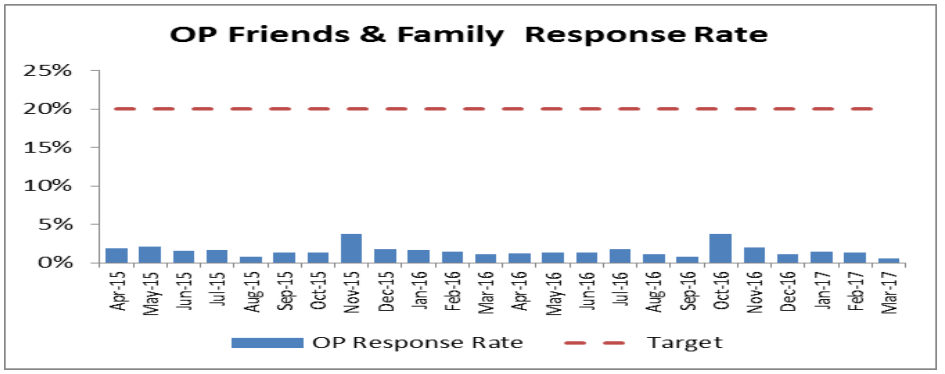
- We have set some quite challenging targets internally for the FFT.
- ED response rate remains above target of 20% however recommendation rate has fallen slightly and remains below target of 95%.
- Inpatient recommendation rate remains above target at 97% however response rate has dipped in the previous 2 months and is slightly beneath target. This has been added to the ward dashboard and additional tablets have been ordered due to wards reporting faults impacting on capturing of response rates.

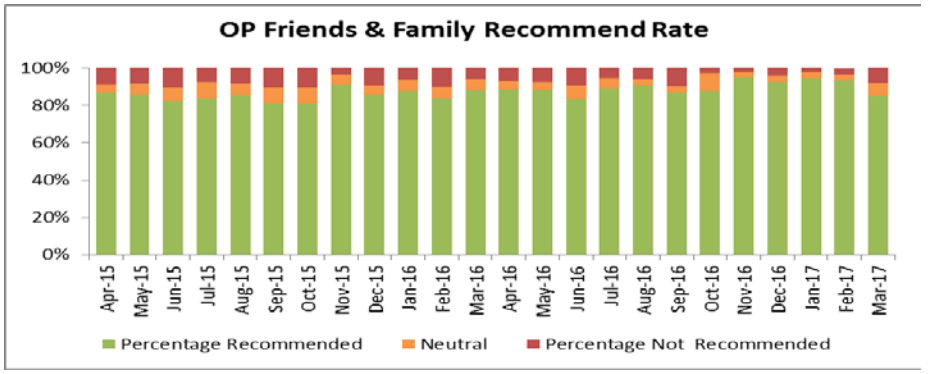








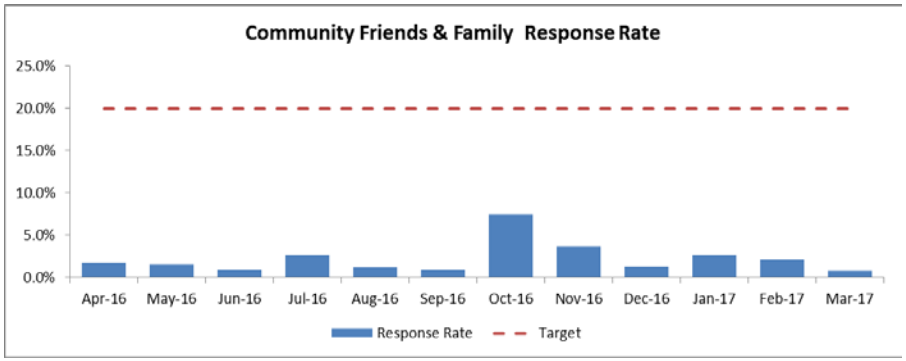


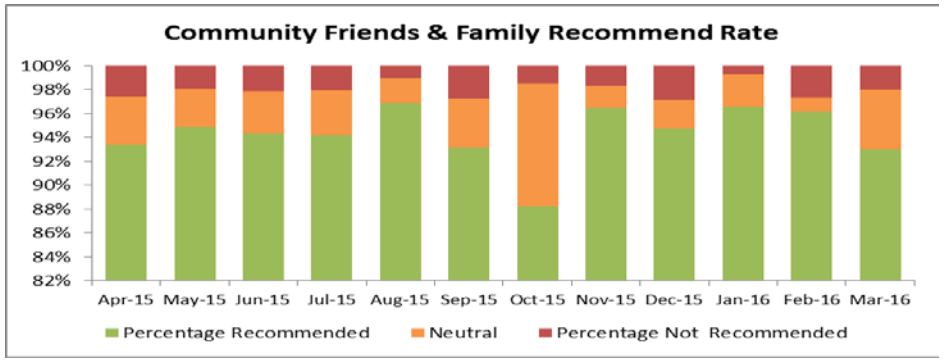


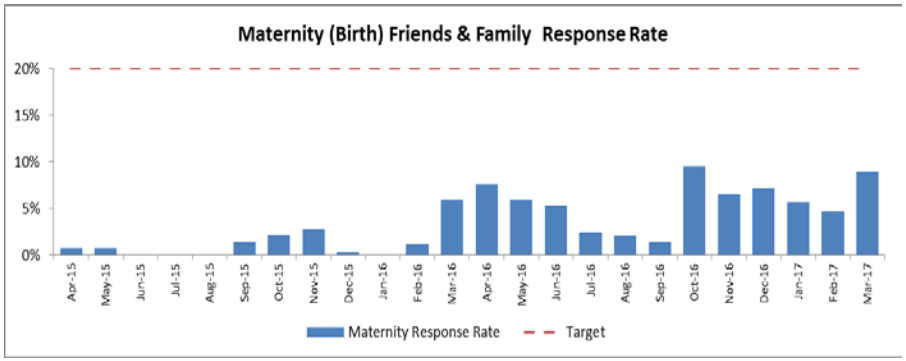
CARING – Friends and Family Test

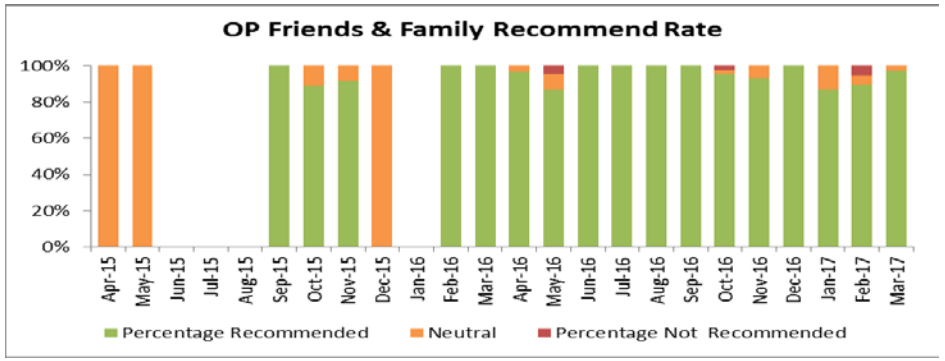
Briefing:

- Both areas achieving above 90% recommendation rate for their services.
- In order to improve response rates for community services and outpatients, the option of text messaging is being explored through the out patient transformation programme.
- Community services sample on average 300-400 patients a month, however due to the number of services users this translates to a low sample size. In October the community services conduct a detailed patient experience survey across the services in line with the commissioning arrangements.









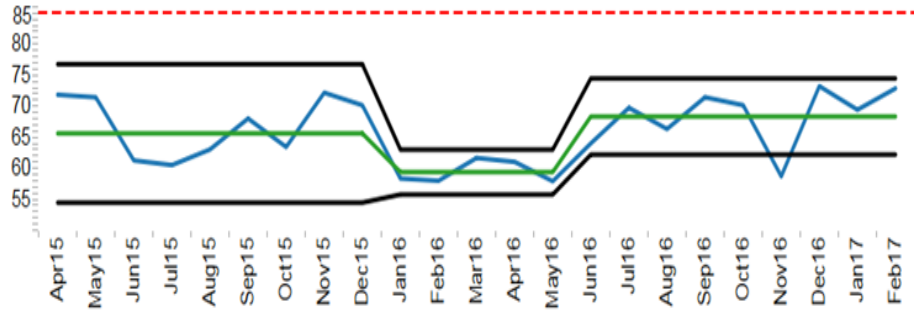
CARING – Complaints

Briefing: Complaints performance remains below the standard expected. In response to this the divisions have been asked to produce a recovery plan and trajectory for compliance. To support this the complaints team will be working to KPI's for the handling of complaints to ensure they are sent to divisions and executives in a timely manner. These KPI's include the registration and distribution of complaints within 2 days, and review of responses within 24 hours. The complaints team will be working with divisions to provide complaints templates to assist with timely completion , and conduct training for staff identified within the divisions.

Target --- Average (Mean) LCL Metric Measure UCL

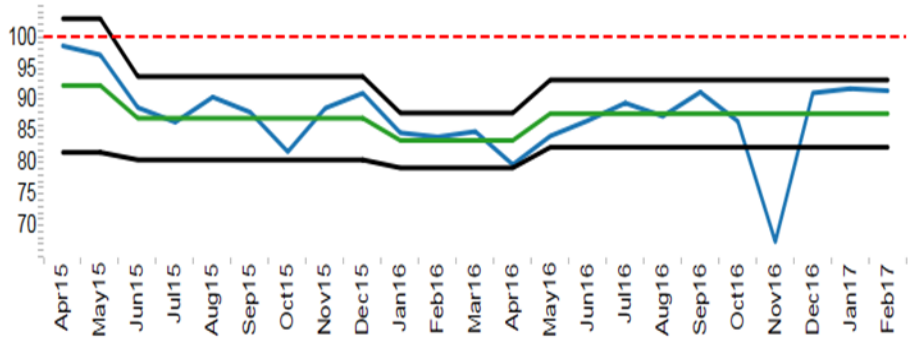
Complaints responded to within 25 days

Target: 85% YTD: 65.60% Jan 17: 69.41% Feb 17: 72.86% Movement: ▲3.45%



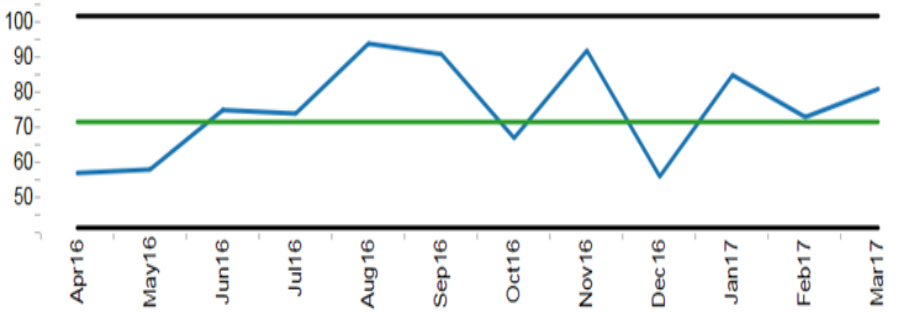
Number of Complaints With Agreed Extensions

Target: 100% YTD: 87.30% Jan 17: 91.76% Feb 17: 91.43% Movement: ▼-0.33%



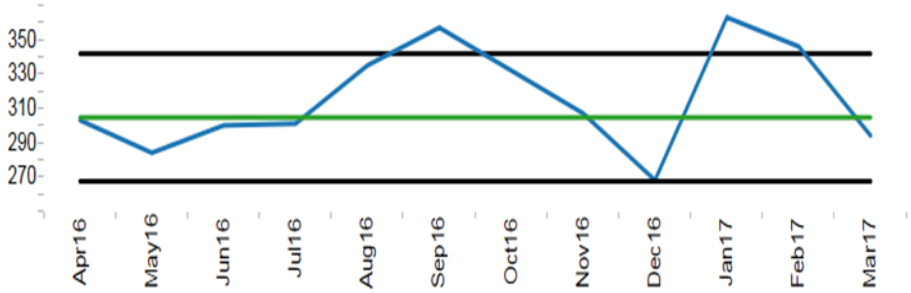
Total Number of Complaints Received

YTD: 903 Feb 17 73 Mar 17: 81 Movement: ▲8



PALS Received at Trust Level

YTD: 3790 Feb 17 346 Mar 17: 294 Movement: ▼-52



RESPONSIVENESS Domain Scorecard

Executive Lead: Mark Gordon, Chief Operating Officer

Theme	Indicator	Ref	Units	Period	Target	Local or national	Mth Rag Rating	Jan-17	Feb-17	Mar-17	Variance	YTD Total	Chart
Waiting Times	A&E 4 hours waiting time	8	%	Mar-17	95%	National		86.63%	90.59%	88.60%		91.80%	Y
	LAS Handover times 15 minutes	120	%	Mar-17	100%	National		46.9%	51.1%	48.2%		N/A	Y
	LAS Handover times 30 minutes	121	%	Mar-17	100%	National		96.40%	95.80%	93.70%		N/A	Y
	LAS Handover times 60 minutes	122	%	Mar-17	0	National		0	0	0		N/A	Y
	18 Weeks RTT compliance: Incomplete	147	%	Mar-17	92%	National		77.50%	75.00%	67.90%		N/A	Y
	18 Weeks RTT number of 52 Wk breaches	75	Number	Mar-17	0	National		41	40	42		N/A	Y
	Diagnostic Waits over 6 Weeks	71	%	Mar-17	99%	National		94.90%	97.20%	97.10%		N/A	Y
	% of patients not treated within 28 days of last minute cancellation		%	Mar-17	0%	National		11.50%	2.20%	11.10%		N/A	Y
								Dec-16	Jan-17	Feb-17	Variance		
	Cancer 14 Day GP Referral	162	%	Feb-17	93%	National		93%	87.90%	87.90%		91%	Y
	Cancer 14 Day Breast Symptomatic	163	%	Feb-17	93%	National		93%	94.00%	93.40%		94%	Y
	31 Day First Treatment	161	%	Feb-17	96%	National		97%	96.40%	97.50%		97%	Y
	31 Day First Subsequent Treatment Surgery	159	%	Feb-17	94%	National		96%	95.10%	100.00%		100%	Y
	31 Day First Subsequent Treatment Drug	160	%	Feb-17	98%	National		100%	100.00%	99.00%		97%	Y
	62 Day Referral	157	%	Feb-17	85%	National		85%	87.70%	86.60%		85%	Y
	62 Day Screening	158	%	Feb-17	90%	National		93%	93.00%	96.20%		93%	Y
	62 Day Consultant Upgrade		%	Feb-17	85%	National		93%	93.00%	97.60%		94%	Y

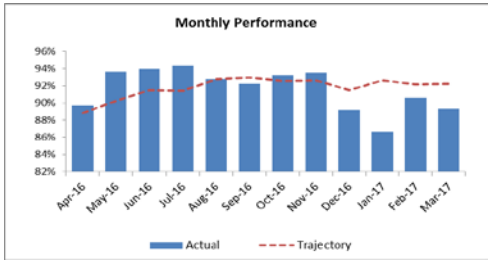
National submission deadline for Cancer standards is one month in arrears, therefore March performance will be submitted on 6th May 2017

RESPONSIVENESS – Emergency Department

Briefing: Emergency Department – Performance against the 4 hour standard in March was 88.60% ending the year on 91.56%. Attendances for the complete year were 1.5% above 2015/16 out-turn. April performance to date is currently at 89.9% against a trajectory of 89.4%. The lack of Assessment (RATT) space continues to cause capacity constraints within the Department and delays to patient pathways. Capacity within ED remained a significant issue and contributed highly to the number of breaches reported to date. Plans to increase the triage area will actively improve flow as well as help overall capacity within ED. The expansion of the Ambulatory Care model as well as an increased focus on DTOC reduction will help to reduce occupancy and limit short-stay admissions over the next months. Overall Non-Elective activity in the Trust was 8.7% higher than March 2016.

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017 (updated to 23/04/2017)

Monthly Actual	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total Attendances	13,737	15,067	14,310	14,752	13,814	14,261	14,558	14,025	14,149	14,057	12,519	14,625	10,829
Attendances<4 Hours	12,321	14,105	13,448	13,923	12,811	13,154	13,569	13,114	12,612	12,178	11,341	12,958	9,775
Breaches >4 Hours	1,416	962	862	829	1,003	1,107	989	911	1,537	1,879	1,178	1,667	1,054
Performance Actual	89.7%	93.6%	94.0%	94.4%	92.7%	92.2%	93.2%	93.5%	89.14%	86.63%	90.59%	88.60%	90.27%
Performance Trajectory	88.8%	90.2%	91.5%	91.4%	92.8%	93.0%	92.6%	92.6%	91.5%	92.6%	92.1%	92.2%	89.39%
Meeting STF	✓ 0.87%	✓ 3.41%	✓ 2.49%	✓ 2.96%	✗ -0.04%	✗ -0.74%	✓ 0.65%	✓ 0.90%	✗ -2.33%	✗ -6.01%	✗ -1.55%	✗ -3.64%	✓ 0.88%



Met STF not National
Not met STF or National
Met STF and National

Quarterly Actual	Q1	Q2	Q3	Q4
Total Attendances	43,114	42,827	42,732	41,201
Attendances<4 Hours	39,874	39,888	39,295	36,477
Breaches >4 Hours	3,240	2,939	3,437	4,724
Performance	92.5%	93.1%	91.96%	88.5%
Performance Trajectory	90.2%	92.4%	92.2%	92.3%
Meeting STF	✓ 2.3%	✓ 0.7%	✗ -0.2%	✗ -3.8%

Remaining Breach Tolerance (as of 23/04/2017)

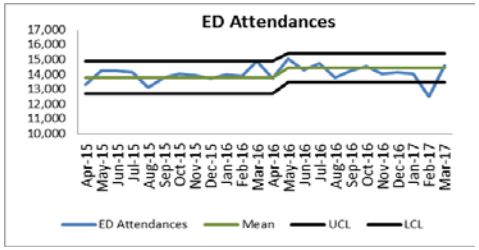
Breach Target Set		
Month	National	SFT
Apr-17	706	1,500
Q1	2188	4,025

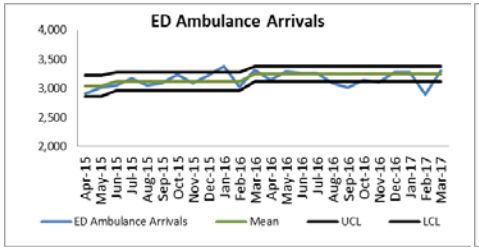
Breaches remaining for Month / Q1		
Month	National	SFT
Apr-17	-348	446
Q1	1,134	2,971

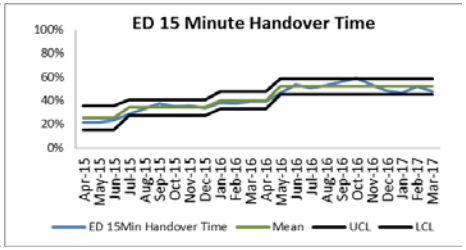
Breaches remaining for Month / Q1 per day		
Month	National	SFT
Apr-17	-50	64
Q1	17	44

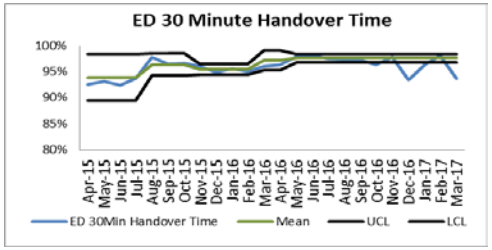
Breach Target Set - Number of breaches set to achieve National and STF
Breaches Remaining for Month - As of w/e how many breaches remain for the month to achieve target
Breaches Remaining per day - Breaches remaining for the month divided by days left to report
Attendances based on projections made as part of STF modelling

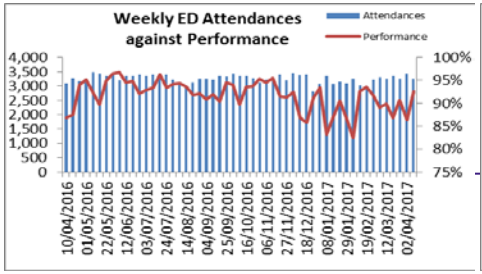
Weekly and Monthly Monitoring

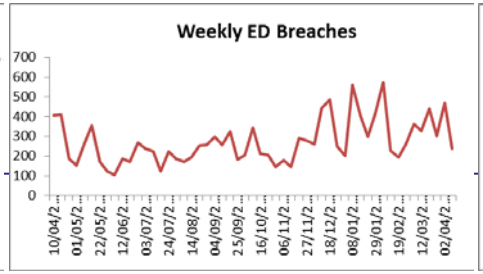


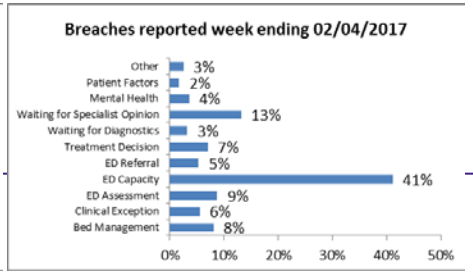


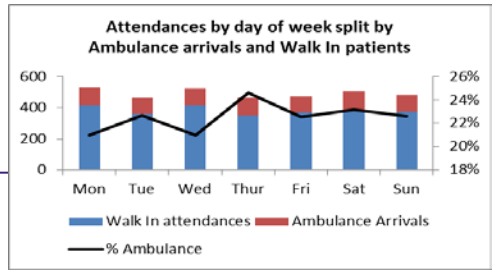












RESPONSIVENESS – Elective Care

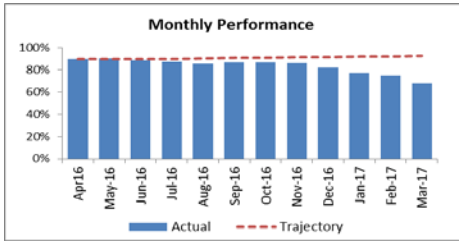
Briefing: 52 week waiters – 42 reported breaches for the month of March. Weekly performance meetings are in place for all specialties focusing on reduction of long waiters and prevention of 52 week breaches. Waits above 18 weeks are mainly within Ear, Nose & Throat, Trauma & Orthopaedics , General Surgery, Dermatology, Plastic Surgery and Gastroenterology, making up 54% of total backlog. As at the end of March elective Inpatient activity was only marginally below plan (-7%, 118 patients), day case activity for March was 9.4% above plan (295 patients). Elective Inpatient activity was nonetheless 15.7% higher than in March 2016 (1,546 cases v 1,336), and Day-Cases were up by 11.1% than in March 2016 (3,463 cases vs.3,116). Elective Inpatient activity was up 9.4% against Plan (3,451 v 3,156 episodes).

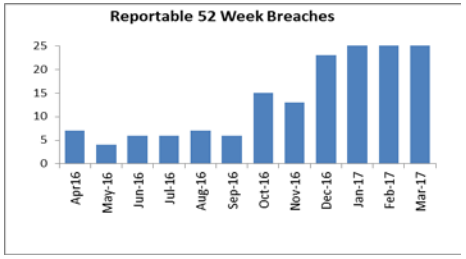
The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

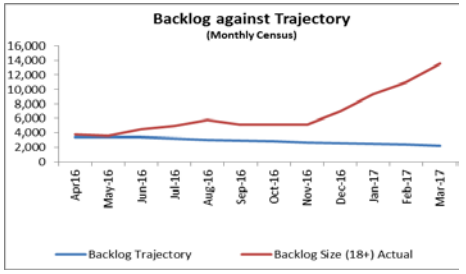
Monthy Performance	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Incomplete Waiting List	35,626	37,243	38,849	39,573	40,299	38,635	38,594	37,608	38,247	41,619	43,848	42,317
Total waits < 18 Weeks	31,873	33,668	34,309	34,635	34,498	33,487	33,454	32,450	31,259	32,269	32,902	28,746
Total waits > 18 Week Breaches	3,753	3,575	4,540	4,938	5,801	5,148	5,140	5,158	6,988	9,350	10,946	13,571
Performance Actual	89.5%	90.4%	88.3%	87.5%	85.6%	86.7%	86.7%	86.3%	81.7%	77.5%	75.0%	67.9%
Meeting STF Trajectory	✗ -0.1%	✓ 0.8%	✗ -1.4%	✗ -2.4%	✗ -4.9%	✗ -4.1%	✗ -4.4%	✗ -5.1%	✗ -9.8%	✗ -14.3%	✗ -16.9%	✗ -24.5%

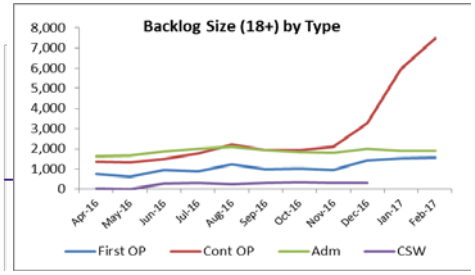
Reportable 52 Week Breaches	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Incomplete Waiting List	7	4	6	6	7	6	15	13	23	41	40	42

Met STF not National
Not met STF or National
Met STF and National



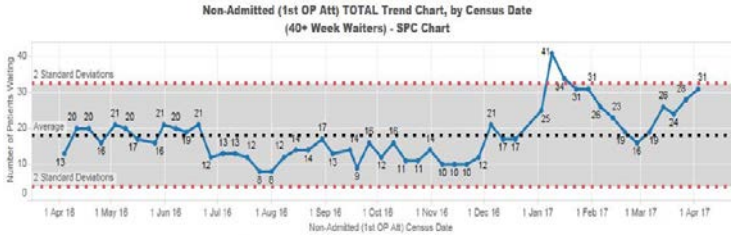


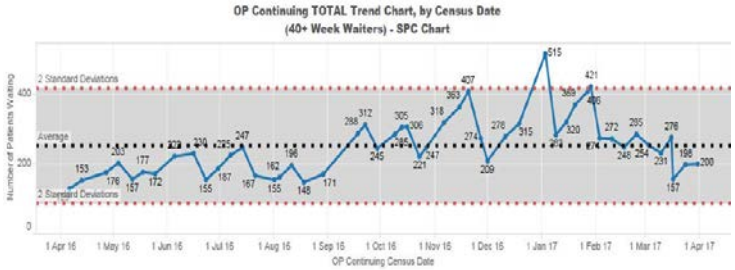


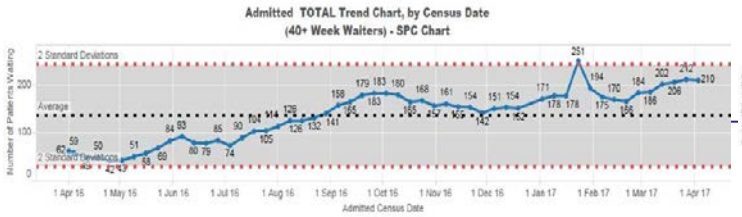


PTL Position (Unvalidated)

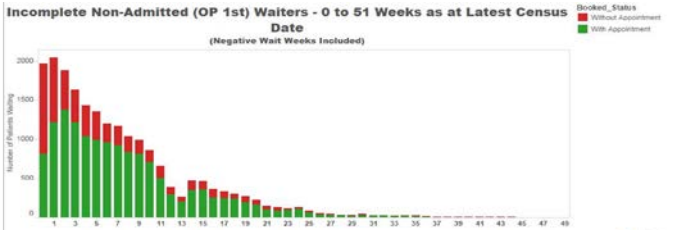
Monitoring the weekly PTLs for the number of patients who have been waiting 40+ weeks

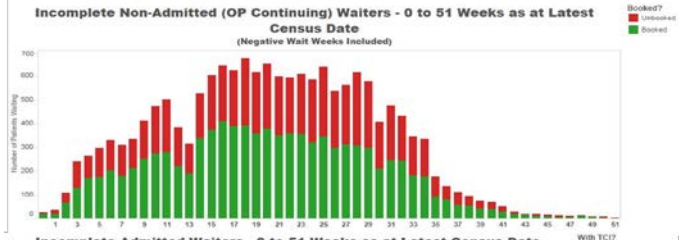


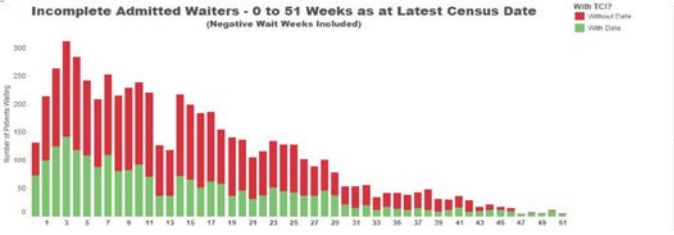




PTL: Booked Vs. Unbooked (unvalidated). An overview of the shape of the PTL's broken down by with / without an appointment booked





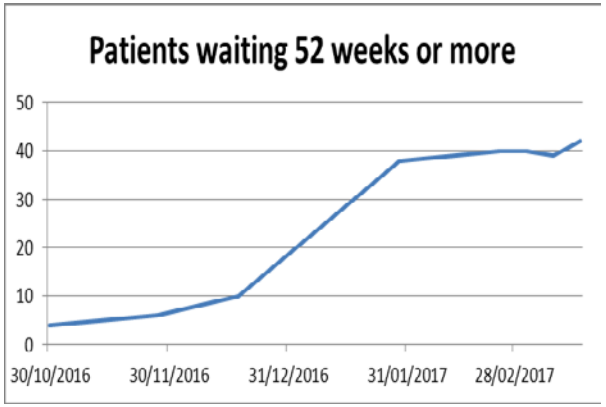


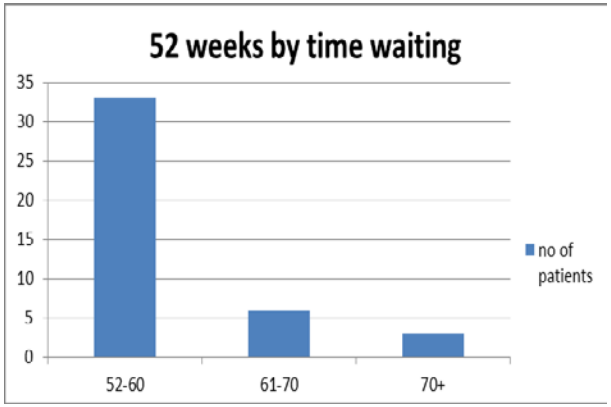
Patients waiting 52 weeks or more – validated position

last week	Tip in this week	removed in week	31/03/2017	No with admitted TCI date	No with Outpatient next event date	Removals other than treatment	Undated	Month end forecast
43	10	11	42	23	9	6	4	42

Prev weeks	30/10/2016	27/11/2016	18/12/2016	29/01/2017	24/02/2017	03/03/2017	10/03/2017	17/03/2017	24/03/2017	31/03/2017
52+	4	6	10	38	40	40	39	42	43	42

Specialty Breakdown	
Cardiac surgery	1
Ear, Nose & Throat	20
Gastroenterology	3
General Surgery	9
Paediatrics Surgery	1
Plastic Surgery	2
Trauma & Orthopaedics	5
Urology	1
Grand Total	**42**





The total number of patients waiting over 52 weeks, validated position, is 42.
The main areas of concern remain: ENT, 20 ; Gen Surgery , 9; T&O, 5.

RESPONSIVENESS – Cancer

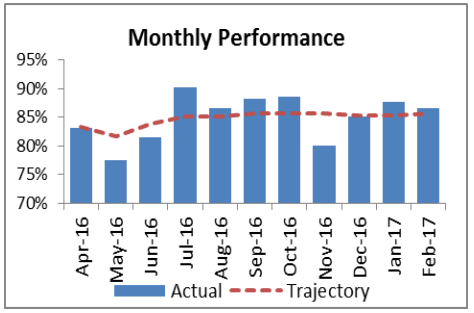
Briefing: National submission deadline for Cancer standards is one month in arrears, therefore March performance will be submitted on May 6th. All Standards were met in January with the exception of Two Week Wait with performance at 87.9% (2.1% below target). 62 day performance achieved 87.7%. Above both national standard and STF trajectory for the month. Two Week Wait Standard fell below target due to a high number of breaches within Skin (60% of all breaches). This is a result of capacity pressures due to clinical vacancies. Recruitment is on-going and a recovery plan in place. Performance in other tumour sites that fell below target are within Gynae and Upper GI. 62 Day Standard –Performance increased in January to 87.7% against the target of 85%. The top three reasons contributing to breaches are: Delay in Diagnostics, Late ITT, Complex pathways.

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017 - 62 Day Standard

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Treatments	60	60	74	74	74	63	70	63	68	68	70	70
Treatments <62 Days	50	49	62	63	63	54	60	54	58	58	60	60
Breaches >62 Days	10	11	12	11	11	9	10	9	10	10	10	10
Performance Trajectory	83.3%	81.7%	83.8%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%
Total Treatments Actual	59.5	71.0	70.5	71.5	59.5	64.0	61.5	70.0	64.0	69.0	59.5	
Total Treatments within 62 Days Actual	49.5	55.0	57.5	64.5	51.5	56.5	54.5	56.0	54.5	60.5	51.5	
Total Breaches Actual	10	16	13	7	8	8	7.0	14.0	9.5	8.5	8.0	
Performance Actual	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.6%	80.0%	85.2%	87.7%	86.6%	
Meeting STF	✗ -0.1%	✗ -4.2%	✗ -2.2%	✓ 5.1%	✓ 1.4%	✓ 2.6%	✓ 3.1%	✗ -5.7%	✗ -0.1%	✓ 2.4%	✓ 0.8%	

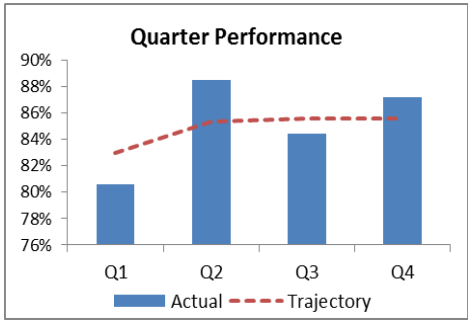
Quarterly Actual	Q1	Q2	Q3	Q4
Total Treatments	201	195	195.5	128.5
Treatments <62 Days	162	173	165.0	112.0
Breaches >62 Days	39	22.5	33.0	16.5
Performance	80.6%	88.5%	84.4%	87.2%
Meeting STF	✗ -2.4%	✓ 3.2%	✗ -1.2%	✓ 1.6%

Met STF not National
Not met STF or National
Met STF and National

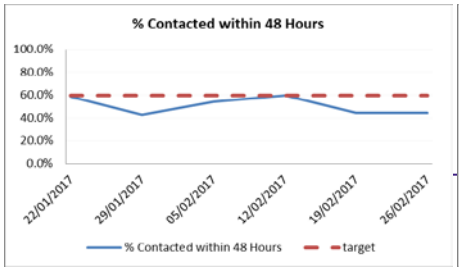


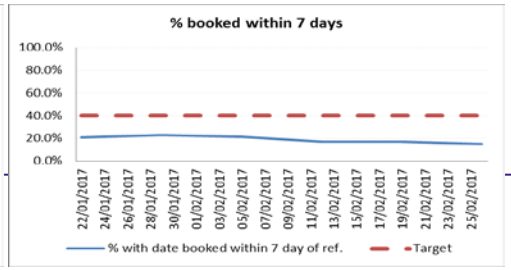
All Cancer Standards Performance Indicators

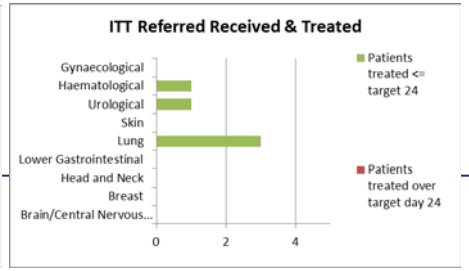
All Cancer Standards	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Trend
14 Day GP Referral (93%)	86.6%	87.3%	90.0%	93.1%	95.1%	94.2%	93.2%	85.7%	93.3%	87.9%	87.9%	
14 Day Breast Symtomatic (93%)	94.8%	95.2%	85.9%	93.8%	94.2%	96.0%	98.9%	94.8%	93.2%	94.0%	93.4%	
31 Day First Treatment (96%)	98.3%	96.3%	98.8%	97.6%	97.4%	96.2%	97.2%	96.9%	96.6%	96.4%	97.5%	
31 Day Subsequent Treatment Surgery(98%	100.0%	94.7%	96.6%	100.0%	100.0%	93.8%	98.8%	96.0%	96.0%	95.1%	100.0%	
31 Day Subsequent Treatment Drug(98%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	100%	99%	
62 Day Referral (85%)	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.8%	80.0%	85.2%	87.7%	86.6%	
62 Day Screening (90%)	93.9%	84.8%	94.8%	95.0%	95.8%	92.0%	96.2%	92.7%	92.7%	93.0%	96.2%	
62 Day Consultant Upgrade (85%)	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	92.6%	87.5%	97.1%	100.0%	97.6%	

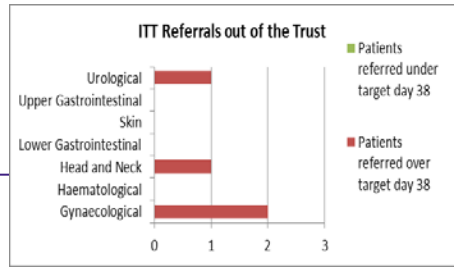


Key Metrics









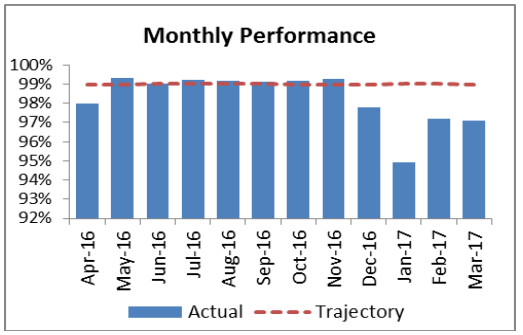
RESPONSIVNESS – Diagnostic Access

Briefing: Diagnostics 6 Week Wait – Diagnostic performance in December fell below national standard and the Trust has not achieved planned trajectory in the last 4 months. In total 222 breaches were reported in March (97.1% performance) Nearly 70% of the 6 week breaches were within Imaging, particular within MRI and Non Obstetric ultrasound. Endoscopy reported 31% of all 6 week breaches reducing significantly compared to previous month. Recovery plans are in place with additional capacity plans including additional Saturday lists for Endoscopy starting in mid April.

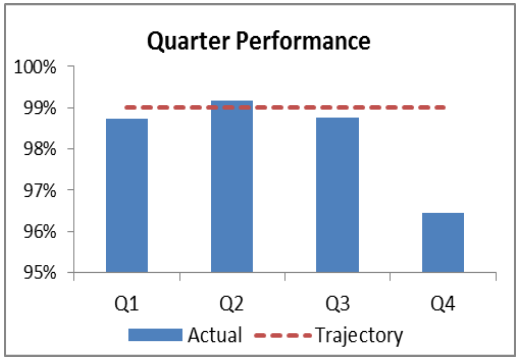
The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Waits	5,788	5,386	6,046	5,718	5,429	5,750	5,803	5,860	5,776	5,813	5,816	5,802
Total Waits <6 Weeks	5,730	5,332	5,986	5,661	5,375	5,693	5,745	5,801	5,718	5,755	5,758	5,744
Total Waits >6 Weeks	58	54	60	57	54	57	58	59	58	58	58	58
Performance Trajectory	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%
Total Waits	7,290	6,588	6,977	6,436	6,085	6,258	6,834	6,878	6,906	7,358	7,871	7,678
Total Waits <6 Weeks	7,142	6,542	6,908	6,386	6,034	6,202	6,777	6,828	6,755	6,986	7,652	7,456
Total Waits >6 Weeks	148	46	69	50	51	56	57	50	151	372	219	222
Performance Trajectory	98.0%	99.3%	99.0%	99.2%	99.2%	99.1%	99.2%	99.3%	97.8%	94.9%	97.2%	97.1%
Meeting STF	✗ -1.0%	✓ 0.3%	✓ 0.0%	✓ 0.2%	✓ 0.2%	✓ 0.1%	✓ 0.2%	✓ 0.3%	✗ -1.2%	✗ -4.1%	✗ -1.8%	✗ -1.9%

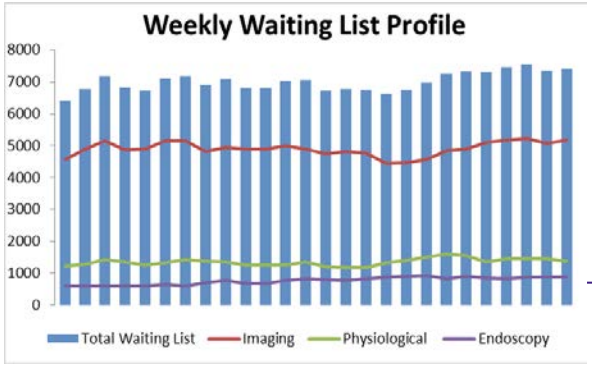
Met STF not National
Not met STF or National
Met STF and National

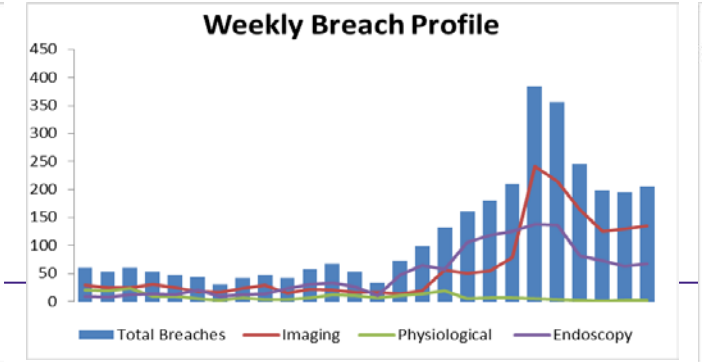


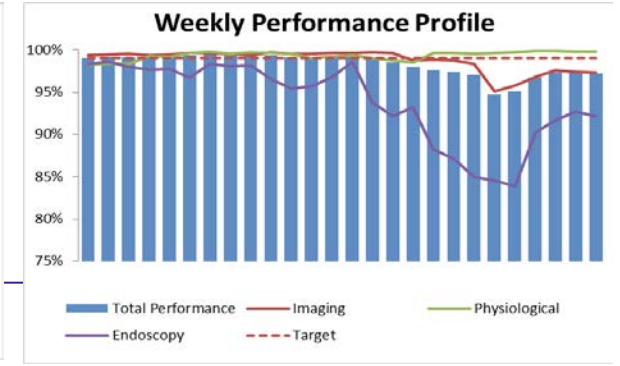
Quarterly Actual	Q1	Q2	Q3	Q4
Total Treatments	20,855	18,779	20,618	22,907
Treatments <62 Days	20,592	18,622	20,360	22,094
Breaches >62 Days	263	157	258	813
Performance	98.7%	99.2%	98.7%	96.5%
Meeting STF	✗ -0.3%	✓ 0.2%	✗ -0.25%	✗ -2.55%



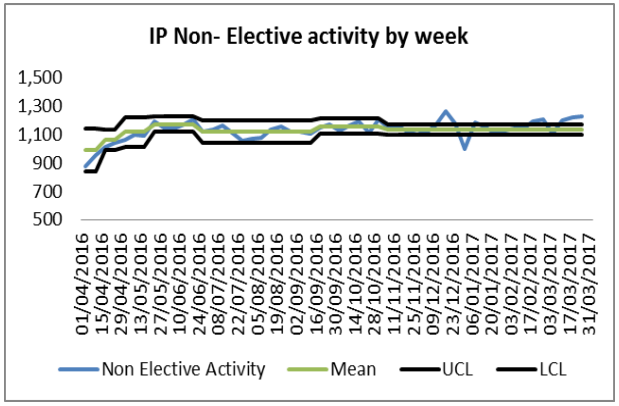
Weekly Performance Monitoring up to 17/04/2017

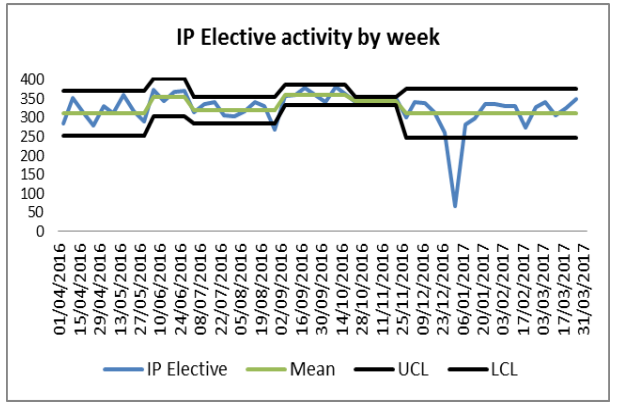


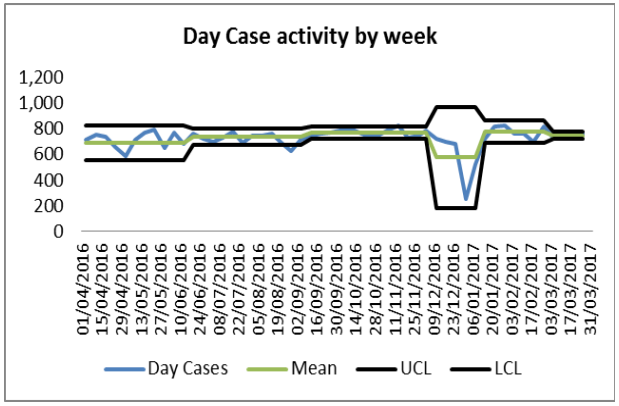


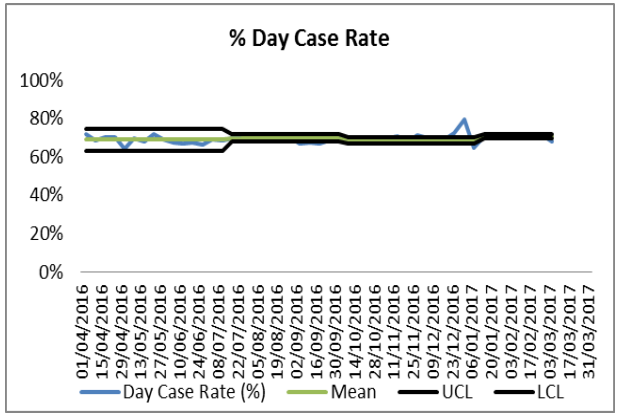


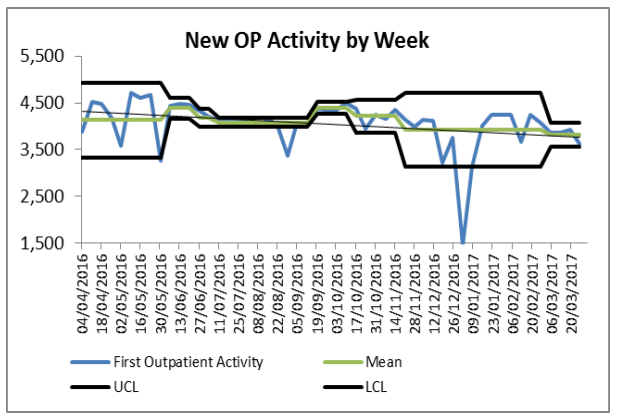
Operational Dependencies

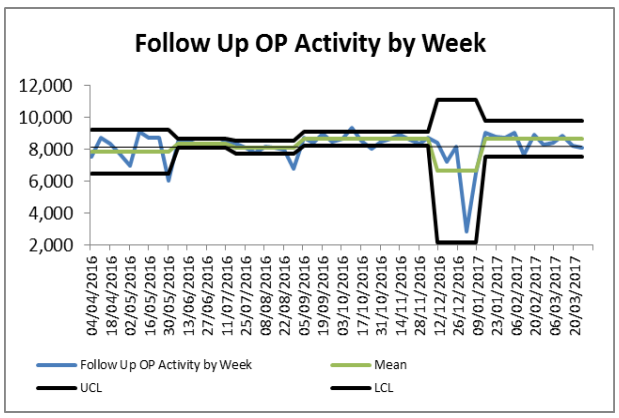


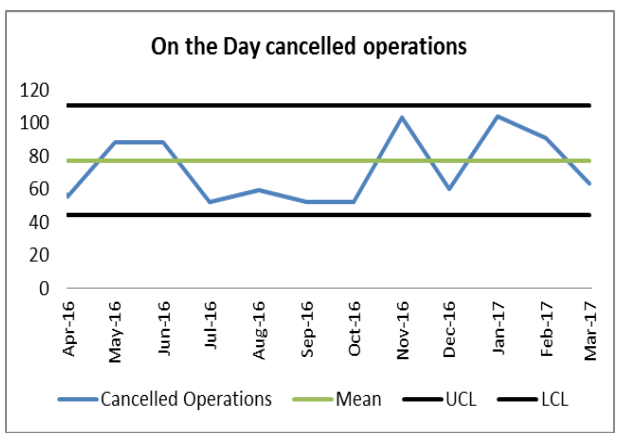


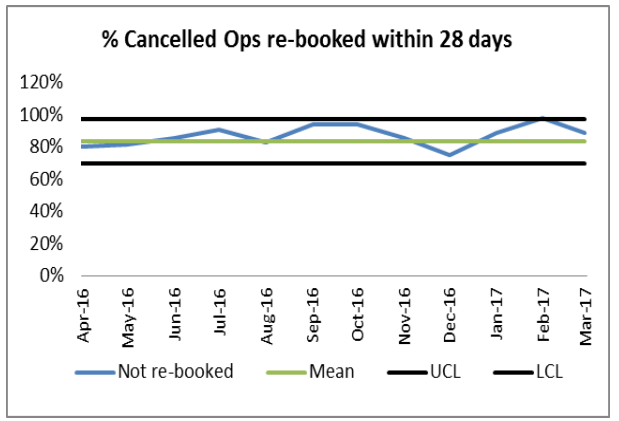


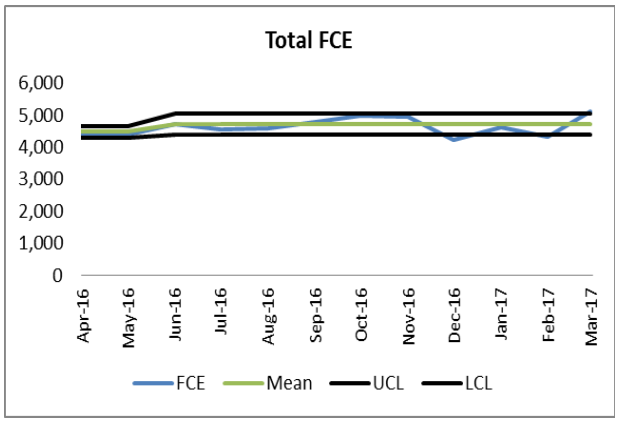




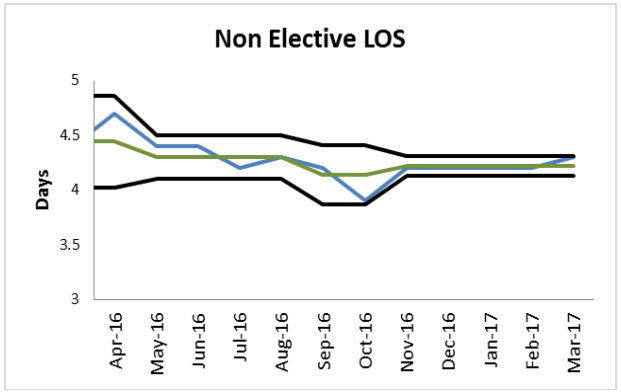


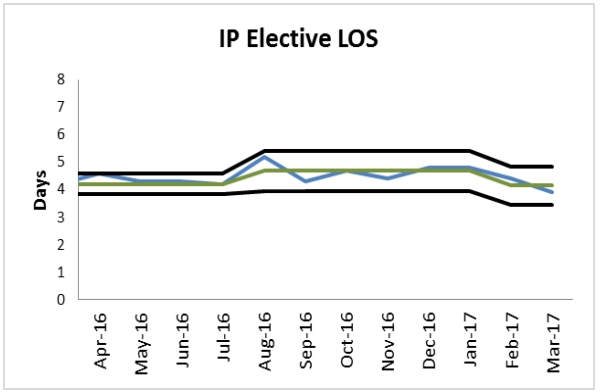


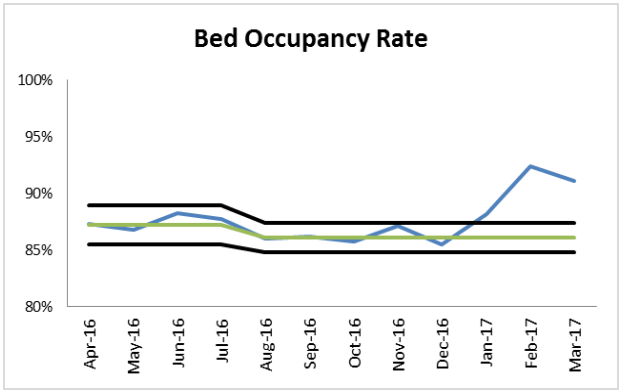


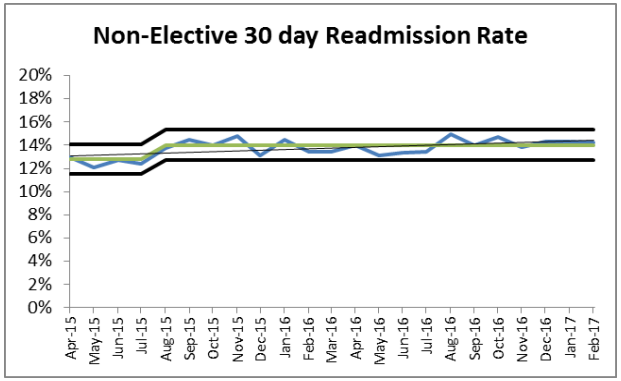


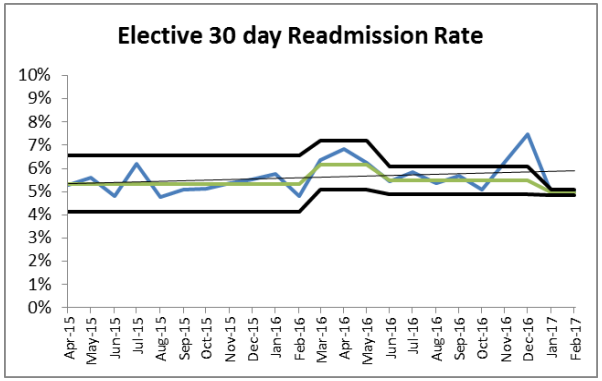
Operational Dependencies

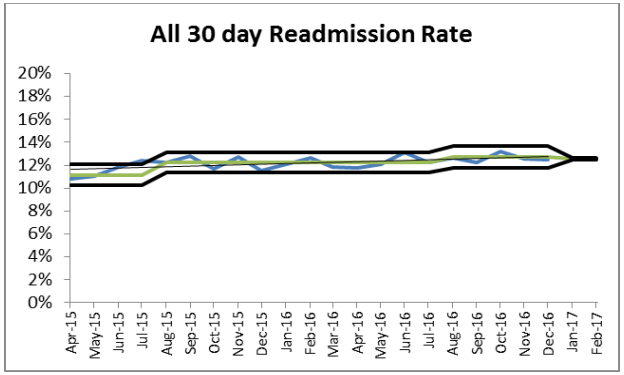


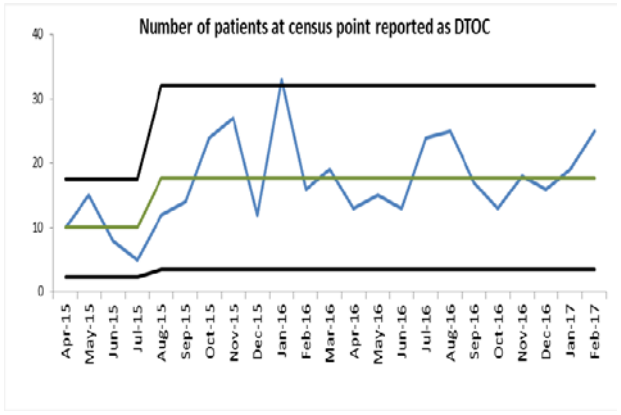


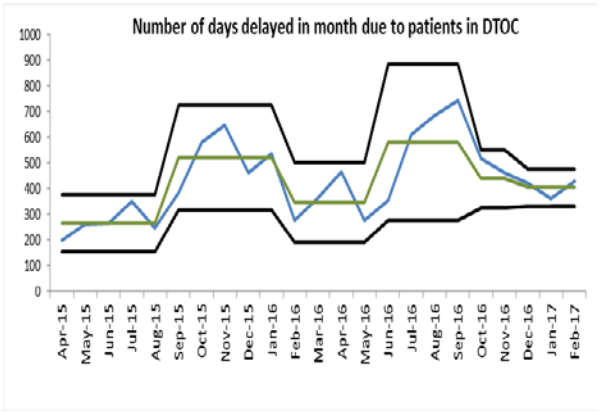


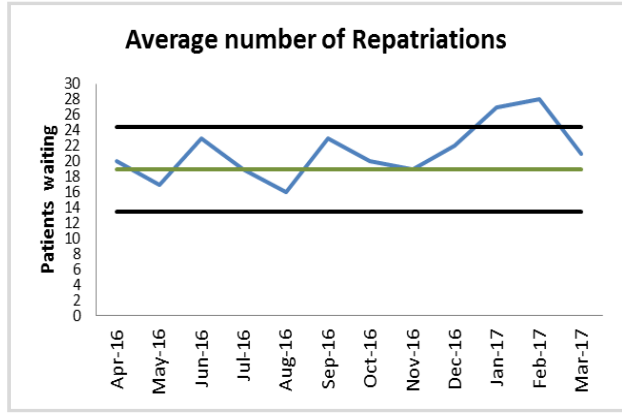




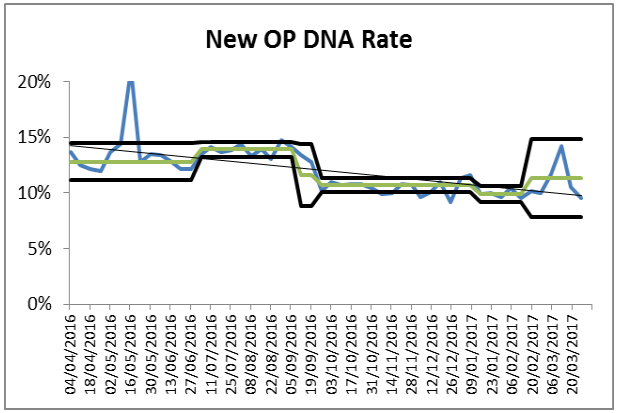


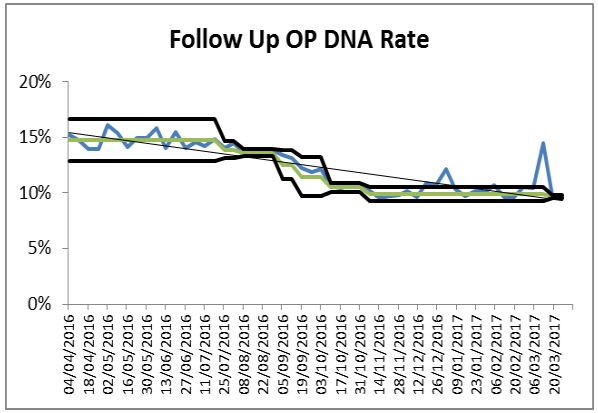


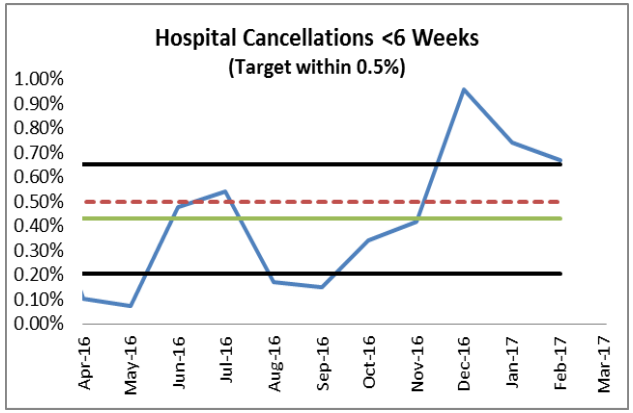


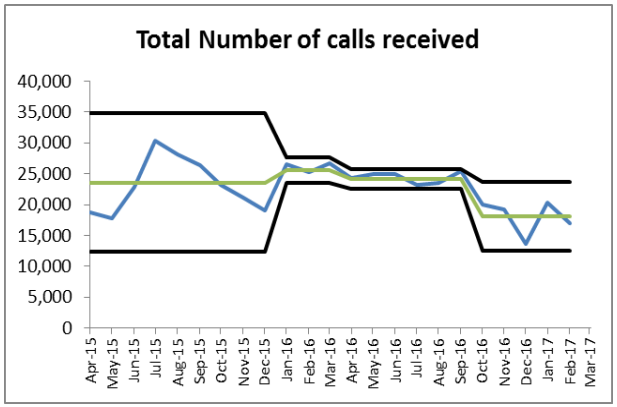


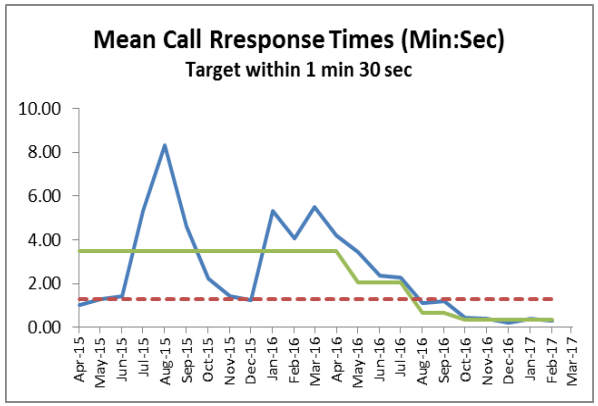
Out Patient Management

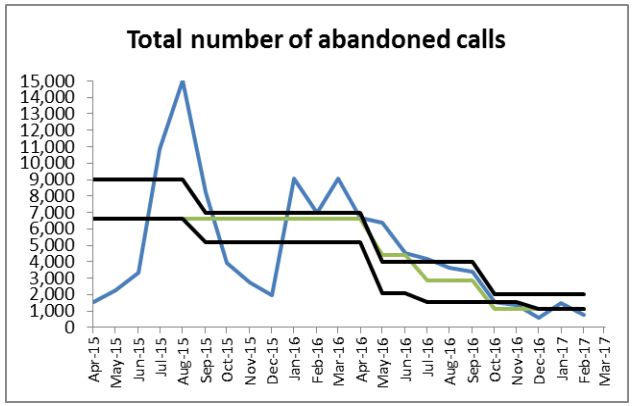


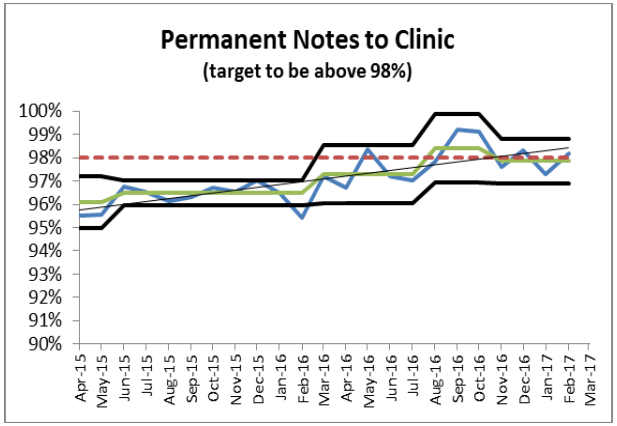


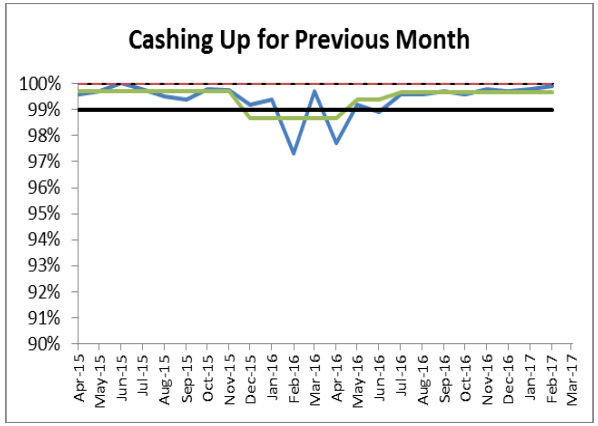












Executive Lead: Mark Gammage, HR Advisor to the Board

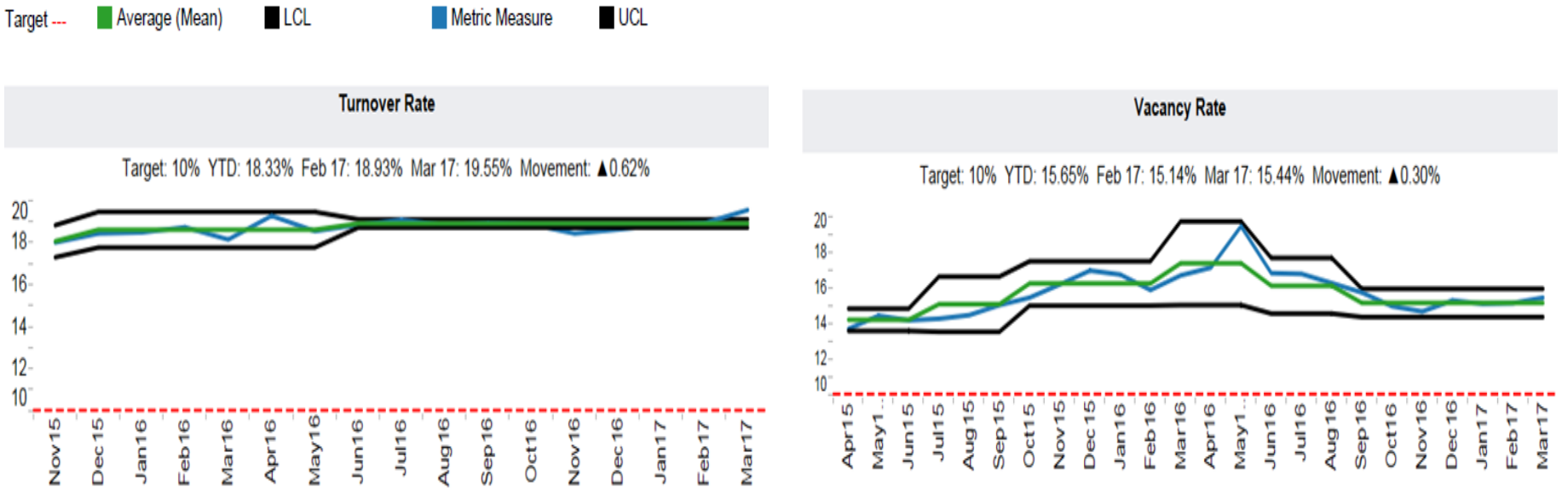
Theme	Indicator	Ref	Units	Period	Target	National or Local	Mth Rag Rating	Jan-17	Feb-17	Mar-17	Variance	YTD Total	Chart
Workforce	Trust Level Sickness Rate	101	%	Mar-17	3%	Local		4.18%	3.78%	3.30%		N/A	Y
	Trust Vacancy Rate	100	%	Mar-17	10%	Local		15.09%	15.14%	15.44%		N/A	Y
	Trust Turnover Rate	99	%	Mar-17	10%	Local		18.84%	18.93%	19.55%		N/A	Y
	IPR Appraisal Rate - Medical	103	%	Mar-17	90%	Local		79.2%	81.37%	77.40%		N/A	Y
	IPR Appraisal Rate - Non Medical	104	%	Mar-17	90%	Local		67.5%	70.42%	72.82%		N/A	Y
	Ward Staffing Unfilled Duty Hours	106	%	Mar-17	10%	Local		4.6%	6.25%	4.83%		N/A	Y
Safe Staffing	Safe Staffing Alerts	237	Number	Mar-17	0	Local		11	7	2		97	Y

								Q1 2016/17	Q2 2016/17	Q3 2016/17	Variance		
Staff Experience	Staff Friends and Family Test Response Rate		%	Q2	TBC	Local		8%	7%			N/A	N
	Staff Friends and Family Test Recommend as a place to work		%	Q2	TBC	Local		50%	37%			N/A	N
	Staff Friends and Family Test Recommend as a place for treatment		%	Q2	TBC	Local		79%	73%			N/A	N

WELL LED – Workforce Indicators

Briefing:

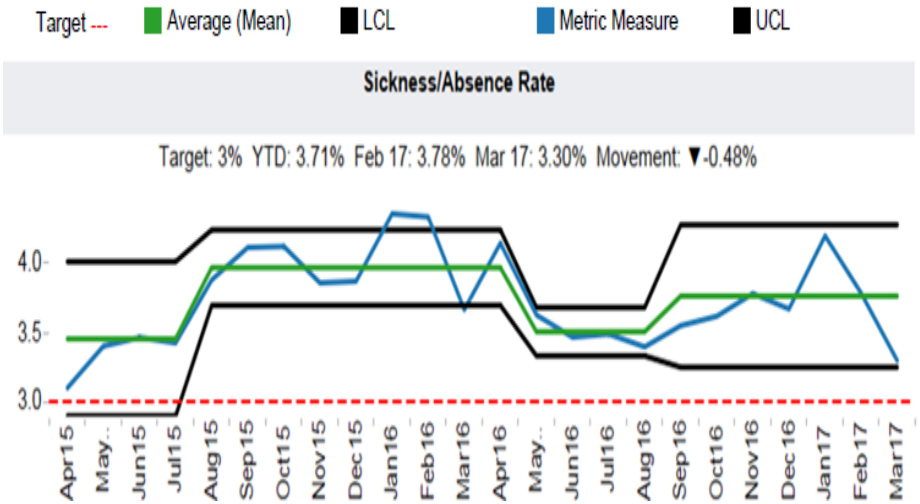
- Turnover remains high (19.55%) and above our target for this year
- Vacancy rates continue to be high at 15.4% and above our 10% target. Some of this vacancy figure is an inflation due to unbudgeted vacant posts sitting in ESR which we are working with managers to remove.

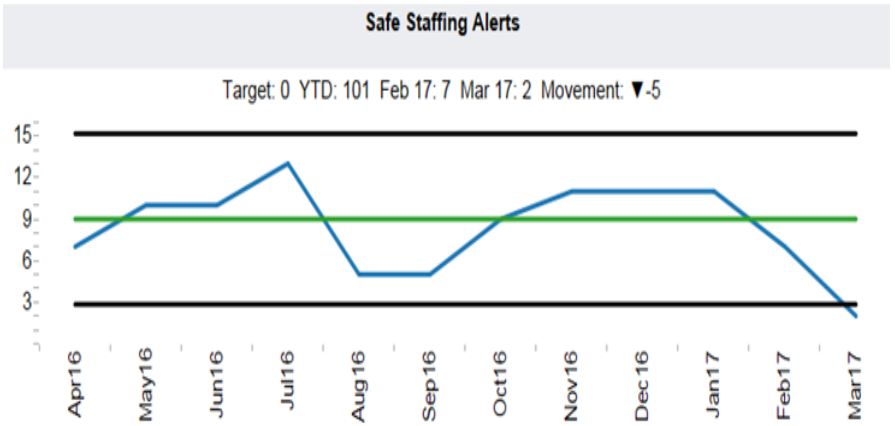


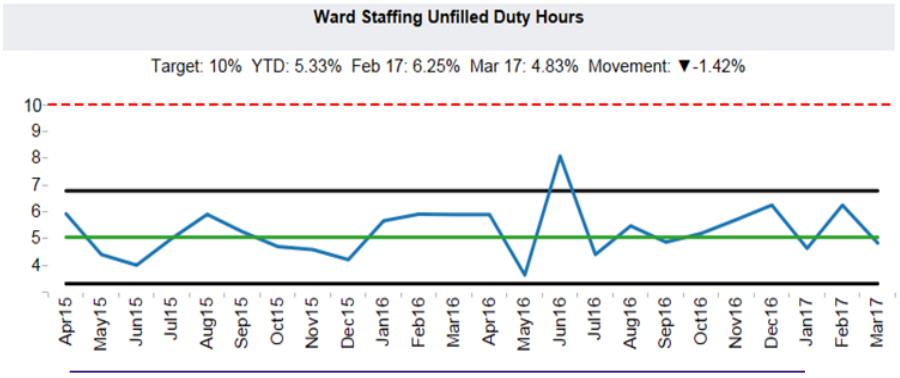
WELL LED – Workforce Indicators

Briefing:

- Sickness absence has remained fairly constant throughout the year although is above the expected local target.
- We continue to have safe staffing levels on the wards despite the sickness, although this is often mitigated through the use of premium cost staff.
- The safe staffing alert system allows early escalation of staffing alerts so that staff can be moved across the trust to ensure patient safety.
- 2 alerts were raised from March 17 which occurred in NNU and Pinckney Ward.







WELL LED – Workforce Indicators

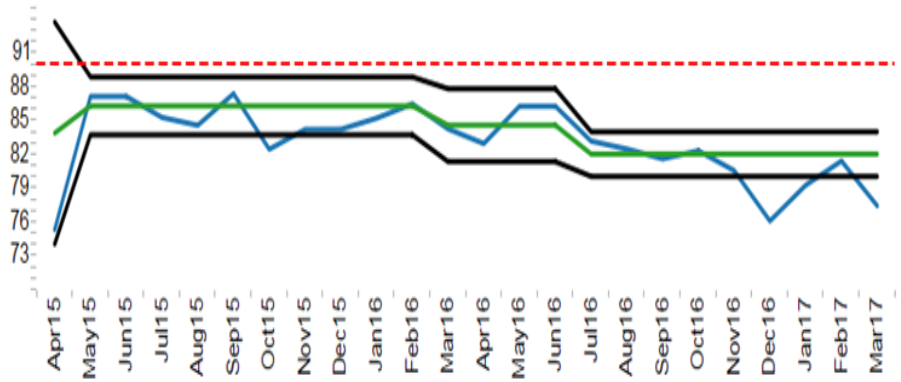
Briefing:

- Appraisal rates remain a concern for both medical and non-medical staff.
- This triangulates with the low scores we see in the staff recommendation rates.

Target --- Average (Mean) LCL Metric Measure UCL

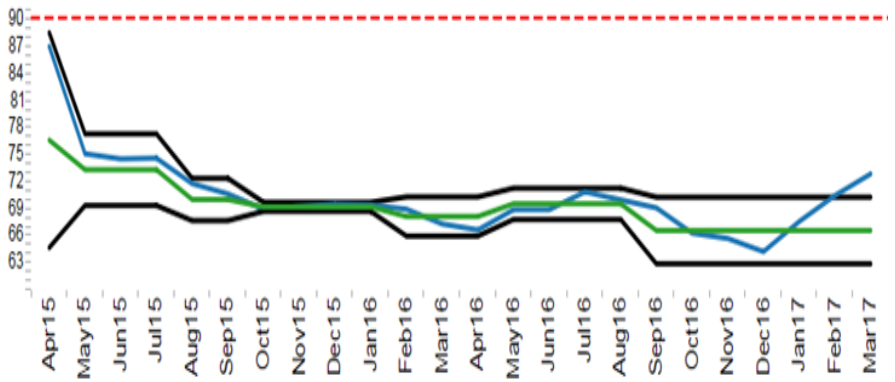
IPR Appraisal Medical

Target: 90% YTD: 80.71% Feb 17 81.37% Mar 17: 77.40% Movement: ▼-3.97%



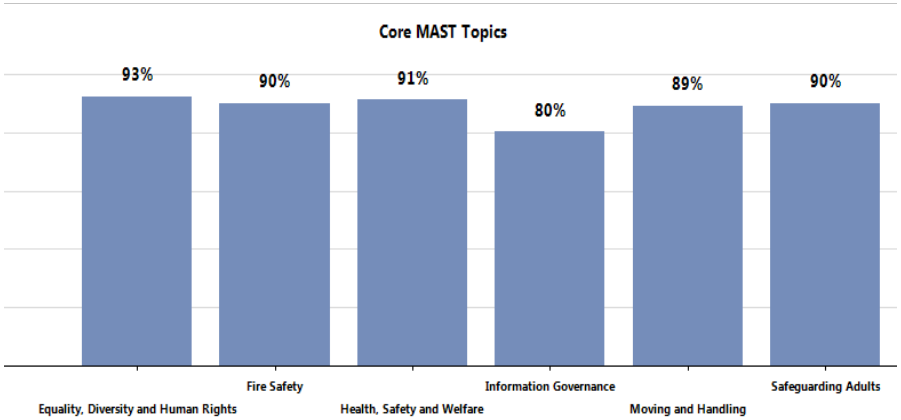
IPR Appraisal Non-Medical

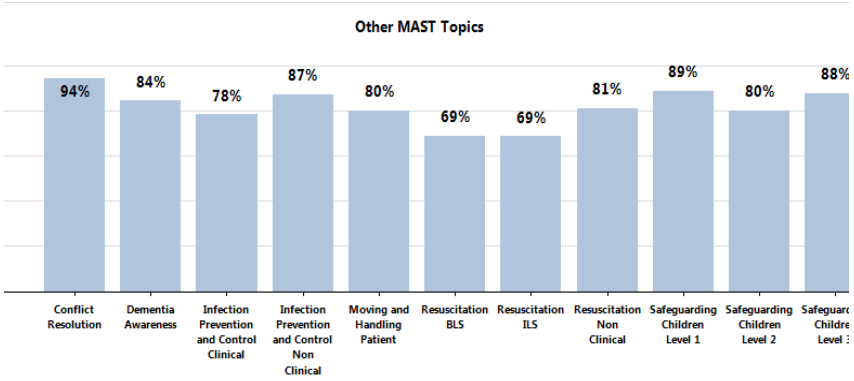
Target: 90% YTD: 69.92% Feb 17 70.42% Mar 17: 72.82% Movement: ▲2.40%

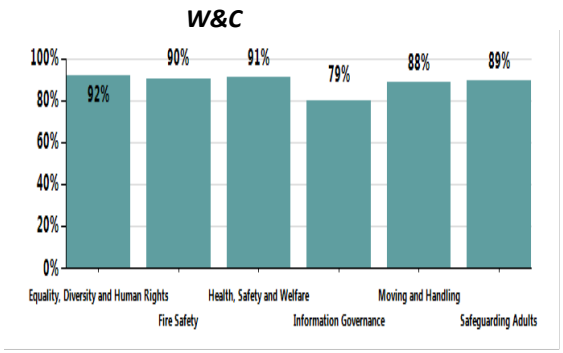


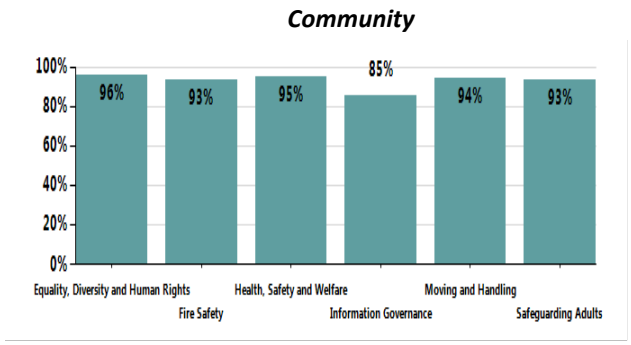
WELL LED – Workforce Indicators

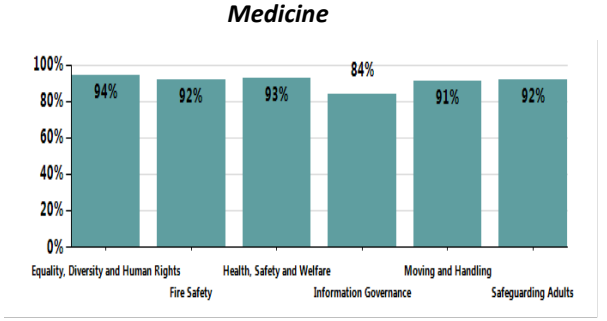
Briefing:
The Trust achieved 85% compliance for MAST in March, meeting its target and achieving the highest level of compliance the Trust has seen. There are some areas where further progress is required, most notably with resuscitation and with doctors' compliance, and this is being addressed.

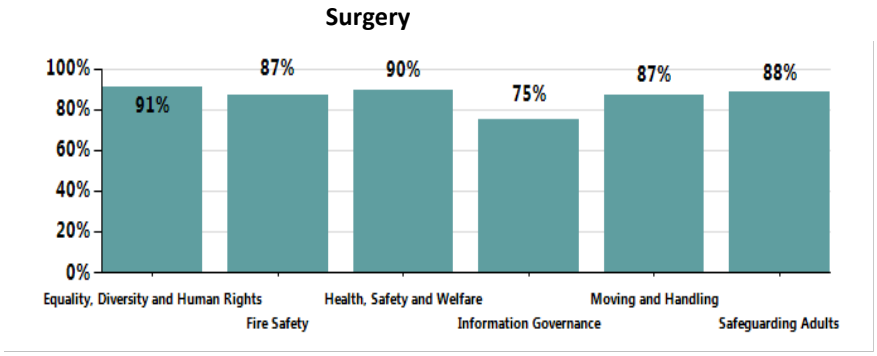


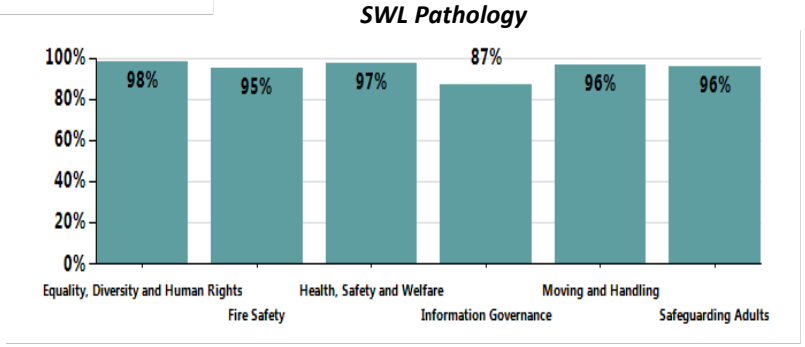












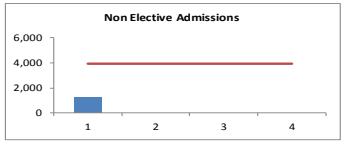
A look ahead

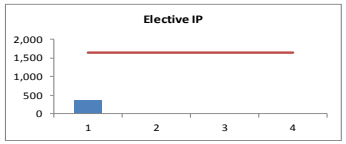
Mar-17																																Apr-17							
Activity Wk 1 (13th March - 19th March)									Activity Wk 2 (20th March - 26th March)								Activity Wk 3 (27th March - 2nd April)								Activity Wk 4 (3rd April - 9th April)							
Indicator	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total
ED Attendances	522	493	465	490	462	459	451	3,342	531	499	425	485	479	444	386	3,249	529	463	524	463	474	505	482	3,440	519	448	416	430	460	498	473	3,244
ED 4 Hr Breaches	121	126	26	42	44	45	36	440	54	54	28	47	75	27	18	303	132	49	82	51	24	61	72	471	35	31	20	24	27	58	43	238
ED Performance	76.82%	74.44%	94.41%	91.43%	90.48%	90.20%	92.02%	86.83%	89.83%	89.18%	93.41%	90.31%	84.34%	93.92%	95.34%	90.67%	75.05%	89.42%	84.35%	88.98%	94.94%	87.92%	85.06%	86.31%	93.26%	93.08%	95.19%	94.42%	94.13%	88.35%	90.91%	92.66%
Ambulance Arrivals	121	114	94	104	94	107	100	734	109	105	79	102	127	106	98	726	111	105	110	114	107	117	109	773	119	112	90	100	102	124	111	758
Re-Pat Waiting	13	24	31	29	33	29	24	26	22	20	18	15	18	18	9	17	4	8	21	21	20	25	21	17	18	20	25	22	15	21	7	18
DTOC	33	30	24	23	30	27	27	28	28	29	37	40	40	39	39	36	39	28	36	34	36	34	34	34	34	33	31	34	35	33	33	33
Non DTOC	27	27	27	30	18	23	23	25	24	21	18	18	19	18	18	19	18	17	16	17	16	15	15	16	14	10	14	15	16	17	17	15
Non Elective admissions	164	191	199	189	206	163	131	1,243	171	200	217	169	205	139	124	1,225	157	151	157	192	181	134	133	1,105	197	168	191	185	195	150	137	1,223
Discharges	159	181	188	180	200	142	121	1,171	159	204	213	176	214	138	139	1,243	162	140	160	202	169	125	122	1,080	174	152	172	156	169	126	130	1,079
Discharge Lounge Use	17	28	31	28	28	Closed	Closed	132	17	35	21	20	31	Closed	Closed	124	24	30	30	27	20	Closed	Closed	131	23	28	30	27	30	Closed	Closed	138
Occupancy Rates	91.10%	92.2%	93.9%	91.1%	91.0%	86.5%	87.3%	90.44%	92.21%	92.2%	88.6%	88.1%	89.5%	86.4%	86.9%	89.12%	87.88%	87.0%	89.4%	90.3%	90.8%	89.3%	85.1%	88.54%	89.88%	89.2%	90.8%	89.0%	87.2%	82.9%	82.2%	87.31%
Electve IP	58	71	46	80	76	7	16	354	88	62	53	62	81	14	16	376	69	81	67	104	79	7	13	420	63	69	62	96	50	4	15	359
Elective Day Case	147	137	163	143	116	5	0	711	115	146	169	159	105	21	0	715	140	114	158	115	134	11	0	672	135	128	148	143	132	9	0	695
Cancelled Operations	8	6	6	8	5	0	1	34	12	10	7	3	6	2	0	40	6	9	5	8	5	2	1	36	8	9	6	10	3	5	1	42
OP New	767	877	726	737	540	74	52	3,773	863	862	709	722	533	67	36	3,792	766	905	679	728	497	61	50	3,686	808	826	734	683	532	72	39	3,694
OP Follow Up	1636	1741	1702	1491	1276	17	6	7,869	1641	1843	1649	1412	1305	27	9	7,886	1469	1776	1617	1267	1253	28	5	7,415	1556	1723	1648	1424	1393	26	2	7,772

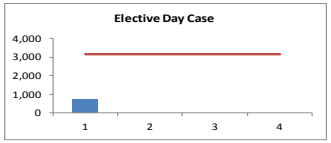
Activity April against Plan

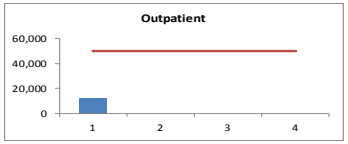
Indicator	Activity	Plan	Variance	% Diff
Non Elective Admissions	1223	889	334	27.3%
Electve IP	384	355	29	7.6%
Elective Day Case	702	685	17	2.4%
Outpatient Activity	10399	10815	-416	-4.0%

Cumulative Weekly Activity against Monthly Plan - Apr 2017







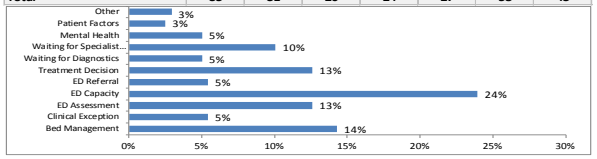


Performance

ED Performance

	Wk 1	Wk 2	Wk 3	Wk 4	MTD	Q1	YTD
ED Patients within 4 Hours	86.8%	90.7%	86.3%	92.7%	91.2%	91.2%	91.2%

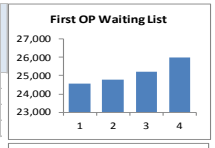
Daily ED Breach Reasons	03/04/2017	04/04/2017	05/04/2017	06/04/2017	07/04/2017	08/04/2017	09/04/2017
Bed Management	4	10	2	0	10	2	6
Clinical Exception	0	0	0	1	4	3	5
ED Assessment	7	5	1	3	1	8	5
ED Capacity	3	4	3	5	1	26	15
ED Referral	2	1	1	2	1	4	2
Treatment Decision	11	4	7	5	1	1	1
Waiting for Diagnostics	1	1	2	1	1	4	2
Waiting for Specialist Opinion	1	2	2	3	4	8	4
Mental Health	2	2	1	1	2	1	3
Patient Factors	2	2	0	0	2	0	0
Other	2	0	1	3		1	0
Total	**35**	**31**	**20**	**24**	**27**	**58**	**43**

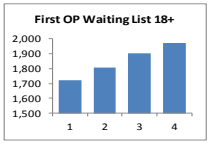


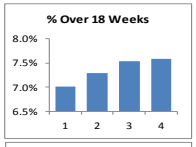
RTT Performance

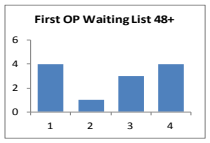
	Apr-16	######	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Incomplete Waiting List Size (All)	35,626	37,243	38,849	39,573	40,299	38,935	38,594	37,608	38,249	41,619	43,848	42,317
Incomplete 18+ (All)	3,753	3,575	4,540	4,938	5,801	5,148	5,140	5,158	6,988	9,350	10,946	13,571
Incomplete 18+ (All)	89.5%	90.4%	89.5%	87.5%	85.6%	86.8%	86.7%	86.3%	81.7%	77.5%	75.0%	67.9%

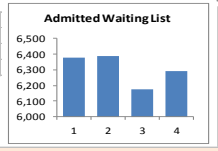
Weekly PTL Updates	17/03/2017	24/03/2017	31/03/2017	07/04/2017
First OP Waiting List	24,554	24,796	25,230	25,985
First OP Waiting List 18+	1,721	1,807	1,900	1,972
% Over 18 Weeks	7.0%	7.3%	7.5%	7.6%
First OP Waiting List 48+	4	1	3	4
Admitted Waiting List	6,375	6,386	6,176	6,292
Admitted Waiting List 18+	2,156	2,143	2,110	2,137
% Over 18 Weeks	33.8%	33.6%	34.2%	34.0%
Admitted Waiting List 48+	42	44	66	59

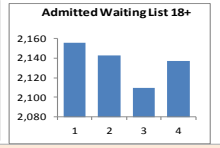


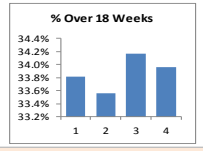


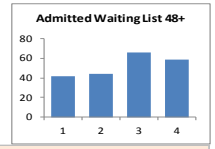












Summary 52 Wk Breaches First OP, Continuing OP & Admitted

Report Date	Last Wk	Tip Ins this Wk	Removed	Total
17/03/2017	39	10	7	42
24/03/2017	42	7	6	43
31/03/2017	43	10	11	42

PTL	Admitted	Outpatient
Total	29	13
Undated	2	2
TCI/next event	10	9
Treated	3	0
ROTT	4	2

Specialty	Total patients
Cardiac surgery	1
Ear, Nose & Throat	20
Gastroenterology	3
General Surgery	9
paediatric Surgery	1
Plastic Surgery	2
Trauma & Orthopaedics	5
Urology	1
Grand Total	**42**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	TRUST BOARD		
Date:	4 May 2017	**Agenda No**	**3.1**
Report Title:	**Outturn Report- Month 12 2016/17**		
Lead Director/ Manager:	Ann Johnson, Acting Chief Financial Officer		
Report Author:	Michael Armour		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The Trust's 2016/17 Revenue Outturn is a £73.9M deficit against a baseline forecast outturn of £76M (excluding £5M recycling of fines), which is a £2.1M improvement to forecast. This is predominantly due to accounting adjustments in depreciation. The underlying position is an in-month deficit of £6.6m which is in line with the prior month.		
Recommendation:	The Trust Board notes the current Trust financial position.		
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:			
Resources:			
Previously Considered by:	Executive Management Team Finance & Performance Committee	**Date**	
Equality Impact Assessment:			
Appendices:	None		

Summary Finance Report

2016/17 Outturn Report (Month 12)

Trust Board 4th May 2017

Contents

1. 2016/17 Revenue Outturn (Month 12)

Income & Expenditure	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £m	Year to Date (YTD) Budget £'m	Year to Date (YTD) Actual £'m	Year to Date (YTD) Variance £m	FY Reforecast @ M11 (£76m deficit control total) Forecast £'m	FY Reforecast @ M11 (£76m deficit control total) Variance £m
SLA Income	650.3	57.3	56.3	(1.1)	650.3	642.1	(8.2)	642.5	(0.5)
STF Income	17.6	1.5	0.0	(1.5)	17.6	0.0	(17.6)	0.0	0.0
Other Income	113.7	10.7	11.6	0.9	113.7	118.5	4.8	116.1	2.4
Overall Income	**781.6**	**69.5**	**67.9**	**(1.6)**	**781.6**	**760.5**	**(21.0)**	**758.7**	**1.9**
Pay	(486.6)	(41.1)	(40.7)	0.4	(486.6)	(494.5)	(7.8)	(494.2)	(0.3)
Non Pay	(277.0)	(22.3)	(30.2)	(7.8)	(277.0)	(308.8)	(31.8)	(305.5)	(3.3)
Overall Expenditure	**(763.7)**	**(63.4)**	**(70.9)**	**(7.5)**	**(763.7)**	**(803.3)**	**(39.6)**	**(799.7)**	**(3.6)**
EBITDA	**17.9**	**6.1**	**(3.0)**	**(9.1)**	**17.9**	**(42.8)**	**(60.6)**	**(41.0)**	**(1.7)**
Depreciation	(24.3)	(2.0)	0.5	2.6	(24.3)	(20.4)	3.9	(24.2)	3.7
Financing costs	(10.8)	(0.9)	(1.0)	(0.1)	(10.8)	(10.8)	(0.0)	(10.8)	0.1
Surplus/(deficit)	**(17.2)**	**3.2**	**(3.5)**	**(6.7)**	**(17.2)**	**(73.9)**	**(56.7)**	**(76.0)**	**2.1**

Key Messages

The Trust's 2016/17 Revenue Outturn is a £73.9M deficit against a baseline forecast outturn of £76M (excluding £5M recycling of fines), which is a £2.1M improvement to forecast. This is predominantly due to accounting adjustments in depreciation. The underlying position is an in-month deficit of £6.7m which is in line with prior months.

- **SLA income is £0.5M below** forecast. This is largely due to lower than forecast CQUIN performance in Hep-C and Cancer.
- **Other income is £2.4M favourable** to forecast broadly due to higher than expected education income from the Learning & Development Agreement (LDA) (£1.1M), higher than forecast RTA income (£0.8M), income from NHS Improvement to fund costs associated with quality special measures (£0.3M) and additional income in Estates (£0.2M).
- **Pay is £0.3M adverse** to forecast is due to lower than forecast capitalisation of estates and IT staff.
- **Non-Pay is £3.3M adverse** to forecast owing to a year-end stock adjustment for drugs in Pharmacy.
- **Depreciation is a £3.7M favourable variance**, £2.9M is due to a re-lifing of our assets in accordance with an independent valuation report and therefore providing a depreciation benefit. There is also a £0.8M depreciation benefit from lower than forecast Capital expenditure in quarters 1-3.

** The Trust's deficit for the purposes of the Annual Accounts is £78.7M due to disposals of assets which are treated as "below the line" items for Management Accounts purposes*

2. Analysis of Cash Outturn M12 YTD

Source and application of funds - cash movement analysis:
2017/18 outturn vs Plan

	Outturn vs Plan YTD			
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*	Notes based on £74m outturn deficit
Opening cash 01.04.16	7.4	7.4		
Income and expenditure deficit	-17.2	-78.7	***-61.5***	
Depreciation	25.0	21.6	***-3.4***	
Interest payable	5.1	5.5	***0.4***	
PDC dividend	6.3	5.2	***-1.0***	
Other non-cash items	-0.2	4.8	***5.0***	
Operating deficit	**19.0**	**-41.6**	***-60.6***	
Change in stock	0.6	-0.6	***-1.2***	
Change in debtors	1.8	-33.0	***-34.8***	
Change in creditors	-5.5	33.8	***39.3***	
Net change in working capital	-3.1	0.2	***3.3***	
Capital spend (excl leases)	-33.4	-30.5	***2.9***	The capital cash spend outturn was £26.6m - comprising an expenditure underspend of £2.3m and an increase in capital creditors of £0.6m against the baseline budget. As previously reported this means no additional borrowing was required to finance capital expenditure in year. The Trust has secured a £16.2m DH capital loan which will de drawn in 2017/18.
Interest paid	-5.1	-5.5	***-0.4***	
PDC dividend paid	-6.3	-5.2	***1.0***	
Other	-8.0	-6.4	***1.6***	
Investing activities	-52.7	-47.6	***5.1***	
WCF/ISF borrowing	32.5	87.6	***55.2***	The borrowing for the year excluded emergency capital funding as the capital programme under spend against the baseline budget. Therefore all the additional borrowing was used to finance the higher I&Edeficit.
Closing cash 31.03.17	3.0	6.0	***3.0***	

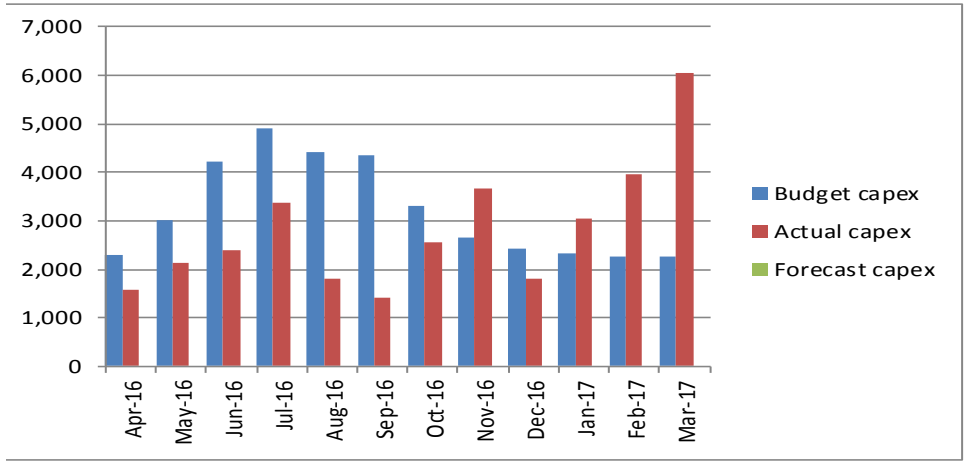
2016/17 cash movement
The better performance on working capital (+£3.3m) and cash under spend (+£2.9m) on the capital programme offset some of the adverse cash impact of the higher operating deficit (-£60.6m) and helped the Trust to restrict the increase in borrowing necessary to finance the higher revenue deficit to £55.2m.

M12 cash movement

- The outturn I&E deficit including disposals is £78.7m. When the asset disposals (in 'non-cash items') are excluded the I&E deficit is £74m.
- Within the I&E deficit of £78.7m, depreciation (£21.6m) does not impact cash. The charges for interest payable (£5.5m) and PDC dividend (£5.2m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £41.6m.
- The operating variance from plan of £60.6m in cash is directly attributable to the I&E deficit.
- The Trust has been able to partially offset the larger operating deficit with better performance on working capital (+£3.3m), the cash under spend on capital (+£2.9m), lower finance lease repayments (+£1m) (in 'Other') enabling the Trust to retain a £3m higher cash balance and restrict the increase in borrowing necessary to finance the higher I&E deficit to £55.2m.
- The total actual borrowing requirement was £87.6m, £55.2m higher than plan. This extra borrowing was required to finance the higher operating deficit.

3. Capital Outturn M12

Capital 2016/17 - budget and actual expenditure per month



CAPITAL EXPENDITURE OUTTURN 2016/17 - BY SPEND CATEGORY

Row Labels	**2016/17 Budget Total**	16/17 Actual YTD	16/17 YTD variance
Infra Renewal -EPC	**9,389**	6,624	2,765
Infra Renewal	**7,491**	2,356	5,135
IMT	**4,972**	7,990	-3,018
Med Eqpt	**4,613**	3,098	1,515
Major Projs	**8,901**	13,305	-4,404
Other	**349**	251	98
SWL PATH	**385**	201	184
Grand Total	**36,099**	33,825	2,274

- Capital expenditure in March was £6m and expenditure for the year was £33.8m, an underspend of £2.3m. The table above shows the outturn under spend relates mainly to the energy performance contract (EPC) (£3.1m – down £1m on M10) for which the programme slipped earlier in the year, and infrastructure renewal (£4.7m), which includes the scheme to replace the stand-by generators. Expenditure on the EPC has accelerated over the last three months.
- The trust is forecasting approx £5m of expenditure this year on CQC related schemes including the Renal unit re-location and the demolition programme against the emergency capital bid. DH approved a capital loan of £16.2m for emergency investment on 28th February. This loan will be drawn down in the first two quarters of 2017/18.
- The Trust submitted a gross capital expenditure forecast of £34.1m for the year to NHSI in January and this must not be exceeded and so the outturn of £33.8m is within this control total.
- The actual cash underspend relating to capital expenditure was approx £2.9m comprising the approx £2.3m expenditure underspend and £0.6m increase in capital creditors.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	4 May 2017	**Agenda No**	
Report Title:	Workforce Information Report		
Lead Director/ Manager:	Mark Gammage, HR Advisor to the Board		
Report Author:	Sion Pennant-Williams, Workforce Intelligence Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	This report provides workforce information for March 2017. Overall agency spend for 2016/17 was £43.32m against a cap of £24.54m. Our cap for 2017/18 (and 2018/19) is £24.54m and the Trust has set an internal ceiling of £22m and a trajectory by professional group and division to achieve this. More granular detail on agency spend will feature in future workforce reports Sickness levels have decreased to below our 3.5% target and stability has increased to 86%. Appraisal compliance has increased to its highest level of 80% for non-medical and 85% for medical staff and MAST compliance has remained at our 85% target. A review of ER cases opened throughout the year requires further analysis to understand the reasons for gender and ethnicity disparity and this is being undertaken in partnership with the Workforce Race Equality Standard Steering Group.		
Recommendation:	The Board is asked to note the workforce performance report and actions outlined within it.		
Supports			
Trust Strategic Objective:	All Trust objectives		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Financial efficiency and operational performance		
Implications			
Risk:	Failure to achieve financial and other targets and manage within agreed control totals		
Legal/Regulatory:	Failure to meet NHSI control total		
Resources:	n/a		
Previously Considered by:	Regular Board report	**Date**	05.01.17
Equality Impact Assessment:	n/a		
Appendices:	Appendix 1 - Workforce Information slides		

Workforce Information Report
Trust Board, May 2017

1.0 PURPOSE

1.1 To provide workforce information for the Trust Board outlining trends and explaining changes in staffing composition to support decision-making and Board assurance.

2.0 CONTEXT

2.1 Revised KPI targets for key areas will be reported on next month.

3.0 ANALYSIS

3.1 The staff in post in February has reduced by 47.45 wte, and funded establishment has decreased by 36.87 wte due to posts being removed as part of restructured services. Vacancy levels are at 15.94% and are expected to reduce as a result of setting budgets for 2017/18.

3.2 Bank & Agency usage has remained constant in month, however agency spend as a percentage of total pay costs has increased to 8.93%. An internal target of £22m agency spend has been set and this is broken down by professional group and division into target maximum spend per month and also number of shifts that can be booked. Plans are in place to reduce agency expenditure in the top 10 areas of spend in 2016/17. Discussions are underway with an external agency supplier (24/7) to move all non-nursing agency usage via themselves to reduce vat payments.

3.3 Sickness levels have decreased by 0.51% to 3.34%. This is below our current target of 3.5%. Stability has increased to 86.08% over the year representing an increase of 3.96%.

3.4 Non-medical appraisal compliance has increased to 79.74%, which is the highest it's been since January 2015. Medical appraisal compliance also increased to 83.53%.

3.5 MAST compliance has remained at 85% resulting in the Trust meeting its current target compliance for the year.

3.6 Comprehensive recruitment plans for nursing are being finalised which outline the plans to recruit for each specialty throughout the year.

3.7. A review of ER cases opened throughout 2016/17 by ethnicity and gender shows that 61% of disciplinary cases were against BME staff, whilst they only make up 42% of total Trust employees. Females comprise 74% of our total staff, but they made up 88% of grievance cases raised by staff and 92% of harassment cases. Males comprise 26% of total staff, but represent 40% of disciplinary cases that are undertaken. Further analysis is being undertaken to understand the reason for the disparity in cases being brought by gender and ethnicity and the Workforce Race Equality Standard Group is undertaking action to reduce the incidence of disciplinary cases against BME staff.

4.0 IMPLICATIONS

Risks

4.1 The risks on staff engagement feature in the Trust's risk register alongside failure of leadership. Similarly, the risks to meeting the Trust's financial control total whilst also providing safe and effective care to patients form the primary focus for the Trust.

5.0 ACTIONS

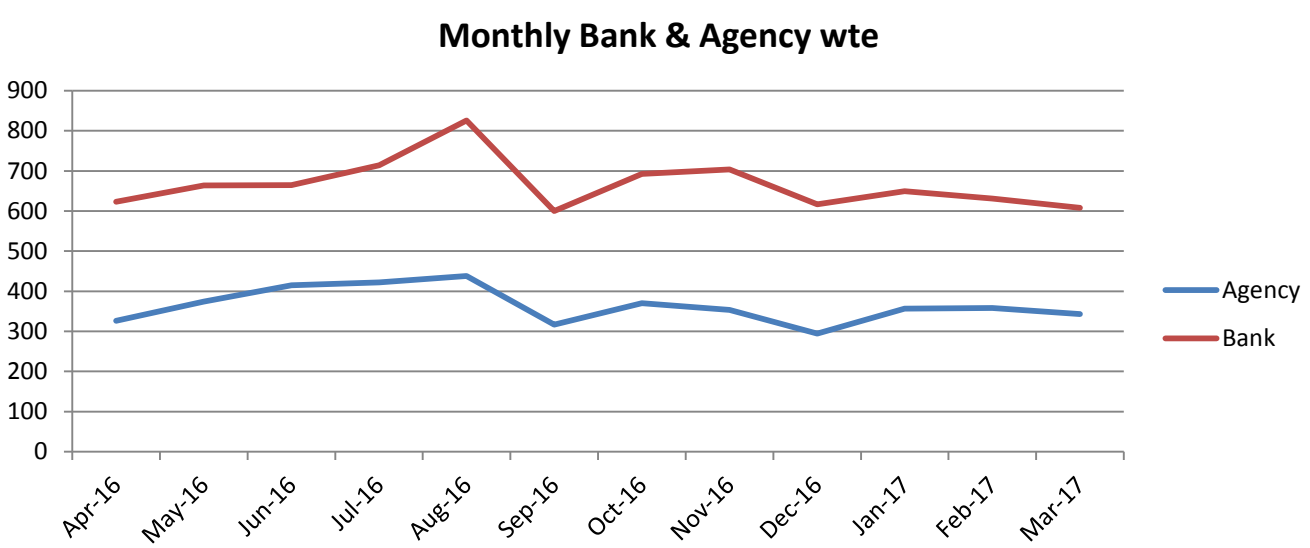
5.1 None

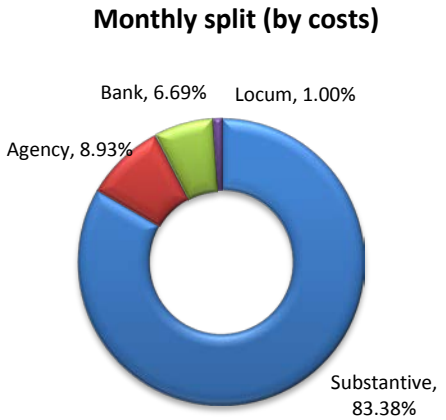
6.0 RECOMMENDATION

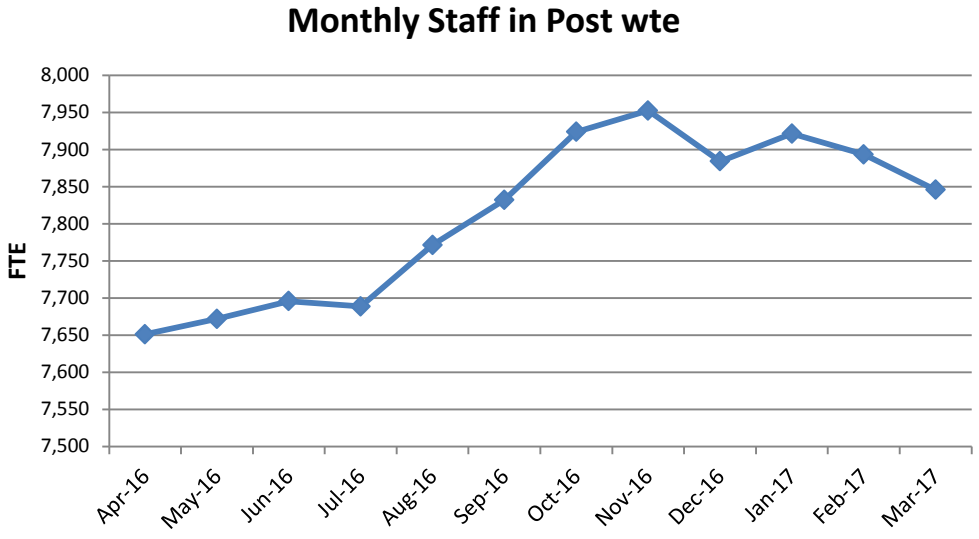
6.1 The Board is asked to note the workforce performance report and actions outlined within it.

Section 1: Current Staffing Profile and Bank & Agency

The data below displays the current staffing profile of the Trust and key bank and agency data







COMMENTARY

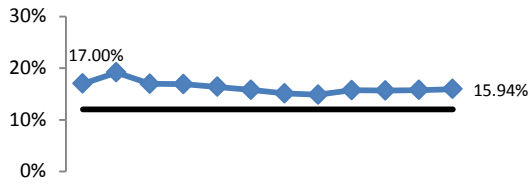
Staff in post has reduced by 47.45 wte, funded establishment has also reduced by 36.87 wte reflecting the outcome of restructures

Bank andAgency usage has remained fairly constant since January.

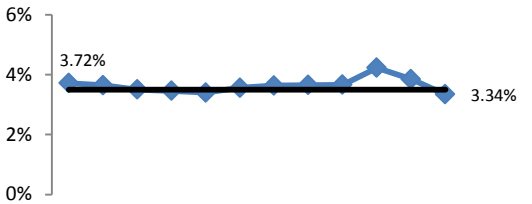
The Trust has set an internal target for agency spend of £22m (NHSI target is £24.54m) for 2017/18 and a trajectory is being finalised for each professional group, division and by ward area to show the cost and shifts per week that this relates to.

Section 2: Workforce KPIs

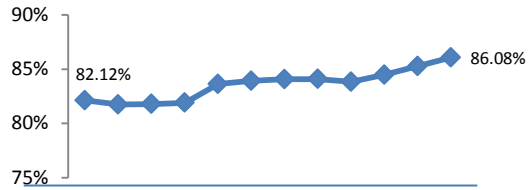
Vacancy Rate Year Trend



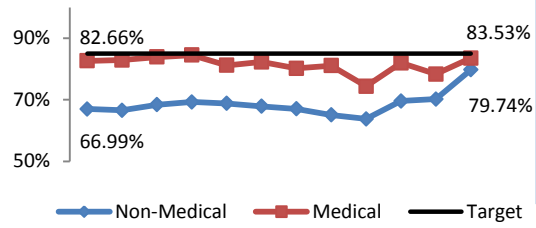
Sickness Rate Year Trend



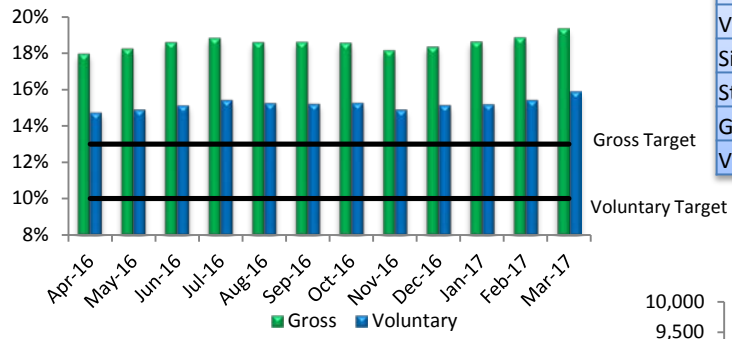
Stability Year Trend



Appraisal Rate Year Trend

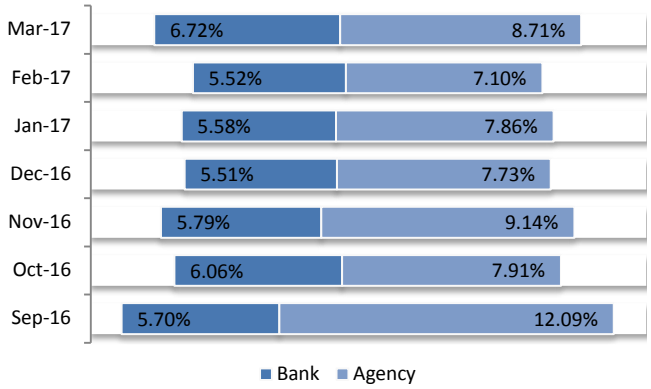


Turnover YTD

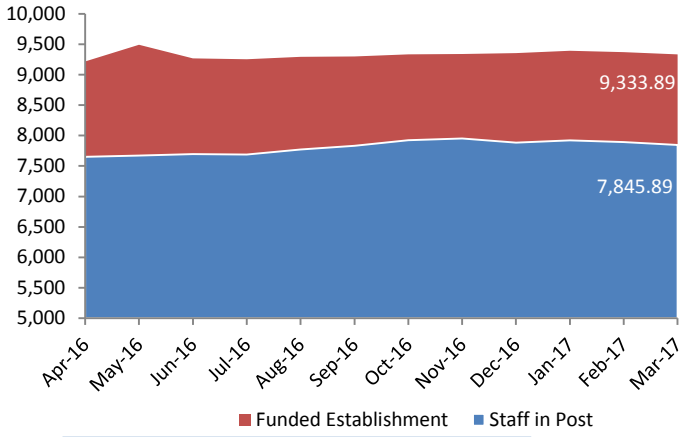


KPI	Change over the year	Change since last month
Vacancy	-1.06%	0.18%
Sickness	-0.38%	-0.51%
Stability	3.96%	0.79%
Gross Turnover	1.40%	0.50%
Voluntary Turnover	1.16%	0.48%

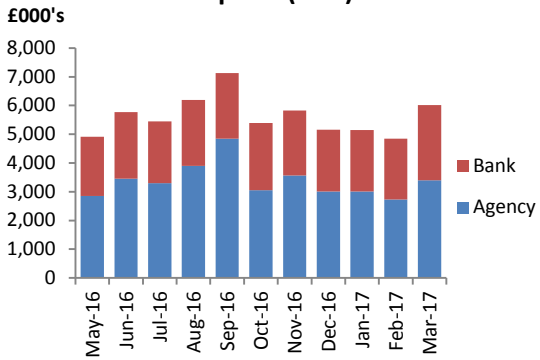
Bank/Agency Mix*



Trust Establishment & Fill Rate

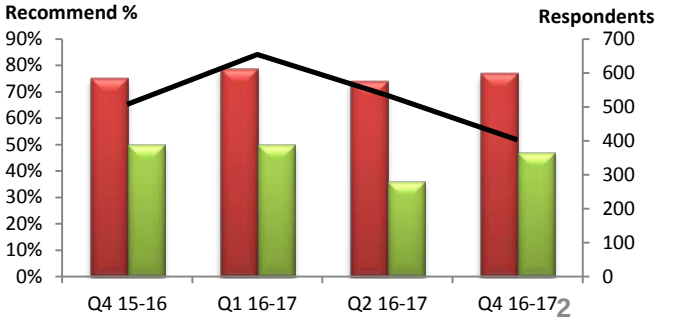


B&A Spend (YTD)*

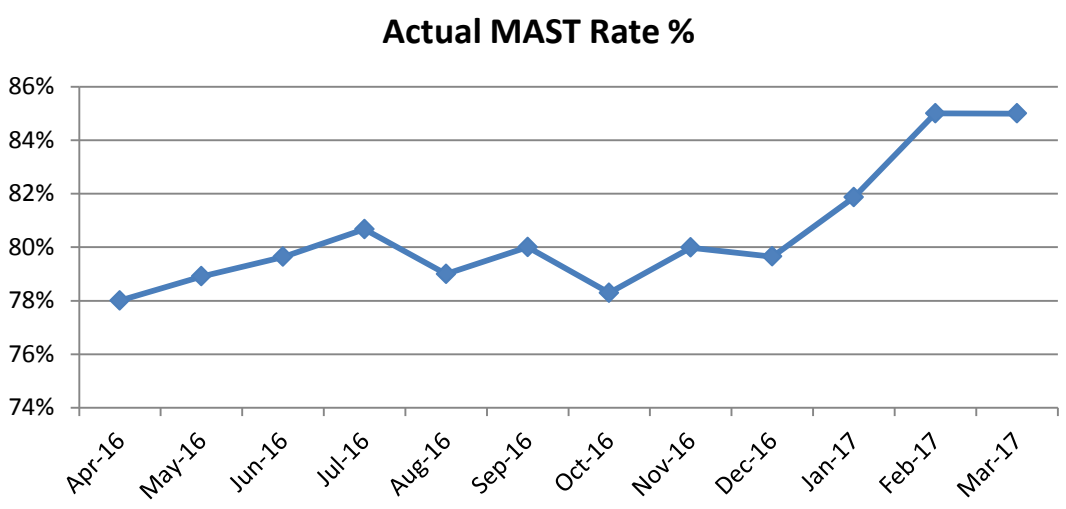


* Does not include SWLP or Central costs

Friends & Family Test



Section 3: MAST Compliance



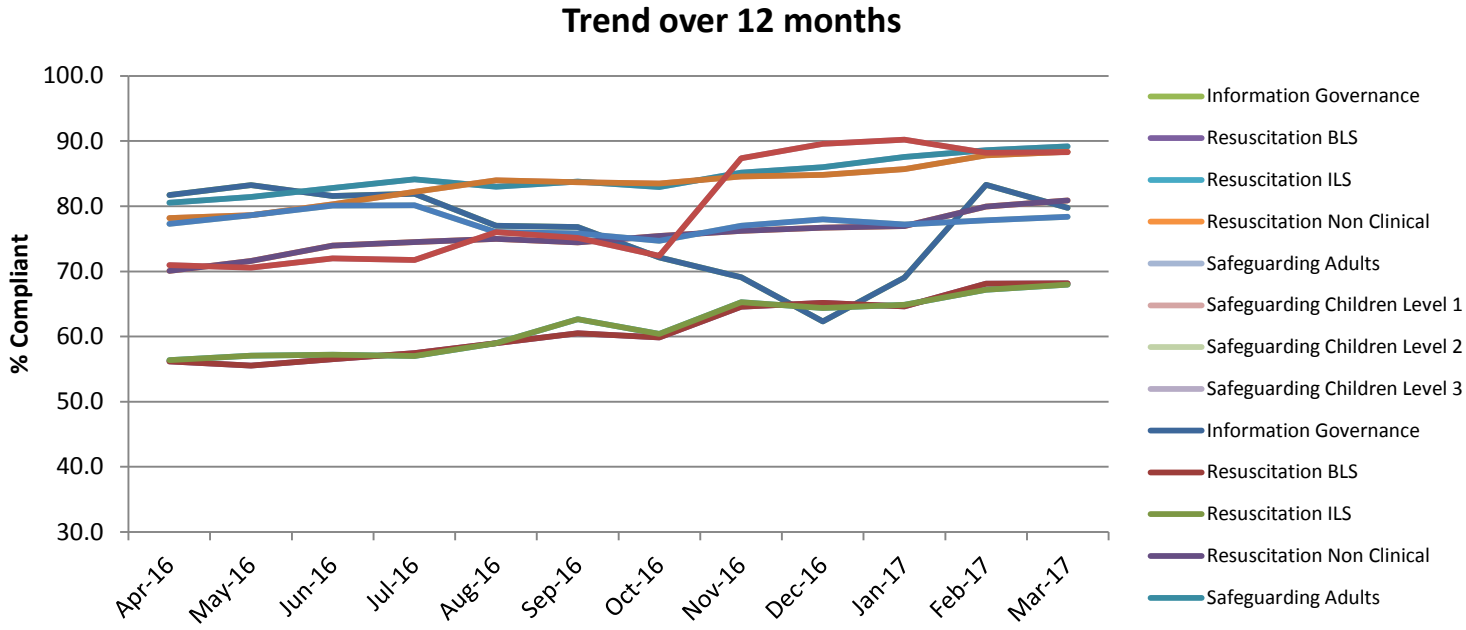
COMMENTARY

The previous compliance target of 85% has now been achieved. This represents a 20% increase in organisational compliance within 15 months. The Workforce Development Committee has increased the organisational compliance target to 90%, with Information Governance remaining at 95% as per external requirements.

A Trust Appraisal and MAST Steering Group has been (re) established. The group will focus on the TNA for Resuscitation courses in order to ensure that the denominator is correct (this has been an historical issue).

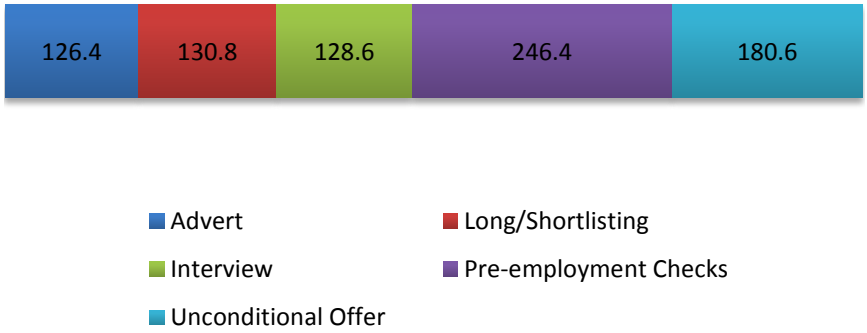
Other areas the Appraisal and MAST Steering group will focus on include:

- Medical Staff compliance
- Reviewing whether additional topics become part of local requirement
- Continuing to support Training requirements as part of transformation and improvement projects
- On going improvements with MAST interface



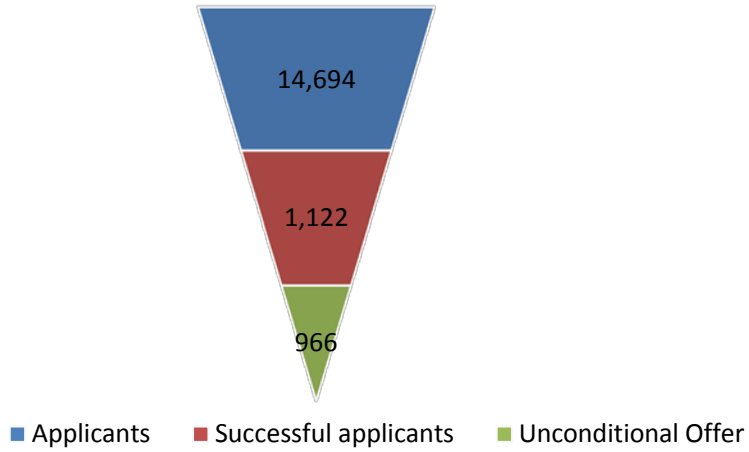
Section 4: Recruitment Pipeline

Non-Medical Current Pipeline (FTE)

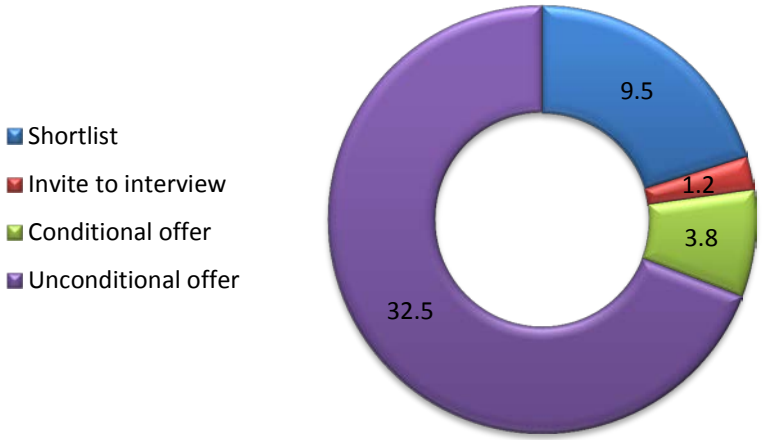


* Data is a snapshot from the end of February

Non-Medical Recruitment volumes (over 6 months)



Average days taken for key stages in Non-Medical Recruitment Process (over 6 months)

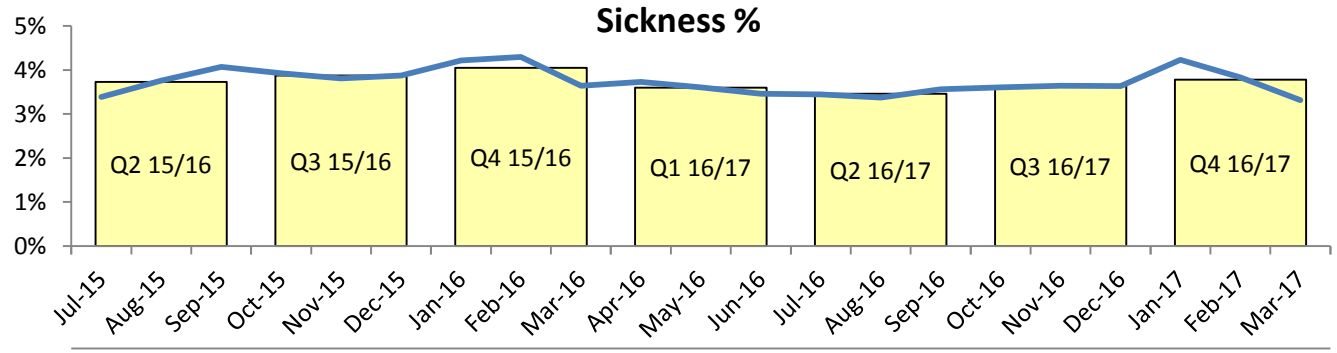


Shortlist – days that Recruiting Managers take to shortlist
Invite to interview – days between shortlisting being received from Recruiting Manager to interview invites being sent out
Conditional offer – days between interview outcome paperwork received to formal conditional offer
Unconditional offer – days between conditional offer and unconditional offer

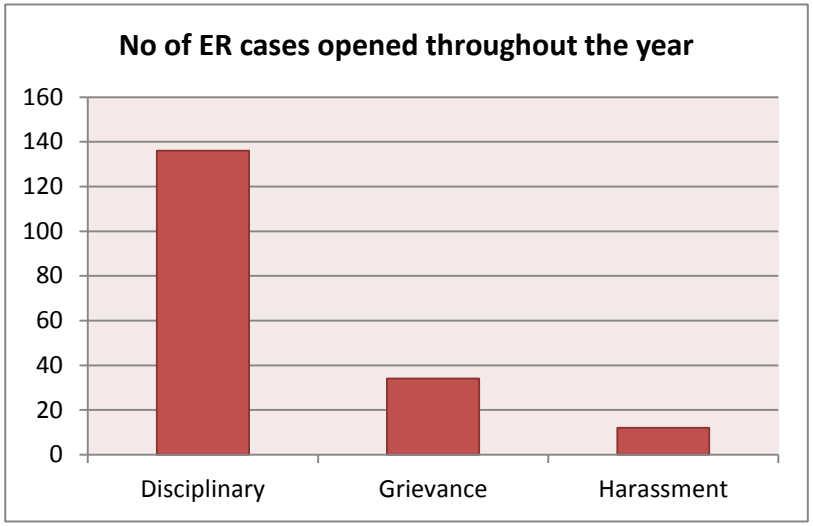
NB: Reporting from the Trac system is relatively new to the Trust and so the figures are intended as a guide only at this stage as they may not be wholly accurate. These reports are highlighting gaps in housekeeping within the Trac system which potentially affect these reports and so Medical recruitment is being removed for the time being

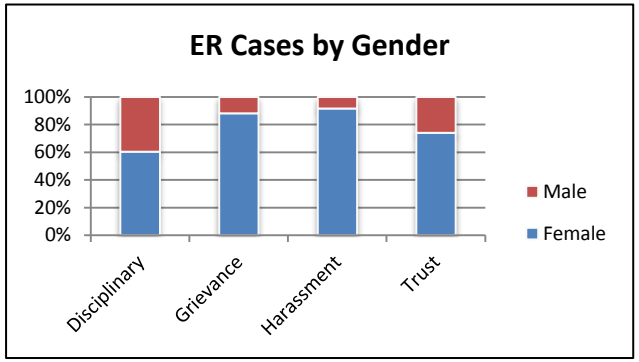
Section 5: Other

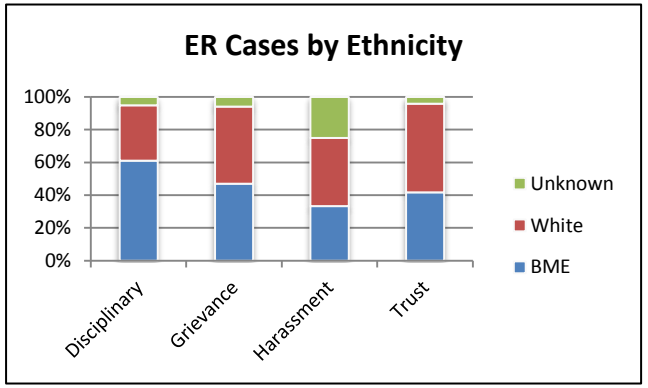
Quarterly vs Monthly comparison:



Employee Relations:







St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	4 May 2017	**Agenda No**	**4.2**
Report Title:	Leadership Development Strategy and Implementation Plan		
Lead Director/ Manager:	Mark Gammage, HR Advisor to the Board		
Report Author:	Sarah James, Associate Director of Workforce – Education & Development Mairead Heslin, Head of Corporate Training and Development Julia Tybura, Zenon Consulting		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Trust recognises the importance of great leadership. Effective leadership is essential to show our staff the way and in creating an environment within which they can develop and flourish in their pursuit of high quality patient care. It is also essential if the Trust is to inspire and energise the talent and capability of its staff to help deliver the improvements required to the Trust's processes and performance. Leadership at all levels was highlighted as an area of deficiency by the CQC and features as one of the Trust's key priorities for 2017/18 and onwards. The golden thread which runs through this leadership programme and implementation plans are the development of four critical capabilities : • Compassionate, inclusive leadership skills • Improvement skills • Talent Management systems, and • Systems leadership skills These are all addressed within the planned leadership strategy and are underpinned by our Trust values of excellence, kindness, respectfulness and responsibility, and the explicit delivery of behaviours which demonstrate these values. An implementation plan sets out the key priorities and associated actions over the next three years. Our priority for 2017-18 will be leadership support for ward managers, clinical leaders and general managers. The objective here is to create a capability and resilience within delivery functions. A Leadership Academy will be established to oversee and co-		

	ordinate all leadership activities and interventions, to ensure there is a consistency to the quality of training and a cohesiveness about the programme. A model for evaluating the effectiveness of our development activities - and the extent to which leadership and management behaviours and competence have improved as a result of investment - is also provided. Implementation of the strategy will be overseen by a newly formed Leadership Strategy Steering Group. Funding to implement this strategy in year one will be met largely from existing educational budgets, with the balance (other than £75k which the Trust will fund) coming from HEESL (Health Education England South London). There will however be a requirement for divisions to free staff to attend events. There are numerous benefits which will arise from implementing this strategy including a more engaged, satisfied workforce which will support an improved level of service to our patients. These benefits also include a reduction in cost due to reduced turnover and a decreased reliance on agency staff.
Recommendation:	The Board is asked to **endorse** this leadership strategy and support its implementation
Supports	
Trust Strategic Objective:	Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience, within available resources.
CQC Theme:	Well-led
Single Oversight Framework Theme:	Leadership and Improvement Capability (well led)
Implications	
Risks:	• Insufficient leadership capacity or capability to deliver turnaround programme. • Lack of alignment across the organisation to its vision and goal with a fragmented organisational culture • Lack of demonstration of the organisation's values and behaviours • Decreased staff engagement, reduced retention and increased turnover • Lack of innovation and improvement • Reduced quality across all measures

	• Lack of diversity across the organisation and inability to meet our stated objectives within our Workforce Race Equality Standard (WRES) • Lack of internal promotion		
Legal/Regulatory:	There are no specific legal or regulatory implications in this paper; however, investment and support for leadership is essential to deliver the improvements required to the Trust's processes and performance and to address issues raised by the CQC in its recent report.		
Resources:	Some financial support has been made available from HEESL and this will be supplemented by our own dedicated educational resources. There will be additional cost of £75k over and above this which we plan to course from other external funding streams, although it is noted that an increase in staff engagement and commensurate reduction in turnover and agency spend would bring significant financial and other savings.		
Previously Considered by:	Executive Management Team Workforce and Education Committee	**Date**	March 2017
Equality Impact Assessment:	To be completed for specific interventions		
Appendices:	Appendix 1. Leadership Development Implementation Plan (with appendices)		

Leadership Development – A Strategy for Great Leadership

Table of Contents

1. Introduction

1.1. The Trust's vision of great leadership is to show our staff the way in creating an environment within which staff can develop and flourish in their pursuit of high quality patient care.

1.2. This builds on the work carried out in the Trust over the past year, developing a coherent framework of leadership development and talent management which will enable the Trust to meet its objectives and become a sustainable high achieving health care organisation.

1.3. The golden threads that run through this vision are the development of four key critical capabilities:

- Compassionate, inclusive leadership skills
- Improvement skills
- Talent Management
- Systems leadership skills

The development of skills in each of these areas features as a central tenet of this leadership strategy.

1.4. In addition, this strategy places emphasis on evaluation of the effectiveness of development activities and the extent to which leadership and management behaviours and competence have improved as a result of investment. This needs to be seen within the context of a wider Workforce Strategy which will support the creation of right environment and culture for the Trust.

1.5. This is a 3 year plan with clear ownership and prioritisation. Some indicative costs and staff numbers have been outlined and more detail on this is shown in the Leadership Development Implementation Plan.

2. The Context

2.1. Great leadership is no longer about 'taking charge' or imposing a strategic vision, but about creating the platforms that allow others to flourish and create[1]

2.2. High quality quantitative and qualitative research has evidenced the link between good leadership and the achievement of a positive difference to patient care outcomes and the experience of care[2]. There is also considerable evidence linking failure in leadership to inadequate patient care. In essence, getting leadership right makes a very positive difference to service outcomes. However it needs careful planning and rigorous and continual implementation.

2.3. Evidence and experience from high performing health and care systems shows that having four critical capabilities enables teams to continuously improve population health, patient care and value for money.

2.4. Developing these capabilities and giving people the time and support required to see them bear fruit is a reliable strategy for closing the leadership gaps identified in the CQC assessment of leadership capability in the Trust.

2.5. These four critical capabilities are:

2.5.1. Compassionate, inclusive leadership skills for leaders at all levels. Compassionate leadership means paying close attention to all the people you lead, understanding the situations they face, responding empathetically and taking thoughtful and appropriate action to help. Inclusive leadership means progressing equality, valuing diversity and challenging power imbalances. These leadership behaviours create learning cultures where improvement methods can engage colleagues, patients and carers, deliver cumulative performance improvements, and make health and care organisations great places to work.

2.5.2. Improvement skills for staff at all levels. Chief Executives of the majority of provider trusts rated 'outstanding' by the Care Quality Commission credit established quality improvement (QI) methods for improvement in their operational performance, staff satisfaction and quality outcomes. The Trust's investment in the Institute for Health Improvement will support this.

2.5.3. Talent management to fill current senior vacancies and future leadership pipelines with the right numbers of diverse, appropriately developed people is an essential part of our leadership strategy.

2.5.4. Systems leadership skills for leaders improving local health and care systems, whether through sustainability and transformation plans, vanguards or other new care models. These skills help leaders to build trusting relationships with our health and social care partners, agree shared system goals and collaborate across organisational and professional boundaries.

[1] Inglehart (2005)
[2] West et al (2012)

2.6. In 2016, the CQC rated the Trust's leadership as 'inadequate'. Leadership was described as weak in several departments as well as at the Executive and Board. The CQC rated SGH as inadequate overall in November 2016, and NHS Improvement put the Trust into special measures for quality. In addition SGH was served with a section 29a warning notice by the CQC for a number of issues that had to be resolved expediently. SGH has set up a quality improvement plan (QIP) in order to coordinate and manage the improvement actions needed following the CQC report. This QIP now needs to be delivered. In order to deliver many of the cultural issues identified there will be a need for far tighter governance and grip within the organisation that has been present previously. The recent (March 2017) placement of the Trust in financial special measures further emphasised the need for consistent high quality leadership and improvement of the operational and financial management within the resources available.

2.7. The Trust therefore needs to ensure that its current and future leaders are prepared and equipped to deal with the ever increasing complexities and pressures of today's NHS. We need to 'grow our own' more effectively, ensuring they have the critical capabilities outlined above as well as routinely develop talented individuals linking this to career progression and making this a core part of our business. This will help support a reduction in turnover and increased stability in the workforce.

2.8. To achieve this, the Trust needs to map, develop and manage its talent. Currently, the Trust does not have a strategic approach or joined up whole system approach with regards to talent management and succession planning which is linked to the needs of the service. This is now being developed as a linked, but separate, talent management strategy.

2.9. This leadership development strategy and programme will be aligned to the Trust's vision, clinical strategy, business plan and related workforce strategies.

3. Our Vision for Leadership

3.1. Our vision for leadership is:

We will ensure our current and future leaders are supported and developed to deliver high quality, compassionate care aligned to needs of the populations we serve, in a cost-effective manner.

3.2. Our vision of leadership style and development in the Trust is based on our Trust vision and our Trust's values and behaviours:

'To provide high quality patient care for the communities we serve, and specialist services, with thriving programmes of education and research'.

- Excellent – leading the organisation to the highest possible standards and set a values based style for own functional area or division
- Kind – demonstrating an empathetic leadership style

- Respectful – demonstrating an inclusive and considered approach to leadership including acknowledging the importance of own leadership role
- Responsible – being truthful and accept responsibility for our actions

3.3. Our strategic approach will:

3.3.1 Create the right conditions and environment in which staff will enable the Trust to fulfil its vision and strategic plan, and deliver a continuously improving culture

3.3.2 Develop the four critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills

3.3.3 Align this strategy with all relevant Trust strategies, and be driven by, our business plan, workforce, Quality Improvement and talent plans

3.3.4 Embed cultural and leadership behaviours that lead to higher quality care cultures amongst all staff in the organisation

3.3.5 Use the NHS Healthcare Leadership Model as our leadership framework for the Trust

3.3.6 Evaluate and measure the return on investment in leadership (financial, reputation, skills development, behaviour change, key workforce indicators e.g. retention, turnover, FFT (staff), improvement in quality and compassionate care) to ensure we use the resources available in the most cost effective way

More detail on how we will do this is in the Leadership Development Implementation Plan (Appendix 1).

4. Leadership Development – Implementation

4.1. To deliver our strategic leadership vision and approach, we will:

4.1.1. Attract excellent leaders through a joined up approach covering the whole 'employee journey'.

4.1.2. Develop our existing leaders with a key focus on developing the four critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills.

4.1.3 Allow the triumvirate divisional structures to work together and deliver effectively.

4.1.4 Support all managers and leaders to understand each other's priorities

4.1.5 Prepare leaders for their next role

4.1.6 Give our leaders time and space to lead service transformation/quality improvement, and find ways to bring their staff along with them

4.2 Some programmes will be mandatory including Induction, the Clinical Leaders programme for new clinical leaders, and mandatory management training for all managers. Other programmes will be offered to aspirant or existing leaders to support their development. These will form part of the appraisal and performance review process and will be evaluated to ensure assessment of return on investment.

4.3 We will develop and brand a new St George's "Leadership Academy" through which all of our leadership development programmes will be run ensuring there is a coherent and consistent approach. The Leadership Academy will undertake further training and development needs analyses, focus groups and reviews of appraisals and personal development plans so that we can design and provide relevant, timely and energizing development for our leaders. This will include regular seminars on leadership topics and accreditation of individuals once they have successful completed basic leadership and management training.

4.4 A Leadership Development Steering Group will oversee the implementation of this strategy.

4.5 In the first year (2017/2018) we will:

4.5.1 Develop the Trust's Leadership Academy, the branding supporting this and the governance to manage our leadership approach

4.5.2 Develop and implement specific leadership events for our priority groups: ward managers, clinical leaders and general managers

4.5.3 Implement mandatory management development training for all managers (new and existing) with a regular refresher programme

5. Dependencies and assumptions

5.1. Our high level assumptions are:

5.1.1 Our organisational structure with Clinical Divisions remains unchanged

5.1.2 Some additional budget is available (see section 7.2 below)

5.1.3 Additional Organisational Development and programme management support is available. This programme does not seek to address wider organisational development and cultural issues which will need to feature in a wider and comprehensive strategy

5.1.4 We take a phased approach (over two to three years)

5.1.5 Senior managers will provide support/buy in to prioritise, develop and release staff

5.1.6 London Leadership Academy resources will be available at nominal or no cost to the Trust

5.1.7 Opportunities to develop improvement capability will be available through a separate but related project.

5.2 The proposed leadership development programmes have been developed in line with roles/levels identified during 2016 as part of the workforce design 'Spans & Layers' project (our programmes can be seen in the Leadership Development Implementation Plan). The spans and layers project used an assessment of the 'time span horizons' for managers defining the maximum time period that a role is responsible for anticipating and planning. This is a key component of the design of the programmes. For the purpose of this strategy, we have used this initial modelling work to clarify our existing leadership layers.

6. Evaluation against the Critical Success Factors and Vision

6.1. We propose using two evaluation models:

- Kirkpatrick model[3]
- Key elements of the NHSI Culture and Outcomes Dashboard

6.2. We propose to use the Kirkpatrick Model to evaluate the impact of the development activities. This considers the value of any type of training, formal or informal, across four levels of increasing sophistication.

6.3. We will also use the NHSI Culture and Outcomes Dashboard to measure tangible outcomes as part of our workforce and leadership development performance dashboard. This links to aspects of the staff survey and the CQC Well-led domain including measuring our ROI (return on investment) from the development programmes.

7. Costs and options for resourcing

7.1. A programme of work of this scale will necessitate investment. We will seek to partially mitigate this by using existing skills and experience and collaborate with other organisations where we can. We will continue to use resources available from the London Leadership Academy for all NHS Trusts at nominal or no cost (e.g. NHS Healthcare Leadership Model, Coaching, Mentoring, and Facilitation resources).

7.2. The total cost of the leadership required over the next 3 years will be approximately £625k although in the first year a total budget of only £150k will be

[3] www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Mode

needed in additional to our current resource and to the costs of staff time required to attended events. The Trust have £75k for clinical leadership development from HEESL which can used to part fund this development and there are other external funding streams which we will seek to gain investment from to meet the remaining £75k.

7.3. It should also be noted that a 1% improvement in our turnover would save the Trust approximately £1,250,000 (Oxford Economics, 2014; Acas, 2014) due to the costs of recruitment, retraining and agency cover, or more conservatively, a direct cost of £200k[4]. The reduction in cost and improvement in tangible and intangible assets as a result of better leadership is hugely significant and outweighs the cost of investment.

8. Next steps

8.1. A Leadership Development Implementation Plan has been developed to outline the stream of work over the next 3 years and key priorities (see Appendix 1).

8.2. A Leadership Development Steering Group has recently been set up and this group will work with the Associate Director of Education and Development and her team to:

8.2.1 Establish the Leadership Academy and promote this throughout the organisation

8.2.2 Confirm the practical implementation and timings of the programmes

8.2.3 Confirm the outcomes/critical success factors and evaluation levels for each programme. The whole programme will be fully evaluated after 12 months

8.2.4 Firm up the detailed costs for each programme and ensure funding is available

8.2.5 Champion the new Leadership Academy and programmes across the Trust

[4] Based 1% reduction in turnover at the Trust and agency costs for 2 months of 50% of these staff needing immediate cover for their roles; not including losses in productivity and intangible costs such as loss of organisational memory

St George's University Hospitals NHS
NHS Foundation Trust

Appendix One: Leadership Development Implementation Plan

1. Introduction

Our Leadership Development Plan is designed to develop four key critical capabilities in our leaders:

- Compassionate, inclusive leadership skills
- Improvement skills
- Talent Management
- Systems leadership skills

In order to deliver the Leadership Development Strategy we will be providing a range of programmes, whilst also utilising a variety of development methods such as coaching, in depth leadership assessments, action learning, Quality Improvement Projects and team development.

Our high level programme plan with yearly milestones is on page 2 for reference.

- A more detailed plan for years 1 and 2 can be found in Section 1.
- Our roles and talent layers architecture can be found in Section 2.
- Roles mapped to the spans and layers analysis are shown in Section 3
- Our draft leadership development programmes can be found in Section 4.
- Our draft high level costs can be found in Section 5.

High level programme plan – yearly milestones

2. Leadership Development Architecture

We have summarised our leadership development architecture on one page. With over 8,000 staff, we need to prioritise and be very clear about the leadership development opportunities available to everyone. Priority groups will include Ward Managers, Clinical Leads, Clinical Directors and General Managers.

This directly links with our Leadership Development Programmes (Section 4) and our Roles and Talent layers in the organisation (Section 3).

3. Implementation Plan

We have developed a detailed implementation plan for years 1 and 2 (see Section 1) which is linked with our draft leadership development programmes plan. This will be led the Leadership Development Steering Group and monitored by the Workforce and Education Committee.

4. Draft costs

Draft high level costs of the programmes can be found in Section 5.

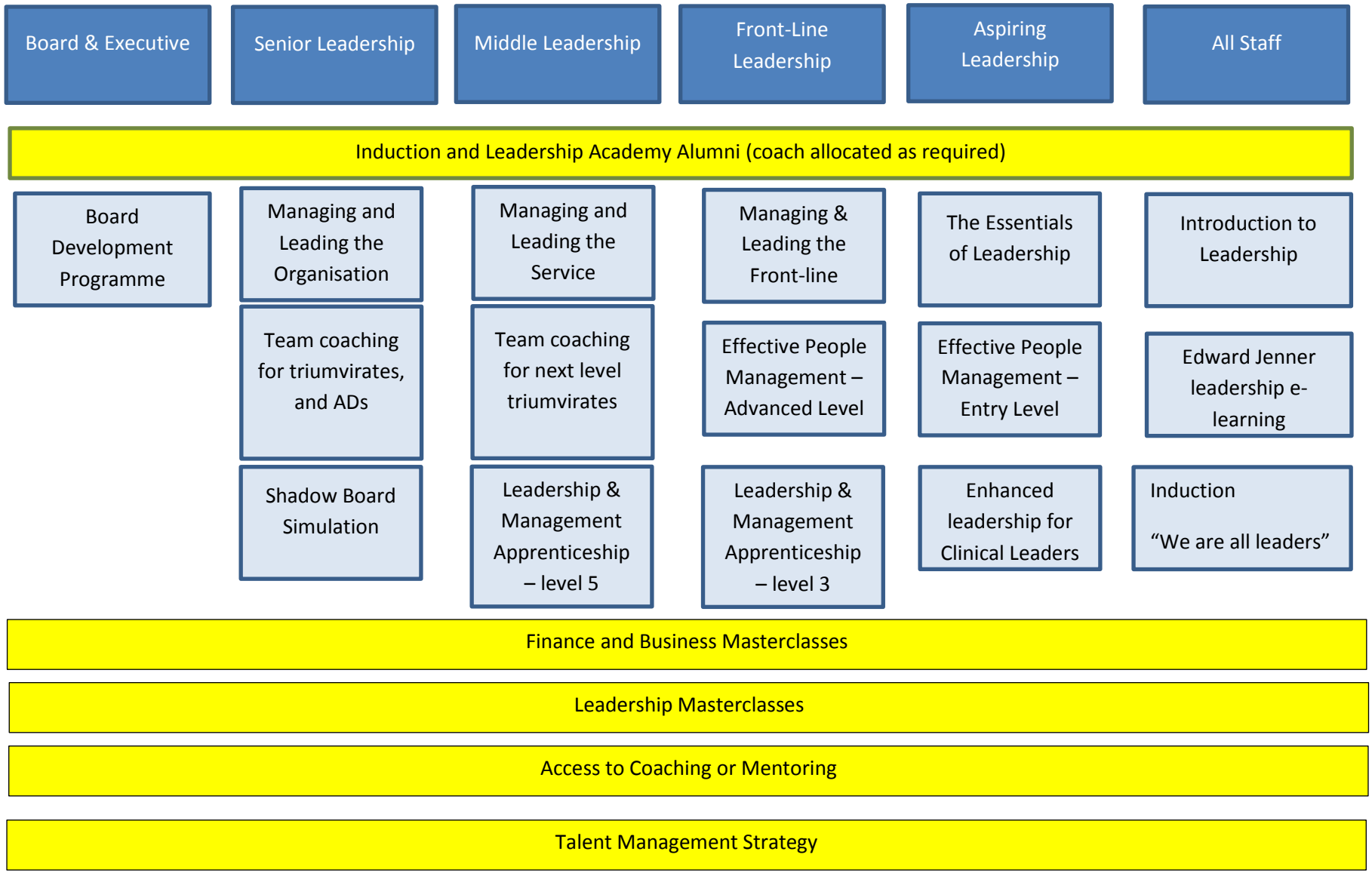
Section 1: Detailed Implementation Plan Years 1 & 2

	Aim/Objective	Task	Lead/involve	1.4.17	1.5.17	1.6.17	1.7.17	1.8.17	1.9.17	1.10.17	1.11.17	1.12.17	1.1.18	1.4.18	1.7.18	1.10.18
1	**Ensure leadership strategy has appropriate governance and stakeholder engagement to promote successful delivery**	Set up leadership strategy steering group	SJ/MH													
		Develop terms of reference for group and confirm critical success factors	SJ/MH													
		Develop detailed implementation plan and PID (project initiation document)	SJ/MH													
		Develop communications and stakeholder engagement plan	SJ/MH													
		Sign off of Project plan, PID communications and stakeholder engagement plan	Leadership steering group and WEC			**Or nearest date**										
2	**Develop appropriate architecture/structures to support successful delivery against strategy (i.e. Leadership Academy)**	Develop any outstanding content for programmes and interventions	SJ/MH													
		Develop branding and communication of the Leadership Academy	SJ/ CR													
		Develop delivery options	SJ/MH													
		Identify partners and suppliers	SJ/MH													
		Develop timetable for delivery	SJ/MH													
		Sign off of delivery options and associated costs	Leadership steering group and WEC													
		Implementation of timetable for delivery	SJ/MH and Leadership steering				**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**

			group													
	Aim/Objective	**Task**	**Lead/involve**	**1.4.17**	**1.5.17**	**1.6.17**	**1.7.17**	**1.8.17**	**1.9.17**	**1.10.17**	**1.11.17**	**1.12.17**	**1.1.18**	**1.4.18**	**1.7.18**	**1.10.18**
3	**Ensure existing leadership and management programmes are providing attendees with appropriate skills based on the requirements of their roles**	Develop methodology to evaluate current programmes	SJ/MH													
		Use methodology to gather data from previous attendees and others	SJ/MH													
		Develop evaluation report for consideration at leadership steering group and WEC	SJ/MH													
		Implement recommendations to current training provided and adapt any planned training as necessary	SJ/MH													
		Develop methodology to evaluate future programmes	SJ/MH							**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**
		Implement mandatory management training for all managers	SJ/ MH													
4	**Develop board commitment and understanding of Talent Management**		MH													
5	**Identify organisational objectives and priorities and convert these into talent related objectives**		MH													
6	**Establish demand for these roles develop appropriate intelligence/analytics to understand movements**		MH													
7	**Identify sources of talent**		MH													
8	**Conduct a talent review and gap analysis**		MH													
9	**Create plans for the development of talent and the overall HR proposition that leads to the attraction, retention and reward of talent**		MH													
10	**Gain executive and management agreement to talent**		MH													

	management approach															
11	**Gain the buy in of the workforce**		MH													
12	**Develop measures of effectiveness**		MH													
13	**Embed Talent Management approach**		MH													
14	**Evaluate Talent Management approach**		MH													

Section 2: Our Leadership Development Architecture



Section 3 Roles in leadership and talent layers showing characteristics, time horizons and approximate numbers

Layer	Positions in this layer	Layer Role	Characteristics	Time Horizon	Approx. Numbers	Suggested Development
Board and Executive	Trust Board	Constructing whole business	Develop/build organisations to meet social needs	10 years	12-20	Board Development
	CEO and Executive Directors (voting and non-voting)	Overseeing whole business	Manage groups of systems, positioning them in context of the external environment and corporate goals	5 years	10	Board Development
Senior Leadership	Divisional Chairs, Div Directors of Operations, Div Directors of Nursing, Associate Directors, Asst Directors	Integrating a whole business	Manage a whole system, handling wide range of internal and external variables	3 years	40-75	Managing and Leading the Organisation
Middle Leadership	Divisional Managers, Clinical Directors, Heads of Nursing, Heads of Departments	Functional Manager	Indirect management of several parallel, interacting operational areas, balancing and trading off resources	2 years	200	Managing and Leading the Service
	Assistant DMs, Service Managers, Matrons, Care Group Leads	Operational Manager	Selecting alternatives, balancing short and long-term objectives. Includes senior professional work	1 year	400	Managing and Leading the Service
Front-line leadership	Consultants, Ward Managers, Team Leaders, Assistant Service Managers, Supervisors	First level management	Some interpretation required, accumulation of data to solve problems. Includes much professional work.	3 months	1700	Managing and Leading the Front Line
	SpRs, Band 6 nurses, Band 6/7 Therapists	Senior Employee	Some interpretation required, accumulation of data to solve problems. Includes much professional work.	3 months	1200	-Essentials of Leadership + Effective People Management - Enhanced Leadership for Clinical Leaders (Aspiring consultants/ward managers)
All staff	Nurses, therapists, Drs in Training, receptionists, secretaries, porters	Employee	Highly procedural, limited independent judgement.		4800	Induction Edward Jenner e-learning Introduction to Leadership

Time Horizon = defining the maximum time period that a role is responsible for anticipating and planning.

Section 4 Draft leadership development programme outline with indicative costs and evaluation processes (CSFs to be inserted once finalised with the LD steering group)

Programme	Who for	Content	Duration	Status	Provision	Evaluation level	Approx no	Cost
Induction	All staff	'We are all leaders' 5 minutes by Exec lead with 3 key messages based on distributive/collective leadership.	Part of induction	Under dev	In house (Execs and educ team)	**Level 1 evaluation** (reaction only)	3000 per year	No direct cost
Introduction to Leadership	Staff group: Staff members who would like to get a basic understanding of leadership and management. Attendees should have very little if any prior experience or knowledge of leadership and management.	• Management roles and responsibilities • Management and leadership behaviours • Your motivations, values, strengths and talents • Selection and interview process • Communication in a managerial context • Introduction to team development and management	1 day	In place	In house (Education team)	**Level 1 evaluation** (reaction only) Link with PDR and career development conversations Track staff movements	TBC out of an est. cohort of 4800 staff	No direct cost Opportunity costs - Internal resource 8a
Essentials of Leadership & Effective People Management	Staff group : 'senior employee' Staff members who are committed to or have recently moved into an entry level leader /	Day 1 & 2 • Leadership styles • Neuroscience of leadership • Managing conflict and challenging situation • Explore strengths • High performance teams	4 days	In place	In house (Education team and HR) 1 cohort per month (16 in	**Level 2 evaluation** pre course self - assessment of knowledge and skills, reaction to training, post course self-assessment of	TBC out of a cohort of est. 1200	No direct cost Opportunity costs – internal resource 8a

	management role Staff members who want to develop their leadership and management knowledge and behaviours and who have a basic understanding of leadership and management	• Implementing change Day 3 & 4 Effective people management entry level • PDR/Appraisals • Performance Management • Equality & Diversity • Recruitment and Selection • Harassment & Bullying • Sickness and Disability			cohort)	knowledge and skills (reflective practice) Part of PDR process		Redesign cost £4k
Enhanced Leadership for Clinical Leaders	Staff group : Aspiring consultants/ward managers Staff members that are currently working in an entry level leader / management role and would like build on their current level of expertise Attendees are likely to be those in a position of leadership, though not necessary in a formal management	The NHS Big Picture - how the money works, current challenges, future developments, STPs - Influencing without authority -Tactful assertiveness - how to challenge people without damaging the relationship - Understanding, and getting the best out of, different personalities - Insights into how you come across to others - Team development and management	3 days	In place	External facilitator	**Level 2 evaluation** pre course self assessment of knowledge and skills, reaction to training, post course self assessment of knowledge and skills	TBC out of a cohort of est. 1200	£4000 per cohort

	role							
Managing and Leading the Front Line	Staff group: Front-line leaders Staff members who are accountable to a senior manager/professional, for a group of staff within the organisation. Frontline leaders are likely to be competent leaders that would like to build on their existing leadership and management skills. Attendees will learn how to translate strategy into effective leadership on the frontline.	-Business Planning/STP -Understanding Ops management -Professional Standards of Management -IG -Leading with impact and authority -Strength Scope -Dr's in training -How services generates income for the Trust -The implications of 'Payment By Results' for clinical practice -Managing Change **Senior Effective People Management:** PDR/Appraisals Performance Management Equality & Diversity Recruitment and Selection Harassment & Bullying Sickness and Disability Legal and Complaints Team development and management	TBC	In develop-ment	In house & external facilitators	**Level 3 evaluation** – pre course self assessment of knowledge and skills, pre course leadership 360, reaction to training, post course self assessment of knowledge and skills, 6 month post course leadership 360, plus a Service Improvement Project and reflection in Action Learning Sets.	**A cohort** of est 1600 Ward managers, & new consultants will be prioritised	£6000 per cohort Redesign cost £4k
Managing and Leading the Service	Staff group : Middle Leadership For senior leaders who work across the across boundaries with diverse groups of people, patients,	This programme will include the mandatory management training required of all new and existing managers and will include, inter alia, how to engage with staff, manage teams, communicate effectively	TBC	In develop-ment	In house & external facilitators	**Level 4 evaluation** – pre course leadership 360, reaction to training, 6 month post course	Out of a cohort of est. 600	£6000 per cohort

	citizens and staff. For those working in a system and, at the same time, acting as a change agent within that system to improve its overall performance, focused on improving the health of the population and providing treatment and care to all who need it.					leadership 360, a Service Improvement Project and analysis of metrics within their span.		
Managing & Leading the Organisation	Staff group : Senior leadership Senior clinical and non-clinical leaders who are responsible for leading the organisation and/or services within it e.g. at divisional level For those that would like to maximise their personal leadership power to drive services forward, achieve results and develop	TBC – under development – may include : • Individual Effectiveness - focus on the effectiveness and resilience of the individual and their role in the organisation and the system. Aims to develop new behaviours and ways of working that promote a collaborative approach. • Relationships and Connectivity - Creating the right kind of relationships with communities and partners; people coming together for a purpose; place based, system/service or pathway led and aiming to develop consistency of approach or to tackle complex issues collectively. • Innovation and Improvement - creating new ways of thinking, experimentation and discovery and the application of improvement methodologies, testing and learning, spreading and adopting better ways of doing things. • Learning and Capacity Building - Creating	TBC	OD work started	In house & external facilitators	**Level 4** through the measurement of improvements in metrics within the services	40 - 75 inc corporates	£1200 per day Design cost, facilitation, follow up

	others	a learning system and a culture of transparency and sharing, enabling the awareness of best practice and development of common understanding. Being inclusive and seeking contributions from all stakeholders including citizens and communities. Building diverse teams and inclusive cultures to enable greater understanding **Possible delivery options** • Wider leadership cadre to include all divisional team members including HR, Finance and key leadership roles such as Chief Pharmacist • 4 Divisional teams to work in their teams using Action Learning Set principles so that they can tackle live issues together with a facilitator • 121 coaching and mentoring would be ideal for the Div Chairs as a minimum and group coaching/mentoring for DDOs and DNs • all 4 teams to work together to build learning and cross-divisional working, facilitated every 3 months • Psychometrics – MBTI, Belbin or other tools could be used to identify preferred leadership styles and behaviours. The key is to build a common language and understanding of each other.						
Executive and Board Development	Board (Chair, NEDs and Executive Directors)	TBC – as new Board members are being recruited	TBC	TBC	Likely to be external facilitators	**Level 4** - measurement of metrics improvements within services	12-20	TBC

Section 5: Draft Costs over period of the programme

	Approximate Numbers	Capacity per programme	Number of programmes required	Indicative cost (£)	Cost per head (£)
Trust Board	20	OD as required		tbc	
CEO & Executive Directors	10	OD as required		tbc	
Triumverates, ADs	60	OD as required		20,000	333
DMs, CDs, HoNs, Heads	200	15	14	84,000	420
ADMs, Service Managers, Matron, Care Group Leads, Department Managers	400	30	14	84,000	210
Front Line Leaders/Managers	1600	30	53	320,000	200
Team Leaders	1140	15	76	(Band 8a) 68,000	180[1]
Employees	5000		Induction Free e-learning (Edward Jenner) Introduction to Leadership	(Band 6) 48,000	10
Estimated Total	**8430**			**£624,000**	

[1] Assuming 3 year delivery programme

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	4 May 2017	**Agenda No**	**5.1**
Report Title:	Corporate Risk Report		
Lead Director/ Manager:	Paul Linehan		
Report Author:	Maria Prete		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	1) Core operational risk exposure areas: • Timely Access to Clinical Services/Patient Harm • Insufficient Resilience/Unstable Critical IT/Estates Infrastructure • Unsustainable Financial Position • Inadequate Governance/Reputation Loss 2) Proceedings of the Risk Management Committee on 12/04/2017 highlighting the discussions and decision taken at RMC.		
Recommendation:	I. The Board are invited to consider the CRR and: II. Work through each decision point highlighted in this report III. Where the Board are not satisfied, to agree further actions required to bring the risks under prudent controls; and IV. Consider the extent to which the Board's appetite for taking risks is adopted or if changes are needed to achieve prudent control.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe / Well-led.		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive). Leadership and Improvement Capability (well-led).		
Implications			
Risk:	These risks could have a direct bearing on requirements within NHSI's Single Oversight Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective.		
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:	There are no specific resource implications		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	N/A		
Appendices:	A. Risk Grading Matrix / Risk Escalation Arrangements (illustrated) B. Table 1: Core Operational Risk Drivers – April 2017 Full Corporate Risk Register is available in the reading room for reference		

Corporate Risk Report
Trust Board, 4 May 2017

1.0 PURPOSE

1.1 To highlight key risks and provide assurance regarding their management.

2.0 BACKGROUND OR CONTEXT

2.1 The Corporate Risk Register (CRR) has been kept under review with input from the Executive during April 2017

2.2 The CRR continues to be developed and reassessed accordingly. It is anticipated that review will be continuous in order to ensure the profile of risk presented to the Committee is relevant and always up to date.

2.3 Training continues to be rolled out to support and assist risk register gatekeepers at divisional and corporate levels. This will allow efficient analysis, better oversight and enhanced risk escalation arrangements.

2.4 It is anticipated that the CRR will evolve as further analysis, challenge and development of the risk profile progresses; and our understanding of uncertainty facing the Committee's strategy emerges.

3.0 ISSUE

3.1 Core Operational Risk

The understanding of corporate risk is evolving rapidly as the Executive identify and address uncertainty ahead. A range of significant/extreme operational risks have been identified and are currently being mitigated. These risks could have a direct bearing on requirements within NHSI's Single Oversight Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. Figure 1 illustrates using a driver diagram the primary cause, effect and potential impact of core operational risks currently on the CRR. The Board remains exposed to extreme risk in the following areas:

- Timely Access to Clinical Services/Patient Harm
- Insufficient Resilience/Unstable Critical IT/Estates Infrastructure
- Unsustainable Financial Position
- Inadequate Governance/Reputation Loss

3.2 Proceedings of the Risk Management Committee

The Risk Management Committee met on the 12th April 2017 to review the corporate risk register and to review in more detail reportable the flowing two risks:

- 'CRR-1143 - Recognising, escalating and responding to the signs of deterioration' (5x4=20). The committee acknowledged that progress has been made to mitigate this risk; however more work is required to strengthen processes within the Emergency Department and Richmond ward. An update on the work will be presented to the July RMC

- 'CRR-1228 - Insufficient Cost Improvement /Transformation Programme in 2017/18' is a new risk .The committee recognised that there is need for more engagement from several departments in order to manage/mitigate this risk.

The Committee was given an update on the UPS/IPS work. The work was completed on 19.04.2017

Internal Audit review on of the Governance Corporate Risks gave an overall reasonable assurance.

Overdue Safety Alert: DH/2014/003 – Reminder for the testing of fire & smoke dampers and ensuring the integrity of fire stopping. The committee was advised of the work done to map all the smoke dampers within the Trust. The work is expected to be completed in the next six weeks

There continues to be inconsistency of the industrial injuries figures reported on ESR and incident reporting. Update on the possible mitigation will be brought back to RMC.

4.0 IMPLICATIONS

Legal Regulatory

4.1 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

5.0 DECISION POINTS

The Board to consider:

(i) Is the Board satisfied that it has sufficient visibility of material risk exposures?
(ii) Is the Board satisfied that the control frameworks for mitigating those material risks are sufficiently understood and complied with by management?

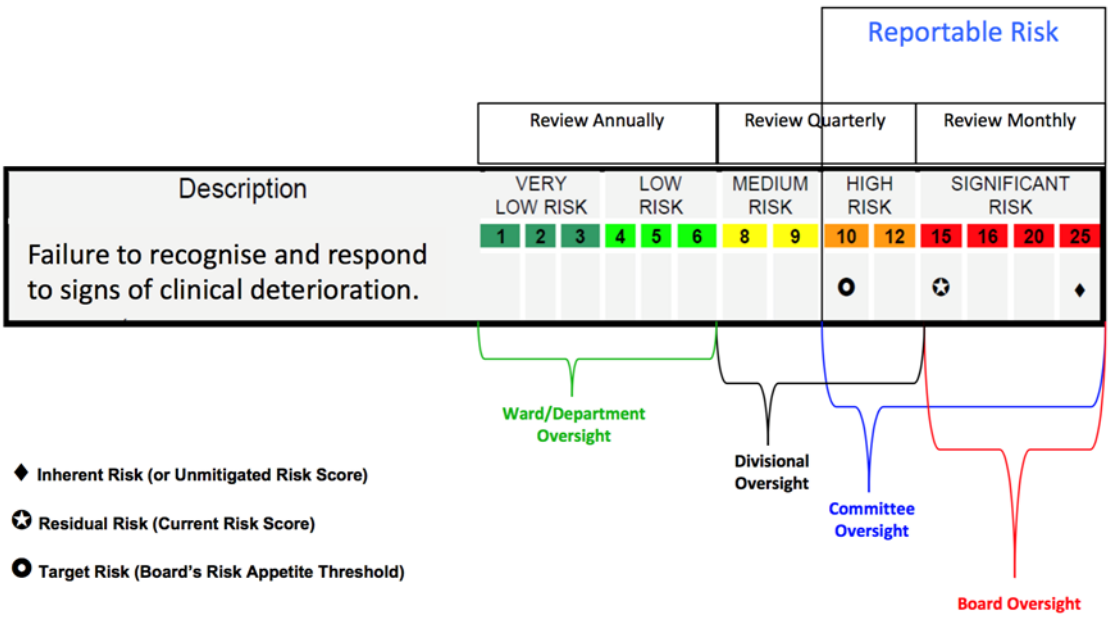
Author: Maria Prete
Date: 28/04/2017

APPENDIX [A]

[Guidance: Risk Grading Matrix]

SEVERITY MARKERS		LIKELIHOOD MARKERS*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more CSUs; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more CSUs; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	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	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

[Guidance: Risk Escalation Arrangement (illustrated)]



APPENDIX [B]

[Table 1: Core Operational Risk Drivers – April 2017]

PRIMARY CAUSE	RATING	IN MONTH CHANGES	EFFECT	POTENTIAL IMPACT 16/17
Increasing 18-Week RTT backlog with potential for clinical harm	20	⇔	Timely Access to Clinical Services / Patient Harm	Continuity of Clinical Services Material Breach of Licence Conditions Integrity of CQC Certificate of Registration
Below target 2-week wait performance	16	⇔		
Below target 62-day cancer performance	15	⇔		
Failure to arrange follow-up appointments or treatments (where clinically required)	16	⇔		
Below target ED 4-hour performance	20	⇔		
Recognising, escalating and responding to the sign of deteriorating patient	20	⇔		
Unsuitable environment of care (Renal Unit, Lanesborough OPD) – risk of premises closure, prosecution, fire	16	⇔	Insufficient Resilience / Unstable critical IT and Estates Infrastructure	
Potential unplanned closure of premises / non-compliance with estates or Fire legislation	20	⇔		
Bacterial contamination of water supply (Legionella, Pseudomonas)	20	⇔		
Inability to address backlog maintenance requirements	20	⇔		
IT storage: unrecoverable IT system downtime (affecting critical clinical, web and email systems)	25	⇔		
Vulnerability to computer virus or attack	20	⇔		
Inability to renew and repair clinical areas due to high bed occupancy and no decant options	20	⇔		
Insufficient CIP delivery in 2016/17	20	⇔	Unsustainable Financial Position in 2016/17 and beyond	
Insufficient cash to meet payment demand	20	⇔		
Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressures	20	⇔		
Potential loss of income due to bidding for newly tendered services being unsuccessful	15	⇔		
Inability to control agency staffing and associated staffing costs	20	⇔		
Risk of failure to deliver the financial control total	20	⇔		
Inability to meet regulatory requirements due to financial system and process failure	16	⇔		
Achieving a Good or Outstanding rating with CQC by 2019	20	⇔	Inadequate Governance / Reputation Loss	
Failure to recognise, communicate and act on abnormal clinical findings	16	⇔		
Fragmented electronic and manual patient records	20	⇔		
Unsustainable levels of staff turnover	15	⇔		
Insufficient management capacity or capability to deliver turnaround programme in 2017/18	20	NEW		
Failure to secure colleague engagement	20	⇔		
Inadequate data quality, completeness or consistency	25	⇔		
↑ = Risk Increase; ↓ Risk reduced; ⇔ No change from previous report to Board.				

Corporate Risk Register - April 2017

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Progress on Action	Actions Due date	Last updated
CRR-0005	Insufficient cash to meet payment demands	01/06/2016	Flanagan, Robert	There is a significant risk that the Trust will have insufficient funds to meet payment demands. The risk has emerged because i) the trust is trading at a deficit ii) unplanned income volatility cannot be managed through timely reduction in related expenditure iii) shortages of key staff groups lead to higher agency premium spend worsening the financial position iv) the trust is struggling to deliver the cost efficiencies planned v) the Trust is struggling to collect debts due to data quality and systems/process issues vi) the trust has failed to secure STFF £17.6m due to adverse performance and I&E	20	5. Catastrophic	4. Likely	20	Extreme	Short term cash flow forecast (STCFF) prepared on a weekly basis - detailed forecast daily Capex approved, monitored and challenged through Investment and Divestment Group (IDDG) Recovery plans developed to minimise deficit Monthly divisional performance meetings to understand and challenge I&E, forecast and recovery plans Targeted collection of aged debts demand and capacity model to understand capacity impacts on ability to deliver income as per plan / forecast, in first draft and tested Close relationship with NHSi relationship partner to monitor performance and requirements for funding are being met Board level committees challenging divisions on recovery plans, investments, divestments Board level committees monitoring cash position and forecast demands on cash. Board level support to secure maintenance funding and loan facility sent letter to NHSI forecast for 34.1m which compare to a budget of 38.4m. Within 34.1m is 3m of emergency infrastructure expenditure Monitor impact of recovery on September and October financials and consider impact on forecast position Working through CQC report plan PMO collates and facilitates production of CIPs Committee at purchase order level to review every week by director of Finance Operation , Director of Estates and Director of Information. Outcome 34.1m capital spent by end March 2017 including 3m emergency infrastructure	Systems and process weaknesses impact the ability of the Trust to accurately capture and report relevant information The trust continues to trade at a deficit with an increasing trend in actual pay costs and income under plan. The cost improvement programme at M9 has a PMO risk assessed full year forecast of £24m of the £50m target. Revers of the increase payment terms from 60 days to 30 days - half still at 60 days M9 increased forecast deficit to 80.7m from 54.5m. Removed 20m headroom contingency £39memergency infrastructure fund request submitted (spending at risk) PMO work not completed	Variable assurance provided by NHSI that the loan will be forthcoming Track record of requesting less work capital facilities from NHSI on a monthly basis than forecasted. Deviation from forecast not material	Emergency infrastructure and costs/capital required to address the impact are still estimates ITFF loan application for funds required to meet the cash requirements of the trust is underway Trust is spending at risk against the £39m backlog maintenance funding request	Director of Finance Operations to write proposition to improve financial systems for next F&P Improve departmental processes to ensure robust cash collection and capture of income Complete process of review decision to revoke the increase supplier payment terms to 60 days, back to 30 days	half of the companies have been changed	28/02/2017 31/03/2017 28/02/2017	Vanessa Davies 01/03/2017 11:33:57
CRR-0015	Lack of access to capital to			The Trust faces higher than						Enhanced monthly divisional	Workforce and financial plans do	Monthly financial reporting of		Implementation of	Ongoing. Target savings will not		Tak Pang

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	address in-year IT, Estates and equipment replacement cost pressure	20/07/2015	Flanagan, Robert	expected costs due to:- unforeseen service pressures loss of SRG and Education funding, with related costs not being removed impairment of assets Underinvestment in prior years resulting in urgent work to address backlog maintenance, stabilise the IT infrastructure, implement improvements required by the CQC and address RTT data quality issues The trust needs to adapt to changes in service/funding arrangements, for example the loss of funding in specific areas such as SRG schemes and Education. There is a high risk that unfunded resource will be required to support capacity and delivery. Unforeseen impairment of assets may have a negative impact on I&E Premium costs related to the supply of scarce resources eg cost of agency nurses due to nursing staff shortages – risk that these costs will not be appropriately monitored and controlled	16	4. Major	5. Almost Certain	20	Extreme	performance meetings Business Planning Process and Business planning steering group - the expected impact of cost pressures on financial performance is considered and robust provisions are made for future increases in cost in line with high level Guidance from NSHI. IDDG has assumed role of managing cost pressures Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover EMT and Business Planning Steering Group oversight of the business planning process. Monitoring of cost pressures in-year through the financial reporting regime. New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee. Vacancy control panel Costs are based on data from robust historical costing systems including PLICS and Reference Costs which have been calculated in line with national guidance. Necessary additional I&E investments to be met by an increase in divisional CIP Impairment risk monitored by F&P and external accounting guidance sought Reduced use of external capacity by better capacity planning and management of internal resources. Transformation programmes have identified controls to mitigate premium agency spend Detailed Agency expenditure tracking and redevelopment of headcount tracker Weekly monitoring of headcount tracker by Executives Development of transformation savings schemes	not explicitly reflect the level and premium costs of agency staffing	performance to the Board Identification and review of cost pressures through the Business Planning cost pressure review process. Divisional monthly performance review meetings		transformation savings schemes Design and implementation of operational levels to reduce deficit	be achieved for 16/17.	30/09/2016 31/08/2016	01/03/2017 16:52:59
CRR-0027	Risk of failure to deliver the financial control total	01/10/2016	agan, Robert	The Trust is unable to deliver activity within the tariff set by NHSE and NHSI. In consequence, the Trust cannot deliver its financial control total.	20	atastrophic	4. Likely	20	Extreme	Analysis and quantification of the drivers of deficit at care group level including premium workforce costs implementation of practical, realistic and deliverable plans to eliminate the drivers of deficit ensuring that contracted activity volumes can and are delivered within the tariff available	Identification of cost drivers does not enable reduction in costs Plans are impacted by issues with the Estates		Although activity can be agreed, costs to deliver the activity are subject to wider market pressures. In addition, further lack of assurance exists due to the trust not delivering its control total over the past two years.				Tak Pang 01/03/2017 16:01:59

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Progress on Action	Actions Due date	Last updated
		11	Flan			5. C				the tariff available	CIP have not delivered						
										Monthly divisional performance meetings to understand and challenge I&E, forecast and recovery plans	System weaknesses expose the Trust to challenges and payment is not received						
										Investment into Turnaround and development/delivery of Cost Improvement plans							
CRR-0028	Inability to meet regulatory requirements due to financial system and process failure	11/10/2016	Flanagan, Robert	There is a significant risk that the Trusts current financial systems and processes are not sufficient enough to meet statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers.	16	4. Major	4. Likely	16	Extreme	The finance function carries out a number of processes to ensure that the trust:	Systems and process weaknesses limit the effectiveness of the processes to accurately capture and report relevant information.	The trust has been audited both internally and externally. Significant regulatory breaches were not reported.	Although no material issues have emerged to date, failure to resolve significant issues leaves the trust exposed to future issues.	Procurement workplan to address process issues across trust and within procurement to be implemented		30/11/2016	Vanessa Davies 13/02/2017 09:32:40
										i) produces robust financial data to enable regulatory reporting (statutory and NHS)	i) Receivables are significantly overdue	No significant contractual or legal challenges have been raised by the trust suppliers					
										ii) identifies fraud and misappropriation of trust resources through control accounts, segregation of duties and approval hierarchy	ii) A significant level of debt is written off as irrecoverable from NHS, private patrients and overseas patients.			Data quality action plan to be implemented		30/11/2016	
										iii) budgets for, reports and forecasts financial position on a regular basis	iii) Insufficient provisions on the balance sheet expose the I&E	No significant contractual or legal challenges have been raised by the trust employees					
										iv) collects debts and makes appropriate payments	iv) Data quality is poor and not all activity is captured						
										v) trains, appraises, performance manages and supports staff as they carry out duties	v) Cost improvement plans are not delivering as planned	No material fraud has been identified					
										vi) Procures goods and services following required Procurement regulations	vi) Demand and capacity modelling is not clearly linked to infrastructure maintenance and activity forecast						
											vii) Trust staff do not comply with required Procurement processes						
											vii)Post Project Evaluations are not always carried out post investment in approved business cases						
CRR-0013	Vulnerability to computer virus or attack 'Ransom ware'	07/04/2016	Murphy, Larry	A large increase in the computer malware known as "Ransom ware" is affecting Trust computer data. There is a high risk that data that has been affected will be lost if the affected files are not identified and restored within a short time frame	20	4. Major	5. Almost Certain	20	Extreme	NHS N3 gateway anti malware software Local Websense anti malware software	Ransom ware infections continue to be reported	ICT systems team restoring identified corrupt files from back-ups.	New ransomware is created daily - the Trust is vulnerable until security patch has been created by vendor and successfully rolled out over estate	Creation of Standard Operation Procedure for Escalation of ICT Incidents		31/03/2017	Vanessa Davies 28/02/2017 14:07:36
										Local Anti-virus software	Project underway to replace xp machines	Minimal data loss reported					
										Regular and repeated user education and communication	Unproven / out of data ICT Business Continuity plan testing		Awaiting procurement of Snow (software management system) to govern ICT estate	test back up solution		28/04/2017	
										Firewall updates have been applied		Regular reports (XP Replacement project, security patching, anti-virus management, change control board) to be tabled at meetings (ICT Management tean, IG Committee)					
										Supplier informed and anti-malware suite security controls increased.	Full back-up solution - full coverage expected in Mar. 2017.						
										Continuous monitoring of reported infections.							
										Replacing more vulnerable XP machines (more prone to infection)							
CRR-0009	IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems			A failure to maintain and invest in the IT infrastructure for a lengthy period (7+ years) caused by a lack of funding in IT has resulted in an 'end of life' infrastructure that is likely to fail and result in catastrophic implication for the Trust in terms of corporate and clinical systems failures.						On-going monitoring of infrastructure.	All issues yet to be exposed.	Some improvement in resilient and storage.	Not all issues have been uncovered	Complete and test the deployment of the full back up solution		31/03/2017	Vanessa Davies 27/02/2017 15:52:23
										Program of work in place to eliminate specific areas of risk							
										Procured two new back up facilities. Email back-up solution now completed and working.							

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Progress on Action	Actions Due date	Last updated
		25/07/2016	Murphy, Larry	The specific areas of risk within the infrastructure are; •Data backup facility outdated and unreliable •IT data storage capacity at limit, high risk to operational viability of the Trust •Computer hardware in clinical areas slow, old and unreliable •High numbers of XP computers in IT estate. Core Trust systems will not be able to be accessed from XP PCs from December 2016	20	5. Catastrophic	5. Almost Certain	25	Extreme	Tactical data storage has been procured and deployed. XP Replacement Project underway with 362 machines replaced to date (07/12/2016) Quarterly Board updates on the ICT Stabilisation and Recovery Programme. Weekly Project progress meetings and Fortnightly Project Board meetings Reporting the progress and exposure, quarterly, to the Information Governance Committee Service desk statistic analysis reporting (Heat Portal) for individuals back-up storage files. On-going Capacity Management to monitor usage On-going maintenance of Network hardware and configuration and manage change undertaken by the IT Opertions Team Deployment of long-term storage facilities has been completed Table-top exercise has been completed	Full back-up solution procured and to be deployed; full coverage expected in March 2017. XP Replacement Project delivery slower than anticipated due to the uncovering of unknown systems and ownership. Lack of detection and asset management software (used to indentify hardware/software conponenets) Testing of the business continuity plan and full disaster recovery	Fewer service desk calls relating to historical issues.	Still not fully resilient and have many single points of failure	Complete the XP Replacement project Test Disaster Recovery Solution implement detection and asset management software		30/06/2017 14/04/2017 31/03/2017	
CRR-1179	Failure to come out of special measures by the next CQC inspection	09/01/2017	Linehan, Paul	The risk the Trust fails to achieve a good or outstanding rating with CQC by 2019. This caused by insufficient QIP delivery, a further deterioration in standards of care. This may result in further regulatory intervention.	15	5. Catastrophic	4. Likely	20	Extreme	Quality improvement plan develped to programme manage all actions identified in CQC inspection prep programme and CQC report findings Director of Quality Governance to lead QIP work and QIP PMO in place Quality Observatory (overaching care audit) looked at across the Trust to promote great visibility and reporting against 5 domains and associated Standards Thematic Back to the florr weekly visits reports to Patient Safety Quality Board / Quality Committee / Trust Board	Lack of robust compliance framework in order to ensure Quality Assurance of services across all services and divisions Refinement of Quality metrics to monitor performance		CQC formal report received- significant issues with estates, IT infrastructure and risk management	Review of Quality Metrics		28/04/2017	Vanessa Davies 05/04/2017 09:42:05
CRR-1180	Potential loss of income due to bidding for newly tendered services being unsuccessful	/06/2014	casa*, Alison	Activity and associated income/contribution will potentially be lost due to:• Service Line Tenders in Q4 2015/16.e.g. Impact on contract from Q3 2017/18. The values are : HV £5.7m, ISHS £6.4m,& CAHS £14.7m potential overall profit loss £6m.potential overall loss of contribution (20%) £5m. Jan 2017 EMT decision not to respond to Invitation to Tender (ITT) for integrated sexual health services.	12	. Major	. Likely	16	Extreme	Deliver services in line with commissioner requirements in advance of any service lines being tendered. This will ensure CSD is well placed to win any tender. For eg, the development and implementation of Communithy Adult Health Services (CAHS) with Wandsworth CCG.Divisional decision made not to bid for RSH services in Wandsworth due to undeliverables in specification Annual business plan for the division clearly programmes tender work and	Time constraint means developing deliverable specifications with commisioners and clinical leads for services that will be tendered are difficult to develop. No trust lead in commercial	CSD services being delivered to commisioner expectations and joint working with commissioners in place where appropriate - eg development of CAHS, outcomes frameworks for CAHS and LD, provision of data for ISHS services etc	Unknown Pre Qualification Questions (PQQ) and tender specification. Lack of benchmarking data	to progress the tender bid for Health visiting in readiness for sept 2017.		01/08/2017	Maria Prete* 23/02/2017 12:35:18

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		12/	Benino			4	4		E	business developments associated with these	function or business development identified to support - so process reliant on CSD leadership team.						
										Strong working relationships with all current commissioners and work together collaboratively.		KPI/ CQUINs / LDIP= currently Green and monitored at DMT monthly					
										February 2017 staff briefing commenced. Staff informed of decision not to progess with Invitatiokn to Tender (ITT) for Integrated Sexual Health Services	Limited expertise in tender writing.		Potential instability in the workforce due to decision not to progress with ITT	Risk assessment to be understand the impact on service provision as a result of any decision relating to not to respond to the tender process/ loss of contract.		28/04/2017	
CRR-0025	Unsustainable levels of staff turnover	01/10/2015	Gammage, Mark	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost. NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing) and most recently this has been increasing at St. George's. The impact is particularly significant in relation to band 5 nurses, where there is a very high volume of recruitment and in some specialist areas such as oncology, paediatrics and theatres. We are reporting staffing fill of 90%~+ in Safe Staffing reports but the difficulties in staffing create pressures in terms of being able to deliver their services Larger financial expenditure as agency therapists and Locum Agency Doctors.	12	5. Catastrophic	3. Possible	15	Extreme	There is a workforce priority plan which has an underpinning action plan. Aproved by the Board in Sept 2016	low level of engagement from managers with their staff		11% target voluntary turnover possibly not reflective of current workforce trends	Implementation of workforce plan		29/12/2017	Maria Prete* 03/04/2017 16:18:25
										The workforce and education committee meets bi-monthly, supports the delivery of the plan and monitors its milestones.							
										There is a concise monthly workforce information report to the board that identifies key trends against the workforce key performance indicators including turnover, vacancy rate and bank and agency usage. The report includes detail of bank fill rates and it will also take a monthly focus on key issues on recruitment							
										The monthly quality report to the board includes detail regarding the nursing workforce including a tracker of SAFE nursing staffing compliance and of staffing alerts that have been reported			External political & economical environment impacting on implementation of workforce plan				
										A medical workforce group meets every tuesday led by the Medical Director. This group will report to the workforce and education committee							
										Executive team reviews SIP headcount number weekly							
CRR-0022	Insufficient management capacity or capability to deliver turnaround programme	01/10/2015	Gammage, Mark	Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual. There is a risk to both effective engagement and support of the turnaround programme delivery where management capacity is insufficient to support the programme whilst delivering business as usual. Similarly, a risk to service delivery may arise if core business is not prioritised appropriately	15	4. Major	5. Almost Certain	20	Extreme	Programme management approach to the requirements of turnaround.	Patchy cascading of information and briefing to all staff	increase in partecipation	Cultural changes will take time	Explore mandate team brief with Comms and EDs to be presented to EMT	Comms to send out monthly team updates to divisional teams and senior leaders distribuition list from the 21st of November 30/01/2012 - Discussion with Comms on-going	30/06/2017	Maria Prete* 03/04/2017 16:18:30
										Regular staff and senior team leader briefings							
										Communication messages sent out are designed to be honest in order to engage staff							
										Clarity to reassure staff around financial position of trust and believe they can contribute to recovery	contingency plan not completed			additional strategy Leadership paper to be presented to Trust Board in April 2017. Outlining plan to develop capability of clinical and general managers	Leadership paper presented to Trust Board in January 2017 Trust Board additional strategy paper to go out in March 2017 Trust Board additional strategy paper to go out in April		
										Expanded Friends & Family test to assess staff quarterly							
										Management skills compulsory for all new starter with management posts		Staff Survey 2016 shows 3.62/5 staff would recommend working /cared for at SGH					

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										Management induction programmes and leadership development. Programmes provided at a number of levels						28/04/2017	
										Use of interim to support management actions	No monitoring of cascaded information or effectiveness of it						
										Plan at Executive Level to replace executives							
										Appointment of Director of Improvement to lead on improvements							
CRR-0014	Failure to secure colleague engagement	01/04/2016	Gammage, Mark	Enhanced risk of disengagement of staff due to changes within senior management team & a potential lack of corporate memory with interim senior team Prolonged risk of inability to effectively enagate the senior management team	20	5. Catastrophic	4. Likely	20	Extreme	Delivery of HR priorities plan with focus on: right staff, right time, right place, right skills	Limited ability to influence or mitigate external factors including; London wide issues of staff turnover, turnaround and financial position	Progress against workforce CIP	Difficult to ascertain level of management engagement	Implementation of actions as a result of staff survey		30/04/2017	Maria Prete* 03/04/2017 15:59:51
										Support from staff side representatives and governors in engaging staff (SNAG)							
										Listening into Action	Levels of disengagement amongst managers makes it difficult to effectively deliver the programme						
										Chair and CEO Exec briefings and Team briefings (monthly)							
										Additional quarterly survey - 'temperature check'	Difficulties in Managers to hold consistent team meeting ensuring staff are kept informed						
										Monthly team briefings			Negative Staff survey results and medical engagement score				
										Appointment of Chairman and Chief Executive	No clear understanding of management role (when and what)			Review bullying and harassment training package. Training package finalised, Implement training		30/05/2017	
										Appointed to all NED positions and the individuals are in post							
										Secured aTrust board secretary	Appointment of Director of Finance, COO and HRD on the way			Raise awareness / publicise the new bullying and harassment policy		31/05/2017	
										Progress against workforce action plan reports to Workforce and Education Committee							
CRR-0026	Inability to control agency temporary staffing and associated staffing costs	30/09/2016	Gammage, Mark	Inability to control agency temporary staffing cost. Unable to demonstrate a control on agency temporary staffing as shown by breach of annual cap value.	16	4. Major	5. Almost Certain	20	Extreme	Completion of NHSI self-certification	No formal Exec Ojectives	Number of agency staff is going down	Booking process are not fully followed	Finalise the Corporate Objectives including Management of agency cost		28/04/2017	Maria Prete* 03/04/2017 16:09:44
										No agency invoice is paid without booking number							
										Monthly data analysis which shows reasons for request and rates of use by ward level - data will be used by the monthly Exec meeting							
										All requests for agency are required to be booked throught the Central Bank Office following approval from Chief Nurse for Nursing, DDOs for medical staff, Medical Director for on day booking	STG in face two of roll out (not completed) of South West London Bank which agree max rates across London and offer banks rates to each other		Not known Central Bank office performance to ensure Max bank fill & Min agency fill & best price				
										Nursing rostering prepared 8 weeks in advance							
										Vacancy control panel (VCP) approving posts							
										Breaching reported to VCP / follow up with those who breach							

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CRR-0019	Failure to recognise, communicate and act on abnormal clinical findings	19/07/2016	Rhodes*, Andrew	Should the Trust fail to ensure robust mechanisms for the timely and appropriate follow up of all diagnostics tests undertaken and critical test results eg blood tests , cell path and radiology this may result in adverse impact upon patient care in terms of delays in treatment	16	4. Major	4. Likely	16	Extreme	All doctors have been reminded of their responsibility for ensuring that tests that they order are followed up	Not all Care Groups have developped Standard Operating Procedures to ensure that this happens	There is limited ability of ensuring that once results are seen, the correct actions are followed.	The feedback from consultants completing the audit indicates compliance issues. Whereas for some consultants the system seems to work satisfactorily, for many it does not. The main issue raised was in respect of correct attribution of patients to consultants. This results in consultants being a) required to endorse patients for whom they are not responsible, and b) results of their own patients not being received for endorsement	SOPs to be reviewed by DCs for each Care Group to ensure fit for purpose		02/01/2017	Maria Prete* 05/04/2017 09:14:33
											Radiology safety net not reliable as emails are not received by the appropriate staff			Re-audit SOPs to ensure fit for purpose		28/02/2017	
										All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions.	A significant proportion of results are attributed to the wrong consultant making the electrical sign off inconsistent		Issues regarding the time required to comply with the system, and the limitations of IT systems were common themes. Some of the specific issues raised could possibly be rectified by additional training, others would require system changes (either technical or in respect of workflows				
											Policy for Acting on Diagnostic test Results to be updated			Review /update policy for acting on results		01/12/2016	
										Radiology have strengthened their safety net system. This now includes e mail to MDT for unexpected cancer (cancer MDTs have instituted a red flag system to ensure oversight).	not all results are reported via iClip		limited assurance as results attributed to wrong consultants				
											There is no ability to track compliance through Tableau of other results at the present			implement RCA recommendations		03/04/2017	
CRR-0001	Inadequate Data Quality, completeness or consistency	22/07/2016	Rhodes*, Andrew	Poor Data Quality within the current methods of generating, monitoring, tracking and reporting against waiting lists The current RTT PTLs pose a risk to patient safety as planned patients and Non-RTT follow up patient are not being managed appropriately & RTT and DM01 externally reported figures are inaccurate The failure to attribute consultant activity appropirately. this is an issue that affetcts all patients and has resulted i a failure to endorse results that may mean missed diagnosis of disease. This has an effect on clinical documentation, coding of activity and discharge processes The risk to patient is compounded by the fact that 3 different systems are used within the Trust (CErner, Rio, iSoft) Delays and inaccuracies in coding activity lead to uncertainties in the validity of risk adjusted mortality and other nationally-published outcome data	25	5. Catastrophic	5. Almost Certain	25	Extreme	Governance accountability at board level. MBI report presented to Board	Use of different IT systems	Initial clinical harm review of 1000 patient notes found no severe harm	No assurance on which data can be trusted	Data quality strategy paper to be presented to EMT (Mark Hamilton)		31/05/2017	Vanessa Davies 05/04/2017 10:44:28
											Clinical Coding - Capacity of clinical teams to provide reviews						
										RTT specialist at board level							
											Clinical Coding - Insufficient interaction between clinical and coding teams						
										Clinical harm board set up to review patient level records							
											Clinical Coding vacancies (5 WTE) lead to delays in activity being coded						
										Clinical Coding - policy in place agreed with clinicians							
											No validation of data through Kite Marking		Risk not able to be quantified until phase one of project complete				
										Clinical Coding - training in place - Income generator supporting clinicians with correct coding	Data Quality policy not up to date						
										Clinical Coding - validation of data							
											RTT - No SOPs on how to input data	Clinical coding backlog cleared (Feb 2017)					
										ECR Board chaired by Diana Lacey							
											Trainings not developped / resources for trainings not identified						
										NHSI on board from 13 February 2017 to procure external provider for technical solutions							
											Inconsistent verification of data prior to be externally submitted		recruitment to post for elective care pathway may not be enough, i.e. training				
										recruitment to post for elective care pathway							
											No IT strategy			ICT strategy to be presented to Board and agreed (Larry Murphy)		30/05/2017	
										Clinical Coding - Programme of coding recovery plan developed							
											Clinical Coding - External audit - Payment by result audit no longer run						
										Clinical Coding - Review programme team in place to improve coding							
											Incomplete/ inaccurate						

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Progress on Action	Actions Due date	Last updated
											information provided/inputted						
CRR-0010	Fragmented Electronic and manual patient records	14/06/2016	Rhodes*, Andrew	A failure of staff to document clinical information in the correct system (paper or electronic) caused by the operation of dual systems may result in inappropriate treatment. A failure of staff to review clinical information caused by a fractured clinical record may result in inappropriate clinical decision making. A failure of staff to transcribe information caused by the need to transition from an electronic process to a paper process (or vice versa) caused by the operation of dual systems may result in transcribing errors resulting in medical errors.	20	5. Catastrophic	4. Likely	20	Extreme	Patients outlying in live areas will remain on paper.	Under reporting of incidences	Organisation paused after completion of roll out to Paediatrics, Cardiac, Nephrology and Neuro which are relatively ring fenced in terms of beds therefore transitions of care within one admission from paper to electronic and vice versa are relatively less likely.	In extenuating circumstances patients may be transferred to live areas from non-live areas.	Roll out eClinical Documentation and ePMA to the remaining IP areas on St Georges Hospital site.	The roll out is currently on hold	01/10/2017	Maria Prete* 05/04/2017 09:19:41
										Monitoring of incidence reports (Datix, SIs, Compliants, Feedback from GPs) for frequency and severity of incidences and to follow up with relevant areas	No Departmental Standard Operational Procedures (SoPs) when gaps are noticed		Multiple use of clinical systems in uncontrolled manner				
										Patients outlying in non-live areas will have a paper record	Development of BC to move to full roll out not complete and agreed						
CRR-0029	Failure to arrange follow-up appointments or treatments (where clinically required)	30/09/2016	Rhodes*, Andrew	Risk failure to follow up patients as clinically required . Caused by inconsistent processes and procedures for ensuring that patients receive timely and appropriate follow up appointments and/or treatment once seen in clinic May result in delayed diagnosis or treatment leading to severe personal harm	16	4. Major	4. Likely	16	Extreme	SOPs / cashing up systems	The Trust does not have robust SOPs or processes in place to ensure follow up of patients in Outpatient clinics or following DNA.	Cashing up of outpatients runs at >99%		SOP audits need to be repeated and quality checked		01/05/2017	Maria Prete* 05/04/2017 09:37:12
										Access Policy	Variable processes for arranging follow up care upon discharge			RTT programme to complete SOPs for processes		01/06/2017	
										RTT project board and programme	Clinical outcome forms @ OP not completed						
										Data quality working group established within trust to address Attribution of consultant	RTT programme has not yet made sufficient progress						
										Communication to Patients & GPS	SOP audits not complete						
										Training in place							
CRR-1143	Recognising, escalating and responding to the signs of deterioration	01/10/2016	Rhodes*, Andrew	Risk of failure of recognising, escalating and responding to the signs of deteriorating patient. This is caused by the suboptimal use of EWS as observations not completed correctly, not clearly escalated or promptly responded in order to commence treatment. This may result in avoidable death, and/or breach of CQC registration requirements.	20	5. Catastrophic	4. Likely	20	Extreme	Policy for Minimum Standard for Adult in-patient observation	Training is not mandatory, It is not part of MAST, Not recorded on TotaraShould be booked through Totora and recorded on ARIS	Critical care liaison project. Showing quality imprvement of EWS.	EWS data not adequate	Review of Agency staff contract to ensure requirements (knowledge of taking obs) are clearly stated	discussion with Geraldine to add nEWS MAST module to contract	30/04/2017	Maria Prete* 05/04/2017 09:44:54
										Critical care liaison project Educational /support project (six month project to improve EWS and Sepsis recognition currently in place) involving 3 nurses: each urse covers one area/ward showing how to identify sick patient and guide them on what needs to be done to prevent deterioration	Training package covers only qualified nurses and not HCA. HCAs are only trained on how to take obs but not reporting						
										Follow up of patient once discharged from ITU	No emergency response team			Deteriorating patient training package to be added to MAST to facilitate training and competency record keeping	in progress	30/04/2017	
										EWS audit undertaken bi-annually							
										STARR project - to promote ward-based learning across the Trust by deploying a mobile education troupe to support local tailored needs analysis, action planning and evaluation							
										Audit programme added to RATE to facilitate local monthly audits				Identify and train senior medical, nurses and HCA chanpions on each ward to lead implemntation of local EWS process	Nurse leads identified, training available. HCA to come on board once core trained.	28/04/2017	
										Locum / agency staff used to ensure safer ratio of staff/patients	Agency staff not knowledgeble on Trust policies despite agency contract stating requirement of knowledge of obs						

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										Policy includes the emergency response and clinical communicaton	knowledge of obs			embed SAFER care bundle		28/02/2017	
										Training package reviewed -delivered by Resus, Simulation and Practice Educators				Observation machine software to be upgraded with new EWS escaltion criteria		30/04/2017	
										Policy disseminated to Divisional Triumvirate for distribution within Division; and to all Sisters	Poor local ownership of processes	EWS audit achieved base line target (80%). Target now has been increased to 100%	No data on who has been trained / competency done	Upload EWS chart on iClip		01/05/2017	
										Review /monitoring of serious incidents for learning				working with IT team on barrier to implement use of white board		31/05/2017	
										EWS chart updated	Currently no use of white board to document obs			Develop business case for technological software		02/10/2017	
										Reporting of adverse incidents							
										Nurses encouraged to do Harm Free Care	No systematic record keeping of competency		QIP - actions behind scheduled time, some overdue actions				
										EWS programm part of QIP							
										EWS monitored and reported to CQRM and PSQB	STARR project - slow progress due to shortage of skills						
CRR-0023	Below target 2-week wait performance	01/08/2016	Gordon, Mark	The Trust are currently not achieving the 2WW performance standard for cancer. Whilst the 2WW performance was recovered in February 2016, this was not acheived in November 2016 and this is not forecast to recover until Q1 2017/18. Process and capacity issues remain a risk, with only 25% of patients being contacted within 2 working days or receipt of referral. Capacity issues are primarily in dermatology where clinical vacancies mean that core capacity to meet demand is not currently being met. Identified risks are: 1.Risk of clinical or psychological harm to patients who are not seen within the access standard 2.Poor patient experience due to delays from GP referral to date 1st seen 3.Financial risk to the organisation from contract penalties where targets are not met 4.Reputational risk to the organisation	12	4. Major	4. Likely	16	Extreme	Recruitment plan agreed in dermatology to recruit to clinical vacancies and appoint locum cover where possible	Patient Choice – patients choosing to be seen outside of the 14 day access standard, even when a choice of dates are offered.	Cancer KPIs are monitored weekly through the cancer performance meeting, chaired by the Deputy COO. Performance continues to demonstrate a month-on-month improvement, with a 100% increase in patients now contacted within 48 hours (30.7% in July 2016 to 60% in January 2017) and a 13% increase (6.6% to 19.9%) in patients booked within 7 days.		Consider options for outsourcing. Agree demand and capacity recovery plan		30/06/2017	Maria Prete* 05/04/2017 16:38:08
										Cancer Programme lead appointed to oversee delivery of key actions and cancer performance recovery	There is a national shortage in dermatology consultants that puts at risk the timeframes of delivery of a recruitment plan						
										Demand and Capacity plan developed to deliver booking by day 7, to ensure that patients are offered choice.	Shortfall in endoscopy capacity impact on abillity to achieve 2WW						
										Recruitment plan agreed to cover endoscopy shortfall. Agreed backlog recovery plan							
CRR-0011	Below target ED four hour performance			Risk to patient experience and safety as a result of potential Trust failure to meet Emergency Access performance trajectory agreed with NHSE and NHSI . This is caused by bed capacity Specialty response times to referrals, delays to assessment and referrals in the ED Mental health breaches. Should the Trust recurrently fail to meet agreed trajectory Emergency Access Standards						1.Emergency department actions – led by DDO, Clinical Director for ED, HoN for ED and GM for ED.	Lack of Interprofesional standards, to minimise delays in speciality response to the ED	Q1 Target - 90.2% Achieved- 92.49%	Continued failure to meet the 95% performance standard - particular challenges in late evenings. In part the lack of physical capacity in the department is a causal factor.	Streaming increase plan to be implemented.			Maria Prete* 05/04/2017 16:17:53
										2.Whole hospital actions – led by Chief Nurse through 'Flow' programme							
										3.Wider system actions – led by SRG through Emergency Care Delivery Board.	Lack of visibility and accountability for speciality performance within divisions	Q2 Target - 93.37% Achieved- 93.13%					
										Progress in delivering action plan regularly reviewed: ED action plan via ED Senior team meeting weekly/ and							

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		01/06/2014	Gordon, Mark	Emergency Access Standards there would be a risk to: -Patient experience whereby patients would not be treated or transferred within four hours -Patient safety – delays in patients receiving ED or specialist senior clinical input -Risk of regulatory action including from commissioners and regulators - Trust reputational damage of failure to deliver the agreed trajectory	20	4. Major	5. Almost Certain	20	Extreme	ED/ Acute Med performance group/ Whole hospital actions via OMT fortnightly/Wider system actions via Emergency Care Delivery Board performance meeting monthly.Three times daily escalation meetings enable constant trust-wide management of ED flow.						30/04/2017	
										Continued close and pro-active working with ECIST. ED dashboard and operational standards agreed, finalised and in place							
										Investments in patient flow schemes (£4m) including ED hot lab, and improved RAT area.	Vacancies within MIU ENP's impacting on workforce	Q3 Target - 92.22% Achieved-93.37%	Mixed performance in specialty attendance and specialty management of ED patients. Also lack of availability of psych beds.				
										Integration of the hospital services within the ED effort at the Front Door - through increase of ambulatory clinics in medicine				Psych strategy for ED, including recruitment of RMNs within dept		30/05/2017	
										Improvements in Bedflow generated by a variety of measures: establishment of integrated discharge team (IDT); reduction of medically fit for discharge (MFD)							
										work to reduce attendance from frequent fliers - trust wide programmes on both adults and paeds.	Pressures on beds (exacerbated by reduced bed stock) causing reduced flow of patients out of ED	Q4 Target - 92.34%		Complete planning strategy to increase ambulatory capacity		30/06/2017	
										GM leads operational management of ED flow from floor of Majors.							
										Three times daily flow meetings between ED and medics patient							
CRR-0024	Failure to meet 62-day GP referral to treatment Cancer Performance standard	01/11/2015	Gordon, Mark	Failure to meet 62-day GP referral to treatment Cancer Performance standard. The Trust are currently achieving the 62 day referral to treatment access standard for cancer, however there are continued risks to sustainability. Identified Risk are: 1. Risk of clinical or psychological harm to patients who ae not treated within the access standard, due to potential disease progression 2. Poor patient experience due to delays in diagnostic and treatment events in pathways 3. Financial risk to the organisation from contract penalties where targets are not met 4. Reputational risk to the organisation 62 day waits are on trajectory and has been achieved in 5 of the last 6 months.	12	5. Catastrophic	3. Possible	15	Extreme	Cancer Performance Recovery Action Plan written and agreed with the board and the Commissoners with a trajectory of improvement to recover performance from July 2016	The Trust is a tertiary and diagnostic centre for a number of pathways, and therefore are dependent on patients being referred from other Trust by day 38 to ensure that treatment can commence by day 62.In some pathways, particularly H & N and lung, there is poor compliance from other Trust, which puts the trajectory at risk	62-day performance has been acheived from July 2016 (6 of 7 months)					Maria Prete* 05/04/2017 16:30:16
										Cancer Programme lead appointed to oversee delivery of key actions and cancer performance recovery							
										RCA completed for all patients who are not treated within the 62 day standard (or 31 days from decision to treatment commencing). Any patient on a cancer pathway 95 days+ (diagnosed and not disgnosed) is assessed by a lead cancer clinician for clinical or psychological harm. All RCAS are signed off by the CEO, director of nursing and medical Director		weekly ITT conference calls are held with all referring Trusts, chaired by GM for cancer, to reduce the risks of patients on two-trust pathways					
										Weekly PTL Assurance meetings are in place, chaired by GM for Cancer Services, to expedite individual patient pathways, ensuring corrective							

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										action is taken when delays are identified								
										Expansion of Bronchoscopy and Thoracic surgery capacity has increased improvement by 9.5%.	Shortfall in theatre capacity in uroilogy due to anaesthetic vacancies and Trustinability to cover evening and weekend operating lists						
										Delivery of actions to Improve of booking against 7-day standard delivered and 60% of patients contacted within 48 hours met from Janaury 2017		24 day soft target from receipt of ITT to treatment agreed and tracked by tumour through weekly cancer performance meetings.					
										Appointment of additional MDT co-ordinator posts to improve the quality and timeliness of tracking of patients on suspected cancer pathways (Mar 17)							
										Agreement reached re: WLI payments and recruitment of anaesthetist in progress. 5 scheduled to start next month							
CRR-0012	Increasing number of patients waiting more than 18 weeks for treatment with potential for clinical harm	31/05/2014	Gordon, Mark	Increasing number of patients waiting more than 18 weeks for treatment with potential for clinical harm Possible impact on patients safety as they may come to harm as a consequence of waiting in excess of 18 weeks for treatment. Impact on Trust performance against the referral to treatment (RTT) standard, and the sustainability and transformation fund (STF) trajectory with subsequent loss of income. Risk to Trust's reputation as a well managed organisation.	20	5. Catastrophic	4. Likely	20	Extreme	Trust in receipt report following review data quality and administartive processes that support management of patient tracking (waiting) lists	National reporting (NHSE) of mandatory data reporting of RTT suspended	80% of targeted staff have been trained	Rising of PTL. Number of patients waiting more than 52 weeks for treatment recovery increasing	all gaps in controls are addressed within the RTT work plan. Work through work plan		31/03/2019	Maria Prete* 05/04/2017 16:15:00
										Director appointed to develop and lead implementation of recovery programme including approach, key milestones and timelines							
										NHSI approved recovery plan with 6 overarching workstreams: Clinical Harm, Validation, Operational grip and capacity management, data quality, training and communication							
										6 work streams have been set up							
										Weekly RTT performance meeting. PTL review + performance meeting have commenced							
										Weekly elective care recovery performance meeting (patient by patient review of long waiters/ 40+ weeks)							
										Performance monitoring report provides overview of current waiting list and progress with backlog reduction, activity run rate using IMAS with optimum waiting list size as target, plus action tracker							
										Revised approach to Business as Usual validation. Staff identified nad training commenced.			Severe harm incidents identified by the Clinical Harm Panel				
										Weekly / monthly PTL production report circulated to GMs)							
										External reporting to Commissioners, regulators, NHSE and NHSI							
										ECR Board (chair recovery Director). Programme performance report	Need additional staff for validation 18 weeks PTL						
										DIP Board (chaired by CEO) review							

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										risks to delivery / mitigation							
										SOG (chair NHSI)							
										Clinical Harm review panel (external chair), reporting to both ECR Board, and Patient Safety and Quality Board. weekly updates to services of patients requiring clinical follow up			No assurance that current patients will not wait more than 18 weeks	Undertake review of resource across the Trust and identify staff for secondment to 18 week team		30/04/2017	
										Technical validation solution in place to undertake Phase 1 historic validation of patient records							
										Revised performance pack incorporating outputs/KPIs in place							
										Contract with supplier to undertake Phase 2 technical historic validation of patient records in place (Cymbio). Validation work in progress							
										Training in place							
										Detailed backlog recovery plan agreed with all RTT specialties							
CRR-1228	Insufficient Cost Improvement/Transformation Programme in 2017/18 and subsequent year 2018/19	04/04/2017	Paice, Jane	The Trust does not deliver transformation cost improvement programme objectives in 2017/18. The Trust needs to deliver an overall CIP target of £60m through its Turnaround Programme. Due to CIP programme not defined This will lead the Trust to breach control total remaining in special measures	20	4. Major	5. Almost Certain	20	Extreme	Turnaround Board ("TAB") to oversee FY17/18 and FY18/19 Transformation programme, driving and delivering a robust programme for 2017/18 and subsequent years through regular review meetings	No detailed implementation plans have been developed to manage the quantitative and qualitative aspects of each programme		Implications of financial special measures not identified	Define 17/18 CIP programme		31/05/2017	Maria Prete* 04/04/2017 12:23:13
										PMO managing Transformation programme, ensuring robust processes in place for tracking, resoucing, change control							
										Change control form to be submitted for each change in financial savings targets/ scope of programme	No divisional finance managers signoff financial scoping for each scheme and own benefit realisation		Turnover of SRO - possible impact tractions on schedules	Division to provide G1 and G2 documentation to support CIP programme		30/04/2017	
										QIA completed - sent to Medical Director and Chief Nurse for schemes with risk of 12 or greater and in excess of £100k							
										Divisional steering groups, meet fortnightly and approve all schemes	Progress reviewed / CIP programme is not part of monthly Divisional performance meetings		Constant challenge to stop changes being implemented	Reallocation of resources where possible to develop 18/19 CIP programme		30/09/2017	
										Executive SRO has oversight of each programme to ensure adherence to scope, timescales and realisation of benefits							
										Divisional involvement in the development and challenge of detailed implementation plans and allocation of targets by division	no reconciliation of CIP delivery to budget by divisional finance managers (data on 31.3.17 shows this has not been done since month 4)		CIP reports presented to Finance & Performance committee within finance report diluting message	Seek Risk Management Committee approval to include divisional CIP on Performance meeting / Head of finance to confirm CIP is reconcile to budget			
										Ongoing detailed analysis to address any slippage and emerging gap and to prepare for future years							
										Reforecast of transformation programme savings and alternative schemes within the programmes proposed to recover shortfalls	CIP divisional steering groups frequently cancelled						
										Report to Finance & Peformance Committee monthly to present progress, challenges, resulting action/ next steps							
										Divisional challenge sessions to	No supporting documentation for						

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										establish identification of CIP	CIP developed by divisions					12/04/2017	
										Non Executive Director observation of performance of TAB and holding workstreams to account in terms of both financial targets and milestone achievements							
CRR-0008	Inability to address backlog maintenance requirements	25/07/2016	Hancock*, Richard	There is a risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of capital investment within run-rate schemes. Reduction of the scale of the Trust's capital programme means that not all of the Trust's high priority projects can be funded at the time they are needed. In order to achieve identified savings targets, the Estates and Facilities Department has to reduce labour and materials expenditure on its planned and reactive maintenance service.	20	4. Major	5. Almost Certain	20	Extreme	The PMO have circulated a mandatory project lifecycle process that now requires mandatory Risk assessments to be completed for business case submissions for projects, approvals are required by either IDDG, EMT or Trust Board dependent on SFI's.	A new PMO has been created but there will be a lead time for the identification of gaps, creation of required governance process & tools and implementation. This work continues as focus moves from outside capital projects to incorporate the whole division.	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards. New Divisional project board will ensure visibility of all works.	Additional schemes/projects were not foreseen, such as demolitions. As buildings are demolished this will allow reallocation of resource to other work required.	The action remains to gain line of sight to this funding in the Trust budget and to have a plan which lays out how and when the initiatives will be delivered.	An Estates recovery plan 2016-2018, approved by EMT, and an Estates Strategy 2018-2021 (EMT approved/ to be presented to Trust Board on 06/04/2017) lays out the priorities and estimated delivery timescales required for initiatives from 2016 to 2021. The Strategy focuses on the need to repair and replace critical infrastructure. The 2017/18 budget is not yet set to provide line of sight to funding in 2017/18.	31/05/2017	Sophia Mehraj* 06/04/2017 11:59:01
										Funding and project management is monitored through the Capital Programme Monitoring Group (CPMG) & Project Programme Boards and the Investment, Divestment and Disinvestment Group (IDDG).							
										Engagement carried out early with the Estates department regarding new projects/works and jointly agreed how this can be managed	Not all PPM jobs are held within the Estates system presently	IDDG has representation from all Divisions and quality and safety of patient care is the highest prioritisation for all capital projects.	Divisional Project Board not yet set up to provide assurance and visibility of projects. Plans are underway to implement the Divisional Project Board by May 2017.	Upon completion of the Six Facet Survey, a prioritised list of repairs will be produced. An asset and PPM programme will then be developed for all estates assets and to complete PPM works.	The six facet survey is on track to be provided by 31/03/2017. There will be a 2 month review of the survey and a further month to develop the PPM programme. There is a current shortage of staff within the Estates team to carry out the prioritised works identified. Any follow-up actions re PPM is dependent on whether divisional or emergency funding is available for the list of priorities produced from the Six Facet Survey.	30/06/2017	
										Health and Safety management function closely involved in maintenance service for assurance to the quality and safety of patient care							
										Works procurement and prioritisation process implemented in September 2015 to ensure tender processes correctly followed and cost effective decisions made	Six Facet Survey report not available to provide prioritisation list. Final report due 31/03/2017. The team is on track to provide the final report which will provide an up-to-date detailed view of the backlog maintenance that is required. A 2 month review of the report will then be undertaken.			Divisional Project Board to be set up to provide assurance and visibility of all Estates and Facilities projects by May 2017.		31/05/2017	
										A Project Management Office (PMO) has been put in place as of September 2016 to track activity in line with plans on the project schedule and report any deviations from plans to senior management		PMO have produced a divisional project schedule that provides visibility of all E&F projects with timescales to senior management. The schedule is updated fortnightly based on information provided by E&F project managers. Visibility allows for early notification of delays which allows the team to rectify issues at faster timescales.	Require the latest six facet survey report to determine which jobs need to be prioritised. A 2 month review to then take place to identify areas of concern and another month to develop an action plan.	Review potential of Planet FM System upgrade following the development of asset and planned preventative maintenance programme.		31/08/2017	
										Planned Preventative Maintenance (PPM) workload controlled through organised work allocation from the Estates system. This is designed to cover all PPM.	Large number of vacancies in Estates team at both management level and trade level. Recruitment underway but approval from VCP still not provided			Full review of PPM programme underway on all statutory maintenance. Progress in this matter is dependent on funding.		31/07/2017	
										Planned Preventative Maintenance (PPM) jobs carried out monthly are reported via Estates Assistant Director.				Recruitment underway for management and trade level vacancies in the Estates team. Presently held up at VCP.		31/07/2017	
CRR-0007	Potential unplanned closure of premises / non-compliance with estates or Fire legislation			Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with						The Director of Estates and Facilities commissioned a fire assessment, initially of the LW during April 2016. This provided a prioritised repair list	Comprehensive surveys and assessments of compartmentation underway to provide action plan to resolve compartmentation issues	External -London Fire Brigade are pleased with the Trusts current progress and the LFB have signed a memorandum of partnership	A number of projects are underway to mitigate this risk: Installation of L1 Fire Alarm system through SGH estate, Fire	A more practical, ward based training event will be delivered for future courses	The team are conducting these ward based mock fire evacuation exercises. The Wards Responsible Persons		Sophia Mehraj* 06/04/2017 11:56:02

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				the Regulatory Reform (Fire Safety) Order 2005 (RRO). Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)						which is monitored through the Health, Safety & Fire Committee.	around the Trust.	with the Trust. A letter from LFB can be provided highlighting the current assessment of the Trust for Fire Safety.	Dampers servicing, and Replacement of Fire Doors. Projects not yet complete with continuous delays due to changing project managers.		book in time slots with the fire administrator, the fire officer will then visit the Ward at the appointed date and conduct the mock exercise with the local staff. The attendance register is completed and the fire administrator updates the Totara record system following the exercise.	31/05/2017	
										Regular meetings/ communication held with Fire Brigade to check progress of ensuring fire safety.							
										Specialist fire safety resource in place to lead on the actions; Planned and reactive monitoring of fire safety.		A review of Fire Safety Management at St Georges Hospital by the Fire Protection Association has been undertaken. The "Review of Fire Safety Management" has been received and highlights the good work undertaken by the Fire Safety Team together with further recommendations which are included in the Estates Action Plan.					
										Two permanent Fire Officers are in post, reporting to Head of Estates Compliance			NHS Hazard Notice received in regards to Fire Dampers across the whole SGH estate.	Installation of L1 fire alarm replacing the L2 alarms in Lanesborough Wing.	Lanesborough Wing works have been completed. Commissioning and handover is underway within Lanesborough Wing on track for completion in April 2017.	14/04/2017	
										Established "Responsible Fire Persons" email circulation list to send personal emails to ward/area managers		Required number of fire wardens trained (1400) has been met and target exceeded		The Fire Compartmentation works are ready to go out to tender via procurement with a project completion date of March 2017. The tender process will have a duration of 4 weeks.	The PM for Fire Compartmentation has left and there was no handover of work. The new PM is currently reviewing the project work to date. A detailed update will be provided in due course.	31/08/2017	
		14/03/2013	Hancock*, Richard		20	5. Catastrophic	4. Likely	20	Extreme	New L1 Fire Alarms installed in LW replace L2 alarms. FRAs of LW undertaken in April 2016.	All main blocks have been assessed for Fire Alarm safety and there is a plan for the whole estate to have upgraded L1 alarms, completion date not yet known.			Replacement of Fire Doors throughout SGUH estate. The provision of Fire Doors require an 8 weeks lead time and after awarding the tender contract, the delivery is estimated to be approximately 3 months.	Tender has been awarded to Ventro Ltd. Doors have been ordered and are currently being manufactured. A 10% deposit has been paid to the supplier. Works will be completed in phases, phase 1 is maintenance to Fire Doors and phase 2 will be the replacement of fire doors that are 'beyond use'. The team are reviewing ways of working to reduce impact regarding Fire Doors installation as there will have to be planned fire routes downtime.	31/08/2017	
										Internal - Reporting on fire risk assessments and KPIs to Health, Safety and Fire Committee, RMC and QRC.		Fire risks assessments (FRAs) prepared by Fire Safety Specialists (the last one via International Fire Consultants – IFC – in April 2016) and issued to the Director, Estates & Facilities, Head of Estates and Compliance Managers. This is an annual compliance report carried out until the closure of this risk.	Inability to gain access to areas [required for project works] delaying projects.	Installation of L1 alarms to replace L2 alarms throughout the whole SGH Estate.	Works are complete within Lanesborough Wing with commissioning underway. Works are due to begin on the remaining Tooting Estate, however this is dependent on receiving the funding as per emergency capital submission, and as a result being able to hire project management resources to deliver.	30/03/2018	
										Estates Fire Managers regularly review the list of trained Responsible Person & Senior Nurses to ensure that their training is up to date. The responsibility for rostering a fire trained ward RP rests with the nursing leadership				The International Fire Consultants will be requested to carry out another fire risk assessment from April 2017.		31/07/2017	
										Fire Compartmentation, surveying, servicing and testing in St. James Wing complete and actions/repairs identified. Actions completed as part of wider compartmentation		Internal FRA's of Clinical areas are carried out annually in line with statutory requirements. LFB have full oversight of Trust FRA's.		Fire Dampers Project - NHS			

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										programme.				Hazard notice was received in regards to Fire Dampers across the SGH estate. The project entails surveying, servicing and testing of fire dampers. Following testing, repairs required will be identified which will produce an action plan.		31/08/2017	
										Fire Risk Assessment's of LW undertaken in April 2016 identified the need for new fire alarms. The L1 Fire Alarm system installed in LW replaces L2 alarms. The L1 Fire Alarm system is undergoing commissioning to complete 14/04/2017.							
CRR-0018	Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire	31/10/2012	Hancock*, Richard	Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with E&F guidance and legislation (HSE & HTM) Until the Premises Assurance Model (PAM) compliance is completed, there are gaps in the mandatory and statutory estates compliance documentation.	16	4. Major	4. Likely	16	Extreme	An assessment was carried out into all the varied control and logging systems across all Trust suppliers and locations.	All recommendations from the estates action plan are not complete	Internal audit review findings: progress has been made with the remaining agreed actions	Full compliance reports not yet available. Only an external audit/cold-eye review would provide the total exposure risk. A super-set of compliance could then be developed and maintained via the Health, Safety and fire Committee.	Premises Assurance Model being undertaken for Trust. An external audit would define the gaps and prioritise the fixes to ensure that regular updates can be provided to the committees monitoring this risk.	PAM is 35% complete. An issue regarding the PO has delayed the works as further funds were required, this is now resolved with NIFES. Further compliance points and actions for the PAM are being collated from interviews for external review.	29/09/2017	Sophia Mehraj* 06/04/2017 12:07:00
											Until PAM is mature, the Trust will continue to have gaps in the completed actions and evidence collated, as well as ensuring we are current with compliance standards		External - H&S Executive – issue with electrical outlets on Richmond ward has resulted in a notice of contravention of the health and safety act (actions underway, activity funded and being installed)				
										The Trust carried out an audit (internal - London Audit Consortium) on the gaps in compliance and the results have fed into actions.				Following completion of the six facet survey on 31/03/2017, Planned Maintenance activities will be developed following the asset inventory.	The survey is on track for completion on 31/03/2017. There will be a 2 month review of the survey and a further month to develop the PPM programme. Staff are critical to deliver the PPM programme and there is a shortage of staff within the Estates Team, thus the backlog is increasing.	30/06/2017	
											There are up to eight different call centres, depending on what building and service a customer requires.		Internal audit review findings: whilst some progress has been made with the remaining agreed actions, overall progress has been slower than desired in key areas.				
										The Estates action plan will be further revised as higher risk items are closed				AE reports will need to be collated, recommendations then reviewed and action plans produced as cohesive programmes. Reports will need to be submitted to the EMT and reformed QRC.	There are 3 action plans. 1. Deficiencies of the Estates 2. AE Reports 3. Fire Risk Assessments	31/05/2017	
											A Six-Facet survey is underway due for completion on 31/03/2017 which will provide a site wide condition report of the Tooting estate. The survey will allow the team to produce a prioritised set of actions and compliance of each will need to be identified. 2 month review and additional one month development of an action plan means this will not be available until 30/06/2017.	In April 2016 an external H&S audit was undertaken by the Authorising Engineer for HTM00 (Empathy EC) which indicated a 75% compliance level.	Authorising Engineers: There are 4 out 8 HTM AEs appointed, with 2 of these positions expiring in April 2017 (Electrical Hv/LV). There is a further AE identified but not yet appointed and there are 2 further vacant AE posts (Ventilation/Lifts).	There are up to nine different call centres, depending on what building and service a customer requires. There is a plan to rationalise as many functions into one Staff Help Centre which is being worked on.	Plans to develop a new HelpDesk tool, a new reception area that consolidates all 9 service helpdesks and a consolidated call centre.	29/12/2017	
										Revised estates management structure is in place that includes a dedicated interim compliance manager within the Estates team.							
											The compliance manager is an interim and the only one within the Estates Team. The Estates team require additional support.		Authorising Persons: There are 6 out 8 HTM APs appointed. The 2 remaining APs have been identified but without AEs cannot be formally appointed to post (Ventilation/Lifts).	Recruit an Electrical HV and Electrical LV authorised engineer to fill the gap once the present AE leaves in April 2017.	The Electrical HV/LV AP's will be formally appointed once the AE has been recruited. The Post will be circulated in April 2017.	31/05/2017	
										London Fire Brigade audited Fire Safety in the outpatient areas and confirmed there were no issues.							
											The Estates team are short-staffed and there is no delegated responsibility to manage PAM, and estates compliance documentation		A six-facet survey report has been received which will provide a set of proritised actions. The report was received on 31/03/2017. A 2 month review will now commence to identify areas of concern to then develop an action plan				
CRR-0016	Bacterial contamination of water supply (Legionella, Pseudomonas)			There is a risk to patient safety from water-borne infection. This risk has been increased as a result of legionella being found in						Water testing regime in place as part of the planned preventative maintenance programme.	Water testing regime in place as part of the PPM programme requires review subject to the water risk management report	Water testing and cross party committee DIPC/IC Committee have recognised improvements across last 18 months.	Authorising Engineer (Water Systems) appointment process incomplete and thus legally unable to start position at Trust.	Replacement of IPS Panels, Sinks, Taps and removal of dead legs, worked tendered with 6 weeks lead in time from order.	A&E and the NNU works have been tendered; JC Watson appointed. The contractor is due to start works end of April		Vanessa Davies 04/04/2017 16:33:48
										If high counts of legionella are found							

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Progress on Action	Actions Due date	Last updated
				isolated areas in the St George's Hospital site. There are different water-borne infections in different buildings; Legionella and Pseudomonas.						it is chemically treated in accordance with trust water management policy	received on 27/03/2017 conducted by the HSE Inspector.				2017. Pinkney's tender specification is being drawn up.		
										Water testing being carried out in accordance with HTM04, L8 and HSG274							
										Testing regime and results kept in electronic evidence log book.(Zetasafe)		The Health Safety Executive inspector was satisfied the Trust had undertaken adequate testing, monitoring and remedial action to mitigate risks in water temperature. Inspector satisfied that the Trust had dealt with prior failures correctly. Inspector agreed with the view to develop an in-house water management team. HSE are aware of discrepancy of temperatures between SGUL and Trust for Grosvenor Wing.				30/06/2017	
										Water responsible persons trained and certified	Capital funding is required to continue removal of deadlegs		The Trust has not reached consecutive 3 months of 100% pseudomonas flushing returns.				
										A Permanent water safety manager is in post to oversee the flushing and water safety processes; also working alongside the Compliance Manager for compliance related activities. We have also added another level of oversight; the H&S Manager will also run internal compliance on all E&F statutory activities.				Design of scheme underway for the replacement of aged plant, we have emergency funding of 1.5m to replace the GW water plant; this and the removal of dead legs will reduce this risk	This scheme is currently with the designers and the aim is to go out to tender before the end of April 2017.	31/01/2018	
										St James calorifier is decommissioned and hot water is fed via plate heat exchangers		Water flushing of pseudomonas is carried out by users and the Estates team collect the data. Water flushing of legionellas is carried out by the Estates team. 100% flushing reported for Legionella on low-use outlets since October 2016 to date (20/03/2017). 100% flushing reported for pseudomonas in January 2017.					
										There is a Water Safety Plan in place that provides the guidance, instruction, specification and infrastructure for the implementation of the Trust's Management & Control programme for: The control of Legionella, hygiene, 'safe' hot water, cold water and drinking water systems including Pseudomonas aeruginosa – advice for augmented care units.				A suitable and sufficient Legionella risk assessment compliant with UKAS ISO/IEC 17020:2012, BS8580:2010 and ACoP (L8) shall be carried out by the Trust's externally appointed specialist independent advisor on all buildings currently owned or occupied by the Trust, In order to identify and assess the risk of Legionellosis and water quality issues from work activities and water sources on the premises and organise any necessary precautionary measures.	The risk assessment has been carried out, the report was received on 27/03/2017. There will be an allowance of one month for review of the report.	31/05/2017	
										Deadlegs are removed as discovered whilst other planned work continues across the estate							
		14/05/2014	Hancock*, Richard		16	5. Catastrophic	3. Possible	15	Extreme		Unable to fit filters to every single tap, as not compliant models of sinks or taps in some cases.Not all mitigating actions can be applied, as PALL filters do not fit some of the sinks.		The Water Safety Committee do not meet regularly enough to provide assurance of water safety. A new chief nurse/DIPC has been recruited who is now responsible for the management of these meetings; meetings proposed to be scheduled monthly.	A suitable and sufficient Pseudomonas aeruginosa risk assessment compliant HTM04-01 (HTM04-01 2016 supersedes the addendum)shall be carried out on all designated augmented care units, in order to identify and assess the risk of Pseudomonas aeruginosa infections from work activities and water sources within the designated areas and organise any necessary precautionary measures.	The risk assessment has been carried out, the report was received on 27/03/2017. There will be an allowance of one month for review of the report.	31/05/2017	
										Up to date policies in place across the Trust to work in conjunction with the Water Safety plan to ensure compliance - The Water Hygiene and Safe Hot Water Temperature Policy was signed off by the Policy Ratification Group in July 2015 and the Dir. E&F in Sept 2015, the next review date is Sept 2018.				The Estates team are to take back	The Estates team are trialling a		

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Progress on Action	Actions Due date	Last updated
														in-house the testing of water from the existing third-party supplier (ClearWater). Water flushing to be discussed with Mitie as cleaning carried out may reduce the need for flushing.	system where Mitie record the cleaning of outlets as part of their cleaning regime so that Estates team are able to identify whether the cleaning carried out by Mitie mitigates the risk of pseudomonas and reduces the number of low-use outlets - AD Estates/Facilities aiming to confirm whether data from Mitie is acceptable and auditable within 4 weeks. Mitie carry out cleaning often enough that outlets would no longer be considered low-use. Bank staff are continuing to flush in parallel whilst this system are being trialled. Testing is being managed by Clearwater, testing will come back in house once team structure in place.	28/04/2017	
										There are alarms in place to alert the Trust if the chlorine levels drops below or exceeds the set specification.		The Estates team have also taken back in-house the testing of water from the existing their-party supplier (ClearWater).					
										There is a standard BAU process in place in the event of filter failure. If there is a failure, the following options are available: 1. a new filter is fitted, 2. the tap is out of use until testing, 3. the tap is put out of action.							
										Water safety committee report presented at the Infection Control committee and Health, Safety and Fire Committee.				Water testing regime in place as part of the PPM programme requires review subject to the water risk management report received on 27/03/2017 conducted by the HSE Inspector. - Recommendations actions to be completed.	There is an initial one month allowance for a full review of the report, the programme will thereafter be developed for action.	31/08/2017	
CRR-0017	Poor quality accommodation is risk to patient/staff safety and care. Inability to renew/repair clinical areas- no decant space	30/05/2014	Hancock*, Richard	Lack of decant space for capital schemes delays the ability to deliver some large capital schemes	16	3. Moderate	5. Almost Certain	15	Extreme	Detailed decant plans have been produced and sit under the Trust's Estate Director with a decant project team under the Demolition Programme managing all decant activities.	No aggregated view of impacts of several decisions not to proceed or to delay works.	Documented risk assessments received by Project boards and reviewed when business cases approved	Financial position may mean potential inability to finance mitigating actions	A review of space and potential decant options have taken place and a proposal will be discussed at the EMT. The Space committee needs to continue to develop the space strategy and assess space issues and location of decant space. The Space Policy will look to implement a Space Utilisation Group.	The Space Policy has been approved by EMT. The policy has also undergone user consultation. A Space Utilisation Group was approved and have been meeting since December 2016. The SUG will manage space approvals, allocation and re-allocation. The Trust continues to face space issues both clinically and non clinically, these are being managed through SUG committee, however the issues are on-going. Once the effectiveness of the SUG meetings have been proven, we will close this action.	28/04/2017	Sophia Mehraj* 06/04/2017 12:38:26
										Space surveys are undertaken on an annual basis to provide room usage data to enable the project manager to work out a plan.							
										Monitored through CPMG, programme monitoring Boards and IDDG. Risk Assessments must be produced to complete a business case for IDDG/EMT.	Short term planning brings forward new priorities that unbalance existing plans.	Impact of turnaround 'collision of priorities' now mitigated by combined planning between Estates and Turnaround leads.		Review of space and potential decant areas well developed and being discussed at EMT. Tasks being undertaken by Estates and Facilities			
										120, The Broadway, identified rental office space offsite for non-clinical staff relocation to free up space for priority requirements.				New modular building being acquired to provide space for decant of Clare House - Willow House.			
										Space Utilisation Group now in place and are responsible for the allocation, re-allocation, monitoring and removal of space. SUG also finalised the Trust space policy which is available on							

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Progress on Action	Actions Due date	Last updated
										Intranet. New Modular Building in place (sits on footprint of former Wandle Annex) to enable the decant of Clare House. Mitigating Action - The Trust received temporary planning permission (up to 5 years) for the new Wandle annex – 4 storeys (circa. 500m2). Capital project delivery is reviewed through CPMG, Project Programme Boards and IDDG. Knightsbridge Wing electrical testing and surveys undertaken.Building was found to be beyond economic use, has been decanted and will be demolished in September 2017.	Lack of formal planning of decant of Clare house has resulted in short-term planning that has impacted on space utilisation.	SUG processes implemented and all clinical and non-clinical teams, on-site, must gain approval from SUG in regards to space requests. This includes projects involving space. Assurance in regards to utilisation and management of space and clearer oversight of space management.		To address clinical decant from Clare house, moving Education from Education Centre to enable clinical staff from Clare House to move into Education Centre. The Education Centre will require conversion into clinical space before decant. New modular building being acquired to provide space for decant of Clare House - Willow House.	Weekend working will be undertaken to place the Willow on site on 08/09 April	19/05/2017	

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	4 May 2017	**Agenda No**	**5.2**
Report Title:	Information Governance Toolkit Attainment and New Legislation		
Lead Director/ Manager:	Larry Murphy ICT Board Advisor & SIRO		
Report Author:	Keith James, Interim Information Governance Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) Action		
Executive Summary:	The Trust has maintained IG Toolkit Level 2 compliance on all requirements within the IG Toolkit. **New Legislation** A summary of the impending new legislation that was introduced in 2016 and will be required to be enacted by the Trust by May 2018 is included in Appendix B. Adherence to the new legislation will require considerable investment and effort across the organisation. It includes the appointment of a Data Protection Officer (DPO) who cannot be the SIRO or the Caldicott Guardian and must report directly to the highest management level of the organisation, does not receive instructions on how to perform his or her tasks, and is protected from disciplinary action.		
Recommendation:	It is recommended that an attitude of Data Protection by Design be adopted across the Trust to ensure that all new initiatives take conscious consideration of the new IG legislation. All projects and programmes should document their IG requirements and clearly state and demonstrate how these are met. It is further recommended that each member of the Board gains a clear understanding of the implication of the new legislation and the Board is updated quarterly on the progress being made to comply with the legislation.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Leadership and Improvement Capability (well-led)		
Single Oversight Framework Theme:			
Implications			
Risk:	The Trust needs to maintain achievement of IG Toolkit Level 2 compliance of all requirements within the IG Toolkit. Failure to maintain compliance: • Limits the Trust's ability to bid for the provision of commissioned services • Increases the risk of CCG's Commissioners micro-managing the		

	Information Governance Toolkit and inserting financial penalties re; lack of level 2 compliance • Increases reputational risk		
Legal/Regulatory:	Does this report have any financial implication? - **Potential ICO Enforcement Notice and possible financial penalty of £500,000 (per instance)** **Please note that the:** At present the fines are limited to £500,000 per incident but in 2018 this will increase to 4% of Income (Capped at £2,000,000 for Health Organisations)		
Resources:	NHS Digital Information Governance Toolkit		
Previously Considered by:	N/A	Date	
Equality Impact Assessment:	N/A		
Appendices:	**Appendix A** Current Information Governance Toolkit Attainment **Appendix B** General Data Protection Regulations (GDPR) Changes		

Information Governance Toolkit Update
Trust Board, May 4 2017

1.0 PURPOSE

1. To advise the Trust Board that the Trust has achieved a compliant evidence based IG Toolkit score of 68% (all requirements Level 2 and above).

2. The board is requested to note the legislative changes to the Data Protection Act as outlined in Appendix B and be aware of the implication of these changes.

2.0 BACKGROUND

2.1 The Information Governance Toolkit is a Department of Health (DoH) Policy delivery vehicle that NHS Digital is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by the DoH policy and presents them in in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against the IG requirements.

Information Governance is to do with the way organisations 'process' or handle information. It covers personal information, i.e. that relating to patients/service users and employees, and corporate information, e.g. financial and accounting records.

3.0 Status

3.1 The Trust achieved a compliant evidence-based IG Toolkit score of 68% (all requirements Level 2 and above); all evidence is contained within the St. George's internal IG network drive.
Appendix A shows the scores achieved against each of the 45 areas to be assessed.

3.2 Scores from last years' assessment are also available in Appendix A. Several scores were lower than the previous year due mainly to resourcing challenges i.e.long term illness.

3.3 Entries in the table highlighted in yellow were audited by the Trusts internal auditors (TIAA); actions resulting from the audit have been completed.

4.0 IMPLICATIONS

Risks

4.1 The Trust needs to maintain achievement of IG Toolkit Level 2 compliance of all requirements within the IG Toolkit. Failure to maintain compliance:

- Limits the Trust's ability to bid for the provision of commissioned services
- Increases the risk of CCG's Commissioners micro-managing the Information Governance Toolkit and inserting financial penalties regarding lack of level 2 compliance
- Increases reputational risk.

Legal Regulatory

4.2 Data protection Act 1998

Resources

4.3 Additional resources will be required to ensure compliance with the new legislation.

A full-time Data Protection Officer (DPO) must be appointed.

Serious consideration must be given to the present level of IG staffing, 1 WTE, which is well below the recommended standard, i.e. 1 WTE / 3000 staff members; this presents a single point of failure in the organisation.

5.0 NEXT STEPS

5.1 Legislative changes to the IG toolkit are expected as follows:

- A change control notice relating to the current IG Toolkit is expected in May / early-June 2017
- The new version of the IG toolkit (GDPR) will be published May/June 2017.

These changes must be assessed and implications to the Trust quantified and planned. There will be overlapping actions from both sets of changes which should be planned accordingly.

5.2 A programme of work to address the changes should be presented to the IG Committee in June 2017 for approval and subsequently to the Trust Board in July. Prerequisite activities have already commenced and overlapping work has been identified.

5.2 The agreed IG Committee Terms of Reference will be reviewed and altered accordingly once the new toolkit is published in May/June 2017.

6.0 RECOMMENDATION

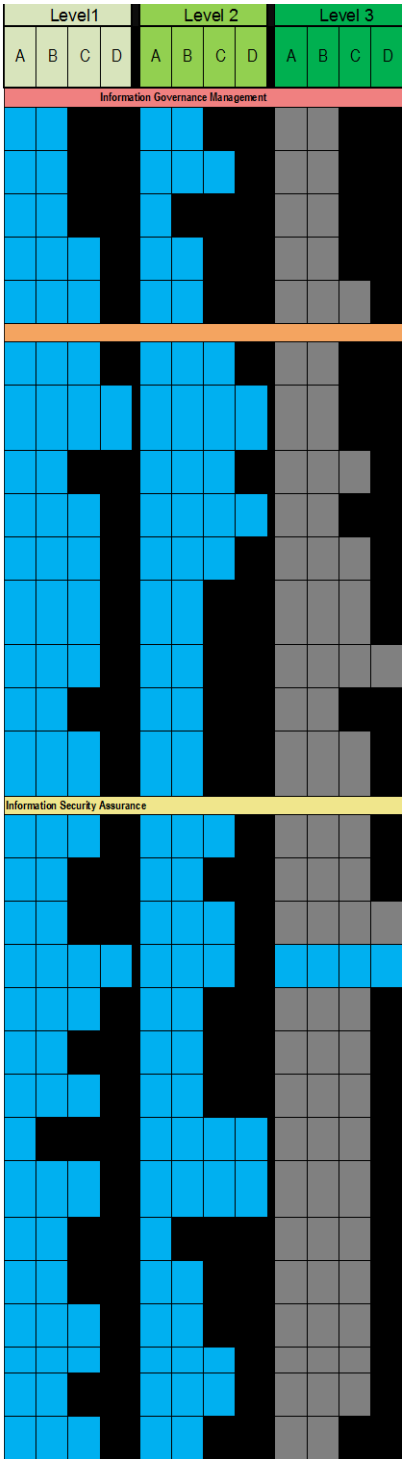
6.1 It is recommended that an attitude of Data Protection by Design be adopted across the Trust to ensure that all new initiatives take conscious consideration of the new IG legislation. All projects and programmes should document their IG requirements and clearly state and demonstrate how these are met.

6.2 It is further recommended that each member of the Board gains a clear understanding of the implication of the new legislation and the Board is updated quarterly on the progress being made to comply with the legislation.

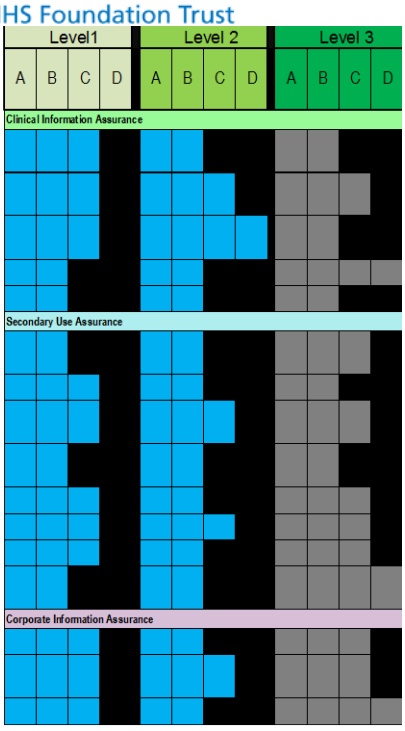
Author: Keith James, Interim Information Governance Manager
Date: 28th April 2017

APPENDIX A

Req No	Description	Past Level	Current Level
Information Governance Management			
14-101	There is an adequate Information Governance Management Framework to support the current and evolving Inform Governance agenda	3	2
14-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	3	2
14-110	Formal contractual arrangements that include compliance with information governance requirements, are in place w contractors and support organisations	3	2
14-111	Employment contracts which include compliance with information governance standards are in place for all individu out work on behalf of the organisation	3	2
14-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	2	2
Confidentiality and Data Protection Assurance			
14-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge experience which meet the organisation's assessed needs	3	2
14-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinate integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure an	2	2
14-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use information are appropriately respected	2	2
14-203	Patients, service users and the public understand how personal information is used and shared for both direct and care, and are fully informed of their rights in relation to such use	2	2
14-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	3	2
14-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronica details about access to a record can be made available to the individual concerned on request	3	2
14-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	2	2
14-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Departmer guidelines	3	2
14-210	All new processes, services, information systems, and other relevant information assets are developed and implem secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and protection requirements	2	2
Information Security Assurance			
14-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experien the organisation's assessed needs	3	2
14-301	A formal information security risk assessment and management programme for key Information Assets has been d implemented and reviewed	2	2
14-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	2	2
14-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	3	3
14-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply wi and conditions of use	2	2
14-305	Operating and application information systems (under the organisation's control) support appropriate access contro and documented and managed access rights are in place for all users of these systems	2	2
14-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk polic information risk management strategy	2	2
14-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and technical and organisational measures adequately secure these transfers	2	2
14-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, com services and data) and service - specific measures are in place	2	2
14-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, hazard or human error	2	2
14-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious unauthorised mobile code	2	2
14-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	2	2
14-314	Policy and procedures ensure that mobile computing and teleworking are secure	3	2
14-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	2	2
14-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation fed appropriate	2	2



Req No	Description	Past Level	Current Level
Clinical Information Assurance			
14-400	The Information Governance agenda is supported by adequate information quality and records management skills, and experience	2	2
14-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	2	2
14-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that supp provision of care	2	2
14-404	A multi-professional audit of clinical records across all specialties has been undertaken	2	2
14-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	2	2
Secondary Use Assurance			
14-501	National data definitions, standards, values and data quality checks are incorporated within key systems and local is updated as standards develop	2	2
14-502	External data quality reports are used for monitoring and improving data quality	2	2
14-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues trends in information over time, ensuring that large changes are investigated and explained	2	2
14-505	An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service approved clinical coding auditor within the last 12 months	3	2
14-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	2	2
14-507	The secondary uses data quality assurance checks have been completed	2	2
14-508	Clinical/care staff are involved in quality checking information derived from the recording of clinical/care activity	2	2
14-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to nation coding standards	3	2
Corporate Information Assurance			
14-601	Documented and implemented procedures are in place for the effective management of corporate records	2	2
14-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	3	2
14-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	2	2



Completed Level 1 and 2 Attainment	100%
Current Attainment	68%

Audited
Complete

APPENDIX B

General Data Protection Regulations (GDPR) Changes

The following provides an overview of the impending new legislation that was introduced in 2016 and will be required to be enacted by the Trust by May 2018.

The legislation is the first major overhaul of Data Protection Legislation since the EU Data Protection Directives (95/46) which was supported in the UK by the change to the UK Data Protection Act 1998.

The new legislation has been designed to support both the change in technology and use of information, but also to provide a more structured approach to engagement.

While we await formal guidance from either the IG Alliance, NHS Digital, NHS England or any of the other thought leaders in NHS and social care IG, it is apparent that there are some clear change needs afoot that will need responding to imminently, by acknowledging both cost and process implications. They include, but are clearly not limited to:

1. Accountability to the data protection principles. This can be demonstrated with effective policies and procedures. They will require regular review as the implications of the GDPRs interpretation for the sector emerges.

2. Consent. The Information Commissioner's Office (ICO), the Data Protection Regulator, has advised organisations to review how they seek, obtain and record consent. Gaining it will be harder, and Subjects will have stronger rights to have their data deleted if it is used as the legal basis for processing. Consent, whether explicit or not, will have to be freely given, specific, informed and unambiguous, not inferred from silence, pre-ticked boxes or inactivity. Data Controllers will have to be able to demonstrate that consent was given via an effective audit trail. Processes will be required to verify the ages of children under 13 and to gather parental / guardian consent for processing their data. This, too, will need to be verifiable. Organisations will need to be clear on what they currently do, so they can reform their processes for the future.

3. Data breaches. Organisations need to ensure current processes for detecting, reporting and investigating breaches are robust. The GDPR will require that where individuals are likely to suffer some form of damage or risk to their rights and freedoms as a result of a breach there will be a requirement to notify the ICO within 72 hours of becoming aware of it. Failure to report may result in a fine, as well as a fine for the breach itself. It will also be mandatory to report high risk breaches to the rights and freedoms of individuals to the Data Subject(s).

4. Data portability. Subjects will be able to transfer their data from one service provider to another in a form of enhanced Subject Access Request (SAR) (see no.13). Where data is electronic, it must be provided in a commonly-used format. Paper or unusual electronic formats mean procedures may need revising.

5. Data processors. They will have new obligations, including notifying Data Controllers where there has been a breach and obtaining their consent prior to using a sub-processor. This will need robustly writing into contracts and / or Confidentiality Agreements.

6. Data protection by design. Privacy Impact Assessments, renamed Data Protection Impact Assessments (DPIA), will become a legal requirement when high-risk data processing is involved. It will include assessing situations requiring a DPIA, along with who will do it and who needs to be involved. This can be covered off in a DPIA Policy, within the suite of policies touched upon in No. 1. It will need to include that where a DPIA indicates high-risk data processing there will be a requirement to consult the ICO to seek its opinion as to whether the processing complies with the GDPR. At time of writing this seems unwieldy for the ICO, and needs greater clarification as to process and threshold.

7. Data protection officer. Organisations are advised to designate a Data Protection Officer to take responsibility for compliance.

8. Erasure of information. Processes will need to be in place to ensure systems allow for the location and (appropriate) deletion of data. IT, IG and key stakeholders will need to guide on this ahead of the GDPR being launched. It will need to be written into contracts and / or Confidentiality Agreements.

9. Higher fines. A two-tier system will be implemented. The lower tier will include breaches of privacy by design obligations, the rules relating to processor contracts, record-keeping obligations and processing security requirements. Fines will be up to €10m or 2% of the organisation's previous annual turnover, whichever is higher. The upper will include breaches of the basic principles for processing, including conditions for consent, infringing data subjects' rights and unlawful transfers to countries outside the European Economic Area. Fines will be up to €20m or 4% of the organisation's previous annual turnover, whichever is higher. Current controls will need to be reviewed to produce a gap analysis and Action Plan. This should include striving for IG Toolkit Level 3 compliance (although scores of 100% always make one suspicious).

10. Information asset management. To assess compliance with the GDPR, organisations will need to document the personal data they hold, where it came from, who it is shared with and with what legal basis it is processed. A robust information asset management (IAM) process meets this requirement, including an information asset register and data flow mapping. Additionally, where organisations have shared inaccurate data with another organisation there will be an obligation to tell them so they can correct it. Effective IAM can help facilitate this.

11. Privacy notices. As currently, this will be required to effectively communicate to subjects the legal basis for processing their data, the retention periods used and that they have

recourse to complain to the ICO. They must be easy to understand for the whole population, particularly children. Regular (probably annual) review will accommodate this, taking into account the ICOs pending updated guidance on the subject.

12. Sensitive personal data. Stricter rules will apply to its processing, including medical information. The definition has been widened to include genetic and biometric data. The IAM initiative will support much of this. Input may be required from clinicians regarding genetic data and IT regarding biometric initiatives.

13. Subject access. It is unlikely any charge will be able to be made for SARs, whereas currently £10 is charged for records held electronically and up to £50 for those held manually. Most will probably need to be responded to within a month, rather than the current 40 days. There will be different grounds for refusing to comply with SARs, including those that are manifestly unfounded or excessive. If it is documented in policies and procedures, it may be possible to charge for these.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	4 May 2017	**Agenda No**	**5.3**
Report Title:	Report on use of the Trust Seal		
Lead Director/ Manager:	Fiona Barr, Trust Secretary and Head of Corporate Governance		
Report Author:	Sumiya Ahmad, Senior Corporate Administrator		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	Report to the Board on the Use of the Trust Seal from Q2 2016-17.		
Recommendation:	It is recommended that the Board notes the use of the Trust Seal from July 2016 – March 2017.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	N/A		
Legal/Regulatory:	Standing Order 8.0 governs the use of the Trust Seal.		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	N/A		
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Report on Use of the Trust Seal
Trust Board, 4 May 2017

1.0 PURPOSE

1.1 The Board is required to receive a regular report on the use of the Trust Seal.

2.0 USE OF TRUST SEAL FROM Q2 2016-17

2.1 Standing Order 8.0 sets out the use of the Trust Seal. The Seal shall be affixed in the presence of the Chief Executive, and Chair, where appropriate, by two senior managers duly authorised by the Chief Executive to sign for the Seal.

2.2 From July 2016 – March 2017, the seal was used ten times for the purposes set out in the table below:

No.	Date	Document
675	14.07.16	Capsticks - Surbiton Health Centre Lease (from CHP to the Trust) x 3
676	24.08.16	Project Agreement for a Cellular Pathology Managed Service x2
677	08.11.16	Lease relating to premises forming part of 4th and 5th floors, Lanesborough Wing. Moorfield's Eye Hospital x3
678	14.11.16	Lease relating to premises forming part of ground floor, Lanesborough Wing x3
679	28.11.16	Lease relating to premises forming part of 4th and 5th floors, Lanesborough Wing x3
680	20.12.16	NMC – Sandra Martinez
681	23.12.16	Wandle Annexe Demolition & Site Clear-up – SGUL & Russell Cawberry Ltd x2
682	23.12.16	Knightsbridge Wing Boarding & Hoarding – Russell Cawberry Ltd x2
683	23.12.16	Peabody's Lease Renewal - AMW
684	23.03.17	SGH & SGH Charity – Trustees of Hospital Charity – MoU and Deed of Restructuring Pack for Department of Health (to enable Charity to complete independence registration from April 2017

3.0 RECOMMENDATION

3.1 It is recommended that the Board notes the use of the Trust Seal from July 2016 – March 2017.

Author: Sumiya Ahmad, Senior Corporate Administrator
Date: 27 April 2017