St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD

8th October 2015, 11.30 – 14.00 -
H2.5 Boardroom

In accordance with the Public Bodies (Admission to Meetings) 1960 Act, the Board resolves to consider other matters in private after this meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business.

Christopher Smallwood**, Chair**

		Presented by	Time
1.	**Chair's opening remarks**		
2.	**Apologies for absence and introductions**		
3.	**Declarations of interest** *For Members to declare if they have any interests as individuals or members of other organisations that might relate to Trust business or items on the agenda.*	C Smallwood	
4.	**Minutes of the previous Meeting** *To receive and approve the minutes of the meeting held 3rs September 2015.*	M Rappolt TB (M) Oct 15	
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	C Smallwood TB (MA) Oct 15	
	• Update and trajectory for call centre performance	A Rhodes / S Colas (tabled)	
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB Oct 15 – 01	
7	**Quality and Performance**		
7.1	**Quality and Performance Report** *To receive assurance regarding actions being taken to improve the quality of care for patients and to review the Trust's operational performance report for month 5* *To receive a report from the Quality & Risk Committee seminar held on 23rd September 2015*	H Tonge / M Wilson TB Oct 15 – 02a-c	
7.2	**Finance Report** *To receive the Trust's financial performance for month 5* *To receive a report from the Finance and Performance Committee held on 23rd September 2015*	S Bolam TB Oct 15 – 03a-c	
7.3	**Workforce Performance Report** *To review month 5 workforce report* *To receive a report from the Workforce Committee held on 17th September 2015*	W Brewer TB Oct 15 – 04a-g	
8.	**Strategy**		
8.1	**Update on South West London Acute Provider Collaborative and Vanguard Bids**	R Elek TB Oct 15 – 05	
9.	**Governance**		
9.1	**Risk and Compliance Report** *To review the Trust's most significant risks and external assurances received*	P Jenkinson TB Oct 15 – 06	
9.2	**Audit Committee** *To receive a report from the Audit Committee held on 9th September 2015*	M Rappolt/J Hulf TB Oct 15 – 07	

10. General Items for Information

10.1 Use of the Trust Seal

To note use of the Trust's seal during the period (September 2015) - The seal has not been used in September 2015.

10.2 Questions from the Public

Members of the public present are invited to ask questions relating to business on the agenda. Priority will be given to written questions received in advance of the meeting.

11. Meeting evaluation

12. Date of the next meeting - *The next meeting of the Trust Board will be held on 5 November 2015*

MINUTES OF THE TRUST BOARD

3rd September 2015

Richmond and Barnes Rooms, 2nd Floor, Queen Mary's Hospital, Roehampton

Present:	Mr Mike Rappolt	Non-Executive Director (chair)
	Mr Miles Scott	Chief Executive
	Professor Jennie Hall	Chief Nurse
	Mr Peter Jenkinson	Director of Corporate Affairs
	Professor Simon Mackenzie	Medical Director
	Mr Eric Munro	Director of Estates and Facilities
	Ms Stella Pantelides	Non-Executive Director
	Mr Martin Wilson	Director of Improvement and Delivery
	Mr Rob Elek	Director of Strategy
	Ms Sarah Wilton	Non-Executive Director
	Professor Peter Kopelman	Non-Executive Director
	Andrew Burn	Turnaround Director
	Dr Judith Hulf	Non-Executive Director
	Mrs Kate Leach	Non-Executive Director
	Mr Steve Bolam	Chief Financial Officer
In attendance:		
Apologies:	Mr Christopher Smallwood	Chair
	Mrs Wendy Brewer	Director of Workforce

15.09.01 Chair's opening remarks

Mr Rappolt noted the trust chairman's apologies for this meeting and therefore he would be chairing the meeting. He welcomed the governors and members of public present to Queen Mary's Hospital and invited those present to attend the formal opening of the Wolfson neuro-rehabilitation centre after the meeting.

15.09.02 Declarations of interest

No interests relating to agenda items were disclosed.

15.09.03 Minutes of the previous meeting

The minutes of the meeting held on 30th July were accepted as an accurate record.

15.09.04 Schedule of Matters Arising

The board received and noted the schedule of matters arising, noting updates given on the schedule.

15.06.05 – the board noted that an update report on the joint work with the Border Agency would be presented in due course, with a date to be confirmed.

15.06.13 – the board noted and accepted the rationale provided for the target figure of 850 fire wardens, as requested. The board noted that the level of recruitment against that target had increased to 250, with a recruitment drive ongoing within the divisions. It was agreed that a more detailed update would be provided to the next audit committee meeting, and that the quality and risk committee had reviewed the risk at its last meeting. **E Munro 9-Sep-15**

15.07.19 – Ms McCullough reported that a process was in place to control and

monitor agency expenditure, and would be provided to the board in October. The board expressed its concern regarding the time taken to confirm the numbers.

W Brewer
8-Oct-15

15.07.21 – the chairman noted that there had been a detailed discussion in the reserved part of this board meeting regarding the current bed capacity plan and risks associated with that and operational pressures.

15.09.05 Chief executive's report

Mr Scott presented his report, highlighting key points.

Mr Scott highlighted the appointments made to key posts within the Cardiology Clinical Academic Group (CAG), including the chief and general manager. September would see a period of transition for the newly established CAG, including further appointments, before go-live in October. Mr Scott also reported that the Joint Implementation Board had agreed a process for initializing development of further CAGs.

Mr Scott provided an update on the bids submitted in relation to the national 'vanguard' programme. The trust had been shortlisted for both bids – one being for the acute provider programme in south west London and the second being to establish a cancer care network with the Marsden and Imperial. A further update would be provided on the outcome of these bids and on south west London at the next meeting.

R Elek / M Scott
8-Oct-15

Mr Scott also provided an update on the Monitor investigation, reporting that Monitor had now concluded its investigation, found the trust in breach of its licence and accepted a range of undertakings from the trust, including the development and implementation of one, two and five year recovery plans. He advised that he would also be meeting with Monitor later that day as part of a challenge process over annual plans – there would be pressure on the trust to achieve better financial performance than planned which would be a significant risk for the trust. It was agreed that the outcome of that discussion would be reported to the next finance and performance committee.

M Scott
8-Oct-15

15.09.06 Quality and performance report

<u>Performance</u>

Mr Rappolt reported that there had been detailed discussions about current performance against access standards at the last finance and performance committee meeting, with a follow-up discussion in the reserved part of the board meeting. Both meetings had considered the risks and potential consequences of continued non-compliance with access standards and the development of additional controls and mitigations.

Mr Wilson presented the performance part of the report, highlighting in particular that four domains of performance were now rated as 'red' which was of concern, but with particular concern over non-compliance RTT, A&E and cancer access standards and rate of cancelled operations.

<u>Quality report</u>

Prof Hall presented the quality part of the report, summarising that the report showed no significant change in performance from quarter 1. She reported that quality assurance mechanisms continued to be strengthened, including strengthening the current quality inspection programme and greater triangulation

of data from other clinical audits and other quality metrics. In addition a group had been established to review and ensure compliance with the CQC fundamental standards, which included a weekly review of emerging or current quality issues such as procurement and estates maintenance.

Effectiveness domain
Prof Hall highlighted the outputs from the PRISM survey, which were generally very positive apart from feedback around the quality of medical records which needed to be addressed.

The board requested that the action plan for improving the quality of medical records be brought back to the board for assurance. **J Hall Tbc**

Safety domain
Prof Hall highlighted the continued rise in serious incidents and never events, as previously discussed by the board in the reserved part of the board meeting. The board also noted that the trust remained on trajectory against the infection control targets and noted improvement in the compliance with safeguarding training, although the trust was not yet compliant and therefore more focused action would continue in this area.

Mrs Pantelides sought assurance over the data quality relating to pressure ulcers in the community. Prof Hall confirmed that the division had been doing a lot of work in this area and therefore their rates had reduced. She was therefore confident that the reported data was accurate.

Mr Rappolt highlighted that while improvements had been made in compliance with VTE assessments, there were still areas of non-compliance and VTE assessment had been raised in a recent serious incident. Prof Hall confirmed that there was now much better clinical engagement and therefore improvement, but agreed that there was still more to do.

Patient experience domain
Prof Hall highlighted the most recent results from the friends and family test surveys and also highlighted continued improvement in response to complaints, with two divisions now consistently meeting the target.

Well-led domain
The board noted the heat map.

Prof Kopelman highlighted the commentary regarding complaints in neurosciences and pre-assessment, seeking assurance that this was already embedded in all pre-operative services. Prof Hall agreed to confirm. **J Hall 8-Oct-15**

The board also noted the service users' feedback regarding lost referrals. It noted that the specific incident referred to had been resolved but sought greater assurance regarding the trust's referral systems. It was agreed that the quality and risk committee would review on behalf of the trust. **P Jenkinson / S Wilton Tbc**

Report from the quality and risk committee
Mrs Wilton gave an oral report from the previous quality and risk seminar meeting, reporting that the focus of the meeting had been on a 'deep dive' review of five estates-related significant risks, including estates maintenance and fire safety. The revised risks would be presented to the next quality and risk committee. The committee had also received a presentation from the community

services division, highlighting key quality assurances and risks, including offender healthcare and staffing.

15.09.07 Finance report (month 4)

Mr Bolam presented the financial performance report for month 4, highlighting overall in-month performance and year to date performance, and the key drivers for underperformance: underperformance in outpatients, unidentified cost saving programmes, prior year issues and fines and penalties levied by commissioners. The board noted a continued improvement in the underlying position but continued underperformance against the year to date budget.

Mr Bolam also presented an update on CIP delivery and cash. The board noted an improvement in supplier payments which led to a reduction in debt owed to the trust.

The board also noted the actions being taken in turnaround, and noted that the monthly divisional budget performance reviews had been established.

Prof Kopelman asked about status of the capital programme and the impact on quality. Mr Bolam gave an update on the recent theatre downtime and assured the board that this was not due to cuts to the capital programme but more related to issues in access to theatres to perform essential maintenance. This was being built into theatre capacity plans going forward.

Mrs Wilton welcomed the improvement in cash but expressed her concern that the position still remained tight and asked whether there was any way to expedite the outstanding £20 million debt owed by NHS bodies. Mr Bolam reported that the trust had received £4m in month 4 but that there remained issues with NHS England and their process for payments. The trust continued to escalate this at a regional level, but issues remained with increasing demand and under-commissioning putting pressure on their affordability and delivery.

Mrs Pantelides highlighted that, triangulating across the workforce and finance report, it was clear that pay costs were not increasing which was welcome. However there was an increase in temporary staff usage. She asked for assurance that there were adequate controls in place over pay costs and that workforce and activity planning were linked. Ms McCullough gave an update on the reconciliation work between finance and workforce systems, which was expected to be completed by the end of September. The board noted that the number of substantive staff had increased by 277, but noted that this was due in part to the implementation of additional controls on temporary staff and that ongoing opportunities to reverse-out some the increases would be identified. The board also noted that the trust had seen a 10% increase in clinical activity but not the same level increase in staff. The board agreed that resources required to deliver the planned activity should be picked up as part of the service line review process, and the budget re-forecasting exercise would identify opportunities to reverse some previous increases in workforce overheads.

The board agreed that Mr Bolam would pick up with Mrs Brewer to provide an explanation of the increase in headcount and the additional controls put in place. **S Bolam / W Brewer 08-Oct-15**

<u>Report from the finance and performance committee</u>

Mr Rappolt gave an oral report from the finance and performance committee meeting held in the previous week. As well as considering the same finance and operational performance reports reviewed by the board at this meeting, the

committee had challenged the actions being taken by divisions to return to being on budget. The committee had also agreed that an integrated overarching performance report would be developed to bring together the various elements of performance and highlight key issues and risks.

Mrs Leach suggested that the actions in the performance report should be explicit regarding timescales and individual accountability.

15.09.08 Workforce report (month 3)

Ms McCullough presented the monthly workforce report and highlighted the vacancy rate being reported, advising that improved visibility on this would be achieved once the ESR reconciliation process had been completed. Prof Hall also highlighted the publication of new national rules regarding limits to agency nursing usage. This would come into force from October and the implications for the trust needed to be worked through.

Mrs Wilton noted differences in the reconciliation in corporate services and asked why such big differences. Mr Bolam explained that the rostering system was used differently in corporate services, to manage annual leave rather than shift rotas.

The board also noted a disappointing decline in MAST compliance and requested a trajectory for improvement. Ms McCullough reported that a fortnightly MAST performance review meeting had been established, as well as the fortnightly appraisal performance meeting. There would also be a review of the MAST syllabus and training methods to determine whether there were ways to improve delivery and compliance. **W Brewer 8-Oct-15**

15.09.09 Risk and compliance report

The board received and noted the risk report, noting in particular the most significant risks on the corporate risk report as recommended by the quality and risk committee and noting the process for 'deep dive' reviews of key risks and their controls and assurances being conducted by the quality and risk committee. The board agreed that MAST compliance should be recognised as a risk on the register and that the quality and risk committee would review progress in resolving compliance issues in the mortuary.

15.09.10 Revalidation and appraisal update

Prof Mackenzie presented an update on medical appraisals and revalidation, recommending to the board that the required compliance statement should be signed, but recognising that additional work was required to strengthen some controls. The board noted the recommendations in the report.

Dr Hulf noted the high percentage increase in new connections reported. Prof Mackenzie advised that the reason for this increase was multi-factorial, including new starters, some related to individuals doctors adopting process and some related to improvements in trust processes in identifying appropriate individuals.

The board noted the draft action plan and agreed that the plan should be brought back to the board once dates and responsibilities were completed and signed off by the executive team. **S Mackenzie 8-Oct-15**

15.09.11 Questions from the public

The chairman invited comments or questions from the public.

Hazel Ingram commented on the reported Listening into Action conversation

regarding complaints, advising that she received or heard of other anecdotal complaints which did not become complaints or PALS concerns.

Hilary Harland shared her own personal experience of the call centre and asked why it would take two weeks to sort out the problems as recruiting telephonists would be straight forward. Mr Wilson responded that sustainable improvement required improvements to the booking system rather than recruitment. He also advised that additional recruitment would not provide a quick fix as the team already had vacancies that it could not fill and appropriate training of new recruits took three weeks.

Thomas Saltiel asked what impact the change in financial approval limits was having. Mr Bolam confirmed that the trust's standing financial instructions and the procurement workflow had been amended to reflect this change. A cash committee had been established which would monitor the impact of the change and the procurement team were engaging with managers across the organisation. He advised that various incidents had been recorded regarding these changes in procurement controls and these were being investigated. Initial findings were that the causes of incidents were multi-factorial, including judgements on the part of the procurement team and also operational teams.

15.06.12 Any other business

There was no other business.

15.06.13 Date of the next meeting

The next meeting of the Trust Board will be held on 3rd September 2015.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
October 2015

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 8 October 2015
15.06.8	25.06.15	Outpatient Strategy	Draft Outpatient strategy to be to the Board	Oct 15	R Elek	Expected December 2015
15.07.17	30.07.15	Joint investigation findings / final report – RTT & A&E	Update on the flow programme to include discharge processes.	Nov 15	J Hall	
15.09.04	03.09.15	Matters Arising – 15.07.09 Agency Expenditure	Process to control and monitor agency expenditure to be provided to the board.	Oct 15	W Brewer	Update included in workforce report
15.09.05	03.09.15	Chief Executive Report	National Vanguard Programme bids – further updater to be provided at next meeting.	Oct 15	R Elek / M Scott	ON AGENDA
15.09.06	03.09.15	Quality and Performance report	Action plan for improving the quality of medical records to be brought back to the board for assurance.	tbc	J Hall	Hazel Tonge to confirm due date and to provide a verbal update at the meeting on Jennie Hall's behalf
15.09.06	03.09.15	Quality and Performance report	Well-led domain – Heat map. To give assurance the commentary regarding complaints is already embedded in all pre-operative services.	Oct 15	J Hall	Hazel Tonge to provide a verbal update at the meeting on Jennie Hall's behalf
15.09.07	03.09.15	Finance Report (M4)	The board agreed that resources required to deliver the planned activity should be picked up as part of the service line review process, and the budget re-forecasting exercise would identify opportunities to reverse some previous increases in workforce overheads. To provide an explanation of the increase in headcount and additional controls put in place.	Oct 15	S Bolam / W Brewer	Update included in workforce report

15.09.08	03.09.15	Workforce report (M3)	Decline in MAST compliance. To be a review of MAST syllabus and training methods to determine improvement, delivery and compliance.	Oct 15	W Brewer	Update included in workforce report
15.09.10	03.09.15	Revalidation and appraisal update	Draft action plan to be brought back to the board once dates and responsibilities have been completed and signed off by executive team.	Oct 15	S Mackenzie	Verbal update to be provided at the meeting

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – OCTOBER 2015

Paper Title:	Chief Executive's Report
Sponsoring Director:	Miles Scott, Chief Executive
Author:	Sofi Izbudak, Corporate Administrator
Purpose:	To update the Board on key developments in the last period
Action required by the board:	For information
Document previously considered by:	N/A

Executive summary

1. Key messages

The paper sets out the recent progress in a number of key areas:

- Quality & Safety
- Strategic developments
- Management arrangements

2. Recommendation

The Board is asked to note the update and receive assurance that key elements of the trust's strategic development are being progressed by the executive management team.

Key risks identified:

Risks are detailed in the report under each section.

Related Corporate Objective:	All corporate objectives
Related CQC Standard:	N/A

Equality Impact Assessment (EIA): Has an EIA been carried out? Yes

If yes, please provide a summary of the key findings

No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

1. Strategy

1.01 Cardiology CAG

The development of the Cardiology Clinical Academic Group continues to progress well. Interviews for the posts of Head of Clinical Services, Research, Education and Audit and Governance are now complete and the new post holders are expected to take up their positions on 1 October 2015. One of the CAG leadership team's first tasks will be the completion of a strategic review to enable a clear direction, supported by CAG members, to be planned and taken forward.

The following individuals have been appointed:

- Head of Research – Professor Sanjay Sharma
- Head of Clinical Service – Dr Raj Sharma
- Head of Education – Dr Robin Ray
- Head of Audit and Governance – Dr Lisa Anderson

1.02 GP Newsletter

As part of our on-going work to improve our communication with primary care Vicky Mitchell, our Primary Care Liaison Manager, has re-established a regular newsletter for GP practices. The electronic newsletter, called "*InTouch"*, is designed to keep colleagues informed of service updates, upcoming events and current news and developments across the Trust.

The publication is currently bimonthly, and the next issue will be sent out in mid-November 2015. Please have a look at the September issue of InTouch here, and feedback any ideas for future articles / topics to Vicky at Vicky.mitchell@stgeoges.nhs.uk

As well as sending a regular electronic newsletter, Vicky is regularly visiting GP practices, finalising the Trust Directory of Services and developing Trust website as a key information portal.

1.03 Wandsworth and Merton CCGs' Annual General Meetings

Both of our local commissioners held their Annual General Meetings in September 2015, and some of the key messages from these are included here.

Wandsworth CCG's AGM consisted of information stalls (e.g.: on smoking cessation) that were run by the CCG's staff; allowing them to showcase their work. There was also a formal meeting, which was streamed and can be watched using the following link: http://www.wandsworthccg.nhs.uk/newsAndPublications/News/Pages/Annual-General-Meeting---today-23.09.2015.aspx. Additionally there were presentations from key Board members covering a review of 2014/15, key achievements and financial performance.

Looking forward: the CCG is keen to invest further in mental health; is planning to work closely with the Trust (both hospital and community services); and wants to develop work around the frail and elderly. They are focusing on the opening hours of primary care and on how PACT will deliver for the most ill and vulnerable patients. They also want to expand the opportunities for diagnostics and testing in GP practices. In terms of ways of working, the CCG is keen to continue to promote the Expert Patients programme, a holistic approach

(including working with social care) and co-production of health with communities. They also want to provide carers with better support, improve learning disability services and increase focus on smoking cessation services.

Merton CCG's AGM included formal presentations covering the year's performance and achievements, including performance against key targets and financials, and a mental health services presentation. Merton CCG achieved all its financial duties, including returning a £2.7 m surplus. The opening of the Nelson was celebrated, and there is a desire to open a second centre, based in Mitcham.

Looking to the future, the CCG is keen to invest in capacity at the Trust, to support us in the delivery of Emergency Department targets. The CCG also wants to focus on the following: comms and engagement; culture and workforce; technology and partnerships. The CCG want to work more closely with community based social care services and are considering a joint integrated commissioning model. The CCG want to review referrals as they have the highest referral rates in the country. A focus on the South West London Collaborative Commissioning 5 year strategy is also high on their priorities.

2. Academic Development

2.01 *GMC (General Medical Council) Survey*

The results and actions from this year's GMC trainees' survey have now been released. The survey assesses trainees' experience in 14 domains, presented by: trust, speciality, and level of training, giving 52 separate training groups. This gives a real insight into the experience of being trained at SGH. Outliers away from national norms are identified and HESL pays attention to the "red outliers" and asks for action plans on many of these. Of the 52 training groups, each with 14 domains, giving rise to 728 reporting fields, SGH received 18 "red outliers" and 45 "green outliers".

Overall, SGH attracted a high number of "red outliers" (7/52) in workload and in regional teaching (6/52). SGH was also seen across the board as good in its access to educational resources (10/52) and local teaching (8/52). Areas of difficulty were also identified in Radiology – Overall satisfaction, Clinical supervision, Workload, Regional Teaching; Emergency medicine F2 – Workload, Handover; Endocrinology/DM – Clinical supervision, Workload, Regional teaching; Gastroenterology – Regional teaching, Educational supervision; Histopath – Overall satisfaction.

For each area, the DME met with specialty leads and trainees to investigate the underlying reasons for the signal. Of particular note, Radiology has for the second year been identified as an issue in the survey across several domains. This is a department that has not grown as fast as demand, and it is difficult to recruit consultants. Standards are exacting and SIs have involved Radiologists. Key to the resolution of this outlier is the development of sustainable staffing, changed work patterns and resilience for trainees. The action plans in response to the survey were reviewed and approved by HESL. HESL is currently also investigating "green outliers" to disseminate good practise.

2.02 Research – National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) South London

The CLAHRC recently held two internal workshops for members of the CLAHRC, entitled 'Know Your CLAHRC'. Theme leaders within the CLAHRC shared progress on their projects and some of the emerging insights and learning. These events were very well attended and provided an excellent opportunity for researchers to meet each other.

3. Workforce

3.01 Management Arrangements

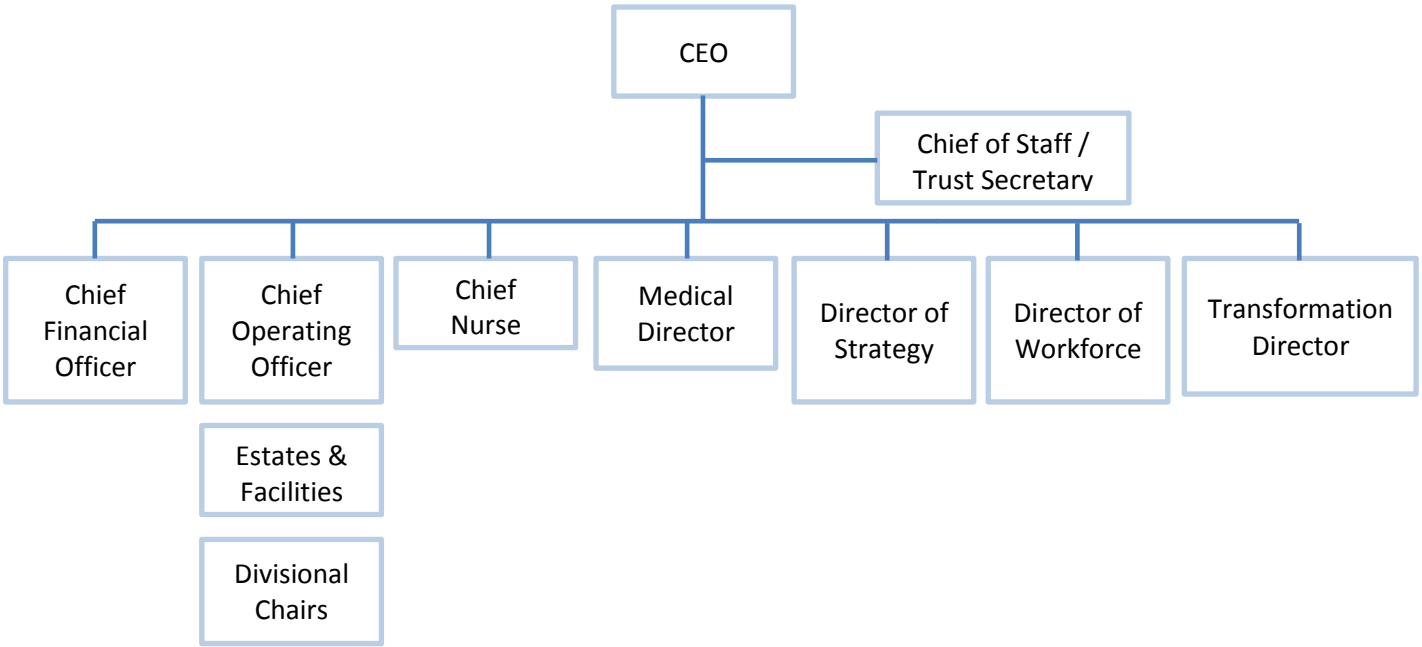
Executive Directors

The trust is also looking to appoint a Chief Operating Officer, to commence in the new year. Paula Vasco Knight has been appointed as interim COO, to manage affairs until a substantive appointee takes up the post.

A Transformation Director will be the successor for our current Turnaround Director, and will take on remaining aspects of the incumbent Director of Delivery and Improvement's remit, that have not been transferred to the COO.

The trust is in the process of succession planning for the Director of Corporate Affairs. We are seeking to appoint a Chief of Staff / Trust Secretary, thus replacing the current role with a post that will not be a director but will operate at Board level.

The proposed executive structure for the trust will now be as follows:



Non-Executive Directors

On 27th October, the Council of Governors will be considering the appointment process for a new Chairman and one NED, to replace Christopher Smallwood and Mike Rappolt

respectively. The Governors will also be considering reappointing Sarah Wilton as NED at the end of her current term. Approval will also be sought from the Board and the Council of Governors to amend the constitution to increase the number of NEDs by one.

3.02 Listening into Action

Friends and Family staff survey

We are required, by NHS England, to run the Friends and Family staff survey again this quarter, in advance of the annual NHS staff survey, which started reaching staff by email from 21st September. The Friends and Family staff survey was open to staff during September and at the time of writing 241 members of staff have responded, with 75% likely or highly likely to recommend the trust as a place to receive treatment and 46% likely or highly likely to recommend as a place to work. This is a smaller sample (so far) than the previous quarter during which the scores were 79% and 50% respectively.

LIAiSE

In August, we wished Sarah Hemmings well in her new role within the St George's Recruitment team and in September we welcomed Karyn Richards-Wright as the new LIAiSE Adviser for the trust. Karyn joins Listening into Action from the St George's staff bank and has been with the trust for 8 years. Karyn is building on the work that Sarah started, including increasing publicity for the service, targeting hard to reach teams and services and taking the LIAiSE service to areas of the trust that have not yet benefitted from the service.

Inclusivitiy

We know from the annual staff survey that the experience of our black and ethnic minority staff is less positive than for white members of staff. To this end we are implementing a number of initiatives including two Listening into Action inclusivity events – one at St George's on 18th September and one at Queen Mary's on 25th September. We used the Listening into Action approach to gauge from staff what – in their experience – gets in the way of providing the best possible care to patients. The St George's as One steering group will take forward the actions arising from these meetings.

Community Services Division

We held a Listening into Action conversation for community staff at the Doddington Health Centre on 15th September to compliment the Listening into Action community conversation that took place at Queen Mary's in July. A small sponsor group is being set up, led by Wendy Brewer, to take forward actions from these events.

Complaints

We held a Complaints conversation on 10th September to review how we can continue to improve the way we handle complaints and reduce the number we receive. Feedback will be used to review our complaints handling.

4. Monitor Investigation / Financial Recovery

4.01 Q1 2015/16 monitoring of NHS foundation trusts

As an NHS foundation trust, there is a requirement under Monitor's compliance framework for the trust to submit a quarterly submission to Monitor. The Board approves the compliance statements which comprise part of the submission.

Monitor has completed its review of the trust's Q1 2015-16 submissions and has now published the results. The trust's current ratings are:

- Continuity of services risk rating: 2
- Governance rating: Red

As previously reported to the trust, the trust continues to be subject to formal enforcement action in the form of additional licence condition and enforcement undertakings. These actions have also been published by Monitor. As such the trust has regular Progress Review Meetings with Monitor in order for the trust to provide assurance to Monitor regarding progress against those undertakings.

Monitor have recently amended the Risk Assessment Framework, published in August 2015. From quarter 2 onwards they will publish a financial sustainability risk rating (replacing the continuity of service risk rating), alongside the trust's governance rating. A rating of less than 3 would lead to Monitor considering further regulatory action. Monitor have advised that the trust's financial sustainability risk rating for quarter 1 would have been 1.

The quarter 2 submission to Monitor is due on 31 October 2015.

5. Communications

5.01 '24 Hours in A&E' at St George's Hospital

Filming finished in early July and there are now 34 episodes in various stages of editing. A draft of the likely first episode has been seen by the trust's viewing panel who were very pleased with it. The production company have fed back how impressed they are by the expertise and care in our emergency department and other clinical areas. They are also grateful to our estates department, without whose help the filming would not have happened. The broadcast date is likely to be the third week of October. It will be a 9pm slot on Channel Four but we don't yet know which day.

5.02 Response to the 2014 staff survey

The communications team have been supporting the HR and Workforce team on four 'themed' months in response to feedback from the national staff survey. The themed months are designed to improve staff retention rates. In September we focussed on bullying, harassment and inclusivity which included direct communication from Wendy Brewer to all staff, a newsletter and the first LiA inclusivity event for BME staff.

5.03 Wolfson Neurorebilitation opening

This month's board meeting was immediately followed by the opening of the Wolfson Neurorehabilitation Centre at Queen Mary's Hospital. Justine Greening MP unveiled the plaque

with Miles after a tour of the hospital and its centenary display. Other special guests included Henry Marsh CBE and patients who have been treated at the centre.

5.04 2015 national staff survey

The 2015 NHS staff survey has launched at the trust. A concerted effort last year to raise the profile of the survey led to an improved response rate (39.1%) which is broadly in line with the national average of 41%. As we draw towards the closing date for the staff survey we will introduce additional incentives for staff to complete it.

5.05 Reflection and sharing common experiences - Schwartz Rounds

Schwartz Rounds started again in September. The events remain well attended with 85 people at the latest round where ED and communications team staff reflected on their participation with '24hrs in A&E'. Previous topics discussed at the Schwartz Rounds have included 'out of site, out of mind' and 'a colleague I'll never forget'. An evaluation of the programme will take place after six rounds.

5.06 Senior leaders' briefing

On 9th September we held a senior leaders' meeting where staff were given updates on our financial position balanced with messages on maintaining quality and workforce developments.

5.07 Media update

Richard Porter, St George's Max Fax consultant, featured in Jamie Oliver's Sugar Rush on Channel 4 which aired on 3rd September. This hour long documentary looks at the impact of sugar on our health. Richard speaks about the role it plays in children's dental decay.

The electronic prescribing and medicines administration (ePMA) team have been shortlisted for a HSJ award in the category of 'Using Technology to Improve Efficiency' for their entry 'How electronic prescribing and medicines administration is delivering safer, better and smarter healthcare**.'** The ePMA team will be presenting to a judging panel on Monday 12th October. This has been tweeted, published on the St George's website and publicised internally. Will Hall the Lead Pharmacist for IT was interviewed by Digital Health about ePMA at St George's and the full article is available here.

St George's was named by The Sunday Times as the best university for UK careers prospects, with a very impressive 93.4% of graduates either working in professional jobs or undertaking postgraduate study six months after leaving. This is another great story demonstrating the many benefits of sharing our site with the university.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – OCTOBER 2015

Paper Title:	Quality and performance Report to Trust Board for Month 5- August 2015
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Martin Wilson: Director of Delivery and Improvement
Author:	Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Matt Laundy- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Martin Wilson – Director of Delivery and Improvement
Purpose: *The purpose of bringing the report to the board*	To inform Trust Board about Quality Performance for Month 5
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	Finance and Performance Committee Quality and Risk Committee

Executive summary

Performance

Performance is reported through the key performance indicators (KPIs) as per Monitor Risk Assessment Framework. The trust is performing positively against a number of indicators within the framework, however existing challenges continue in particular: ED 4 hour target, RTT, Cancer waiting time targets and cancelled operations by the hospital for non-clinical reasons.

The trust has seen positive performance improvement in Diagnostics with number of patients waiting greater than 6 weeks reducing significantly. The trust shows the quality governance score against the Monitor risk assessment framework of 4 and Monitor have imposed additional license conditions in relations to governance.

The report lists by exception those indicators that are being underachieved and provides reasons why target have not been met, remedial actions being taken and forecasted dates for when performance is expected to be back on target.

Key Points of Note for Trust Board in relation to the August Quality Performance:

The Overall position in August does not indicate any key changes from the Quarter One position in terms of the trends for the metrics with some moderate improvement across a number of indicators. Serious Incident numbers remain an area of focus in relation to themes seen and actions being taken. This is monitored through the Patient Safety Committee and SIDM.

Effectiveness Domain:

- Mortality and SHMI performance remains statistically better than expected for the Trust. Despite this position we continue to proactively investigate mortality signals at procedure and diagnosis level.
- We were required to investigate higher than expected mortality for the diagnosis group 'Coronary atherosclerosis and other heart disease'. The review has indicated that there are points of learning, in particular ensuring more detailed clinical summary information to GP's and strengthening mortality review processes.
- Several National Audits are within the report. The management of Mental Health within the Emergency Department indicates that SGH met the fundamental standards in this area, the remaining development standards the Trust is in line with the national results however the Board will note a number of actions to be taken. In relation to the assessment of cognitive impairment in Older People within ED the findings indicate that there are a number of actions which need to be taken to improve compliance against both the fundamental and developmental standards.
- The report indicates the position with compliance with NICE guidance for the period August 2011 to May 2015. Detail is available of all areas where we have declared noncompliance, the reasons for this position and action being taken. Further assurance is being sought in relation to the risk profile; any findings of note will be reported back to the board following the DGB meetings at the end of this month.

Safety Domain:

- The number of general reported incidents in August indicates a similar trend in terms of numbers and level of harm. The Board should note that the trend for Serious Incidents

indicates a gradual increase. Of those declared for July the Board will note the issues are across a range of clinical issues, some are mandatory in terms of reporting.

- Safety Thermometer performance decreased slightly from July performance remaining above the national average. There was again an increase in patients with CAUTI, with a decrease in other harms reported. The Trust is participating in a wave 1 programme with the HIN to improve practice in association with the use and management of catheters to support improvement of current infection rates.
- The pressure ulcer profile for August mirrored that of the previous 2 months with a single grade 3 ulcer reported but with a slight decrease in grade 2 ulcers. Of note progress within the community Division who for the third month have reported no serious grade 3 or 4 pressure ulcers.
- The Trust has now reported 3 MRSA bacteraemia cases and 13 C-Difficile to the end of August. The Board should note that the MRSA case declared in August is going to arbitration and may subsequently be removed, we are now on track against the annual Trajectory for C Difficile which is set at 31 cases for 15/16. All cases are currently subject to an RCA process.
- Safeguarding Children's data is presented this month following a review of the database. The Trust is now demonstrating a compliance of 75% for level 3 training. The board will note that the numbers of staff to be trained is known and there are agreed actions both for adult and Children's safeguarding which are being monitored by the respective safeguarding Committees. Safeguarding Adult training data is also now a cause for concern, Data quality is being checked and actions agreed to improve the current profile.

Experience Domain:

- The response rate for FFT improved slightly with but response rates for inpatient wards decreased. The overall score for the Trust decreased in August to a score of 93.6%. A snapshot of information that is available on rate has also been included to demonstrate how the focus on FFT is now moving towards triangulation of patient feedback and development of themes from the feedback.
- The complaints profile in relation to numbers has decreased slightly in terms of numbers. Areas where complaints increased were largely within the accident and emergency department.
- In relation to turnaround times of complaints a decline still continues to be seen following improvement through to May 2015, although the clinical Division (Community) continues to achieve the target.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 93.99 % across these areas against current staffing figures. This is against current staffing figures. This figure is being reviewed alongside other Trust information about run rates, the Trust information for staffing alerts (Red Flags) which has been implemented across the Trust, and Trust Bank information about the temporary staffing profile and fill rates.

Ward Heat map:

- The Heat map for In patient areas for August is not currently included in the Report due to data problems.

Key risks identified: Complaints performance (on BAF) Infection Control Performance (on BAF) Safeguarding Children Training compliance Profile (on BAF) Staffing Profile (on BAF)	
Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	
Equality Impact Assessment (EIA): Has an EIA been carried out? **If yes, please provide a summary of the key findings** No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme. **If no, please explain your reasons for not undertaking an EIA.**	

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St George's University Hospitals NHS
NHS Foundation Trust

Performance & Quality Report

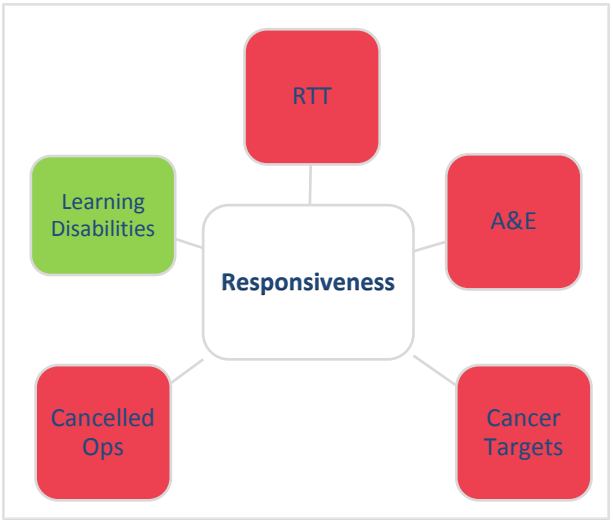
to the Trust Board

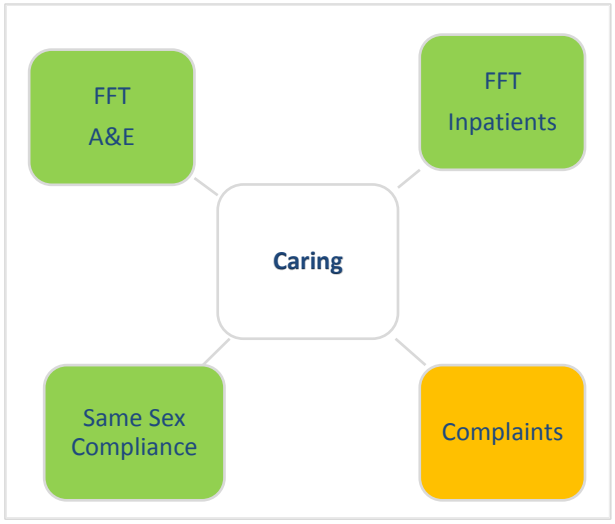
Month 5 - August 2015

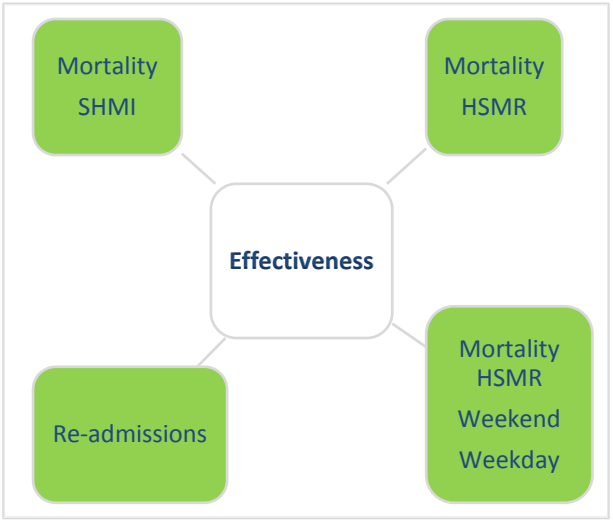
Excellence in specialist and community healthcare

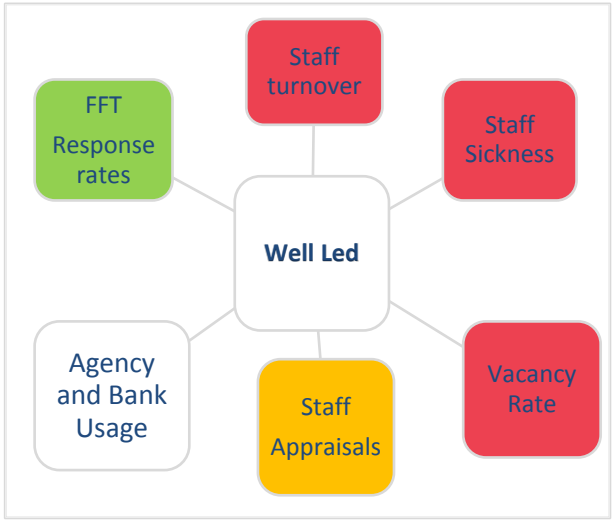
CONTENTS

1. Executive Summary - Key Priority Areas August 2015*









The above shows an overview of August 2015 performance for key areas within each domain and also as detailed in the Monitor Risk Assessment Framework. These domains correlate to those of the CQC intelligent monitoring framework.

The overview references where the trust may not be meeting 1 or more related targets. (*Note Cancer RAG rating is for July as reported one month in arrears)

This report is produced in line with the trust performance management framework which encompasses the Monitor regulatory requirements.

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Performance against Frameworks

Excellence in specialist and community healthcare

2. Monitor Risk Assessment Framework KPIs 2015/16: August 15 Performance (Page 1 of 1)

ACCESS

Metric	Standard	Weighting	Score	YTD	Jul-15	Aug-15	Movement
Referral to Treatment Admitted	90%	N/A	N/A		85.25%	80.20%	-5.05%
Referral to Treatment Non Admitted	95%	N/A	N/A		95.18%	93.00%	-2.18%
Referral to Treatment Incomplete	92%	1	1		90.62%	89.70%	-0.92%
A&E All Types Monthly Performance	95%	1	1	92.67%	91.88%	94.25%	2.37%
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q1**	**Q2***	**Movement**
62 Day Standard	85%	1	1	79.63%	79.27%	80.52%	1.24%
62 Day Screening Standard	90%			84.56%	82.08%	90.70%	8.62%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	95.33%	95.18%	95.83%	0.65%
31 Day Standard	96%	1	0	97.54%	97.24%	98.45%	1.21%
Two Week Wait Standard	93%	1	1	91.08%	92.38%	86.01%	-6.37%
Breast Symptom Two Week Wait Standard	93%	1		91.28%	90.45%	94.49%	4.04%

* Not Yet Avalibale (NYA)

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Jul-15	Aug-15	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	13	2	2	0
Certfication of Compliance Learning Disabilities;							
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant	1	0	Yes	Yes	Yes	
Data Completeness Community Services:							
Referral to treatment * data is for April and May 2015	50%	1	0		55.1%	55.1%	0.0%
Referral Information	50%	1	0		87.9%	87.9%	0.0%
Treatment Activity	50%	1	0		70.7%	72.3%	1.6%

Trust Overall Quality Governance Score	4	4	0

August 2015 Performance against the risk assessment framework is as follows:

The trust's quality governance rating is 'Red' as the trust has a governance score of 4 and Monitor have imposed additional license conditions in relations to governance. (further details in appendix 1.)

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Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- Cancer Waits
- Diagnostic Waits > 6weeks
- Cancelled Operations

Further details and actions to address underperformance are further detailed in the report.

*Cancer Data is reported a month in arrears. Q2 relates to June and July.

Legend	
↑	Positive Performance Change
↓	Negative Performance Change
→	No Performance Change

MONITOR GOVERNANCE THRESHOLDS	
	Green: a service performance score of <4.0 or <3 consecutive quarters' breaches of a single metric
	Governance Concern Trigger and Under Review : a service performance score of >=4.0 or 3 consecutive quarters' breaches of single metric with monitor undertaking a formal review, with no regulatory action.
	Red: a service performance score of >=4 and >=3 consecutive quarters' breaches of single metric and with regulatory action to be taken

2. Trust Key Performance Indicators 2015/16: August 15 Performance (Page 1 of 1)

RESPONSIVENESS

Metric	Standard	YTD	Jul-15	Aug-15	Movement
Referral to Treatment Admitted	90%		85.25%	80.20%	-5.05%
Referral to Treatment Non Admitted	95%		95.18%	93.00%	-2.18%
Referral to Treatment Incomplete	92%		90.62%	89.70%	-0.92%
Referral to Treatment Incomplete 52+ Week Waiters	0	11	3	3	0
Diagnostic waiting times > 6 Weeks	1%		2.03%	2.33%	0.30%
A&E All Types Monthly Performance	95%	92.67%	91.88%	94.25%	2.37%
12 Hour Trolley Waits	0	0	0	0	0.00%
Urgent Ops Cancelled for 2nd time (number)	0	0	0	0	0.00%
Proportion of patients not treated within 28 days of last minute cancellation	0%	16.67%	11.11%	16.22%	5.11%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Jun-15	Jul-15	Movement
62 Day Standard	85%	79.63%	79.19%	80.52%	1.32%
62 Day Screening Standard	90%	84.56%	87.50%	90.70%	3.20%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	95%	100%	96%	-4.17%
31 Day Standard	96%	97.54%	98.41%	98.45%	0.04%
Two Week Wait Standard	93%	91.08%	91.67%	86.01%	-5.65%
Breast Symptom Two Week Wait Standard	93%	91.28%	98.40%	94.49%	-3.91%

EFFECTIVENESS

Metric	Standard	YTD	Jul-15	Aug-15	Movement
Hospital Standardised Mortality Ratio (DFI)	100		88.2	87.2	-1.0
Hospital Standardised Mortality Ratio - Weekday	100	0	86.1	86.1	0.0
Hospital Standardised Mortality Ratio - Weekend	100	0	83.7	83.7	0.0
Summary Hospital Mortality Indicator (HSCIC)	100	0	89	89	0.0
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%	3.10%	2.20%	2.90%	0.7%
Bed Occupancy - Midnight Count	85%		94.4%	95.0%	0.006
LOS - Elective			4.3	4.3	0.0
LOS - Non-Elective			4.8	4.3	-0.5

CARING

Metric	Standard	YTD	Jul-15	Aug-15	Movement
Inpatient Scores - Friends & Family Test	60		94	93.6	-0.400
A&E Scores - Friends & Family Test	46		85.8	86.5	0.7
Complaints			83	87	4.0
Mixed Sex Accomodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Jul-15	Aug-15	Movement
Clostridium Difficile - Varience from plan	31	13	2	2	0
MRSA Bacteramia	0	2	0	0	0
Never Events	0	5	1	1	0
Serious Incidents	0	73	9	13	4
Percentage of Harm Free Care	95%		94.8%	93.8%	0
Medication Errors causing serious harm	0	1	0	1	1
Overdue CAS Alerts	0	10	2	2	0
Maternal Deaths	1	1	0	0	0
VTE Risk Assessment (previous months data)*	95%		96.6%		

WELL LED

Metric	Standard	YTD	Jul-15	Aug-15	Movement
Inpatient Respose Rate Friends & Family	30%		43.8%	41.9%	-1.9%
A&E Respose Rate Friends & Family	20%		29.6%	21.7%	-7.9%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		17.4%	10.0%	-7.4%
Trust level sickness rate	4%		3.4%	3.9%	0.44%
Total Trust Vacancy Rate	11%		14.3%	14.5%	0.2%
% of staff with annual appraisal - Medical	85%		87.1%	84.5%	-2.6%
% of staff with annual appraisal - non medical	85%		74.6%	72.6%	-2.0%

The trust continues to monitor the above key performance indicators following authorisation as a Foundation Trust. The indicators are grouped into domains parallel to that defined by the CQC. The trust is currently reviewing additional indicators for inclusion which will be incorporated in forthcoming reports.

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Performance – areas of escalation

Excellence in specialist and community healthcare

3. Performance Area of Escalation (Page 1 of 6) - A&E: 4 Hour Standard

Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	Jul-15	Aug-15	Movement	2015/2016 Target	Forecast for Aug-15	Forecast for Sep-15	Date expected to meet standard
FA	91.88%	94.25%	↑ 2.37%	>= 95%	R	R	TBC

Peer Performance July 2015 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
2	3	4	5	1
91.88%	91.80%	90.80%	89.60%	96.10%

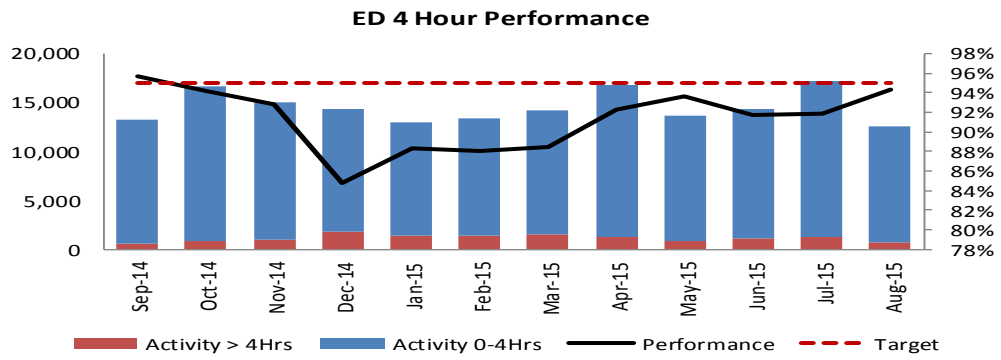
The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. Performance remains challenged being below that target at both the weekly and monthly level. In August 94.25% of patients were seen within 4 hours, this is a marked improvement on July performance of 91.88% . The trust is also below the target YTD with performance of 92.67%

. Factors that continue to affect performance include:

- Increase in breaches for patients awaiting a specialist opinion.
- Number of mental health patients breaching. Even though the initial assessment from mental health has improved, long delays in placing the patient into the appropriate setting is resulting in breaches.
- Increase in the numbers of delayed transfer of care patients (DTOC) and the level of delay remains a focus area for the organisation as this has a significant impact on flow through the hospital and impact upon ED flow into the organisation. As at 07/09/2015 there were 15 delayed transfer of care patients within the hospital accounting to 204 bed days lost due to delays. In addition to this there were also 19 NDTOC (pending delays) patients within the organisation, of which 7 were due to requiring either nursing home placement or homecare packages.

As at 07/09/2015 there were 73 of 471 patients being tracked within the organisation that were medically fit for discharge. These encompass the DTOC, NDTOC, patients awaiting transfer to another provider and patients going home that day. The trust is working with commissioners and external agencies to expedite this.

The trust continues to implements Joint Investigation action plans to recover performance which continue to be reviewed monthly. In addition to this and following a process of continual review further internal actions continue to be taken, both by the ED department who focus on what direct impact changes they can make from initiatives within ED and as a whole system approach by the rest of the organisation as to how they can implement initiatives which will continue to enhance flow and release capacity within ED. This is being reviewed pro-actively by the Executive Director of Delivery bi-weekly in an ED performance improvement forum.



Performance Overview by Type			
Period	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month to Date (Aug)	93.66%	99.82%	94.25%
Quarter to Date	92.13%	99.89%	92.89%
Year to Date	91.89%	99.54%	92.67%

3. Performance Areas of Escalation (Page 2 of 6) - RTT Incomplete 52+ Week Waiters

Referral to Treatment Incomplete 52+ Week Waiters							
Lead Director	Jul-15	Aug-15	Movement	2015/2016 Target	Forecast for Aug-15	Forecast for Sep-15	Date expected to meet standard
MW	3	3	0	0	R	R	Oct-15

Specialty	Patient Type	Date for patient to be treated	Commentary
Haematology	OP	14/09/2015	This patient is being pro-actively actioned by the service. An appointment was expedited for 14/09/2015. The patient attended the appointment and we are currently awaiting a clinical decision from the consultant.
Urology	IP	02/09/2015	The patient has been contacted about the delays in booking their treatment. An appointment for pre-operative assessment has been agreed and scheduled for 25/08/2015, with a subsequent date for surgery of 21/09/2015.
Gynae	OP Cont	23/09/2015	The patient attended an OP appointment on 09/09/2015 and has been added to the WL for a Cystoscopy. This has now been scheduled for 23/09/2015.

The trust continues to pro-actively addressing the issue of long waiters and in particular the prevention of 52+ week waiters. The following actions continue to support this:

- Weekly RTT management meetings by care group are in place which track the PTL and review at patient level, review capacity and escalate long waits.
- A weekly email of long waiters is sent to divisional managers to review and action those patients waiting for more than 40 weeks. A monthly review of all patients waiting greater than 44 weeks, detailing reasons for delay and plans for treatment is being undertaken post submission and shared with commissioners going forward.
- A monthly RTT Compliance meeting chaired by the Executive Director of Delivery and Improvement is held which reviews; performance by care group with a particular focus on patients waiting 40+ weeks to ensure treatment plans are in place, review/facilitate escalation, provide senior decision making support to drive actions forward, reviews and monitors elective cancellations, their rebooking to target and their impact on RTT performance.

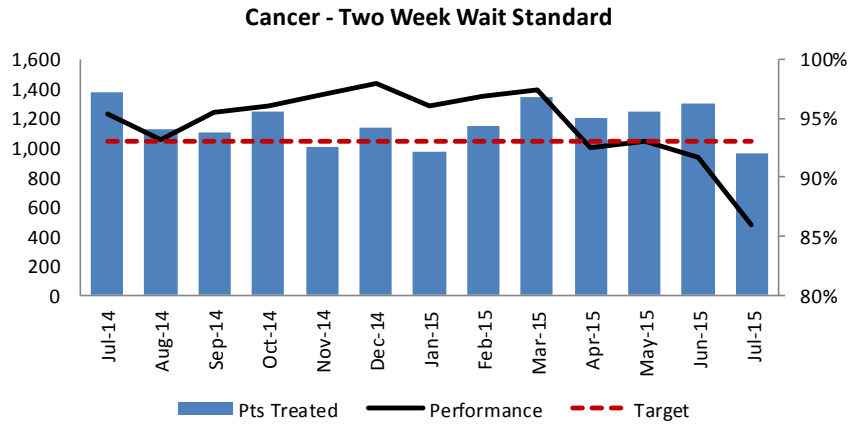
3. Performance Areas of Escalation (Page 3 of 6) - Cancer Performance

Cancer Performance								Peer Performance Latest Published July 2015- 2016				
Lead Director – CC	Jun-15	Jul-15	Movement	2015/2016 Target	Forecast for Jul-15	Forecast for Aug-15	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
14 Day GP Referral for all Suspected Cancers	91.67%	86.01%	-5.65%	93%	R	R	Jan-16	86.01%	94.34%	95.27%	97.49%	95.12%
62 Day Wait Standard	79.19%	80.52%	1.32%	85%	R	R	Oct-15	80.52%	81.51%	88.89%	86.77%	73.44%

The trust was non compliant against two of the national cancer wait targets for the month of July as detailed in the table above. In response to the recent underperformance in Q1, escalation actions including fortnightly escalation meetings continue as directed by the the Executive Director of Delivery. Continued areas of focus include:

- Rigorous PTL visibility and tracking.
- Actions being undertaken to address capacity constraints . In particular within the modalities of; Breast, Urology, and Lower GI and Lung.
- Renewed focus and improvements to MDT meetings. The meeting will also be expediting actions `arising from MDT meetings.
- Reviewing DNA rates and patient choice breaches in accordance with guidance and highlighting mechanisms by which this could be reduced.

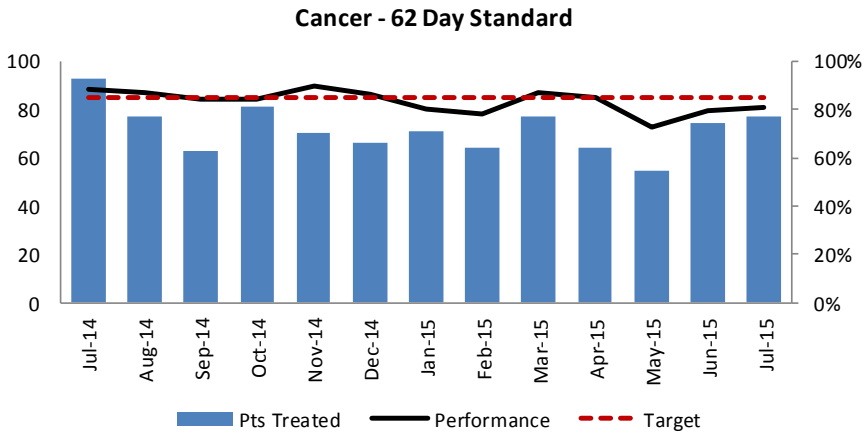
A trust cancer performance improvement action plan has been developed and is being reviewed at the escalation meetings. This forms part of the national work being undertaken by NHS England. The action plan has been focuses on actions by tumour type which need to be taken to address specific key issues within each modality, This was presented to commissioners in the September Clinical Quality Review meeting, where commissioners stated a feeling of assurance that appropriate actions are being taken by the trust to drive performance improvement. Supporting the action plans a resulting performance trajectory was presented detailing that the trust envisages to be compliant with all standards from January 2016 (This is dependant on other provider organisations referring into the trust to deliver on their improvements in reducing shared breaches)



Two Week Wait Standard - Non-achievement of this target relates to 134 breaches which is unfortunately higher than the average number of breaches of 95 seen in Q1, with a correlating reduction in the number of treatments in month. Modalities of breach include: Breast, Gynae, Skin, Haematology and Upper GI.
Key issues affecting performance in July:

- patient choice - this accounted for 36 patients breaching.
- Capacity in particular in relation to Gynae and Skin. Capacity is currently being reviewed to ensure for future performance sustainability and the following actions are also being undertaken:
- Recruitment of additional outpatient nursing staff to ensure additional clinics requested for 15/16 are consistently staffed.
- Work with affected services to achieve better capacity planning for the summer months. Use planning tools provided by the IST
- Daily update on capacity concerns and breach numbers from the Two Week Wait Referral Office.

3. Performance Areas of Escalation (Page 4 of 6)
- Cancer Performance



62 day GP Referral to Treatment Wait Standard - Non-achievement of this target in July relates to 22 patients breaching of which 12 were on a shared pathway. SGH performance excluding shared patients would have been 86.2% and within target. Breaches occurred in the modalities of; Lower GI, Upper GI, Lung, Breast, Head and Neck, Gynae and Urology.

Key issues affecting performance were:

- Late referrals from other trusts (referrals received after day 42) and referrals with no information (a supporting completed ITT from for tracking). Work with shared providers to improve relationship s and transfer of information is being undertaken . This is also being supported by the recently formed SWL Cancer forum.
- Patients on complex diagnostic pathways,.
- Diagnostic capacity constraints within Endoscopy, and lost theatre capacity due to technical issues.
- Patient choice.

Capacity constraints within Endoscopy are being actioned as part of the on-going work in diagnostics. Additional capacity continues to be arranged and is supporting further delivery of service. The trust continues to work on contingency plans for emergency loss of theatre capacity and forward planning.

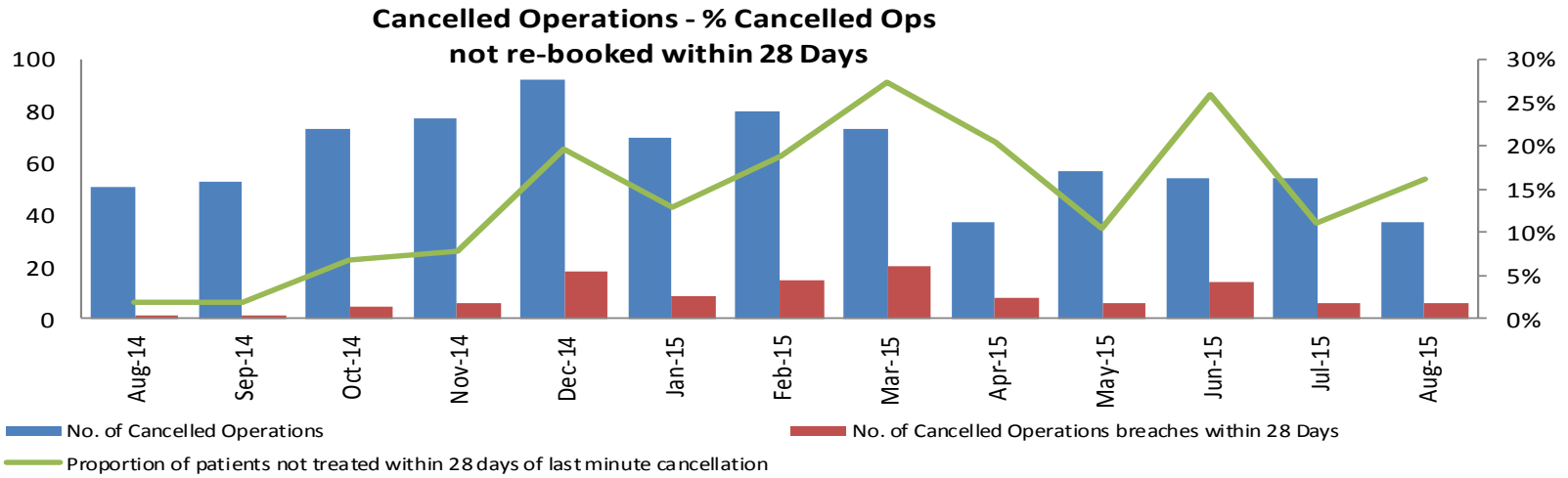
July-2015 performance against national cancer targets by tumour type.

Cancer Indicator	Target	All Types	Breast	Childrens	Gynae	Haem	Head & Neck	Lower GI	Lung	Skin	Upper GI	Urological
14 Day GP Referral for all Suspected Cancers	93%	86.0%	86.0%	100.0%	70.04%	82.4%	93.3%	95.6%	95.7%	75.2%	88.8%	97.1%
14 Day Breast Symptomatic Referral	93%	94.5%	94.5%									
31 Day First Treatment	96%	98.4%	100.0%		66.75%	100.0%	100.0%	100.0%	100.0%	96.3%	100.0%	97.8%
31 Day Subsequent Surgery Treatment	94%	95.8%										
31 Day Subsequent Drug Treatment	98%	100.0%										
62 day GP Referral to Treatment	85%	80.5%	73.1%		60.0%	100.0%	80.0%	76.5%	80%	100%	50.0%	77.8%
62 Day Screening Referral to Treatment	90%	90.07%										

3. Performance Areas of Escalation (Page 5 of 6) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Jul-15	Aug-15	Movement	2015/2016 Target	Forecast for Aug-15	Forecast for Sep-15	Date expected to meet standard
CC	11.11%	16.22%	↓ 5.11%	0%	G	G	Sep-15

Peer Performance Comparison – Latest Available Q1 2015/16				
STG	Croydon	Kingston	King's College	Epsom & St Helier
18.70%	2.04%	9.40%	7.60%	0%



The national standard is that all patients whose operation has been cancelled for non clinical reasons should be treated within 28 days.

The trust had 37 cancelled operations from 4055 elective admissions in August. 31 of those cancellations were rebooked within 28 days with 6 patients not rebooked within 28 days, accounting for 16.22 % of all cancellations. There were 244 operations cancelled in the year to date, with 201 rebooked within 28 days. The overall number of breaches in the year to date is 43.

The breaches were attributable to: Vascular, Paediatric surgery, Gynaecology and ENT. Key contributory factors for the cancellations were related to emergency cases taking precedent, insufficient time due to previous complex cases over running, ITU bed capacity issues, and cancellation due to technical theatre ventilation issues.

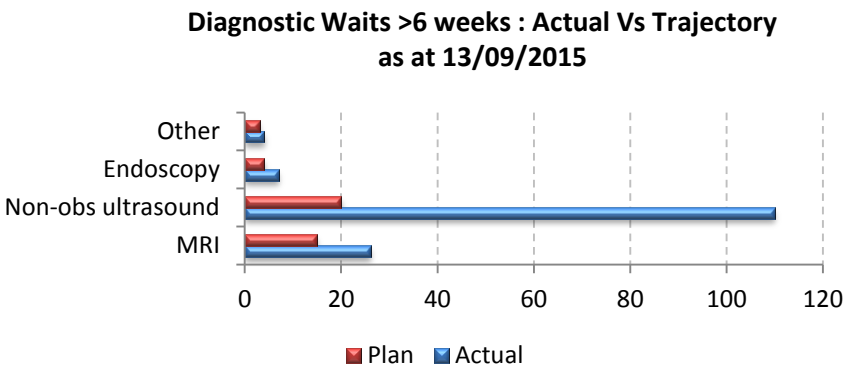
All 6 patients now have scheduled dates for their operations.

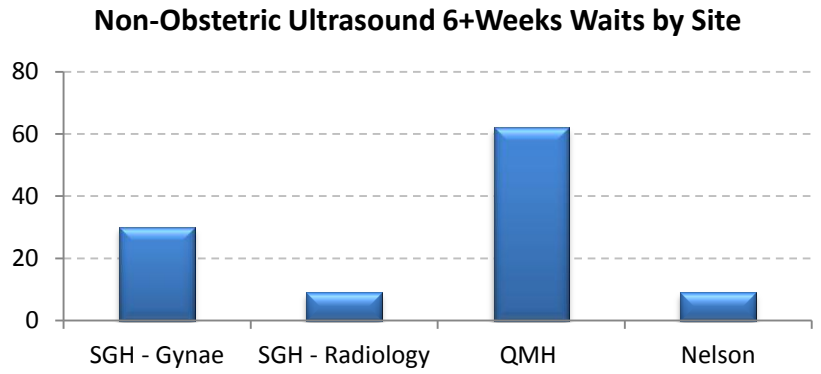
3. Performance Areas of Escalation (Page 6 of 6) - Diagnostic 6+ Weeks Wait

Diagnostic waiting times > 6 weeks							
Lead Director	Jul-15	Aug-15	Movement	2015/2016 Target	Forecast for Aug-15	Forecast for Sep-15	Date expected to meet standard
SC	2.03%	2.33%	↓ 0.30%	1%	R	R	Oct-15

No of Patients waiting >6 weeks – Latest Published Data July 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
93	10	14	122	22

The trust has maintained positive performance improvement with diagnostic waits greater than 6 weeks, with the exception of non-obstetric ultrasound. The trust is exceeding the target of number of patients waiting greater than 6 weeks of 1% of all waiters with performance at 2.33%. The trust continues to drive actions to further reduce the number of patients waiting in excess of 6 weeks. The pre-dominant modalities of challenge continue from Q1, namely; MRI and Non-obstetric ultrasound.





Further actions continue to be undertaken to expedite recovery so we are back on track for non-obstetric ultrasound.

- Significant improvements within the modality of Gynaecology have been made. However, this has been seen to have increased over the last few weeks. Additional sessions to reduce waiting times and recover performance have now been scheduled. Further to this and to support long term stability, the trust is actively in the recruitment process for an additional sonographer, The vacancy has now closed, and the trust are hopeful that a successful appointment will be made.
- Radiology related non-obstetric ultrasound remains the key area of focus. A significant increase in waits greater than 6 weeks is being experienced at QMH. The pre-dominant factor driving this is in relation to the end of the trust contractual agreement with Kingston Hospital Trust delivering non-obstetric ultrasound services for SGH, in particular MSK sessions. The transitional departure was not as envisaged and has resulted in a lack of MSK sessions which were expected,
    - Additional sessions at QMH have been agreed and scheduled, in particular MSK sessions. This will support the reduction of the backlog created during August.
    - Continuation of additional sessions to at SGH to allow for continued sustainability.
    - Increased utilisation of capacity at the Nelson, to actively reduce the backlog within the Community Division.

The trust is currently in the process of collating a revised performance trajectory in view of the remedial actions being taken. This will be signed-off and along with actions for service improvement continued to be monitored weekly with executive oversight from the Executive Director of Delivery .

4. Divisional KPIs Overview 2015/16: August 15 Performance (Page 1 of 2)

			Aug 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVE
Access Metrics	52 WEEK WAITERS	No.	0	0	0	0	0
	A&E WAITS (4 HOURS)	%	99.8	93.7			94.3
	CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION)	%	0	12.5	5.6	66.7	13.5
	LAS HANDOVER WITHIN 15 MINS	%					32.4
	LAS HANDOVER WITHIN 30 MINS	%					93
	LAS HANDOVER WITHIN 60 MINS	No.					2

Note: Cancer performance is reported a month in arrears, thus for July 2015

			Jul 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION)	%	0	0	94.5	0	94.5
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION)	%	0	0	86	0	86
	31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION)	%	0	0	100	0	100
	31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DIVISION)	%			95.8		95.8
	31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISION)	%			98.4		98.4
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION)	%			80.5		80.5
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION)	%			90.7		90.7

4. Divisional KPIs Overview 2015/16: August 15 Performance (Page 2 of 2)

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY)	%				25.5	25.5
	HSMR	Ratio					90.7
	INCIDENCE OF C.DIFFICILE	No.	0	2	0	0	2
	INCIDENCE OF E-COLI	No.	1	3	2	1	7
	INCIDENCE OF MRSA	No.	0	0	0	0	0
	MATERNAL DEATHS	No.	0	0	0	0	0
	MEDICATION ERRORS CAUSING SERIOUS HARM	No.	0	0	0	0	0
	MSSA	No.	0	1	0	1	2
	NEVER EVENTS	No.	0	0	1	0	1
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	1	5	4	2	13
	SHMI	Ratio					0.9
	TRUST ACQUIRED PRESSURE ULCERS	No.	0	0	0	0	0
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%	94.3	96.7	90.3	94.6	93.6
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	84	85.2	84.3	84.1	84.5
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	72.8	74.8	75.2	69.2	71.7
	SICKNESS/ABSENCE RATE - (DIVISION)	%	5.7	3.9	3.1	3.7	3.8
	STAFF TURNOVER - (DIVISION)	%	21	17.5	13.7	17.4	17.3
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	16.2	15.4	12.3	14	14.3

Key Messages:

This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components, as Cancer metric and complaints performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of August, 32.4% of patients had handover times within 15 minutes and 93% within 30 minutes. both of which are not within target. The 30 minute handover data is currently being validated and is envisaged to significantly increase post validation. The trust had 2 60 minute LAS breaches in June which are being validated

The trust has a zero tolerance on avoidable pressure ulcers and has placed significant importance on its prevention. In August the trust had 1 grade 3 pressure ulcer SI's and 0 Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

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Corporate Outpatient Services Performance

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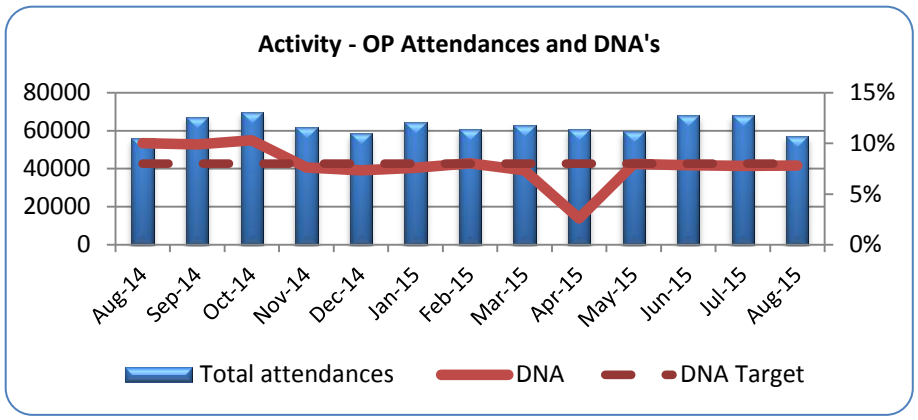
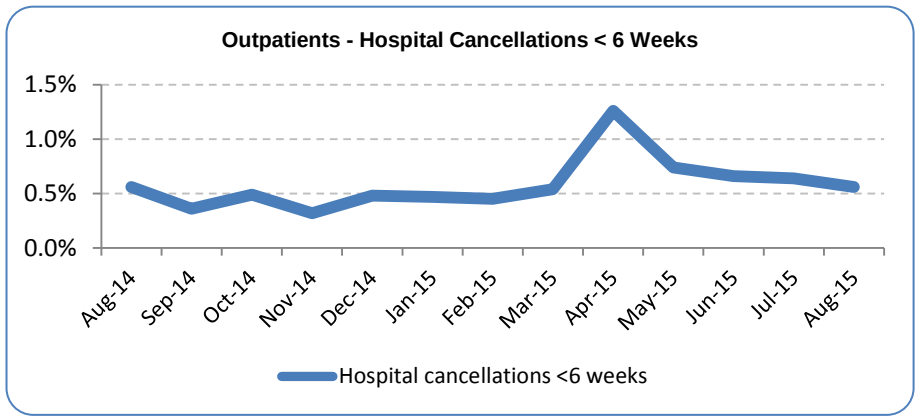
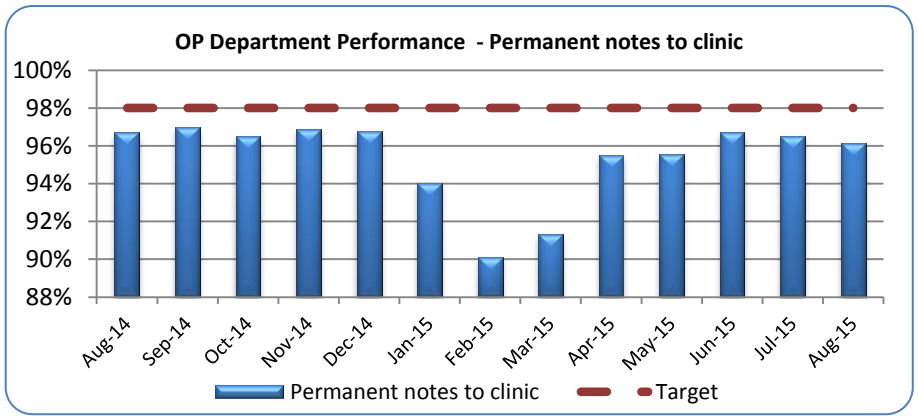
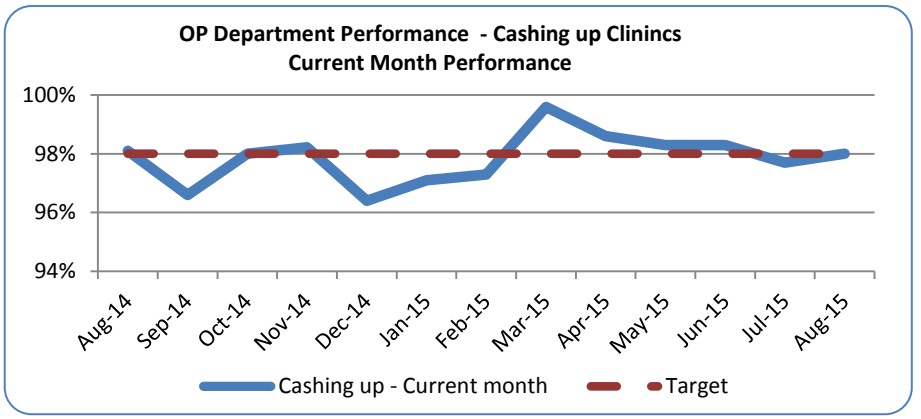
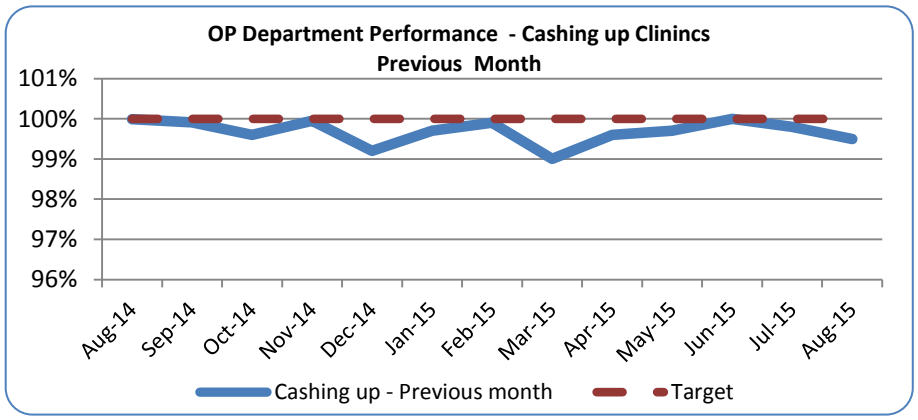
5. Corporate Outpatient Services (1 of 2) - Performance Overview

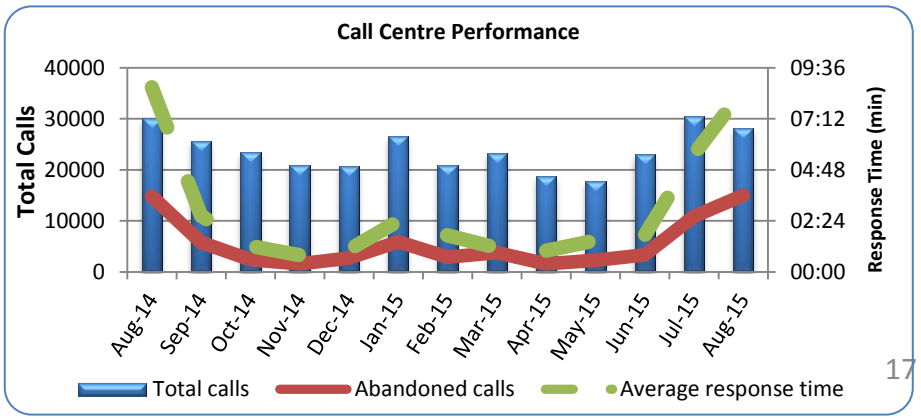












5. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Activity	Total attendances	N/A	56102	67188	69507	61879	58659	64609	60659	62946	60564	59841	68002	68277	57188
	DNA	<8%	10.02%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	2.59%	7.97%	7.84%	7.77%	7.82%
	Hospital cancellations <6 weeks	<0.5%	0.56%	0.36%	0.49%	0.32%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%	0.66%	0.64%	0.56%
OPD Perf	Permanent notes to clinic	>98%	96.71%	96.98%	96.51%	96.88%	96.77%	94.05%	90.12%	91.32%	95.52%	95.54%	96.74%	96.54%	96.14%
	Cashing up - Current month	>98%	98.10%	96.60%	98.00%	98.22%	96.40%	97.10%	97.30%	99.60%	98.60%	98.30%	98.30%	97.70%	98.00%
	Cashing up - Previous month	100%	99.99%	99.91%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%	100.0%	99.80%	99.50%
Call Centre Perf	Total calls	N/A	30004	25674	23420	20964	20639	26565	20842	23235	18710	17732	22955	30426	28095
	Abandoned calls	<25%/<15%	14825	5794	2376	1558	2681	5923	2908	3782	1551	2237	3309	10828	15019
	Mean call response times	<1 minute	08:41	02:38	01:13	00:47	01:02	02:24	01:43	01:08	01:00	01:29	01:42	05:31	08:34

Key Messages:

- Decrease in activity from July position which is envisaged due to the holiday period. DNAs have marginally increased and remain within target of less than 8%. Hospital cancellations have seen a gradual continued reduction since May. However, this is still not within target of less than 0.5%. Performance of permanent notes to clinic maintains improvement from last month with performance greater that 96%, however this is still short of the trusts 98% target. This remains a priority area for the service.

- The level of activity and the number of abandoned calls have significantly increased since Q1, with 15,019 abandoned calls in August, which accounts for 54% of all calls. Key reasons for this are:
  - Re-instatement of PB1 process from Mid-June which has seen the level of calls significantly rise and has had a subsequent impact on the level of abandoned calls.
  - Annual leave and sick leave in August resulted in reduced capacity within the department with an increase call volume.
  - A programme of reducing agency staff to bank staff in COS during Q2 has resulted in a loss of capacity as some agency members have chosen to leave. Additional recruitment via staff bank is in operation. However, it takes approximately 8 weeks to get new starters fully trained and efficiently operating, thus affecting current performance.
  - Following change of telephone flow options, there are a high number of calls that have been abandoned within 30 seconds. It is thought that this is likely due to patients choosing incorrect options and abandoning the call.
- Correlating to the increase in abandoned calls in August is the increase in average response time to 8min 34 seconds which is in excess of the 1.0minute target. Renewed focus is being placed on this to ensure consistent low response times are achieved. **As from 07/09/2015 this has reduced to 5min**.

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Clinical Audit and Effectiveness

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6.Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)						
Lead Director	June 15	July 15	Movement	2015/16 Target	Forecast March 16	Date expect to meet standard
SM	88.2	87.2	↓	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
Jul 2014	Oct 2014	Jan 2015	Apr 2015	Jul 2015
0.80	0.81	0.84	0.86	0.89

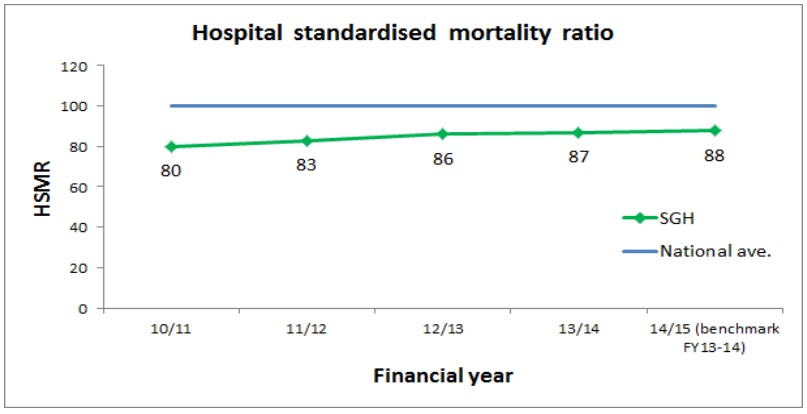
Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available; currently June 2014 to May 2015 as data has not been updated since the last report , and benchmark period is to March 2014. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 29th July 2015 relates to the period January 2014 to December 2014. The next publication will be issued in October.

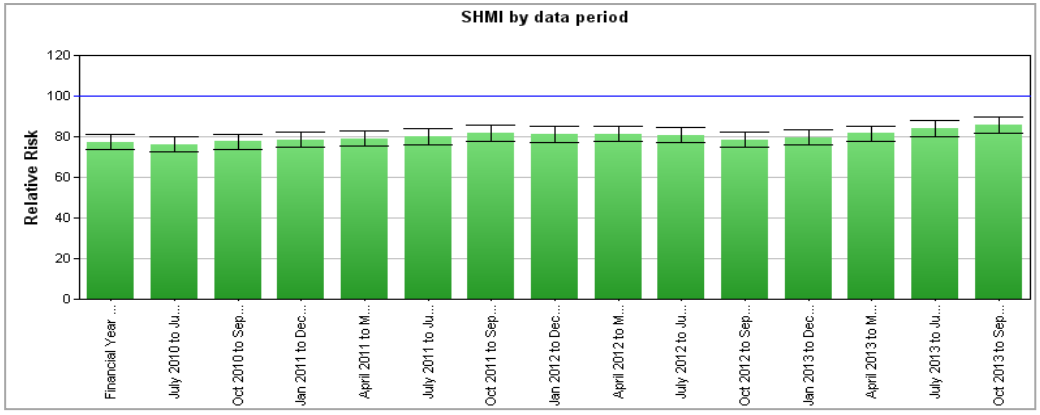
Overview:

Dr Foster Intelligence have made changes to their data update schedule and there has been no recent refresh, therefore our HSMR remains unchanged from that reported last month. It is expected that data up to June 2015 will be updated very shortly. We have held a number of meetings with Dr Foster in recent months and are due to meet with the Healthcare Information Specialist for London, when we will reiterate the importance of having a regular and reliable data refresh schedule.

A mortality outlier alert for the diagnosis group 'Coronary atherosclerosis + other heart disease' was received from the Dr Foster Unit at Imperial in June 2015, followed by an alert from the CQC. A full casenote review of deaths between March 2014 and February 2015 has been completed. This was led by Dr Nigel Kennea (AMD) with support from cardiology and cardiac surgery clinicians. The analysis concluded that the alert was contributed to by case mix issues due to the severe underlying conditions in this patient group, with several coding issues identified. The review considered 1 death possibly avoidable. Additionally the review identified 2 cases where the delivery of care was sub-optimal. These cases had been previously identified by the Trust's risk management processes and investigated as serious incidents.

The reviewers identified a number of learning and developmental points from individual reviews and also from evaluating the systems for documentation and coding that are described in the report. In the majority of cases there was a lack of a detailed clinical summary to the GP; this is highlighted as a principal area for improvement. Strengthening mortality review processes and ensuring this is applied to all deaths is also identified as a key area for action. These actions will improve the identification of coding issues in a timely way and work is underway to strengthen collaboration between clinicians and the coding team.

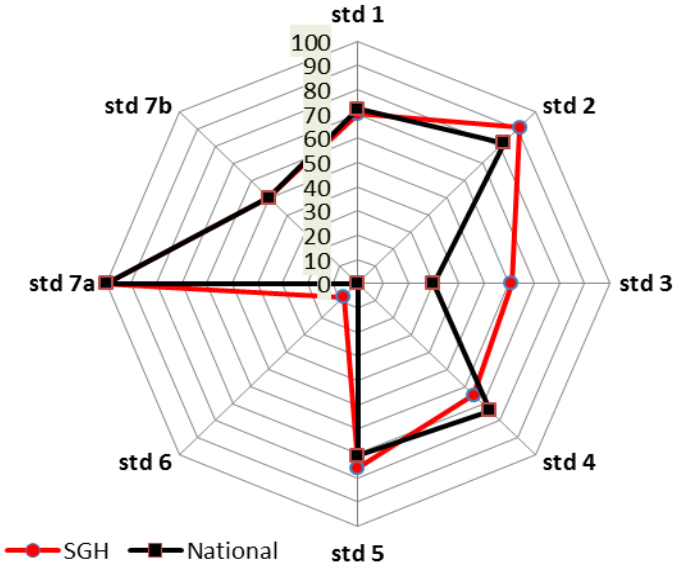




6.Clinical Audit and Effectiveness
- National Audits

Mental Health in the Emergency Department (College of Emergency Medicine)

Standards	
1	Risk assessment in the ED
2	Previous mental health issues documented
3	Mental state examinations documented
4	Provisional diagnosis documented
5	Referral or follow-up documented
6	Mental health practitioner sees patients within 1 hour of referral
7a	Appropriate assessment facility available (assessed at unit level)
7b	Assessment facility meets PLAN standards (assessed at unit level)



A total of 7913 patients from 183 Emergency Departments were audited. St George's submitted the required 50 cases.
Two standards are classified as fundamental, chosen to represent the minimum standard of safe and dignified care for patients with mental health issues and the staff who are looking after and assessing them. In these two areas St George's performance was very similar to the national average. 70% of patients met standard 1 (patients who have self harmed should have a risk assessment in the ED) and we met standard 7a, as the unit was judged to have an appropriate assessment facility. However, the room did not meet all the standards set out by the Psychiatric Liaison Accreditation Network (PLAN).
The remaining standards are classified as developmental and St George's performance is largely in line with national results. It is positive to note our compliance with Standard 2, indicating that mental health issues are both observed by clinicians and documented in patient notes; however, the quality of documentation as indicated by standards 3, 4 and 5, needs to be improved. The main issue requiring action is the time between referral to assessment by a mental health practitioner.
A number of actions are underway, led by ED consultant Dr Sunil Dasan.

Action plan	
1	ED revising mental health risk assessment
2, 3 ,4, and 5	Reinforcing good clinical documentation is an on-going piece of ED work in ED, and shall now include emphasis on reporting mental health. Meeting with trainees to discuss documentation. Improving
6	Meeting held between ED and Liaison team. Liaison team have data showing mean time from referral to being seen was 25 minutes. To improve accuracy of data Liaison team have been asked to inform ED co-ordinator when they attend to see a patient
7a, 7b	Facilities requests have been submitted to make the necessary changes to the assessment room. Requests supported by GM.

6.Clinical Audit and Effectiveness
- National Audits

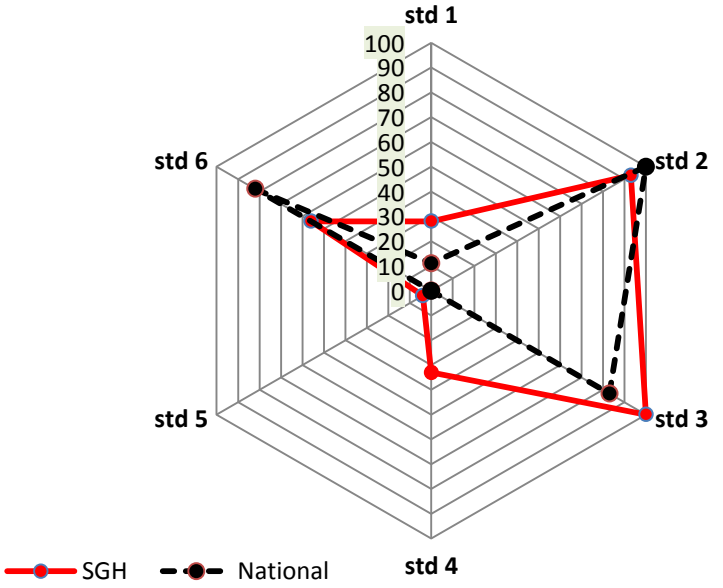
Assessing for Cognitive Impairment in Older People (College of Emergency Medicine)

Standards	
1	All overs 75s are assessed for cognitive impairment (CI) in the ED
2	Use of a structured tool for CI assessment
3	CI assessment findings shared with admitting services
4	CI assessment shared with GP if new onset or deterioration
5	CI assessment shared with carers
6	All over 75s to have at least one Early Warning Score Assessment

A total of 13, 748 patients aged over 75 from 170 Emergency Departments were audited. St George's submitted the required 50 cases.

RESULTS: The results indicated that compliance with standard 1 (cognitive assessments) is poor, although above the national average. However, where assessments occur 93% are correctly done using a structured assessment tool (standard 2) and the results are handed over on the transfer / admission of the patient. Information on cognitive impairment is inconsistently reported to GPs; although better than the national improvement is needed. Standard 6 requires that all patients aged over 75 should have at least one EWS assessment in ED; this was the only fundamental standard measured by the audit. St George's compliance rate is 56% compared to the national rate of 82% and action is required to improve.

CONCLUSION: St George's performance in standard 1 is above the national average but still requires improvement. Standards 3 -5 are referred to by CEM as 'aspirational' standards and reflect relatively recent requirements of practice so new and continued focus is required to ensure these are met.
Standard 6 is classified as fundamental, and as this is part of nursing practice and documentation it requires a senior nurse to lead on



ACTION PLAN:

- ED clinical notes will need amending as they currently state that all patients >65 require assessment (Lead – Arv Sadana, ED Consultant).
- Information to the GP will require an iCLIP modification so that this information is transferred (Lead – Arv Sadana, ED Consultant).
- Further investigation of how information can be given to carers is required and how best practice units are achieving this (Lead – Arv Sadana, ED Consultant).
- Nursing input is required to ensure EWS scores are calculated and reported for all patients (Lead – Heather Jarman, Clinical Director)

6.Clinical Audit and Effectiveness
- Local Audits

Tissue Handling Audit (HTA) 2015 (#DB1297)

Consent Audit Results	Plastic Surgery (n=2)	T&O (n=10)	Cardiac Surgery (n=10)
Discussion of procedure documented in the notes	50% (n=1)	80% (n=8)	100% (n=10)
Responsible health professional Identified	100% (n=2)	50% (n=5)	100% (n=10)
Proposed treatment detailed	100% (n=2)	100% (n=10)	100% (n=10)
Procedure specifically indicated graft	100% (n=2)	20% (n=2)	100% (n=10)
Explanation of procedure documented	100% (n=2)	100% (n=10)	100% (n=10)
Patient ticked the boxes to indicate agreement	100% (n=1/1)	86% (n=6/7)	N/A
Name of procedure indicated graft	100% (n=2)	20% (n=2)	100% (n=10)

This is an annual re-audit looking at compliance to the 'Policy for Maintaining the Quality and Safety of Organs, Tissues & Cells Intended for Patient Treatment' (Clin. 5.42) and is a requirement for Human Tissue Authority. The audit focussed on three aspects of the policy namely storage, consent, and knowledge of the correct procedure for bone, skin, vein and artery grafts. T&O, Plastics, Max-Fax, ENT, Neurosurgery and Cardiac Surgery were audited.

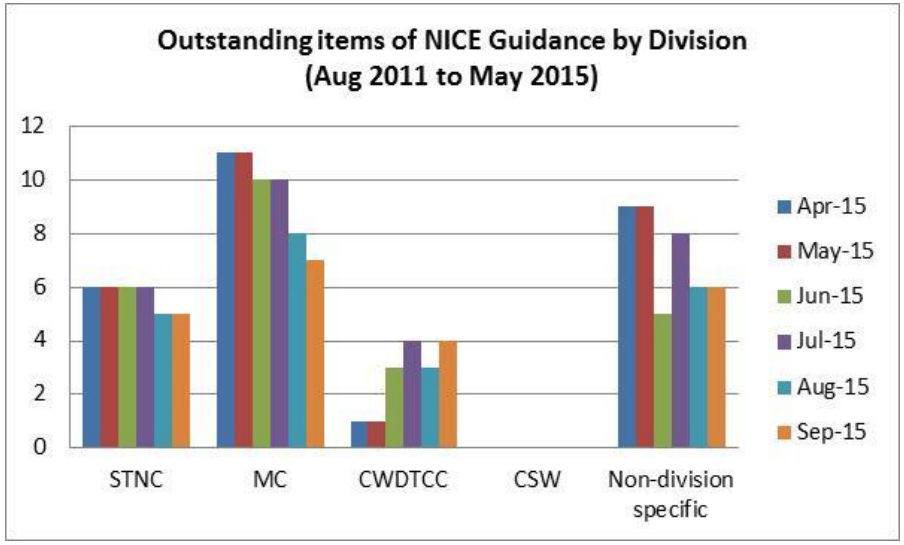
Storage: In July 2015 on 4 days the T&O freezer temperature in St James Wing was not documented. For frozen bone samples details of the type of allograft were not recorded for 2 out of 5 samples, and in one case the time taken out and staff signature were not recorded. All 5 samples were recorded in the Bone Graft Book, as per policy. For freeze dried bone all 5 samples audited had all the details recorded and were recorded in the bone graft book.

Consent: 22 sets of notes were audited. Documentation, as recorded on the consent form, was generally high but there are aspects that require improvement. Providing the name of the Consultant responsible is important and needs to be significantly improved in T&O. When detailing the procedure on both the consent form and the operation note it should be clear that a graft procedure will be carried out. This needs to be significantly improved in T&O where in only 20% of cases it was clear that a bone graft would be used. In all cases in Cardiac Surgery and Plastic Surgery the graft was specifically indicated. Effort should also be made to ensure that patients fully complete the consent form and indicate that they either consent to, or refuse to allow, the use of tissue in diagnosis and audit, teaching and research. Discussion with the patient at the time of decision to operate was not evident in 3 cases.

Knowledge: Knowledge of the SOPs and their rationale appears to be generally good and comparable to the previous audit in 2014. However, out of the 50 staff members audited there were some aspects where the knowledge was not complete, such as storage/testing requirements, quarantine process and procedure, and the act/legislation. It is recommended that staff are formally trained and competency assessed by implementing a training schedule to cover all activities, including the information regarding legal requirements.

It is recommended that theatre matrons schedule regular teaching sessions and presentations. All new staff should be supervised to promote adherence to the protocols and SOPs, ensuring clinical competence. All the SOPs and quarantine procedures for autologous tissues are to be reviewed by the theatre team. The report will be presented in the STNC and M+C divisional governance boards and discussed in theatres care group meeting for local action planning. The findings of this report have been discussed and actioned through the quarterly tissue quality meetings with theatre staff.

6.Clinical Audit and Effectiveness
- NICE (National Institute of Health and Social Care Excellence) Guidance



Items of NICE Guidance with Compliance Issues (Jun 2010 to Feb 2015)

Division	2010	2011	2012	2013	2014	2015
STNC (n=7)		1	2	1	3	
M+C (n=12)	2	2	4	1	3	
CWDTCC (n=15)	3	1	1	3	6	1
CSW (n=0)						
Non-division specific (n=8)		2		4	1	1

Overview

A large amount of guidance was released in June and July 2015, with 44 items issued. To date we have received 26 responses.

Our position in terms of compliance remains unchanged from that reported last month. Divisional reports were issued in August. These include details of all items of guidance outstanding and guidance where there are aspects with which we are either non-compliant or partially compliant. It is expected that there will be discussion at each of the next Divisional Governance Boards and updates to Clinical Effectiveness have been requested.

We are currently in discussion with our commissioners to agree a level of reporting that will provide them with greater insight and a more in-depth understanding of implementation at the trust. The detailed report that is considered at the Clinical Effectiveness and Audit Committee has been submitted for consideration and we await feedback.

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St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

Excellence in specialist and community healthcare

7. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

S	Q1 SIs Declared by Division (Inc. Pus)				
	Med & Card	Surgery & Neuro	Comm unity	Children's and Womens	Corporate
June	6	3	**2**	5	0
July	3 (1 shared)	3 (1 shared)	**0**	3 (including 1 never)	1 in Pathology
August	5 (1 shared)	4 (1 shared)	**1**	2	1 (shared)

Closed Serious Incidents (not PUs)					
Type	May	June	July	Aug	**Movement**
Total	9	8	9	11	▲
No Harm	7	5	4	8	▲
Harm	2	3	5	3	▼

Table 1

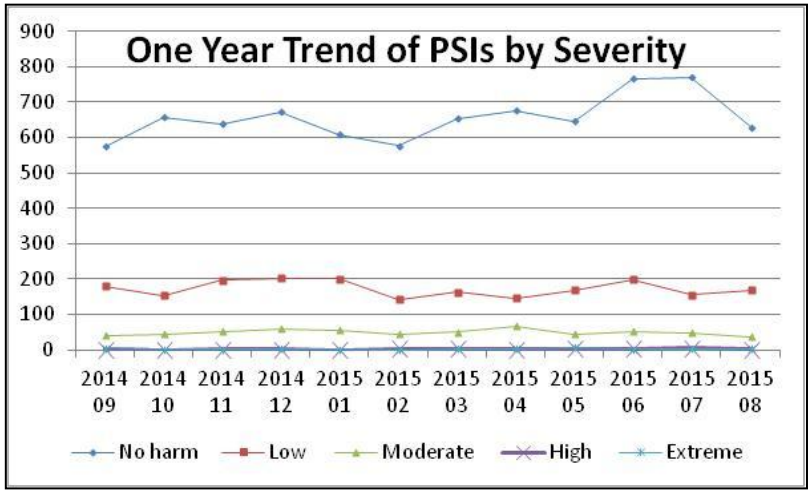
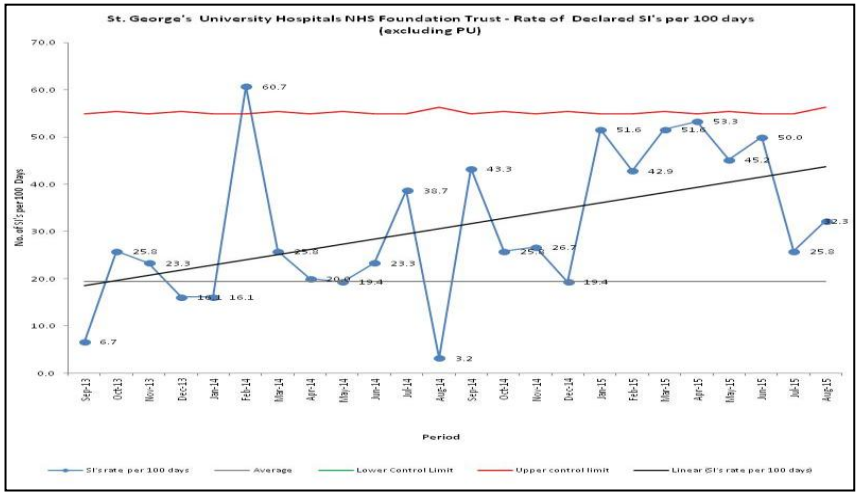


Table 2



Overview:

The numbers of general reported incidents are shown in Table 1. The number of no harm incidents has steadied this month. This trend should be observed carefully in conjunction with the trends and profile of SIs. High reporting of low or no harm incidents is generally felt to be an indication of a good reporting culture.

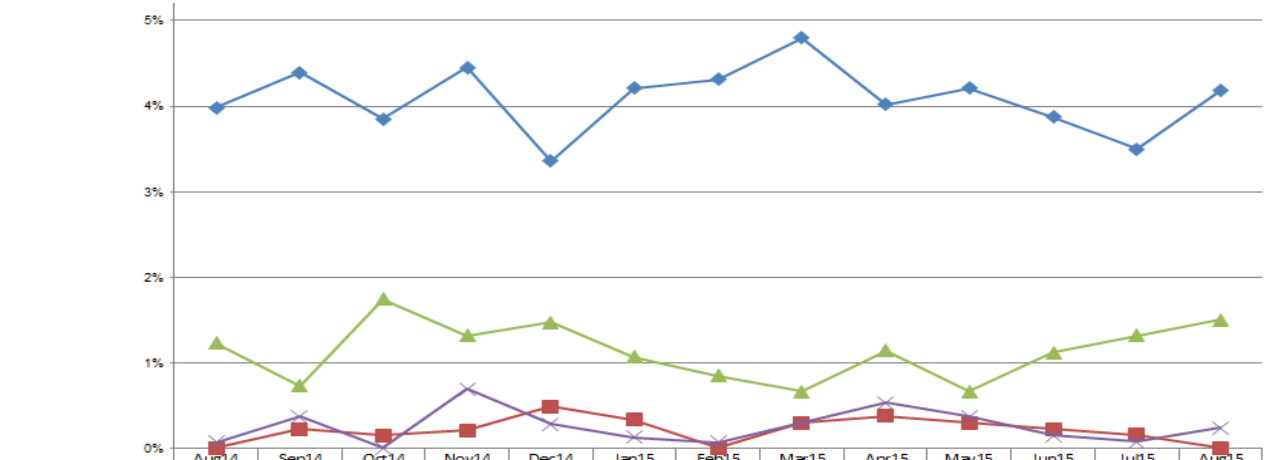
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase. There were 10 general SIs reported in August (+1 pressure ulcer) and the subjects are varied.

The 10 general SIs declared in August relate to a range of issues. They include:

- 2 maternity unexpected admissions to the neo-natal unit
- A delay in handover from London Ambulance Service
- 2 surgical SIs including one retained foreign object
- 3 related to clinical omissions/errors
- 1 medical device incident
- 1 medication SI

7.Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	June 2015	July 2015	August 2015	**Movement**	**2015/2016 Target**	**National Average August 2015**	**Date expected to meet standard**
J Hall	94.56%	95.25%	94.40%	↓	95.00%	94.10%	March 16



	Aug14	Sep14	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15
Pressure Ulcers	3.98	4.39	3.85	4.45	3.36	4.21	4.31	4.8	4.02	4.21	3.87	3.5	4.18
Falls	0	0.22	0.15	0.21	0.49	0.33	0	0.3	0.38	0.3	0.22	0.16	0
Catheter & UTI	1.23	0.73	1.74	1.32	1.47	1.07	0.85	0.66	1.14	0.66	1.12	1.32	1.5
New VTE	0.07	0.37	0	0.69	0.28	0.13	0.07	0.3	0.53	0.37	0.15	0.08	0.24
Patients	1458	1368	1377	1439	1429	1495	1415	1355	1320	1354	1343	1285	1268

Pressure ulcers (53)

- 29 grade 2 (9 new, 20 old)
- 20 grade 3 (2 new, 18 old)
- 4 grade 4 (0 new, 4 old)

CAUTI (19)

- 12 new
- 7 old

Falls (0)

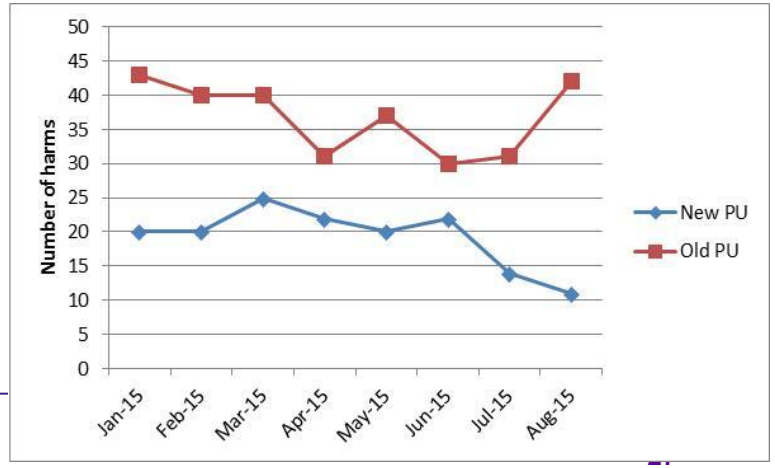
- No falls with harm

VTE (3)

- 1 new DVT
- 2 new PE

In August 2015 the proportion of our patients that received harm free care was 94.4%, which is a slight decline and just below our target, but remains above the national average. We reported 75 harms to 71 patients; 67 patients experienced one harm and 4 patients had 2 harms. 26 harms are categorised as new, meaning that they either developed or treatment began whilst under our care. All harms, other than falls, increased this month. However, it should be noted that this increase is largely due to a higher incidence of old harms, with 49 reported.

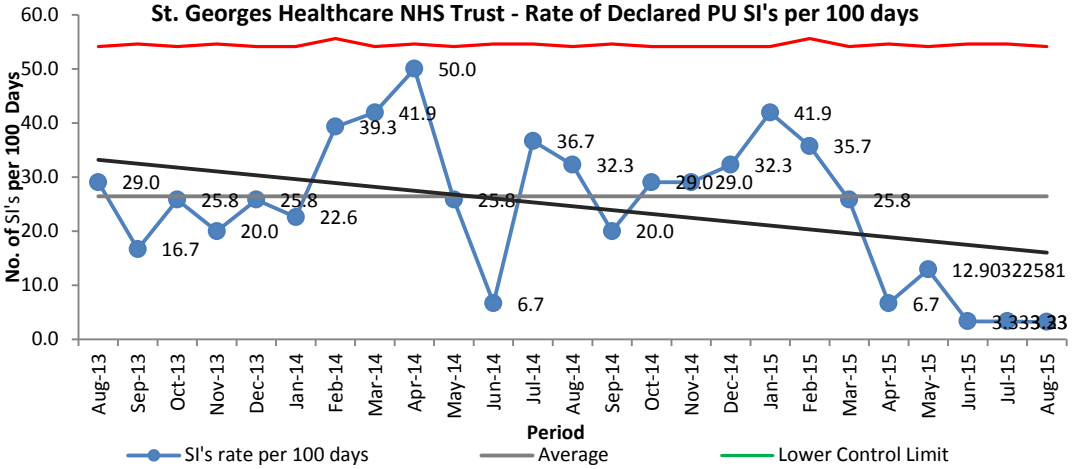
The increase in pressure ulcers is attributable to a greater number of old pressure ulcers, as shown alongside. It is encouraging that the number of new harms continues to decrease. Catheter associated urinary tract infections increased once again, with the number of newly treated infections rising to 12 this month.

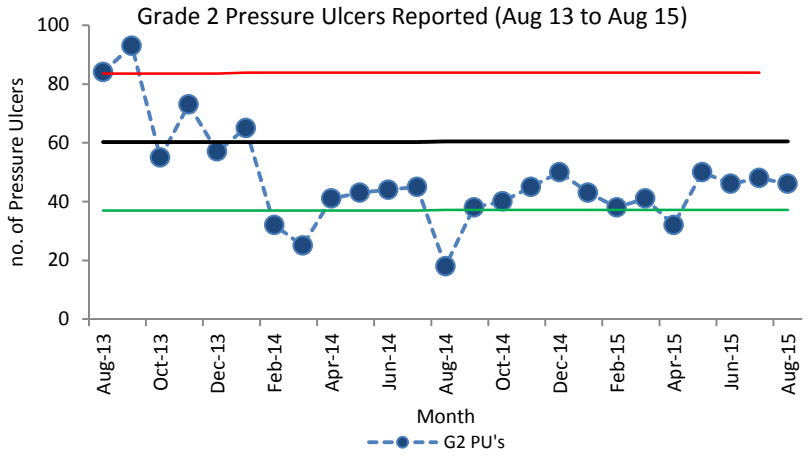


7. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Apr	May	Jun	Jul	Aug	YTD April – May 2016	Movement	2015/2016 Target	Forecast March 2015	Date expected to meet standard
Acute	1	4	1	1	0	**7**			G	-
Community	1	0	0	0	1	**2**			G	-
Total All	2	4	1	1	1	**9**			G	-
Total Avoidable	**2**	**4**	**1**	1	1	**9**		40		-

Grade 2 Pressure Ulcers						
Apr	May	Jun	Jul	Aug	Movement
25	37	28	25	23	
7	17	18	23	23	
32	50	46	48	46	





Overview:

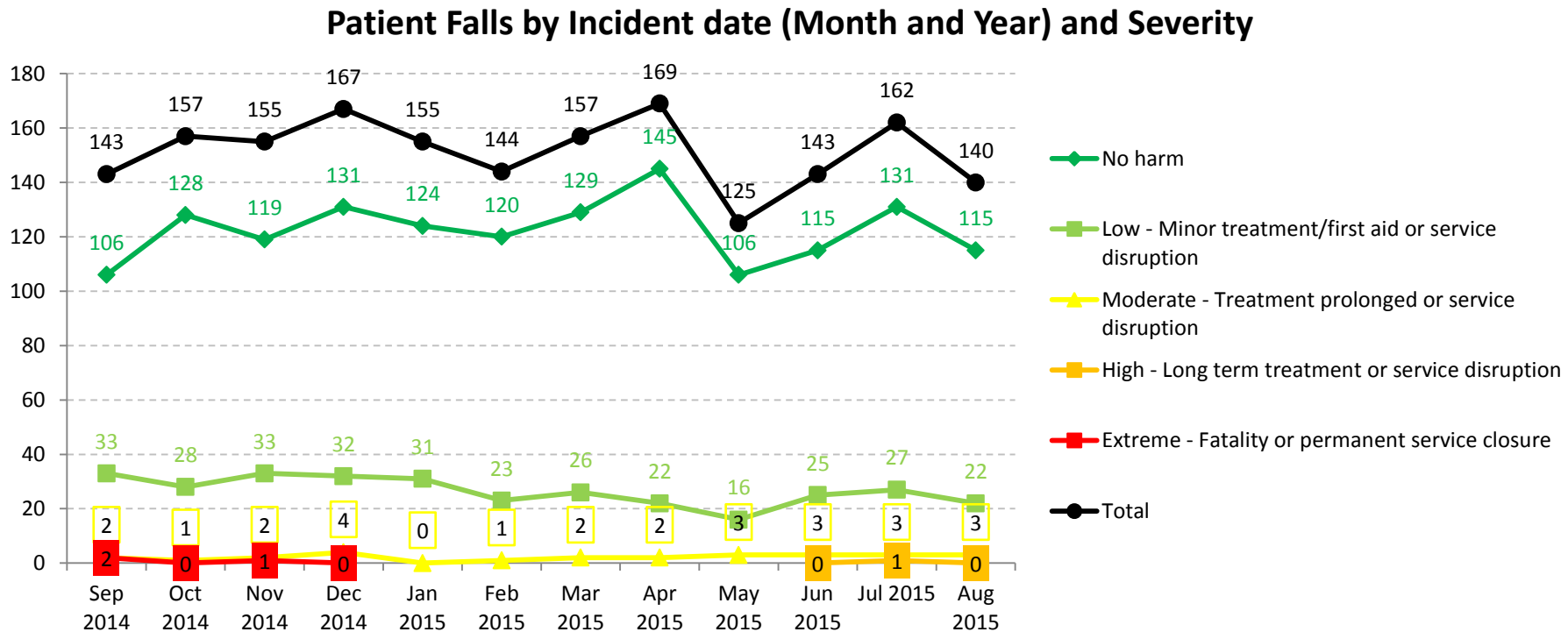
August continued the trusts trend of only having 1 avoidable pressure ulcer declared, this is for the 3rd month in a row. A reduction was also seen in the number of Grade 2 pressure ulcers overall with further reductions seen in the acute sector for the 3rd month running.

Actions:

- Recruitment underway for both acute and community TVN services
- Job description for Acute revised to incorporate integration of services
- Planning under way with Community services to further integrate TVN's and provide seamless service
- Business case for mattress provision submitted to BCAG
- Trial of mattresses underway within Orthopaedics and GICU , this will enable us to evaluate the effectiveness and suitability of the selected companies which were chosen following the Show and Tell day

7. Patient Safety: August 2015
- Incident Profile: Falls

Falls																Falls with Harm April 2014- to date				
Lead Director	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Movement	2014/2015 Target	Date expected to meet standard	No Harm	Moderate	Severe	Death	Falls related Fractures
JH	125	143	157	154	169	154	144	157	165	126	144	163	140	➢	100	Jul-15	2445	29	3	0	7



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been a decrease in falls incidence this month which may be a seasonal variation as the decrease has been linked to reduced bed occupancy in the AMU. The Falls Prevention Committee have completed a Trust wide bed rail risk assessment audit. Preliminary analysis has shown poor compliance in assessment of bed rails across the Trust. **Actions:** Results from audit to be shared across all areas with action plan to raise awareness of safe use of bed rails. Post fall protocol audit data collection to commence September 2015.

7. Patient Safety
- Infection Control

MRSA						
Lead Director	July	August	Movement	2015/2016 Threshold	Forecast September-15	Date expected to meet standard
JH	0	1	▲	0	G	-

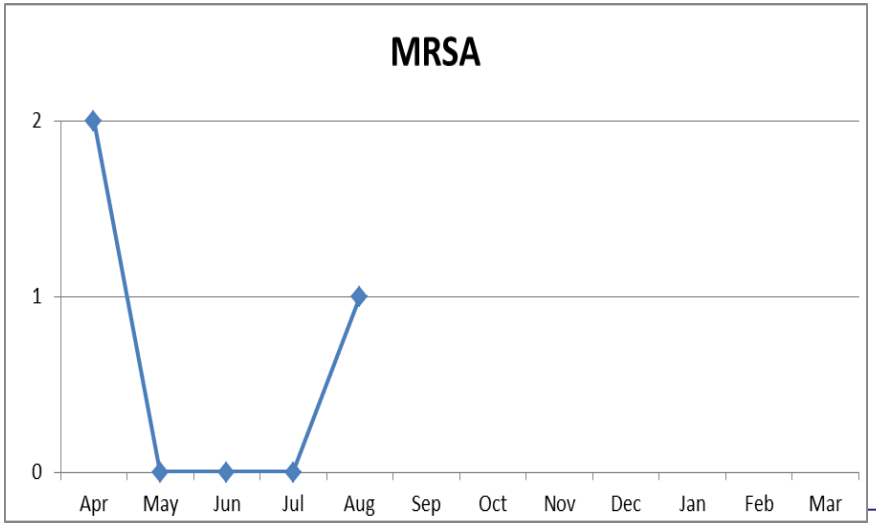
Peer Performance – YTD August 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	2	0	0	2

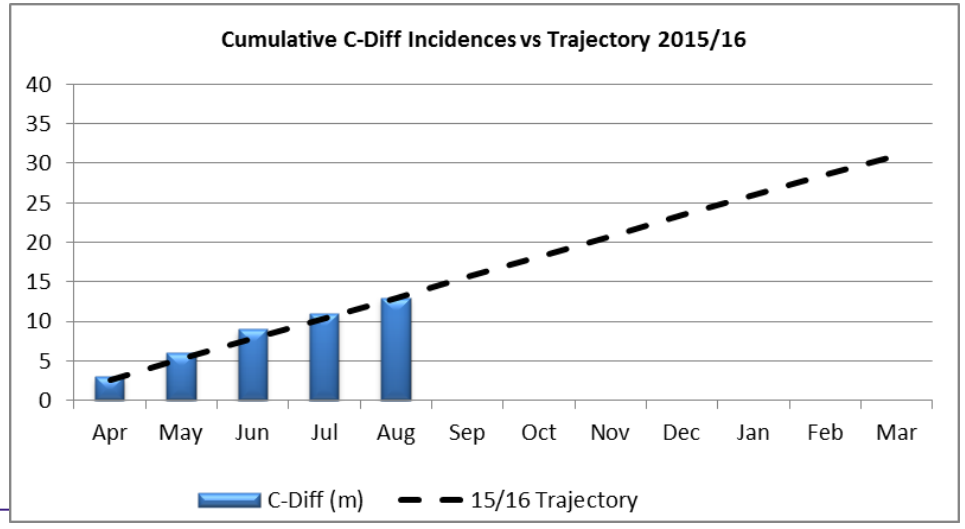
C-Diff						
Lead Director	July	August	Movement	2015/2016 Threshold	Forecast September - 15	Date expected to meet standard
JH	2	2	➤	31	G	-

Peer Performance – YTD August 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
13 (31)	12(16)	8(9)	39(72)	11(39)

The MRSA bacteraemia threshold is zero. There were no cases of MRSA bacteraemia in July, and 1 case in August. The one case in August will go for arbitration and this case may be subsequently be removed from the trusts numbers. The trust is non-compliant , with 3 incidents in total.

In 2015/16 the Trust has a threshold of no more than 31 C. diff incidents. In Jul and August there was 2 C. diff incidents each, a total of 13 for the FY to end August. We are right on trajectory.





7. Patient Safety
- VTE

VTE Risk Assessment

1. Overview: The target for patients being assessed for risk of VTE **during** admission is set at 95%. Data is extracted from electronic records following discharge from the Trust, measuring the number of patients where a record of risk assessment has been made (either on Merlin discharge summary or via electronic assessment on iClip) against the total number of admissions.

Data Source	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June	July	August
Unify2	96.84%	94.91%	93.18%	93.51%	95.94%	96.03%	96.27%	96.64%	96.45%	96.75%	96.56%	

2. Overview: Nursing staff collect data monthly across a range of safety indicators, including completion of VTE risk assessment, via the safety thermometer. Data is collected for all patients across the Trust on a single day of the month, representing a snapshot in time. Data is obtained from the drug chart and measures the total number of complete VTE risk assessments at the point of audit against the total number of beds occupied. **NB. The RAG ratings for the safety thermometer changed in April 2015 to be consistent with the UNIFY targets. This accounts for many of the red rated months below**

Data Source	Sept	Oct	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June	July	August
Safety Thermometer (SGH)	86.44%	85.39%	86.56%	75.92%	79.08%	83.89%	85.74%	89.83%	90.19%	95.14%	94.84%	92.38%
National average	85.50%	85.04%	84.19%	83.98%	84.69%	84.82%	84.69%					

Comparison of data streams:

Although there are differences in the methodology of collecting the different data streams, triangulation of both shows similar trends. A dip in results was observed over quarter 3 during the launch of the iClip electronic prescribing system across half the Trust. The RAG ratings represented on this data sheet (**from April 2015 onward**) are as follows: **Green** >95%, **Amber** >90-<95%, **Red** <90% (this may differ to RAG ratings used in other reporting tools).

Current and Future developments:

- An electronic prompt has been installed in iClip to alert physicians if an admission VTE assessment has not been completed when a patient record is opened (a second prompt also triggers 18 hours after completion of the admission assessment if the follow up assessment has not been completed). Initial reports indicate that this has had a significantly positive impact on risk assessment completion and the timeliness of assessment completion in the 'live' areas. It has recently become possible to audit individual clinicians who are overriding alerts and to cross reference the specialty with data on risk assessments which allows clear accountability to be established.

Root Cause Analysis (RCA) of Hospital Acquired Thrombosis (HAT)

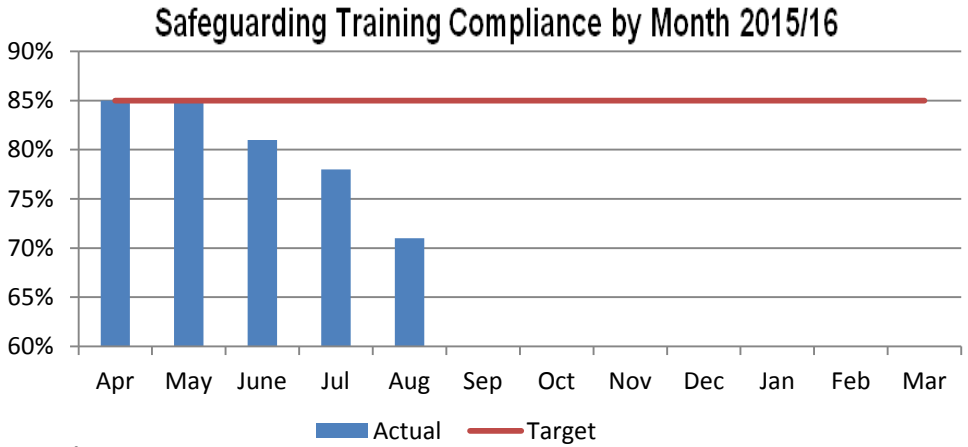
Year		2015
HAT cases identified to date (attributable to admission at SGH)		130
Mortality rate	Total	12.3% (16/130)
	VTE primary cause of death	5.38% (7/130)
Initiation of RCA process		100%
RCA pending	<28 days since notification	20
	>28 days since notification (notes requested)	5
RCA complete		80.8% (105/130)

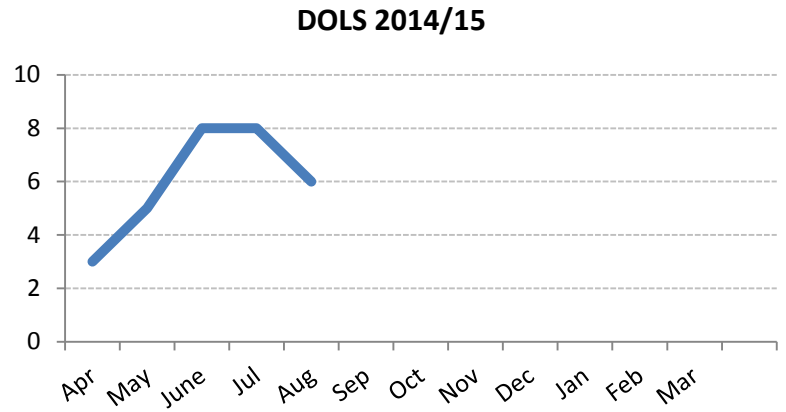
HAT case finding has significantly improved since the start of 2015 resulting in an observed increase in frequency of HAT. This increase brings incidence of HAT at SGH in line with rates observed at other Trusts in London that are of a similar size and status.

7. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Mar	April	May	June	July	Aug	2015/20165 Target	Forecast April 2015	Date expected to meet standard
JH	87%	85%	85%	81%	78%	71%	85%	A	-

Safeguarding Adults Training Compliance by Division – Aug 15				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
70%	71%	83%	70%	39%





Overview:

There is consistency across the whole Trust with regard to adult safeguarding training which is part of induction and e-MAST training. This awareness is reflected in the high number of referrals to the lead nurse for safeguarding adults.

Apr 90, May – 70, June 78, July 70, Aug 60

DOLS: Since April 2014 and the Supreme Court judgement there has been a significant increase in DOLS activity which is to expected and reflected nationwide.. There has been new guidance from the Chief Coroner around the reporting of deaths of those patients subject to DOLS . New Law Society Guidance now indicates that the a significant number of patients are being understandably deprived of their liberty in their best interests. This is not necessarily a reflection of poor care and treatment.

Actions:

Continue to monitor safeguarding training via ARIS. Divisions to take action around low compliance

Review procedures following implementation of Care Act - Awaiting revision of Pan London Procedures due Dec 2015

Roll out MCA training across trust, audit effectiveness

Review DOLs activity and impact on resources. Monitor demand on services versus capacity to complete assessments. Produce fresh guidance on DOLS in conjunction with Law Society guidance. Revised briefing paper with legal team was presented to EMT In November indicating current position, impact on resources and future options to manage the governance and workload.. New procedure in place to ensure reporting of those subject to DOLS are reported to the coroner~~. July 15 – fresh legal advice obtained around risk to organisation and patients with regard to non application of DoLs. Revised briefing paper prepared~~ for QRC July 2015. Task and Finish Group to commence work on outstanding actions Autumn 2015

7. Patient Safety
- Safeguarding Children

Division	No. requiring Level 3 training	No of staff compliant	compliant %	no. of staff not compliant	additional no. of staff to be trained to achieve 85% compliance
Children and Women's Diagnostic and Therapy Services	621	500	81%	121	30
Community Services	203	143	70%	60	29
Corporate	5	4	80%	1	1
Medicine and Cardiovascular	193	132	68%	61	32
Surgery & Neurosciences	13	0	0%	13	13
Total	**1035**	**779**	75%	**256**	**96**

Training : Following an in-depth look at the training figures by the Safeguarding Children team, it was evident that staff who were known to be compliant were not recorded as such on ARIS. This is still an unresolved issues, which is being addressed through monthly meetings between the Safeguarding Children team and the Learning and Development team.
Mandatory face-to-face level 2 and level 3 training content being updated, in the Acute services. There is a plan to deliver bespoke sessions across paediatric areas , the neo-natal unit and adult areas, to raise awareness of "see the Adult – see the Child" agenda.
The community team continue to offer level 3 as per their annual training plan but included an extra session in Quarter 2 to increase compliance.
Serious Case Reviews and Internal Management Reviews: Hampshire Safeguarding Children Board, has declared a SCR for a baby cared for on PICU. The Named Nurse for Safeguarding Children (Acute services) is completing the report and chronology – deadline for submission is 30th September 2015.
Other: The Safeguarding Children team (Acute, Community and Maternity), currently have a weekly team brief, to discuss operational matters and on a monthly basis to discuss strategic matters – the purpose is to monitor and improve compliance across all areas in the Trust.

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Patient Experience

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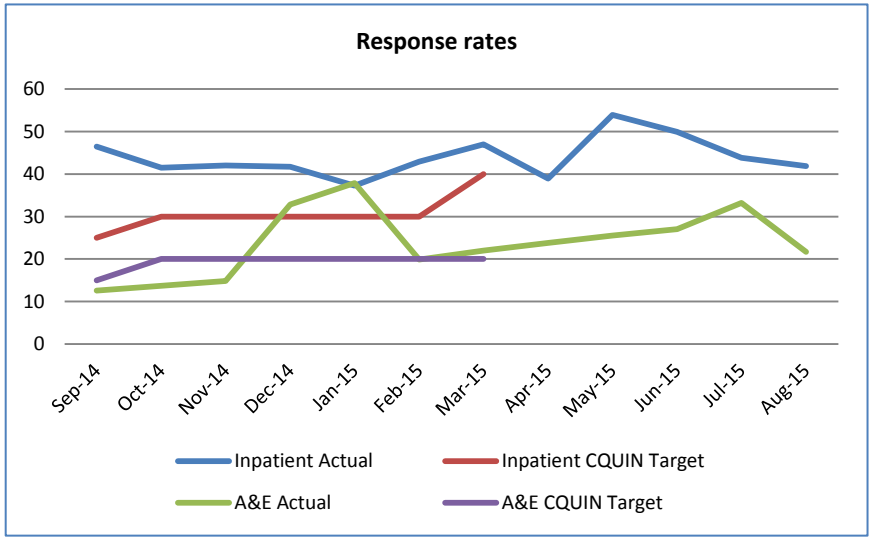
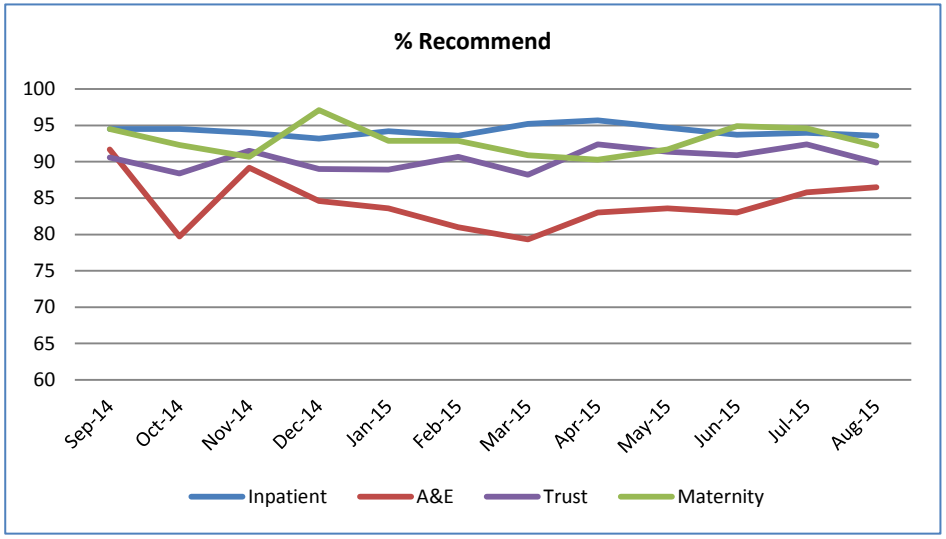
8. Patient Experience
- Friends and Family Test

FFT Response Rate							
Domain	Jun-15	Jul-15	Aug-15	Movement	2015/2016 Target	Forecast	Date expected to meet standard
Trust	34.3	37.9	27.4	⮟	-	-	-
Inpatient	49.9	43.8	41.9	⮟	-	-	-
A&E	27	33.2	21.7	⮟	-	-	-
Maternity	23.9	21.7	N/A		-	--	-

	FFT Response Score			
	Jun-15	Jul-15	Aug-15	Movement
	90.9	92.4	89.9	⮟
	93.7	94	93.6	⮟
	83	85.8	86.5	⮝
	94.9	94.6	92.2	⮟





Overview : All CQUINs were met for last year. We are now exploring how to shift our focus from response rates to the content of what our patients are telling us. We are trialling new reports that focus on the 3 areas we score the lowest on. You can preview our latest draft on the next slide.

Action :

Continue to monitor response rates, and monitor the 5 poorest performing services in the key areas of noise at night, information about medication side effects and involvement in the discharge process.

Improve the co-ordination of patient experience data with other quality metrics.

8. Patient Experience
- Triangulation of FFT, Complaints and PALS data

Directorate	Complaints	PALS	FFT	FFT responses
(CW) Childrens Directorate	2	4	94.3%	141
(CW) Critical Care Directorate	1	0	No data	0
(CW) Diagnostics Clinical Directorate	2	6	No data	0
(CW) Therapeutics Clinical Directorate	6	36	88.6%	35
(CW) Womens Directorate	15	30	94.1%	254
(MC) Accident and Emergency Directorate	11	4	86.5%	1420
(MC) Acute Medicine Clinical Directorate	2	8	93.2%	132
(MC) Cardiovascular Clinical Directorate	9	14	97.3%	264
(MC) Renal, Haematology, Palliative Care & Oncology Directorate	4	5	94.0%	150
(MC) Specialist Medicine Clinical Directorate	1	32	100.0%	8
(SN) Neurosciences Clinical Directorate	6	15	96.3%	242
(SN) Surgery Clinical Directorate (inc. Trauma and Orthopaedics)	12	77	87.2%	469
Community Services	11	3	TBC	TBC
Corporate Directorates	5	21	N/A	N/A
External Organisations		2	N/A	N/A
Grand Total	**87**	**257**	**93.2%**	**3115**

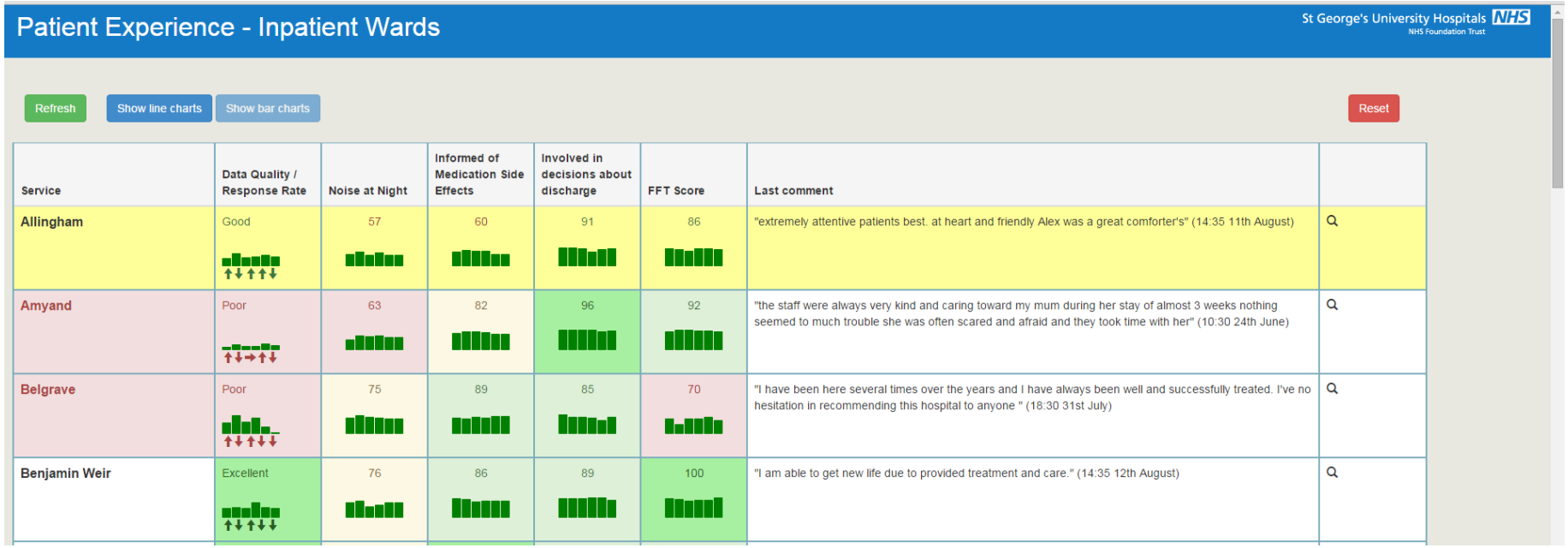
Triangulation of Patient Experience Data

Notes on the data:

This report only shows directorates that have received a complaint or PALS concern in August 2015.
Not all services are represented, due to the way that we record patient survey data (on RaTE) and PALS/Complaints data (on Datix). We are working to merge the datasets, and the accuracy of these reports will improve once this is complete.

8. Patient Experience
- New Patient Experience Reports

A detailed overview of the entire survey, showing data quality and performance in our three poorest performing areas (noise at night, information on medication side effect and involvement in the discharge process). Trends for the last 6 months are shown, and a detailed breakdown of the scores can also be displayed.



Patient Experience - Inpatient Wards

St George's University Hospitals NHS
NHS Foundation Trust

Refresh | Show line charts | Show bar charts | Reset

Service	Data Quality / Response Rate	Noise at Night	Informed of Medication Side Effects	Involved in decisions about discharge	FFT Score	Last comment	
Allingham	Good	57	60	91	86	"extremely attentive patients best. at heart and friendly Alex was a great comforter's" (14:35 11th August)	
Amyand	Poor	63	82	96	92	"the staff were always very kind and caring toward my mum during her stay of almost 3 weeks nothing seemed to much trouble she was often scared and afraid and they took time with her" (10:30 24th June)	
Belgrave	Poor	75	89	85	70	"I have been here several times over the years and I have always been well and successfully treated. I've no hesitation in recommending this hospital to anyone " (18:30 31st July)	
Benjamin Weir	Excellent	76	86	89	100	"I am able to get new life due to provided treatment and care." (14:35 12th August)	

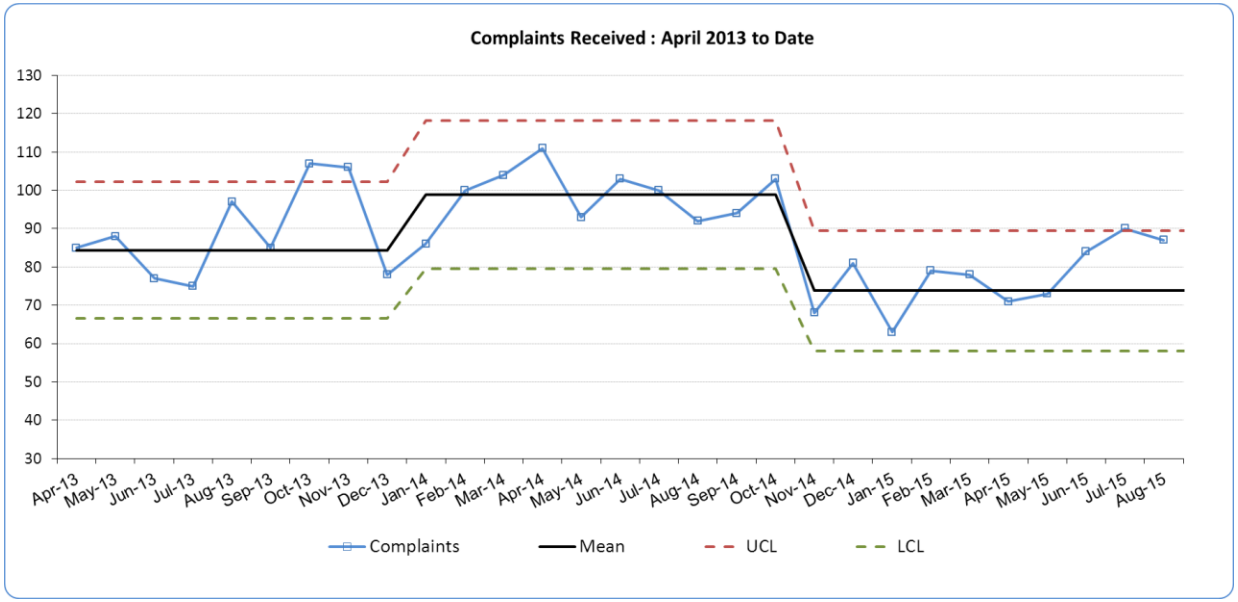
A breakdown of a service's scores, explaining what their patients are telling them.

Scores explained:	There were 28 responses out of a predicted 57 discharges. This gives a response rate of **49%**. For this area: Excellent = 61% or above Good = 44% Acceptable = 28% Poor = below 28%	6 said noise was caused by both staff and patients. 0 said noise was caused by staff. 12 said the noise was caused by patients. 10 said they were not bothered by noise.	6 patients were not told about medication side effects. 5 were told 'to some extent' 10 were told about all side effects.	0 patients did not feel involved in their discharge from hospital. 5 felt involved to some extent. 23 said they were 'definitely' involved in their discharge.	24 were 'Extremely likely' or 'Likely' to recommend the service. 3 were 'Neither likely nor Unlikely'. 0 were 'Unlikely' 0 were 'Extremely Unlikely.' 1 answered 'Don't know.'	

This work is part of an overall quality framework that allows us to monitor patient experience and safety data in real time from a single point of access.

8. Patient Experience
- Complaints Received

Complaints Received																	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Movement
Total Number received	111	92	100	99	92	94	107	68	81	63	79	78	71	72	84	90	87	↓



Overview:

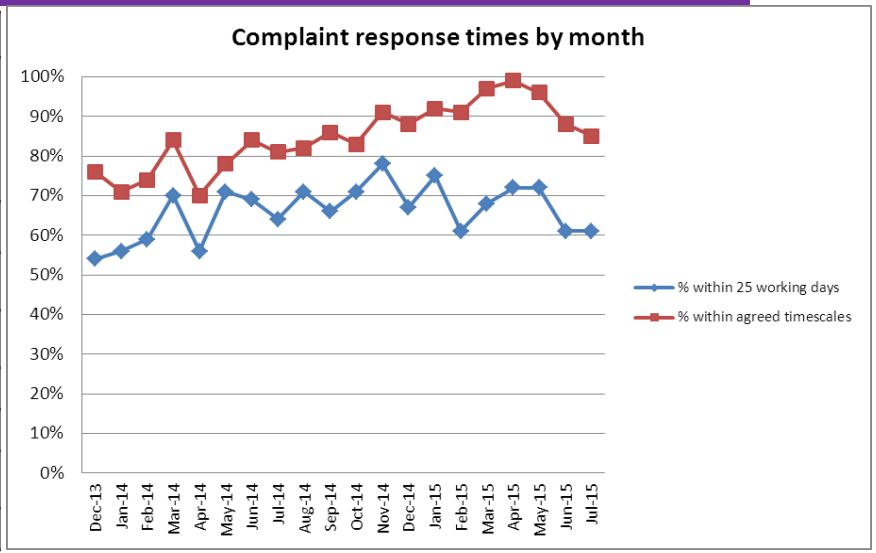
This report provides a brief update on complaints received since the last board report (so in August 2015) and information on responding to complaints within the specified timeframes for complaints received in July of 2015/2016. It also includes some posts made on NHS Choices and Patient Opinion. The board will receive more detailed information about complaints received in quarter 2 with divisional breakdowns, analysis of the data to provide trends and themes with actions planned and a severity rating report and once the target date for complaints received in quarter 2 is reached (so November 2015).

Total numbers of complaints received in June 2015

There were 87 complaints received in June of 2015, a very slight reduction on July when 90 complaints were received. The biggest reductions were for General Surgery Care Group (from 5 to 1) and Outpatients and Medical Records care group (from 11 to 4). Although complaints reduced overall there was a significant increase in complaints received for the Accident and Emergency care group (from 3 to 11) where the most common themes were clinical treatment – diagnosis and lost property. Complaints about the Gynaecology care group increased from 3 in July to 9 in August, the majority being about outpatients across a number of subjects. Two complaints were about the fertility clinic and two about the closure of the uro-gynaecology service.

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets July of 2015/2016				
Division	**Total number of complaints received**	**Number within 25 working days**	**% within 25 working days**	**% within 25 working days or agreed timescales**
Children's & Women's	29	19	66%	(4) 79%
Medicine and Cardiovascular	19	14	74%	(5) 100%
Surgery & Neurosciences	31	14	45%	(13) 87%
Community Services	2	2	100%	(0) 100%
Estates and Facilities	7	7	100%	(0) 100%
Other corporate departments	2	0	0%	(0) 0%
Totals:	90	56	62%	(22) 85%



Commentary:

There was no improvement in complaints performance in July when compared to quarter 1, rather there was a significant decline. 62% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 68% in quarter 1 with 85% within agreed timescales (against internal trust target of 100%) compared to 95% in quarter 1. Community Services Division and Estates and Facilities Directorate are the only areas which are reaching both targets with Medicine and Cardiovascular Division meeting the agreed timescales target only. In addition to actions previously reported the following actions are planned to achieve improvement:

Medicine and Cardiovascular Division

The division has continued to maintain its position of complaints responded to in agreed timescales, having achieved 100% in May, 98% June, and 100% in July. The division has continued to improve its position in responding to complaints within 25 days from 62% in May, 65% in June and 74% in July.

In order to sustain this performance the division has extended the additional resource it has bought in for areas with high volume of complaints. The division continues to meet with the Directorate teams on a weekly basis to ensure complaints are being responded to in the required timescales and we are reviewing the re-opened complaints to ensure any learning regarding response styles can be applied.

8. Patient Experience - Performance against targets

Women's, Children, Diagnostics and Therapeutics Division

The Children's and Women's directorates continue to be the main areas of concern in relation to achievement of the complaints targets, both in terms of the 25 working days and the agreed timescales target.
This is largely related to manpower issues and the complexity of some of the complaints. The resource issues have now been addressed in both directorates and new processes implemented within women's to improve the management of the complaints process and ensure achievement of the targets. Additional staff have also been trained in complaints management and response writing within these directorates; these staff are currently being supported to in order that this training can be put into practice and benefits realised.

There is also on-going work across the wider division to ensure there is a consistent standard in complaint responses, with additional training being provided by the complaint team in focused areas. This will prevent delays and assist the division in improving its overall performance.

Surgery and Neurosciences Division

There is an increase in the overall number of complaints being received for the division. Complaints within surgical directorate have been increasing month on month. Headlines this month are as follows:

- Divisional process continues to oversee complaints and provide support to areas with higher volumes/complex complaints
- Local complaints/governance meetings are in place – The purpose of these meetings is to review complaints themes, agree focused actions and share learning
- Engagement from managers and clinicians is good and has been sustained over the last 7 months- this has been pivotal to the change in our performance, however in the last two months our performance in meeting the Trust's target has dropped.
- Due to drop in performance for June (61% 25 days, 89% with extensions) and July (39% within 25 working days, 81% with agreed extensions - unvalidated by the GMs as yet) the divisional chair has asked for an urgent update on the issues that teams are facing. The full listing for June and July is currently being validated by the GMs to ensure accurate reporting on the DATIX main.
- Divisional oversight via DGB will continue monthly

The number of complaints being received about the Plastics, Trauma Orthopaedics and Neurosurgery care groups across a number of subjects. Some actions that have resulted in response to these areas include:

- Handover of all patient concerns to SHO and registrar from Night practitioner to avoid confusion in reviewing patients overnight
- Increased patient referrals in the breast service and the team have put in formal measures to ensure these patients are seen promptly
- Neuro started the neuro OP bookings pilot. This will mean outpatient appointments are managed in house with a dedicated team. Have also produced information cards/ website / twitter and email contact for patients.
- The Trust is to ensure that consultant leave is actioned appropriately and clinics are rescheduled and patients are notified in advance.
- Outpatients team to updated patients on a regularly basis if there are any known delays.

8. Patient Experience
- Service User comments posted on NHS Choices and Patient Opinion

Overview:
The Patient Experience Manager and Patient Advice and Liaison Service Manager are responsible for checking and responding to comments posted on the NHS Choices website and the Patient Opinion website. Comments are passed on to relevant staff for information/action. Often the comments are anonymous so it is not possible to identify the patient or the staff involved, but such comments are still fed back to departments to consider themes and topics.

If a comment is a cause for concern then the individual is given information via the website about how to obtain a personalised response via the Patient Advice and Liaison service (PALS) or the complaints and improvements department. The number and nature of comments are reported to the Board quarterly. Below are some examples of comments/stories posted on NHS Choices and Patient Opinion since the last board report.

Janet gave Nephrology at St George's Hospital (London) a rating of 5 stars
Kidney transplant at Buckland Ward (08/2015)
The staff on Buckland ward are absolutely wonderful. No matter how busy they were they always have time for you. But beware there is a witch but don't let her bother you she is harmless enough.

As for the surgical team they are absolutely a1 I felt completely safe in their hands and they had a great sense of humour as well.

I am also blind and they were extremely helpful and caring in that respect.

Visited in August 2015. Posted on 07 August 2015

Anonymous gave Accident and Emergency services at St George's Hospital (London) a rating of 5 stars
Treatment in Resus unit
I was taken to the Resus unit on Tuesday night (18 Aug 2015) with very high blood pressure. I was treated immediately with the utmost care, attention and professionalism. All the necessary tests were conducted to rule out a possible mini stroke and I was allowed to go home after my blood pressure had returned to normal with the medication provided. Thank you so much to the paramedic, the ambulance crew and all the staff in the Resus unit at St. Georges Hospital.

Visited in August 2015. Posted on 20 August 2015

Anonymous gave Dermatology at St George's Hospital (London) a rating of 1 stars
Disappointing
I travelled a long way to see a supposed expert in their field, only to find out they were no help at all. I could have been told that nothing could be done beforehand and saved myself a journey.

What I didn't understand is why the doc who took my history said I would need scans etc but the other doctor just said no point and that was the end of the matter - did the first doctor just not know what they were talking about?

Odd, and very disappointing.

Visited in August 2015. Posted on 13 August 2015

Anonymous gave Nephrology at St George's Hospital (London) a rating of 1 stars
Disgusting
I am writing on behalf of my mother who has been neglected and ignored by staff at this hospital.
I complained two years ago and they failed to respond , she has been waiting for 10 months for an operation which was classed as urgent..

Today after being messed about and lied to all weekend she waited for transport this morning which didn't turn up then when she telephoned she was told that transport was never supplied for the ward she was due to be admitted to (this is a lie)..Eventually 4 hours late a taxi finally showed up...

Visited in August 2015. Posted on 10 August 2015

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Workforce

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9. Workforce: August 2015
- Safe Staffing profile for inpatient areas

Overview

The information provided on the table below relates to staffing numbers at ward/department level submitted nationally on Unify for July 2015. In line with new national guidance this table shows the number of filled shifts for registered and unregistered staff during day and night shifts. In July the trust achieved an average fill rate of 93.99%, a slight decrease from 94.93% submitted in June.

Data cleansing continues to ensure that the report is being run consistently and only relevant front line nursing roles are included.

Although some of our wards are operating below 100% the data does not indicate if a ward is unsafe. Safe staffing is much more complex than an observation of percentages and takes in to account many key aspects such as:

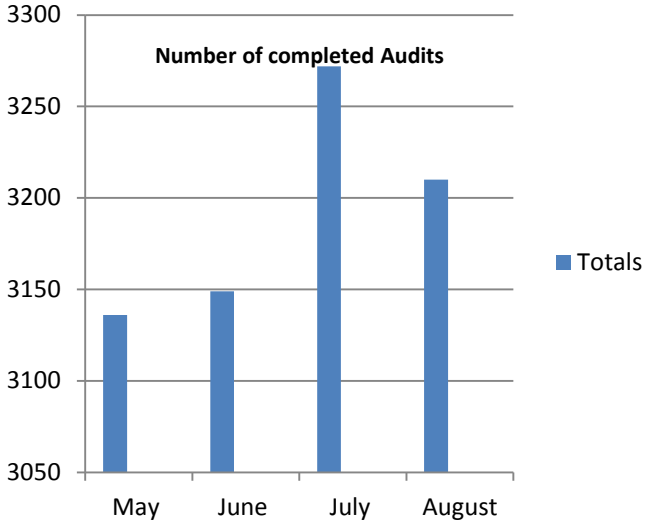
- Nurses, midwives and care staff work as part of a wider multidisciplinary ward team. The demand on wards can change quickly and it will always be a clinical judgement as to whether to bring more staff in or reduce the amount the staff as per requirement.
- The data does not take into account the on-going considerations for ward managers in ensuring that on each shift there is the right level of experience and expertise in the ward team.
- The nature of each ward varies. The number and type of patients seen on some wards will be relatively consistent. The number and type of patients seen on other wards will vary more dramatically, meaning that there could be greater change from the planned level and the average will be somewhere in the middle of the highs and lows of this variation.
- There needs to be the operational context of the reasons for staffing levels month on month, for example reduced demand.
- St George's Healthcare NHS Trust has a safe staffing policy and a system in place for monitoring staffing levels on a daily basis. Nursing and midwifery clinical leaders visit their clinical areas across the trust at least once a day to ensure safe staffing and staff are encouraged to escalate any concerns they have to the chief nurse on duty. The acuity/dependency of patients (how sick or dependent they are) is also monitored closely as this ultimately affects the type and amount of care patients need. If concerns are raised about staffing levels, the clinical leaders may make the decision move members of staff across the trust so that the area is safely staffed. This ensures that our patients are well cared for.

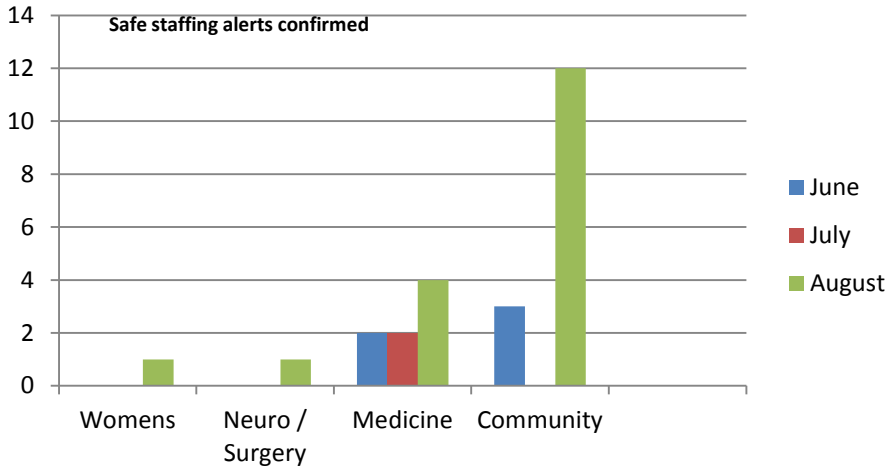
Actions

- The Deputy Chief Nurse has set up a task force to review the way UNIFY data is collected, validated and reported.
- Reporting guidance from NICE expected in June 2015 is still awaited,

	Day		Night		
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	
Cardiothoracic Intensive Care Unit	90.2%	100.0%	95.0%	100.0%	
Carmen Suite	106.4%	70.6%	99.3%	89.3%	
Champneys Ward	94.8%	93.6%	100.0%	100.0%	
Delivery Suite	101.6%	84.2%	109.3%	96.8%	
Fred Hewitt Ward	88.0%	101.4%	94.8%	#DIV/0!	
General Intensive Care Unit	95.8%	91.6%	98.5%	87.5%	
Gwillim Ward	115.1%	64.2%	99.2%	80.1%	
Jungle Ward	100.1%	#DIV/0!	#DIV/0!	#DIV/0!	
Neo Natal Unit	93.6%	#DIV/0!	99.1%	#DIV/0!	
Neuro Intensive Care Unit	91.0%	73.9%	98.0%	90.0%	
Nicholls Ward	95.1%	98.2%	99.2%	86.9%	
Paediatric Intensive Care Unit	97.6%	100.2%	101.2%	100.0%	
Pinckney Ward	104.1%	88.0%	96.1%	#DIV/0!	
Dalby Ward	98.4%	99.6%	97.8%	100.0%	
Heberden	94.7%	98.3%	98.2%	98.9%	
Mary Seacole Ward	84.0%	96.0%	98.3%	97.6%	
A & E Department	93.7%	82.4%	93.3%	85.3%	
Allingham Ward	90.1%	113.7%	97.8%	99.9%	
Amyand Ward	87.2%	99.3%	94.3%	99.0%	
Belgrave Ward AMW	86.4%	91.6%	98.0%	100.0%	
Benjamin Weir Ward AMW	84.1%	80.8%	96.2%	100.0%	
Buckland Ward	84.9%	78.6%	100.0%	96.9%	
Caroline Ward	87.3%	88.3%	94.1%	100.0%	
Cheselden Ward	90.7%	80.7%	97.9%	96.8%	
Coronary Care Unit	99.9%	#DIV/0!	96.7%	#DIV/0!	
James Hope Ward	88.3%	76.5%	86.3%	#DIV/0!	
Marnham Ward	86.1%	86.3%	92.2%	97.6%	
McEntee Ward	91.1%	96.8%	96.8%	100.0%	
Richmond Ward	89.7%	88.0%	94.6%	96.3%	
Rodney Smith Med Ward	91.9%	102.3%	97.2%	99.0%	
Ruth Myles Ward	100.8%	100.0%	100.1%	100.0%	
Trevor Howell Ward	100.0%	94.2%	95.6%	98.5%	
Winter Ward (Caesar Hawkins)	79.8%	93.9%	93.7%	91.4%	
Brodie Ward	98.0%	98.7%	99.8%	100.0%	
Cavell Surg Ward	88.7%	88.1%	94.2%	96.8%	
Florence Nightingale Ward	89.9%	90.4%	99.2%	100.0%	
Gray Ward	89.9%	75.1%	98.5%	96.8%	
Gunning Ward	89.5%	89.3%	98.9%	96.8%	
Gwynne Holford Ward	83.4%	90.3%	91.2%	99.3%	
Holdsworth Ward	88.5%	87.7%	95.7%	100.0%	
Keate Ward	95.8%	96.6%	99.0%	100.0%	
Kent Ward	87.4%	86.1%	98.4%	100.0%	
Mckissock Ward	89.1%	101.0%	98.3%	97.1%	
Vernon Ward	87.0%	86.4%	96.7%	100.0%	
William Drummond HASU	86.8%	84.5%	94.1%	100.4%	
Wolfson Centre	90.6%	87.4%	100.0%	100.0%	
Gordon Smith Ward	87.2%	101.6%	100.2%	101.9%	
Brodie Stroke Ward	94.1%	61.0%	97.8%	100.0%	
Trust Total	92.03%	90.22%	97.24%	97.11%	
	Day Qual	Day HCA	Night Qual	Night HCA	Overall
	92.03%	90.22%	97.24%	97.11%	93.99%

9. Workforce
August 2015 - Safe Staffing alerts





Overview: The purpose of the daily safe staffing audit is to identify areas that are unsafely staffed (known as alerts) and to ensure through a process of escalation that this situation is remedied. Alerts (identifying that a ward is unsafely staffed) are raised to senior nurses through a daily report on the RATE system. The safe staffing policy provides guidance on escalation and interventions that can be undertaken to make areas safe.

The total number of safe staffing audits completed over the past three months were: June 3149, July 3149 and August 3210. There was a significant increase in the number of final alerts reported from 2 in July to 12 in August. The number of alerts relate to one community service which is unable to provide planned care due to reduced numbers. The HON for the area is aware and a plan is in place. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has remained increased slightly in August following on the day investigation (June16, July 17, August 24).

13 nursing related safe staffing concerns were raised on Datix system in August compared to 10 in July. 4 of the alerts matched a similar entry on the RATE system and 3 others matched a concern.

Actions: Raise the link between datix and the rate system with the nursing body with the aim to achieve greater consistency.

Risk: In light of the required financial savings on temporary staffing that are required, this may impact on staffing over the next month. It is agreed that safety, not finance, will be paramount when agreeing / declining temporary staffing.

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Community Services Dashboard

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10. Community Services
- CQR Scorecard – Aug 2015

Domain	Patiend Safety & Experience																Direction	Comments
	Indicator	Frequency	2015/2016 Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16		
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
Patient Safety	SI's REPORTED	Monthly		1	1	2	0	1								↑	
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0	0								→	
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0	0	1								↑	
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0	0	0	0								→	
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7	4	12	8								↓	
Patient Safety	Number of moderate falls	Monthly	0	2	1	0	1	0								↓	
Patient Safety	Number of major falls	Monthly	0	0	0	0	0	0								→	
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0	0	0								→	
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0								→	
Patient Safety	CDiff (cumulative)	Monthly	31	1	0	0	0	0								→	
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2	2	2	2								→	
Patient Safety	Number of Quality Alerts	Monthly		3	5	2	5	3								↓	
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	95%	89.0%	86%	85%	84%	81%								↓	
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	90.0%	90.0%	85%	82%	79%								↓	changed to green because aris show as
			Level 2 85%	84.0%	84.0%	82%	82%	74%								↓	
			Level 3 85%	69.0%	69.0%	82%	90.00%	70% (TBC)								↓	
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.86	0.86								→	
Patient Experience	Active Claims	Monthly		0	0	1	3	1								↓	
Patient Experience	Number of Complaints received	Monthly		16	18	6	5	2								↓	
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	88% April 2015	78% May 2015	100%	100%								→	
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100% April 2015	100% May 2015	100%	100%								→	
Patient Experience	FFT Score (Mary Seacole and MIU)	Monthly			14.3												http://www.qualityobservatory.nhs.uk/index.php?option=com_cat&view=item&temid=28&cat_id=589
Patient Outcomes	Catheter related UTI (Trust)			1.14	0.66	1.12	1.32	Not yet available									http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22nhs+safety+thermometer+report%22&area=&siz
	Number of new VTE (Trust)		National 0.005	0.55	0.37	0.30	0.08										
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A									
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	6.04%	6.00%	4.69%	Not yet available								↓	
Workforce	Turnover Rate-	Monthly	13%	19.64%	19.94%	20.40%	20.08%									↓	
Workforce	Vacancy Rate-	Monthly	11%	19.41%	19.06%	19.40%	12.60%									↓	
Workforce	Appraisal Rates - Medical	Monthly	85%	66.67%	72.73%	72.70%	69.57%									↓	
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	76.80%	75.84%	75.40%	76.02%									↑	

Community Services - Quality scorecard exception report

- **KPI Exception Report for (for period up to August 2015)**
- **Serious Incidents:** In August one serious incidents was reported on STEIS: PU G3 community nursing. However to note: early September 2015, one incident of Grade 3 PU has been reported for Mary Seacole ward and one Grade 3 Pu SI reported for community nursing. Additionally. ,one Si has been reported for HIV/GUM service for failure of failsafe for positive result reporting.

- **Complaints:** Community Services numbers of formal complaints decreasing due to de-escalation by senior manager and complainant. In August on 2 complaints were received.

- **Child safeguarding Level 3:** (to be confirmed) L3 training is required every three years. 100 places are available each year, plus bespoke sessions as required. Attendance at sessions are approx. 75% of capacity.

- **Human Resources:**
- Vacancy rate has reduced from 19 to 12%. However, this may be due to cleansing of ESR system and re-alignment of budgets and establishments. Sickness rates have reduced, turnover rates remain unchanged.

- **Key areas of concern for workforce:**
- Access to MAST training as IT limitations prevent access for community services
- Appraisal rate falling
- Nursing recruitment and retention, particularly offender healthcare, Mary Seacole ward (QMH), community nursing, school nursing, specialist posts
- GP recruitment: Offender healthcare, rapid response

Appendix 1. Monitor Risk Assessment Framework 2015/16 Governance Rating Overview

Access targets and outcomes objectives

Monitor uses a limited set of national measures of access and outcome objectives as part of their assessment of governance at NHS foundation trusts. These metrics are as detailed in page 5 of this report. NHS foundation trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action. The trust performance report details performance against these metric and forecasts a governance rating for the quarter.

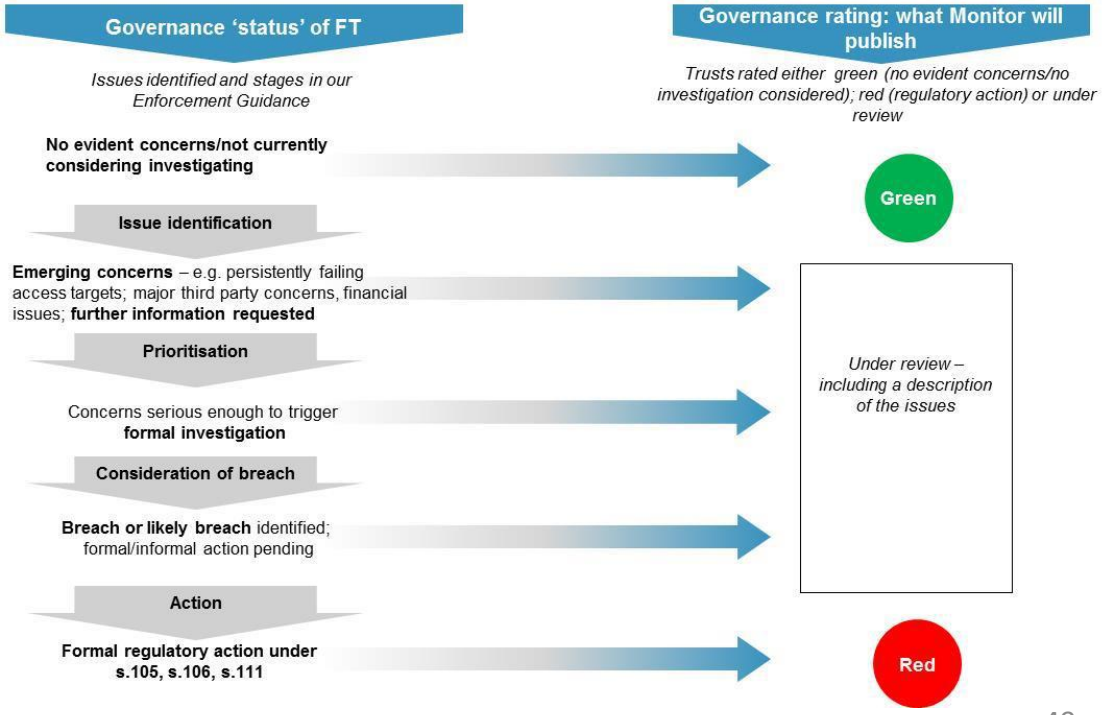
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

- outcomes of CQC inspections and assessments relating to the quality of care provided
- relevant information from third parties
- a selection of information chosen to reflect organisational health at the organisation
- the degree of risk to continuity of services and other aspects of risk relating to financial governance and
- any other relevant information.

The governance rating assigned to the trust reflects Monitor's views of its governance :

- **A green rating** will be assigned if no governance concerns are evident or where Monitor are not currently undertaking a formal investigation
- Where Monitor identify potential material causes for concern with the trust's governance in one or more of the categories (requiring further information or formal investigation), they will replace the trust's green rating with **'under review'** and provide a description of the issue(s).
- **A red rating** will be assigned if following review of causes for concern, they take regulatory action.

- The trust will detail in its performance report , a forecasted governance rating for the quarter and the current rating assigned by Monitor.



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REPORT TO THE TRUST BOARD – OCTOBER 2015

Paper Title:	Chair's Report: Quality and Risk Committee – 23rd September 2015
Sponsoring Director:	Sarah Wilton, Non-Executive Director
Author:	Sarah Wilton, Non-Executive Director
Purpose:	To provide the Board with a summary of the proceedings from the last Quality and Risk Committee
Action required by the board:	To note the update
Document previously considered by:	N/A

Report

This was a full (not seminar) meeting of QRC, attended by all three NED members and observed by two governors.
Full minutes will be circulated by the secretariat in due course, but the principal issues to be drawn to the Board's attention are:

1. The Trust is now participating in the national diabetes audit, with data collection issues now substantially resolved.

2. QRC reviewed a detailed report from Martin Wilson which sought to provide quality assurance about the proposed provider of the Recovery at Home service. His report provided examples of the quality reporting made available to other trusts using this outsourced service, together with detailed references from several trusts. QRC was satisfied that, in principle, the quality of the service provided elsewhere is at least satisfactory and mostly good, but stressed to Martin the need for our governance processes around the contract to be very robust so that we manage the delivery of the contracted services effectively from the start. Other specific aspects which QRC considered need more clarity relate to staff recruitment, ongoing consultant involvement, quality monitoring, outcomes, selection of pathways on which to use Recovery at Home initially, and discharge processes. It was suggested that a NED should join the steering group to provide added challenge and assurance.

3. Concern was expressed, during QRC's review of the regular trust quality report, that divisional quality dashboards are still not in place. This must be completed very promptly now, across the Trust, so that clear and transparent reporting and oversight of quality issues reaches the required standard. QRC requested that the completed risk dashboards are reported to the next full QRC meeting, in November.

4. The quality report also showed that there is still poor compliance with safeguarding training.

While it was suggested that this may be caused by data collection problems, QRC urged that any data issues must be urgently resolved, so that reporting of safeguarding training can be relied upon and action taken to ensure training rates at least meet the required target.

5. QRC reviewed the annual complaints report. While noting that response times across the Trust had improved earlier in the year, particularly in CS where efforts have been made to deal promptly with concerns and complaints face-to-face, average response times have slipped back more recently. QRC asked both for clearer reporting in future of trends, and breakdown by division/care group and also for further evidence that complaints analysis and trends are being used, promptly, to rectify problems and shortcomings identified.

6. QRC was very concerned to note that the resource allocated to SI investigations has been reduced, particularly since there continues to be an increase in the number and frequency of reported SIs.

7. QRC confirmed that CQC standards would be the principal subject for the October seminar meeting. We asked for this report to include relevant issues from the recent Addenbrook's CQC report, and also confirmation that all matters raised in the last CQC report have been fully dealt with.

8. Also to be addressed at the October seminar QRC will be the over-arching review of 'failure to follow-up' SIs.

9. QRC was concerned to note the policy ratification report, showing that regular review and update of some important policies, eg water safety, has been outstanding for some time. We were assured that this is in hand and will be done, but will ensure attention is focussed on these at the next QRC, when we will require clarification of the responsible officer for PRG once Peter Jenkinson has left the trust.

10. QRC was unable to review the Offender Healthcare progress report, and the updated estates and facilities risks, owing to absent presenters and paper. Firm reminders have been issued to ensure the necessary attendance of presenters or deputies in future. Both items will be addressed by QRC in November.

Key risks identified:

Risks are detailed in the report under each section.

Related Corporate Objective:	All corporate objectives
Related CQC Standard:	N/A

Equality Impact Assessment (EIA): Has an EIA been carried out?

If yes, please provide a summary of the key findings

No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

St George's University Hospitals NHS
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REPORT TO THE TRUST BOARD –OCTOBER 2015

Paper Title:	Trust Finance Report : Month 05 Overview
Sponsoring Director:	Steve Bolam, Chief Financial Officer & Deputy Chief Executive
Author:	Nigel Baker, Interim Director of Operational Finance
Purpose:	Monthly report to the Board on the financial position of the Trust
Action required by the board:	To review the report and identify areas where further action or assurance is required
Document previously considered by:	N/A

Executive summary

Income & Expenditure

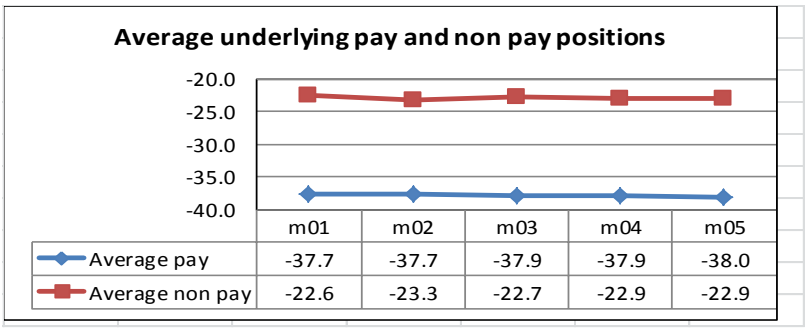
- As at month 5 the Trust is showing a deficit of £31.2m against its monitor plan deficit of £23.9m giving an adverse variance of £7.3m comprising:
  - Income £4.5m adverse
  - Pay £3.3m adverse
  - Non-pay £0.1m adverse
  - Depreciation £0.5m favourable

- The key drivers are:
  - underperformance in Outpatient activity £2.4m adverse
  - unidentified CIPs (showing mainly against pay as unallocated CIPs are split 80% pay 20% non pay) £1.9m adverse
  - prior year costs and income issues previously reported £2.5m adverse
  - potential penalties and challenges from commissioners £0.6m adverse

- Performance month on month had begun to stabilize and improve. However as noted last month this was particularly influenced by income fluctuations rather than cost improvements. Last month we adjusted to remove prior year items, to recognise the move of interim contract staff from the non-pay consultancy line back up to pay, and to adjust for the contingency that was accrued in months 1 to 3 but released in month 04 to show the underlying actuals. Two further adjustments have been made this month. Firstly some capital items were identified in the revenue expenditure and secondly the non-recurrent costs of the turnaround support have been deducted. The revised underlying monthly deficit pattern is as follows and is shown in the table below:
  - M01 £6.7m deficit
  - M02 £6.1m deficit
  - M03 £4.5m deficit
  - M04 £3.8m deficit
  - M05 £6.4m deficit

	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	YTD £m	Trends
Reported Actuals							
Income	56.4	57.6	57.7	60.5	57.6	289.8	
Pay	(37.4)	(37.4)	(38.0)	(38.8)	(38.4)	(189.9)	
Non pay	(23.5)	(25.9)	(22.8)	(22.1)	(22.8)	(117.1)	
Post EBITDA	(3.0)	(2.7)	(2.6)	(2.9)	(2.9)	(14.1)	
Reported Deficit	**(7.6)**	**(8.3)**	**(5.7)**	**(3.3)**	**(6.5)**	**(31.3)**	
Adjustments							
Income	0.3	0.7	0.2	0.0	0.0	1.2	prior yr
Non pay	0.3	1.0	0.0	0.0	0.0	1.3	prior yr
Pay	(0.3)	(0.3)	(0.3)	0.9	0.0	0.0	interim contractors
Non pay	0.3	0.3	0.3	(0.9)	0.0	0.0	interim contractors
Non pay		0.2	0.4		(0.6)	0.0	transfers to capital
Non pay			0.3	0.3	0.7	1.3	Turnaround/PWC non rec
Non pay	0.3	0.3	0.3	(0.9)	0.0	0.0	accrued contingency
Adjustments	**0.9**	**2.2**	**1.2**	**(0.6)**	**0.1**	**3.8**	
Underlying actuals							
Income	56.7	58.3	57.9	60.5	57.6	291.0	
Pay	(37.7)	(37.7)	(38.3)	(37.9)	(38.4)	(189.9)	
Non pay	(22.6)	(24.0)	(21.5)	(23.6)	(22.7)	(114.5)	
Post EBITDA	(3.0)	(2.7)	(2.6)	(2.9)	(2.9)	(14.1)	
Underlying Deficit	**(6.7)**	**(6.1)**	**(4.5)**	**(3.8)**	**(6.4)**	**(27.5)**	
Costs / income (%)	111.7%	110.5%	107.7%	106.3%	111.1%	109.4%	

- SLA income is £4.1m behind plan and £2.9m behind plan when the prior year issues are excluded. The key drivers of this are outpatient income £2.4m, where activity is above 14/15 levels but behind plan (i.e growth is not being delivered) and income, and increasing levels of challenges from commissioners. Elective income has improved in month despite the impact of theatre closures.
- The underlying actuals table above shows that there has been an increase in total pay. This includes a reduction in substantive pay but an increase in temporary staff costs. A detailed review is being undertaken of this change to understand the reasons for it. The process for generating the agency accrual where usage data is not immediately available from our rostering systems is being jointly reviewed with HR colleagues. It is possible there is some overprovision in the month 05 position but the detailed work will surface this.
- There has been some fluctuation in the underlying actuals for non pay but the average remains at c£23m per month.
- As the chart below shows however, the pay and non pay positions on average (taking April as the start point in each case) have stabilised.



- As noted last month currently the key driver to changes in the deficit from month to month are the fluctuations in Income.

Turnaround actions

- As noted previously a significant number of steps have been taken as part of the GRIP workstream under Turnaround to stabilise and control the financial position
- Examples of these include weekly detailed headcount tracking, vacancy control panels and challenge sessions to agree exit plans for every member of non clinical temporary staff on pay, changes in SFIs and authorisation levels, reviews of individual discretionary spend lines, cost awareness work on non pay and debt recovery group actions, improved cash forecasting, extended creditor terms and early payment from CCGs on cash
- The Turnaround Board has been established including Non-Execs in order to provide oversight of the programme and its progress and for the Board to ensure there is challenge and robust evidence of delivery provided by KPMG and the Exec team
- As the above commentary shows it is hard to see any material shift in the pay or non pay positions at this stage (although there is material progress on cash noted below). The CFO is working with KPMG to identify a set of more granular and detailed KPIs to ensure the Board can see evidence of the changes taking affect in the performance.
- A significant part of the Turnaround resource has focussed on the BUILD workstream and this is covered under CIP progress below.

Cost improvement programme

- Year to date, the Trust has delivered £9.4m of savings, comprising £4.7m of CIPs (of which £3.0m is from 'Green' rated schemes) and a further £4.7m of non-recurrent and run rate/vacancy control savings
- This is a shortfall of £1.9m against the phased plan
- The full year forecast for Green rated CIPs totals £9.5m being a £2.0m increase on M04 due to the addition of further schemes and progression through governance reviews
- Run-rates/non-recurrent are being counted against the CIP target and therefore there are currently no mitigations to the £7.3m I&E underperformance. The divisions are being tasked with considering what additional actions are required, including reviewing activity levels in loss making activities.
- As noted above, the BUILD part of the Turnaround programme focusses on the development of CIPs. The following objectives have been agreed through to the end of October.
- Further development of initiatives to exceed the in year 2015/16 CIP target of £38m in clinical and corporate overhead
- Support the maturation of schemes to green (noting that multi-cost code schemes in procurement and medicines management may be limited to Amber until supplier negotiations complete)
- Validate or remove the residual Trust Wide run rate schemes
- Finalise validation of procurement schemes and begin development of specific pipeline
- Support maturity of 15/16 Workforce Efficiency Group (WEG) schemes
- Support finalisation of 'In Patient' Nursing Establishment review
- Support 'Out Patient' strategy review
- Identify 16/17 CIP schemes to the value of the LTFM target (£35m) to be incorporated into budget reforecasting exercise, (these will be at varying stages of maturation from pipeline to PMO signed off green).
- Finalise clinical benchmarking and develop 16/17 opportunities across Theatres, Diagnostics, patient flow and clinical overhead
- As noted above, the Trust is £1.9m behind the risk adjusted plan of £34.2m. This plan includes a 10% risk for non delivery and is phased more in the second half of the year

anticipating greater turnaround impact. If the objectives above are delivered and greater than the full £38.1m is identified and the Board can be assured that its implementation will take effect in full during 2015/16 then this will make a material difference to the current run rate deficit per month.

- The CEO and CFO have a pipeline and CIP review session with the KPMG team on 6th October and the Divisions have set up their challenge and review sessions as part of the Turnaround Reforecast Process and these begin w/c 5th October.

Cash

- The cash balance was £6.1m at 31st August which is £2.1m favourable to plan. The adverse cash impact of the £0.7m revenue overspend in August was offset by an underspend on capital expenditure.
- The Trust cleared a further proportion of the supplier invoice backlog in August and reduced the outstanding debtor balances ahead of the new debt collection target that has been set
- Since month end the Trust has drawn down a further £9.4m under the working capital facility which is now fully utilised

Capex

- Capital expenditure in August was £1.8m and YTD expenditure is £13.8m against the new YTD budget, an under spend of £7.1m.
- The Trust is carefully controlling the pace of capital expenditure where appropriate to support the cash position until the interim support funding is agreed with Monitor/ITFF.
- Budget holders indicate that the YTD under spend relates primarily to in-year timing differences and so the forecast outturn is an underspend of £3.1m.

Divisional Financial Performance

At month 04 the Board agreed to the allocation of contingency budgets to support shortfalls in funding that were compromising the ability to establish the right recurrent levels of capacity in certain areas. In addition, the Board agreed the recommendation that certain unavoidable pressures put forward by Divisions for which no specific mitigations could be found but for which no funding could be provided should be recognised when considering Divisional financial performance. The total of these pressures was £7.14m or £2.98m year to date.

The Table below shows the financial performance for each Division to month 05 when these issues are taken into account. The unavoidable issues are moved to the other column to ensure the underlying variance is consistent with the table above i.e. a deficit of -£27.5m against a plan of -£23.9m and therefore an underlying variance to date of -£3.6m

	MedCard £m	SNT £m	CWDT £m	CS £m	E&F £m	Corp £m	Other £m	Total £m
YTD variance at m05	-4.1	-1.5	-1.7	-1.1	0.1	0.1	1.0	-7.3
Unavoidable overspends	0.5	1.3	0.4	0.3	0.0	0.5	-3.0	0.0
Prior year issues							2.5	2.5
Non-recurrent Turnaround							1.3	1.3
Underlying Divisional variance	**-3.7**	**-0.3**	**-1.3**	**-0.8**	**0.1**	**0.5**	**1.8**	**-3.5**

To address the adverse variance to date, monthly performance review meetings have been set up with each division. These review meetings address both financial and operational performance. The outputs of these meetings include agreed actions to improve the financial position of each division. These will be monitored over the coming months to assess their effectiveness and whether further measures will need to be taken. The monitoring will include cross divisional checks where

improvement is dependent on the actions of another division.

Whilst CIP progress will be included in the performance management reviews, the main governance vehicle for CIP performance will remain the turnaround board.

Meetings with SNT, CWDT, Community Services and Estates were held w/c 28th September and were chaired by the CFO, supported by the DoD&I and KPMG. Medcard and the remaining corporate areas are reviewed w/c 5th October.

Each of the actions arising from the sessions will be allocated an owner, a timescale is being agred for delivery and estimates of the financial impact of the action are being calculated. These action plans will be written up and shared with Board members and the Divisional leadership will account for their progress against them at the next Finance & Performance Committee.

The key actions arising from the latest reviews are:

Community Services

- Work with HR around; training up SGUH staff to work at HMPW; encouraging more staff to work in community; employing specific marketing campaign to attract people to community roles; implementing an 'invest to save' role to focus on community recruitment & retention and reduce bank & agency
- Develop and submit business case for additional WICES funding to Wandsworth CCG
- Implement continence nurse post and plan review of work to reduce continence spend (including identification of impact in M11/12 2015/16 and over 2016/17.
- Work to ensure all SRG monies and flow funds are retained so that Nightingale budget is adequate and the ward can be opened as early as possible to support Winter flow
- Construct recovery plans for outpatients & diagnostics, rehab & therapies, GUM and Mary Seacole ward. To include:
    - What can be done to contribute to recovery
    - What needs to be done to reduce income underperformance
    - What staffing and other costs can be reduced or flexed to mitigate any remaining income loss

Surgery

- A small multi-disciplinary team to step through the process for the capture and recording of high cost drugs by 2nd Oct as a potential under reporting has been picked up for month 05 which is understating the Neuro income position
- Construct recovery plans for outpatient underperformance to improve income position and to reduce RTT penalties
- Challenge EOC re underperformance and establish forecast outturn
- Where activity has permanently reduced, identify cost reductions
- Review iClip issues which may be preventing the proper coding of Neurosurgery emergency activity as average price per case has fallen
- Reconcile activity undertaken for Gibraltar with income by specialty as Division believe some income is missing from the month 05 position
- Grip team to identify and replicate good practice in control of clinical consumables in T&O and Neuro and replicate throughout
- Investigate possibility of additional Neuro clinics at the Nelson
- Plastics to reduce capacity and cost given levelling off in demand

Childrens, Womens, Diagnostics and Therapies

- Use of patient status tracker to support optimum use of available critical care capacity
- Joint working with anaesthetics to review 2 specific surgical pathways and improve productivity
- Joint work with other SWL ccu's re the agency vs bank debate. Is there scope for a common strategy to reduce agency costs
- Demonstrate the evidence of late referral of complex births to St George's from other providers without any reimbursement
- Pan London meeting to discuss how to sort the maternity pathway provider to provider reimbursement system out
- Root cause analysis on discrepancy between K2 and SLAM systems for maternity care
- Consider case for the use of contingency capital / invest to save to recover the ability for QC income recovery in pharmacy.
- Review the volume of patients waiting > 6weeks and define outpatient resource required to sort ite
- In year renegotiation with external provider re potential overcharging on storage contract

Estates & Facilities

- Review clinical waste usage with SWLP to ensure reimbursement for / control of their increasing volumes
- Finalise the agreement with SGUL for utility and space charging
- Review rates liabilities
- Forensic review of invoicing and charges to identify any potential historic overpayments
- Ensure leases are in place covering all Trust occupations of CHP and NHSP facilities
- Conduct a review of medical physics non pay including all leases and maintenance costs

Key risks identified:

The allocation of the contingency to fund divisional cost pressures and the setting of control totals with divisions in respect of unavoidable cost pressures has indicated a risk of a further £7m deficit.

Related Corporate Objective:*Reference to corporate objective that this paper refers to.*	1) Achieve financial targets in the near term 2) Achieve long term financial sustainability
Related CQC Standard:*Reference to CQC standard that this paper refers to.*	N/A

Equality Impact Assessment (EIA): Has an EIA been carried out? Yes

If yes, please provide a summary of the key findings

No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

If no, please explain your reasons for not undertaking an EIA.

Summary Finance Report
Month 05 2015/16

Trust Board 8th October 2015

(Please see Appendix H for a summary of the reporting and accounting developments that have been taking place that underpin this Finance Report.)

❶ Month 05 Headlines & Actions – I&E

Area of Review	Metric	Key Highlights	Actions	RAG
Financial Position	YTD Deficit £31.3m, £7.3m adverse to plan	The key drivers are underperformance in Outpatient activity, the prior year items previously notified and unidentified CIPs. The in month deficit is £6.5m, which is worse than recent months. Pay and non pay are in line with recent trends but SLA income is £2.9m lower due to fewer working days in August and further underperformance due to annual leave.	A turnaround reforecast is underway to be completed by November which will review the fundamental demand and capacity issues.	
Activity / Income	YTD £4.1m adverse to plan.	The key drivers are outpatient income (4% down on activity and income) and the prior year items. Emergency and A&E income collectively is slightly below plan, but most of this element of the contract is operated as a block which means that the under-performance is not reflected in reduced income. Elective income has improved in month.	Activity variances were challenged at the Divisional performance review meetings and actions agreed to investigate underperformance and to adjust for any unrecoverable variances in the reforecast process. Contracts team to negotiate income penalties and challenges with commissioners.	
Expenditure - Pay	YTD £3.3m adverse to plan	In August, the Trust incurred £38.4m of pay costs compared to £38.8m in July. Pay in-post represented 85% of costs in month compared to 86% in July. The element of the pay CIP target that has no 'Green' schemes to support it, created a £9.6m YTD adverse variance. Partially offsetting this are savings being made in nursing, non clinical staffing and professional and scientific pay which brings the overall adverse position on pay to £3.3m.	The Trust has adopted a Turnaround approach supported by KPMG to work with budget holders on increasing 'grip' of pay costs and developing / implementing credible CIP schemes. Individual review of all non clinical agency staff and agreed exit dates and also reviewing clinical agency.	
Expenditure – Non Pay	YTD £0.1m favourable to plan	The element of the non-pay CIP target that has no 'Green' schemes to support it created a £3.8m YTD overspend. Partially offsetting this are savings made in a number of areas which bring the overall favourable position on non-pay to £0.1m.	The Trust has adopted a Turnaround approach supported by KPMG to work with budget holders on increasing 'grip' of non-pay costs and developing / implementing credible CIP schemes.	
CIP	YTD £1.9m adverse to plan	Year to date, the Trust has delivered £9.4m of savings, comprising £4.7m of CIPS (of which £3.0m are 'Green') and a further £4.7m of 'run-rate' and non-recurrent savings. This is a £6.5m adverse variance to the internal plan and £1.9m adverse to the Monitor plan.	Turnaround board established and progress on developing and implementing CIP schemes regularly challenge with Divisions.	

❶ Month 05 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights	Actions	RAG
Cash	Balance of £6.1m, £2.1m better than plan	The cash balance was £6.1m at 31st August which is £2.1m favourable to plan. The adverse cash impact of the £0.8m revenue overspend was offset by an underspend on capital expenditure. The current cash forecast indicates the cash balance will be c£5m on 30th September – as required under the terms of the working capital facility (WCF). Since month-end the Trust has drawn down a further £9.42m under the WCF which is now fully utilised	As forecast in previous months the Trust will require access to a new ITFF loan/facility from October to secure sufficient cash until the level of interim support funding for the year is confirmed in January. Separate paper on F&P agenda.	
Capital	YTD spend £13.8m, £7.1m less than plan.	Capital expenditure was £1.8m in August, an under spend of £2.7m in month against the new reduced £48m capital programme agreed in June. The YTD figure of £13.8m is £7.1m less than the revised budget.	In order to support the cash position the Trust is continuing to slow down the rate of capital expenditure where possible until the discussions with Monitor on the interim support funding are concluded.	
FSRR (formally COSRR)	Rating of 1	The Trust scored a rating of 1 at M5, compared to a plan of 2, due to the adverse variance in YTD I&E performance.	To increase the rating to a 2, would require an improvement in the deficit variance to less than 2% of total income as the other metrics are driven by the overall deficit and the low cash balance.	

❷ Overall Position

	Annual Budget £m	Current Budget £m	Current Amount £m	Current Variance (adv) / fav £m	YTD Budget £m	YTD Amount £m	YTD Variance (adv) / fav £m	%
SLA Income	624.36	50.11	48.99	(1.12)	252.89	248.84	(4.06)	*-2%*
Other Income	99.96	8.97	8.61	(0.37)	41.46	40.98	(0.49)	*-1.2%*
Overall Income	**724.32**	**59.08**	**57.59**	**(1.49)**	**294.36**	**289.81**	**(4.54)**	***-1.5%***
Pay	(450.38)	(38.09)	(38.36)	(0.26)	(186.56)	(189.89)	(3.33)	*-1.8%*
Non Pay	(283.42)	(23.71)	(22.83)	0.88	(117.18)	(117.11)	0.07	*0.1%*
Overall Expenditure	**(733.80)**	**(61.80)**	**(61.19)**	**0.61**	**(303.74)**	**(307.00)**	**(3.27)**	***-1.1%***
EBITDA	(9.48)	(2.72)	(3.59)	(0.87)	(9.38)	(17.19)	(7.81)	*-83.3%*
Dpn, PDC div etc	(36.72)	(3.02)	(2.91)	0.11	(14.56)	(14.08)	0.48	*3.3%*
Surplus / (deficit)	**(46.21)**	**(5.74)**	**(6.50)**	**(0.76)**	**(23.94)**	**(31.27)**	**(7.33)**	***-30.6%***

- The YTD deficit of £31.3m is £7.3m adverse to plan with the in month deficit of £6.5m being £0.8m adverse
- Income and Pay are adverse to plan YTD, with the main drivers being underperformance in Outpatient activity, the prior year costs previously notified and unidentified CIPs
- The pay adverse variance consists of £9.7m of unidentified CIPs offset by planned and unplanned underspends on Nursing, Scientific & Technical and Admin.
- The non pay favourable variance includes £3.8m of unidentified CIPs offset by underspends on clinical consumables, premises and release of some reserves.
- It is important to note that some £6.8m of additional CIP delivery has not achieved the milestones to be allocated in the ledger but is effectively held as favourable variances offsetting the £9.7m and £3.8m noted above.
- As noted previously, some £2.5m of prior year costs and income losses have contributed to the adverse position to date.

❷ Overall Position – Adjusted Underlying

	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	YTD £m	Trends
Reported Actuals							
Income	56.4	57.6	57.7	60.5	57.6	289.8	
Pay	(37.4)	(37.4)	(38.0)	(38.8)	(38.4)	(189.9)	
Non pay	(23.5)	(25.9)	(22.8)	(22.1)	(22.8)	(117.1)	
Post EBITDA	(3.0)	(2.7)	(2.6)	(2.9)	(2.9)	(14.1)	
Reported Deficit	**(7.6)**	**(8.3)**	**(5.7)**	**(3.3)**	**(6.5)**	**(31.3)**	
Adjustments							
Income	0.3	0.7	0.2	0.0	0.0	1.2	prior yr
Non pay	0.3	1.0	0.0	0.0	0.0	1.3	prior yr
Pay	(0.3)	(0.3)	(0.3)	0.9	0.0	0.0	interim contractors
Non pay	0.3	0.3	0.3	(0.9)	0.0	0.0	interim contractors
Non pay		0.2	0.4		(0.6)	0.0	transfers to capital
Non pay			0.3	0.3	0.7	1.3	Turnaround/PWC non rec
Non pay	0.3	0.3	0.3	(0.9)	0.0	0.0	accrued contingency
Adjustments	**0.9**	**2.2**	**1.2**	**(0.6)**	**0.1**	**3.8**	
Underlying actuals							
Income	56.7	58.3	57.9	60.5	57.6	291.0	
Pay	(37.7)	(37.7)	(38.3)	(37.9)	(38.4)	(189.9)	
Non pay	(22.6)	(24.0)	(21.5)	(23.6)	(22.7)	(114.5)	
Post EBITDA	(3.0)	(2.7)	(2.6)	(2.9)	(2.9)	(14.1)	
Underlying Deficit	**(6.7)**	**(6.1)**	**(4.5)**	**(3.8)**	**(6.4)**	**(27.5)**	
Costs / income (%)	111.7%	110.5%	107.7%	106.3%	111.1%	109.4%	

- The table shows the Trust underlying position stripping out the impact of prior year adjustments, the recategorisation of interim contractors costs between pay and non pay, revenue expenditure transferred to capital and the non recurrent PWC and Turnaround costs..
- For Month 5 the trend has worsened although this can largely be attributed to the lower level of SLA income expected in August due to impact of holidays and fewer working days to see elective inpatients and outpatients. Pay and non pay are close to previous trends

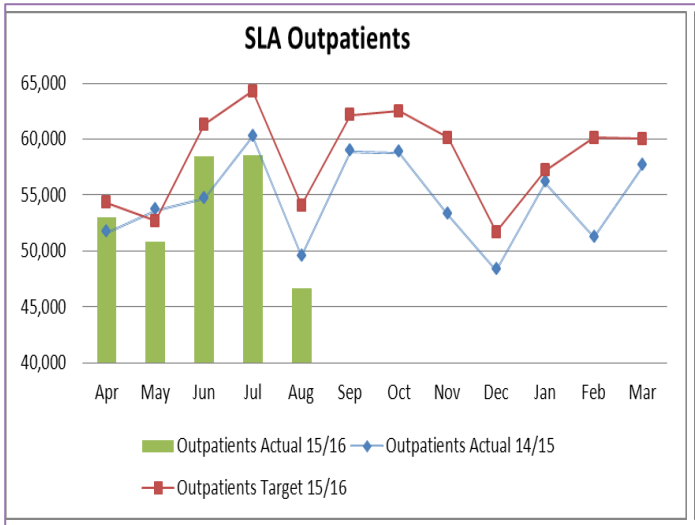
❸ SLA Income

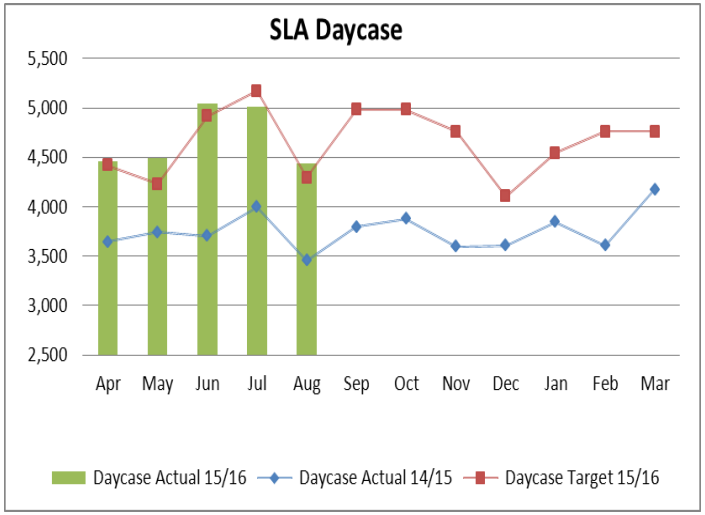
Variance YTD 2015/16 (adv) / fav	CWDT £m	CSD £m	Medicine & CV £m	Surgery & Neuro £m	Overheads £m	Central £m	Grand Total £m
SLA A&E	0.00	(0.04)	(0.04)	0.00	0.00	(0.05)	(0.13)
SLA Bed Days	(0.08)	(0.17)	0.00	(0.15)	0.00	0.00	(0.40)
SLA Daycase	0.16	0.00	0.04	0.13	0.00	0.00	0.33
SLA Elective	(0.37)	0.00	(0.00)	0.90	0.00	0.00	0.52
SLA Exclusions & Prog.	0.09	(0.01)	0.13	0.22	(0.05)	0.00	0.38
SLA Non Elective	0.45	0.00	0.43	(0.50)	0.00	(0.42)	(0.04)
SLA Other	(0.07)	(0.04)	(0.37)	(0.34)	(0.00)	(1.54)	(2.37)
SLA Outpatients	(0.86)	(0.84)	(0.85)	0.08	0.19	(0.08)	(2.34)
Grand Total	**(0.68)**	**(1.10)**	**(0.67)**	**0.33**	**0.14**	**(2.08)**	**(4.06)**

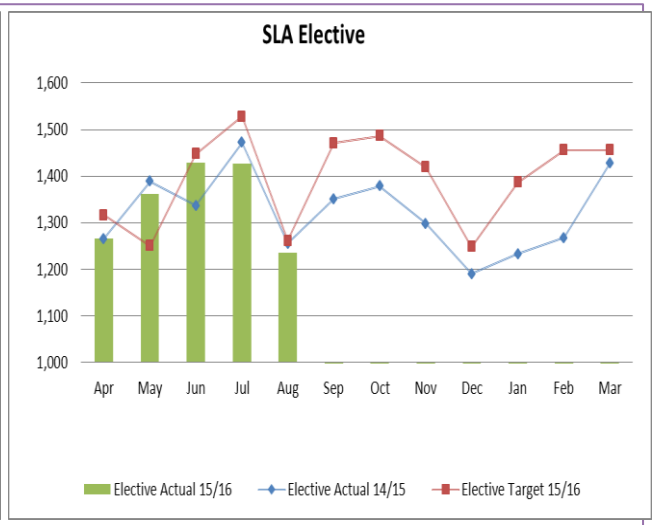
Variance Current Month (adv) / fav	CWDT £m	CSD £m	Medicine & CV £m	Surgery & Neuro £m	Overheads £m	Central £m	Grand Total £m
SLA A&E	0.00	(0.02)	(0.01)	0.00	0.00	(0.01)	(0.04)
SLA Bed Days	(0.06)	(0.11)	0.00	(0.18)	0.00	0.00	(0.36)
SLA Daycase	0.03	0.00	0.05	(0.00)	0.00	0.00	0.08
SLA Elective	(0.04)	0.00	0.19	0.44	0.00	(0.06)	0.53
SLA Exclusions & Prog.	0.07	(0.02)	0.04	0.11	0.03	0.00	0.23
SLA Non Elective	0.07	0.00	(0.01)	(0.17)	0.00	(0.11)	(0.21)
SLA Other	0.01	(0.22)	(0.12)	0.03	0.06	(0.34)	(0.59)
SLA Outpatients	(0.33)	(0.10)	(0.23)	0.02	(0.09)	(0.02)	(0.75)
Grand Total	**(0.26)**	**(0.48)**	**(0.10)**	**0.24**	**(0.00)**	**(0.53)**	**(1.12)**

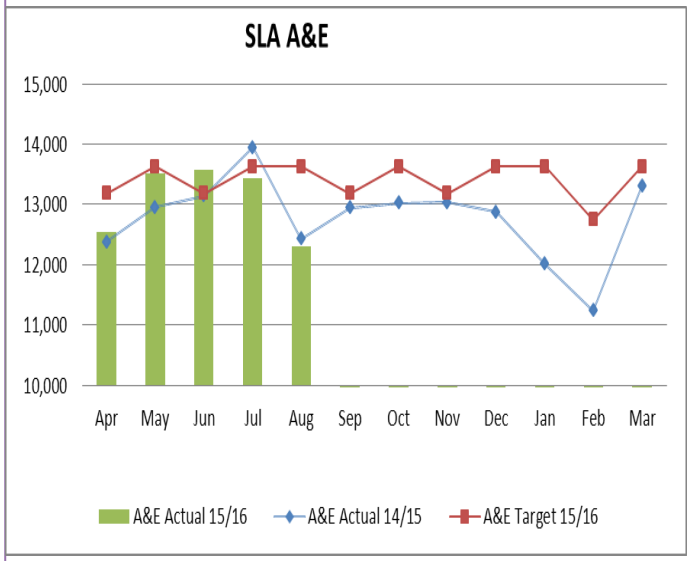
- SLA income in total is cumulatively £4.1m behind plan. Adjusting for prior period issues £1.2m, the underlying variance would be £2.9m (1.2%) adverse to plan
- As noted in Appendix H, the Trust has changed the way it treats 'excluded' drugs by re-profiling the in-month income and expenditure budget to remove the variances. To date £2.6m has been removed from income and expenditure budgets.
- The main POD behind plan is Outpatients with many specialties under plan. Nelson activity has been profiled to reflect a slow start and the level of activity is under performing although the Trust is working to book more patients in.
- An important part of the SLA with local CCGs is a block around emergency activity supported by additional investment in capacity. Emergency activity for these CCGs is below target by £0.3m and on the basis that this is a block, the income has been increased leaving no variance for these CCGs.
- Estimates of penalties and KPI challenges are £2.5m against the budget of £1.9m YTD. This adverse variance is included in SLA Other (together with the prior year items)
- All SLA income is now included in one SLAM system covering Acute, QMH, Community and the Nelson.
- Trends of income and activity are shown on the following pages.

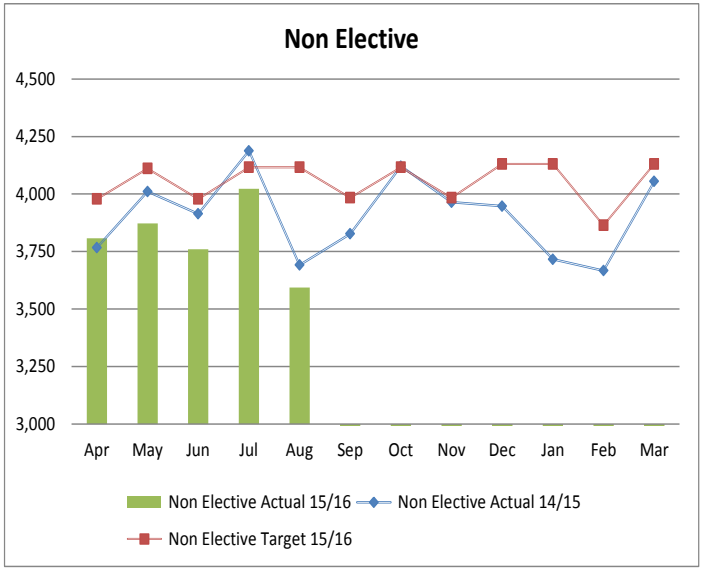
❸ Activity - 2015/16 actuals vs 2015/16 plan vs 2014/15 actuals









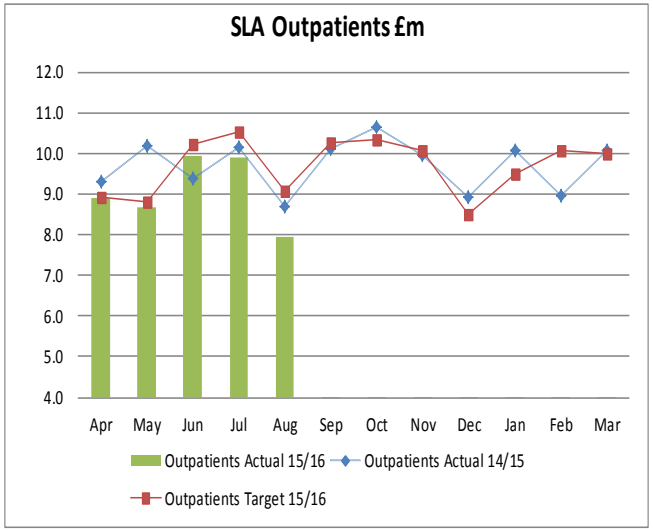


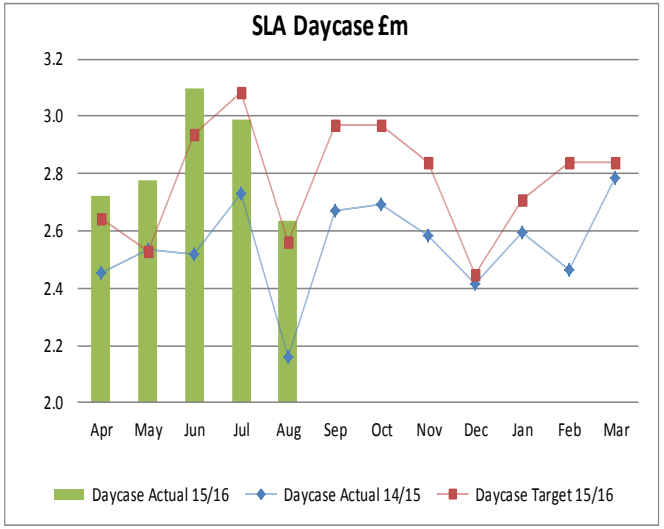
For month 5, there is a significant fall in Outpatients and A&E attendances and for Non elective activity compared to previous months and they are all significantly below the plans for the month

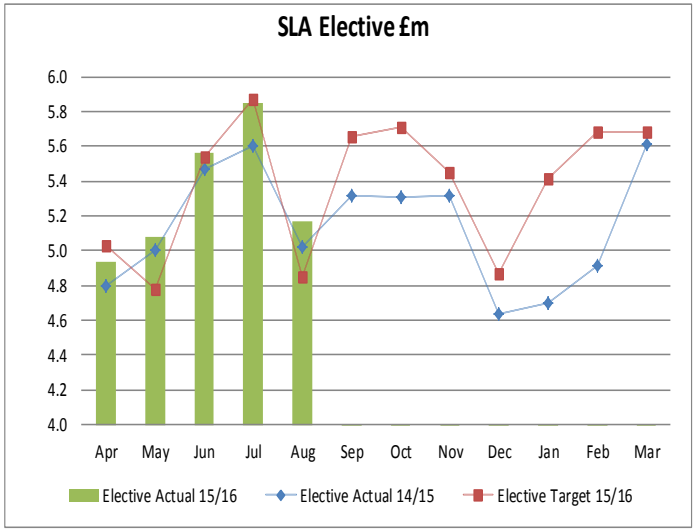
Whilst Daycase and Elective activity also reduced from the previous months they are close to the plan for month 5.

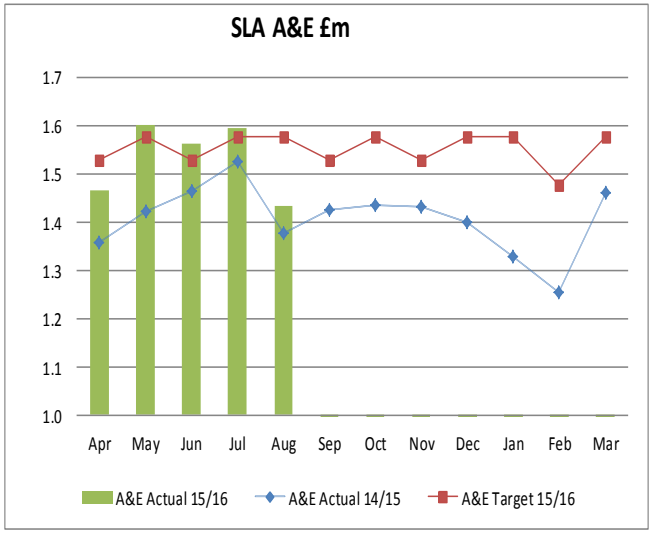
The month 5 plans for Outpatients, Daycase and Elective are lower than previous month due to the fewer working days in the month

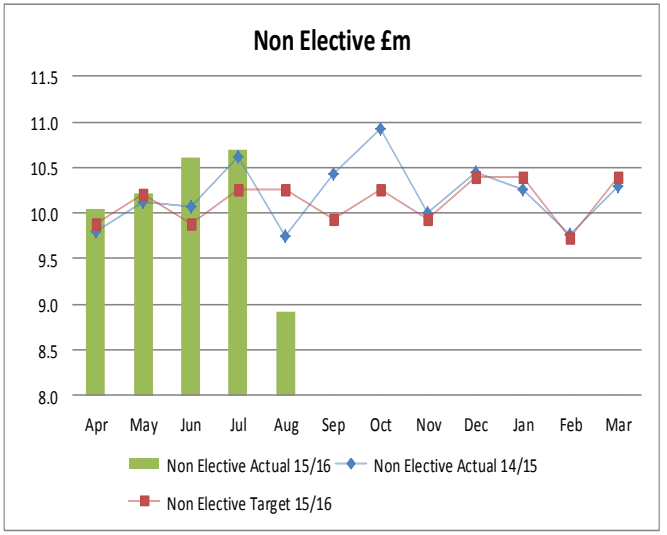
❸ Income – 2015/16 actuals vs 2015/16 plan vs 2014/15 actuals











For M05, there is a significant fall in Outpatients, A&E and Non elective income compared to previous months and they are all significantly below the plans for the month

Whilst Daycase income also reduced from the previous months it is close to the plan for M05

Elective income also reduced from previous months is over plan for the month due to additional cardiac surgery cases

The month 5 plans for Outpatients, Daycase and Elective are lower than previous month due to the fewer working days in the month

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❸ SLA Income – Commissioner Analysis

All Figures in £m's Month 05	Annual Budget	YTD Budget	Actual	Variance fav/(adv)
NHSE Specialist	212.85	85.70	89.60	3.90
NHSE Public Health	23.71	9.75	9.87	0.11
NHSE Secondary Dental Care Services	8.56	3.54	3.68	0.14
NHSE Cancer Drugs Fund	2.88	1.13	1.12	(0.00)
Public Health England	0.86	0.36	0.42	0.06
Subtotal NHSE	**248.87**	**100.48**	**104.69**	**4.21**
NHS Wandsworth CCG	146.88	60.89	61.63	0.74
NHS Merton CCG	58.53	24.25	25.66	1.41
NHS Lambeth CCG	19.96	8.27	8.52	0.25
NHS Croydon CCG	21.33	8.82	9.38	0.56
NHS Sutton CCG	13.56	5.61	5.47	(0.14)
NHS Kingston CCG	12.91	5.35	5.00	(0.35)
NHS Richmond CCG	11.82	4.90	4.93	0.04
Surrey CCG	20.02	8.27	8.10	(0.17)
Other CCGs	21.25	8.43	7.36	(1.07)
Subtotal CCGs	**326.26**	**134.78**	**136.03**	**1.25**
NCA	7.79	3.22	3.61	0.39
Other Trusts	1.06	0.44	0.53	0.09
Other Local Authority	7.18	3.24	3.14	(0.10)
Subtotal CCGs	**16.03**	**6.90**	**7.28**	**0.38**
Internal Targets: Growth, Business Cases etc	25.60	7.58	-2.29	(9.87)
Ex SLA Income	7.60	3.15	3.12	(0.03)
Total NHS Healthcare Income	**624.36**	**252.89**	**248.84**	**(4.06)**

This table shows the Trust's performance against the contract values agreed with each major commissioner.

For the YTD, the Trust is significantly overperforming on the NHSE contracts and local CCGs - Wandsworth, Merton and Croydon.

The Trust has set additional internal targets to reflect activity that is planned but was not commissioned in the contract values. Taking this into account overall the Trust is under-performing its total planned activity targets by £4.1m YTD.

❸ Provision for SLA Penalties & Challenges

ANNUAL BUDGET	£'000	ACTUAL M1	M2	M3	M4	M5	YTD	BUDGET YTD	VAR YTD
1,200	RTT 18 weeks	197	117	75	151	136	**676**	500	(176)
0	RTT 52 weeks	20	5	0	15	20	**60**	0	(60)
360	A&E 4 hour wait	52	21	52	60	11	**196**	150	(46)
240	Ambulance handovers	29	24	33	25	27	**138**	100	(38)
100	Diagnostic waits	25	29	5	8	6	**73**	42	(31)
80	Cancer	7	7	7	7	7	**35**	33	(2)
0	MRSA	20	0	0	0	0	**20**	0	(20)
0	Never events	2	2	2	2	2	**10**	0	(10)
570	Readmissions to SGH	63	49	52	26	47	**237**	238	1
90	Readmissions critical care	6	4	6	14	8	**38**	38	(1)
440	Readmissions to other	64	64	64	64	65	**322**	183	(139)
3,080	**National terms**	**485**	**322**	**296**	**372**	**329**	**1,805**	**1,283**	**(522)**
600	Follow up ratio	50	51	50	51	50	**252**	250	(2)
140	Follow up ratio QMH	29	28	25	27	29	**138**	58	(80)
370	DC to OP adult	31	30	38	26	32	**157**	154	(3)
80	DC to OP paeds	7	6	5	8	7	**33**	33	0
120	High Cost Drugs	11	11	11	11	11	**55**	50	(5)
120	Automated challenges		11	15	14	14	**54**	50	(4)
1,430	**Local terms**	**128**	**137**	**144**	**137**	**143**	**689**	**596**	**(93)**
4,510	**Total**	**613**	**459**	**440**	**510**	**472**	**2,495**	**1,879**	**(616)**

The budget for SLA national penalties and local contract term challenges is £4.5m for the year, and £1.9m YTD. The provision calculated in the table is for £2.5m, an adverse variance of £0.6m.

The basis of the RTT 18 week penalty has been changed and backdated to the start of the year and is now measured on incomplete pathways only with target of 92%.

The M05 numbers consists of known Q1 challenges and some estimates based on the month 4 position.

These amounts have now all been allocated to Divisions and their performance will be monitored going forward.

Penalties for local KPIs are capped at 14/15 levels although we are currently below this cap at M5.

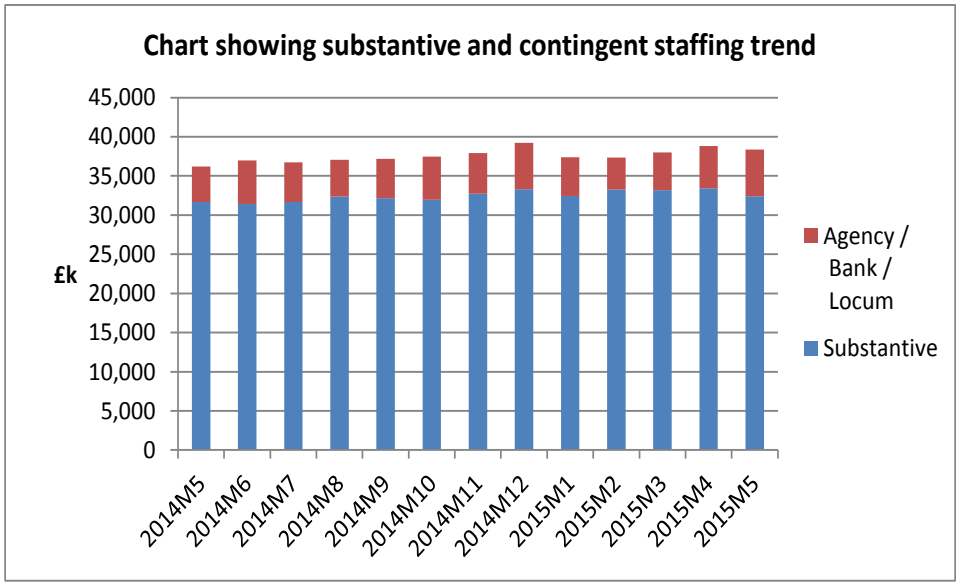
❹ Pay costs

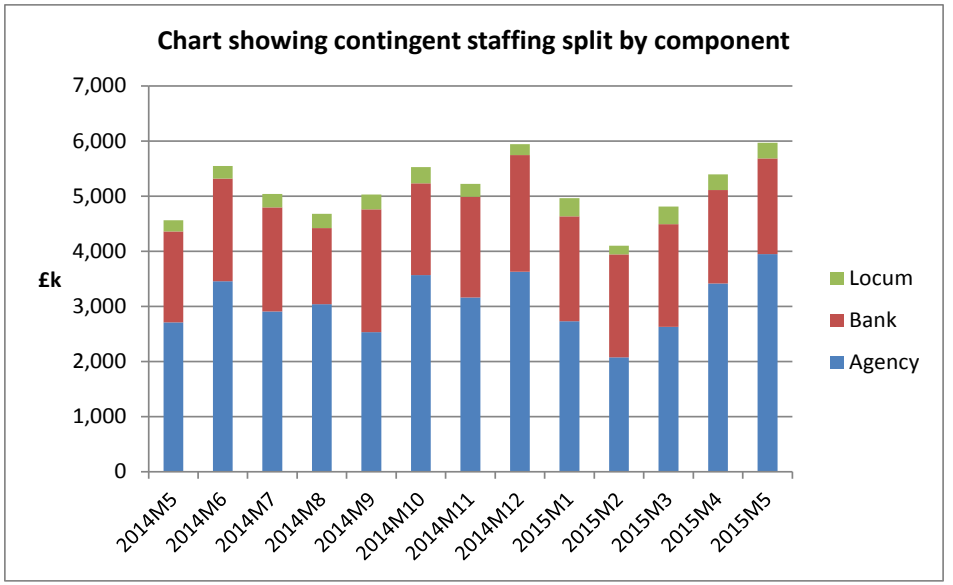
Variance YTD 2015/16 (adv) / fav	CWDT £m	CSD £m	Medicine & CV £m	Surgery & Neuro £m	Overheads £m	R&D £m	SWL Path £m	Central £m	Grand Total £m
Pay Consultants	(0.21)	0.00	0.20	(0.22)	0.01	(0.01)	(0.06)	(0.06)	(0.35)
Pay Jnr Drs	0.09	(0.35)	(0.03)	0.08	0.07	0.01	0.00	0.00	(0.12)
Pay Non Clinical	0.34	0.16	(0.01)	(0.04)	0.93	(0.39)	0.09	(0.10)	0.99
Pay Nursing	1.09	1.29	0.75	1.53	0.05	(0.04)	(0.01)	0.08	4.73
Pay Other	(0.05)	0.00	(0.24)	(0.51)	(0.00)	(0.00)	0.05	0.00	(0.75)
Pay Sci, Techs, Therap	0.65	0.40	0.08	0.20	0.19	(0.00)	0.06	0.00	1.57
Pay Unallocated CIP	(2.32)	(1.75)	(2.62)	(1.83)	(0.88)				(9.41)
Grand Total	(0.42)	(0.25)	(1.87)	(0.79)	0.38	(0.43)	0.13	(0.08)	(3.33)

Variance Current Month (adv) / fav	CWDT £m	CSD £m	Medicine & CV £m	Surgery & Neuro £m	Overheads £m	R&D £m	SWL Path £m	Central £m	Grand Total £m
Pay Consultants	0.11	0.03	0.09	(0.19)	(0.04)	(0.01)	0.08	0.00	0.07
Pay Jnr Drs	(0.03)	(0.10)	(0.01)	0.01	0.02	0.00	0.00	0.00	(0.11)
Pay Non Clinical	(0.01)	0.07	(0.10)	(0.01)	0.27	(0.11)	0.03	0.00	0.14
Pay Nursing	0.12	0.35	0.23	0.23	0.00	(0.02)	(0.00)	0.00	0.90
Pay Other	(0.04)	0.00	(0.18)	(0.10)	0.00	(0.00)	0.01	0.00	(0.32)
Pay Sci, Techs, Therap	0.06	0.04	0.02	(0.02)	0.05	0.00	(0.01)	0.00	0.13
Pay Unallocated CIP	(0.19)	(0.39)	(0.40)	0.04	(0.14)				(1.08)
Grand Total	0.01	(0.00)	(0.36)	(0.05)	0.16	(0.14)	0.11	0.00	(0.26)

- In month 5 total pay expenditure of £38.4m (M4 £38.8m) was £0.3m adverse (M4 £0.8m adv) and is cumulatively £3.3m over budget.
- Total pay fell compared to last month which included a back dated impact of the change in accounting treatment for Interim contractors who were previously recorded as consultancy under non pay but are now properly included under pay. Stripping out the backdated impact pay was £0.2m higher.
- There has been an increase in Agency of £0.6m primarily in Nursing due to change estimation of unpaid costs for nurses not booked through the e-roster system.
- Overall agency costs rose from 9% to 10% of total pay and bank unchanged at 4.5%.
- All clinical divisions have YTD adverse overall variances for pay.
- As noted in the CIP section the unidentified CIP balance of £9.4m is after only allocating Green rated schemes to specific cost codes. Further schemes are reporting as achieving after including amber and run rate schemes and these reflect the favourable variances on staff group lines
- The unidentified CIP balance has been split 80% to pay and 20% to non-pay (except in Estates which has used the reverse percentages) after the green rated schemes have been allocated to specific cost centre/account codes
- It should be noted that all Divisions are achieving an element of their run-rate targets and that this reduces the variance from unidentified CIPs

❹ Pay trend (1)



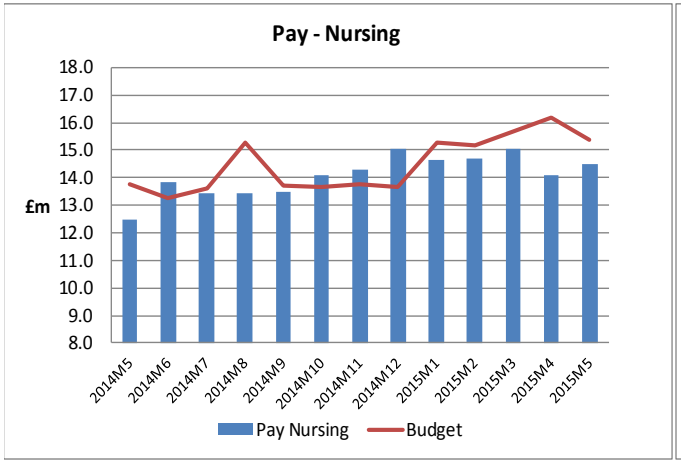


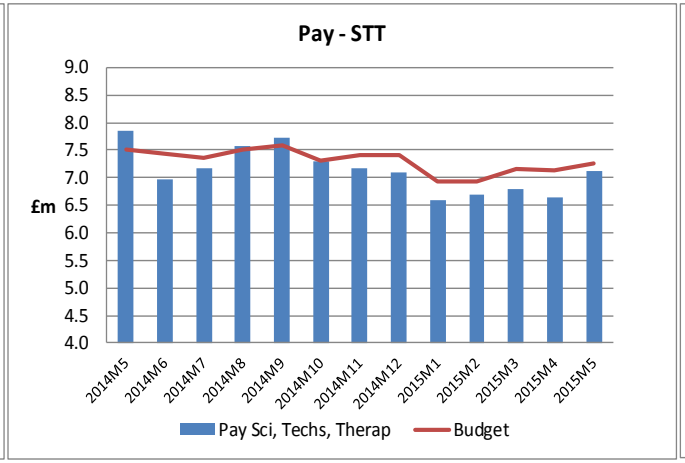
monthly trend	prev £k	current £k	%	trend change
Substantive	164.38	136.74	0.4%	better
Agency /Bank / Locum	-8.91	29.01	0.5%	worse
Total	155.47	165.76	0.4%	worse

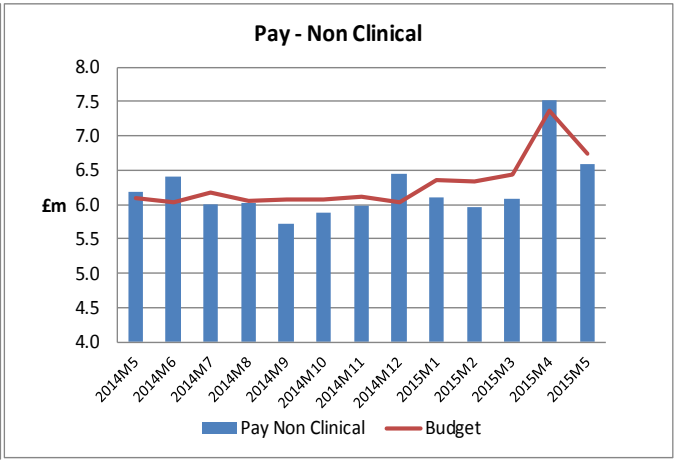
monthly trend	prev £k	current £k	%	trend change
Agency	-28.25	20.06	0.5%	worse
Bank	16.37	4.94	0.3%	better
Locum	2.98	4.01	1.4%	worse
Total	-8.91	29.01	0.5%	worse

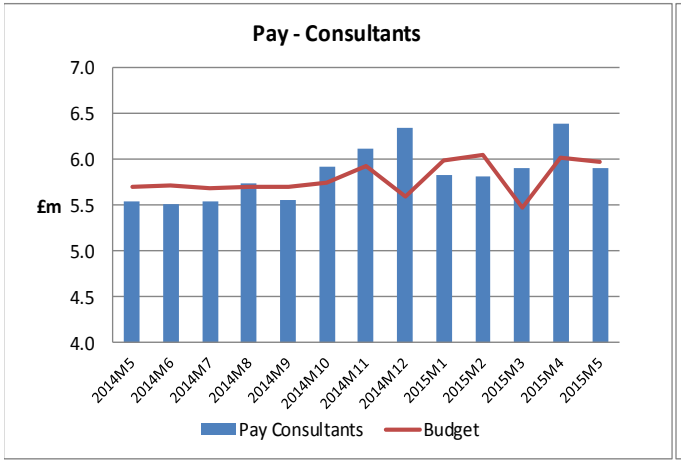
- Total pay of £38.4 in month 5 is £2.2m (6%) higher than the same month last year. Of which 2.5% can be attributed to Pay inflation as noted below,
- There is a small increase in the rate of total pay increase per month from £155k (0.4%) to £166k (0.4%).
- The average rate of temporary agency spend has risen by £20k over the past year while bank usage has risen marginally by £4k mainly due to the initiative to increase bank use of admin staff.
- Pay costs increase for pay awards inflation, increments, pensions changes and service developments, and reduce through reduction in agency premiums, staff utilisation and CIP schemes.

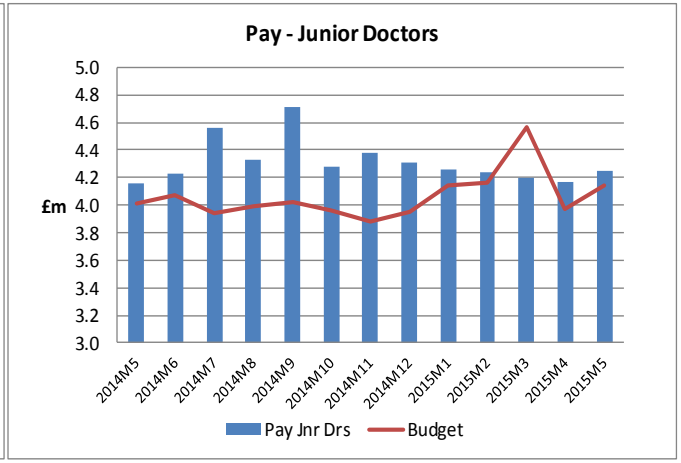
❹ Pay trend (2)











- Nursing and Consultants remain the main drivers of the annual trended increase in pay. Total nursing costs rose in month 5 due to catch up arising from change in estimation of unpaid agency shifts for areas not on e-roster system. Total consultants costs fell back in month 5.
- Non clinical pay fell compared to last month as that contained the impact of changing accounting treatment of Interim contractors from non pay consultancy to a pay cost category had a one off backdating impact on month 4.

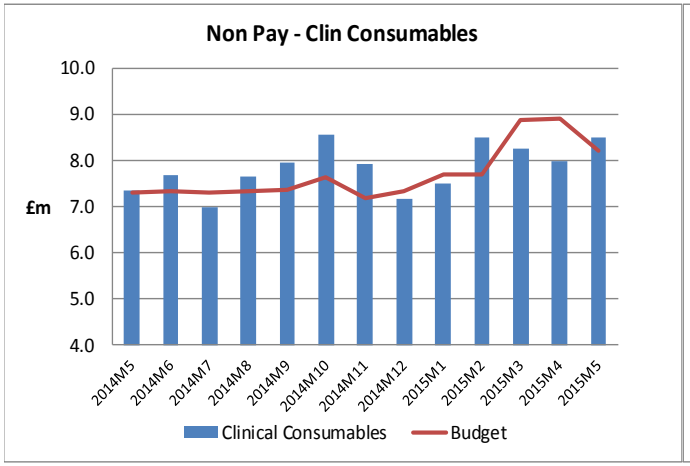
❺ Non pay costs

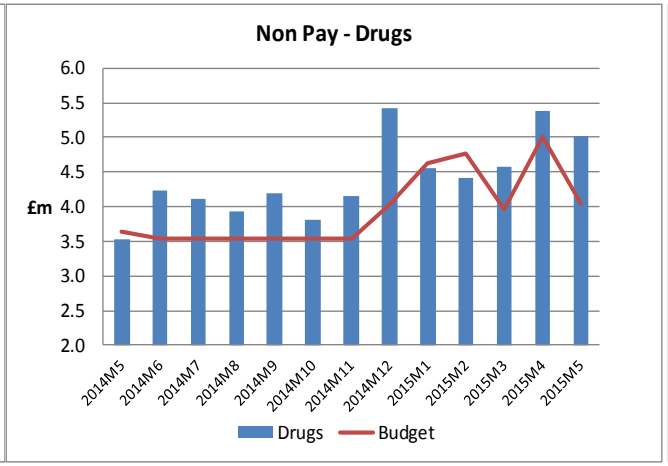
Variance YTD 2015/16 (adv) / fav	CWDT £m	CSD £m	Medicine & CV £m	Surgery & Neuro £m	Overheads £m	R&D £m	SWL Path £m	Reserves / Central £m	Grand Total £m
Clinical Consumables	0.28	0.41	(0.09)	0.59	(0.10)	(0.00)	0.11	0.00	1.19
Drugs	(0.28)	(0.22)	(0.71)	(0.30)	0.01	0.00	(0.00)	0.00	(1.50)
Other	(0.16)	0.25	0.12	0.06	(0.29)	0.13	0.19	0.00	0.31
Premises	0.10	0.02	0.10	0.04	1.03	0.00	(0.08)	0.00	1.22
Clinical Negligence	0.00	(0.00)	0.00	(0.00)	(0.12)	0.00	(0.07)	0.00	(0.20)
NHS and External Facilties	0.05	0.27	(0.02)	(0.46)	(0.00)	0.00	0.03	0.00	(0.13)
True Reserves	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.94	1.94
Prior Year Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(1.30)	(1.30)
Central Adjustments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.38	2.38
CIP Unallocated	(0.73)	(0.46)	(0.92)	(0.52)	(1.21)	0.00	0.00	0.00	(3.84)
Grand Total	**(0.74)**	**0.28**	**(1.52)**	**(0.60)**	**(0.69)**	**0.13**	**0.18**	**3.02**	**0.07**

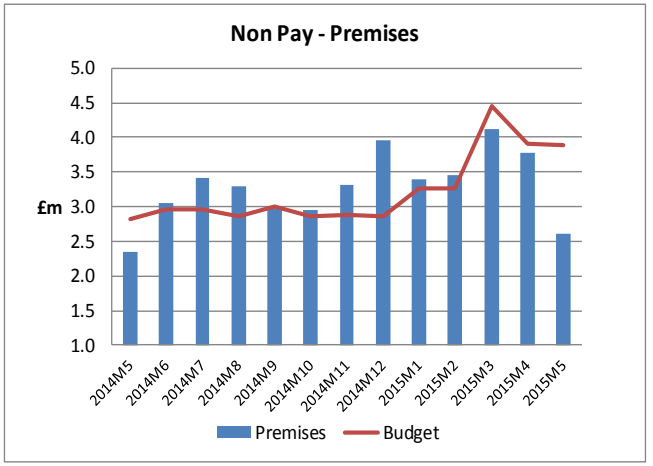
Variance Current Month (adv) / fav	CWDT £m	CSD £m	Medicine & CV £m	Surgery & Neuro £m	Overheads £m	R&D £m	SWL Path £m	Reserves / Central £m	Grand Total £m
Clinical Consumables	(0.09)	0.04	(0.14)	0.01	0.01	(0.00)	(0.05)	0.00	(0.21)
Drugs	(0.12)	0.03	(0.55)	(0.36)	0.01	0.00	(0.00)	0.00	(0.99)
Other	(0.02)	(0.01)	0.14	(0.06)	(0.71)	0.03	0.20	0.00	(0.44)
Premises	0.02	0.02	0.02	0.00	0.70	0.00	0.08	0.00	0.84
Clinical Negligence	0.00	(0.00)	0.00	(0.00)	(0.01)	0.00	(0.07)	0.00	(0.07)
NHS and External Facilties	0.01	0.29	0.12	(0.09)	0.02	0.00	0.24	0.00	0.60
True Reserves	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.90	0.90
Prior Year Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Central Adjustments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.21	1.21
CIP Unallocated	(0.17)	(0.09)	(0.23)	(0.30)	(0.16)	0.00	0.00	0.00	(0.95)
Grand Total	**(0.38)**	**0.29**	**(0.65)**	**(0.79)**	**(0.14)**	**0.03**	**0.41**	**2.11**	**0.88**

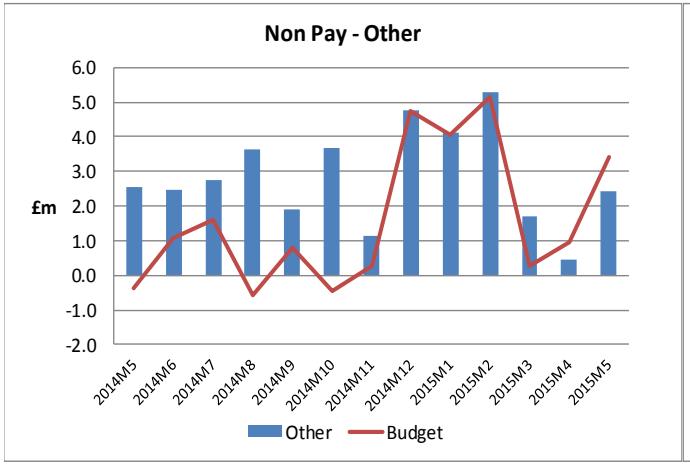
- Overall non pay spend is close to budget, despite the impact of the prior year costs previously reported
- As noted in the CIP section the unidentified CIP balance of £3.8m is after only allocating Green rated schemes to specific cost codes. Further schemes are reporting as achieving after including amber schemes and these reflect the favourable variances on other lines
- Unallocated CIP targets have been split 80% to pay and 20% to non-pay, except in Estates which has used the reverse percentages
- Clinical consumables spend rose by £0.5m in M5 but is underspent YTD by £1.2m after excluding prior year costs.
- As noted in Appendix H, the Trust has changed the way it treats 'excluded' drugs by re-profiling the in-month income and expenditure budget to remove the variances. To date £2.6m has been removed from income and expenditure budgets.
- Expenditure on Drugs was £0.3m lower than M4 but there is a £1.5m YTD adverse variance, after making the phasing adjustment for High Cost Drugs. A detailed review of HCD expenditure and income is being undertaken to ensure that all relevant charges are being made
- Premises costs reduced due to lower site maintenance costs incurred and favourable adjustment of disputed estates contractor costs.
- Please note as per pay section, that interim contractors were reclassified from non pay other to pay, last month. There has been some budget realignment as a result of this.

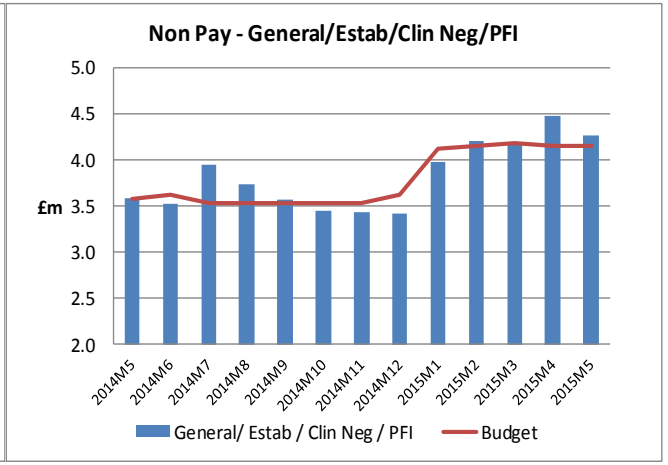
❺ Non pay trends











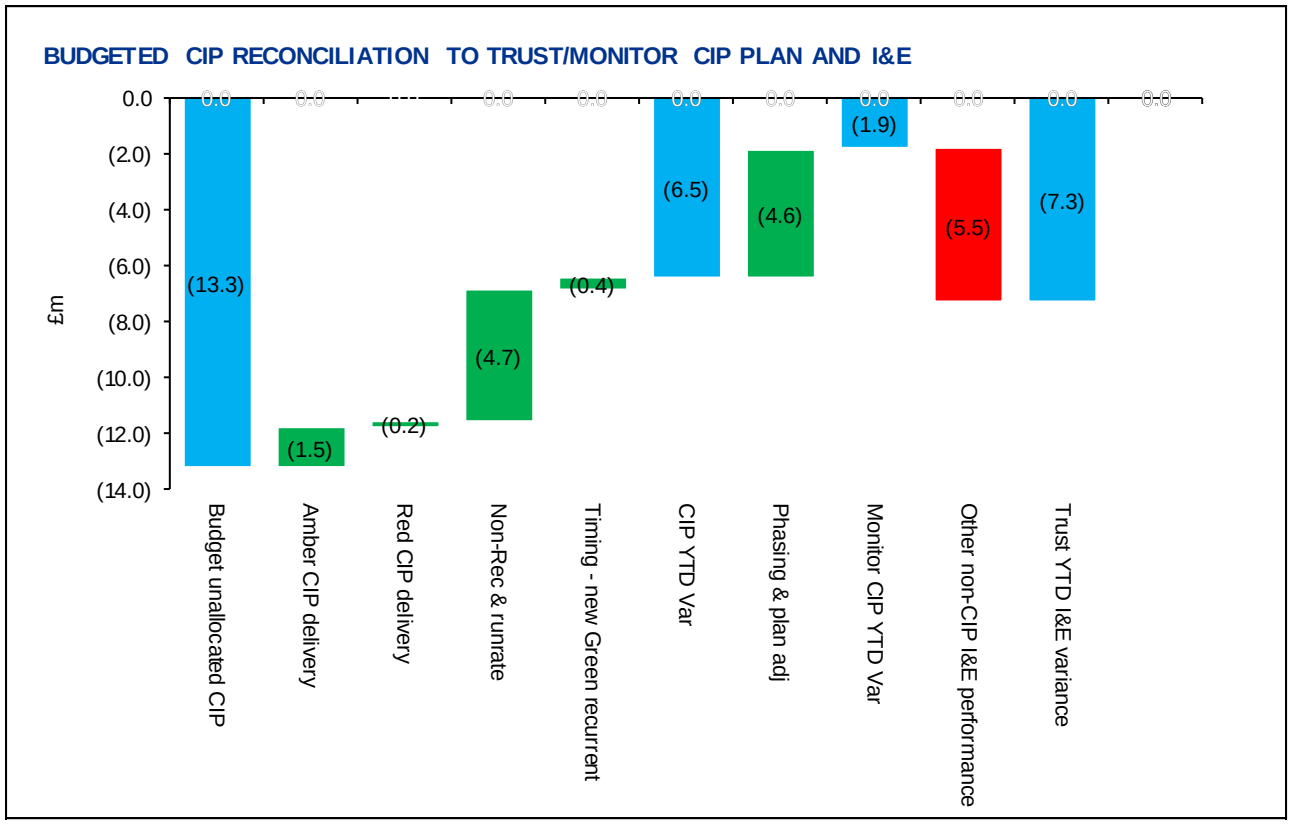
Overall Non pay expenditure has increased over the last year.. This is largely driven by increased CNST costs, reclaimable drugs costs, new premises costs and use of external facilities. The increase in consumables is largely due to reclaimable exclusions.
Premises costs reduction in M5 is due to £0.6m expenditure that has now been capitalised and £0.5m reduction compared to M4 in IT costs due to the reclassification of professional services costs .

⑥ Trust CIP performance

- The CIP target for 2015/16 is £38.1m and this is profiled in the budget in equal twelfths. The Monitor target is £34.2m (90%) which has a different profile to that set out in the budget.
- Year to date, the Trust has delivered £9.4m of savings, comprising £4.7m of CIPS (of which £3.0m is from 'Green' schemes) and a further £4.7m of non-recurrent and run rate/vacancy control savings. This represents a £6.5m adverse variance to the planned £38.1m CIP target (£1.9m adverse to Monitor).
- Total CIPs have decreased by £2.5m. These are mainly from Medcard not forecasting runrate savings through the remainder of the year, resulting in £1.7m being removed from the Red runrate forecast, Procurement full year forecast has decreased by £0.3m, £0.1m removed from Imatinib savings in Spec Med, HR removed schemes valued at £0.1m and reduced forecasts across a number of schemes in Neuro.
- Green CIPS total £9.5m being a £2.0m increase on M04 as further schemes have been added and progressed through governance reviews.
- Run-rates/non-recurrent are being counted against the CIP target and therefore there are currently no mitigations to the £7.3m I&E underperformance. The divisions are being tasked with developing schemes to close the gap in full and the consequences thereof will be considered at TAB.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	SUM	M4 F&P	CHANGE
TRUST TARGET	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	38.1		
ACHIEVED YTD / FORECAST :															
GREEN CIPS	0.6	0.5	0.6	0.9	0.4	0.9	1.0	0.9	0.9	1.0	0.9	0.9	9.5	7.5	2.0
AMBER CIPS	0.5	0.4	0.2	0.2	0.2	0.5	0.6	0.7	0.7	0.7	0.8	0.8	6.2	7.6	-1.3
RED CIPS	0.1	0.1	-0.2	0.1	0.1	0.2	0.4	0.4	0.4	0.4	0.4	0.4	2.8	4.1	-1.3
DELIVERED RUNRATES/NON-RECURRENT	1.3	1.5	0.8	0.5	0.6								4.7	4.1	0.6
FORECAST RUNRATES					0.0	1.1	0.9	0.7	0.7	0.7	0.7	0.7	5.3	7.8	-2.5
	2.5	2.5	1.3	1.7	1.3	2.7	2.8	2.6	2.7	2.8	2.8	2.8	28.6	31.1	-2.5
YTD		5.0	6.3	8.1	9.4	12.1	14.9	17.5	20.3	23.1	25.8	28.6			
TRUST CIP VARIANCE	-0.7	-0.7	-1.8	-1.4	-1.8										
YTD TRUST CIP VARIANCE VAR	-0.7	-1.4	-3.2	-4.6	**-6.5**										
FYFC CIP VARIANCE - GREEN FC ONLY												**-22.2**			
FYFC CIP VARIANCE - GREEN& AMBER FC												**-17.4**			
FYFC CIP VARIANCE - ALL RAG, N/R & RUNRATES												**-9.5**			
MONITOR TOTAL TARGET	2.2	2.2	2.3	2.3	2.3	2.4	3.1	3.1	3.1	3.8	3.8	3.8	34.2		
TRUST TARGET	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	38.1		
DIFFERENCE	-1.0	-1.0	-0.9	-0.9	-0.9	-0.8	-0.1	-0.1	-0.1	0.6	0.6	0.6	-3.9		
MONITOR VAR	0.4	0.3	-1.0	-0.6	-1.0	-0.8	-1.2	-1.1	-1.1	-1.6	-1.7	-1.7	-11.0		
YTD MONITOR VAR	0.4	0.7	-0.3	-0.9	**-1.9**										

❻ Budgeted CIP reconciliation to Trust & Monitor CIP reporting and I&E



Budgets show an unallocated CIP of £13.3m across Pay and Non-pay in the divisions.

The reported YTD adverse against CIP target is £6.5m.

The difference represents CIPs delivered which have not been moved out of the CIP unidentified budget line due to timing or RAG rating.

CIP reporting is against the £38.1m internal target. The difference between the Monitor target and the internal target is £4.6m (£3m phasing and £1.6m adjusted 90% target). In months 1-6 the phasing adjustment improves the Trust I&E by lessening the impact of adverse CIP. From M7 the phasing in of higher monthly targets will expose the adverse CIP performance.

Adverse non-CIP I&E is £5.5m of the trusts overall £7.3m I&E deficit.

Runrate and non-recurrent schemes are reported against CIP and are therefore not available to offset this adverse performance and further mitigations need to be found to ensure delivery of the trust's £46m deficit plan.

❼ Divisional Summaries
KEY HEADLINES

Area of Review	Key Highlights
CWDT	Division is £1.7m adverse to plan YTD, driven by underperformance in SLA income re the cessation of the Urogynaenacology service, and pay and non pay overspends due to unidentified CIPs. Redeployment of staff and transfer of patients in Urogynaenacology.
CSD	Division is £1.1m adverse to plan YTD, largely driven by underperformance in SLA outpatient income across a number of services at QMH. Division engaged with other services to resolve this issue.
Medicine & Cardiovascular	Division is £4.2m adverse to plan YTD. SLA income is £0.7m adverse due to underperformance on Outpatients. Pay is £1.9m and non pay £1.5m adverse. These are driven by unidentified CIPs and drugs overspend. Rechargeable high cost drugs being checked to ensure all income due is received
SNTC	Division is £1.5m adverse to plan YTD, driven by pay overspend of £0.8m and non pay overspend of £0.6m. These are driven by unidentified CIPs, use of external providers and drugs overspend. Rechargeable high cost drugs being checked to ensure all income due is received
Overheads	Division is £0.3m adverse to plan YTD, driven by SWL Pathology recharges and additional turnaround costs.

CWDT - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M2 £m	Actual M3 £m	Actual M4 £m	Budget M5 £m	Actual M5 £m	Variance M5 £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
SLA Income	127.92	11.13	11.52	10.05	10.23	9.97	(0.26)	51.64	50.96	(0.68)
Other Income	18.93	1.95	2.04	1.70	1.97	1.79	(0.18)	7.87	8.04	0.17
Pay	(125.33)	(10.26)	(10.16)	(10.04)	(10.45)	(10.43)	0.01	(51.08)	(51.50)	(0.42)
Non Pay	(24.87)	(3.93)	(4.54)	(2.51)	(1.73)	(2.10)	(0.38)	(10.18)	(10.91)	(0.73)
Other	(6.45)	(0.59)	(0.60)	(0.54)	(0.54)	(0.56)	(0.02)	(2.69)	(2.71)	(0.02)
Grand Total	(9.79)	(1.70)	(1.74)	(1.34)	(0.51)	(1.33)	(0.82)	(4.44)	(6.12)	(1.69)

YTD Var 2015/16 (adv) / fav	Childrens Services		Critical Care		CWDT Division Management		Diagnostics		Outpatients	
	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	0.81	5.5%	(0.11)	-0.9%	0.00		0.04	0.5%	0.00	
Other Income	0.01	0.8%	(0.04)	-10.1%	0.00		(0.03)	-1.1%	(0.01)	-23.1%
Pay	(0.39)	-3.1%	(0.40)	-4.6%	(0.04)	-8.4%	(0.09)	-1.1%	0.20	4.2%
Non Pay	(0.16)	-7.3%	(0.11)	-6.7%	(0.00)		0.07	2.3%	(0.48)	-322.9%
Other	(0.00)	0.0%	0.00	0.3%	0.00	0.0%	(0.02)	-2.3%	(0.00)	-0.4%
Grand Total	0.27	31.1%	(0.66)	-27.0%	(0.04)	-8.5%	(0.03)	-1.1%	(0.28)	-5.9%

YTD Var 2015/16 (adv) / fav	Pharmacy		Therapies		Womens Services		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%
SLA Income	0.00		(0.15)	-9.1%	(1.26)	-7.9%	(0.68)	-1.3%
Other Income	0.26	10.1%	(0.06)	-50.3%	0.04	5.0%	0.17	2.2%
Pay	(0.04)	-1.4%	0.01	0.3%	0.32	3.7%	(0.42)	-0.8%
Non Pay	(0.21)	-13.8%	0.06	27.0%	0.09	5.4%	(0.73)	-7.2%
Other	0.00	0.0%	(0.00)	0.0%	(0.00)	-0.3%	(0.02)	-0.9%
Grand Total	0.01	0.4%	(0.13)	-3.5%	(0.82)	-13.4%	(1.69)	-38.0%

Commentary

The position in M05 is an adverse variance of £1.7m YTD and £0.8m in month. The variance includes unfunded cost pressures of £0.4m YTD

SLA Income in M05 is £10m which is similar to M04 and down on trend partly due to seasonal variation. It is adverse £0.7m YTD and £0.3m in month. Childrens is overperforming across all income although the rate has reduced over the summer especially in Emergency activity which had been higher than expected activity in Q1. Bedday activity (£84k YTD adverse), Adult Critical Care is adverse £0.2m YTD but has recovered slightly in M05. Gynae underperformance in Outpatients £0.3m YTD and Elective £0.4m is mainly due to stopping the Urogynae service. Antenatal activity is below plan in Obstetrics. And deliveries are adverse by £0.1m YTD. Penalties are £0.4m YTD of which £0.2m relates to18 weeks RTT pressures in Gynae.

Pay has an adverse variance of £0.4m YTD but is breakeven in month. Unallocated CIP savings of £2.3m are offset by underspends of £1.9m. Pay expenditure in month of £10.4m is an increase in trend but includes a catch up on agency expenditure of £0.2m and is below last year's average trend. There has been reprofiling of budgets in Critical Care for business cases and this has worsened the YTD variance by £0.3m.

Non pay has an adverse variance of £0.8m YTD and £0.4m in month. This includes unallocated CIPs of £0.7m YTD. Cross Charges for additional Outpatient clinics to Specialties is £0.4m adverse which will match favourable variances in other Divisions. Drugs are overspent by £0.3m but consumables are overall underspent by £0.3m. There is a cost pressure in Outpatients for storage costs ahead of implementing Electronic Document Management.

Actions

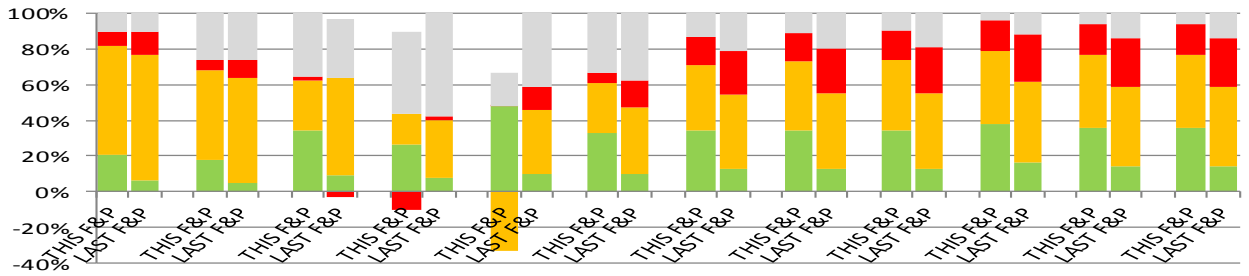
- Redeploy Urogynae. staff and complete transfer of patients waiting for treatment to other providers.
- Review activity data for Obstetrics to ensure income is accurate
- Corporate Outpatients Cross Charge SLA is now being implemented but budgets will need to be reset
- CIP schemes included in the unallocated budget to be progressed under the direction of Division Turnaround Steering Group to achieve Green status and coded to where the savings will be achieved
- GMs to continue to identify new schemes to close the CIP shortfall with support from KPMG

CWDT - Divisional CIP performance

FORECAST CWDT SUMMARY	ANNUAL TARGET	FORECAST AT M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
C&W OVERHEADS	0.15	0.00	0.01	0.01	0.00	0.01	0.00	0.14	A
CHILDRENS	1.70	0.24	1.33	1.57	0.12	0.24	1.21	0.13	A
CRITICAL CARE	1.91	0.11	1.39	1.50	0.16	0.79	0.55	0.41	A
DIAGNOSTICS	1.45	0.48	0.65	1.12	0.16	0.56	0.40	0.33	A
OUTPATIENTS	0.55	0.00	0.45	0.45	0.02	0.32	0.10	0.10	A
PHARMACY	0.91	0.51	0.00	0.51	0.00	0.12	0.39	0.40	A
THERAPIES	0.86	0.02	0.49	0.51	0.00	0.30	0.21	0.35	A
WOMENS	1.36	0.09	1.14	1.22	0.35	0.07	0.81	0.14	A
Grand Total	**8.90**	**1.45**	**5.44**	**6.90**	**0.80**	**2.42**	**3.67**	**2.00**	A
OF WHICH RECURRENT:		1.45	3.73	5.19	0.79	1.77	2.63	3.71	A
OBJECTIVE 2 (FULL YEAR EFFECT		2.22	4.84	7.06	1.30	2.78	2.97	1.84	A

PERFORMANCE CWDT SUMMARY	YTD TARGET	ACTUAL YTD M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
C&W OVERHEADS	0.06	0.00	0.00	0.00	0.00	0.00	0.00	0.06	A
CHILDRENS	0.71	0.08	0.62	0.70	0.00	0.06	0.64	0.01	A
CRITICAL CARE	0.80	0.05	0.47	0.51	0.02	0.28	0.22	0.28	A
DIAGNOSTICS	0.60	0.01	0.22	0.23	0.00	0.03	0.20	0.38	A
OUTPATIENTS	0.23	0.00	0.15	0.15	0.00	0.04	0.10	0.08	A
PHARMACY	0.38	0.16	0.00	0.16	0.00	0.02	0.14	0.22	A
THERAPIES	0.36	0.00	0.20	0.20	0.00	0.00	0.20	0.16	A
WOMENS	0.57	0.02	0.36	0.38	0.01	0.02	0.35	0.19	A
Grand Total	**3.71**	**0.31**	**2.02**	**2.33**	**0.02**	**0.45**	**1.86**	**1.37**	A
OF WHICH RECURRENT:		0.31	0.79	1.10	0.02	0.21	0.87	2.60	A

PHASED RAG RATED DIVISIONAL PROGRAMME - ACTUAL AND FORECAST



The CWDT Division target is £8.9m. To date there are plans valued at £6.9m and a shortfall of £2.0m which has reduced from £2.5m in M04. The number of plans rated Green has increased from £1.0m to £3.6m. Non recurrent schemes have been removed and moved to run rate savings and double counts with procurement saving programme have been removed

The YTD M05 plan is £3.7m and schemes have achieved £2.3m resulting in a YTD shortfall of £1.4m. Medicines Management schemes are £42k adverse YTD and Procurement savings are £118k adverse YTD. In the Directorates, two Champneys CIP schemes that relate to Theatre costs are being confirmed in Womens, Therapies have confirmed their staff saving schemes but some will be split into CIP and run rate savings. Critical Care are reviewing the nurse savings scheme

The Division has a pipeline list of schemes it is actively working up to achieve the Target for the year with support from KPMG. Run-rates will continue to contribute to the performance against the target

CSD - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M2	Actual M3	Actual M4	Budget M5	Actual M5	Variance M5	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	105.48	8.33	8.43	9.17	8.87	8.39	(0.48)	44.11	43.01	(1.10)
Other Income	3.42	0.28	0.22	0.30	0.28	0.25	(0.03)	1.42	1.38	(0.04)
Pay	(48.89)	(4.20)	(4.35)	(4.24)	(4.24)	(4.24)	(0.00)	(21.07)	(21.32)	(0.25)
Non Pay	(31.31)	(2.60)	(2.61)	(3.01)	(2.72)	(2.43)	0.29	(13.38)	(13.10)	0.28
Other	(0.21)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.00)	(0.09)	(0.09)	(0.00)
Grand Total	28.50	1.80	1.68	2.20	2.18	1.95	(0.23)	10.99	9.88	(1.11)

YTD Var 2015/16 (adv) / fav	Ambulatory Care Services		Community Adults & Children		Community Services		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%
SLA Income	(0.81)	*-4.0%*	(0.29)	*-1.2%*	0.00	*100.0%*	(1.10)	*-2.5%*
Other Income	(0.02)	*-4.8%*	(0.03)	*-2.5%*	0.00	*21.9%*	(0.04)	*-2.8%*
Pay	(0.26)	*-4.1%*	(0.03)	*-0.2%*	0.04	*10.5%*	(0.25)	*-1.2%*
Non Pay	(0.08)	*-0.9%*	0.35	*8.1%*	0.01	*14.9%*	0.28	*2.1%*
Other	(0.00)	*-0.6%*	0.00	*0.1%*	0.00	*#DIV/0!*	(0.00)	*-0.6%*
Grand Total	(1.16)	*-22.7%*	(0.00)	*-0.1%*	0.05	*12.5%*	(1.11)	*-10.1%*

Commentary

The M05 position for CSD shows a £9.9m surplus YTD actual performance against an YTD planned surplus budget of £11m, which resulted in an YTD adverse variance of £1.1m.

SLA income relating to QMH underperformed by £0.6m YTD, with underperformances in Dermatology, Cardiology, Neurology Outpatients and Urology. In Community Adult Health Services (CAHS) there was a loss of £0.1m on income from Elderly wards relating to unoccupied beds which is unrecoverable. Integrated Sexual Health Services underperformed by £0.2m in Outpatients. Reallocation of patients to other clinics within the service that have adequate staff would result in improved activity and a discussion is currently taking place with Wandsworth CCG to pursue this. SLA challenges of £0.1m are included for first to follow ups.

Pay is adverse £0.3m YTD which is mainly within Offender Health and Children's and Family Services. In Offender Health Services, Agency spend was £0.6m and Bank spend £0.3m offset against vacant posts of £0.8m. In Palliative Care there are additional agency costs of £0.5m.

Non-pay is showing an overall underspend of £0.7m. Within Integrated Sexual Health Service, HIV drugs expenditure has reduced in month and is in line with current trend.

Actions

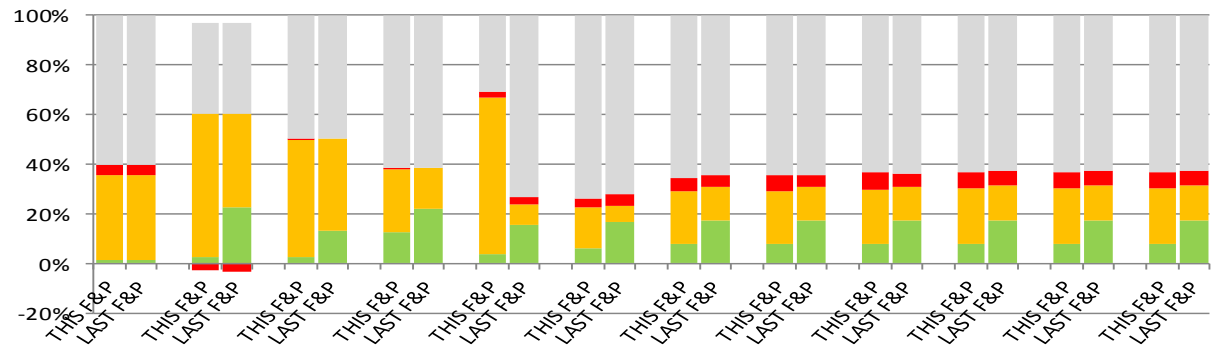
- Develop an action plan to mitigate the underperformance in Outpatients income at QMH by liaising with General Managers to ensure that clinics are running and activity is taking place to understand what the bottlenecks are and the likely impact on income targets
- Assess viability of current CIP schemes with the view to turning our amber schemes to green. There are two amber items one relating to Community Adults Healthcare Service (CAHS) £600k and out of borough adults services £300k which should turn green in M06.
- Agree changes of clinic times and redirecting activity for the GU Medicine outpatients' service with Wandsworth CCG
- Minimise the use of agency through weekly reviews at Divisional level and recruitment of permanent staff
- Transfer Community Therapies Service and Palliative Care from Community Services division to Children's and Women division
- Review all excess expenditure lines and cost pressure allocation.
- A comprehensive review of all High Cost Drugs ensuring these are being fully reclaimed, as well as reviewing the HIV drugs (Homecare) with Pharmacy ensuring there are no further risks in relation to a substantial increase in expenditure.

CSD - Divisional CIP performance

FORECAST	ANNUAL TARGET	FORECAST AT M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
CSD SUMMARY									
AMBULATORY CARE	1.68	0.16	0.25	0.41	0.01	0.14	0.26	1.27	A
COMM ADULT AND CHILD SVCS	3.84	0.40	0.81	1.21	0.17	0.95	0.09	2.63	A
PROV MANAGEMENT	0.04	0.00	0.07	0.07	0.02	0.05	0.00	-0.04	F
PROV OVERHEADS	0.00	0.00	0.63	0.63	0.00	0.63	0.00	-0.63	F
Grand Total	**5.56**	**0.56**	**1.76**	**2.32**	**0.21**	**1.76**	**0.35**	**3.24**	A
OF WHICH RECURRENT:		0.56	1.14	1.70	0.21	1.14	0.35	3.86	A
OBJECTIVE 2 (FULL YEAR EFFECT)		0.65	1.36	2.01	0.39	1.23	0.40	3.55	A

PERFORMANCE	YTD TARGET	ACTUAL YTD M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
CSD SUMMARY									
AMBULATORY CARE	0.70	0.05	0.07	0.12	0.00	0.05	0.08	0.58	A
COMM ADULT AND CHILD SVCS	1.60	0.17	0.28	0.45	0.01	0.41	0.03	1.15	A
PROV MANAGEMENT	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.02	A
PROV OVERHEADS	0.00	0.00	0.62	0.62	0.00	0.62	0.00	-0.62	F
Grand Total	**2.32**	**0.23**	**0.97**	**1.20**	**0.01**	**1.07**	**0.11**	**1.12**	A
OF WHICH RECURRENT:		0.23	0.35	0.58	0.01	0.45	0.11	1.74	A

PHASED RAG RATED DIVISIONAL PROGRAMME - ACTUAL AND FORECAST



Community Services division has a CIP target of £5.6m excluding SLA income. At present, the division is forecasting to achieve £2.3m of which £1.7m relates to recurrent savings. The Division is working with KPMG to develop a CIP pipeline to try to minimise the gap although the Division does not currently have ideas to fully deliver the CIP target.

The year-to-date shortfall of £1.1m against a target of £2.3m is reflective of the overall CIP gap. There are non-recurrent run-rate savings of £0.6m mainly relating to holding vacancies and non-pay spend controls in the Wheelchair services. These are not sustainable in the long term and there will be a reduction in these over the second half of the year.

Medicine & Cardiovascular - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M2	Actual M3	Actual M4	Budget M5	Actual M5	Variance M5	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	221.57	18.34	17.04	18.90	17.63	17.53	(0.10)	89.22	88.55	(0.67)
Other Income	19.27	1.50	1.56	1.38	1.61	1.92	0.31	8.01	7.95	(0.06)
Pay	(101.63)	(8.72)	(9.03)	(8.91)	(8.36)	(8.72)	(0.36)	(42.01)	(43.88)	(1.87)
Non Pay	(75.92)	(5.98)	(6.33)	(6.28)	(5.96)	(6.61)	(0.65)	(29.78)	(31.30)	(1.52)
Other	(4.52)	(0.38)	(0.38)	(0.38)	(0.38)	(0.38)	(0.00)	(1.88)	(1.88)	0.00
Grand Total	58.78	4.75	2.86	4.71	4.54	3.75	(0.79)	23.55	19.43	(4.12)

YTD Var 2015/16 (adv) / fav	Acute Medicine		Cardiothoracic & Vascular Services		Emergency Department		Renal & Oncology		Specialist Medicine		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	0.27	*1.8%*	(0.56)	*-2.1%*	(0.10)	*-1.3%*	(0.04)	*-0.2%*	(0.23)	*-1.4%*	(0.67)	*-0.7%*
Other Income	(0.03)	*-2.9%*	0.17	*7.5%*	(0.07)	*-3.2%*	(0.21)	*-21.0%*	0.09	*5.3%*	(0.06)	*-0.7%*
Pay	(0.57)	*-5.1%*	(0.57)	*-5.9%*	(0.07)	*-1.1%*	(0.27)	*-3.2%*	(0.39)	*-6.3%*	(1.87)	*-4.5%*
Non Pay	0.13	*7.9%*	0.10	*1.2%*	(0.17)	*-16.4%*	(0.89)	*-7.3%*	(0.69)	*-11.7%*	(1.52)	*-5.1%*
Other	0.00	*0.0%*	0.00	*0.6%*	(0.00)	*0.0%*	(0.00)	*0.0%*	(0.00)	*0.0%*	0.00	*0.1%*
Grand Total	(0.19)	*-7.3%*	(0.86)	*-9.1%*	(0.42)	*-17.6%*	(1.41)	*-40.3%*	(1.23)	*-22.4%*	(4.12)	*-17.5%*

Commentary

The £4.1m YTD adverse variance is a deterioration of £0.8m in month

Income is £0.2m favourable in M05, and £0.7m adverse YTD. The in-month favourable variance is mainly due to RTA income catch up from previous months.

The adverse income variance YTD is in large part due to Outpatient activity not delivering the growth as planned, due to delay in setting up clinics and vacancies. Penalties and also adverse by £0.1m.

Pay is £0.4m adverse in month and £1.9m YTD driven by the unidentified CIP. Nursing is underspent due to non-recurrent run rate savings.

Non-pay is adverse by £0.6m in month and £1.5m YTD. The adverse in month position is driven by drugs overspend in Specialist Medicine. Drugs spend has increased due to increased spend in Hepatitis C drugs. The division is working with Pharmacy to ensure these are reclaimed. The YTD adverse variance is driven by prior year invoices in RHO £0.5m, and the unidentified CIP balance of £0.9m.

Actions

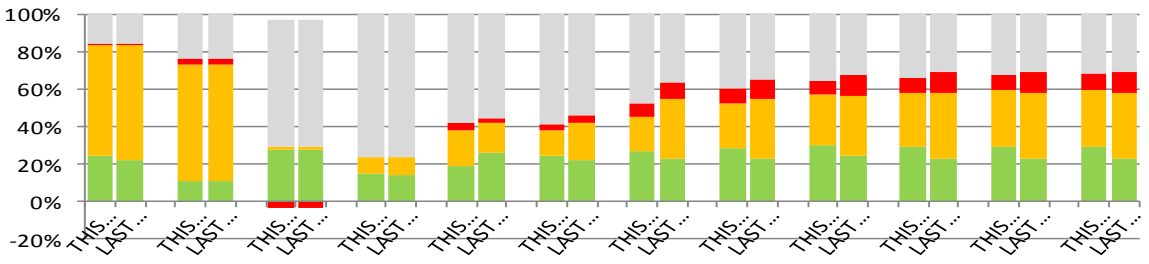
- Actions are being completed to increase Nelson activity alongside Community Services Division
- Meeting with Corporate Outpatients to ensure that resources are available and in place to deliver SLA growth
- KPIs to be reviewed for the SLA income penalties and to identify mitigations.
- RTA submissions claim forms process being reviewed
- Challenge Renal transplant outpatient follow ups marginal rate with NHSE
- GMs working with KPMG to close CIP gap, and move schemes from amber and red, to green. In addition run rate schemes are in place to mitigate the shortfall on a temporary basis
- Participating in the trust wide review of nursing budgets

Medicine & Cardiovascular - Divisional CIP performance

FORECAST MEDCARD SUMMARY	ANNUAL TARGET	FORECAST AT M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
ACUTE MED	2.41	0.00	0.78	0.78	0.16	0.51	0.11	1.63	A
CARDIOVASCULAR	2.66	0.15	0.86	1.01	0.10	0.86	0.05	1.65	A
ED	1.67	0.13	1.17	1.30	0.02	0.42	0.86	0.37	A
MEDICINE OVERHEADS	0.22	0.00	0.00	0.00	0.00	0.00	0.00	0.22	A
RENAL & ONCOLOGY	2.21	1.21	1.06	2.27	0.18	0.76	1.34	-0.07	F
SPECIALIST MED	1.45	0.14	0.46	0.59	0.02	0.32	0.25	0.86	A
Grand Total	**10.62**	**1.62**	**4.33**	**5.95**	**0.47**	**2.87**	**2.61**	**4.66**	A
OF WHICH RECURRENT:		1.58	3.37	4.94	0.47	1.96	2.51	5.67	A
OBJECTIVE 2 (FULL YEAR EFFECT)		2.10	3.82	5.91	0.94	2.03	2.95	4.70	A

PERFORMANCE MEDCARD SUMMARY	YTD TARGET	ACTUAL YTD M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
ACUTE MED	1.01	0.00	0.39	0.39	0.03	0.32	0.04	0.61	A
CARDIOVASCULAR	1.11	0.09	0.19	0.28	0.00	0.24	0.04	0.83	A
ED	0.69	0.02	0.48	0.50	0.00	0.33	0.17	0.19	A
MEDICINE OVERHEADS	0.09	0.00	0.00	0.00	0.00	0.00	0.00	0.09	A
RENAL & ONCOLOGY	0.92	0.50	0.40	0.90	0.00	0.36	0.54	0.02	A
SPECIALIST MED	0.60	0.02	0.15	0.17	0.00	0.09	0.09	0.43	A
Grand Total	**4.42**	**0.63**	**1.62**	**2.24**	**0.03**	**1.34**	**0.87**	**2.18**	A
OF WHICH RECURRENT:		0.59	0.69	1.28	0.03	0.46	0.79	3.14	A

PHASED RAG RATED DIVISIONAL PROGRAMME - ACTUAL AND FORECAST



- Medcard is reporting YTD actual CIP achieved of £2.2m against a target of £4.4m. The shortfall of £2.2m is largely in CVT and Acute Medicine, however the risk is also significant in Specialist Medicine.
- The Acute Medicine position includes non-recurrent savings of summer bed closures, which will not continue into winter.
- The major risk to CVT in meeting its target is the availability of beds and theatre capacity to deliver activity in cardiovascular. A business case to provide additional capacity in Cardiac Theatre 4 has been approved which will give Cardiac Surgery capacity to deliver activity that is currently delivered in the private sector, back on site. This comes online in April 2016 so has no impact for 15/16, but is a significant scheme for 16/17.
- The division has significant pipeline schemes that should be converted into full schemes over the coming weeks, and is working closely with the KPMG turnaround team to close the gap.
- The division has completed an exercise to look at what it would take to close the gap. This was presented to TAB, with schemes from this list being worked up where possible, subject to clinical and governance sign off.

SNTC - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M2	Actual M3	Actual M4	Budget M5	Actual M5	Variance M5	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	153.14	11.76	12.81	13.13	11.77	12.02	0.24	61.22	61.55	0.33
Other Income	18.44	1.42	1.50	1.31	1.54	1.41	(0.14)	7.66	7.17	(0.49)
Pay	(103.50)	(8.47)	(8.64)	(8.63)	(8.72)	(8.77)	(0.05)	(42.24)	(43.03)	(0.79)
Non Pay	(34.09)	(2.40)	(2.86)	(2.78)	(2.19)	(2.99)	(0.79)	(13.32)	(13.92)	(0.60)
Other	(3.96)	(0.33)	(0.33)	(0.33)	(0.33)	(0.32)	0.01	(1.65)	(1.64)	0.01
Grand Total	30.03	1.98	2.48	2.70	2.07	1.34	(0.73)	11.66	10.12	(1.54)

YTD Var 2015/16 (adv) / fav	Cancer		Neuro		Surgery		Theatres and Anaesthetics		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%	£m	%	£m	%
SLA Income	0.00	*#DIV/0!*	(0.42)	*-1.7%*	0.75	*2.1%*	(0.01)	*-1.6%*	0.33	*0.5%*
Other Income	0.00	*#DIV/0!*	(0.12)	*-7.2%*	(0.36)	*-10.0%*	(0.01)	*-0.4%*	(0.49)	*-6.4%*
Pay	(0.02)	*-6.5%*	(0.09)	*-0.8%*	(0.69)	*-4.4%*	0.01	*0.1%*	(0.79)	*-1.9%*
Non Pay	0.00	*20.2%*	0.23	*4.6%*	(0.90)	*-14.4%*	0.07	*3.4%*	(0.60)	*-4.5%*
Other	(0.00)	*0.0%*	0.01	*3.2%*	0.00	*0.2%*	(0.00)	*0.0%*	0.01	*0.5%*
Grand Total	(0.01)	*-4.7%*	(0.39)	*-3.9%*	(1.20)	*-7.2%*	0.06	*0.4%*	(1.54)	*-13.2%*

Actions

- Resolve outstanding significant budget issues in neurosciences.
- SNTC will continue to deliver run rate savings through careful roster management in all areas.
- Continue to work closely with KPMG to close CIP gap, by turning red schemes green and converting pipeline schemes into viable CIPs.
- Reduce commissioner penalties, in particular by creating a team to minimise RTT breaches.

Commentary

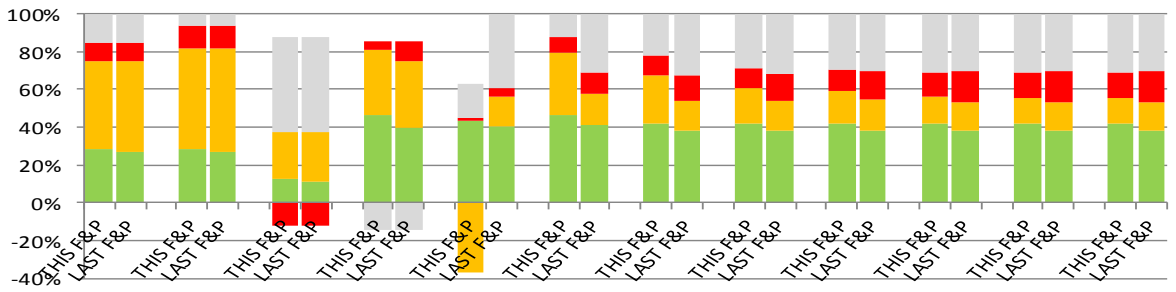
The Division is reporting a YTD M05 adverse variance of £1.5m, with an in month adverse of £0.7m.
The overall SLA position is £0.5m surplus, £0.7m other income deficit, pay over spend £0.8m and unmet CIP non pay gap £0.5m. The M05 deficit comprises: £0.1m income over performance and £0.8m non pay deficit
SLA income YTD is over performing on elective, OP and emergencies totalling £0.9m, which is being offset by adverse variances on other non-elective, bed days and commissioner penalties £0.4m
Other income is in deficit YTD due to not receiving any profit from EOC (T&O) £0.3m, Neuro PP income £0.2m and other non SLA income £0.2m.
The YTD **pay** overspend of £0.8m is driven by the unidentified CIP gap of £1.8m, a one off prior year cost of £0.2m, which is partially offset by £1.2m of vacancies and run rate savings mainly in nursing.
Non-pay YTD is a deficit of £0.6m due to the unidentified CIP gap. The key under spends are clinical consumables / equipment £0.6m and theatre charges outside SNTC for additional sessions / overruns £0.2m.
These are offset by Neurology drugs overspend £0.3m and costs of healthcare in the private sector £0.5m which is acknowledged as a Trust cost pressure.

SNTC - Divisional CIP performance

FORECAST	ANNUAL TARGET	FORECAST AT M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
SCNT SUMMARY									
CANCER, HEAD & NECK	1.31	0.03	0.32	0.35	0.03	0.20	0.12	0.96	A
GEN SURG & UROLOGY	1.35	0.07	1.04	1.11	0.14	0.11	0.85	0.24	A
NEUROSCIENCES	1.89	0.79	1.69	2.47	0.02	0.55	1.90	-0.58	F
SURGERY OVERHEADS	0.24	0.00	0.00	0.00	0.00	0.00	0.00	0.24	A
THEATRES	2.42	0.00	1.58	1.58	0.50	0.33	0.76	0.84	A
TRAUMA & ORTHO, PLAST	1.50	0.25	0.59	0.84	0.00	0.06	0.78	0.66	A
Grand Total	**8.71**	**1.13**	**5.22**	**6.36**	**0.69**	**1.26**	**4.41**	**2.35**	A
OF WHICH RECURRENT:		1.13	3.26	4.39	0.66	0.76	2.97	4.32	A
OBJECTIVE 2 (FULL YEAR EFFECT)		1.22	3.73	4.95	0.79	0.97	3.20	3.76	A

PERFORMANCE	YTD TARGET	ACTUAL YTD M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
SCNT SUMMARY									
CANCER, HEAD & NECK	0.54	0.00	0.15	0.15	0.02	0.07	0.06	0.39	A
GEN SURG & UROLOGY	0.56	0.01	0.27	0.28	0.00	0.02	0.26	0.29	A
NEUROSCIENCES	0.79	0.27	0.92	1.20	0.00	0.15	1.04	-0.41	F
SURGERY OVERHEADS	0.10	0.00	0.00	0.00	0.00	0.00	0.00	0.10	A
THEATRES	1.01	0.00	0.67	0.67	0.09	0.02	0.56	0.34	A
TRAUMA & ORTHO, PLAST	0.62	0.07	0.26	0.33	0.00	0.01	0.32	0.29	A
Grand Total	**3.63**	**0.35**	**2.27**	**2.63**	**0.12**	**0.28**	**2.23**	**1.00**	A
OF WHICH RECURRENT:		0.35	0.86	1.22	0.09	0.22	0.90	2.41	A

PHASED RAG RATED DIVISIONAL PROGRAMME - ACTUAL AND FORECAST



SNTC has a CIP target of £8.7m., with £6.4m of developed schemes leaving a gap of £2.3m.

Green schemes are £4.4m (an increase of £1.2m from that reported in M04), amber £1.3m and red schemes £0.7m.

The largest red schemes are procurement draw down opportunities £0.3m and theatre productivity / agency spend reduction which will go green shortly.

The majority of schemes are to reduce pay spend by £3.5m to improve pay productivity, reduce consultant PA's during job planning, using HCA's instead of RMN specials and run rate savings across all staff groups.

The £1.8m non-pay schemes are to reduce costs in the private sector for healthcare and reduce clinical consumable spend . The main income scheme is the inclusion in M05 of £0.8m Neuro-rehab tariff uplift.

SNTC will continue to work with care group leads , procurement, medical staffing and other trust support services to improve efficiency and maximise SLA income.

The YTD M05 CIP target is £3.6m, with schemes to save £2.6m leaving a shortfall of £1.0m. However, the reporting of M05 CIP achievement is understated by £0.4m and will be updated for M06.

Overheads - Divisional I&E

	2015/16 Annual Budget	Previous Months Actuals Trend			2015/16 Current			2015/16 YTD		
		Actual M2	Actual M3	Actual M4	Budget M5	Actual M5	Variance M5	Budget YTD	Actual YTD	Variance YTD
		£m	£m	£m	£m	£m	£m	£m	£m	£m
SLA Income	12.04	0.33	0.24	1.01	1.02	1.02	(0.00)	4.99	5.13	0.14
Other Income	20.63	1.27	1.22	1.79	1.55	1.50	(0.04)	8.59	8.40	(0.19)
Pay	(42.98)	(3.34)	(3.34)	(4.04)	(3.83)	(3.66)	0.16	(17.90)	(17.52)	0.38
Non Pay	(110.14)	(6.95)	(7.77)	(8.91)	(8.95)	(9.09)	(0.14)	(45.62)	(46.31)	(0.69)
Other	(10.86)	(0.84)	(0.84)	(0.90)	(0.91)	(0.90)	0.01	(4.53)	(4.49)	0.04
Grand Total	(131.31)	(9.53)	(10.48)	(11.06)	(11.11)	(11.13)	(0.02)	(54.46)	(54.79)	(0.33)

YTD Var 2015/16 (adv) / fav	Corporate Directorates		Estates & Facilities		Total Sum of YTD Budget £k	
	£m	%	£m	%	£m	%
SLA Income	0.16	*4.6%*	(0.02)	*-1.2%*	0.14	*2.8%*
Other Income	0.06	*1.2%*	(0.25)	*-6.3%*	(0.19)	*-2.2%*
Pay	0.14	*1.1%*	0.25	*4.3%*	0.38	*2.1%*
Non Pay	(0.76)	*-3.4%*	0.07	*0.3%*	(0.69)	*-1.5%*
Other	0.00	*0.2%*	0.03	*1.3%*	0.04	*0.8%*
Grand Total	(0.41)	*-1.4%*	0.08	*0.3%*	(0.33)	*-0.6%*

Actions

- The improvements for E&F will be from continued run-rates schemes.
- Inflation budgets to be funded.
- Car parking income will increase from 1st September, therefore will mitigate the current loss of income.
- There is an agreement which should be finalised soon for space with Moorfields and this will bring an income benefit
- Budget for the service cost of running the Nelson Clinic £0.3m, to be agreed with Community Services
- Review internal Pathology charges from SWL Pathology to ensure that the proper growth budgets have been allocated

Commentary

- Corporate Services have an adverse variance of £0.4m. This is driven by an overspend on Turnaround costs of £0.3m and an overspend on SWL Pathology recharges of £0.3m offset by underspends in Operations and Service Improvement of £0.3m due to continue. Strategy is also contributing a surplus of £94k due to a salary recharge of a general manager post. Procurement have recruited interim contractors which are costing more than budgeted. The YTD overspend in Procurement is £0.1m.

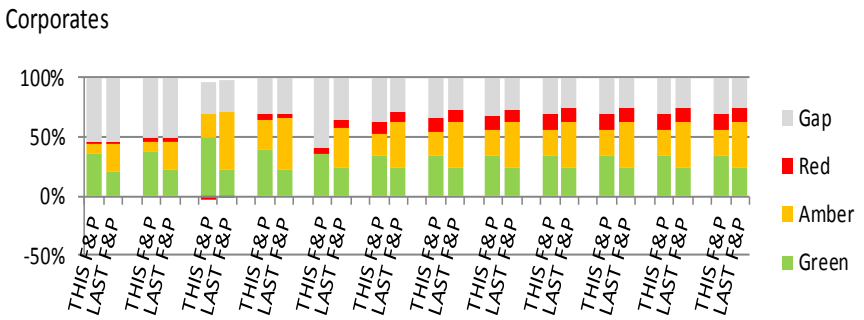
- Estates and Facilities service has a favourable YTD variance of £0.1m and an in month favourable of £0.2m. Engineering Services had an underspend in month of £0.2m due to some of the Mitie settlement costs being capitalised. Medical Physics has a small YTD overspend mainly due to MSSE costs. Car park income was down in August by £33k and YTD is down by £102k. SLA income for Transport over-performed in month by £42k. Community Estate budgets are now set up and work is ongoing to budget against contracts.

- Uncertainties are mainly around the Community Estate costs and the costs of the Wolfson and Nelson. Also any issues with the boilers or water will result in additional expenditure.

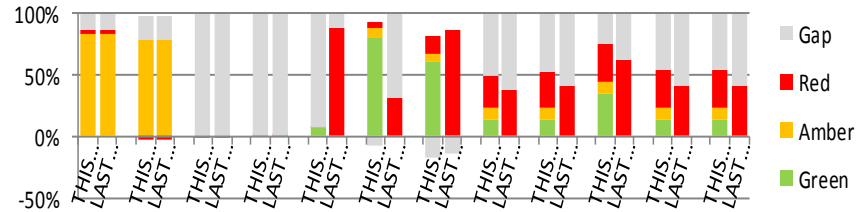
Please note that Internal Pathology budget responsibility transferred from CWDT to Corporates in Month 4.

Overheads - Divisional CIP performance

FORECAST	ANNUAL TARGET	FORECAST AT M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL FORECAST RAG RED	AMBER	GREEN	SHORT FALL	
OVERHEADS SUMMARY									
ESTATES & FACILITIES	2.89	0.53	1.15	1.68	0.43	0.56	0.68	1.22	A
OF WHICH RECURRENT:		0.39	0.43	0.82	0.43	0.16	0.23	-0.82	
CORPORATES:									
Finance & IT	1.44		0.95	0.95	0.21	0.30	0.44	0.48	A
CEO & Governance	0.20		0.20	0.20			0.20	0.00	A
HR & Education	0.38		0.03	0.03		0.03		0.35	A
DoN & Bed Manageme	0.34	0.02	0.18	0.19		0.12	0.07	0.15	A
SI & Strategy	0.24		0.24	0.24			0.24	-0.00	F
Grand Total	**2.60**	**0.02**	**1.60**	**1.62**	**0.21**	**0.45**	**0.96**	**0.98**	A
OF WHICH RECURRENT:		0.02	0.02	0.03	0.18	0.43	0.85	2.57	A
OBJECTIVE 2 (FULL YEAR EFFECT)		0.02	1.49	1.51	0.22	0.43	0.85	1.10	A



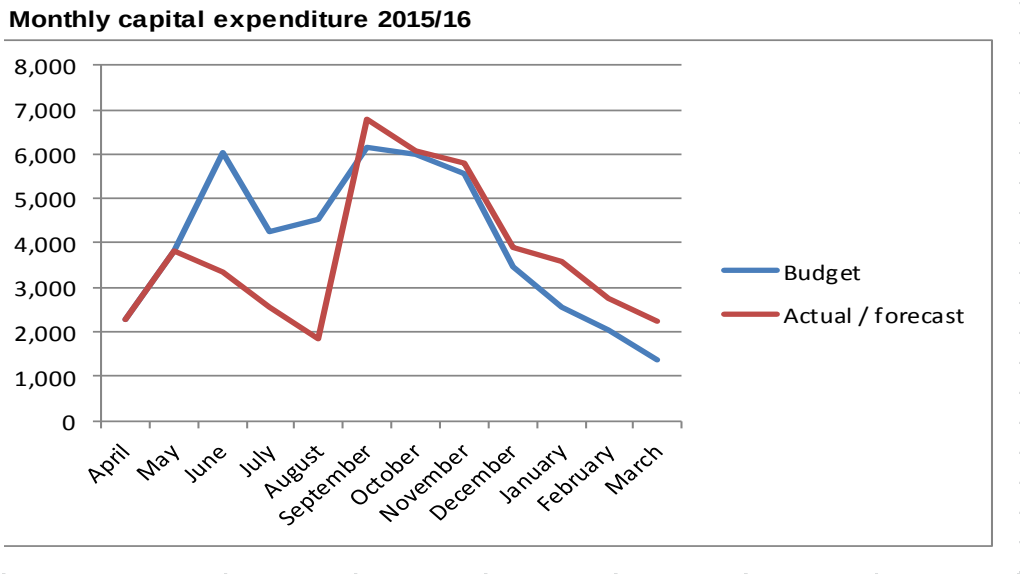
PERFORMANCE	YTD TARGET	ACTUAL YTD M5 (£m) INC	EXP	TOTAL	OF WHICH TOTAL ACTUAL YTD RAG RED	AMBER	GREEN	SHORT FALL	
OVERHEADS SUMMARY									
ESTATES & FACILITIES	1.21	0.02	0.40	0.42	0.00	0.40	0.02	0.79	A
OF WHICH RECURRENT:		0.01	0.00	0.01	0.00		0.01	1.20	A
CORPORATES:									
Finance & IT	0.60		0.31	0.31	0.02	0.11	0.18	0.29	A
CEO & Governance	0.09		0.08	0.08			0.08	0.00	A
HR & Education	0.16		0.00	0.00		0.00		0.15	A
DoN & Bed Manageme	0.14	0.01	0.07	0.07		0.03	0.04	0.07	A
SI & Strategy	0.10		0.13	0.13			0.13	-0.03	F
Grand Total	**1.08**	**0.01**	**0.59**	**0.59**	**0.02**	**0.14**	**0.43**	**0.49**	A
OF WHICH RECURRENT:		0.01	0.48	0.49	0.02	0.12	0.35	0.59	A



Estates & Facilities CIP YTD target is £1.2m. To date only £42k of savings have been achieved and these are currently at amber. Estates & Facilities plan to achieve the 2015/16 target by non-recurring run-rates.
The Corporate CIP YTD target is £1.1m and to date have found £0.6m, of which £0.4m are green, resulting in a shortfall of £0.5m. Run-rate savings are being achieved in the Corporate areas . These have not been specifically reported as CIP schemes in the CIP reporting. Corporate areas are finding it increasingly difficult to find their CIP and will use run-rate mitigations. The biggest scheme in Corporates is the cancellation of consultancy spend in Service Improvement £0.2m and to date has achieved £83k. ICT have achieved £42k ytd in establishment reduction and Telecommunications have achieved £35k by reducing switchboard operators. Finance have contributed £80k of savings ytd.

❽ Capital

- The 2015/16 capital programme budget was reduced from £56.7m to £48m in June. The net cash impact of the changes to capital financing expenditure assumptions was £3.8m and this was applied to reducing the forecast interim support funding requirement from £52.2m to £48.7m



- Capital expenditure in August was £1.8m and YTD expenditure is £13.8m against the new YTD budget of £20.9m i.e. an under spend of £7.1m. The detailed breakdown of the capital programme is given in appendix F.
- The Trust is deliberately slowing down capital expenditure where appropriate to support the cash position until the interim support funding is agreed with Monitor/ITFF and the Trust is forecasting an outturn under spend of approx £3.1m
- Budget holders indicate that the YTD under spend relates primarily to in-year timing differences. Consequently the monthly rate of expenditure is forecast to increase over the next 4 months and the forecast outturn is an underspend of £3.1m compared to the YTD under spend of £7.1m

❾ Cash 1

Cash balance

	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000
2015/16 Plan cash	n/a	14,200	6,187	3,000	3,000	3,000
Actual cash	**24,179**	**14,188**	**7,925**	**7,265**	**6,175**	**6,097**
Cash bal fav / (adv) variance to plan	0	-12	1,738	4,265	3,175	3,097

Working Capital Facility - ***cumulative*** drawdowns within cash balance above

	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000
Plan drawdown	0	0	0	2,138	6,991	14,625
Actual drawdown	**0**	**0**	**0**	**0**	**7,671**	**15,580**
WCF cum drawdowns fav / (adv) variance to plan	0	0	0	2,138	-680	-955

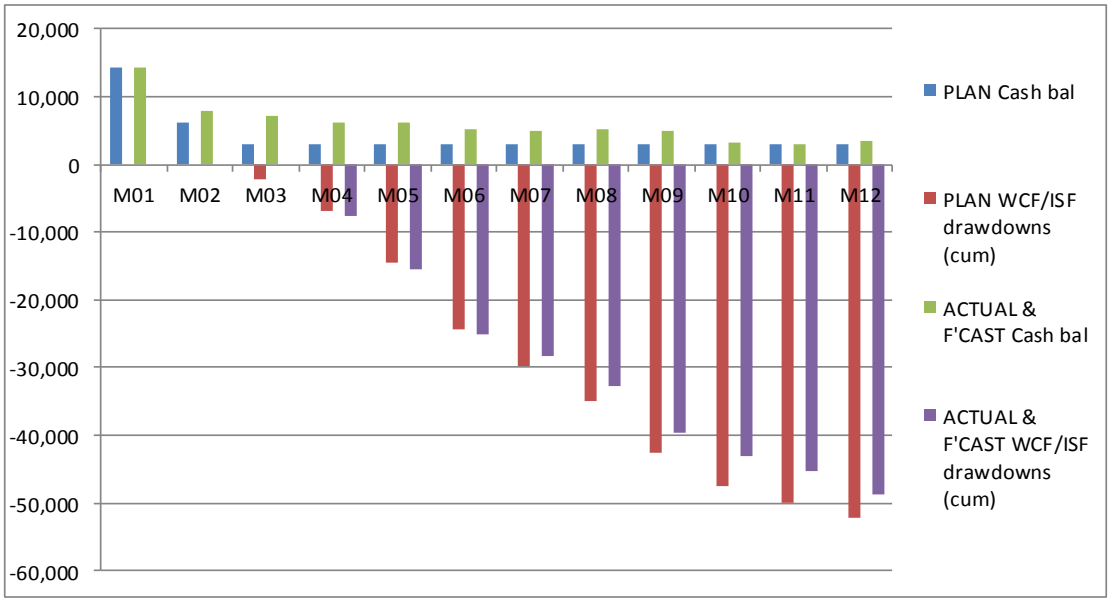
Overall Cash fav / (adv) variance to plan	**0**	**-12**	**1,738**	**6,403**	**2,495**	**2,142**

- Actual cash balance was £6.1m at 31st August including cumulative WCF drawdowns of £15.6m.
- Plan cash balance was £3m including cumulative WCF drawdown of £14.6m.
- Therefore the cash balance was £2.1m better than plan overall..
- The cash balance includes £12.3m unexpended LEEF loan for the energy performance contract and so the cash balance excluding LEEF would be negative: -£6.2m
- The main factors explaining the reduction in the cash balance since year end are:
  - revenue deficit of £31.3m and
  - deterioration of £3.2m in working capital (stock, debtors and creditors) – better than plan (-£5.8m).
- The better performance on working capital and the capital underspend offset the impact of the higher trading deficit enabling the Trust to achieve an August cash balance £2.1m above plan.

Cash 2

- The Trust is estimating an interim cash support funding request of £48.7m (Plan £52.2m) for the year to finance the planned revenue deficit.
- Additional cash has been secured since July using the £25m approved working capital facility. The Trust drew down £7.9m on 17th August bringing cumulative drawdowns to £15.6m. Since month-end the Trust has drawn down a further £9.4m and so has exhausted the WCF in September – in line with previous forecasts.
- Therefore the Trust requires a new temporary loan/facility from October and the Trust has advised Monitor it requires £18.2m cash from October to January inclusive. This would take cumulative WCF/interim borrowing to £43.2m for the 10 month period ended 31/01/15 – consistent with previous forecasts. From the end of January the Trust will use the agreed **interim support funding (ISF)** for further cash requirements. The ISF will be confirmed with Monitor/ITFF as result of the re-forecasting exercise.
- The Trust has developed measures including longer standard supplier payment terms (60 days implemented w/e 10th July), reduced debtor levels and lower inventory levels to support the cash position. Stretch targets have now been set for reductions in overdue debt by year end which would increase the level of cash benefits to approx £20m if achieved in full. The Trust has included approx £7m of these cash benefits into the monthly cash forecast (appendix E) and this benefit mitigates the £7.14m I&E risk relating to the allocation of contingency and divisional control totals in respect of unavoidable cost pressures which was approved by the board w/c 17/08.

CASH AND ISF/WCF funding: Actual/Forecast vs Plan



Cash 3

Debt reduction targets

- The Cash Committee has approved 'stretch' debt reduction targets for 2015/16. The baseline for these stretch targets is the level of overdue debt (over 30 days old) as at M04.
- Target for NHS debt – reduction in overdue debt of 60% by March 2016
- Target for non-NHS debt – reduction in overdue debt of 18% by March 2016. The non-NHS stretch targets exclude DWP/CRU debt and overseas patients debt as these categories are not sensitive to Trust collection activity
- Delivery of the stretch targets by March 2016 would reduce the requirement for interim support funding by approx £14.2m
- Performance in August: **overdue debt reduced by £5m vs £1.8m target**.
- The detailed aged debt report is in appendix G.

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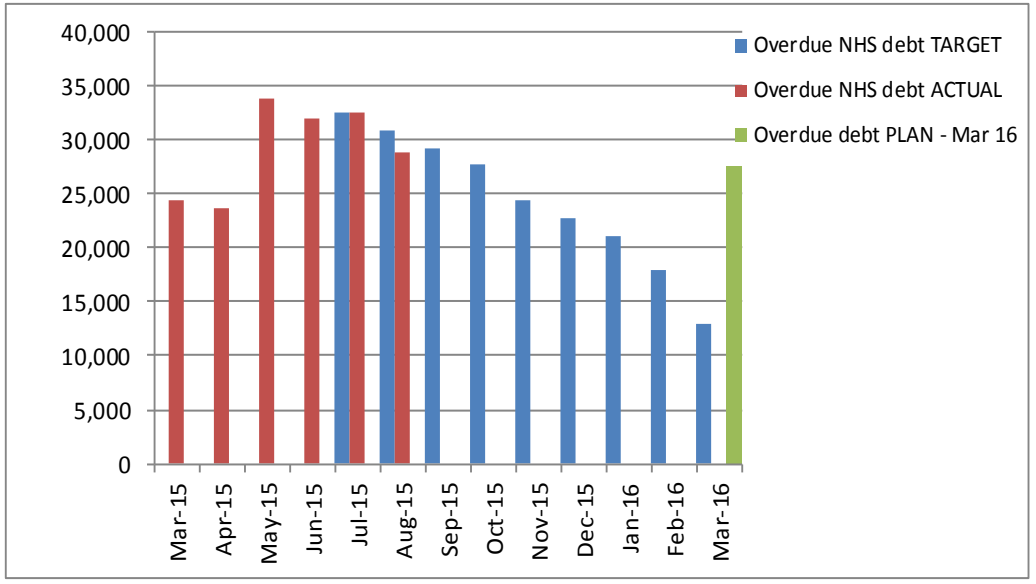
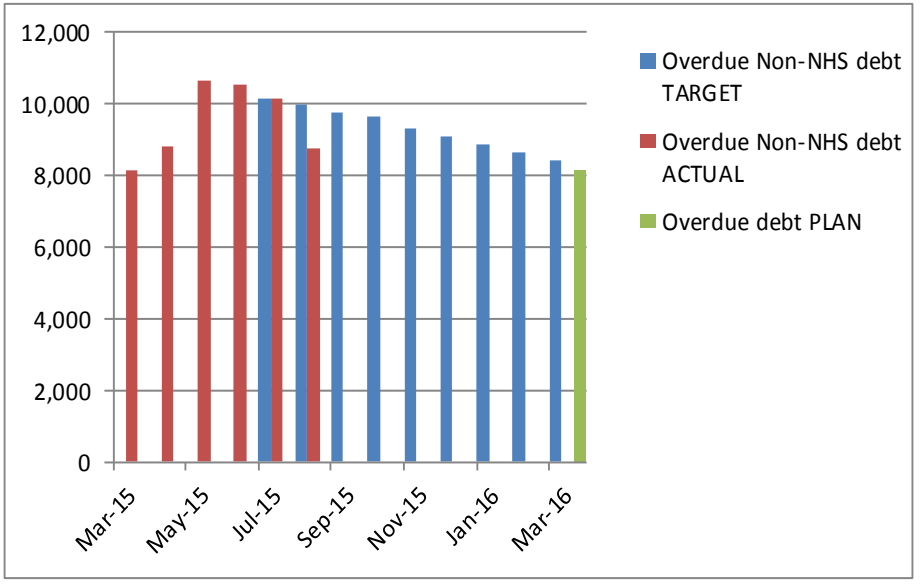
Overdue NHS debt: performance vs stretch reduction targets



Overdue non-NHS debt: performance vs stretch reduction targets



10 Balance sheet as at M05 2015/16

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department
Balance sheet AUGUST 2015

	Aug-15 Plan £000	Aug-15 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	344,698	334,699	*9,999*	Lower capital expenditure - so lower fixed assets
Stock	6,932	7,751	*-819*	Pharmacy stock reduced from last month but central store stock higher than plan
Debtors	78,733	82,669	*-3,936*	See appendix D
Cash	3,000	6,100	*-3,100*	Lower capex, better working capital movement - see appendix D
				Cash is £2.1m better than Plan (£3.1m - £1m re: more WCF drawn: £5m min cash bal)
Creditors	-84,602	-91,957	*7,355*	See appendix D
Capital creditors	-3,476	-2,424	*-1,052*	
PDC div creditor	-2,950	-2,950	*0*	
Int payable creditor	-181	-221	*40*	
Provisions< 1 year	-602	-512	*-90*	
Borrowings< 1 year	-21,544	-6,366	*-15,178*	(NB: WCF is classified as non-current liability c/f Plan)
Net current assets/-liabilities	**-24,690**	**-7,910**	*-16,780*	
Provisions> 1 year	-1,181	-1,146	*-35*	
Borrowings> 1 year	-89,799	-103,945	*14,145*	£7.7m WCF drawn in July. Lower capex financed by leases.
Long-term liabilities	**-90,980**	**-105,091**	*14,110*	
Net assets	**229,027**	**221,698**		
Taxpayer's equity				
Public Dividend Capital	133,761	133,761	*0*	
Retained Earnings	-7,244	-13,866	*6,622*	YTD I&E deficit worse than plan
Revaluation Reserve	101,360	100,653	*707*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**229,027**	**221,698**		

11 Financial Sustainability Risk Rating (FSRR)

From August 2015 Monitor have implemented an update to the Risk Assessment Framework (RAF) requiring Foundation Trusts to assign a financial sustainability risk rating (FSRR) to their current financial performance, to replace the existing CoSRR. The FSRR includes the liquidity and capital servicing capacity metrics of the CoSRR, supplemented by two new metrics. The trust is required to calculate I&E margin (the degree to which the organisation is operating at a surplus/deficit) and variance from plan in relation to I&E margin (the variance between the organisation's plan and its actual margin). The details around scoring and weighting are outlined below (scoring for existing metrics are unchanged, whereas the weightings for each have halved to incorporate the new metrics):

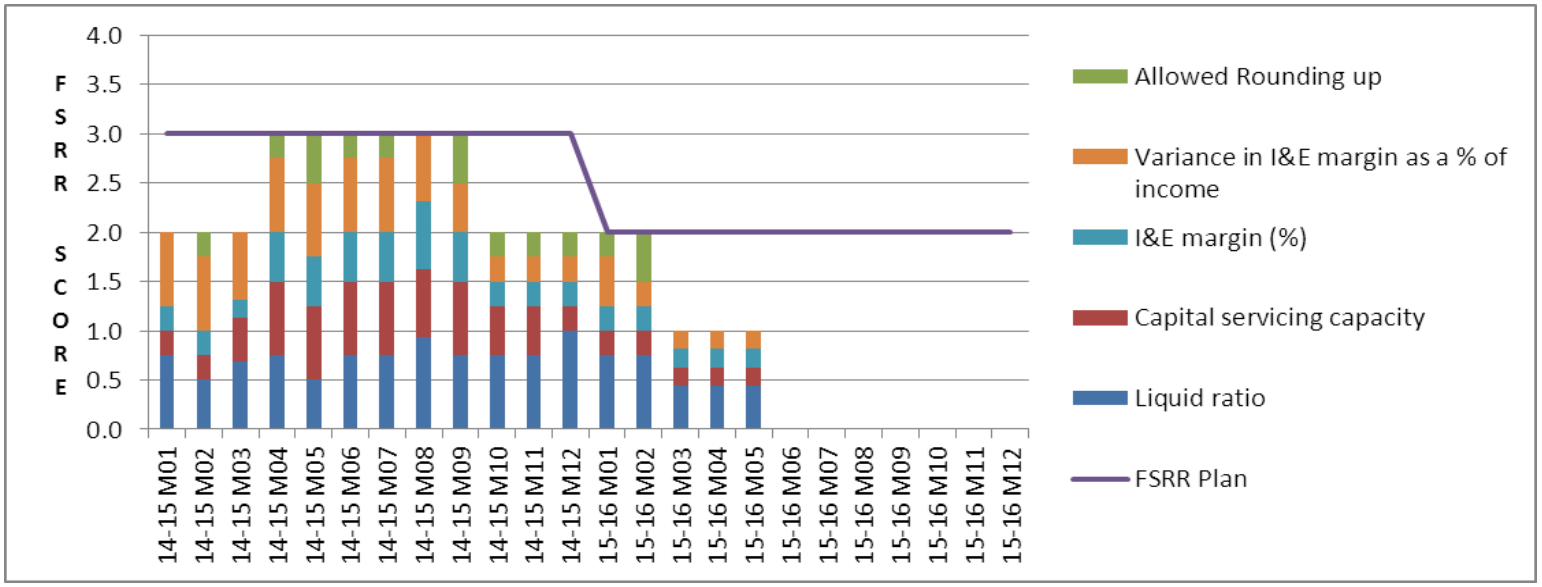
	Financial criteria	Weight (%)	Metric	Rating categories**			
				1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75-2.5x	>2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)–0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

*Scoring a 1 on any metric will cap the weighted rating to 2, potentially leading to investigation.
**Scores are rounded to the nearest number, ie if the trust scores 3.6 overall, this will be rounded to 4; if the trust scores 3.4, this will be rounded to 3.
***A 2* rating may be awarded to a trust where there is little likelihood of deterioration in its financial position.

Financial Sustainability Risk Rating (FSRR)

	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	14/15	15/16	15/16	15/16	15/16	15/16
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
Metric Scores	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	M01	M02	M03	M04	M05
Liquid ratio	-3.6	-7.7	-5.6	-5.5	-8.6	-0.6	-0.3	0.3	-2.2	-2.2	-4.5	1.4	-2.8	-6.6	-9.4	-7.7	-7.5
Capital servicing capacity	1.0	1.1	1.4	2.2	1.8	1.9	2.1	2.1	1.9	1.5	1.3	1.0	-3.6	-4.1	-3.6	-2.8	-2.8
I&E margin (%)	-3.0%	-2.4%	-1.7%	-0.7%	-0.7%	-0.4%	-0.1%	0.0%	-0.5%	-1.5%	-1.8%	-2.4%	-13.4%	-13.9%	-12.5%	-10.7%	-10.8%
Variance in I&E margin (%)	-0.3%	-0.3%	-0.3%	-0.2%	-0.4%	-0.6%	-0.8%	-0.7%	-1.0%	-2.1%	-2.4%	-3.1%	-2.0%	-2.7%	-3.3%	-2.8%	-2.5%
Metric Rating (See Thresholds)	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating	Rating
Liquid ratio	3	2	3	3	2	3	3	4	3	3	3	4	3	3	2	2	2
Capital servicing capacity	1	1	2	3	3	3	3	3	3	2	2	1	1	1	1	1	1
I&E margin (%)	1	1	1	2	2	2	2	3	2	1	1	1	1	1	1	1	1
Variance in I&E margin (%)	3	3	3	3	3	3	3	3	2	1	1	1	2	1	1	1	1
Weighted Average	2.0	1.8	2.3	2.8	2.5	2.8	2.8	3.3	2.5	1.8	1.8	1.8	1.8	1.5	1.3	1.3	1.3
Overriding Score	**2**	**2**	**2**	**3**	**3**	**3**	**3**	**3**	**3**	**2**	**2**	**2**	**2**	**2**	**1**	**1**	**1**

In M05 the Trust achieved a 1 overall for FSRR with the liquidity metric 2 and all other metrics 1. These are all in line with the Annual Plan for M05 apart from the variance metric that has a plan of 4 and liquidity that has a plan of 1.



Appendices

A. Detailed Income & Expenditure
B. Income & Expenditure time series of actuals
C. Trend graphs of income and expenditure
D. Movement in working capital chart and explanation
E. Detailed cash flow plan 2015/16
F. Detailed capital expenditure
G. Aged Debt Profile
H. Developments in financial reporting

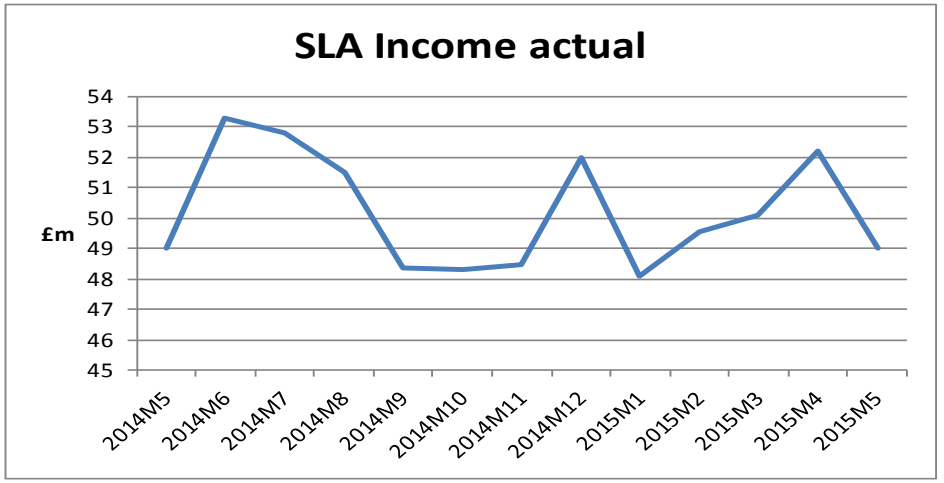
Appendix A– Detailed Income & Expenditure

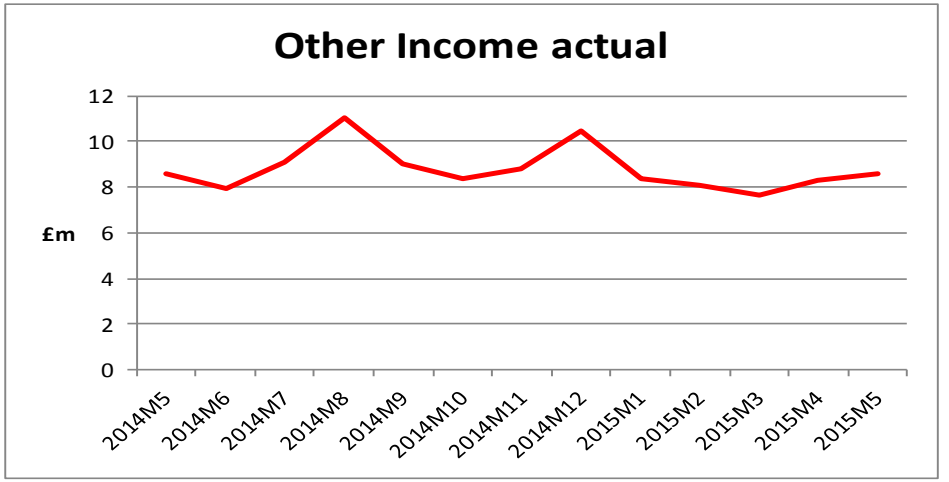
	CURRENT MONTH M5				CUMULATIVE YTD					
	Current Mth Budget £m	Current Mth Amount £m	Current Mth Variance (adv)/Fav £m	% Variance	YTD Budget £m	YTD Amount £m	YTD Variance (adv)/fav £m	% Variance	*Previous Variance (adv)/fav* £m	Annual Budget £m
Income										
SLA Elective	4.85	5.38	0.53 F	11.0%	26.08	26.60	0.52 F	2.0%	*-0.01* A	64.54
SLA Daycase	2.25	2.32	0.08 F	3.3%	12.06	12.38	0.33 F	2.7%	*0.25* F	29.27
SLA Non Elective	10.26	10.05	-0.21 A	-2.1%	50.51	50.47	-0.04 A	-0.1%	*0.17* F	121.54
SLA Outpatients	11.12	10.36	-0.75 A	-6.8%	58.23	55.89	-2.34 A	-4.0%	*-1.59* A	142.48
SLA A&E	1.58	1.54	-0.04 A	-2.5%	7.79	7.66	-0.13 A	-1.7%	*-0.09* A	18.63
SLA Bed Days	4.94	4.58	-0.36 A	-7.3%	24.42	24.01	-0.40 A	-1.7%	*-0.04* A	61.22
SLA Exclusions & Programme	5.68	5.92	0.23 F	4.1%	27.54	27.91	0.38 F	1.4%	*0.15* F	76.23
SLA Other	9.80	9.31	-0.49 A	-5.0%	48.15	46.40	-1.75 A	-3.6%	*-1.26* A	114.95
SLA Provisions QiPP/KPIs & Y/E Settlement	-0.38	-0.47	-0.09 A	-24.6%	-1.88	-2.50	-0.62 A	-32.8%	*-0.52* A	-4.51
Subtotal - SLA Income	50.11	48.99	-1.12 A	-2.2%	252.89	248.84	-4.06 A	-1.6%	-2.94 A	624.36
Private & Overseas Patient	0.23	0.40	0.17 F	74.5%	1.86	2.10	0.24 F	12.6%	*0.07* F	4.51
RTAs	0.50	0.65	0.15 F	30.0%	1.88	1.76	-0.12 A	-6.4%	*-0.27* A	4.52
Other Healthcare Income	0.01	-0.01	-0.02 A	-209.7%	0.06	0.11	0.05 F	93.9%	*0.08* F	0.14
Levy Income	3.65	3.65	0.00 A	0.0%	18.26	18.23	-0.03 A	-0.2%	*-0.03* A	43.83
Other Income	4.58	3.92	-0.66 A	-14.4%	19.37	18.76	-0.61 A	-3.1%	*0.05* F	46.88
Total income	**59.07**	**57.59**	**-1.48** A	**-2.5%**	**294.33**	**289.80**	**-4.53** A	**-1.5%**	***-3.04*** A	**724.24**
Expenditure										
Pay Total	-38.09	-38.36	-0.26 A	-0.7%	-186.56	-189.89	-3.33 A	-1.8%	*-3.07* A	-450.38
Drugs	-4.04	-5.03	-0.99 A	-24.5%	-22.43	-23.93	-1.50 A	-6.7%	*-0.51* A	-61.35
Clinical Consumables	-8.22	-8.50	-0.28 A	-3.5%	-41.35	-40.77	0.58 F	1.4%	*0.87* F	-98.33
Reserves	-0.93	-0.03	0.90 F	96.5%	-4.70	-2.76	1.94 F	41.2%	*1.04* F	-13.04
Other Total	-10.52	-9.27	1.25 F	11.9%	-48.71	-49.66	-0.95 A	-2.0%	*-2.20* A	-110.70
Total expenditure	**-61.80**	**-61.19**	**0.61** F	**1.0%**	**-303.74**	**-307.00**	**-3.27** A	**-1.1%**	***-3.88*** A	**-733.80**
EBITDA (note 1)	**-2.72**	**-3.60**	**-0.87** A	**-31.9%**	**-9.41**	**-17.20**	**-7.79** A	**-82.8%**	*-6.92* A	**-9.56**
Disposal of Assets	0.00	0.00	0.00 F	0.0%	0.00	0.00	0.00 F	0.0%	*0.00* F	0.00
Interest payable	-0.38	-0.35	0.03 F	7.3%	-1.74	-1.68	0.06 F	3.7%	*0.04* F	-5.03
Interest receivable	0.01	0.00	0.00 A	-59.7%	0.03	0.01	-0.02 A	-57.5%	*-0.01* A	0.08
PDC Dividend	-0.59	-0.59	0.00 A	0.0%	-2.95	-2.95	0.00 A	0.0%	*0.00* A	-7.08
Depreciation	-2.05	-1.97	0.08 F	4.1%	-9.87	-9.45	0.42 F	4.2%	*0.33* F	-24.61
Total interest, dividends & deprec'n	**-3.02**	**-2.91**	**0.11** F	**3.6%**	**-14.53**	**-14.07**	**0.46** F	**3.2%**	***0.36*** F	**-36.65**
NET +Surplus /-Deficit	**-5.74**	**-6.50**	**-0.76** A	**-13.3%**	**-23.94**	**-31.27**	**-7.33** A	**-30.6%**	***-6.57*** A	**-46.21**

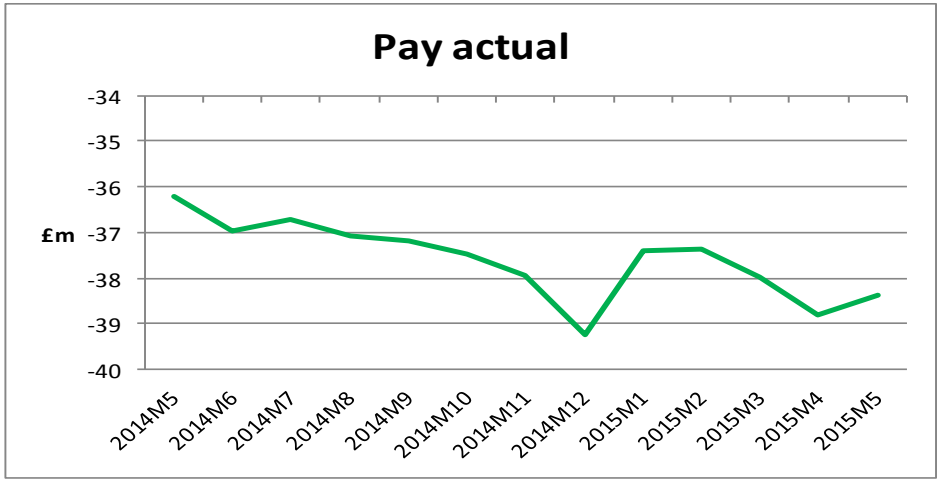
Appendix B - Time series of Actuals

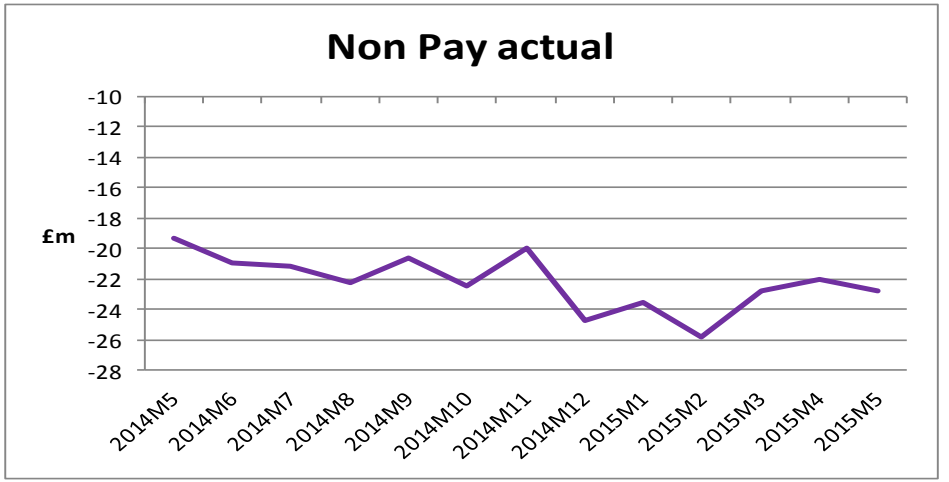
I&E Type	Type	Catergory	2014M5	2014M6	2014M7	2014M8	2014M9	2014M10	2014M11	2014M12	2015M1	2015M2	2015M3	2015M4	2015M5
Income	SLA Income	SLA A&E	-1.19	-1.29	-1.32	-1.24	-1.33	-1.22	-1.20	-1.33	-1.53	-1.54	-1.10	-1.95	-1.54
		SLA Bed Days	-4.72	-5.08	-4.93	-4.93	-5.35	-4.88	-5.11	-5.57	-4.83	-5.01	-4.99	-4.61	-4.58
		SLA Daycase	-2.11	-2.32	-2.58	-2.15	-2.00	-2.22	-2.16	-2.49	-2.31	-2.39	-2.79	-2.57	-2.32
		SLA Elective	-5.04	-4.73	-5.26	-4.61	-4.01	-4.79	-4.23	-5.32	-5.08	-4.86	-5.50	-5.77	-5.38
		SLA Exclusions	-4.09	-3.40	-4.11	-3.46	-3.98	-2.12	-3.54	-3.50	-4.23	-3.75	-4.32	-4.92	-4.92
		SLA Non Elective	-8.94	-10.21	-9.84	-9.17	-9.25	-8.98	-8.86	-9.19	-10.10	-10.34	-10.24	-9.75	-10.05
		SLA Other	-12.64	-13.88	-13.67	-14.09	-13.08	-12.84	-12.67	-13.47	-8.32	-9.41	-7.97	-9.36	-8.84
		SLA Outpatients	-8.86	-10.80	-9.87	-10.29	-8.01	-9.84	-9.18	-9.65	-10.58	-10.54	-12.06	-12.34	-10.36
		SLA Programme	-1.41	-1.55	-1.19	-1.57	-1.37	-1.43	-1.53	-1.46	-1.09	-1.68	-1.11	-0.91	-1.00
	SLA Income Total		**-49.02**	**-53.25**	**-52.77**	**-51.49**	**-48.38**	**-48.32**	**-48.48**	**-51.97**	**-48.06**	**-49.53**	**-50.08**	**-52.17**	**-48.99**
	Other Income	Levy Income	-3.98	-3.96	-4.11	-4.13	-4.31	-4.00	-3.75	-3.84	-3.65	-3.63	-3.64	-3.66	-3.65
		Other Healthcare Income	-0.01	-0.01	-0.01	-0.02	-0.01	-0.01	-0.01	-0.02	-0.04	-0.02	-0.03	-0.02	0.01
		Private & Overseas Patient	-0.25	-0.31	-0.48	-0.50	-0.54	-0.61	-0.27	-0.51	-0.45	-0.33	-0.48	-0.44	-0.40
		RTAs	-0.32	-0.32	-0.36	-0.43	-0.35	-0.45	-0.45	-0.38	-0.36	-0.27	-0.30	-0.18	-0.65
		Other Income	-4.00	-3.32	-4.15	-5.93	-3.78	-3.33	-4.31	-5.73	-3.83	-3.82	-3.18	-4.01	-3.92
	Other Income Total		**-8.56**	**-7.91**	**-9.11**	**-11.01**	**-9.00**	**-8.39**	**-8.79**	**-10.48**	**-8.33**	**-8.07**	**-7.64**	**-8.32**	**-8.60**
Income Total			**-57.58**	**-61.16**	**-61.88**	**-62.50**	**-57.38**	**-56.71**	**-57.27**	**-62.45**	**-56.40**	**-57.59**	**-57.73**	**-60.49**	**-57.59**
Expenditure	Pay	Pay Consultants	5.53	5.52	5.54	5.73	5.55	5.91	6.11	6.35	5.83	5.81	5.90	6.39	5.91
		Pay Jnr Drs	4.15	4.23	4.56	4.32	4.71	4.28	4.38	4.31	4.25	4.24	4.19	4.16	4.25
		Pay Non Clinical	6.19	6.40	6.00	6.01	5.72	5.89	5.98	6.44	6.10	5.95	6.08	7.52	6.59
		Pay Nursing	12.50	13.85	13.44	13.42	13.48	14.09	14.30	15.05	14.62	14.68	15.02	14.09	14.48
		Pay Other	0.00	0.00	0.01	0.00	0.00	0.01	0.00	0.00	0.01	-0.01	0.00	0.01	0.00
		Pay Sci, Techs, Therap	7.84	6.96	7.17	7.57	7.73	7.28	7.17	7.08	6.58	6.68	6.79	6.63	7.13
	Pay Total		**36.21**	**36.96**	**36.72**	**37.06**	**37.20**	**37.47**	**37.93**	**39.23**	**37.39**	**37.36**	**37.98**	**38.80**	**38.36**
	Non Pay	Drugs	3.53	4.23	4.11	3.94	4.20	3.80	4.15	5.41	4.55	4.41	4.57	5.37	5.03
		Clinical Consumables	7.36	7.69	6.98	7.64	7.97	8.57	7.92	7.16	7.50	8.51	8.26	8.00	8.50
		Clinical Negligence	0.81	0.83	0.92	0.76	0.79	0.83	0.75	0.83	1.22	1.21	1.22	1.44	1.29
		Establishment	0.90	0.67	1.03	0.86	0.81	0.90	0.79	0.87	0.81	1.04	0.96	1.04	0.87
		General Supplies	1.31	1.46	1.42	1.54	1.39	1.15	1.33	1.14	1.35	1.37	1.42	1.42	1.51
		PFI Unitary payment	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.57	0.59	0.58	0.58	0.58	0.58
		Premises	2.35	3.05	3.42	3.29	2.97	2.95	3.31	3.95	3.39	3.45	4.12	3.77	2.61
		Other	2.57	2.47	2.74	3.65	1.90	3.69	1.13	4.75	4.12	5.29	1.95	0.44	2.44
	Non Pay Total		**19.39**	**20.98**	**21.20**	**22.25**	**20.60**	**22.46**	**19.95**	**24.69**	**23.54**	**25.86**	**22.83**	**22.06**	**22.83**
Expenditure Total			**55.60**	**57.94**	**57.92**	**59.31**	**57.80**	**59.93**	**57.89**	**63.93**	**60.93**	**63.22**	**60.81**	**60.86**	**61.19**
Post Ebitda	Other Income	Interest Receivable	0.00	-0.01	-0.01	-0.01	-0.01	-0.01	0.00	-0.01	0.00	0.00	0.00	0.00	0.00
	Other Income Total		**0.00**	**-0.01**	**-0.01**	**-0.01**	**-0.01**	**-0.01**	**0.00**	**-0.01**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	Other	Depreciation	1.69	1.69	1.73	1.73	1.73	2.19	1.75	1.85	2.05	1.80	1.67	1.97	1.97
		Disposal of Assets	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.09	0.00	0.00	0.00	0.00	0.00
		Interest Payable	0.26	0.27	0.26	0.26	0.29	0.29	0.27	0.31	0.40	0.28	0.32	0.33	0.35
		PDC Dividend	0.61	0.63	0.71	0.64	0.64	0.62	0.64	0.64	0.57	0.61	0.59	0.59	0.59
	Other Total		**2.56**	**2.60**	**2.71**	**2.63**	**2.66**	**3.10**	**2.66**	**2.90**	**3.02**	**2.68**	**2.58**	**2.89**	**2.91**
Post Ebitda Total			**2.56**	**2.59**	**2.70**	**2.62**	**2.65**	**3.09**	**2.65**	**2.89**	**3.02**	**2.68**	**2.58**	**2.88**	**2.91**
Grand Total			**0.59**	**-0.63**	**-1.25**	**-0.57**	**3.07**	**6.31**	**3.27**	**4.36**	**7.56**	**8.30**	**5.66**	**3.25**	**6.50**

Appendix C – Trends of Income and Expenditure





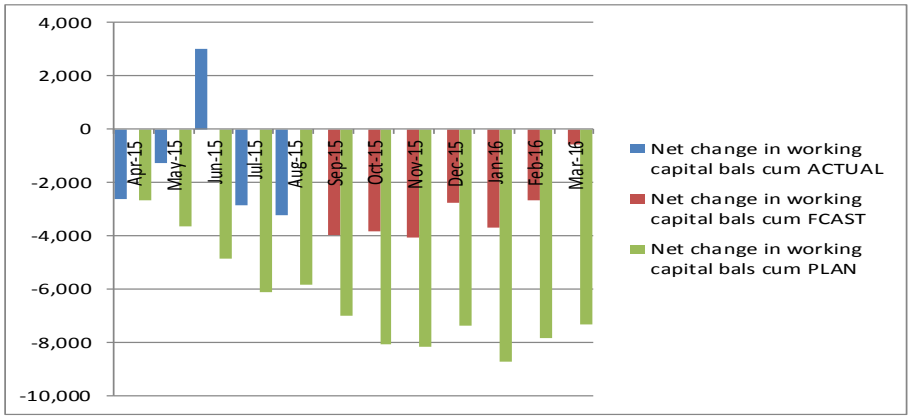




Please note that the recode of £1.2m of interim staffing costs from non pay to pay in M04 will have impacted on these graphs

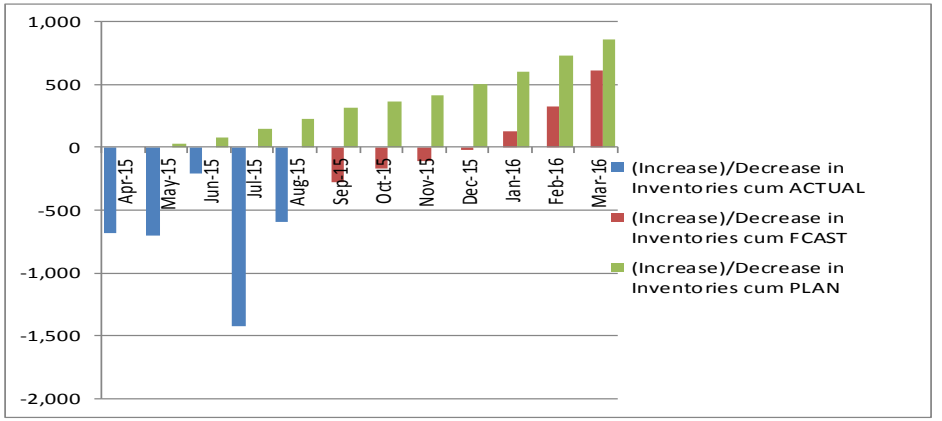
Appendix D - Working Capital movements – YTD and forecast

Change in all working capital balances 2015/16 actuals vs plan



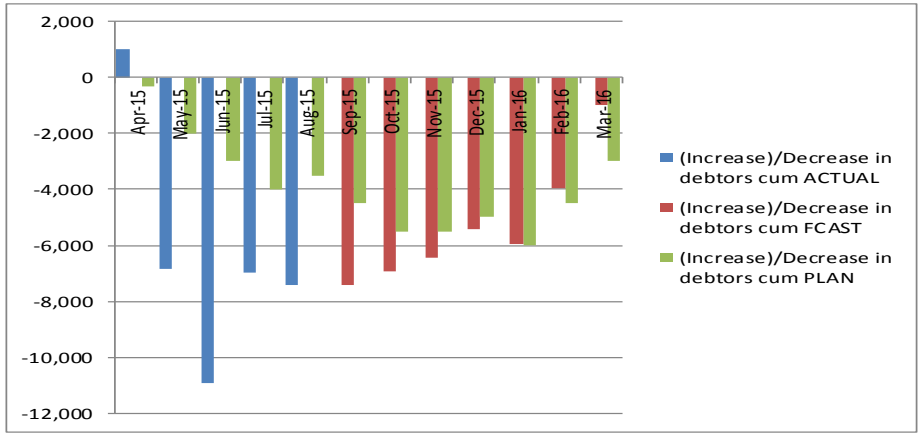
Working capital bals deteriorated by £0.4m M05 but YTD is still better than plan by £2.6m
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories 2015/16 actuals vs plan



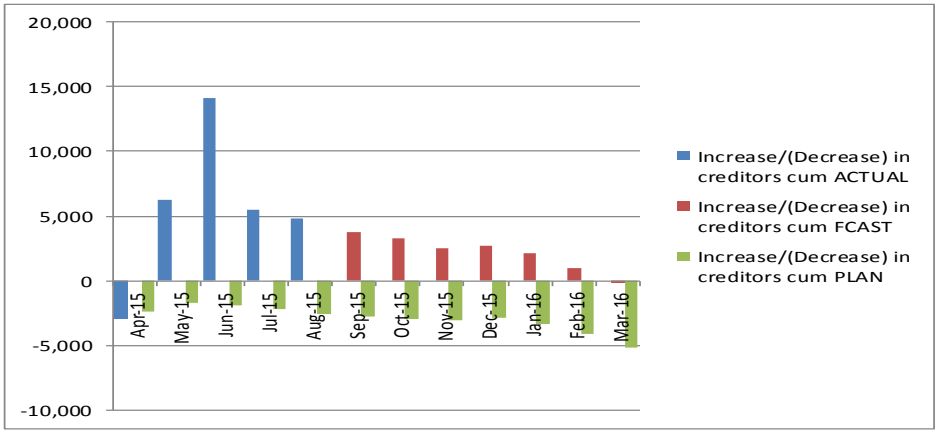
Inventories reduced by £0.8m in M05: reported pharmacy stock in line with financial system.
Steady reduction (releasing cash) planned to year end - mainly from Central Store.

Change in debtors 2015/16 actuals vs plan



Debtors increased by £0.5m in M05 and are £4m worse than plan I total
However the increase relates to current (,30 days) debt and overdue debt reduced by £5m
- exceeding the target for the month by £3.2m. See separate Debt Reduction targets slide.

Change in creditors 2015/16 actuals vs plan



Trust again reduced backlog of supplier invoices and at the end of August was able to pay invoices due up to 20th August.

Appendix E - Detailed monthly cash flow forecast 15/16

2015/16 projected monthly cash flow	PLAN 2015/16 YTD £000	Actual 2015/16 YTD £000	VAR 2015/16 YTD £000	PLAN 2015/16 Sep-15 £000	2015/16 Sep-15 £000	PLAN 2015/16 Oct-15 £000	2015/16 Oct-15 £000	PLAN 2015/16 Nov-15 £000	2015/16 Nov-15 £000	PLAN 2015/16 Dec-15 £000	2015/16 Dec-15 £000	PLAN 2015/16 Jan-16 £000	2015/16 Jan-16 £000	PLAN 2015/16 Feb-16 £000	2015/16 Feb-16 £000	PLAN 2015/16 Mar-16 £000	2015/16 Mar-16 £000	PLAN 2015/16 TOTAL £000
IFRS net surplus/-deficit	-23,942	**-23,942**	**0**	-3,195	*-3,195*	-2,375	*-2,375*	-3,192	*-3,192*	-6,002	*-6,002*	-3,425	*-3,425*	-2,508	*-2,508*	-1,561	*-1,561*	**-46,200**
I&E risk - control totals approved by board w/c 17/08		**-7,330**	**-7,330**															
Profit on disposal of fixed assets		**0**																
Add back:																		
Interest payable	1,699	**1,679**	**-20**	406	*406*	438	*438*	448	*448*	477	*477*	502	*501*	490	*489*	515	*527*	**4,974**
Interest receivable	-31	**-14**	**17**	-6	*-7*	-6	*-7*	-6	*-7*	-6	*-8*	-6	*-8*	-6	*-8*	-6	*-12*	**-75**
PDC Dividend	2,950	**2,950**	**0**	590	*590*	590	*590*	590	*590*	590	*590*	590	*590*	590	*590*	592	*592*	**7,082**
Depreciation	9,870	**9,454**	**-416**	2,050	*1,967*	2,100	*2,017*	2,100	*2,017*	2,100	*2,017*	2,130	*2,047*	2,130	*2,047*	2,130	*2,044*	**24,610**
EBITDA	**-9,455**	**-17,203**	**-7,748**	**-155**	***-239***	**747**	***663***	**-60**	***-144***	**-2,841**	***-2,926***	**-210**	***-295***	**695**	***610***	**1,670**	***1,590***	**-9,609**
	YTD £000	**YTD £000**	**YTD £000**	Sep-15 £000	*Sep-15 £000*	Oct-15 £000	*Oct-15 £000*	Nov-15 £000	*Nov-15 £000*	Dec-15 £000	*Dec-15 £000*	Jan-16 £000	*Jan-16 £000*	Feb-16 £000	*Feb-16 £000*	Mar-16 £000	*Mar-16 £000*	**Mar-16 £000**
Opening cash balance	**24,179**	24,179		**3,000**	***6,097***	**3,000**	***5,265***	**3,000**	***5,039***	**3,000**	***5,227***	**3,000**	***5,000***	**3,000**	***3,102***	**3,000**	***3,000***	24,179
EBITDA	-9,455	**-17,203**	**-7,748**	-155	*-239*	747	*663*	-60	*-144*	-2,841	*-2,926*	-210	*-295*	695	*610*	1,670	*1,590*	**-9,609**
Non-cash income	-73	**-72**	**1**	-15	*-14*	-15	*-14*	-15	*-14*	-15	*-15*	-15	*-15*	-15	*-14*	-15	*-14*	**-174**
Interest paid	-1,617	**-1,558**	**59**	-342	*-342*	-371	*-371*	-484	*-484*	-530	*-530*	-436	*-436*	-529	*-529*	-449	*-490*	**-4,759**
PDC dividend paid	0	**0**	**0**	-3,540	*-3,540*											-3,542	*-3,542*	**-7,082**
Operating surplus/-deficit less interest and dividends paid	**-11,145**	**-18,833**	**-7,688**	-4,052	*-4,135*	361	*278*	-558	*-642*	-3,386	*-3,471*	-660	*-746*	152	*67*	-2,336	*-2,456*	**-21,623**
Change in working capital																		
Change in stock	225	**-594**	**-819**	89	*320*	50	*110*	50	*50*	93	*93*	100	*150*	125	*200*	125	*285*	**857**
Change in debtors	-3,500	**-7,437**	**-3,937**	-1,000	*0*	-1,000	*500*	0	*500*	500	*1,000*	-1,000	*-250*	1,500	*1,750*	1,500	*2,937*	**-3,000**
Change in creditors (excl int pay/cap/pdc)	-2,550	**4,806**	**7,356**	-250	*-2,962*	-150	*-500*	-150	*750*	200	*160*	-450	*-660*	-750	*-689*	-1,108	*-1,113*	**-5,208**
Net change in working capital	**-5,825**	**-3,225**	**2,600**	-1,161	*-2,642*	-1,100	*110*	-100	*1,300*	793	*1,253*	-1,350	*-760*	875	*1,261*	517	*2,109*	**-7,351**
Provisions used		**-126**	**-126**	0	*-34*	0	*-23*	0	*-23*	0	*-23*	0	*-23*	0	*-23*	0	*-23*	**0**
Interest received	31	**13**	**-18**	6	*8*	6	*8*	6	*8*	6	*8*	6	*8*	6	*8*	6	*8*	**75**
Proceeds from sale of fixed assets	0	**0**	**0**													2,500	*0*	**2,500**
Capital spend (pymts) - external finance	-6,831	**-1,183**	**5,648**	-2,208	*-2,256*	-1,252	*-3,200*	-674	*-1,949*	-880	*-544*	-841	*-1,426*	-772	*-1,518*	-773	*-885*	**-14,231**
Capital spend (pymts) - internal capital	-14,025	**-11,900**	**2,125**	-2,672	*-2,453*	-3,475	*-442*	-3,146	*-2,386*	-2,979	*-3,269*	-1,769	*-2,058*	-1,576	*-1,140*	-1,696	*-1,258*	**-31,338**
Net cash inflow/-outflow from investing activities	**-20,824**	**-13,070**	**7,754**	-4,874	*-4,701*	-4,721	*-3,634*	-3,814	*-4,327*	-3,853	*-3,805*	-2,604	*-3,476*	-2,341	*-2,650*	38	*-2,135*	**-42,994**
Working capital loan received																		
Interim support funding	14,625	**15,580**	**955**	**9,858**	***9,420***	**5,324**	***3,256***	**5,093**	***4,488***	**7,644**	***6,981***	**5,074**	***3,480***	**2,274**	***2,116***	**2,293**	***3,379***	**52,185**
Loans received - LEEF	0	**0**	**0**															**0**
Loans received - DH capital	4,125	**3,569**	**-556**	882	*1,825*	595	*234*	26		0		0		0		0		**5,628**
Loan repayments - LEEF	0	**0**	**0**							-739	*-739*							**-739**
Working capital loan repyments	-500	**-500**	**0**											-499.5	*-499.5*			**-999**
Loans repayments - DH capital	0	**0**	**0**					-186	*-186*							0	*0*	**-186**
Loans repaid - SALIX	0	**0**	**0**	-193	*-193*													**-193**
PFI & finance lease repayments	-1,636	**-1,478**	**158**	-460	*-372*	-460	*-447*	-460	*-422*	-460	*-422*	-460	*-372*	-460	*-373*	-511	*-373*	**-4,907**
PDC capital (assume £1.5m extra received)	0	**0**	**0**															**0**
Net cash inflow/-outflow from financing	**16,615**	**17,172**	**557**	10,087	*10,680*	5,459	*3,043*	4,473	*3,880*	6,445	*5,820*	4,614	*3,108*	1,314	*1,244*	1,782	*3,006*	**50,789**
Net cash movement in period	**-21,179**	**-18,083**	**3,097**	0	*-832*	0	*-226*	1	*188*	-1	*-227*	0	*-1,898*	0	*-102*	1	*501*	**1**
Closing cash balance	**3,000**	**6,097**	**3,097**	**3,000**	***5,265***	**3,000**	***5,039***	**3,000**	***5,227***	**3,000**	***5,000***	**3,000**	***3,102***	**3,000**	***3,000***	**3,000**	***3,501***	**3,000**
LEEF loan	**-13,303**	**-13,303**		-13,303	*-13,303*	-13,303	*-13,303*	-13,303	*-13,303*	-13,303	*-13,303*	-13,303	*-13,303*	-13,303	*-13,303*	-13,303	*-13,303*	**-13,303**
EPC capital exp (cumulative)	**1,875**	**1,050**		3,201	*2,509*	3,858	*2,970*	4,506	*3,362*	5,386	*4,332*	6,227	*5,263*	6,999	*6,167*	7,772	*7,015*	**7,772**
Exclude unexpended LEEF loan	**-11,428**	**-12,264**		-10,102	*-10,794*	-9,445	*-10,333*	-8,797	*-9,941*	-7,917	*-8,971*	-7,076	*-8,040*	-6,304	*-7,136*	-5,531	*-6,288*	**-5,531**
Cash balance excl unexpended LEEF loan	**-8,428**	**-6,167**		**-7,102**	***-5,529***	**-6,445**	***-5,294***	**-5,796**	***-4,714***	**-4,917**	***-3,971***	**-4,076**	***-4,938***	**-3,305**	***-4,136***	**-2,531**	***-2,787***	**-2,531**
Interim support funding cumulative (WCF £25m)	**14,625**	**15,580**	**955**	**32,117**	***25,000***	**37,441**	***28,256***	**42,534**	***32,744***	**50,178**	***39,725***	**55,252**	***43,205***	**57,526**	***45,321***	**59,819**	***48,700***	

Trust will apply for increase in WCF facility on 20/07/15 to provide cash support through to 31/01/16 pending results of re-forecasting exercise.

Appendix F – capital programme 2015/16

CPG Finance report Month 05

BUDGETS APPROVED BY FINANCE COMMITTEE JUNE 2015: Discretionary budgets have been removed M04-M12 inclusive

	NEW	Budget	Budget	Budget	Budget	Budget	Budget	Actual	Actual	Actual	Actual	Actual	Actual	*Variance*	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Budget	Forecast	Forecast
Summary cap exp	**Budget**	M01	M02	M03	M04	M05	**YTD**	M01	M02	M03	M04	M05	**YTD**	*YTD*	M06	M07	M08	M09	M10	M11	M12	**Total**	**Outturn**	outturn var
by source of finance	**£000**	£000	£000	£000	£000	£000	**£000**	£000	£000	£000	£000	£000	**£000**	*£000*	£000	£000	£000	£000	£000	£000	£000	**£000**	**£000**	£000
Internal capital	**24,994**	1,164	2,302	3,499	2,517	2,640	**12,122**	1,165	2,304	2,098	1,489	1,456	**8,512**	*3,610*	2,876	2,312	3,339	2,399	1,821	1,140	1,258	**24,994**	**23,658**	*1,337*
LEEF loan	**6,782**	-210	107	312	332	276	**817**	-210	107	190	150	11	**248**	*569*	1,459	461	392	970	931	904	848	**6,782**	**6,213**	*569*
DH capital loans	**6,810**	922	363	1,219	1,217	1,029	**4,750**	922	363	377	850	347	**2,859**	*1,891*	682	769	504	444	495	614	37	**6,810**	**6,404**	*406*
PDC capital	**1,103**	137	0	188	75	75	**475**	137	0	219	41	24	**421**	*53*	192	100	100	0	237	0	0	**1,103**	**1,050**	*54*
Lease finance	**8,337**	266	1,036	825	100	500	**2,727**	265	1,035	450	24	1	**1,775**	*952*	1,574	2,431	1,445	100	100	100	100	**8,337**	**7,625**	*712*
Total	**48,027**	2,279	3,808	6,043	4,241	4,519	**20,890**	2,279	3,809	3,334	2,554	1,839	**13,815**	*7,075*	6,783	6,073	5,780	3,913	3,584	2,758	2,243	**48,027**	**44,949**	*3,078*

Summary cap exp	**Annual**	Budget	Budget	Budget	Budget	Budget	**Budget**	Actual	Actual	Actual	Actual	Actual	**Actual**	*Variance*	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	**Budget**	**Forecast**	Forecast
by budget category	**budget**	M01	M02	M03	M04	M05	**YTD**	M01	M02	M03	M04	M05	**YTD**	*M02*	M06	M07	M08	M09	M10	M11	M12	**Total**	**Outturn**	Outturn Var
and source of finance	**£000**	£000	£000	£000	£000	£000	**£000**	£000	£000	£000	£000	£000	**£000**	*£000*	£000	£000	£000	£000	£000	£000	£000	**£000**	**£000**	£000
Infrastructure renewal																								
Internal capital	**2,608**	165	184	247	238	279	**1,113**	165	185	197	470	650	**1,667**	*-554*	153	173	228	256	308	296	82	**2,608**	**3,161**	*-553*
LEEF loan	**6,782**	-210	107	312	332	276	**817**	-210	107	190	150	11	**248**	*569*	1,459	461	392	970	931	904	848	**6,782**	**6,213**	*569*
Lease finance	**240**	0	0	240	0	0	**240**	0	0	0	0	0	**0**	*240*	240	0	0	0	0	0	0	**240**	**240**	*0*
Medical equipment																								
Internal capital	**3,980**	144	1,065	297	132	475	**2,113**	145	1,066	10	191	174	**1,586**	*527*	563	359	970	268	73	66	213	**3,980**	**4,098**	*-119*
Lease finance	**8,097**	266	1,036	585	100	500	**2,487**	265	1,035	450	24	1	**1,775**	*712*	1,334	2,431	1,445	100	100	100	100	**8,097**	**7,385**	*712*
IMT																								
Internal capital	**5,423**	240	470	1,811	784	648	**3,953**	240	470	1,005	270	339	**2,324**	*1,629*	641	546	375	487	302	119	97	**5,423**	**4,891**	*532*
PDC capital	**1,103**	137	0	188	75	75	**475**	137	0	219	41	24	**421**	*53*	192	100	100	0	237	0	0	**1,103**	**1,050**	*54*
Major Projects																								
Internal capital	**10,927**	365	431	806	1,165	1,146	**3,913**	365	431	689	568	205	**2,258**	*1,655*	1,296	1,093	1,625	1,197	906	427	644	**10,927**	**9,445**	*1,481*
DH capital loans	**6,810**	922	363	1,219	1,217	1,029	**4,750**	922	363	377	850	347	**2,859**	*1,891*	682	769	504	444	495	614	37	**6,810**	**6,404**	*406*
Other																								
Internal capital	**1,557**	168	131	295	157	50	**801**	168	131	192	44	82	**617**	*184*	181	100	100	150	150	150	150	**1,557**	**1,598**	*-41*
SWL Path																								
Internal capital	**500**	82	21	42	42	42	**229**	82	21	5	-54	6	**60**	*169*	42	42	42	42	82	82	72	**500**	**464**	*36*
Total	**48,027**	2,279	3,808	6,043	4,241	4,519	**20,890**	2,279	3,809	3,334	2,554	1,839	**13,815**	*7,075*	6,783	6,073	5,780	3,913	3,584	2,758	2,243	**48,027**	**44,949**	*3,078*

Forecast assumptions

1 Contingency budget of £1m. £100k committed at M04 leaving unallocated budget of £0.9m.
Forecast assumes remaining contingency budget is spent in full by year end.
Lithotripsy and DSU equipment unfunded - potential cal;l on contingency of £822k.
2 PPU land disposal £2.5m capital receipt is NOT received in 2015/16
3 CCU2 scheme (£900k) is now included - replaced Mortuary which is deferred to 2016/17 following executive review of programme.

Appendix G - aged profile of debt M05 2015/16

AGED DEBT REPORT M05 2015/16

NHS Invoices outstanding

NHS DEBT Category of debt	% of unpaid invoices	Total Outstanding Debt at 31/08/15 £000s	Total Outstanding Debt at 31/07/15 £000s	Total Outstanding Debt % change since last report	Prior year position at 31/08/14 £000s	Prior year position % change since year end	Bad Debt Provision available	Up to 30 Days at 31/08/15 £000s	Up to 30 Days at 31/07/15 £000s	1 - 3 months old at 31/08/15 £000s	1 - 3 months old at 31/07/15 £000s	3 - 6 months old at 31/08/15 £000s	3 - 6 months old at 31/07/15 £000s	6 - 12 months old at 31/08/15 £000s	6 - 12 months old at 31/07/15 £000s	Over 12 months old at 31/08/15 £000s	Over 12 months old at 31/07/15 £000s
(1) Clinical Commissioning Groups	2%	**2,650**	*2,122*	25%	**1,339**	98%		689	*(102)*	1,060	*596*	(224)	*773*	1,070	*852*	55	*3*
(1.1) NHS England	18%	**11,974**	*13,350*	(10%)	**6,932**	73%		3,182	*349*	1,445	*6,181*	4,867	*3,889*	2,463	*2,920*	17	*11*
(1.2) NHS Wandsworth CCG	9%	**4,739**	*4,816*	(2%)	**8,088**	(41%)		1,116	*870*	1,808	*2,027*	1,193	*1,265*	346	*372*	276	*282*
(1.2.1) WCCG - non EEA incentive scheme	9%	**70**	*70*		**0**			0	*70*	70	*0*	0	*0*	0	*0*	0	*0*
(1.3) NHS Croydon CCG	1%	**352**	*(22)*		**1,126**	(69%)		373	*(1)*	3	*(22)*	(25)	*0*	0	*0*	1	*1*
(1.4) NHS Sutton CCG	0%	**(36)**	*(41)*	(12%)	**(34)**	6%		5	*3*	25	*(75)*	(68)	*29*	0	*0*	2	*2*
(1.5) NHS Lambeth CCG	0%	**43**	*39*	10%	**215**	(80%)		6	*0*	1	*39*	36	*0*	0	*0*	0	*0*
(1.6) NHS Kingston CCG	0%	**(107)**	*(105)*	2%	**255**	(142%)		(1)	*0*	1	*(109)*	(111)	*0*	0	*0*	4	*4*
(1.7) NHS Merton CCG	-1%	**513**	*(420)*	(222%)	**780**	(34%)		266	*12*	12	*(443)*	235	*11*	0	*0*	0	*0*
(1.8) NHS England - Legacy PCT balances	0%	**1**	*1*	0%	**5**			0	*0*	0	*0*	0	*0*	0	*0*	1	*1*
(2) English CCG NCA Debt	4%	**4,029**	*3,613*	12%	**2,481**	62%		706	*576*	1,366	*1,335*	725	*651*	852	*765*	380	*286*
(3) Non English NHS NCA Debt	1%	**687**	*611*	12%	**506**	36%		78	*51*	118	*86*	65	*60*	52	*54*	374	*360*
(4) Other NHS Organisations	0%	**87**	*88*	(1%)	**1,157**			8	*13*	6	*5*	19	*19*	2	*0*	52	*51*
(4.1) The Department Of Health	4%	**0**	*0*		**0**			0	*0*	0	*0*	0	*0*	0	*0*	0	*0*
(4.2) NHS Property Services Ltd	1%	**664**	*664*	0%	**0**			0	*0*	0	*0*	56	*56*	167	*167*	441	*441*
(4.3) Public Health England	1%	**287**	*286*	0%	**0**			53	*42*	176	*185*	42	*44*	1	*0*	15	*15*
(4.4) Jersey Health & Social Services	0%	**270**	*273*	(1%)	**0**			1	*(1)*	(2)	*3*	0	*2*	2	*0*	269	*269*
(4.5) Health Education England	0%	**62**	*131*	(53%)	**76**			11	*42*	48	*89*	3	*0*	0	*0*	0	*0*
(5) NHS Trusts	5%	**3,508**	*3,306*	6%	**7,313**			590	*482*	1,071	*945*	495	*542*	292	*71*	1,060	*1,266*
(5.1) Kingston Hospital NHS Foundation Trust	5%	**3,236**	*3,073*	5%	**0**			164	*126*	921	*876*	1,186	*1,234*	298	*224*	667	*613*
(5.2) Croydon Health Services NHS Trust	3%	**2,185**	*1,878*	16%	**0**			205	*82*	1,132	*765*	248	*255*	230	*499*	370	*277*
(5.3) Epsom & St Helier University Hospitals NHS	2%	**751**	*1,063*	(29%)	**0**			129	*85*	179	*540*	256	*253*	127	*134*	60	*51*
(5.4) Chelsea & Westminister Hospital NHS Foun	1%	**580**	*568*	2%	**0**			274	*255*	262	*292*	38	*15*	0	*0*	6	*6*
(5.5) Moorfields Eye Hospital NHS Foundation Tru	1%	**391**	*327*	20%	**0**			138	*157*	172	*56*	(12)	*11*	69	*58*	24	*45*
Total NHS Invoices outstanding	57%	**36,936**	**35,691**	3%	**30,239**	22%	**0**	**7,993**	***3,111***	**9,874**	***13,371***	**9,024**	***9,109***	**5,971**	***6,116***	**4,074**	***3,984***

Uninvoiced NHS debt		
NHS Debt - accruals	6,430	7,042
2013/14 Partially Completed Spells	4,748	4,748
Total NHS Debt	**48,114**	***47,481***

	Up to 30 Days	1 - 3 months old	3 - 6 months old	6 - 12 months old	Over 12 months old
Target - NHS overdue debt M05		**12,702**	**8,654**	**5,810**	**3,785**
Variance - NHS overdue debt M05		**2,828**	**-370**	**-161**	**-289**

Non-NHS Invoices outstanding

Non-NHS Debt Category of debt	% of unpaid invoices	Total Outstanding Debt at 31/08/15 £000s	Total Outstanding Debt at 31/07/15 £000s	Total Outstanding Debt % change since last report	Prior year position at 31/08/14 £000s	Prior year position % change since year end	Bad Debt Provision available	Up to 30 Days at 31/08/15 £000s	Up to 30 Days at 31/07/15 £000s	1 - 3 months old at 31/08/15 £000s	1 - 3 months old at 31/07/15 £000s	3 - 6 months old at 31/08/15 £000s	3 - 6 months old at 31/07/15 £000s	6 - 12 months old at 31/08/15 £000s	6 - 12 months old at 31/07/15 £000s	Over 12 months old at 31/08/15 £000s	Over 12 months old at 31/07/15 £000s
(6) Compensation Recovery Unit	19%	**12,553**	*12,287*	2%	**10,649**	18%	**(1,847)**	699	*249*	826	*922*	1,074	*1,137*	1,880	*1,640*	8,074	*8,339*
(7) Local Authority	7%	**3,317**	*4,506*	(26%)	**0**			567	*221*	1,018	*1,307*	687	*1,176*	774	*1,550*	271	*252*
(8) General Debtors	5%	**3,737**	*3,399*	10%	**4,704**	(21%)	**(1,207)**	1,166	*464*	680	*1,014*	804	*877*	486	*499*	601	*545*
(9) Overseas Visitors NHS Chargeable	4%	**2,769**	*2,672*	4%	**2,322**	19%	**(1,396)**	151	*103*	196	*178*	206	*220*	347	*301*	1,869	*1,870*
(10) Private Patients	1%	**792**	*809*	(2%)	**1,346**	(41%)	**(182)**	67	*122*	203	*128*	51	*117*	139	*108*	332	*334*
(10.1) Bupa Insurance Services Ltd t/a Bupa	1%	**607**	*518*	17%	**0**			91	*84*	126	*85*	84	*49*	31	*61*	275	*239*
(10.2) AXA PPP Healthcare Ltd	1%	**579**	*523*	11%	**0**			55	*79*	222	*153*	60	*81*	75	*52*	167	*158*
(11) Medical School	2%	**898**	*694*	29%	**625**	44%	**(28)**	205	*196*	655	*471*	23	*12*	5	*5*	10	*10*
(12) St George's Hospital Charity	1%	**496**	*441*	12%	**344**	44%	**(10)**	99	*122*	318	*241*	7	*(3)*	(9)	*66*	81	*15*
(13) Salary Overpayments	1%	**571**	*583*	(2%)	**511**	12%	**(120)**	0	*37*	*127*	*93*	*34*	*43*	*64*	*62*	*346*	*348*
(14) UK Border Agency	0%	**181**	*181*	0%	**110**	65%		0	*1*	*1*	*1*	*3*	*27*	*93*	*68*	*84*	*84*
Total Non-NHS Invoices outstanding	43%	**26,500**	***26,613***	(0%)	**20,611**	**12%**	**(4,790)**	**3,100**	***1,678***	**4,372**	***4,593***	**3,033**	***3,736***	**3,885**	***4,412***	**12,110**	***12,194***

Uninvoiced non-NHS Debt:		
Provision for impairment of Non-NHS invoiced debt	(4,791)	(4,791)
Non-NHS Debt -accruals	3,203	2,588
VAT and Prepayments	3,281	3,815
Total Non NHS Debt	**28,193**	***28,226***

	Up to 30 Days	1 - 3 months old	3 - 6 months old	6 - 12 months old	Over 12 months old
Actual - Non-NHS overdue debt M05 (excl CRU, Oseas & UKBA)		**3,349**	**1,750**	**1,565**	**2,083**
Target - Non-NHS overdue debt M05		**3,440**	**2,317**	**2,367**	**1,872**
Variance - Non-NHS overdue debt M05		**91**	**567**	**802**	**-211**

Grand Total Debt	**76,307**	**75,706**

Appendix H - Developments in financial reporting

A significant amount of work is being undertaken to improve the financial reporting to the organisation. The following have been reflected in the month 5 finance report:

a) Specific accounting changes
   a) Updated how CIPs are shown in the Divisions – only 'Green' Schemes are removed in detail from Divisional budgets. However all other schemes 'Amber' 'Red' and 'run-rate' are contributing to the Divisional positions and a schedule of the impact of these is include in this pack
   b) SLA challenges have been devolved to Divisions / Directorates as they are best placed to have an impact on the challenges
   c) Excluded drugs – rather than report over-achievement of income targets and overspends on expenditure budgets (or the converse), the in-month budget has been re-profiled to remove these variances. This simplifies the understanding of the individual income and expenditure positions by removing a set of equal and opposite variances and does not affect the bottom-line position.

b) Reporting developments
   a) An additional view of the I&E position has been included showing the underlying trend
   b) Clarity has been refined over the treatment of central adjustments and true reserves with the establishment of unique cost-centres to record these items
   c) The reporting ledger hierarchies have been overhauled to be able to make reporting meaningful (eg removal of Other/Other categories) and to clearly separate business as usual operations from technical adjustments
   d) In month 4 we reallocated £1.2m from non pay to pay relating to interim staff costs that had previously been recorded against 'professional services/consultancy'. This includes £0.9m relating to months 1 to 3
   e) Some other costs were also been moved from the 'professional services/consultancy' code to more appropriate codes within non pay in month 4.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – OCTOBER 2015

Paper Title:	Chair's Report: Finance and Performance Committee – 23rd September 2015
Sponsoring Director:	Christopher Smallwood, Chairman
Author:	Christopher Smallwood, Chairman
Purpose:	To provide the Board with a summary of the proceedings from the last Finance and Performance Committee
Action required by the board:	To note the update
Document previously considered by:	N/A

Report

Issues Arising from the F&P Meeting on 23 September 2015 for Board Discussion/Noting

The Board needs to be aware of the following issues which were discussed at the last meeting of the F&P Committee and may like to debate them further.

1. Call centre performance. Considerable progress was made earlier in the year in improving the timeliness of responses to calls, but there has been a major deterioration recently, with up to half of all calls now being abandoned and an average waiting time of 5 minutes. This is partly connected with staff shortages (17 call handlers last year compared with 12 now) but it is not expected that there will be a quick return to the performance achieved earlier this year. The Committee asked that a trajectory should be provided to the 8 October Board meeting together with a report on the current run rate so that there can be assurance that the actions taken in September will bring performance back to an acceptable level.

2. PwC report 'at a glance' section. The Committee expressed concern about the balance of the PwC summary. In the Committee's view, it still underplayed operational pressures and overplayed the importance of system failures as causes of last year's deficit. The chief executive agreed to relay these concerns to PwC to see if further amendments could be made. If they could not, it would be important for the Trust to issue its own view alongside PwC's when the summary was issued.

3. Interim Cash Support Application. The Committee supported the proposal to give the Chairman and Chief Executive delegated authority to sign the £19.6m loan facility agreement on behalf of the Trust Board. The level of interim support funding for 2015-16 will be finalised after the budget reforecasting exercise is completed. The Board needs to ratify the facility agreement.

4. Update on Turnaround. KPMG reported they were hoping to 'get a line of sight past the £38 million CIPs target' this year. The challenge sessions involved in the Turnaround Programme (TRP) could produce additional CIPs in areas such as corporate overheads. In addition, the nursing establishment review could produce additional savings. The Committee went on to discuss the position in relation

to Year 2 CIPs, noting that the focus so far had been heavily on Year 1 and that if a Year 2 plan were to be ready in November, this left very little time to finalise the CIP programme for that year. KPMG said that the focus of work was beginning to shift to Year 2, but that an adequate set of green-rated schemes would not be available for the Year 2 plan. Judgments would be required on the degree of confidence which could be attached to CIP schemes for next year, and these would need to be debated by the Board, along with the prudent level of contingency in these circumstances.

The Committee further noted that if a five-year plan is to be produced on schedule in January, efficiencies well beyond conventional CIPs programmes would need to be identified, involving major reconfiguration of services arising partly from SLR and transformation work in the Trust and partly from system-wide reconfiguration across SW London. Very little work on this appeared to have been done so far. It was agreed that the Board requires positive assurance that the right steps are been taken now to enable us to deliver what has been committed to. The Board needs to be satisfied with the process for identifying the big opportunities for the five year plan between now and the end of January. The Board also needs assurance that the advisory and other support needed to carry this work through, internal and external, will be available.

5. Reforecast plan. The Committee discussed some of the assumptions on which the reforecast would be based. The committee was concerned that there should be time and opportunity for proper NED challenge of the plan and for Board and Governor engagement before the Board meeting to sign it off on 5 November. It was noted that there were due to be two periods of divisional plan review before that date and Mr Diggles undertook to circulate the dates of the challenge sessions. The Board needs to discuss whether this is adequate.

6. Capacity plan and risk management. The Committee discussed a presentation on the adequacy of capacity under different scenarios covering levels of activity, bed capacity and length of stay. The prospect for winter looks extremely difficult and the chief executive has started discussions with key partners through the systems resilience group to assess responses to a deteriorating outlook. The Committee was assured that the capacity work will be fed into the turnaround process, and was concerned that proper attention should be paid to the staffing implications of the scenarios as well as quality and safety impacts.

7. Finance report to month 5. Concern was expressed that the report failed to contain any quantified and trackable remedial actions by the divisions showing what they are doing to get back on track. It was necessary to demonstrate that planned remedial actions would be adequate to the task and that they could be tracked so that the Board could be assured they were being achieved. The Finance Director provided assurance that further work on the Finance Report was ongoing as a result of challenge sessions in progress and that quantifiable remedial actions which could be tracked would be available for the 8 October Board.

The Committee expressed concern that substantial in-month deficits have been incurred throughout the financial year, the latest being £6.5 million (cumulatively £31.1 million so far), albeit with some non-recurring elements. On the face of it, the impact of the work which has been taking place on 'grip' and 'build' has been disappointing. In these circumstances, the Committee concluded that a report should be provided to the Board setting out what turnaround/grip actions have been taken over the past few months and why their impact does not seem to be coming through in reported performance.

Key risks identified: Risks are detailed in the report under each section.	
Related Corporate Objective:	All corporate objectives.
Related CQC Standard:	N/A
Equality Impact Assessment (EIA): Has an EIA been carried out? **If yes, please provide a summary of the key findings** No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.	

REPORT TO THE TRUST BOARD *October 2015*

Paper Title:	Workforce Performance Report
Sponsoring Director:	Wendy Brewer, Director of Workforce and Organisational Development
Author:	Wendy Brewer, Director of Workforce and Organisational Development Rebecca Hurrell, Head of Workforce Information Jacqueline McCullough, Deputy Director of HR Sarah James, Associate Director for Education and Development Elaine Mills, Occupational Health Adviser
Purpose:	*To provide a report to the board on performance against key performance indicators*
Action required by the board:	For information
Document previously considered by:	Executive Management Team Meeting

Executive summary
Key points in the report and recommendation to the board

1. Key messages

The workforce report includes:

- The workforce performance report September 2015
- A report from the Chair of the Workforce and Education Committee
- Detail of year on year growth in the workforce.
- A report setting out progress in establishing temporary staffing controls.
- A report on the programme to increase compliance with statutory and mandatory training.
- Staff influenza vaccination report

The workforce performance report contains detail of workforce performance against key workforce performance indicators for June 2015. The report also includes available benchmark information.

Key points to note are:

- Budgeted posts have not yet been confirmed for FY16. The Finance department are being supported so that the work on reconciliation of the general ledger to the electronic staff record can be completed. Until this work is completed, the vacancy factor should be treated with caution.
- Turnover has stabilised but is behind the target trajectory.

Key risks identified:
Key workforce risks include:

- Failure to recruit and retain sufficient staff in relation to annual turnover rates and to safely support future increases in capacity'
- Failure to reduce the unacceptable levels of bullying and harassment reported by staff in the annual staff survey.
- Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas.
- Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	**To develop a highly skilled and engaged workforce championing our values that is able to deliver the trust's vision.**
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	**Are services well led?**

Commentary on performance in key workforce indicators

Introduction

The August workforce information report is concerning. Although there is continued stabilisation in the turnover rate this has settled at an unacceptably high level. In addition the majority of other indicators have moved negatively.

Vacancy rate

There has been greater urgency in the work to reconcile the general ledger with the electronic staff record information, with support being given to the Finance department. The corporate nursing team are leading a review of nursing levels required for safe staffing and of service led demand. Once this work is complete and agreed, the changes made within the financial ledger will be synchronised with the electronic staff record data. This project missed the 75% completion date by the end of July but assurance has been given that it is on track for completion by the end of September. The work is on track for completion in September and this will include the establishment of a process that will mean that systems remain synchronised.

There is an additional workforce and education committee due to take place in October that will consider the findings of the nursing establishment review.

Turnover and stability

Turnover has stabilised in August but has missed the proposed trajectory. As more than 50% of leavers leave for reasons that relate to their experience at work, it is clear that the trust has the potential to reduce turnover. Divisions have reported to the workforce and education committee with their plans to reduce turnover and further reports with more detailed plans were received. Of particular concern is the high turnover rate in the community services division.

The benchmark information available on page 11 shows that this is a London wide problem with St George's not showing as an outlier.

Sickness absence

Sickness absence levels have increased. This may be a relatively minor fluctuation as the key reason for absence is cold, coughs and flu.

Agency and bank staff usage

The agency figures have been amended to include interim consultancy, which was previously reported through non-pay. The temporary staffing duties worked in August (page 16) have increased significantly in August. The highest increase has been in Medicine and Cardiovascular in both nursing and medical staff. This increase is continuing throughout September, as can be seen by the weekly tracker detail provided on page 17. More detail on the work being undertaken to control and monitor temporary staffing usage is included in the attached temporary staffing paper.

Mandatory training and appraisal rates

Appraisal rates have reduced for all staff groups. There will be a 6 monthly appraisal refresh for all senior leaders identified as budget holders. This is due to take place in October. Mandatory training levels have slipped again. Recommendations from the recent internal audit report will be implemented. There is a programme of work in place to assess the level of risk and to increase uptake. There is a separate paper attached on increasing the uptake of mandatory and statutory training.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 5 - August 2015

Excellence in specialist and community healthcare

Workforce Performance Report Sep ‘14 - Aug ‘15

Contents

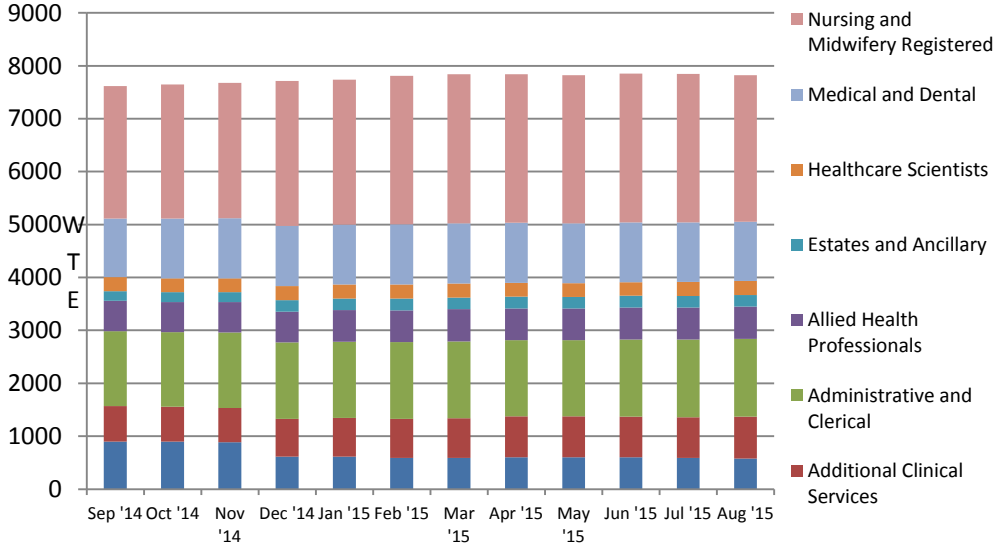
Performance Summary

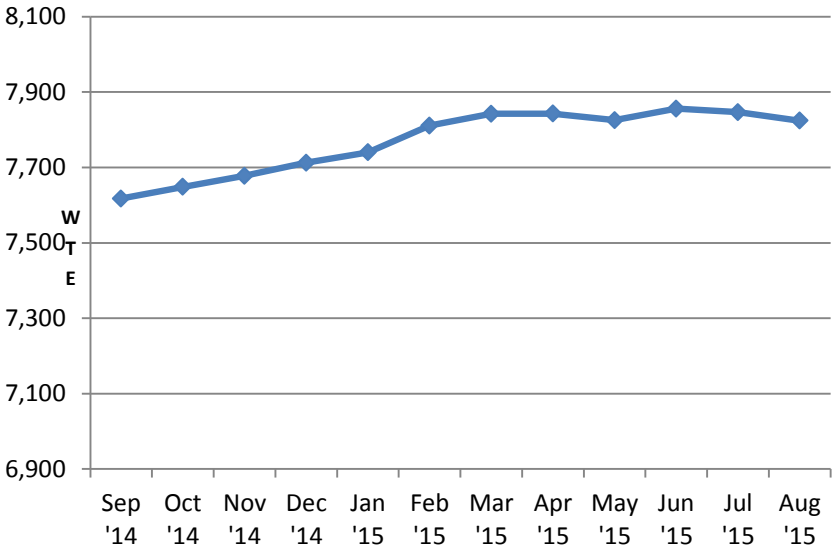
Summary of overall performance is set out below

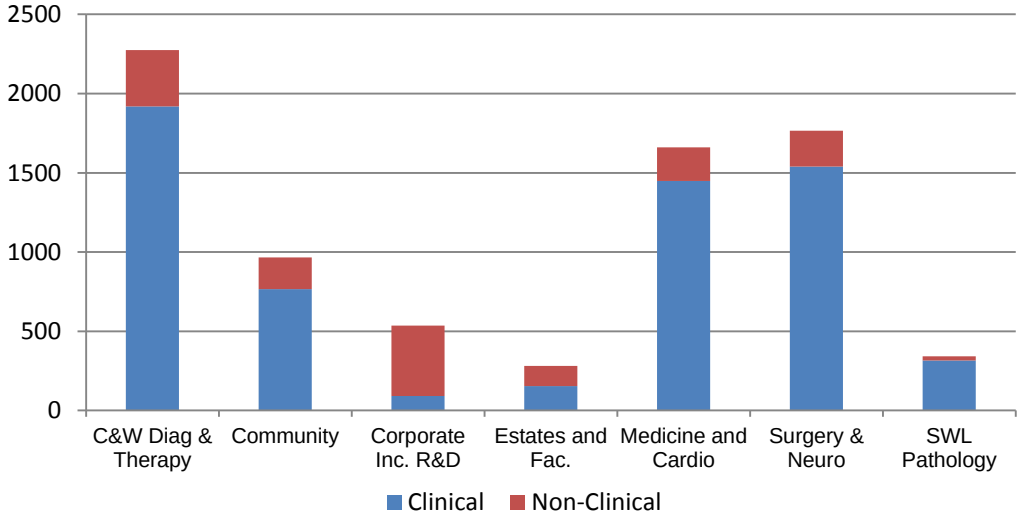
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 0.3%	12.9%	14.9%	15.2%	↗
6	Turnover	Turnover has remained the same	16.3%	17.3%	17.3%	↔
7	Voluntary Turnover	Voluntary Turnover has remained the same	13.4%	14.0%	14.0%	↔
8	Stability	Stability has decreased this month by 0.4%	85.2%	83.5%	83.1%	↘
10	Sickness	Sickness has increased by 0.4%	3.1%	3.4%	3.8%	↗
13-14	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 1.1%	15.9%	14.8%	15.9%	↗
17	Mandatory Training	MAST compliance has decreased by 3.2%	77.2%	71.0%	67.8%	↘
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 2.5%	80.8%	74.0%	71.5%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





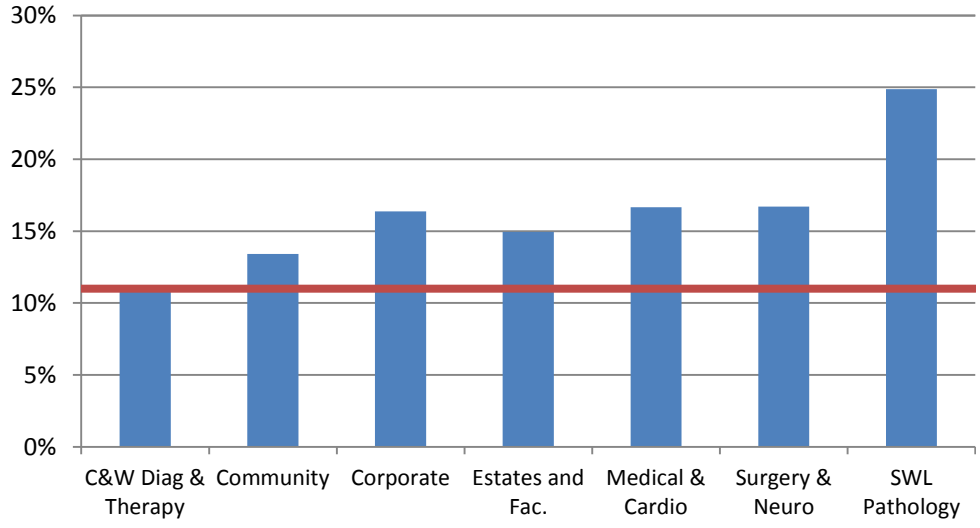


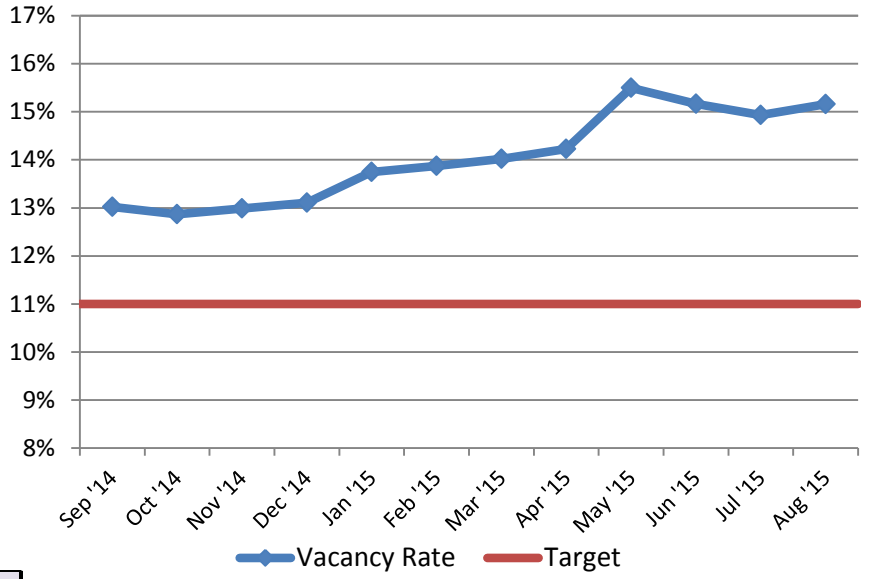
COMMENTARY

The Trust currently employs 8383 people working a whole time equivalent of 7824 which is 23 WTE fewer than July. The growth rate in the directly employed workforce since August 2014 is 206 WTE or 2.7%.

The Trust has also employed an additional 468 WTE GP Trainees in August covering the South London area making bringing the total WTE to 8292.

Section 1: Vacancies





Vacancies by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diag & Therapy	9.8%	9.9%	9.5%	10.9%	↗
Community	19.1%	19.4%	12.6%	13.4%	↗
Corporate	16.5%	16.4%	18.2%	16.4%	↘
Estates and Fac.	22.8%	23.0%	15.6%	15.0%	↘
Medical & Cardio	13.5%	12.8%	17.4%	16.7%	↘
Surgery & Neuro	17.7%	16.9%	16.7%	16.7%	↔
SWL Pathology	28.4%	24.0%	23.6%	24.9%	↗
Whole Trust	**15.5%**	**15.2%**	**14.9%**	**15.2%**	↗

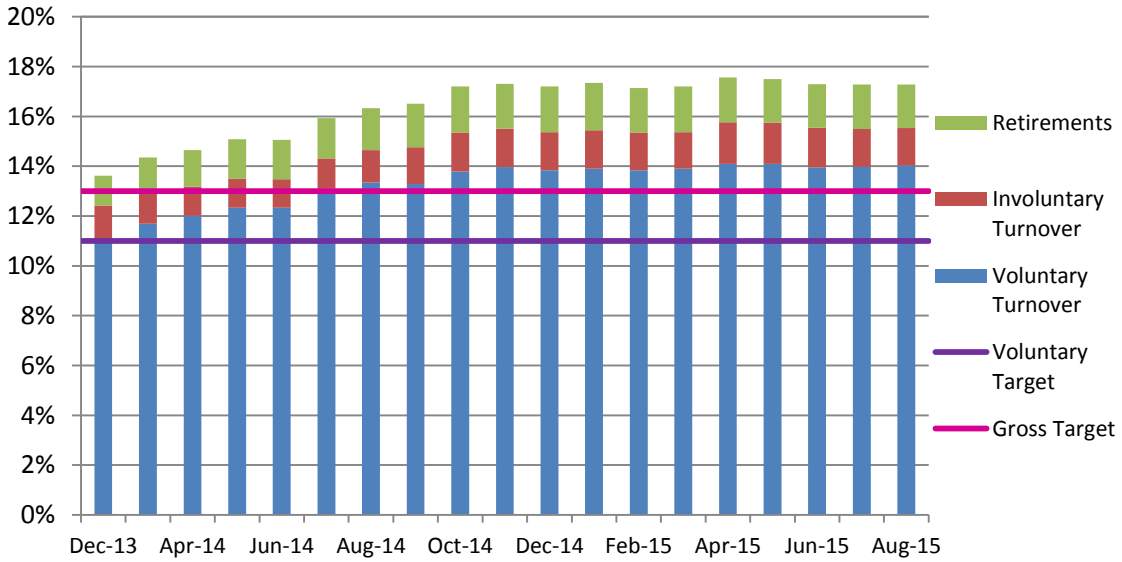
Vacancies Staff Group	May '15	Jun '15	Jul '15	Aug '15	Trend
Add Prof Scientific and Technic	16.4%	17.5%	17.5%	21.9%	↗
Additional Clinical Services	18.7%	18.8%	18.5%	17.3%	↘
Administrative and Clerical	22.6%	20.9%	16.8%	15.2%	↘
Allied Health Professionals	3.6%	3.1%	8.6%	9.4%	↗
Estates and Ancillary	22.5%	25.8%	18.9%	20.1%	↗
Healthcare Scientists	21.8%	21.7%	18.7%	18.2%	↘
Medical and Dental	3.2%	4.5%	6.8%	5.9%	↘
Nursing and Midwifery Registered	15.7%	14.9%	15.9%	16.8%	↗
Total	**15.5%**	**15.2%**	**14.9%**	**15.2%**	↗

COMMENTARY

Budgeted posts have not yet been confirmed for FY16. Once these are confirmed, variances against plan will be reported by Division, Directorate and Staff Group. The Finance department are being supported so that the work on reconciliation of the general ledger to the electronic staff record can be completed.

Section 2a: Gross Turnover

The chart below shows turnover trends. Tables by Division and Staff Group are below:



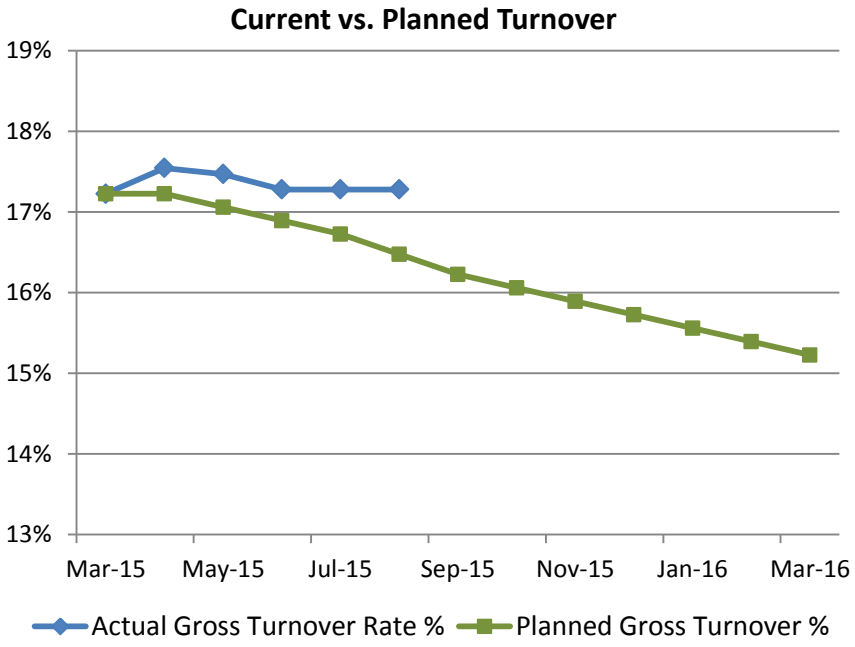
COMMENTARY

The total trust turnover rate has remained static this month at 17.3%. This is significantly above the current target of 13%. In the last 12 months there have been 1227 WTE leavers.

Each Division is developing a plan and target trajectory in response to the increase in turnover rates which are based on the information available through exit questionnaire data.

	All Turnover				
Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	17.7%	17.2%	17.5%	17.4%	↘
Community Services	19.9%	20.4%	20.1%	21.0%	↗
Corporate	18.5%	19.7%	20.0%	20.6%	↗
Estates and Facilities	17.4%	17.0%	16.5%	16.8%	↗
Medical & Cardiothoracics	18.0%	17.7%	17.7%	17.5%	↘
Surgery, Neurosciences & Anaes	14.3%	14.4%	14.4%	13.7%	↘
SWL Pathology	19.7%	17.3%	16.3%	16.9%	↗
Whole Trust	**17.5%**	**17.3%**	**17.3%**	**17.3%**	↔

	All Turnover				
Staff Group	May '15	Jun '15	Jul '15	Aug '15	Trend
Add Prof Scientific and Technic	18.2%	17.9%	18.6%	19.2%	↗
Additional Clinical Services	20.6%	20.8%	20.1%	19.5%	↘
Administrative and Clerical	16.6%	16.9%	17.0%	16.5%	↘
Allied Health Professionals	17.9%	17.1%	17.9%	17.0%	↘
Estates and Ancillary	11.3%	10.8%	10.0%	8.9%	↘
Healthcare Scientists	16.2%	14.3%	12.7%	14.6%	↗
Medical and Dental	14.1%	13.6%	12.2%	11.8%	↘
Nursing and Midwifery Registered	18.0%	17.9%	18.2%	18.7%	↗
Whole Trust	**17.5%**	**17.3%**	**17.3%**	**17.3%**	↔



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Aug 2015	
Division	May '15	Jun '15	Jul '15	Aug '15	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	13.2%	13.2%	13.6%	14.0%	↗	1.9%	1.5%
Community Services	15.8%	16.1%	15.6%	16.2%	↗	1.1%	3.7%
Corporate	15.1%	15.8%	15.9%	15.0%	↘	3.1%	2.5%
Estates and Facilities	7.6%	6.4%	5.9%	6.6%	↗	7.5%	2.7%
Medical & Cardiothoracics	15.7%	15.4%	15.3%	15.4%	↗	0.6%	1.4%
Surgery, Neurosciences & Anaes	12.6%	12.8%	13.0%	12.3%	↘	0.5%	0.9%
SWL Pathology	16.7%	15.1%	14.6%	15.3%	↗	0.6%	1.1%
Whole Trust	**14.1%**	**14.0%**	**14.0%**	**14.0%**	↔	**1.5%**	**1.8%**

	Voluntary Turnover					Other Turnover Aug 2015	
Staff Group	May '15	Jun '15	Jul '15	Aug '15	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	12.0%	11.7%	12.6%	13.2%	↗	5.8%	0.2%
Additional Clinical Services	17.4%	17.6%	16.9%	16.3%	↘	1.1%	2.2%
Administrative and Clerical	13.0%	13.2%	13.2%	12.7%	↘	1.7%	2.1%
Allied Health Professionals	16.8%	15.9%	16.6%	15.9%	↘	0.2%	0.9%
Estates and Ancillary	7.3%	6.8%	5.5%	4.8%	↘	0.9%	3.2%
Healthcare Scientists	11.5%	10.7%	9.9%	11.8%	↗	0.8%	2.0%
Medical and Dental	8.2%	8.1%	6.9%	6.6%	↘	3.9%	1.3%
Nursing and Midwifery Registered	15.5%	15.4%	15.7%	16.3%	↗	0.5%	1.9%
Whole Trust	**14.1%**	**14.0%**	**14.0%**	**14.0%**	↔	**1.5%**	**1.8%**

Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Gynaecology	43.0	15.7	34.3%
Cardiac Surgery	85.7	24.8	33.9%
Offender Healthcare HMPW Services	54.3	19.5	33.4%
Trauma & Orthopaedics	123.5	31.2	29.7%
SWLP Microbiology	67.5	21.3	28.3%

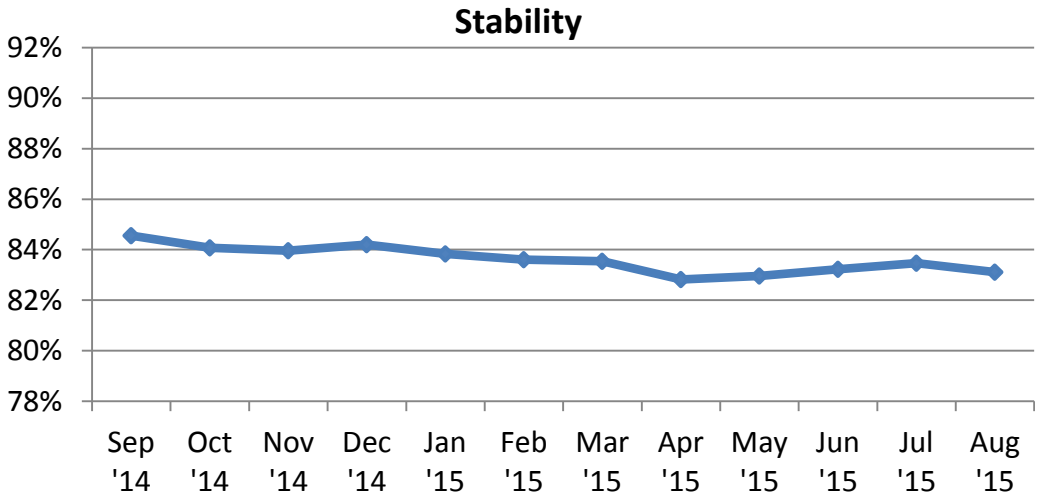
COMMENTARY

The 5 care groups currently with the highest voluntary turnover rates are shown in the bottom table. This includes care-groups with more than 20 staff only. Divisional HR Managers are working with divisions to tackle any issues within these areas.

Communications with staff this month have focused on opportunities for wellbeing and support available.

Section 3: Stability

The chart below shows performance over the last 12 months, the tables by Division and Staff Group are below



Stability by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	82.9%	82.5%	82.8%	83.1%	↗
Community Services	80.4%	80.4%	80.9%	80.1%	↘
Corporate	85.1%	83.7%	82.6%	78.1%	↘
Estates and Facilities	84.9%	85.4%	86.1%	84.9%	↘
Medical & Cardiothoracics	82.4%	82.4%	82.5%	82.1%	↘
Surgery, Neurosciences & Anaes	84.5%	85.1%	85.5%	86.2%	↗
SWL Pathology	82.2%	88.3%	89.4%	89.2%	↘
Whole Trust	**83.0%**	**83.2%**	**83.5%**	**83.1%**	↘

Stability Staff Group	May '15	Jun '15	Jul '15	Aug '15	Trend
Add Prof Scientific and Technic	73.5%	73.7%	72.8%	70.4%	↘
Additional Clinical Services	82.8%	85.1%	85.6%	86.3%	↗
Administrative and Clerical	86.1%	85.7%	85.7%	85.5%	↘
Allied Health Professionals	80.8%	81.2%	81.5%	81.9%	↗
Estates and Ancillary	86.7%	86.0%	86.8%	86.7%	↘
Healthcare Scientists	87.3%	88.3%	92.8%	92.3%	↘
Medical and Dental	87.1%	88.5%	89.1%	88.3%	↘
Nursing and Midwifery Registered	82.6%	82.4%	82.5%	82.1%	↘
Total	**83.0%**	**83.2%**	**83.5%**	**83.1%**	↘

COMMENTARY

The stability rate provides an indication of the retention rate amongst more experienced employees. It is calculated by dividing the number of staff with one years service by the number of staff in post a year earlier.

A higher stability rate means that more employees in percentage terms have service of greater than a year which gives rise to benefits in consistency of service provision and more experienced staffing in general which hopefully impacts upon quality.

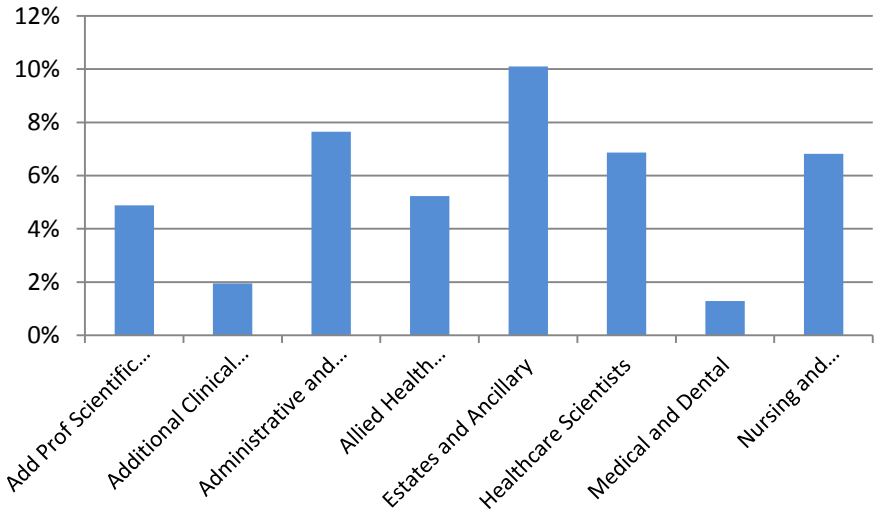
The stability rate has decreased by 0.4% this month.

A reduction in the stability rate is of concern because of the implication that staff with longer service are leaving.

Over the last 12 months the stability rate has declined by 2.1% and is now at 83.1%.

Section 4: Staff Career Development

The chart below shows the percentage of current staff promoted in each staff group over the last 12 months.



COMMENTARY

Staff exit survey data tells us that one of the key drivers for retaining staff is to support their development within the trust. In August 73 staff were promoted, there were 121 new starters to the Trust and 239 employees were acting up to a higher grade.

Over the last year 5.9% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Estates and Facilities Division (where a team have recently been upgraded) followed by the Corporate and Medical & Cardiothoracics Divisions.

The graph shows that Estates & Ancillary staff were most likely to be promoted over the last year (NB this is the smallest staff group), followed by Admin & Clerical staff.

	No. of Promotions				
Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	11	18	15	13	↘
Community Services	15	15	12	16	↗
Corporate	5	7	6	10	↗
Estates and Facilities	0	2	0	0	↔
Medical & Cardiothoracics	6	4	6	17	↗
Surgery, Neurosciences & Anaes	7	12	5	6	↗
SWL Pathology	0	0	0	11	↗
Whole Trust Promotions	**44**	**58**	**44**	**73**	↗
New Starters (Excludes Junior Doctors)	**71**	**94**	**83**	**121**	↗

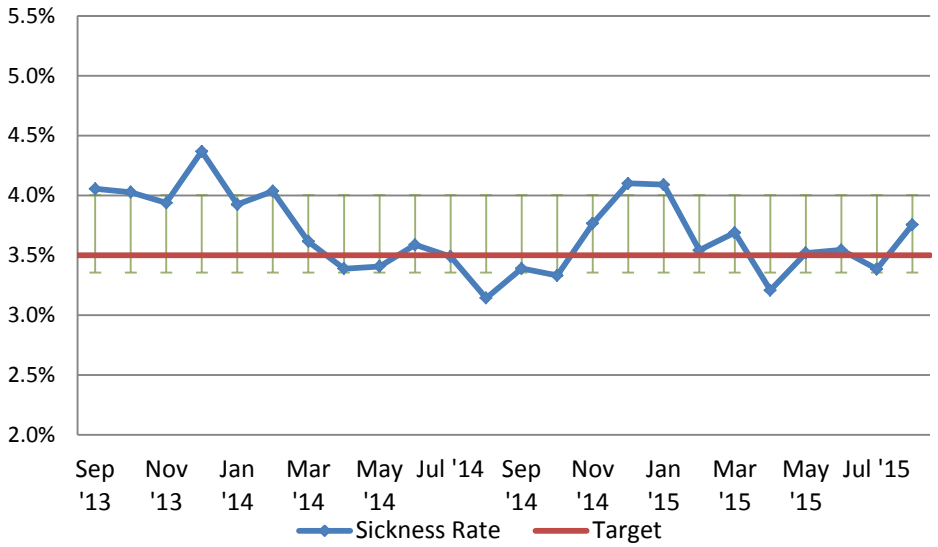
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1858	106	5.7%	120
Community Services	915	51	5.6%	16
Corporate	447	36	8.1%	23
Estates and Facilities	259	25	9.7%	6
Medical & Cardiothoracics	1165	68	5.8%	40
Surgery, Neurosciences & Anaes	1353	66	4.9%	23
SWL Pathology	323	20	6.2%	11
Whole Trust	**6320**	**372**	**5.9%**	**239**
New Starters (Excludes Junior Doctors)		**1470**		

	No. of Promotions				
Staff Group	May '15	Jun '15	Jul '15	Aug '15	Trend
Add Prof Scientific and Technic	4	2	1	3	↗
Additional Clinical Services	4	2	6	7	↗
Administrative and Clerical	14	22	16	21	↗
Allied Health Professionals	7	10	7	7	↔
Estates and Ancillary	0	2	0	0	↔
Healthcare Scientists	2	0	0	5	↗
Medical and Dental	0	3	1	0	↘
Nursing and Midwifery Registered	13	17	13	30	↗
Whole Trust	**44**	**58**	**44**	**73**	↗

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	491	24	4.9%	32
Additional Clinical Services	666	13	2.0%	9
Administrative and Clerical	1307	100	7.7%	87
Allied Health Professionals	554	29	5.2%	30
Estates and Ancillary	198	20	10.1%	3
Healthcare Scientists	262	18	6.9%	7
Medical and Dental	467	6	1.3%	3
Nursing and Midwifery Registered	2377	162	6.8%	68
Whole Trust	**6322**	**372**	**5.9%**	**239**

Section 5: Sickness

The chart below shows performance over the last 24 months, the tables by Division and Staff Group are below.



COMMENTARY

Sickness absence is at 3.8% for August, which is a increase of 0.4% on the previous month.

Sickness absence is closely monitored and action initiated by HR, in support of divisions, once pre defined sickness triggers are breached.

The table below lists the five care groups with the highest sickness absence percentage during August 2015. Below that is a breakdown of the top 5 reasons for absence, both by the number of episodes and the number of days lost.

Sickness by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	2.9%	3.1%	3.0%	3.7%	↗
Community Services	6.0%	6.0%	4.7%	5.7%	↗
Corporate	4.0%	4.8%	2.5%	3.2%	↗
Estates and Facilities	7.6%	4.5%	3.8%	3.9%	↗
Medical & Cardiothoracics	2.9%	2.6%	3.2%	3.9%	↗
Surgery, Neurosciences & Anaes	3.1%	3.4%	3.6%	3.1%	↘
SWL Pathology	2.6%	2.5%	2.6%	2.2%	↘
Whole Trust	**3.5%**	**3.5%**	**3.4%**	**3.8%**	↗

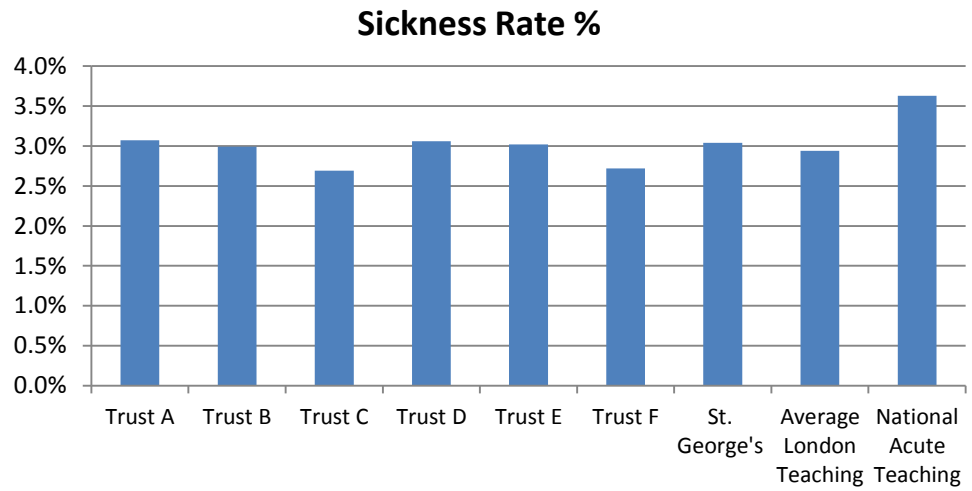
Sickness Staff Group	May '15	Jun '15	Jul '15	Aug '15	Trend
Add Prof Scientific and Technic	3.0%	3.0%	2.9%	3.6%	↗
Additional Clinical Services	6.8%	6.7%	6.8%	7.1%	↗
Administrative and Clerical	4.3%	4.5%	3.4%	4.2%	↗
Allied Health Professionals	2.8%	2.7%	2.2%	1.9%	↘
Estates and Ancillary	6.4%	5.7%	4.4%	5.6%	↗
Healthcare Scientists	1.8%	1.6%	2.0%	1.4%	↘
Medical and Dental	0.9%	0.6%	1.0%	0.9%	↘
Nursing and Midwifery Registered	3.5%	3.7%	3.7%	4.2%	↗
Total	**3.5%**	**3.5%**	**3.4%**	**3.8%**	↗

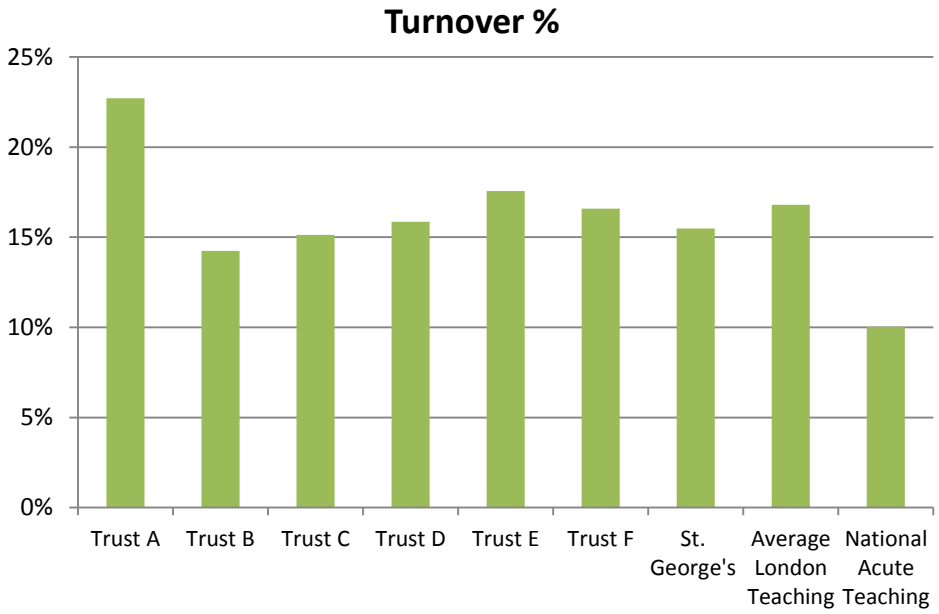
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Offender Healthcare HMPW Services	54.30	208.77	12.8%	£20,033
Procurement & Materials Mgmt	37.00	117.00	10.1%	£8,008
Integrated Sexual Health Services	67.54	172.35	8.7%	£28,952
Dentistry	46.47	119.20	8.6%	£6,754
Security & Car Park Management	22.00	57.00	8.4%	£2,918

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	22.31%
S25 Gastrointestinal problems	15.41%
S12 Other musculoskeletal problems	10.13%
S16 Headache / migraine	7.80%
S10 Anxiety/stress/depression/other psychiatric illnesses	7.26%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	15.57%
S12 Other musculoskeletal problems	13.50%
S13 Cold, Cough, Flu - Influenza	12.25%
S11 Back Problems	8.24%
S25 Gastrointestinal problems	7.80%

Section 6: Workforce Benchmarking





COMMENTARY

This benchmarking information comes from iView the Information Centre data warehouse tool.

Sickness data shown is from May '15 which is the mot recent available. Compared to other Acute teaching trusts in London, St. Georges had a slightly higher than average rate at 3.04%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was significantly lower than the national rate for acute teaching hospitals in April.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has a lower than average turnover compared to the group (12 months to end June). Stability is also slightly higher than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is over 5% lower than St. Georges.

**As with all benchmarking information, this should be used with caution. Trusts will use ESR differently depending on their own local processes and may not consistently apply the approaches.

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	22.71%	77.92%	3.07%
Trust B	14.24%	85.18%	2.99%
Trust C	15.14%	84.46%	2.69%
Trust D	15.86%	83.90%	3.06%
Trust E	17.57%	82.66%	3.02%
Trust F	16.58%	83.01%	2.72%
St. George's	15.49%	84.23%	3.04%
Average London Teaching	16.80%	83.05%	2.94%
National Acute Teaching	10.03%	90.01%	3.63%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	1073.5	1074.5	1068.5	1069.5	↗
Community Services	593.6	594.6	569.3	569.5	↗
Corporate & R&D	59.9	60.9	59.9	68.2	↗
Medical & Cardiothoracics	1220.8	1207.3	1268.1	1248.3	↘
Surgery, Neurosciences & Anaes	1107.7	1098.7	1097.7	1111.7	↗
Total	**4055.5**	**4036.0**	**4063.5**	**4067.2**	↗

Nursing Staff in Post WTE

Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	984.7	985.3	984.0	973.1	↘
Community Services	473.9	471.3	466.5	461.2	↘
Corporate & R&D	49.2	54.0	50.0	46.0	↘
Medical & Cardiothoracics	1007.6	1006.5	994.3	985.9	↘
Surgery, Neurosciences & Anaes	880.1	884.0	897.6	906.8	↗
Total	**3395.6**	**3401.2**	**3392.4**	**3373.0**	↘

Nursing Vacancy Rate

Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	8.3%	8.3%	7.9%	9.0%	↗
Community Services	20.2%	20.7%	18.1%	19.0%	↗
Corporate & R&D	17.8%	11.2%	16.4%	32.5%	↗
Medical & Cardiothoracics	17.5%	16.6%	21.6%	21.0%	↘
Surgery, Neurosciences & Anaes	20.5%	19.5%	18.2%	18.4%	↗
Total	**16.3%**	**15.7%**	**16.5%**	**17.1%**	↗

Nursing Sickness Rates

Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	3.9%	4.3%	4.1%	5.3%	↗
Community Services	6.3%	6.2%	5.3%	6.3%	↗
Corporate	1.6%	6.6%	1.6%	3.5%	↗
Medical & Cardiothoracics	3.5%	3.3%	4.0%	4.4%	↗
Surgery, Neurosciences & Anaes	4.1%	4.5%	5.1%	4.2%	↘
Total	**4.2%**	**4.3%**	**4.4%**	**4.8%**	↗

Nursing Voluntary Turnover

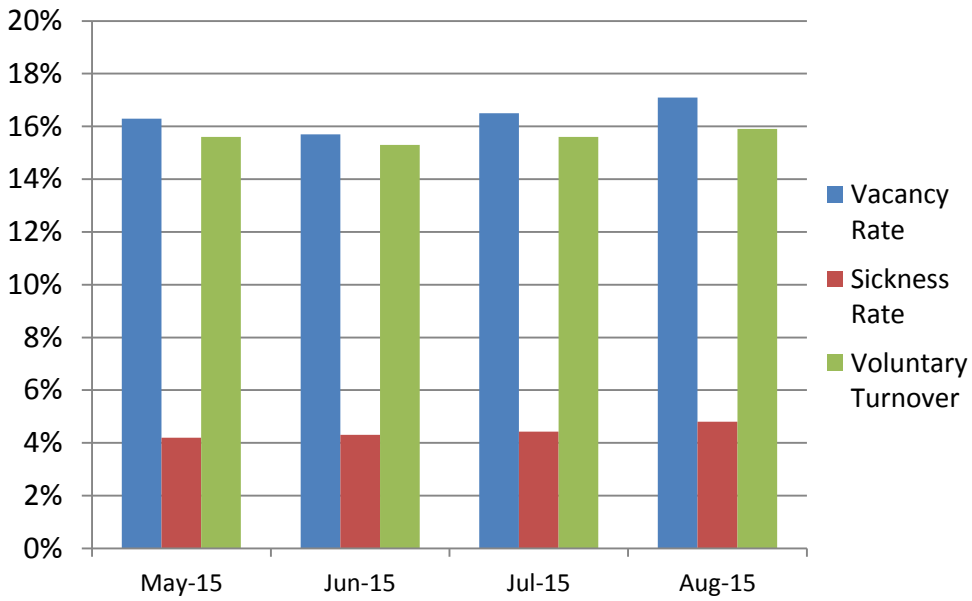
Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	14.22%	14.02%	14.11%	14.81%	↗
Community Services	16.30%	17.31%	16.61%	18.23%	↗
Corporate & R&D	14.98%	14.25%	16.97%	15.37%	↘
Medical & Cardiothoracics	17.91%	17.48%	17.46%	17.97%	↗
Surgery, Neurosciences & Anaes	14.10%	13.96%	14.42%	13.49%	↘
Total	**15.6%**	**15.5%**	**15.5%**	**15.9%**	↗

COMMENTARY

This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

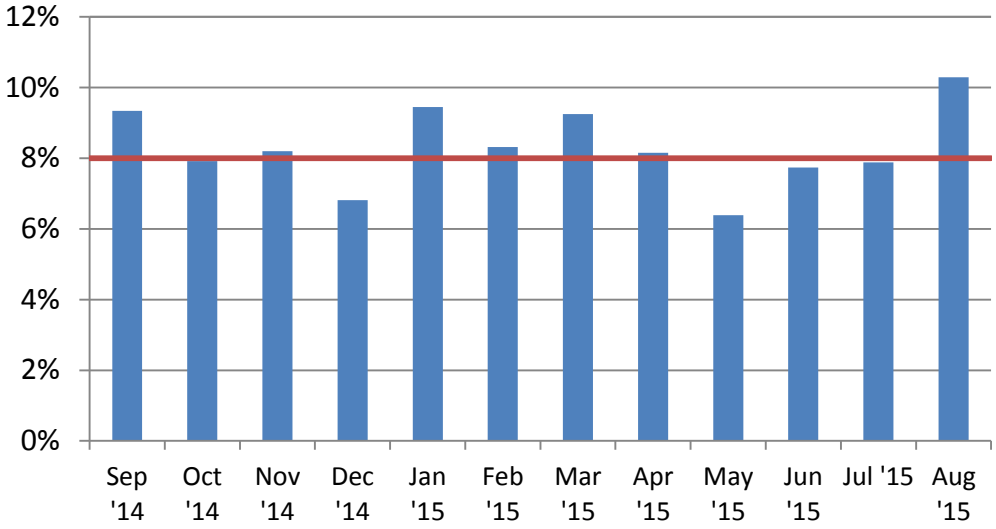
The nursing workforce has decreased by 19.5 WTE in August. The output of the review of nursing establishments will be a revised trajectory for demand for nursing.

Both the sickness rate and voluntary turnover are above the Trust's targets of 3.5% and 10% respectively.



Section 8: Agency Staff Costs

The chart below shows agency spend by month to show both annual and seasonal trends.



COMMENTARY

The agency spend percentage has increased by 2.4% since Jul.

Currently, the highest percentage spend is seen in the Corporate Division due to additional interim staff that are supporting the Turnaround process. The highest spend is seen in Medicine and Cardiothoracics at £888K for August.

The table below lists the five care groups with the highest agency spend percentage this month.

Agency % Spend by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	6.7%	6.4%	4.6%	8.4%	↗
Community Services	9.5%	12.9%	10.0%	3.5%	↘
Corporate	9.8%	11.5%	12.0%	17.1%	↗
Estates and Facilities	1.5%	3.5%	8.5%	9.3%	↗
Medical & Cardiothoracics	6.1%	8.4%	9.1%	10.2%	↗
Surgery, Neurosciences & Anaes	3.2%	3.9%	3.1%	6.9%	↗
Whole Trust	**6.4%**	**7.7%**	**7.9%**	**10.3%**	↗

Agency Costs £ by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	£689,981	£647,593	£460,175	£879,472	↗
Community Services	£396,492	£560,800	£421,845	£669,773	↗
Corporate	£28,027	£65,977	£725,851	£439,482	↘
Estates and Facilities	£15,389	£37,748	£95,853	£100,971	↗
Medical & Cardiothoracics	£532,189	£754,322	£814,214	£888,472	↗
Surgery, Neurosciences & Anaes	£274,484	£333,300	£266,435	£603,013	↗
Whole Trust	**£2,069,291**	**£2,618,293**	**£3,379,352**	**£3,938,062**	↗

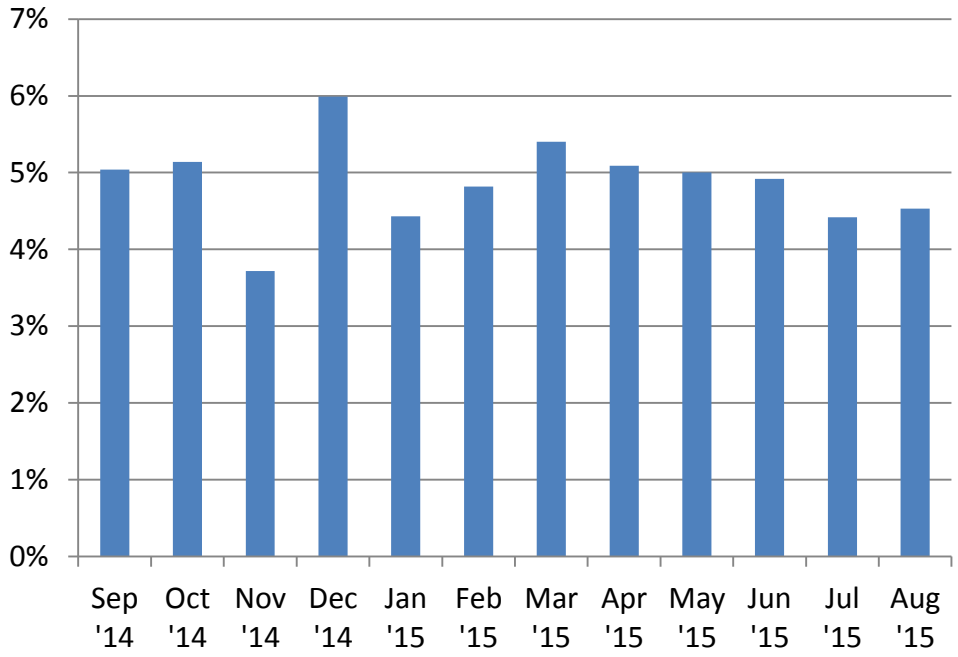
Care Group	Agency Spend % Aug-15	Staff In Post WTE
Offender Healthcare HMPW	45.4%	54.3
Information Directorate	26.2%	38.2
Outpatients	25.0%	264.6
Executive Dir of Nursing	23.2%	68.5
SWLP Haematology	21.5%	65.8

Booking Reason	Medical Agency & Bank £ Aug-15	%
Annual Leave AL	£435	0.10%
Increased Care Needs ICN	£844	0.20%
Maternity Leave ML	£0	0.00%
Sickness S	£0	0.00%
Study Leave SL	£0	0.00%
Vacancy V	£423,200	99.70%
Total	**£424,480**	**100.00%**

Nursing & Midwifery Staff Group	May '15	Jun '15	Jul '15	Aug '15
Agency Spend %of Paybill	9.44%	10.45%	9.10%	12.61%
Agency Spend £	£1,248,172	£1,414,034	£1,152,439	£1,644,350

Section 9: Staff Bank Costs

The chart below shows bank spend by month to show both annual and seasonal trends.



COMMENTARY

Bank spend percentage has increased by 0.1% between July and August.

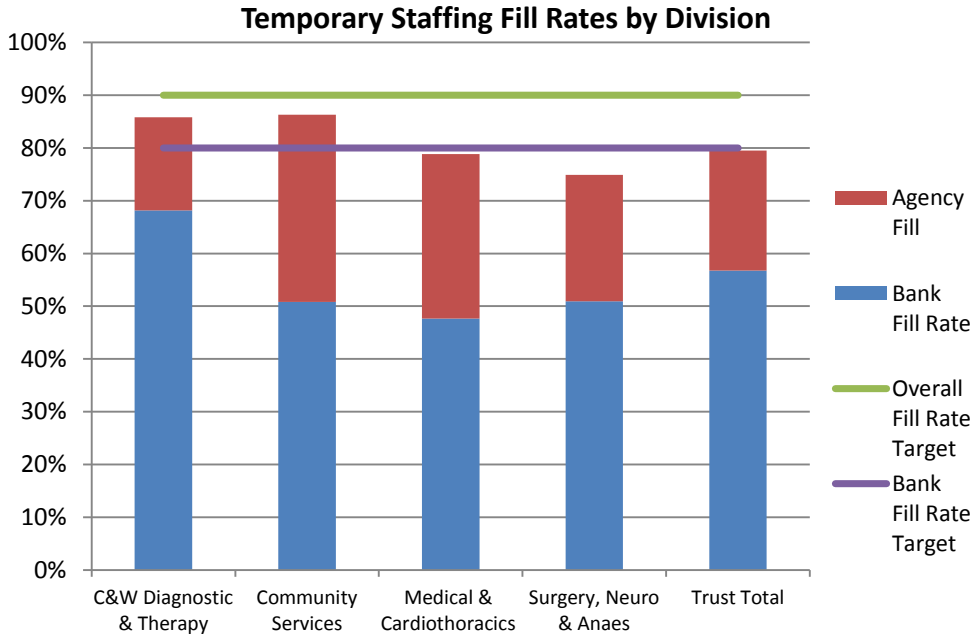
Analysis of hours worked shows a decrease in Admin and Estates bank usage in August but an increase in Registered and Unregistered Nursing & Midwifery staff and in bank Medical staff.

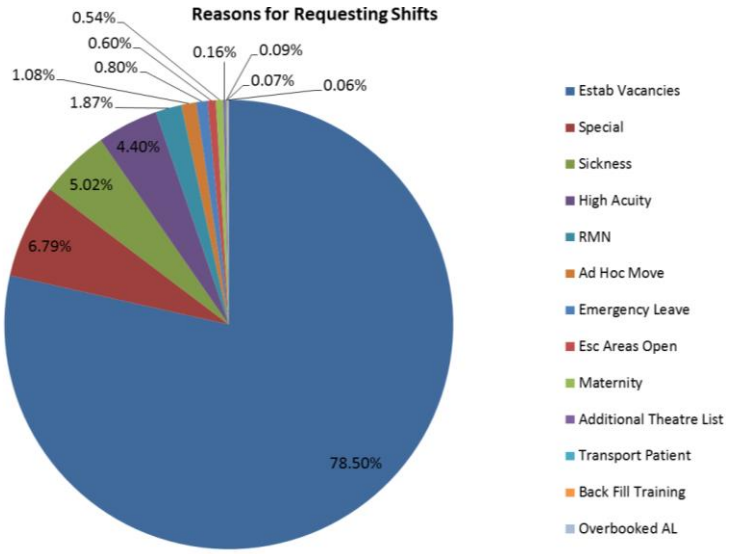
The table below lists the five care groups with the highest bank percentage spend for this month.

Bank Spend % by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	5.8%	5.5%	10.0%	4.7%	↘
Community Services	4.5%	3.5%	3.5%	3.5%	↗
Corporate	5.0%	4.9%	4.4%	3.7%	↘
Estates and Facilities	10.4%	12.7%	10.2%	8.3%	↘
Medical & Cardiothoracics	6.1%	6.7%	5.4%	6.9%	↗
Surgery, Neurosciences & Anaes	3.3%	3.3%	3.4%	2.4%	↘
Whole Trust	**5.0%**	**4.9%**	**4.4%**	**4.5%**	↗

Care Group	Bank Spend % Aug-15	Staff In Post WTE
Portering	20.7%	77.7
Acute Medicine	17.0%	336.0
Pharmacy	14.9%	177.3
Security & Car Park Mgmt	13.4%	22.0
Imaging	10.7%	194.5

Section 10: Temporary Staff Fill Rates





COMMENTARY

This data comes from the Trust's e-rostering system.

The "Overall Fill Rate" is the percentage number of requests made to the Staff Bank to cover shifts which were filled by either trust bank staff, or by an agency. The remainder of requests which could not be covered by either group are recorded as being unfilled. The "Bank Fill Rate" describes requests that were filled by bank staff only, not agency.

In August the Bank Fill Rate was reported at 56.8% which is 0.5% higher than the previous month. The Overall Fill Rate was 79.5% which is an increase of 0.6% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

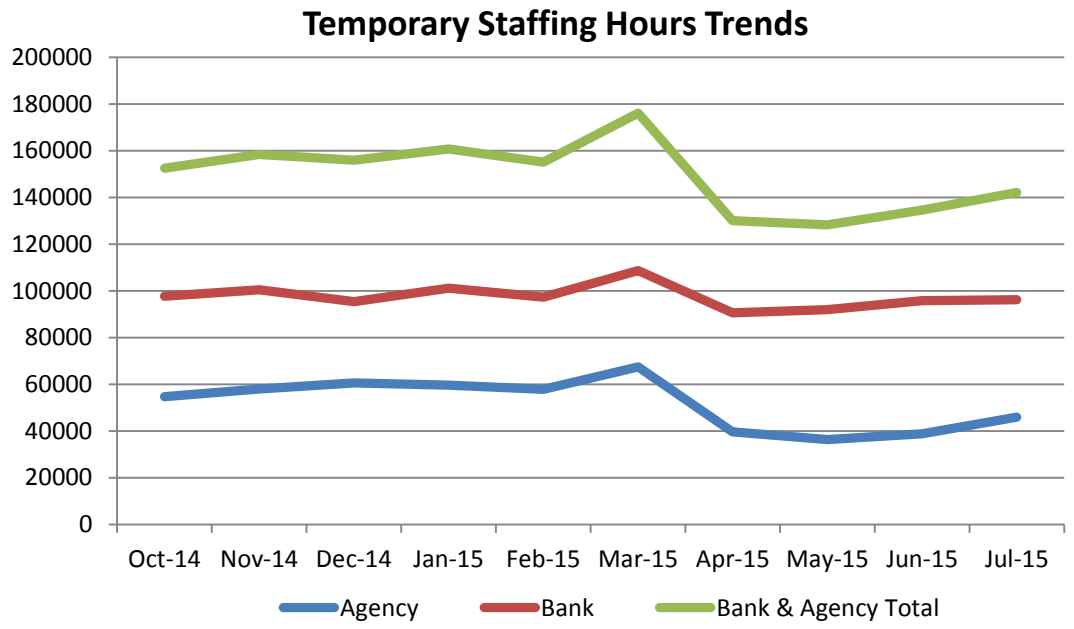
The pie chart shows a breakdown of the reasons given for requesting bank shifts in August. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

This data only shows activity requested through the Trust's bank office.

Bank Fill Rate % by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	52.14%	64.34%	63.41%	68.14%	↗
Community Services	49.51%	52.46%	49.76%	50.84%	↗
Medical & Cardiothoracics	51.69%	47.10%	47.72%	47.68%	↘
Surgery, Neurosciences & Anaes	57.66%	57.94%	52.50%	50.91%	↘
Whole Trust	**56.35%**	**57.45%**	**56.22%**	**56.78%**	↗

Overall Fill Rate % by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	84.90%	85.58%	80.00%	85.82%	↗
Community Services	89.19%	90.39%	87.80%	86.29%	↘
Medical & Cardiothoracics	77.84%	79.92%	79.93%	78.84%	↘
Surgery, Neurosciences & Anaes	75.73%	77.42%	77.08%	74.92%	↘
Whole Trust	**80.64%**	**81.20%**	**78.95%**	**79.53%**	↗

Section 11: Temporary Staffing Duties



COMMENTARY

This data comes from the Trust's e-rostering system combined with numbers of hours booked via Hi-com.

The figures show the number of bank and agency hours worked by month by Division. Hours have increased significantly in August, the highest increase is seen in the Medical & Cardiothoracics Division in bank usage. Hours have increased across all clinical divisions this month but have reduced in Corporate and Estates areas. The increase in hours is mostly attributable to Nursing (2391 hrs), Medical and Dental Staff (2309hrs) and Healthcare Assistants (2285hrs).

TYPE	Division	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Agency	C&W Diagnostic & Therapy	15399	18212	17355	15424	15305	16737	9525	10750	8656	9638	9408
	Community Services	5482	6626	6035	6111	7424	9595	7938	5769	5245	6077	6422
	Corporate	4251	4061	3772	3454	2763	3488	1246	1331	949	529	46
	Estates and Facilities	0	0	0	0	0	0	0	0	0	0	0
	Medical & Cardiothoracics	19047	18425	22413	24222	21659	25750	14492	13202	17823	20429	20348
	Surgery, Neurosciences & Anaes	10541	10604	10984	10418	10739	11798	6582	5462	6386	9195	8730
	SWL Pathology	0	0	0	0	0	0	119	204	241	228	245
Agency Total		**54720**	**57929**	**60559**	**59629**	**57890**	**67367**	**39901**	**36717**	**39299**	**46097**	**45199**
Bank	C&W Diagnostic & Therapy	26343	26993	27287	28597	27691	31831	28052	28994	29353	25997	26657
	Community Services	10073	10976	11088	10061	9354	10548	8379	7619	7704	8252	9033
	Corporate	5481	7131	7405	7497	6939	7641	7176	6915	8116	7965	7205
	Estates and Facilities	6962	7026	6867	7446	6808	7744	6885	7502	8178	9216	8910
	Medical & Cardiothoracics	28236	27707	24432	25536	25076	27528	23755	24829	24969	26255	29728
	Surgery, Neurosciences & Anaes	17839	18005	15389	18840	18430	20376	13521	13495	14553	14740	15545
	SWL Pathology	2783	2619	2901	3134	2947	2953	2753	2620	3052	3751	3389
Bank Total		**97717**	**100457**	**95368**	**101111**	**97245**	**108622**	**90522**	**91956**	**95732**	**96142**	**100454**
Temporary Staff Total		**152436**	**158386**	**155927**	**160741**	**155136**	**175990**	**130423**	**128672**	**135031**	**142239**	**145654**

Section 11: Temporary Staffing Weekly Tracking

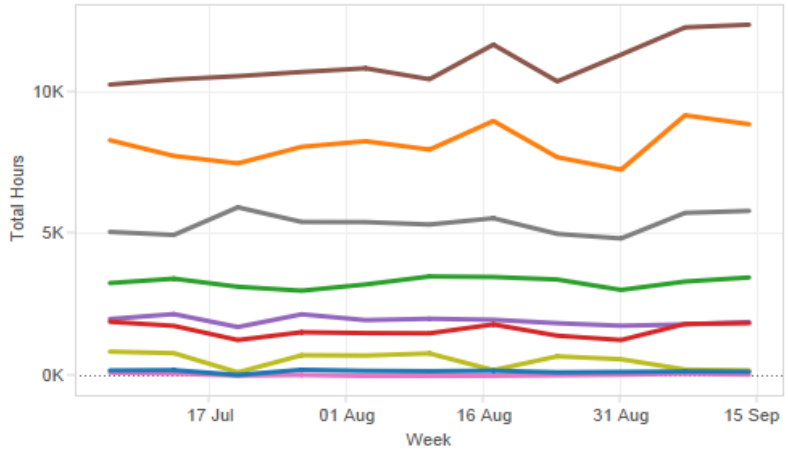
Weekly Hours Used

Division	20 Jul	27 Jul	03 Aug	10 Aug	17 Aug	24 Aug	31 Aug	07 Sep	14 Sep
Capital Division	40	225	187	174	192	134	148	163	153
Children and Women's Diagnostic and Ther..	7,476	8,058	8,254	7,960	8,964	7,690	7,254	9,164	8,852
Community Services Division	3,140	3,002	3,222	3,503	3,484	3,396	3,030	3,324	3,466
Corporate Division	1,269	1,543	1,514	1,505	1,817	1,421	1,270	1,835	1,863
Estates and Facilities Division	1,725	2,173	1,969	2,017	1,981	1,861	1,771	1,817	1,900
Medicine and Cardiovascular Division	10,540	10,687	10,815	10,430	11,647	10,356	11,296	12,253	12,347
Research & Development Division	20	40	8		13		47	85	50
Surgery & Neurosciences Division	5,932	5,418	5,413	5,328	5,548	4,999	4,838	5,736	5,806
SWL Pathology Division	134	735	725	798	211	697	595	233	205
Grand Total	30,276	31,879	32,106	31,715	33,856	30,552	30,247	34,610	34,641

Division
- ☑ Capital Division
- ☑ Children and Wome..
- ☑ Community Service..
- ☑ Corporate Division
- ☑ Estates and Faciliti..
- ☑ Medicine and Cardi..
- ☑ Research & Develo..
- ☑ Surgery & Neurosci..
- ☑ SWL Pathology Divi..

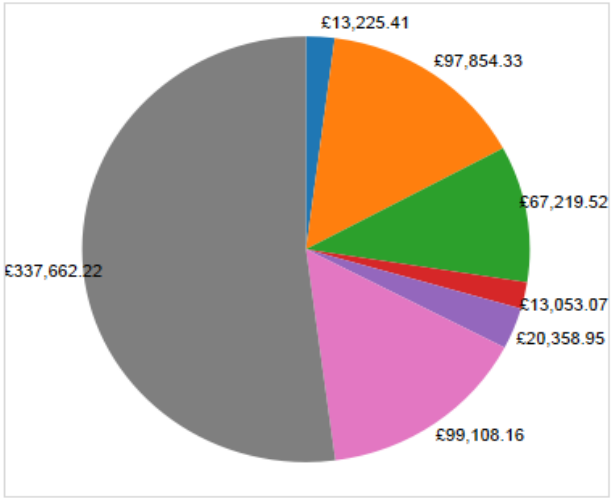
Type
- ☑ Agency
- ☑ Bank

Weekly Hours Used



Division
- Capital Division
- Children and Women's Diagnostic and Therapy Services Division
- Community Services Division
- Corporate Division
- Estates and Facilities Division
- Medicine and Cardiovascular Division
- Research & Development Division
- Surgery & Neurosciences Division
- SWL Pathology Division

Weekly Spend by Staff Group



Weekly Cost £
£648,481.64

Select Week
14/09/2015

Staff Group
- Add Prof Scientific
- Additional Clinical Services
- Admin & Clerical
- Allied Health Professionals
- Estates & Facilities
- Medical & Dental
- Nursing & Midwifery

Section 12: Mandatory Training

MAST Topic	Jul '15	Aug '15	Trend
Conflict Resolution	72.9	73.2	↗
Equality, Diversity and Human Rights	81.0	77.5	↘
Fire Safety	75.6	72.3	↘
Health, Safety and Welfare	80.6	76.8	↘
Infection Prevention and Control Clinical	61.2	58.2	↘
Infection Prevention and Control Non Clinical	73.3	70.0	↘
Information Governance	64.4	61.1	↘
Moving and Handling	76.8	72.3	↘
Moving and Handling Patient	53.9	52.0	↘
Resuscitation BLS	40.4	37.9	↘
Resuscitation ILS	43.7	40.7	↘
Resuscitation Non Clinical	60.0	59.3	↘
Safeguarding Adults	78.2	74.3	↘
Safeguarding Children Level 1	77.3	73.8	↘
Safeguarding Children Level 2	76.8	73.6	↘
Safeguarding Children Level 3	69.7	71.3	↗

MAST Compliance % by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	75.0%	74.7%	73.6%	70.4%	↘
Community Services	74.7%	73.8%	72.9%	70.4%	↘
Corporate	71.9%	70.5%	68.8%	64.1%	↘
Estates and Facilities	65.9%	66.0%	64.9%	64.5%	↘
Medical & Cardiothoracics	66.4%	66.3%	64.4%	60.8%	↘
Surgery, Neurosciences & Anaes	70.3%	69.4%	68.5%	65.9%	↘
Whole Trust	73.1%	72.4%	71.0%	67.8%	↘

COMMENTARY

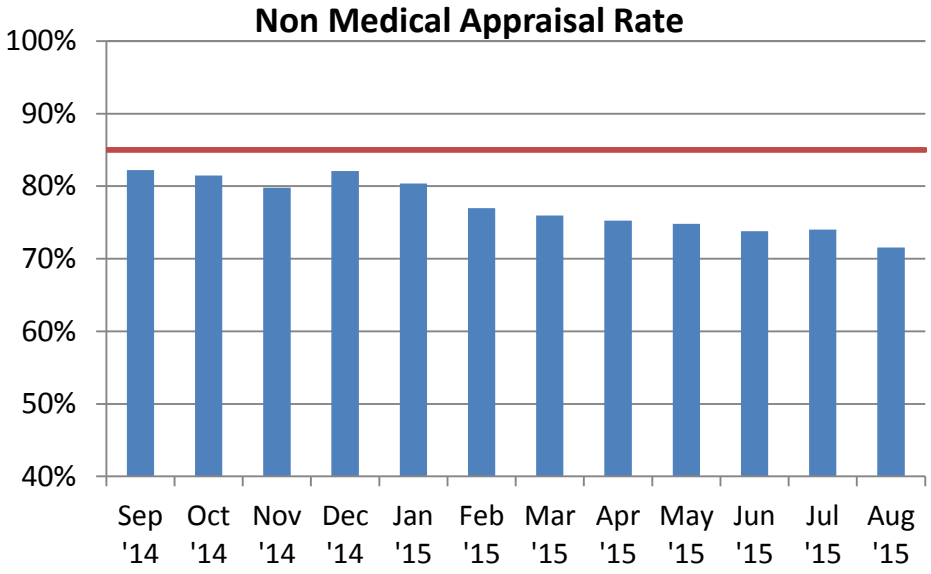
A programme of working is taking place including:

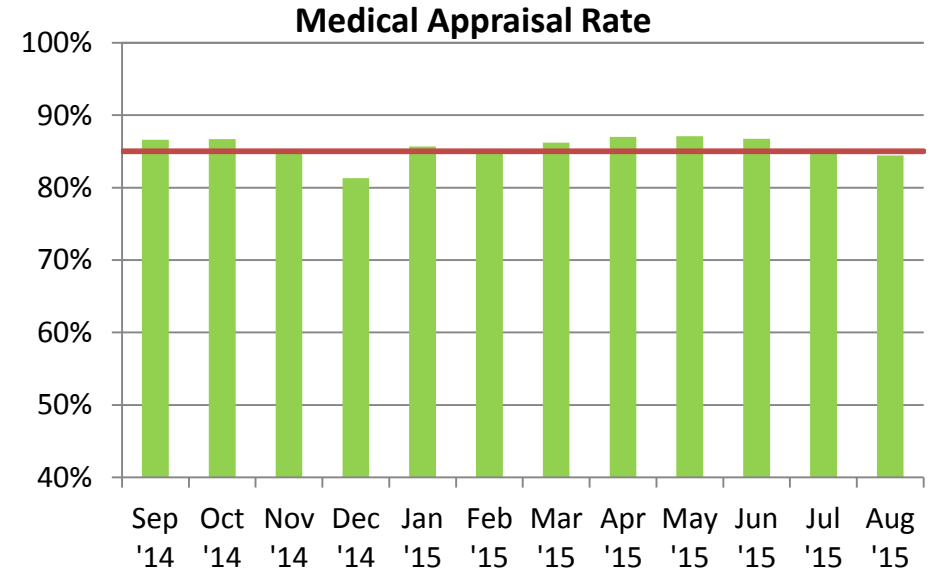
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Providing and accessible on-line system
- Introduced monthly meetings where divisions report on progress and are held to account by Director of Workforce
- Embedded Training evaluation to e-learning
- Reporting compliance futures for departments so that they are proactive with compliance
- System changes so that accessibility issues are resolved.
- Introduced governance meetings with training leads to ensure that issues are resolved and all are working together.

Current Issues:

- Fall in compliance rates – largely due to staffing pressures
- Community access to Totara is on the risk register, in the interim we are visiting community sites with tablets and developing a permanent solution in parallel
- Staff unable to access training externally- Software and licencing and IG issue
- Process review between Recruitment/Payroll/Education Department for new starters
- Study leave policy to be changed to say that CPPD will not be offered if the individual is not compliant
- Non-medical appraisal documentation to include confirmation of the staff members' compliance.

Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 2.5% this month to 71.5%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

Medical appraisal rate compliance has decreased this month to 84.4% which is just below target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Paediatric Surgery	42.9%	53.63
SWLP Central Reception	43.8%	39.37
Procurement & Materials Mgmt	44.1%	37.00
SWLP Haematology	48.4%	65.81
Breast Screening	50.0%	54.95

Non Medical Appraisals by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	74.9%	74.4%	73.7%	73.2%	↘
Community Services	75.8%	75.4%	76.0%	70.9%	↘
Medical & Cardiothoracics	78.8%	77.8%	77.8%	76.3%	↘
Surgery, Neurosciences & Anaes	75.1%	74.2%	75.1%	69.8%	↘
Corporate	65.2%	66.4%	66.8%	66.0%	↘
Estates & Facilities	80.7%	80.7%	74.7%	66.5%	↘
Whole Trust	**74.8%**	**73.8%**	**74.0%**	**71.5%**	↘

Medical Appraisals by Division	May '15	Jun '15	Jul '15	Aug '15	Trend
C&W Diagnostic & Therapy	87.8%	87.1%	82.6%	84.1%	↗
Community Services	72.7%	69.6%	69.6%	84.0%	↗
Medical & Cardiothoracics	87.6%	87.7%	91.2%	85.2%	↘
Surgery, Neurosciences & Anaes	84.9%	84.9%	88.8%	84.3%	↘
Corporate	100.0%	50.0%	50.0%	100.0%	↗
Whole Trust	**87.1%**	**86.7%**	**85.1%**	**84.4%**	↘

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – OCTOBER 2015

Paper Title:	Chair's Report: Workforce Committee – 17th September 2015
Sponsoring Director:	Stella Pantelides, Non-Executive Director
Author:	Stella Pantelides, Non-Executive Director
Purpose:	To provide the Board with a summary of the proceedings from the last Workforce Committee
Action required by the board:	To note the update
Document previously considered by:	N/A

Report

Workforce Plan

In response to an outstanding action from the July meeting a snapshot was presented by Wendy Brewer of the change in the trust's WTE staff numbers, by staff group and division, in the course of 14/15. The report showed a net increase of 265.44 WTE from 1 April 2014 to 31 March 2015. Of this, 109 was in nursing, 56 in medical and dental, 61 in AHPs and nearly 100 in admin & clerical staff. Part of the explanation for the growth was the replacement of temporary with permanent staff (e.g. in Outpatients), part of it was a response to planned growth in capacity and other business cases. The Committee was cautious not to over-interpret the figures in the report until the HR team completes a process of reconciliation that connects specific business cases to staff growth, thereby enabling conclusions to be drawn about the proportion of growth that was planned and that which was not properly controlled. It was agreed that the reconciled figures will be brought back to the Committee in November.

Questions were also asked about the extent to which the trust had now become better equipped in aligning activity with staff growth. Wendy assured the Committee that there were many more controls in place now such as the weekly staff tracker, the vacancy control panel, more rigorous control over the booking of temporary staff which, together, ought to enable the trust to ensure that staff growth in 15/16 is more closely aligned to activity levels.

Nursing and Midwifery Programme Update

The Chair invited Jennie Hall to introduce her paper and to share with the Committee what this programme had achieved one year on. Jennie provided her update in two parts:

<u>Establishment Review</u>

Jennie explained that a major plank of this programme was the establishment review for 15/16. Unlike the review of 14/15 this is comprehensive (not just confined to inpatient areas), produced with much more

divisional engagement and fully integrated with the Turnaround and Budget Reconciliation Processes. The Programme had received a great deal of valuable support from KPMG.

Jennie reported that the recommendations from the first phase of the programme (50 Inpatient Areas) will be brought to an additional Workforce & Education Committee meeting on 15 October with a report to Board in November. The report is expected to indicate the financial impact of the recommendations, how they link with safe staffing and any perceived operational impact.

The second phase of the programme (Above Ward Nursing, Outpatients, Theatres and Community and ambulatory areas) were expected to be concluded in October with a report to the Workforce Committee and Board in November.

Assurance was also given that the work is not proceeding in isolation from other workforce areas. All relevant interdependencies, e.g. with the medical workforce review (led by the Medical Director and also supported by KPMG) as well as with the Service Line Review are being explored.

The Committee welcomed the progress reported but did not discuss this programme in detail pending the actual submission of the report for the October 15th dedicated meeting.

Nursing and Midwifery Programme (excluding Establishment Workstream).

Jennie explained that the focus on trying to establish how many nursing staff we need and how many vacancies we are trying to fill has inevitably taken up a great deal of programme resource. Consequently, whilst progress had been made on other work streams (Direct entry to Nursing, Band 5 Career Pathway, Overseas Nurses Preceptor, Nurse Induction and Band 6 & 7 Development Programmes) retention rates remained disappointing and attraction and recruitment of nursing staff slower than required to make a material impact on vacancy rates. It was also acknowledged that the Marketing and Branding lever had not been developed or used, as yet, to an extent that could make more of a difference.

Looking ahead at the rest of the year, Jennie confirmed that the trust is clearly going into the winter period with known risks on staffing. The national agency 'rules' now being applied to the nursing workforce with a financial cap of 10% of total nursing costs for the next six months from 1 October 2015, pose an additional constraint that needs to be managed. When asked what aspect of the Programme could make a material difference to the emerging risk profile Jennie responded that in the short term that would be International Recruitment that aims to bring in 200 staff. This work stream is however behind its original timescale (Red RAG rated) as there are issues with agreeing the business case and the approach to funding. Otherwise, Jennie said, the impact of all other workstreams on recruitment and retention is expected to be incremental and gradual.

Response of HR Director to Outstanding Questions Raised by the Board on 3rd September

The Chair invited Wendy to respond to three important issues that were raised at the last Board meeting, in her absence.

Reconciliation of ESR and Finance System

Wendy assured the Board that the reconciliation between the general ledger and the electronic staff system was due to be completed by the end of September. Questions were then asked about the assurance that the

Committee could take that the two systems would not get out of sync again. Wendy explained that the updating of both systems was the responsibility of Finance-not HR. She would therefore ask the Finance Director to provide the assurance to the Committee and to the Board.

Controls over Booking of Temporary Resource

Wendy explained that the trust's Bank had grown over the last 3-4 years to handle requests for temporary staff for four different staff groups: nurses, medical locums, allied health professionals and admin and clerical staff. She further explained that the capacity of Bank to handle the additional demands placed upon it had not kept up with those demands. As a result, divisions sourced some of their temporary staff, especially in the admin area, directly. A recent investigation into temporary staff numbers conducted with the help of KPMG had surfaced the issue of poor controls and had led to a number of temporary staff being offered permanent roles, exited or given exit dates. Questions were asked about the extent to which the Committee could be assured that the controls that are now in place will not permit a similar situation from arising again. Wendy assured the Committee that lessons had been learnt, systems and processes had been tightened and other sources of clerical and admin staff (in the form of apprentices) are now being employed as alternatives to temps. However, full compliance was dependent upon the strength of divisional accountability and enforcement.

MAST Compliance Rates

Wendy explained that MAST compliance rates are receiving a great deal of attention by all those who can influence them and that she was due to report to the Audit Committee and to QRC on this issue.

When asked about the underlying causes of the drop-off in compliance, Wendy explained that an electronic system of assessment had gone live 2 years ago. Systems problems are still being experienced by users two years on. These have been further compounded recently by increased demand as the 2-year anniversary from the introduction of the system is upon us. Availability of resource and difficulties with release of staff are additional reasons for the drop-off in compliance. Wendy assured the Committee that her team and subject matter leaders are taking a number of actions to address declining compliance. The Committee recommended that a programmatic approach be adopted so that the impact of each action can be monitored and managed. The Committee also recommended that the pre-winter window be used as effectively as possible to improve compliance as it was inevitable that release would become even more challenging during winter.

Annual Plan Q2

The Committee reviewed reported progress against the annual plan focussing on the three Red RAG areas:

Workforce Plan

It was reported that agreed budgeted posts for 15/16 had not as yet been confirmed as these were contingent on the completion of the nursing establishment review and a series of other actions aligned with the budget reconciliation and reforecasting effort.

Recruitment Process

It was reported that 'time to recruit' remains an area of risk in the light of increased pressure on numbers

recruited. Assurance was given that agreement had been secured to expand the recruitment team and to implement the TRAC system (due for implementation in Q3/4).

Efficiency Programme

The Workforce efficiency programme is led by the Workforce Efficiency Group which is accountable to this Committee but whose work is now subject to scrutiny by the PMO with progress being regularly reported to the Turnaround Board. The Committee received the latest report to TAB which set out progress against a number of schemes under way (management structures review, medical efficiency, increased use of apprentices, medics rostering, Pan- London/ SWL Bank, Medical Secretaries, temporary staffing review and Salary Sacrifice schemes). The common concern about all these schemes, at the time of the latest report to the PMO was the lack of Finance Resource which would clarify the financial benefits of these schemes and thereby enable draw down.

It was reported that with recent support from KPMG these schemes are now being worked up in detail and are showing a huge potential for full year savings (upwards of £20m) in future years.

The Committee received the report with 'cautious optimism'. In principle, it accepted the premise that a Trust which had grown organically over the years to its present size must be capable of making substantial efficiency savings on its workforce. However, the Committee would wish to see the detailed evidence. Particularly welcome was the plan to commence the sharing of temporary staff with neighbouring trusts in SWL. This had the potential to increase the pool of bank staff available and decrease dependency on agency staff across the entire SWL health economy.

Wendy was asked to report back to the Committee on the progress of the efficiency programme as it grows in specificity and as the potential for benefits becomes clearer.

Leadership Development Programme

Sarah James introduced a paper which set out the key features of a programme aiming to enhance leadership capability at the trust by :

- Giving leaders the tools to lead service transformation;
- Ensuring that their behaviours reflect the trust values;
- Ensuring that they understand each other's priorities, especially across professional divides and learn to work in a collaborative way;
- Preparing leaders effectively for their next role.

The Committee welcomed the programme and praised Sarah's approach in:

- Setting out a clear architecture for the programme geared to the specific needs of different groups;
- Targeting the programme on the top 100 leaders;
- Securing the required funding;
- Consulting extensively with the leaders themselves and setting up a core reference group who will support programme development and serve as in-house faculty;
- Ensuring that paired learning was a key feature of the programme;
- Including Organisational Development (OD) days for divisional leadership.

The key issues and concerns raised by the Committee were as follows:

- **Attention over who attends:** it was important that those who attended were those who could benefit most from such programmes. The Committee encouraged the divisions to use the outputs of performance appraisals and 360 degree feedback to identify the specific developmental gaps of their leaders and target development. The 'community of 100' should also be used actively to create momentum and encourage participation;
- **Role of CEO:** The Committee recommended that Miles takes a prominent role in launching and promoting the programme;
- **Learning methods:** Sarah was asked to review the learning methods and ensure that there is an appropriate balancebetween didactic and scenario based learning;
- **Measuring effectiveness of programme:** In the light of the investment in the programme (especially in senior time) and the expectations from it, Sarah was encouraged to identify early on ways in which the programme's effectiveness could be assessed.

Divisional Updates on Action Plans to Address High Staff Turnover

The Committee received reports from two of the four divisions (Medcard and Surgery) on their plans to reduce staff turnover. (NB the other two clinical divisions had come prepared to present their plans as well but had not submitted those beforehand. Discussion was therefore deferred to the November meeting).

The Committee welcomed the increased detail in the two divisional plans reviewed which took the form of specific actions (down to directory, staff group and ward) and appeared to be tailored to address specific issues (shortcomings in leadership, known areas of poor behaviour, pay). Accountability in the plans was also pleasingly enhanced through the provision of dates and names of matrons and other senior staff set against proposed actions.

The key question to the divisions was how they would monitor progress against these plans and assess their effectiveness. Both divisions offered assurances that these action plans will be monitored with the same rigour as progress against their CIP plans. Surgery's DDO also agreed to provide a trajectory for staff turnover against which progress could be assessed. No similar undertaking was sought from Medcard at the meeting as the report was presented by the HR Manager. However she was asked to take the request to her divisional leadership.

Report on Progress in Tackling Bullying

The Committee briefly reviewed the report which covered the extent of bullying across the trust in its various manifestations and the actions that are being taken to address it. Attention focussed on the fact that the majority of allegations of bullying were not upheld. The underlying reasons for this were discussed.

Wendy announced that a lead HR Advisor was asked to undertake a review of the Trust's response to bullying which would include learning from other trusts with a better, or improving, track record on this issue. She is due to report back with recommendations at the end of October.

Medical Workforce Review

The report was presented by Claire Low in the absence of the Medical Director who was on annual leave. By way of background the report highlighted the increase in the medical workforce (122 posts between 2012 and 2015) and the importance of understanding the reasons behind this increase in the context of safe

staffing, the move towards 7 days' service, the future intentions to reduce doctors in training and a range of other factors.

The review, which is supported by KPMG has three areas of focus:

- **Safe staffing out of hours**: this follows on the work of Sarah Hammond but extended to cover the whole trust. It aims to capture accurately current practice and ascertain degree of fit against assessed needs of the trust both out of hours and with seven day services for each specialty in mind;
- **Medical workforce vacancies**: this aims to review all medical vacancies to understand which and how many posts are difficult to recruit to (e.g. clinical fellow posts in Acute Medicine) and to come up with alternative options for resourcing.
- **Consultant job plans**: this involves a review of all submitted job plans to check that any savings identified for 14/15 have been realised. This will also include a review of all recharges to ensure these are still correct, including a review of educational funding (does activity within departments match undergraduate and post graduate funding?)

Before opening the paper to comment, Wendy was careful to set expectations: Although this work was ambitious, it was not of the scale of the nursing establishment review, neither was it subject to the same deadlines. In the light of the sensitivities involved, the first step was to gather the data and carry out the analysis with the support of KPMG so that a dashboard could be established for each care group for further analysis and scrutiny.

The Committee welcomed the report and acknowledged that this was probably the first time that the medical workforce was being analysed systematically. The steer to Claire and others leading the work was:

- To ensure that the focus on 7 days does not mean we lose sight of how to raise productivity within the five day working week;
- To take account of interdependencies with the nursing review and SLR;
- To be aware of/anticipate the implications of changes to the Consultant contract;
- To be mindful that this work may add to cost pressures in certain areas, although that did not mean that the analysis should not be done.

Committee agenda organisation, length of meetings and governor attendance

This was the first Committee meeting attended by one of our governors, Hilary Harland, as an observer.

Although each of the Committee's meetings has an intended area of focus (now published in advance for the next six meetings) it was judged next to impossible to keep the agendas short and complete the business within 2.5 hours. In the light of the importance of ensuring that Workforce issues receive the attention they deserve, especially in the present climate, it was agreed to extend the length of meetings to 3 hours with effect from January '16.

Key risks identified:

Risks are detailed in the report under each section.

Related Corporate Objective:	All corporate objectives.
Related CQC Standard:	N/A

Equality Impact Assessment (EIA): Has an EIA been carried out?

If yes, please provide a summary of the key findings

No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

Is the run rate reducing following Non Nursing agency exits

The bank team are reporting a steady rate of weekly £ usage – but there are two offsetting factors (i) greater compliance with using the bank team to book agency and (ii) a gradual reduction in number of agency staff used

Directorate	Temporary staff exits confirmed	Agency cost/£k 30 Aug-6 Sep	Agency cost/£k 7 Sep – 13 Sep	Agency cost/£k 14 Sep – 20 Sep	Agency cost/£k 21 Sep – 27 Sep
Outpatients	22	15	18	18	19
Estates and Facilities	9	19	19	20	19
SWL Pathology	9	0	0	0	0
Corporate Directorates	3	10	11	12	11
Procurement	2	1	2	1	2
Theatres and Anaesthetics	2	15	20	18	19
Other	10	78	79	77	76

Considerations

- The financial data appears to contain a significant proportion of costs in relation to prior months and is therefore not reflective of 'usage' or costs by month
- Whilst policy is for all bookings to go via the Bank, we are aware a proportion do not (which contributes to late payments and recording of invoices), although recently this has started to improve
- Not all Directorates have fully provided information on non nursing agency usage to the challenge team. This is being addressed and will be resolved via payment controls

Progress

- The 57 exits of non nursing agency which have been validated have only recently left and will take some time to deliver the full benefits

Are Non Nursing Agency reductions causing increases in reported WTE

To 30th September, 57 of the 317 'exits' of Non Nursing agency staff have been confirmed and validated with budget holders. Of these exits, almost half (27 heads) have not required replacements with substantive or bank staff

Directorate	Exit without replacement	Converted to substantive/ bank	Waiting VCP decision on recruitment	Investigating apprentice use	Total confirmed exits to 30th September
Outpatients	8	7	7	-	**22**
Estates & Facilities	9	-	-	-	**9**
SWL Pathology	6	3	-	-	**9**
Corporate Directorates	-	3	-	-	**3**
Procurement	1	1	-	-	**2**
Theatres & Anaesthetics	2	-	-	-	**2**
Other	1	5	2	2	**10**
TOTAL	**27**	**19**	**9**	**2**	**57**

Key messages

- Nearly half (47%) of the temporary staff exits confirmed to 30th September have not resulted in recruiting a substantive or bank replacement
- 9 of those needing to be replaced are waiting on Vacancy Control Panel decisions and 2 are considering using apprentices
- Exit plans exist for c.90% of the 260 remaining known Non Nursing Agency personnel. It is expected that a similar proportion of 'exits without replacement' will be achieved

Temporary workforce controls – report to Trust Board – 8th October 2015

Introduction

The Trust will always require some temporary workforce in order to respond to changing demand and to provide flexibility. Currently with increased demand in the external market along with very high levels of turnover, the temporary staffing demand is acute.

The purpose of this paper is to provide assurance regarding the programme of work that supports the further establishment of controls on the temporary workforce. There is a complex programme of work in place as the challenges are different according to the different occupational groups. Support is being provided by KPMG to ensure that there is sufficient grip and transparency of information for all occupational groups and that control can become part of routine divisional and corporate performance management.

This paper solely focuses on the work relating to temporary staffing. There is a further whole programme of work relating to recruiting and retaining the substantive workforce, thereby reducing the need for temporary staff.

Background information

Until 2013 acute nursing was the only occupational group routinely booked through the bank office. Since that date a programme of enabling work has taken place that has included:

- The roll out of e-rostering across acute and community sites for all professional groups except medical staff.
- The introduction of an Allocate system to manage bank bookings that is connected to the e-rostering system.
- The introduction of 247 for medical staffing.
- Centralisation of booking all groups of staff through the bank office
- From 1st October 2015 production of weekly bank and agency usage and spend reports for bookings made through the Staff Bank to assist managers in monitoring usage and spend.

Since August KPMG has been providing support on the reduction of temporary staffing, particularly focusing on areas where controls have been weaker, i.e. all areas other than nursing. A series of challenge meetings have been undertaken focusing on usage on a post by post basis. The outcome of these meetings is set out below. Exit plans for agency staff include transfer to bank, transfer to permanent appointments, transfer to apprenticeships or removal of the post altogether.

	Left - Confirmed	Left Unconfirmed	September	October	November	December	Later	TOTAL
Exit date	42	8	14	36	20	19	22	**161**
TRF date	15	15	62	62	17	108	37	**316**

Total	57	23	76	98	37	127	59	**477**

Current position and challenges

The current position and challenges are set out by professional group on the table on 3, 4 and 5.

Longer term

In the longer term a number of factors will influence demand and supply:

- It is anticipated that Monitor will introduce external controls and target trajectories for further staff groups, probably focusing on medical staff in the first instance.
- The Trust is working with partner trusts in South West London (including all acute trusts, the mental health trust and the Royal Marsden) to establish a shared staff bank. Feasibility work is complete and the work has now progressed to the planning and approval stages. It is anticipated that a paper will be presented to boards in January or February 2016 setting out progress and seeking commitment to a memorandum of understanding between partner trusts. The work is being funded in part by the South West London Network via the South West London Provider Collaborative. If successful, it is estimated that the shared bank might save the trust up to £7m per annum in temporary staffing costs.
- Winter pressures, high turnover and continuing challenge in the recruitment market will influence the trust's demand for workforce and the labour market's position to supply.

Increased control

KPMG are providing support in a programme of work that will include the introduction of clear controls and reporting processes for all categories of temporary staffing. The programme of work is set out in the attached slides.

The end point will be that

- all temporary staffing will be booked through the bank
- all interim appointments will have been authorised by the Vacancy Control Panel and through the Procurement department.
- No temporary staffing costs that are incurred outside these agreed processes will be paid.

Professional group	Drivers for demand	Current responses	End state control
Registered nursing (approx. 50% of bank and agency usage)	Vacancy factor Fluctuations in activity and demand including high acuity Sickness and maternity absence	All booking is through the bank office with clearly communicated divisional levels of control. Nursing establishment review will clarify demand requirements. Agreements in place to lock down rotas in order to plan. Support being given by Monitor Agency team. Monitor controls require a % reduction across the trust and this has been broken down by division.	Agreed % usage on a ward by ward basis to be monitored through divisional performance management. In place by 1st October. All out of hours bookings made by the Site Team must be made using the HealthRoster system so this usage is appropriately captured.
Additional clinical services (approx. 12% of bank and agency usage). This group largely comprises health care assistants.	Special mental health nursing needs. Fluctuations in activity. Sickness and maternity absence	All booking is through the bank office with clearly communicated divisional levels of control. Nursing establishment review will clarify demand requirements. Agreements in place to lock down rotas in order to plan. Training programme to develop mental health nursing skills in place and being rolled out.	Management of usage through divisional performance management.
Administrative and clerical staff (approx. 8% of bank and agency usage).	Long term posts to cover vacancy and allow for flexibility in outpatients, medical secretaries, hard to recruit areas. Some areas have defaulted to agency rather than attempting permanent recruitment.	Booking was previously directly to Reed and other agencies. A programme of transferring to bank has been in place for several months. Booking is now through the bank office and subject to a temporary staffing vacancy control process. Permanent recruitment and the introduction of apprentices (circa 100) is taking place.	KPMG support being provided to identify process to ensure that all temporary staffing usage is being identified and controls are in place to prevent temporary staffing bookings outside the bank process. Process to be in place by end of October.

Professional group	Drivers for demand	Current responses	End state control
		Challenge meetings are in place. Appendix 1 sets out progress to date.	
Medical and dental staff (approx. 15% of bank and agency usage)	Gaps in training rotas. Fluctuations in activity and increased acuity. Sickness and maternity absence.	All booking should be through the bank office though compliance is not complete. '247' introduced as a service to ensure that VAT is not paid to doctors who are engaged on a contract for service basis (the majority). Some doctors are engaged on zero hours' contracts and are 'not counted' as temporary staffing. These contracts are being moved to bank booking but agreement is required for a standard locum rate. Medical staff are not included in e-rostering. The bank system (Hi-Com) that manages medical staff is old and failing. There is an urgent project to review systems that can support e-rostering of medical staff and bank staff administration. Plans to introduce consistent rates for locum work are being worked through by workforce efficiency group. Project to undertake a review of the medical staffing establishment in development.	Standard locum rate being developed by workforce efficiency group. Resolution of the HI-Com bank system and e-restoring challenge. KPMG support being provided to identify process to ensure that all temporary staffing usage is being identified and controls are in place to prevent temporary staffing bookings outside the bank process. Process to be in place by 1 January 2016.
Allied health professionals (therapy staff) (approx. 3% of total bank and agency usage)	Very specialist hard to recruit posts. Fluctuations in activity and increased acuity. Sickness and maternity absence.	All booking should be through the bank. (The exception is the general X-Ray bookings are not always done through the bank as some of the bank shifts are set up as part of their rotas. Their consultation on changes is on-going but will be finalised by 31.3.16) Increasing leadership and compliance following appointment of Head of Therapies post. Conversion to bank where possible.	KPMG support being provided to identify process to ensure that all temporary staffing usage is being identified and controls are in place to prevent temporary staffing bookings outside the bank process. Process to be in place by end of October.

Professional group	Drivers for demand	Current responses	End state control
		Some agency usage is likely to continue because of specialised nature of roles.	
Estates and facilities (approx. 10% of total usage)	Requirement for flexibility in the workforce. Hard to recruit posts in estates. Fluctuations in activity and increased acuity. Sickness absence.	All booking is now going through the bank. Exit plans in place to remove agency usage and convert to bank, permanent or apprentice workforce. The one group that would remain going through Procurement or with direct booking to contractors would be the people who are involved in capital projects and things such as the air conditioning units etc.	KPMG support being provided to identify process to ensure that all temporary staffing usage is being identified and controls are in place to prevent temporary staffing bookings outside the bank process. Process to be in place by end of October.
Scientific professional group(approx. 3% of temporary usage)	Deliberate use of temporary workforce whilst SW London Pathology embeds.	Some of the labs are still functioning at other sites and use Kingston and Croydon networked computers so cannot use our HealthRoster system or book through BankStaff. The staff in SWLP on site here are not on HealthRoster because they are still consulting on some of their rotas and we had agreed they would only move to using HealthRoster when they have done this. They cannot book through BankStaff but we do book them through HiCom. High cost of interims being challenged through temporary staffing challenge sessions. As new structures come into place exit plans are removing bank and agency usage or converting to permanent posts.	KPMG support being provided to identify process to ensure that all temporary staffing usage is being identified and controls are in place to prevent temporary staffing bookings outside the bank process. Process to be in place by end of October.

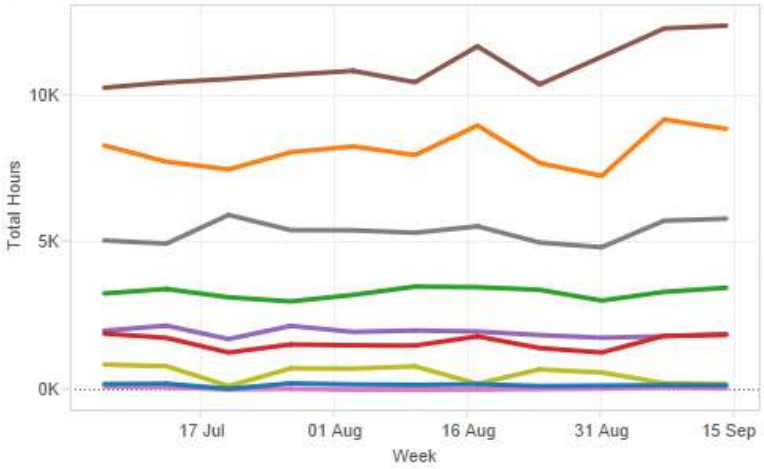
Weekly Hours Used

Division	20 Jul	27 Jul	03 Aug	10 Aug	17 Aug	24 Aug	31 Aug	07 Sep	14 Sep
Capital Division	40	225	187	174	192	134	148	163	153
Children and Women's Diagnostic and Ther..	7,476	8,058	8,254	7,960	8,964	7,690	7,254	9,164	8,852
Community Services Division	3,140	3,002	3,222	3,503	3,484	3,396	3,030	3,324	3,466
Corporate Division	1,269	1,543	1,514	1,505	1,817	1,421	1,270	1,835	1,863
Estates and Facilities Division	1,725	2,173	1,969	2,017	1,981	1,861	1,771	1,817	1,900
Medicine and Cardiovascular Division	10,540	10,687	10,815	10,430	11,647	10,356	11,296	12,253	12,347
Research & Development Division	20	40	8		13		47	85	50
Surgery & Neurosciences Division	5,932	5,418	5,413	5,328	5,548	4,999	4,838	5,736	5,806
SWL Pathology Division	134	735	725	798	211	697	595	233	205
Grand Total	30,276	31,879	32,106	31,715	33,856	30,552	30,247	34,610	34,641

Division
- [x] Capital Division
- [x] Children and Wome..
- [x] Community Service..
- [x] Corporate Division
- [x] Estates and Faciliti..
- [x] Medicine and Cardi..
- [x] Research & Develo..
- [x] Surgery & Neurosci..
- [x] SWL Pathology Divi..

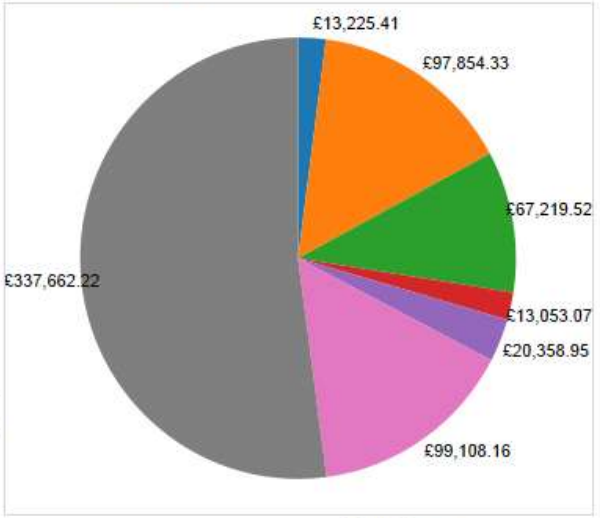
Type
- [x] Agency
- [x] Bank

Weekly Hours Used



Division
- Capital Division
- Children and Women's Diagnostic and Therapy Services Division
- Community Services Division
- Corporate Division
- Estates and Facilities Division
- Medicine and Cardiovascular Division
- Research & Development Division
- Surgery & Neurosciences Division
- SWL Pathology Division

Weekly Spend by Staff Group



Weekly Cost £
£648,481.64

Select Week
14/09/2015

Staff Group
- Add Prof Scientific
- Additional Clinical Services
- Admin & Clerical
- Allied Health Professionals
- Estates & Facilities
- Medical & Dental
- Nursing & Midwifery

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting: **TRUST BOARD**
Document Title: **Mandatory and Statutory Training (MAST)**
Action for the Board: For approval and to agree if sanctions should be applied to individuals who are in breach
Summary: This report is intended to summarise the actions being taken in response to the recent internal audit report into MAST compliance in September 2015. The report will be presented by Wendy Brewer, Director of Workforce
Author and Date: Sarah James and Marvin Perrott 24th September 2015
Presented by: Wendy Brewer

Introduction
The internal auditor examined MAST during May and July of this year using data from ARIS (the reporting tool) and an anonymous survey of 105 people.

As at July, a compliance rate of 71% was reported for the Trust, against a Trust target of 85% and a national target rate of 95%. This was a fall from the previous year which was 75%.

The most recent figures taken from ARIS show a further fall, with compliance now standing at 67%.

Division	**% Compliance Rate July**	**% Compliance Rate Current**
Capital	83	81
SWL Pathology	77	76
CWDTS	74	69
Community Service	73	72
Corporate	69	64
Surgery and Neurosciences	69	65
Estates	65	62
Medicine and Cardiovascular	64	61
R&D	63	47
Total Trust	**71**	**67**

This is important because:

The following risks are included in the Trust Board Assurance Framework 01-04: Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of numbers and levels of staff trained in safeguarding children (risk score of 12)

A610-06: The Trust will not attain its nationally mandated target of 95% of all staff receiving information governance training (risk score of 15); A520-04: Failure to maintain required levels of attendance at core mandatory and statutory training (risk score of 12).

A failure to ensure all staff receive appropriate MAST training may result in: Risks to staff and patients from non-compliance with key legislation and Trust policies and procedures; Non-Compliance with legal and regulatory, including Monitor License, requirements, leading to adverse publicity and litigation. Staff not being effectively trained to fulfill the requirements of their role.

The Audit opinion was of limited assurance as set out below:

Control Objective / Risk Area	**Assurance Level**	**Recommendations by Priority**		
		High	Medium	Low
1. There is an effective system in place to determine MAST requirements for all staff	Significant		1	
2. Staff are aware of training courses required and these are made available and accessible to them	Limited	2	1	
3. There is an effective system in place to record and to report staff compliance with MAST requirements accurately and in a timely manner *	Reasonable		1	
4. There is an effective performance management of staff compliance rates, at both local and Trust levels	Limited	1	3	
Overall Assessment	**Limited**	**3**	**6**	

The Audit Report made 9 recommendations for improvement and our progress and plan to achieve these are given in the following sections.

Control Objective	Recommendation	Progress	Plan
There is an effective system in place to determine MAST requirements for all staff	The Trust MAST Policy should be finalised and issued		MAST Steering Group to review each subject, method of delivery and target groups in the TNA. Next meeting of the Steering group is 11th November. Policy to include that all new staff will be expected to complete MAST within 2 weeks of starting, and that there will be fines for non-attendance for classroom based training. Policy to be updated and reissued December 2015.
Staff are aware of training courses required and these are made available and accessible to them.	Further awareness raising to be provided to check compliance. Clear guidance on how to report errors in the data. The Intranet should be clear how to access to MAST training. Trust-wide Access to Totara/ARIS Notification of compliance status	A user guide has been produced and sent to ORC for members to disseminate to their divisions/departments. The user guide is available on the intranet. It was also sent to Practice Educators and a range of managers. Any enquiry to the MAST email account receives the user guide as part of the response. Totara and ARIS are demonstrated at every Corporate Induction. Totara and ARIS are demonstrated as part of nursing away days. Totara and ARIS are demonstrated at Practice Educators meetings. Error reporting has been raised at ORC, HSF	Reminder to go into EG on 1st October 2015 on then quarterly. Low compliance areas to be targeted monthly starting 30th September 2015. Email reminders to be sent until the training is undertaken. Requires system development. Cost being sought by 9th October 2015.

		committees and corrections are being received. A low compliance report by area is available on ARIS. Testing has taken place in the community in August and September. Drop in sessions are being held. Community staff accounts are being enabled on request by managers for groups of staff, departments are being prioritised where compliance is lowest. 938 staff members are now able to access Totara. Email reminder functionality was turned on late August. Reminders go to the member of staff and their manager once.	
Staff are aware of training courses required and these are made available and accessible to them.	Organisers of face to face training should use the on-line booking system on Totara, to facilitate more robust recording of training attendances.	This was on the agenda for the Operational Management Team in September. Subject Matter Experts (SME) have been offered training.	Outstanding SMEs to be re-invited to attend training on how to administer the system. By end of October 2015.
There is effective performance management of staff compliance, at both	The performance target should be consistently included in all MAST	The 85% target has been included in performance reports since the end of August 2015.	Meeting with developers to resolve on-going problem between the system and the application, and contract review by mid-October

local and Trust levels.	performance reports. Line managers should be reminded of their responsibilities to ensure that their staff are fully compliant with MAST. The Trust should document actions including responsibilities and timescales for delivery for all actions identified by the Trust and this internal audit report to improve compliance rates. Risks of non-compliance with MAST targets should be included on Divisional Risk Registers.	Email reminders to members of staff include their managers; these have been going out since late August September ORC requested that Divisions include this on their Risk Registers.	Trust wide objectives for managers have been drafted including that they and their staff will be compliant with MAST. Dependant on the issue resolution, these will be populated in the on-line appraisal system embedded in Totara. There are development requirements to be finalised and costed (circa £27k). December 2015. To be addressed through ORC November 2015.

In addition to the responses to the audit report we are undertaking other pieces of work:

- Holding drop in sessions for staff – One drop in session has been done at QMH and another is being set up for early October. There are 9 onsite drop in sessions from 2nd October – 27th November.

- Reviewing capacity of the SMEs to deliver the requirements – There are known issues with some services, such as resuscitation, who now have long waiting lists for training. Whilst the review can be conducted before the next Steering Group, the solutions may take 12 months before an improvement is seen in the compliance figures.

- Reviewing Corporate Induction and producing some options to include some core subjects on day 1. Options paper to be presented to the Workforce and Education Committee November 19th 2015.

- Reviewing the Inter Authority Transfer process on ESR to see if training data can be obtained at Conditional Offer stage without adversely impacting on PAYE. This would involve a change to procedures by Payroll. To be completed by end October 2015.

- Exploring the use of pre-employment e-learning.
    - We are obtaining prices for an on-line training programme for junior Doctors. If funding allows, the programme will need customising, but could be ready by January 2016.

    - We will set up a Task and Finish Group to produce an on-line programme for nurses and midwives, the finished product to be ready June 2016.

- Proposed changes to the Policy are outlined against recommendation 1 above. The Steering Group will agree how this is to be enforced, and what sanctions might be available for non-compliance. November 2015.

Recommendations

The board is asked to note the progress that has been made, agree the planned actions.

Influenza Delivery Strategy 2015/16 Campaign Overview

Introduction

The aim this season is to administer flu vaccination to 75% of patient facing staff and to deliver the CQUIN flu vaccine delivery target of 55%

The Occupational Health (OH) Flu Lead is Elaine Mills (EM) who will organise, run and report on the campaign

Vaccine delivery

- Vaccines available from 18 09 15
- Egg-free vaccine expected on 09 10 15

SGH: Main site

- Central base –Monckton Lecture Theatre Foyer
- Dates 05 10 15 – 29 01 16
- Opening times 08.00 – 18.00 Monday – Friday
- Weekends & evenings- Shivas Pharmacy
- Timetable of clinical area visits by vaccination team
- Peer vaccinators
- Vaccination offered to all new starters and opportunistically at all OH appointments

Community Services: QMH, NH, HMPW & CSW Clusters

- Timetable of clinical area visits by vaccination team
- CSW clinics have dates for drop-in clinics
- Shivas Pharmacy days/weekends/evenings
- Peer vaccinators
- Vaccinators comprised of:

Staff Bank Nurses, 1 Agency Nurse for 6 weeks, peer vaccinators , Occupational Health staff and external Pharmacists via a CCG funded programme who will offer the service for as long as it meets their business model needs

- Peer vaccinators have commenced vaccinations in their own areas (from dates of training/ signing of PGD)
- Shivas pharmacists commenced vaccination in high risk areas from 29/09/2015
- SGUL & KU healthcare students vaccinated during intakes, commencing 18 09 20
- Staff attending OH appointments opportunistically offered flu vaccination at their appointment time

Peer vaccinators

Peer vaccination has proven to be critical in attaining flu vaccination targets and in promoting positive education and infection control awareness pertaining to flu and associated illnesses.

Peer vaccination training has been delivered by OH clinical Medical staff

- 27 peer vaccinators have volunteered to date
- 23 peer vaccinators trained
- Peer vaccinators from wide range of ward/clinic areas - of note ITU's, NNU, HMPW and Theatres
- More peer vaccinators sought – to include staff on phased return to work or restrictions

Communication

- EM working with allocated Comms officer & awaiting reply on progress of project form
- Awaiting pictures & information to be added to trust intranet page, then will circulate via mail drop/all-staff e-mail
- Information loaded onto OH intranet page
- TV screen saver designed for TV's across trust
- Myth busting posters in flu clinic, OH departments, link from OH intranet page
- Banners in GW main foyer
- Booked Flu update slots on agendas of monthly Nursing Board and ICC
- Flu vaccination will be promoted at weekly trust induction
- T-shirts/tabards for vaccination team

Incentives

- Sweets will be offered, with stickers, to staff who have had a vaccination
- Unsuccessful in obtaining rewards from e.g. free / money off drinks vouchers to be traded at SGH staff canteens
- Unsuccessful in obtaining funding for an incentive for receiving or administering vaccinations such as an iPad or Kindle
- Unsuccessful in obtaining support from on-site franchises for e.g. free hot drinks or money off vouchers

Senior teams

- Awaiting reply from Miles Scott regarding whether he is available to be photographed opening the flu clinic for SG magazine. It is understood that Simon Mackenzie is willing to be photographed being vaccinated

- Sam Thayalan had his photo taken whilst delivering peer vaccination training and will write a piece for SG magazine for November

- A GSTT tip for improving uptake was for recognisable Senior Nursing/IC staff to be involved in vaccinating in the flu clinic or on the wards, however in the current climate there appears to be limited time resource to allow this

Vaccinations given to date

- Student vaccinations from 18 09 15 to date approx. 900

- Staff consent/record forms will be collated once a Flu Administrator is in post

Reporting

- Statistics will be collated from Flu consent forms and records entered onto Cohort, OH software
- Workforce Information is working on an improved method of recording vaccination data on ESR
- ESR to report weekly
- Uptake rates for patient facing staff, non-patient facing staff and clinical areas will be reported on with HRD being first point of reporting
- National reporting processes remain unchanged
- Monthly reporting will be as per DH requirements

NHS Employers will offer support to organisations that are not performing well. OH will liaise with them, via HRD, to ascertain what support the trust may choose to engage with.

Elaine Mills
Occupational Health Nurse Adviser
Annie Stewart
Senior OHNA / Business Manager

WTE changes over the course of FY15

In the year to 31 March 2015, the Trust employed 231 more WTEs, of which 61% were supported by business cases or as part of the safer staffing review. Net Establishment posts only increased by 124; posts were removed as well as added during the year.

Reason for increase in headcount (year to 31 March 2015)	Increase in headcount/WTE
Accounted for in approved Business Cases	64
Result of safer staffing review	77
Other reason (not replacement staff for exits)	90
WTE in post	**231**
Net Establishment increase	**124**

Source: RH – Positions analysis 01-apr-14, and Establishment Mar 2015

Key messages

- 39% (90) of increases of WTE in posts appear unsupported by business cases or as a result of safer staffing
- Net establishment only increased by 124
- Vacancy factor (difference between in posts and establishment) therefore decreased during the year
- Further analysis and investigation is required to ascertain whether activity levels match those anticipated in Business Cases
- All numbers are from ESR and are therefore indicative for each Caregroup until the reconciliation to Agresso is completed

The largest movements are in the following Caregroups:

Care group	Increase in headcount / WTE	Increase in establishment posts / WTE	Comments
Therapies	46	1	Recruitment drive to fill vacancies
Ops & Service Improvement	44	41	Increase does not appear to have been supported by a Business Case
Paediatric Medicine	32	5	Recruitment drive to fill vacancies
Cardiac Dir. Overheads	26	18	Movement of budgets, offsetting impact in 'Other'
Clinical Haematology	22	45	Gordon Smith Ward opening
Neurosurgery	16	0	Filling vacancies
Other	45	14	
Total	**231**	**124**	

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – OCTOBER 2015

Paper Title:	South West London Acute Provider Collaborative and South West London & Cancer Vanguard bids update
Author:	Rob Elek – Director of Strategy
Purpose:	To update the board on progress and surface the next steps.
Action required by the board:	To consider the contents of the report in the context of our strategic position.
Document previously considered by:	EMT received an update on 28th September. The board has received regular progress reports.

Executive summary

An update from the South West London Acute Provider Collaborative (SWL APC) Programme Director is appended (Appendix 1) to this covering paper. The key issues for the board to note with respect to SWL APC are:

- Whilst the SWL APC report was submitted as planned in July, no formal feedback has been received to date.
- The informal feedback from commissioners, and the tripartite, has been generally positive.
- The SWL APC vanguard bid was not successful – the key selection criteria appear to have been focused on hospital chains.
- The entire SWL health system is in discussion with the tripartite around the most appropriate delivery vehicle and governance structure. Key challenges to this relate to the need to view the health system holistically, whilst maintaining focus on the key workstreams, developing an appropriately resourced and timed programme, and garnering the appropriate local, regional and national support.
- Over and above the risks associated with these processes, CCGs, SWL sector and NHSE have been releasing their commissioning intentions for 2016/17; at first sight these follow the standard planning approaches, and do not appear to be fully aligned with the wider SWL system issues as expressed in the SWL APC report nor the financial / operational pressures that the system is currently experiencing.

The Royal Marsden / Imperial / St George's vanguard bid for an accountable clinical network for cancer was successful, alongside other cancer vanguard bids. The confirmation letter from the Royal Marsden is attached (Appendix 2). The board is asked to note:

- The reference in the letter to clinical engagement – this remains a key issue, both in the context of the impact of the vanguard on the London Cancer Alliance, and the requirement to develop the detail behind the proposal at pace over the coming months.

A further verbal update will be provided at the board as:

- The SWL health system / tripartite discussions may have reached a conclusion.
- The board supported the cancer vanguard bid on the basis that key concerns were adequately resolved and these are yet to be fully addressed.

Appendix 1

Update to Boards on the South West London Acute Provider Collaborative

30 September 2015

Introduction

At the end of 2014 the four South West London (SWL) acute providers agreed to work together as the SWL Acute Provider Collaborative, to find ways to jointly address the challenges that the acute sector in SWL are facing.

The four trusts worked together during the first half of this year to develop some initial directions of travel, which were put to commissioners in July. The report will be published in due course alongside other responses that commissioners are receiving to the 5 Year Strategic Plan, and the Issues Paper for SWL which was published by commissioners over the summer.

This note updates Boards on

- The directions of travel emerging from the first stage of the work
- Next steps

Background and context

The four SWL acute providers (Epsom and St Helier University Hospitals NHS Trust, Kingston Hospital NHS Foundation Trust, Croydon Health Services NHS Trust, and St George's University Hospitals NHS Foundation Trust) agreed in late 2014 to work together as a 'virtual organisation', the South West London Acute Provider Collaborative.

The aim of the Collaborative is to consider how to deliver the strategic direction laid out in the 5 Year Strategic Plan for South West London. In particular, it aims to identify clinical improvements and financial savings that the four trusts would not be able to deliver just by working alone.

At the end of July, the four SWL acute providers agreed, and submitted to the commissioners, a report laying out some directions of travel.

The directions of travel laid out in the report formed the basis of a Vanguard bid. SWL received very positive feedback on the bid, and it was shortlisted out of more than 60 schemes nationally to present at the national final selection event. Although SWL was ultimately not selected for the final group, having been shortlisted for the Vanguard is likely to mean that SWL will have access to some ongoing peer support and support in developing best practice going forward.

Appendix 1

Directions of travel

The report focused on updating and analysing the case for change, in order to focus in on four key workstreams around clinical quality and financial sustainability:

- Shared administrative functions
- Reducing length of stay
- Reducing non-elective admissions
- Strengthening clinical networking.

Shared administrative functions
The work of the Collaborative focused on those back-office and support functions which are currently carried out across the trusts, and which could be done more efficiently in a pooled arrangement. For example, backoffice functions such as payroll are currently carried out separately in the four trusts, and staff who work at different providers in SW London have to go through separate sets of training covering similar issues in each. The providers have agreed to work together to make backoffice and workforce functions more efficient and streamlined.

Reducing length of stay
The Collaborative found that a high proportion of patients in acute beds in SWL, particularly frail elderly, do not need to be receiving full acute care. In some cases they could go home, while in other cases they could receive better care from an intermediate ward where they have access to medical care if it is needed. The Collaborative looked at a pilot carried out at Epsom Hospital, to identify whether it might provide lessons for a new model of care for the frail elderly. The report also pointed towards the need for much better working with the out of hospital sector.

Reducing non-elective admissions
The Collaborative found that another major contributor to poor quality care and higher cost is high levels of non-elective admissions. The report looked at strengthening the approach to Ambulatory Emergency Care in providers, as a mechanism to reduce the number of people spending unnecessary nights in hospital. It also pointed towards the need for much better working with the out of hospital sector.

Strengthening clinical networking
The Collaborative looked at work that has been done elsewhere in the country, for example by the South East Coast Clinical Senate, to network services across a health economy. The main driver behind this is to ensure that all SW London services can meet the London Quality Standards, by making the best use of the workforce available across the four providers. The report pointed towards the need to do much more work on the options and potential of this, in partnership with patients.

So far, the report has been well received by both commissioners and the national organisations (NHS England, Monitor and the Trust Development Authority), although the commissioners have not responded formally to the report. The informal feedback that SWL received on the Vanguard bid particularly emphasised the level of close and collaborative working that has been carried out between the four trusts, and the progress that this represents in SWL.

Appendix 1

Next steps

The Chief Executives and Chairs of the acute providers agreed in August that they would take forward the Acute Provider Collaborative, and agreed to appoint a permanent Programme Director to take forward the proposals in the report

- **Early October:**
    - **Design governance structure**: this will be discussed at a workshop with NHS England in early October. NHSE are keen that the work of the Collaborative should be joined up more closely with work on the future of the OOH providers and the commissioners.
    - **Modelling:** work will get underway with NHSE to agree the scale of the financial challenge
    - **Shared administrative functions:** work will be taken forward on the development of the staff bank.

- **Mid-late October:**
    - **Agreement of MoU and other programme documentation:** this will go to Boards at the end of October.
    - **Agreement of funding:** the proposed budget, with deliverables, will be circulated to Boards at the end of October.
    - **Development of scenarios will begin:** clinical groups will be set up to develop the main scenarios by end December
    - **Development of clinical groups on LoS and NEL admissions** will begin and their work will be scoped.

Alexandra Norrish
Programme Director SWL Acute Provider Collaborative

Appendix 2

The ROYAL MARSDEN
NHS Foundation Trust

The Royal Marsden
Fulham Road
London SW3 6JJ
Tel 020 7352 8171
www.royalmarsden.nhs.uk

Dear Partners and Colleagues,

Accountable Clinical Network for Cancer

We are delighted to let you know that our application to develop an Accountable Clinical Network for Cancer has been successful, and was announced by Simon Stevens today. Thank you very much for the advice and support you have provided to date. This is a really exciting opportunity for us all to transform the quality, efficiency and models of care for patients with cancer and we are looking forward to working with you.

In practical terms, we have agreed with the LCA Members' Board that we will develop a plan for alignment of the emerging new service delivery model with the quality and accreditation function of the LCA. We will also set up some "Town Hall" style meetings for wider clinical discussion on the concept and next steps as soon as possible, just as we did when the LCA was first established.

We have been asked by NHS England and the New Models of Care Team to ensure our partnership also works with The Christie in Manchester and UCLH so that there is an appropriate national focus on cancer improvement. We do not expect this to change the partnership model we have discussed for West London, but it is clearly sensible to work with the other Vanguard applicants in the overall ACN model for cancer to ensure that whatever we develop it can ultimately be reproduced nationally.

We will be in touch to set up clinical and partner meetings as soon as possible. If you have any queries in the meantime please do not hesitate to ring either of us.

We look forward to working with you on such an important national initiative.

Kind regards,

Cally Palmer

Shelley Dolan

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St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD *Oct 2015*

Paper Title:	Risk and Compliance report for Board incorporating: 1. Corporate Risk Register 2. External assurances
Sponsoring Director:	Peter Jenkinson, Director of Corporate Affairs
Author:	Sal Maughan, Head of Risk Management
Purpose:	To highlight key risks and provide assurance regarding their management. To provide assurance to Board regarding compliance with external regulatory requirements
Action required by the committee:	To note the report and consider the assurances provided.
Document previously considered by:	Quality and Risk Committee (QRC)

Executive summary

Key messages:

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- There is one new extreme risk and one risk has been closed.
- Controls are developed for all risks, with a rolling programme of review by QRC during 2015.

External Assurances:

- Following an unannounced inspection by the Human Tissue Authority (HTA) in July, a repeat inspection was undertaken on 1st September where the HTA was satisfied that work is well under way to address the issues previously identified.
- The trust responded to two CQC Mortality Outlier Alerts in August 2015:
  - Cardiac pacemaker or defibrillator introduced through the vein
  - Coronary atherosclerosis and other heart disease

  The trust response has been acknowledged and an action plan has been requested to address the learning points identified.

Risks
The most significant risks on the Corporate Risk Register are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All CQC Fundamental standards & regulations

Equality Impact Assessment (EIA): Has an EIA been carried out? Yes
If yes, please provide a summary of the key findings

1. Risks – Corporate Risk Register (CRR):

This report identifies the extreme risks on the Corporate Risk Register with the details of the most significant risks (scoring 20 or above) summarised in Table 1. An executive overview of the CRR is included at appendix 1. The rating is prior to controls being applied to the risk. Risks are reduced once there is evidence that controls are effective and detailed controls for the most significant risks is included at appendix 2.

Table one: highest rated risks (detail at Appendix 2)

Ref	Description	C	L	Rating ↓↑
01-12	Bed capacity for adult G&A beds may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	**5**	**4**	**20 →**
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	**5**	**4**	**20 ↓**
01-07	Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	**4**	**5**	**20 →**
01-06	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	**5**	**4**	**20 →**
01-18	Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	**5**	**4**	**20 →**
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	**4**	**5**	**20 →**
3.14-05	Working capital – the trust will require more working capital than planned due to: Adverse in year I&E performance Adverse in year cash-flow performance	**5**	**4**	**20 →**
3.15-05	Risks to income – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust.	**5**	**4**	**20 →**
3.20-05	Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.	**5**	**4**	**20 NEW**

1.1 New risks proposed for inclusion on the CRR

There has been one new risk included during the reporting period:

- Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.

One new risk was identified at the QRC meeting in September:

- General management resource in divisions as well as executive capacity to safeguard core business whilst meeting the demands of turnaround programme.

The above risks and one further potential new risk are under risk assessment:

- Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment

A further potential new risk was also previously identified:

- Risk to theatre capacity through downtime of theatres due to maintenance issues.

This risk has not been included in the CRR as a new risk but has been incorporated into risk *01-13: theatre capacity*. The risk score was increased to 25 at the time the risk materialised (end of August) but has now been reduced to 20 following urgent works to address the maintenance issues.

1.2 Changes to risk scores

Four risk scores have increased and nine have decreased as detailed in table three, the rationale for each change is included at Appendix one.

Table three: changes to risk scores

Ref	Risk	Previous	Change ↑↓
A516-04	Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	6	9↑
A518-04	Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey	12	16↑
A520-04	Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	12	16↑
01-13	Theatre capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	25	20↓
01-15	Adult critical care capacity may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience	20	16↓
03-02	Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	16	12↓
01-01	A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.	12	9↓
3.8-06	Low compliance with new working practices introduced as part of new ICT enabled change programme	16	12↓
03-06	There is a risk of regulatory action should the trust fail to ensure compliance with its HTA licence in relation to the mortuary	20	15↓
3.13-05	Working capital – the trust will not be able to secure the working capital necessary to meet its current plans	20	10↓
3.16-05	Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.	20	10↓
3.17-05	Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives	20	15↓
3.19-05	Cash-flow Risks – Cash balances will be depleted due to: Delays in receipt of SLA funding from Commissioners Capital overspends	12	16↑

1.3 Closed risks

One risk has been proposed for closure during the reporting period:

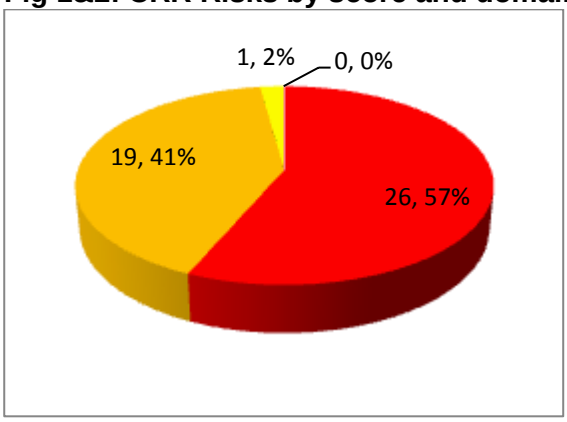
- 3.12-06 Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability to be able to monitor patient pathways and manage 18 week performance.

This risk has now been treated with the configuration of the IT system being reverted back to previous with impacted data having been corrected.

1.4 Summary of risks by score and domain

There are 28 extreme risks on the CRR (a score of 15 or above) which equates to 62% of the total risks, this compares with 57% in Sept 2015. Of these extreme risks, 11 sit within the domain of Quality and eight within Finance and Operations. Of the total risks on the CRR, 44% relate to Quality and 22% to the Finance and Operations domain.

Fig 1&2: CRR Risks by score and domain



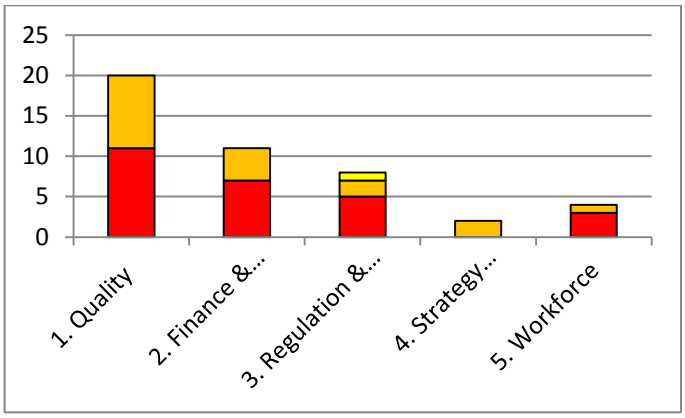


Table three: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Moderate)	0-3 (low)	Total
1. Quality	11	9	0	0	20
2. Finance & Operations	7	4	0	0	11
3. Regulation & Compliance	5	2	1	0	8
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	3	1	0	0	4
Total	**26**	**18**	**1**	**0**	**45**

1.5 Deep Dive: Quality Risk Committee

The QRC are due to undertake a deep dive into the following risks on 28th October 2015:

- A534-07: Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety
- 01-08: Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results

The QRC deep dive will also be informed by a presentation and update around the work currently underway to address each of the risks with an appraisal of any identified gaps and future recommended actions.

1.6 Extreme Divisional Risks

The extreme divisional risks as reported at the Organisational Risk Committee in September can be found at appendix 3.

2. Assurance Map

The Trust Assurance Map is a schedule of all external visits, inspections and reporting which captures on-going actions in response to external reviews and those underway to prepare for forthcoming visits. The assurances received from these external inspections help inform the board as to continued compliance with regulatory requirements including Care Quality Commission standards. The following section provides a summary of all external assurances acquired via external reports, visits and inspections during the reporting period.

2.1 Summary of external assurance and third party inspections – Sept 2015

2.1.1 Human Tissue Authority (HTA) licence no. 12387

The HTA works under two laws: the Human Tissue Act 2004 (HT Act) and the Human Tissue (Quality and Safety for Human Application) Regulations 2007 (Q&S Regulations). As part of the regulatory framework, the HTA licenses establishments and carries out inspections to assess whether sector specific standards are met.

The trust underwent an unannounced inspection of its mortuary premises on 27th July 2015 at which time the HTA considered the trust was in breach of its licence and must take a number of urgent actions in response In relation to:

- Limited storage capacity of the mortuary – leading to use of bespoke temporary storage units;
- Length of stay of some deceased patients (a high proportion are Coronial cases);
- Air quality in the post-mortem room and;
- Ability to safeguard the dignity of deceased patients and maintain high hygiene standards whilst using temporary storage.

The HTA re-inspected the mortuary on 1st September at which time they were satisfied that significant works had been carried out or were underway to address the identified issues.

The task and finish group convened to oversee the urgent work will continue to meet fortnightly to ensure the identified actions continue to be delivered within the required timescales.

2.1.2 HTA Inspection re Licence 12462: 20th August (announced)

The trust underwent site inspection by the HTA in relation to its licence to carry out the procurement, testing, storage, and distribution of human tissues and cells for human application.
The draft report has now been received. Two minor non-conformities were identified and an action plan has been submitted to the HTA in response and will be monitored through the divisional structure.

2.1.3 CQC Mortality Outlier Alerts

The trust responded to two CQC Mortality Outlier Alerts in August 2015:

- Cardiac pacemaker or defibrillator introduced through the vein
- Coronary atherosclerosis and other heart disease

The trust was already aware via Dr Foster monitoring of the alerts and a full investigation and response was provided to the CQC on 4th August 2015. These have been acknowledged and an action plan has been requested to address the learning points identified in the first alert.

There were two previous Serious Incidents (SIs) associated with the second alert; the investigation reports were also shared with the CQC as part of the overall trust response. The CQC will seek assurance via the Wandsworth CCG Clinical Quality Review Group meeting on 21st October that all actions arsing for the SI investigations have been completed and have been effective.

2.1.4 Haematology/Cancer Peer Review

The trust has received notification from NHs England, Specialised Commissioning of a serious concern identified via Cancer peer review in relation to the Haemato-oncology MDT. The concern relates to under attendance at the joint SGH/Kingston MDT which they considered means that a large proportion of patients may not benefit from the knowledge and expertise of a full multidisciplinary team when decisions are being made about their diagnosis and care.

NHS England define a serious concern at peer review as an issue that, 'whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve'.

The service have provided further detail in response to support attendance at MDTs and have acknowledged the mina issue to be recording of this. A full formal response will be provided by 9th October.

2.2 Forthcoming inspections

2.2.1 NHS Quality Assurance: Breast Cancer Screening Programme

Quality assurance (QA) is the process of checking that national standards are met (ensuring that screening programmes are safe and effective) and encouraging continuous improvement. Public Health England (PHE) is responsible for the NHS Screening Programmes and National Screening Quality Assurance.

The Trust is currently providing information ahead of a QA inspection in November 2015.

3. Conclusion

The programme of detailed review of risks included on the Corporate Risk register continues in order to provide stronger assurance to the Trust Board around the management of risks.

The overall long-term risk profile for the trust continues to be driven by the continued financial and operational pressures faced by the trust.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	In month change	Change/progress
1.1 Patient Safety								↓↑	
01-12 Bed capacity for adult G&A beds may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	20	20	20	20	20	20	→	
01-13 Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	20	20	20	20	25	20	↓	Urgent theatres maintenance undertaken has lessened the likelihood from 5 to 4.
01-15 Adult critical care capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	20	20	20	20	16	16	↓	Likelihood decreased due to effectiveness of controls
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	12	12	12	12	12	12	→	
01-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.	JH	12	12	12	12	12	9	↓	New guidance and protocol management becoming embedded.
01-02: 01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	EM	9	9	9	9	9	9	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	EM	9	9	9	9	9	9	→	
01-04 Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children.	JH	12	12	12	12	12	12	→	
01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the trust.	JH	12	12	12	12	12	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	MW	15	15	15	15	15	15	→	
01-07 Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	MW	20	20	20	20	20	20	→	

01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	SM	16	16	16	16	16	16	→	
01-09 Risk to patient safety due to a lack of a trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices	EM	12	12	12	12	12	12	→	
01-10 Risk to patients, staff and public health and safety in the event the trust has failed to prepare adequately for an Ebola incident.	JH	10	10	10	10	10	10	→	
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments	MW			12	16	16	16	→	
01-18 Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	SM				20	20	20	→	
01-16 There is a potential 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 run rate schemes.	EM					16	16	→	
01-17 There is a potential risk to the quality and safety of patient care in the event that required works cannot be undertaken due to capital funding decisions not to fund such projects.	EM					12	12	→	

Strategic Objective/Principal Risk	**Lead**	**Apr 2015**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**In month change**	**Change/progress**
1.2 Patient Experience								↓↑	
A410-O2: Failure to sustain the trust response rate to complaints	JH	16	16	16	16	16	16	→	
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	JH	16	16	16	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**Apr 2015**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**In month change**	**Change/progress**
2.1 Meet all financial targets								↓↑	
3.13-05 -Working capital – the trust will not be able to secure the working capital necessary to meet its current plans					20	20	10	↓	Likelihood reduced to 2: ITFF approval of temporary loan

3.14-05 Working capital – the trust will require more working capital than planned due to: - Adverse in year I&E performance - Adverse in year cash-flow performance					20	20	20	→	
3.15-05 Risks to income – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust					20	20	20	→	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.					20	20	10	↓	Likelihood reduced to 2: limited evidence of reductions in referred activity
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives					20	20	15	↓	Likelihood reduced to 3: positive impact of controls
3.18-05 Cost Pressures - The trust faces higher than expected costs due to:- - unforeseen service pressures - higher than expected inflation - higher marginal costs or costs required to deliver key activity					16	16	16	→	
3.19-05 Cash-flow Risks – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends					12	12	16	↑	Likelihood increased to 4:Data quality issues persist and new contract query notice served
3.20-05 Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.							20	**NEW**	

Strategic Objective/Principal Risk	**Lead**	**Apr 2015**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**In month change**	**Change/progress**
2.2 Meet all operational & performance requirements								↓↑	
3.7- 06 Failure to meet the minimum requirements of the NTDA Accountability Framework: Quality and Governance Indicators/Access Metrics.	SB	20	20	20	20	20	20	→	
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	SB	16	16	16	16	16	12	↓	Likelihood decreased – positive assurances around roll out

3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	16	16	16	12	12	12	→	
3.12-06 Risk to patient safety due to data quality issues with Patient Administration System (PAS), Cerner, inhibiting ability to be able to monitor patient pathways and manage 18 week performance.	SB	9	9	9	9	9			Closed:

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	In month change	Change/progress
3.1 Maintain compliance with all statutory & regulatory requirements								↓↑	
A534-O7:Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety	PJ	5	5	5	5	5	5	→	
A537-O6:Confidential data reaching unintended audiences	SM	12	12	12	12	12	12	→	
A610-O6: The trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training	SM	15	15	15	15	15	15	→	
03-01: Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	EM	16	16	16	16	16	16	→	
03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	EM	16	16	16	16	16	12	↓	Likelihood reduced following QRC deep dive review
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM	16	16	16	16	16	16	→	
03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works.	EM	16	16	16	16	16	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM	12	12	12	12	12	12	→	
03-06 There is a risk of regulatory action should the trust fail to ensure compliance with its HTA licence in relation to the mortuary	JH					20	15	↓	Positive return inspection by HTA on 1st Sept and action plan underway

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	In month change	Change/progress
4.2 Redesign & configure our local hospital services to provide higher quality care								↓↑	
A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances	RE	12	12	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	In month change	Change/progress
4.5 Drive research & innovation through our clinical services								↓↑	
05-05 Research does not form a key part of St. George's future activity which may result in the loss of funding and an inability to recruit and retain staff.	SM	8	8	8	8	8	8	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Apr 2015	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	In month change	Change/progress
5.1 Develop a highly skilled & engaged workforce championing our values								↓↑	
A518-O4:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey	WB	12	12	12	12	16	16	↑	Feedback from individual staff following trust wide comms campaign
A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	WB	6	6	6	6	9	9	↑	Greater likelihood risk may materialise
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	12	12	12	12	16	16	↑	Levels of training have dropped and emerging risks on divisional risk registers
5.1-01 Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost	WB	12	12	12	16	16	16	→	

JH	Jennie Hall	Chief Nurse (DIPC)	EM	Eric Munro	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
PJ	Peter Jenkinson	Director of Corporate Affairs	WB	Wendy Brewer	Director of Human Resources
SB	Steve Bolam	Director of Finance Performance & Information	MW	Martin Wilson	Director of Delivery & Performance

Appendix 2 – Most significant risks (>20)

Principal Risk	**01-12 Bed capacity** for adult G&A beds may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Root cause: Requirement for high activity volumes in order to meet patient and commissioner needs, and to deliver income margin as part of Trust Cost Improvement Programme. Unlimited demand on A&E which impacts on increase in emergency admissions & capacity for elective admissions affecting 28 day rebook timeframes. Delayed patient repatriation to host hospitals block beds for emergency/elective activity. 14.2% increase in emergency admissions in patients over 70 Challenges in both delivering addition capacity and releasing capacity through flow, to agreed timelines Impact: Potential for commissioner challenges and financial penalties due to breach of ED and RTT targets Potential subsequent impact on patient pathways & patient safety. Adverse reputation				
Domain	1. **Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Oct 15**	**Exec Sponsor**	Martin Wilson
Consequence	5	4	4	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	5	5	5	**Date closed**	
Score	25	20	**20**		
Controls & Mitigating Actions	**Controls:** Overall: Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Manager dedicated to capacity. Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Existing capacity: Maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved New capacity: Business Planning identified ~72 beds are required in 15/16 to deliver required activity volumes based on 13/14 length of stay. Analysis of 13/14 LOS indicates 8% increase which is			**Assurance**	Negative assurance: - 4 hour operational standard performance - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 Internal capacity assurance: Joint trust & CCG capacity planning for 15/16 undertaken and approved by SRG Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. Follow-up capacity audit is to be completed in Q4 Flow programme dashboard provides real-time analysis of performance against targets External assurance: ALOS benchmarking will provide insight into areas of strong and weak patient flow

	driving an additional 70 bed gap Proposals for additional bed capacity agreed with commissioners Risks exist with respect to the timing and delivery of plan. To control these risks, we have increased capital project management capability **Mitigations:** • Build/commission additional 70 beds of capacity • Cap demand for services • Increased command and control of bed management and hospital flow Work with SRG to produce system-wide solutions Development of critical path for all forecast building schemes, and embedding the holding to account of Senior Responsible Owners for delivery of agreed schemes. •		
Gaps in controls	Ability to deliver agreed additional capacity schemes to agreed timelines remains a challenge	**Gaps in assurance**	
Actions next period:	Realisation of new physical bed capacity New integrated demand & capacity model being developed for 5 year view by KPMG		

Principal Risk	**01-13 Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to deliver 18 week RTT standards, and to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties Adverse reputation				
Domain	1. **Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Oct 15**	**Exec Sponsor**	Martin Wilson
Consequence	5	5	5	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	**Controls:** Overall: Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity. Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Theatre Capacity Plan for 2015 to 2018 developed by Director of Delivery and Improvement with senior leadership from SNCT leadership team. Plan reviewed by extraordinary OMT and regularly reviewed by EMT. Existing capacity: Business Planning for 2015/16 increased alignment between divisional activity and capacity plans. Star chamber held by Director of Finance and Director of Delivery and Improvement with each divisional leadership team to ensure that planned activity numbers are robust. Additional capacity being realised through: • Increased in session utilisation within existing theatre sessions • All day operating sessions within day surgery • Extended day operating in main theatres • Commissioning the planned Hybrid theatre as an additional theatre • Offsite capacity options (NHS and independent sector) • Business case developed for opening Cardiac 4 as additional theatre • Expert external engineers developing plans for planned preventative maintenance, remedial works and theatre upgrades to minimise loss of capacity Specific theatre capacity analysis and plan developed linked to a longer term theatres strategy currently in development.. A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway. **Mitigations:** • Seek additional external capacity • Cap demand for services • Divisional management teams & boards to monitor	**Assurance**	Negative assurance: - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 - Cancelled elective surgery Aug 15 due to loss of air pressure and ventilation Internal assurance: Internal theatres capacity plan and tactical implementation plan Approved by Executive Management Team. Reported to Finance and Performance committee. Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. 6 of the 13 Day Surgery Unit extended day, (including reallocating sessions of activity from main theatres) Theatres dashboard in use – enables tracking of theatres throughput and utilisation External assurance: Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 elective RTT funds. Score increased – based upon recently materialised risk regarding theatre ventilation and maintenance

	activity against plan ensuring full use of allocated capacity, driving productivity improvements within sessions and outsourcing activity to other providers		
Gaps in controls	Maintenance of theatres behind plan for a number of years, leading to a materliased risk that theatres will break down Urgent plans being developed.	**Gaps in assurance**	Admitted backlog of over 18 week waiters greater than sustainable. Non-admitted backlog numbers not being reduced at planned rate. Theatre performance data dashboards not yet fit for purpose with divisional clinical teams.
Actions next period:	1. Go live with new DSU & paediatric CEPOD timetable 2. Continue installation of new hybrid theatre 3. PPM, remedial works and theatre upgrade plan to be completed & considered by EMT 4. Cardiac 4 business case to be reviewed and approved 5. Secure additional off site theatre and bed capacity through other providers		

Principal Risk	01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists				
Description	Risk to patient safety and patient experience as patients waiting greater than 18 weeks on elective waiting lists. Possible impact that patient's condition deteriorates. Specific issues regarding cardiothoracic surgery waiting lists in particular.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Oct 2015**	**Exec Sponsor**	Martin Wilson (shared with Jennie Hall re Patient Safety)
Consequence	5	5	5	**Date opened**	31.5.2014
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	Management of the RTT 18 week standard is the responsibility of clinical divisions and their general management teams. They are supported in their work by the Information Team and the 18 Week Validation Team which reports into Deirdre Baker – Assistant Director of Finance. Governance arrangements are: Executive leadership for RTT transferred to the Director of Delivery & Improvement Joint trust & CCG contractual investigation to develop and deliver RTT sustainability plan completed June 2015 overseen by DoDI, Surgical Divisional Chair and GP CQR lead (Dr T Coffey). Joint Trust & CCG RTT action plan in place with fortnightly reporting to joint trust & CCG action planning performance group. Compliance Meeting chaired monthly by the Director of Delivery & Improvement, attended by General Managers, Information Team and the 18 weeks team Sub groups for admitted and non- admitted pathways which involve service managers and the 18 weeks team. RTT performance is reported to the FPI Committee on a monthly basis and the issues concerning any particularly challenged specialty are discussed in detail. Performance is also monitored by commissioners at the monthly commissioner/SGH meeting and any clinical quality issues discussed at the monthly commissioner/SGH Clinical Quality Review meetings. RTT performance delivery plan to ensure full chronological booking and achievement of RTT aggregate trust levels standards agreed with commissioners. Divisions have reviewed clinical review of waiting lists to ensure any clinical risks due to waiting are reviewed and managed. Approach reviewed by QRC and CQRM committees. Trust data quality group established 1. Specialty based clinical summits to be held with Trust & Commissioner led clinicians and managers to review the RTT position and agree actions to improve performance. To include potential increases in commissioned activity, altered pathways and diversion of referrals to other	**Assurance**	Negative assurances Identified system wide gap of £12-14m of activity required to deliver RTT sustainability Some cancellations in routine elective surgery due to bed pressures Some cancelled patients are not able to be rebooked within 28 days target (7 out of 90 in January) RTT backlog rising in Q4 and now back to end of 2013/14 level of circa 800 patients. Whole system does not yet have a plan for sustainable delivery of RTT standard – specialty summits to address this

	providers 2. RTT internal improvement plan developed		
Gaps in controls	Delivery on action plan	**Gaps in assurance**	
Actions next period:	1. Develop specialty level sustainability plans for all RTT specialties 2. RTT programme manager to be appointed 3. Move to use of patient tracking lists for booking all outpatient appointments in sequential order 4. Data quality board established		

Principal Risk	01-07 Risk to patient experience and safety as a result of potential Trust failure to meet 95% Emergency Access Standards				
Description	Should the Trust recurrently fail to meet 95% 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 95% clinical standard				
Domain	**2. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Oct 2015**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	1/6/2014
Likelihood	5	5	5	**Date closed**	
Score	20	20	20		
Controls & Mitigating Actions	Trust and CCG Joint Investigation Action Plan developed covering capacity, pathway improvement and performance management in three areas: 1. Emergency department actions – led by DDO and Clinical Director for ED 2. Whole hospital actions – led by Chief Nurse through 'Flow' programme 3. Wider system actions – led by SRG Progress in delivering action plan regularly reviewed: • ED action plan via ED Senior team meeting weekly • Whole hospital actions via OMT fortnightly • Wider system actions via System Resilience Group			**Assurance**	Q4 and Q1 performance standard has not been met 2015/16 performance forecast under delivery with trajectory of circa 93% Daily reporting to Exec team Escalation meetings between division & DoDI Joint Trust & CCG Investigation completed

	performance meeting monthly • Overall the plan is reviewed with the CEO and Director of Delivery and Improvement on a fortnightly basis Continued close and pro-active working with ECIST ED dashboard and operational standards agreed, finalised and in place 4. Increases in bed capacity (72 beds) 5. Investments in patient flow schemes (£4m) including ED hot lab		
Gaps in controls		**Gaps in assurance**	
Actions next period:	Continue implementation of improvement plan (particularly focussed on whole hospital and wider system actions)		

Principal Risk	01-18 – Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products				
Description	Kiosks are old and are breaking down on a daily/weekly basis Trust virus scanner impacts on system responsiveness Loss of Connectivity which results in gaps to Cold Chain records Current version not compatible with Windows Operating System 7 and there is no possibility of development of functionality to system Loss of System leads to unrestricted access to blood fridge and incomplete cold chain records				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update**	**Exec Sponsor**	TBC
Consequence	4	4	4	**Date opened**	1.7.2015
Likelihood	5	5	5	**Date closed**	
Score	20	20	20		
Controls & Mitigating Actions	Kiosks are sent for repair When system fails manual/papers based system is used. On-going monitoring of failures Functionality complies with current BSQR - but may not be compliant if future changes are required Paper records can be introduced that will satisfy BSQR, but increased risk of non-compliance with recording requirements			**Assurance**	Repair times for kiosks are adequate, however breakdown is now happening far more frequently (increased over last 6 months) and time to repair increases. Number of failures and several clinical incidents related to delays in providing blood. Failures are happening on a daily/weekly basis. Presented to Organisational Risk Committee in July 2015;agreement to escalate to CRR. £50K of the required capital agreed and identified from IM&T; remaining

	03/02/2015 - SWLP met with SGH Director IM&T - Recognised that full mitigation will require system upgrade. Business case prepared. A preliminary business proposal for the Trust to financially support a system upgrade was presented to CIOC and a full business case is being prepared for presentation at the Capital Bids Meeting		amount to be confirmed from finance therefore risk is anticipated to be closed imminently once new system procured. Lead time for the upgrade: it is likely to take at least 12 weeks.
Gaps in controls		**Gaps in assurance**	
Actions next period:	Procure new system Implement new system		

Principal Risk	3.7-06 Failure to meet the minimum requirements of the Monitor Risk Assessment Framework may result in reputational damage or regulatory action.				
Description	There is a risk to the Trust's authorisation should it fail to perform against the Access Metrics set out by Monitor Performance Framework particularly in relation to:- 18 weeks- A&E Waits (4 hours)- Cancer waits (TWR, 31 & 62 day targets).Individual risks, controls and actions to mitigate are set out in Divisional risk registers				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.2 Meet all performance targets**
	Original	**Residual**	**Update Sept 15**	**Exec Sponsor**	Steve Bolam
Consequence	4	4	4	**Date opened**	30/05/2013
Likelihood	4	5	5	**Date closed**	
Score	16	20	20		
Controls & Mitigating Actions	Management framework in place which measures performance across key domains including operational performance. Divisions are held to account through formal quarterly performance reviews, monthly reporting and monitoring and escalation where required through the DoFPI The Trust has a performance management framework A&E performance meeting is held routinely within the Med/Card division to scrutinise and review ED performance Finance & Performance Committee meets monthly to review in detail the performance report including all areas of the TDA accountability framework Reporting to F&P includes description of key actions and sharing of recovery plans where necessary e.g. cancer recovery plan 12/13 Q4 Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train External scrutiny: Performance is reviewed by the TDA as part of the Accountability Framework and the Trust is held to account at a monthly meeting of senior			**Assurance**	Positive assurance •HDD, BGAF and QGAF assessments •Internal audit Worsening ED performance across Q1– cross ref BAF Risk 01-07 RTT performance issues in relation to the incomplete pathway target. Following a period of joint investigation with commissioners, remedial action plans have been agreed for performance improvement in ED and RTT. Contract query notice served for cancer performance

	teams Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised **Mitigating Actions** •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads •Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train •Developmental work in place to introduce formal monthly scoring system for Divisions within the performance framework to improve visibility over performance risks and the effectiveness of remedial action •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads		
Gaps in controls	Absence of risk forecasting which is in development	**Gaps in assurance**	
Actions next period:	Recruit to staff new capacity		

Principal Risk	**3.14-05 Working capital –** the Trust will require more working capital than planned due to: Adverse in year I&E performance Adverse in year cashflow performance				
Description	The Trust's working capital requirement will increase further due to a deterioration in the income and expenditure plans and adverse cashflow movements Details of the contributory risks to working capital from the Income and Expenditure performance are provided under the following financial risks: • Income - Tariff • Income - Capacity • Income - Market Share • Cost Pressures • Cost Improvement Programme Details of the additional risks to working capital due to other cashflow changes are set out in the cash flow risk.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Oct 15**	**Exec Sponsor**	Steve Bolam

Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	**Mitigating Actions:** **Minimising Support requirement** • Trust has reviewed the commitments against the current capital programme to ensure that the Trust does not need to make an application for capital interim support • Through the cost pressure process, the Trust has ensured that increases in the requirement for new revenue expenditure have been minimised. • The Trust is reviewing its working capital management processes to maximise liquidity; extending creditor payment terms to 60 days; setting targets for debt reduction; and plans to reduce stock. **Interim Financial Support application** • Through the APR and monthly monitoring discussions, the Trust has advised Monitor of the uncertainty of its financial difficulties. • Monitor has agreed to prepare a submission to the ITFF for Interim Financial support on behalf of the Trust once a Turnaround plan has been submitted. • The Trust has engaged KPMG to assist in preparing a Turnaround plan for submission to Monitor in November. • The Trust has also applied directly to the ITFF for a temporary loan facility at the end of September to cover the Trust's working capital requirements for the period up to the end of January.	**Assurance**	Monitor have agreed that the Trust should submit a provisional application for Interim financial support to the ITFF in September and intend to submit a further application once the Trust has revised its financial plans in November.
Gaps in controls	The PWC review identified a number of weaknesses in the Trust's forecasting processes, which the Trust is currently working through to address.	**Gaps in assurance**	Monitor will only approve the Trust Forecasts once the Trust has submitted its re-forecasting exercise and Turnaround Plan
Actions next period:	**Reforecasting Exercise** • Trust is conducting a re-forecasting exercise to ensure that the Trust has a robust evaluation of the working capital requirement for 2015-16 to assure monitor that the forecasts have been thoroughly challenged and that the scale of the funding request is robust.		

<table>
<tr><td>Principal Risk</td><td colspan="5">3.15-05 Income Tariff Risk – that national and local tariffs do not deliver the required income.</td></tr>
<tr><td>Description</td><td colspan="5">A key determinant of Trust overall financial position is the tariff that the trust receives for its clinical work and the business rules that govern the application of the tariff.

There is the potential for the income position for the trust to worsen due to a range of factors linked to the tariff and application of tariff business rules. Key issues are:
▪ The impact of the Non-Elective Threshold Adjustment (NETA) on the value of increases in non-elective work, where the trust is only paid a proportion of the tariff (currently 30%)
▪ The impact of alternative contract arrangements eg the introduction of the block contract to cover non-elective work, with the associated transfer of risk to St. George’s
▪ The reduction in Trust income due to contractual penalties related to poor performance against quality standards and KPIs- payment challenges e.g. RTT performance or 1st to follow up ratios; failure to achieve best practice tariffs and non-payment by CCGs of coding related improvements
▪ That proposed changes in the national tariffs and business rules may adversely impact the trust financial position from 2016-17 eg
o the introduction of HRG4+ from 2016/17
o changes in best practice tariffs
o reinstatement of CQUIN income
o changes in application of marginal rates to non-elective work / specialist work</td></tr>
<tr><td>Domain</td><td colspan="3">Finance & Operations</td><td>Strategic Objective</td><td></td></tr>
<tr><td></td><td>Original</td><td>Residual</td><td>Update Oct 15</td><td>Exec Sponsor</td><td>Steve Bolam</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td>Date opened</td><td>20/07/15</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td colspan="2"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Controls
▪ Engagement with and development of good and positive relationships with all main commissioners.
▪ Proactive identification of changes to patient pathways which impact on the level of emergency admissions
▪ Good clinical engagement to ensure that services maximise income e.g. by not incurring payment or performance penalties
▪ Negotiation of appropriate and realistic thresholds and targets with local CCG’s to minimise trust exposure to challenges.
▪ Robust assumptions in business planning and income targets with respect to NETA impacts, Commissioner challenges etc
▪ Mechanisms for the accurate coding and appropriate charging for all activity
▪ Central role played on System Resilience Working Group will allow St. George’s to influence the local health economy
▪ Active membership of Project Diamond provides the Trust with</td><td>Assurance</td><td>▪ Role on System Resilience Working Group to positively influence how emergency care is managed in the local health economy and how retained funds are spent
▪ Reported value of emergency threshold tariff loss
▪ SWL system receiving support from PWC as part of 5 year planning process to ensure plans are coherent, consistent and deliverable.
▪ Annual business plans and business planning process though to Finance & Performance Committee and Trust Board</td></tr>
</table>

	a London wide voice to reflect Tertiary Hospital views in the development of the tariff. ▪ Active membership of FT Network to influence tariffs at a national level. ▪ Engagement with Consultation on changes to National Tariff / assessment of impact ▪ Participation with and through South West London Collaborative Commissioning to influence and mitigate the impact of the BCF on St. George's. **Mitigating actions:** ▪ Support commissioners to develop realistic and deliverable QIPP plans to manage demand for emergency services ▪ Development of admissions avoidance projects in-year which reduce the total number of patients being admitted to the trust ▪ Year End Settlement discussions to mitigate income losses by agreement with commissioners to a year-end settlement through the SLA negotiation process.		
Gaps in controls	▪ Inability to influence QIPP schemes or lack of delivery of those QIPP schemes ▪ The Trust needs to more pro-actively identify specific areas of risk ahead of payment/performance challenges	**Gaps in assurance**	Access to representation on System Resilience Working Groups outside of Wandsworth/ Merton/Lambeth where significant level of STG funding sits
Actions next period:	▪ Begin process of business planning for 2016/17 ▪ Issue of "Six month notice letter" to Commissioners ▪ Robust dialogue and negotiations with commissioners for additional funding through 2016/17		

Principal Risk	**3.20-05 Income Volume Risk (Capacity)** – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.				
Description	A key determinant of Trust overall financial position is the level of income that the trust receives for the volume of clinical work that it undertakes. The delivery of activity is dependent upon the availability of the necessary capacity in terms of beds, theatres, clinics, critical care and diagnostics. There is the potential for the income position for the trust to worsen due to a range of factors linked to the likely volume of work delivered by the Trust. Key issues are: ▪ The availability of clinical capacity in terms of beds, theatres, clinics, critical care and diagnostic services ▪ The length of stay of patients and flow of activity through the hospital and its impact on bed, theatre and clinic utilisation, especially patient repatriation. ▪ The level of investments made by Commissioners in supporting the Trust's flow and capacity plans ▪ The delivery of the Trust's flow and capacity plans				
Domain	**Finance & Operations**			**Strategic Objective**	
	Original	**Residual**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5	5		**Date opened**	30/09/15

Likelihood	4	4		**Date closed**	
Score	20	20			
Controls & Mitigating Actions	**Controls** ▪ Business planning process – development of annual capacity plan, agreeing service volumes, capacity utilisation rates and identifying capacity requirements ▪ Benchmarking and monitoring of capacity related performance measures: i.e. capacity availability, productivity and length of stay ▪ Business Case Assurance Group (BCAG) and the business case process for approval of all investments in capacity ▪ OMT, EMT, TAB and Trust board oversight of Flow and Capacity plans and delivery **Mitigating actions:** ▪ Sourcing additional capacity in independent sector at tariff to minimise loss of income associated with performance fines ▪ Ring-fencing elective beds to secure elective income ▪ Developing outpatient recovery plans to mitigate under delivery M1-6			**Assurance**	▪ Reporting of performance against planned SLA income and activity targets ▪ Live activity tracking via tableau ▪ Development of integrated demand and capacity model with scenario capabilities
Gaps in controls	▪ Integrated demand and capacity model			**Gaps in assurance**	Integrated demand and capacity model outputs to confirm capacity requirements
Actions next period:	▪ Completion of 2015-16 Reforecasting process and 2016-17 business planning process including development of integrated demand and capacity model				

Appendix 3: Divisional extreme risks

Risk Ref.	CW&DT Risk	Score	Sept 15 Change ↑↓	Rationale for change
CW026	Delay in starting or continuing Induction of Labour on Delivery Suite due to High activity and capacity Issues leading to avoidable adverse outcomes	15	↑	
CW049	Delivery of sub-standard care to sick and premature infants due to insufficient neonatal trained nurses on the neonatal unit	12	↓	Risk reviewed and upgraded June review meeting
CW057	The Division is significantly overspent due to a number of adverse movements.	25	→	
B205	Loss of data due to clinical database no longer being supported	16	→	
CW0068	Financial risk – CQUIN From 15/16 Maternity will no longer get CQUIN funding and instead CCG will develop a local tariff for 2015/16. Estimated value of risk in 14/15 = £2.5m	16	→	
CW0070	Financial risk – cost. The division fails to achieve its CIP programme	15	→	
CW0071	CW0071 - Financial risk – cost. The division does not receive funding for identified cost pressures. Estimated value of risk in 14/15 = c. £1.1m	16	→	
CW0081	Temperature during the summer months in Lanesborough Wing	16	→	
CW084	Insufficient capacity in the mortuary resulting in closure of the mortuary	12	↓	Solution in the process of being procured.
CW0087	Call alarms in St James' wing therapy dept not working properly – risk to patient safety in the event of an emergency	15	→	
CW089	Insufficient number of CTG monitors for a full triage and full induction bay meaning some women need to wait for monitoring	20	→	
CW090	Lack of NICU capacity – presenting both clinical and financial risk	15	→	
CW091	Lack of GICU capacity – presenting both clinical and financial risk	15	→	
CW092	Lack of CTICU capacity – presenting both clinical and financial risk	15	→	
CW093	Roof leak in room 5.011, 5th Floor Lanesborough Wing	25	→	
CW0097	Critical Care Run Rate Risks impacting Patient Care & Staff morale	16	→	
CW0094	Call bell system on delivery suite has failed on a number of occasions. Temporary system has been used but this has also failed to work.	closed		Risk closed - treated
CW0097	Critical Care Run Rate Risks x 2 Patient Care & Staff morale		→	
CW098	Medical Records patient safety & staff safety risk	16	→	
CW099	Unable to meet requirements for accreditation by UKAS due to Genetics Vacancies	15	→	
CW101	Lack of Storage Trauma & Orthopaedic Therapy Gym, 5th Floor St James' Wing	15	→	

CW105	(C4 x L5 = 20) - STOW (safe transfer of women) maternity system - Missed or delayed postnatal care for mother and baby	**20**	→	
	M&C		**Change**	
Risk Ref.	**Risk**	**Score**	**↑↓**	
MC13-D1	Risk to patient safety from delay in diagnosis or failure to follow up.	**15**	→	
MC31-D5	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting list for Cardiac surgery, Thoracic Surgery and Vascular Surgery.	**15**	→	
MC32-D1	The division is at risk of not delivering a balanced budget if robust CIP schemes are not found. Not all schemes identified in 14/15 have delivered and therefore knock on effect for schemes in 15/16.	**15**	→	
MC37-D1	Financial and reputational risk arising from failure to meet the 95% ED standard for time attending to leaving the ED	**15**	→	
MC46-D2	Financial Risk – cost pressures within division are not funded	**16**	→	
MC48-D2	Financial risk - Volume - decommissioning of cardiology services	**15**	→	
MC50-D2	Financial Risk – Tariff. Emergency threshold tariff	**15**	→	
MC55-D2	Financial – Volume. Lack of theatre and ITU capacity for cardiac surgery impacts on income	**20**	→	
MC57-D3	Fire risk on Knightsbridge wing – following review at April DGB, this risk was increased to reflect the concerns of the LFB regarding no means of stopping smoke from spreading.	**15**	→	
MC59-D1	Risk to patient safety that vulnerable patients are able to access the helipad form wards in St James Wing	**15**	→	
MC61-D1	Risk to patient safety, arising from delay in seeing patients categorized as "clinically urgent" within 2 weeks of referral.	**9**	↓	Action plan completed
MC66-D1	-Risk to patient safety and organisation's reputation through increase in cardiac surgical site infection.	**12**	↓	Downward trend sustained
	STN&C		**Change**	
Risk Ref.	**Risk**	**Score**	**↑↓**	
B253	SSD risk upgraded in light of recent significant failures and down time of SJW equipment. On-going issues.	**20**	→	
B268	Sterilisation equipment requires replacing and breakdown may cause service failure potentially resulting in cancelled surgery.	**15**	→	
C11	Failure to prescribe essential medication for patients having elective surgery	**16**	→	
C05	Financial Risk – cost. Failure to deliver CIP programme	**20**	→	
C06	Financial Risk – cost. Failure to receive divisional funding for cost pressures	**15**	→	
C19	GPs in some regions (Surrey, Croydon) not prescribing Antiepileptic drugs (AEDs) recommend by consultant neurologists	**15**	→	
C20	Lack of trained fire wardens	**15**	→	
C23	Risks to patient safety associated with roll out of electronic documentation	**20**	→	

C24	Failure to ensure Standard Operating Procedures (SOPs) for reviewing diagnostic tests results are in place in all areas and are effective	**15**	→	
tbc	A number of incidents have been seen with regard to availability of necessary equipment for certain surgical procedures	**20**	**NEW**	
C33	Neuro MRI scanner. Functionality is unreliable leading to delays in diagnosis and treatment for neuro patients.	**20**	↑	Finance has been approved - however still waiting for PFI variation approval.
tbc	current staffing levels for the anaesthetic team	**15**	**NEW**	
tbc	Feedback from Major trauma National Peer review – March 2015: Performance against the BOAST 4 guidelines for the management of open fractures is below the national average.	**15**	→	
	E&F		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
EF132	Risk of legionella management controls as Flushing of low use outlets and departments not returning data/records.	**tbc**	→	
EF176	Estates compliance – survey revealed gaps in compliance in statutory and mandatory items	**16**	→	
EF189	Standby Generators within Lanesborough Wing are at the end of their useful life and have insufficient capacity to meet the needs of current healthcare demands and will not need the demand as the building is re-developed and refurbished to modern standards.	**16**	→	
EF195	Electrical upgrades/maintenance to UPS and IPS in AMW	**16**	→	
EF198	Risk of noncompliance with fire regulations as a result of the lack of fire risk assessments for some areas on the St George's Hospital site.	**15**	→	
EF200	Delay to ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for works	**16**	→	
EF204	Failure of hot water system (HWS) calorifiers serving St James Wing.	**25**	→	
EF211	Failure of electrical switchgear causing loss of essential power in STJ for most of the wards and other departments	**25**	**NEW**	
EF215	Master Pact M Circuit Breakers no longer supported by the manufacturer.	**16**	**NEW**	
EF216	Automatic changeover contactors are no longer supported by the manufacturer	**25**	**NEW**	
EF217	Failure of Genie Evo High Voltage vacuum circuit breakers. The HV Maintenance contract is currently being tendered.	**25**	**NEW**	
	IM&T		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
IT016	Reduction in capacity to deliver new infrastructure, systems and change programs	**20**	→	
IT018	Community staff experiencing access difficulties and slow response to RIO	**16**	→	
IT029	There is a risk of onsite data centre (DC) failure due to inadequate provision and	**closed**		Permanent fix in place

	support of air conditioning cooling in the DC.			
IT031	There is a risk to the provision of existing and future ICT applications hosted in the onsite DC due to poor environmental monitoring [UPS, air conditioning, BMS push alerts]	**16**	→	
IT032	Increased risk to network availability due to inadequate electrical supply to key locations.	**15**	→	
IT033	Increased clinical risk to patient safety resulting from lack of UPS protection for main Trust Switchboard.	**12**	↓	Equipment commissioned reduce likelihood to 3
	CSW		**Change**	
Risk No.	**Risk**	**Score**	**↑↓**	
CSW1032-COM-D5	2015/16 Cost Improvement Programme and run rate reduction plans not achieving target.	**20**	→	
CSW 1035-COM- 04	staff in community services at risk of not achieving compliance levels with MAST due to inability to access new learning management system (TOTARA)	**15**	**NEW**	

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – OCTOBER 2015

Paper Title:	Chair's Report: Audit Committee – 9th September 2015
Sponsoring Director:	Mike Rappolt, Non-Executive Director
Author:	Mike Rappolt, Non-Executive Director
Purpose:	To provide the Board with a summary of the proceedings from the last Audit Committee
Action required by the board:	To note the update
Document previously considered by:	N/A

Report

The key points which the Audit Committee feels it needs to bring to the Board's attention this month based on its last meeting are listed below:

1. The Audit Committee runs an assiduous action follow up process through the Audit Tracker. We were disappointed and concerned in reviewing the actions this time to find:
    a. 72 actions outstanding
    b. 45 (62%) had not been completed by the promised date
    c. 13 (18%) were over *one year late*
    d. 4 (6%) were over *two years late*

    This is an unacceptable state of affairs and clearly indicates a lack of ownership of agreed actions arising from Audits by the Executive. There is little point in undertaking a programme of audit work if agreed recommended actions either are not implemented or the reasons they are not implemented given.

    We also had cause to question the integrity of the update reports to the Audit Tracker in the area of Central Stores. See 4 below.

    We look to the Executive to inform us how this situation will be improved and agreed actions implemented to time.

2. We received an updated Internal Audit report on the Strategic Partnership between the Trust and SGUL. Several points were clarified and the audit gave reasonable assurance that the arrangement was working well although there are areas that can be strengthened. We understand that these points are being taken on board. We were pleased to receive assurances that all decisions where potential conflicts of interest could arise from having a joint post holder will be formally documented to indicate how the conflict was avoided.

3. Reasonable assurance was provided for an Internal Audit of the controls over Bank and Agency

staffing although it was recognised that this was a "work in progress" and further actions are required to strengthen controls. In particular there is still work to be done on reconciling the establishment on ESR to the ledger, the budget setting process needs to be completed in order to update the e-rostering templates and the nursing workforce review programme needs to complete in order to ensure staffing levels are fully under control. We urge the Executive to complete these actions as soon as possible. The review did not cover medical staff and as this is an area of high cost we have asked for a further internal audit to review controls in this area this year.

4. Internal Audit undertook a review of recommendations made in January 2014 for better control of Central Stores. The Audit Committee was dismayed to learn that 9 of the original recommendations reported as complete on the audit tracker were only partially complete. This brings into question the integrity of Trust reporting and we have requested that all reporting on actions in the Audit Tracker are now signed off by the responsible Executive.

   We were reassured by the new Interim Head of Procurement that these actions would now be tackled and that Central Stores was rapidly being brought under control. We requested assurances that controls either are in place or would be put in place to pick up fraud, past and present.

5. An Internal Audit of Diagnostic Test follow up gave Limited Assurance. This is worrying from a Patient Safety perspective as failures to follow up diagnostic tests SIs continue to be raised. The audit identified some progress but highlighted the lack of robust SOPs for all Care Groups linked to an IT solution and the fact that a Trustwide action plan although drawn up is not being specifically tracked. New action plan is currently being developed. We were informed that this will come as no surprise to the Medical Director but we urge him to tackle this area with the utmost priority and speed and have asked for a follow up audit to be undertaken which can report to the November Audit Committee meeting.

6. Internal Audits of properties out with the main St George's site used for community services were conducted at the request of the Director of Estates. Not unexpectedly, as the Director of Estates had initiated this Internal Audit, Limited Assurance was reported for compliance for properties other than QMH and we are satisfied that the issues are being addressed. Reasonable Assurance was reported for the management of the QMH PFI contract.

7. Improvements continue to be made on Fire Safety and we are confident enough in the controls being put in place by the Director of Estates now to pass this issue over to QRC for continued monitoring via the ORC.

8. We reviewed SFI Waivers and felt that this year at 3.3% of relevant expenditure the Waivers were running at an uncomfortably high rate. In particular over one third of the waivers were accounted for by Estates and Facilities with £650,000 of this going to one company. We have asked for further explanation of this. We were also concerned at this time of significant cost constraint to see the use of Cannizaro House for an away day event without any evidence of this being the most cost effective option. This waiver had already been queried by Finance and we await an explanation for our next meeting. Several waivers related to SWLP and we requested Finance to remind SWLP of the rules.

9. An update on the revised Trust approach to Whistleblowing was presented. As the revised approach has not yet been implemented the Audit Committee and therefore the Board has no assurance that whistleblowing is being effectively enabled within the Trust. We request the Executive to expedite this.

10. The Audit Committee reviewed the balance of the Internal Audit Plan and added a number of

Internal Audits for this year consequent on the PWC report recommendations. In particular it requested that the results of the CIP and Financial Management, Budgetary Control and Forecasting audits be brought to the November meeting of the committee and that they include sampling down to the Directorate and Care Unit level. Also added were a follow-up to the Diagnostic Tests follow up system where patient safety issues still remain, and a follow-up of Community Properties Health and Safety compliance.

At the request of Finance a new audit to cover the handling of payments from patients in the foetal medicine unit was agreed. The Capacity/Business Planning review, originally due to be reported in November 2015, has been deferred at Trust request. Following discussions at the planning stage, deferral was requested as PWC have commented on the current system in place, and KPMG are assisting in introducing a new integrated planning model. It was proposed therefore that the audit start date would be revised to November. The Safeguarding audit was stood down as a new self assessment process using an NHSE tool is now in place. The review of Nursing Staffing has been deferred until the comprehensive nursing establishment review is further down the track.

Internal Audit was requested to draw up a revised plan and budget for the remainder of this year and discuss the budget implications with the Executive before coming back with a revised plan and budget to the November Audit Committee meeting.

11. The Committee reviewed its Terms of Reference against Monitor's Code of Governance and found the Trust to be compliant with the main principles.

The Audit Committee reviewed the process and timescale for tendering for Internal Audit and will hold a clarification with prospective suppliers in October to enable the firm appointed to start at the beginning of the next financial year.

Key risks identified:

Risks are detailed in the report under each section.

Related Corporate Objective:	All corporate objectives
Related CQC Standard:	N/A

Equality Impact Assessment (EIA): Has an EIA been carried out?

If yes, please provide a summary of the key findings

No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

If no, please explain your reasons for not undertaking an EIA.