St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD

3rd December 2015, 9.00 - 12.00 -
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**	C Smallwood	
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.*		
4.	**Minutes of the previous meeting** *To receive and approve the minutes of the meeting held November 2015*	TB (M) Public	
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	TB (MA) Public	
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB Dec 15 - 01	
7	**Quality and Performance**		9.15
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 7*	J Hall/S Bolam TB Dec 15 - 02	
	To receive a report from the Quality & Risk Committee seminar held on 25 November2015	S Wilton TB Dec 15 - 03	
7.2	**Finance Report** • *To receive the finance report month 7* • *To receive an oral report from the Finance & Performance committee held on 23th November 2015*	S Bolam TB Dec 15 - 04	9.45
7.3	**Workforce & Performance Report** *To review month 7 workforce report*	W Brewer TB Dec 15 – 05	
	• *To receive an update from the Workforce and Education Committee meeting – 19 November*	S Pantelides TB Dec 15 - 06	
8.	**Strategy**		10.20
8.1	**Q2 annual plan progress report**	R Elek/T Ellis TB Dec 15 - 07	
8.2	**Outpatient Strategy**	R Elek TB Dec 15 - 08	
8.3	**Divisional Medicine & Cardiovascular Presentation**	F Ashworth	

8.4	**Emergency Planning (Annual Report)**	P Vasco-Knight/J standing TB Dec 15 - 09	
8.5	**Travel Plan for approval**	E Munro TB Dec 15 - 10	
8.6	**South West London Acute Collaborative Providers (update)**	R Elek TB Dec 15 - 11	
9.	**Governance**		11.40
9.1	**Risk and Compliance Report**	S Maughan TB Dec 15 - 12	
9.2	**Audit Committee** *To receive a report from the Audit Committee held on 11 November 2015*	M Rappolt TB Dec 15 - 13	
10.	**General Items for Information**		
10.1	**Use of the Trust Seal** *To note use of the Trust's seal during the period (November 2015) – The seal was used four times.*		
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 14 January 2016 in H2.5*		

MINUTES OF THE TRUST BOARD

5th November 2015

Hunter boardrooms, 2nd Floor, Hunter Wing, St. George's Hospital

Present:	Mr Christopher Smallwood	Chair
	Mr Miles Scott	Chief Executive
	Mike Rappolt	Non-Executive Director
	Professor Jennie Hall	Chief Nurse
	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
	Mr Steve Bolam	Chief Financial Officer
	Mrs Wendy Brewer	Director of Workforce
	Ms Paula Vasco-Knight	Interim Chief Operating Officer
In attendance:	Dr Andrew Rhodes	Divisional Chair
	Dr Paul Alford	Divisional Chair
Apologies:	Mr Peter Jenkinson	Director of Corporate Affairs Director of Corporate Affairs
	Andrew Burn	Turnaround Director
	Mrs Kate Leach	Non-Executive Director
	Dr Judith Hulf	Non-Executive Director

1. Chair's opening remarks

The chairman started the meeting by informing the board that Dr Judith Hulf would be formally stepping down on the 31 January 2016. This would also have been Peter Jenkinson's last Board Meeting and the chairman wanted to note the terrific contribution he had made to the Trust especially successfully guiding us through the difficult Foundation Trust process.

The four Divisional Chairs will from now on be attending every board between their clinics.

He also welcomed governors and other members of the public to the meeting. He reminded all present that this was a meeting of the Board in public rather than a public meeting. However members of the public present would be given the opportunity to raise questions at the end of the meeting.

3. Declarations of interest

No interests relating to agenda items were disclosed.

4. Minutes of the previous meeting

The minutes of the meeting held on 8th October were accepted as an accurate record. It was agreed that the draft minutes needed to circulated a few weeks in advance of the next meeting.

Ms Wilton requested that the circulation of sub-committee minutes be reinstated.

Mr Scott will be resetting the executive directors' objectives for the second half of the year and discussing priorities which will be brought back to the board.

5. Schedule of Matters Arising

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

Well led domain/heat map – Prof Hall confirmed action complete.

Call centre – Ms Vasco-Knight reported that things had started to improve after changes but had deteriorated again. Dr Rhodes confirmed they are recruiting more staff to improve service to previous level.

Workforce Report – Mrs Brewer reported that work is still ongoing with process agreed with KPMG. The financial systems reconciliation needs to be implemented which Anna Anderson is leading for finance team.

Ms Pantelides felt that the board had received limited assurance on progress and the system needed to be tested. Mr Rappolt appreciated all the hard effort that had been done to date but this needs a target date for completion as its key to the turnaround and has been dragging on for 3 months. Mr Bolam stated he would push this forward with his team but they do have many priorities, all equally important,

Questions from public – Mr Scott has responded direct to Mr Poloniecki.

6. Chief executive's report

Mr Scott presented his report, highlighting key points including welcoming Prof Jenny Higham, who succeeds Prof Kopelman. Prof Higham will be both the Principal for SGUL and a non-Executive Director of the Trust. There are two new Divisional Chairs – Dr Lisa Pickering and Dr Tunde Odutoyem.

The Listening into Action pass it on event this year - when teams showcase and celebrate their work - will take place alongside the Clinical Audit half day on Friday 4th December 2015 from 8.30am to 1pm in the Hunter Wing Boardrooms.

In relation to executive changes, we have advertised for a permanent Chief Operating Officer with interviews in 2-3 week's time. We will also be appointing a new Trust Board Secretary with some changes to the role and in the interim Jill Hall will be starting in 2 weeks time with a week's handover with Mr Jenkinson.

Mr Scott advised that the Chairman's and two Non-Executive Director appointments recruitment proposals had been agreed by the Council of Governors on the 27th October. These proposals included the composition of the appointment panel and stakeholder involvement in the process. The intention would be to appoint the new chairman before Christmas so that he / she could be involved in the appointment of new non-executive directors in January.

7. Quality and performance report

The board received and noted the monthly quality and performance report.

Performance

The board received and noted the monthly performance report from Ms Vasco-Knight, noting that the trust was failing to achieve the standard in four areas: the RTT performance had deteriorated over the month, A&E performance was currently at 91.4% which was the second best performance amongst London trauma centres and fourth best out of seven trusts in south west London, and

cancer standards with two of the nine cancer standards having been missed and having deteriorated further in month.

A&E
Mr Wilson reminded colleagues that despite the ED department being very busy, national benchmarking data shows Wandsworth and Merton have low levels of emergency ED attendances and low levels of non-elective admissions per 1,000 weighted population compared to the rest of London. This is a successful consequence for the local healthcare system of many years work to ensure that only sick patients who require emergency care come to the emergency department, and patients with low level urgent care needs go direct to primary care services elsewhere. The impact on the Trust is that patients coming to the ED are proportionately sicker than in alternative health economies where patients with non-acute urgent care needs also attend their local emergency department. The impact of this needs to be a key feature in the review of the Trust's strategy going forward

Cancer
Ms Vasco-Knight assured the board that the cancer waiting target will be back on track during November and was being closely monitored. Mr Rappolt stated that looking at August data in November was unhelpful. Assurance was given that current data was being looked at during the weekly monitoring meetings.

Diagnostic waits
Mr Rappolt asked about the financial penalties we are incurring due to targets not being met. Mr Bolam reported that there is a forecast of £10.5m compared to £7.2m last year. The way penalties are imposed have been changed and the Trust is working with the CCGs and Monitor to minimise the penalties.

Ms Wilton asked about what action is being taken now that bed occupancy is now increased to 98.5%. Ms Vasco-Knight stated that there are meetings daily of how this figure can be reduced.

Cancelled Operations
The number of cancelled operations has decreased.

8. <u>Quality report</u>
Prof Hall presented the quality part of the report, summarising key messages with each section of the report.

The number of general reported incidents in September 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 September the Board noted that the issues are across a range of clinical issues, some are mandatory in terms of reporting. A paper will be circulated on trends concerning 'never, never incidents'. **J Hall Dec 2015?**

The Trust has now reported 4 MRSA bacteraemia cases and 17 C-Difficile to the end of September. The Board noted that the MRSA case declared in early September is going to arbitration and may subsequently be removed; we are one case above the annual Trajectory for C Difficile which is set at 31 cases for 15/16.

Ms Wilton queried the CAS alerts where clinicians can over-ride electronic system. Prof MacKenzie assured the board that this meant that doctors could override electronic system so that they could deal with more urgent work before

returning to task.

There has been a modest improvement in the complaints figures since August's figures but below where we need to be. Mr Rappolt mentioned that the example patient experience story of a patient failing to contact the Cardiology Department on the number given has also happened to a friend of his. Prof Hall stated that she would look into this.

9. Update on flow programme

Prof Hall gave a presentation on the flow programme with four members of her team, Jane Galloway, Dr Helen Jones, Brendan McDermott and Helen Anderson. The flow of patients through the hospital is key to supporting discharge arrangements. The Trust started at a low base when Prof Hall joined in summer 2014. There is now a framework in place but still more work to do. A work process has been designed to aim to get patients discharged before 11am rather than post 4pm. The target set is 200 patients a week with 126 currently being discharge before 11am at present. The roll out is nearly complete with much better planning for discharge using discharge co-ordinators. Both nursing and pharmacy staff have been trained The work has revolved around setting a discharge date on admittance to hospital; closer liaison with pharmacist over discharge medications and closer liaison with patient transportation.

Mr Munro commented that the previous day there had been 73 on the day bookings for patient transportation which can be difficult to plan for. It was agreed that booking should ideally be done the day before or with sufficient notice. IClip can assist with running a daily report of predicted date of discharge for patients.

The departure lounge which opened last December looks after 80 patients a week and a business case has been submitted for 2 beds. The discharge co-ordinators cover the evenings and weekends and monitor patients across the hospital. There has been good progress in getting patients out of AMU and onto the appropriate ward. There has been better use of the ward whiteboard with primary and secondary bed choices. The ward managers will bleep when beds become available. Telephone handover has also been introduced for those patients who do not need to be escorted. Funding has been granted for 2 dedicated porters for 2 weeks in A&E as a trial.

Mr Rappolt said there had obviously been a huge amount of work going on to free up bed capacity and asked whether using a bed management system software would help the Trust further. Prof Hall stated that it would certainly help and it is compatible with systems on site but data quality not there yet.

Ms Wilton stated that the patient experience must not be forgotten with patients discharge or transferred late at night. Prof Hall stated that each case was looked at individually and some patients just wanted to get home regardless of the time.

10. Finance report (month 6)

Mr Bolam presented the financial performance report for month 6, 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. The board noted a stabilisation in pay and non-pay expenditure but fluctuations in income which was driving the deficit variance. It was noted that £11.7m of CIPs have been achieved

to date, and there are plans for a further £15.2m of red/amber/green schemes for the rest of the year. There is also a pipeline of £13.3m of further initiatives. £22.4m needs to be delivered in the second half of the year to reach the £34.2m, 90%, requirement in the annual plan.

11. Report from the finance and performance committee

The board noted the report from the finance and performance committee, including a summary of key discussions and decisions. The committee had noted concern regarding the development of CIPs for 2016/17, but acknowledged that the focus was beginning to shift towards this. There was also concern about the progress made to date on the five year plan. The committee had agreed the need for assurance regarding the process to identify some of the 'big ticket' opportunities

Mr Rappolt endorsed the summary presented. The PwC Report recommends reports and actions that can be monitored but even with the finance and performance committee scheduled a week before it does not give enough time to report back as the board papers are sent out a week before the meeting. It was agreed that this would be discussed in more detail in the private board.

It was noted that an extraordinary board meeting had been arranged for the 19th November, at which the board would approve the 2015/16 reforecast budget to be submitted to Monitor– this would be discussed later in more detail by the board in private session due to the confidential nature of the discussion, but would be made public once approved and submitted. **S Bolam Dec 2015**

Ms Pantelides stated that the Trust needed to be watertight on systems and protocols around usage of agency staff and managers disciplined if not using these.

Prof Kopelman noted the declining performance in outpatients and wondered whether the targets were overambitious. Mr Scott stated that the targets had been agreed with each division who felt they could be achieved.

12 Workforce report (month 6)

The board received and noted the monthly workforce performance report, noting key points: turnover remained flat but high, although the level was comparable to peer benchmarks; detailed bank and agency usage; compliance levels for MAST; and appraisal rates which were deteriorating due to management constraints at an organisational level despite some good improvement made by specific services. The board noted the importance of appraisal in reducing turnover.

Mrs Brewer highlighted the risk posed by the junior doctors BMA ballot over the new contract offered by the Government. If doctors vote for industrial action they have to give 7 days notice each time they take action and would take place during period 16th December to mid-January. Other members of BMA could come out on strike in sympathy to the junior doctors. However the Trust has experience of previous industrial action and emergency care and inpatient care would be relative unaffected. It would be outpatients and elective care that would be most affected

13. Report from the workforce committee

The board received and noted the report from the previous workforce committee, noting in particular the role of the committee in considering the output from the establishment review and the ongoing initiatives being launched by divisions to

tackle recruitment and retention. The committee had noted that the establishment review had been prioritised over the recruitment and retention initiatives, and noted concern regarding the lack of transformational impact on recruitment and retention, but that focus would return to that subject. **W Brewer Dec 2015**

14. Risk and compliance report

Mr Scott reported that the Quality and Risk Committee carried out 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*

The risk was reviewed following a detailed presentation around trust compliance with CQC Regulations and Fundamental standards of Care which came in to force on 1st April 2015. The presentation set out the current quality assurance arrangements in place to provide assurance to the board; the current trust position, and work underway to strengthen collection and utilisation of ward audit to understand and provide assurance around standards of quality of care.

The QRC considered the information presented, which included a gap analysis with the findings of other recent CQC inspection and agreed the risk score should be updated to C5 x L5 = 15 (extreme). The detailed risk description, controls and assurances will be updated to reflect the deep dive discussion and will be approved by QRC before inclusion in December board report.

Mr Scott noted the risk around the junior doctors' industrial action, noting that the risk related to income loss rather than patient safety.

Prof Hall felt the risk to our staff managing a large number of equally important priorities should be noted. It was agreed by the board that this ought to noted and priorities regularly reviewed.

15. Report from the audit committee

Mr Rappolt apologised for the late circulation of the report. The audit committee has met twice since the last board - once with both the internal and external auditors to consider the implications of the PwC report on audit and once with others in an evaluation team to select new internal auditors. He had found it surprising that PwC had not met or spoken to either firms while preparing their report.

Some of the conclusions in the report include; there needs to be clear priorities, judgements and assumptions in the annual audit plan; both sets of auditors would need to go deeper into the organisation than the Divisional level; in future the auditors would need to test inputs and outputs and devote more time to testing the quality of management information and increase sampling approaches.

The Trust decided to put the Internal Audit out to competitive tender with the selected company to start contract on the 5th April 2016, following a handover. The Trust has adopted an accelerated tendering process which limits us to a pre-authorised list of prospective 1A companies. LAC, our current Internal Auditor, is not on that list. The selection panel, which included a Governor, met 4 prospective suppliers of internal audit services last week and shortlisted two. The final selection will be made when certain supplementary questions have been satisfactorily answered.

As a result there is an estimated increase of 77 days at a cost of £31,000 for the

additional work that will be required. As a consequence of these conclusions above and other Trust requirements revisions have been made to the 2015/16 Audit Plan and which were agreed by the Board.

16. Trust Travel Plan for approval

Mr Munro apologised as this item had been withdrawn as more time was needed to consult with staff so this would be resubmitted at a later date. **E Munro Dec 2015**

17. Trust seal

The board noted that the trust seal had been used on one occasion during the reporting period, relating to the Nelson contract.

18. Questions from the public

Mrs Baker asked what the Trust Seal was. The Trust Seal is used to seal a wafer on legal documents which the Chairman and Chief Executive both sign on behalf of the Trust.

Mr Saltiel asked in relation to the possible industrial action by the BMA, how many doctors the trust employed and how we could be sure of appropriate clinical cover. Mrs Brewer responded that we employ around 2,000 doctors and was confident that we would be able to still provide most services but outpatients and elective surgery would likely be most affected.

Ms Ingram introduced an appointment letter she had received which was a proforma which was very confusing to patients. Dr Rhodes agreed to take a look and see how that could be changed.

A question was raised regarding the announcement yesterday by Transport for London (TfL) about rerouting the proposed Cross Rail 2 (CR2) service from Tooting Broadway Station to Balham Station. Mr Scott responded that this decision was disappointing for the Trust as it was more beneficial for our staff, patients to visitors to have CR2 service at Tooting Broadway. We would respond to TFL possibly jointly with local stakeholders.

19. Any other business

There was no other business.

20. Date of the next meeting

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

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
3 December 2015

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 3 December 2015
15.10.15	08.10.15	Minutes of previous meeting	Action plan for improving the quality of Medical records.	Jan15	J Hall	
15.10.15	08.10.16	15.06.08 – Outpatient Strategy	To be brought to board in December.	Dec 15	R Elek	On Agenda
7.2	05.11.15	Quality Report	The number of general reported incidents in September 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 September the Board noted that the issues are across a range of clinical issues, some are mandatory in terms of reporting. A paper will be circulated on trends concerning 'never, never incidents'.	Dec 15	J Hall	
7.4	05.11.15	Workforce report (month 6)	The committee had noted that the establishment review had been prioritised over the recruitment and retention initiatives, and noted concern regarding the lack of transformational impact on recruitment and retention, but that focus would return to that subject	Dec 15	W Brewer	On Agenda
9.	05.11.15	Trust Travel Plan for approval	Item had been withdrawn from November meeting as more time was needed to consult with staff so this would be resubmitted at a later date.	Dec 15	E Munro	On Agenda

7.3	05.11.15	Report from the finance and performance committee	It was noted that an extraordinary board meeting had been arranged for the 19th November, at which the board would approve the 2015/16 reforecast budget to be submitted to Monitor– this would be discussed later in more detail by the board in private session due to the confidential nature of the discussion, but would be made public once approved and submitted.	Dec 15	S Bolam	The Board approved the submission to monitor of the Turnaround Reforecast and also agreed a series of actions and work streams that would reduce that forecast to an targeted outturn of £50.2m. The Board will receive further updates at each meeting on performance against the Turnaround Reforecast and the actions being taken to deliver

St George's University Hospitals NHS
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REPORT TO THE TRUST BOARD – DECEMBER 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. Health Sector Developments

1.01 Comprehensive Spending Review

On 25th November 2015, the government published its comprehensive spending review (CSR), setting out the budget for each department over the course of this parliament.

Within the CSR, the government made a commitment to invest an additional £10bn in the NHS by 2020/21 (including the £2bn already announced for 2015/16 in last year's Autumn Statement). Further to this – in response to a request made by the Department of Health and NHS England – 2016/17 will see a 3.6% increase of the NHS's budget in real terms, resulting in an additional £3.8bn for the next financial year. The funding is welcome, and whilst in and of itself it does not resolve the trust's deficit, it does support us in our recovery.

A summary of the CSR has been attached, providing detail of the impact of cuts in other areas of health spending. There is still a substantial amount of detail to be provided by the government and a further update will be provided in next month's Chief Executive's report.

2. Strategy

2.01 Business Development

The Trust carefully considers opportunities that arise to bid for services. We are currently waiting to hear the outcome regarding two recent tender submissions: one for breast screening services and one for accreditation as a Centre for Intestinal Failure (providing complex medical and surgical care for patients with intestinal failure). We decided not to bid on a new Community – Contraceptive and Sexual Health Services contract which is out to tender from Wandsworth and Richmond local authorities. The specification and prescribed model were considered to pose risks around patient safety, clinical governance and quality.

3. Academic Developments

3.01 News Headlines

- Congratulations to Cleave Gass, who has been appointed to Head of the London Academy of Anaestheisa, he will commence his new role on 2nd November 2015.

- Congratulations are also to be extended to Nicholas Gosling, Manager of the Simulation Centre, who is a finalist for 2 London Leadership Awards: NHS Development Champion of the Year and NHS Leader of Inclusivity of the Year.

- We continue to be one of the leading Trusts in South London in terms of number of Apprentices employed, and are projecting to increase the number to over 100. We are exploring training and employing Apprentices in Allied Health technician roles. If we do we will be the first Trust in London to do so.

- We have also launched a monthly PGMDE newsletter for all medical staff in training, which will contain news relating to training at St George's, information on courses, how to's, contact information and more.

- Clare Ramstead will be joining the team in the New Year as a Lead Nurse for Professional Development with a portfolio covering Preceptorship and Return to Practice.

- We are delighted to have produced a new video to be used on Induction, showcasing the many facets of St. George's and the values demonstrated by our staff in a range of roles.

- Education and Development have introduced the New Consultant and New Managers Programme as part of the Leadership Academy here at St. George's. These innovative 5-day programmes, combining face to face training, paired learning and mentoring, commencing in November have been designed to ensure leaders within the organisation have the support and skills to deliver the trust's strategic objectives.

- Work is on-going to support the Streamlining Project for Foundation Doctors led by South Thames Foundation School.

- Part-Task Training for Healthcare Support Workers in Venepuncture and Cannulation are now available to further develop those responsible for taking bloods on the wards.

- Having successfully merged trainee data with other London Trusts, St. George's is part of the single system for Intrepid, an online system which manages trainees rotations as they move between training posts in London.

- Mairead Heslin has joined the Trust as the Head of Corporate Training and Leadership. She is an experienced Organisational Development Consultant, and amongst many workstreams will be leading on talent management, coaching,

4. Workforce

3.01 Listening into Action

The Listening into Action teams for next year are confirmed as:

Continuing from 2015	**New for 2016**
Therapies	MaxilloFacial
Fracture Clinic	Call Centre
Theatres – paediatric, neuro, St James/Paul Calvert	Cardiac theatres
Community	Cardiology (St George's)

There are also discussions around engaging with prison and security teams and the newly established teams at the Nelson.

One of the teams graduating from this year's programme is the Day Surgery Unit. Their conversation took place in late January 2015 and action awaited the arrival of a new manager in September. Since then, much progress has been made and can be summarised as follows:

You said we need to:	We have:
Improve how we order and store supplies	Appointed a lead to improve issues and organise our stores better
Provide training for all DSU staff	Recruited a Clinical Support Facilitator to co-ordinate all training
Improve the environment we work in	Committed to report issues swiftly, and treat where we work with respect
Improve communication	Identified the following improvements – newsletters, notice boards, team briefings, updating list orders, employee of the month
Increase staffing	Recruited to a number of vacant and new posts

5. Operational Developments

4.01 Update from the System Resilience Group on 'One Version of the Truth' work

On 26th October the trust started work on a comprehensive review of the root causes of the continued challenges in meeting the 4-hour wait emergency standard. This review process, named 'One version of the truth' will be supported by McKinsey and Company and carried out in collaboration with our partners in the CCGs, Local Authorities and community providers.

A preliminary presentation took place on 18th November, and the trust's Interim Chief Operating Officer, Paula Vasco-Knight, is leading the work for the hospital. The whole exercise will take six weeks to complete. At the end of the work we will have an externally validated diagnosis of root causes that is agreed across the whole health economy, as well as a high level implementation plan to tackle those root causes.

A full report will be submitted to the next Trust Board meeting.

6. Communications

5.01 Urogynaecology Public Consultation

There has been a considerable response to the Urogynaecology Public Consultation, therefore the trust has further extended the consultation period to 4th December: an action that has been welcomed by Wandsworth Health and Overview and Scrutiny Committee. Additionally, a consultation drop-in session has been arranged for the evening of 1st December.

Futhermore the trust has worked with Healthwatch Wandsworth to ensure that all invested parties have the opportunity to comment and a period to review all comments has been built into the overall process. The reviewed proposal will be brought to Board in January 2016

5.02 Chief Nurse Surgery

The corporate nursing and communications team recently launched the first Chief Nurse Surgery as a new way to engage with nursing and midwifery staff.

The aim of the briefing is to bring together nursing and midwifery staff from each ward to discuss performance and quality issues in a safe space. Where there is evidence for improvement, a ward will be held to account for their actions, in a supportive way, and will have an opportunity to self-improve by learning from their peers. It is also an opportunity to laterally transfer best practice by celebrating successes and achievements by wards or individual staff.

The Chief Nurse facilitates the session and presents the latest key messages to nursing and midwifery staff so that they can be immediately responsive to change. Other senior members of staff such as the Medical Director will be encouraged to attend. All staff are welcome, but there must be a senior nurse representative (matron etc) from each ward and a comms representative.

5.03 Induction video is a vehicle for social media recruitment campaign

Our induction video is playing a key role in both increasing awareness of what we do at St George's and delivering greater volumes of web traffic to the 'work with us' pages on our public website. It's been watched 2,738 times in three weeks and generated 29,694 unique page views to our website (an increase of 25%) as a result of publicising the film on Twitter and Facebook.

5.04 Twitter

This month we reached 10,000 Twitter followers, overtaking Guys and St Thomas, Imperial and UCLH. We continue to build stronger relationships with key stakeholders using this medium, making sure we listen and respond as well give updates. Campaigns in November that have helped us achieve this include HIV test week, our recruitment campaign, alcohol awareness week and flu fighters.

5.05 Facebook

We are reaching new levels of engagement with stories that resonate well with our core Facebook community, e.g. Edith Cavell, launch of induction video and teasers for 24 Hours in A&E. Some of our best stories reach over 15,000 people, receive more than 100 'likes', and are shared 80 times.

5.06 November's Schwartz Round

125 staff attended the November Schwartz Round 'Fear of the unknown - the challenges of managing a family's anxiety'.

The recent evaluation of the first six rounds demonstrated that over 85% of participants said attending a Schwartz Round 'will help them to care for patients' in the future. Some of the participant feedback includes "excellent!", "a very positive forum to attend" and "an excellent innovation".

5.07 *By George!*

The October/November edition of the staff newsletter *By George!* was published and distributed around the trust last month. Key features include Jamie Oliver filming at St George's, Queen Mary's centenary event, the opening of the Wolfson Neurorehabilitation Centre, the 100,000 Genomes Project and an introduction from turnaround director Andrew Burn.

5.08 Patient information

We're thrilled to report that at long last, all patient information leaflets (circa 500) now sit within the communications team in an editable format, allowing patient information to be updated at source as and when clinical and operational changes take place. Leaflets formerly sat within Digital Services as Quark and InDesign files, meaning that a fee was charged each time an amendment or reprint was required.

Now that we have regained ownership of the copy, an exercise is planned to work through each of the historical leaflets to ensure that each publication is subject to the trust's robust review process, which involves multidisciplinary clinical involvement, communications support and patient feedback. We anticipate that all existing information given to patients will join new publications in being fully trust-approved and appropriately reviewed by the end of 2016.

5.09 Media update

'The House of Hypochondriacs' aired on Tuesday 24th November on Channel Four. Dr Christian Jessen invited three people with health anxiety to meet other people living with the conditions they fear the most. Filming took place at St George's Hospital, a GP practice and an ambulance service.

On 25th November the work of St George's obstetrics/gynaecology consultant Dr Theodora Pepera appeared on the BBC during their news reports and The One Show as part of a feature entitled 'Giving back and going back'. The two-day 'mini series' is an attempt to look at the subject of migration beyond the recent headlines and will span the scope of Dr Pepera's valuable work at home and in her birth country of Ghana.

St George's Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD **Paper ref:**

Paper Title:	Quality and performance Report to Board Month 7- October 2015
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Paula Vasco-Knight – Chief Operating Officer
Authors:	Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Paula Vasco-Knight – Chief Operating Officer
Purpose:	To inform Board/ QRC about Quality Performance for Month 7.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	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, 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 and has also seen marked improvement with regards to cancelled operations and the number of patients not re-booked within 28 days.

The trust shows the quality governance score against the Monitor risk assessment framework of 4 as Monitor have imposed additional license conditions in relation 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 the Board to note in relation to October Quality Performance:

The Overall position in October remains consistent with the previous two quarters 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. Routine oversight of serious incidents continues to be monitored through the Patient Safety Committee and SIDM.

Effectiveness Domain:

- Mortality performance remains statistically better than expected for the Trust. Despite this position we continue to proactively investigate mortality signals at procedure and diagnosis level.

- The Board will note that the SHMI position has moved to the "As expected" range for the first time. The mortality monitoring group is considering the full breakdown of the diagnosis groups in November to prioritise any areas for investigation. The board should note that in 5 out of 6 of the SHMI groups with the greatest absolute difference between expected and observed deaths there is or has recently been an observed signal through Trusts analysis of the Dr Foster data. Each of these has already been investigated.
- National Audits within the report: The national audit of inpatient falls indicates that the Trust rates of falls resulting in harm and rate of falls per 1000 bed days is favourable compared against the national average. However the ambition still needs to be an improvement in performance. The audit summary indicates a number of actions that the Trust is taking in relation to improving performance. Progress against actions will be monitored by the Patient Safety Committee.
- The report indicates the position with compliance with NICE guidance for the period June 2010 to June 2015. The number of outstanding areas of non-compliance has increased, however actions have been put in place to recover this position, 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 September 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 October the Board will note the issues are across a range of clinical issues, some are mandatory in terms of reporting.
- Safety Thermometer performance was consistent with the previous month and performance remaining above the national average. There was a decrease in patients with CAUTI, and other harms reported, this will be need to monitored over a period of time to see of this position can be sustained.
- The pressure ulcer profile for October improved from the previous month with 2 grade 3/4 ulcers. Actions being taken to sustain an improvement in performance are outlined in the report,
- No further MRSA bacteraemia cases were reported for October. There are now a total of 22 C-Difficile cases to the end of October. The Board should note that the MRSA case declared in early September is going to arbitration and may subsequently be removed; we are one case above 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 Adults and Children's compliance for training remains a key area of focus. The Trust is now demonstrating a compliance of 75% for level 3 Children's training and 72% for adult 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.
- In November St Georges have been invited to join the VTE Exemplar Centre Network which confirms our adherence to best practice standards in the prevention and management of VTE. It is a significant achievement that recognises the work of the Thrombosis team and the whole Trust in implementing these standards. We are joining a network of twenty or so Trusts which are exemplary in VTE prevention. Patients can be assured that they will receive the best care in VTE prevention which will minimise their risk of morbidity and mortality through proactive application of national guidelines.

Experience Domain:

- The response rate for FFT decreased again. Gaining feedback from patients is an important component in the triangulation of quality data The overall score for the Trust in October is a score of 88.4% 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 increased slightly in October in terms of numbers. The board will note the Q2 position regarding numbers of complaints

compared to Quarter 1 and the significant increase in numbers for services in the Women's and Children's Division. The report indicates both the profile for complaints by service but also the actions that Divisions are taking to support learning and improvement in practice.

- 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 94.40 % 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 October is included this month for both Acute and Community services.

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 no, please explain you reasons for not undertaking and EIA. Not applicable

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St George's University Hospitals NHS
NHS Foundation Trust

Performance & Quality Report

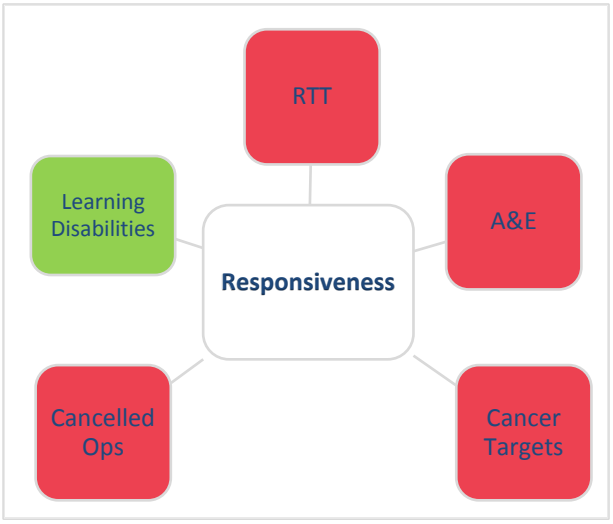
to the Finance and Performance Committee

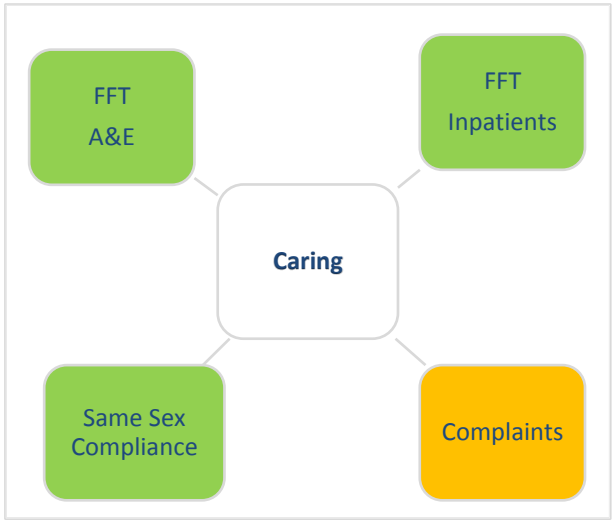
Month 7 - October 2015

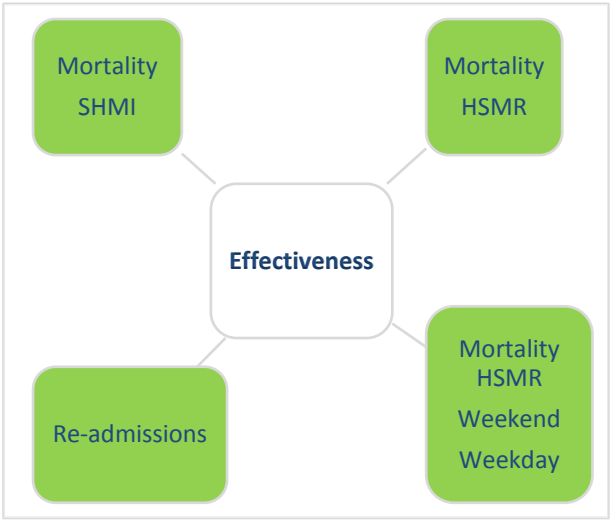
Excellence in specialist and community healthcare

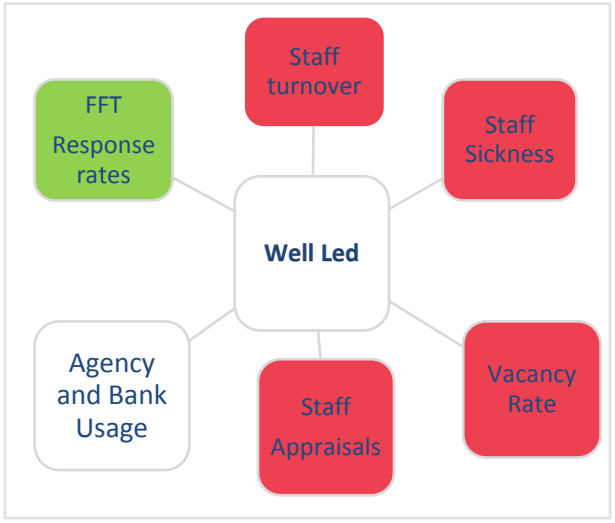
CONTENTS

1. Executive Summary - Key Priority Areas October 2015*









The above shows an overview October 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 September 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: October 15 Performance (Page 1 of 1)

ACCESS

Metric	Standard	Weighting	Score	YTD	Sep-15	Oct-15	Movement
Referral to Treatment Admitted	90%	N/A	N/A		77.70%	78.60%	0.90%
Referral to Treatment Non Admitted	95%	N/A	N/A		92.50%	86.50%	-6.00%
Referral to Treatment Incomplete	92%	1	1		89.08%	90.20%	1.12%
A&E All Types Monthly Performance	95%	1	1	92.47%	90.70%	91.89%	1.19%

Metric	Standard	Weighting	Score	YTD	Q1	Q2	Movement
62 Day Standard	85%	1	1	80.65%	79.27%	81.93%	2.65%
62 Day Screening Standard	90%			87.77%	82.08%	92.68%	10.61%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	96.32%	95.18%	97.50%	2.32%
31 Day Standard	96%	1	0	97.61%	97.24%	97.95%	0.71%
Two Week Wait Standard	93%	1	1	85.66%	92.38%	77.85%	-14.53%
Breast Symptom Two Week Wait Standard	93%	1		92.15%	90.45%	94.48%	4.03%

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Sep-15	Oct-15	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	22	5	4	-1
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 July and August 2015	50%	1	0		56.3%	55.1%	-1.2%
Referral Information	50%	1	0		88.0%	88.0%	0.0%
Treatment Activity	50%	1	0		69.5%	70.4%	0.9%

Trust Overall Quality Governance Score	4	4	0

October 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.)

.

Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- Cancer Waits
- 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 July and August.

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: October 15 Performance (Page 1 of 1)

RESPONSIVENESS

Metric	Standard	YTD	Sep-15	Oct-15	Movement
Referral to Treatment Admitted	90%		77.70%	78.60%	0.90%
Referral to Treatment Non Admitted	95%		92.50%	86.50%	-6.00%
Referral to Treatment Incomplete	92%		89.08%	90.20%	1.12%
Referral to Treatment Incomplete 52+ Week Waiters	0	17	2	4	2
Diagnostic waiting times > 6 Weeks	1%		1.01%	0.61%	-0.40%
A&E All Types Monthly Performance	95%	92.47%	90.70%	91.89%	1.19%
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%	15.13%	6.45%	7.50%	1.05%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Aug-15	Sep-15	Movement
62 Day Standard	85%	80.65%	80.28%	85.71%	5.43%
62 Day Screening Standard	90%	87.77%	91.67%	95.45%	3.79%
31 Day Subsequent Drug Standard	98%	100%	100%	100.0%	0.00%
31 Day Subsequent Surgery Standard	94%	96%	100%	96.7%	-3.33%
31 Day Standard	96%	97.61%	99.35%	96.13%	-3.23%
Two Week Wait Standard	93%	85.66%	79.33%	70.40%	-8.93%
Breast Symptom Two Week Wait Standard	93%	92.15%	93.86%	95.04%	1.18%

EFFECTIVENESS

Metric	Standard	YTD	Sep-15	Oct-15	Movement
Hospital Standardised Mortality Ratio (DFI)	100		91.1	91.6	0.5
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	92	3.0
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%	3.10%	2.20%	3.36%	1.2%
Bed Occupancy - Midnight Count	85%		98.5%	95.1%	-3.4%
LOS - Elective			3.9	1.9	-2.0
LOS - Non-Elective			4.76	4.4	-0.36

CARING

Metric	Standard	YTD	Sep-15	Oct-15	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		93.6	93.8	0.2
A&E Scores - Friends & Family Recommendation Rate	46		86.5	83.1	-3.4
Complaints			87	88	1.0
Mixed Sex Accomodation Breaches	0	5	5	0	-5.0

SAFE

Metric	Standard	YTD	Sep-15	Oct-15	Movement
Clostridium Difficile - Varience from plan	31	22	5	4	-1
MRSA Bacteramia	0	4	2	0	-2
Never Events	0	7	1	1	0
Serious Incidents	0	97	14	10	-4
Percentage of Harm Free Care	95%		95.1%	95.0%	-0.001
Medication Errors causing serious harm	0	1	0	1	1
Overdue CAS Alerts	0	14	2	2	0
Maternal Deaths	1	1	0	0	0
VTE Risk Assessment (previous months data)*	95%		97.2%		

WELL LED

Metric	Standard	YTD	Sep-15	Oct-15	Movement
Inpatient Respose Rate Friends & Family	30%		35.7%	25.1%	-10.6%
A&E Respose Rate Friends & Family	20%		21.6%	22.4%	0.8%
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%		17.7%	17.5%	-0.2%
Trust level sickness rate	3.5%		4.1%	4.1%	0.0
Total Trust Vacancy Rate	11%		15.0%	16.4%	1.4%
% of staff with annual appraisal - Medical	85%		87.3%	82.4%	-4.9%
% of staff with annual appraisal - non medical	85%		70.6%	68.9%	-1.7%

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	Sep-15	Oct-15	Movement	2015/2016 Target	Forecast for Oct-15	Forecast for Nov-15	Date expected to meet standard
FA	90.70%	91.89%	⇧ 1.19%	>= 95%	R	R	TBC

Peer Performance September 2015 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	4	2	5	1
90.70%	90.60%	91.50%	89.90%	94.50%

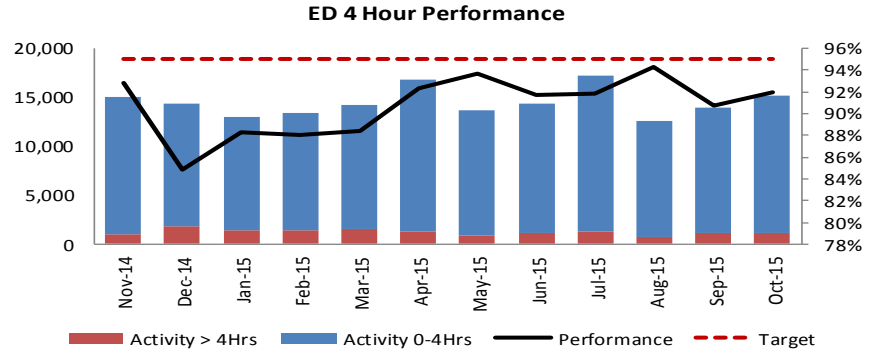
Performance Overview by Type			
Period	ED (Type 1)	MIU (Type 3)	ED & MIU (Type 1+3)
Month to Date (Oct)	90.42%	99.56%	91.89%
Quarter to Date	91.33%	99.56%	91.33%
Year to Date	91.46%	99.59%	92.28%

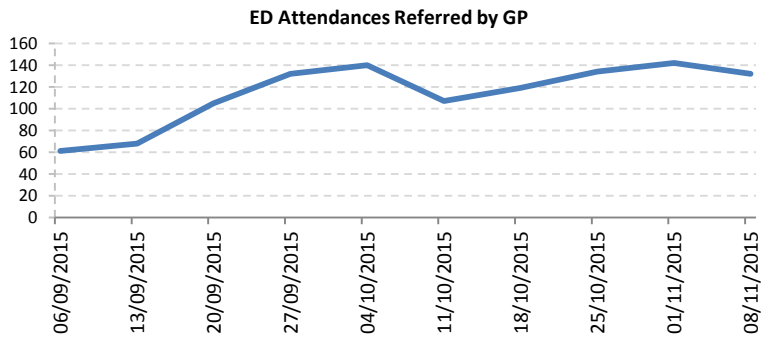
The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. Performance remains challenged being below the target at both the weekly and monthly level. In October 91.89% of patients were seen within 4 hours which was a slight improvement on previous month, this also correlates with an improvement in rank position against peers to 3 from 4 the previous month. The trust is also below the target YTD with performance of 92.28%

. Factors that continue to affect performance include:

- Continued high number of breaches for patients awaiting a specialist opinion and bed capacity where the Trust had an increase in bed occupancy.
- Number of mental health patients breaching, with particularly long delays in placing the patient into the appropriate setting blocking cubicles. There were 59 MH attributable breaches in the month.
- 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 19/10/2015 there were 29 DTOC and 36 Non-DTOC.
- As at 10/11/2015 there were 92 of 620 (15%) 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.
- Other factors impacting performance include an increase in conversion rate a trend that has been observed since May and an increase in ED Attendance following a referral from a GP

Mckinsey and Company are currently undertaking a system wide review of Emergency Care Performance and current issues to establish 'one version of the truth' and to support in developing a recovery plan going forward. This is being overseen by a Emergency Care Review Steering Group chaired by the interim Chief Operating Officer on behalf of the Trust.



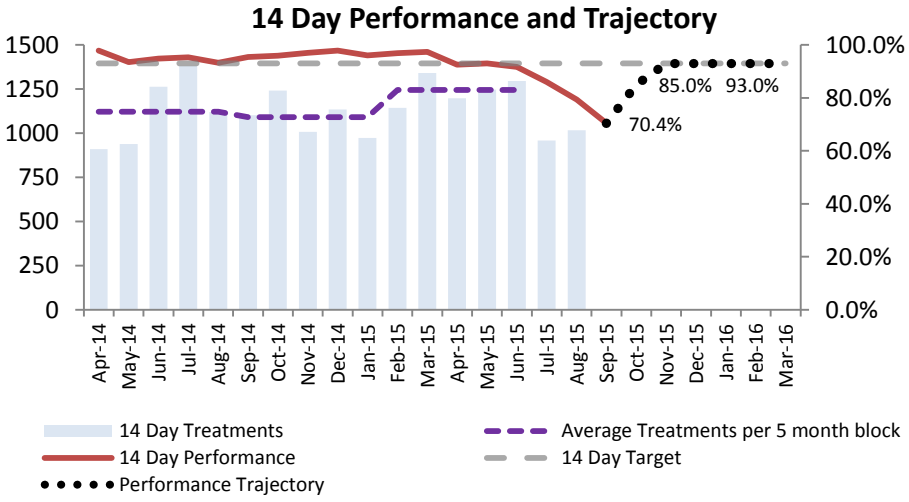


3. Performance Areas of Escalation (Page 2 of 6)
- Cancer Performance – Two Week Wait Standard

Cancer Performance								Peer Performance Latest Published September 2015- 2016				
Lead Director – CC	Aug-15	Sep-15	Movement	2015/2016 Target	Forecast for Sep-15	Forecast for Oct-15	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
14 Day GP Referral for all Suspected Cancers	79.33%	70.40%	-8.93%	93%	R	R	Nov-15	70.40%	93.49%	94.31%	97.69%	94.63%

The trust was non compliant against one of the national cancer wait targets for the month of September as detailed in the table above. In response to the continued under-performance in Q2 the following actions are being undertaken:

- Fortnightly escalation meetings continue to be undertaken as directed by the Chief Operating Officer. These will now be increasing in frequency to weekly.
- A tri-partite executive meeting has been held to discuss issues regarding cancer performance. The trust have presented recovery plans detailing issues affecting underperformance and actions being taken in key tumour groups to improve performance. It is forecasted that the 14 day performance will be recovered by November.
- A weekly Elective Care Recovery Programme sub-group led by commissioners has been set-up following the tri-partite meeting to track progress against action plans and to drive performance improvement.
- A demand and capacity review has been undertaken for two week wait referrals. Following this specialties now have a clear understanding of any shortfall in capacity, which is being addressed.
- PTL development is in progress to enhance tracking and escalation mechanisms.
- Reviewing DNA rates and patient choice breaches in accordance with guidance and highlighting mechanisms by which this could be reduced.



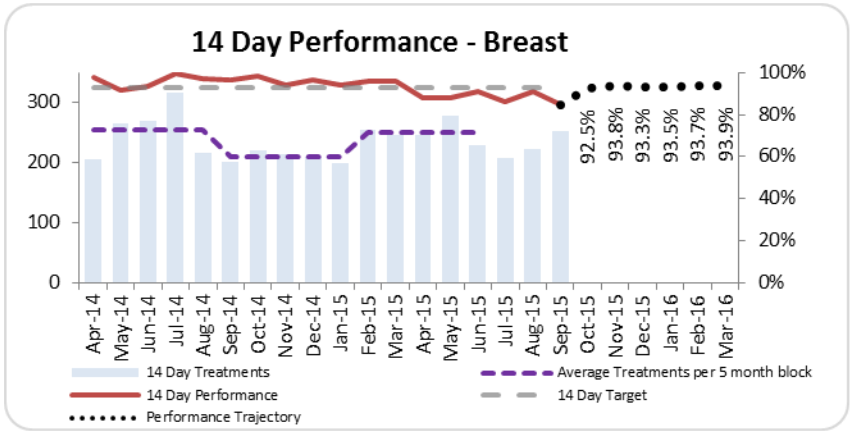
Non-achievement of this target relates to 370 breaches which is unfortunately higher than the average number of breaches of 95 seen in Q1 and an increase of 160 compared to previous month

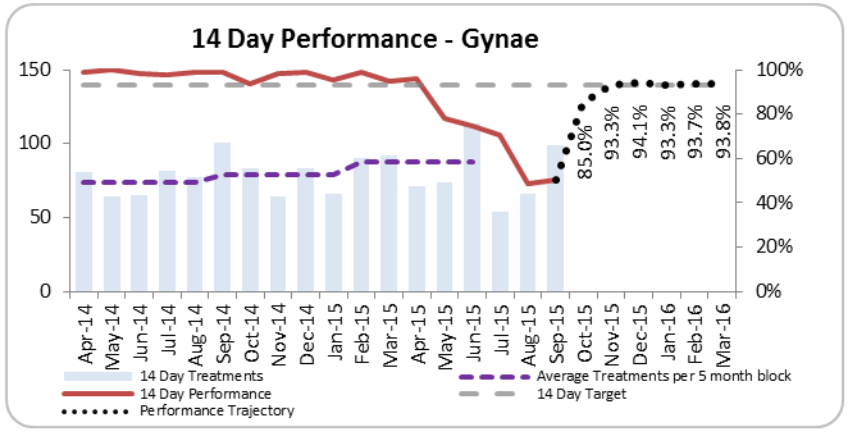
Modalities of breach include: Breast, Gynae, Skin, Haematology and Upper GI.

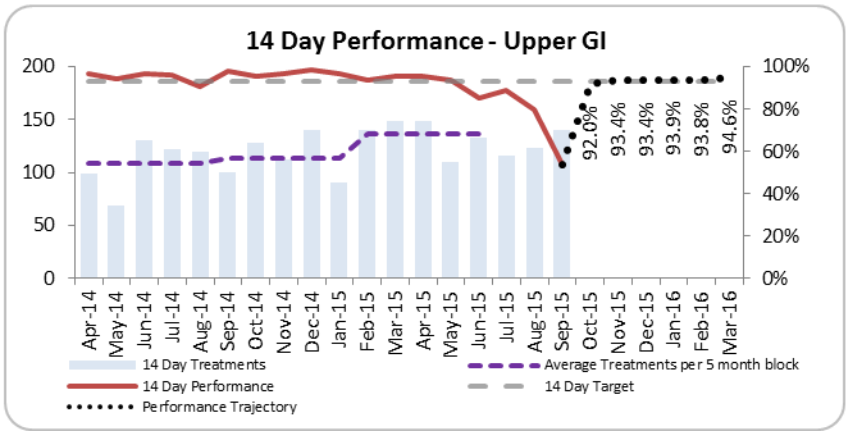
Key issues affecting performance in September:

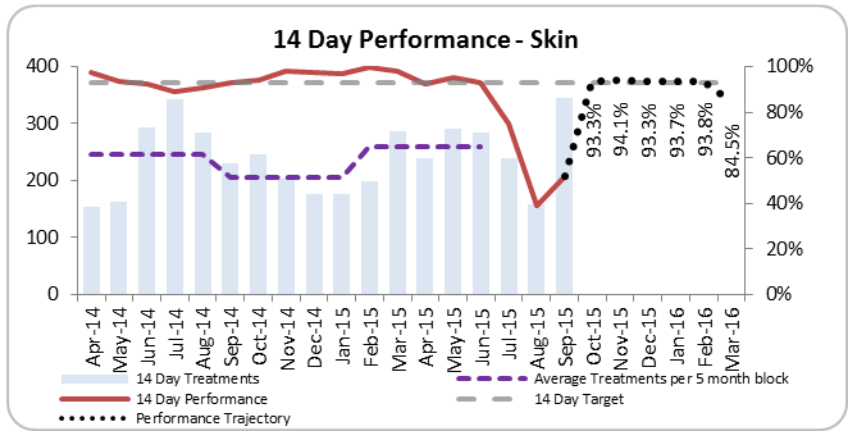
- patient choice - this accounted for 60 patients breaching.
- Capacity in particular in relation to Upper GI and Skin. Capacity is currently being reviewed to ensure for future performance sustainability and the following actions are also being undertaken:
- Recruitment of additional outpatient nursing staff to ensure additional clinics requested for 15/16 are consistently staffed.
- Daily update on capacity concerns and breach numbers from the Two Week Wait Referral Office.

14 Day GP Referral for all Suspected Cancers – Trajectory by Tumour Type







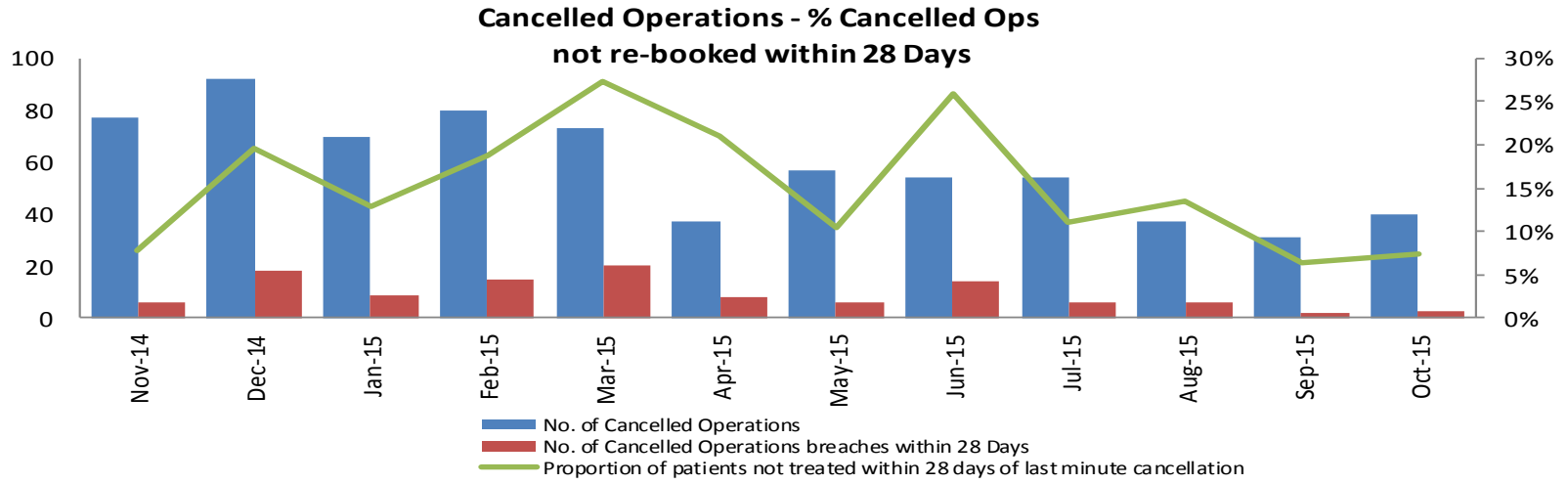


- The above trajectories are for challenged tumour groups to support performance recovery as submitted to the tri-partite forum.
- The Cancer Team with Divisions have undertaken a TWR demand and capacity review. Following the review divisions have a clear understanding of the shortfall in number of TWR slots required by tumour type. These now need to be reviewed and built into ring-fenced substantive capacity at 85% of average weekly referrals to allow for sustainability.

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

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Sep-15	Oct-15	Movement	2015/2016 Target	Forecast for Oct-15	Forecast for Nov-15	Date expected to meet standard
CC	6.45%	7.50%	⇩ 1.05%	0%	G	G	Nov-15

Peer Performance Comparison – Latest Available Q2 2015/16				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	5	3	1
12.50%	3.20%	21.40%	6.30%	1.90%



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 40 cancelled operations from 4497 elective admissions in September. 37 of those cancellations were rebooked within 28 days with 3 patients not rebooked within 28 days, accounting for 7.5 % of all cancellations. There has been a significant decrease in the number of cancelled operations in particular compared to the same period last year. This correlates with a reduction in the number of patients not re-booked within 28 days. There were 315 operations cancelled in the year to date, with 267 rebooked within 28 days.

The cancelled operations not re-booked were attributable to: Orthopaedics and Cardiothoracic specialties. Key contributory factors for the cancellations were related to emergency cases taking precedent and bed capacity issues for a complex case.

3. Performance Areas of Escalation (Page 5 of 6) - RTT 52+ Week Waiters

Referral to Treatment Incomplete 52+ Week Waiters							
Lead Director	Sep-15	Oct-15	Movement	2015/2016 Target	Forecast for Oct-15	Forecast for Nov-15	Date expected to meet standard
PVK	2	4	↓ 2	0	R	R	Nov-15

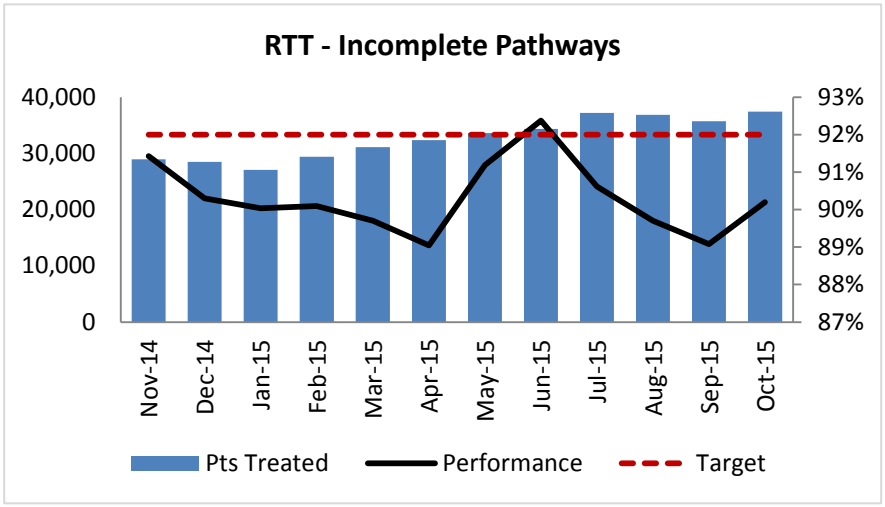
Peer Performance September 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
2	1	0	-	0

Specialty	Patient Type	Date for patient to be treated	Commentary
Gynae	Inpatient	23/11/15	Awaiting comments from Specialty
Gynae	Outpatient Continuing	11/11/15	Awaiting comments from Specialty
Gynae	Outpatient Continuing	05/11/15	Awaiting comments from Specialty
Surgery	Inpatient	14/11/15	Patient was offered a date in August. However patient unable to make date due to holiday. Patient originally had 2 month suspension as patient was unavailable for 2 months. Once patient made themselves available again (as planned) patient offered a new date. Patient treated 14 /11 /2015

The trust continues to pro-actively address 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 new Interim Chief Operating Officer 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 6 of 6)
- RTT Incomplete Performance



The trust has been non-compliant against RTT Incomplete pathways for a number of months, significantly falling below the target of 92% in September. Although October performance increased by 1.12% a great challenge remains to increase performance and to sustain an achievable target.

The Trust acknowledges as well as an immediate improvement which is being addressed through additional validation there also needs to be plans for long term sustainability and are currently in the process of proposing and implementing a **Waiting List Improvement Programme.**

The following are the expected outcomes of the waiting list programme:

- Clean PTL with an acceptable tolerance for BAU validation.
- Accurate reflection of trusts performance and waiting list position.
- Clear understanding of root causes for DQ issues with defined processes for correction.
- Understanding of re-training requirements to prevent DQ issues and to maintain a clean PTL. This is to be supported with a clear DQ improvement function within the trust.
- Improved pathway management with an enhanced and pro-active tracking function with early escalation protocols.
- Clearly defined trajectories for performance improvement and forecasting models for predicting sustained delivery of targets.

Waiting List

Specialty	Jul-15	Aug-15	Sep-15	Oct-15	Variance (Sep vs Oct)	
Gen Surg	3,479	3,622	3,535	3,594	59	⇧ 1.7%
Urology	1,602	1,614	1,557	1,595	38	⇧ 2.4%
T&O	3,186	3,111	3,245	3,330	85	⇧ 2.7%
ENT	3,090	3,320	3,151	3,193	42	⇧ 1.4%
Ophthalmology	242	260	242	251	9	⇧ 3.7%
Oral Surgery	2,216	2,069	2,192	2,222	30	⇧ 1.4%
Neurosurgery	1,260	1,176	987	1,030	43	⇧ 3.4%
Plastic Surgery	1,339	1,274	1,274	1,195	-79	⇩ -5.9%
Cardiothoracic	264	289	303	310	7	⇧ 2.7%
General Medicine	678	611	638	700	62	⇧ 9.1%
Gastroenterology	2,690	2,504	2,403	2,426	23	⇧ 0.9%
Cardiology	2,113	2,004	1,875	1,822	-53	⇩ -2.5%
Dermatology	2,785	2,865	2,793	2,831	38	⇧ 1.4%
Thoracic Surgery	1,067	873	1,091	1,034	-57	⇩ -5.3%
Neurology	1,302	1,243	1,200	1,265	65	⇧ 5.0%
Geriatric Medicine	34	35	38	38	0	⇧ 0.0%
Rheumatology	1,014	885	861	982	121	⇧ 11.9%
Gynaecology	3,475	3,648	3,109	3,137	28	⇧ 0.8%
Other	5,336	5,386	5,169	5,598	429	⇧ 8.0%
Total	37,172	36,789	35,663	36,553	890	⇧ 2.4%

Proportion of Patients within 18 Weeks

Specialty	Sep-15	From Target	Oct-15	From Target	Variance	
Gen Surg	✗ 87.9%	144	✗ 88.1%	142	⇧	0.2%
Urology	✗ 85.9%	94	✗ 88.5%	56	⇧	2.6%
T&O	✗ 84.7%	238	✗ 86.5%	186	⇧	1.8%
ENT	✗ 82.0%	317	✗ 81.9%	325	⇩	-0.1%
Ophthalmology	✓ 100.0%	-19	✓ 99.6%	-18	⇩	-0.4%
Oral Surgery	✓ 98.7%	-147	✓ 98.5%	-143	⇩	-0.2%
Neurosurgery	✓ 95.4%	-34	✓ 96.8%	-49	⇧	1.4%
Plastic Surgery	✗ 83.9%	103	✗ 82.1%	118	⇩	-1.8%
Cardiothoracic	✗ 74.6%	53	✗ 75.5%	52	⇧	0.9%
General Medicine	✓ 95.3%	-21	✓ 95.7%	-26	⇧	0.4%
Gastroenterology	✗ 82.9%	219	✗ 83.8%	201	⇧	0.9%
Cardiology	✓ 92.4%	-8	✓ 94.7%	-48	⇧	2.3%
Dermatology	✓ 93.2%	-35	✗ 91.7%	10	⇩	-1.5%
Thoracic Surgery	✗ 87.9%	45	✗ 87.3%	48	⇩	-0.6%
Neurology	✓ 97.7%	-67	✓ 98.1%	-77	⇧	0.4%
Geriatric Medicine	✓ 100.0%	-42	✓ 100.0%	-48	⇩	0.0%
Rheumatology	✓ 96.9%	-3	✓ 96.8%	-3	⇩	-0.1%
Gynaecology	✗ 82.1%	309	✗ 85.2%	214	⇧	3.1%
Other	✓ 94.4%	-124	✓ 96.8%	-268	⇧	2.4%
Total	✗ 89.1%	1022	✗ 90.2%	627	⇧	1.1%

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

Monthly View

			October 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	A&E WAITS (4 HOURS)	%	99.6	90.4			91.3
	CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION)	%	0	4.3	7.7	25	7.5
	LAS HANDOVER WITHIN 15 MINS	%					32.5
	LAS HANDOVER WITHIN 30 MINS	%					89.6
	LAS HANDOVER WITHIN 60 MINS	No.					0

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

			September 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION)	%	0	0	95	0	95
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION)	%	0	0	70.4	0	70.4
	31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION)	%	0	0	100	0	100
	31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DIVISION)	%			96.7		96.7
	31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISION)	%			96.1		96.1
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION)	%			85.7		85.7
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION)	%			95.5		95.5

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

			October 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY)	%				20.8	20.8
	HSMR	Ratio					91.6
	INCIDENCE OF C.DIFFICILE	No.	0	2	1	1	4
	INCIDENCE OF E-COLI	No.	0	1	0	0	1
	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	1	1
	MSSA	No.	0	0	0	0	0
	NEVER EVENTS	No.	0	0	0	1	1
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	1	4	3	1	10
	SHMI	Ratio					0.9
	TRUST ACQUIRED PRESSURE ULCERS	No.	1	1	0	0	2
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%	100	95.6	91.6	93.4	93.4
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	79.4	83.4	81.4	83.5	82.4
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	64.9	71.6	76.2	68.1	68.9
	SICKNESS/ABSENCE RATE - (DIVISION)	%	5.9	4.1	3.5	3.9	4.1
	STAFF TURNOVER - (DIVISION)	%	20.8	19.1	13.3	18	17.7
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	16.2	17.1	11.8	16.6	15.4

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 October 32.5% of patients had handover times within 15 minutes and 89.6% 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 zero 60 minute LAS breaches in October.

The trust has a zero tolerance on avoidable pressure ulcers and has placed significant importance on its prevention. In October the trust had 2 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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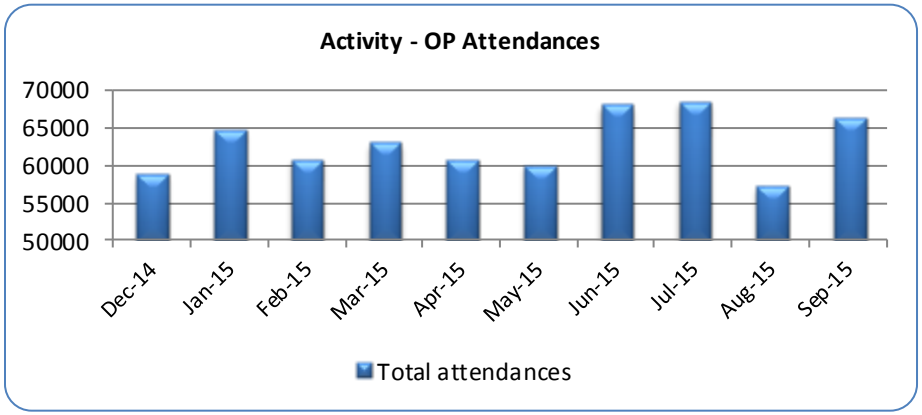
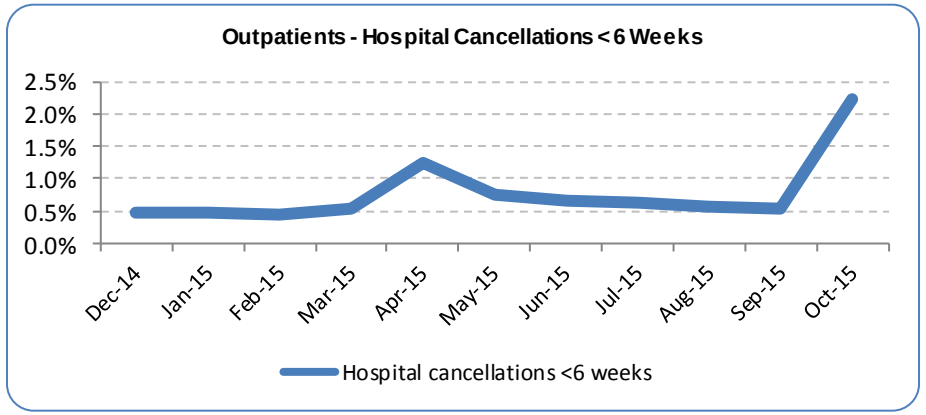
NHS Foundation Trust

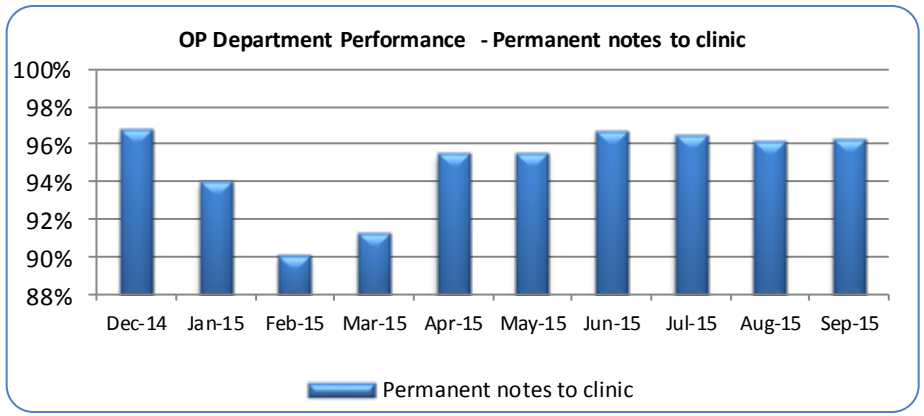
Corporate Outpatient Services Performance

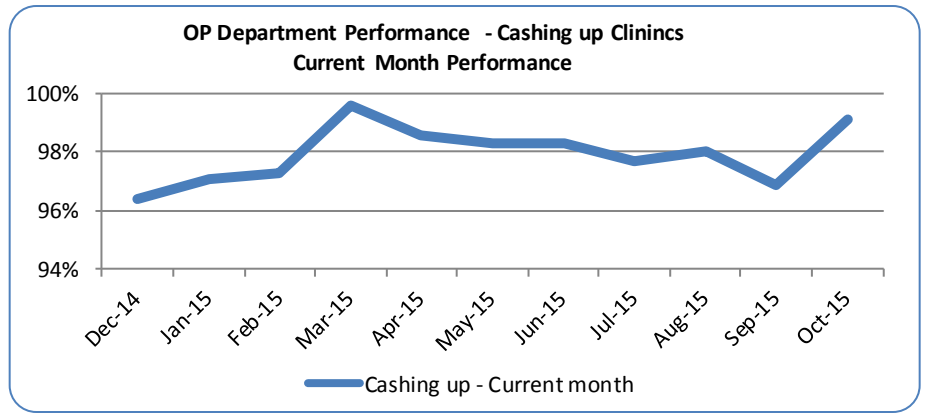
Excellence in specialist and community healthcare

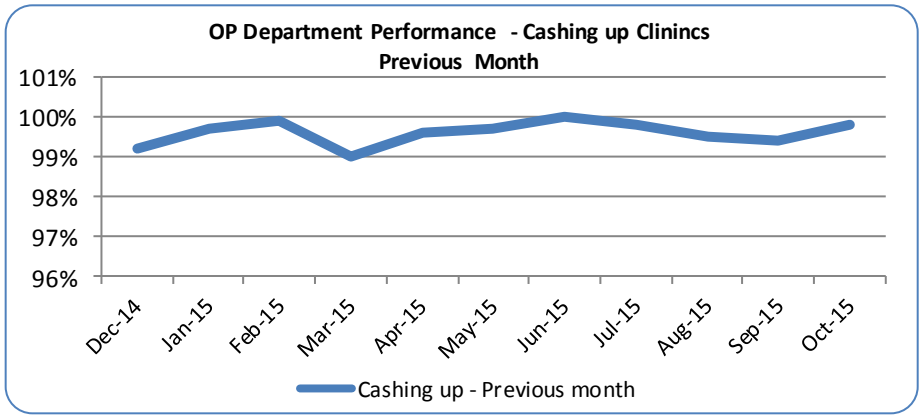
5. Corporate Outpatient Services (1 of 2) - Performance Overview

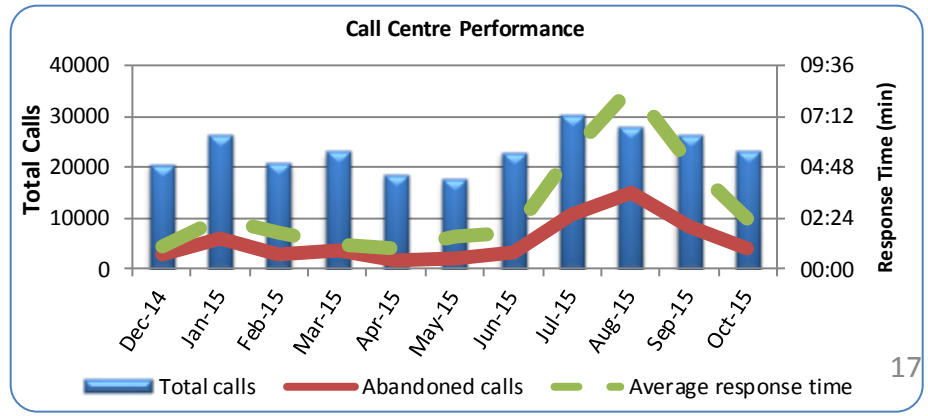












5. Corporate Outpatient Services (2 of 2) - Performance Overview

		Target	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Activity	Total attendances	N/A	69507	61879	58659	64609	60659	62946	60564	59841	68002	68277	57188	66271	66501
	Hospital cancellations <6 weeks	<0.5%	0.49%	0.32%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%	0.66%	0.64%	0.56%	0.54%	2.24%
OPD performance	Permanent notes to clinic	>98%	96.51%	96.88%	96.77%	94.05%	90.12%	91.32%	95.52%	95.54%	96.74%	96.54%	96.14%	96.31%	96.72%
	Cashing up - Current month	>98%	98.00%	98.22%	96.40%	97.10%	97.30%	99.60%	98.60%	98.30%	98.30%	97.70%	98.00%	96.90%	99.10%
	Cashing up - Previous month	100%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%	100.00%	99.80%	99.50%	99.40%	99.80%
Call Centre Performance	Total calls	N/A	23420	20964	20639	26565	20842	23235	18710	17732	22955	30426	28095	26357	23138
	Abandoned calls	<25%/<15%	2376	1558	2681	5923	2908	3782	1551	2237	3309	10828	15019	8253	3930
	Mean call response times	<1 m/<1m30s	01:13	00:47	01:02	02:24	01:43	01:08	01:00	01:29	01:42	05:31	08:34	04:59	02:24

Key Messages:

- Increase in activity from August position which is envisaged due to the holiday period, and now appears to be back on track.
- Hospital cancellations have seen a gradual continued reduction since May. However, in October a significant increase was reported at 2.24%. This is currently being reviewed and a route cause analysis has been requested to determine if this is specific to a particular specialty or cause.
- Performance of permanent notes to clinic has slightly increased and continues to see a steady improvement however remains 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 decreased for a second month when compared with July and is now within target of 15%.
- Positive performance improvement observed for mean call response time in October. However further work continues to bring this within target.

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Clinical Audit and Effectiveness

Excellence in specialist and community healthcare

6. Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)							
Lead Director	August 15	September 15	October 15	Movement	2015/16 Target	Forecast March 16	Date expect to meet standard
SM	91.8	91.3	91.3	↔	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
Oct 2014	Jan 2015	Apr 2015	Jul 2015	Oct 2015
0.81	0.84	0.86	0.89	0.92

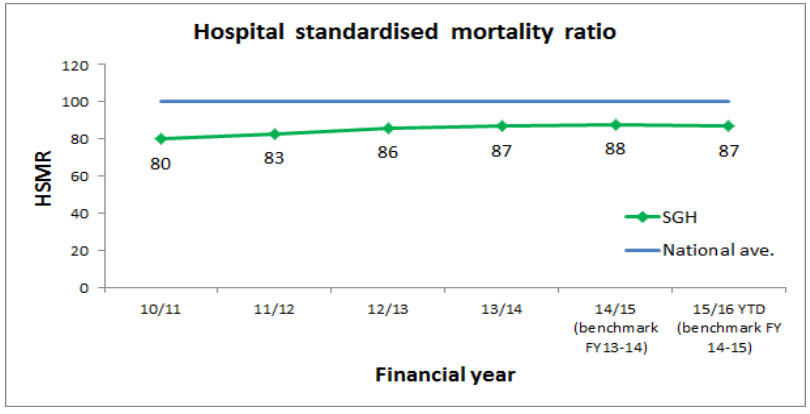
Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available; currently August 2014 to July 2015, and benchmark period is the financial year 2014/15 (NB this is unchanged from last month as refreshed data has not been received from Dr Foster). SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 28th October 2015 relates to the period April 2014 to March 2015. The next publication will be issued in January 2016.

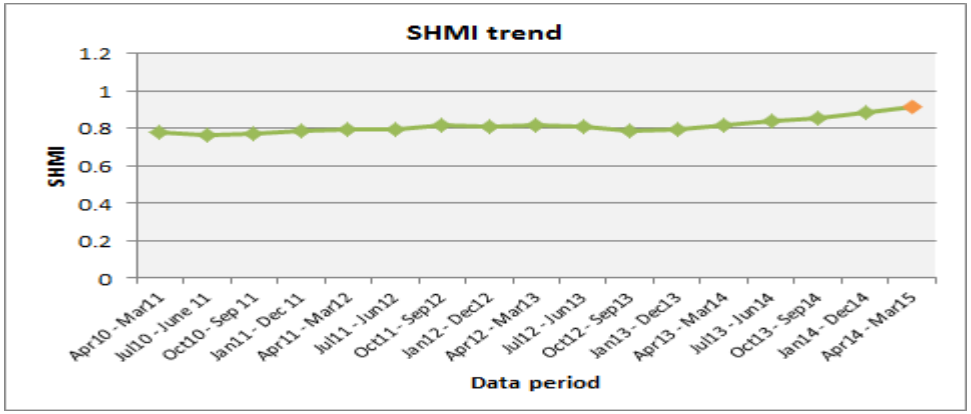
Overview:

The Health and Social Care Information Centre published the summary hospital-level mortality indicator for the period April 2014 to March 2015 on the 28th October. Our score has continued to increase and now stands at 0.92, which is categorised as 'as expected', meaning that our observed mortality is not statistically significantly different to expected. This is the first time that we have been in this banding; in every previous period of analysis our mortality has been categorised as 'lower than expected'. For this period 107 of 137 non-specialist acute trusts are categorised as 'as expected', 16 as 'higher than expected' and mortality for 14 trusts is 'lower than expected'.

The quarterly data release includes observed and expected deaths by trust for each of the 140 diagnosis groups that make up the SHMI. For St George's there are 43 diagnosis groups where observed deaths are less than expected, ranging from a difference of 0.25 to 73.5. For 61 groups the difference cannot be calculated as the number of events is too small. There are 36 diagnosis groups where observed deaths exceed expected, with a difference ranging from 23.2 to 0.3.

The Mortality Monitoring Committee will consider the full breakdown of diagnosis groups at the meeting on 18th November and will identify those that should be prioritised for investigation. It is noted that in 5 of the 6 SHMI diagnosis groups with the greatest absolute difference between observed and expected deaths, there is, or has recently been, a corresponding signal derived from our analysis of Dr Foster data. Common diagnoses include those related to trauma, cardiology and stillbirths and neonatal deaths. (NB: the diagnosis groups used in the SHMI may include more than one of the diagnosis groups used by Dr Foster). Each of these has been, or is being investigated and those reviews will be considered when prioritising the areas to be examined.





6. Clinical Audit and Effectiveness - National Audits

National Audit of Inpatient Falls 2015

Overview

This national audit was undertaken in May 2015 with the aim of measuring current performance in the assessment and prevention of falls against standards laid out in National Institute for Health and Care Excellence guidance on falls assessment and prevention (NICE CG161) and other guidance on preventing falls in hospital. The audit comprised an organisational questionnaire concerning procedures, protocols and the number of reported falls per occupied bed day (OBD) and a snapshot audit of the care of 30 in-patients, which was carried out by examining casenotes and observational assessments of the environment.

Audit Results

St George's reported 0.03 falls resulting in moderate or severe harm or death per 1000 OBD's and our mean rate of falls was 6.31 per 1000 OBD's. This compared well with the national averages of 0.19 and 6.63 respectively.

The report identifies seven falls interventions as particularly indicative of good practice and which are achievable aims for quality improvement. For these key indicators, we should aim for 100% compliance. Our performance is shown in Chart 1 which also provides a comparison of our results to the average performance of all sites participating in the audit. The report uses a RAG rating system for compliance [0-49% (red), 50–79% (amber), 80–100% (green)]. We are amber for 4 categories and red for 3. Nationally only one indicator (having the call bell in sight) was rated as green.

Recommendations

Twelve key recommendations were made as a result of the audit findings. Five relate to the organisational audit and our compliance to these is detailed in Table 1 . The remaining seven relate to the key indicators in Chart 1. Action to improve performance on each of these items is already underway and will be monitored by the Falls Steering Group.

Chart 1: Percentage compliance to key indicators

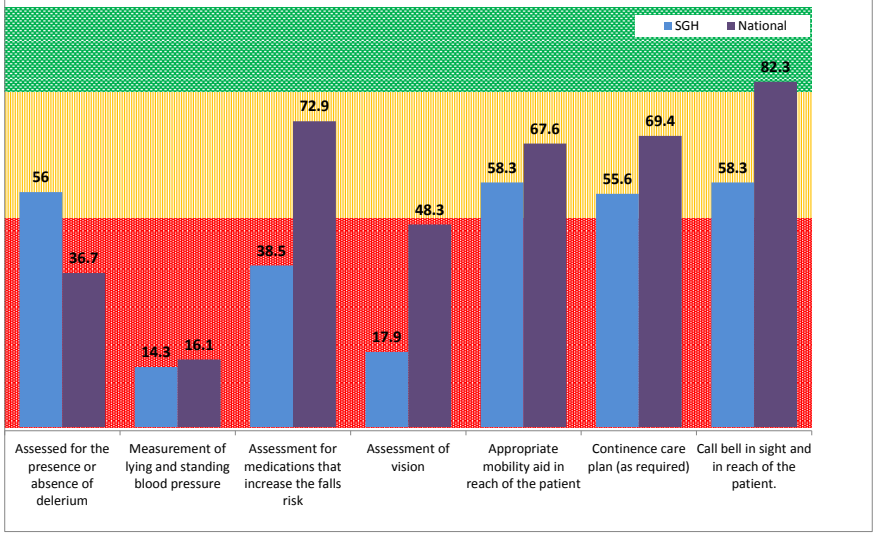


Table 1: Recommendations from the organisational audit

Recommendation (abbreviated)	SGH Current position/action
1.Falls steering group –To review data on falls and assess the success of their practice against trends in these figures.	Falls data is currently measured by incident reporting which is not individually verified. The Falls Prevention Committee monitor the incidence of falls per ward and division. Any falls that result in moderate or severe harm are initially notified to Risk and then investigated at a Divisional Level. The chair of the Falls Prevention Committee has been invited onto a number of SI panels.
2 Falls multidisciplinary working group – to monitor interventions to improve prevention of falls in hospital and use proven methods to embed these changes.	The Trust do not have resources for a MDT working group. Due to unforeseen circumstances, the Darzi fellow for falls 2015-2016 has had to step down and this opportunity is unable to go ahead.
3 Do not use a fall risk prediction tool –	We are replacing our Stratify tool with a multi- factorial risk assessment tool to be used for all patients at risk of falling
4 Audit bed rail use –	An audit has recently been completed and the report will be published shortly
5 Review multifactorial falls risk assessments (MFRAs) –to include all the domains in the audit. and link to quality improvement projects to ensure that what is included in the policy translates into what happens on the ward.	See response to 3. above. The new tool will be introduced with concurrent training and audited once embedded into practice

6. Clinical Audit and Effectiveness - National Audits

MBRRACE-UK - Perinatal Mortality Surveillance Report Recommendations from June 2015

Table 1 - Recommendations from June 2015 report	Met/Unmet or Not applicable to these recommendations and comments from respective clinicians.	
	Neonatal unit	Midwifery Unit
1) All organisations which have been identified as having a stabilised & adjusted stillbirth, neonatal or extended perinatal mortality rate that fall in the red band should conduct a local review in order to check their data and to identify factors which might be responsible for their reported high stabilised and adjusted mortality rate.	**N/A** *We are fortunate to have one of the lowest neonatal mortality rates in the country.*	**N/A**
2) Organisations whose stabilised & adjusted stillbirth, neonatal or extended perinatal mortality rate fall within the amber band should similarly consider carrying out a local review.	**Met**	**Met**
3) NHS England, NHS Scotland, NHS Wales, Health and Social Care in Northern Ireland, in conjunction with professional bodies and national healthcare advisors responsible for clinical standards in the relevant specialties should establish national aspirational targets for rates of stillbirths, neonatal deaths, and extended perinatal deaths against which all services can be assessed in future. This could be based on a stepwise approach working towards rates achieved by the current best performing countries in Europe .	**N/A** *We are fortunate to have one of the lowest neonatal mortality rates in the country. However, we intend to monitor our trends against national trends and continue to strive to maintain and decrease our mortality rates.*	**Not Met** (no comment received)
4) Units should ensure that a post-mortem examination is offered in all cases of stillbirth and neonatal death in order to improve future pregnancy counselling of parents.	**Not Met** *We have a reasonable record of offering Post Mortems to families compared to national figures 78% vs 77%. We record this data and an audit will be carried out to look at the data critically. This will then be presented at a clinical governance meeting to raise awareness of the issues.*	**Met**
5) In order that Trusts and Health Boards can comply with the recommendations arising from the Morecambe Bay Investigation, they should fully engage with the MBRRACE-UK data collection so as to ensure the "systematic recording and tracking of perinatal deaths".	**Met** *The neonatal data collection is good. It is difficult for the neonatologists to access the maternity data - BMI and intended type of care at booking.*	**Met** *We track mortality via Dr Foster platform and local systems.*
6) In order data are of the highest quality, Trusts and Health Boards must collaborate with each other in the provision of information to MBRRACE-UK about mothers and babies who change provider units during pregnancy and after delivery.	**Met** *We attempt this but still difficult to obtain full maternal details from location of booking. The MBRRACE system for requesting that information has been very helpful. We are trying to remind people to complete the data within the trust at perinatal meetings and I reveiw the data requred at regular intervals.*	**Met** *We attempt this but still difficult to obtain full maternal details from location of booking.*
7) It is essential that all Trusts and Health Boards provide data which are complete, accurate and reported in a timely manner in order that the most accurate comparative mortality estimates can be calculated and used for quality assurance. In particular by: a) Improving the provision of maternal data for neonatal deaths; b) Working closely with MBRRACE-UK to improve the classification of cause of death.	**Met** *As above and discussed with maternity colleagues regarding maternity data. We are trying to work with MBRRACE regarding the classification of cause of death by attending meetings and sharing our thoughts.*	**Met** *We are offering post mortems to families will be audited and the results available and presented by March 2016*
8) All organisations responsible for maternity services should report to MBRRACE-UK all births between 22(+0) and 23(+6) weeks gestational age who do not survive the neonatal period.	**N/A** *Generally the births of 22+0 to 22+6 week births are attended by obstetric/midwifery staff. The data for 23+0 to 23+6 week births is currently reported from the trust to MBRRACE by maternity and neonatal services.*	**Met**

Background: This is the first UK perinatal surveillance report produced under the auspices of the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP). This report represents one element of the work programme run by the MBRRACE-UK collaboration, and acknowledges the full support provided by clinical staff.
This report focuses on surveillance of all late fetal losses (22+0 to 23+6 weeks gestational age), stillbirths and neonatal deaths, and relates to the period January to December 2013.

Aim: The aim of this programme is to better understand the causes, risks and inequalities which impact on the health and survival rates of babies, so that organisations can measure whether they are providing the right care. The ultimate goal of the work is to support the NHS in improving the quality of services women and babies receive.

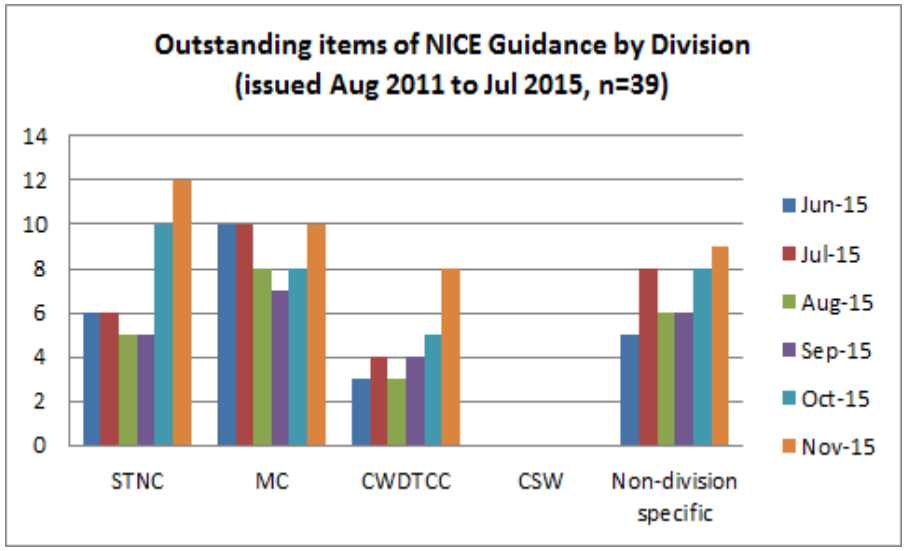
Results: The findings from this report indicate overall improvement in the rates of stillbirths and neonatal deaths continuing the trend from 2003 onwards. One of the key findings from this report is that engagement of Trusts and Health Boards in reporting data on stillbirths and neonatal deaths was inconsistent. However, this Trust had established structures of good practice to monitor and review such deaths and report data to MBRRACE-UK in a timely fashion.

Trust results against recommendation: On receipt of the report, the recommendations were extracted and a questionnaire prepared to guide self-assessment of practice. The questionnaire was completed by both lead clinicians in the neonatal and midwifery units (please refer to table 1). The Trust met all except one recommendation (item 4) and an audit will be undertaken to raise awareness of the issues.

Action Plan: Both units have agreed to audit the offering of post mortems to families and results will be presented early next year.

For full report please click on the link below:
https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Surveillance%20Report%202013.pdf

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 Jul 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=11)		2		4	1	4

Overview

In October there were 6 items of guidance published and compliance with two of these has already been established. There were also six technology appraisals published.

A further increase in the number of outstanding items of guidance is observed this month. This is due in part to the large volume of guidance issued by NICE in June and July following the 'Purdah period'. In these two months 31 items of guidance and 13 technology appraisals were published. The audit team has also had significantly less resource to dedicate to the follow-up of outstanding guidance. The team has continued to review and disseminate guidance promptly, but fewer reminders have been sent over the last two months. Recruitment is currently underway, and coupled with a review of our systems and processes, it is anticipated that the support provided to divisions will shortly return to previous levels. Re-evaluating our approach to the dissemination and monitoring of implementation will also be used to inform our policy review.

Our position for guidance where we are not fully compliant remains largely unchanged. Over the next two months the audit team will be completing the bi-annual assessment of compliance, liaising with divisions to ascertain progress and barriers. An overview of risks will be collated for each division and the Clinical Effectiveness and Audit Committee will require divisions to report on the management of these risks.

In December NICE will hold their Board meeting at St George's and our Chief Executive has been invited to participate. Following that NICE will be hosting a 'Question Time' session and a Public Board meeting. These events have been advertised to all members of staff as an opportunity to engage with NICE, learn about latest developments and question the Board about policy.

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NHS Foundation Trust

Patient Safety

Excellence in specialist and community healthcare

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

	2015 SIs Declared by Division (incl. PUs)				
	M&C	STN&C	CSD	C&W	Corporate
August	5 (1 shared)	4 (1 shared)	1	2	1 (shared)
September	6	3	4	1	0
October	4	3	1	1	1

Closed Serious Incidents (not incl. PUs)				
Type	August	September	October	**Movement**
Total	11	8	11	
No Harm	8	1	2	
Harm	3	7	9	

Table 1

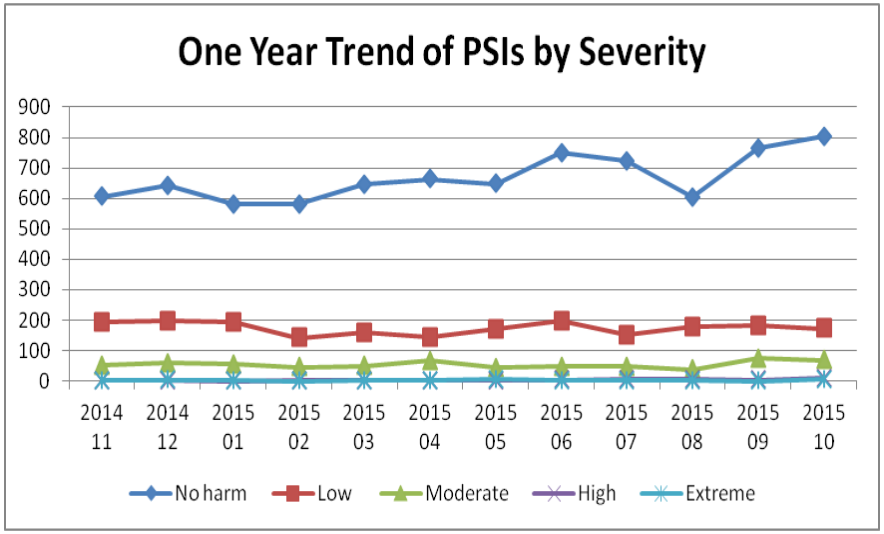
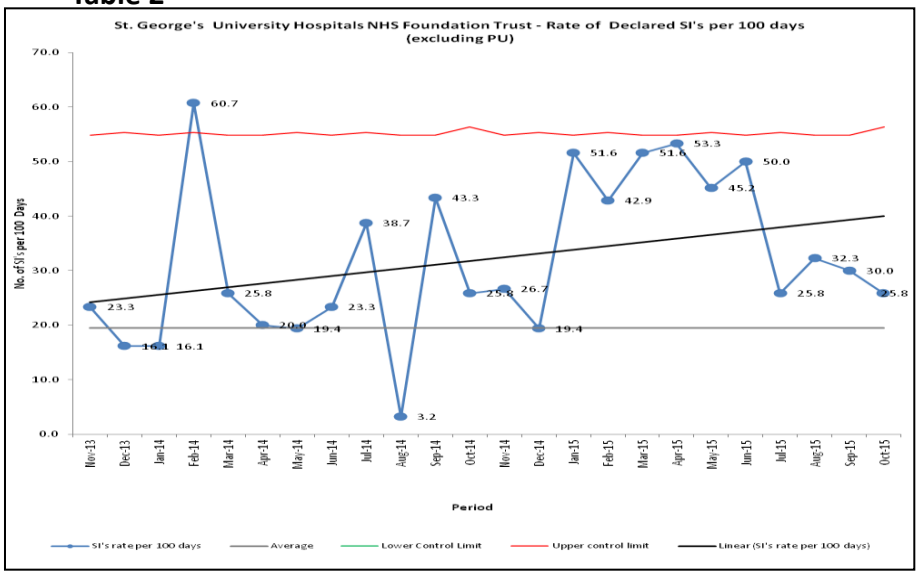


Table 2



Overview:
The numbers of general reported incidents are shown in Table 1. 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.

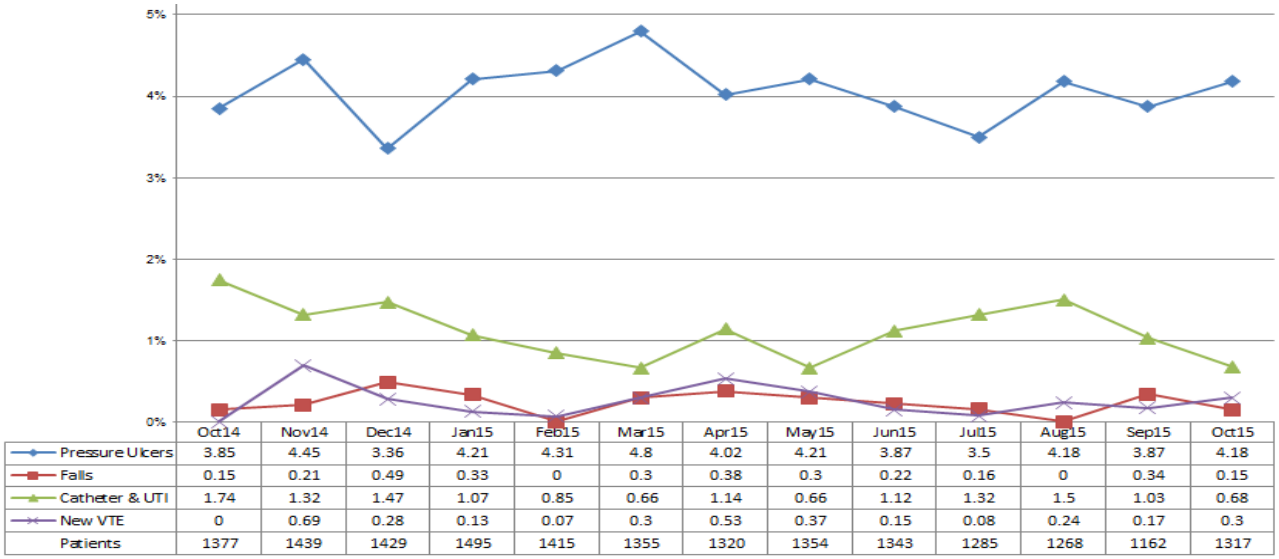
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase. There were 8 general SIs reported in October (+2 pressure ulcers) and the subjects are varied.

The 8 general SIs declared in October relate to a range of issues. They include the following categories:

- Delay to act on adverse symptoms
- Failure to follow up x3
- Patient absconded
- Alleged abuse of patient
- Legionella
- Maladministration of insulin

7.Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	August 2015	September 2015	October 2015	**Movement**	**2015/2016 Target**	**National Average October 2015**	**Date expected to meet standard**
J Hall	94.40%	94.84%	94.84%	↔	95.00%	94.30%	March 16



	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Pressure Ulcers	3.85	4.45	3.36	4.21	4.31	4.8	4.02	4.21	3.87	3.5	4.18	3.87	4.18
Falls	0.15	0.21	0.49	0.33	0	0.3	0.38	0.3	0.22	0.16	0	0.34	0.15
Catheter & UTI	1.74	1.32	1.47	1.07	0.85	0.66	1.14	0.66	1.12	1.32	1.5	1.03	0.68
New VTE	0	0.69	0.28	0.13	0.07	0.3	0.53	0.37	0.15	0.08	0.24	0.17	0.3
Patients	1377	1439	1429	1495	1415	1355	1320	1354	1343	1285	1268	1162	1317

Pressure ulcers (55)

- 26 grade 2 (8 new, 18 old)
- 21 grade 3 (6 new, 15 old)
- 8 grade 4 (1 new, 7 old)

CAUTI (9)

- 6 new
- 3 old

Falls (2)

- 2 low harm falls

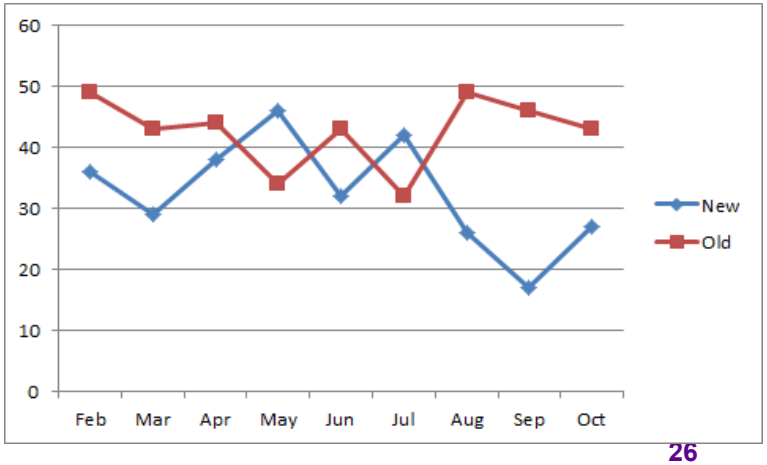
VTE (4)

- 1 new DVT
- 1 new PE
- 2 new 'other'

In October 2015 the proportion of our patients that received harm free care remained at 94.84%, which is slightly better than the national average. Comparing our proportions of each type of harm to the national average shows that we are very similar for pressure ulcers, catheter associated urinary tract infections (CAUTIs) and new VTEs; however, our proportion of patients with falls is considerably lower than the national rate of 0.6%.

Our overall level of harm over time is consistent, with our mean rate over 13 months standing at 94.59%. There is variation however in the split between new and old harms.

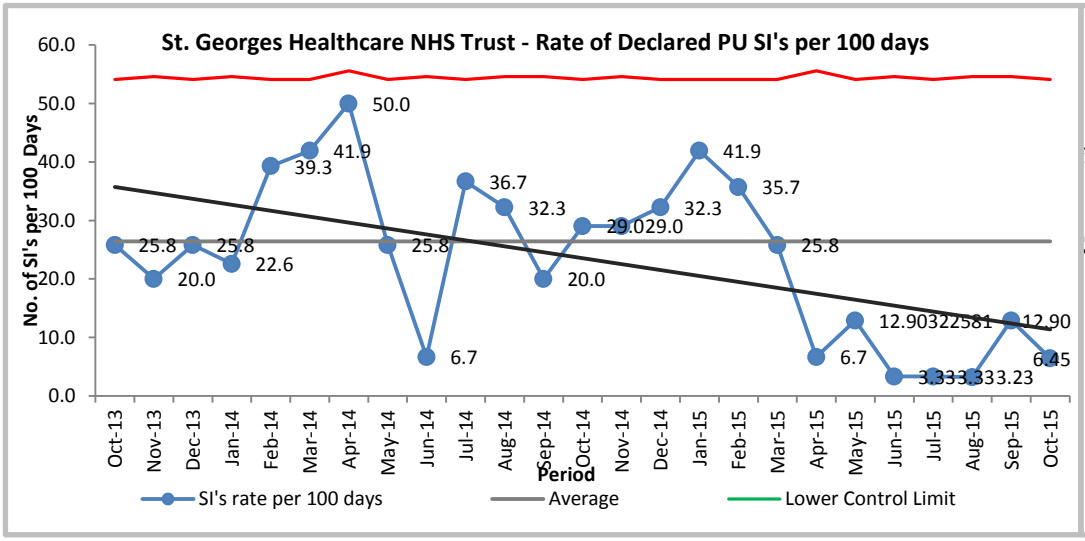
This month we reported 70 harms to 68 patients; 66 patients experienced one harm and 2 patients had 2 harms. 27 harms are categorised as new, meaning that they either developed or treatment began whilst under our care. Both pressure ulcers and new VTEs increased slightly this month. For the second consecutive month catheter associated urinary tract infections decreased.

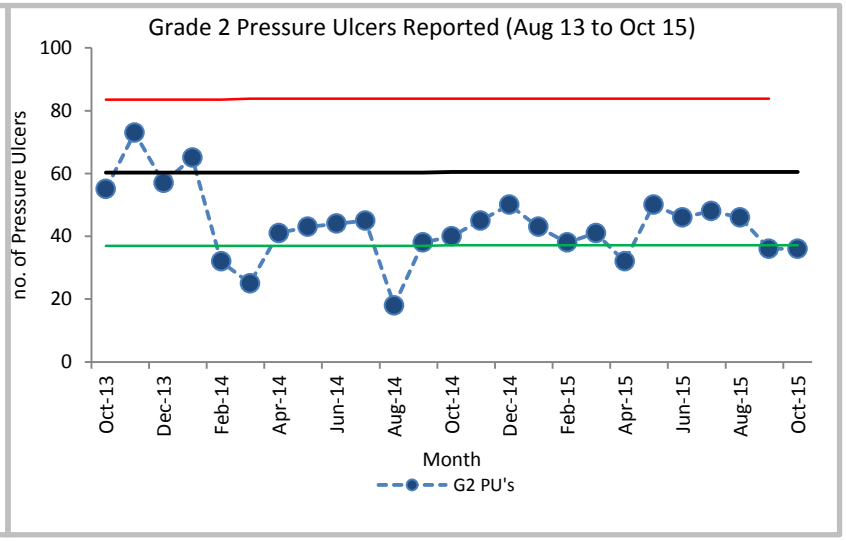


7. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	YTD April – May 2016	Movement	2015/2016 Target	Forecast March 2015	Date expected to meet standard
Acute	1	1	0	2	1	**10**			G	-
Community	0	0	1	2	1	**5**			G	-
Total All	1	1	1	4	2	**15**			G	-
Total Avoidable	**1**	1	1	4	2	**15**		40		-

Grade 2 Pressure Ulcers						
Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Movement
28	25	23	21	21	
18	23	23	15	15	
46	48	46	36	36	





Overview:

October saw a reduction in the number of pressure ulcer serious incidents across both acute and community settings. There was an equal number of Grade 2 pressure ulcers in both areas, further work will focus on reducing these numbers utilising IHI quality improvement methodology .

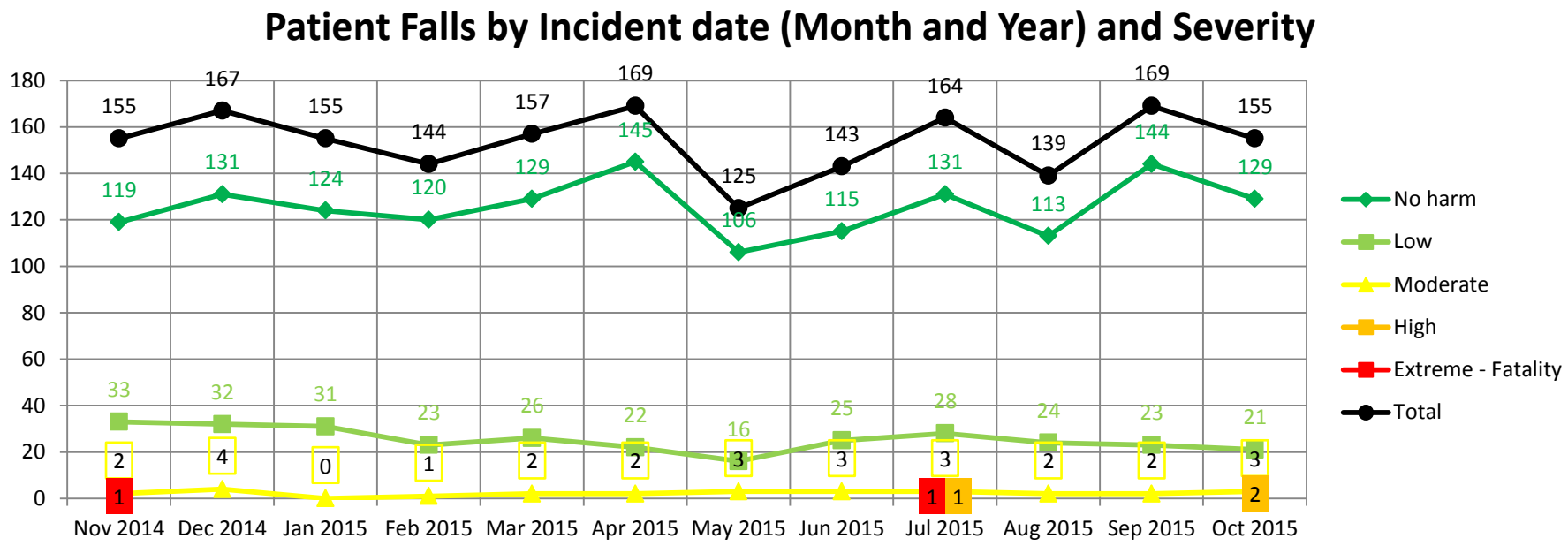
Actions:

- Shortlisting of Tissue Viability Support Nurse candidates currently underway, the successful applicants will rotate between acute and community areas to ensure further integration of the service.
- Trial of pressure relieving mattress solutions is now completed and the group will decide on the most effective delivery system for the trust, providing a high standard of care but still reducing cost.
- Further teaching undertaken for nurses across the trust to raise awareness of pressure ulcers, teaching sessions also planned for allied health professionals.

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

Falls																			
Lead Director	June 14	July 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	April 15	May 15	June 15	July 15	Aug 15	Sep 15	Oct 15	Movement	2014/2015 Target	Date expected to meet standard
	151	151	125	143	157	154	169	154	144	157	165	126	144	163	140	168	155	⟷	100	July 2015

Falls with Harm April 2014- to date				
No Harm	Moderate	Severe	Death	Falls related Fractures
2629	35	5	1	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 small reduction in falls incidence on the head injury unit and across the medical wards. **Actions:** Results from bed rails 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 November 2015. Roll out of NICE compliant multifactorial falls risk assessment and integration of this document into the ED. Action plan following our performance in the National Inpatient Falls Audit to be drawn up at the next Falls Prevention Committee meeting November 2015.

7. Patient Safety - Infection Control

MRSA						
Lead Director	September	October	Movement	2015/2016 Threshold	Forecast November- 15	Date expected to meet standard
JH	2	0	↓	0	G	-

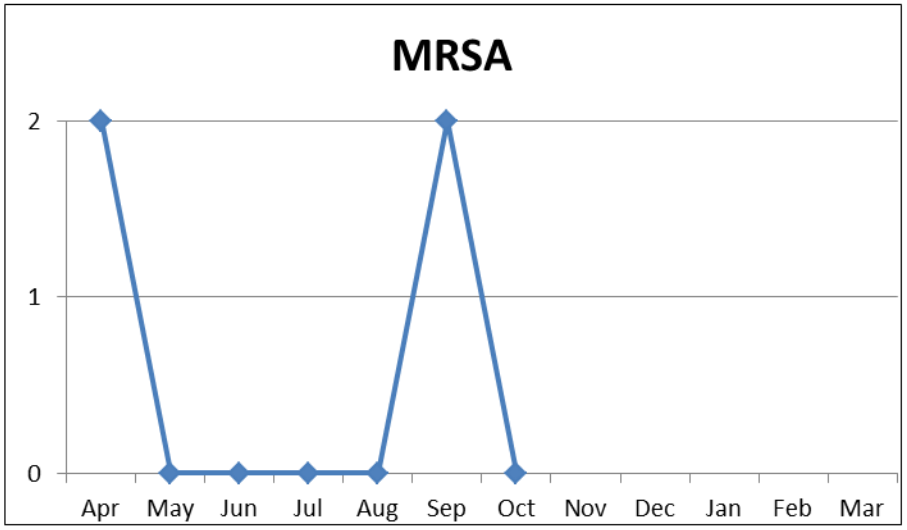
Peer Performance – YTD October 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1	1	2

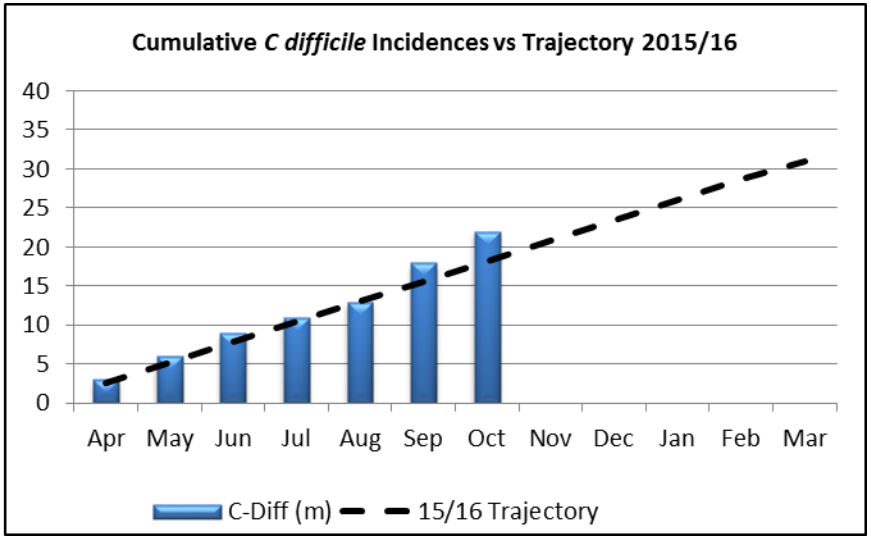
C-Diff						
Lead Director	September	October	Movement	2015/2016 Threshold	Forecast Noember - 15	Date expected to meet standard
JH	5	4	↓	31	G	-

Peer Performance – YTD October 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
22 (31)	14(16)	12(9)	52(72)	16(39)

The MRSA bacteraemia threshold is zero. There were no MRSA bacteraemias in October. The Trust is non-compliant , with 4 incidents in total.

In 2015/16 the Trust has a threshold of no more than 31 *C. difficile* incidents. in September there were 5 episodes (corrected from 4 in previous report) and in October 4 episodes, a total of 22 for the FY to end October. This means that the Trust is currently one episode above the trajectory for the end of October but can still achieve the target at the end of the FY 2015/16.





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	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June	July	August	Sept	Oct
Unify2	93.18%	93.51%	95.94%	96.03%	96.27%	96.64%	96.45%	96.75%	96.56%	96.78%	97.22%	

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	Nov	Dec	Jan (2015)	Feb	Mar	April	May	June	July	August	Sept	Oct
Safety Thermometer (SGH)	86.56%	75.92%	79.08%	83.89%	85.74%	89.83%	90.19%	95.14%	94.84%	92.38%	91.28%	93.40%
National average	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:

- The Hospital Thrombosis Group is expanding its VTE champion network and working to further establish the network to drive improvement in VTE prevention across the Trust. The group hold monthly meetings with the Champions to discuss issues highlighted at HTG and listen to feedback from the Champions about clinical practice relating to VTE prevention from across the Trust. The network is multi-disciplinary with representation including doctors, pharmacists, physician's associates and midwives. The group are interested in recruiting nursing staff in addition to increasing the numbers of other staff groups already present. The aim of the network is to grow a culture of engagement with the VTE prevention programme, and embed good practice relating to VTE prevention as part of routine clinical practice.

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

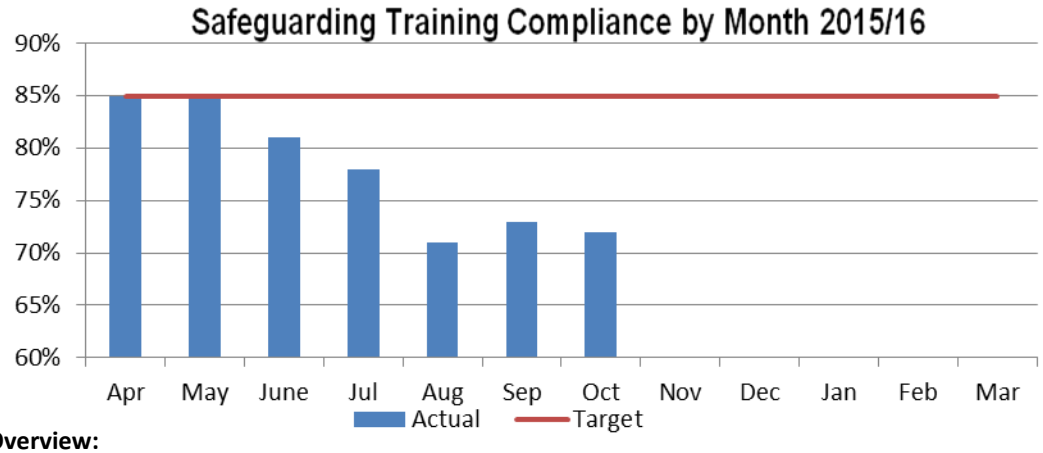
Year		2015
HAT cases identified to date (attributable to admission at SGH)		156
Mortality rate	Total	12.2% (19/156)
	VTE primary cause of death	4.5% (7/156)
Initiation of RCA process		100% (156/156)
RCA pending	<28 days since notification	11
	>28 days since notification (notes requested)	22
RCA complete		78.8% (123/156)

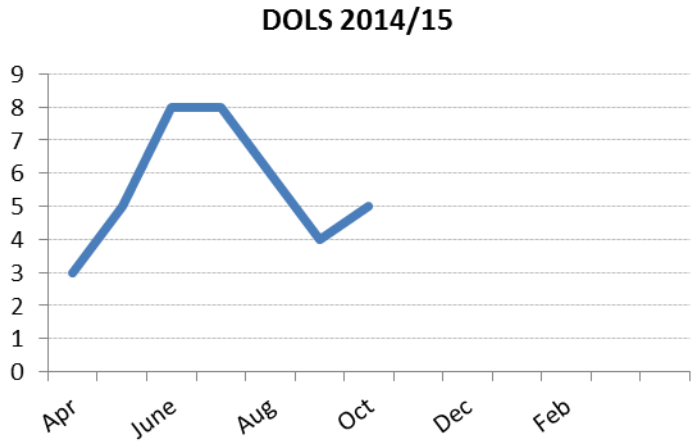
HAT case finding has significantly improved since the start of 2015 resulting in an observed increase in frequency of HAT. This increase brings incidence of HAT at SGH in line with rates observed at other Trusts in London that are of a similar size and status.

7. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	May	June	July	Aug	Sep	Oct	2015/20165 Target	Forecast April 2016	Date expected to meet standard
JH	85%	81%	78%	71%	73%	72%	85%	A	-

Safeguarding Adults Training Compliance by Division – Oct 15				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
68%	71%	77%	75%	70%





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, Sep 91, Oct 75

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

Safeguarding Children Level 3 training Organisation Compliance

These figures are as a result of data cleansing

29-Oct-15

200 Children and Women's Diagnostic and Therapy Services Division	**Amt. Completions**	**Required Training**	**Compliant (%)**
	498	**623**	**80%**
200 Community Services Division	**Amt. Completions**	**Required Training**	**Compliant (%)**
	104	**199**	**87%**
200 Corporate Division	**Amt. Completions**	**Required Training**	**Compliant (%)**
	4	**4**	**100%**
200 Medicine and Cardiovascular Division	**Amt. Completions**	**Required Training**	**Compliant (%)**
	100	**199**	**50%**
200 Surgery & Neurosciences Division	**Amt. Completions**	**Required Training**	**Compliant (%)**
	4	**13**	**31%**
Overall for the Trust	**716**	**958**	**75%**

Training : The training data on ARIS remains slightly inaccurate, however the safeguarding team continue to check the data and are undertaking a data cleansing exercise quarterly to try to ensure the data is as accurate as possible. It should be noted that new staff are classed as non compliant immediately they join the trust and are dependant on being released for training, staff turnover has an impact on compliance levels, however regular advertising of safeguarding training in eG as well as targeting individuals has resulted in increased numbers attending this month.

Serious Case Reviews and Internal Management Reviews: No new SCR's have been declared this month.

Other: The safeguarding team have completed the Safeguarding Children Half Yearly Report (October 2015), as well as formulating a workplan for 2015/16. FGM remains a priority, as does CSE. We are awaiting the outcome of the Trust Safeguarding Children restructuring. The Named Nurse and Named Midwife will attend a consultation event for 0-5 services in Merton on 18/11/15.

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Patient Experience

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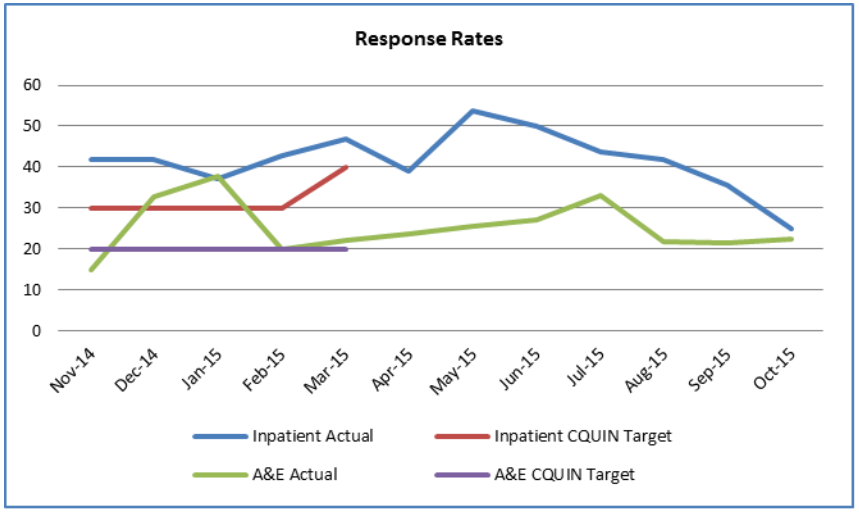
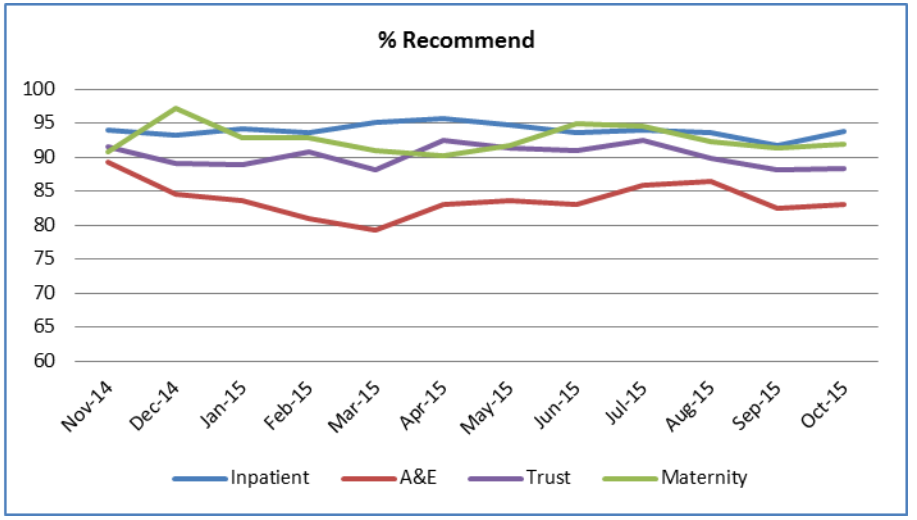
8. Patient Experience - Friends and Family Test

FFT Response Rate							
Domain	Aug-15	Sep-15	Oct-15	Movement	2015/2016 Target	Forecast	Date expected to meet standard
Trust	27.4	26.9	23.6	▼	-	-	-
Inpatient	41.9	35.7	25.1	▼	-	-	-
A&E	21.7	21.6	22.4	▲	-	-	-
Maternity	N/A	N/A	N/A		-	-	-

	FFT Response Score			
	Aug-15	Sep-15	Oct-15	Movement
	89.9	88.1	88.4	▲
	93.6	91.7	93.8	▲
	86.5	82.4	83.1	▲
	92.2	91.4	92	▲





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.
Inpatient figures now include day cases – this has increased the denominator for the metric by approximately 50%, and the response rate is much lower for October as a result.

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

	Complaint	PALS	FFT	FFT responses
(CW) Childrens Directorate	4	12	99.1%	112
(CW) Diagnostics Clinical Directorate	2	9	No data	0
(CW) Therapeutics Clinical Directorate	12	29	53.2%	62
(CW) Womens Directorate	6	24	92.5%	294
(MC) Accident and Emergency Directorate	0	0	83.1%	1537
(MC) Acute Medicine Clinical Directorate	6	8	93.4%	137
(MC) Cardiovascular Clinical Directorate	4	24	96.5%	226
(MC) Renal, Haematology, Palliative Care & Oncology Directorate	2	6	95.0%	159
(MC) Specialist Medicine Clinical Directorate	6	34	No data	0
(SN) Neurosciences Clinical Directorate	7	13	97.1%	209
(SN) Surgery Clinical Directorate (inc. Trauma and Orthopaedics)	20	104	89.2%	508
(SN) Theatres Clinical Directorate	1	0	98.0%	50
Community Services	5	11	TBC	TBC
Corporate Directorates	6	18	N/A	N/A
External Organisations	0	2	N/A	N/A
Grand Total	88	304	89.1%	3227

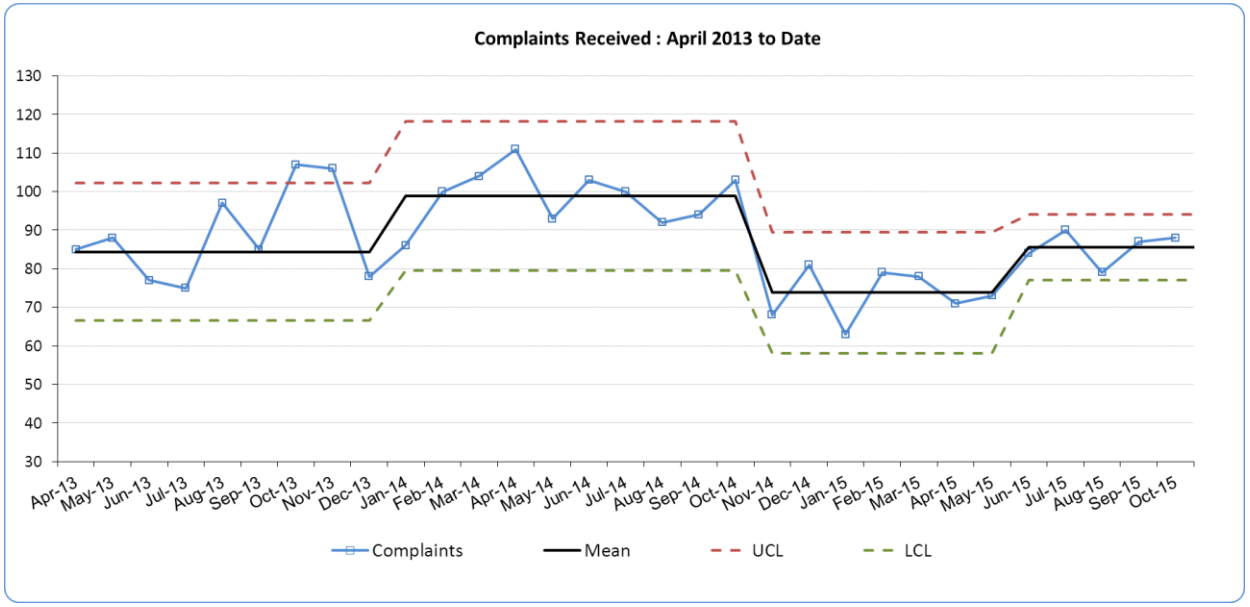
Triangulation of Patient Experience Data

Notes on the data:

This report only shows directorates that have received a complaint or PALS concern in October 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 - Complaints Received

Complaints Received											
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Movement
Total Number received	63	79	78	71	72	84	90	79	86	88	▲



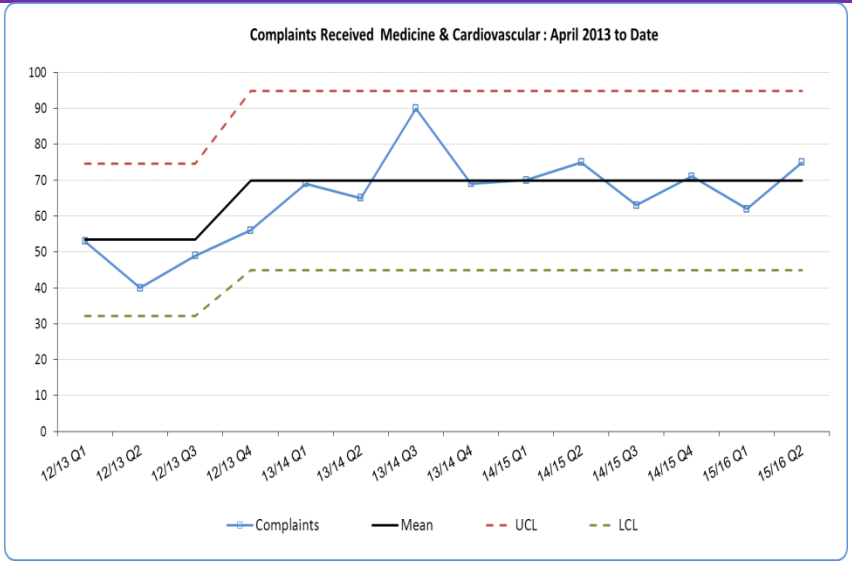
Overview:

This report provides an update on complaints received in quarter 2 of 2015/2016 and information on responding to complaints within the specified timeframes for the same period with divisional breakdowns and analysis of the data to provide some trends and themes. It also includes some actions taken and planned in quarter 2, a report of the latest work on severity rating of complaints and posts on NHS Choices and Patient Opinion.

Total numbers of complaints received in Quarter 2 of 2015/2016

There were 255 complaints received in quarter 2 of 2015/2016, an increase when compared to quarter 1 when 227 complaints were received. Complaints remained stable in the Surgery and Neurosciences Division and reduced in the Community Services Division but rose in all other areas, most significantly in the Women's and Children's Division where complaints increased from 48 in quarter 1 to 72 in quarter 2.

8. Patient Experience
- Complaints – Q2 by division



Medicine and Cardiovascular Division

COMMENTARY

The Medicine and Cardiovascular Division saw an increase in complaints from 62 in Q1 to 75 in Q2. Accident and Emergency had the highest number of complaints with 20 which was an increase on quarter 1 when 15 complaints were received. Increases were also seen in dermatology, gastroenterology, cardiology and cardiothoracic surgery.

The most common themes of complaints in the division are: clinical treatment (diagnosis), verbal communication, clinical treatment (operative procedure) and nursing care.

ACTIONS

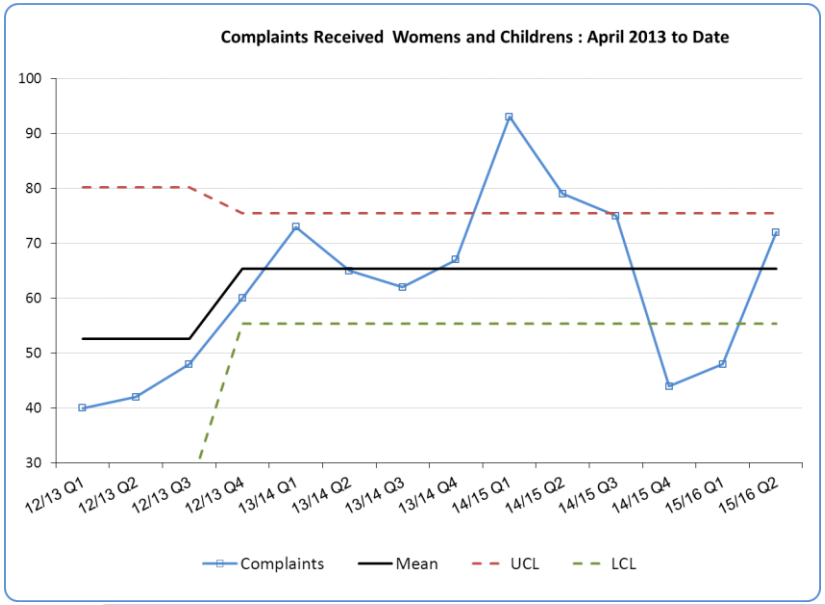
Specialist medicine
Following complaints relating to appointment waiting times, evening clinics are being established in order to accommodate current demand, so that appointments can be offered with less delay.

Emergency Department (ED)
Following a complaint regarding clinical treatment of patients with Post Traumatic Stress Disorder, teaching sessions for awareness and management of patients with PTSD and similar conditions have been delivered. In order to address recurring instances of missing patient property, a Healthcare Assistant is being recruited, in order to take responsibility for dealing with patient property issues. In order to address complaints arising from communication problems in ED Triage, Matrons and band 7 team leaders are holding weekly team meetings.

Cardiovascular
(Red) Complaint & SI regarding cardiac surgery waiting list - Patient Pathway Co-ordinators are being recruited, who will be responsible for ensuring that patients are actively managed through the referral pathway and not lost in the system. This will enable each patient to be tracked and have an active plan for the next appointment. It will also provide the patient with a single point of contact if they have any queries.

Renal
Complaints regarding discharge co-ordination and transport arrangements - there is now a robust system in place to ensure safe discharge and on-going care. Buckland Ward now have a specific discharge co-ordinator post which is held by a senior qualified nurse who is responsible for ensuring safe and appropriate discharge of patients.

8. Patient Experience
- Complaints – Q2 by division



Children's, Women's, Diagnostics and Therapeutics Division

COMMENTARY

The Children's, Women's, Diagnostics & Therapeutics Division saw an increase in complaints from 48 in Q1 to 72 in Q2. Women's services had the highest number of complaints within the division, which is a consistent picture. Therapies and Outpatients did however have the e highest percentage increase in complaints when compared to Q1.

The top themes of complaints in the division are: communication, waiting times and clinical treatment

ACTIONS

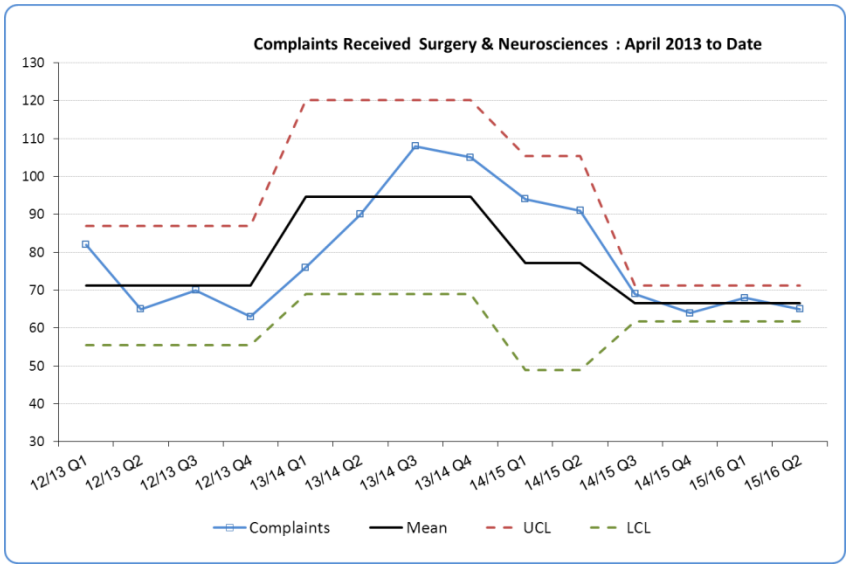
Communication
A new appointment reminder system (NetCall) is set to commence in November 2015, this aims to enable patients to actively confirm their outpatient appointment attendance.

Customer care training in outpatients is being expanded to include the use of a short film made in the Trust, by staff and patients, which focuses on the patient pathway and how this can be improved. This this will be watched by all staff and feature as part of future staff induction.
A series of complaints received within children's services have been re-enacted by actors to develop educational films for staff; giving staff the opportunity to reflect and learn from incidences of poor communication.

Waiting Times
The second phase of the Netcall project in outpatients will see the introduction of a "Queue Buster" for peak times in the call centre. This will give the patient an option to either be called back later, or to be automatically reconnected when the lines are less busy.
There is also focus in outpatients and pharmacy on ensuring that patients are suitably briefed about waiting times within the clinic.

Clinical Treatment
Clinical treatment concerns are being addressed on a case by case basis, with no single directorate / service flagging as a cause for concern
The suspension of the urogynaecology service has featured within this quarter and all complaints are being managed with a consistent message in this regard, similarly all patients have been offered alternative hospitals for treatment.

8. Patient Experience
- Complaints – Q2 by division



Surgery, Neurosciences, Theatres and Cancer Division

COMMETARY

The Surgery, Neurosciences, Theatres and Cancer Division saw a slight decrease in complaints from 68 in Q1 to 65 in Q2. The most complained about speciality is trauma and orthopaedics with 16 complaints being received which was not a significant increase when compared to the previous quarter when 15 complaints were received. General surgery, neurology and neurosurgery also received high numbers of complaints but not significant increases on the previous quarter either .

The most common themes of complaints in the division are: clinical treatment (diagnosis), verbal communication, written communication and clinical treatment - medication.

ACTIONS

Neurosciences
Opened 16 additional neurosurgical beds in October- has immediately reduced the numbers of bed moves and delays to patients waiting for admission
The specials project on Kent ward has seen 10 HCA's specifically recruited and trained to support the head Injury patients- has stopped use of ad hoc specials and improved continuity and quality of care as well as reducing costs

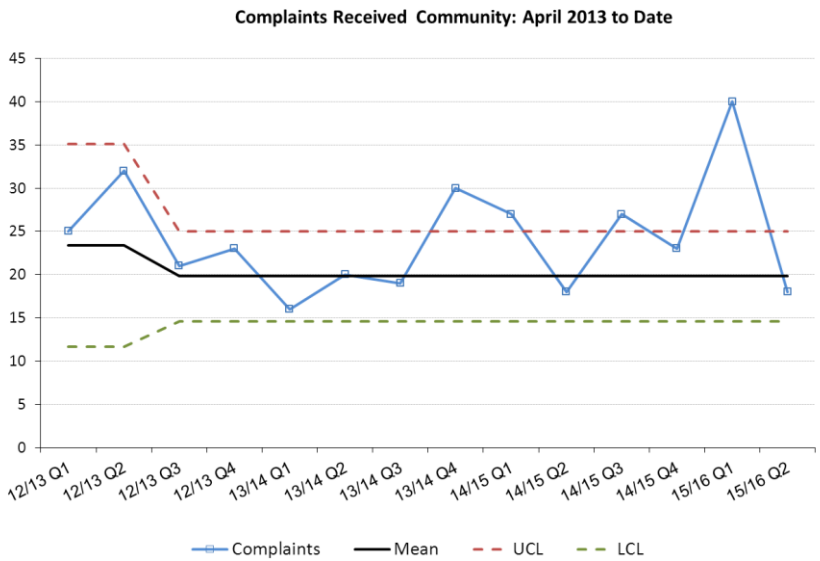
Trauma and Orthopaedics
Outpatient Department work – specifically fracture clinic- 6 key themes, each with a project group leading the work: radiology, IT, staffing levels, capacity/demand, patient information & experience

Secretarial workforce- prolonged response times to calls and messages- performance indicators set to ensure timely responses e.g 24 hrs for a message, aiming to reduce variability and improve experience.

Work on roles and responsibilities with the personal assistants/consultant body to ensure patients receive a consistent and safe service with good continuity of care. PA handbook developed and senior coordinating PA

Day Surgery Unit
Complaints around the environment and discharge planning – made some changes to the clinical environment to make it more patient friendly/ clarity around discharge arrangements with clear written information supported by consistent communication form the nursing team- education programme in place to support these changes.

8. Patient Experience
- Complaints – Q2 by division



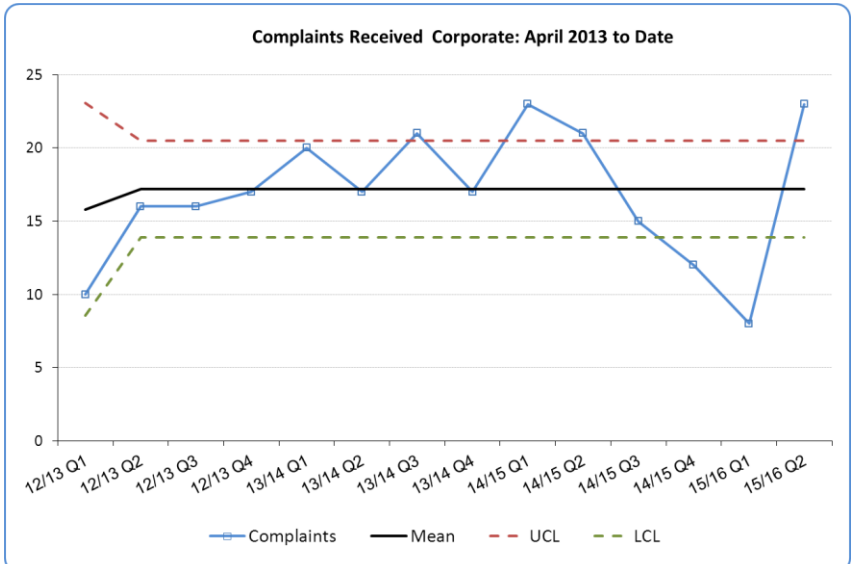
Community Services Division

COMMENTARY

There was a reduction in complaints being received for the Community Services Division from 39 to 18 with the largest reduction being in Offender Healthcare where complaints reduced from 18 to 5. The most common theme for complaints in the division is clinical treatment with complaints also being received about waiting times and staff attitude.

ACTIONS

- The matron on Mary Seacole Ward is promptly discussing any concerns with patients/families and carers –so many are re solved informally before turning into complaints.
- In Offender Healthcare a triage system has been introduced to respond to comment/complaints cards and proactively managing appointment requests.



Corporate Directorates

COMMENTARY

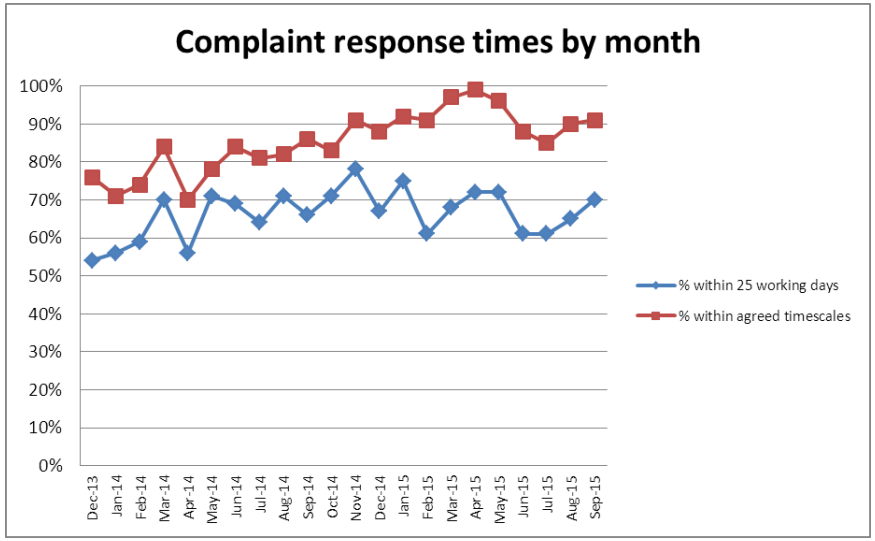
There was an increase in complaints being received about transport from 3 to 10 across a variety of themes including long waits, time taken to answer the lounge phone and attitude of the staff. There has been a higher turnover of staff than usual. The use of agency has been higher whilst recruitment is undertaken (drivers cannot start without DBS checks). A new checking system has been introduced into the TAB service to reduce errors in bookings.

The visitors car park has seen a rise in complaints as a result of a shortage of space and higher costs. There are a number of actions planned to manage demand including a review of the current allocation of staff permits. A new travel plan has been written for board approval.

As a result of a complaint received regarding cleanliness (or lack thereof) of the toilets in the main entrance to ensure that any concerns are escalated quickly and actions taken as soon as possible.

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets Quarter 2 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	72	49	68%	(10) 82%
Medicine and Cardiovascular	75	50	67%	(21) 95%
Surgery & Neurosciences	65	35	54%	(24) 91%
Community Services	18	13	72%	(3) 89%
Estates and Facilities	19	17	89%	(2) 100%
Other Corporate Depts	6	3	50%	(1) 67%
Totals:	255	167	65%	(63) 90%



Commentary:

There was a slight improvement in complaints performance against the first target in quarter 2 when compared to quarter 1. 65% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 62% in quarter 1. There was a decline in performance again the second target with 90% of complaints responded to within agreed timescales (against internal trust target of 100%) compared to 95% in quarter 1.

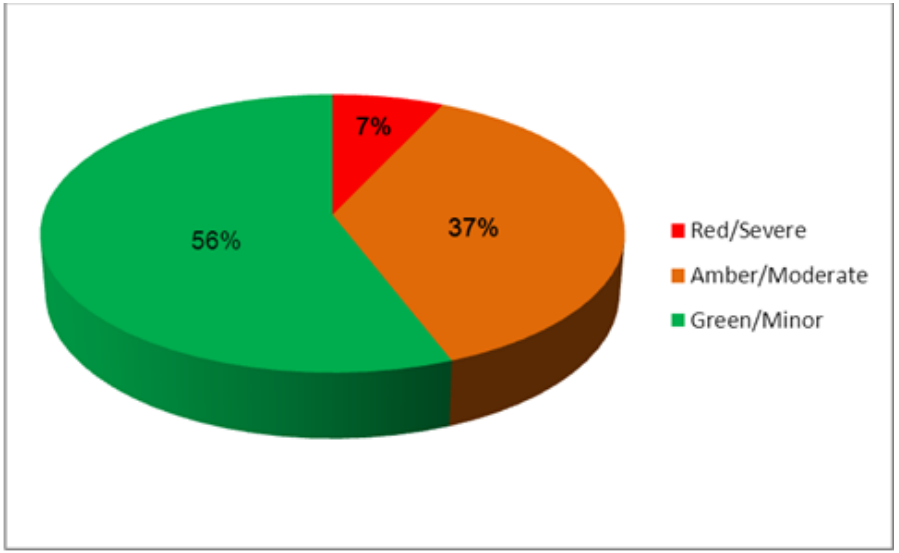
Estates and Facilities Directorate is the only area which is reaching both targets. As reported to November trust board, action plans in place in divisions to improve and to deliver performance against internal standards. Improvements were made month on month during the quarter with 70% and 91% being achieved for complaints received in the month of September.

8. Patient Experience
- Complaints severity rating overview

The Complaints and Improvements Co-ordinators make an initial assessment of each complaint and grade them for severity in accordance with a matrix. It is the responsibility of the General Manager/Head of Nursing investigating the complaint to adjust the grading if necessary following the investigation.

This is vital to ensure that urgent/critical matters are dealt with by relevant senior staff and in a timely way. If there is a concern about a possible serious incident (SI) or safeguarding issue these are discussed with the risk department and the relevant safeguarding lead(s) for children or adults.

This system is an internal flag to ensure critical issues or incidents are escalated and investigated appropriately. It is not an attempt to determine how serious the complainant thinks/feels it is.



A summary of ratings for quarter 2 of 2015/2016 is presented below. A more detailed report will be presented at the Patient Experience Committee.

In Quarter 2 a total of 17 complaints were categorised as Red/Severe.
The red severity cases have been examined to decipher if they should still remain red after investigation and response completed. However some of the cases are still open therefore the total figure for red severity cases may change and will be reflected in the end of year final report.

The reasoning for the red ratings included:

- Death noted.
- Serious Injury/ Serious Adverse Outcome.
- Vulnerable patient, possible neglect. Safeguarding issues.
- Complex case as more than one service involved.
-

In Quarter 2 a total of 95 complaints were categorised as Amber/Moderate.
The most common reasons for the amber ratings were an adverse injury or outcome and the complaint being complex and/or involving 2-4 services.

In Quarter 2 a total of 143 complaints were categorised as Green/Minor.

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.

Talib *gave Obstetrics at St George's Hospital (London) a rating of 1 stars*

Sent invitation for scan after scheduled date
My wife is 18 weeks pregnant and got her obstetrics op appointment on 7th November 15, but on the day of appointment just 2 hours before they called to say that she cannot be seen on that day coz they are out of time. We rang the dept. after few days to know what's going on, and told that her appointment is booked on 26th November 15, but we insist it's too late as she needs to have her scan done as well. We were transferred to the scan department, she told us that it's not late and scan will be arranged after that. But on 12th November15, we received 2 letters, 1 for 26th Nov appointment and the other is for scan scheduled 10th of November15 which is already passed.

I don't understand why St George's hospital sent letter for appointment after the scan date. Is it just for formalities? This time no body pics the phone if you call them.

Question is what other better services we can expect from them !!

Visited in November 2015. Posted on 14 November 2015

Anonymous gave Accident and emergency services at St George's Hospital (London) a rating of 4 stars

Experience of my 80 year old father in A&E
Last week I attended A&E with my father who is very frail and has significant difficulty walking.

We were transported by ambulance. No wheelchairs were available when we arrived and no member of staff seemed to think that it was their responsibility to find one. The result was that my elderly father had to sit on metal, slippery chairs in the waiting room for an hour - chairs which are very difficult to sit on if you are weak and frail.

The medical care that he received was excellent, tests were expedited due to his frail condition and all medical and nursing staff were extremely efficient and professional.

Visited in October 2015. Posted on 14 October 2015

Anonymous gave Endocrine and thyroid surgery at St George's Hospital (London) a rating of 5 stars

outstanding staff and hospital
I has my first surgery at the age of 45, on 07/11/15 I cannot thank all the staff enough. starting from surgical admission lounge team the surgeon,. then onto Cavell ward where I spent 2 nights there .thank you to all the nurses for all your wonderful care . the staff who served the food and the ward clerk. you were all so kind and caring.. . keep up the good work . we are so lucky we have people like you working in the nhs. With kind regards Ellen.

Visited in November 2015. Posted on 10 November 2015

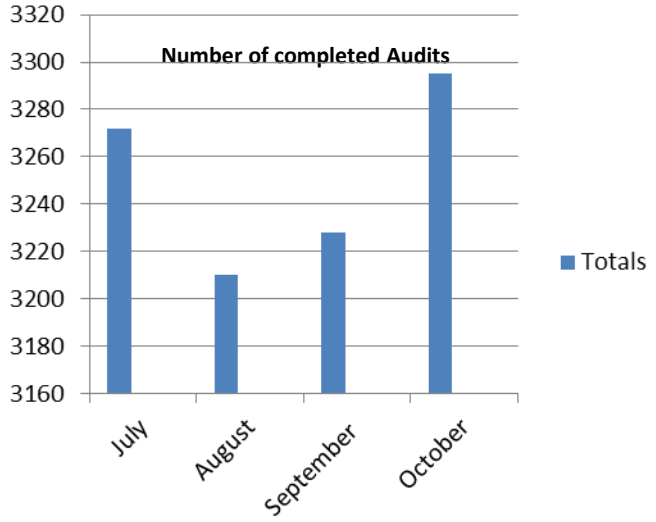
excellent / kind / responsible / respectful /

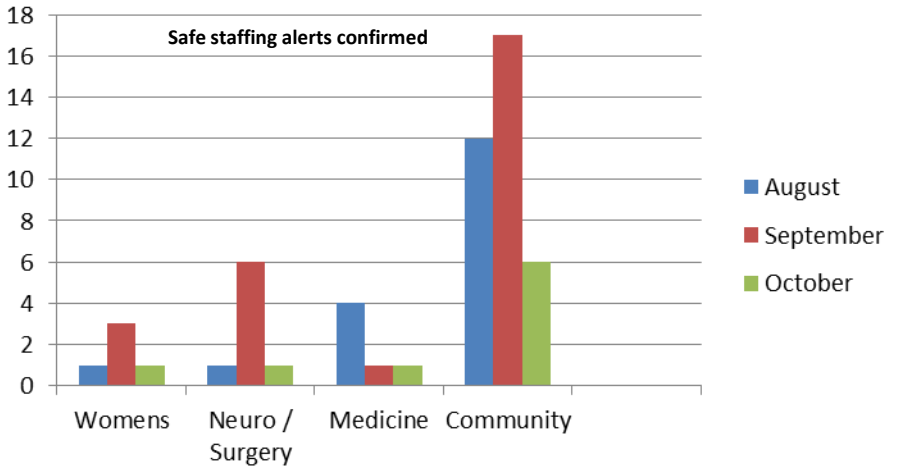
St George's University Hospitals NHS
NHS Foundation Trust

Workforce

Excellence in specialist and community healthcare

9. Workforce
October 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: August 3210, September 3228 and October 3295. There was a significant decrease in the number of final alerts reported from 27 in September 2015 to 9 in October 2015. Six of the alerts relate to community services which are unable to provide planned care due to reduced staffing and disruption during their service redesign. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has increased following on the day investigation (August 24, September 14, October 37). This would indicate that interventions are being made to support safe staffing in the ward areas.

7 nursing related safe staffing concerns were raised on Datix system in October, the same number as in September. None of the alerts and none of the concerns matched a similar entry on the RATE system.

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

Risk: A safe staffing review is commencing in November.

9. Workforce: October 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 October 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 October the trust achieved an average fill rate of 94.40%, a slight decrease from 94.60% submitted in September

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

None required at present.

9. Workforce: Safe Staffing for inpatient areas

	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	93.9%	#DIV/0!	99.5%	100.0%
Carmen Suite	132.6%	70.3%	98.7%	90.3%
Champneys Ward	93.4%	90.3%	96.8%	96.8%
Delivery Suite	110.6%	69.9%	110.1%	90.3%
Fred Hewitt Ward	93.6%	101.9%	97.7%	#DIV/0!
General Intensive Care Unit	94.5%	88.7%	98.6%	92.9%
Gwillim Ward	119.5%	82.3%	98.6%	91.9%
Jungle Ward	101.3%	#DIV/0!	#DIV/0!	#DIV/0!
Neo Natal Unit	91.6%	#DIV/0!	92.1%	#DIV/0!
Neuro Intensive Care Unit	92.8%	84.4%	96.5%	75.4%
Nicholls Ward	92.5%	96.7%	98.1%	100.0%
Paediatric Intensive Care Unit	112.4%	97.4%	112.7%	100.0%
Pinckney Ward	102.0%	151.6%	96.2%	100.0%
Dalby Ward	97.4%	112.1%	100.0%	103.5%
Heberden	88.2%	100.6%	100.0%	100.0%
Mary Seacole Ward	91.8%	102.3%	99.9%	99.2%
A & E Department	96.5%	83.7%	95.3%	85.2%
Allingham Ward	90.9%	112.8%	99.1%	100.0%
Amyand Ward	85.8%	100.0%	99.4%	100.1%
Belgrave Ward AMW	95.4%	91.7%	99.5%	100.0%
Benjamin Weir Ward AMW	81.8%	90.9%	95.7%	94.6%
Buckland Ward	85.9%	88.0%	99.9%	100.0%
Caroline Ward	87.0%	83.8%	97.9%	100.0%
Cheselden Ward	91.4%	93.6%	98.9%	96.4%
Coronary Care Unit	97.7%	109.5%	97.9%	100.0%
James Hope Ward	84.0%	95.2%	92.9%	#DIV/0!
Marnham Ward	76.8%	92.9%	96.2%	96.2%
McEntee Ward	94.8%	96.7%	98.7%	100.0%
Richmond Ward	89.9%	83.3%	95.9%	94.7%
Rodney Smith Med Ward	89.7%	95.9%	98.8%	99.3%
Ruth Myles Ward	103.3%	106.2%	100.0%	100.0%
Trevor Howell Ward	102.2%	83.9%	98.9%	100.0%
Winter Ward (Caesar Hawkins)	79.5%	89.1%	99.2%	96.4%
Brodie Ward	97.8%	97.4%	99.3%	100.0%
Cavell Surg Ward	88.6%	88.8%	97.0%	100.0%
Florence Nightingale Ward	89.9%	83.7%	96.8%	100.0%
Gray Ward	91.1%	81.5%	99.2%	96.7%
Gunning Ward	92.6%	87.7%	99.0%	100.0%
Gwynne Holford Ward	93.1%	76.4%	92.8%	93.0%
Holdsworth Ward	90.7%	75.6%	100.0%	93.7%
Keate Ward	94.0%	101.9%	100.0%	99.5%
Kent Ward	91.5%	89.2%	100.0%	98.3%
Mckissock Ward	95.6%	91.7%	98.3%	100.0%
Vernon Ward	86.4%	80.4%	95.2%	97.2%
William Drummond HASU	91.2%	85.8%	95.7%	92.0%
Wolfson Centre	69.6%	72.4%	98.0%	94.7%
Gordon Smith Ward	93.8%	91.3%	105.3%	96.9%
148 - Nightingale Step Down, Off Site Facility	0.0%	0.0%	0.0%	0.0%
Brodie Stroke Ward	41.3%	33.0%	55.9%	61.3%
Trust Total	93.03%	89.80%	97.83%	95.47%

Day Qual	Day HCA	Night Qual	Night HCA
93.03%	89.80%	97.83%	95.47%

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Heatmap Dashboard
Ward view

Excellence in specialist and community healthcare

10. Ward Heatmap

Division	Ward	INCIDENCE OF C.DIFFICILE	TRUST ACQUIRED PRESSURE ULCERS	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FAMILY)	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RAT (WARD)
COMMUNITY SERVICES	MARY SEACOLE	0.0	0.0	87.5	100.0	133.3	1.9	10.0	0.0	4.4
MEDICINE	ALLINGHAM	0.0	0.0	100.0	93.1	41.4	1.4	1.0	0.0	12.6
	AMYAND	0.0	0.0	93.8	100.0	9.0	5.7	7.0	0.0	3.8
	BELGRAVE	0.0	0.0	100.0	100.0	35.9	3.8	5.0	0.0	1.2
	BENJAMIN WEIR	0.0	0.0	90.3	100.0	33.9	11.9	1.0	0.0	6.1
	BUCKLAND	0.0	0.0	95.0	100.0	65.2	8.6	5.0	0.0	
	CAESAR HAWKINS	0.0	0.0	90.5	100.0	17.2	11.0	5.0	0.0	15.5
	CARDIAC CARE UNIT	0.0	0.0	100.0	100.0	120.0	2.1	1.0	0.0	2.0
	CAROLINE	0.0	0.0	100.0	87.9	55.1	9.3	3.0	0.0	3.2
	CHESELDEN	0.0	1.0	95.2	96.8	44.9	5.7	3.0	1.0	6.3
	DALBY	0.0	0.0	80.8	100.0	40.6	-3.6	5.0	0.0	1.6
	EMERGENCY DEPARTME	0.0	0.0				5.7	3.0	0.0	5.0
	GORDON SMITH	0.0	0.0	94.1	100.0	30.4	2.9	3.0	0.0	4.8
	HEBERDEN	0.0	0.0	82.6	92.9	29.8	3.1	13.0	0.0	4.8
	JAMES HOPE	0.0	0.0	100.0	100.0	13.3	12.9	1.0	0.0	0.3
	MARNHAM	0.0	0.0	92.9	66.7	13.0	12.1	4.0	0.0	6.9
	MCENTEE	0.0	0.0	100.0	83.3	13.0	3.0	4.0	0.0	5.0
	RICHMOND	0.0	0.0	94.2	92.5	18.5	8.7	7.0	1.0	6.0
	RODNEY SMITH	0.0	0.0	96.4	100.0	6.0	5.0	9.0	0.0	1.5
	RUTH MYLES DAY UNIT	0.0	0.0		90.9		-2.5	0.0	0.0	1.1
	TREVOR HOWELL	0.0	0.0	100.0	94.1	56.5	2.0	5.0	0.0	4.8

10. Ward Heatmap

Division	Ward	INCIDENCE OF C.DIFFICILE	TRUST ACQUIRED PRESSURE ULCERS	PERCENTAGE OF HARM FREE CARE	PATIENT SATISFACTION (FRIENDS & FAMILY)	FRIENDS & FAMILY RESPONSE RATE	WARD STAFFING: UNFILLED DUTY HOURS	FALLS (WARD LEVEL)	SERIOUS INCIDENTS (WARD LEVEL)	SICKNESS/ ABSENCE RAT (WARD)
SURGERY	BRODIE NEURO	0.0	0.0			53.8	1.5	2.0	0.0	1.9
	CAVELL	0.0	0.0	100.0	72.2	37.7	8.2	0.0	0.0	3.8
	FLORENCE NIGHTINGALE	0.0	0.0	100.0	94.3	94.6	8.9	1.0	0.0	4.5
	GRAY WARD	0.0	0.0	96.8	92.6	71.7	8.1	2.0	0.0	5.5
	GUNNING	0.0	0.0	89.3	96.4	39.0	5.9	2.0	0.0	1.1
	GWYN HOLFORD	0.0	0.0	95.2	100.0	9.1	12.9	6.0	0.0	5.3
	HOLDSWORTH	0.0	0.0	100.0	100.0	58.1	9.1	2.0	0.0	3.2
	KEATE	0.0	0.0	94.4	94.7	81.0	2.4	0.0	0.0	1.1
	KENT	0.0	0.0	96.4	92.9	32.9	5.9	6.0	1.0	1.3
	MCKISSOCK	0.0	0.0	100.0	98.2	75.3	4.0	1.0	0.0	8.4
	VERNON	0.0	0.0	93.1	87.2	36.7	11.1	1.0	0.0	13.9
	WILLIAM DRUMMOND HA	0.0	0.0	94.7	100.0	41.7	7.5	1.0	0.0	1.3
WOMEN & CHILDREN	CARDIOTHORACIC INTEN	0.0	0.0	93.3		0.0	3.3	2.0	0.0	3.1
	CARMEN SUITE	0.0	0.0	100.0			-6.4	0.0	0.0	4.0
	CHAMPNEYS	0.0	0.0	100.0	97.9	34.5	5.3	0.0	0.0	6.9
	DELIVERY	0.0	0.0	100.0	94.4		-5.4	0.0	0.0	5.8
	FREDDIE HEWITT	0.0	0.0		100.0	377.8	4.0	0.0	0.0	10.0
	GENERAL ICU/HDU	0.0	0.0				3.5	0.0	1.0	5.6
	GWILLIM	0.0	0.0	100.0	90.1		-3.1	0.0	0.0	4.7
	JUNGLE	0.0	0.0		97.3	137.0	-1.3	0.0	0.0	0.0
	NEONATAL ICU	0.0	0.0			0.0	7.7	1.0	0.0	5.9
	NEURO ICU	0.0	0.0	91.7			6.5	2.0	0.0	4.2
	NICHOLLS	0.0	0.0		100.0	87.5	4.9	0.0	0.0	8.5
	PICU	0.0	0.0		100.0		-10.8	1.0	0.0	4.0
	PINCKNEY	0.0	0.0			0.0	-2.5	0.0	0.0	10.0

10. Ward Heatmap
CWDT&CC Division

Cardiothoracic Intensive Care (CTICU)
93.3% scored for harm free care. 15 patients surveyed, with 1 harm reported. This was a patient with a new grade 3 pressure ulcer.

General Intensive Care (GICU)
90% scored for harm free care. 20 patients were surveyed with 2 patients noted to have harms that related to old grade 3 pressure ulcers. Of note this has not been recorded on the heat map for this month.
GICU reported a serious incident this month according to the heat map. This is fact a 'Never Event' and relates to the mal - administration of insulin. This is currently being investigated. This is the second never event in the last three months in this area and whilst the incidents are very different, the issue of nursing skill mix does seem to feature in both incidents. This is being explored further and measures being put in place to address this.

Neuro Intensive Care (NICU)
91.7% scored for harm free care. 12 patients surveyed, with 1 harm reported. This was a patient who had a catheter and old UTI

Sickness
Sickness was above the trust threshold in many areas in October 2015. This was a combination of long term sickness and an increase in short term sickness. As reported last month the level of support provided by the HR team to address sickness is being increased to ensure proactive management of sickness across the division.

Friends and Family
As with previous months the results for the Friends and Family test for the division have significant data errors; with some areas reporting a response rate of 377.8 % to areas who do not capture this data presenting as 0%. The information team have been asked to review this data for the division.

10. Ward Heatmap
Medcard Division

Trevor Howell –Two of the falls were the same patient. The ward also had falls that were due to confusion and spinal cord compression and specials were appropriately requested for these patients. Sickness is being managed as per policy and one member of staff who is on long term sickness has a planned return date. Staff who have triggered on short term sickness are being managed with stage 1 meetings being arranged.

Gordon Smith – Falls are 3 this month. On review no trends have been found, and no patient fell more than once. On review of November currently the ward has had no falls so far. Sickness is 4.8% and the ward has have had LTS of one staff member who is now up to 75% on a phased return. STS has been high with no staff member triggering stage 1 management. Staff are being supported by the ward leadership team and have seen an improved picture in November.
Dalby: 5 falls were reported in month and this was due to the nature of the patients on the ward at this time. None have resulted in injury. They are red for harm-free care based on 26 patients surveyed. 5 patients had harms reported on the ward. 1 patient had 2 harms reported, an old grade 3 pressure ulcer and a catheter and new UTI. 2 other patients also had old grade 3 pressure ulcers. 1 other patient had a catheter and new UTI and 1 patient had a new grade 2 pressure ulcer.

Heberden: The matron is reviewing the falls that have been reported in month, with several being attributed to the same patient. Appropriate specials have been in place, and none of the falls have resulted in injury. The low FFT response rate has been caused by a higher-than-normal percentage of patients who cannot complete the survey because of their dementia, and a high number of families for whom English is not their first language, so they cannot complete on behalf of the patient. Sickness relates to a member of staff on long term sickness who is being appropriately managed in line with policy. Harm Free Care, 23 patients surveyed. 4 harms reported. 1 patient had 2 harms, patient had an old grade 4 pressure ulcer and a catheter and new UTI. 2 patients had old grade 2 pressure ulcers and 1 patient had an old grade 3 pressure ulcer.

McEntee: Linda is looking at the FFT data, but there has been a high number of cognitively impaired patients on McEntee in the past month (mostly TB encephalitis), so fewer patients to complete the survey and more falls.

Allingham: Sickness is triggering due to a combination of long and short term sickness. These cases are being managed in line with the policy.

Ben Weir: The ward is actively recruiting to its vacancies and have seen a number of staff start within month. The sickness is being managed but some of these cases relate to pregnancy related and may represent. The reduction in harm free care relates to staff education regarding completion of the data set and recording of VTE screening which the Matron is addressing with the ward staff.

James Hope : The FFT data input is being reviewed by the ward manager as this has been allocated to individuals on shift, and staff moved across the units to ensure substantive staff collect this data set

10. Ward Heatmap
Medcard Division cont'd

Amyand: FFT remains low and the ward manager has reviewed the patient case mix for the month. The low numbers are due to the case mix of patients and their ability to complete the FFT survey. Falls this month are due to an increase in the number of confused patients that whilst specials have been in place and patients have been cohorted, due to this a number of patients have fallen whilst the member of staff was with another patient. These falls were low or no harm incidents and the patients were appropriately reviewed in conjunction with the staffing at this time. The sickness is a result of a member of staff who has been on long term sickness, and they are being supported through this process in line with policy

Caesar Hawkins: Whilst the FFT score is flagged this is an improved position for the ward as a result of recruitment to the ward clerk and house keeper posts. The falls recorded this month were patients who were cohorted and this created difficulties in their management due to increased confusion. These falls were low and no harm falls, and the staffing and care of these patients were reviewed appropriately. The ward has a high sickness and vacancy rate currently. In order to support the ward additional staff are being moved from other areas in the division to support which is anticipated may also help in managing short term sickness. The staff currently on long term sickness are being managed in line with policy and anticipated return to work dates have been set.

Marnham: The ward has a higher number of vacancies and therefore this has impacted on the number of unfilled hours. The ward rota is being created 8 weeks in advance and appropriate shifts being requested to bank. Additionally the practice educator and nurses from other areas within the division have been moved to this ward for a number of months to support during this time. The ward currently has a number of staff on long term sickness who are being managed in line with policy. The ward manager has been asked to ensure that a discharge list is produced daily and that the capturing of FFT is allocated to a member of staff to ensure increased response rates.

Richmond: The matron is reviewing the low responses for FFT and will allocate this role to key individuals on a shift to ensure improved response rates. Falls have reduced on the ward and one of the sisters is the link nurse for this area and is conducting documentation audits and teaching regarding falls prevention. There is 1 serious incident reported this month which is under investigation by the infection control teams regarding a patient that may have contracted legionella. Water flushing has taken place and filters have been placed on appropriate taps.

Cheselden: Sickness is being managed and the ward has one member of staff on long term sick. This is likely to remain an issue until January, but is being managed with HR support.

10. Ward Heatmap

STNC

The report focuses on areas with any red indicator or those with three or more indicators. The key areas where alerts are seen are consistent with previous reports and relate to falls and FFT and harm free care. The areas where there has been an improvement in performance is reflected by a reduction to zero in alerts for pressure ulcers, FFT satisfaction and zero incidents of MRSA and C/Diff.

There are 5 red alerts for October 2015 compared to 17 for the previous reporting period. There is a decrease in the overall number of alerts from 24 to 8. However these appears to be a significant amount of data missing from Octobers information e.g. no sickness absence rate and no unfilled duty hours information as well as percentage of harm free care and FFT satisfaction data missing from Brodie Neuro ward.

Florence Nightingale – No red/amber indicators

Gunning – 1 red indicator relating to 89.3% harm free care. A patient was admitted to the ward from ED with a grade 2 old pressure ulcer and one patient was admitted post a fall in their home environment

Keate-1 red indicator relating to 94.4% harm free care. This was due to a patient who was admitted with a grade 2 pressure ulcer from the community.

Vernon-1 amber indicator. This related to 93.1% harm free care. 1 patient was admitted with a new UTI and 1 patient had an old pressure ulcer – from the community

Brodie Neuro- No data for % harm free care or FFT patient satisfaction (area grey) although data has been collected. For % harm free care – 10 patients were recorded as not having had a completed VTE assessment and 1 patient at risk did not have prophylaxis commenced.

Kent – 2 red indicators. The first red indicator related to 6 falls. 5 falls were no harm. 1 patient fell twice – due to patient being impulsive and not listening to staff. 1 patient had an assisted fall during therapy sessions and 2 patients lost balance on mobilising. 1 fall was moderate harm – patient fell cutting her eyebrow and right knee. This required a plastics review and district nurse follow up when the patient was discharged.

Gwynne Holford – 2 red indicators. The first red indicator is for FFT response rate which is 9.1. This is being addressed by the ward Sister. FFT on Gwynne Holford ward is now being collected by administrative support, unfortunately, they failed to initially capture all data required but further training has now addressed this .

The second red indicator is related to 6 falls. 5 falls no harm and included 1 patient falling twice. 1 patient high severity, this patient sustained a fractured NOF (patient mobilised to wash basin and did not use his walking aid).

There is no data recorded on heat map for sickness absence or ward fill rates for any area, however Gwynne Holford has high sickness at 11% which is due to 1 staff member being on long term sick leave and 10 short term episodes.

William Drummond- 1 amber indicator related to Safety Thermometer 94.7%. This is related to 1 patient who was admitted to the ward with a grade 2 pressure ulcer.

There was no data for ward staffing unfilled hours or sickness/ absence. Sickness/ absence report data from e-Rostering = 1.36%

Thomas Young- There is no recorded data for Thomas Young.

Sickness/ absence report data from e-Rostering = 5.55 %. This relates to 2 x long term sickness of staff one who returned mid October and short term sickness of staff.

Falls data is green. Current combined threshold= 11 (Brodie Stroke= 4, Thomas Young= 7). Thomas Young had 11 falls- all no harm. Two patients fell x 2

Keate and Holdsworth wards have both made improvements with no flags this month and McKissock, Gunning and Florence Nightingale wards have successfully reduced their level of falls in October 2015.

10. Ward Heatmap
STNC

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11. Community Services
CQR Scorecard – Oct 2015

Patiend Safety & Experience

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	Direction	Comments
			Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16				
SI's REPORTED	Monthly		1	1	2	0	1	4	1							
Number of SI's breached	Monthly	0	0	0	0	0	0	0	0							
Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0	0	1	2	1							
Grade 4 Pressure Ulcers	Monthly		0	0	0	0	0	0	0							
Number of Fall of No Harm and Low Severity	Monthly		10	7	4	12	8	13	10							
Number of moderate falls	Monthly	0	2	1	0	1	0	0	0							
Number of major falls	Monthly	0	0	0	0	0	0	0	0							
Number of falls resulting in death	Monthly	0	0	0	0	0	0	0	0							
MRSA (cumulative)	Monthly	0	0	0	0	0	0	0	0							
CDiff (cumulative)	Monthly	31	1	0	0	0	0	0	0							
CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2	2	2	2	2	2							
Number of Quality Alerts	Monthly		3	5	2	9	11	4	6							
% of staff compliant with safeguarding adults training	Monthly	85%	89.0%	86%	85%	84%	81%	81%	77%							
% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	90.0%	90.0%	85%	82%	79%	88%	89%							changed to green because aris show as achieving
		Level 2 85%	84.0%	84.0%	82%	82%	74%	66%	67%							
		Level 3 85%	69.0%	69.0%	82%	90.00%	70%	85%	87%							
Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.86	0.86	tbc	tbc							
Active Claims	Monthly		0	0	1	3	1	0	tbc							
Number of Complaints received	Monthly		16	18	6	5	2	5	5							
Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	88% April 2015	78% May 2015	100%	100%	85%	tbc							
Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100% April 2015	100% May 2015	100%	100%	92%	tbc							
FFT Score (Mary Seacole and MIU)	Monthly							Mary Seacole A - 98% Mary Seacole B - 93%	tbc							http://www.qualityobservatory.nhs.uk/index.php?option=com_cat&view=item&Itemid=28&cat_id=589
Catheter related UTI (Trust)			1.14	0.66	1.12	1.32	Not yet available		NA							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			NA							
Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
Sickness Rate -	Monthly	3.50%	5.72%	6.04%	6.00%	4.69%	5.75%	5.53%	Data available after 17th Nov 2015							
Turnover Rate-	Monthly	13%	19.64%	19.94%	20.40%	20.08%	21.00%	21.15%								
Vacancy Rate-	Monthly	11%	19.41%	19.06%	19.40%	12.60%	13.42%	12.59%								
Appraisal Rates - Medical	Monthly	85%	66.67%	72.73%	69.57%	69.57%	84.00%	84.00%								
Appraisal Rates - Non-Medical	Monthly	85%	77.25%	76.80%	75.84%	75.42%	76.02%	68.22%								

11. Community Services

Quality scorecard exception report

•**KPI Exception Report for (for period up to 31 October 2015)**
•**Serious Incidents:** In October only 1 new SI = Grade 3 PU (community nursing). SI investigations for those in Q1 and Q2 are progressing within timescales and Q1 audit are due for reporting at December DGB.

•**Complaints:** Community Services numbers of formal complaints consistent at 5, monthly numbers gradually reducing and stabilising. Pro active measure to resolve comments/ complaints at an early stage are showing benefits. Timeliness of response times maintaining targets.

•**Child safeguarding Level 1 & 3:** prioritised for training including bespoke sessions and now achieving targets.

•**Quality alerts:** Continue to raise due to capacity issues within CAHS.

•**Annual patient surveys:** data collection period closed 31/10/2015. Result analysis and report compilation to commence.

•**Human Resource/workforce:** Data not available until 17th of month
•**Key areas of concern for workforce:**
–Access to MAST training as IT limitations prevent access for community services to TOTORA.
–Nursing recruitment and retention, particularly offender healthcare, Mary Seacole ward (QMH), community nursing, school nursing, specialist posts
•**Key areas of concern -other:**
–QIA on CIPS- need to re –risk assess against run rate measures (October DGB)

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.

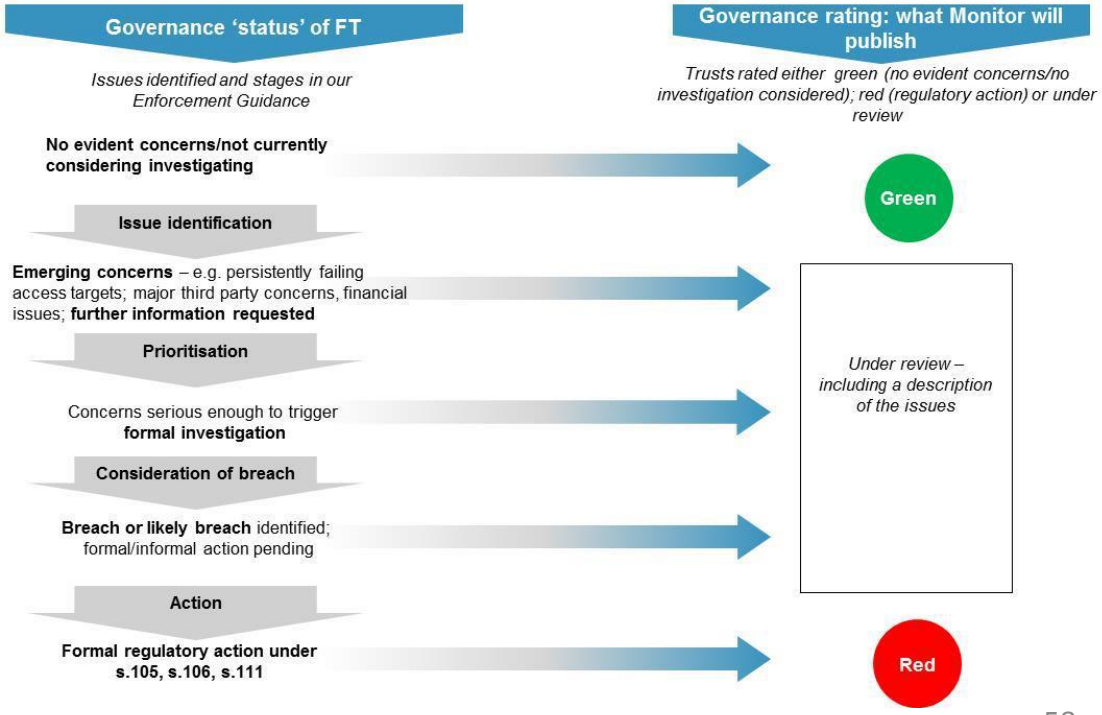
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

- 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.



Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – December 2015 **Paper Ref:**

Paper Title:	**Finance Report for Month 7 2015/16**
Sponsoring Director:	Steve Bolam, Chief Financial Officer & Deputy Chief Executive
Author:	Anna Anderson, Interim Operational Director of Finance
Purpose:	To inform the Board about the Trust's financial position at the end of October 2015
Action required by the board:	For review and to identify where further action or assurance is required
Document previously considered by:	Finance and Performance Committee

Executive summary

Income and expenditure performance in October showed a further improvement on previous months, and actual performance was a deficit of £2.1m, which was £0.3m better than plan. However this reflected the benefit of a number of one off items totalling £1.5m, of which the most significant was the speeding up of high cost drug accounting. The underlying position was a deficit of £3.6m in the month. The Trust is now starting to see some evidence of a reduction in pay costs and an increase in income which is positive.

The cumulative deficit was £36.7m, £7.2m worse than plan and, as reported in previous months, the main contributory factors are: low outpatient income, £3.6m, costs/income adjustments relating to the prior year, £3.3m, and a £1.2m shortfall on savings. Work is progressing to improve data capture, systems and the accuracy of reporting (particularly for temporary staff and drugs), and to ensure actions are being taken to manage performance issues in each division.

£15.6m of CIPs have been achieved to date, and there are plans for a further £15.2m of red/amber/green schemes for the rest of the year. A total of £31m is included in the outturn projection from the reforecasting exercise.

The cash balance at the end of October was £9.8m higher than plan.

The continuing improved cash position and the lower deficit in the month are the main factors which have led to the improvement in the Trust's overall risk rating from a 1 to a 2 for a second month.

Capital spend is continuing to be slowed down as part of the overall cash management plan and to date spend has been £18.3m against a plan of £33m.

The reforecasting exercise has been completed, approved by the Board and submitted to Monitor. This shows a year end deficit of £63m but this is before a range of further actions which are being developed to reduce the deficit further. An initial assessment of these actions was presented to the Board and as a result the Board has agreed a target deficit of £50.2m by year end (including exceptional one off items relating to prior year costs and turnaround support). The Trust will now switch to reporting against the reforecast plan for the rest of the year.

Enclosure:

Key risks identified:

The control of expenditure and the delivery of a higher level of savings in the second half of the year when winter pressures will also be experienced.
The need to balance financial measures with maintaining the quality of patient care.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Achieve financial targets in the near term 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? No
No specific groups of patients of communities will be affected by the items in this report. Where there may be an impact on patients consultation will be managed as part of that specific programme.

St George's Healthcare NHS
NHS Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better heath outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
				15 Oct 2010
1.1 Who is responsible for this service / function / policy?				

Enclosure:

1.2 Describe the purpose of the service / function / policy? *Who is it intended to benefit? What are the intended outcomes?*
1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*
1.4 What factors contribute or detract from achieving intended outcomes?
1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights
1.6 If yes, please describe current or planned activities to address the impact.
1.7 Is there any scope for new measures which would promote equality?
1.8 What are your monitoring arrangements for this policy/ service
1.9 Equality Impact Rating [low, medium, high] **2.0. Please give your reasons for this rating**

Summary Finance Report
Month 7 2015/16

Trust Board 3 December 2015

1. Month 7 Headlines & Actions – I&E

Area of Review	Metric	Key Highlights	Actions	RAG
Overall financial performance in October	Deficit £2.1m, £0.3m better than plan	In October the deficit was £0.3m better than plan, the first positive variance this year. The Trust has benefitted from a number of one off items totalling £1.5m so the underlying position was a deficit in month of £3.6m. The biggest adjustment was c£1m benefit from speeding up high cost drug accounting and income.	Continue monthly divisional performance reviews Revise budgets to reflect the reforecast (TRP) agreed by the Board Agree and implement actions eg bold ideas and further recovery of outpatient activity set out in the 'overlay' to the reforecast Implement agreed CIPs and work up schemes in the pipeline Continue work to improve the quality of information reported	
Overall financial performance - year to date	Deficit £36.7m, £7.2m worse than plan	The year to date deficit increased from £34.6m at the end of September to £36.7m at the end of October. The 3 main contributory factors to the deficit are as reported previously: outpatient activity shortfall, prior year items and a shortfall on CIPs. The monthly trend indicates an improving position since the start of the year with a particular increase in income.	As above	
Activity/Income	Income is £7m below plan year to date	Day case and elective activity reduced in October and activity in all other areas went up. Low outpatient activity, prior year items and higher penalties continue to be the main reason for lower than planned activity.	Further develop outpatient recovery plans Take actions to minimise penalties eg RTT and high cost drug where high quality data is critical. Ensure recording problems identified are resolved and track progress Minimise loss of theatre capacity as a result of theatre closures	
Pay spend	Year to date £1.3m above plan, £2.2m below plan in October	Pay spend in October was the lowest reported this year, taking into account a £0.4m one off adjustment for agency spend, spend in the month was £0.8m less than in month 6.	Recruit permanent staff where possible and continue switch away from agency Agree scope for further reduction through 'overlay' to reforecasting exercise Continue to improve controls on temporary staff eg by booking more through e-rostering system Continue to improve processes to improve data quality and minimise 'blips' in reported spend	
Non pay spend	Year to date matches plan, in October £2.3m above plan	Drug spend was up in the month due to more up to date high cost drug reporting and higher spend in pharmacy commercial unit (generating extra income)	Continue grip actions – use of POs, reduction of discretionary spend Identify further savings in bold ideas etc and implement Continue to review reporting processes to maximise clarity of information and allow better control	
CIP	£15.6m delivered to date, £1.2m below plan	Of £15.6m delivered so far £8.6m is CIPs and £7.0m is run rate savings Green schemes are up by £3m to £22.1m this month A total of £31m is assumed to be delivered in the reforecast outturn.	Continue focus on turnaround Complete work on Red/Amber schemes to enable them to be implemented. Agree, work up and implement bold ideas and pipeline schemes to achieve more than £31m.	

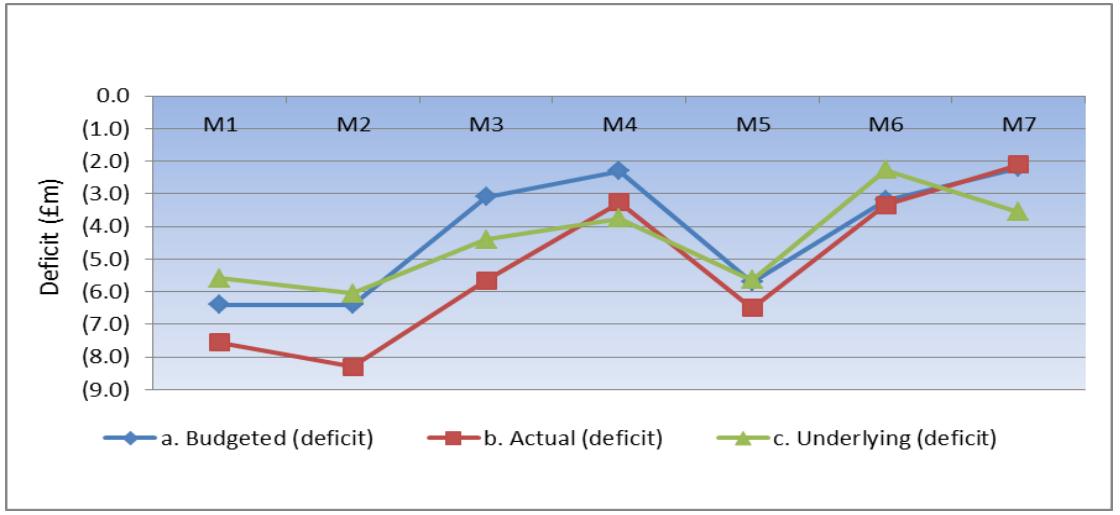
2. Month 7 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights	Actions	RAG
Cash	Balance of £12.8m	The month 7 cash balance was £12.8m, £9.8m above the plan of £3m. In addition, the drawdown of the working capital facility was £3.5m lower than the planned £29.8m.	The Trust has in place a new Working Capital Facility of £19.6m to cover forecast cash financing requirements for October to January inclusive. The level of interim support funding for 2015/16 will be finalised following the budget re-forecast exercise. Continue work to secure maximum cash improvement from local sources.	
Capital	YTD spend £18.3m, £14.7m less than plan	Capital expenditure was £2.1m in October, an under spend of £3.9m in month against the reduced £48m capital programme agreed in June. Year to date expenditure is £18.3m which is £14.7m 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.	
Working capital	YTD movement - £0.4m, £7.7m better than Plan	Working capital improved by £5.1m in month due mainly to a timing difference on HESL quarterly funding which will unwind in M08 and M09. Creditors continue to contribute significantly to the working capital position.	Trust needs to continue to maintain the longer supplier payment termns and secure reductions in overdue debt to build on the improvements made YTD on working capital given the restrictions currently in place over the WCF. In addition stock levels need to reduce further.	
FSRR (formally COSRR)	Rating of 2 compared to plan of 1	The Trust had a rating of 2 at month 7, ahead of the plan for October. This is the same as month 6. The rating reflects the higher than planned cash balance and the improved deficit reported this month.	Despite work on delivering savings and strong cash management the Trust is expected to have a rating of 1 later in the year.	

3. Overall Position for the 7 months to 31st October

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income	626.1	54.0	53.7	(0.3)	362.2	355.4	(6.8)
Other Income	102.9	8.9	9.1	0.2	59.0	58.8	(0.2)
Overall Income	**729.0**	**62.9**	**62.8**	**(0.1)**	**421.2**	**414.2**	**(7.0)**
Pay	(455.7)	(38.9)	(36.7)	2.2	(263.2)	(264.4)	(1.3)
Non Pay	(282.8)	(23.3)	(25.6)	(2.3)	(166.8)	(166.8)	(0.0)
Overall Expenditure	**(738.5)**	**(62.2)**	**(62.3)**	**(0.1)**	**(430.0)**	**(431.3)**	**(1.3)**
EBITDA	(9.5)	0.8	0.5	(0.2)	(8.8)	(17.0)	(8.3)
Financing Costs	(36.7)	(3.1)	(2.6)	0.5	(20.7)	(19.7)	1.1
Surplus / (deficit)	**(46.2)**	**(2.4)**	**(2.1)**	**0.3**	**(29.5)**	**(36.7)**	**(7.2)**

Budget, Actual & Underlying surplus/(deficit) by month



Commentary

- The October deficit of £2.1m is £0.3m better than plan which is an improvement on previous months. The year to date deficit is £36.7m, £7.2m worse than plan
- Income for month 7 is in line with plan with shortfalls in SLA income mitigated by other income over performance. Income to date is £7m under plan mainly due to underperformance in outpatients, prior year income losses and provision for challenges/fines as reported previously.
- Pay to date is £1.3m worse than plan due to agency cover of vacancies and unidentified CIPs. In the month pay is £2.2m better than planned due to additional pay budgets (SRG funding, Electronic Data Management funding allocated from non-pay, transfer unallocated CIP target to 'other income') and correction of month 6 bank costs (accrued extra 2 weeks)
- Non pay spend to date is in line with budget and £2.3m overspent in month. This includes erroneous M6 flexing adjustment for high cost drugs (£0.8m), budget reduction to align ledger phasing to Monitor plan (£0.8m), £0.9m drugs over-spend half of which is offset by Pharmacy wholesale dealer income, partly mitigated by £0.5m benefit from release of prior year PO Creditor accruals.
- Monthly underlying deficits are shown in the graph. Month 7 benefitted by £1.5m for one off items. The biggest element of this was the speeding up of accounting for high cost drugs mentioned above. The underlying deficit in the month was £3.6m.

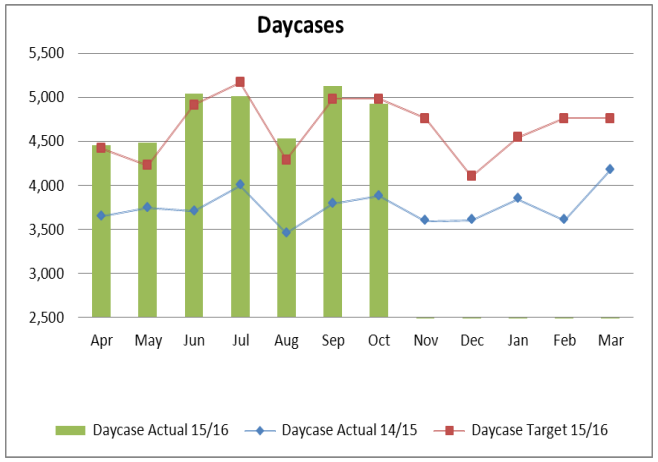
4. SLA Income for the 7 months to 31st October

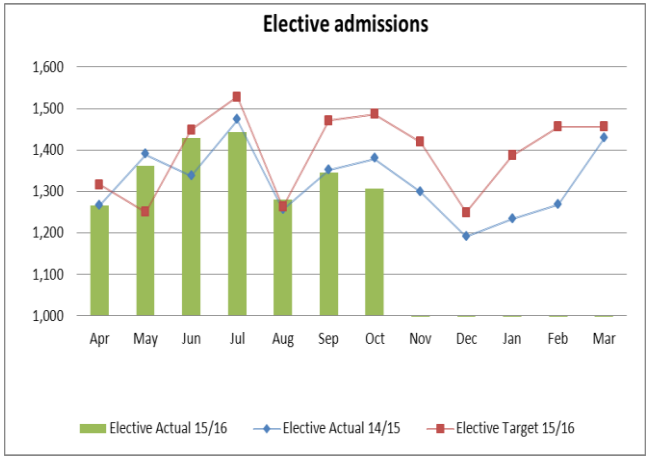
Activity	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
A&E	18.6	1.6	1.5	(0.0)	10.9	10.7	(0.2)
Bed Days	61.2	5.1	5.4	0.3	34.5	34.2	(0.2)
Daycase	29.3	2.6	2.7	0.1	17.3	17.8	0.5
Elective	64.5	5.7	5.2	(0.5)	37.4	37.4	(0.1)
Non Elective	121.5	10.3	10.0	(0.2)	70.7	70.4	(0.3)
Outpatients	142.8	12.7	12.2	(0.5)	83.6	80.0	(3.6)
High Cost Drugs & Devices (HCD)	76.3	6.6	7.7	1.1	42.6	43.7	1.1
Community Block	49.5	4.1	4.1	0.0	28.9	28.9	0.0
Fixed Block (HIV)	21.8	1.9	1.8	(0.0)	12.7	12.7	0.0
Unbundled	21.9	1.8	1.8	(0.1)	12.8	12.1	(0.6)
In Patient Deliveries	11.2	0.9	1.0	0.0	6.5	6.4	(0.1)
Out Patient Regular Attenders	4.1	0.4	0.4	0.0	2.4	2.6	0.1
Challenges/Penalties	(4.5)	(0.4)	(1.0)	(0.7)	(2.6)	(4.6)	(1.9)
Other (Ex SLA)	7.8	0.7	0.8	0.1	4.6	3.0	(1.6)
Grand Total	**626.1**	**54.0**	**53.7**	**(0.3)**	**362.2**	**355.4**	**(6.8)**

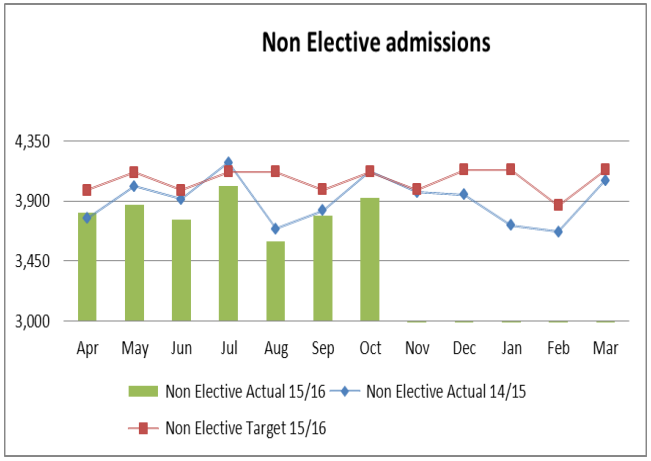
Commentary

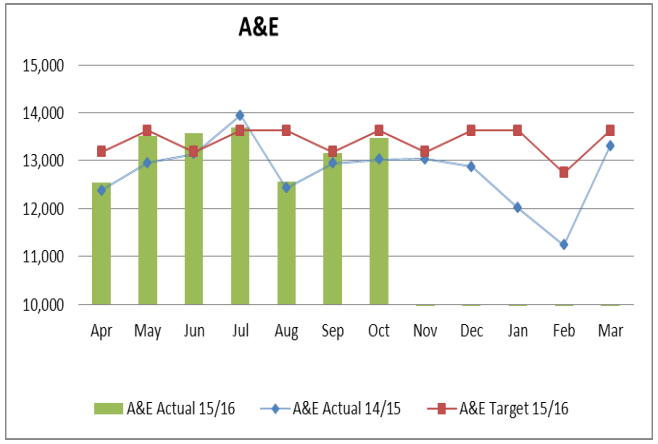
- SLA income was £0.3m below plan in the month and £6.8m below for the year to date.
- The greatest variance to date is in outpatients where income is £3.6m below plan. £2.2m of this relates to the main hospital, the rest of the shortfall is at QMH and the Nelson. Outpatient activity and income overall is below the level in the same period last year. Emergency activity for 4 local CCGs is covered by a block contract which is currently providing a benefit of £0.2m as activity to date is below the block level. This benefit is reducing as the number of emergency patients rises and it is likely that there will be a net loss before the end of the calendar year.
- Provisions of £4.6m have been made for penalties and KPI challenges. This included additional provision of £0.48m for high cost drugs based on accepted challenges from commissioners in Quarter 1. Action is needed to minimise this loss which largely reflects operational recording issues.
- Activity trends are shown on the next page

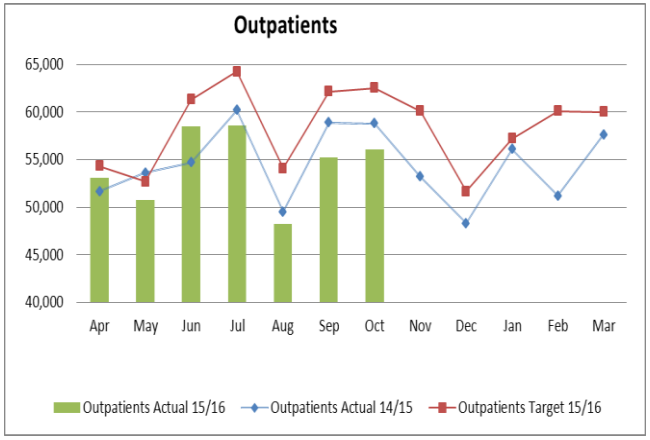
5. Patient activity compared to plan for the 7 months to 31st October











Commentary

Activity across Non Elective, A&E and Outpatients has increased compared to September as expected, whilst Elective and Day case numbers have fallen partly due to a closure of some theatres which has affected General Surgery and Plastics. Gynecology activity has fallen due to the suspension of part of the service.

Elective activity is 0.2% lower than 2014-15

A & E activity is 1.9% higher than last year and outpatients are 2.3% lower than last year. The Chief Operating Officer is working with divisions to assess scope for improvement beyond what is included in the reforecast plan.

6. SLA Income by Commissioner for the 7 months to 31st October

Income	Annual Budget (£m)	Year to Date		
		Budget (£m)	Actual (£)	Better/(Worse) than Budget
NHSE Specialist	212,854	121,609	131,695	10,087
NHSE Public Health	23,713	13,733	13,846	113
NHSE Secondary Dental Care Services	8,560	5,058	5,095	37
NHSE Cancer Drugs Fund	2,882	1,609	2,171	563
NHSE SPECIALIST (IFR)	0	0	3	3
Public Health England	422	246	593	347
Subtotal NHSE	**248,430**	**142,254**	**153,404**	**11,149**
NHS Wandsworth CCG	146,926	86,021	86,612	592
NHS Merton CCG	58,570	34,296	36,633	2,338
NHS Lambeth CCG	19,964	11,675	11,940	265
NHS Croydon CCG	21,334	12,482	13,401	919
NHS Sutton CCG	13,449	7,868	7,680	(188)
NHS Kingston CCG	12,912	7,563	7,259	(304)
NHS Richmond CCG	11,818	6,950	7,056	106
SURREY CCG	20,023	11,700	11,671	(29)
Other CCGs	21,225	12,137	10,495	(1,642)
Subtotal CCGs	**326,221**	**190,692**	**192,748**	**2,056**
NCA	7,943	4,624	5,074	450
Other Trusts	1,060	624	736	112
Other Local Authority	7,976	4,723	4,615	(108)
Subtotal CCGs	**16,978**	**9,971**	**10,425**	**454**
Internal Targets: Growth, Business Cases etc	26,561	14,722	(5,698)	(20,420)
Ex SLA Income	7,904	4,600	4,535	(65)
Total NHS Healthcare Income	**626,094**	**362,239**	**355,414**	**(6,826)**
Private & Overseas Patients	5,215	2,976	3,125	150
RTAs	4,524	2,632	2,270	(362)
Other Healthcare Income	137	80	171	91
Education and Training Levy Income	43,862	25,587	25,555	(31)
Other Income	49,085	27,650	27,677	28
Total Other Income	**102,824**	**58,924**	**58,798**	**(125)**
Total income	**728,918**	**421,164**	**414,213**	**(6,951)**

Commentary

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

The Trust is over performing significantly on the NHSE and local CCG (Wandsworth, Merton and Croydon) contracts.

The Trust set an additional internal target of £26.5m to reflect patient activity that was expected over and above agreed contract values. Taking this into account the Trust is below its total planned activity targets by £6.8m year to date.

The actual value shown on the internal target line is mainly contract penalties (not split by CCG until agreed with the CSU). All other income is shown by CCG hence the negative variance on this line.

Other income is the income that is generated by South West London Pathology (£12m), Pharmacy Income (£3.5m), R & D Project income (£3.3m) and Parking Services income (£1m).

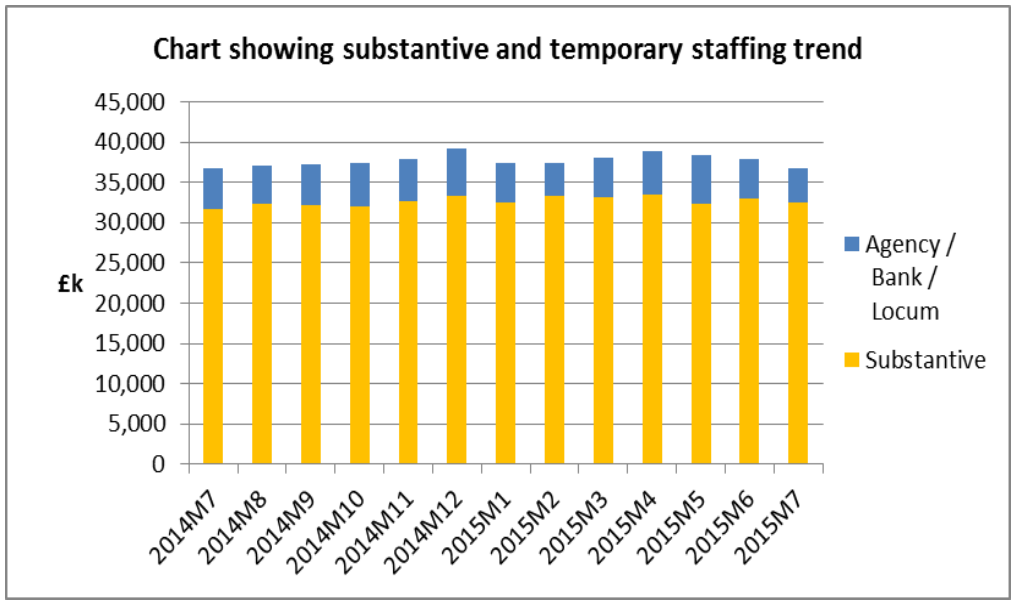
7. Pay costs for the 7 months to 31st October

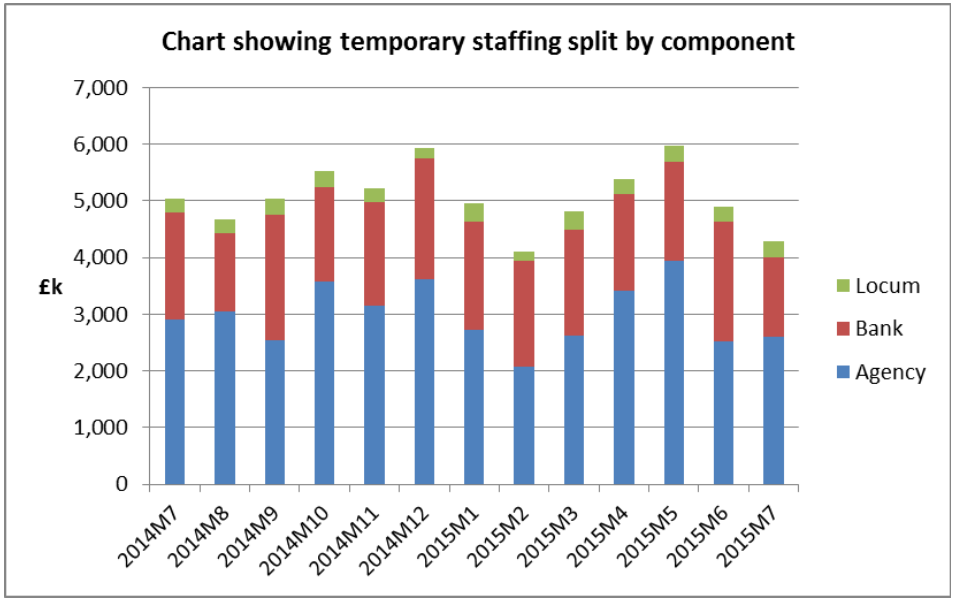
Pay Summary by Staff Type	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Consultants	(71.1)	(5.9)	(5.9)	(0.0)	(41.1)	(41.9)	(0.8)
Junior Doctors	(49.8)	(4.1)	(4.2)	(0.1)	(28.8)	(29.3)	(0.6)
Non Clinical	(79.3)	(7.0)	(6.0)	1.0	(46.1)	(44.6)	1.6
Nursing	(185.7)	(14.8)	(14.0)	0.8	(106.4)	(101.6)	4.8
Scientists, Technicians, Therapists	(83.4)	(6.8)	(6.6)	0.2	(48.3)	(47.0)	1.3
Other (CIP)	12.3	(0.4)	(0.0)	0.4	6.7	(0.0)	(6.7)
Unallocated (Pay Provisions)	1.4	0.1	0.0	(0.1)	0.8	0.0	(0.8)
Grand Total	(455.7)	(38.9)	(36.7)	2.2	(263.2)	(264.4)	(1.3)

Commentary

- Month 7 total pay spend was £2.2m less than budget. October pay budget was £1.5m higher than the M1-6 monthly average, the increase comprises of tranche 2 SRG funding for Pharmacy support as agreed with Commissioners, Electronic Document Management establishment budget allocated from non pay and transfer of unallocated CIP target to Pharmacy 'other income'.
- Actual pay for the month is £1.2m lower than the monthly average spend as at M6. £0.4m of the M7 reduction relates to correction for the overstated M6 bank spend while substantive and agency pay spend in October are lower than M6 average by £0.5m and £0.3m respectively.
- Substantive pay reduction is due to favourable net staff recharges of £200k in Children's & Women's division -some back-dated to 2 years following dispute resolution, £200k in R&D overstated (correct in M8), £50k transfer to capital and staff turnover particularly in Corporate.
- The reduction in agency spend is across clinical divisions however, this is partly eroded by an increase in Corporate agency spend arisen due to reclassification of some turnaround spend from consultancy to agency. The reduced agency spend in clinical areas as indicated last month reflects 'Grip' efforts and is expected to improve in line with the 'temporary workforce planned exit/transfer' HR project.
- Cumulative pay is £1.3m over budget which is mainly due to CIP shortfalls and premium on agency spend.
- Overall agency spend as a percentage of the total pay bill in October is 7% which is slightly lower than the previous average of 8%, while bank spend after adjusting for the overstated month 6 spend is unchanged from the average of 5%.

8. Pay trend for the 7 months to 31st October





Commentary

- Month 7 actual pay is £1.2m lower than the monthly average spend for the first half of the year. £0.4m of the month 7 reduction relates to correction for the overstated month 6 bank spend while substantive and agency pay spend in October are lower than the previous average by £0.5m and £0.3m respectively.
- Temporary (bank/locum/ agency) spend in month is slightly improved from the previous months' average of 13% to 12% of the monthly pay bill.
- The reduction in temporary staff spend is due mainly to correction in month of overstated bank spend in month 6 (c£0.4m).
- The reduction in substantive pay is due to favourable net staff recharges (catch-up and settlement of disputed charges), transfer to capital and staff turnover.
- Progress has been made to document processes to record and report temporary pay in order to minimise swings between months due to timing and processing issues and to allow a better understanding of trends. However it is clear that further work is required.

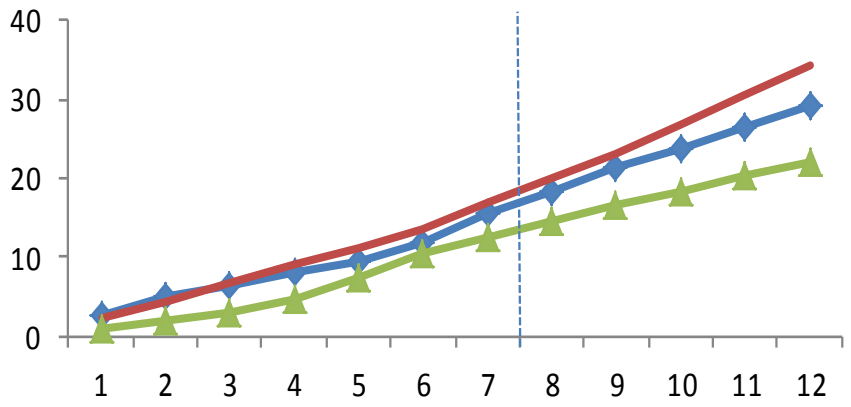
9. Non pay costs for the 7 months to 31st October

Non Pay Category	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
Clinical Consumables	(97.6)	(7.9)	(8.1)	(0.3)	(57.4)	(56.1)	1.3
Drugs	(63.3)	(5.7)	(6.6)	(0.9)	(35.2)	(36.5)	(1.4)
Premises	(43.1)	(3.7)	(3.8)	(0.2)	(25.4)	(24.7)	0.8
Clinical Negligence	(14.9)	(1.2)	(1.5)	(0.2)	(8.7)	(9.1)	(0.4)
Establishment	(10.7)	(0.8)	(1.1)	(0.2)	(6.2)	(6.7)	(0.5)
General Supplies	(16.6)	(1.3)	(1.3)	0.0	(9.7)	(9.7)	0.0
Non Pay Unallocated	0.2	0.0	(0.0)	(0.0)	0.1	(0.0)	(0.1)
PFI Unitary payment	(7.0)	(0.6)	(0.6)	0.0	(4.1)	(4.1)	(0.0)
Consultancy	(4.7)	(0.8)	(1.1)	(0.3)	(3.5)	(4.0)	(0.4)
External Facilities	(4.8)	(0.4)	(0.5)	(0.0)	(2.6)	(3.5)	(0.9)
Other NHS Facilities	(7.2)	(0.6)	(0.5)	0.0	(4.3)	(3.9)	0.4
Diagnostic Services	(25.9)	(2.2)	(2.2)	(0.1)	(15.1)	(15.4)	(0.3)
Other	(5.8)	(0.7)	(0.8)	(0.0)	(3.0)	(5.8)	(2.8)
Reserves	(11.2)	(0.7)	(0.1)	0.6	(6.2)	(3.1)	3.1
Prior Year Costs	0.0	0.0	0.0	0.0	0.0	(1.3)	(1.3)
Old Year Creditor Adjustments	2.0	0.2	0.2	0.1	1.2	0.8	(0.4)
Trust Central (Diagnostic Services & Cross charges)	27.8	3.1	2.3	(0.8)	13.4	16.3	2.9
Grand Total	**(282.8)**	**(23.3)**	**(25.6)**	**(2.3)**	**(166.8)**	**(166.8)**	**(0.0)**

Commentary

- October non pay spend was £2.3m higher than budgeted, mainly comprised of £0.9m drugs overspend (some income offset) and £1m budget reductions (£0.8m Monitor budget alignment adjustment and Electronic date establishment allocated from non-pay).
- Non pay spend to date is on budget. Overspends on drugs, consultancy, external facilities, unidentified CIPS and prior year costs are offset by benefits from Reserves and prior year PO accrual releases, and favourable cumulative budget adjustments to match the Monitor plan.
- M7 clinical consumables spend was £0.3m more than plan. Spend to date, is £1.3m under budget (PO accrual release & activity underperformance).
- Clinical negligence £0.2m overspend in month relates to GP insurance which is fully offset by recovered income (pass through cost).
- Drug spend in month was £0.9m over budget, of which £0.4m relates to Pharmacy costs for which there is £0.5m income from the Pharmacy wholesale dealer licence. £0.2m relates to the back-log of HIV homecare drugs for which an accrual has been made in month.
- Consultancy is £0.3m over budget in month and relates to turnaround spend (note £0.1m costs reclassified in M7 as Agency for KPMG 'Embeds').
- M7 £0.6m reserves variance reflects release of the monthly CIP reserve, and reduction of accruals relating to R&D and excellence awards.
- 'Trust Central' comprises SWLP Consortium accounting adjustments and Monitor phasing adjustment. The M7 variance is £0.8m worse than plan, and year to date is £2.9m better than the plan. These reflect budget adjustments to align the ledger with Monitor plan (difference is due to CIP phasing.

10. Trust CIP performance



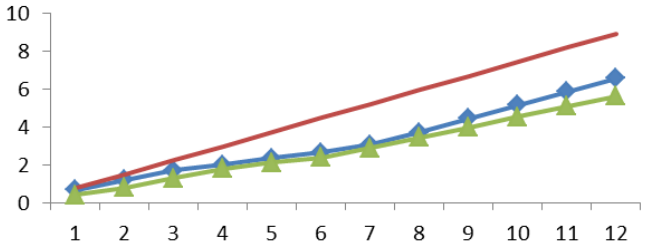
Commentary

- The divisional CIP target for 2015/16 is £38.1m and this is profiled in the budget in 1/12s. The financial plan agreed with Monitor assumes 90% of this, i.e. £34.2m, is achieved and that delivery is phased more towards the latter part of the year
- The chart below shows CIP plans and delivery against the Monitor plan
- In the year to date the Trust has delivered £15.6m of savings compared to a plan of £16.8m. Of the £15.6m delivered so far, £8.6m is CIPs and the balance of £7.0m is non-recurrent and run rate/vacancy control savings
- £18.6m more CIPs are required in the last 5 months of the year to meet the overall financial plan but there are currently only plans for £13.7m. The reforecast deficit assumes £31m is delivered.
- Since month 6 the total value of red/amber and green schemes has increased by £2.4m, which includes a £1.5m depreciation benefit from lower capital spend and reviewing the useful life of IT equipment. The total annual value of green schemes has increased from £18.1m last month to £22.1m at the end of October, which is positive.
- A further £2.9m of pipeline CIP schemes have been identified as part of the reforecasting exercise and there is a developing pipeline of a further £4.2m.
- Looking to 2016/17 the extra full year effect of 2015/16 schemes is £5.2m however this is more than offset by the loss of 2015/16 non recurring schemes of £9.9m. In addition £4.2m of new CIPs have so far been identified for 2016/17.

11. Trust CIP performance - divisions

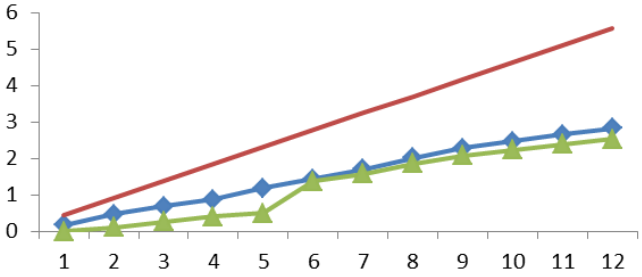
Children and Women

£6.5m schemes have been developed against the £8.9m target so there is a gap of £2.3m. To date £2.1m less than plan has been saved, although this gap is expected to reduce slightly with run rate schemes. Green schemes are 86% of the total identified so far.



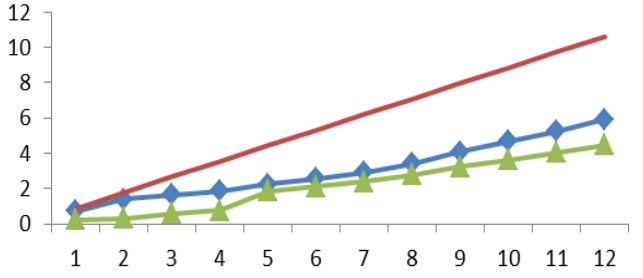
Community Services

£2.9m schemes have been developed against the £5.6m target, the gap is £2.7m and is not expected to be eliminated. Year to date underperformance is £1.5m. Green schemes are 90% of the total.



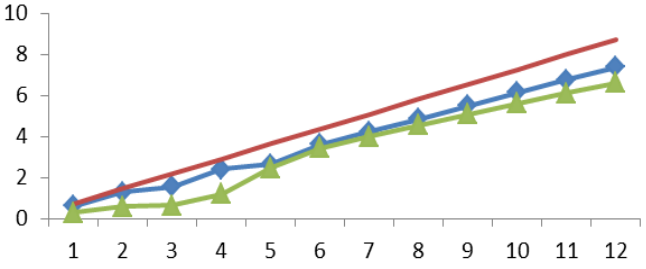
Medicine & Cardiovascular

£5.9m schemes have been developed against the £10.6m target. The gap is £4.7m. Year to date underperformance is £3.3m. Green schemes are 75.6% of the total.



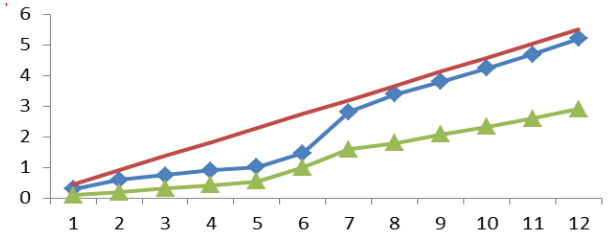
Surgery and Neurosciences

£7.4m schemes have been developed against a £8.7m target. The gap is £1.3m. Year to date savings are £0.8m below plan. Green schemes are 90% of the total. The division expects to close the gap with run rate schemes.



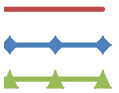
Overheads

£5.5m schemes have been developed against a £5.6m target. In the year to date £0.4m less than plan has been saved. Green schemes are 56% of the total. Corporate functions have closed the gap with the schemes submitted recently. Estates & Facilities expect to close the remaining gap through run rate run rate savings.



Commentary

- Divisional targets are based on the £38.1m target phased in 1/12s.The 10% CIP provision is held centrally.
- Overhead departments' performance has improved significantly.
- The biggest forecast shortfall is £4.7m in Medicine.
- Further work is on-going to firm up on red/amber schemes and to complete governance processes so they can become green.



Target
All schemes (Red, Amber & Green)
Green schemes only

12. Divisional Summaries for the 6 months to 30th September
KEY HEADLINES

Area of Review	Key Highlights
Medicine & Cardiovascular	The division's month 7 surplus was £0.2m worse than plan and is £4.1m worse than plan to date. SLA income is £1m lower than plan due to underperformance on outpatients. In month pay is broadly in line with plan and non pay is £0.78m worse than plan following the correction for high cost drugs/devices flexing in month 6.
Surgery, Neurosciences Theatres & Cancer	The division's surplus is £2.5m worse than plan to date, comprised of £1.9m overspend due to unidentified CIPs and use of external providers, and £0.6m income underperformance partly because no profit has been generated by the Elective Orthopedic Centre, non elective activity is also less than expected. In month, the division is £0.2m below its planned surplus. This is due to the impact of theatre closures on elective activity and low non elective income.
Community Services	The division is £1.1m behind plan year to date, largely driven by underperformance on outpatient income (£1.2m) across a number of services at QMH. There are also unidentified CIPs contributing to the adverse variance from plan. In month, the division performed slightly better (£0.1m) than plan and included £0.2m special schools income which has been recently agreed and a slight improvement in outpatient income offset by £0.2m backlog HIV drug costs.
Children, Women and Diagnostics	To date, the division overall is £0.8m behind plan, mainly as a result of low outpatient income (some in maternity and also due to suspension of the uro-gynaencology service), and elective activity underperformance. Pharmacy commercial activity is continuing to do well. In month position is £0.7m better than plan which is due to transfer of unallocated pay CIP to 'other' income (Pharmacy commercial income), and a catch up in pay recharges.
Overheads	Overhead services performance was £0.3m under budget in October and £0.4m over budget cumulatively. In month position reflects benefit of renegotiated Moorfield's income (£0.2m) while cumulative position mainly reflects turnaround costs.

Medicine & Cardiovascular - Divisional I&E for the 7 months to 31st October

Medicine and Cardiovascular

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
A&E	17.4	1.5	1.4	(0.0)	10.2	10.1	(0.1)
Daycase	11.4	1.0	1.1	0.1	6.7	6.9	0.2
Elective	23.5	2.1	2.0	(0.1)	13.9	14.0	0.1
Exclusions	33.0	2.0	2.4	0.4	18.4	18.8	0.4
Non Elective	64.3	5.4	5.4	(0.0)	37.6	37.8	0.2
Other	19.0	1.6	1.5	(0.1)	11.1	10.5	(0.7)
Outpatients	37.0	3.3	3.3	0.0	21.8	20.8	(1.0)
Programme	15.9	2.2	2.6	0.4	8.7	9.1	0.4
	221.6	19.2	19.8	0.6	128.4	128.0	(0.4)
Other Income	19.5	1.6	1.4	(0.2)	11.3	10.9	(0.4)
Overall Income	**241.1**	**20.8**	**21.2**	**0.4**	**139.7**	**138.9**	**(0.8)**
Pay							
Consultants	(19.6)	(1.6)	(1.7)	(0.0)	(11.4)	(11.3)	0.1
Junior Doctors	(18.7)	(1.6)	(1.5)	0.1	(10.9)	(10.9)	(0.1)
Non Clinical	(8.6)	(0.8)	(0.7)	0.1	(5.0)	(5.0)	0.0
Nursing	(55.0)	(4.6)	(4.2)	0.5	(31.8)	(30.7)	1.0
Other	4.7	0.4	0.0	(0.4)	2.7	0.0	(2.7)
Scientists, Technicians, Therapists	(5.0)	(0.3)	(0.3)	(0.0)	(2.9)	(2.9)	0.0
Pay Unallocated	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
	(102.2)	(8.5)	(8.4)	0.1	(59.3)	(60.9)	(1.6)
Non-Pay							
Clinical Consumables	(37.4)	(3.1)	(3.4)	(0.3)	(22.3)	(22.8)	(0.5)
Drugs	(33.0)	(3.0)	(3.2)	(0.2)	(18.3)	(18.1)	0.2
Establishment	(1.5)	(0.1)	(0.2)	(0.1)	(0.9)	(1.1)	(0.2)
General Supplies	(0.2)	(0.0)	(0.0)	(0.0)	(0.1)	(0.3)	(0.1)
Non Pay Unallocated	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Other	(2.7)	(0.2)	(0.3)	(0.1)	(1.4)	(2.7)	(1.2)
Premises	(0.5)	(0.0)	(0.0)	0.0	(0.3)	(0.2)	0.1
	(75.3)	(6.5)	(7.1)	(0.7)	(43.3)	(45.1)	(1.8)
Overall Expenditure	**(177.5)**	**(15.0)**	**(15.5)**	**(0.5)**	**(102.6)**	**(106.0)**	**(3.3)**
EBITDA	**63.6**	**5.8**	**5.7**	**(0.2)**	**37.0**	**32.9**	**(4.1)**
Financing Costs	(4.5)	(0.4)	(0.4)	(0.0)	(2.6)	(2.6)	0.0
Surplus / (deficit)	**59.1**	**5.4**	**5.3**	**(0.2)**	**34.4**	**30.3**	**(4.1)**

Commentary

The surplus in month 7 was £0.2m below plan. Cumulatively the division has a surplus of £30.3m which is £4.1m below plan due to a CIP gap, underperformance against outpatient income target (£1m), and prior year invoices (£0.8m)

Income was £0.4m above plan in month due to the resolution of the renal outpatient tariff dispute resolution. Correction of month 6 flexing of pass through budgets has led to a favourable variance in income but this is offset by an opposite adjustment in non-pay. The year to date position is worse than plan due to underperformance against outpatient target.

Pay is £0.1m favourable in month due to adjustment of an overstated bank accrual in September. In addition, nursing agency fill rates have been below trend. This is offset by the shortfall on CIPs. The year to date pay variance is due to the CIP gap.

Non-pay is £0.7m over budget in the month due to the pass through flexing budget correction above as wells as CIP gaps. The year to date variance is adverse due to CIP gap and prior year invoices.

Actions

- Working closely with KPMG to convert pipeline schemes into deliverable CIP schemes
- Recovery plans in place to recover some outpatient underperformance.

Reforecast

This shows an outturn of £47m surplus compared to £30m at the end of October. Whilst this includes a modest benefit from further CIPs there are additional costs for capacity and SRG schemes, a reduction in elective income and extra fines.

Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for the 7 months to 31st October

Surgery and Neurosciences

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
Bed Days	7.4	0.6	0.8	0.2	4.3	4.3	(0.0)
Daycase	13.5	1.2	1.2	0.0	8.0	8.1	0.1
Elective	35.9	3.2	3.0	(0.2)	20.5	21.0	0.5
Exclusions	10.6	1.2	1.3	0.2	6.5	6.8	0.3
Non Elective	50.0	4.2	3.9	(0.3)	28.9	28.4	(0.5)
Other	2.5	0.2	0.2	(0.1)	1.5	1.1	(0.4)
Outpatients	31.3	2.8	2.8	(0.0)	18.3	18.4	0.1
Programme	1.9	0.0	0.0	0.0	0.3	0.3	0.0
	153.2	13.4	13.2	(0.2)	88.2	88.2	0.0
Other Income	18.5	1.5	1.5	(0.0)	10.8	10.1	(0.6)
Overall Income	**171.6**	**15.0**	**14.8**	**(0.2)**	**98.9**	**98.3**	**(0.6)**
Pay							
Consultants	(25.5)	(2.1)	(2.2)	(0.1)	(14.7)	(15.2)	(0.5)
Junior Doctors	(15.2)	(1.3)	(1.3)	(0.0)	(8.8)	(9.1)	(0.3)
Non Clinical	(9.3)	(0.8)	(0.7)	0.0	(5.4)	(5.4)	(0.1)
Nursing	(45.4)	(3.5)	(3.4)	0.1	(25.5)	(24.4)	1.1
Other	1.5	(0.2)	0.0	0.2	0.4	0.0	(0.4)
Scientists, Technicians, Therapists	(11.0)	(0.9)	(0.9)	(0.0)	(6.3)	(6.2)	0.1
Pay Unallocated	1.2	0.1	0.0	(0.1)	0.7	0.0	(0.7)
	(103.9)	(8.7)	(8.5)	0.1	(59.5)	(60.3)	(0.8)
Non-Pay							
Clinical Consumables	(21.8)	(1.5)	(1.7)	(0.2)	(12.6)	(12.2)	0.4
Clinical Negligence	(0.0)	(0.0)	0.0	0.0	(0.0)	(0.0)	(0.0)
Drugs	(9.6)	(0.9)	(0.9)	(0.0)	(5.5)	(5.4)	0.1
Establishment	(0.4)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.0)
General Supplies	(0.3)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0
Non Pay Unallocated	0.2	0.0	0.0	(0.0)	0.1	0.0	(0.1)
Other	(0.8)	(0.3)	(0.3)	0.0	(0.3)	(1.7)	(1.5)
Premises	(0.8)	(0.1)	(0.0)	0.0	(0.4)	(0.3)	0.1
	(33.6)	(2.8)	(3.0)	(0.2)	(19.0)	(20.1)	(1.1)
Overall Expenditure	**(137.4)**	**(11.5)**	**(11.5)**	**(0.0)**	**(78.5)**	**(80.4)**	**(1.9)**
EBITDA	**34.2**	**3.5**	**3.3**	**(0.2)**	**20.4**	**17.9**	**(2.5)**
Financing Costs	(4.0)	(0.3)	(0.3)	0.0	(2.3)	(2.3)	0.0
Surplus / (deficit)	**30.2**	**3.1**	**2.9**	**(0.2)**	**18.1**	**15.6**	**(2.5)**

Commentary

The division delivered a net contribution of £2.9m in October which is £0.2m worse than plan. In the year to date the surplus is £2.5m worse than plan.

Income Elective income in the month was £0.2m lower than plan due to theatre closures, a reduction in the bariatric tariff and breast activity under plan. The division has also not assumed any profit share from the Elective Orthopaedic Centre (£0.5m adverse variance).

Pay -The year to date pay overspend of £0.8m is mainly due to the unidentified CIP gap of £0.4m, non-recurrent prior year costs of £0.2m (Wandsworth council social workers), junior doctors overspend and additional sessions.

Non-Pay - £1.0m overspent which relates to £0.6m for unidentified CIPs and £1.0m on the use of the private sector which was an agreed cost pressure. These overspends are partially offset by underspends on clinical consumables.

Actions to Improve Position

- Work with KPMG to identify new CIPs
- Ensue all high cost activity is correctly recorded in SLAM
- Validate the PTL to minimise penalties

Reforecast – The forecast outturn is £8.6m worse than plan compared to a £2.5m shortfall at month 7. This is due to a £1.5m CIP gap, recognised cost pressures of £3.4m, £2.8m reduction in non-SLA income and an increase in penalties. The deterioration is due to higher costs for winter and greater use of the private sector as well as reallocation of education income which is neutral across the Trust.

Community Services - Divisional I&E for the 7 months to 31st October

Community Services

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
A&E	1.3	0.1	0.1	(0.0)	0.7	0.7	(0.1)
Bed Days	5.6	0.5	0.4	(0.0)	3.3	3.1	(0.1)
Exclusions	8.4	0.6	0.8	0.2	5.0	5.2	0.2
Other	65.4	5.5	5.6	0.2	38.2	38.1	(0.1)
Outpatients	26.0	2.3	2.2	(0.2)	15.4	14.1	(1.2)
	106.7	9.0	9.1	0.1	62.6	61.2	(1.4)
Other Income	3.4	0.3	0.3	(0.0)	2.0	1.8	(0.1)
Overall Income	**110.1**	**9.3**	**9.4**	**0.1**	**64.6**	**63.1**	**(1.5)**
Pay							
Consultants	(2.4)	(0.2)	(0.2)	0.0	(1.4)	(1.4)	0.0
Junior Doctors	(1.4)	(0.1)	(0.2)	(0.1)	(0.8)	(1.4)	(0.5)
Non Clinical	(7.6)	(0.7)	(0.6)	0.0	(4.5)	(4.4)	0.1
Nursing	(28.3)	(2.1)	(1.9)	0.2	(16.5)	(14.6)	1.9
Other	2.9	(0.1)	0.0	0.1	1.7	0.0	(1.7)
Scientists, Technicians, Therapists	(13.6)	(1.2)	(1.0)	0.1	(8.1)	(7.7)	0.4
Pay Unallocated	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
	(50.4)	(4.3)	(4.0)	0.4	(29.5)	(29.4)	0.1
Non-Pay							
Clinical Consumables	(9.2)	(0.8)	(0.8)	(0.0)	(5.7)	(5.4)	0.3
Clinical Negligence	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
Drugs	(11.3)	(0.9)	(1.1)	(0.2)	(6.7)	(7.1)	(0.4)
Establishment	(1.0)	(0.1)	(0.1)	0.0	(0.6)	(0.7)	(0.0)
General Supplies	(0.1)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Non Pay Unallocated	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Other	(9.1)	(0.6)	(0.7)	(0.1)	(5.4)	(5.0)	0.4
Premises	(0.6)	(0.0)	(0.0)	0.0	(0.4)	(0.4)	0.0
	(31.4)	(2.4)	(2.7)	(0.3)	(18.8)	(18.5)	0.3
Overall Expenditure	**(81.7)**	**(6.7)**	**(6.7)**	**0.0**	**(48.4)**	**(47.9)**	**0.5**
EBITDA	**28.3**	**2.5**	**2.7**	**0.1**	**16.2**	**15.1**	**(1.1)**
Financing Costs	(0.2)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Surplus / (deficit)	**28.1**	**2.5**	**2.7**	**0.1**	**16.1**	**15.0**	**(1.1)**

Commentary

The division has a £15m surplus to date which is £1.1m worse than plan.

Income - Outpatient income improved in October but activity is still lower than plan at Queen Mary's Hospital and within the Sexual Health service.

Expenditure - The pay budget for month 7 was underspent by £0.4m due to on-going vacancies in hard to recruit areas - Offender Health, Community Adult Health service and Elderly rehabilitation.

Non-pay spend in October was over budget mainly due to a £0.2m backlog for HIV Homecare drugs. In the year to date other non pay is £0.3m under budget due to underspends on services provided by Kingston Hospital, the wheelchair contract and escort & bed watch service.

Actions

- Deliver income recovery plans for Outpatients & Diagnostics, Rehab & Therapies, GU Medicine and achieve higher occupancy of Mary Seacole to increase income and reduce pressure on beds in the hospital.
- Formalise contract with Wandsworth Borough Council for special schools nursing.
- Resolve HIV homecare invoicing issues

Reforecast - this shows an outturn surplus of £26m compared to £15m at the end of October. This reflects investment in winter capacity (Nightingale) and the Nelson. Other work on productivity and follow up rates is not yet developed enough to be included in the reforecast.

Children, Women, Diagnostics & Therapies - Divisional I&E for the 7 months to 31st October

C&W, Diagnostics, Therapies

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
Bed Days	48.2	4.0	4.2	0.2	26.9	26.8	(0.0)
Daycase	4.4	0.4	0.4	(0.0)	2.6	2.8	0.2
Elective	5.1	0.5	0.3	(0.1)	3.0	2.4	(0.6)
Exclusions	1.8	0.2	0.2	(0.0)	1.1	1.2	0.1
Non Elective	8.1	0.7	0.8	0.2	4.7	5.3	0.6
Other	20.1	1.7	1.7	(0.0)	11.7	11.6	(0.1)
Outpatients	40.3	3.5	3.2	(0.3)	23.3	21.8	(1.5)
Programme	0.4	0.1	0.1	(0.0)	0.2	0.2	(0.0)
	128.3	11.0	10.8	(0.2)	73.5	72.1	(1.4)
Other Income	21.6	2.0	2.4	0.4	11.5	12.8	1.3
Overall Income	**150.0**	**13.1**	**13.3**	**0.2**	**85.0**	**84.9**	**(0.1)**
Pay							
Consultants	(16.8)	(1.4)	(1.3)	0.1	(9.7)	(9.9)	(0.2)
Junior Doctors	(13.2)	(1.1)	(1.1)	0.0	(7.6)	(7.4)	0.2
Non Clinical	(14.7)	(1.3)	(1.1)	0.2	(8.4)	(7.9)	0.5
Nursing	(52.6)	(4.1)	(4.2)	(0.0)	(30.0)	(29.2)	0.8
Other	2.0	(0.4)	0.0	0.4	1.2	0.0	(1.2)
Scientists, Technicians, Therapists	(32.0)	(2.7)	(2.5)	0.2	(18.1)	(17.6)	0.5
Pay Unallocated	0.2	0.0	0.0	(0.0)	0.1	0.0	(0.1)
	(127.2)	(11.0)	(10.2)	0.9	(72.4)	(72.0)	0.5
Non-Pay							
Clinical Consumables	(14.3)	(1.2)	(1.1)	0.1	(8.2)	(7.4)	0.8
Drugs	(9.2)	(1.0)	(1.4)	(0.4)	(4.6)	(5.9)	(1.2)
Establishment	(0.7)	0.0	(0.0)	(0.1)	(0.4)	(0.4)	0.0
General Supplies	(0.5)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Non Pay Unallocated	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Other	(1.0)	(0.1)	(0.2)	(0.1)	(0.5)	(1.5)	(0.9)
Premises	(1.5)	(0.1)	(0.0)	0.1	(0.9)	(0.7)	0.2
	(27.2)	(2.4)	(2.8)	(0.4)	(15.0)	(16.1)	(1.1)
Overall Expenditure	**(154.5)**	**(13.5)**	**(13.0)**	**0.5**	**(87.4)**	**(88.1)**	**(0.6)**
EBITDA	**(4.5)**	**(0.4)**	**0.3**	**0.7**	**(2.4)**	**(3.2)**	**(0.8)**
Financing Costs	(6.4)	(0.5)	(0.5)	(0.0)	(3.8)	(3.8)	(0.0)
Surplus / (deficit)	**(11.0)**	**(1.0)**	**(0.3)**	**0.7**	**(6.2)**	**(7.0)**	**(0.8)**

Commentary

The division has a cumulative deficit of £7m which is £0.8m worse than plan largely due to low outpatient activity off set by pharmacy commercial income.

Income - low outpatient activity includes the impact of the suspension of the urogynaecology service and lower than expected obstetric bookings and high antenatal DNA rates. Other Healthcare income is £1.3m above plan due to the success of the pharmacy wholesale dealer operation.

Pay is £0.9m below plan in month and £0.4m of this relates to movement of the unallocated CIP target from pay to other income reflecting the mix of CIPs in the division, and £0.2m to a catch-up in recharges. Cumulatively pay budgets are £0.5m underspent due to vacancies e.g. in hard to recruit areas of Genetics and Breast Screening.

Non pay – The clinical consumable underspend is due to lower than planned critical care and urogynaecology activity while the drug overspend relates to pharmacy commercial income which is above plan.

Actions

- Conclude the consultation on the future of the urogynaecology service and assess the financial implications
- Investigate and identify corrective actions regarding high DNA rates in outpatient Gynaecology and Antenatal services
- Improve cashing up of outpatient clinics and ensure timely recording of post natal activity
- Maintain improvements in high cost drug reporting and minimise recording errors to reduce lost income

Reforecast

The year end forecast is a deficit of £12.3m which is marginally worse than the current trend, but like other divisions, it is distorted by the movement of budgets e.g. for SIFT.

Overheads - Divisional I&E for the 7 months to 31st October

Overheads

Income & Expenditure	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Corporate Directorates							
Chief Executive & Governance	(19.8)	(2.2)	(2.6)	(0.4)	(12.4)	(13.4)	(1.0)
Executive Director of Nursing	(5.1)	(0.4)	(0.2)	0.2	(2.9)	(2.9)	0.1
Finance, Performance & IT	(25.8)	(2.3)	(2.3)	0.0	(15.0)	(14.9)	0.0
Human Resources Directorate	(4.3)	(0.4)	(0.3)	0.0	(2.5)	(2.5)	(0.0)
Ops & Service Improvement	(1.7)	(0.1)	(0.1)	0.0	(1.0)	(0.6)	0.4
Pathology - STG	(12.3)	(1.1)	(1.1)	(0.1)	(7.2)	(7.7)	(0.5)
Strategy	(1.3)	(0.1)	(0.1)	(0.0)	(0.7)	(0.6)	0.1
Total Corporate	(70.3)	(6.6)	(6.8)	(0.2)	(41.7)	(42.7)	(0.9)
Estates & Facilities							
Energy & Engineering	(11.1)	(0.9)	(0.9)	(0.0)	(6.6)	(6.2)	0.3
Estates	(12.1)	(1.0)	(0.7)	0.3	(7.0)	(6.8)	0.2
Estates Community Premises	(16.2)	(1.5)	(1.4)	0.1	(9.5)	(9.4)	0.1
Facilities Services	(4.6)	(0.4)	(0.3)	0.0	(2.7)	(2.8)	(0.1)
Hotel Services	(13.5)	(1.1)	(1.1)	0.0	(7.9)	(8.0)	(0.1)
Medical Physics	(2.2)	(0.2)	(0.1)	0.0	(1.3)	(1.3)	(0.0)
Project Management	(0.5)	(0.0)	(0.0)	0.0	(0.3)	(0.2)	0.1
Rates	(2.1)	(0.2)	(0.2)	(0.0)	(1.2)	(1.2)	(0.0)
Total Estates & Facilities	(62.3)	(5.3)	(4.9)	0.4	(36.4)	(35.8)	0.5
Total Overheads	**(132.6)**	**(11.9)**	**(11.7)**	**0.3**	**(78.1)**	**(78.5)**	**(0.4)**

Overheads Summary

Corporate Services to date is £0.9m worse than plan while Estates & Facilities is £0.4m worse compared to plan.

Corporate

Chief Executive - in month and cumulative overspends of £0.4m & £1m respectively, are due to turnaround costs.

Executive Director Nursing - under spend in month and year to date is mainly due to the lower costs for the Productive Ward which is not expected to be fully running until January 2016.

Finance, Performance & IT – pay underspends (vacancies) is offset by non pay overspends.

Pathology: St Georges – reflects the different in growth assumptions for the Trust's activity and the Consortium's.

Estates & Facilities

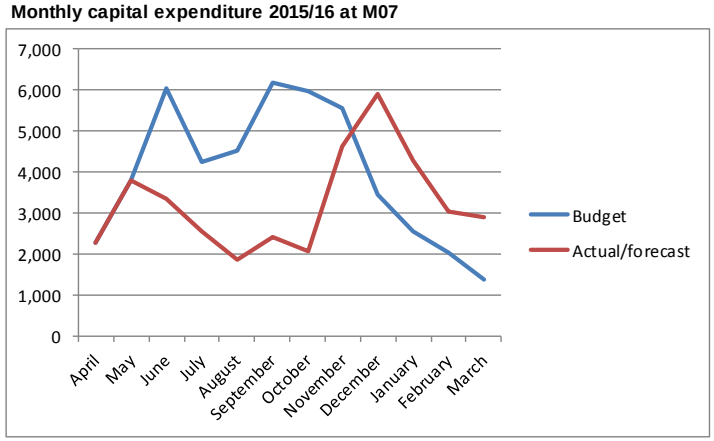
Month 7 is £0.4m better than plan and £0.5m better than the plan to date. The favourable position mainly relate to arrears of £0.2m for the renegotiated Moorfields contract, unfilled vacancies and, energy underspends reflecting the mild weather.

Risks

- Over-run consultancy costs relating to turnaround
- Estates backlog maintenance jobs continue to increase

13. 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



Summary cap exp by spend category	New Budget £000	YTD Budget £000	YTD Actual £000	YTD Var £000	F/cast Outturn £000	F/cast Var £000
Infrastructure renewal	9,680	4,416	2,820	1,596	7,447	2,233
Medical equipment	12,412	9,345	4,232	5,113	10,807	1,605
IMT	6,526	5,405	3,440	1,965	5,707	819
Major Projects	18,137	12,906	7,187	5,719	14,183	3,954
Other	772	657	563	94	678	94
SWL Path	500	312	60	252	240	260
Total	48,027	33,041	18,302	14,739	39,062	8,965

- Capital expenditure in October was £2.1m and to date expenditure is £18.3m, £14.7m less than budget.
- The Trust is deliberately slowing down capital expenditure where appropriate to support the cash position. The forecast outturn under spend is approximately £9m (M05 £5.4m) which indicates an acceleration in spend in the last 5 months of the year.
- The Executive Management Team agreed to delay completion of several major projects to conserve cash this year. The surgical assessments unit, endoscopy unit scheme and coronary care unit 2 scheme have been re-profiled to support the liquidity position between now and the year end.
- The overall effect of the changes to the capital forecast outturn is to increase the underspend from £5.4m to £8.9m.The cash benefit of this forecast outturn underspend is estimated at £7.8m (excluding leases)

14. Cash

Cash balance

	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000	30-Sep £000	31-Oct £001
2015/16 Plan cash	n/a	14,200	6,187	3,000	3,000	3,000	3,000	3,000
Actual cash	**24,179**	**14,188**	**7,925**	**7,265**	**6,175**	**6,097**	8,258	12,846
Cash bal fav / (adv) variance to plan	0	-12	1,738	4,265	3,175	3,097	5,258	9,846

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	30-Sep £000	01-Oct £001
Plan drawdown	0	0	0	2,138	6,991	14,625	24,483	29,807
Actual drawdown	**0**	**0**	**0**	**0**	**7,671**	**15,580**	**25,000**	**26,256**
WCF cum drawdowns fav / (adv) variance to plan	0	0	0	2,138	-680	-955	-517	3,551

Overall Cash fav / (adv) variance to plan	**0**	**-12**	**1,738**	**6,403**	**2,495**	**2,142**	**4,741**	**13,397**

Cash movement: M07 Actuals vs Plan and TRP forecast outturn vs Plan

	Plan M07 YTD £m	Actual M07 YTD £m	Var M07 YTD £m	Plan Outturn £m	TRP Outturn £m	Var Outturn £m
Opening cash 01.04.15	24.2	24.2		24.2	24.2	
Operating surplus/-deficit	-14.8	-22.8	**-8.0**	-21.6	-40.0	**-18.4**
Sale proceeds re: PPU land	0.0	0.0	**0.0**	2.5	0.0	**-2.5**
WCF/ISF requirement	29.8	26.3	**-3.6**	52.2	48.7	**-3.5**
Cash gap			**-11.5**			**-24.4**
Net change in working capital	-8.1	-0.4	**7.7**	-7.4	4.2	**11.6**
Capital spend (excl leases)	-30.4	-16.7	**13.7**	-45.5	-35.6	**9.9**
Other	2.4	2.3	**-0.1**	-1.4	-1.3	**0.1**
Sub-total			**21.4**			**21.6**
Closing cash M07 / M12 forecast	3.0	12.9	**9.8**	3.0	0.2	**-2.8**

- The **cash balance** table above shows the actual cash balance and WCF drawdowns vs the plan figures.
- The M07 actual cash balance was £12.8m £9.8 ahead of plan.
- Cumulative drawdowns to 31st October are £26.3m which is £3.5m lower than plan.
- LEEF loan impact: The cash balance includes £11.9m unexpended LEEF loan for the energy performance contract and so the cash balance excluding LEEF would be:+£0.9m
- The **cash movement table** compares the actual movement in the cash position YTD versus plan and TRP forecast versus plan.
- YTD position: The higher operating deficit (£8m higher than plan) and £3.5m lower drawdowns from the WCF have been more than offset by the £7.7m better performance on net working capital (longer supplier payments terms etc) and £13.7m cash under spend on capital enabling the Trust to achieve a cash balance at 31st October £9.8m higher than plan.
- Forecast outturn position: The forecast deterioration in the operating deficit and forecast acceleration in capital spend in the last 5 months of the year result in a forecast reduction in the cash balance from £12.9m to just £0.2m by year end. This forecast assumes the Trust can access ISF/WCF drawdowns of £48.7m for the year per the TRP. ***In the event no further drawdowns are permitted the Trust would face a resulting cash gap of approx £22.3m and would need to implement some or all of the cash actions set out in the separate cash paper considered at the extraordinary board meeting on 19th November – see cash graphs 1 and 2 on next slide.***

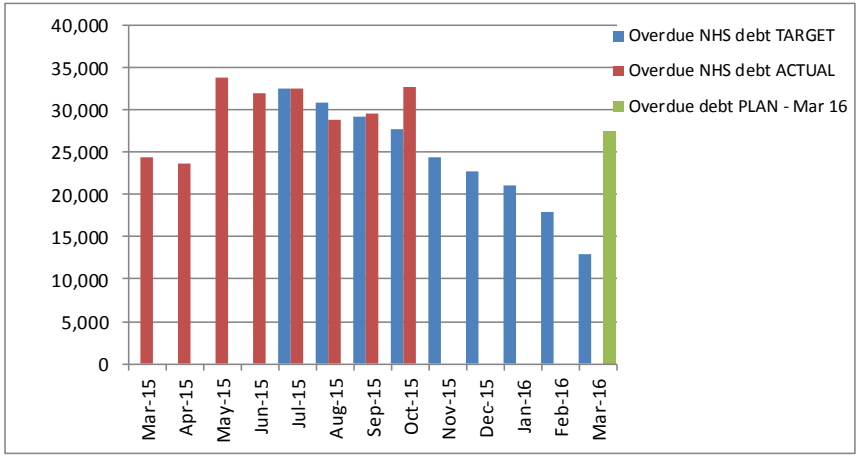
15. Debt management

- The Cash Committee approved 'stretch' debt reduction targets for 2015/16 and the baseline is the level of overdue debt (over 30 days old) as at M04.
- Delivery of the stretch targets by March 2016 would reduce the requirement for interim support funding by approx £14.2m.
- Overdue debt has reduced by £4.5m in the period M04 – M06 and was ahead of target by £0.9m at M06.
- In M07 NHS overdue debt increased by £3.3m and is now behind target. The increase in overdue NHS debt relates primarily to NHS England (£1.4m) and Croydon Hospital NHS Trust (£1.2m). The Trust is resolving the overdue debt relating to 14/15 with NHS England and is seeking settlement by the end of this month and is escalating the debt position with Croydon .
- The Trust continues to press NHS England for an agreement for a payment on account arrangement for in-year over performance similar to the arrangement already in place wit SWL CCGs. Unless such an agreement is secured the Trust is likely to miss the overdue debt reduction targets.

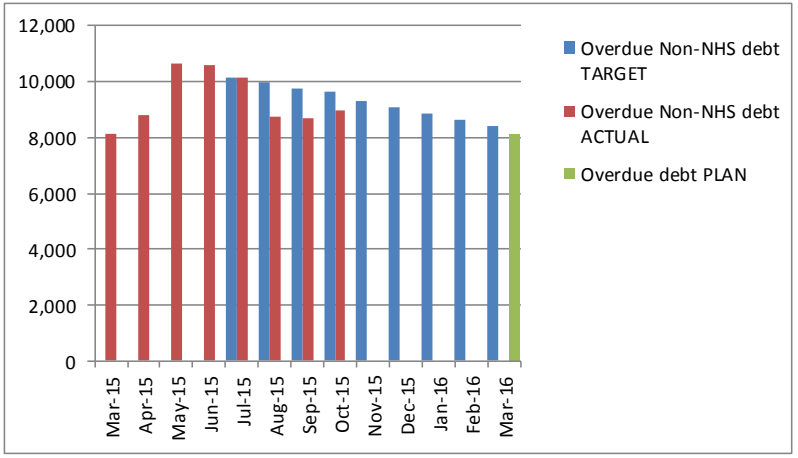
Debtor days	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
NHS income debtor days	18.5	18.8	19.5	19.4	19.4	20.1	21.6	22.1
Non-NHS income debtor days	204.9	202.0	219.3	229.0	205.1	199.2	198.4	190.9
DWP/CRU debt	981.1	986.8	1,000.1	1,029.1	1,077.7	1,019.2	1,038.3	1,080.3
Overseas patient income	807	789	769	753	761	740	677	793

Debtor days = debt by average daily income for last 12 mths

Overdue NHS debt: performance vs stretch reduction targets



Overdue non-NHS debt: performance vs stretch reduction targets



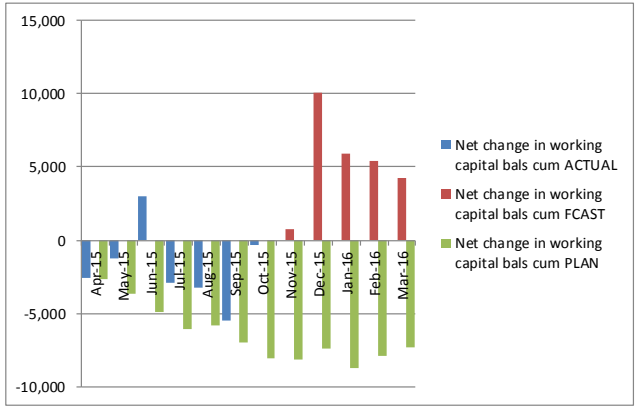
16. Balance sheet as at month 7 2015/16

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

	Oct-15 Plan £000	Oct-15 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	354,239	335,524	*18,715*	Lower capital expenditure than plan - so lower fixed assets
Stock	6,792	7,515	*-723*	Stock action group formed to progress safe reductions in levels.
Debtors	80,733	77,308	*3,425*	This includes accruals and current debt. Overdue debt has reduced since M04
Cash	3,000	12,849	*-9,849*	Lower capex, and better working capital performance has enabled the Trust to finance a higher deficit without requiring higher WCF drawdowns.
Creditors	-84,202	-89,222	*5,020*	Longer supplier payment terms implemented in July - slowing rate of payments
Capital creditors	-3,476	-2,850	*-626*	
PDC div creditor	-590	-590	*0*	
Int payable creditor	-312	-363	*51*	
Provisions< 1 year	-602	-512	*-90*	
Borrowings< 1 year	-37,181	-5,570	*-31,612*	(NB: WCF is classified as non-current liability c/f Plan)
Net current assets/-liabilities	**-35,839**	**-1,434**	*-34,405*	
Provisions> 1 year	-1,181	-1,146	*-35*	
Borrowings> 1 year	-93,762	-116,696	*22,934*	(NB: WCF is classified as non-current liability c/f Plan)
Long-term liabilities	**-94,943**	**-117,842**	*22,899*	
Net assets	**223,457**	**216,248**		
Taxpayer's equity				
Public Dividend Capital	133,761	133,761	*0*	
Retained Earnings	-12,814	-19,175	*6,361*	YTD I&E deficit worse than plan
Revaluation Reserve	101,360	100,512	*848*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**223,457**	**216,248**		

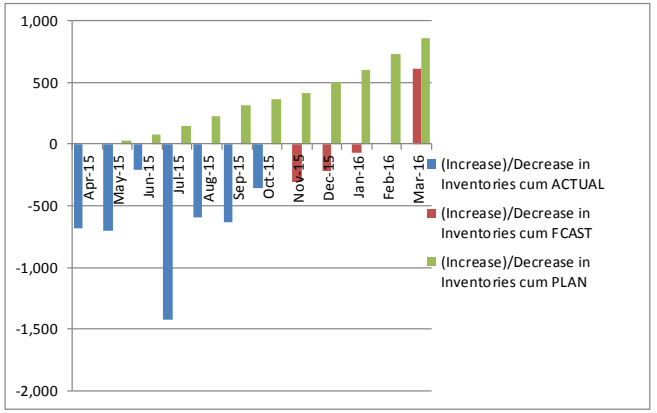
17. Working Capital

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



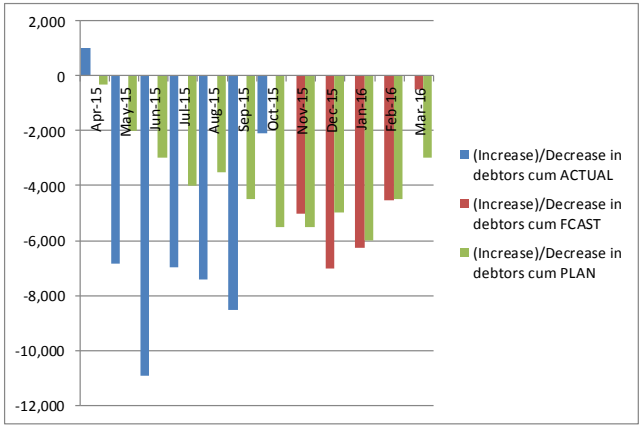
Working capital bals improved by £5.1m M07 and YTD is still better than plan by £7.7m
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories 2015/16 actuals vs plan



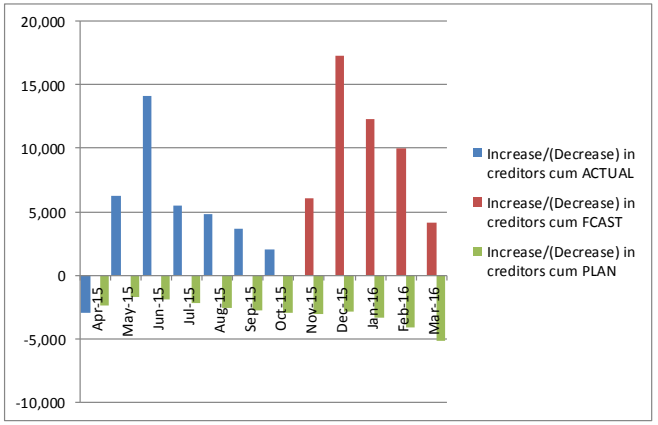
Inventories reduced by £0.26m in M07 but is behind plan by £0.4m.
Steady reduction (releasing cash) planned to year end - mainly from Central Store.

Change in debtors 2015/16 actuals vs plan



Debtors (invoice and accrued debt) reduced by £6.4m in M07 and are £3.4m ahead of plan
This relates to a timing difference on HESL Q3 SLA momies which were received in October.
Meeting the overdue debt targets for NHS debt is dependent on timely receipt of over-performance invoices

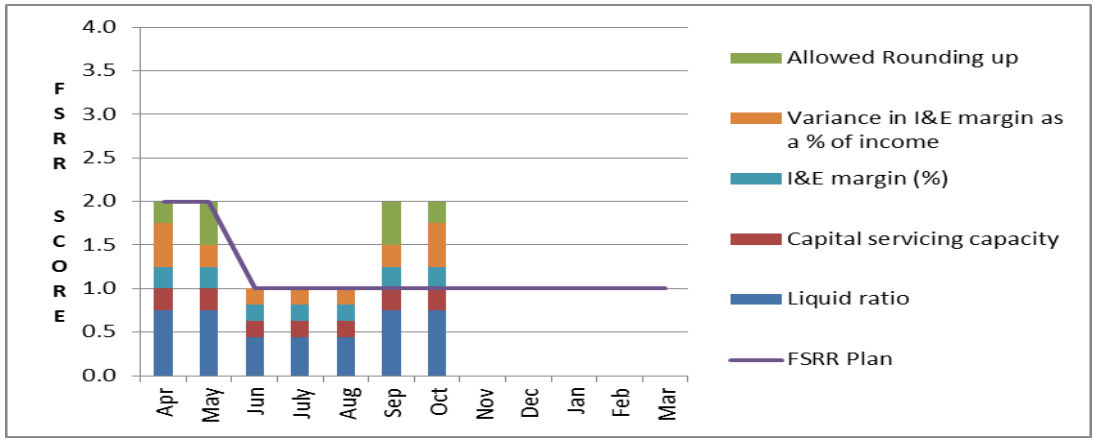
Change in creditors 2015/16 actuals vs plan



Overall level of creditors reduced in October by £1.5m.
Trust continues to pay approved invoices to the new terms.

18. Financial Sustainability Risk Rating (FSRR)

2015/16 ACTUALS	Month						
Metric Scores (4 best, 1 worst)	April	May	June	July	August	Sept	Oct
Liquid ratio	3	3	2	2	2	3	3
Capital servicing capacity	1	1	1	1	1	1	1
I&E margin (%)	1	1	1	1	1	1	1
Variance in I&E margin (%)	2	1	1	1	1	1	2
Weighted Average	1.8	1.5	1.3	1.3	1.3	1.5	1.8
Overriding Score (with rounding)	**2**	**2**	**1**	**1**	**1**	**2**	**2**
2015/16 PLAN	**2**	**2**	**1**	**1**	**1**	**1**	**1**



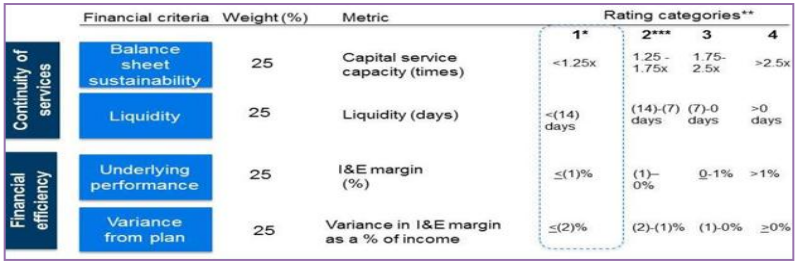
In October the Trust achieved a score of 2 for its risk rating which is ahead of the planned rating of 1. Ratings for capital servicing and I&E margin are in line with planned scores of 1 and variance and liquidity metrics are both better than plan.

Following the change in definition of the risk rating, Monitor has confirmed that the plan value from June should be a 1, reflecting performance in 2014/15 .

Last month's stronger cash position has been further improved resulting in a second month when the actual liquid ratio metric is 3.

The I&E variance of -1.7% as a percentage of income to date is now within the range for a score of 2 due to improved performance against the I&E plan in October.

Threshold details:



	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%

REPORT TO THE TRUST BOARD ***December 2015***

Paper Title:	Workforce 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
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 October 2015

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

Key points to note are:

- Turnover has steadied in month. High turnover is a problem for all London trusts and St George's compares well with benchmarked trusts. However, high turnover has a significant impact on the trust.
- KPMG are providing support on getting a grip on pay costs, both in temporary staffing and in ledger and ESR reconciliation.

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 key message from the September workforce data is that turnover continues to be at high levels, impacting all workforce metrics.

Vacancy rate

Although there is now an agreed protocol in place to reconcile ESR and ledger records, the turnaround reforecast budgets need to be updated. Until this work is completed the vacancy rate is likely to continue to be overstated.

Turnover and stability

Turnover has steadied in October. Trust briefings are clearly stating the importance of working according to the trust values and the impact that all of us can have on retaining colleagues.

Sickness absence

Sickness absence levels have reduced marginally and appear to be returning to the trust target.

Agency and bank staff usage

A detailed paper was provided to the board in September regarding the drivers for temporary staffing usage and the programme of work being undertaken to manage usage and costs. There are two key strands to this agency grip work, which KPMG are supporting:

1) Ensuring that all non-nursing agency usage has a planned exit strategy, via bank, substantive staffing or removal of the post. Good progress has been made with this work.
2) Understanding financial spend versus usage. Usage information does not include any activity that is not booked through the bank (specifically it does not include interims). On review there appear to be issues with the timeliness of the spend information and this information is not currently an accurate indicator of usage.

Support is being given to ensure that all usage is able to be measured accurately and to ensure that cost information reflects in month spend.

The Monitor guidance on the implementation of the agency cap will support the trust to implement reductions in agency usage further.

Mandatory training and appraisal rates

There will be a mid-year appraisal for all management posts from November with agreed and consistent objectives being delivered to all leaders.

A detailed paper regarding mandatory training was provided to the board in September. Further work is taking place on identifying gaps in process and capacity in order to be able to produce a realistic trajectory for achieving 85% compliance. .

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St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 7 - October 2015

Excellence in specialist and community healthcare

Workforce Performance Report Nov ‘14 - Oct ‘15

Contents

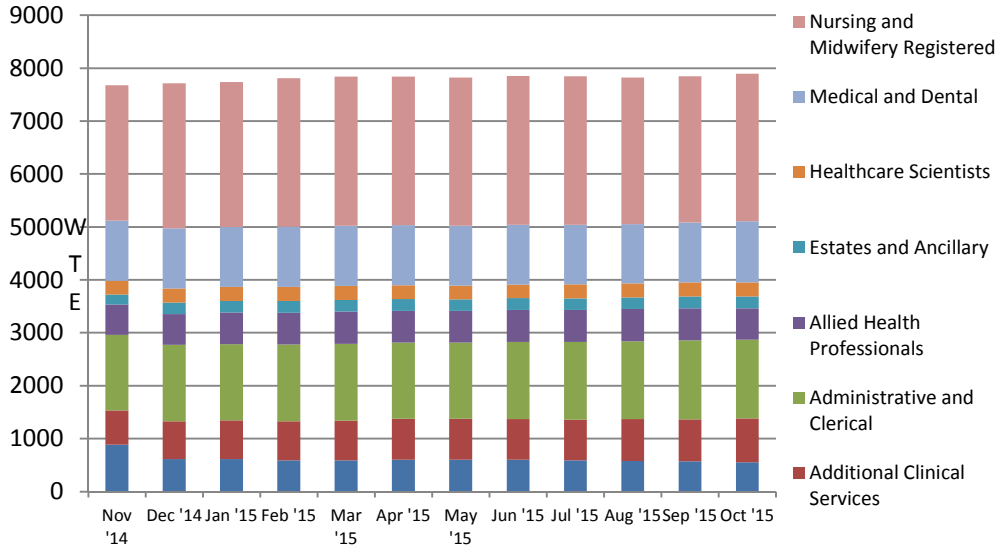
Performance Summary

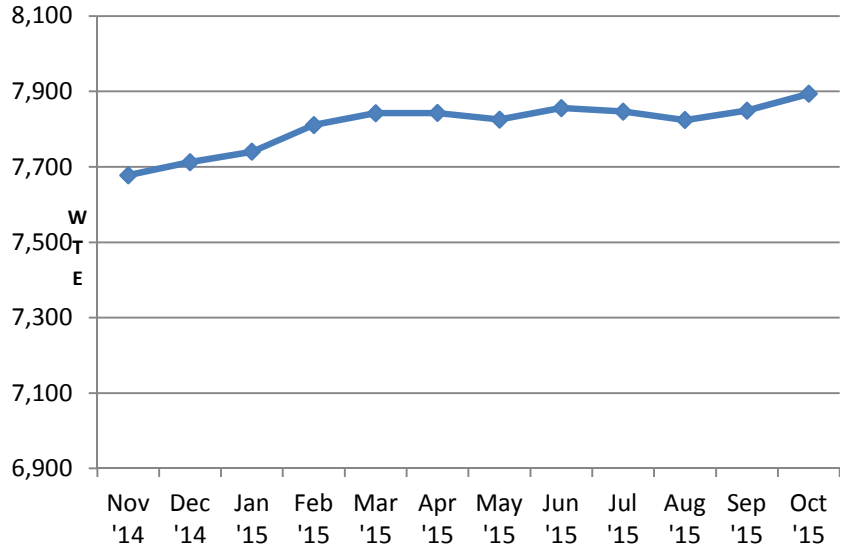
Summary of overall performance is set out below

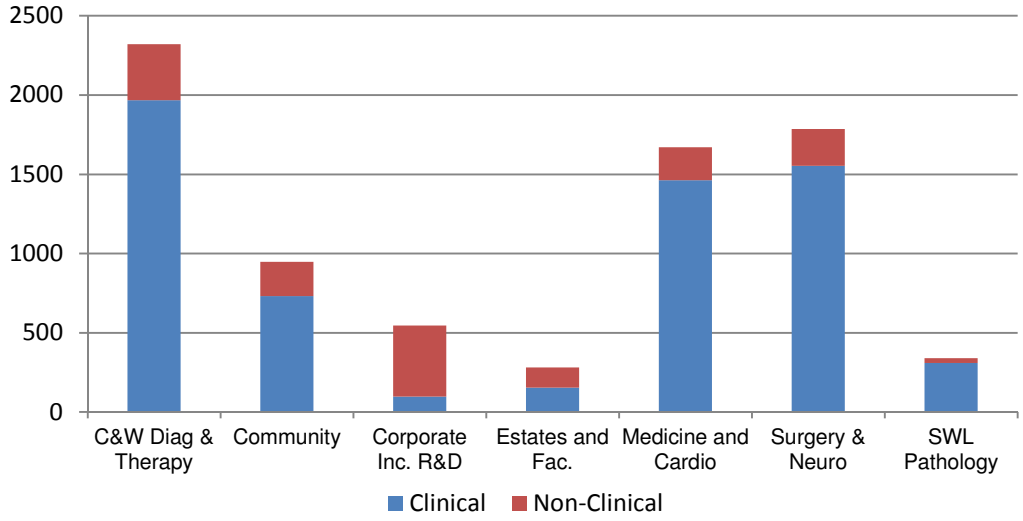
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 0.7%	12.9%	15.7%	16.4%	↗
6	Turnover	Turnover has remained the same	17.2%	17.5%	17.5%	↔
7	Voluntary Turnover	Voluntary Turnover has decreased by 0.1%	13.8%	14.6%	14.5%	↘
8	Stability	Stability has decreased by 0.1%	84.1%	83.2%	83.1%	↘
10	Sickness	Sickness has decreased by 0.2%	3.3%	4.1%	3.9%	↘
13-14	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has decreased by 2.7%	16.0%	14.8%	12.1%	↘
18	Mandatory Training	MAST compliance has decreased by 0.6%	75.0%	67.2%	66.6%	↘
19	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 2.1%	81.5%	70.0%	67.9%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





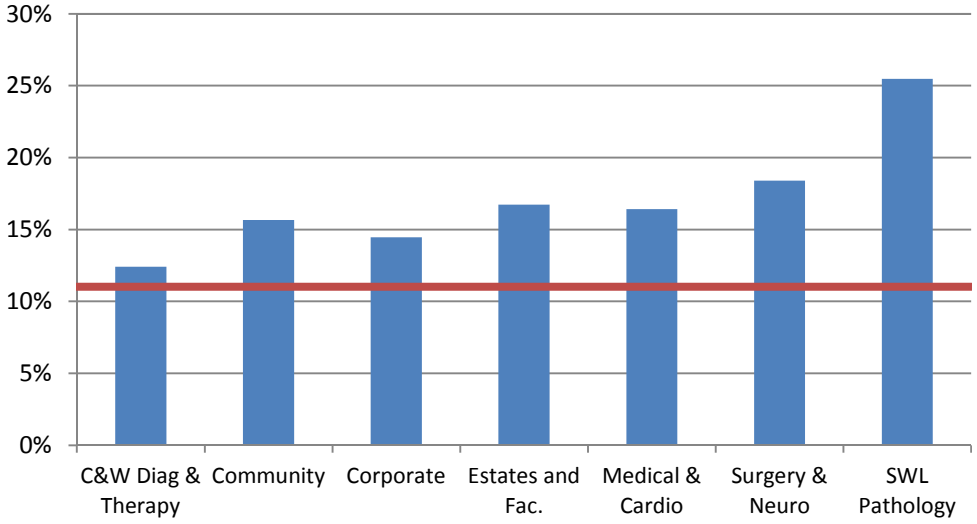


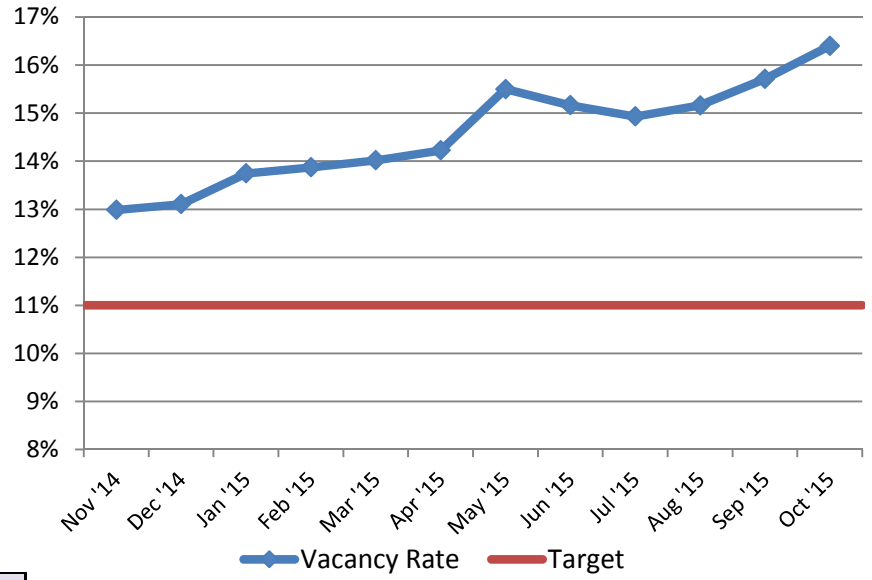
COMMENTARY

The Trust currently employs 8442 people working a whole time equivalent of 7894 which is 45 WTE higher than September. The growth rate in the directly employed workforce since October 2014 is 245 WTE or 3.2%.

The Trust also employs an additional 467 WTE GP Trainees covering the South London area, which makes the total WTE 8360.

Section 1: Vacancies





Vacancies by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diag & Therapy	9.5%	10.9%	11.8%	12.4%	↗
Community	12.6%	13.4%	12.6%	15.7%	↗
Corporate	18.2%	16.4%	12.9%	14.5%	↗
Estates and Fac.	15.6%	15.0%	15.5%	16.7%	↗
Medical & Cardio	17.4%	16.7%	16.8%	16.4%	↘
Surgery & Neuro	16.7%	16.7%	19.1%	18.4%	↘
SWL Pathology	23.6%	24.9%	25.5%	25.5%	↔
Whole Trust	**14.9%**	**15.2%**	**15.7%**	**16.4%**	↗

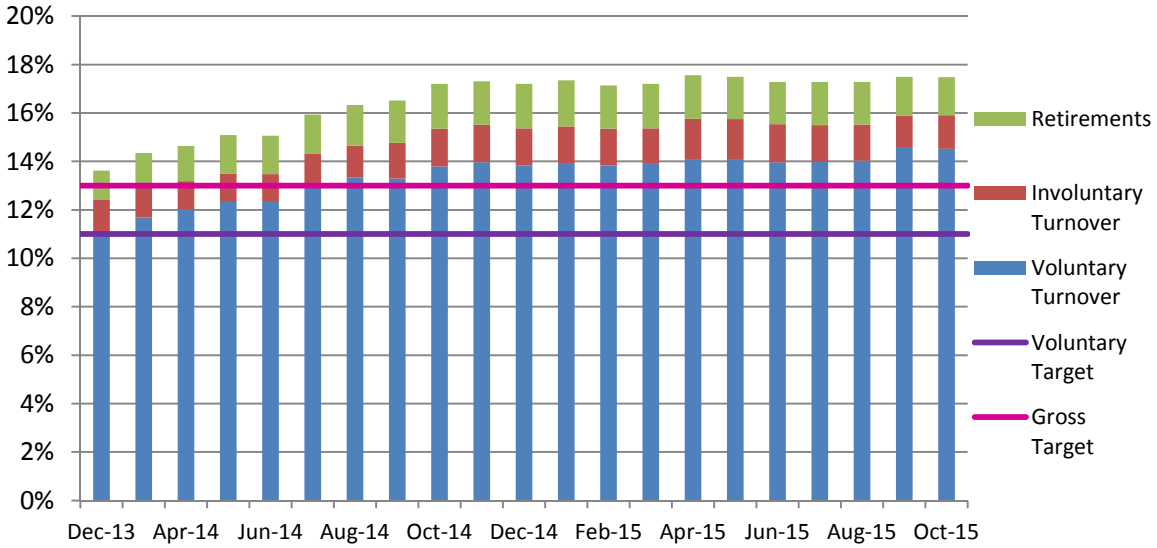
Vacancies Staff Group	Jul '15	Aug '15	Sep '15	Oct '15	Trend
Add Prof Scientific and Technic	17.5%	21.9%	22.7%	22.7%	↔
Additional Clinical Services	18.5%	17.3%	19.4%	19.3%	↘
Administrative and Clerical	16.8%	15.2%	15.2%	17.0%	↗
Allied Health Professionals	8.6%	9.4%	5.9%	14.0%	↗
Estates and Ancillary	18.9%	20.1%	19.1%	19.3%	↗
Healthcare Scientists	18.7%	18.2%	18.5%	19.4%	↗
Medical and Dental	6.8%	5.9%	5.6%	4.4%	↘
Nursing and Midwifery Registered	15.9%	16.8%	18.3%	18.1%	↘
Total	**14.9%**	**15.2%**	**15.7%**	**16.4%**	↗

COMMENTARY

Trust establishments will be reset following the completion of the Turnaround Reforecasting Process. Once completed this will confirm the basis for vacancies going forward.

Section 2a: Gross Turnover

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



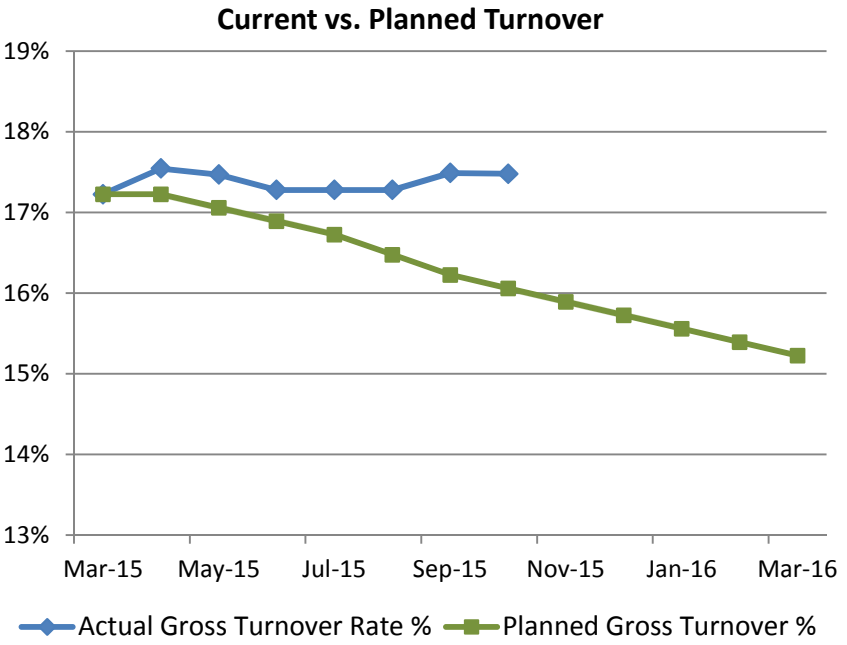
COMMENTARY

The total trust turnover rate has remained the same this month at 17.5%. This is significantly above the current target of 13%. In the last 12 months there have been 1247 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	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	17.5%	17.4%	18.1%	18.0%	↘
Community Services	20.1%	21.0%	21.1%	20.8%	↘
Corporate	20.0%	20.6%	18.8%	20.1%	↗
Estates and Facilities	16.5%	16.8%	16.5%	16.0%	↘
Medical & Cardiothoracics	17.7%	17.5%	19.1%	19.1%	↔
Surgery, Neurosciences & Anaes	14.4%	13.7%	13.3%	13.3%	↔
SWL Pathology	16.3%	16.9%	14.4%	14.8%	↗
Whole Trust	**17.3%**	**17.3%**	**17.5%**	**17.5%**	↔

	All Turnover				
Staff Group	Jul '15	Aug '15	Sep '15	Oct '15	Trend
Add Prof Scientific and Technic	18.6%	19.2%	18.6%	20.2%	↗
Additional Clinical Services	20.1%	19.5%	19.6%	19.2%	↘
Administrative and Clerical	17.0%	16.5%	16.4%	16.2%	↘
Allied Health Professionals	17.9%	17.0%	16.3%	17.5%	↗
Estates and Ancillary	10.0%	8.9%	8.5%	8.6%	↗
Healthcare Scientists	12.7%	14.6%	14.5%	14.0%	↘
Medical and Dental	12.2%	11.8%	11.5%	10.6%	↘
Nursing and Midwifery Registered	18.2%	18.7%	19.6%	19.4%	↘
Whole Trust	**17.3%**	**17.3%**	**17.5%**	**17.5%**	↔



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Oct 2015	
Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	13.6%	14.0%	14.8%	14.9%	↗	2.0%	1.2%
Community Services	15.6%	16.2%	16.8%	16.2%	↘	1.1%	3.5%
Corporate	15.9%	15.0%	14.7%	15.7%	↗	2.1%	2.2%
Estates and Facilities	5.9%	6.6%	8.3%	8.1%	↘	5.2%	2.7%
Medical & Cardiothoracics	15.3%	15.4%	17.2%	17.1%	↘	0.8%	1.2%
Surgery, Neurosciences & Anaes	13.0%	12.3%	12.0%	11.8%	↘	0.5%	1.0%
SWL Pathology	14.6%	15.3%	12.6%	13.2%	↗	0.6%	0.9%
Whole Trust	**14.0%**	**14.0%**	**14.6%**	**14.5%**	↘	**1.4%**	**1.6%**

	Voluntary Turnover					Other Turnover Oct 2015	
Staff Group	Jul '15	Aug '15	Sep '15	Oct '15	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	12.6%	13.2%	14.4%	15.5%	↗	4.2%	0.4%
Additional Clinical Services	16.9%	16.3%	16.9%	16.5%	↘	0.8%	1.9%
Administrative and Clerical	13.2%	12.7%	12.6%	12.4%	↘	1.8%	2.0%
Allied Health Professionals	16.6%	15.9%	15.6%	16.8%	↗	0.1%	0.7%
Estates and Ancillary	5.5%	4.8%	5.4%	5.4%	↔	0.0%	3.2%
Healthcare Scientists	9.9%	11.8%	12.0%	11.5%	↘	0.8%	1.7%
Medical and Dental	6.9%	6.6%	6.7%	5.8%	↘	4.0%	0.8%
Nursing and Midwifery Registered	15.7%	16.3%	17.2%	17.1%	↘	0.6%	1.7%
Whole Trust	**14.0%**	**14.0%**	**14.6%**	**14.5%**	↘	**1.4%**	**1.6%**

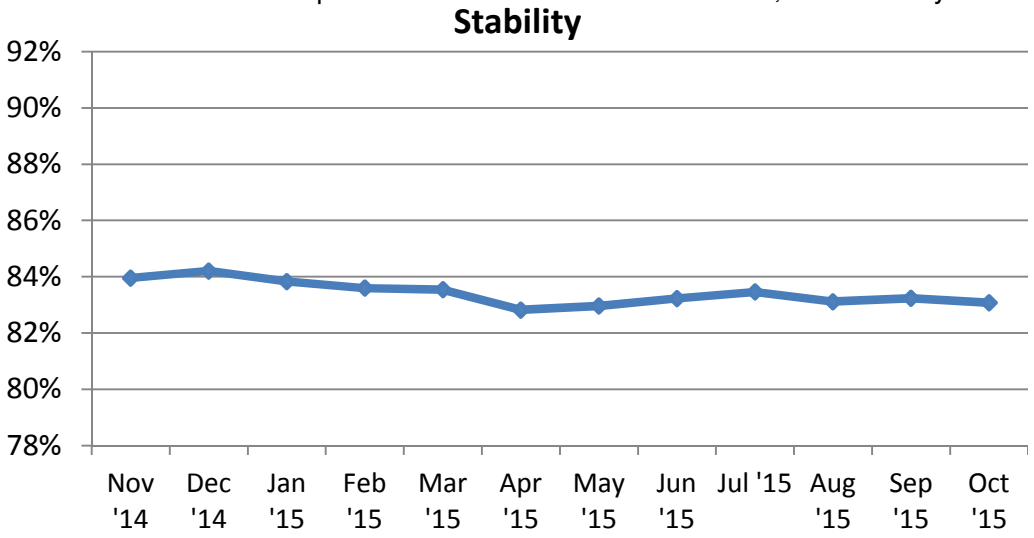
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Cardiac Surgery	92.7	26.8	35.2%
Medical Oncology & Palliative Care	88.4	24.4	32.2%
Gynaecology	43.5	14.1	31.0%
Procurement & Materials Mgmt	39.0	13.0	30.2%
SWLP Microbiology	66.1	21.3	28.6%

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.

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	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	82.8%	83.1%	83.1%	83.0%	↘
Community Services	80.9%	80.1%	79.7%	79.8%	↗
Corporate	82.6%	78.1%	79.1%	78.4%	↘
Estates and Facilities	86.1%	84.9%	85.5%	85.1%	↘
Medical & Cardiothoracics	82.5%	82.1%	81.7%	81.2%	↘
Surgery, Neurosciences & Anaes	85.5%	86.2%	86.2%	86.4%	↗
SWL Pathology	89.4%	89.2%	92.1%	91.0%	↘
Whole Trust	**83.5%**	**83.1%**	**83.2%**	**83.1%**	↘

Stability Staff Group	Jul '15	Aug '15	Sep '15	Oct '15	Trend
Add Prof Scientific and Technic	72.8%	70.4%	70.6%	69.8%	↘
Additional Clinical Services	85.6%	86.3%	83.8%	87.0%	↗
Administrative and Clerical	85.7%	85.5%	85.6%	85.9%	↗
Allied Health Professionals	81.5%	81.9%	83.0%	81.3%	↘
Estates and Ancillary	86.8%	86.7%	88.8%	88.6%	↘
Healthcare Scientists	92.8%	92.3%	92.8%	93.9%	↗
Medical and Dental	89.1%	88.3%	88.3%	90.1%	↗
Nursing and Midwifery Registered	82.5%	82.1%	82.6%	81.3%	↘
Total	**83.5%**	**83.1%**	**83.2%**	**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.

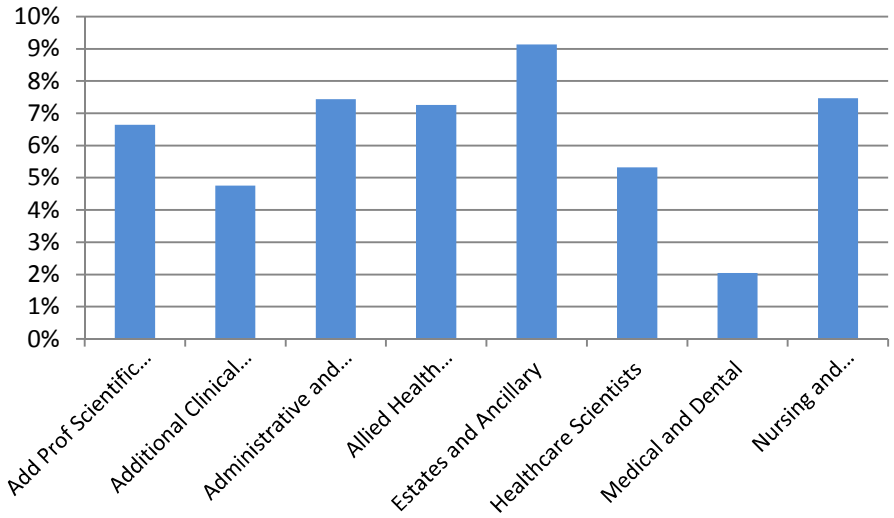
The stability rate has decreased by 0.1% this month.

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 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 October 64 staff were promoted, there were 144 new starters to the Trust and 213 employees were acting up to a higher grade.

Over the last year 6.6% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the SW London Pathology Division followed by the Corporate and Estates & Facilities 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 Nursing & Midwifery staff.

	No. of Promotions				
Division	Jul '15	Aug '15	Sept '15	Oct '15	Trend
C&W Diagnostic & Therapy	15	13	16	21	↗
Community Services	12	16	18	2	↘
Corporate	6	10	5	3	↘
Estates and Facilities	0	0	1	0	↘
Medical & Cardiothoracics	6	17	8	6	↘
Surgery, Neurosciences & Anaes	5	6	11	9	↘
SWL Pathology	0	11	2	23	↗
Whole Trust Promotions	**44**	**73**	**61**	**64**	↗
New Starters (Excludes Junior Doctors)	**83**	**121**	**153**	**144**	↘

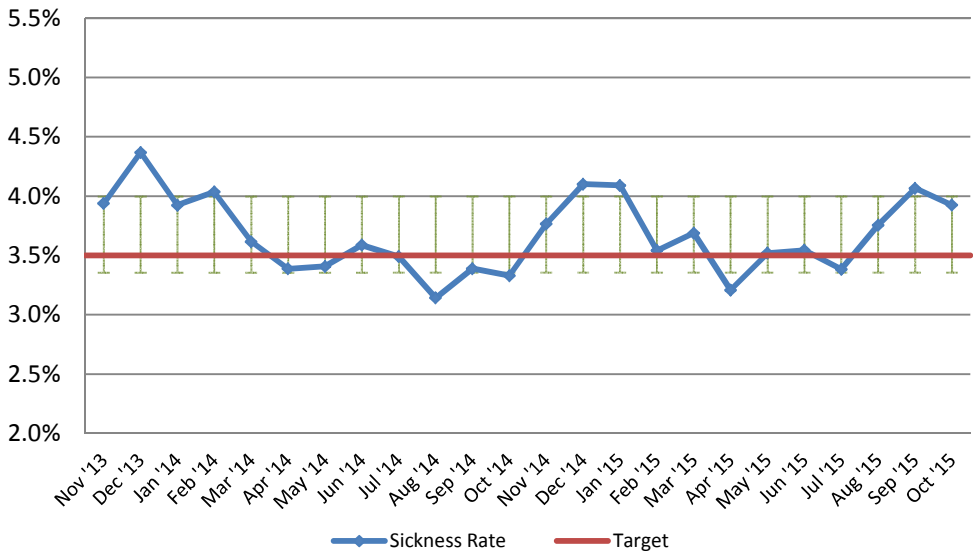
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1902	127	6.7%	102
Community Services	895	47	5.3%	15
Corporate	445	35	7.9%	23
Estates and Facilities	254	18	7.1%	9
Medical & Cardiothoracics	1167	78	6.7%	39
Surgery, Neurosciences & Anaes	1361	75	5.5%	19
SWL Pathology	320	41	12.8%	6
Whole Trust	**6344**	**421**	**6.6%**	**213**
New Starters (Excludes Junior Doctors)		**1453**		

	No. of Promotions				
Staff Group	Jul '15	Aug '15	Sept '15	Oct '15	Trend
Add Prof Scientific and Technic	1	3	7	2	↘
Additional Clinical Services	6	7	4	19	↗
Administrative and Clerical	16	21	15	12	↘
Allied Health Professionals	7	7	9	6	↘
Estates and Ancillary	0	0	1	0	↘
Healthcare Scientists	0	5	1	1	↔
Medical and Dental	1	0	2	2	↔
Nursing and Midwifery Registered	13	30	22	22	↔
Whole Trust	**44**	**73**	**61**	**64**	↗

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	482	32	6.6%	34
Additional Clinical Services	673	32	4.8%	5
Administrative and Clerical	1305	97	7.4%	76
Allied Health Professionals	551	40	7.3%	23
Estates and Ancillary	197	18	9.1%	5
Healthcare Scientists	263	14	5.3%	5
Medical and Dental	488	10	2.0%	3
Nursing and Midwifery Registered	2385	178	7.5%	62
Whole Trust	**6344**	**421**	**6.6%**	**213**

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 3.9% for October, which is a decrease of 0.2% 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 October 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	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	3.0%	3.7%	3.9%	3.9%	↔
Community Services	4.7%	5.7%	5.5%	5.9%	↗
Corporate	2.5%	3.2%	3.6%	3.7%	↗
Estates and Facilities	3.8%	3.9%	4.0%	2.2%	↘
Medical & Cardiothoracics	3.2%	3.9%	4.4%	4.1%	↘
Surgery, Neurosciences & Anaes	3.6%	3.1%	3.4%	3.5%	↗
SWL Pathology	2.6%	2.2%	4.3%	2.1%	↘
Whole Trust	**3.4%**	**3.8%**	**4.1%**	**3.9%**	↘

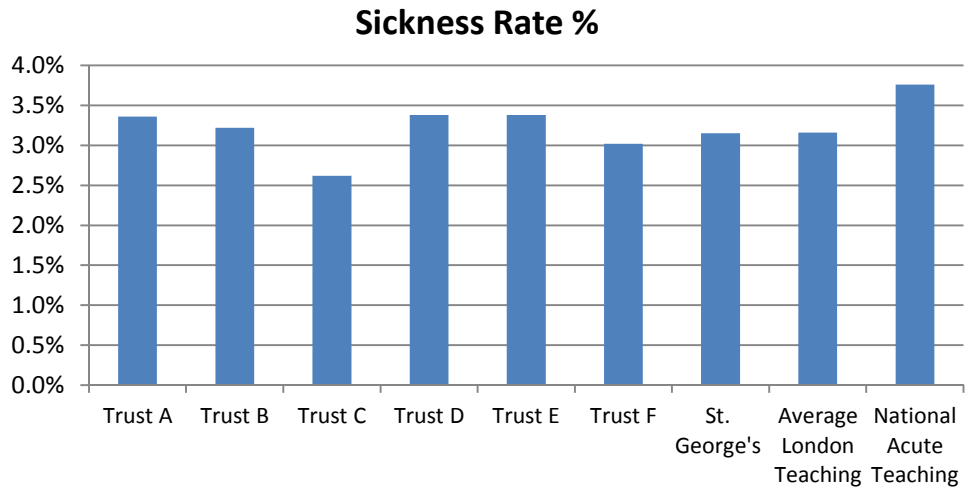
Sickness Staff Group	Jul '15	Aug '15	Sep '15	Oct '15	Trend
Add Prof Scientific and Technic	2.9%	3.6%	3.2%	4.1%	↗
Additional Clinical Services	6.8%	7.1%	7.5%	6.4%	↘
Administrative and Clerical	3.4%	4.2%	4.2%	3.9%	↘
Allied Health Professionals	2.2%	1.9%	2.9%	2.5%	↘
Estates and Ancillary	4.4%	5.6%	5.7%	3.2%	↘
Healthcare Scientists	2.0%	1.4%	3.0%	2.4%	↘
Medical and Dental	1.0%	0.9%	1.2%	1.7%	↗
Nursing and Midwifery Registered	3.7%	4.2%	4.6%	4.6%	↔
Total	**3.4%**	**3.8%**	**4.1%**	**3.9%**	↘

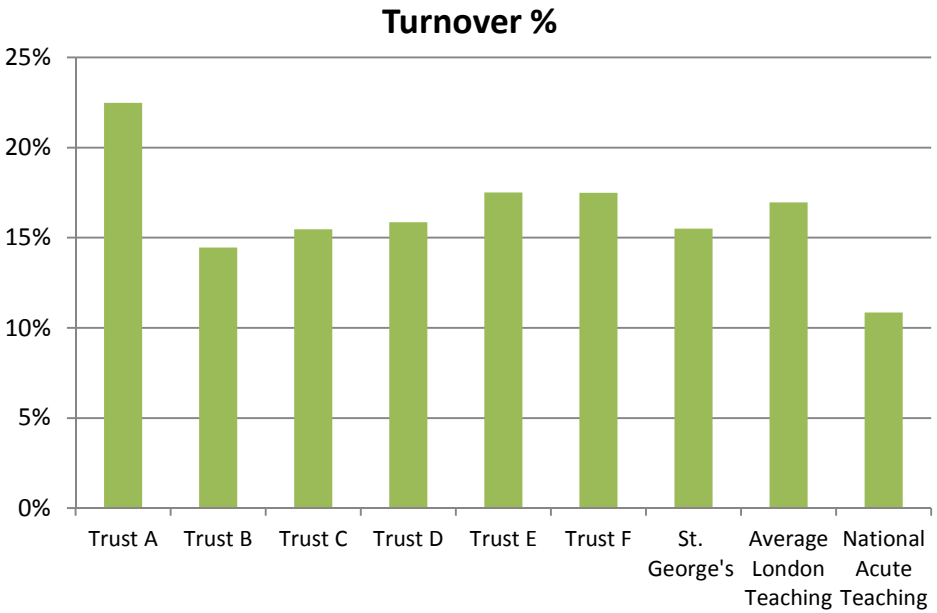
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Procurement & Materials Mgmt	39.00	105.00	8.8%	£7,402
Vascular Surgery	54.20	139.97	8.3%	£12,096
Medicine Directorate Overheads	24.84	54.00	7.3%	£7,528
Cardiac Directorate Overheads	28.27	59.00	7.1%	£5,050
Offender Healthcare HMPW Services	56.42	121.22	7.1%	£12,278

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	34.80%
S25 Gastrointestinal problems	16.13%
S12 Other musculoskeletal problems	7.14%
S10 Anxiety/stress/depression/other psychiatric illnesses	6.18%
S11 Back Problems	5.49%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	21.46%
S10 Anxiety/stress/depression/other psychiatric illnesses	13.95%
S12 Other musculoskeletal problems	12.99%
S25 Gastrointestinal problems	9.42%
S11 Back Problems	7.56%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from July '15 which is the mot recent available. Compared to other Acute teaching trusts in London, St. Georges had a slightly lower than average rate at 3.15%. 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 July.

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 August). 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 4.6% 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	22.49%	77.96%	3.36%
Trust B	14.46%	85.02%	3.22%
Trust C	15.47%	84.13%	2.62%
Trust D	15.86%	83.84%	3.38%
Trust E	17.52%	82.65%	3.38%
Trust F	17.49%	82.20%	3.02%
St. George's	15.50%	84.18%	3.15%
Average London Teaching	16.97%	82.85%	3.16%
National Acute Teaching	10.85%	88.94%	3.76%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	1068.5	1069.5	1098.6	1094.9	↘
Community Services	569.3	569.5	583.1	596.4	↗
Corporate & R&D	59.9	68.2	68.2	94.2	↗
Medical & Cardiothoracics	1268.1	1248.3	1248.3	1246.1	↘
Surgery, Neurosciences & Anaes	1097.7	1111.7	1152.0	1151.0	↘
Total	4063.5	4067.2	4150.2	4182.6	↗

Nursing Staff in Post WTE

Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	984.0	973.1	982.8	1007.4	↗
Community Services	466.5	461.2	447.7	441.6	↘
Corporate & R&D	50.0	46.0	46.0	52.5	↗
Medical & Cardiothoracics	994.3	985.9	985.8	986.0	↗
Surgery, Neurosciences & Anaes	897.6	906.8	899.2	906.5	↗
Total	3392.4	3373.0	3361.5	3394.0	↗

Nursing Vacancy Rate

Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	7.9%	9.0%	10.5%	8.0%	↘
Community Services	18.1%	19.0%	23.2%	26.0%	↗
Corporate & R&D	16.4%	32.5%	32.5%	44.2%	↗
Medical & Cardiothoracics	21.6%	21.0%	21.0%	20.9%	↘
Surgery, Neurosciences & Anaes	18.2%	18.4%	21.9%	21.2%	↘
Total	16.5%	17.1%	19.0%	18.9%	↘

Nursing Sickness Rates

Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	4.1%	5.3%	5.6%	5.6%	↗
Community Services	5.3%	6.3%	6.4%	6.7%	↗
Corporate	1.6%	3.5%	4.5%	8.4%	↗
Medical & Cardiothoracics	4.0%	4.4%	5.3%	4.6%	↘
Surgery, Neurosciences & Anaes	5.1%	4.2%	4.2%	4.2%	↘
Total	4.4%	4.8%	5.2%	5.1%	↘

Nursing Voluntary Turnover

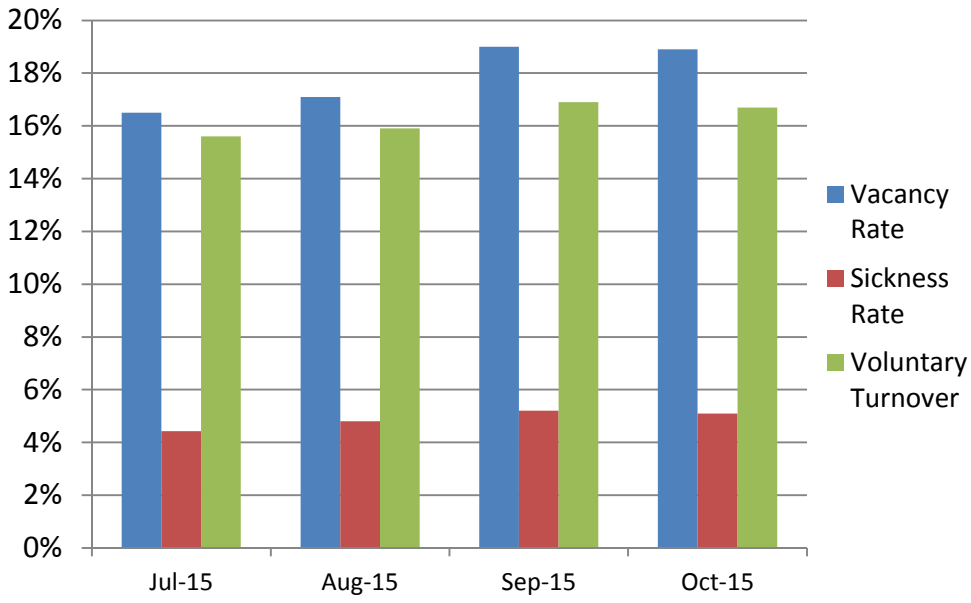
Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	14.11%	14.81%	15.59%	15.43%	↘
Community Services	16.61%	18.23%	19.38%	18.14%	↘
Corporate & R&D	16.97%	15.37%	14.88%	13.53%	↘
Medical & Cardiothoracics	17.46%	17.97%	19.82%	20.01%	↗
Surgery, Neurosciences & Anaes	14.42%	13.49%	13.72%	13.70%	↘
Total	15.5%	15.9%	16.9%	16.7%	↘

COMMENTARY

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

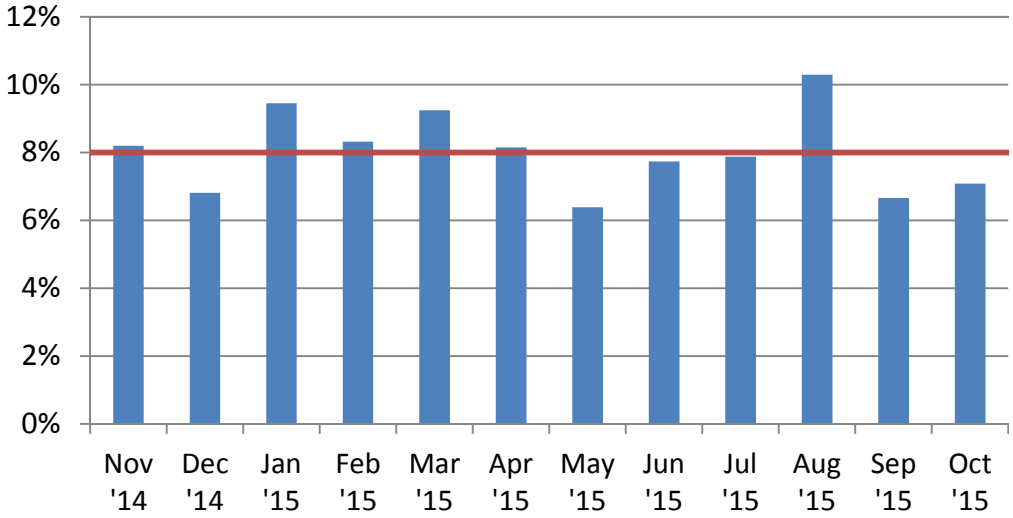
The nursing workforce has increased by 33 WTE in October. The output of the review of nursing establishments will be a revised trajectory for demand for nursing.

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 0.4% since September. The agency costs including Interims rose slightly by £83K. Excluding the interims, costs fell by £150K so movement was mostly due to interims supporting turnaround, other "business as usual" agency spend was down.

Currently, the highest percentage spend is seen in the Corporate Division. The highest actual spend is seen in Medicine and Cardiothoracics at £646K for October.

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

The agency cost data does not appear to reflect known usage. KPMG are supporting a detailed review of how costs are reported.

Agency % Spend by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	4.6%	8.4%	5.4%	5.8%	↗
Community Services	10.0%	3.5%	9.6%	8.7%	↘
Corporate	12.0%	17.1%	5.8%	17.5%	↗
Estates and Facilities	8.5%	9.3%	3.2%	1.4%	↘
Medical & Cardiothoracics	9.1%	10.2%	8.8%	7.7%	↘
Surgery, Neurosciences & Anaes	3.1%	6.9%	3.8%	3.1%	↘
Whole Trust	**7.9%**	**10.3%**	**6.7%**	**7.1%**	↗

Agency Costs £ by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	£460,175	£879,472	£558,470	£585,555	↗
Community Services	£421,845	£669,773	£397,852	£343,807	↘
Corporate	£725,851	£439,482	£141,546	£439,776	↗
Estates and Facilities	£95,853	£100,971	£36,523	£14,450	↘
Medical & Cardiothoracics	£814,214	£888,472	£756,538	£645,649	↘
Surgery, Neurosciences & Anaes	£266,435	£603,013	£336,308	£261,656	↘
Whole Trust	**£3,412,750**	**£3,944,780**	**£2,519,156**	**£2,602,456**	↗

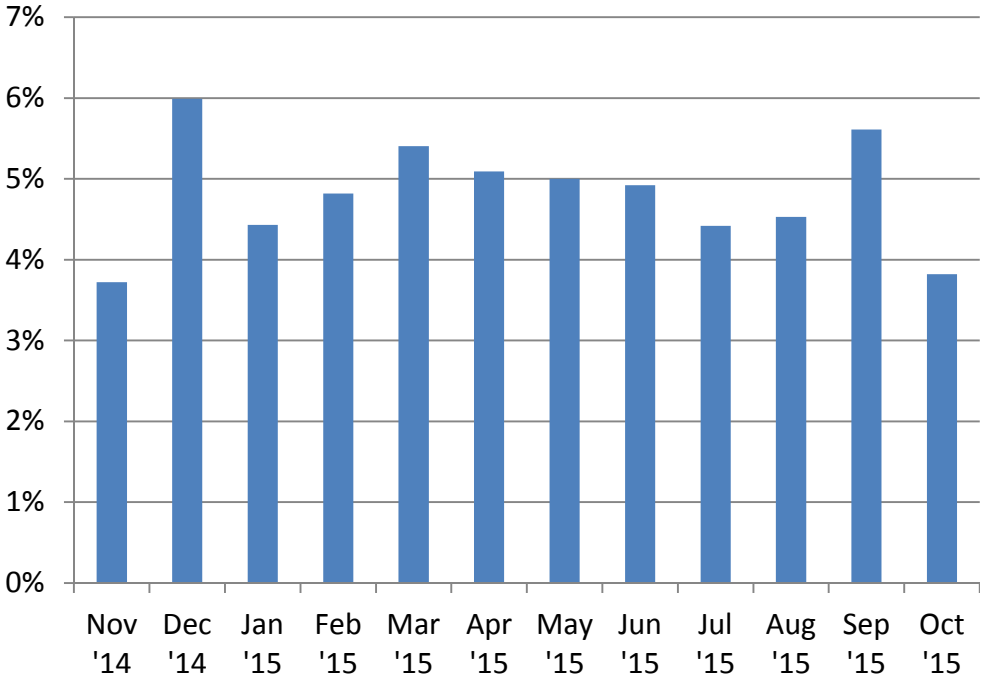
Care Group	Agency Spend % Oct-15	Staff In Post WTE
Finance Directorate	39.8%	114.3
Computing Directorate	31.0%	49.7
Offender Healthcare HMPW Servi	28.8%	56.4
Procurement & Materials Mgmt	26.0%	39.0
Obstetrics	16.9%	293.1

Booking Reason	Medical Agency & Bank £ Oct-15	%
Annual Leave AL	£0	0.00%
Increased Care Needs ICN	£2,683	0.62%
Maternity Leave ML	£0	0.00%
Sickness S	£13,112	3.02%
Study Leave SL	£0	0.00%
Vacancy V	£418,527	96.36%
Total	**£434,322**	**100.00%**

Nursing & Midwifery Staff Group	Jul '15	Aug '15	Sep '15	Oct '15
Agency Spend %of Paybill	9.10%	12.61%	10.24%	9.59%
Agency Spend £	£1,152,439	£1,644,350	£1,350,555	£1,204,270

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 decreased by 1.8% between September and October.

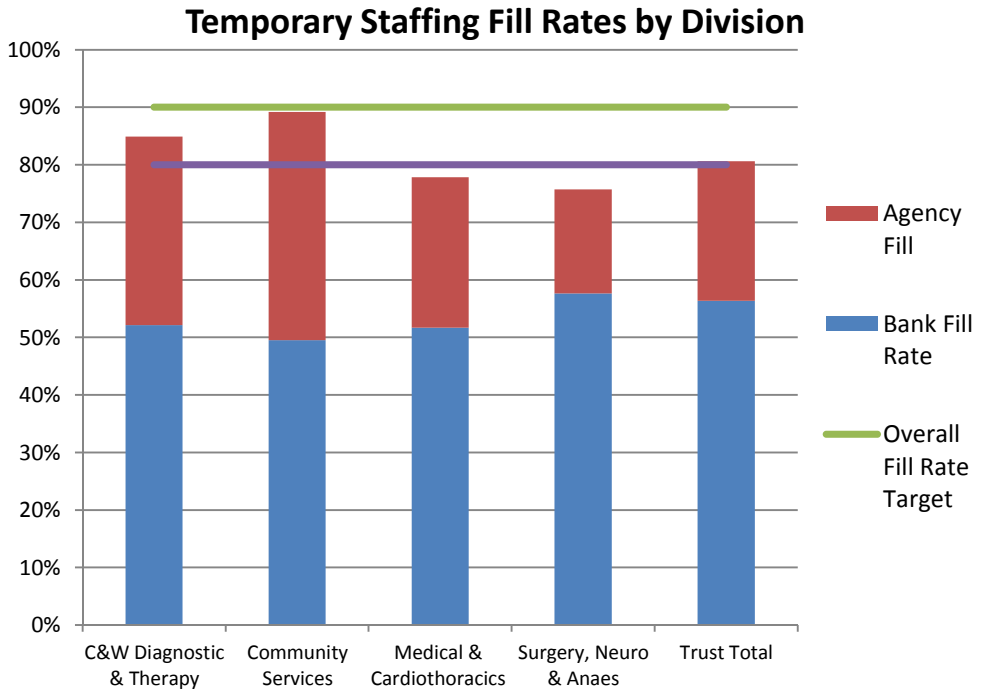
In October, the analysis of actual hours worked shows an increase in Admin & Clerical staff in Children and Women's outpatient clinics. Nursing & Midwifery bank hours were higher than September across all Divisions apart from the Medicine and Cardiothoracics Division which saw a reduction of 500 hours.

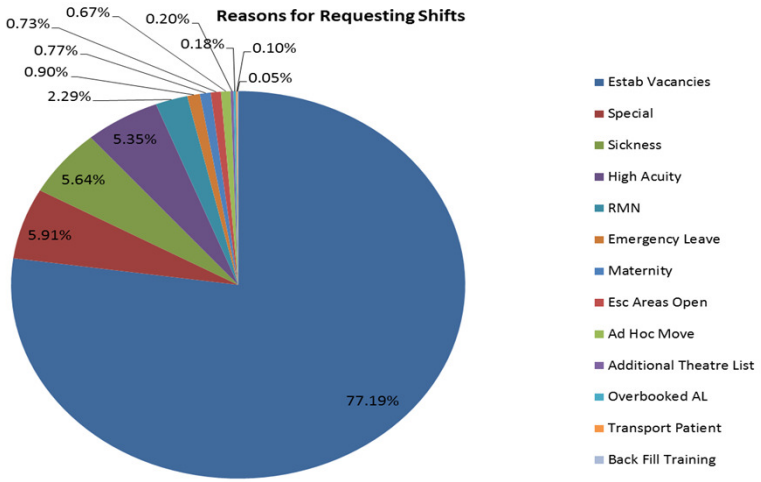
The table below lists the five care groups with the highest bank percentage spend for this month.

Bank Spend % by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	10.0%	4.7%	6.0%	5.2%	↘
Community Services	3.5%	3.5%	5.0%	3.3%	↘
Corporate	4.4%	3.7%	8.3%	0.6%	↘
Estates and Facilities	10.2%	8.3%	13.1%	9.0%	↘
Medical & Cardiothoracics	5.4%	6.9%	5.5%	3.8%	↘
Surgery, Neurosciences & Anaes	3.4%	2.4%	4.7%	2.9%	↘
Whole Trust	**4.4%**	**4.5%**	**5.6%**	**3.8%**	↘

Care Group	Bank Spend % Oct-15	Staff In Post WTE
Facilities Services	19.4%	111.2
Pharmacy	17.8%	170.8
Outpatients	17.2%	265.4
Offender Healthcare HMPW	10.7%	56.4
SWLP Central Reception	10.3%	47.8

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 October the Bank Fill Rate was reported at 58.1% which is 2.4% higher than the previous month. The Overall Fill Rate was 81.6% which is an increase of 1.8% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

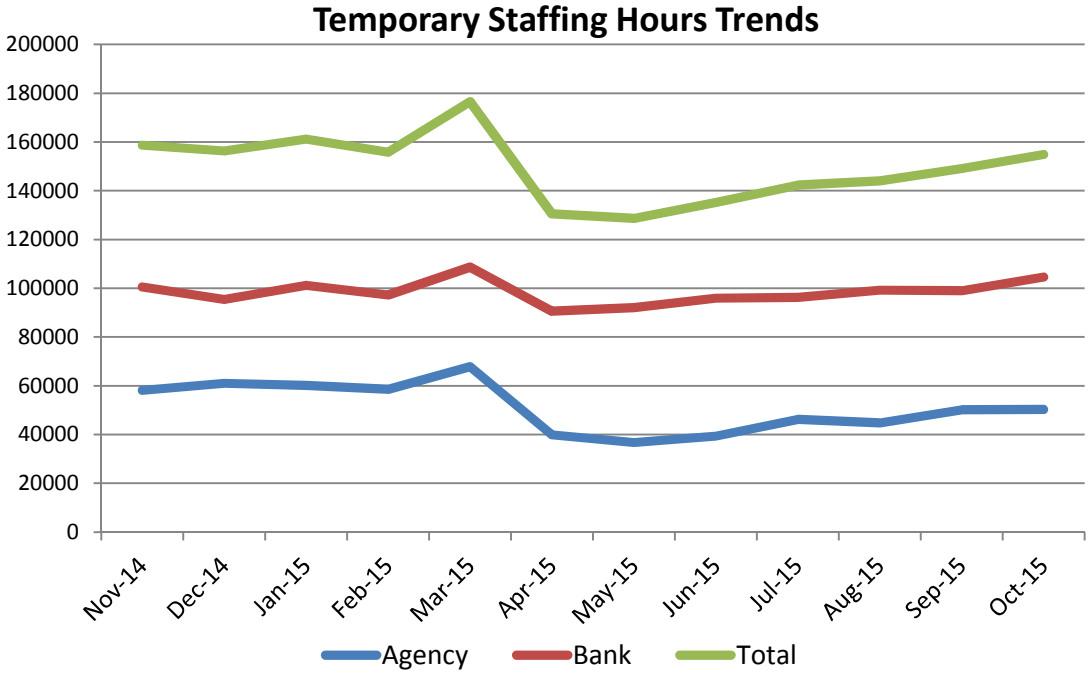
The pie chart shows a breakdown of the reasons given for requesting bank shifts in October. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	63.4%	68.1%	66.3%	65.3%	↘
Community Services	49.8%	50.8%	48.6%	49.7%	↗
Medical & Cardiothoracics	47.7%	47.7%	44.1%	46.2%	↗
Surgery, Neurosciences & Anaes	52.5%	50.9%	53.0%	50.3%	↘
Whole Trust	**56.2%**	**56.8%**	**55.7%**	**58.1%**	↗

Overall Fill Rate % by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	80.0%	85.8%	83.9%	81.9%	↘
Community Services	87.8%	86.3%	86.5%	88.2%	↗
Medical & Cardiothoracics	79.9%	78.8%	80.0%	79.4%	↘
Surgery, Neurosciences & Anaes	77.1%	74.9%	76.7%	76.8%	↗
Whole Trust	**78.9%**	**79.5%**	**79.8%**	**81.6%**	↗

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. Bank & agency hours have both increased in October. The most significant increases are seen in the Children & Women's Division where agency usage has increased in the Intensive Therapy Unit and bank hours are higher in outpatients as clerical staff move from agency to bank.

TYPE	Division	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Agency	C&W Diagnostic & Therapy	18378	17489	15550	15363	16791	9525	10750	8656	9638	9210	9921	11066
	Community Services	6333	6146	6208	7800	9890	7938	5769	5245	6077	6422	6421	6977
	Corporate	4061	3772	3454	2763	3488	1246	1331	949	529	32	423	402
	Estates and Facilities	0	0	0	0	0	0	0	0	0	0	0	4
	Medical & Cardiothoracics	18614	22515	24387	21773	25876	14492	13202	17823	20429	20285	24408	21668
	Surgery, Neurosciences & Anaes	10732	11041	10454	10809	11833	6582	5462	6386	9195	8560	8620	9898
	SWL Pathology	0	0	0	0	0	119	204	241	228	237	352	267
Agency Total		**58118**	**60964**	**60053**	**58508**	**67877**	**39901**	**36717**	**39299**	**46097**	**44746**	**50145**	**50282**
Bank	C&W Diagnostic & Therapy	26759	26979	28329	27388	31536	27789	28714	29038	25990	26258	28178	32502
	Community Services	10996	11092	10097	9360	10560	8379	7619	7704	8252	9030	8659	9068
	Corporate	7373	7706	7766	7248	7922	7424	7165	8430	7972	7321	11048	11144
	Estates and Facilities	7050	6867	7446	6807	7744	6885	7502	8178	9216	8910	8264	8496
	Medical & Cardiothoracics	27769	24451	25548	25083	27553	23755	24829	24969	26255	29159	26958	26269
	Surgery, Neurosciences & Anaes	17994	15382	18855	18438	20376	13521	13495	14553	14740	15202	15268	16268
	SWL Pathology	2619	2901	3134	2947	2953	2753	2620	3052	3751	3314	638	821
Bank Total		**100559**	**95376**	**101175**	**97272**	**108643**	**90507**	**91944**	**95925**	**96177**	**99193**	**99013**	**104568**
Temporary Staff Total		**158677**	**156340**	**161227**	**155780**	**176520**	**130408**	**128661**	**135224**	**142273**	**143940**	**149157**	**154850**

Section 11: Temporary Staffing Weekly Tracking

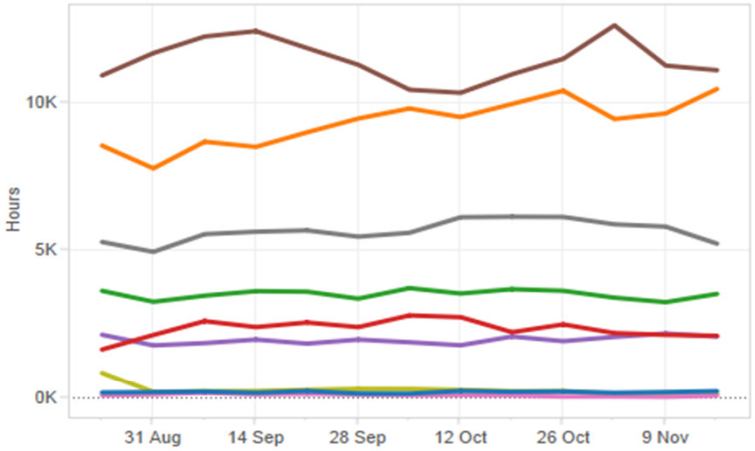
Weekly Hours Used By Division

Division	24 Aug	31 Aug	07 Sep	14 Sep	21 Sep	28 Sep	05 Oct	12 Oct	19 Oct	26 Oct	02 Nov	09 Nov	16 Nov
Capital Division	164	178	198	153	214	130	126	215	186	198	151	176	209
Children and Women's Diagnostic and Th..	8,540	7,772	8,673	8,498	8,991	9,456	9,797	9,506	9,949	10,397	9,439	9,628	10,454
Community Services Division	3,632	3,262	3,468	3,621	3,603	3,367	3,724	3,540	3,688	3,633	3,400	3,248	3,527
Corporate Division	1,647	2,138	2,607	2,405	2,560	2,404	2,801	2,741	2,232	2,496	2,202	2,142	2,111
Estates and Facilities Division	2,146	1,786	1,863	1,984	1,846	1,983	1,892	1,791	2,088	1,928	2,074	2,188	2,083
Medicine and Cardiovascular Division	10,915	11,669	12,229	12,411	11,839	11,275	10,430	10,327	10,952	11,474	12,606	11,245	11,091
Research & Development Division	67	100	152	97	114	91	69	76	66	24	27	16	59
Surgery & Neurosciences Division	5,283	4,949	5,548	5,631	5,676	5,463	5,595	6,120	6,138	6,130	5,880	5,803	5,228
SWL Pathology Division	846	183	208	212	255	286	283	252	206	210	117	109	109
Grand Total	33,238	32,036	34,944	35,011	35,097	34,454	34,715	34,567	35,504	36,490	35,895	34,554	34,871

Type
- Agency
- Bank

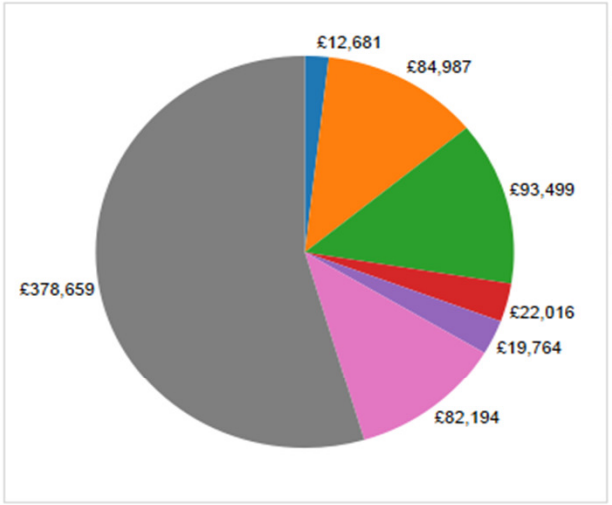
Division
- Capital Division
- Children and Women's D..
- Community Services Divi..
- Corporate Division
- Estates and Facilities Div..
- Medicine and Cardiovasc..
- Research & Developmen..
- Surgery & Neuroscience..
- SWL Pathology Division

Weekly Hours Used Trends



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



Total Cost
£693,800

Select Date (W/C)
16/11/2015

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

Staff Group
- Add Prof Scientific
- Additional Clinical Servic..
- Admin & Clerical
- Allied Health Professiona..
- Estates & Facilities
- Healthcare Scientists
- Medical & Dental
- Nursing & Midwifery

Section 12: Mandatory Training

MAST Topic	Sep '15	Oct '15	Trend
Conflict Resolution	73.2	73.3	↗
Equality, Diversity and Human Rights	76.4	75.9	↘
Fire Safety	71.1	70.8	↘
Health, Safety and Welfare	75.6	75.0	↘
Infection Prevention and Control Clinical	58.1	57.0	↘
Infection Prevention and Control Non Clinical	67.8	68.3	↗
Information Governance	60.3	59.9	↘
Moving and Handling	69.7	68.8	↘
Moving and Handling Patient	50.2	48.2	↘
Resuscitation BLS	41.2	40.7	↘
Resuscitation ILS	52.9	50.6	↘
Resuscitation Non Clinical	59.1	59.7	↗
Safeguarding Adults	72.7	72.2	↘
Safeguarding Children Level 1	71.7	72.0	↗
Safeguarding Children Level 2	72.2	70.8	↘
Safeguarding Children Level 3	71.9	69.3	↘

MAST Compliance % by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	73.6%	70.4%	68.4%	67.8%	↘
Community Services	72.9%	70.4%	70.1%	68.8%	↘
Corporate	68.8%	64.1%	65.4%	66.1%	↗
Estates and Facilities	64.9%	64.5%	61.9%	61.9%	↘
Medical & Cardiothoracics	64.4%	60.8%	61.6%	61.4%	↘
Surgery, Neurosciences & Anaes	68.5%	65.9%	66.5%	65.2%	↘
Whole Trust	71.0%	67.8%	67.2%	66.6%	↘

COMMENTARY

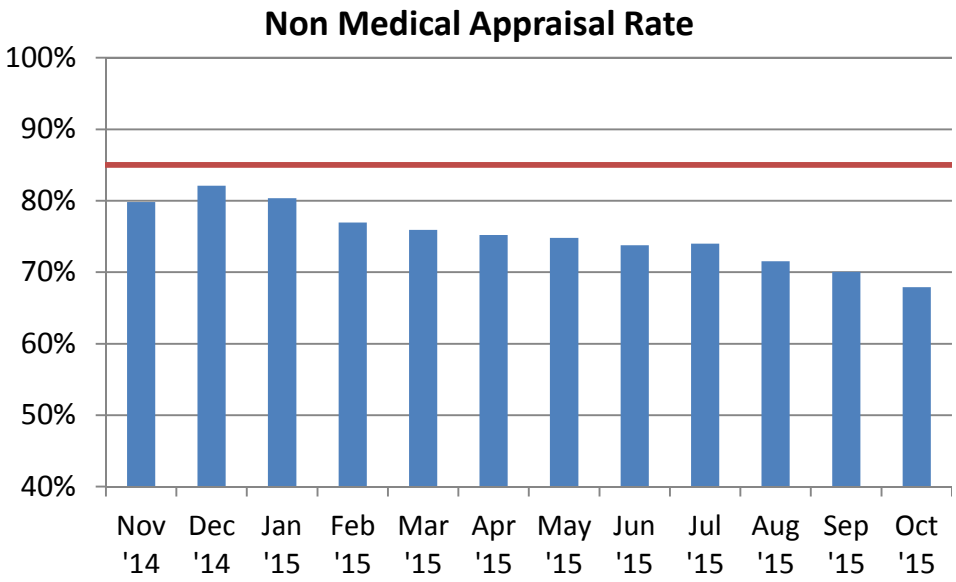
A programme of working is taking place including:

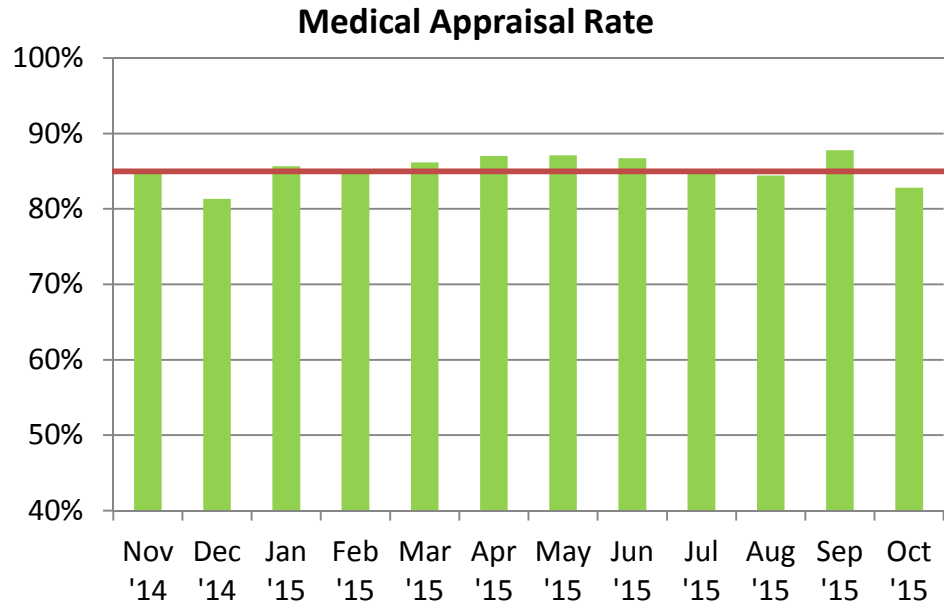
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Providing and accessible on-line system
- Introduced monthly meetings where divisions report on progress 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.
- Not enough capacity to provide the training for the needs identified, particularly in resuscitation.

Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 2.1% this month to 67.9%. 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 82.8% which is still above target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Energy and Engineering	2.7%	49.00
SWLP Biochemistry	32.2%	60.35
Procurement & Materials Mgmt	33.3%	39.00
Obstetrics	33.6%	293.12
Finance Directorate	35.0%	114.35

Non Medical Appraisals by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	73.7%	69.2%	69.0%	68.1%	↘
Community Services	76.0%	72.8%	68.2%	64.9%	↘
Medical & Cardiothoracics	77.8%	74.8%	73.6%	71.6%	↘
Surgery, Neurosciences & Anaes	75.1%	75.2%	74.5%	76.2%	↗
Corporate	66.8%	63.6%	64.3%	53.7%	↘
Estates & Facilities	74.7%	77.7%	64.0%	64.0%	↔
Whole Trust	**74.0%**	**71.5%**	**70.0%**	**67.9%**	↘

Medical Appraisals by Division	Jul '15	Aug '15	Sep '15	Oct '15	Trend
C&W Diagnostic & Therapy	82.6%	84.1%	86.9%	83.5%	↘
Community Services	69.6%	84.0%	84.0%	79.4%	↘
Medical & Cardiothoracics	91.2%	85.2%	87.7%	83.5%	↘
Surgery, Neurosciences & Anaes	88.8%	84.3%	87.7%	81.4%	↘
Corporate	50.0%	100.0%	100.0%	75.0%	↘
Whole Trust	**85.1%**	**84.4%**	**87.8%**	**82.8%**	↘

St George's University Hospitals NHS
NHS Foundation Trust

Workforce & Education Committee Meeting of 19 November 2015

Report of Stella Pantelides, Chair

Workforce Plan / HR Strategy

The Committee requested that from 16/17 onwards the trust achieves close alignment between activity and associated costs, of which workforce costs form a significant part. It was acknowledged that complete alignment could not have been achieved for prior years given that not all staff growth had been planned. However, in the light of PWC recommendations and support from KPMG, alignment should now be a feasible objective.

The Committee also requested that as part of the wider strategic refresh (2 year and five year plan) the HR Director and other executives evaluate the workforce implications of any agreed strategic shifts and reflect those in a refreshed HR Strategy Implementation Plan. In particular the Committee advised that:

- Activity is focused on a smaller number of priority issues (recruitment/retention, communications, morale, provision of accommodation, if judged feasible).
- Resources are diverted away from initiatives that have proven to be ineffective.
- Activity that has strong potential to impact positively on important KPIs (such as the leadership development programme) continues to be invested in.

ESR Finance System Reconciliation

Anna Anderson (an interim manager) attended the meeting for this item. Anna explained that she had been charged with developing a sustainable solution to this issue, reporting to the Director of Finance. In response to questions Anna confirmed that:

- The Finance Director is the Senior Officer responsible for ensuring the integrity of the data in the two systems.
- At month 6 the residual discrepancy between the two systems stood at 56 WTE.
- A clear (albeit complex) workflow had been developed to regulate data entry into the two systems.
- A process of monthly reconciliation had been instituted which will ensure that discrepancies are dealt with as they occur.

Anna considered that it would be unrealistic to commit to elimination of all discrepancies. However, she assured the Committee that the processes in place now, if adhered to, will ensure that the number of discrepancies at any point in time will remain very small.

Control of temporary staff

Wendy Brewer referred to the paper tabled at the October public board which set out by staff group the measures that are being taken to achieve full control over temporary staff use and costs.

The Committee asked whether the deadlines for compliance referred to in that paper had been met.

Wendy explained that of all staff groups, the most compliant is nursing. For all other staff groups there are now clear policies that users of temporary resource must comply with. Compliance is being monitored and the performance management mechanisms will be used where compliance is found to be poor.

Wendy explained that the effectiveness of the trust's efforts to reduce dependence on temporary resource is also impacted by the supply of resource, government policy (e.g. enforcement of caps) and a number of external factors. All of these are being monitored as is the response of other comparable trusts to the same challenges.

Chair's comment to Board: The Board should note that good progress has been made in clarifying the policy and accountability framework and putting in place systems and processes that have the potential of ensuring convergence between ESR/general ledger and control of temporary staff use and costs. None of the above is however failsafe. The extent of their success will depend on whether:

(a) divisional managers and staff adhere to the frameworks that have been put in place;
(b) senior divisional and executive leaders monitor and, if necessary, effect compliance through the trust's performance management processes.

If compliance is lax and/or performance management is weak, there continues to be a risk that data sets will diverge and control over the trust's pay costs becomes loose again.

Staff Turnover

The Committee received action plans from the remaining two clinical divisions, CWTD and CSD, setting out what each division is proposing to do and, in many cases is already doing, to reduce staff turnover.

In summary, three of the four clinical divisions have produced granular plans that connect specific causes of staff turnover (identified through exit interviews, the staff survey or other local management processes) to specific actions. The actions go down to ward/care group level and hold named individuals accountable for delivering them by specific dates. CSD is the only division whose plans are still at the diagnostic stage. This is disappointing as this is the division with the highest turnover. It is understood that the Chief Nurse and interim COO will be providing support to the management of this division which will include focus on its chronic staff turnover issues.

Chair's comment to board: It took a considerable amount of time to get to the stage at which divisions (with the exception of Community Services) could specify precisely what they need to do to stem the rising voluntary outflow of staff. Although divisions may not

have control over the overall organisational climate or the external opportunities that may be available to staff, it is well evidenced that in more than 50% of the cases it is the level of skill and behaviours of their managers that contribute to high turnover. Divisions now have granular plans in place to address these issues. The Committee sought and obtained assurance that the implementation of these plans will receive comparable attention to the implementation of their CIP schemes. (Reducing turnover drastically could be the most promising CIP scheme of all). As with control over pay costs, success will depend of divisional actions and effective executive oversight of those actions via the trust's performance management framework.

Education

Sarah James presented the Annual Education and Development Review for 14/15 in which the output of the Department was set out against a very challenging environment of diminishing funding, high operational pressures that stretch commitment to teaching, restrict release of staff and compromise mandatory training compliance rates.

The Committee praised Sarah for an impressive output notwithstanding the difficulties described in her report. The Committee advised some reflection though, before embarking on an even more ambitious work plan for 16/17. Clarity was sought on the following:

1. Governance: Role, scope and leadership of the Education Board; relationship with Workforce and Education Committee; visible involvement of the Trust's executive and of the board in the formulation of the Education Strategy. (Example of decision to become Lead Employer for all South London GPs in Training, with the implication of taking on 500 GP trainees in 2015, more than trebling the annual intake of trainees in the trust. What was the strategic intent behind it? Who assessed its resourcing and financial implications? Was there a business case? Who approved it?)
2. Enhanced transparency over who receives the educational income, how it translates to training activity and what the associated costs are. It is understood that the Commercial Board has made a comparable request to the Education and Development Department, in the light of the very substantial education and training income that the trust continues to attract.
3. Additional income: In the light of the successful example set by the simulation centre, where else can the trust derive additional income from?
4. Re-focusing of 16/17 plan: In the light of the considerable resource and funding constraints, the Committee requested that the Department focuses on a smaller number of activities than indicated in their current plan. These should directly support critical strategic objectives such as improved recruitment and retention, service re-design and whatever else emerges as a priority from the strategic refresh.

Wendy Brewer agreed to take these issues to her Executive colleagues and come back to the Committee in January with a paper charting the proposed direction for Education and Development for 16/17 and beyond.

The Committee dealt with a number of other issues on its agenda which will be summarized in the minutes of the meeting.

Stella Pantelides

27.11.2015

Name and date of meeting:

TRUST BOARD 4TH DECEMBER 2015

Document Title:

Annual (Operational) Plan Q2 monitoring report

Action for the Trust Board:

To note the detailed progress report against the objectives and associated actions that underpin delivery of our strategy, and to consider the critical path progress report against the top priorities set by the Board.

Introduction:

The Annual Plan document was approved by the board in April, subjected to further amendments to the corporate objectives proposed by the board, council of governors and patient reference group; and final updates to the narrative to ensure coherence with the annual report; and was submitted to Monitor on 15th May 2015 (the 14th May deadline was extended for a further day).

The corporate objectives were qualified within the document as follows: "The priorities represent the trust's plan for 2015/16 at the time of writing this document; the outcome of the strategic and service line reviews, and the outputs of the work around financial viability, may result in the trust reconsidering its priorities during the year."

The Board considered Q1 progress towards delivery of the Annual Plan in July, this Q2 report was rescheduled from the early November board meeting.

Progress report:

The Annual Plan is the primary delivery vehicle for the trust's strategy and the objectives and actions are presented within the strategic themes.

The Q2 detailed report on our granular progress towards delivery of the annual plan is attached to this cover paper as a separate document (Appendix 1).

The dashboard on the following page below highlights the key issues and presents an appraisal on performance against the objectives and associated actions associated with each strategic theme.

The Board requested that we also develop a critical path approach to monitoring the annual plan, highlighting those key milestones that would give assurance on delivery against these priorities.

The critical path appraisal is shown on the page following the objective based dashboard.

Annual Plan dashboard – Q2 performance summary

Theme	Commentary	Q2 Rating
0. Overall Progress	6 themes – 3 green, 2 (Q1 3) amber, 1 (Q1 0) red 34 objectives – 18 (Q1 16) green, 13 (Q1 17) amber, 3 (Q1 1) red	↔
1. Redesign care pathways to keep more people out of hospital	6 objectives – 4 green, 1 amber, 1 red; no change from Q1 Community and Adult Health service – response to revised specification in progress; Marsden vanguard bid successful; A&E and RTT targets not met.	↔
2. Redesign and reconfigure our local hospital services	5 objectives – 1 green, 2 amber, 2 red; net change -2 amber +2 red Slippage in capacity schemes; 5th floor scheme reprogrammed to 2016 (now red due to interdependencies); private patient strategy in progress (PPU project now red); Nelson implementation still slow though income recovery scheme in progress (remains at amber); SWL acute provider work progressing well (green)	↓
3. Consolidate and expand our key specialist services	5 objectives – 3 green, 2 amber, 0 red; net change +1 green -1 amber Renal scheme delayed due to link with PPU (amber); MacMillan partnership now in implementation phase; Neurosciences – beds open / new prof appointed / rehab strategy progressing (both objectives now green).	↔
4. Drive research and innovation	4 objectives – 2 green, 2 amber, 0 red; net change -1 green +1 amber R&D strategic objective stalling (now amber); Cardiology CAG key posts appointed; Fetal medicine professorial appointments made; key commercial projects progressing well.	↓
5. Improve productivity, the environment and systems to enable excellent care	9 objectives – 5 green, 4 amber, 0 red; no net change from Q1 Good progress on EDM, e-triage and e-referral (objective now green); Outpatient strategy revised 10-week programme; Flow programme continues, linked to winter preparedness; follow-up to diagnostic tests compliance due December; Sign up to Safety funding bid unsuccessful (objective now amber).	↔
6. Develop a highly skilled and engaged workforce championing our values	5 objectives – 3 green, 2 amber, 0 red; net change +2 green -2 amber Leadership development programme approved (now green); OD programme accelerating (now green); values - staff feedback continues to highlight behaviours as an issue (now amber); bank / agency usage decreasing (now green); SWL shared bank programme progressing.	↑

Annual Plan critical path appraisal – Q2 performance summary and Q3 forecast

	Q1 report	Q2 report	Q3 forecast	Q4 forecast
Strategic plan	SLR	SLR	SLR	SLR
	PPE post 2013 investments	Wider scope investment review	2016/17 business planning	2016/17 annual plan
	SWL acute provider scoping	SWL APC report & Vanguard	SWL APC workshops	SWL strategy
		Radical service redesign	Strategy refresh	5 year plan
Capacity and	QMH beds	7 beds / Hybrid theatre	55-70 beds / 7 ICU	Rehab strategy + beds
Flow	Re-profile	Winter planning	Winter delivery	Winter delivery
(Income)				
Quality - outcomes,	Audit programme		Publish clinical outcome indicators	
safety,	Sign up to Safety planning	Implement safe environments action plans	Complete implementation of process to reduce avoidable harm	
Experience	MacMillan partnership	Outpatient strategy scoping	Cancer services redesign starts	Outpatient strategy implementation
(Operational performance)				
Leadership / OD	Leadership scoping	OD programme	Leadership programme	
Workforce	Workforce controls	International recruitment↓	HR processes	
Financial viability	CIP development	Grip	Optimise	Grow

Overall position				

Conclusion:

The trust set 34 corporate objectives for 2015/16:

- 18 are RAG rated as Green at quarter 2,
- 13 as Amber, and
- 3 Red.

Of the 6 strategic themes, 3 are RAG rated as Green, 2 at Amber and 1 Red.

Overall performance, when measured quantitatively against these objectives, would therefore be assessed as **Amber / Red** (Amber in Q1).

However, the appraisal of the priorities articulated within the main body of the Annual Plan, how they impact on income and operational performance, and what we consider the resultant overall organisation position to be would lead to a **Red** assessment (Red in Q1).

The Board is asked to consider the assessments arising from these different approaches, and note both the on-going work around Turnaround, and the consequential impact on prioritisation.

Author and Date:	Rob Elek, Director of Strategy	20th November 2015
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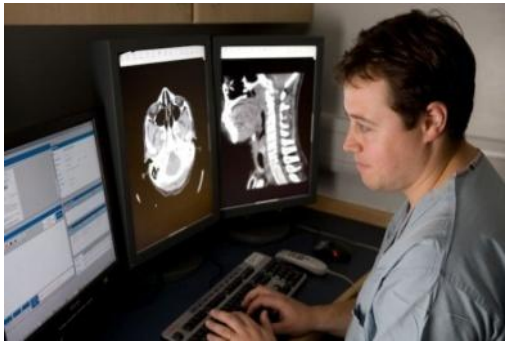
St George's University Hospitals NHS
NHS Foundation Trust

ST GEORGE'S HEALTHCARE NHS TRUST: THE NEXT DECADE

Corporate Objectives 2015/16
Delivery Plan and Monitoring – Quarter 2

Delivery of our 15/16 Annual Plan and Objectives



This document sets out the proposed corporate priorities (in line with the discussions at the Board Strategy Seminar in February 2015), and key actions and milestones that the Trust will take to ensure these are delivered.

The priorities identified by the Board for 2015-16 are:

- The strategic plan
- Additional capacity
- Quality
- Financial viability
- Workforce and leadership

These are the priority objectives that the Board will oversee delivery of, with quarterly reporting of progress. There are further objectives that need to be delivered in 2015-16, that will be monitored by the relevant Board Sub-Committees, in line with the governance arrangements detailed on the following slide (previously presented to the Board in February 2015).

Governance: Reviewing progress

We will use a number of different mechanisms to ensure that we are able to track progress against the annual objectives. These are:

- Reporting to the Trust Board quarterly on the corporate priorities for 2015-16
- The monthly scorecard for the Trust Board to monitor delivery against quality, finance, workforce and operational targets
- Detailed review of key plans through the relevant Board sub -committees/ EMT:
    - Quality and Risk Management: QRC
    - Workforce and Education: Workforce Committee
    - IT: EMT
    - Estates: EMT
    - Business Development: Commercial Board
    - Research: Research Committee
    - Communications: Trust Board
- Quarterly reviews with the clinical divisions
- Clinical Divisions monitoring their own plans at Division and Directorate levels via DMB and DGB

Progress Tracker – Position at Q1

RAG STATUS	QUARTER				Quarter 1Commentary
	Q1 Position	Q 2 Position	Q3 Position	Q4 Position	
GREEN	16	18			47% of objectives (16 / 34) have been classified as Green. Good progress made to delivering the milestones set for the quarter.
	47 %	53%			
AMBER	17	13			50% of objectives (17/ 34) have been classified as amber. In the main there has been significant progress towards achieving the milestones set for the objectives during the quarter but the actual delivery will be during quarter 2. It is not possible for many of these project to predict whether this will have knock-on effects on delivery for the remainder of the year
	50 %	38%			
RED	1	3			3% of objectives (1/34) have been classified as red. This relates to delivery of access targets.
	3 %	9%			

Redesign care pathways to keep more people out of hospital: 1

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Implement the new model of care in community adult health services (CAHS) *Chief Operating Officer*	No specific actions noted in Q2	• CAHS model operational from 1st April 2015. • Service challenged to some extent by staff vacancy levels. • WCCG has determined not to tender service before 2018. • New CAHS interim specification developed by CCG. Trust working up plan for delivering interim specification for go live December 2015.	=
Complete the redesign of services for frail older people *Chief Operating Officer*	• Work jointly with commissioners via the SRG to identify required frailty provision for local population • Identify / implement HARI model and OP clinics at the Nelson. • Link CAHS into Frailty Model at both prevention of admission and supporting discharge to NHS or social care route	• Secured funding from CCGs to develop a front door frailty service. Model being recruited to. • WCCG & MCCG working with trust to develop integrated frailty and community geriatrician services.	=
Bid to provide Community Services to the residents of Merton *Director of Strategy*	Submit ITT if successful at PQQ stage	An ITT was developed in partnership with other providers, however the trust decided not to submit a bid owing to the risk profile of the specification / staffing / activity data / intermediate care provision / potential capital costs / mobilisation costs (in-year) and delivery RAG rating green as Trust has made an informed decision to withdraw from the process	=

Redesign care pathways to keep more people out of hospital: 2

Objective and lead	Actions		RAG
	Q2 Actions	Update on progress	
Support the delivery of the Wandsworth joint health and well being strategy *Director of Strategy*	Will be updated once Health & Well being programme agreed in Q1	The trust continues to support the H&WB – there were no specific actions in Q2. Liaison is on-going with respect to the new healthcare premises in Nine Elms / Vauxhall.	=
Develop and implement new models of care and further develop the St. George's network as per 5YFV *Director of Strategy*	Scope opportunities for closer working and new models of care	• The Vanguard bid for acute provider new models of care was unsuccessful; discussions continue around the delivery vehicle for implementing the SWL provider sustainability agenda. • The Royal Marsden to develop an Accountable Care Network vanguard for cancer was successful. • The 2 and 5 year turnaround plans will also further consider 5YFV. • Engagement with GP federations and the Out of Hospital forum continue.	=
Deliver access targets - RTT, A&E and Cancer through 1. Robust use of information 2. Aligning capacity and demand 3. Working in partnership with providers *Director of Delivery & Improvement / Chief Operating Officer*	Deliver off-site capacity where required through working with a range of NHS and private providers	• RTT and A&E targets not being met though A&E has shown recent signs of improvement as a result of flow and accountability framework that has been put in place • "One Version of the Truth" programme started on unplanned care to support delivery of 4 hour standard and create capacity for RTT • COO commenced waiting list improvement programme /validation exercise • OPD capacity plans being revised for income and performance recovery • Revised cancer action plan – will hit 2 week wait in November and 62 met internally but failed due to tertiary referrals. • Repatriation and delayed transfer of care being escalated to System resilience group and action being taken.	=

Redesign and reconfigure our local hospital services to provide higher quality care: 1

Objective and lead	Actions		RAG
	Q2 Actions	Update on progress	
Delivering additional capacity in line with clinical need *Director of Delivery and Improvement / Director of Estates & Facilities*	• Open Cardiology 7 beds • Open Hybrid theatre • Close Nightingale beds over summer	• Slippage in AMW bed schemes due to PFI approval delays. • Recovery at Home business case approved with Jan 16 start date. • Hybrid theatre being built, with 13 week delay due to estates issues. • Nightingale was closed over the summer; due to reopen in November	=
Women and Children's Hospital *Director of Strategy*	Commence work on the 5th Floor redevelopment	• The 5th floor scheme still has unresolved critical interdependencies with Dalby ward relocation and Moorfields vacation – engagement continues.	↓
Private Patients Unit *Director of Strategy*	Board approval of business case	• Private patient strategy refresh is underway, to deliver in early 2016	↓

Redesign and reconfigure our local hospital services to provide higher quality care: 2

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Implement all Merton CCG requirements at the Nelson Health Centre *Director of Delivery and Improvement*	Scope out and agree redesign for respiratory, gastroenterology and ophthalmology services	• Service delivery commenced early April. • Direct referrals and outpatient activity well below plan. Outpatient recovery plan requested from divisions. • Activity and contract query notice issued by CCGs. Project meetings set up with CCG. • Redesign groups not established due to focus on ensuring sufficient clinic activity.	=
South West London Service Reconfiguration Continue to work closely with the SW London Collaborative Commissioning Programme and take a leadership role in the Acute Provider and Out of Hospital projects *Director of Strategy*	Communication with key stakeholders	• The report was successfully completed and submitted in July. • Informal commissioner feedback has been very positive. • Substantive programme director in place. • Immediate workstreams are recommencing whilst the wider governance and funding arrangements are under discussion with commissioners and tripartite. • Surrey Downs CCG now formally part of collaborative. • Out of Hospital forum starting to consider longer term strategy.	=

Consolidate and expand our key specialist services: 1

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Renal Redevelopment at St. George's *Divisional Chair MC Division*	FBC approved by Trust Board	The FBC is being completed. The case is linked to the proposed development of the PP Unit. The PP Strategy refresh underway will inform next steps for the renal FBC.	↓
Cardiology expansion *Director of Delivery and Improvement*	No explicit actions	Scheme delayed due to PFI / capital building works issues and reduced CCG funding for heart failure. 7 beds Expected to open 18 January 2016.	=
Deliver redesigned cancer services in partnership with MacMillan *Chief Nurse & DIPC / Divisional Chair SNT Division*	Will be updated once annual programme agreed in Q1	A great deal of progress has been made – development work has been completed and the grant application to MacMillan was approved, securing £600,000 funding for the first year of a three year programme.	=

Consolidate and expand our key specialist services: 2

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Neurosciences Expansion *Director of Delivery and Improvement*	No specific actions in Q2	• QMH beds opened. • Thomas Young beds due to open before the end of October 2016 • Professor of Neurology appointed.	↑
Develop and implement a rehabilitation strategy Establish a 6 bedded spinal rehabilitation service in partnership with the Royal National Orthopaedic Hospital, Stanmore *Director of Delivery and Improvement*	Evaluation of pilot spinal unit and report to commissioners	• Rehab strategy groups established meeting monthly. • Cohorting of patients on new Thomas Young beds. • Discussions underway with CCG re commissioning a spinal rehab unit in partnership with RNOH. • New neuro rehab consultants in post.	↑

Drive research and innovation through our clinical services: 1

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Continue to increase the number of patients recruited into NIHR studies excluding the impacts of large one off studies *Medical Director*	• Appointment of Divisional Research facilitators • EDGE recruitment reporting live • Annual Research report published	• The Vacancy Control Panel refused permission for Research Facilitators in July. Review of R&D funding, and increase in commercial activity means that this can be met without investment from Divisions for a one year Pilot. These posts are critical in ensuring we can continue to deliver increases in number of trials active and number of investigators active • EDGE recruitment remains delayed, and is likely to move to Q4, as the delay with contracting between the CRN and EDGE providers meant that St George's missed the 'data migration slot' weeks ago (was expected by April 2015) – South London CRM is the prime contract holder, St George's is a subcontract partner. • Local event run on Grant Writing 01/10/015 - well attended by over 50 consultants/researchers. Follow-up continues with participants to look at submission. • Research Annual report delayed, due to lack of capacity.	↓
Ensure the Trust is in a position to make a successful bid for NIHR Clinical Research Facility funding *Medical Director*	Steering Group to approve action plan	Initial management group has met to discuss. The group now needs to extend membership and review fully the requirements of the NIHR Clinical Research Facility Funding to ensure (i) we are eligible (ii) There is an effective business case	=

Drive research and innovation through our clinical services: 2

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Increase collaborations between SGUL Institutes and Trust clinical directorates through the development of further CAGs: **Cardiology** **Neurosciences** *Director of Strategy*	CAG Chief of Cardiology appointed	The Chief of Cardiology CAG was appointed in July 2015, and the supporting team have since been appointed including: General Manager; Lead for Research; Lead for Education; Lead for Clinical Services and a Lead for Audit & Governance. A first key task for this team is to complete a 'Strategic Review' which will be launched in early Q3. Fetal / Women's CAG – the Trust has appointed 2 Canadian professors	=
Develop additional commercial income streams *Director of Strategy*	NIPT testing for Down's Syndrome in place	• Gibraltar contract signed and activities have commenced. • NIPT lab refurbishment to complete in November; NIPT service commenced in shadow form; pre-launch marketing underway. • Pharmacy commercial strategy under development, with business case for initial priority in draft.	=

Improve productivity, the environment and systems to enable excellent care: 1

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Prepare plans to complete the deployment of electronic prescribing, drug administration and clinical documentation for all inpatients, operating theatres and the Emergency Department on the St. George's campus in 2016/17 *Chief Financial Officer*	• Medical Device integration • RiO Mobile working deployed in Battersea • Completion of nursing whiteboards deployment • Begin to utilise the information provided to support the delivery of clinical services (Please note Objective and actions updated for Q2)	• Wireless devices commissioned to transfer readings and early warning to Cerner via wireless. New devices have been have been deployed to three areas. Once the priority areas for deployment have been agreed with Nursing board all the available devices (total 145) will be deployed • Business case and funding agreed to upgrade Maternity system. This is being planned for this calendar quarter 2016 • Near time reports on results endorsement, discharge summary completeness and VTE assessments are now being published. • Deployment of electronic whiteboards for wards commenced and will be completed in the 3rd qtr.	=
Implement electronic document management and electronic referral system for all new out-patient registrations at St. George's *Chief Financial Officer*	• All newly registered outpatient records scanned for St. George's campus activity • All GP referrals triaged electronically • Choose and book referrals incorporated in the electronic triage system	• Approach for new records scanning agreed with Clinical Directors and all newly registered o/patients will be complete by end of 3rd quarter • Electronic triage deployed to all specialities • National e-Referrals (formerly Choose and Book) – incorporated into e-triage process	↑

Improve productivity, the environment and systems to enable excellent care: 2

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Develop and implement an Outpatient Strategy *Director of Strategy*	Agree the optimal service model including delivery of OP flow and process	Project reprioritised to focus on 10 week programme to develop recommendations around patient experience, process and business model – report to come to November's board. The innovation workstream will follow.	=
Objective to support both effective elective and non-elective flow through the organisation to improve the Patient Experience and support performance standards where applicable *Chief Nurse & DIPC*	• Finalise outstanding actions and ensure preparation for Winter period. • To consider running another Breaking the Cycle Process	• Work programme re-profiled in Q1. • Flow scorecard now developed and implemented to understand impact of programme • Preparation for Winter continues, "winter warm up" (Breaking the cycle) exercise held and data evaluated to inform winter preparations. • Work being finalised to ensure Winter preparedness, now involving the interim COO post holder.	=
Provide transparency on outcomes by publishing consultant level activity data, clinical quality measures and survival rates from all nationally agreed audits *Medical Director*	Establish infrastructure for collation and distribution	• Comply with publication of Consultant-level national audit data. Link on website. • Published activity data available for National Audits. No mortality or complication outliers. • Action to continually improve participation in national audit, and develop local activity data sources. • National Audit data provided in Board report. Ensure development plan from each National Audit	=

Improve productivity, the environment and systems to enable excellent care: 3

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Creating Reliable processes for reducing avoidable harm - Follow Up of Diagnostic Tests - to implement a framework which will mitigate risk to an acceptable position *Medical Director*	• Clinical Engagement concluded • Begin the process of implementation	A new Trust Policy on this including mandatory electronic sign off of radiology and histopathology was implemented in September. The ability to monitor compliance is due in December 2015. There are some issues with ensuring that all results reach the correct consultant which are being investigated. Following the internal audit report the Medical Director has instructed Divisional Chairs to ensure that recommendations are implemented in full.	=
Commence Sign Up to Safety Programme as element of Quality Improvement Strategy *Chief Nurse & DIPC / Medical Director*	Begin Implementation of discrete programmes i.e. Sepsis Bundle, Deteriorating Patients	The trust was not been successful in its bid to NHSLA for funding for the programme (equivalent to 10% of NHSLA premium charged). Discrete work programme in relation to sepsis are in place and continue.	↓

Improve productivity, the environment and systems to enable excellent care: 4

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Ensure delivery of safe clean environments and use of patient feedback as a vehicle for continuous improvement and adoption of best practice *Chief Nurse & DIPC*	Implementation of actions plans, review and evaluation of data to inform further action	• Outpatient Improvement programme transferred to Outpatient Strategy objective • Feedback for divisional teams on-going on outcomes of patient feedback • Looking to triangulate information by clinical area to develop a truly informed picture of current position which can be shared with clinical teams • Patient and Public Involvement/Engagement is behind schedule and will report in Q2	=
Evaluation of Clinical Audit results and Acting on findings to ensure audit contributes to improvements for patients *Chief Nurse & DIPC*	As per Q1 • Agreed Divisional Programme in place • Quarterly monitoring of Programme against Plan. • Monthly reporting to Board of Key Audits • Ensure Key Actions from Audit findings	• Audit programme is in place, taken down to a monthly level of planned activity • Undertaking a process of reviewing and refreshing outputs of previous audits in relevant committees to ensure previous learning is being embedded – Patient consent and WHO surgical checklist a key focus of Q1 and Q2	=

Develop a highly skilled and engaged workforce championing our values: 1

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Develop leadership behaviours to deliver high quality *Director of HR and OD*	• Secure process for accreditation and assessment • Agree content of Leadership programme • Commence tender for leadership programme provider • Identify excellence in medical leaders • Succession planning process developed for Exec Directors and at Divisional level	• Leadership development programme designed and agreed by workforce and education committee September 2015. • Assessment process for executive directors commissioned • Medical leaders – development programme for new consultants is in place. First session October	↑
Implement an organisational development programme that supports the Divisional governance review findings *Director of HR and OD*	• Identify a coherent programme of team support that can be delivered by workforce and development department , including LiAise manager, staff support unit, HRMs and leadership development team.	• Organisational Development Manager in post with effect from 1st October. • Divisional leadership teams are being allocated organisational development days to meet specific team building and coaching requirements. • Development programmes are being well received by the divisions • Mid year appraisal, with Trust wide agreed objectives to take place with senior leaders in November.	↑

Develop a highly skilled and engaged workforce championing our values: 2

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
Embed the Trust values, recognise achievement and ensure staff achieve their maximum potential as well as tackling poor performance *Director of HR and OD*	• Take formal action as appropriate and let outcome be known	• Values awards included as part of all staff briefings. • 2 board development sessions have taken place. • Mid year review now due to take place in November, • Reduced turnover evidenced in area where bullying has been tackled. • There is no room for complacency however, as the feedback from staff continues to identify behaviour as a problem	↓
Ensure the right number of skilled members of staff are available to provide the best possible quality of care *Director of HR and OD / Chief Nurse & DIPC*	• Develop induction programme for overseas nurses • Streamline recruitment process	• Nursing establishment review completed • Proposals for SW London bank in development • Business case for recruitment of overseas nurses has been approved. • Turnover remains high however	=

Develop a highly skilled and engaged workforce championing our values: 3

Objective and lead	Actions		RAG
	Q2 actions	Update on progress	
To deploy the workforce in the most efficient way possible and improve the efficiency of internal workforce departmental processes *Director of HR and OD*	• Scope workforce benchmarking as part of SLM	• Benchmarking of workforce department evidences very low cost but efficiency opportunities available. • Programme of work to reduce temporary staffing usage and costs being supported by KPMG. Reduced temporary staffing costs in month 6.	↑

St George's University Hospitals NHS
NHS Foundation Trust

TRUST BOARD 3RD DECEMBER 2015

Outpatient Strategy summary paper

Action for the board: ***To consider the detailed report and approve the recommendations***

Summary:

The Outpatient Strategy Board (OSB) was formed in May 2015 to review outpatient services, and to recommend and implement solutions to improve the quality and efficiency of services.

Initially the OSB developed three work streams around:

- Tactical, short-term technical and process changes.
- Strategy, medium-term process, management and business model changes.
- Innovation, longer-term improvements, new models of care, technology and tele-health.

This was reprioritised in the summer so that an accelerated 10 week programme, starting in September, could deliver the main components of the tactical and strategic workstreams.

The attached paper details the work undertaken, options and recommendations arising from that 10 week piece of work. The paper includes consideration of both the strategic and granular process issues, by its nature these are complex independent issues – this executive summary presents the key findings and recommendations.

The key OSB findings are:

1. Consistent and simplified processes are required to ensure the delivery of a safe and high quality service.
2. There is no single best practice solution – other trusts have both centralised and devolved models and there are advantages and disadvantages to both.
3. Current trust processes have developed organically, with multiple variations and many back-office fixes to technical problems; there are trust-wide protocols for some service aspects, but these are not consistently adhered to.
4. In general terms, the current patient experience in outpatients is poor.
5. GPs find our referral systems confusing and are referring elsewhere because it is 'easier'.
6. There is no central oversight of outpatient performance or room utilisation, and there is no consistent set of KPIs.
7. The different income models cause confusion and do not appropriately incentivise clinical services to maximise capacity or fully incentivise supporting services to maximise efficiency.
8. The different management models are a barrier to efficient use of capacity.

OSB therefore recommends:

a) A single payment method should be adopted across the Trust. This should entail clinical specialities receiving all PbR income, with supporting outpatient delivery functions receiving payment via an SLA which incentives high quality customer care and maximises room utilisation across all sites. This is similar to the current Corporate Outpatient Services model at SGH.
b) Referral and administration (booking) systems, and the provision of outpatient services themselves, should be consistently delivered across the trust through the adoption of simplified processes.

c) There should be a single point of referral for GPs in the short-term. In the longer-term we should work collaboratively with commissioners to actively promote e-referral take-up.
d) These processes (as detailed within the paper) should be rapidly developed and documented, in parallel with the creation of a single suite of KPIs, and compliance monitored through OSB.
e) A single management model should be adopted across the Trust, ensuring the best use of available capacity through the use of an electronic room booking system that reflects the standardised and simplified clinic templates.
f) The management model, combined with standardised and simplified processes, does not preclude local delivery of outpatient services – the Neurosciences pilot should be allowed to continue and report as planned at the end of the year.
g) The Corporate Outpatient Services and QMH outpatients' management, administration and service delivery teams should be merged into a single function – this will ensure the efficient and consistent delivery of services utilising a single set of processes. This function would require a new dedicated GM. OSB considers that as the central booking service already sits within CWDT that this would be a logical alignment.
h) The existing Corporate Outpatient Services SLA should be changed to ensure that it meets the needs of patients, GPs and clinical services and that it includes appropriate mechanisms to incentivise good performance and to penalise poor performance.

The key productivity opportunities identified are:

- QMH clinic utilisation is currently at 70% and COS is 80% which represents 59,708 unused available clinic slots, OSB recommends a year 1 target of moving to 85% across all sites.
- DNA rates at SGH are 13%, OSB recommends a target of 10% in year 1 and 8.5 % in year 2 (best in class benchmarking for London outlined by KMPG) this represents 18,615 missed appointments.
- Automation of referral processes will lead to efficiency savings in terms of WTE as well as productivity gains.

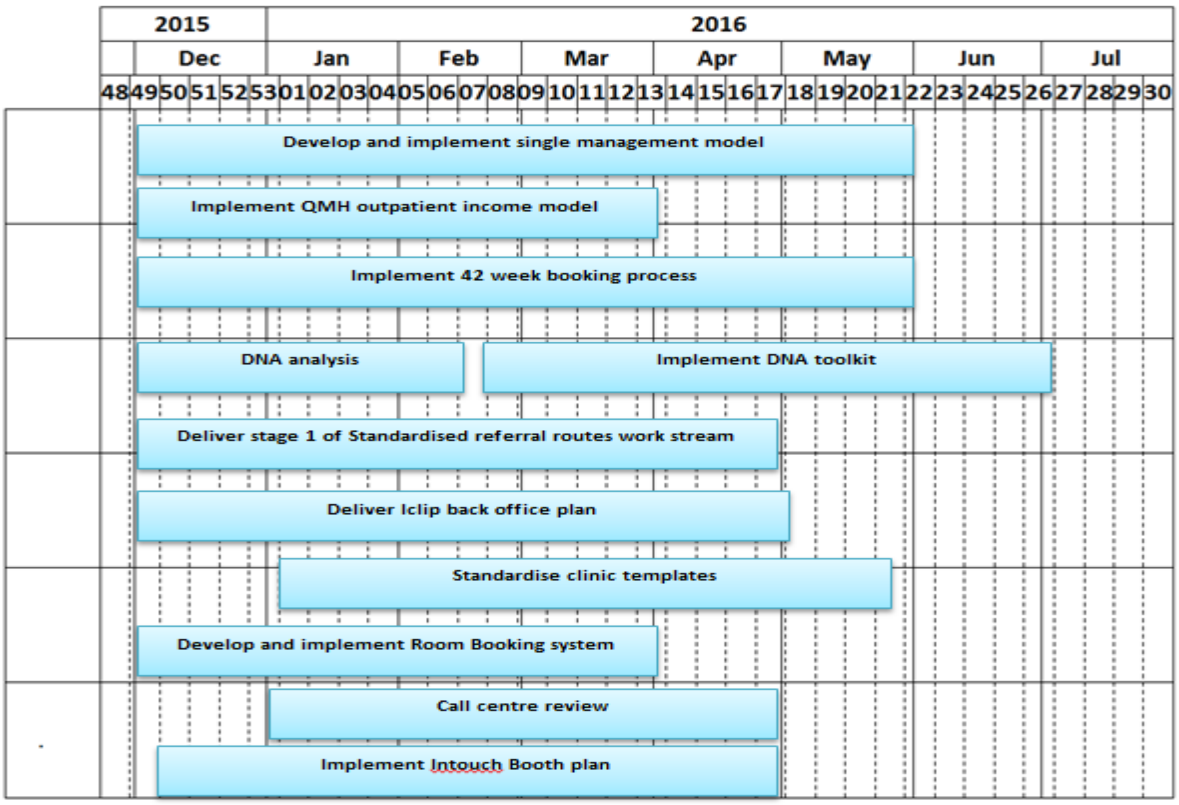
  Financial values have not been ascribed to these as the work to establish whether these are cost savings or income opportunities will form part of the implementation phase and this needs to be aligned with the income recovery plans and CIP processes.

- Centralised outpatient management and delivery team would deliver a 2% efficiency gain against the current budget delivering circa £300k savings

The outpatient income recovery plan currently sits with the COO, however a lack of resources have prevented significant progress. As this workstream is synergistic with the OSB recommendations it is also proposed that the outcome income recovery plan is implemented and monitored by OSB as a component of the strategic change programme. To ensure delivery a further consequential recommendation is that the project resource, currently part of the service improvement team, transfers to the strategy function.

The board is asked to consider the paper and these recommendations, cognisant that the debate around centralisation or devolution is a by-product of inconsistent processes and supporting systems, and a perceived lack of customer care – these are all soluble through standardisation, compliance and models that incentivise good performance and customer care.

The implementation plan for the project is shown below:



The additional resource requirement to deliver the project relates to approximately £100k of IT support, the existing outpatient service improvement team (3 wte) and HR and finance support.

EMT approved this outpatient strategy on 23rd November subject to:

1. Further quantification of the financial benefits and income opportunities.
2. Further work to accelerate the implementation plan, ensuring benefits are brought forward wherever possible.
3. The development of a communications and engagement plan.
4. OSB membership is expanded to include the COO and representation from all divisions.

The board is therefore asked to approve the OSB recommendations:

1. Create a single management function for all outpatient services across all trust sites, with the authority to manage room utilisation flexibly.
2. Apply a single business model in relation to income.
3. Standardise key processes, including a single suite of KPIs.
4. Merge the outpatient income recovery workstream with the strategy implementation.
5. Continue to develop strategic and innovation workstreams to further improve outpatient services.
6. Authorise OSB, through the director of strategy, to implement these recommendations utilising dedicated resources.

Author and Date:
Rob Elek 27th November 2015

Outpatient Paper

This paper will set out the strategy for achieving a unified approach to delivering outpatient services at St George's.

It will provide the Board with a series of recommendations to deliver the strategy:

- Management of outpatients
- Delivering Outpatients
    - Processes
    - Systems
- Innovation (technology to drive efficiency and improve patient access to outpatient services)

1. Introduction and Background

Outpatient services are a major part of St George's University Hospitals Foundation Trust (SGUH, the Trust), it is the front door to the Trust providing in excess of 800,000 patient appointments and generating over £110m in income each year.

The Trust provides outpatient services across four sites, St George's Hospital (SGH), Queen Mary's Hospital (QMH), Nelson medical centre and St John's centre; at present the majority of outpatient services are managed by two divisions: Community - at QMH and Nelson and CWDT - Corporate Outpatient Services (COS) at SGH and St John's. There are also a number of specialities who manage their outpatient services themselves. (please see appendix 4 for full details)

The Trust Board acknowledged the requirement to have an overarching strategy for outpatient services across the Trust and in May 2015 the Outpatient Strategy Board (OSB) was formed with the remit of developing:

- **Short to medium term strategy** to align the current multiple processes and approaches to delivering outpatients and develop a streamlined and optimum outpatient model for all of St George's outpatients.
- **Innovation strategy** to transform the way outpatient care is delivered and how patients access outpatient services through the use of technology and new models of care.

This paper will focus on the delivery of the short to medium term strategy and will touch on innovation, however there will be further work required to develop the long term innovation strategy this work will commence in 2016.

To enable the development of the short to medium term strategy the OSB conducted a 10 week scoping exercise starting in September:

- **Internal Review;** meeting with care groups and management teams to discuss how their clinics templates are structured; identify what issues they experience with the current outpatient models and to gather suggestions for improvement. (please see appendix 13)
- **External Review;** how do other NHS Trust's deliver outpatient, to identify the best parts of their delivery models. Initial engagement with GPs and patients to gather their views on the current outpatient services at St George's. (please see appendix 3)
- **Process review**; mapping of the COS, QMH and Nelson referral and appointment management processes and opportunities to standardise and unify have been identified.
- **System review**; what developments are possible fitting with the existing IT strategy to support process innovation .

Outpatients as described in this paper mean the provision of outpatient services i.e. the management and administration of outpatient referrals received by the Trust. It does not include walk in or emergency referrals into clinics but focuses on the volume of outpatient referrals received from GP's from other providers into the Trust.

2. Case for Change - The Patient

The primary driver for this paper is to improve the experience of outpatients at St George's through developing an outpatient service that meets the evolving needs of the patient population.

Outpatients is the front door to the hospital and is often a patients first contact with the Trust, it creates critical first impressions. St Georges deliver in excess of 800,000 outpatient appointments a year across all four sites therefore it is essential that the processes and systems that support this delivery are robust and of the same high standard across all sites.

Some of the key factors that impact patients when using outpatient services are as follows, the OSB will aim to positively impact them through the proposed strategy:

2.1 Access: All patients referred to St Georges should be booked in a timely fashion in line with the RTT policy, at present there are multiple routes and points of contact available to patients and their GPs who are referring them. This is confusing both for the patient and the service users when trying to book an appointment and they get transferred to other departments that sit outside of the outpatient process or to one of the alternative sites.

2.2 Waiting times: The length of wait for appointments is not equitable with patients booked to St Georges and St Johns site having to wait the longest, by developing a unified approach to the management of clinic room capacity, addressing DNAs and through working with specialities to improve their clinic utilisation then OSB hopes to positively impact on the current waiting times experienced by patients.

2.3 Complaints: Received by COS are low in proportion to the activity around 1.2 complaints per 1000 in January 2015 however the themes for complaints made to COS are time waiting to

get an appointment new and follow-up and then the environment that patients attending at St George's site have to wait when clinics are overbooked and running behind time.

2.4 Environment: There is huge variety between the different sites in terms of the quality of the outpatient estate, QMH is a PFI build and has a suite of modern clinic rooms, and the Nelson was opened earlier in 2015 and provides a modern and pleasant environment for patients.

The outpatient estate at St Georges is extensive with a high footfall and this high usage leads to some areas needing regular maintenances these areas are often seen as low priority. If the footfall could be shared across all sites this would reduce the overcrowding of clinics ensure equitable access to appointments and a more robust clear process for booking, the proposal in this document will ensure a patient centred high quality service for an ever growing demand.

2.5 User Engagement: During the scoping process we engaged with patients and GPs to gather opinion on current outpatient services and to learn more about what they think could be improved upon. Outcomes of these engagement sessions can be found in appendix 5 (GP engagement) and Appendix 6 (Patient engagement). From December 2015 the OSB will start to form User engagement group(s) as part of the implementation plan; the group(s) will be formed of patients and GPs who will be invited to contribute to a number of areas of the development of the outpatient delivery model.

3 Case for Change – Current approach

The outcomes of the 10 week scoping programme identified the following issues relating to the management and delivery of outpatient services.

3.1 Management of Outpatients

There are currently a number of different teams who manage the administration of outpatient services across the four sites.

- COS Central Booking Services (CBS) manage the majority of the outpatient administration for St George's hospital site (appendix 2) shows a breakdown of the services and which elements of the corporate model they use.
- There are 11 services who do not use any part of the COS model, this means they have their own local teams registering patient referral letters onto the Iclip system (appendix 2)
- QMH and the Nelson have their own booking teams who manage the outpatient administration for their patients.
- There are no standard KPIs in place for the management of outpatient referrals across the numerous different teams. (CBS target is to register referrals within 24 hours of receipt into the organisation, QMH Nelson have similar targets but there is no central reporting of them)

- Neurosciences are running a 6 month pilot where they have devolved from the COS model and are managing all core outpatient functions themselves. (see appendix 7 for full details)
- Two financial models; COS/Nelson income sits with specialities, QMH model income sits with Community Services.
- Three main performance reports for outpatients, there is no consistency in KPIs and Trust Board generally only receives the Corporate Outpatients scorecard therefore do not have full picture of outpatient performance. (appendix 1)

3.2 Process Issues

- Varied approach to provision of patient information, text messaging service is not consistently used and patient appointment letters are reported as an issue by most care groups.
- No Trust wide business rules in place for outpatients (COS currently have an SLA that is in the process of being approved by the divisions please see appendix 10 for details).
- COS has an average DNA rate of 13%, QMH 10% and Nelson 28%. This represents in excess of 90,000 missed appointments per year. There is no plan in place to understand which parts of the current outpatient system are causing patients to DNA.
- There are in excess of 1200 clinic templates in the iClip system; at least 30% of these templates have not been used in the last 6 months.
- Consultant clinics booked to 52 weeks when consultants work 42 weeks. This represents a potential 10 week loss of activity per consultant.
- Iclip back office with >9 week turnaround time for clinic template builds which leads to specialities building their own AdHoc clinic templates.

3.3 System issues

- Multiple points of contact for patients and GPs to access outpatient services. (Central Booking Service, specialties secretaries, QMH call centre, Nelson call centre)
- Multiple means of making a referral to outpatients. (letter, email, fax, e_Referrals)
- E_Triage system for the electronic triaging of referrals rolled out to COS, partially available for Nelson and QMH is paper based referrals.
- QMH clinic templates are built in separate PAS system; there is a separate process for updating and building these templates.
- The “In touch” check in booths aimed at helping the flow of patients through clinics on St George’s site have not been rolled out properly and therefore not delivering benefits or Return on Investment. (See appendix 5 for full details)
- Different IT platforms (COS/Nelson on Iclip and QMH on PAS) means unable to roll out systems each as e_Triage to QMH.

In summary there are a number of different teams, processes and methods being used to deliver outpatient services across St Georges. With variation comes inefficiency as processes and tasks

are being duplicated and OSB recognises that at present there is no standardised approach to managing and delivering safe and high quality outpatient services at St George's.

4 Opportunities and Efficiencies

OSB has identified a number of opportunities to improve the performance of outpatient services and the use of the available resources that will deliver a financial benefit to the Trust.

Please note detailed financial analysis needs to be conducted to full scope out the high level opportunities outlined below.

4.1 Cost of Outpatients

Current costs	Budget WTE	Annual Budget	Annual planned activity (approx.)	15/16 planned income
COS	412.54	£12,794,621.00	720,000	
QMH	59.86	£1,700,044.00	118,541	
Total	472.4	£14,494,665.00	838,541	£111,713,428

*The Nelson has been excluded at this stage as it is being reviewed by a management team external to OSB.

Through bringing together the multiple teams who are managing and delivering outpatients there will be opportunities to realise efficiencies and develop a flexible, deployable resource that can be deployed across all four of the sites to ensure effective use of investment.

- Aligning the main outpatient staffing models into one model will deliver cost efficiencies through the implementation of one management structure and one central team.
- OSB is proposing that a centralised management structure would deliver a 2% efficiency gain against the current budget delivering circa £300k savings.
- A full HR, operational and financial review is needed to agree the final model.

4.2 DNA Rates

- COS DNA rates average at 13% or approximately 90,000 missed appointments.
- QMH DNA rate average at 10% or approximately 11,854 missed appointments.
- Represents a total loss of approx. £12 m (based on average cost of outpatient appointment of £130 per patient)

OSB proposes that by setting a Trust wide target of 8.5% DNA rate (best in class is 8.5 based on KPMG analysis) this represents the opportunity to utilise approximately 30,000 missed appointments.

The DNA rate reduction would be achieved through analysis of the root cause of DNA's, reviewing clinic templates, working with specialities to address their DNA issues and improving patient information and access.

The central outpatient management team would manage and monitor the performance of each speciality in their achievement of this target.

4.3 Clinic utilisation

The current clinic utilisation based on clinic appointments available compared to clinic appointments used is as follows (please see appendix 14 for further details):

- Corporate Outpatients has an average utilisation of 80%.
- QMH has average utilisation of approximately 70%

	Annual planned activity	Clinic appointments used (current utilisation)	Clinic appointments used (85% utilisation)	Opportunity
QMH	118,541	82,978	100,759	17,781
COS	838,541	670,832	712,759	41,927
Total	957,082	753,810	813,518	59,708

This table provides indicative figures, QMH utilisation is based on a manual calculation, COS utilisation is based on iClip data and the COS capacity and demand model.

OSB proposes that there is a Trust wide utilisation target set for outpatient clinics of 85%, based on the indicative figures above this would create an opportunity to utilise 59,708 unused slots. A plan will need to be developed with each speciality as OSB acknowledges that there will be variation in utilisation between specialities and clinics.

OSB is proposing removing the current barriers for specialities to deliver clinics from QMH associated with the financial model and management structure. All specialties who are able to deliver clinics from the site will be tasked with increasing their clinic activity, with a focus will be on specialities with RTT problems as this will also help to offset the number of adhoc and out of hours clinics that are delivered at premium costs at St Georges site.

4.4 Phased delivery

There will be a phased approach to the delivery of the opportunities outlined previously; a full analysis is needed into each of the opportunities before milestones dates can be identified for the realisation of each proposed opportunity.

Proposed phasing	15/16	16/17
Staffing model	HR to complete review and develop new structure	2% to be realised by July 2016
DNA rates	Understanding the root cause of DNA	Phased targets to be agreed with each speciality to move them to 8%
Clinic utilisation (QMH)	Baseline of clinic utilisation agreed across all sites	Target of 50% increase in utilisation realised by December 2016

4.5 Next Steps

- A strategic financial review is needed to identify the true value of opportunity available from the proposal listed above.
- Map the relationship between DNA and clinic utilisation as there is an assumption that a reduction in DNA's will lead to improved clinic utilisation.
- Staffing mode; HR and operational input needed to map out the integrated staffing structure, the expectation is this will be completed and new structure in place by the next financial year
- QMH Clinic utilisation is currently calculated manually as QMH is not on iClip, further work is needed to map out the actual utilisation per speciality
- The increase in clinic utilisation will in part be predicated on having sufficient consultant capacity across all sites.

5 Proposed Recommendations

The OSB has considered the range of issues that have been outlined above and has developed a set of recommendations that will deliver a unified and simplified outpatient model; the key proposal is that high quality services are delivered by ensuring that documented processes are followed consistently.

5.1 Management of Outpatients

OSB has considered a number of options based upon the findings from the internal and external scoping when to inform the decision around best approach to the management of outpatients.

5.1.1 **Option 1 Do nothing**

Continue with an uncoordinated approach to the management, administration and delivery of outpatients; the four sites remain as separate entities and the issues that have been identified continue.

5.1.2 **Option 2 Devolve**

Completely devolve the administration and delivery of outpatients entirely to the specialities, and remove the corporate outpatient function and move the admin nursing and clerical teams under the management of directorates.

This model is currently being piloted by Neurosciences, the team is developing a performance scorecard so that the outcomes of this pilot can be assessed against the performance of the COS model.

- Risk there will be even less of an understanding about the outpatient performance in the Trust if the model is completely devolved.

- The set up costs and on-going staffing costs to manage local booking teams.
- No central oversight of performance, room utilisation, patient satisfaction therefore no means of releasing efficiencies by utilising room capacity across the organisation.
- Each speciality needs to understand the financial risk of decentralising and what cost pressures they will inherit if the COS ANC teams are given back to the directorates to manage. A full financial analysis will need to be completed to understand this
- The Neuro model outcomes only cover managing the administration of outpatient booking – they have not taken on staffing the clinics so this will need to be looked at in more detail.
- A decision will need to be made about who manages Medical Records
- No central management of clinic builds will require each speciality to have their own clinic build team.
- Epsom and St Helier have moved from a central outpatient model to a devolved model, they list a number of issues with the administration of this type of model, the lack of control regarding access policy and performance. They are now in the process of moving back to a centrally administered model for their patients. (appendix 3)

5.1.3 **Option 3 Centralise Core Functions**

Appoint a central outpatient management team who are responsible for managing the core functions (Call centre, medical records) and performance reporting for all outpatient services across the four sites. This team will be managed by one division but will also be accountable for reporting on outpatient performance to the Chief Operating Officer and the Divisional Directors for the Trust.

The central management team will be responsible for the following core functions:

- Registration of all outpatient referrals (onto Iclip and e_Triage)
- Management of central room booking system
- Performance reporting of Outpatient performance
- Implementation and management of core business rules
- Call centre
- Medical Records
- All admin nursing and clerical provision
- Clinic template builds

As a starting point the central management team will need to review the current admin, nursing and clerical structure to identify opportunities to introduce roles such as clinic coordinators, an e-Referrals coordinator, identify how to work collaboratively with medical secretaries in their new clinical roles and develop a divisional communication plan with named booking partners in each division to be the conduit between the central booking service and the outpatient clinical teams.

OSB recommends option 3 as the preferred option; the findings from the 10 week scoping exercise highlight the current multitude of issues that there are with the current hybrid model for the delivery of outpatients. If these issues are to be addressed then a new model of delivery is needed, that supports a unified and standardised approach with simplified processes and a centralised system for performance reporting and management of outpatient capacity. A central team is needed to drive efficiencies and performance of the clinics, call centre and implement the core business rules.

This programme of work will address the issues identified, once this has been completed then there will be the option for services to review the outcomes from the Neuro pilot and if feasible develop a business case for local management of their outpatient service with the caveat that they will still be subject to adhere to the core principles, business rules and processes that will have been embedded across all four outpatient sites.

5.2 Next Steps

- EMT decision about which division will manage outpatient services (Nov 2015)
- EMT decision about which outpatient model to implement (Nov 2015)
- HR consultation to begin to form central outpatient management team (Dec 2015 onwards)
- Development of optimal staffing structure to commence once management team agreed (Jan 2016)
- Central management team to develop core business rules (Jan 2016)

5.3 Outpatient Income models

At present there are two different income models for the delivery of outpatient services:

- Specialties receive the income for all outpatient services delivered at SGH, with COS paid through a SLA.
- CSD receives the income for outpatient services at QMH.
- Nelson outpatients are on the same model as COS

The current QMH financial model does not incentivise the specialties to run clinics from there as any income generated will not sit in their budget; this has been identified as a barrier to using the room capacity at QMH.

OSB recognises to have a simplified system then there needs to be one financial model. It is recommended that all income is to sit with the specialities (as per the COS/Nelson financial model). Work is underway with the finance team to develop a plan for implementing this; they have advised that it will take 1 month for them to develop a financial model once the decision has been approved by the Board regards QMH finances. (appendix 17)

A pricing structure to incentivise behaviours will also be considered – for example delivering clinics at QMH where there is capacity offered at a cheaper cost than running out of hour sessions at a high cost at SGH.

5.4 Next Steps

- Decision to be made by Board to approve moving QMH onto financial model. (Nov 2015)
- Finance team to develop financial model for QMH.(Jan 2016)

6 Processes

6.1 Standardise and simplify the clinic templates in iClip for all outpatient specialities

6.1.1 Current

There are in excess of 1200 clinic templates that are stored in the iClip system; approximately 30% of these templates have not been used in the past 6 months. There is a need to review these templates to identify where we can reduce variation and standardise to ensure that patients are booked into the right clinic first time.

As part of the internal scoping we engaged with 18 care groups and their management teams to understand more about the challenges faced with clinics, scheduling and to identify where there are opportunities to standardise and improve the clinic templates. The following issues were raised:

- Iclip Back Office have a >9 week turnaround time for clinic builds
- Specialities can build their own templates as often need short notice clinics which has led to the vast volumes of templates in the system
- There is formal process/timeline across the Trust for updating and deleting templates
- Information in Iclip does not reflect clinic information in e_Triage or on the e_Referrals Directory of Services which causes confusion.

6.1.2 Recommendation

- Iclip back office to develop clean all empty unused templates off the Iclip system
- Care Groups to produce set of standardised and simplified clinic templates
- Governance process to be implemented to manage template builds, changes
- Iclip Back office improvement plan to be developed in more detail (see appendix 12 for outline plan)
- QMH to be moved onto Iclip 2016, the clinic templates are to be reviewed at the time of the move.

6.1.3 Benefits

- Opportunity for care groups to develop the optimal set of templates they need to deliver outpatient clinics.
- Standardised and simplified approach to clinic templates.
- Reduce margin for booking errors as old and incorrect templates will be removed from the system.
- Use this opportunity for specialities to review their capacity and demand.

6.1.4 Next Steps

- Decision to be taken for resource of Iclip back office plan (Nov 2015)
- Implement Iclip Back Office plan (Dec 2015 to Apr 2016)
- Continue engagement with care groups to start process of them starting to work towards standardising and simplifying their clinic templates.
- Agree process and timelines for removal of all old/unused templates
- Pilot speciality to be identified to work through the process of :
    - Designing their set of optimum clinic templates
    - Updating Iclip clinic templates
    - Updating clinic information in e_Triage
    - Updating Directory of Services for e_Referrals

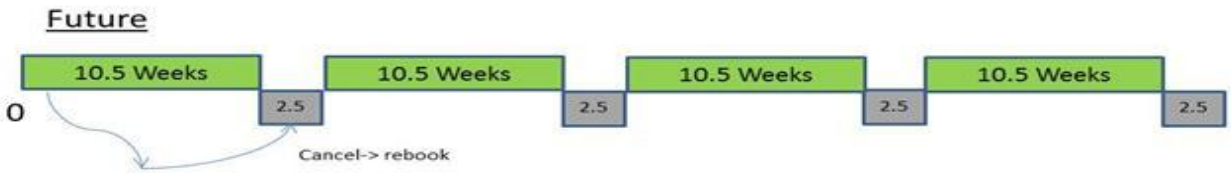
6.2 Implement 42 week booking process

6.2.1 Current

At present all specialities at St George's currently manage their outpatient clinics on a 52 week year booking horizon for each clinic/consultant.

- Consultants work 42 weeks of the year which means there is a potential for each speciality to lose 20% of their possible activity. (10 weeks)
- No central view of all outpatient clinics therefore cannot offer out the additional slots to specialities who need it i.e. ones with RTT issues.
- Additional admin created for central booking team as having to rebook slots on a frequent basis.
- Increases need for adhoc clinics as consultants booked to 52 weeks therefore no slack in the system to reschedule patient clinics when a consultant gives 6 weeks' notice for annual leave.

Consultant appointments are booked for the whole 52 weeks, Consultants are only available for 42 weeks due to annual leave and study leave
If there is an appointment cancellation there is no slack in the system to rebook appointments



Introducing a 2.5 week break that no team can book into. This capacity can be used by the speciality or will be offered up centrally for distribution to other teams who need the clinic slots.

6.2.2 Recommendation

- Implement a 42 week scheduling plan across all outpatients
- Central Outpatient management team to own the central capacity tracker where all
- COO and DDO's to meet with outpatient team to agree how to allocate the spare capacity out across the Trust
- Consultants to provide 10 weeks' notice for annual leave
- Link between consultant availability and clinic room bookings to be identified.

6.2.3 Benefits

- Maximising the opportunity to use any spare clinic capacity across the Trust
- Central outpatient team working with COO and DDO's to manage the capacity
- Effective planning of consultant leave and clinic capacity
- Reduction in adhoc clinic builds.

6.2.4 Next Steps

- Policy to be developed for management of Trust wide 42 week outpatient scheduling (Feb 2016)
- Agreement between DDOs and COO on the how the "spare capacity" will be utilised (timeframes and priority) (Feb 2016)
- Training plan to be developed for central booking and specialities to advise how to move to 42 week schedule (Mar 2016)
- Implementation plan to be developed for moving all specialities onto 42 week plan (March 2016)

Central tracker developed for capturing 42 week plan for each speciality, work to be undertaken to identify how to link 42 week capacity plan to a room booking tool

6.3 DNA analysis to understand the root cause of DNA's and a plan identified to deliver improvement to DNA rates

6.3.1 Current

UK National average DNA rate for outpatient appointments is 7.5% (Dr Foster 2013), and London has a best in class average of 8.5% (based on KPMG analysis) St George's average DNA rates are:

- Corporate Outpatients is 13% (see appendix 1 for speciality level data)
- QMH is 10%
- Nelson 28% (based on September 2015)

This represents upwards of 90,000 appointments that are not attended each year, specialities will try to account for their DNA rates by overbooking clinics to ensure that clinics are not left empty and consultants clinical contact time is maximised.

This is not a sustainable means of managing the scheduling and delivery of outpatient's clinics as if all patients arrive to an overbooked clinic then the clinic will overrun and patient waiting times will soar.

There are a number of theories shared by the care groups that we engaged with as part of the internal review as to why their patients DNA including:

- Patient letters being sent out late.
- Patients not receiving text reminders.
- Patients not being engaged in the appointment booking process.
- Lack of capacity meaning some patients are "cured" by the time their appointment date arrives.
- Call centre waiting times mean patients give up when they ring to cancel or reschedule an appointment.

However no focussed analysis work has been undertaken to identify the root cause(s) of DNA's at St George's. GSTT and Kings have both conducted DNA projects and they have recommended developing a DNA toolkit to enable specialities to review and start to understand what the main causes are that are pertinent to their patient demographic.

6.3.2 Recommendation

This is a great opportunity for St George's to improve patients experience, ensure that no clinic slots are wasted and maximise the performance of all outpatient clinics. As a first step it is proposed that a pilot speciality is identified to map out the following:

Investigate:	What are the known factors contributing to DNAs, what does the data tell us?
Identify interventions	Review booking systems, are the appointments necessary? What reminders are sent? Is it easy to reschedule?
Learn from others	Kings, GSTT have all conducted DNA projects
Review Trust Access Policy	how are we managing DNAs in line with Access Policy?

The outcomes from this pilot will form a Trust wide DNA toolkit and implementation plan for each speciality to start to actively address their DNA's.

6.3.3 Benefits

- Trust target for DNA's at 8.5% will deliver financial benefits through reducing missed appointments.
- Reduce the risk of clinics being left empty
- Reduce the need for additional admin created by DNA's and rebooking of patients
- Positively impact on the RTT waits for specialities, by ensuring they are using their clinic capacity using capacity efficiently.
- Reduce the need for specialities to overbook clinics which lead to long patient waiting times and complaints
- Positively impact on patient experience.

6.3.4 Next steps

- Speciality to be identified with high DNA rate to start the 4 week focussed analysis into root cause of DNA's (Dec 2015)
- DNA toolkit to be developed (Feb 2016)
- Outcomes of pilot will inform the development of Trust wide DNA workstream and target setting with each speciality

6.4 E-Referrals Service (eRS)

6.4.1 Current

At present St Georges does not have one standard target for the publication of outpatient slots on eRS, there is variation between specialities and sites in terms of the percentage of slots they choose to publish, whether they protect slots as eRS and which clinics they wish to open up on

eRS. Due to these factors it has not been possible to gather any meaningful data regarding the total availability of clinic slots available on eRS.

- COS there is no target set with specialities about what slots they publish on eRS
- QMH publish 80% of their clinic slots on eRS
- Nelson publish 50% of their slots on eRS

We have been able to identify the uptake of eRS from those referring into St Georges, the table below shows the % of GP referrals received via eRS.

Table of % GP referrals received via eRS from May 14 – Feb 15

GP Referrals received via e-referral system										
GP CCG	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**
NHS KINGSTON	53%	56%	57%	56%	57%	56%	56%	60%	51%	54%
NHS LAMBETH	29%	26%	28%	27%	26%	26%	27%	25%	29%	30%
NHS MERTON	19%	20%	23%	19%	20%	19%	18%	19%	18%	18%
NHS SUTTON	14%	16%	17%	15%	15%	14%	16%	13%	14%	13%
NHS WANDSWORTH	31%	34%	33%	31%	32%	31%	32%	28%	31%	30%

The success of the eRS system is predicated on its Directory of Services (DOS) being regularly reviewed and updated by specialities to reflect their outpatient clinics and consultants. As there is no Trust wide standard for specialities to publish and update the eRS DOS then this hasn't been fully reviewed since 2009.

6.4.2 Benefits

The NHS E-Referral Service (the system formally known as choose and book) enables GPs to directly refer and book their patient into an outpatient appointment. There are a number of benefits to using this service for patients, referrers and providers including:

Referrer	**eRS provides a safe, secure and reliable system, available 24 hours a day, 365 days a year, which supports patients in their choice decisions**
Patient	Can choose the time and date of their appointment, can leave GP surgery with their outpatient appointment confirmed.
Provider	An increase in the appropriateness of referrals and reduction in DNA's

*extract taken from the HSCIC eRS website

If utilised fully eRS offers the solution to a number of issues such as missing referrals, needing a large call centre to handle the volume of calls from patients chasing their outpatient appointments. The system would enable a fully automated referral pathway between referrers and St Georges for urgent and routine referrals.

6.4.3 Next Steps

- Trust wide target to be set by OSB for publishing outpatient clinic slots on eRS
- As part of the clinic template review specialities need to update their eRS DOS information to reflect their new simplified and standardised clinic templates.

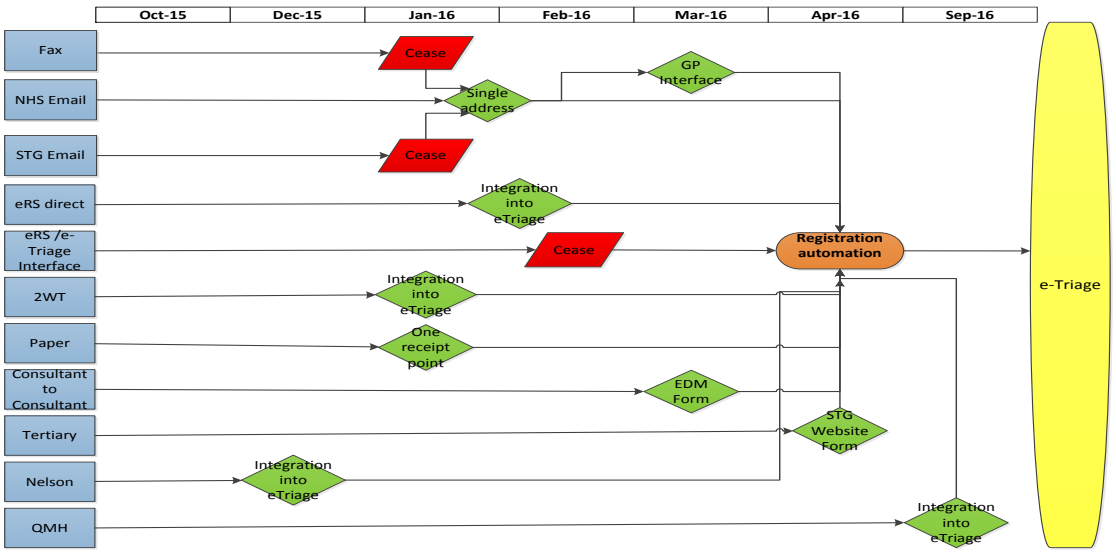
7 Innovation

To ensure there is a standardised process in place for the administration of outpatient services, it is recognised that there will need to be a number of systems in place to support the central outpatient management team. The key recommendations from OSB are as follows:

- Standardise referral routes into the Trust
- Develop a Room Booking Solution
- Procure a Patient Access Solution

7.1 Standardise the referral routes into the Trust through reducing the number of referral processes and developing eTriage system for all referral types.

- There are currently 9+ referral routes into St George's for an outpatient referral (see table below)
- Appendix 11 outlines the detailed plan for how these processes can be ceased or automated to ensure that there is a robust, secure and efficient means of sending, receiving and triaging outpatient referrals across all St Georges sites.



7.1.1 Benefits

- Improve patient care by reducing delays in the referral management process
- Converge on a single referral management process for all referrals
- Improve communication with primary care, though the automation of the entire referral process.
- Introduce a standard process for tertiary and C2C referrals
- Reduce costs through the automation of the referral registration process

7.2 Review current call centre function to identify the most effective solution and system for managing outpatient patient calls to the Trust.

- The Central booking team handle around receive on average 5500 calls a week and answer on average 74% of the calls (based on 8 weeks performance appendix 4) there are issues with the call centre performance as it is not meeting its target of 30 second response time to inbound calls. There is an operational action plan in place that is being led by the COS management team.
- QMH and Nelson have their own teams who manage the patient calls, there are no known reported issues, they do not have any standard KPI's in place for call management.
- A review of the call centre function is needed to identify the most effective solution and system for managing patient calls in relation to their outpatient appointments:
    - Identify model to align the three current call centre functions
    - Identify potential outsourcing solutions
    - OSB to review options and agree on final solution

7.3 Develop and implement a central room booking system

- There is currently no central means of identifying which of the 160+ outpatient clinic rooms across the four outpatient sites are in use at any one time.
- This means there is loss of opportunity to maximise the utilisation of every clinics room.
- A central system is needed to provide a trust wide view of all rooms, the Royal Free have a successful system that they have developed themselves (appendix 3) whereby the room availability is published on the Trust intranet enabling all outpatient teams to identify where there is spare capacity and to offer up their rooms if they need to cancel/reschedule a clinic.
- Patient information to be reviewed and effective solutions identified for communicating with patients about appointments (emails, text, online access)
- OSB acknowledges the current barrier to improvement that is QMH to be moved onto iClip enabling roll out of e_Triage, central booking team to access clinic slots.

7.3.1 Next steps

- Approval of referrals work stream proposal and resource request (appendix 11)
- Commence call centre review and options appraisal (Jan 2016)
- Commence development of central room booking system (Dec 2016)

7.4 Patient Access

OSB has considered and investigated the availability of Patient Access systems to improve direct communications with Patients. An implementation would expect to deliver the following benefits:

- Improved Patient Experience through the use of smartphones tablet & web access for :
    a. Providing Patient choice – patient would be able to book, cancel, or amend their own outpatient appointments.
    b. Direct access to test results, clinic letters, relevant Health Information
    c. Reminders, direct patient diary entries
    d. Messaging between clinician and patient
    e. Proxy management for Parent and siblings.
- Cost reduction through Patient booking their own appointments
- Reductions in Appointment DNAs through better messaging and patient diary management
- Patient Demographic updating
- Patient Surveys (eg post stay, post OP appointment)
- On line assessments (eg preop assessments)

7.4.1 Next Steps

- Identify preferred provider and Agree Commercial Arrangement (Jan 2016)
- Develop plan for a pilot with a specific cohort of frequent attending patients
    - Agree objectives, cohort
    - Involve patient reference group/ clinicians in design
    - Implement
    - Review

7.5 Improve usage of InTouch Check in Booths

The Trust has invested in procuring and implementing Intouch check-in booths across 6 of its outpatient areas (please see appendix 9 for the full review paper). The purpose of these booths is to allow patients to register their arrival at an appointment without attending reception. When the patient has checked in clinicians can call a patient to a clinic room using a screen. These kiosks alleviate demand on staff in clinics by freeing time for value added tasks and allow patients manage their own demographic record.

Usage of these booths has been low, with the latest performance report showing 19% of patients used the booths to check in and 81% chose to check in at reception. The external review identified that Barts, UCLH and GSTT have deployed these booths in a number of their central outpatient areas and are reporting benefits in terms of improved patient flow through clinics, ability to capture data around patient waiting times and clinic appointment times.

The review paper in appendix 9 outlines the current deployment and technical issues that have occurred with the Intouch booths to date. There is real opportunity for these booths to be implemented properly into the current outpatient areas and so that the clinic teams and the patients will benefit from their usage.

7.5.1 Next Steps

Implement the recommendations from the review:

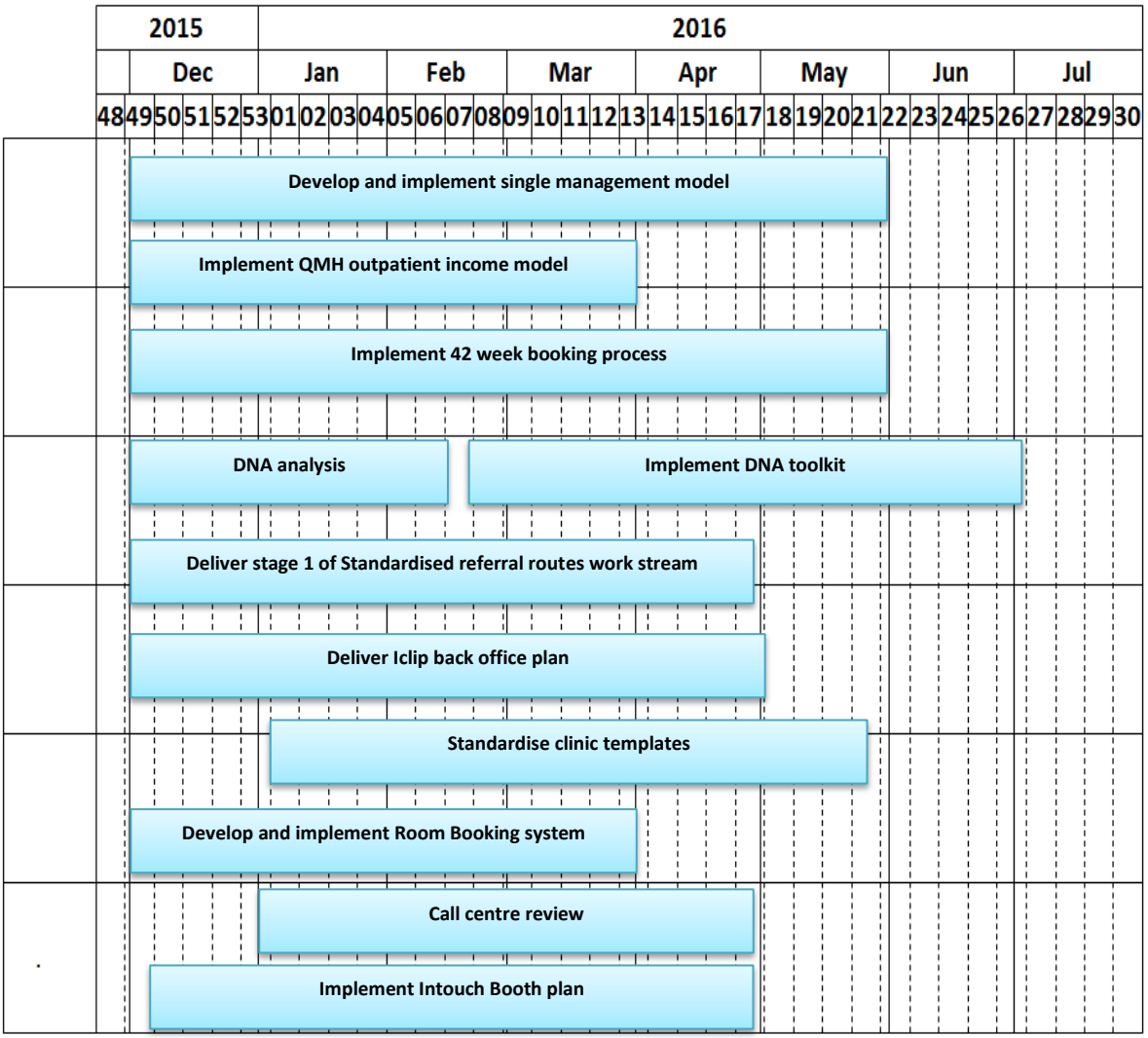
- Use of human stewards
- Rebrand/re promote the kiosks
- IT to review the opportunity to invest in the upgraded software
- Review Training of clinic teams
- Review location of kiosk

8 High Level Implementation Plan & proposed project team

The plan below provides an overview of the key work streams and indicative delivery dates that will be required to deliver the Outpatient strategy, this plan is dependent on approval of the required vacancies and once approved a detailed plan will be developed for each work stream.

Team	Resource	Role	Cost
Improvement	Programme Manager x 1 Band 8c (9 months)	Lead delivery of programme	£63,737
Improvement	Project Manager x 1 Band 8a (9 months)	Manage delivery of programme	£42,266
Improvement	Assistant Project Manager x 1 Band 7 (9 months)	Support delivery of programme	£38,896
IT	Iclip back office team x 5 (4 month support) Band 5	Deliver Iclip back office plan	£60,933
IT	Iclip Back office team x 1 (4 months) Band 6	Deliver Iclip Back Office plan	£14,866
IT	Specialist change and configuration expert as required	Deliver Iclip back office plan (8 weeks at £350-400 a day)	£16,000
IT	0.5 x assistant project manager (6 months) band 7	Project Assistance support for Referral system, patient portal & Room Booking system development	£12,956
Finance	1 X SFM 8c	Develop and deliver plan to move QMH onto COS financial model. Complete financial analysis required to map out the "new" outpatient model and proposed	£42,491

		opportunities. (4 months)	
HR	1 x HR manager 8a	Lead the development and implementation of the new outpatient staffing model (6 months)	£30,844
Total			£322,989



Appendix Content

Appendix 1	Monthly reporting for Outpatients • COS Scorecard • QMH table • Nelson table
Appendix 2	DNA Rates for Corporate Outpatients split by speciality (based on Iclip data April 2014 to Oct 2015
Appendix 3	Notes from external review meetings
Appendix 4	Current overview of COS outpatient model functions split by speciality
Appendix 5	GP Engagement Session Outpatient Workshop
Appendix 6	Patient Interviews
Appendix 7	Neuro Sciences Booking Pilot paper
Appendix 8	Call Centre – Board Update
Appendix 9	In touch Self Check in Review
Appendix 10	Corporate Outpatient Service Level Agreement
Appendix 11	Referrals Workstream Proposal
Appendix 12	Back Office/Clinic template proposal - Dec15 to Apr 16
Appendix 13	Summary of internal review meetings
Appendix 14	Clinic Utilisation by Speciality 2015 YTD
Appendix 15	October COS Clinic Cancellations
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Appendix 17	Statement of costs from Finance team

APPENDIX 1

Monthly Reporting for Outpatients

Corporate Outpatient Services Monthly Scorecard

		Source	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	Cerner	N/A	56102	67188	69507	61879	58659	64609	60659	62946	60564	59841	68002	68277	57188
	DNA	Cerner	<8%	10.02%	9.89%	10.30%	7.64%	7.33%	7.58%	8.04%	7.33%	7.27%	7.97%	7.84%	7.77%	7.82%
	Hospital cancellations <6 weeks	Cerner	<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 performance	Permanent notes to clinic	Manual count	>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	Cerner	>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	Cerner	100%	99.99%	99.91%	99.60%	99.95%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%	100.00%	99.80%	99.50%
Call Centre Performance	Total calls	Netcall	N/A	30004	25674	23420	20964	20639	26565	20842	23235	18710	17732	22955	30426	28095
	Abandoned calls	Netcall	<25%/<15%	14825	5794	2376	1558	2681	5923	2908	3782	1551	2237	3309	10828	15019
	Mean call response times	Netcall	<1 m/<1m30s	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
Nursing Performance	Safe staffing	RaTE	85%	93%	93%	94%	90%	93%	93%	96%	92%	96%	94%	94%	94%	96%
Phlebotomy Performance	Phlebotomy <30 min waiting time	Phlebotomy queue system	90%	72.44%	47.86%	72.90%	67.00%	69.00%	57.00%	81.00%	81.00%	70.00%	81.00%	92.07%	91.00%	80.00%
Quality & Experience	Complaints	C&I	<8	21	8	17	5	4	8	4	5	3	5	3	10	4
	Compliments	Local record	N/A	3	2	4	3	6	4	3	3	2	2	3	2	3
	Datix reported incidents	Gemma Astafanous	N/A	7	16	12	13	13	6	20	12	11	10	9	29	12
	Serious incidents	Gemma Astafanous	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Workforce	IPR completion rate	Workforce report	>85%	78.64%	76.79%	77.17%	77.06%	77.31%	80.18%	86.76%	84.40%	80.54%	80.36%	79.91%	74.09%	69.19%
	MAST completion rate	Wired	>95%	81.85%	78.30%	67.40%	67.56%	67.68%	71.00%	74.00%	66.00%	74.00%	72.00%	75.00%	75.00%	74.00%
	Sickness rate	Workforce report	<3.5%	5.19%	5.90%	4.78%	6.12%	5.35%	5.23%	3.86%	2.83%	3.23%	4.48%	4.26%	3.61%	4.66%
	Vacancy factor	Workforce report	<20%	26.08%	25.70%	25.35%	26.58%	26.45%	27.53%	29.17%	28.73%	29.86%	30.18%	26.83%	25.77%	24.87%
	Bank & agency spend as proportion of total pay budget	Budget statement	<20%	32.79%	43.66%*	34.15%	31.73%	33.64%	35.43%	30.26%	32.65%	24.20%	39.92%	41.29%	23.02%	33.14%
Finance	Budget position in month	Budget statement	In balance	-101,977	-276,579	-255,861	-73,219	555,327	-203,000	73,579	-119,680	-279,426	-120,011	-202,710	78,841	-101,157
	CIP	CIP database	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber
EDM	Number of notes planned to have been scanned	EDM Business Case	N/A									210	210	210	210	210
	Number of Records Scanned								567	623		562	639	915	831	757
	Number EDM Appointments											3081	3216	4162	4299	3869
	Number of Clinicians using EDM											TBC				
Comments																

QMH have a performance tracker through tableau – there are a range of Outpatient reports available

Community Reports - Table of Contents

Source	Name	Description	
QMH PAS	Appointment Details with Service Line	Appointment Details with Service Line	
	AppointmentCountWithServiceLine	AppointmentCountWithServiceLine	
	Clinical Audit QMH IP Data	QMH IP Data - Click on the Export Button to export to Excel	
	Ethnicity by Location or Treatment Function	Ethnicity by Location or Treatment Function	
	Patient Count in Clinics	Patient Count in Clinics	
	QMH Clinic Activity	QMH Clinic Activity	
	QMH Financial Summary 2014-15	QMH Financial Position - To Month 12 2014-15	
	QMH Financial Summary 2015-16	QMH Financial Summary 2015-16	
	QMH in-month activity target monitoring	QMH in-month activity target monitoring	
	QMH Monthly Discharges Report	Number of monthly discharges on Mary Seacole ward	
	QMH Outpatient Appointment Measures and Clinic Sessions	QMH Outpatient Appointment Measures and Clinic Sessions	
RiO	Community Activity by ServiceLines	Community Activity by ServiceLines	
	Community Activity Charts	Community Activity Charts	
	Community Appointment Details by Caseload	Next 7 days Appointment Details by Caseload	
	Community HCP Activity	Number of Rio Attended activity for the selected HCP	
	Community HCP and Locations	Number of Rio Attended activity for the selected HCP at the selected l..	
	Community Nutrition & Dietetics Referrals - Excluding Weight Management Team	Number of Referrals to Nutrition & Dietetics Service by Month/Year	
	Community Referrals by Service Line	Time between Referrals & First Appointment (Direct as well as Face-t..	
	Community Team Caseload	Team Caseload - Number of Referrals Active within the Month	
	Community Teams and Locations	Number of Rio Attended activity for the selected Teams at the selecte..	
	Ethnicity by HCP	List of Patients (by HCP) whose Ethnicity is Not Known at the time of I..	
	No_Outcomes_By_HCP	Number of Rio noutcomed activity by HCP for each day of the selecte..	
	Out Of Borough Patient Map	Out Of Borough Patient Map	
	Out Of Borough Report	List of Patients with a Wandsworth GP (CCG-08X) and Non-Wandsw..	
	Outcome Measures	Outcome Measures	
	RiO Cancellations Analysis	RiO Cancellations Analysis	
	RiO Community Activities by ServiceLines	Number of RiO Attended Activities by Service Line for selected Month..	
	RiO DNA Rates by Clinic	% DNA and number of DNAs by Clinic for the selected Service Line	
	RiO DNA Rates by HCP	% DNA and number of DNAs by HCP for the selected Service Line	
	RiO Ethnicity Summary	RiO Ethnicity Summary	
	RiO Podiatry AQP Report	RiO Podiatry AQP Report	
RiO Data Quality	CSW RiO Equality Report	Activity by Age, Gender and Ethnicity on Attended and DNA activities	
	RiO Data Quality Report	Number of clients on an active caseload by age and gender	
	RiO Open Referrals	RiO Open Referrals	
SystmOne	HMPW Activity and Unused Slots report	HMPW Activity and Unused Slots report	

QMH Outpatient Appointment Measures And Clinic Sessions

Appointment Measures by Treatment Function

	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016	Grand Total
Attended	7,535	6,884	8,073	8,277	7,091	7,905	8,183	1,059	0	0	0	0	55,007
No Outcomes	1	1	2	6	0	0	27	6,116	3,257	1,427	625	296	11,758
First DNA	390	372	390	539	460	548	502	55	0	0	0	0	3,256
Follow Up DNA	644	607	630	710	593	805	704	79	0	0	0	0	4,772
First DNA Rate	8.9%	9.4%	8.5%	10.7%	10.5%	11.3%	9.9%	1.5%	0.0%	0.0%	0.0%	0.0%	8.5%
Follow Up DNA Rate	8.9%	9.2%	8.1%	9.0%	8.7%	10.1%	9.0%	1.4%	0.0%	0.0%	0.0%	0.0%	7.6%
First to Follow Up Ratio	1.6	1.6	1.7	1.5	1.5	1.6	1.4	1.3					1.5
Cancelled by Hospital	1,204	1,100	1,421	1,383	1,174	1,491	1,496	1,071	576	260	126	75	11,377
Cancelled by Patient	1,630	1,458	1,729	1,894	1,761	1,968	1,818	917	262	61	29	11	13,538
Cancelled on the Day	246	112	119	140	114	153	131	8	0	0	0	0	1,023
% Cancelled Slots Unused	48.9%	46.1%	48.7%	46.9%	47.6%	47.2%	45.3%	49.0%					47.3%
Cancelled Slots Unused	1,163	989	1,288	1,268	1,149	1,343	1,255	193					8,648
Avg. WaitDays	28.3	30.1	34.5	30.6	29.2	31.6	34.6	30.9					31.4
Avg. Wait (Weeks)	3.7	4.0	4.5	4.0	3.8	4.2	4.6	4.0					4.1

Nelson Monthly Reports - KPIs and Activity reports

Numerator - Number of first OP appointments cancelled by the patient in a month

	Sep-15		Grand Total
	Merton	Non-Merton	
Cancellation_Reason			
Administrative Error		1	**1**
Alternate Treatment (Other Trust)		1	**1**
Appointment not required	2		**2**
DNA- Remove from waitlist	2		**2**
Moved away		1	**1**
NULL	30	49	**79**
Other - Patient cancellation	2		**2**
Patient - Other more pressing engagement		1	**1**
Patient Cancel	3	13	**16**
Patient gone private	1	1	**2**
Patient got better	2		**2**
Patient in hospital		1	**1**
Patient not well	1		**1**
Patient on Holiday	2		**2**
Working commitments		1	**1**
Grand Total	**45**	**69**	**114**

Denominator - Total number of first OP appointments booked in a month

	Sep-15	Grand Total
Merton	555	**555**
Non-Merton	440	**440**
Grand Total	**995**	**995**

Numerator - Number of follow up appointments cancelled by the patient in a month

	Sep-15		Grand Total
	Merton	Non-Merton	
Cancellation_Reason			
Appointment not required	1	2	**3**
NULL	32	32	**64**
Other - Patient cancellation	1		**1**
Other patient reason- reschedule		1	**1**
Patient Cancel	4	5	**9**
Patient gone private	1		**1**
Patient in hospital	1		**1**
Patient not well		1	**1**
Patient on Holiday	1		**1**
Patient unable to attend	1		**1**
Working commitments		1	**1**
Grand Total	**42**	**42**	**84**

Denominator - Total number of follow up appointments booked in a month

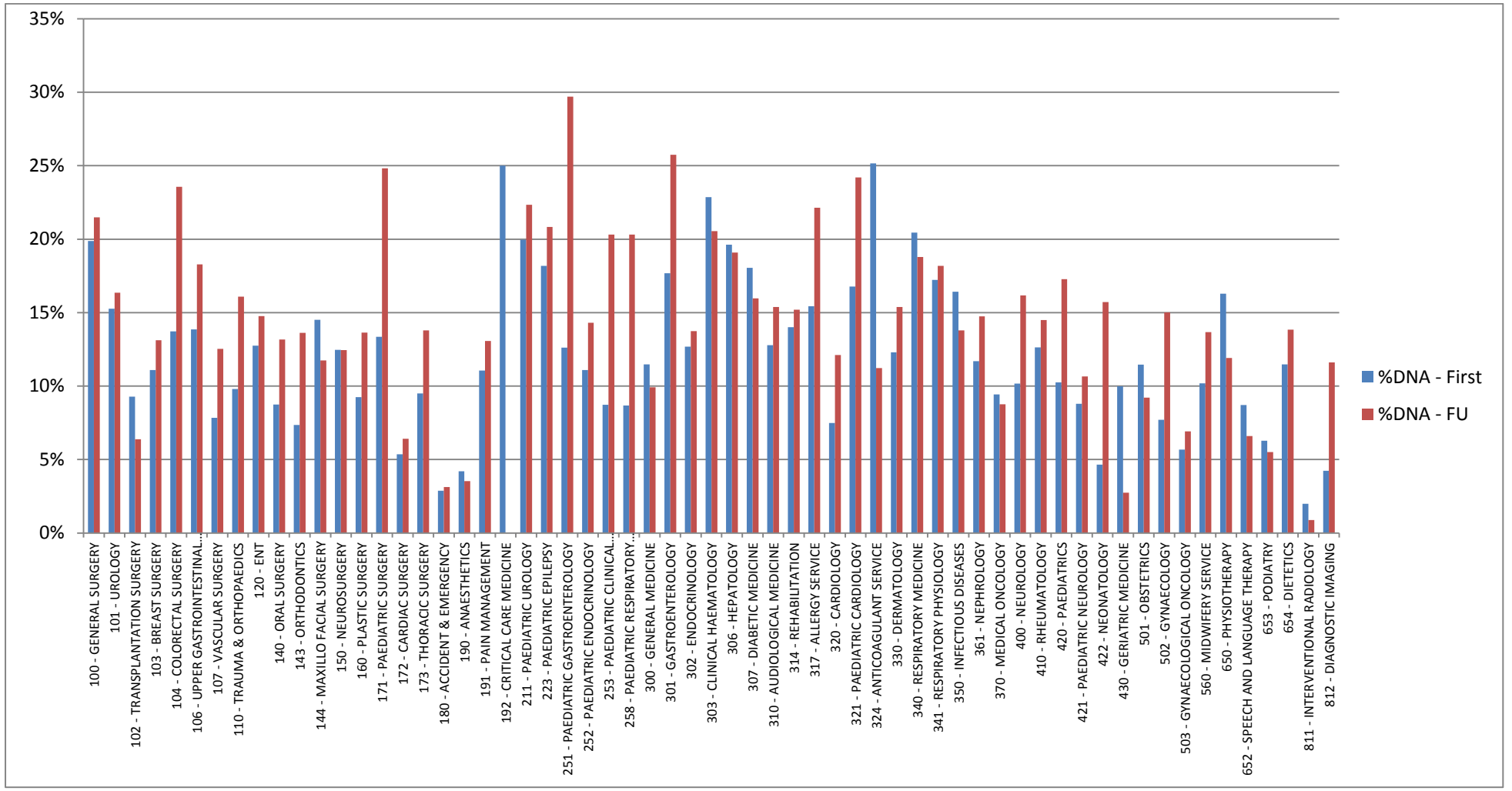
	Sep-15	Grand Total
Merton	323	**323**
Non-Merton	287	**287**
Grand Total	**610**	**610**

APPENDIX 2

DNA Rates for Corporate Outpatients split by speciality (based on Iclip data April 2014 to Oct 2015

Row Labels	%DNA - First	%DNA - FU
100 - GENERAL SURGERY	20%	21%
101 - UROLOGY	15%	16%
102 - TRANSPLANTATION SURGERY	9%	6%
103 - BREAST SURGERY	11%	13%
104 - COLORECTAL SURGERY	14%	24%
106 - UPPER GASTROINTESTINAL SURGERY	14%	18%
107 - VASCULAR SURGERY	8%	13%
110 - TRAUMA & ORTHOPAEDICS	10%	16%
120 - ENT	13%	15%
140 - ORAL SURGERY	9%	13%
143 - ORTHODONTICS	7%	14%
144 - MAXILLO FACIAL SURGERY	15%	12%
150 - NEUROSURGERY	12%	12%
160 - PLASTIC SURGERY	9%	14%
171 - PAEDIATRIC SURGERY	13%	25%
172 - CARDIAC SURGERY	5%	6%
173 - THORACIC SURGERY	9%	14%
180 - ACCIDENT & EMERGENCY	3%	3%
190 - ANAESTHETICS	4%	4%
191 - PAIN MANAGEMENT	11%	13%
192 - CRITICAL CARE MEDICINE	25%	0%
211 - PAEDIATRIC UROLOGY	20%	22%
223 - PAEDIATRIC EPILEPSY	18%	21%
251 - PAEDIATRIC GASTROENTEROLOGY	13%	30%
252 - PAEDIATRIC ENDOCRINOLOGY	11%	14%
253 - PAEDIATRIC CLINICAL HAEMATOLOGY	9%	20%
258 - PAEDIATRIC RESPIRATORY MEDICINE	9%	20%
300 - GENERAL MEDICINE	11%	10%
301 - GASTROENTEROLOGY	18%	26%
302 - ENDOCRINOLOGY	13%	14%
303 - CLINICAL HAEMATOLOGY	23%	21%
306 - HEPATOLOGY	20%	19%
307 - DIABETIC MEDICINE	18%	16%
310 - AUDIOLOGICAL MEDICINE	13%	15%
314 - REHABILITATION	14%	15%
317 - ALLERGY SERVICE	15%	22%
320 - CARDIOLOGY	7%	12%
321 - PAEDIATRIC CARDIOLOGY	17%	24%
324 - ANTICOAGULANT SERVICE	25%	11%
330 - DERMATOLOGY	12%	15%
340 - RESPIRATORY MEDICINE	20%	19%
341 - RESPIRATORY PHYSIOLOGY	17%	18%
350 - INFECTIOUS DISEASES	16%	14%
361 - NEPHROLOGY	12%	15%
370 - MEDICAL ONCOLOGY	9%	9%
400 - NEUROLOGY	10%	16%
410 - RHEUMATOLOGY	13%	15%
420 - PAEDIATRICS	10%	17%
421 - PAEDIATRIC NEUROLOGY	9%	11%
422 - NEONATOLOGY	5%	16%
430 - GERIATRIC MEDICINE	10%	3%
501 - OBSTETRICS	11%	9%
502 - GYNAECOLOGY	8%	15%
503 - GYNAECOLOGICAL ONCOLOGY	6%	7%
560 - MIDWIFERY SERVICE	10%	14%
650 - PHYSIOTHERAPY	16%	12%
652 - SPEECH AND LANGUAGE THERAPY	9%	7%
653 - PODIATRY	6%	6%
654 - DIETETICS	11%	14%
811 - INTERVENTIONAL RADIOLOGY	2%	1%
812 - DIAGNOSTIC IMAGING	4%	12%
AVERAGE	12%	14%

DNA Rates – Chart



APPENDIX 3

Notes from external review meetings

Trust	General	Staffing	IT system	Receipt	Review	Booking	Delivery	Follow up	Additional Info
Barts Health	2 session days Fixed times for slots (1 Dr = 1 List = 1 room) Clinic Templates managed by Template team who sit within Outpatients 6 weeks cancellation 2 week notice for AdHoc	Staff split across sites - 550 total staff for Outpatients across 4 sites 2 teams for central booking/call centre	CRS	All referrals received booked immediately with fixed appointment (Triage occurs after booking) Fax/Email/paper 30% of specialities manage own referrals	Paper triage Milk round to take referrals to consultants/back to CBS Triage letters are scanned onto EPR	Room capacity is managed manually - no electronic system	Text reminder goes out to patients quotes £150 cost to Trust if patient doesn't arrive 12% DNA rate at Royal London Rolled out Intouch booths for clinics at Barts		Have undertaken Outpatient Review 3 years ago - will share SOP/letter templates Intouch Business case
Royal Free	2 session days 5 sites 1 million + patients per year	One management team across 5 hospitals	Cerner PAS	Issue Fixed appointments. 2 booking offices who have call centre/booking of referrals.	Mix of e_triage and paper triage Letters scanned onto EPR "Paper lite"	Designed an in-house room booking template that is on Intranet All template requests have to go through Outpatient management - no local builds. Back office template build team sits within Outpatients Charge £150 for AdHocs	Use a CRONOS telecalling system Text reminders used at Chase. Use check in booths to check in patients - have not rolled out consultant calling yet but do plan too.	Patients book appointment on the day in clinic Don't partially book and do have capacity issues for f/u slots	ALL referrals come into one centre (TWR) Admin teams move around and come into main hub RF to learn the processes Merging Chase Farm onto PAS systems - replacing current paper
Imperial	40% of Outpatients on corporate model - Trust has target of moving 100% of services onto corporate model. Trust strategic vision - one model, one process for all sites. 2 session days No evening weekend working No management to templates	CBS function - 55 WTE call centre and booking and admin Multi site (4 acute sites) Booking office based on one site - one route in (Charing Cross)	Cerner Millenn	Booking office based on one site - one route in (Charing Cross) Some areas have paper deliveries to sites St Mary's bus delivering referral Paper based referrals	Triage protocols - referral comes in and admin staff look at referral and will book into clinic All FIXED appointments apart from TWR	WebChat portal - patient can reschedule Patients ring in to rearrange 8-8 call centre Monday to Friday Generic email account Looking at local Patient Portal Planning on implementing Royal Free model of intranet/excel sheet to publish room availability	Choose and Book uptake is poor Directory of Services review - not set up to be able to use it. Has work stream to improve the % uptake of C&B	Aiming for patients to be booked on the day - monitors number of outcomes forms on the day. **Innovation** Room usage 40% time clinic DCC 60% doing admin (oncology) HUB all clinician come to hub and have discussion. Dr has COW go to patient - all admin/notes/junior conversation	Email correspondence - outsource all printing and postage function All letters will then be sent by email 50p to 5p per email Synatec - exiting relationship with the rest of Trust Use check in booths - asked to provide email and mobile numbers 2000 a month rolled out check in consultant calling function Waiting time information - using calling function to calculate Floor walker model to meet and greet - pro actively use the check in booth Letters about kiosk goes out - promote on the intranet. Procuring services of Natalie Grays (Guys and Thomas Outpatient Disney model) to deliver customer care training. She has also delivered
Epsom and St Helier	1900 referrals per month across the 3 sites Use Access Policy to drive outpatient care	Now have decentralised model (this came in when trust was in Turnaround) there is a plan to move back to centralised model and Trust will take advice from PWC on this shortly.	Isoft	Referrals recvd to nhs.net email address Faxed, manual letters sent. - there is central booking team who register referrals - each directorate has its own POD who then manage the booking/rescheduling of referrals	Paper triage process - the referral letters and patient notes are moved between sites by hospital bus	PODs handle the booking of appointments locally. A twice weekly meeting is held with all PODS to address RTT/performance issues - these are mapped against a performance. No fixed appointments - they have same process as us of 2 letters/calls and then discharge back to GP if no response.	Intouch Booths in most outpatient clinic areas only use them for patients to check in with not implemented consultant calling system - they do plan to do this no timeframe given. PODs have Admin and Nursing teams assigned to them (from what was the central function)	PODs manage all follow up appointments locally	Outsourced the call centre 5% DNA rate. ERS Connect are the company - they have targets for creating free'd up slots through contacting patients prior to appointment - these slots are then rebooked by the POD's which means reduction in DNAs/wasted slots on the day. Consultant leave is 6 weeks in advance. Any last minute clinic cancellations consultants are expected to reproved

APPENDIX 4
Current overview of specialities at St Georges Hospital site who use the Corporate Outpatients model

Service Line	Yearly OP volume	Referrals - registrations Cos Used?	Referrals - booking COS used?	Clinic A&C COS used?	Clinic Nursing COS used?
Senior Health	3,652	TRUE	FALSE	tbc	TRUE
Blood Pressure Unit	4,168	TRUE	TRUE	TRUE	TRUE
Cardiac Surgery	3,284	TRUE	TRUE	TRUE	TRUE
Thoracic Surgery	880	TRUE	TRUE	TRUE	TRUE
Cardiology	77,244	TRUE	TRUE	TRUE	TRUE
Chest Medicine	19,856	TRUE	TRUE	TRUE	FALSE
Clinical Haematology	8,464	TRUE	TRUE	FALSE	TRUE
Haematology : Anti-Coagulant Clinics	22,508	TRUE	FALSE	TRUE	FALSE
Clinical Infection Unit	1,928	TRUE	TRUE	TRUE	TRUE
Dermatology	23,988	TRUE	TRUE	TRUE	TRUE
Lymphodema	8,848	TRUE	TRUE	TRUE	FALSE
Chiropody	7,952	FALSE	FALSE	TRUE	TRUE
Diabetes/Endocrinology	17,200	TRUE	TRUE	TRUE	TRUE
Emergency Department	4,416	FALSE	FALSE	tbc	tbc
Gastroenterology	13,520	TRUE	TRUE	TRUE	TRUE
Oncology	11,040	FALSE	FALSE	FALSE	TRUE
Renal Medicine	4,880	TRUE	TRUE	TRUE	TRUE
Renal Transplant	4,396	TRUE	FALSE	FALSE	FALSE
Rheumatology	22,364	TRUE	TRUE	TRUE	TRUE
Vascular Surgery	6,220	TRUE	TRUE	TRUE	TRUE
Gynaecology	34,660	TRUE	TRUE	TRUE	TRUE
Radiology	176	FALSE	FALSE	FALSE	TRUE
New Born Services	1,048	FALSE	FALSE	TRUE	FALSE
Obstetrics	44,220	FALSE	FALSE	TRUE	TRUE
Paediatric Medicine	19,320	TRUE	TRUE	TRUE	FALSE
Paediatric Oncology	12	FALSE	FALSE	TRUE	FALSE
Paediatric Surgery	4,224	TRUE	TRUE	TRUE	FALSE
Dietetics	2,524	TRUE	TRUE	FALSE	FALSE
Paediatric Physiotherapy	2,852	TRUE	FALSE	TRUE	FALSE
Physiotherapy	65,420	TRUE	TRUE	TRUE	FALSE
Speech and Language Therapy	1,640	TRUE	TRUE	TRUE	TRUE
Dental	17,132	TRUE	TRUE	FALSE	FALSE
Audiology	15,616	TRUE	TRUE	TRUE	TRUE
ENT	21,528	TRUE	TRUE	TRUE	TRUE
General Surgery	25,956	TRUE	TRUE	TRUE	TRUE
Maxillofacial	13,740	TRUE	TBC	FALSE	FALSE
Neurology	20,224	TRUE	FALSE	TRUE	TRUE
Pain Clinic	3,700	TRUE	FALSE	TRUE	TRUE
Neuro Surgery	9,140	TRUE	FALSE	TRUE	TRUE
Plastic Surgery	26,456	TRUE	TRUE	TRUE	TRUE
Neuro Rehabilitation	1,436	FALSE	FALSE	FALSE	TRUE
Trauma & Orthopaedics	39,044	TRUE	TRUE	TRUE	TRUE
Theatres	11,116	FALSE	0	FALSE	FALSE
Urology	14,448	TRUE	TRUE	TRUE	TRUE

Appendix 5

GP Engagement Session Outpatient Strategy Workshop

2 September 2015

Present:	**Organisation**
Dr Rosie Savage (RS)	GP Principal Falcon Road Medical Centre
Shelby Gibbs (SG)	Balham Park Surgery
Sharon Bailey (SB)	Balham Park Surgery
Dr Haider Saad (HS)	The Haider Practice, St John's Therapy Centre
Dr Patrick Bower (PB)	Balham Park Surgery
Reena Sidhu (RS)	Central Booking Services (CBS)
Laura Yarnell (LY)	Programme Manager, Service Improvement
Dyhian MacKenzie (DM)	Strategy team
Vicky Mitchell (VM)	Strategy team

1. What works well about our outpatient service?

- Booking follow up appointments works well, and the secretaries of the consultants are very helpful and seem to be knowledgeable.
- e-Referral (eR) is good and works well. There are just not enough appointments offered on it (in particular, RS mentioned Haem, Neuro, Pain clinic and ENT not on at all). We should have 80% of our capacity on it. Information on eR is not very good, and it's hard to tell which clinics are which.
- PB advised that eR is very good, and works well for them, and should be convenient for the provider too, as it requires less work for all. Also the advice system on eR is good and free- should the trust not be using that instead? This would need to be taken up with the CCG.
- RS advised that in general patient experience with us is good, and she found the GI service in particular to be very good.
- QMH- system generally good. ENT, orthotics and cardiology services work very well.

2. What can we improve on?

- PB advised that getting hold of CBS is very difficult and call times are bad. Vicky advised this was a known issue and that there is work going on to improve this.

- e-R: some discussion about what a referrer does when there are no appointments on and the defer to provider option. Advice given to patients from the eR national office is to go back to get re-referred from their GP. Reena explained that how eR works is rather out of our control. PB advised this is no excuse and that after so long we should be able to make the systems work for us.

- RS- timeliness of letters from outpatient appointments- one letter took 3 months to get to the patient, which is unacceptable. RS to send patient details to Reena so she can track what happened.

- RS- inappropriate delegation of tasks from hospital staff (usually junior doctors we assume) to GPs, such as GP to chase blood results., or follow up with patient about some other unrelated symptom. This is across the board. PB argued that it comes down to how letters are worded, ie "During the appointment the patient mentioned getting headaches, and I felt you should be made aware of this…." As opposed to GP to follow up as patient complains of headaches.

- PB- too long for follow-up with patients, who need a review of results or new meds, not clinically appropriate to see a blood pressure patient on new meds for a f/u after 6 months.

3. What can we learn from other Trusts you refer to?

- Ultrasound is on paper and should be done electronically. Question, can this be done via DXS?

4. Other comments, questions and suggestions

- GPs and practice staff would feel better emailing non eR referrals to the email address if they got some automated read receipt so they know that it has arrived and been opened. Reena said she would set that up.

- PB- suggest that healthcare needs to move with the times, and that consultants and GPs should meet in person to discuss what an op appointment should look like now (for example, specialist nursing taking on follow up appointments etc.) **poss BtG event topic here?!

- TWR- confirmed it was fine to follow up an eR with a fax or letter, and that duplicates would be deleted.

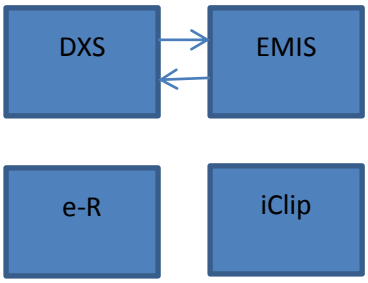
- Consultant to consultant referrals – still issues of inappropriate patients being sent back to GP (although very rarely twr) and feeling is that new doctors need reminding that in WW this has relaxed. Why if ENT refer patient to aud colleagues, do aud have to ask the GP to resend the referral to them? Reena explained, need clarity on this.

- Q: Do you find that you get a better service when referrals are service managed or CBS managed? The response was that the services tend to only have 1 person managing the referrals and therefore are much harder to get hold of when you need help. (eg RAPC). It works better when one team owns and manages all the referrals. Reena explained how eTriage helps with the triage process and enables everyone to see clearly where the referral is in the process.

- DXS- some missing forms on DXS, eg RAPC and retinal screening – Vicky advised this was a work in progress and she would follow this up.

- PB asked if clinic letters are on an electronic system. Reena advised we are working on Dictate IT talking to EDM, which would automatically put them on.

- I asked the GPs about how they felt about the fax ban and the possibility of sending referrals by email. They said they were fine with that, because DXS populates the form which is already electronic, and all you have to do is attach to an email and send.



Appendix 6

Mary Bluden – Carer of Ian Blunder	*Aneta Gordon – Patient*
What worked well for you? Any positives you can think of? Mr Paviour's - Neurology. Feel like an individual not a number. He asks if it's ok to have a student in the room. Shuts the door after entering. Receptionist also very good, speaks to patients individually if there is a delay. Honest about waiting time reasons for delay. **What would have added to your experience?** Communication – When an appointment has been rescheduled letter says this has been changed but no reason why. CBS – varied experiences. Some good and have rebooked and explained why the change was required. Others are really bad. Transparency is needed – straight talking and honest. **Do you use any similar services we could learn from at STG?** Internal Referral – took over a month to refer to a consultant in the same wing of the hospital due to internal paper process. Electronic referral could have saved weeks Orthopaedics – at Kingston hospital patient goes for x-ray and is asked to report to nurse when back. At STG nurse seems to be calling patients that aren't there. X-ray – 95% of patients need an x-ray so why do you have to wait to see the consultant to be told to go for an x-ray and come back. Frustrating and time consuming. Pain form – No option to say no change. Could introduce an option that says if no change tick here. Or if there is a change please complete the part that has changed. Minimise time. **Your thoughts on more access/ control on appointments?** Would be useful. As currently have many different appointments. Currently have something similar in GP. Would save paper. Really liked the texting option. **Anything else** Notes between hospitals – Secretary hadn't filled notes that had been sent through from another hospital. Even though patient called to confirm they had been received. Discharge summary should be available electronically between	**What worked well for you? Any positives you can think of?** When a member of staff really listens to what you are saying and responds appropriately. Giving realistic timeframes **What would have added to your experience?** GP referral - Process is too slow. Appointments have been cancelled 6 times then booked into wrong clinic to be told you need to see the consultant that clinic had been cancelled. Customer relations person – Could available at clinics to deal with issues before they escalate to complaints. **Do you use any similar services we could learn from at STG?** Guys Hospital – Made a complaint and manager came and resolved before it needed to be escalated. Getting a manager at STG is very difficult. No one seems to say sorry or care when a complaint is made. **Your thoughts on more access/ control on appointments?** Don't like online access to appointments personally but should be a choice available to patients. **Anything else** Portering – localised portering waited 4 hours in the past for ultrasound. Some porters are very rude and not nice at all to you. Wondered if there are targets for portering services? Really liked the text message service. This should be reintroduced.

APPENDIX 7

Paper on proposed Neurosciences Booking Pilot

Proposal and Outline

This paper is to outline the process involved in setting up the outpatient bookings pilot within Neurosciences which has been run in conjunction with the Neurosciences department and Corporate Outpatients. The proposal for this pilot was initially approved in 2013 and the development of an Outpatients booking team has been the subject of much discussion between Outpatients and Neurosciences in order to finalise the details and scope of the pilot. In August 2015, a formal agreement was made between the two departments to transfer two staff members from Central Booking Service from 07 September – an equivalent of the staffing levels funded by the Neurosciences' cross charge to Central Booking Service (CBS). The agreement was that the two staff members would transfer for six months – the duration of the pilot – in order to support the pilot team. At this point, all CBS functions for Neurosciences including the booking of Neurology and Pain Clinic new patient appointments would be transferred to the Outpatients pilot team. These two staff members would then support the team currently funded by the Neurosciences department to oversee the booking of Neurosurgery appointments including new and follow up appointments.

Implementation Process

The Neurosciences management team took responsibility for setting up all the arrangements for the booking team within the Neurosciences department. This meant finalising the recruitment of the bookings staff for Neurosurgery, arranging the transfers of the staff from CBS for the duration of the pilot. From a logistical perspective, new phone lines had to be set up for the staff to use, department NHS.net accounts set up for the receipt of referral, pathways for referrals to be transferred to the team within the department, the office itself set up with computers and printers ordered and set up by IT. We also had to request new letters on iClip to show all the information for the new telephone numbers for the booking team, agree referral pathways with CBS and agree phone scripts and training for all staff members in the team in consultation with the clinical teams.

Findings at Month 1

The findings at Month 1 of the pilot have been very positive thus far, with the clinical teams in particular, responding very positively to having the bookings team based within the area. The response for feedback has been positive and generally they have found the team to be very approachable and have noticed a real impact in terms of the feedback they receive in terms of the booking process themselves and also from patients. Particular feedback has revolved around the close feedback the clinician receives from the team when a tertiary referral is sent to them but the patient does not respond to their call – this allows the clinician to decide whether to proceed with a booking or to discharge the patient.

In terms of performance, the Neurosciences department has witnessed an extraordinarily positive swing in terms of its first outpatient waiting list with the waiting list itself ranking among the best in the Trust in terms of data quality and the accuracy of the information. Furthermore the team have been proactively booking patients into telephone clinics – a key financial action for Neurosciences - as well as trying to reuse slots where possible through bringing patients forward on the waiting list. In terms of issues, the lack of dedicated telecommunications support has been challenging and impacted on our ability to effectively monitor the volume and quality of calls the team are receiving. There have also been issues in terms of the phone lines which were set up, which has caused issues internally and externally for patients to get through – however any instance where this occurred has been investigated and the team have proven to be thoroughly responsive to any issues raised. Once the electronic telephone system has been set up, we anticipate that these issues will be resolved. In terms of patient feedback, overall the level of feedback has been positive, however the issues in terms of telephone systems and incorrect phone numbers being given was raised on two or three feedback calls and is something we will monitor moving forward. In comparison to feedback pre-pilot, generally there was a view that the system involved less waiting and felt more intelligent, but there was no significant swing in terms of positive or negative feedback in comparison to the pre-pilot findings.

Metrics at Month 1

Unfortunately due to aforementioned issues with IT and the ongoing budget reset process – it has been challenging to collate a completed scorecard based on the metrics mentioned. We hope to have these resolved by Month 2 – but the metrics outlined below are the completed set we have currently at Month 1 in terms of performance and previous benchmarking figures.

OP Monthly Metric	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Median Waiting Time in Neurology	5	6	5	5	4
Median Waiting Time in Pain	5	4	4	4	3
Median Waiting Time in Neurosurgery	5	5	4	5	5
Number of total referrals on Waiting List - Neurology	1119	1192	1173	1045	1047
Number of referrals on Waiting List - Neurosurgery	859	928	886	805	747
Number of referrals on Waiting List - Pain	389	436	457	238	249
Number of unutilised slots - Neurology	389	499	393	300	404
Number of unutilised slots - Pain	55	71	31	42	37
Number of unutilised slots - Neurosurgery	88	132	86	90	91
Number of patients at referral status - Neurology	329	289	283	290	59
Number of patients at referral status - Pain	107	100	107	60	22
Number of patients at referral status - Neurosurgery	303	284	303	298	103
Number of patients at deferred status - Neurology	21	15	17	11	12
Number of patients at deferred status - Pain	13	12	17	1	3
Number of patients at deferred status - Neurosurgery	147	133	49	78	35
Number of patients at requested status - Neurology	51	86	180	109	54
Number of patients at requested status - Pain	23	31	71	33	36
Number of patients at requested status - Neurosurgery	2	1	5	1	2
Triage turnaround time	5 days	5 days	5 days	5 days	1 day
DNA Rate for Neurology	11%	11%	12%	13%	17%
DNA Rate for Pain Clinic	10%	12%	10%	15%	15%
DNA Rate for Neurosurgery	9%	11%	10%	11%	20%

Triage turnaround has been exceptionally high across the board, however due to issues with IT we have been unable to use e-triage effectively. We hope to resolve this as part of the pilot. Complaints data has been relatively low, and there was only one PALS concern raised in September about a patient who was unable to get through to the call centre line – with further telecommunications support we anticipate this will be resolved moving forward.

Month 1 Issues

1) Lack of Telecommunication and IT support
2) Inability to resolve issues about email and telephone changes
3) Communications internally as a result of the above
4) Lack of a compatible scanner due to issues within Procurement

Next Steps

The next phase of the pilot will seek to do the following:

1) Reduce DNA rates through identifying problematic clinics and contacting patients– our DNA rates were higher in September and we need to identify why this happened. Given the time taken to bed in the pilot, we think this is likely to be a coincidence but this is something we need to improve upon.
2) Improve communications and marketing for Neurosciences – we have drafted a business card for all letters as well as for use at the clinic reception to improve the image of Neurosciences bookings.
3) Complete the integration of telephone system to enable comprehensive and intelligent use of phones throughout the team
4) Arranging communication days with GPs to market the Neurosciences service.

Greater use of our website as a portal for GPs and patients to communicate with our clinical teams and also seek to increase our potential market-share through better marketing

Set up costs

Scanner	£400
Licence for Scanner from Kodak TBC	£2500
Barcode Scanner -	£350
Barcode Equipment	£100
Phones	£815
General Office Equipment	£150
Netcall system	£1500
Total	£5815

Staffing Costs

The Neuro team have offset some of the staffing costs through using underspend in other areas from their budget.

The total staff costs for running this model will be £146,824 for a volume of 350 referrals a week or 18,000 referrals a year.

Job Role	Band	Comments	Costs	Cost comment	14/15	15/16	Balance
Team Leader	Band 4	Role created from Band 5 vacancy to support bookings management for Neurosurgery	£28,174	Overall in year saving of £11,581	£39,755	£28,174	£11,581
Co-ordinator	Band 3	Transfer from CBS - covered by cross charge	£23,730	Offset by cross charge - costs within OP	£23,730	£23,730	£0
Co-ordinator	Band 3	Transfer from CBS - covered by cross charge	£23,730	Offset by cross charge - costs within OP	£23,730	£23,730	£0
Co-ordinator	Band 3	Previously temporary staff member - converted role to permanent – circa £63k spend overall in Neurosciences last year	£23,730	Saving of £7770	£31,472	£23,730	£7,742
Co-ordinator	Band 3	Previously temporary staff member - converted role to permanent – circa £63k spend overall in Neurosciences last year	£23,730	Saving of £7770	£31,472	£23,730	£7,742
Co-ordinator	Band 3	Role created from savings from funding for other roles in Neuro budget to support booking team due to demands on service.	£23,730	Role created from previous roles within Neurosciences - converted budget to create 1 WTE Band 3.	£0	£23,730	-£23,730
						TOTAL:	£3,335

APPENDIX 8

23.10.15 –Board Update

Call Centre

The Board has previously been informed of issues encountered in the call centre, which have resulted in long queues and poor patient experience.

As reported in the previous action plan update a revised plan to address the issues has been developed and is being implemented. Current actions taken and planned actions are below. It is estimated that response times will return to the 1 minute expectation by the 4th January 2016.

The last eight weeks performance and full information on the action plan can be found below:

Table 1 - Current Performance:

Performance from the last 8 weeks:

Week Commencing	Total calls	Answered	% answered	Mean response	Median response (answered calls only)	% answered within 30 secs
31st August 2015	5869	2902	49.40%	10:32	08:36	1.7%
7th September 2015	6022	4118	68.40%	05:06	04:23	9.2%
14th September 2015	5762	3988	69.20%	05:13	04:42	7.9%
21st September 2015	5140	4162	81.00%	02:39	01:29	26.9%
28th September 2015	5680	4540	79.90%	03:01	02:14	19.5%
5th October 2015	5424	4582	84.50%	02:13	01:33	28.1%
12th October 2015	5806	4312	74.30%	03:42*	03:11	12.7%

19th October 2015**	4514	3920	86.80%	01:43	01:01	33.8%

**there were network issues which affected our ability to answer/process calls during this week

**data up until 12 noon Friday 23rd October

Table 2 – Action plan:

No.	Action	Owner	Completion Date	Detail/ Anticipated impact	Progress/Rag
1	Confirm cease of escalation email from call centre team leaders	JF/AM	12/10/2015	This information is already available on the PTL. Due to the time consuming nature of this task (filtering and searching of the PTL) ceasing of this task will enable team leaders to focus on daily call centre performance and assess the need for more call handlers if necessary.	Email sent – action completed
2	Ensure all vacancies covered with appropriate and competent staff bank staff	RS	31/10/2015	Having removed all agency staff from the call centre there have been some issues with the competency of applicants supplied by staff bank. RS to meet with staff bank to ensure job role and department stated to applicant appropriately and calibre of candidate at appropriate level. This would reduce vacancies and ensure continued appropriate level of call handlers.	Meeting held – action completed No new Staff Bank staff supplied to date with assessment to be carried out on suitability of applicants once in post.
RISK – Inappropriate or unavailable bank staff would mean lack of vacancy coverage/ call handlers and inability to improve call response times					
3	Ensure efficient and timely processing of recently recruited staff	RS/AM	30/11/2015	2 part time staff recruited in June have had offer letters issued recently. 5 external applicants were successful at interview at the end of August – offer letters recently sent	Offer letters have been sent.
4	Recruit permanently to remaining vacancies	RS/AM	30/11/2015	Following the recent recruitment the call centre still has 10 vacancies. Recruiting to these as soon as possible would also enable efficiency gains as per the above. *Assessment of whether*	HR1s to be submitted and signed off prior to advertising.

				increased budgeted WTE needed can take place once department fully established.	
RISK – Delay with processing of staff through the recruitment department would mean delayed start dates and training period and therefore a delayed date to return to the 1 minute response time.					
5	Implement new fixed appointment process for patients	JF/AM/RS	30/11/2015	Currently patients are required to call to confirm when an appointment is to take place. A new process of calling a patient twice (at two different times over the course of two separate days) and then offering a fixed appointment would result in reduced call numbers and better response times from call handlers	
The implementation of the above process would have a dramatic effect on reducing call response times. However, due to current capacity issues within services and the number of patients awaiting appointments, the risk to patient care and potential of large numbers of breaches means a robust process with all influencing parties (Specialities, 18 week team, CBS) in agreement needs to be confirmed before this is implemented.					

Current issues/actions

- Week commencing 12th October saw CBS experience a number of network issues which had a detrimental impact on our call answering ability.
- Continued significant growth in booking requests as part of work to address RTT compliance and targeted actions for some specialities diverting resource from inbound calls.
- Previously recruited staff bank staffs are being fast tracked through training to provide further resource on call answering.
- Re-allocation of work on a Monday morning has meant only 1 staff member processing E-Triage urgent referrals. All other resource is allocated to call handling.
- Team leaders, due to ceasing of escalation emails, have been allocated to aid with call handling when high numbers can be seen.
- Vacancy rate is still high within CBS and although recruitment has taken place and continues to take place training periods have resulted in less resource being available to answer calls. Weekly discussions are taking place with recruitment to ensure successful applicants are fast tracked through the recruitment process.
- Issues with repeat callers may be able to be mitigated with a new call handling system. The current provider, Netcall, have communicated this may be possible. We are meeting with them in the next couple of weeks to confirm and provide an implementation date.
- On-going issues with outpatient capacity causing a backlog of referrals and thus higher demand for immediate capacity, as indicated by “Escalation Email” activity code. Last eight weeks performance shown below:

Week commencing	**Count of calls not resolved first time**

31st August 2015	1406
7th September 2015	1595
14th September 2015	1633
21st September 2015	1466
28th September 2015	1634
5th October 2015	1695
12th October 2015	1801
19th October 2015	1173

Next Steps

- Analysis of incoming calls to determine numbers associated with inappropriate calls for CBS and repeat callers.
    - Carried out for the period 5th August to 16th September we received 40,735 calls.
    - Of these calls 11,559 were patients calling to cancel or rebook their appointment.
    - And 11,352 were general enquiries or follow up appointment bookings.
    - With 5,488 calls regarding appointments on the day of the total amount of calls only 12,336 calls were for New Appointments.
- Meeting with Netcall to discuss text messaging andcall handling management system to take place in next two weeks.
- General Managers from all specialties across the organisation must take a grip of their capacity and demand and be able to be flexible in using all capacity across the organisation, this has to include QMH and the Nelson,
- Robust management of short notice clinics (either adding capacity or removing capacity) is managed via DDO sign off as these are on the increase and have a huge impact on all services due to the short notice. These need to be the exception not the norm, data provided by COS to the DDOs.

APPENDIX 9

Outpatient Strategy Work Stream: Intouch Self-check in and Patient flow

1. Introduction

Intouch check-in kiosks allow patients to register their arrival at an appointment without attending reception. When the patient has checked in clinicians can call a patient to a clinic room using a screen. These kiosks alleviate demand on staff in clinics by freeing time for value added tasks and allow patients manage their own demographic record.

Kiosks are enablers that support the outpatient strategy's aims; reduction of unnecessary administration tasks and less confusion for users of the service. UCLH, Bart's Health and Guy's and St Thomas' are using these kiosks and are reporting benefits. This scoping paper aims to identify current kiosk usage, understand on-going issues and the next steps for kiosks implementation in other outpatient clinic areas. To do this the following stakeholders were engaged; intouch delivery manager, service manager, IT managers receptionists, patients and informatics managers.

2. Background

The Intouch kiosks were first introduced in 2012 at the Rose centre. In 2014 they were extended across other corporate outpatient locations in phases 2/3 at the cost of £110,893 + £12,568 maintenance costs. Whilst initially introduced by an IT project manager the administrative aspects of the kiosks are now being managed by an outpatient service manager and information manager alongside their day jobs. Any technical issues are raised

by them to be completed by the Intouch online helpdesk through a service contract.

Future locations for the kiosks have been identified and the extension cost (quoted in June 2015) was £114,424 + £9,787 support costs. Locations can be found below.

Current	Highlighted for future
Trauma & Orthopaedics	Chest Clinic 2
Therapies	Dermatology Clinic B
ENT/Audiology	Rheumatology Clinic C
Clinic D	Thomas Addison Unit
Paediatrics	Anticoagulant St James's Wing
The Rose Centre	Clinic A
	Antenatal
	Hoop

Use of the kiosks is fragmented and inconsistent as detailed below; further investment cannot be justified without an analysis of current working processes.

2.1. Performance

Analysis using the Intouch reporting system found that over the last 6 months (01/03/2015-31/08/2015) Kiosk check in as an arrival method was 19% with 81% of patients choosing to check in at reception. Another search over a 2 month period (01/08/15-30/09/15) found a clinic breakdown below

Total Kiosk Check-in 22%

Breakdown across areas:

- Rose Centre 18%
- Lanesborough Wing 26%
- St James Wing Therapies 38%
- St James Wing Clinic 2 17%
- Radio6logy 100% (11 Patients)
- Dragon Centre 0%

This variable use across the sites and specialities indicates different clinic practices. As a sample in the whole of August 2015 kiosk use was at 20% in 2015, but in August 2014 not long after roll out of phase 2/3 it was at 27%. This change perhaps indicates reduced corporate visibility as the project got larger.

The numbers of patients using the kiosks is very low, with numbers as high as 80% using the kiosk being reported at other trusts. To understand why this is There are a number of reasons why this is of this which can be grouped into technical and cultural issues (captured in full in Appendix 1).

2.2. Issues

- The technical issues are caused by issues with the connection of the intouch Blue Prism system and ICLIP preventing patients being recognised and delays in demographics update. There is also an issue with kiosk success rate that means that 41% of patients using are not successful (see Appendix 1)
- The cultural issues are that the kiosks are not well signposted and are not in convenient places causing many patients to walk straight past them. Clinicians

also do not use the system to convey patients.

2.3. Risks

- The return on investment for Intouch health kiosks will not be realised
- Confusion in clinics where booths are visible but not being used/switched on

2.4. Summary

The kiosks have real benefits for management of clinics, queue reduction and patient conveying, however clinics are still very busy with long lines at reception, kiosks have little to no effect. These benefits aren't being optimised due to inefficient use of kiosks. Patients have also noticed that the system was underutilised; being mentioned in 2 patient complaints. The Trusts investment must be maximised before considering further roll out.

3. Recommendations

Best practice and observations were used to inform the below recommendations. Time frames for these will feed into the first phase of the turnaround outpatient programme (Dec 2015 -June 2016)

1. ***Use of Human Stewards.***

   Human stewards have been shown to increase usage in busy clinics by encouraging people to use the kiosk. This concierge person would provide patient education and assistance in using the kiosk in the waiting area. The Trust already uses volunteers to complement our services and make a difference to patient experience. The clinic managers should request a volunteer through volunteer services or designate a HCA to assist if they are idle.

2. ***Rebrand/Promote the kiosks.***
   Reduced uptake since 2014 suggests lost momentum in use. A *marketing plan to improve employee motivation, highlighting benefits to receptionists will help understanding.* Receptionists play an important role in increasing comfort levels among patients. This should be raised at admin meetings with a discussion on the focus; calling through or checking in.

3. **Training.**
   It was clear from conversations that receptionists and clinicians were not sufficiently engaged in the initial roll out. Some didn't feel prepared to use and promote the kiosk to patients. For this to happen there needs to be a greater understanding of its full capability and utility. Technical assistance should be easily accessible and documentation should be written for any common issues. This training should be included in a receptionist's local induction. Receptionists should be encouraged to turn patients away from the desk to the kiosk at first instance and busy times.

4. **Location.**
   Kiosks placed before reception which are easy to access and allow privacy for patients have increased usage. There needs to be increased focus on the signage and positioning of these kiosks to maximise their use. In situations where the locations of kiosks cannot be moved bright posters and/or patient instructions to assist usage are recommended.

5. **Invest in upgrade.**
    - The organisation should consider investing in the new software moving from 6.3 to 6.4. This would also increase functionality and can be used as an opportunity to continue the rebrand with receptionists/clinicians. This will allow the ability to monitor clinical productivity accurately in Outpatient clinics and track the patient in real-time throughout their outpatient attendance
    - Changing Blue prism to HL7 as part of the code upgrade for Cerner Millennium, due to be completed in December 2015 will allow all patients who have an appointment in ICLIP to self-check in. This will also improve successful demographic updates and reduce the time taken.
    - IT should investigate increasing IP addresses for the Intouch kiosks if it will speed up connections to the server.
    - Patients can currently check in to the system for one hour before and 15mins after their clinic times, the time before should be increased and uniform as it is a key reason for unsuccessful check in (appendix 1).
    - Use the kiosk idle screens to convey clinic messages like waiting times

4. Next Steps

1. I would then recommend analysing usage data again at the end of the first phase of turnaround to see if the improvement has worked. This data can then be used to reassess investment in new booths and roll out in 6 months.
2. The current St Georges Intouch administration function can be strengthened by inviting receptionists, managers and nurses to form a committee/user group. These front line users would be responsible for enacting a continuous improvement plan based on observation in clinics using the kiosks, as well as user generated feedback. This committee would; review upgrade suggestions and ensure consistent changes to the kiosks Trust-wide.
3. A lot of energy and time was spent in implementing kiosks throughout the trust but the follow-up plan was not clear. A comprehensive strategic plan visible to stakeholders from outpatients, information and IT should be written It could outline a 1–3 year plan to achieve on-going success of the kiosks. This plan should include goals for: Usage rates, monitoring, Evaluation, Marketing and Training

Appendix

Technical issues

- There are some mandatory fields that are preventing successful demographic updates. When there are slight discrepancies when entering address and D.O.B or the templates used the patient is rejected forcing them to register at reception. The connection from ICLIP to Intouch is very strict locking out patients for simple mistakes
- There used to be many Data Quality issues where there were issues getting the patients appointment information across and into Intouch. These Data quality issues have improved but are not perfect.
- It is understood that if every booth had their own IP address it would speed up access, at the moment the data is being routed through one IP address at one booth and if there are issue with that one if affects the speeds. To be investigated by IT
- Intouch is currently only allowing 70% of patients to self-check-in. We need to be at 98% for it to be effective.
- Consultants can't call patients through the intouch system if they are checked in through reception

- There have been issues with people turning off screens through the plug. This takes a while to get fixed by technicians.
- There is a system problem that sometimes means that real time updates into Intouch take up to 20mins to appear on ICLIP.
- Patients can check in to the system for one hour before and 15mins after their clinic times. Outside of those times they have to check in at reception. Some clinics only have a 30min window (clinic D)

Cultural Issues

- There can be issues with pooled clinics with registrars seeing patients in order. It could be difficult for an individual consultant to call through the patient; they normally check who is next by looking at the notes.
- Consultants have many systems and do not use intouch at the main sites
- Clinicians weren't engaged in the initial roll out process and weren't trained
- Consultants are only calling people through to clinics at the Rose Centre and many don't do so at busy times
- The receptionists and nurses have become used to calling patients themselves and ignore the capabilities of the systems.
- Patients walked straight past the kiosks as they were not at eye level, patients did not know that the service was available.
- System was viewed as unreliable and many patients were told to check in at the desk in the past so avoid kiosks.
- Receptionists need to double check when a patient has checked in on intouch to then pull out the patient notes; if the patient checking in on the kiosk is not visible they can fail to pull out notes. Patients have been missed in the past

Kiosk Sessions success rate analysis

Kiosk Sessions - Success Rate

Kiosk Area:	**All Kiosk Areas**	Start Date:	**01/08/2015**
Include abandoned sessions?	**False**	End Date:	**30/09/2015**

Arrived		
Completed session - directed to wait area	3384	59 %
Completed session - directed to reception to change demographics	13	0 %
Sub-total	**3397**	**59 %**
Unsuccessful		
No matching or unique patient - demographic check	884	15 %
Directed to reception after selecting 'No' on disclaimer page	402	7 %
Clinic code not valid	333	6 %
Too early to check-in	318	6 %
Too late to check-in	189	3 %
No matching or unique patient - no postcode entered	84	1 %
Not called for second checkin	72	1 %
Incorrect kiosk area	49	1 %
Patient blocked, reception alert	40	1 %
Sub-total	**2371**	**41 %**
Total number of kiosk sessions	**5768**	

Analysis

- The highest cause is no matching or unique patient, this could be due to data quality issues as well as the aforementioned strict demographic templates that are used by Intouch. If these blocks were eased more patients would be successful
- Before Time allowed for check-ins – 318 patients were too early. After Time allowed for check-ins – 189 patients were late. Perhaps the time parameters could be

increased to allow more patients to be able to check-in successfully, particularly the 'too early' ones

- A high number of patients said No on the disclaimer page (402), – this is unusual so maybe they are misinterpreting it? It may be worth looking at the current disclaimer message and seeing if it needs to be amended

APPENDIX 10

Service Level Agreement relating to services provided by the Department of Corporate Outpatient Services

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Corporate Outpatient Services – Service Level Agreement

Contents:

Appendices:

1. Key objectives of the SLA

1.1. To aid Corporate Outpatient Services (COS) in managing resources whilst meeting demand.

1.2. To provide transparent information on the cost of outpatient administrate and clerical, nursing and management support to support specialities in their outpatient activity.

1.3. To detail the responsibilities of all parties and reporting mechanisms to ensure that performance is satisfactory

2. Background:

2.1. The aim of establishing a service level agreement is to manage the workload of

Corporate Outpatient Services in an orderly and efficient way, ensuring that the facilities and resources available are managed to meet the needs of the service user in the support of caring for their patients. Pre-agreeing additional growth, activity/changes and capacity in clinic volumes should enable Corporate Outpatient Services to manage the flow of patients and to respond to changes in clinical activity.

3. COS Functions Included

3.

3.1. Central Booking Service (CBS) – This includes referral management; scanning referrals to eTriage for specialties to review and prioritise (per Appendix 1); management of Choose & Book (C&B); contacting patients after referral for first outpatient appointment scheduling; and outpatient call centre functions including appointment scheduling. The CBS also encompasses the outpatient back office, which is responsible for cancelling appointment and ad hoc clinic build requests. See the Referral to Treatment Access Policy, and the CBS and C&B SOPs for further information.

3.2. Health Records Library – This includes the pulling of records from the library for outpatient care; inpatient admissions via the Emergency Department or electively where no pre-operative appointment is planned; and requests for notes from the library, offsite or in microfilm format. See the Health Records Policy for further information.

3.3. Outpatient Administration – This includes the preparation of health records for clinic; provision of reception function; cashing up of appointments; and scheduling of further outpatient appointments.

3.4. Outpatient Nursing – This includes registered nurses, healthcare assistants, and plaster room technicians for generic outpatient clinics; and specialist functions by local agreement and resource provision, such as dressings clinics or triage of referrals.

4. Exclusions

4.

4.1. The following services are excluded from this SLA

- 4.1.1. Phlebotomy services
- 4.1.2. TWR new patient scheduling
- 4.1.3. Other areas, where a local agreement exists to provide services outside of the terms outlined
- 4.1.4. The scanning bureau or EDM functions, until such time as the roll out is complete and management is transitioned from IT to COS.
- 4.1.5. Building of permanent clinics once capacity has been confirmed by COS. This function sits within IT

5. Terms of Engagement

5.

5.1. It is expected that specialty service users and patients engage with COS proactively and responsibly, to promote efficient use of resource and deliver excellent outcomes.

5.2. In return, it is expected that service users receive a service which represents good value for money, as per the level of investment which they have made.

5.3. A summary of the expectations of and service level provided to a range of COS users is in the compact found in Appendix 1.

6. KPIs for COS

6.1. COS will provide a service in line with the following KPIs:

- 6.1.1. 95% of referrals will be ready for triage within 48 hours of receipt in CBS

6.1.2. 90% of calls to the call centre will be answered
6.1.3. 75% of calls to the call centre will be answered within 30 seconds
6.1.4. 98% of notes will be in provided to outpatient clinics
6.1.5. At month end, 98% of outpatient appointments will be cashed up
6.1.6. At freeze date, 100% of outpatient appointments will be cashed up
6.1.7. There will be safe nursing staff in 90% of clinics

6.2. These metrics will be monitored monthly, through the COS Scorecard and results provided for DMBs.

6.3. Escalation of operational issues and shortfalls against these metrics can be made via the contact list in Appendix 2.

7. KPIs for Specialties

7.1. COS will expect the following KPIs to be met by services:
7.1.1. Fewer than 0.5% of patients will have their appointments cancelled at less than six weeks' notice
7.1.2. 98% of referrals will be triaged within 24 working hours
7.1.3. 98% of consultants will arrive on time in clinic
7.1.4. 95% of escalated patients will be given a solution within one week
7.1.5. 98% of notes in wards and offices will be tracked within 24 hours of receipt

7.2. These metrics will be monitored monthly, through the COS Scorecard and results provided for DMBs.

8. Funding for COS

8.1. Funding from COS originates from the original budget transferred at the point of COS' creation in 2006. In the intervening period, there has been extensive unsupported growth, CIP targets and emerging pressures of service development (e.g. Kinesis, Cerner upgrades) which have created changes to demand and reductions in budget. Whilst specialties receive outlines of the cost of their outpatient service through SLR, this does not translate to baseline readjustment for COS.

8.2. COS incurs fixed costs as a result of planned activity, even when such planned activity does not take place, such as nursing and reception staff. Furthermore, there are variable costs, directly attributable to changes in demand from fluctuations to clinical activity, e.g. pulling and prepping of records, scheduling of appointments.

8.3. At the outset of the financial year 2015/16, there will be a trust-wide baseline readjustment which will reset the COS budget to reflect actual expenditure to deliver patient care. For subsequent financial years, the baseline COS budget will be reviewed annually to determine whether the resource limit model adequately covers the costs incurred as a result of unplanned growth.

8.4. Any request for additional clinic builds or overbookings should first be confirmed with the senior nurse and clinic manager to ensure that it can be supported. These must subsequently be approved by the DDO for CWDT or in some cases, a member of the COS senior management team (GM, HoN, DGM).

8.5. Any work which results in over-performance will be charged.

8.6. Any work done outside of the COS core hours of 09.00-17.00 (unless formal agreement is in place) will be charged at the rates outlined in Appendix 3.

8.7. Any ad hoc clinic carried out in hours may be charged, depending on the resource required to support the clinic.

8.8. Any changes in baseline which are done as part of business planning should be covered under the marginal costing model. Any changes in baseline activity which are not part of business planning will be charged.

8.9. Clinics should not be cancelled at less than six weeks' notice, unless in the event of emergency, sickness or compassionate leave. Clinics which are cancelled at less than six weeks' notice may be charged.

8.10. A summary of the costs is in Appendix 3.

9. Challenge Regarding Service Provision

9.1. Should a service user feel that the service provided is not acceptable, challenge should be made in the first instance to the General Manager of COS.

9.2. If this does not result in a satisfactory outcome, the issue should be escalated to the DDO for CWDT.

Section 1 - Compacts with Outpatient Services

Whom?	I will get	I will
Consultant compact with Outpatient Services	• Referrals will be available for triage electronically within 48 hours of their receipt into the hospital • Notice will be given of any missing notes at least 24 hours prior to the start of the clinic • An available and appropriately equipped clinic room in which to see my patients • A professional outpatient staffing team consisting of nursing and admin & clerical support • A minimum of 98% of patient notes will be available in clinic • Outcomes for all appointments completed on Cerner within 72 hours • A named contact to direct queries to about clinics, and a clear escalation process where a satisfactory response is not received	• Give a minimum of six weeks' notice fo planned absence and aspire to give months or more notice for planned leave • Triage referrals within 24 hours of ther being made available on eTriage • Arrive in clinic prior to the first schedule patient's appointment time • In the event of notes being unavailable, I wi give my time to speak to the patient an proceed with the consultation if possible • Fill in follow up appointment/cashing u forms legibly, adequately describing th treatment function of the patient and tak responsibility for any DNAs, discharging a unless clinically inappropriate • Where it is possible to anticipate the test required for a patient, book these in advanc of clinic to save delay
Care group lead compact with Outpatient Services	• Transparently available COS performance metrics • Metrics regarding the performance of my care group's clinicians, including DNA, new to FU ratios, discharge rates • Attendance from COS SM and/or matron at care group meetings • Weekly reports on outstanding referrals in the eTriage system	• Give clinical leadership to foster bes practice and commitment to partnershi objectives • Appropriately challenge requests fo cancellations with less than 6 weeks' notice • Encourage forward planning of leave and a hoc clinic requests to facilitate departmenta clinical cover
Operational Manager (Directorat	• Transparently available COS performance metrics	• Give constructive, live, feedback on areas c concern for specialities • Appropriately challenge requests fo

e Level eg GM)compact with Outpatient Services	• Metrics regarding the performance of my care group's clinicians, including DNA, new to FU ratios, discharge rates • Input and engagement on operational concerns and strategic initiatives • Weekly reports on outstanding referrals in the eTriage system	cancellations with less than 6 weeks' notice • Encourage forward planning of leave and ad hoc clinic requests to facilitate departmental clinical cover • Proactively engage with COS to invest in resource to support my service's clinical activity, including business plans, service developments, growth and ad hoc clinics
Operational Manager (Speciality level eg AGM/SM) compact with Outpatient Services	• Competent data entry in Cerner to facilitate good data quality on first and continuing PTLs • Timely response to issues raised to corporate outpatient services, with a clear escalation process • All appointments will be cashed up by clinic co-ordinators as per the information specified by clinicians • A named person to deal with enquires or requests within both the CBS and main outpatient teams • A member of the COS management or nursing team to deal with patients in clinic who are dissatisfied as a result of a COS error	• Proactively manage future clinic capacity mitigating for consultant leave periods to reduce C&B ASIs and escalation of patient scheduling • Provide solutions for escalated patients in a timely fashion • Follow the trust's processes for requesting additional clinics • Be available in person, or through a deputy, to liaise with patients in clinic who have an issue as a result of a specialty error • Encourage the members of staff in my area to track notes and track any notes I have in my possession
Medical Secretary compact with Outpatient Services	• Health records will be made available for collection at the reception desk of the main library, following requests made on FileTrail • A confirmation email will be sent following the completion of any clinic cancellation requests • Outpatient appointment scheduling requests will be completed following a request to the COS team • A named contact to direct queries to about clinics, and a clear escalation process where a satisfactory response is not received	• Where a referral is being made internally to a different speciality, these should all be sent c/o Central Booking Service • All cancellation requests for planned leave should be submitted to the OP back office within 24 hours of the request from your consultant • Any referrals received by paper, fax or email that have not come from CBS will be sent directly to CBS rather than await consultant review • Track 100% of notes which are received after clinic or requested from the health records library within 1 hour of receipt • Request the diagnostic results for tertiary referrals prior to the patients' appointments • Release notes back to the main library no longer than 5 working days after they were last used for clinic/theatre.

Patient compact with Outpatient Services	• On average, calls to the call centre will be answered within 1 minute. • Will wait less than 30 minutes to be seen • Will be kept informed of any delays to clinic • 90% of patients requiring phlebotomy will wait less than 30 minutes to be bled • Receive notification of any cancellation or amendment to my appointment, by letter, telephone call or SMS • Queue at the reception desk for less than 3 minutes before and after my appointment • Leave clinic with a follow up appointment where necessary • First class consultation and care and treated with respect	• Arrive on time for clinic appointments. • Give notice when not able to attend • Avoid repeated cancellations • Hand in my outcome form to the reception desk prior to leaving clinic • Behave with courtesy to staff • Update my demographic details at the reception desk, or via the call centre • Give feedback about my experience where appropriate

Appendix 11 Referral Workstream – Outpatients Strategy

The core focus of the referrals workstream can be broken into three strands:

1. A review and proposal of referral routes into the Trust
2. Review and proposal for Trust standardised referral forms
3. **IT plan to support these processes**

A summary for each of the above has been put together which also include key recommendations that the Board is asked to make a decision on. Also included is the feedback from two patient interviews that were held. Next steps for patient involvement is also detailed in this paper.

5.1 Review and proposal of the referral routes into the Trust

Part of the remit of the OSB was to review referral routes into the Trust with the aim of standardising and simplifying the process for GP's and patients.

Current situation

Central booking service (CBS) currently books 95% of referrals into the Trust. These are received through a number of routes including fax, SGH & NHS email, paper, & e-Referral Service (eRS) (previously known as Choose and Book(CAB)). The variety of referral routes in has proved problematic, increasing the time it takes to book a referral appointment and duplicating steps. For example the paper based referrals are currently printed off registered, barcoded and scanned into e-triage before reaching the speciality for triage. Referrals received by the e-Referral route are the most efficient as they are able to put straight into e-triage.

Within the Trust there are a total of 10 specialities that currently do not use CBS to book their referrals, which total 85,068 referrals annually out of approximately 600,000 The details of these specialities including their annual volume and current referral routes in can be found in section 1. Of the specialties that do not use CBS, 5 of these can potentially be excluded from the scope of this programme. Details of these can be found in section 2.

Proposed referral process

In order to improve the referral process within the Trust the proposed preferred option is to improve our utilisation of the eRS. The eRS is a national electronic referral service that allows patients and GP's to choose the place, time and date for the patient's first outpatient. Currently at across SGH (QMH, SGH and Nelson) 305 services are available to book on eRS but these have restricted capacity compared to other Trusts across England. Limited capacity has adversely impacted GP's utilisation of the service which hasn't seen any notable increase over the last year. See section 3 for more detail.

Issues

Feedback from GP's and the clinic review sessions that were held as part of this programme showed there are a number of issues that need addressing order for eRS to gain user support and become our preferred route to refer.

Challenges raised by GP's include:

- No communication channel with speciality to check the appropriate clinic is being booked
- Required clinic not listed on the eRS portal
- No availability of required clinic required

Challenges raised by specialities include:

- GP's and CBS not booking into appropriate clinics

Challenges raised by CBS include:

- Limited capacity available on eRS
- Lack of speciality engagement to increase availability and update appointment details
- Lack of user awareness to efficiently use the system

- eRS slots are not protected so CBS & GP's trying to book into same slot
- Business rules for specialities are not explicit so roles and responsibilities are unclear

Recommendations

From the issues noted above the following recommendations are suggested:

1. *Marketing*

There is a clear underutilisation of the eRS by a proportion of GP's. In order increase GP usage a marketing plan needs to be put together to make GP's aware of the service and what the benefits of using it are.

2. *Availability of services*

The Trust should consider protecting slots just for eRS referrals. This has been done at QMH which currently has 80% of their total clinics available on eRS compared to only 50% at SGH. The slots that are available on the eRS are currently not protected which means CBS and GP's both are trying to book into the same slot.

3. *Directory of services*

The directory of services needs to be updated and maintained. There needs to be a process to continue this going forward. All services should be keeping their details up to date and review what is on the system on a regular basis.

4. *Training*

A training roll out of how to use the eRS should be undertaken as there was a lack of training provided when the system was first introduced which has meant users (specialities, GP's, CBS staff) do not understand the full functionality of what is available to them.

5. *Resource*

The Trust only has 1 person who is currently responsible for the training of the whole organisation alongside being the service manager of CBS. This is not sustainable so other resource needs to be found.

5.2 Review and proposal for Trust standardised GP referral forms

GP's refer their patients to St George's outpatient services using speciality specific referral forms. The Outpatient Strategy programme is reviewing the processes for referring patients into the Trust with the aim of standardising, simplifying and automating processes where possible.

Current

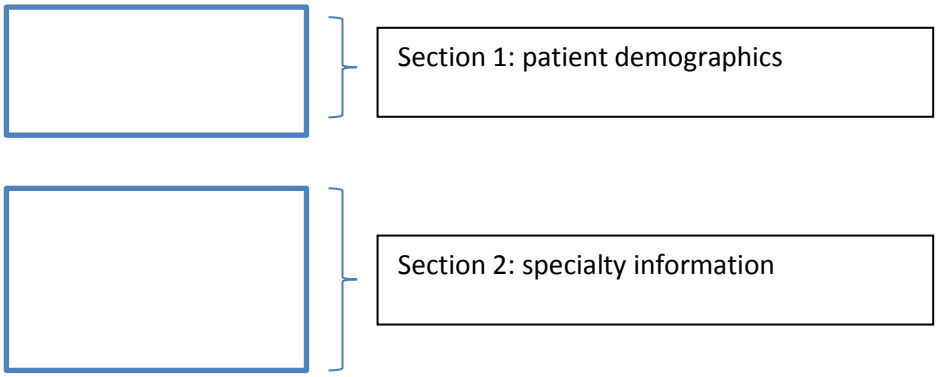
- Currently in excess of 200 referral forms in use for speciality referrals
- No standard format for the forms
- No coordinated process for updating forms, this is currently done on an ad-hoc basis
- No coordinated process for sharing updated forms with GP's
- No process for recalling and deleting old forms from GP practices.

Future

We propose that there should be a standard approach to referral forms Trustwide. The challenge in this is that each specialty requires a specific set of data to receive a patient. Therefore the proposal is that the form will be made up of two sections:

Section 1: the patient demographic section which will be standard across the Trust.

Section 2: the specialty specific section requesting data required, including test results, symptoms. The style of section 2 would be consistent across the Trust.



Each form will have a 'last updated' record at the bottom of the page.

Benefits

- Standardisation will help to reduce the volume of forms in circulation
- It will improve the quality for the forms- some forms in circulation are very old, out-dated and difficult to read from years of photocopying. Most display an old logo.
- From a marketing perspective, the work will ensure the forms fit the St Georges 'brand'; they will be professional, standardised and identifiable.
- The forms will be easier for GPs to use, access and identify.
- CCGs are moving to use DXS, an electronic hub which holds all provider forms and pathways. Each CCG would only need to upload Section 1 onto DXS once

Next steps: (Please see detailed programme attached in section 4)

- Engage with care group leads (CGL) for each specialty to communicate the intentions to them as decision makers on specialty content
- Plan out required content for Section 1 (identified on old forms)
- Meet with one CGL to plan out one form and gain an idea of style, timescales and work involved – This pilot will take 1 month to test the process from start to finish and then a roll out plan will be developed for the remaining specialties.
- Meet with each CGL to agree specialty section 2 content- this would take longer, timescales will be more evident once the first specialty trial form is complete
- Obtain GP review on each of the forms to ensure all requests are reasonable
- Share finalised forms with relevant parties, GPs and CCG DXS leads
- Upload all forms onto GP section of our website

Resources required:

- Dedicated person to meet with 40+ CGLs to finalise content for section 2
- Assistance in agreeing all forms with a GP/group of GPs
- Assistance in uploading completed forms onto website

Outstanding decisions:

- Who has final sign off for referral forms? Clinical - Care group lead
- Where will the central hub for all forms be held? – This needs to be agreed
- Based on trial form, how long will the review of all specialty forms take?

5.3 IT plan to support these processes

This section of the paper considers the issues relating to the Trust's management of incoming referrals, describing the various forms of referral and receipt points and proposes a consolidation exercise, the introduction of a single set of processes and a widening of remit the Trust's eTriage system to introduce automation, improved communications with referrers and reduction in administration overheads.

Background

The Trust received 149k GP referrals in 2014/15 an increase of 2% over the previous year. Of these approx 95% were managed by CBS, 2.5% by the 2WT and remainder by various specialties not using CBS. Nine separate methods of referral have been identified, many of which with multiple receipt points. These are:

- Fax
- Paper
- SGH email
- NHS email
- 2WT Cancer Referrals
- eRS (previously Choose & Book (CAB))
- eTriage Interface
- Consultant to Consultant (C2C)
- Tertiary
- Community
- QMH

In addition to any internal drivers for change and consolidation there are also external factors affecting the referral process:

- Discontinuation of the SGH email and FAX service
- Introduction of referral management systems into primary care
- Introduction of Pan London standardised referral templates
- NHS operating framework (2015/16) requirements to cease the use of email for GP referrals

In the last year the Trust has developed an IT solution (eTriage) for the management of referrals. Using workflow technologies it manages the majority of inbound referrals for the main site, excluding 2WT referrals. The current version supports the scanning of referrals post CBS iCLIP registration, triaging, then management through to appointment booking. It replaces the manual process of moving paper referrals around the Trust.

The project aimed to deliver the following benefits:

- Reduction in referral turnaround times
- A single process for all main site referrals

- Readily available performance data
- Bottleneck identification

Progress

- The 23 July 2015 saw the final main site specialty go live.
- At the time of writing:
    - Some 56k referrals have been managed through eTriage
    - Some 10k referrals actively being managed (without appointments) of which :
        - 2079 await triaging
        - 2649 in escalation without capacity
        - 839 awaiting local service management action
        - 1262 awaiting local booking action
        - 2731 awaiting CBS action
- The July 2015 upgrade incorporated eRS referrals providing a unified solution for non Cancer referrals.

Issues

The implementation exposed several issues:

- The need for triagers, & service managers to regularly manage their queues – a report goes to DDOs, GMs SMs identifying 'stagnant' records weekly.
- The solution has exposed many local processes not originally specified or envisaged.
- Individual routing issues for some specialties.

Proposed Referral Management solution

The underlying proposal is to reduce the number processes and receipt points and develop eTriage for all referral types. This involves/requires:

- A single email address for all inbound referrals
- The development of eTriage for services not currently using it.
- Working with Merton & Wandsworth to introduce an electronic referral interface for primary care systems
- Develop an inbound interface for auto registration of referrals within iCLIP and outbound messaging system for appointment notification.
- Developing a web based Tertiary referral interface.
- Development of eTriage for C2C referrals
- Development of standardised referral templates

Benefits

When implemented the proposals will:

- Improve patient care by reducing delays in the referral management process
- Converge on a single referral management process for all referrals
- Improve communication with primary care, though the automation of the entire referral process.
- Introduce a standard process for tertiary and C2C referrals
- Reduce costs through the automation of the referral registration process

Cost

- £100k eTriage capital development costs (£100k found from remaining Innovation Funding (£50k available 15/16)).
- £50k Project & Change Management.

Assumptions

- The referral template review meets the requirements of the Merton & Wandsworth referral interface.
- No additional IT infrastructure is required, requirements can be met from other IT infrastructure developments.
- Referrals for QMH will be encompassed in line with the planned migration of QMH into iCLIP.

Plan

The availability of innovation funding means several of the proposed developments will proceed independently, though at a slower pace determined by other IT plans. The plan is presented diagrammatically in section 5, but the broad miles stones are as follows:

- December 2015 – Nelson Triaging integration
- January 2016 – removal of St George's email accounts for inbound referrals
- January 2016 – 2WT referrals, in line with the team's planned move to Trident.
- January 2016 – 2WT eRS referrals, in line with the team's planned move to Trident.
- March 2016 – C2C referrals management, in line with rollout of Dictate2
- April 2016 – Referral registration automation
- April 2016 – Tertiary referral solution
- April 2016 – Merton referral Interface
- Sept 2016 – QMH Integration , in line with QMH migration to iCLIP

Section 1 – Table of specialities not currently using CBS to manage their referrals

Specialty	Volume	Referral routes in
Senior Health	3,652	1. Letter 2. E-Referral – 40% 3. Fax – 0208 725 2855
Chiropody	7,952	1. Telephone patient / GP 2. Occasional letter/fax
ED	4,416	1. GP letter 2. Rarely fax – 0208 725 3450
Radiology	176	1. Fax 2. Letter 3. GP Form 4. Internal email or fax or straight onto iClip
Oncology	11,040	1. Letter 2. email consultant 3. Fax

Obstetrics	44,220	1. Fax 2. Paper letter paper triage
New Born Services	1,048	1. Fax 2. Paper letter paper triage
Paediatric Oncology	12	1. Fax 2. Letter
Neuro Rehabilitation	1,436	1. Letter 2. STG email 3. Fax
Theatres	11,116	1. Speciality manages and books

Section 2 – Specialities excluded in the scope of this project and rationale

- ED as the clinics run here are admission avoidable so not run in the outpatients setting.
- Theatres pre op as these are patients that have already been referred into a speciality who now being booked for surgery
- Oncology – Due to the nature of the appointment types these are received and booked by the speciality
- Paediatric oncology as these are already in the Trust through TWR route and are then booked by the speciality
- Neuro rehabilitation as these are not outpatient appointments and are booked directly through the speciality.

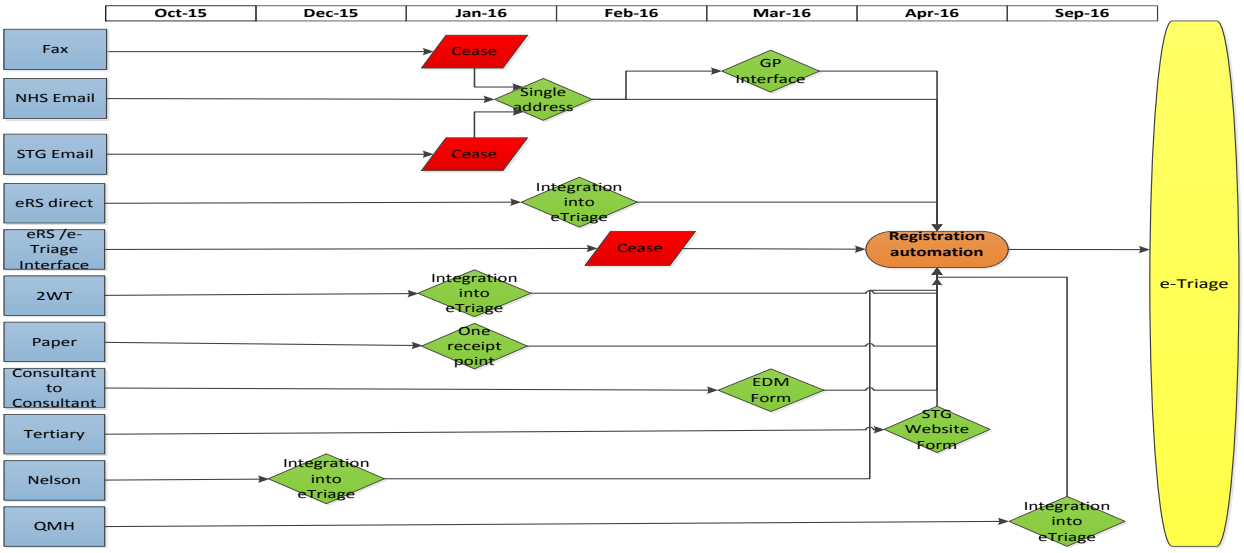
Section 3 – Table of % GP referrals received via eRS from May 14 – Feb 15

GP Referrals received via e-referral system										
GP CCG	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**
NHS KINGSTON	53%	56%	57%	56%	57%	56%	56%	60%	51%	54%
NHS LAMBETH	29%	26%	28%	27%	26%	26%	27%	25%	29%	30%
NHS MERTON	19%	20%	23%	19%	20%	19%	18%	19%	18%	18%
NHS SUTTON	14%	16%	17%	15%	15%	14%	16%	13%	14%	13%
NHS WANDSWORTH	31%	34%	33%	31%	32%	31%	32%	28%	31%	30%
NHS WESTMINSTER	44%	47%	54%	49%	45%	49%	48%	46%	40%	48%
NHS RICHMOND	36%	46%	43%	45%	44%	39%	39%	39%	38%	38%

Section 4 – Table of plan for standardised GP referral forms

Task	How	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Status
Initial explanation to care groups explaining the project and what is required from them	Email to all CGLs							complete
Work up list of what we have already	administrative work							In progress
Create template of basic demographics and appendices								In progress
Engage with one CGL who is responsive to trial one form and see how well this works, also to get approx time frame	meeting with Dr Daniel Jones 26.10.15							booked
Contact all CGLs to propose to meet to design the form in the format designed with lead CGL.	Email to all CGLs							
Get all forms signed off by division-CGL/DDO								
Get forms reviewed by GP representative to sense check								
send all forms to CCGs to upload to DXS	Vicky to email							

Section 5



Appendix 12

Back Office / Clinic template proposal: Dec 15 to Apr 16

1. Background

St George's has a back office team who manage the build of all clinic templates for all outpatient clinics across all four SGH sites. The scoping work has highlighted the need to streamline and review the processes that are in place to deliver a clinic build service to the Trust.

The team is currently aligned as follows:

- 1.8 WTE on Cerner template builds
- 2 WTE QMH, PAS and RIO
- 1.2 WTE Correspondence, Locations and other business

	Volume	Example
Appt Types	2482	Currently active to be booked

Slots	5292	Total No of differing slots
Discrete	4270	Individual slots
Contiguous	1022	Surgical slots

Resources	2843	Total No. of differing schedulable resources
Service	109	Theatre rooms
Personnel	637	Lead clinician
General	2097	E.g. technicians

-

1.1. Current volume of work

The Cerner team receives the following approximate requests each week for template

builds:

- 30 amendments and deletion requests
- 15 new build requests
- 45 requests per week

The agreed turnaround time is 6 weeks, the following are still to be processed:-

1.2. Number of Clinic in the 6 week window (currently working on clinics no later than 21/09/15)

- 103 amendments & deletions
- 33 new build requests
- 136 total

1.3. Current BACKLOG pre 21/09/15:-

- 80 amendments & deletions
- 79 new build requests
- 159 total

2. Objectives:

- Agreed authorisation for ownership and sign off for templates
- To create a streamlined business process to manage changes within the Trust for outpatient clinic templates
- Streamline process and pertinent standard operating procedures for starters and leavers
- Standardisation of clinic and letter builds
- Robust process to reassure correct build checklist has been followed
- Derive a local service level agreement internally for expected delivery times for change requests

3. Goals/Aspirations:

Target	Current average turnaround time
Routine clinic template > 5 working days turnaround	2 months
Single Urgent template > 24 hours (Mon –Fri)	3-5 days
Full new service build (new speciality, large clinic restructure) > 4-6 weeks	3 months
New facility / clinic relocation: • Like for like >10 working days • New service build > 4-6 weeks	 1 month 2 months

4. Implementation Plan

4.1. Phase 1 (interim proposal)

- One source of request entry point via service desk portal
- Investigate building a new submission form / database to streamline requests for users

- Application managed service to build all clinics against existing build where possible
- Reinforce process for starters and leavers
- Centralised phone numbers
- Authorisation process to be reviewed to sign off change

4.2. Back Office own:
- New appointment types
- New locations
- New resources

4.2 Phase 2 (medium proposal) – Centralised team
- Including interim steps
- Displacement Trust Back Office to be based in same location
- Inclusive of EDM, Central Booking and Scanning team

4.3 Phase 3
- Allow access to tool for end users / specialities to make changes to templates

5. Next Steps

For the above to be achieved the following high level steps outlined below will need to be completed to assist. The expectation the following steps will be completed within the current financial year.

This is reliant on resource and financial agreements for additional staff to be trained, up skilled and managed throughout the course.

Based on the figures outlined in the background the table below outlines the resources to deliver the action plan and reconfigure the standard templates. Additional resources are in order to execute and implement the plan for rapid completion of template review.

Resources required	Time frame
1 x Band 6	16 weeks
5 x Band 5	16 weeks
Specialist change and configuration experts as required	8 weeks at £350-400 a day
Displacement and rebooking to be assessed via specialities dependant on quantum of patients affected	

Action Plan for resources	
Nov-15	November permission to recruit resources
Nov-15	Identify agreement on budget and budget source
Dec-15	Recruit and review template structure
Jan-16	Training and preparation time
Feb-Apr 16	Template redesign and build new structure

This will also require engagement from Trust staff to assist and champion through standardisation of clinic structures and build.

Action Plan	Status
Update current template submission forms	Not started
Investigate ability to automate and streamline submission of clinic requests	In progress
Single point of entry for change request	In progress
Review build steps and document fully end to end process	In progress
Analyse backlog and work effort to complete 1) This may result in the need for a mix of overtime/additional resources	In progress
Optimise working relationship with Application Managed Services to undertake new build of clinics	In progress
Service Improvement Team to identify optimal process review for sustainable back office process and business as usual resources required	Not started
Review current build and fix current build issues (e.g. suggest functionality, clinician aliases)	In progress
Work with Cerner for future enhancements 1) Batch update/transfer of encounters and episodes	Not started
Upskill of IT Staff to maintain logs, transparency and productivity levels	Not started
Consolidate correspondence across specialities	Not started
Investigate ability to automate pertinent build steps	Not started

Appendix

13 Internal Review

Internal Review – Summary of discussions

As part of this programme clinic template review sessions were held with 13 care groups. Feedback was positive and a number of consultants expressed they were pleased to have been engaged and in some cases this was the first time they had been involved in organisational change. Below are the care groups that were consulted:

• Dermatology • Diabetes • Gastro & Endoscopy • Haematology • Head & Neck • Oncology • Urology	• Paediatric Surgery • Plastics • Rheumatology • Rheumatology • T&O • Therapies

The purpose of these sessions was to find out from clinical and managerial staff what they believed the key issues with outpatients were, to provide them with clinic data to show their utilisation of slots and to ask them review their clinic templates with the aim of removing ones that are no longer needed and standardising as much as possible the templates that they will use going forward.

There were a number of different themes that were prevalent during the sessions, many of which were around operational processes that could be refined. A summary of these are below:

eTriage

There were a number of concerns by clinicians that many of the letters on eTriage are not referrals but standard letters/ enquiries and duplicates in the system. It is to be noted that scanning all received letters onto eTriage mirrors the process of paper referrals but feedback suggested it takes a lot longer now due to the speed of the system. Previously the paper letter would be sorted by the speciality before reaching the consultants. It was suggested a step could be added to the process where the speciality manager triages either before or after the consultant sees the referral.

Additional eTriage concerns included:

- Lack of alerts for the referrals sitting in your personal queue.
- Consultants are not up to date
- No option for the Nelson on the dropdown menu

Clinic templates / letters

The process for changing clinic templates is too long. It was highlighted that it is often quicker to put on an ad-hoc clinic than it is to change a template. There was unified feedback that the process of amending templates needs to be simplified with a quicker turnaround.

Patient letters often have incorrect information (contact numbers and/or location) Making any changes to the letters is lengthy and takes months. It was suggested there should be an option on the change template to request a change in location to the patient letters.

Texting service

- Text reminder service for all patients needs to be turned back on and should not be an opt in service.
- Patient details need to be up kept up to date for the text service to work more efficiently. Reception staff do not consistently ask patients to check their details knowledge.

DNA's

There are significant numbers of DNAs in a number of areas. Suggestions for these were:

- Patients did not receive a letter in time for short notice appointments.
- Patients with follow up appointments did not receive a letter at all.
- A number of overbook patients do not show up.
- Patients also no longer receive text reminders.

Choose & book

- GP's are booking the wrong type of patients into choose & book clinics.

CBS

- CBS to not have specialty knowledge so book patients into the wrong clinic.
- CBS rules regarding rebooking are too ridged. They need to work with the speciality. i.e. when speciality is unable to cash up patient encounter.
- When CBS calls to confirm appointment they just say you have an appointment on X date not giving any time or location so patient then has to phone to find out what the appointment is for.

Appendix 14

COS Clinic Utilisation by Speciality - 2015 YTD

This data has been extracted from the Outpatient capacity and demand model, the model is based on iClip data, it does not include QMH or the Nelson outpatient figures.

http://stg1tableau01/#/site/L/views/OPmodel/byspecialty?:iid=1

Specialty	Templated Capacity (Slots)	Planned Activity (1516 plan)	Total Attendances	Used Templated Capacity	Unused Templated Capacity	% Utilisation	Number of DNAs	% DNA rate	% Utilisation (adjusted by actual DNA rate)	% Utilisation (adjusted by DNA, using parameter)	Attendances outside Templated Profile (Adhocs)	% Attendances outside Template Profile
ANE	3,370	2,444	2,774	2,766	604	82.10%	98	3.40%	85.00%	82.10%	8	0.30%
ANT	5,679	10,316	12,290	4,767	912	83.90%	1,827	12.90%	96.40%	83.90%	7,523	61.20%
AUD	10,273	7,045	8,397	6,207	4,066	60.40%	1,612	16.10%	72.00%	60.40%	2,190	26.10%
BPU	2,721	2,073	2,494	1,888	833	69.40%	373	13.00%	79.80%	69.40%	606	24.30%
CAR	37,469	45,056	38,388	31,516	5,953	84.10%	3,924	9.30%	92.70%	84.10%	6,872	17.90%
CHI	3,752	4,069	4,775	3,365	387	89.70%	289	5.70%	95.10%	89.70%	1,410	29.50%
CIU	1,382	739	1,112	1,006	376	72.80%	192	14.70%	85.40%	72.80%	106	9.50%
CLG	267	0	0	0	267	0.00%	0			0.00%	0	100.00%
CMD	13,972	11,182	11,556	8,453	5,519	60.50%	3,008	20.70%	76.20%	60.50%	3,103	26.90%
CRS	2,295	1,648	2,051	1,843	452	80.30%	157	7.10%	86.50%	80.30%	208	10.10%
DEN	9,545	8,224	9,895	6,591	2,954	69.10%	1,464	12.90%	79.30%	69.10%	3,304	33.40%
DER	14,571	14,505	12,644	9,562	5,009	65.60%	2,339	15.60%	77.80%	65.60%	3,082	24.40%
DTC	1,657	2,056	1,572	1,251	406	75.50%	206	11.60%	85.40%	75.50%	321	20.40%
END	12,249	9,259	9,405	7,375	4,874	60.20%	1,820	16.20%	71.90%	60.20%	2,030	21.60%
ENT	13,834	10,188	12,085	8,830	5,004	63.80%	2,161	15.20%	75.20%	63.80%	3,255	26.90%
GER	564	1,710	2,020	481	83	85.30%	45	2.20%	87.20%	85.30%	1,539	76.20%
GMD	1,076	2,059	1,463	817	259	75.90%	186	11.30%	85.60%	75.90%	646	44.20%
GSG	13,630	13,642	13,942	8,478	5,152	62.20%	3,072	18.10%	75.90%	62.20%	5,464	39.20%
GST	10,196	7,124	7,596	5,674	4,522	55.60%	2,185	22.30%	71.70%	55.60%	1,922	25.30%
GYN	19,820	22,387	18,648	14,844	4,976	74.90%	2,103	10.10%	83.30%	74.90%	3,804	20.40%
HAE	5,229	3,696	4,576	3,463	1,766	66.20%	961	17.40%	80.10%	66.20%	1,113	24.30%
ITU	135	11	76	70	65	51.90%	30	28.30%	72.30%	51.90%	6	7.90%
LYM	6,050	4,283	5,090	4,082	1,968	67.50%	727	12.50%	77.10%	67.50%	1,008	19.80%
MFN	7,482	6,114	7,961	5,599	1,883	74.80%	1,310	14.10%	87.10%	74.80%	2,362	29.70%
NEO	984	539	835	801	183	81.40%	104	11.10%	91.50%	81.40%	34	4.10%
NEU	14,811	9,666	12,275	9,983	4,828	67.40%	1,978	13.90%	78.30%	67.40%	2,292	18.70%
NRE	445	892	893	293	152	65.80%	136	13.20%	75.90%	65.80%	600	67.20%
NSU	5,758	6,337	5,730	3,797	1,961	65.90%	793	12.20%	75.10%	65.90%	1,933	33.70%
OBS	28,227	27,154	24,273	20,247	7,980	71.70%	2,745	10.20%	79.80%	71.70%	4,026	16.60%
ONC	6,530	5,640	6,383	4,987	1,543	76.40%	555	8.00%	83.00%	76.40%	1,396	21.90%
PAS	2,894	1,949	2,410	1,637	1,257	56.60%	684	22.10%	72.60%	56.60%	773	32.10%
PCL	2,256	1,717	2,205	1,637	619	72.60%	356	13.90%	84.30%	72.60%	568	25.80%
PHY	32,243	34,041	34,536	24,339	7,904	75.50%	5,385	13.50%	87.30%	75.50%	10,197	29.50%
PLA	15,581	12,284	15,230	11,968	3,613	76.80%	2,202	12.60%	87.90%	76.80%	3,262	21.40%
PMN	10,525	7,920	10,992	6,372	4,153	60.50%	2,260	17.10%	73.00%	60.50%	4,620	42.00%
POL	17	1	9	8	9	47.10%	4	30.80%	68.00%	47.10%	1	11.10%
PPH	2,504	1,669	1,957	1,821	683	72.70%	283	12.60%	83.20%	72.70%	136	6.90%
RAD	123	3,020	97	97	26	78.90%	10	9.30%	87.00%	78.90%	0	0.00%
REN	3,798	2,554	3,110	2,709	1,089	71.30%	507	14.00%	83.00%	71.30%	401	12.90%
RHE	14,445	11,519	12,052	9,991	4,454	69.20%	1,979	14.10%	80.50%	69.20%	2,061	17.10%
RNS	2,038	2,309	2,546	1,656	382	81.30%	165	6.10%	86.50%	81.30%	890	35.00%
SLT	811	1,331	1,077	598	213	73.70%	70	6.10%	78.50%	73.70%	479	44.50%
THE	6,107	5,341	6,746	5,373	734	88.00%	280	4.00%	91.60%	88.00%	1,373	20.40%
THO	503	124	483	302	201	60.00%	75	13.40%	69.40%	60.00%	181	37.50%
TNO	23,264	19,899	22,021	16,100	7,164	69.20%	3,526	13.80%	80.30%	69.20%	5,921	26.90%
URO	10,149	8,060	8,759	6,173	3,976	60.80%	1,872	17.60%	73.80%	60.80%	2,586	29.50%
VAS	4,430	5,203	4,181	3,370	1,060	76.10%	475	10.20%	84.70%	76.10%	811	19.40%
Totals	385,661	358,999	369,610	273,187	112,474	69.16%	56,533	13.73%	80.20%	69.16%	96423	27.53%

QMH Clinic Utilisation Total – 2015 YTD

Manual Calculations conducted in Feb 2015

Physical Capacity		
(am/pm = 2)	QMR	
Including Suite 6		%
Total number of clinics spaces available including suite 6:	288	100%
Used clinic rooms	194	67%
Unused clinic rooms	**94**	**33%**
Not including Suite 6		
Total number of clinics spaces available not including suite 6:	258	100%
Used clinic rooms	194	75%
Unused rooms not including suite 6	**64**	**25%**

Absolute physical capacity	
Clinic x Slots x 42 weeks	10 slots per clinic
Unutilised slots (Suite 6 included)	**39,480**
Unutilised slots (Suite 6 not included)	**38,220**

Appointment Capacity	QMR		
(All New, Followup, New urgent, Follow up urgent and choose and book slots)		% of total slots	% of unutilised slc
Total Available slots (based on templates):	156,025	100%	
Total un booked slots (adhoc capacity for urgent or other need or incorrect clinic template)	25,360	16%	54%
Cancelled Slots Unused	21,459	14%	46%
Current total unutilised slots	**46,819**	**30%**	100%

QMH OP Clinic Sessions

Year of Clinic_Date	Month of Clinic Date	Treatment Function	Clinic	Doctor	Session Start Time	Session End Time	Appt Category	Booking Units	Booking Units Used	Booking Units Free
			QAUD99	QAUD99	830	1230	FOL	12	2	10
							NEW	12	3	9
			QAUDAQP	QAUDAQP	830	1300	FOL	3	4	-1
			QAUDC	QAUDC	800	1230	FOL	27	18	9
							NEW	27	11	16
					1230	1730	FOL	0	2	-2
							NEW	60	9	51
					1300	1700	FOL	24	6	18
							NEW	24	5	19
			QAUDPHA	QAUDPHA	800	1200	NEW	10	10	0
					1230	1700	FOL	0	1	-1
							NEW	10	9	1
			QAUDTINN	QAUDTINA	730	1030	FOL	3	1	2
							NEW	3	2	1
						1200	FOL	5	1	4
							NEW	5	4	1
				QAUDTINN	800	1300	FOL	0	7	-7
							NEW	25	10	15
			Total					1,925	654	1,271
Grand Total								418,590	127,668	290,922

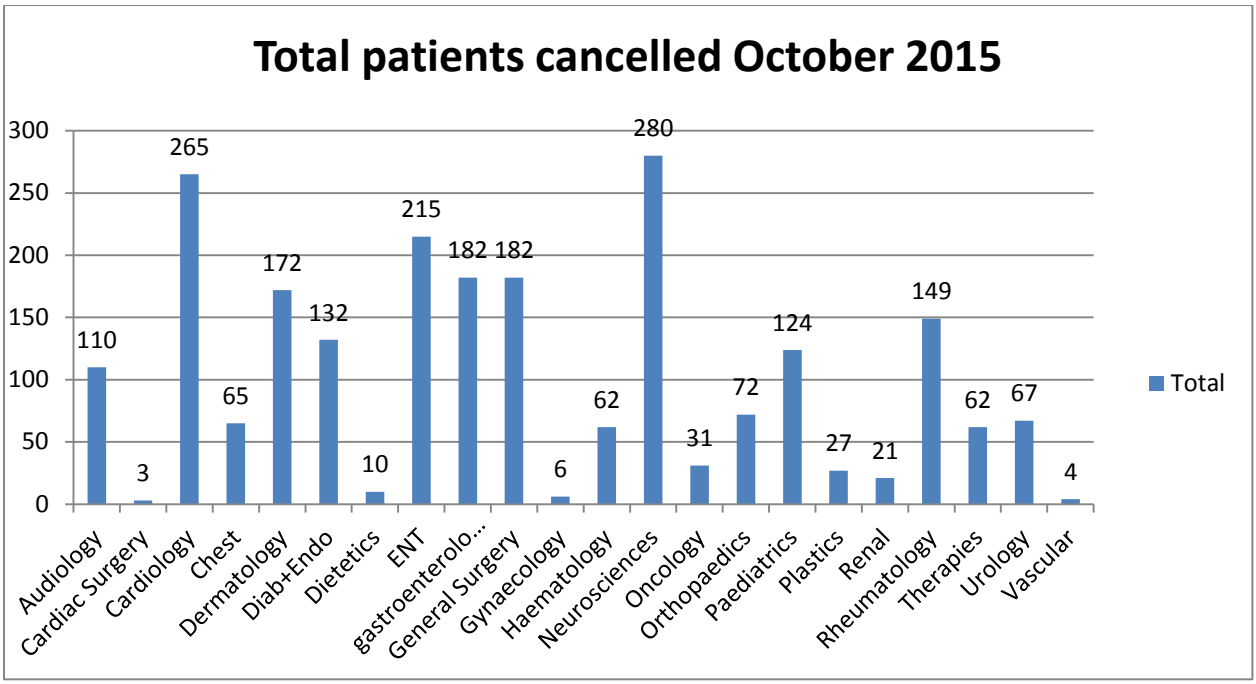
Treatment Function: (All)
Fin_Yr: FY 2015
Month, Year of Clinic Date: (All)
Appt Category: (All)
Clinic: (All)
Doctor: (All)

*tableau extract

http://stg1tableau01/#/site/L/views/QMHOutpatientAppointmentMeasuresAndClinicSessions/QMHOutpatientAppointmentMeasuresAndClinicSessions?:iid=2

As QMH are not on iClip it has not been possible to include their clinic activity in the COS capacity and demand model that has been developed, therefore further work will be required to identify the actual utilisation rate as the current rate is based on a manual count undertaken in early 2015.

Appendix 15 – COS total patients cancelled October 2015



Appendix 16

Text Messaging Service

1. Introduction

Patients' failing to attend an outpatient clinic is a problem in the Trust with an above average DNA rate of 12%. Anecdotally clinicians, managers and care group leads have complained that their patients are no longer receiving appointment reminder texts. This paper aims to investigate this hypothesis with a brief update about the outpatient's texts service.
Appointment reminders via text messages can reduce DNAs and assist Trusts in meeting their 18 week targets. Nationally DNA rates currently account for 10% of all first appointments and 13% of follow up appointments, costing the NHS in the region of £614 million a year and a significant loss in performance.

2. Old provider

St George's Trust has used MJOG to send appointment reminders via text message over the last 5 years. MJOG sends an up to 160 character text confirming basic information; including date and time of appointment but not location. These texts were being sent 28 days, 14 days and 7 days before the appointment but more recently were only sent 7 days before. This service is managed by central outpatients by a service manager who can change/remove phone numbers and edit clinic locations.

The extract used for MJOG was pulled from PAS 5 years ago when it was introduced and it does not interact with iclip. This is why some of the old clinics still receive reminders but the newer clinics are less likely to be on the MJOG system. It was a big administrative task to get these new clinics on the system. A decision was made to change providers as there were issues with the service where patients were getting a reminder text the same day as numerous clinic cancellation messages.

3. Provider issues

The contract was put out to tender and Netcall won the contract. Netcall has a unique interactive text messages capability where the patient can confirm that they got the message and cancel appointments. This would eliminate concerns from some services hesitant when discharging DNA patients because they were unsure they received the message.

Netcall required the use of the NHS mail texting service but when the proposal went through governance boards, the trust was alerted that NHS mail is turning the texting service off. We have now allocated EE as a provider for the texts but there still needs to be a platform to deliver the texts to the provider; this will be Netcall

Instead it was decided that there would be a 6 month roll out which was put on hold due to the Trusts financial situation. As a result MJOG use was continued as before with a rolling contract. With this new contract no service changes were allowed and no new services were allowed to access the service with no reason to develop the old service. The MJOG contract ended on October 1st and MJOG ceased provision of all patient reminder texts.

4. Future provision

The plan is to get a like for like contract with Netcall to replace the service provided by MJOG. Discussions will be had in the first week of November with a roll out to follow as soon as the following week. MJOG will be removing their software from, the St Georges' server and scope of the new Netcall service is not clear which may require some more back office work to get the new services from ICLIP and on to Netcall.

Texts were free to send on MJOG but the new EE service will have a charge of approx. ~ £1000 per month to send texts. Finances still need to be confirmed as to whether this will be combined with the current HR contract or from a central budget.

The aim is to deliver this to all services and it will be an opt out service this will be done with a n undated advertising roll out asking services to make sure all of their templates are accurate as they will be used as the base.

5. Services

The services that use MJOG are outpatient clinics at St Georges main site and St Johns Therapy. There is a different texts system being used in the community. For a single outpatients service in the future this need to be consolidated on Netcall.

Appendix 17

Statement from Finance team – response to request to move QMH finances onto COS model

Income

	St Georges Hospital	QMH	Nelson	Total
Income - Outpatients	43,795,844	7,793,437	745,741	52,335,022

The income figures are taken directly from the SLAM report for Month 6.

Direct Costs relating to Outpatients

Expenditure	St Georges Hospital	QMH	Nelson	Total
Pay				
Medical	8,517	441,345	14,173	464,035
Nursing	1,202,051	986,024	267,031	2,455,106
Other	4,213,506	1,333,735	362,502	5,909,744
	5,424,075	2,761,103	643,707	8,828,885
Non Pay	558,171	4,285,318	171,456	5,014,945
Cross Charges	-25,684	4,187	2,914	-18,584
Total Expenditure	5,956,563	7,050,607	818,076	13,825,247

Notes

The St Georges Medical Pay value, does not include the cost of the Consultants, these costs are held within the clinical division.

The QMH Medical Pay value, does include the cost of Kingston Hospital Consultants (Recharge)

The Nelson values reflect the first year of costs.

The Finance team have confirmed they are able to move the QMH cost centre onto the same financial model where the clinical specialities receive all PBR income. Finance can start the process of mapping QMH against the new staffing and delivery model once the decision has been taken by the Board and will aim to deliver a completed financial model within 1 month.

St George's University Hospitals NHS
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Notable achievements include:

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- Reviewing the Business Continuity Arrangements and introduction of Business Impact Analysis process

- **Recommendation**

To note the report for information and to receive as assurance that focus is given to emergency preparedness.

Key risks identified:
None

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Objective 1 -
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	Outcome 4, Regulation 9, 4b

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes)
If yes, please provide a summary of the key findings

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Headline outcomes for the Equality Delivery System (EDS)

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				13th Nov 2015

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Ensure compliance with the Civil Contingencies Act 2004

1.4 What factors contribute or detract from achieving intended outcomes?

- Engagement of Lack thereof by stakeholders

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Neither

1.6 If yes, please describe current or planned activities to address the impact.
n/a

1.7 Is there any scope for new measures which would promote equality?
n/a

1.8 What are your monitoring arrangements for this policy/ service
Sitreps and assurance processes as required by NHS London and SWL Cluster

1.9 Equality Impact Rating [low, medium, high]
Low

2.0. Please give you reasons for this rating
See question1.5

Emergency Preparedness Annual update 2015-2016

Introduction

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- Continuing review of the Business Continuity arrangements for the trust.
- Closer integration with Local Authority Safety Advisory Groups in Wandsworth, Merton and Lambeth to ensure that the trust is aware of significant public events that may impact on its ability to carry out business as usual
- A Substantial rating as a result of the NHS England (London) 2015 EPRR annual Assurance process. The Trust was assessed against 8 Core Standards of EPRR which incorporated a total of 37 supporting standards. The standards were given a Red, Amber or Green (RAG) status. Of the 37 supporting standards there was only one (1) Amber rating with the rest being assessed as Green. The full assessment findings and actions to improve the Amber ratings are in a separate document.

The trust did not achieve:

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This work is progressing and a DRAFT operational plan is now at the consultation stage.

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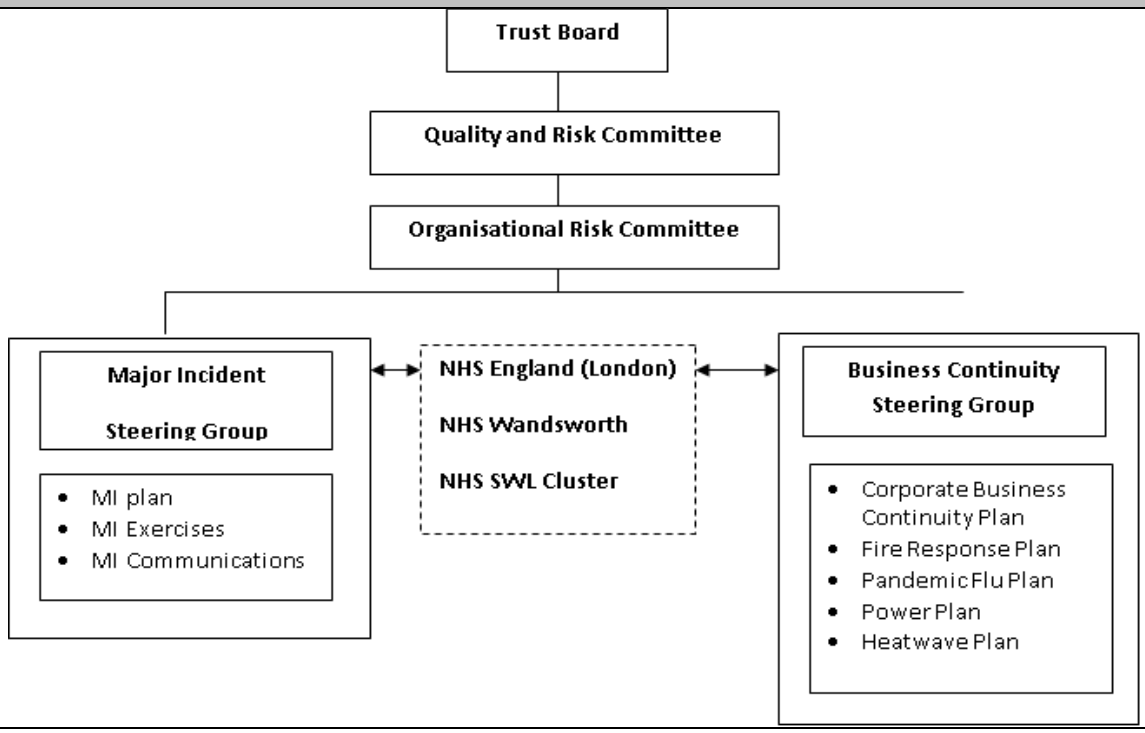
Planning across the trust.	
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Emergency Planning:	• The Major Incident Steering Group continues to met three times a year to ensure that continual improvement in major incident planning continues. • There was one activation of the Major Incident plan for the Staines bus crash in March 2015. The incident was declared by South East Coast Ambulance Service and resulted in just one casualty. • The trust has a Major Incident Plan in place. The trust completed a review and revision of the Major Incident Plan and this was updated in October 2015 • The trust has a HazMat (CBRN) plan in place. The trust completed a review and revision of the HazMat (CBRN) plan and this was updated in September 2015
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Communicating with the Public:	• The Communications Department implemented communications campaigns during incidents via its internal and external communication methods to help provide information and assurance where needed to the public in a variety of situations.
Information Sharing	See 'Communicating with the Public' and 'Training and Exercising' sections.
Co-operation between responders:	The trust is fully engaged and takes an active part in local relevant forums including: • London Borough of Wandsworth Borough Resilience Forum • London Borough of Merton Borough Resilience Forum • London Borough Safety Advisory Groups (SAG) for Wandsworth, Merton and Lambeth • SWL Sub-Regional Resilience Forum • SW London and Surrey Trauma Network Meetings • SWL EPLOs meeting

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	• Dedicated training events for the Clinical Site Management team have been delivered and this will develop into an annual training event.
	• A table top exercise, Exercise Avoco, was run in conjunction with local partners and external agencies at St. George's Hospital in May 2015. The exercise tested the ED temporary Redirect plan.
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A work plan has been completed for 2015-16. The focus of this work will broadly be:

- Develop a single Incident Management and Response Plan that ensures that Command and Control processes are mirrored for all types of incidents and that links to Major Incident and Business Continuity arrangements.
- Completing the command and control requirements of an Incident Coordination Centre (ICC) to incorporate all command and control room options open to the trust.
- Develop Business Continuity arrangements to seek to certificate one of the trusts core services to the international standard on Business Continuity (ISO22301)
- Strengthen the trust's Surge Capacity Management Plan, incorporating winter planning, to build on the learning of winter 2014-15.

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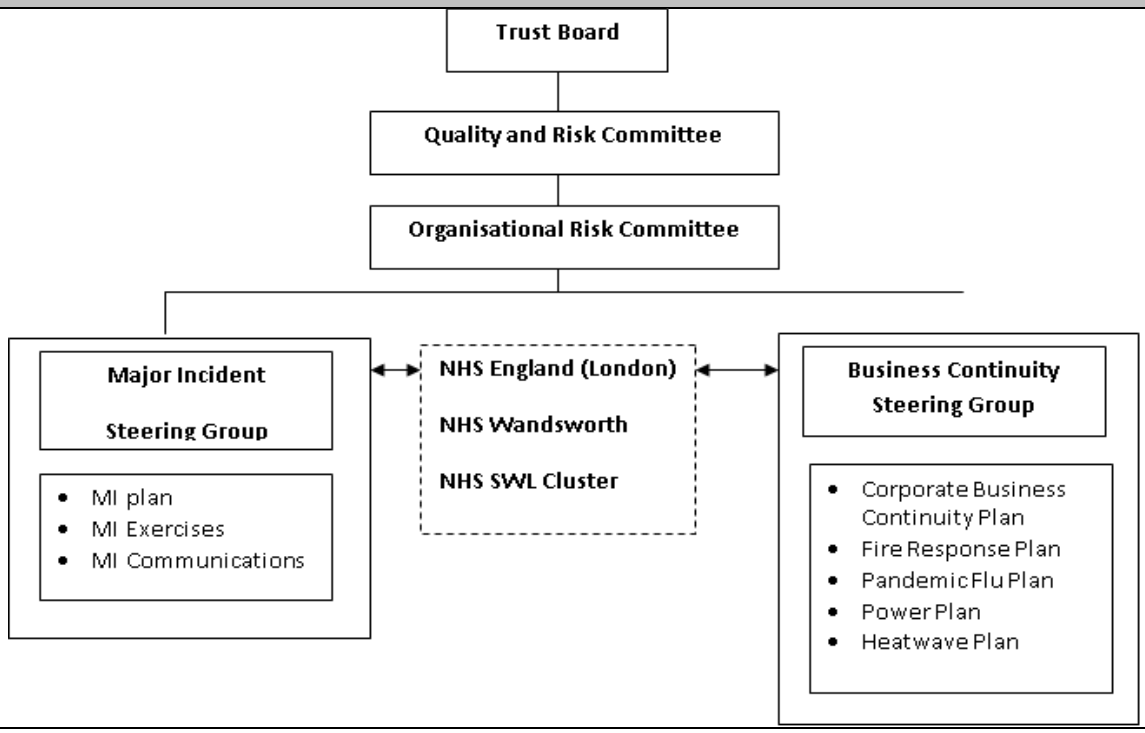
Planning across the trust.	
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A work plan has been completed for 2015-16. The focus of this work will broadly be:

- Develop a single Incident Management and Response Plan that ensures that Command and Control processes are mirrored for all types of incidents and that links to Major Incident and Business Continuity arrangements.
- Completing the command and control requirements of an Incident Coordination Centre (ICC) to incorporate all command and control room options open to the trust.
- Develop Business Continuity arrangements to seek to certificate one of the trusts core services to the international standard on Business Continuity (ISO22301)
- Strengthen the trust's Surge Capacity Management Plan, incorporating winter planning, to build on the learning of winter 2014-15.

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
Governance										
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	• Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas		G				
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	• Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation. .		G				
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity	Y			G				
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y			G				
Duty to assess risk										
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed		G	24 EPRR risks aligned to the BRF RR. Suggested to link into the LHRP Risk Register			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y			G				

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y			G	All BRF members are invited to the trust EP and BC forums			
Duty to maintain plans – emergency plans and business continuity plans										
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.		G	Looking to have one sole C3 plan which links to both the BCP and MIP, at the moment this is listed in both in similar ways.			
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y			G (with comments)	Excellent plan, well laid out, some great appendices on log keeping. Critical areas plans well laid out / Suggestion to include both levels of criticality as well as RTO's			
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y			G				
		Severe Weather (heatwave, flooding, snow and cold weather)	Y			G				
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y			G				
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y			G				
		Mass Casualties	Y			G				
		Fuel Disruption	Y			G				
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y			G				
		Infectious Disease Outbreak	Y			G				
		Evacuation	Y			A	AMBER from Green - 14/10/15 EPRR Review - Trust now has plan in place, however with recent change in fire officers and the need to undertake further testing in key zones the Trust wishes for this to remain AMBER. ACTION - Plan to be sent to NHSE	To engage with the Fire Safety Advisor to finalise and carry out testing of colour coded "zoning" areas within the Trust	**EPLO and Fire Safety Advisor**	Feb-16
		Lockdown	Y			G				
		Utilities, IT and Telecommunications Failure	Y			G				
		Excess Deaths/ Mass Fatalities	Y			G	Hospital mortuary is also for Sutton and Merton LA's / for past year 3 nutwells given extra 36 spaces, HTA informed new work on extra capacity of 77 spaces in progress			
		N/A	N/A			N/A		N/A	N/A	N/A
		N/A	N/A			N/A		N/A	N/A	N/A
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).		G				

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#	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.		G				
#	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y			G				
#	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y			G	This is a separate plan			
#	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specify who has been consulted on the relevant documents/ plans etc.		G				
#	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y			G				
Command and Control (C2)										
#	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.		G				
#	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England published competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (i.e. operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.		G	14/10/15 EPRR Review - Policy to next Organisational Risk Committee (OCR) / New staff on-call assessment aligned to core standards in place based on one from the acute learning set - NOW GREEN ACTION - Plan to be sent to NHSE			
#	Documents identify where and how the emergency or business continuity incident will be managed from, i.e. the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and sco	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/coordination centre and manage any events required.		G	New ICC in Larch 2016			
#	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y			G				
#	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y			G				

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
#	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y			G				
#	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y			G				
Duty to communicate with the public										
#	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.		G			

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#	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.		G				
Information Sharing – mandatory requirements										
#	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and include DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supersedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.		G	Attends both Wandsworth and Lambeth SAG's when incidents relating to the Trust/			
Co-operation										
#	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and membership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area		G				
#	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y			G				
#	Arrangements include how mutual aid a	NB: mutual aid agreements are wider than staff	Y			G	14/10/15 EPRR Review -Sections in the policy, MIP and BCP. Discussion over clarity from region to expectation's of this standard GREEN ACTION - NHS England			
#	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.					N/A		N/A	N/A	N/A
#	Arrangements outline the procedure for responding to incidents which affect two or more regio					N/A		N/A	N/A	N/A
#	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y			G				
#	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared					N/A		N/A	N/A	N/A
#	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months					N/A		N/A	N/A	N/A
#	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y			G				
Training And Exercising										
#	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidents have been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise		G				

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#	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	annually and live exercise at least every three years		G				
#	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y			G	Trust put forward for funded Emergo next year			
#	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	**Core standard to be considered as part of co**	Y			N/A		N/A	N/A	N/A

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *MONTH & YEAR* **Paper Ref:**

Paper Title:	**Travel Plan 2015**
Sponsoring Director:	**Eric Munro – Director of Estates and Facilities**
Author:	**Mary Prior – General Manager Facilities**
Purpose: *The purpose of bringing the report to the board*	*For approval of the Travel Plan for the St George's Hospital Site*
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For approval**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Transport For St George's Committee**

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

1. Key messages

The overall aim of the Travel Plan is to:
"Facilitate and promote convenient, efficient, healthy, sustainable travel to St. George's Hospital for staff, patients and visitors through improvements to information and transport facilities."

The aim is supported by the following objectives:

- To reduce the number of staff travelling to work by car
- To increase the number of staff travelling to work by sustainable methods of travel.
- To assist in reducing the Trust's carbon footprint through transport emissions;
- To contribute to the Trust's corporate social responsibility agenda and assist in being a good member of the community;
- To ensure St. George's Hospital Staff are engaged, informed and aware of the impacts of their travel patterns in terms of health, the environment, and the community; and
- To seek opportunities for additional funding for infrastructure improvements relating to walking, cycling and public transport.
- To improve access to the St. George's Hospital site for Patients, Visitors and staff;

These objectives are supported both by a set of targets and a range of supporting initiatives focused on meeting the objectives set out above and facilitating sustainable travel by the full range of transport options available for those travelling to St. George's Hospital.

2. Recommendation

To approve the Travel Plan for the St George's Hospital site at Blackshaw Road.

Enclosure:

Key risks identified: *Are there any risks identified in the paper (impact on achieving corporate objectives) – e.g. quality, financial performance, compliance with legislation or regulatory requirements?* The key risk is unavailability of future funding to support the objectives contained in the plan.	
Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	10 year strategy: Maximise the wellbeing of our staff and their levels of contribution and engagement Trust Values : Responsible : Use resources wisely NHS Sustainable Development Management Plan – National Carbon Reduction Strategy and Healthier Communities
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	
Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes / No) **If yes, please provide a summary of the key findings** **If no, please explain you reasons for not undertaking and EIA.**	

St George's Healthcare NHS
NHS Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better heath outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Facilities	Corporate	Mary Prior	Revised Plan	15 Oct 2015
1.1 Who is responsible for this service / function / policy? **Transport For St George's Committee**				
1.2 Describe the purpose of the service / function / policy? *Who is it intended to benefit? What are the intended outcomes?* Key motivations for development of this Travel Plan are: • To improve access to the St. George's Hospital site for Patients, Visitors and staff; • To bring transport and travel policies together in a coordinated way; • To lead by example in terms of promoting the health benefits of active travel; • To provide a mechanism for educating staff about the benefit of sustainable travel options;				

- • To contribute to St. George's corporate social responsibility agenda;
- • To mitigate the resultant loss of car parking from the re-development proposals; and
- • To mitigate the environmental impacts of staff travel.

1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*

National Policy
Travel Plans have become an important tool for the delivery of national, regional and local transport policy. There have been a number of national, regional and local policies and other initiatives that have influenced Travel Plan development and take-up both nationally and across London. Transport policy is contained in the following documents

- National Planning Policy Framework;
- The London Plan (March 2015); and
- London Borough of Wandsworth Local Plan.

London-specific Policy/ Guidance
The Mayor's Transport Strategy (2010) intends, through TfL, and working with the London Boroughs and other stakeholders to use smarter travel initiatives, including travel planning, across London to formulate more effective use of the transport system including mode shift to cycling, walking, and public transport and encouraging take up of healthier travel options.

1.4 What factors contribute or detract from achieving intended outcomes?

The main factors will be a shortage of funding to invest in alternative travel options and also a shortage of space on site to accommodate some of the schemes (for example communal showers and more space for cycles).

1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights

Positive impact in improving access for patients, staff and visitors with a disability. There is an objective for reducing the number of staff that drive to work which will need to be carefully managed to ensure staff are supported through this change.

1.6 If yes, please describe current or planned activities to address the impact.

1.7 Is there any scope for new measures which would promote equality?

1.8 What are your monitoring arrangements for this policy/ service
The objectives of the plan will be measured by the Transport for St Georges Committee as this will be a standing item on the agenda.

1.9 Equality Impact Rating [low, medium, high]
Low

2.0. Please give your reasons for this rating
The plan has been written to improve access and will have a positive impact.

Buses from St George's Hospital

Key

- Connections with London Underground
- Connections with London Overground
- Connections with National Rail
- Connections with Tramlink
- Connections with river boats

Red discs show the bus stop you need for your chosen bus service. The disc A appears on the top of the bus stop in the street (see map of town centre in centre of diagram).

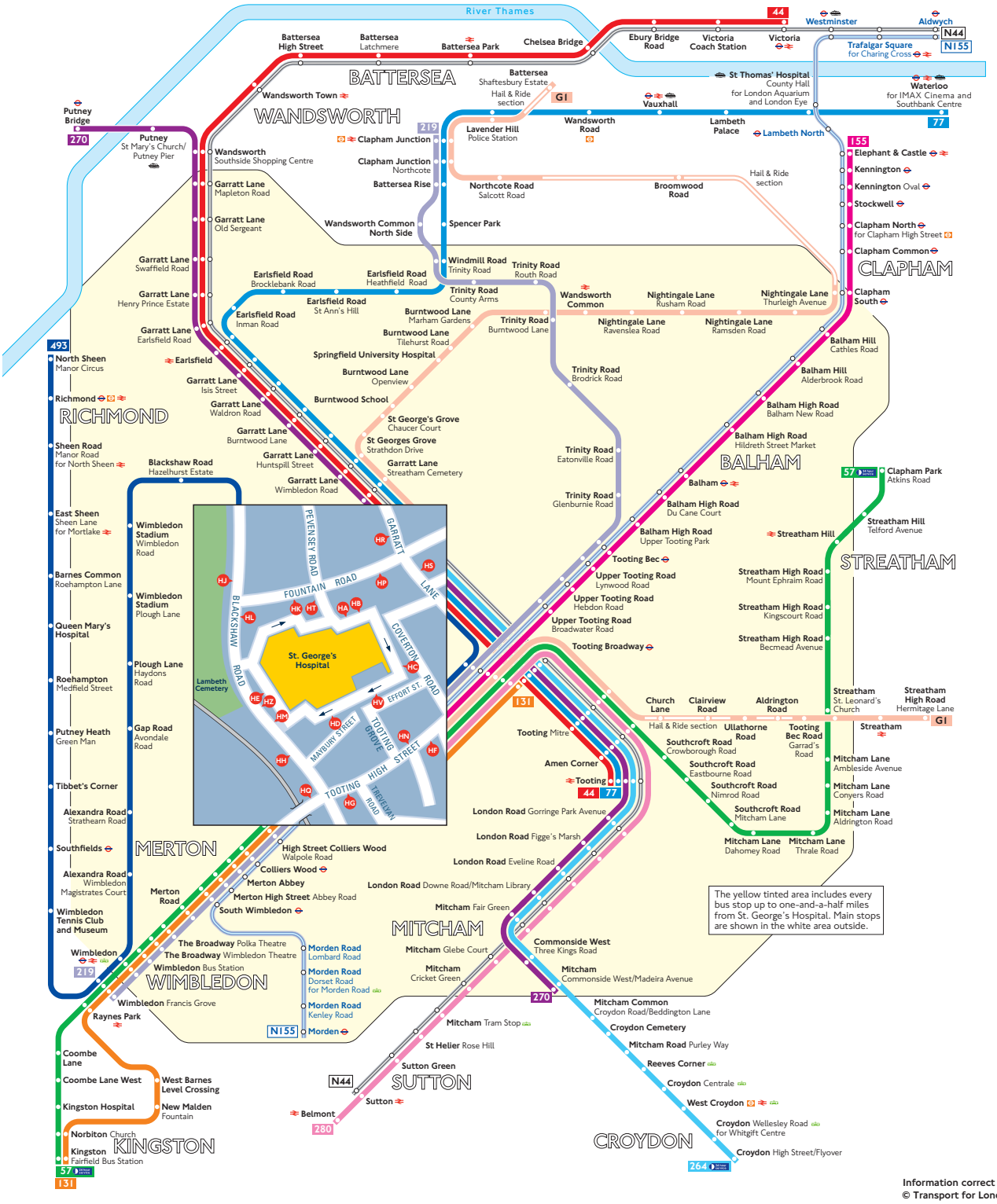
Route finder

Day buses including 24-hour services

Bus route	Towards	Bus stops
44	Tooting	HS
	Victoria	HR
57 (24 hour service)	Clapham Park	HN HO
	Kingston	HF HG
77	Tooting	HS
	Waterloo	HR
131	Kingston	HF HG
	Tooting Broadway	HN HO
155	Elephant & Castle	HM HN
219	Clapham Junction	HN HO
	Wimbledon	HF HG
264 (24 hour service)	Croydon	HM HN
270	Mitcham	HS
	Putney Bridge	HR
280	Belmont	HM HN
493	Richmond	HB HC HD HE HF HG HH HJ HL HS HT HV
G1	Battersea	HA HC HD HE HF HG HH HK HT HV
	Streatham	HA HC HD HN HP HV

Night buses

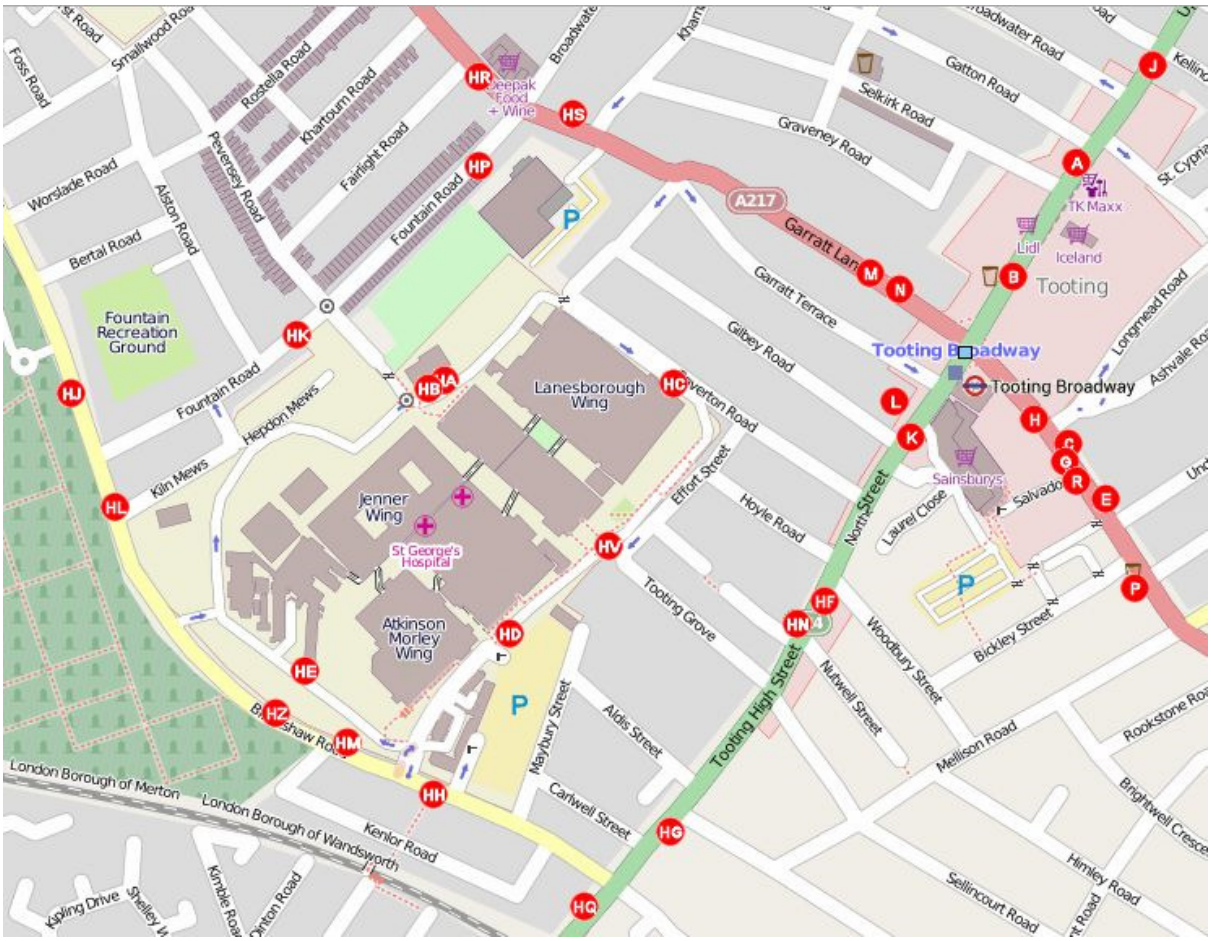
Bus route	Towards	Bus stops
N44	Aldwych	HR
	Sutton	HS
N155	Aldwych	HN HO
	Morden	HF HG



Information correct from 26 September 2014
 TFL28873.09.14 (F)

Appendix A - Public Transport.

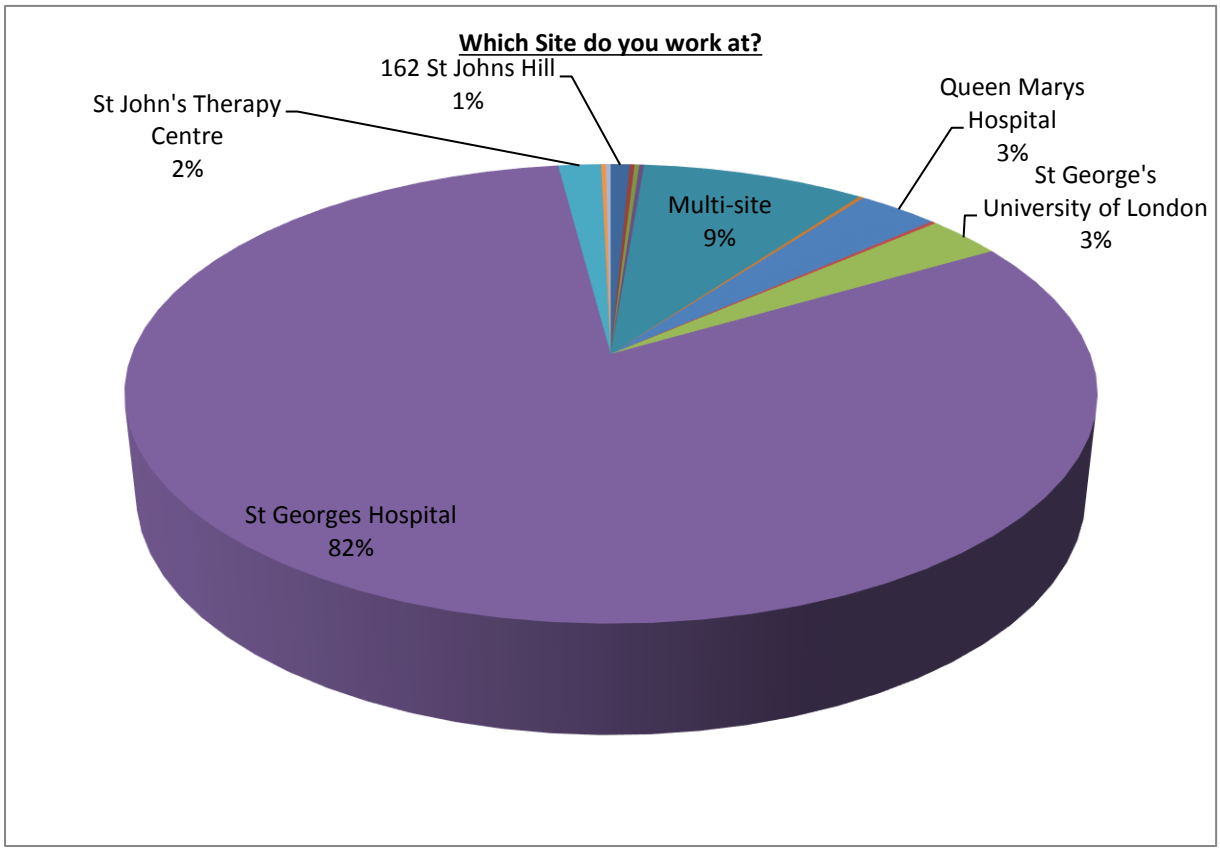
Map of existing bus stops in the area of the hospital.



ST GEORGE'S TRUST STAFF TRAVEL SURVEY
Results Summary 25/03/2015

Which Site do you work at?

	Response	Percentage
162 St Johns Hill	4	1%
249 Garratt Lane	1	0%
311 Battersea Park Rd	1	0%
63 Bevill Allen Close	1	0%
Multi-site	47	9%
Putney	1	0%
Queen Marys Hospital	17	3%
Roehampton	1	0%
St George's University of London	16	3%
St Georges Hospital	435	81%
St John's Therapy Centre	9	2%
Tudor Lodge Health Centre	1	0%
Westmoor Clinic DN	1	0%
	535	100%

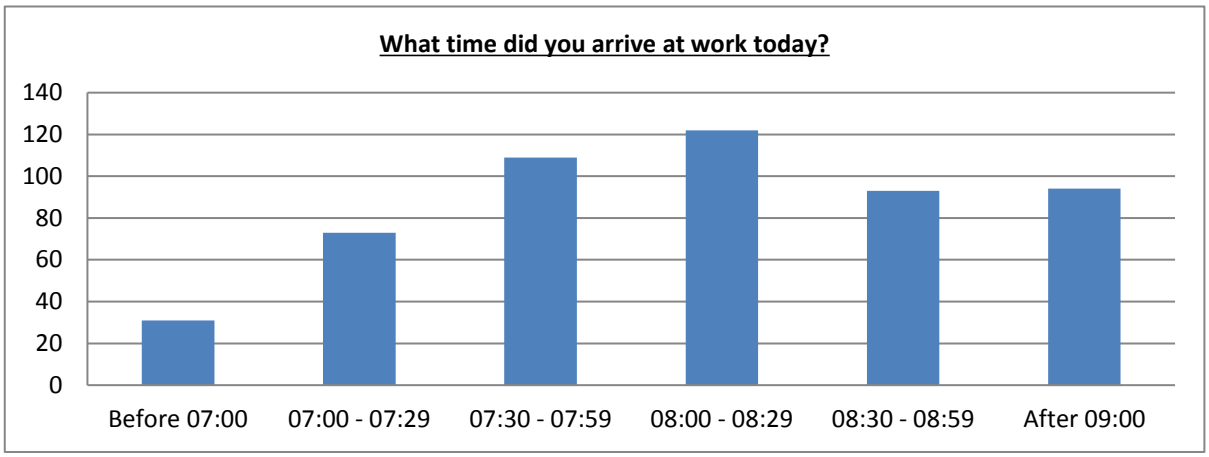


ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

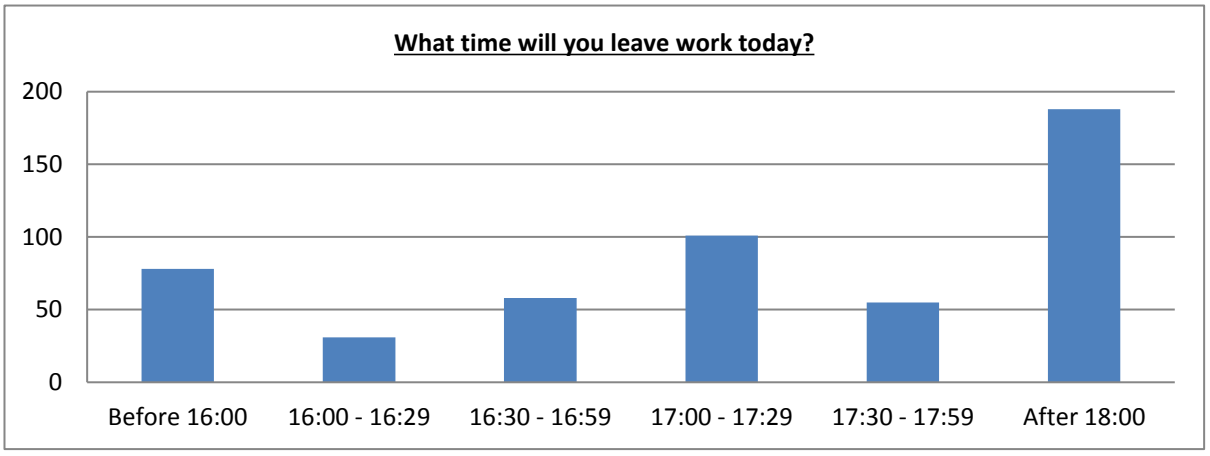
What time did you arrive at work today? (Please use 24 hour clock)

	Response	Percentage
Before 07:00	31	5.9%
07:00 - 07:29	73	14.0%
07:30 - 07:59	109	20.9%
08:00 - 08:29	122	23.4%
08:30 - 08:59	93	17.8%
After 09:00	94	18.0%
	522	100.0%



What time will you leave work today? (Please use 24 hour clock)

	Response	Percentage
Before 16:00	78	15.3%
16:00 - 16:29	31	6.1%
16:30 - 16:59	58	11.4%
17:00 - 17:29	101	19.8%
17:30 - 17:59	55	10.8%
After 18:00	188	36.8%
	511	100.0%



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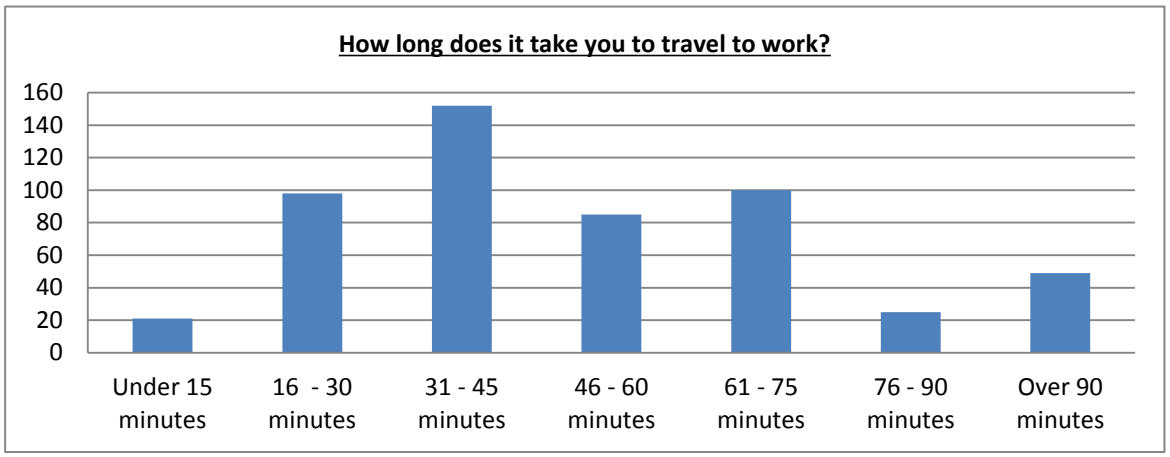
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

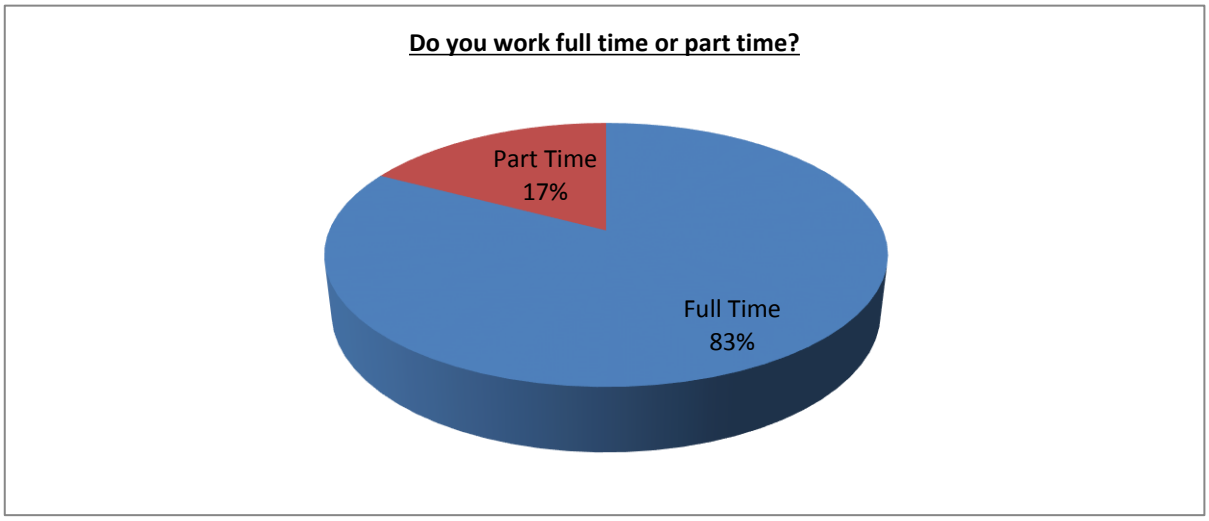
How long does it take you to travel to work?

	Response	Percentage
Under 15 minutes	21	4.0%
16 - 30 minutes	98	18.5%
31 - 45 minutes	152	28.7%
46 - 60 minutes	85	16.0%
61 - 75 minutes	100	18.9%
76 - 90 minutes	25	4.7%
Over 90 minutes	49	9.2%
	530	100.0%



Do you work full time or part time?

	Response	Percentage
Full Time	440	82.7%
Part Time	92	17.3%
	532	100.0%



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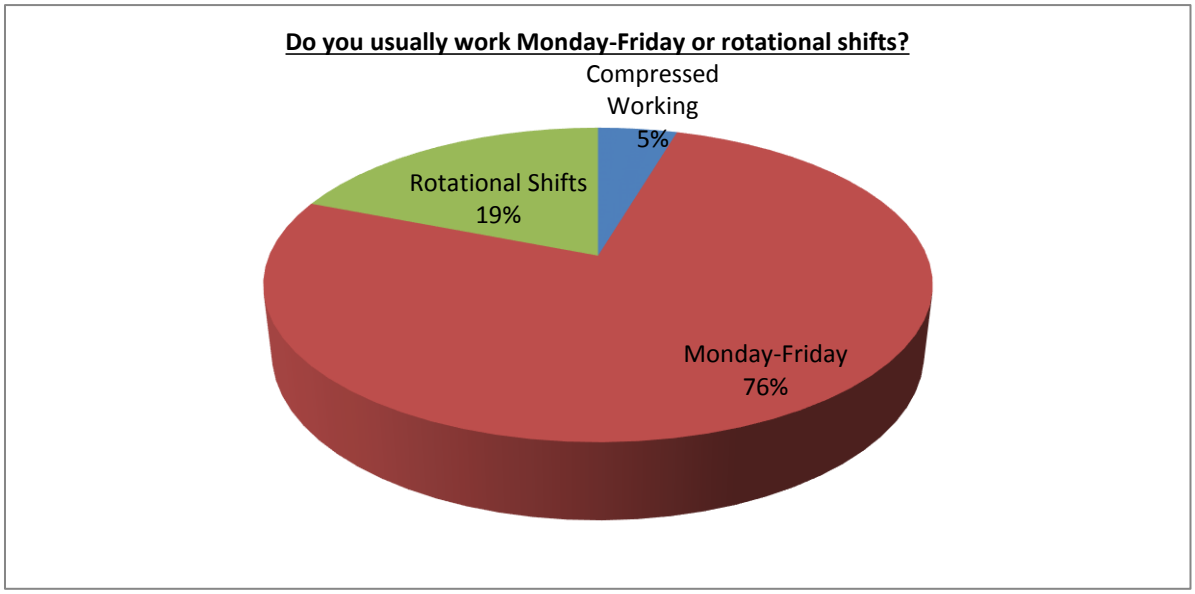
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

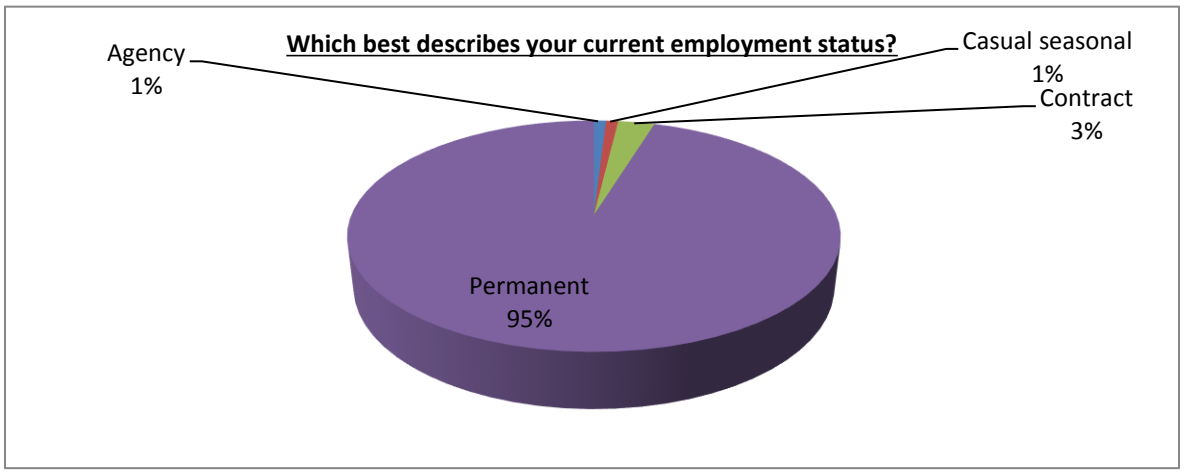
Do you usually work Monday-Friday or rotational shifts?

	Response	Percentage
Compressed Working	24	4.6%
Monday-Friday	401	76.4%
Rotational Shifts	100	19.0%
	525	100.0%



Which best describes your current employment status?

	Response	Percentage
Agency	5	1.0%
Casual seasonal	5	1.0%
Contract	15	2.9%
Permanent	501	95.2%
	526	100.0%



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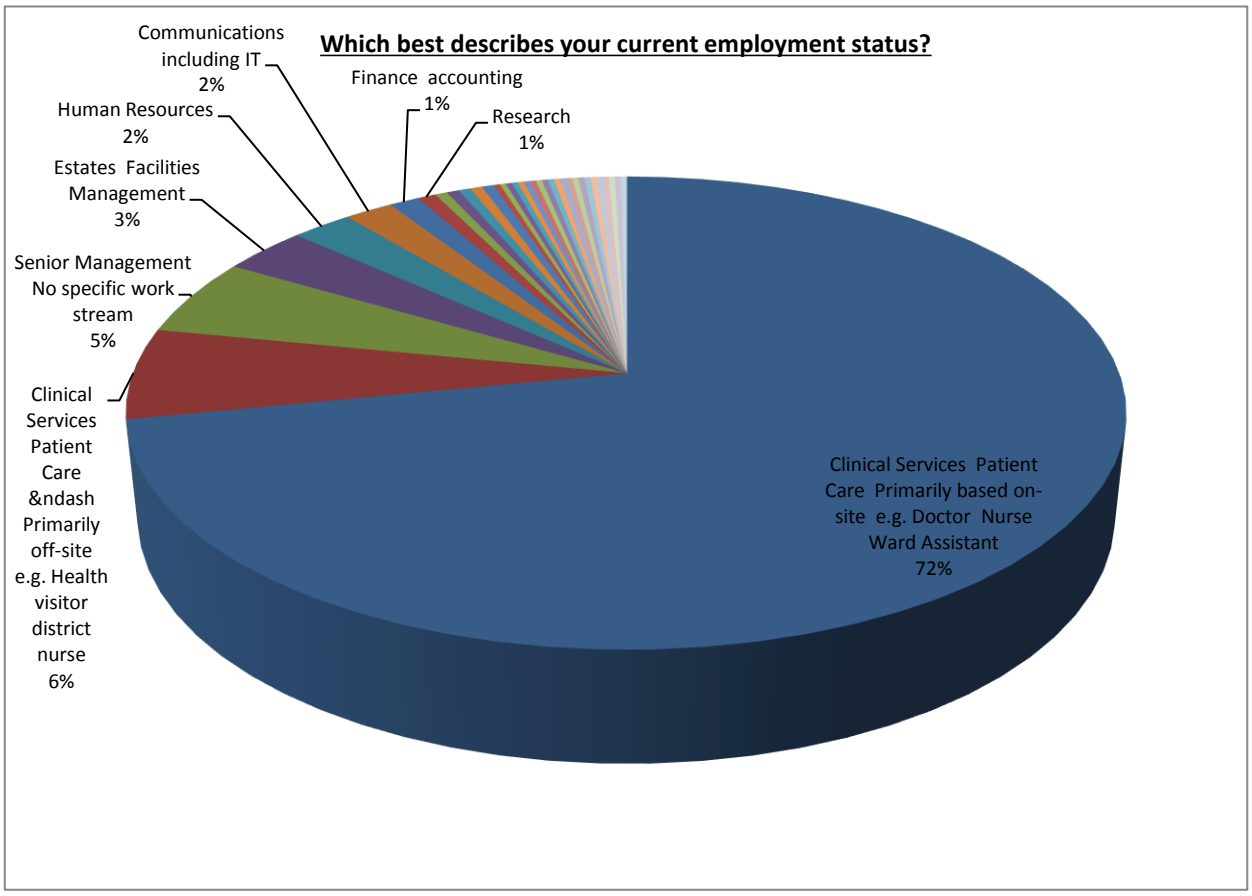
ST GEORGE'S TRUST STAFF TRAVEL SURVEY
Results Summary 25/03/2015

Which of the following best describes the role which you fulfil for your NHS Trust?

	Response	Percentage
Clinical Services Patient Care Primarily based on-site e.g. Doctor Nurse Ward Assistant	312	71.9%
Clinical Services Patient Care &ndash Primarily off-site e.g. Health visitor district nurse	27	6.2%
Senior Management No specific work stream	23	5.3%
Estates Facilities Management	14	3.2%
Human Resources	10	2.3%
Communications including IT	8	1.8%
Finance accounting	5	1.2%
Research	3	0.7%
8C manager	2	0.5%
Diagnostics	2	0.5%
Diagnostics	2	0.5%
Laboratory	2	0.5%
Matron	2	0.5%
Allied health professional	1	0.2%
Assistant Project Manager	1	0.2%
Clinical Coder	1	0.2%
clinical psychologist	1	0.2%
Community Serveces	1	0.2%
Discharge Co-ordinator	1	0.2%
Health promotion -Bowel screening	1	0.2%
IT Projects	1	0.2%
Laboratory staff	1	0.2%
Legal	1	0.2%
Medical Physicist	1	0.2%
Medical Physics	1	0.2%
MHA	1	0.2%
Midwife	1	0.2%
Mortuary	1	0.2%
Pharmacy Technician	1	0.2%
Procurement	1	0.2%
Project Management	1	0.2%
Renal Technologist	1	0.2%
Scientific clinical support	1	0.2%
Senior Housekeeper	1	0.2%
Trainer / Adviser	1	0.2%
	434	100.0%



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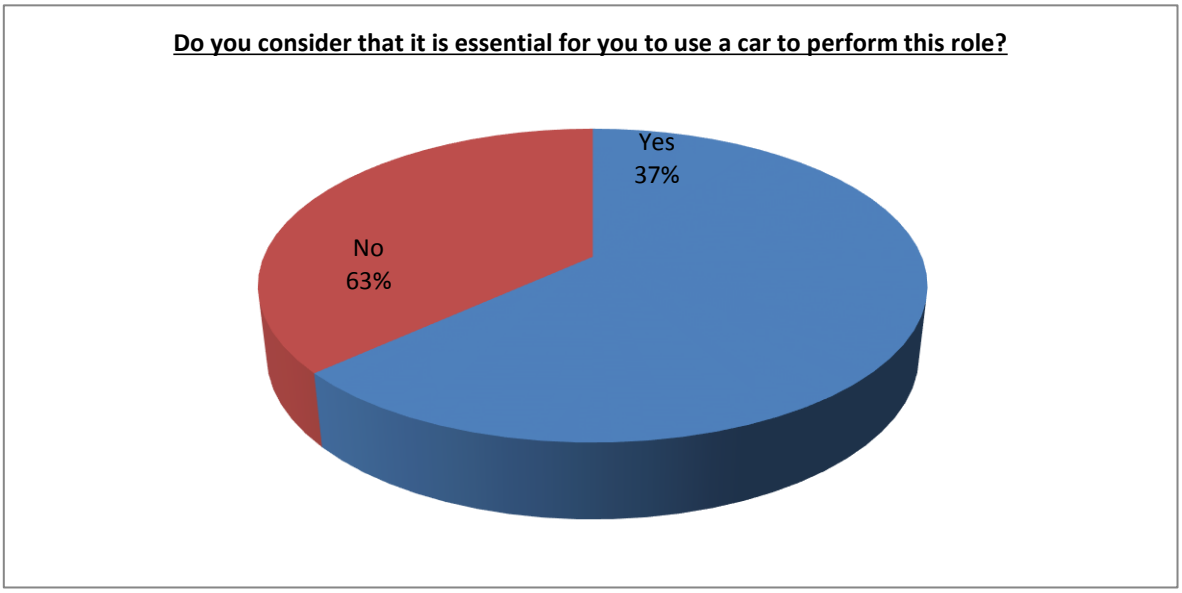
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

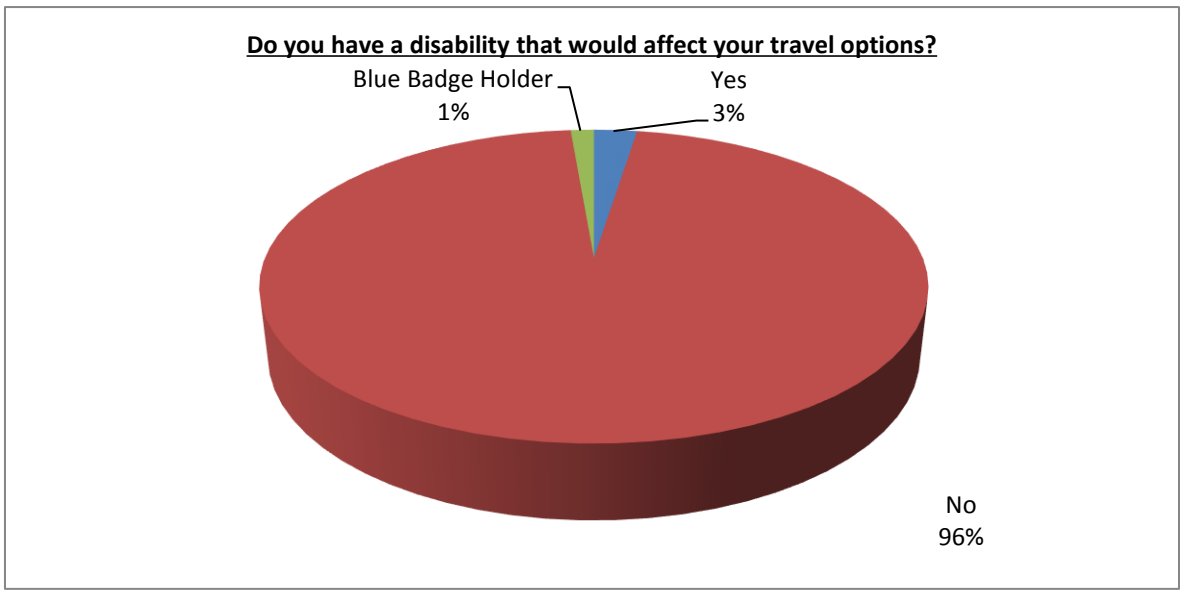
Do you consider that it is essential for you to use a car to perform this role?

	Response	Percentage
No	336	63.3%
Yes	195	36.7%
	531	100.0%



Do you have a disability that would affect your travel options?

	Response	Percentage
Yes	13	2.5%
No	502	96.2%
Blue Badge Holder	7	1.3%
	522	100.0%



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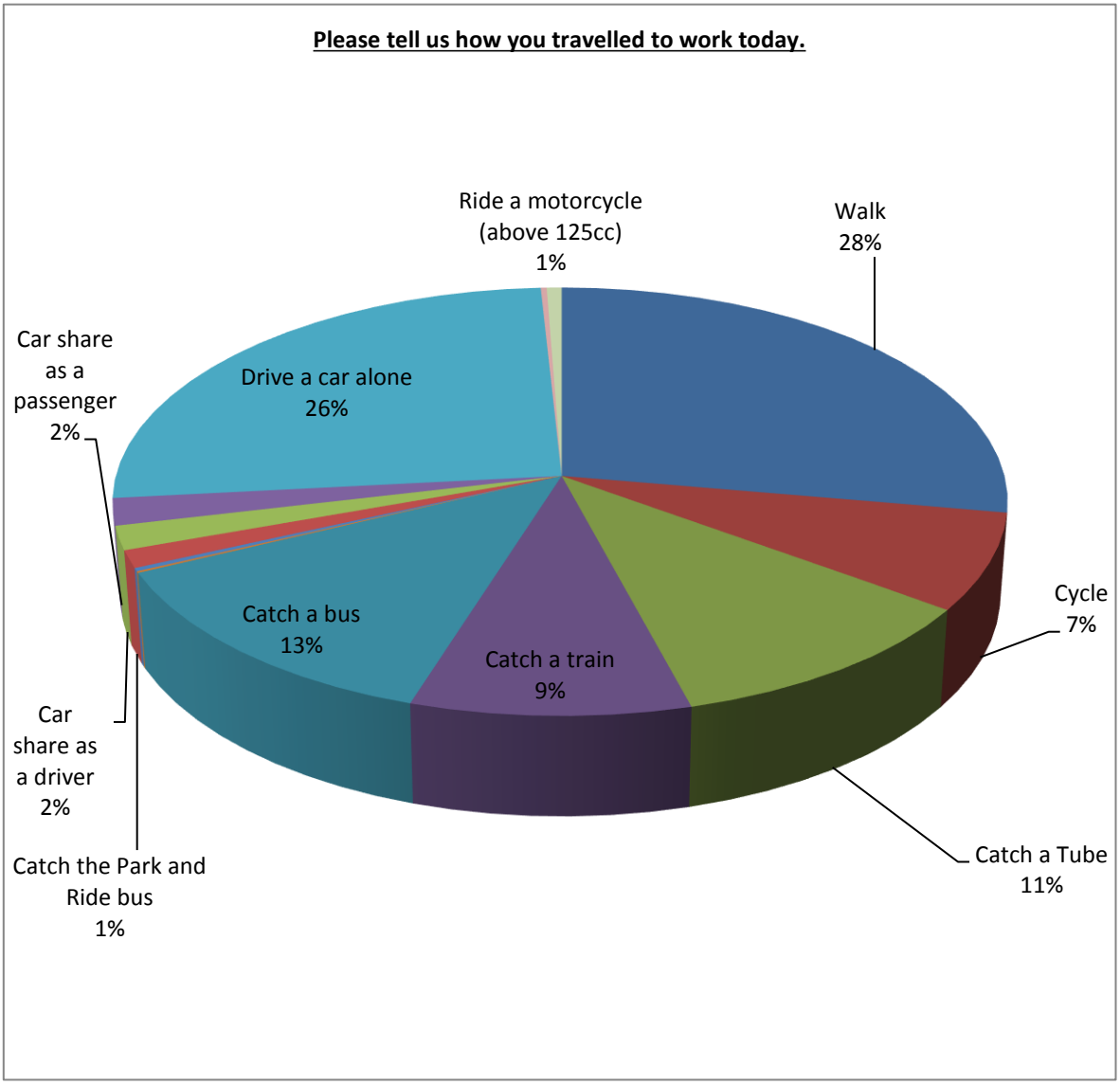
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

Please use the table below to show how you travelled to work today

	Response	Percentage
Walk	231	27.7%
Cycle	61	7.3%
Catch a Tube	90	10.8%
Catch a train	75	9.0%
Catch a bus	108	13.0%
Catch the DLR	1	0.1%
Catch the tram	2	0.2%
Catch the Park and Ride bus	11	1.3%
Car share as a driver	15	1.8%
Car share as a passenger	17	2.0%
Drive a car alone	215	25.8%
Catch a taxi	0	0.0%
Catch a riverboat	0	0.0%
Ride a scooter/ motorcycle (below 125cc)	2	0.2%
Ride a motorcycle (above 125cc)	5	0.6%
	833	100.0%



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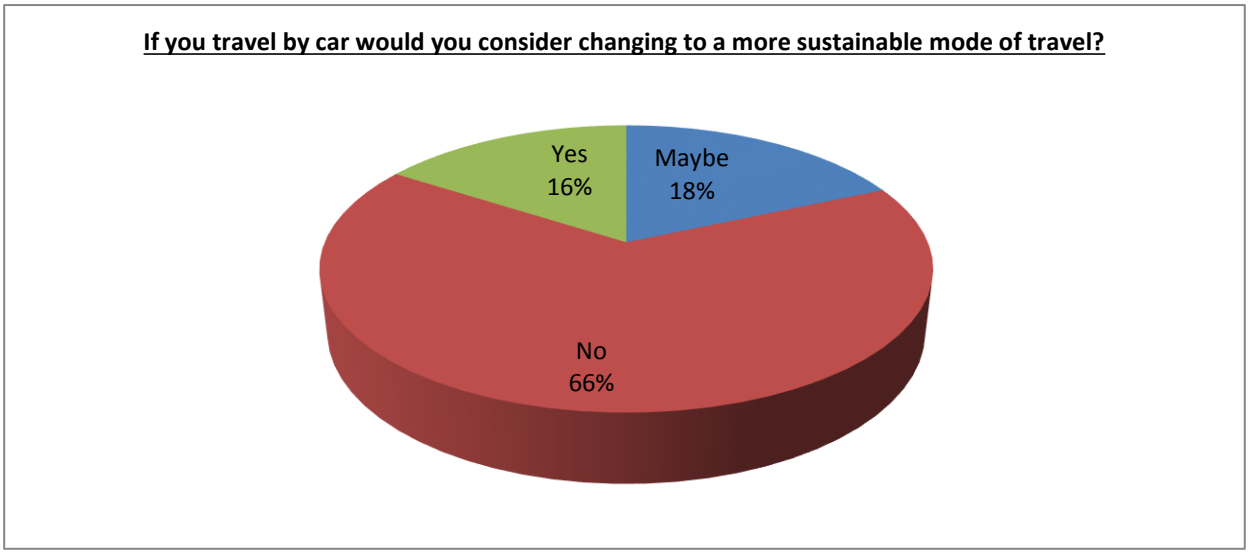
ST GEORGE'S TRUST STAFF TRAVEL SURVEY
Results Summary 25/03/2015

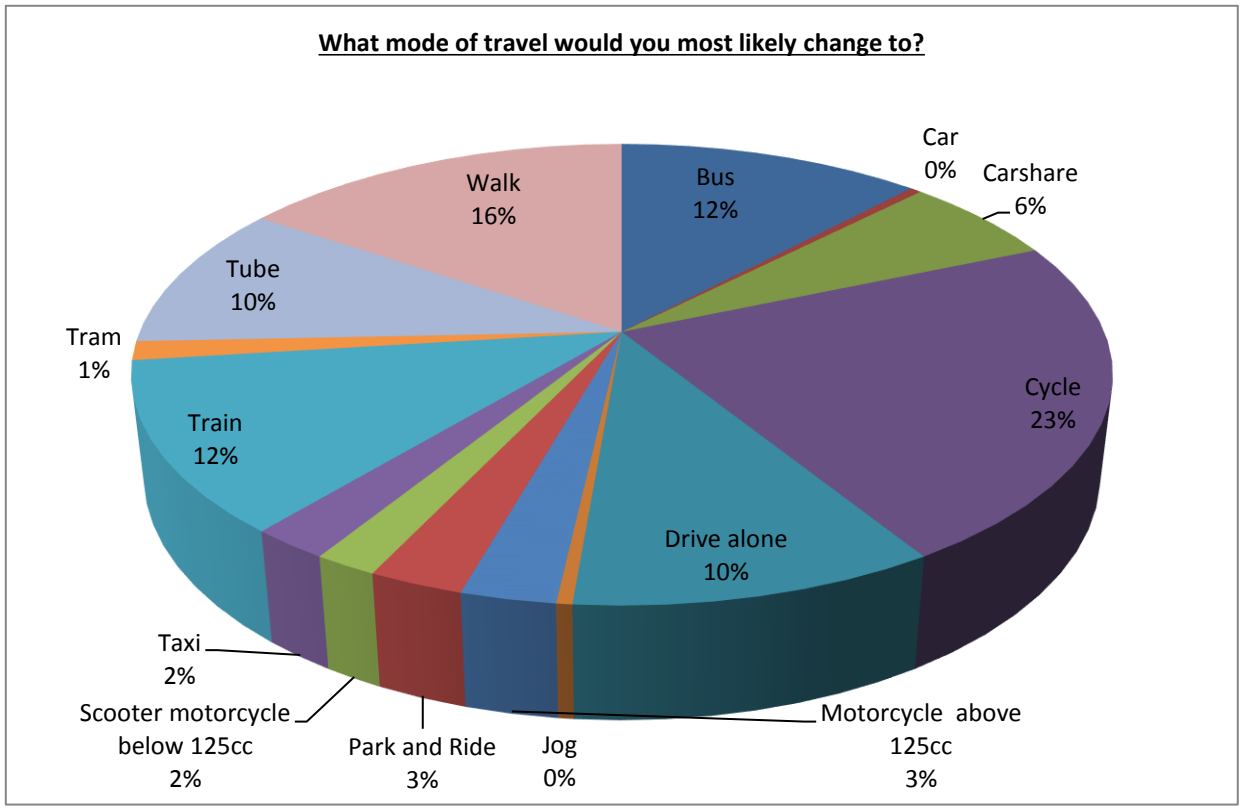
If you travel by car would you consider changing to a more sustainable mode of travel?

	Response	Percentage
Maybe	52	18.4%
No	186	65.7%
Yes	45	15.9%
	283	100.0%



What mode of travel would you most likely change to?

	Response	Percentage		Response	Percentage
Bus	27	11.9%	Park and Ride	6	2.7%
Car	1	0.4%	Scooter motorcycle below 125cc	4	1.8%
Carshare	14	6.2%	Taxi	5	2.2%
Cycle	51	22.6%	Train	27	11.9%
Drive alone	23	10.2%	Tram	3	1.3%
Jog	1	0.4%	Tube	23	10.2%
Motorcycle above 125cc	6	2.7%	Walk	35	15.5%
				226	100.0%



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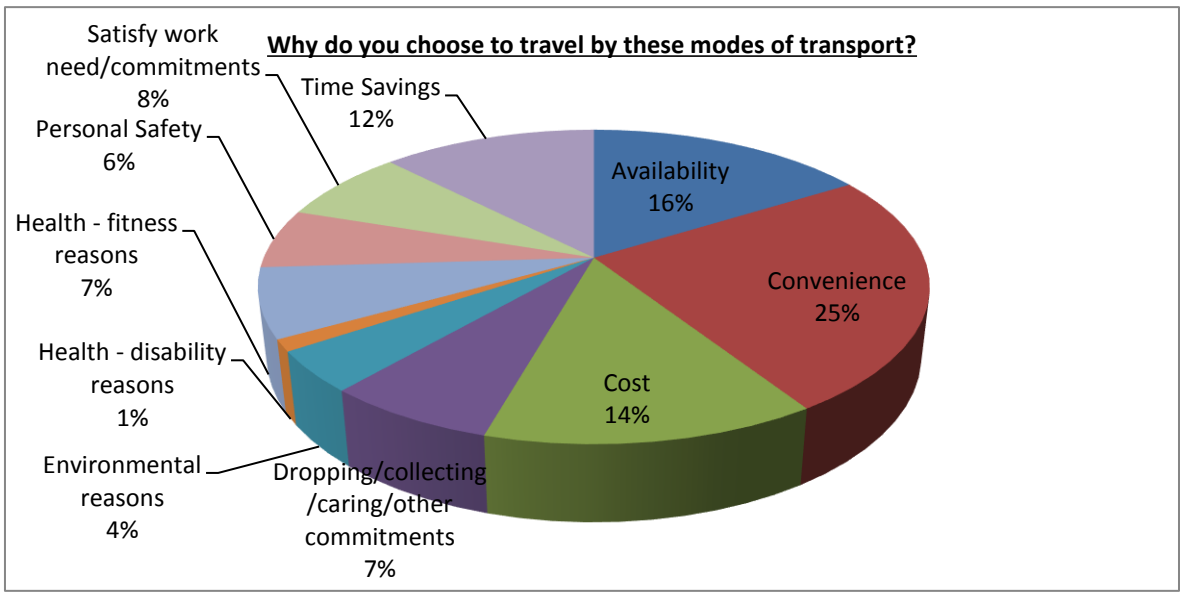
ST GEORGE'S TRUST STAFF TRAVEL SURVEY
Results Summary 25/03/2015

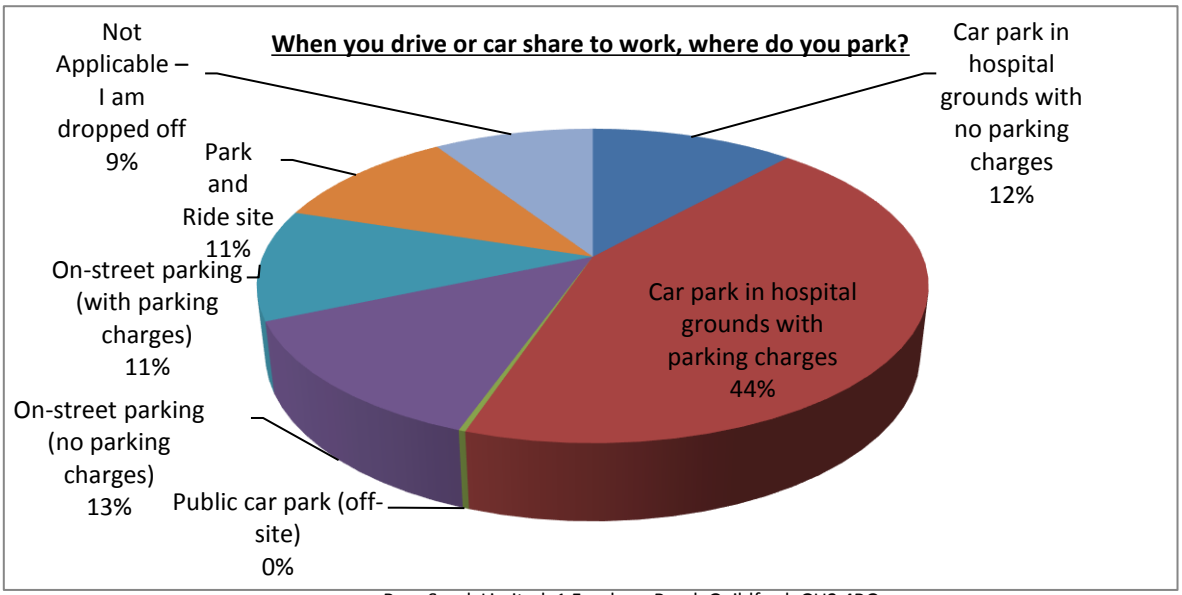
Why do you choose to travel by these modes of transport?

	Response	Percentage
Availability	187	16.1%
Convenience	286	24.7%
Cost	157	13.6%
Dropping/collecting/caring/other commitments	81	7.0%
Environmental reasons	49	4.2%
Health - disability reasons	14	1.2%
Health - fitness reasons	83	7.2%
Personal Safety	71	6.1%
Satisfy work need/commitments	87	7.5%
Time Savings	143	12.3%
	1158	100.0%



When you drive or car share to work, where do you park?

	Response	Percentage
Car park in hospital grounds with no parking charges	42	11.7%
Car park in hospital grounds with parking charges	156	43.5%
Public car park (off-site)	1	0.3%
On-street parking (no parking charges)	47	13.1%
On-street parking (with parking charges)	41	11.4%
Park and Ride site	39	10.9%
Not Applicable – I am dropped off	33	9.2%
	359	100.0%



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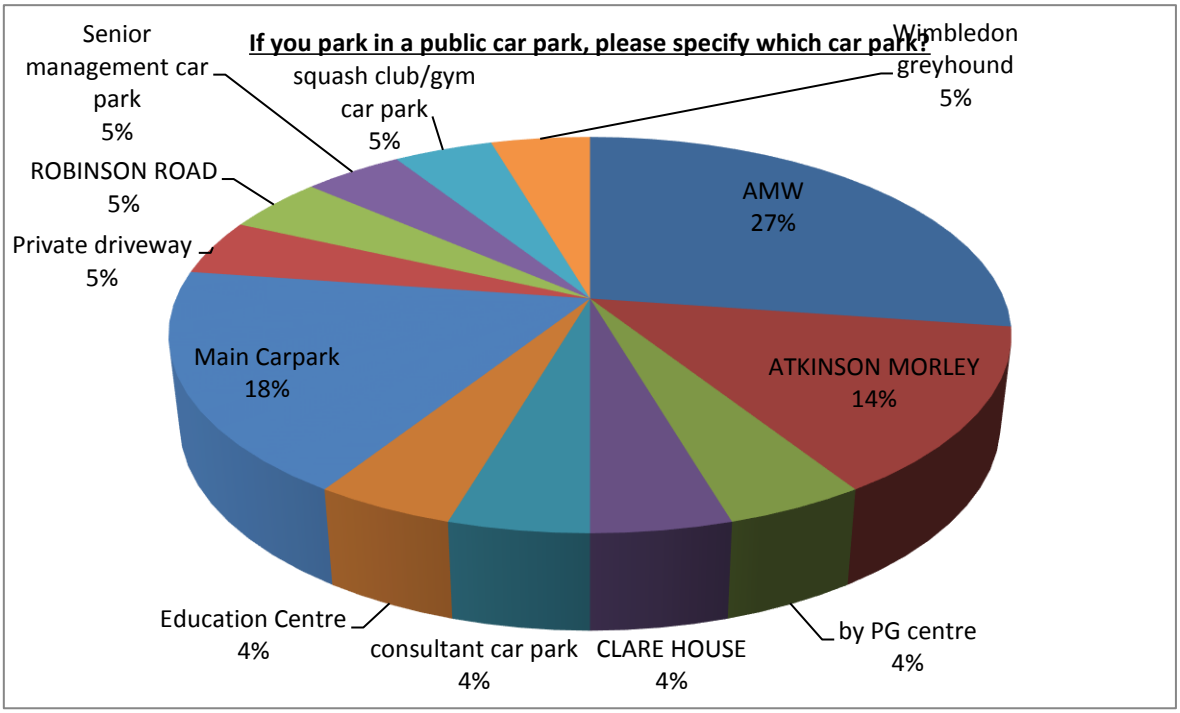
Results Summary 25/03/2015

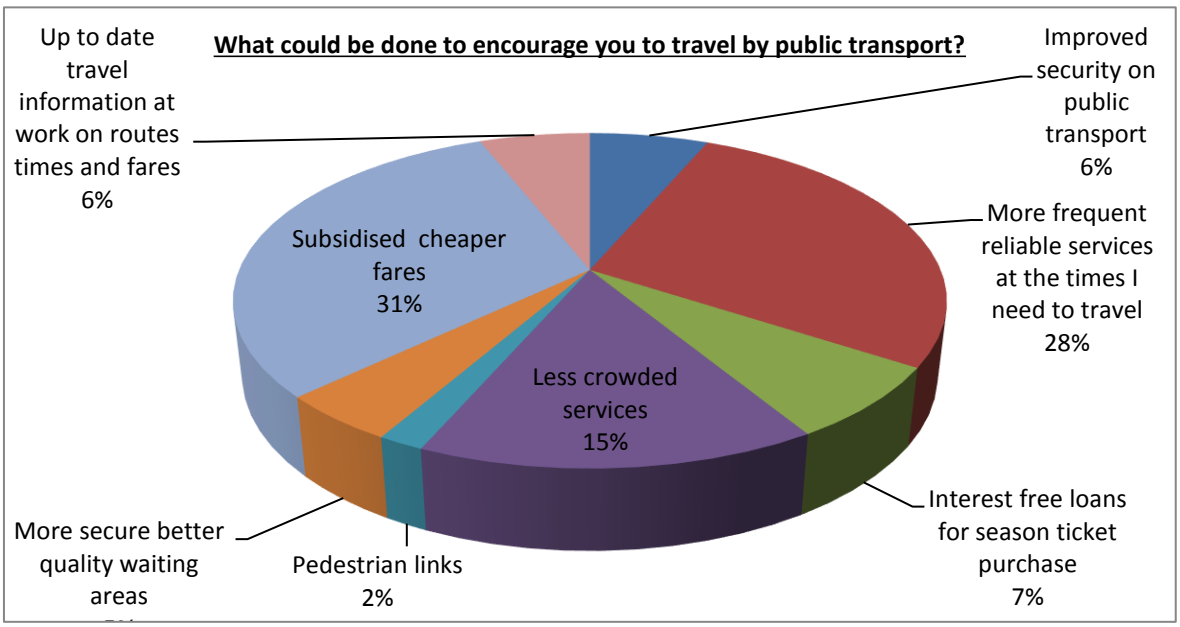
If you park in a public car park, please specify which car park?

	Response	Percentage		Response	Percentage
AMW	6	27.3%	Main Carpark	4	18.2%
ATKINSON MORLEY	3	13.6%	Private driveway	1	4.5%
by PG centre	1	4.5%	ROBINSON ROAD	1	4.5%
CLARE HOUSE	1	4.5%	Senior management car park	1	4.5%
consultant car park	1	4.5%	squash club/gym car park	1	4.5%
Education Centre	1	4.5%	Wimbledon greyhound	1	4.5%
				22	100.0%



What could be done to encourage you to travel by public transport?

	Response	Percentage		Response	Percentage
Improved security on public transport	29	6.4%	Less crowded services	69	15.3%
			Pedestrian links	8	1.8%
More frequent reliable services at the times I need to travel	125	27.7%	More secure better quality waiting a	21	4.7%
			Subsidised cheaper fares	140	31.0%
Interest free loans for season ticket purchase	32	7.1%	Up to date travel information at wor	27	6.0%
				451	100.0%



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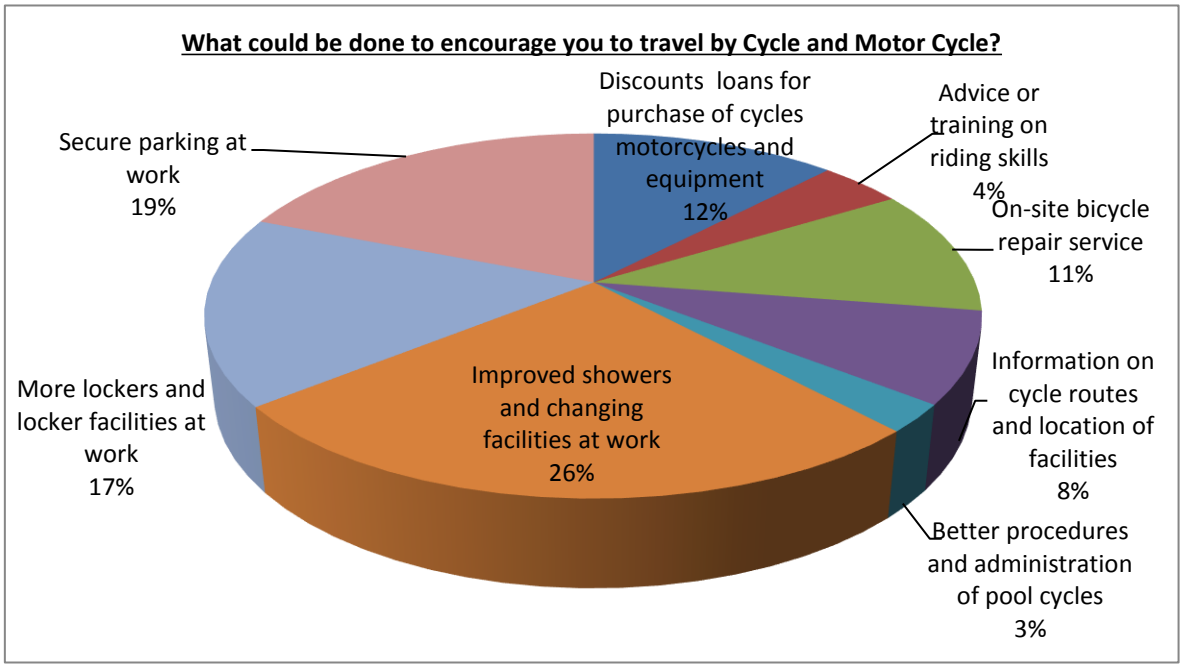
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

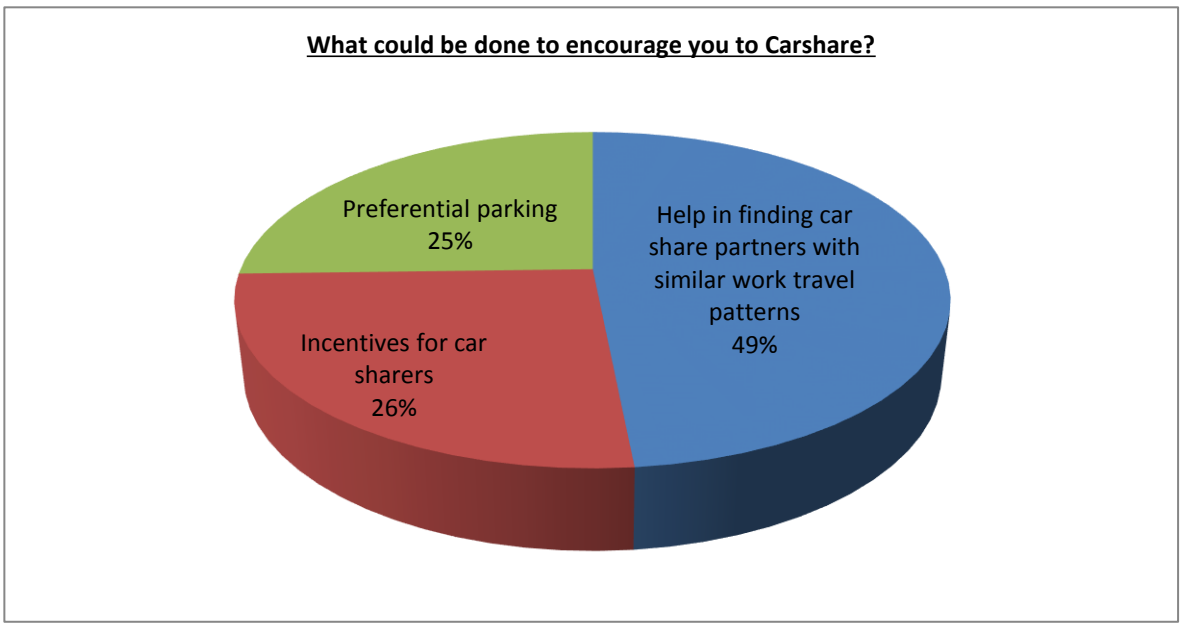
What could be done to encourage you to travel by Cycle and Motor Cycle?

	Response	Percentage
Discounts loans for purchase of cycles motorcycles and equipment	59	12.2%
Advice or training on riding skills	20	4.1%
On-site bicycle repair service	54	11.2%
Information on cycle routes and location of facilities	39	8.1%
Better procedures and administration of pool cycles	12	2.5%
Improved showers and changing facilities at work	127	26.2%
More lockers and locker facilities at work	81	16.7%
Secure parking at work	92	19.0%
	484	100.0%



What could be done to encourage you to Carshare?

	Response	Percentage
Help in finding car share partners with similar work travel patterns	141	48.5%
Incentives for car sharers	76	26.1%
Preferential parking	74	25.4%
	291	100.0%



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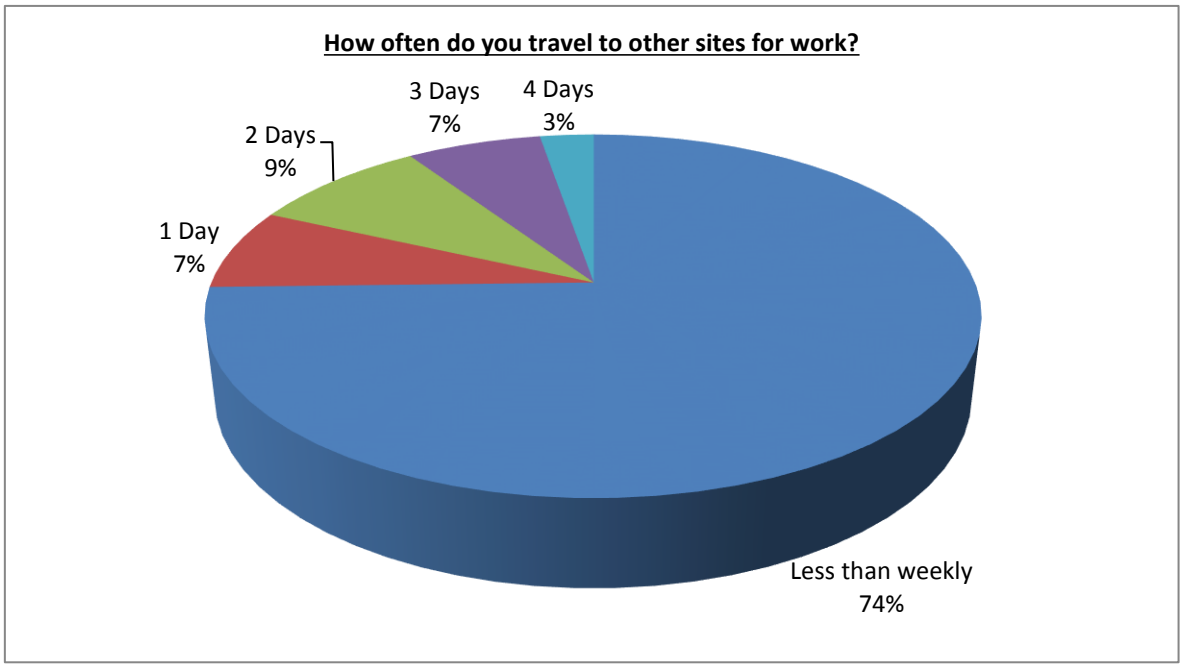
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

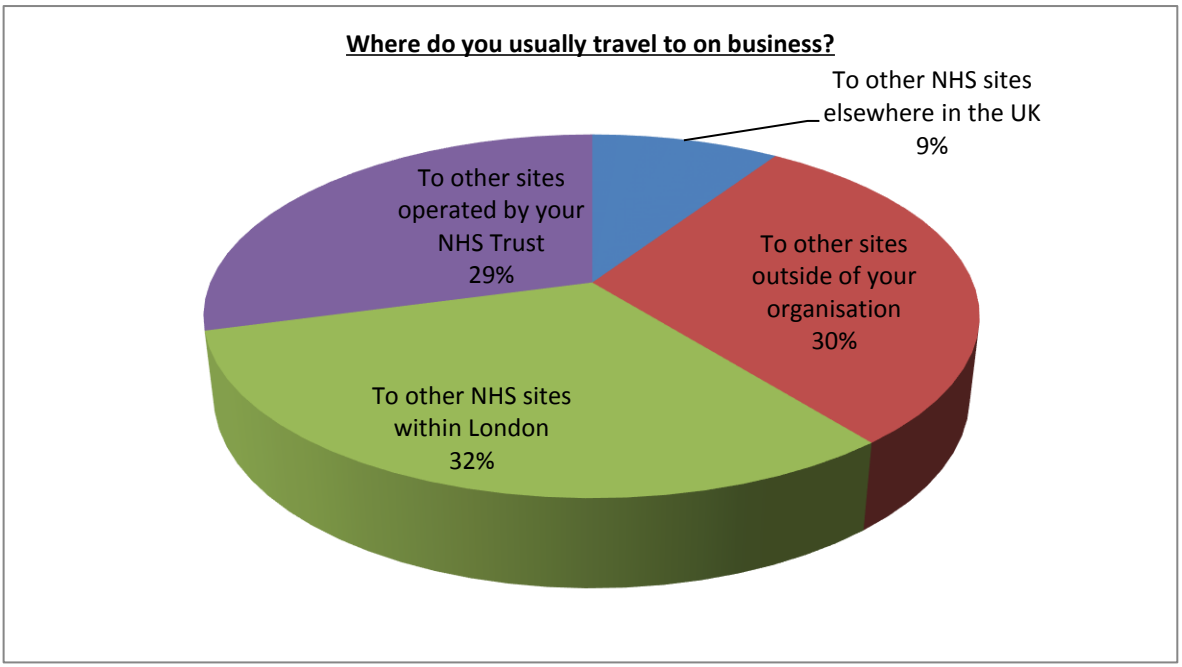
How often do you travel to other sites for work?

	Response	Percentage
Less than weekly	279	74.6%
1 Day	27	7.2%
2 Days	33	8.8%
3 Days	25	6.7%
4 Days	10	2.7%
	374	100.0%



Where do you usually travel to on business?

	Response	Percentage
To other NHS sites elsewhere in the UK	40	9.3%
To other sites outside of your organisation	128	29.9%
To other NHS sites within London	135	31.5%
To other sites operated by your NHS Trust	125	29.2%
	428	100.0%



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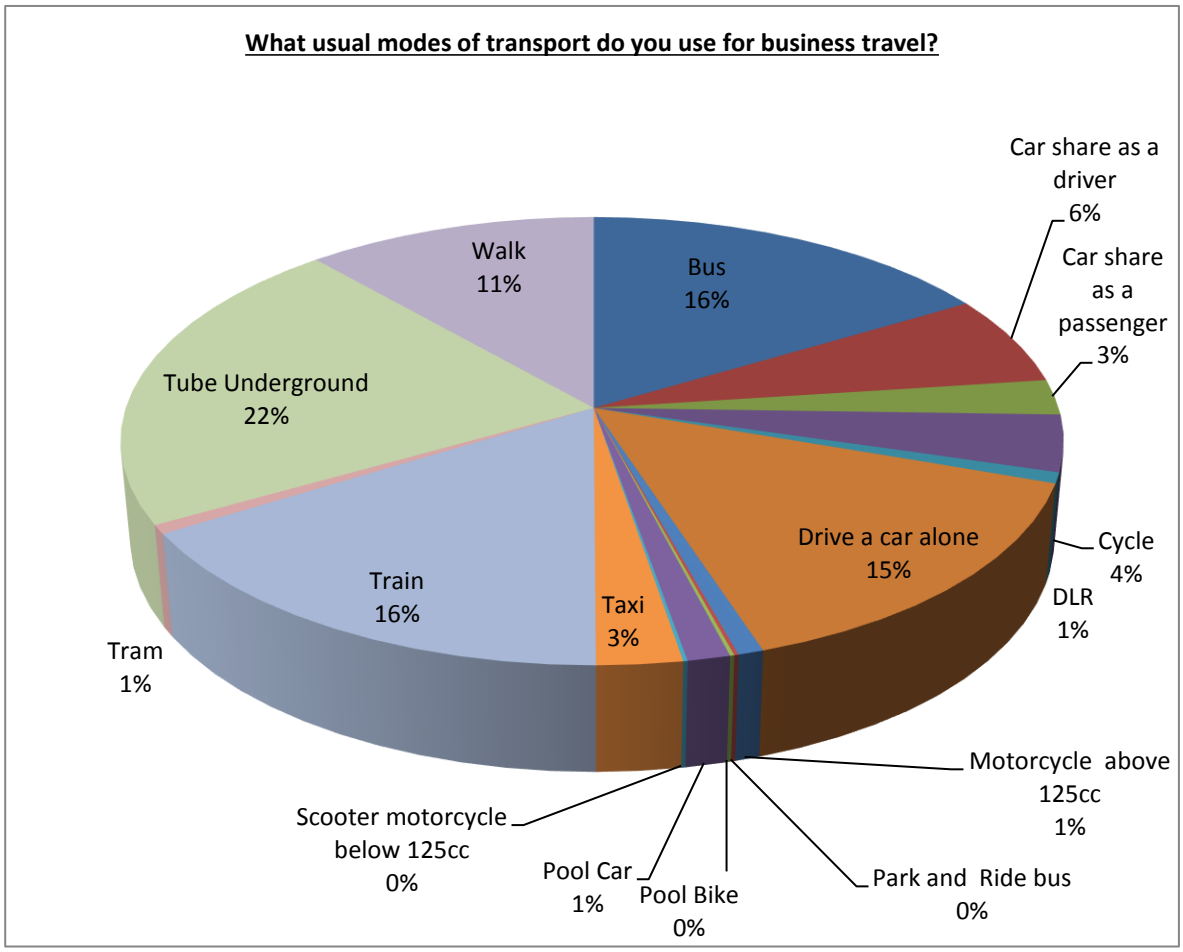
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

What usual modes of transport do you use for business travel?

	Response	Percentage
Bus	129	16.4%
Car share as a driver	51	6.5%
Car share as a passenger	20	2.5%
Cycle	32	4.1%
DLR	6	0.8%
Drive a car alone	115	14.6%
Motorcycle above 125cc	6	0.8%
Park and Ride bus	1	0.1%
Pool Bike	1	0.1%
Pool Car	10	1.3%
Scooter motorcycle below 125cc	1	0.1%
Taxi	20	2.5%
Train	127	16.2%
Tram	5	0.6%
Tube Underground	171	21.8%
Walk	90	11.5%
	785	100.0%



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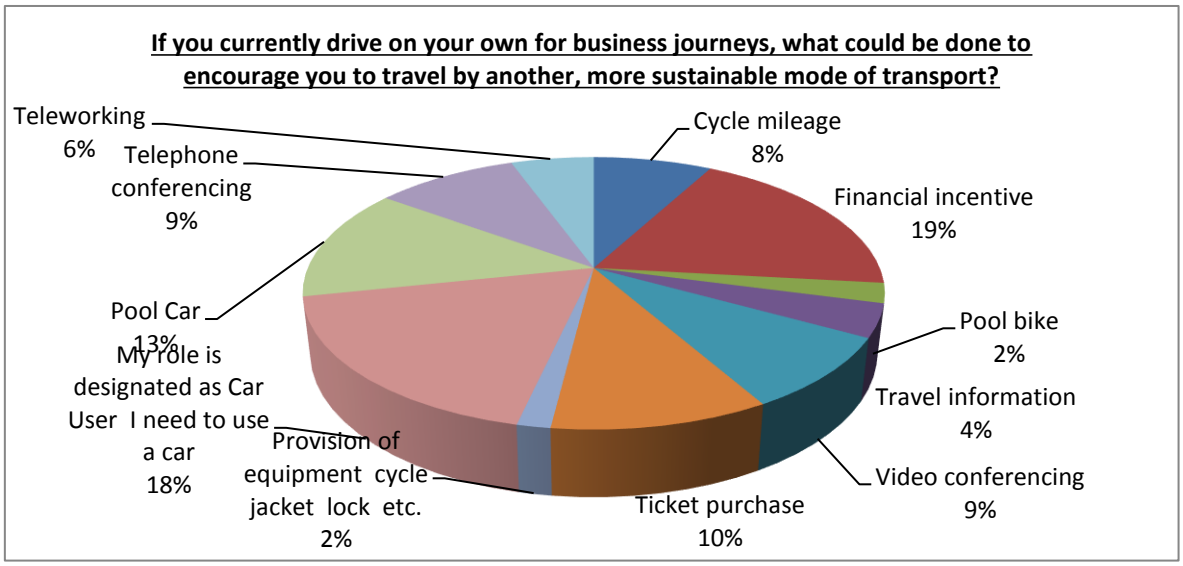
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

If you currently drive on your own for business journeys, what could be done to encourage you to travel by another, more sustainable mode of transport?

	Response	Percentage
Cycle mileage	10	7.9%
Financial incentive	24	18.9%
Pool bike	3	2.4%
Travel information	5	3.9%
Video conferencing	11	8.7%
Ticket purchase	13	10.2%
Provision of equipment cycle jacket lock etc.	2	1.6%
My role is designated as Car User I need to use a car	23	18.1%
Pool Car	17	13.4%
Telephone conferencing	12	9.4%
Teleworking	7	5.5%
	127	100.0%



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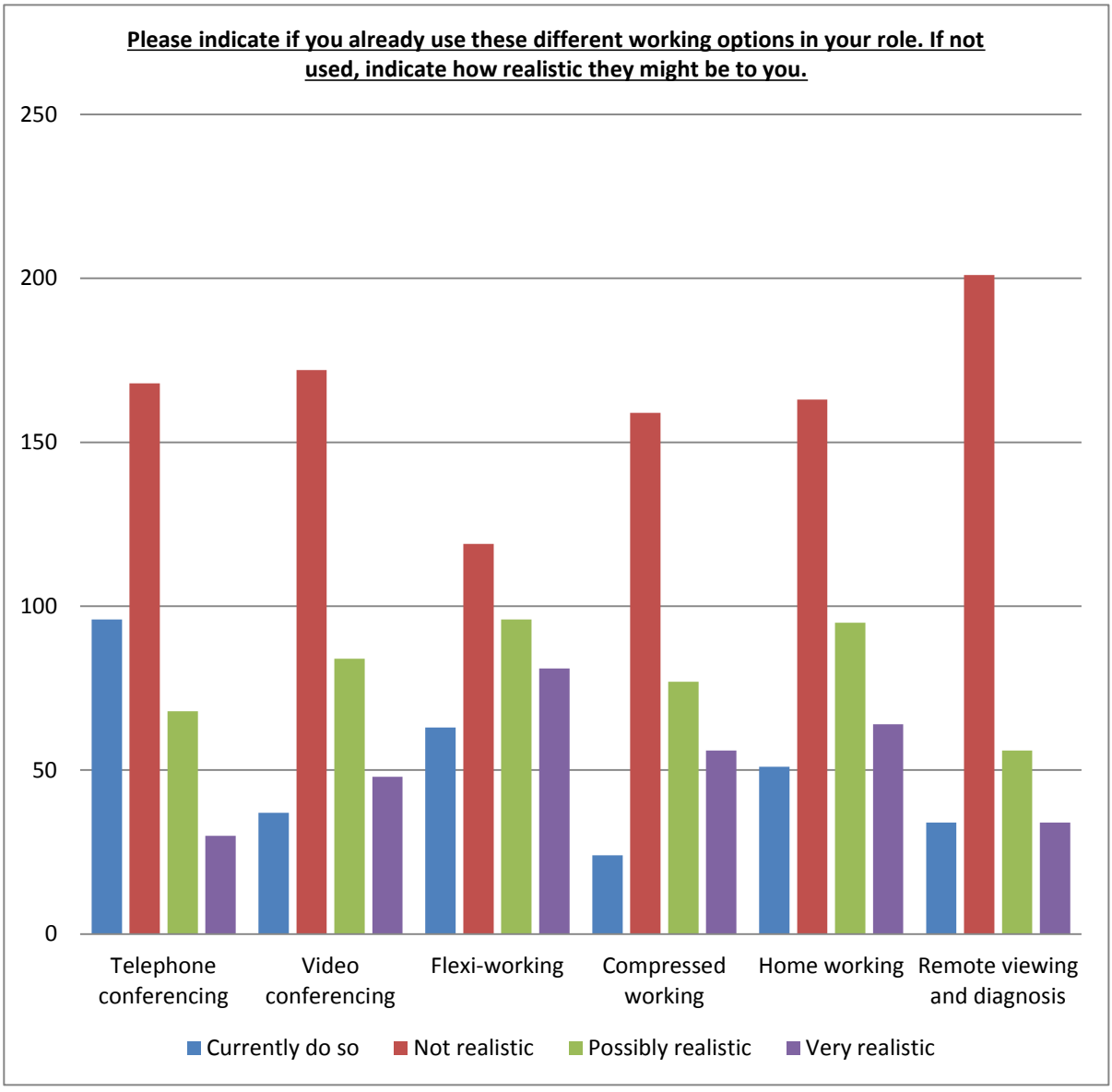
Results Summary 25/03/2015

Please indicate if you already use these different working options in your role. If not used, indicate how realistic they might be to you.

	Currently do so	Not realistic	Possibly realistic	Very realistic	Total
Telephone conferencing	96	168	68	30	362
Video conferencing	37	172	84	48	341
Flexi-working	63	119	96	81	359
Compressed working	24	159	77	56	316
Home working	51	163	95	64	373
Remote viewing and diagnosis	34	201	56	34	325



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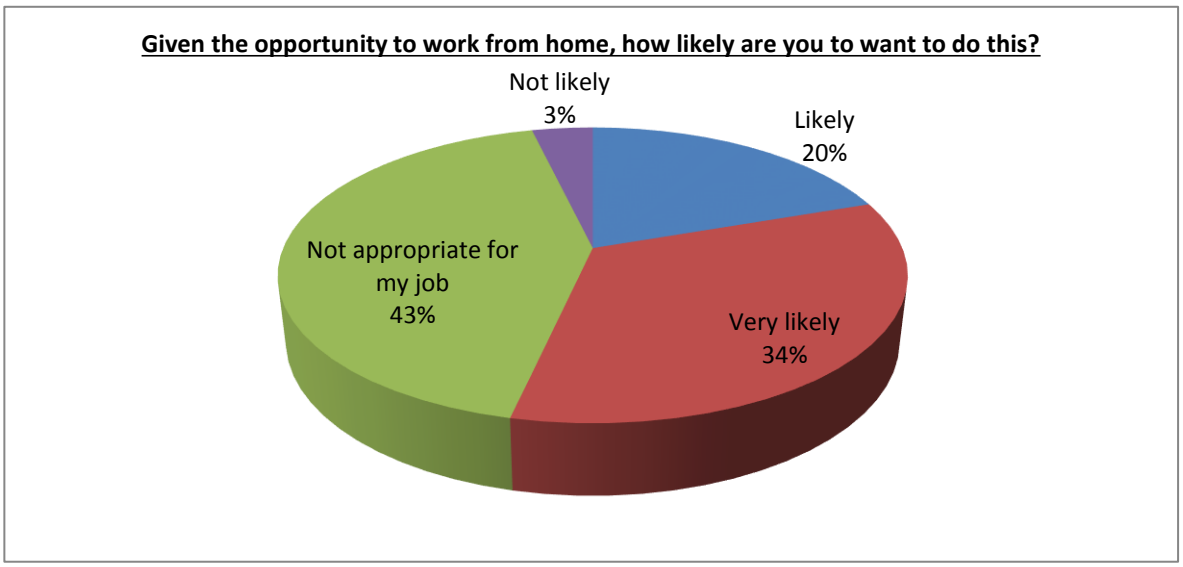
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

Given the opportunity to work from home, how likely are you to want to do this?

	Response	Percentage
Likely	90	19.7%
Very likely	154	33.8%
Not appropriate for my job	195	42.8%
Not likely	17	3.7%
	456	100.0%



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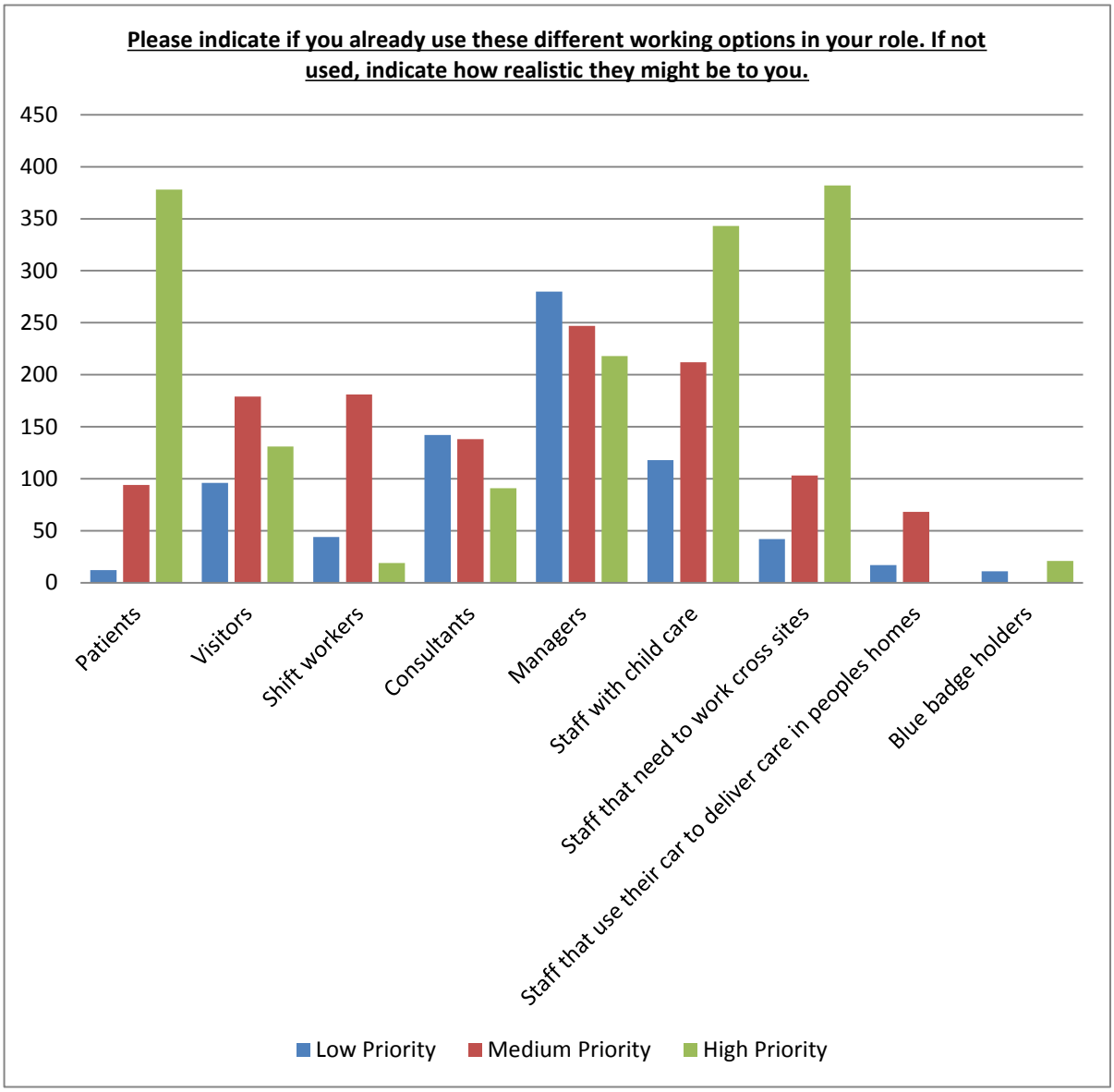
ST GEORGE'S TRUST STAFF TRAVEL SURVEY

Results Summary 25/03/2015

As with many NHS Sites, parking is limited across the trust and therefore the spaces that we have need to be prioritised. Please tell us what you think should be the priority for parking;

	Low Priority	Medium Priority	High Priority	Total
Patients	12	94	378	484
Visitors	96	179	131	406
Shift workers	44	181	19	244
Consultants	142	138	91	371
Managers	280	247	218	745
Staff with child care	118	212	343	673
Staff that need to work cross sites	42	103	382	527
Staff that use their car to deliver care in peoples homes	17	68	0	85
Blue badge holders	11	0	21	32



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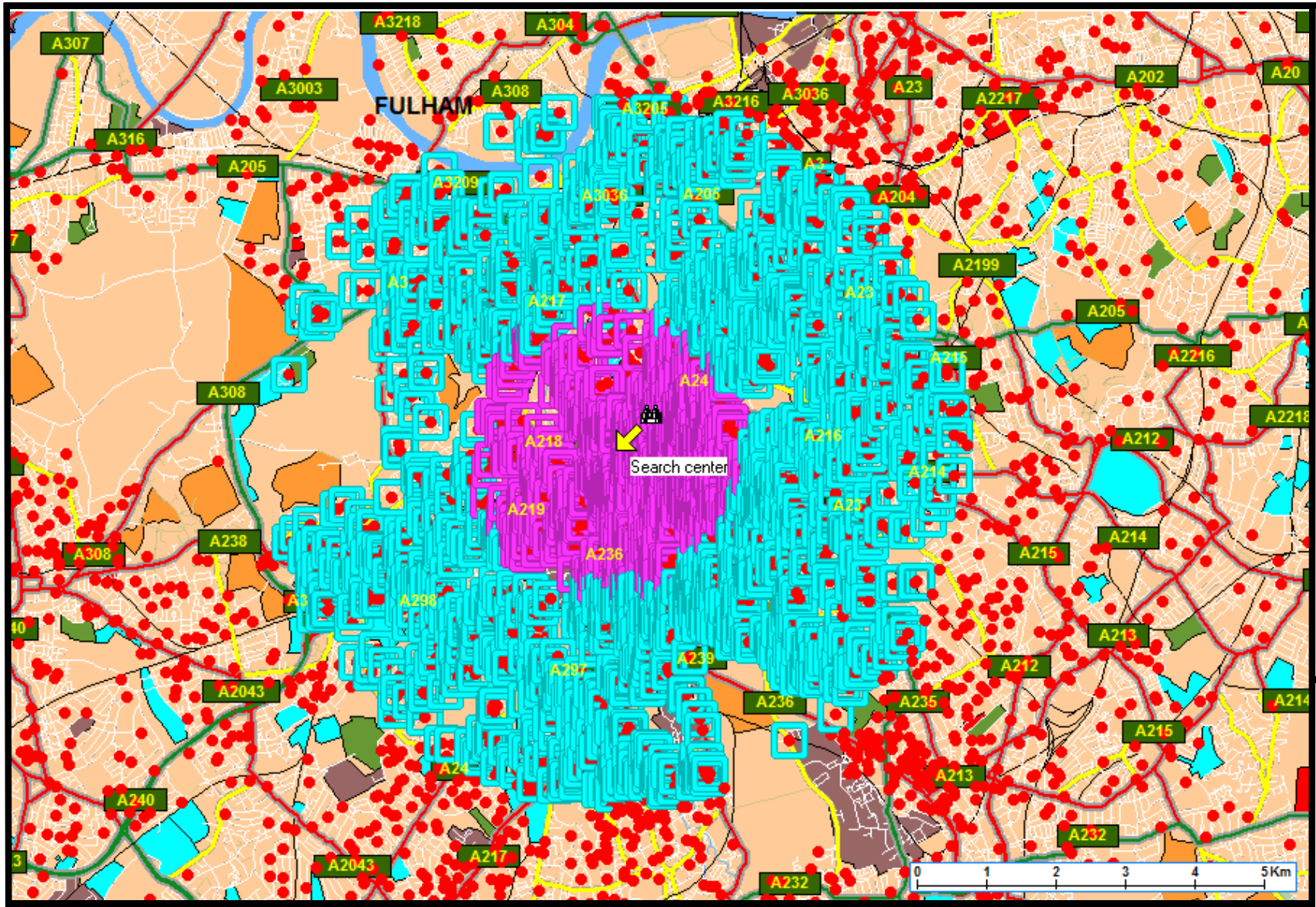
St Georges Hospital – Walking (2km) and Cycling (5km) Catchment



This map is based upon Ordnance Survey maps with the permission of the Controller of Her Majesty's Stationery Office.
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Spot Map

- Employee Postcode
- Employee within 2km radius of the site, walking distance (995)
- Employee within 2km to 5km radius of the site, cycling distance (1,538)

Prepared by Rare Spark Limited June 2015

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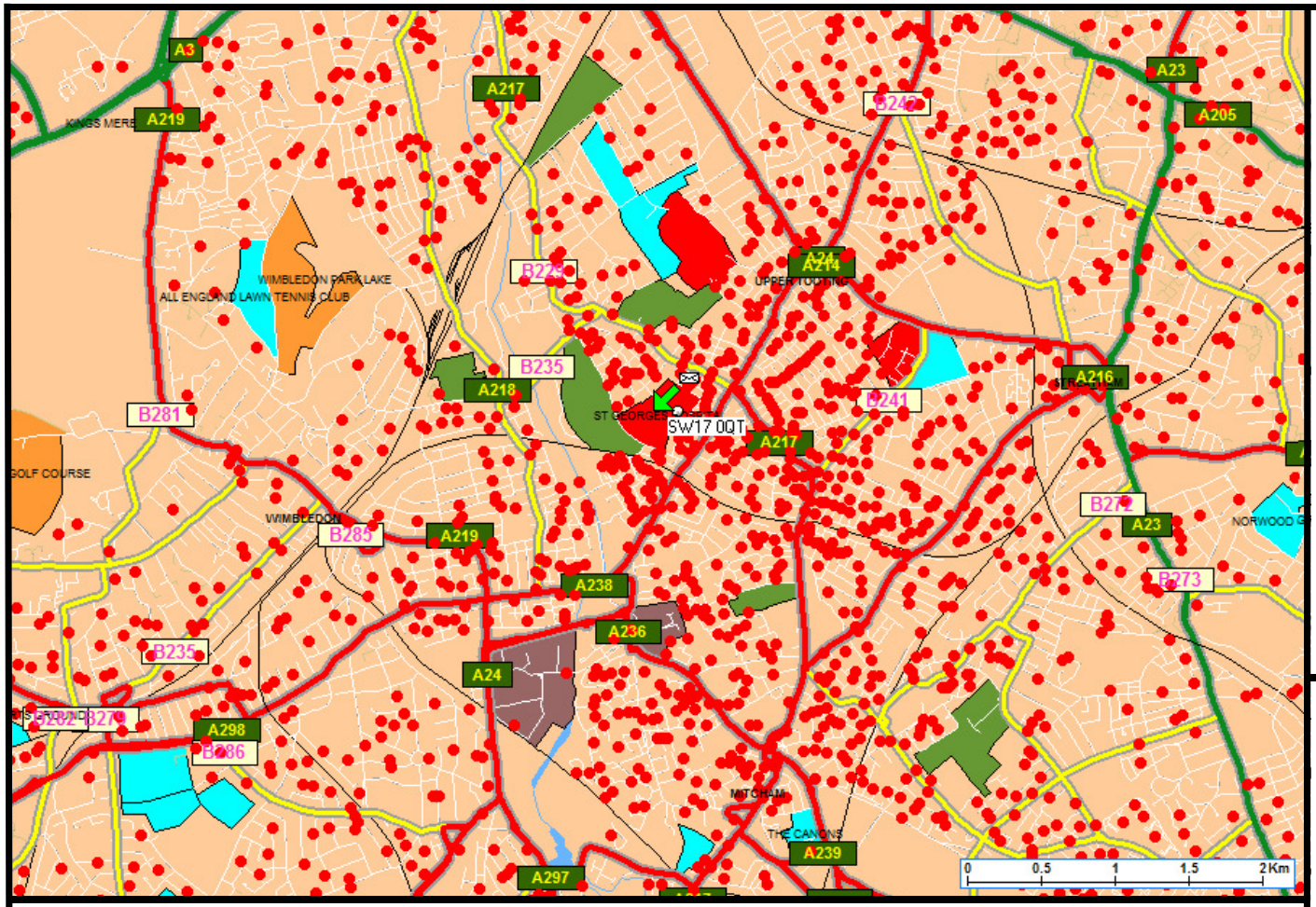
1 Farnham Road
Guildford GU2 4RG

St Georges Hospital - Employee Residence Distribution Map



Spot Map

- Employee Postcode

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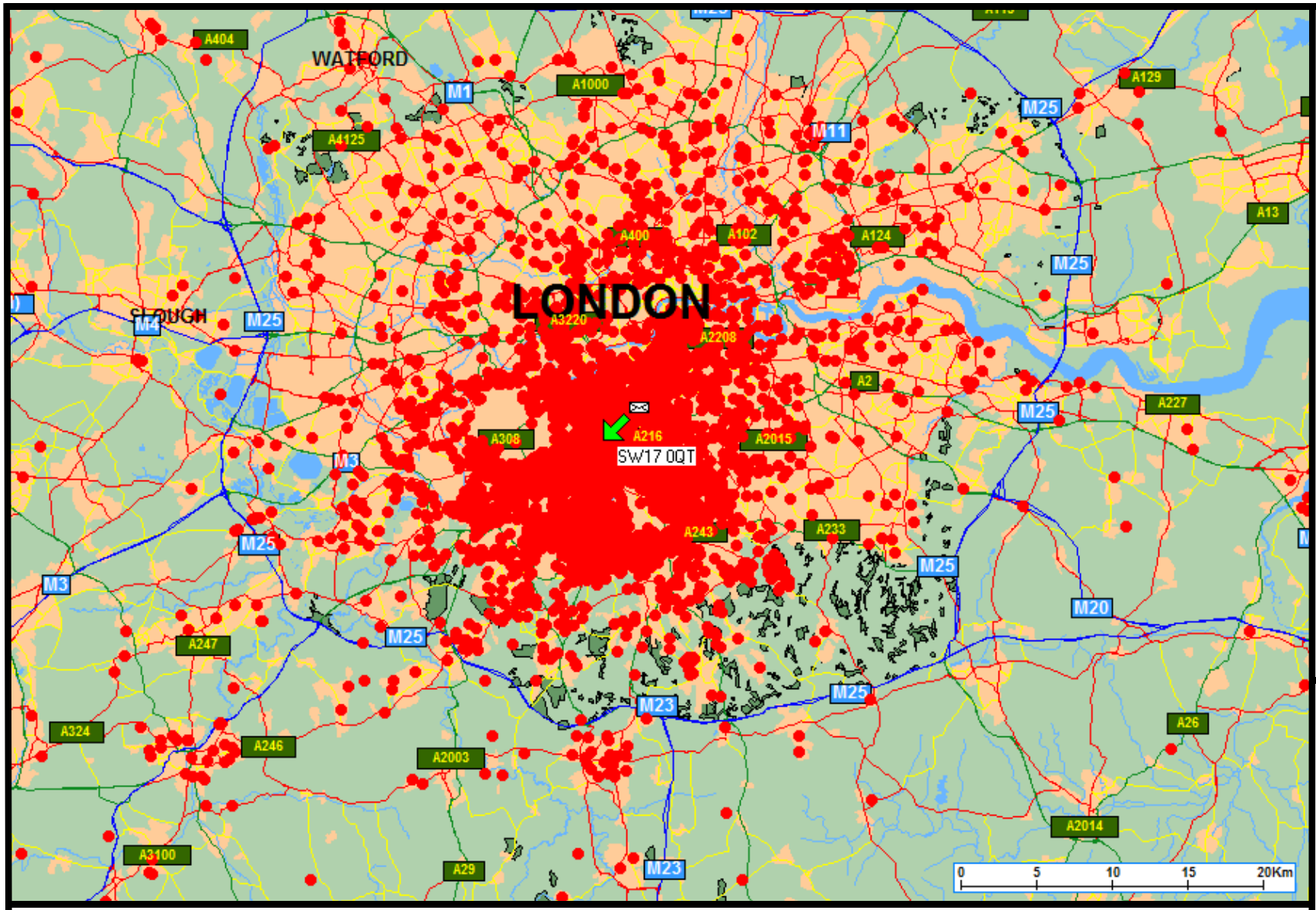
St Georges Hospital - Employee Residence Distribution Map



Spot Map

● Employee Postcode

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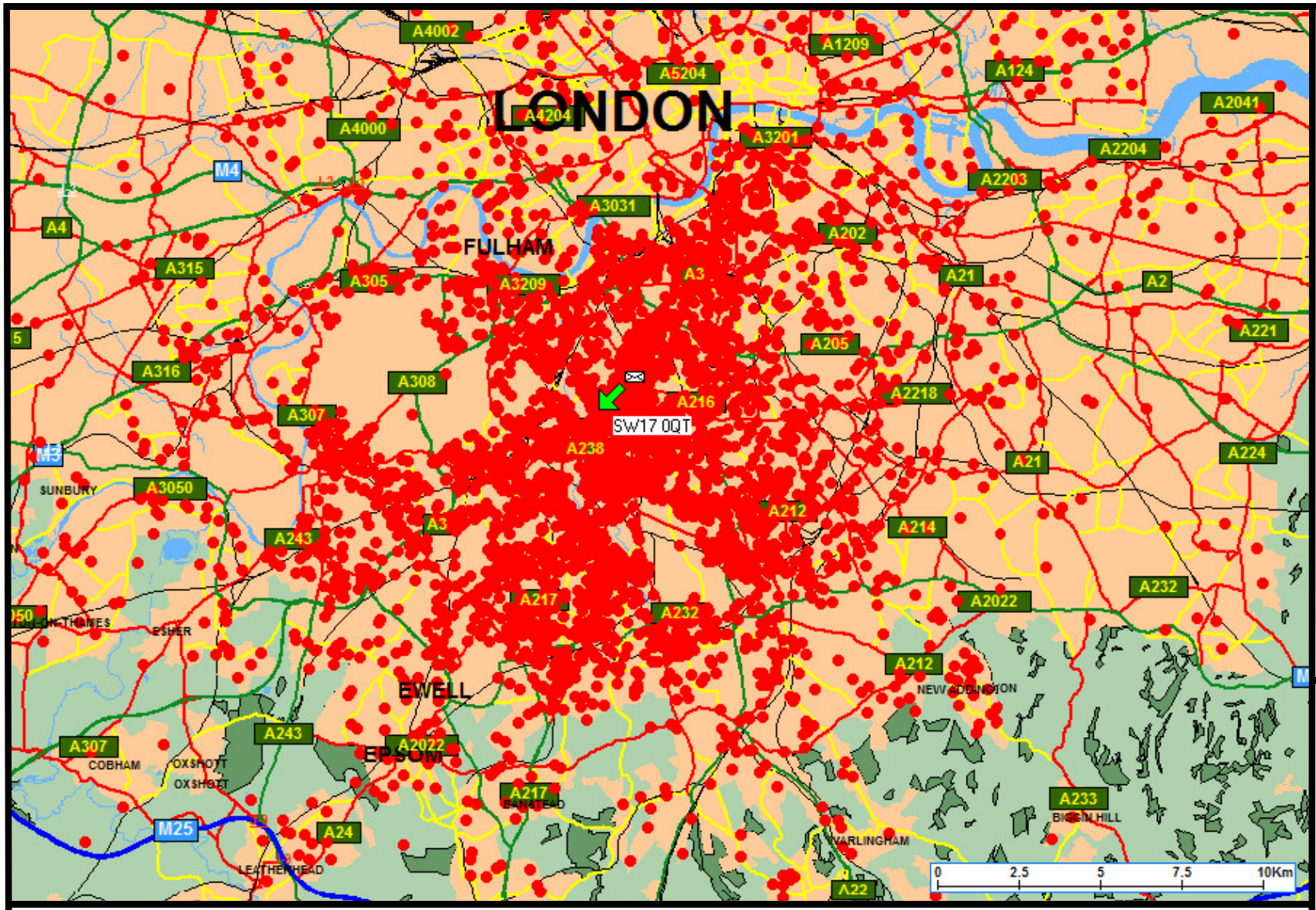

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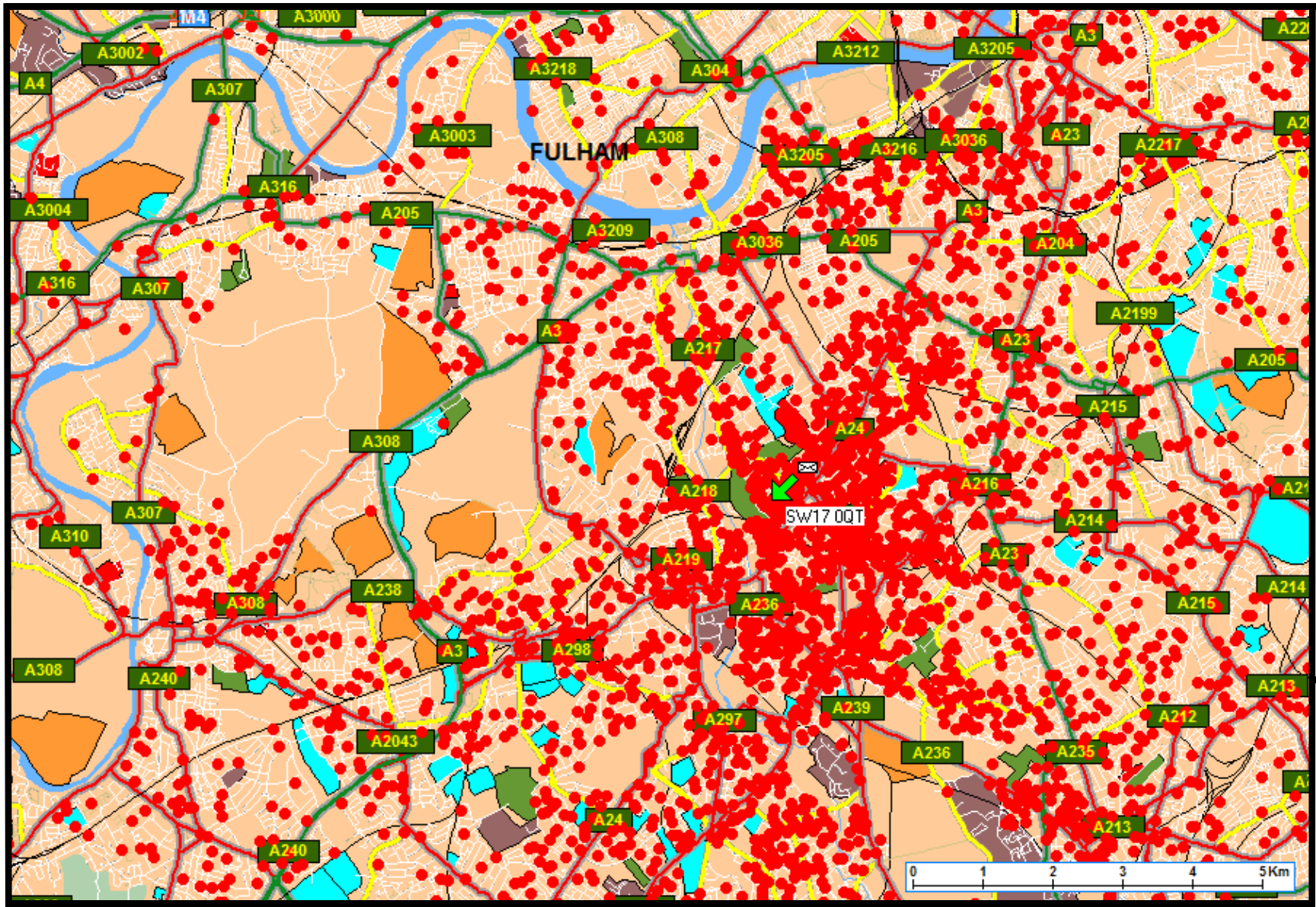

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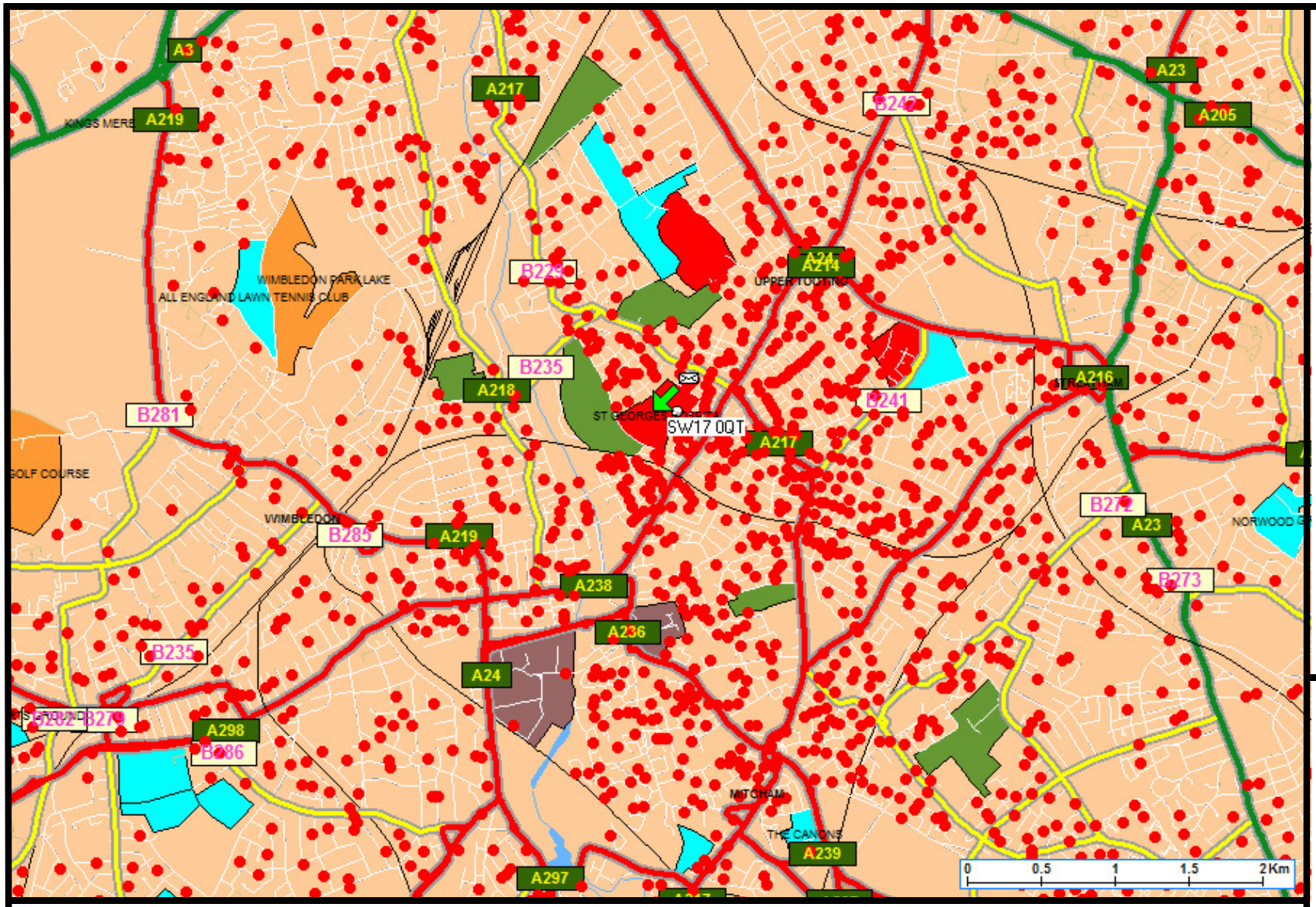

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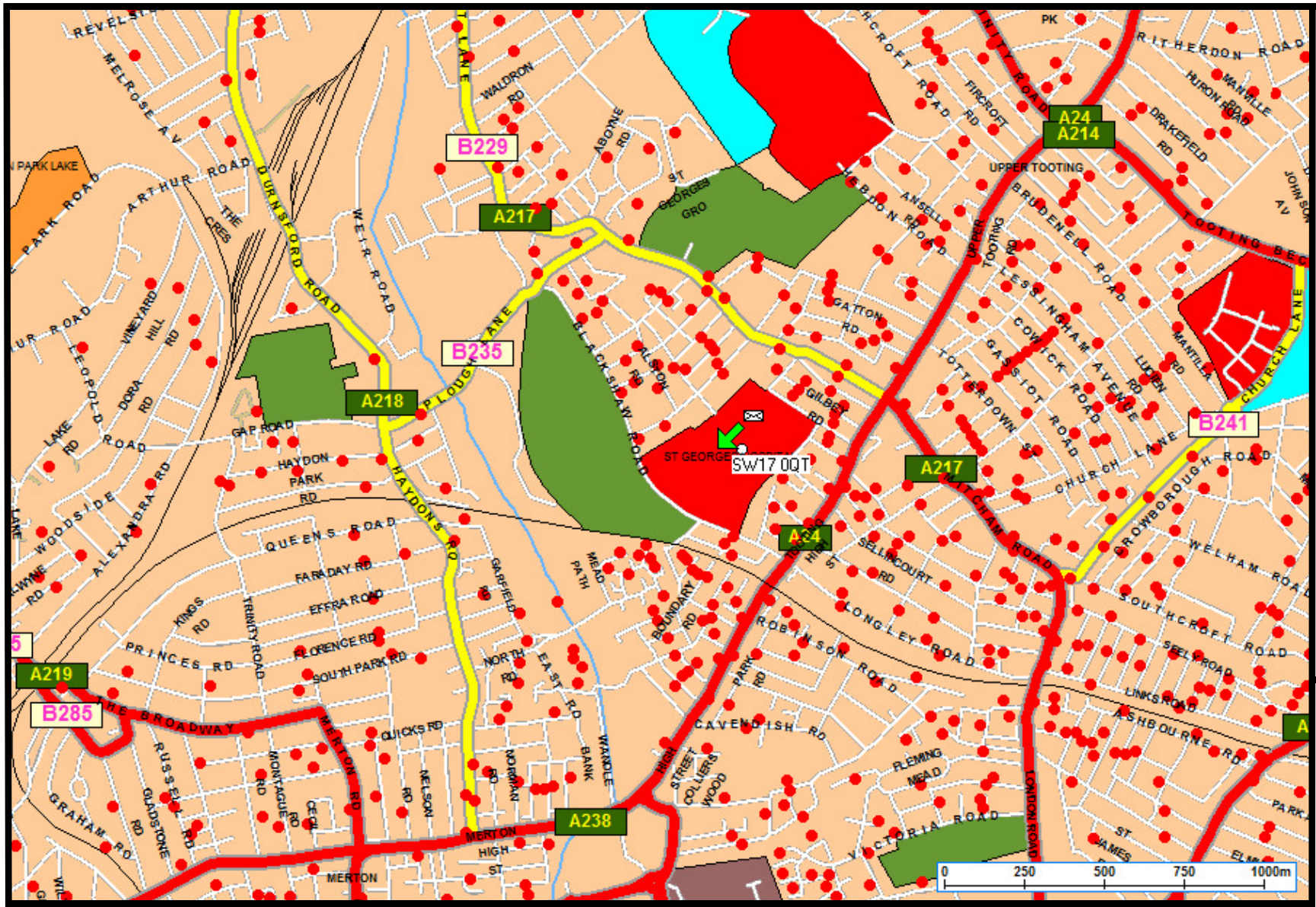

Spot Map

- Employee Postcode

Prepared by Rare Spark Limited June 2015

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1 Farnham Road
Guildford GU2 4RG

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting:

TRUST BOARD 3RD DECEMBER 2015

Document Title:

South West London & Surrey Downs Healthcare Partnership
Proposed Governance

Action for the Trust Board:

The Trust Board is asked to review and approve the proposed governance arrangements and Terms of Reference.

Executive Summary:

The board has received regular updates around the South West London Acute Provider Collaborative (SWL APC).

The outcome of recent discussions is an agreement to further strengthen and build on the programme of work that has been carried out in South West London and Surrey Downs to date, by forming closer working arrangements and developing a single programme of work – the South West London and Surrey Downs Healthcare Partnership programme (SSHP).

The appended paper details the governance arrangements, and associated terms of reference, for the SSHP programme.

The key risks and opportunities for the trust in relation to the programme relate to:

1. Co-terminosity of strategic direction between SSHP and the trust's strategy.
2. Ability of SSHP and trust to resource required workstreams.
3. Deliverability of requisite goals across the health economy.

Presented by:

Rob Elek
Director of Strategy

South West London & Surrey Downs Healthcare Partnership

Proposed Governance

V1.1

1. EXECUTIVE SUMMARY

The NHS in South West London is working on a long term plan to improve local health services.

In February 2014 the six South West London NHS Clinical Commissioning Groups (CCGs) – Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth – and the health commissioners from NHS England (London) agreed to work together with hospitals, mental health, primary and community care service, local councils, local people and patients to improve health services for everyone in South West London. The partnership between the CCGs and NHS England has been known as the South West London Commissioning Collaborative (SWLCC). In June 2014 SWLCC published a five year strategy to improve services and since that point have been taking forward this work. A South West London Acute Provider Collaborative (APC) was established during 2014/15 to enable the South West London acute providers to work collaboratively together to respond proactively to the Commissioner's plan. South West London Out of Hospital providers have also been meeting during 2015 to discuss their response to the issues faced by the local NHS.

Since the summer of 2015 local NHS commissioners and providers have been in discussions as to how they could best work together in the future to address the challenges faced by the NHS in South West London. Surrey Downs have been included in the discussions because they, along with Sutton CCG and Merton CCG, commission services from Epsom and St Helier Hospital. Similarly, SWL CCGs commission elective service from the South West London Elective Orthopaedic Centre (SWLEOC) at Epsom Hospital.

The outcome of these discussions is an agreement to further strengthen and build on the programme of work that has been carried out in South West London and Surrey Downs to date, by forming closer working arrangements and developing a single programme of work – the South West London and Surrey Downs Healthcare Partnership programme (SSHP).

During these discussions the providers and commissioners have also been working with NHS England, Monitor and the Trust Development Authority who are supportive of this action.

This paper sets out the proposed governance arrangements for the new SSHP programme.

The objectives of the programme, and the benefits to be delivered, will build on the five year strategy already published by the SWLCC, which seeks to put the health economy on to a clinically and financially sustainable footing, addressing workforce and quality issues. However, these objectives and benefits, along with the detailed scope of the programme, will need to be refreshed following a financial diagnostic to be conducted by the Tripartite[1] during the winter of 2015/16, and a full review of strategies and current programmes of work underway in South West London and Surrey Downs. The resulting proposed objectives, benefits, workstreams and scope will be agreed by the new programme board through signing off a Programme Initiation Document.

The Governing Body/Board is asked to review and agree the proposed governance arrangements and Terms of Reference.

[1] Monitor, NHS England and TDA

Document Revision History

Revision date	Author(s)	Change summary	Version*
09/11/15	Kay McCulloch		0.1
11/11/15	Kay McCulloch	Add AN comments	0.2
13/11/15	Kay McCulloch	Reflect feedback from working group and COs	0.3
13/11/15	Kay McCulloch	Corrupted file - resaved	0.4
16/11/15	Kay McCulloch	Comments from review of v0.4	0.5
16/11/15	Kay McCulloch	Resaved following crash	0.6
17/11/15	Kay McCulloch	Final comments including legal advice	0.7
17/11/15	Kay McCulloch	NHSE feedback	0.8
20/11/15	Kay McCulloch	Changes following meeting on 20/11 (minuted)	0.9
23/11/15	Kay McCulloch	Final updates	1.0
25/11/15	Kay McCulloch	Update approvals list	1.1

Approvals

This document requires the following approvals before finalisation.

Name and position/group	Scheduled date for approval		Date approved		Version
	Chair's Action/ Part 2	Part 1 approval/ ratification	Chair's Action/ Part 2	Part 1 approval/ ratification	
Programme Board (shadow)	20/11/15	N/A		20/11/15 (subject to agreed changes)	0.8
Croydon CCG	N/A	1/12/15 Part 1	N/A		1.1
Kingston CCG	8/12/15 Chair's action	12/1/16 Part 1			1.1
Merton CCG	N/A	17/12/15 EGM	N/A		1.1
Richmond CCG	8/12/15	19/1/16			1.1
Surrey Downs CCG	18/12/15 Chair's action	29/1/16 Part 1			1.1
Sutton CCG	N/A	6/1/16 Part 1	N/A		1.1
Wandsworth CCG	N/A	9/12/15 Part 1	N/A		1.1
Croydon Health Services NHS Trust	N/A	9/12/15 Part 1	N/A		1.1
Epsom & St Helier University Hospitals NHS Trust		27/11/15			1.1
St George's University Hospitals NHS Foundation Trust	N/A	3/12/15 Part 1	N/A		1.1
Kingston Hospital NHS Foundation Trust	25/11/15 Part 2	27/1/16 Part 1			1.1
South West London & ST Georges NHS Trust	N/A	3/12/15 Part 1	N/A		1.1
South London & Maudsley NHS Foundation Trust	N/A	15/12/15 Part 1	N/A		1.1

Contents

1. PURPOSE

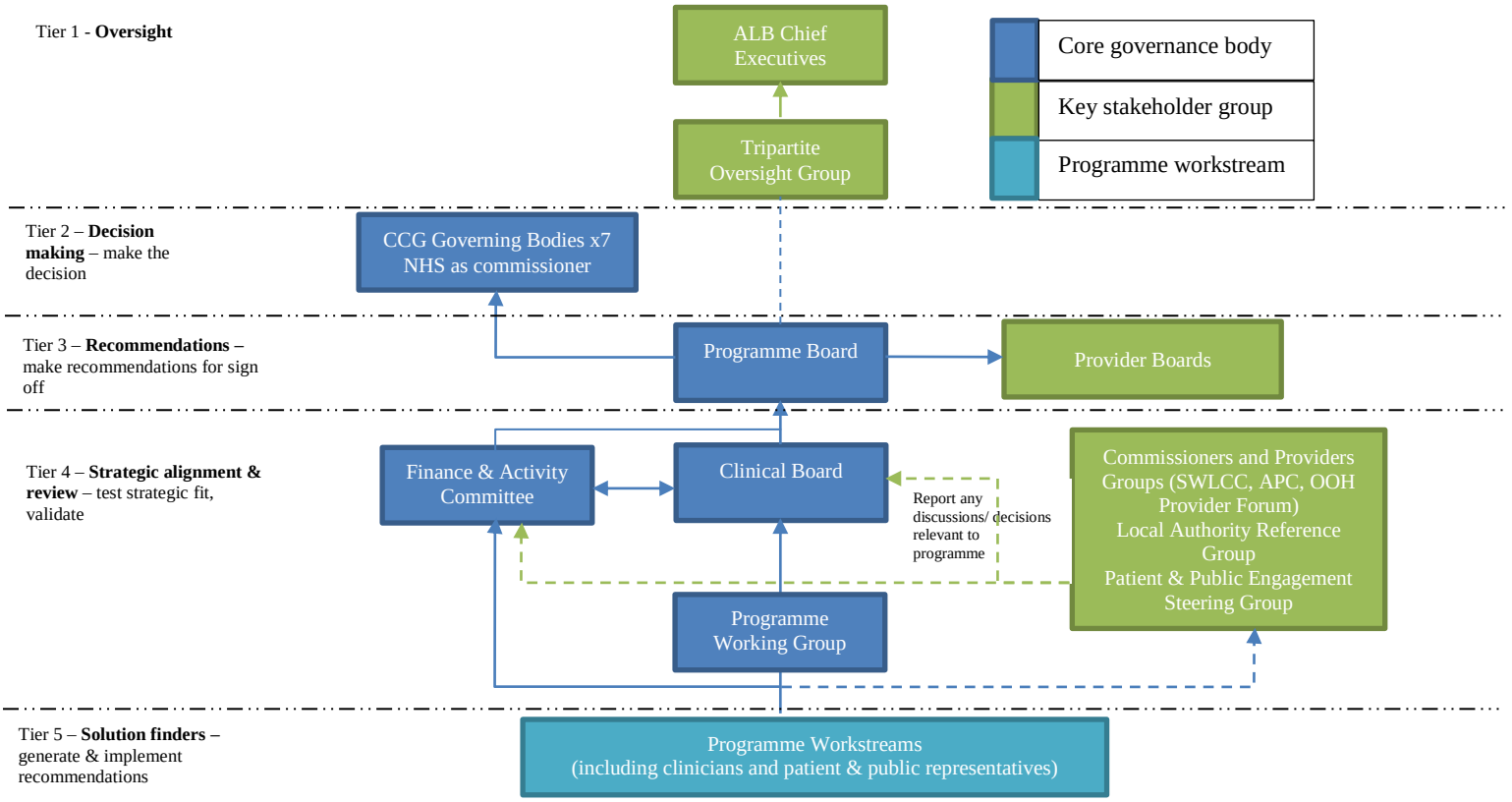
Since the summer of 2015 local NHS commissioners and providers have been in discussions as to how they could best work together in the future to address the challenges faced by the NHS in South West London. Surrey Downs have been included in the discussions because they, along with Sutton CCG and Merton CCG, commission services from Epsom and St Helier Hospital. Similarly, SWL CCGs commission elective service from the South West London Elective Orthopaedic Centre (SWLEOC) at Epsom Hospital.

The outcome of these discussions is an agreement that to further strengthen and build on the programme of work that has been carried out in South West London and Surrey Downs to date, closer working arrangements should be formalised into a single programme of work – the South West London and Surrey Downs Healthcare Partnership programme (SSHP).

Formal governance is essential to ensure that the programme is directed to maximise the delivery of benefits. This document outlines proposals for how the SSHP programme will be designed and delivered, and how interdependencies with other programmes will be managed. It describes the roles of individual organisations and the Tripartite[2] in achieving consensus on how change will be delivered and where decisions will be made.

This paper does not include how stakeholders will be managed (e.g. engagement with patients and the public and with local authorities). Stakeholder management will be included in the Programme Initiation Document.

2. PROPOSED GOVERNANCE STRUCTURE



[2] Monitor, NHS England, TDA

An Independent Chair has been appointed by the Tripartite to lead the programme.

The role of the Programme Board is to oversee the progress of the programme and to drive consensus on change to be delivered.

The Clinical Board will be responsible for developing and agreeing models of care with the wider clinical community and consider any impacts of recommendations by other workstreams.

The Finance and Activity Committee will be responsible for overseeing the financial implications of all the workstreams. It will validate and sign off all financial modelling and other technical work. It will ensure that the finance work across all workstreams is consistent and is of a quality that will support public consultation and engagement and Regulators' expectations.

Terms of Reference for the Programme Board and Clinical Board are set out in Appendices 2 and 3 of this document. A monthly meeting of provider and commissioner Directors of Finance/Chief is likely to fulfil the proposed function of the Finance and Activity Committee. The Terms of Reference will be reviewed and refreshed by this group and submitted to the Programme Board once completed.

3. ROLES AND RESPONSIBILITIES OF INDIVIDUAL ORGANISATIONS

The governance structure laid out above is intended to reflect both the legal accountabilities of organisations, and the need for consensus. CCGs (and NHS England in their role as specialist commissioner) are the only organisations which can define which services will be commissioned in the health economy. The Governing Bodies of Foundation Trusts also have a legal responsibility to act in the best interests of their own organisations. In practice, the agreement, active support and co-operation of all organisations will be essential to delivering service change.

The Programme Board, which includes representation from providers and commissioners will be the governance body making recommendations in respect of the way forward with the programme.

The expectation is that all organisations will work together in good faith and as constructively as possible to develop the programme and support its work. This is a recognition of the fact that, in the current financial and clinical situation, it is in the interest of all commissioners and providers to develop a solution that restores the South West London and Surrey Downs NHS economy to financial and clinical sustainability. To support this, all the organisations have agreed to work together to develop a statement of behaviours, which will define how organisations will behave and interact with each other.

Inevitably, during the course of the programme, disagreements will arise, between sectors or between individual organisations. The expectation is that organisations will engage constructively with each other to address and resolve these and aim to achieve consensus at the Programme Board. However, if organisations cannot achieve consensus between themselves, the programme allows for intervention by neutral third parties through two routes:

1) Neutral facilitation by the Chair

The role of the Chair is to act as a neutral arbiter and facilitator between the organisations involved in the process. The Chair will work with both commissioners and providers to develop solutions and resolve conflicts. Ultimately the SSHP Chair cannot abrogate the responsibilities of individual organisation Chairs or accountable officers, but all the organisations will be expected to engage constructively with him in his role.

2) Neutral facilitation by the Tripartite

NHS England, Monitor and the Trust Development Authority will have a key role to play in helping the South West London and Surrey Downs organisations to address the challenges that they are facing. As third parties with specific regulatory roles, they are able to stand outside of the individual organisational interests in South West London and Surrey Downs and will be expected to play a significant role in supporting the development of solutions. They will have a particular role in working with organisations which may be individually disadvantaged by proposals in the short term, if this is necessary to deliver wider system sustainability, and thus a longer term advantage for all organisations.

The specific legal powers of the Tripartite to intervene with commissioner and provider organisations are laid out in Appendix 4. As importantly, the relationships that the Tripartite organisations have with each of the organisations in South West London will enable them to work closely with South West London and Surrey Downs and support the development of a way forward. Tripartite roles will be further defined in the Programme Initiation Document.

4. PROGRAMME LEADERSHIP AND MANAGEMENT ROLES

While the Tripartite organisations will be closely involved with the programme, the day to day leadership and management of the programme will rest with three roles: the Chair, SRO and Programme Director. The responsibilities of these roles will be laid out in the job descriptions for each role and will be confirmed in the Programme Initiation Document.

5. RELATED DOCUMENTATION

The table below provides details of other documentation relevant to this paper:

Document name	**Relevance**
South West London & Surrey Downs - Stocktake of challenges & current activities	Sets out the challenge and current South West London and Surrey Downs transformation initiatives

Appendix 1

Terms of Reference

South West London & Surrey Downs Healthcare Partnership

Programme Board

Contents

1. Purpose

This document details the Terms of Reference for the South West London & Surrey Downs Healthcare Partnership (SSHP) Programme Board.

2. Role of the Board

The Board will bring together representatives of the organisations across South West London and Surrey Downs which are included within the South West London & Surrey Downs Health Partnership. It will be the main group for the senior leaders of those organisations to discuss and resolve issues around the delivery of the Partnership programme.

The objectives of the programme as a whole will be set out in a Programme Initiation Document that will be submitted to the Programme Board.

The objectives of the programme, and the benefits to be delivered, will build on the five year strategy already published by the SWLCC, which seeks to put the health economy on to a clinically and financially sustainable footing, addressing workforce and quality issues. However, these objectives and benefits, along with the detailed scope of the programme, will need to be refreshed following a financial diagnostic to be conducted by the Tripartite during the winter of 2015/16, a full review of strategies and current programmes of work underway in South West London and Surrey Downs against the five year sustainability and transformation plans required in the new planning guidance. The resulting proposed objectives, benefits, workstreams and scope will be agreed by the new programme board through signing off a Programme Initiation Document.

Within this, the Programme Board will act as the main forum for the affected healthcare organisations to discuss the proposals, to review and draw together the evidence from the Clinical Board and the Finance and Activity Committee as well as other relevant information, and to shape and discuss any service recommendations to be made to CCGs and NHS England in its role as commissioner.

The Programme Board will seek to achieve consensus over the vision and service model, and work to ensure that these are supported by all Programme Board members. It is possible that several options for service change may be developed for public consultation which may be viewed more or less favourably by organisations and there may not be agreement between Programme Board members over a preferred option. The expectation is that all organisations will support implementation of the final decision post-consultation.

The recommendations will be put to the Governing Bodies of the 7 CCGs for final agreement and sign off.

As such, the role of the Programme Board will be:

- To shape the development of the workstreams of the programme, defining priorities and key areas for inclusion
- To review progress on the programme, by owning the programme dashboard and holding the Programme Director to account for delivery of the workstreams
- To review and challenge the analysis produced by the workstreams
- To act as a forum for discussion and resolution of important or contentious issues relating to the programme
- Once the analysis is agreed, to use it to shape service recommendations around how the SWL and SD health economy may best be put on a clinically financially sustainable footing. These will draw on the clinical recommendations made by the clinical group but will also need to take account of financial and operational constraints, and statutory requirements

- To share these recommendations with the Boards and Governing Bodies of providers, and other stakeholders as appropriate, and finally to put them to the Governing Bodies of the Clinical Commissioning Groups for approval
- To ensure effective patient and public involvement in the preparation and delivery of the strategy
- To oversee resources for the programme and ensure that sufficient resources are made available to carry out the requirements of the programme

3. Responsibilities

The responsibilities of the Programme Board include:

- Responsibility for oversight and delivery of the SSHP programme
- Review and make recommendations in respect of the objectives, scope and benefits of the programme of works
- Share these recommendations with the Boards and Governing Bodies of providers, and finally put them to the Governing Bodies of CCGs for final approval
- Be the forum where all the organisations included within the programme can hold each other to account
- Ensure that the programme delivers on its objectives of safety, quality and clinical and financial sustainability, through delivery of agreed strategic changes
- Promote and support engagement across South West London and Surrey Downs, ensuring that the views of all relevant stakeholders, including organisations who are directly and indirectly represented, as well as other organisations which may be indirectly affected, as well as the views of patients and the public, are given due weight and consideration in decision making.

4. Membership of the Board

The membership of the board will be drawn from the healthcare organisations and Local Authorities that are included within the South West London & Surrey Downs Health Partnership. Some of these will be directly represented around the table, while others will be indirectly represented by individuals nominated by the organisations in question.

4.1. *Membership*

- Chair: Independent Chair, as appointed by NHS England, Monitor and the Trust Development Authority
- Chief Officers of each of the seven CCGs (NHS Croydon CCG, NHS Kingston CCG, NHS Merton CCG, NHS Richmond CCG, NHS Surrey Downs CCG, NHS Sutton CCG, and NHS Wandsworth CCG)
- Clinical Chairs of each of the seven CCGs (NHS Croydon CCG, NHS Kingston CCG, NHS Merton CCG, NHS Richmond CCG, NHS Surrey Downs CCG, NHS Sutton CCG, and NHS Wandsworth CCG)
- Chief Executives of the four acute providers (Croydon Health Services NHS Trust, Epsom and St Helier University Hospitals NHS Trust, Kingston Hospital NHS Foundation Trust, St George's University Hospitals NHS Foundation Trust)

- Chief Executive of South West London & St Georges NHS Trust
- Chief Executive of South London and Maudsley NHS Trust
- Chief Executive of Royal Marsden NHS Foundation Trust
- Two representatives from the Out of Hospital Provider Forum
- One representative from a Surrey Downs Out of Hospital Provider
- Representatives from Local Authorities (1 representing the Local Authorities of South West London and 1 Surrey Downs)
- Representative from London Ambulance Service
- Representatives from NHS England, Monitor and the Trust Development Authority (1 per organisation) in their role as the Tripartite
- 1 Representative from NHS England in its role as commissioner
- The Co-Chairs of the programme's Clinical Board and Finance and Activity Committee
- South West London Representative from Clinical Board
- Programme Director of the SSHP programme
- Programme Director of the Acute Provider Collaborative
- Director of Communications & Engagement
- Patient & Public Representative

4.2. *Additional Attendees*

- Representation from other clinical, financial or workforce workstreams as required
- Representatives of patients or the public as required

5. Quoracy

No business will be transacted unless the following are present:

- The Independent Chair, or a nominated deputy from NHS England, Monitor or the Trust Development Authority.
- One representative from each of the seven Clinical Commissioning Groups and NHS England in their role as commissioner. If the Chair or Chief Officer is unable to attend a deputy may be nominated.
- One representative from each of the four acute providers. If the Chief Executive is unable to attend a deputy may be nominated.

- One representative from the out of hospital providers. If none of the designated Board members are able to attend a deputy may be nominated.

- One representative from either South London and Maudsley NHS Foundation Trust or South West London and St George's Mental Health NHS Trust. If neither of the Chairs or Chief Executives are able to attend a deputy may be nominated.

The Programme Board is responsible for making recommendations to the Governing Bodies of the seven Clinical Commissioning Groups ((NHS Croydon CCG, NHS Kingston CCG, NHS Merton CCG, NHS Richmond CCG, NHS Surrey Downs CCG, NHS Sutton CCG, and NHS Wandsworth CCG), The Governing Bodies will make decisions involving their membership as laid down within their constitutions.

The recommendations of the Programme Board will also be put to the Boards or Governing Bodies of the providers who are represented on the Programme Board. While the providers do not have formal final decision power over the programme, it is anticipated that the views of the provider Boards and Governing Bodies will be taken into account and that the Chair will work to develop proposals which have the agreement of all the Boards and Governing Bodies.

In order to develop recommendations, the Chair will work to establish unanimity as the basis for the recommendations of the committee. In the event of disagreement, NHS England, Monitor and the Trust Development Authority will also work with commissioners, Foundation Trusts and NHS Trusts respectively to broker agreement and develop solutions.

6. Accountability

The programme will report to the seven CCGs and NHS England in their role as commissioners, who will have ultimate decision-making power. It will also report to the Tripartite oversight group, in their roles as regulators, who will work with the Programme Board and the individual organisations under their jurisdiction to develop the way forward.

Individual member provider organisations of the Programme Board will also be accountable to the Boards or Governing Bodies of their own organisations.

7. Frequency of Meetings

Meetings will take place monthly and usually be of 2 hours' duration. A full year meeting schedule for 2016 will be produced and agreed by 30 November 2015 by the Secretariat. On occasion exceptional meetings may be called subject to the agreement of the Chair.

8. Confidentiality

No member of the Programme Board shall disclose: any information disclosed or discussed at, or in the period between, meetings of the Board, which should reasonably be regarded as confidential; any other information which is not publicly available including, but not limited to, any information specifically designated as confidential; any information supplied by a third party in relation to which a duty of confidentiality is owed or arises; and any other information which should otherwise be reasonably regarded as possessing a quality of confidence or as having commercial value.

9. Conflicts of Interest

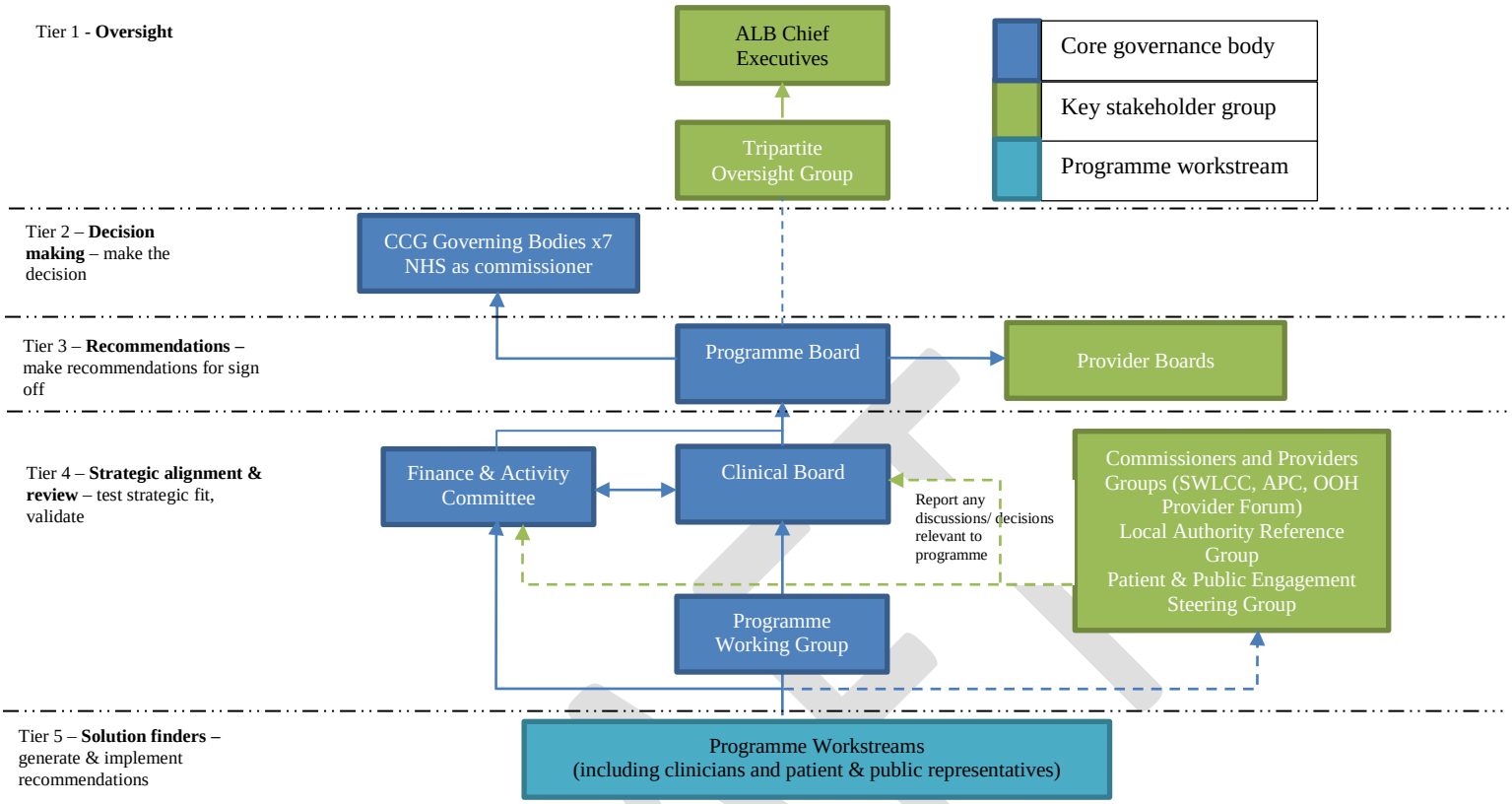
A conflict of interest is where an individual has a direct or indirect pecuniary or non-pecuniary interest in a matter that is being discussed. These can be defined as follows:

- A direct pecuniary interest is when an individual may financially benefit from a decision (for example moving services to them from an alternative provider)
- An indirect pecuniary interest is when an individual may financially benefit from a decision though normally via a third party (for example where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a reconfiguration decision)
- A direct non-pecuniary interest is where an individual holds a non-remunerative or not-for-profit interest in an organisation (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract)
- An indirect non-pecuniary interest is when an individual may enjoy a qualitative benefit from the consequences of a decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house.
- In addition, where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories, this will constitute a conflict of interest.

Members of the Programme Board must declare if they have any interests, whether pecuniary or non-pecuniary, as defined above, which relates to the matters being discussed. Individuals will declare any such interest that they have to the Chair as soon as they are aware of it, and in any event no later than 28 days after becoming aware.

Should any such interest be declared, the Chair of the Programme Board should exercise discretion as to whether to disqualify that member (voting or non-voting) from taking any further part, or in any way influencing by proxy or otherwise, discussion and/or voting on that matter.

Annex 1 Governance structure of SSHP



Annex 2 Core Membership

Chair	Andrew Morris
Chief Officer Croydon CCG	Paula Swann
Chief Officer Kingston CCG	Tonia Michaelides
Chief Officer Merton CCG	Adam Doyle
Chief Officer Richmond CCG	Kathryn Magson
Chief Officer Surrey Downs CCG	Claire Fuller
Chief Officer Sutton CCG	Chris Elliott
Chief Officer Wandsworth CCG	Graham Mackenzie
Clinical Chair Croydon CCG	Tony Brzezicki
Clinical Chair Kingston CCG	Naz Jivani
Clinical Chair Merton CCG	Andrew Murray
Clinical Chair Richmond CCG	Graham Lewis
Clinical Chair Surrey Downs CCG	Claire Fuller
Clinical Chair Sutton CCG	Brendan Hudson
Clinical Chair Wandsworth CCG	Nicola Jones
Chief Executive Croydon Health Services NHS Trust	John Goulston
Chief Executive Epsom & St Helier University Hospitals NHS Trust	Daniel Elkeles
Interim Chief Executive Kingston Hospital NHS Foundation Trust	Ann Radmore
Chief Executive St Georges University Hospital NHS Trust	Miles Scott
Chief Executive South West London & St Georges NHS Trust	David Bradley
Chief Executive South London and Maudsley NHS Trust	Matthew Patrick
Chief Executive Royal Marsden NHS Foundation Trust	Cally Palmer
Representative from the Out of Hospital Provider Forum	Darren Tymens (Richmond GP Federation & Interim Chair OOH Provider Forum)
Representative from the Out of Hospital Provider Forum	TBC
Representative from the Out of Hospital Providers of Surrey Downs	Thirza Sawtell
Local Authority Representative – South West London	Simon Williams
Local Authority Representative – Surrey Downs	TBC
London Ambulance Service	TBC
NHS England (London)	Anne Rainsberry/ Matthew Trainer/David Mallett
NHS England (South)	Felicity Cox
Monitor	Mark Turner/Victoria Woodhatch
TDA	Andrew Hines/Jen Leonard
Co-Chair Clinical Board	Jane Fryer
Co-Chair Clinical Board	Steve Ryan
SWL Representative from Clinical Board	TBC
Chair Finance & Activity Committee	Hardev Virdee
SSHP Programme Director	Kay McCulloch
APC Programme Director	Alexandra Norrish
Director of Communications	Rory Hegarty
Patient & Public Representative	TBC

Appendix 2

Terms of Reference

South West London & Surrey Downs Healthcare Partnership

Clinical Board

Contents

1. Purpose

This document details the Terms of Reference for the South West London & Surrey Downs Clinical Board, an advisory Board to the Programme Board of the South West London & Surrey Downs Health Partnership (SSHP).

2. Role of the Board

The role of the SSHP Clinical Board is to:

- Provide expert clinical and public health advice and guidance to support the work of the Programme Board.
- Provide clinical input and oversight of the SSHP, ensuring buy-in from the clinical community, in line with requirements on major service change.
- Drive delivery of the objectives of the wider SSHP programme in respect of designing, developing and assuring specific clinical elements of transformation, as defined in the programme scope as agreed by the SSHP programme board.
- Guide, support and enable the work of the workstreams based on the direction set by the Programme Board.
- Ensure the workstreams have appropriate representation to undertake the specified tasks, providing advice and guidance on membership as appropriate.
- Oversee the alignment of work between workstreams; providing guidance and advice where necessary to ensure models of care developed by each workstream are compatible.
- Act as a conduit for the management and escalation of clinical risks across the programme.
- Provide assurance and sign-off of the outputs of the clinical workstreams.
- Provide a clinical view on options for any public consultation.

3. Responsibilities

The Clinical Board will report to and be accountable to the Programme Board.

Responsibilities of the Clinical Board include:

- Fulfilling its role as specified above.
- Overseeing and assuring the development of models of care and key interventions by each workstream.
- Ensure that the models of care developed, and associated hospital and community based interventions:
    - reflect national and London clinical quality standards
    - are evidence based
    - are compatible with the ambition of the collaborative to improve outcomes for patients in south west London
    - reflect the advice of the CFOs/finance workstream in respect of the affordability of proposed solutions

- are deliverable and sustainable.

- Consider the workforce implications of models of care and provide recommendations to the workforce workstream

- Ensure clinical targets, waiting times and performance targets are included within the models of care.

- Act as a communication channel with clinical colleagues in their organisation about the work of the Clinical Board and feedback any key issues or concerns raised by them

- Promote and endorse the vision and objectives of the programme to NHS and external stakeholders where necessary.

- Provide regular reports regarding each workstream to the Programme Board.

- Provide recommendations to the Programme Board.

4. Membership of the Board

- Co-Chairs: 1 external independent chair from non South West London provider organisation and South London Medical Director NHSE (London)
- Seven CCG Clinical Chairs
- Medical Directors from acute, community and mental health providers service South West London
- Nursing Directors from acute, community and mental health providers service South West London
- Representative from GP Federations
- Representative from community providers in Surrey Downs
- Chair of Finance & Activity Board
- Patient & Public Representative

4.1. *In Attendance*

- Public Health representation from Local Authority
- London Ambulance Service representation
- Programme Director & Medical Directors/ Central PMO as required

4.2. *Additional Attendees*

- Representation from other clinical and social care professions and programme workstreams as needed

5. Quoracy

No business will be transacted unless the following are present:

- One Co-Chair (1)
- Four commissioner representatives (CCG Chairs) (4)
- Four provider representatives (Trust Medical or Nursing Directors) (4)

The Chair will work to establish unanimity as the basis for decisions of the committee. If the Clinical Board cannot reach a unanimous decision, the Chair will put the matter to a vote, with each organisation having one vote, with decisions confirmed by both a majority of those voting members present and a majority of the clinical commissioning representatives, subject to the meeting being quorate.

The Clinical Board is responsible for making recommendations to the South West London & Surrey Downs Programme Board.

6. Accountability

The Clinical Board will report to the SSHP Programme Board. It will have delegated limits of authority from the Board to manage the Programme including Change Control.

7. Frequency of Meetings

Meetings will take place every 4-8 weeks and usually be of 2 hours duration to discharge its responsibilities as above and to achieve the aims of the Programme Board. A full year meeting schedule for 2016 will be produced and agreed by the Secretariat by 30 November 2015. On occasional exceptional meetings maybe called subject to the agreement of the Co Chairs.

Times, venues and notice of meetings will be arranged to enable attendance by clinicians.

8. Confidentiality

No member of the Clinical Board shall disclose; any information disclosed or discussed at, or in the period between, meetings of the Board, which should reasonably be regarded as confidential; any other information which is not publicly available including, but not limited to, any information specifically designated as confidential; any information supplied by a third party in relation to which a duty of confidentiality is owed or arises; and any other information which should otherwise be reasonably regarded as possessing a quality of confidence or as having commercial value.

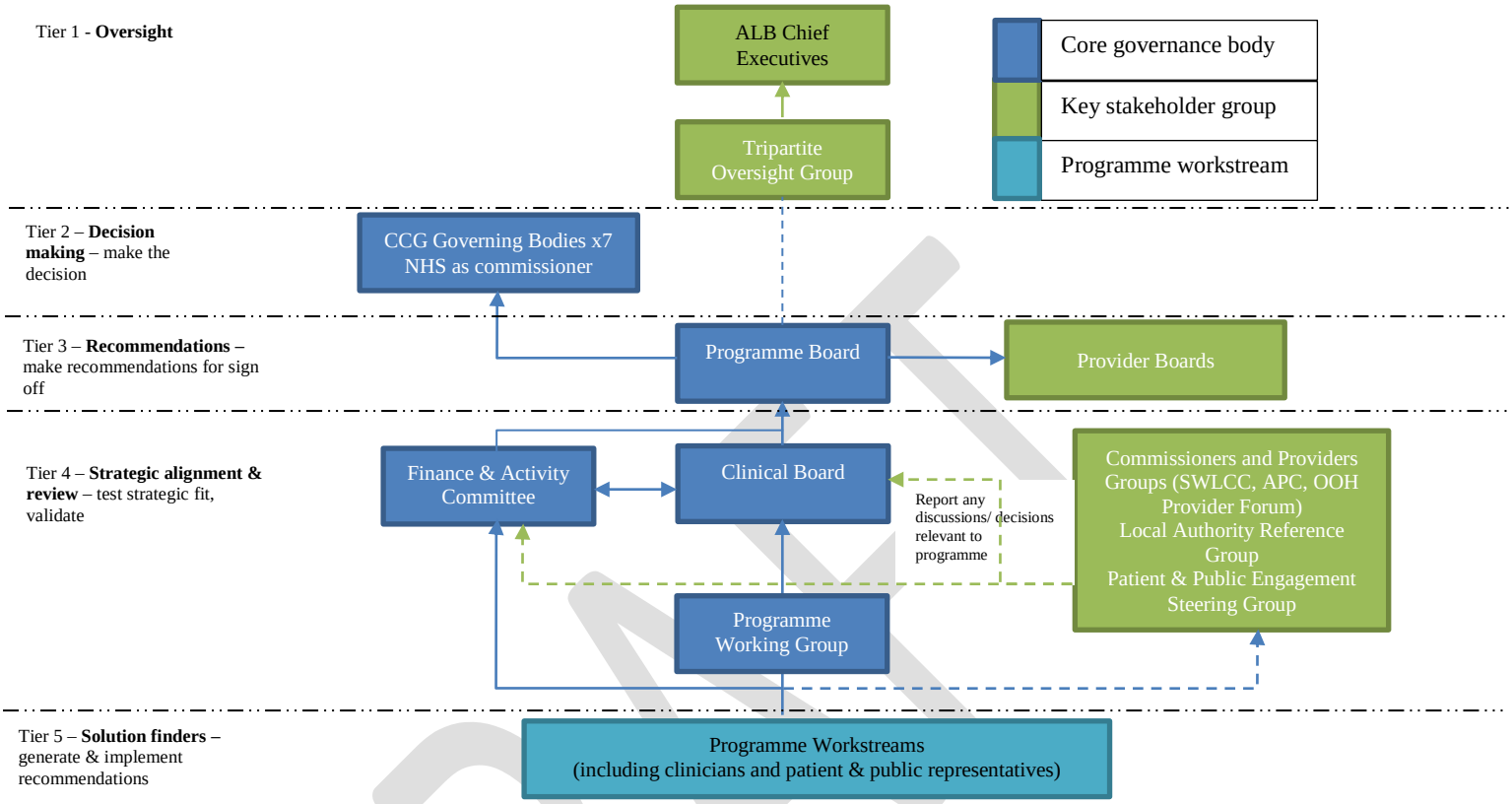
9. Conflicts of Interest

A conflict of interest is where an individual has a direct or indirect pecuniary or non-pecuniary interest in a matter that is being discussed. These can be defined as follows:

- A **direct pecuniary interest** is when an individual may financially benefit from a decision (for example moving services to them from an alternative provider).
- An **indirect pecuniary interest** is when an individually may financially benefit from a decision though normally via a third party (for example where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a reconfiguration decision).
- A **direct non-pecuniary interest** is where an individual holds a non-remunerative or not-for profit interest in an organisation (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract).
- An **indirect non-pecuniary interest** is when individual may enjoy a qualitative benefit from the consequence of a decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house).
- In addition, where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories, this will constitute a conflict of interest.

Members of the Clinical Board must declare if they have any interests related to the matters being discussed. Should an interest be declared, the Chair of the Programme Board should exercise discretion as to whether to disqualify that member (voting or non-voting) from taking any further part, or in any way influencing via proxy or otherwise, discussion and/or voting on that matter.

Annex 1 Governance structure of SSHP



Annex 2 Core Membership

To be confirmed

Appendix 3

Terms of Reference

South West London & Surrey Downs Healthcare Partnership

Finance & Activity Committee

Contents

TO BE COMPLETED

Appendix 4

Statutory powers of the Tripartite and their role in the programme

In the event that the commissioners and providers represented in the programme cannot reach consensus, the Tripartite will work with them to achieve this. This section lays out the extent of the powers that the member organisations of the tripartite have in law to take forward proposals should consensus prove difficult to achieve.

The legal powers of the tripartite, under the Health and Social Care Act 2012 and the Care Act 2014, are as follows:

- **NHSE** has no power to override the decisions of a CCG as long as that organisation is successfully performing its functions under its terms of authorisation. If the CCG fails to perform those functions, under the 2012 and 2014 Acts NHSE can direct a CCG to take certain actions. However, while the legal position is not entirely clear, it seems that this could only include overriding a CCG's decision on service reconfiguration or design *both* if the CCG was failing *and* if the provider involved was part of a Trust Special Administration regime. This power has however not been tested and in any case changes to services are far more likely to be effective if agreed by consensus. NHSE has a formal role in assuring public consultations before they can be launched.

- **Monitor** has no power to direct an Foundation Trust (FT) as long as that FT is meeting the terms of its licence conditions. However if an FT breaches its licence conditions (which include the delivery of financial balance) Monitor can direct the organisation to undertake certain actions to ensure that the breach does not reoccur. In most cases this would take the form of governance changes such as appointing an improvement director. It seems that in theory Monitor's legal powers would enable it to require a trust to make some changes to the services that it provides, although it would not have powers to compel a transaction (such as a merger) with another organisation. Again, however, the legal position is complex, and what is deliverable in practice is likely to fall short of the full legal powers the organisation holds.

- **TDA** has wider powers than the other organisations as it can intervene with NHS Trusts before they hit a threshold of poor performance. The Secretary of State has powers of direction over NHS Trusts, which are delegated to the TDA, thus giving the TDA powers to direct Trusts in their provision of services, governance etc.

At present the statutory powers laid out above are not affected by the move to NHSI, although there is always the possibility that this could change.

As this demonstrates, the only organisation with significant powers which do not need to be triggered by poor performance, is the TDA. However, all three of the organisations have the powers to work closely with their respective organisations to address concerns.

Tripartite roles will be further defined in the Programme Initiation Document.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***Dec 2015***

Paper Title:	Risk and Compliance report for QRC incorporating: 1. Corporate Risk Register 2. External assurances
Sponsoring Director:	Jennie Hall, Chief Nurse/DIPC
Author:	Sal Maughan, Head of Risk Management
Purpose:	To highlight key risks and provide assurance regarding their management.
Action required by the committee:	To receive assurance regarding compliance with external regulatory requirements
Document previously considered by:	**Quality and Risk Committee**

Executive summary

Key messages:

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- Controls are developed for all risks, with a rolling programme of review by QRC during 2015

Assurance:

- A full review and redesign of the board assurance framework is currently underway. The underpinning procedural document will now be developed to be presented to the Executive Management Team with a view to presenting to Trust Board in Jan 2016.

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. All risks on the CRR are currently undergoing a full bi-monthly update and will be presented to Trust Board in December. Those risks already updated have been included in this report.

Table one: highest rated risks (detailed controls 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 →**
01-19	Risk to patient safety arising from delays and/or failures to ensure the correct medical equipment is available	**5**	**4**	**20 NEW**
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	**5**	**4**	**20 NEW**

1.1 New risks included on the CRR

There have been two new risks included during the reporting period, detailed controls are included at appendix 3.

5.1-02	Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.	**3**	**5**	**15**
01-19	Risk to patient safety arising from delays and/or failures to ensure the correct medical equipment is available	**5**	**4**	**20**

There are a further two potential risks escalated through the Workforce and Education Committee which are currently under formal risk assessment:

- Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes (C5 x L5 before controls applied)

Controls:

Planning meetings underway for strikes on 2, 8 and 16 December – led by Chief Operating Officer
All consultants to cover strike period s and to confirm – if inadequate cover services may be cancelled
Decisions around whether to limit or cancel elective services and outpatient clinics currently underway

- Risk of inability to retain adequately staffing levels arising from a shortage of agency staffing resulting from the national introduction of a cap on agency rates for nurses and locum doctors (C4 x L4 before controls applied)

Controls:
Response to the consultation
Trust currently modelling the impact of the cap

1.2 Changes to risk scores

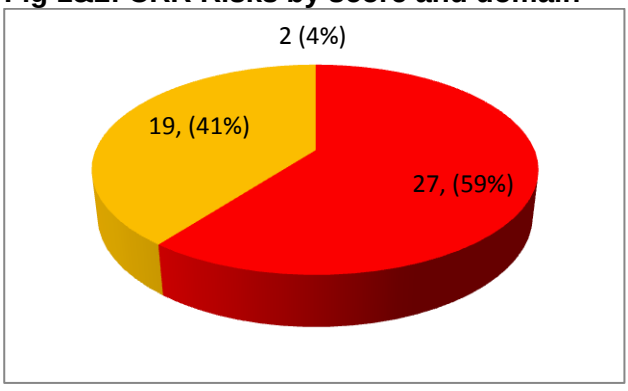
There has been one change to risk score:

Ref	Risk	Prev	New
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	**16**	**20↑**

1.3 Summary of risks by score and domain

There are 48 risks on the CRR of which 29 are extreme (a score of 15 or above) this equates to 60% of the total risks, which compares with 56% in Oct 2015. Of these extreme risks, 12 sit within the domain of Quality and seven within Finance and Operations. Of the total risks on the CRR, 44% relate to Quality and 19% to the Finance and Operations domain.

Fig 1&2: CRR Risks by score and domain



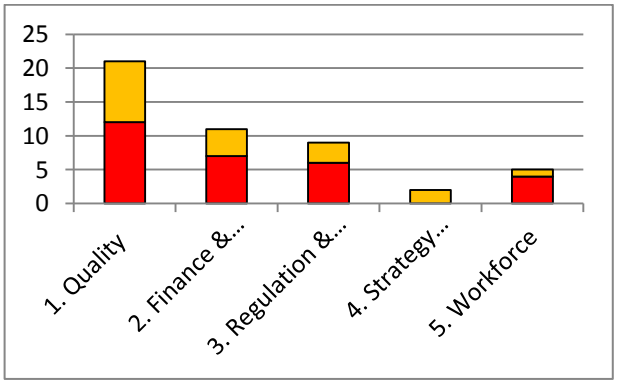


Table three: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Mod)	0-3 (low)	Total
1. Quality	12	9	0	0	21
2. Finance & Operations	7	4	0	0	11
3. Regulation & Compliance	6	3	0	0	9
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	4	1	0	0	5
Total	**29**	**19**	**0**	**0**	**48**

1.5 Deep Dive: Quality Risk Committee

The QRC carried out 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*

The risk was reviewed following a detailed presentation around trust compliance with CQC Regulations and Fundamental standards of Care which came in to force on 1st April 2015. The detailed risk description, controls and assurances have been updated and are included at Appendix 4 having been approved by QRC.

1.6 Divisional Extreme Risks

Extreme risks included within each of the clinical division and corporate directorate risk registers are included at appendix five. These are discussed at the bi-monthly Organisational Risk Committee and are considered in conjunction with the corporate risk register.

2. Board Assurance Framework and 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 – Oct/Nov 2015

2.1.1 JAG Accreditation Assessment Report – QMH 16 October 2015

The trust underwent a Joint Advisory Committee (JAG) accreditation visit at Queen Mary's Hospital site on 16th October. The JAG accredits organisations using the he Global Rating Scale (GRS) as a quality improvement and assessment tool for the gastrointestinal endoscopy service.

The unit was commended for several areas of good practice including

- A caring and professional patient centred endoscopy team.
- Passionate and visible General Manager
- An established and empowered nursing team who are enthusiastic -demonstrated by excellent morale and long service at the hospital.
- A clean and modern environment that helps create a positive experience for patients who use the service.
- High quality clinical care as demonstrated by the results of recent audits.
- A strong philosophy of continual improvement of care by learning from audits and patient feedback.

A number or recommendations for improvement were also made to further improve practice around privacy and dignity of changing areas and for breaking bad news and in relation to the decontamination of equipment.

Full accreditation was achieved.

2.1.2 Health Education England/South London (HESL) visit 23d Nov 2015.

As part of Health Education England, HESL are responsible for educating, training and supporting doctors, dentists, nurses and all health professionals. HESL therefore monitor the quality of training provision in trusts on behalf of the general Medical Council (GMC). On 23rd November, HESL representatives visited the Trust in response to concerns raised regarding trainee supervision and support in Vascular Surgery and Interventional Radiology. Having interviewed a number of staff HESL wrote to the trust to convey a number of urgent (unconfirmed) concerns and have asked the trust to urgently investigate these and to provide a response and action plan. This is currently being coordinated by the Medical Director and Chief Nurse.

2.2 CQC Intelligent Monitoring Report update

The CQC have announced that they will no longer be issuing Intelligent Monitoring Risk reports (formerly issued on a quarterly basis). They have advised that as their inspection regime throughout 2014/15 has meant the majority of acute trusts have now undergone a new style CQC inspection, further inspections will now be based upon the risks as identified through inspections and through the overarching quality alert system in place. The trust continues to develop, via the Quality Fundamental Standard group, a comprehensive ward audit programme to provide quality intelligence aligned to the CQC fundamental standards. This allows triangulation with other trust quality data, in order to support early identification of any early quality signals or concerns; this method effectively mirrors the new CQC approach, enabling the trust to focus support and resource to addressing any identified gaps at the earliest possible point.

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.

The board assurance framework is currently in development and is designed to strengthen the types and level of assurance to board and to support the board discharge its duties in relation to the annual governance statements and compliance with the CQC Well Led Domain for Trusts.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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	25	20	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	MW	20	20	20	16	16	16	→	
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	9	9	→	
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	20	20	20	→	

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	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	16	→	
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	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	12	→	
01-19 Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment	JH						20	→	

Strategic Objective/Principal Risk	**Lead**	**May 2015**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**Nov 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	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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	10	→	
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	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	20	→	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.				20	20	10	10	→	
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives				20	20	15	15	→	
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	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	16	→	
3.20-05 Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.						20	20	→	

Strategic Objective/Principal Risk	Lead	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	In month change	Change/progress
2.2 Meet all operational & performance requirements								↓↑	
3.7- 06 Failure to meet the minimum requirements of Monitor Risk Assessment Framework:	PVK	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	12	12	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	16	16	12	12	12	12	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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	JH	5	5	5	5	5	15	↑	Following deep dive review at QRC
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	12	12	→	
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	15	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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	May 2015	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 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	16	16	16	→	
A516-O4: Possible reductions in the overall number of junior	WB	6	6	6	9	9	9	→	

doctors available with a possible impact on particular specialty areas									
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	12	12	12	16	16	16	→	
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	16	16	16	20	↑	Increase associated with cross referenced new risk around agency cap and impact
5.1-02 Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.							15	→	

JH	Jennie Hall	Chief Nurse (DIPC)	EM	Eric Munro	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
PVK	Paula Vasco-Knight	Chief Operating Officer	WB	Wendy Brewer	Director of Human Resources
SB	Steve Bolam	Director of Finance Performance & Information	MW	Martin Wilson	Director of Delivery & Performance

Appendix 2: Significant CRR risks (Score >20): detailed controls

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 Nov 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:			**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

	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 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. •		targets External assurance: ALOS benchmarking will provide insight into areas of strong and weak patient flow
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 Nov 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	**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.

	• 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 activity against plan ensuring full use of allocated capacity, driving productivity improvements within sessions and outsourcing activity to other providers		Score increased – based upon recently materialised risk regarding theatre ventilation and maintenance
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 Nov 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.	**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

	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 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 Nov 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 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	**Assurance**	Q4 and Q1 performance standard has not been met 2015/16 performance forcast under delivery with trajectory of circa 93% Daily reporting to Exec team Escalation meetings between division & DoDI Joint Trust & CCG Investigation completed
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	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 Nov 15**	**Exec Sponsor**	Paula Vasco-Knight
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 teams Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action			**Assurance**	Positive assurance •HDD, BGAF and QGAF assessments •Internal audit Following a period of joint investigation with commissioners, remedial action plans have been agreed for performance improvement in ED and RTT. Negative assurance Worsening ED performance across Q1 and continued under-delivery in Q2 – cross ref BAF Risk 01-07 RTT performance issues in relation to the incomplete pathway target. Contract query notice served for cancer performance. Tripartite meeting with NHSE & Commissioners held and a recovery plan presented. Weekly performance recovery meetings in place both internally and a separate meeting being chaired by commissioners

	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 • Continue to implement joint I investigation actions • Implement cancer recovery plan • Cancer PTL development • Waiting list improvement programme – present proposal to TB and gain agreement		

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 Nov 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			**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.

	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.		
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 will submit the results of the 2015-16 re-forecasting exercise to monitor. • The Trust will develop additional cash mitigation plans to address the impact on cash where the planned deficit is exceeded		

Principal Risk	**3.15-05 Income Tariff Risk** – that national and local tariffs do not deliver the required income				
Description	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				
Domain	**Finance & Operations**			**Strategic Objective**	
	Original	**Residual**	**Update Nov 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	**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 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. ▪ Monthly SLAM review group is using SLAM to monitor the benefit/disbenefit of the block contract arrangement. **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.		**Assurance**	▪ 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

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:	▪ Robust dialogue and negotiations with commissioners for additional funding through 2016/17 ▪ Discuss NHSE NETA reinvestment at Finance & Recovery Group ▪ Review local tariffs as part of 16/17 contracting round		

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 Nov 2015**	**Exec Sponsor**	Steve Bolam
Consequence	5	5	5	**Date opened**	30/09/15
Likelihood	4	4	4	**Date closed**	
Score	20	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			**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

	▪ 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		
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		

Principal Risk	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				
Description	NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing) and most recently this has been increasing at St. George's. We are also increasing capacity in the Trust, often to areas where we have identified staffing as hard to recruit to, and the combination of these factors has meant that supply has outstripped demand, resulting in a heavier reliance on temporary staff. The impact is particularly significant in relation to band 5 nurses, where there is a very high volume of recruitment and in some specialist areas such as oncology, paediatrics and theatres. We are reporting staffing fill of 90%~+ in Safe Staffing reports but the difficulties in staffing create pressures in terms of being able to deliver their services.				
Domain				**Strategic Objective**	
	Original	**Residual**	**Update Nov 15**	**Exec Sponsor**	Director of Workforce and Organisational Development Chief Nurse for nursing workforce
Consequence	4	4	4	**Date opened**	
Likelihood	3	4	5	**Date closed**	
Score	12	16	20		
Controls & Mitigating Actions	There is a workforce strategy which has an underpinning action plan. This plan is refreshed each year. The overarching objectives and progress is reported to the board. The workforce and education committee meets bi-monthly, supports the development of the plan and monitors its implementation. There is a monthly workforce information report to the board that identifies key trends against the workforce key performance indicators including turnover, vacancy rate and bank and agency			**Assurance**	In response to the increases in turnover, the workforce strategy action plan has been refocused for 2015/16. Divisions have been asked to produce plans to reduce turnover that take into account the information available through exit survey data and the detail of turnover patterns within the division. These plans will be presented to the committee in July. There have been some areas that have reduced vacancy rate and turnover significantly such as paediatrics. This directorate has

	usage. The report includes detail of bank fill rates. The monthly quality report to the board includes detail regarding the nursing workforce including a tracker of SAFE nursing staffing compliance and of staffing alerts that have been reported. The nursing recruitment and retention board is chaired by the Chief Nurse and meets on a 3 weekly basis to steer a programme of work to ensure recruitment and retention of the nursing workforce. A workforce planning meeting takes place weekly, chaired by the Director of Workforce and Education with the purpose of aligning workforce information and developing an annual plan. A medical workforce group is being formed, led by the Medical Director. This group will report to the workforce and education committee. Workforce plans form part of the annual business planning round.		undertaken a focused piece of staff engagement work that has resulted in reduced turnover and vacancies. A business case for overseas recruitment for nursing has been approved by EMT. The nursing board, with the support of HESL, have agreed to recruit all student nurses currently on placement in the trust in the summer of 2015. (Approximately 100 nurses). A simplified process for internal promotion and movement has been introduced in response to feedback from the exit questionnaire data. The nursing and workforce leadership teams met with HESL to review the trust's submission for nursing commissions on 26th June. The trust was assured that the submission was considered to be of high standard. The trust will work with HESL on some suggested approaches such as identifying overseas qualified nurses working as health care assistants already working for the trust and providing a HESL supported nursing conversion course. A planned trajectory for turnover was presented to the trust board in May. Turnover has stabilised but remains at high levels. KPMG are providing support to the workforce planning group to speed the process for reconciling ESR and ledger workforce information. The nursing workforce staff-in-post has grown by 134.3 WTE since September 2014. KPMG have produced a detailed weekly tracker analysing staff in post movements.

Gaps in controls		**Gaps in assurance**	The workforce information on ESR and on the ledger needs to be resolved. KPMG have set a deadline to the finance team for end of July. The nursing recruitment plan needs to be reviewed against current activity and capacity plans. A process will be developed to ensure that the workforce plan is updated as activity and capacity plans change. This process will be managed through the workforce planning group.
Actions next period:	The July meeting of the workforce and education committee will: • Review progress with the workforce plan including progress with reconciling the ledger to ESR. • Review progress on the nursing recruitment plan. • Receive an update on the activity to deliver the workforce strategy action plan. • Receive divisional plans to reduce turnover. • Receive a report from the newly established medical workforce planning group.		

Appendix 3: Newly included CRR risks

Principal Risk	01-19: Risk to patient safety arising from delays and/or failures to ensure the correct medical equipment is available				
Description	Risk to patient safety due to problems with interface between wards and departments and finance/procurement/supply chain which in turn results in a failure to ensure the correct medical equipment is tin the right place at the right time. Escalated through the Quality Fundamental Standards group, incident reporting and escalated concerns to managers.				
Domain				**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Jennie Hall
Consequence	5	5		**Date opened**	1 Nov 2015
Likelihood	4	4		**Date closed**	
Score	20	20			
Controls & Mitigating Actions	Clinical products procurement group set up – chaired by Assoc medical director More robust reporting categories introduced on Datix to allow closer monitoring Quality Fundamental Standards (QFS) Group regular agenda item with regular attendance and reports from Finance/procurement QFS email alert group in place and extended to include finance/procurement staff Serious Incident Declaration Meeting monitoring weekly data Regular trust communications through eGazette to update staff and support timely planning & ordering of items			**Assurance**	High turnoff staff in procurement Incidents still being reported with no reduction in volume or frequency Recent further delays in supplies due to manufacturers not wishing to adhere to new 60 day terms of payment
Gaps in controls	Processes for procurement still not robust No second/alternate suppliers lists Critical list of equipment still not agreed			**Gaps in assurance**	High turnoff staff in procurement – lack of access to Datix for new starters means an inability to monitor incident reports Often clinical staff too busy to report as an incidents and info/feedback can get lost
Actions next period:	Resolve access to Datix issues Commence work on alternate suppliers list Review TOR and scope of Clinical products procurement group Gain clarity around roles and responsibilities in procurement/supply chain with a dedicated 'trouble-shooting' role put in place to resolve urgent issues Communications to all staff around what to do out of hours and under normal circumstances				

Principal Risk	5.1-02 Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.				
Description	There is a risk to both effective engagement and support of the turnaround programme delivery where management capacity is insufficient to support the programme whilst delivering business as usual. Similarly, a risk to service delivery may arise if core business is not prioritised appropriately.				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**		**Exec Sponsor**	Wendy Brewer
Consequence	3	3		**Date opened**	30/11/2012
Likelihood	5	5		**Date closed**	
Score	15	15			
Controls & Mitigating Actions	Programme management approach to the requirements of turnaround. Regular staff and senior team leader briefings Communication messages are designed to be engaging and positive Monthly Chief Nurse open forum launched Nov 2015 Leadership programme launched			**Assurance**	
Gaps in controls	None identified			**Gaps in assurance**	
Actions next period:	Communications to be developed in follow up to Nov Senior team leaders meeting to reassure staff around financial position of trust..				

Appendix 4: revised risk following Deep Dive at QRC

Principal Risk	A534-07:Failure to demonstrate full compliance with the CQC Fundamental Standards				
Description	Lack of a sufficiently robust approach to self-assessment and subsequent actions to ensure compliance may lead to a CQC inspection finding of non-compliance. Improvement and/or enforcement action imposed by the CQC with associated reputational risk and risk to the FT application Ref BAF Risk A509. Ultimate risk of loss of licence to operate certain services.				
Domain	**3. Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Residual**	**Update Nov 2015**	**Exec Sponsor**	Jennie Hall
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	1	1	3	**Date closed**	
Score	5	5	15		
Controls & Mitigating Actions	**Controls:** Quality inspections programme underway Quality Fundamental standards meeting established, chaired by Chief Nurse/Deputy Chief Nurse with clear programme of meetings to review each fundamental standard and regulation across a rolling programme Regulation leads established for each regulation New quality intelligence framework in development with clear audit cycles and review at all levels within organisation- developed on electronic rate system Regular reports to QRC/Trust Board			**Assurance**	Chief Inspector of Hospitals inspection report published 24th April 2014, with overall rating of 'Good'. Two compliance actions identified. All actions on compliance action plan completed and presented to commissioners and CQC in June 2015. Commissioners are content to close the action plan in July subject to the on-going monitoring around two actions reverting to business as usual monitoring. Quality Inspection programme has recommenced on 1st June 2015 following a pause. Deep dive into risk and programme of work underway to assess compliance with standards GAP analysis undertaken against recently inspected trusts to highlight key areas of focus for StG
Gaps in controls				**Gaps in assurance**	
Actions next period:	Continue to develop the quality inspection programme to further align to CQC inspection frameworks and KLOEs Pilot new quality intelligence audit in adult in patient areas (Med- Card) throughout December				

Appendix 5: Divisional Extreme Risks

Risk Ref.	CW&DT Risk	Score	Nov 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	↑	
CW027	Dirty water leaking through Ceiling on Delivery Suite, Gwillim Ward office and Parent Education room. Leading to loss of usage of space and possible infection control issues	20	↑	Work started on the leak but fumes became too bad. Risk upgraded from 12
CW049	Delivery of sub-standard care to sick and premature infants due to insufficient neonatal trained nurses on the neonatal unit	16	↑	Sickness rates increased, skill mix is poor, risk remains; to be reviewed in Jan 2016.
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	→	
CW0067	Financial risk – growth. Risk of CCG not paying for increased income assumptions particularly in children services, radiology and women's	15	→	
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	→	
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	→	
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	**closed**		
CW105	(C4 x L5 = 20) - STOW (safe transfer of women) maternity system - Missed or delayed postnatal care for mother and baby	**20**	→	
CW108	Deterioration of non-medical staff appraisal rates	**15**	**NEW**	
CW109	Failure of Responsible Persons to address and/or rectify Significant Findings contained in Fire Risk Assessments, leading to an increased risk of injury or loss of life in the event of a fire or fire evacuation.	**20**	**NEW**	
CW110	Failure of responsible persons to identify sufficient staff to be trained as Fire Wardens, leading to an increased risk of injury or loss of life in the event of a fire or fire evacuation.	**20**	**NEW**	
	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**	→	
MC34-D1	Risk to patient safety as lack of capacity in hospital is leading to regular occurrences of exit blocking and overcrowding in the ED.	**20**	↑	Likelihood increased
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**	→	
MC68-D1	Risk to patient safety and patient experience on Caroline ward due to inadequate staffing levels and thoracic pre assessment clinics.	16	**NEW**	
MC67-D1	Violent and aggressive patient (on Gordon-Smith ward) towards staff. Impact of violent episodes on staff well –being, both psychologically and physical injury. One staff member on sickness absence following a violent episode.	**16**	**NEW**	
MC69-D1	Risk to patient safety as no identified haemodialysis machine replacement programme for machines reaching the end of their service.	**20**	**NEW**	
	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	→	
C33	Neuro MRI scanner. Functionality is unreliable leading to delays in diagnosis and treatment for neuro patients.	20	→	
C28	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	→	
	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	→	
	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.	20	→	
EF176	Estates compliance – survey revealed gaps in compliance in statutory and mandatory items	12	↓	Planned programme of maintenance in place
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.	6	↓	Comprehensive maintenance contract in place
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**	→	
EF202	Absconding patients on the helipad as access is via a fire escape route		→	
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**	→	
EF215	Master Pact M Circuit Breakers no longer supported by the manufacturer.	**16**	→	
EF216	Automatic changeover contactors are no longer supported by the manufacturer	**25**	→	
EF217	Failure of Genie Evo High Voltage vacuum circuit breakers. The HV Maintenance contract is currently being tendered.	**25**	→	
EF222	The Fire escape from the Helena Robinson gym at QMH leads through to a stairwell which leads to difficulties in evacuating non ambulatory patients	**15**	**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**	→	
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]	**12**	↓	Reduced likelihood (to 3) due to more remedial works having been carried out
IT032	Increased risk to network availability due to inadequate electrical supply to key locations.	**12**	↓	Reduced likelihood (to 3) due to more resilience through electrical estates programme
IT0035	Fire Risk Assessment compliance.	**20**	**NEW**	
IT0036	Low number of fire wardens	**20**	**NEW**	
	Corporate Affairs			
Risk No.	**Risk**	**Score**		
CORP02	Risk of regulatory action or penalties upon the Trust in the event of a failure to comply with the legislative requirements of the Freedom of Information Act (2000) Update: position and level of compliance has not improved – risk score remains unchanged	**15**	→	
CORP06	Capacity to deliver plans due to and increased turnover of staff in the Corporate Affairs directorate – Update: further vacancies and limitations on bank and agency mean risk remains.	**16**	→	
COM03	Potential risks to patient safety by staff accessing out of date policies via the intranet	**16**	→	

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KEY MESSAGES TO THE BOARD FROM AUDIT COMMITTEE HELD ON 11th November 2015.

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 Board and the Executive will remember that in our last report we highlighted the lack of ownership of agreed actions arising from Audits by the Executive. Little has changed; indeed we seem to have gone backwards. The Audit Tracker for this month was unreliable and in many instances had not been completed despite the commitments made by the Executive to the last Board meeting. Reasons given were that it is not a high priority for Executives currently, changes in Executives and Executive responsibilities had confused matters and that the process was "clunky". We would remind the Board that on the Tracker we have actions to mitigate High Risks agreed to by Executives that are more than 2 years overdue. There are 32 High Risk actions on the Tracker that are now overdue. We repeat what we reported last time. 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. Indeed it could be argued that most of the Internal Audit programme is a waste of money unless the Trust acts on agreed recommendations.

   We recommend that then Executive consider how they wish to handle tracking of actions arising from Audits and report back in the form of a paper to the next Audit Committee in January.

   In the meantime the Trust Secretary has committed to enter all the overdue High Risk action areas onto the Risk Register.

2. Internal Audits reported reasonable assurance for progress with implementation of the IT strategy which has been impacted by the financial challenges facing the Trust. It recommended an overall refresh of the IT strategy to realign it with the current Trust circumstances.

3. Limited Assurance was given in the Network security/Penetration Testing Follow Up primarily because a number of recommendations from the original test have not been implemented yet. The Chief Financial Officer and ITC Director have agreed a programme either to implement the remaining recommendations or to not implement them but explicitly document the risk in so doing. A follow up discussion identified that with the recent broadening of Trust systems into partner organisations and the Community there was a need to review fundamentally security and the need for encryption of sensitive data. This report will come to the January meeting of the Audit Committee.

4. Reasonable Assurance was given from an Internal Audit of South West London Pathology although work remains to be done on assessing the benefits in the light of a £2.4 m negative variance in Business Case financial assumptions.

5. We received the usual excellent briefing from Clinical Audit. One issue raised which we need to bring to the Board's attention is an issue with Clinical Coding where the patient has passed through the hands of several services. Discharge and statistical information is derived from the last code in the series whereas earlier treatments may be moiré relevant. This may have significant implications. Clinical Audit and the Chief Financial Officer are following this up.

6. We received a very good report from Counter Fraud which contained three potentially serious cases which are being followed up.

7. The level of Tender Waivers is high and the reasons for this are currently being investigated by Internal Audit.

8. We received a very honest report from the Director of Estates explaining a procurement error in respect of a major contract.

9. We received an Internal Audit on Financial Management and Budgetary Control and one on the CIP process. While improvements were cited and Reasonable assurance was given for the basic framework for the processes both audits gave Limited Assurance reflecting the late commencement of these processes, the increased deficit, the shortfall in CIPs so far and the incomplete current action plan to improve them. The Audit Committee has asked for a follow up audit early in the next financial year. These reports are still in draft awaiting some final comments.

10. The Audit Committee received a report on the National Reference Cost Assurance Programme which gave the Trust an overall green rating although provided some helpful recommendations which the Chief Financial Officer is following up.

11. The Audit Committee was very concerned at the detailed analysis of expenditure on consultancy services and general management support costs for 2014/15. This totalled £5.5 m and there was significant expenditure on interim management in Divisions (£3.7 m). The Audit Committee was not assured that this area is yet under control and has asked the Trust to present the report to the next F&P Committee, to explain the largest expenditures in 2014/15 and to provide assurance that this area of expenditure is now under control.

MSJR

St George's University Hospitals NHS
NHS Foundation Trust

12 November 2015.