St George's University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting (Public)

Thursday 2nd June 2016 commencing at 10:00 am
H2.5 2nd Floor Hunter Wing, Boardroom 5

Item	Time	Item	Owner:	Board Action	Paper No:
Board Business					
1.	**10.00**	**Welcome and Apologies**			-
2.		**Declarations of Interest**	All	Board Members to declare any pecuniary or non-pecuniary interest in particular agenda items, if appropriate	-
3.		**Minutes of the meeting**	Sir David Henshaw	To consider the Minutes of the previous meeting held on 5th May16 and check for amendments and approve	TB June 16 - 01
4.		**Key Issues**	All	Board members to identify any key issues	
5.		**Schedule of Matters Arising**	Sir David Henshaw	To discuss any matters arising from previous meetings and provide updates and review where appropriate	TB June 16 - 02
6. Patient Safety, Quality and Performance					
6.1	**10.45**	**Performance & Quality Report**	Corrine Siddall & Jennie Hall	To inform the Board about the latest performance and quality report including the Complaints Action Plan and RTT Action Plan	TB June 16 - 03
6.2		**Workforce & Performance Report**	Wendy Brewer	To inform the Board about the latest position on workforce.	TB June 16 - 04
6.3		**Quality & Risk Committee**	Sir Norman Williams	To inform the Board about the key issues arising from the Committee	Verbal
6.4		**Urogynaecology Report**	Andy Rhodes	To provide the Board with the latest update	TB June 16 - 05
7. Strategy					
7.1	**11.45**	**Estates Strategy**	Richard Hancock		TB June 16 - 06
7.2		**Outpatient Review**	Andy Rhodes	Next Steps on implementing recommendations	TB June 16 - 07
8. Finance and Performance					
8.1		**Finance Report – month 1**	Nigel Carr	To inform the Board about the latest project outturn	TB June 16 - 08

Item	Time	Item	Owner:	Board Action	Paper No:
8.2		**Finance & Performance Committee**	Sarah Wilton	To inform the Board about the key issues arising from the Committee	Verbal
8.3		**Annual Report and Accounts**	Sarah Wilton & Nigel Carr	To approve the financial accounts, quality account and annual report and receive the report from the Audit Committee.	TB June 16 - 09
9. Governance and Risk					
9.1		**Risk and Compliance Report**	J Hall	To review the Trust's most significant risks and external assurances received	TB June 16 - 10
9.2		**Board Assurance Statements**	L Edwards	To the level of compliance with the two governance statements	TB June 16 - 11
10 Items for Information					
10.1		**Annual Plan**		To note final submitted version for information	TB June 16 - 12
11.		**Use of the Trust Seal**		To note use of the Trust seal in May 2016. The seal has not been used in May 2016	
12		**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	
13		**Key reflections**	All	The Board to reflect on key issues	

Date of next meeting

The next scheduled meeting of the Board to be held in public will be 7 July 2016

Minutes Trust Board

Minutes of the meeting Trust Board of St George's University Hospitals NHS Foundation Trust, held on Thursday 5 May 2016 at the Rose Centre, St George's Hospital commencing at 10am.

PRESENT

Sir David Henshaw	DH	Chairman
Sarah Wilton	SW	Non-Executive Director
Stella Pantelides	SP	Non-Executive Director
Jennie Hall	JH	Chief Nurse
Simon Mackenzie	SM	Acting Chief Executive Officer
Iain Lynam	IL	Chief Finance Officer
Wendy Brewer	WB	Director of Workforce
Rob Elek	RE	Director of Strategy
Corrine Siddall	PVK	Chief Operating Officer
Richard Hancock	RH	Director of Estates and Facilities
Alison Benincasa	AB	Divisional Chair, Community Services
Andy Rhodes	AR	Acting Medical Director and Divisional Chair, Women and Children
Luke Edwards	LE	Head of Governance
Nigel Carr	NC	Finance
Leslie Robertson	LR	Patient Representative, Item 7.5

Agenda Item		Action
1.	**Welcome and Apologies** The Chair welcomed everyone to the meeting. Apologies were received from Jenny Higham, Kate Leach, Lisa Pickering and Tunde Odutoye.	
2.	**Declarations of Interest** There were none.	
3.	**Minutes** The Board considered the minutes of the last meeting held on 7 April. LE informed the Board the Mike Rappolt had requested a number of amendments to the Minutes by correspondence and SW asked for clarification regarding the agreed next steps on the PWC Review. **Resolved** that the Board**:** approved the minutes as an accurate record subject to the amendments described above and published on the Trust website.	**LE June 16**

4. Key Issues

No key issues were identified for discussion.

5. Matters Arising

SP asked that the matters arising track key commitments made. This should include the expectation was that the trust would be sustainably hitting all seven standards from April 2016. This was agreed. **LE June 16**

6 BUSINESS PLANNING 2016/17

6.1 Estates Plan including Renal Development

RH provided an update of progress. Key areas of focus included: work to support the CQC Inspection preparation; a rolling programme of audits and assessments including fire, water and heating; and a rolling programme to renovate the boilers. Action had been taken to: increase the number of porters available; conduct 'dump the junk' exercises more frequently; work through the backlog of estates maintenance issues. Water in the pipes would be pasteurised to contain the risk of infection. Work was being taken forward with the University and each issue would be tackled in turn.

RH summarised progress on renal development and noted that the renal facilities were his highest non-estates priority. The renal facilities in the Knightsbridge Wing are not fit for purpose and an initial option analysis had been undertaken. This considered the renal service under four domains of operational delivery: the inpatient ward; dialysis; the transplant clinic and administration. The preferred option at this point was to undertake a two stage decant plan. Firstly, the day dialysis facilities would be transferred to a third party provider in Colliers Wood. This could be undertaken relatively quickly. Secondly a temporary modular build would be erected to house the remaining functions. This could be in place in around 24 weeks and initial discussions had been undertaken with 3 modular building suppliers. The Board had previously agreed, in principle, to demolish the Knightsbridge Wing and the intention would be to erect a permanent modular build. The work is being led by the Renal Project Board and supported by the steering group who will be responsible for driving forward the work.

RH confirmed to the Board that a more detailed proposal would be presented to the Board in June 2016 for agreement. This would include a return on investment analysis and be supported by a full service review. JH noted that the key objective of the work was to mitigate clinical risk. **RH June 16**

Resolved that the Board**:** noted the update

7. PATIENT SAFETY, QUALITY AND PERFORMANCE

7.1 Performance and Quality Report

CS summarised the current performance across the three key areas: RTT, cancer and A&E. The trusts remains below the target for A&E and non-compliant against the 62-day standard cancer targets and RTT incomplete pathways. A technical review of RTT had been completed and a further review and deep dive into data issues was underway.

Additional assurance meetings had been implemented both at the strategic level and operational level. These have significant senior management involvement. A supporting recovery and sustainability action plan had been developed and commissioners are supportive of the work and action we have been taking. Following under performance in January the trust had agreed some changes to the recovery plan with NHSE and commissioners.

On A&E we had achieved the recovery trajectory in March and April however recent weeks have seen significant pressure and high attendances. Improving performance will be a key area focus at the highest level within the trust. CS concluded by highlighting that she would draw out the impact of cancelled operations and diagnostics on cancer and the 18-week target for the next board.

The Board discussed current performance. DH highlighted that fact that RTT was in the process of recovery and the full scale of the challenge still needed to be understood. The expectation was recovery would take at least 2-3 months. SW noted that the STP funding was dependent on meeting the trajectories and asked for assurance that we would do so in quarter 1. CS confirmed that the divisions had been closely involved in developing the plans but there remain risks around delivery. Commissioners understood the potential need to re-negotiate the RTT trajectory in view of the data challenges. DH outlined to the Board that he intended to meet with commissioners with a view to developing a collegiate approach focused on building partnerships and working together to resolve the issues supported by the necessary level of investment. JH assured SP that two maternal deaths were not related to maternity service provision and agreed to provide further detail on the percentage of harm free care in community services.

The Board agreed the performance and quality report needed to be simplified and that the rising trend on cancelled operations was concerning.

JH updated the Board on key quality indicators. In the effectiveness domain mortality HMSR performance remains better than expected and the SHMI position between October 14 and February 15 is categorised ‘as expected’. The Boards attention was drawn to the results of the National Diabetes inpatient audit and highlighted that the local audit in relation to the use of NEWS had identified a number of issues in practice and an action plan had been put in place. In the safety domain, Safety Thermometer performance was 94.6%, slightly above the national average but below the target of 95%, C-Difficle cases had reduced by 24% compared to the previous year and pressure ulcer performance shows a 57% improvement in performance for avoidable pressure ulcers compare to the last 12 months. Safeguarding training compliance had improved for both adults and children but work will continue. Complaints performance remains a concern and a workshop had been held which will result in the development of an action plan.

The Board welcomed the progress on infection control but highlighted the need to focus on complaints both in terms of responding and also

learning the lessons. The Board asked for an Action Plan on complaints to be submitted for approval at the June Board following consideration by the Quality and Risk Committee.

NW introduced himself as a new Non-Executive Director and member of the Board and sought assurance that the trust had work on going to prepare for the introduction of the new avoidable mortality measure. JH confirmed that this was being led by Nigel Kennea, Associate Medical Director.

Resolved that the Board**:**

(i) Noted the content of the report;

(ii) Asked that JH submit a complaints action plan for approval in June; and — **JH June 16**

(iii) Asked for work to be undertaken to simplify and improve the performance quality report — **JH/CS July 16**

7.2 Workforce and Performance Report

WB introduced the report noting that there had been a positive movement on all key indicators with voluntary turnover reducing by 0.7% and sickness absence has reduced to 3.6% after an unusually long period of above average sickness. The trust will build on this by developing a wellbeing programme in response to the national CQUIN. The programme will include provision of fast track musculo-skeletal physiotherapy support for staff, support for physical activity and mental wellbeing. Managers had been asked to resolve all acting up arrangements which have extended beyond 6 months by the end of July. The new agency cap has been in place since April 2016 which had led to an increased number of nursing and mid-wifery breaches in the week commencing 28 March. A detailed plan is in place to respond to this issue. The deterioration in mandatory training has reversed although more work and continued effort is required. Appraisal rates however had continued to deteriorate. A paper based appraisal system will be rolled out as it has not been possible to deliver an IT based system.

The Board noted that it remained challenging to recruit to key specialities in medical and dental where vacancy rates have increased significantly since December. DH asked that the trust develop a monthly 'dipstick' for engagement by using a sample of focus group approach and that this is reported to the Board. WB provided assurance that staff will not be paid unless they have been booked through the staff bank and that resources have been increased to ensure they can manage the additional workload.

Resolved that the Board**:** noted the report and asked that a monthly engagement 'dipstick' is developed and incorporated in the report. — **WB June 16**

7.3 Quality and Risk Committee

SW highlighted the key issues from QRC including progress towards the upcoming CQC Inspection, the Quality Improvement Plan, estates and environmental discussion and safeguarding policies.

7.4 Frequent A&E Attenders

AB outlined the proposed new approach to adopt a new approach with 500 patients to facilitate alternative planned care/support away from the Emergency Department and summarised the paper. Wandsworth CCG have developed an initiative to manage the top 500 patients who attended A&E over 6000 times in 2015/16. The GP and the patient will discuss the reasons for their attendance and an analysis will be undertaken to consider changes in community provision that better suit patient needs. The trust proposes to support the initiative and develop a programme building on the approach adopted by the Homerton Hospital. The work will be taken forward in partnership with Wandsworth and Merton CCGs. The intention is to start with 500 patients but then seek to broaden the approach.

DH welcomed the proposal noting that there were around 14,000 regular attenders. The initiative therefore had the potential to have a significant impact on relieving the pressures on A&E and improving patient outcomes. It would form part of the strategic conversation with commissioners. NW asked that careful thought be given to the evaluation of the approach and that appropriate measures both in terms of the impact on demand and on patient outcomes were built in from the start. AB agreed to share the more detailed analysis with NW.

AB
June 16

Resolved: that the Board agreed that work should be taken forward as proposed.

7.5 **PPI/PPE Strategy**

DH welcomed LR to the meeting and thanked her for agreeing to present the strategy. LR outlined to work that had been undertaken to co-design the strategy through the Patient Reference Group and the critical role that patients can play as a critical friend to the trust. Patients can offer different perspective and it was welcome that the strategy offered greater scope to increase patient involvement at all levels within the trust. There was a need to change the culture and involve patients in decision which affected them.

A colleague had captured the patient view as follows: "*To convey the need for real commitment from the Board to champion line management to engage with patient led bodies and understand the volunteer's contribution given for the well-being of patients and benefit to the Trust*".

DH welcomed the report and the contribution that patients had made to its development. He was delighted with the work and the key was making turning the strategy into action. The potential energy and power that could be unleashed for harnessing volunteers is huge and if focused would be of significant benefit.

JH outlined the next steps. These included appointing a project manager to drive forward the work programme. Understanding the current landscape was a key early priority alongside strengthening training and development. The actions identified in the plan were a good first step but would need to iterate and be developed.

The Board agreed that establishing a baseline position was a critical first step. DH asked JH to work with patient representatives to explore whether the delivery of the strategy could be patient led, supported by the trust, as this may provide greater impetus. He concluded by thanking LH and the other patient representatives who had developed the strategy.

Resolved: that the Board agreed that strategy and asked JH to set out an action plan, working with patient representatives. **JH June 16**

8 Strategy

8.1 Update on Outpatient Strategy

RE summarised the progress made in delivering the Outpatient Programme since it was agreed by the Board in November. There had good progress in a number of areas including the introduction of new business rules, the adoption of a common income model and an evaluation of the use of patient check in booths. However there had been less progress sin other areas including limited service capacity and IT constraints. A review of the outpatient strategy had been undertaken. This had concluded that the existing strategy was correct but focused on process and was insufficient to drive transformative change. There need to be a greater focus on innovation.

SW asked whether the governance, resource and direction of travel were fit for purpose. RE confirm the new governance arrangements were more robust and AR identified that the key was to understand the totality of the impacts on the system from the different proposals. DH indicated that the 'state of preparedness' of the business to deliver needs continued attention. He had meet with senior representatives at Cerner, a key external dependency for the outpatient strategy, and agreed how to move this work forward quickly.

Resolved: that the Board noted the update and agreed:

(i) That the Outpatient Strategy Review should be circulated in correspondence after it had been discussed at EMT on 9 May; and **RE May 16**

(ii) A paper outlining next steps on implementing the recommendations from the review is tabled at the June Board **IL June 16**

8.2 Outpatient Programme – Call Centre Performance

AR introduced the paper and summarised the key issues. The current poor performance has been caused by a range of factors including increased demand, impact of junior doctor strikes, and current vacancy and sickness rates. Action has been taken to address weaknesses in the current leadership, recruit additional staff and extend opening hours from July 2016, remove the 11 week booking cap and move volumes away from peak time. A DNA Team has been set up to improve attendance rates and reduce income less. A text message system will be introduced from next month.

SW asked how quickly progress would be made in reducing the current wait times and the scope for booking appointments while the patient was in the hospital. AR confirmed that performance was expected to improve

rapidly but that this was dependent on capacity. Performance would however be significantly impaired by any further strikes or issues which required significant numbers of patients to be rebooked. The Board noted that there were lessons to be learned in ensuring that managers with the appropriate skills and experience are recruited. DH said he felt more assured that the performance issues had been gripped and this was another illustration of the continuing need to ensure a focus on getting the basics right.

Resolved: that the Board noted the update and supported the actions identified.

8.3 Commercial Board Annual Report

RE introduced the first annual report from the Commercial Board and explained that it was coming to note. Any information that was commercially sensitive had been excluded from the Report.

Resolved: that the Board noted the Report.

8.4 2015/16 Annual Plan, Q4 Review and End of Year Summary

RE introduced the report and indicated that the report detailed a number of achievements set out in the appendix. Overall, however, the overall organisational position is self-assessed as red given the significant impact of those areas that are currently off target. RE agreed to provide an update on the EDM and e-prescribing projects following the Board. **RE June 16**

Resolved: that the Board noted the Report.

8.5 SW London Acute Provider Collaborative

RE introduced the report noting that it had been discussed in detail at the away day so had been circulated for completeness. The trust was involved with on-going conversations. WB provided SP with assurance that challenges around agreeing a shared bank rate does not stop the project from moving forward.

9. Finance and Performance

9.1 2015/16 Annual Report

RE introduced the draft Annual Report, which includes the Quality Account. The Annual Report and Accounts are required for submission no later than 27th May 2016 and the key internal and external approval requirements were set out in the cover paper. The Board were requested to provide any initial comments and confirm it is compliant with the Code of Governance.

SW noted that the next two weeks were going to be a busy period in finalising the accounts and she was grateful to Brian Dillon and Felicity Merz for agreeing to continue to support the Audit Committee in the interim period. No concerns were raised regarding compliance with the Code of Governance. The Board agreed that any initial comments should be provided to LE.

9.2 2016/17 Annual Plan and APR

RE introduced the update. The narrative plan needed to reflect the outputs of the finalised financial plan. An updated version of the narrative plan will be finalised once the financial position is established. DH outlined that agreement on the 2016/17 financial position was critical and that the Annual Plan and APR would follow.

Resolved: that the Board noted the Report and that any concerns should be provide to RE by close of play 6th May.

9.3 Month 12 Finance Report

IL summarised the end of year position. The trust finished the year with an end of year deficit of £55.1m. This was in line with the latest forecast and £1m better than the revised budget. Pay budgets have continued to underspend and these have been partially offset by continuing underperformance on SLA income and higher than expected penalties. CIPs delivered £41.5m compared to the plan of £43.1m. The cash balance was £4.4m better than plan and the working capital facility was £11.8m lower than expected so the overall cash position was £16.2m better than plan. The trust's overall risk rating in March was 2. NC updated the Board and provided assurance that significant work had been completed into ensuring the year end position 'cut off' in term of expenditure.

Resolved: that the Board noted the position and assurance provided

9.4 2016/17 Annual Plan

NC introduced the report which detailed the action that had been taken to align the final budget with the control total of £17.2m. The approach taken had been to challenge costs over and above the level of funded development. This process has reduced projected costs by around £20m. A further £6m of unallocated savings have been added to transformational savings line as a balancing item however this remains a significant reduction in the initial level of savings identified. The total level of savings requirement is £35.5m, with gross benefits of £42.2m and non-recurrent implementation costs of £6.7m. The budget excludes any provision for addressing the significant estate and IT infrastructure challenges where separate discussions are on-going with NHSI. The budget does not include an assumed asset disposals. Funding a deficit of this size is within the trust's existing finance facilities however there is only £0.8m of headroom. Therefore additional facilities may be required. There remains a risk that NHSI revises the control total down however the trust has on balance more downside than upside risk.

The Board discussed a range of significant risks and outstanding issues including: the need to finalise the position on CQUINN funding; addressing services which are not currently funded by commissioners over the longer term; the risks around liquidity and the challenge of negotiating additional cash facilities; the reliance on meeting the trajectories to secure the STF funding; and the capacity implications of a 12% increase in elective activity.

DH was pleased with the progress that had been made both in terms of understanding the budget position and in recalibrating the transformation programme. This will enable the trust to enter discussions with commissioners on a firm foundation and at a strategic level. Further work, however, will be required to bridge the funding gap and driving forward the work on transformation while integrating it within the core trust business. IL noted that significant effort had been undertaken to produce new transformation plans and steps were being taken to strengthen project delivery.

SW noted that the planned capital allocation was lower than the allocation in 2015/16. IL outlined that the existing capital budget met the known requirements. Further work was on going to determine the level of additional funding required for catch up maintenance and the resource consequentials of any major capital projects. This as previously noted was subject to a separate set of discussions.

NC indicated that the next phase of the work was to finalise the budgets at divisional level and that some discretion was required to settle the final numbers and any adjustments required. Formal budget delegations would then follow. The phasing of benefits would also need to be considered as part of the budget setting process and it was likely that this would result in a backloading of benefits.

Resolved: that the Board approved the budget noting the risks and next steps.

10 Risk and Compliance

10.1 JH introduced the report. She noted that two additional risks have been included: loss of trust data due to malware; and the risk of to the successful delivery of the turnaround/transformation programme in the event there is a lack of engagement across the workforce. Two risks previously identified are undergoing risk assessments. Preparations for the CQC inspection were on-going and a detailed information request was returned to the CQC on 19th April. An external Sterile Service Department Inspection had been undertaken been 29th February and 4th March 2016. Two minor non conformities were identified. Information on corrective actions was provided and the external company (Interk) approved the accreditation.

SW noted that the fire risk rating score (03-01) was too low in view of known issues regarding Lanesborough Wing and that closing the working capital risk (3.14-05) did not seem appropriate in view of the discussion on 2016/17 financial plans. RH and IL agreed to review these points and provide revised scores to JH for incorporation on the risk register. NW asked that the wording of the theatre risk (01-13) be reviewed to incorporate efficiency as well as capacity. **JH June 16**

DH indicated that work would be undertaken to review the risk register as the current process was insufficiently robust and was not adequately capturing the critical issues, for example estates. This would be developed over the coming months.

Items for Information

11. Use of the Trust Seal

The seal was not used in April.

12. Questions from the Public

Barbara Bohana asked whether the Board would be able to set out the process in place to inform and engage with patients around planned service reduction and changes. She expressed her concern that the trust had not done so effectively in the past. DH answered that the trust was focused on establishing the baseline and the current position and then need to work with other across the system to identify options and understand the impacts on patients. He provided assurance that this would be done in a measured and thoughtful way and the proper path for consultation exercises would be followed.

13. Date of next meeting

The next scheduled meeting of the Board to be held in public will be 2nd May 2016.

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
2 June 2016

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 2 June 2016
8.4	14 Jan 16	One Version of the Truth	6 month update	July.16	C Siddall	Due July 2016
8.3	14 Jan 16	Update on Outpatient additional activity income	The strategy had a set of trajectories and KPIs. More granular patient focused KPIs are being developed by the Outpatient Strategy Board. An update on progress.	May16	A Rhodes	Will be covered within the outpatient strategy update for April 16 Due to pressure on the agenda the item was deferred to the May Board **Verbal update to be given at meeting**
7.	3 Mar 16	Urogynaecology Report	It was agreed that the Board would receive an update in 2-3 months' time.	June 16	A Rhodes	**ON AGENDA**
12.	3 Mar 16	Outpatients Recovery Plan Update	Outpatients Strategy due at April meeting.	May 16		Due to pressure on the agenda, has been deferred to May **ON AGENDA**
13.	7 April 16	Workforce and Performance Report	Provide a clarification around the 35% vacancy factor reported for the SWLP	April 16	W Brewer	
10	7 April 16	Key Trajectories - RTT	Written report on RTT to be submitted to the board	July 16	C Siddall	
23.	7 April 16	Report from the Audit Committee	That diagnostic follow up tests is a significant risk and a report on progress is scheduled for Board with regular progress reports to the QRC thereafter; and Board	TBC	S Mackenzie	
10	7 April 16	Key Trajectories	The expectation was that the trust would be sustainably hitting all seven standards	TBC	C Siddall	
6.1	5 May	Estates Plan including Renal Development	A more detailed proposal would be presented to the Board in June 2016 for agreement. This would include a return on investment analysis and be supported by a full service review.	June 16	R Hancock	**ON AGENDA**
7.1	5 May 16	Patient Safety, Quality and Performance	To submit a complaints action plan for approval	June 16	J Hall	**ON AGENDA**

7.1	5 May 16	Patient Safety, Quality and Performance –Quality Report	Work to be undertaken to simplify and improve the performance quality report	TBC	J Hall	
7.4	5 May 16	Frequent A&E Attenders	Proposed new approach to facilitate alternative planned care away from Emergency Department. Wandsworth CCG have developed an initiative to manage the top 500 patients who attended A&E over 6000 times in 2015/16. The trust proposes to support the initiative and develop a programme building on the approach adopted by the Homerton Hospital and working in partnership with Wandsworth CCG and Merton CGG. AB to share detailed analysis with NW	June 16	A Benincasa	The programme is still in the development phase so nothing as yet to brief the Board on. At future board meetings feedback should come as part of the wider flow programme rather than a separate update.
7.5	5 May 16	PPI/PPE Strategy	Board agreed with the Strategy. JH to set out an action plan working with Patient representatives.	Aug16	J Hall	
8.	5 May 16	Strategy – Update on Outpatient Strategy	A paper outlining next steps on implementing the recommendations from the review is tabled at the June Board	June 16		**ON AGENDA**
8.	5 May 16	Strategy – Update on Outpatient Strategy	The Outpatient Strategy Review should be circulated in correspondence after it had been discussed at EMT on 9 May; and	June 16	I Lynam	**ON AGENDA**
8.4	5 May 16	2015/16 Annual Plan Q4 Review and End of Year Summary	RE introduced the report and indicated that the report detailed a number of achievements set out in the appendix. Overall, however, the overall organisational position is self-assessed as red given the significant impact of those areas that are currently off target. RE agreed to provide an update on the EDM and e-prescribing projects following the Board.	June 16	I Lynam	

10.	5 May 16	Risk and Compliance Report	It was noted that the fire risk rating (03-01) looked low in view of known issues regarding Lanesborough Wing and that closing the working capital risk (3.14-05) did not seem appropriate in view of the discussion on 2016/17 financial plans. RH and IL agreed to review these points. NW asked that the wording of the theatre risk (01-13) be review to incorporate efficiency as well as capacity	June 16	J Hall / S Maughan	

REPORT TO TRUST BOARD **Paper ref:**

Paper Title:	Quality and Performance Report to Month 1- April 2016
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Andrew Rhodes - Acting Medical Director Corinne Siddall -Chief Operating Officer
Authors:	Jennie Hall- Chief Nurse/ DIPC Andrew Rhodes - Medical Director Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Head of Performance
	To inform Board about Quality and Operational Performance for Month 1.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	Finance and Performance Committee QRC

Executive summary

Key Points of Note for the Board to note in relation to April Performance:

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

(Note: Cancer performance is reported one month in arrears, thus March performance is reported in April)

Cancer Two Week Wait Standard
The trust did not meet the 93% standard in March with performance of 91.0%. The standard was not met due to underperformance in the following specialties: Gynaecology, Lung, Skin and Upper GI. Key reasons cited for breaches were patient choice and capacity constraints. The trust is working with commissioners to improve communications with patients in a primary care setting. To support this, patient information leaflets were launched by Merton CCG this month.

Specialties are working to address capacity shortfalls, in particular; Gynaecology who have increased OP capacity with effect from May and Skin who have agreed additional capacity to meet summer demand commencing from June 2016.

Cancer 62 Day Standard
The trust did not meet the 85% standard in March with performance of 82.6%. The standard was not met due to underperformance in the following specialties: Gynaecology, Head and Neck, Lung, Upper GI and Skin. Key reasons cited for breaches were: patient choice, capacity constraints, delays in working-up patients, referrals being received from other trusts with no information and a number of patients being on complex diagnostic pathways.

The trust is undertaking weekly conference calls with referring trusts to address key issues pertaining to quality of referrals. This is also being reviewed at the SWL Cancer forum.

Specialty teams are reviewing capacity constraints .Gynaecology capacity, in particular for OP and

hysteroscopy is an issue. As mentioned above increased OP capacity is due to come live from May 2016 and plans to increase hysteroscopy capacity are currently being reviewed. In relation to capacity the trust are also reviewing the increased pressure on the trust from the SWL Head and Neck Pathway and CT Colonography capacity constraints.

Diagnostics 6 Week Waiting Time Standard
The trust did not meet the diagnostics wait standard in April with performance of 2.08% with a total of 148 patients waiting greater than six weeks for a diagnostic test. The standard was not met due to underperformance in the following specialties: Paediatric Ultrasound and Gynae non-obstetric ultrasound. Key reasons cited for breaches were: staffing capacity constraints, increased demand for the service, staff sickness and associated administrative issues.

The trust has now added additional capacity for Paeds Ultrasound via the appointment of a locum consultant and for Gynae non-obstetric ultrasound via additional lists being secured using agency staff. However, there are some future risks to diagnostic performance, namely the loss of capacity for Paeds Ultrasound between July and August due to two SPRs rotating out. The service is trying to increase capacity by utilising current resource differently to mitigate this.

RTT Incomplete Pathways Standard
The trust did not meet the 92% standard in April with performance of 89.47%. However, the backlog has reduced by 60 patients since last month.

The trust reported 7 patients waiting 52+weeks at end April. These were in the following specialties: Paediatric surgery, T&O, Gynaecology, Gastroenterology, Thoracics. Root cause analysis investigations are currently being completed for these patients.

RTT remains a challenge and the trust acknowledges the importance of not just reducing long waiters but achieving a position of sustainability. The trust following work with the IST has developed a trajectory for performance recovery for 2016/17. A supporting recovery and sustainability action plan to deliver the trajectory has been developed and is currently under review with commissioners. The plan details the operational and process changes required to deliver sustainability and improve the management of patient pathways. The action plan alongside the Trust and speciality based trajectories were submitted in April and is appended (to follow).

However, following the original submission the trust in support with commissioners and NHSE have commissioned an external review of RTT. It has been agreed that the trust will review and revise its recovery action plan and supporting trajectories following the review and have them agreed with commissioners and NHSE by the end of Q1. The Board will be formally updated in July following the report from the external review.

ED 4 Hour Standard
The trust did not meet the 95%standard in April with performance of 89.7%. Key details in relation to the underperformance are as follows:

The trust did not meet the diagnostics wait standard in April with performance of 2.08%. Key details in relation to the underperformance are as follows:

- Performance was below the target at both the weekly and monthly level. However, performance saw an increase of 3.20% compared to March position.
- Contributing factors to ED performance were: Capacity and bed flow, increase in number of DTOC patients and an increase in the number of patients who were medically fit for discharge. These included patients awaiting transfer to another provider and patients going home that day. The trust is working with commissioners and external agencies to expedite this.
- The trust continues to implementing its recovery action plan which comprises of 10 themes linked to the OVOT.

The trust monitors progress against its recovery plan and trajectory with both external and executive oversight via the Flow Programme Board. The trust was also ahead of their submitted trajectory in April of 88.82%.

The trust shows the quality governance score against the Monitor risk assessment framework of 5 and the Monitor imposed additional license conditions in relation to governance remain.

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 April Quality Performance:

The report highlights the key quality metrics which have been reported during 2015/16 against the domains of safety, effectiveness and outcomes.

In terms of Quality Metrics, the overall position in April remains consistent with the profile of the previous quarter in terms of the trends for the metrics with some moderate improvement across a number of indicators.

Effectiveness Domain:

- Mortality HSMR performance remains statistically better than expected for the Trust. Mortality remains in line with expected for admissions at the weekend and for emergency weekday admissions is better than expected. The SHMI position for the period October 14 to September 15 is now categorised "as expected". QRC will note the proactive programme of work led by the Mortality Committee.
- National Audits within the report: The results of the End of Life Care audit are shown. The audit indicates the Trust position against national benchmarks which shows the Trust is be fully compliant with 2 out of 5 of the benchmarks with the Trust performing better than average of 4 out of 5. The report indicates the actions the EOLC programme board is taking. The national PCI audit indicates the profile for SGH in relation to data completeness and information about aspects of the pathway of care for patient undergoing PCI. The Trust is performing well in relation to Primary PCI being carried out within 72 hours but slightly below the national average for the 90 minute standard. Finally the national sentinel stroke Audit indicates a positive rating for the HASU with a good rating for the stroke unit. Improvements are seen across a range of actions for the stroke unit.
- The Local Audit in relation to use of the WHO checklist has been considered by the PSC and actions are being taken forward to improve compliance for specialities where standards are not been consistently met. It is a concern that the Trust has not yet reached a consistent position for this key safety practice.

- The report indicates the position with compliance with NICE guidance for the period June 2010 to December 2015. The Board will note the actions being taken to review the current position with NICE compliance by July 2016 and the improved response profile in the last two months.

Safety Domain:

- The number of general reported incidents in April indicates a similar trend in terms of numbers and level of harm, however absolute numbers were higher in April.
- Safety Thermometer performance is 95.11% slightly above the national average for that month. There is a reduction in new harms from the previous month.
- No further MRSA bacteraemia cases were reported for April with no new cases since Mid-September 2015. One C Difficile case was reported in April. All cases are currently subject to an RCA process.
- Following validation of the Safeguarding Children data the compliance for the Trust is now 85% at level 3. This is the required standard and focus will now be on the maintenance of the standard. Safeguarding Adults compliance for training remains a key area of focus. The Trust is now demonstrating a compliance of 81% for adult training, with a continuing improving profile over the last 3 months. The board will note that the numbers of staff to be trained is known and there are agreed actions both for adult safeguarding which is being monitored by the respective safeguarding Committee. .

Experience Domain:

- The FFT data has been re-profiled to indicate Patient feedback in relation to likely/ very likely to recommend a service. This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient that would have trouble understanding the standard survey question. Further breakdowns are available for services and location type. The overall annual position indicates that 94% of patients were extremely likely or likely to recommend a service to family or friends.
- The complaints profile in relation to numbers is consistent; however the performance profile within the Divisions is of significant concern. An action Plan has been agreed following a Trust wide workshop to understand the key blocks to delivering of the performance targets

and to support learning from complaints. This is being presented to the committee today. Learning from complaints during Quarter Four is also outlined in the report.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 94.52 % 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 April is included this month for Community services.

During this month one clinical ward area remained in escalation to support further intervention in relation to the staffing profile and to support some aspects of clinical practice. There is a plan being led by the Division which coordinates all of the intervention actions. This is being overseen by the Chief Nurse.

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 and Quality Report For Trust Board

Month 1 – April 2016

Excellence in specialist and community healthcare

CONTENTS

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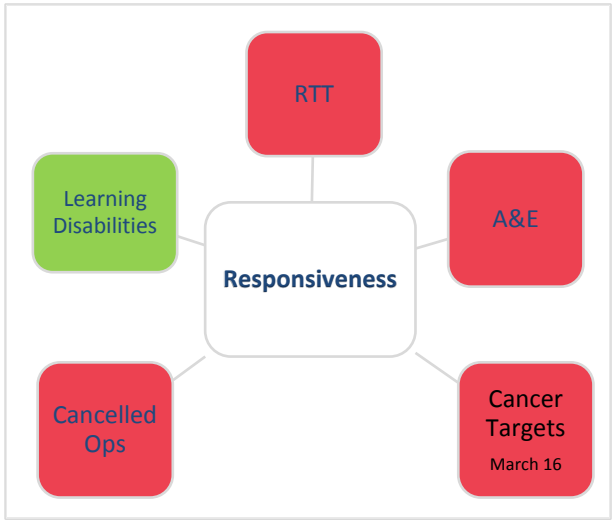
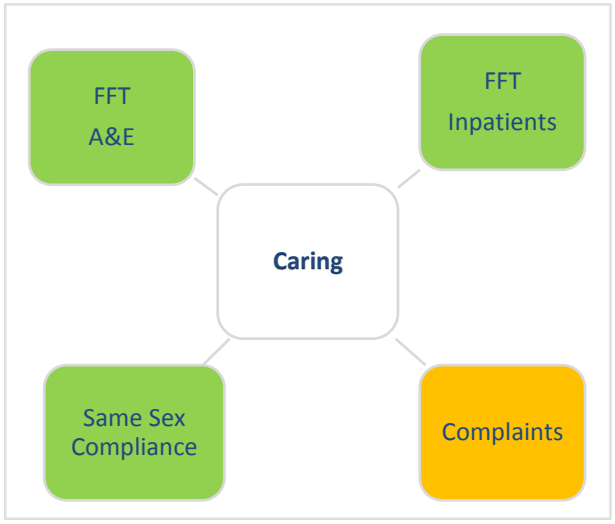
St George's University Hospitals NHS
NHS Foundation Trust

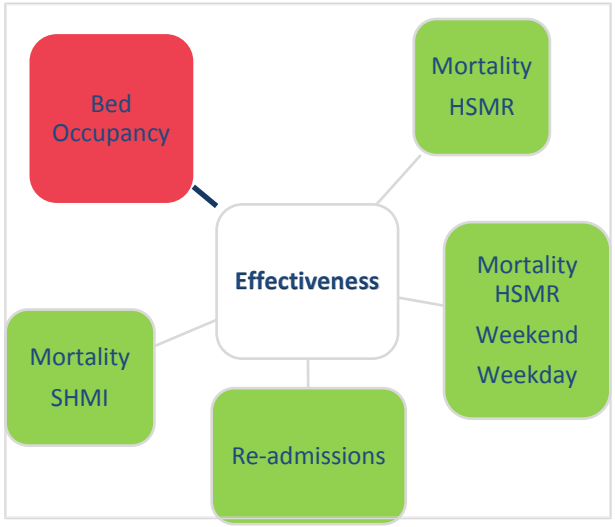
Performance against Frameworks

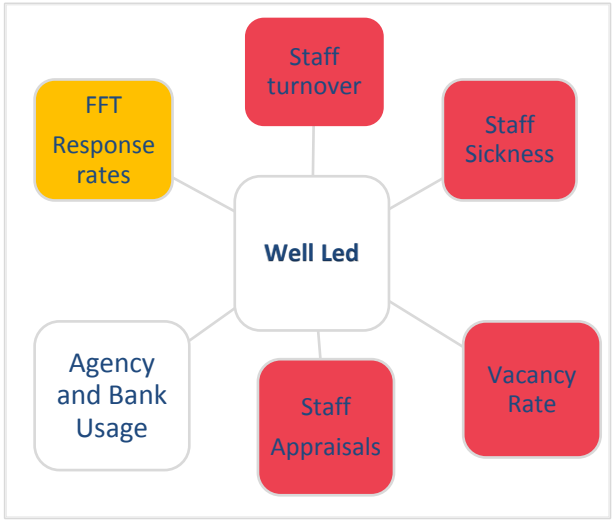
Excellence in specialist and community healthcare

1. Executive Summary - Key Priority Areas April 2016*









The above shows an overview April 2016 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 March 2016 as reported one month in arrears)

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

2. Monitor Risk Assessment Framework KPIs 2016/17: April 2016 Performance (Page 1 of 1)

ACCESS

Metric	Standard	Weighting	Score	YTD	Mar-16	Apr-16	Movement
Referral to Treatment Admitted	90%	N/A	N/A		78.00%	75.80%	-2.20%
Referral to Treatment Non Admitted	95%	N/A	N/A		90.90%	88.80%	-2.10%
Referral to Treatment Incomplete	92%	1	1		88.02%	89.47%	1.45%
A&E All Types Monthly Performance	95%	1	1	89.32%	86.50%	89.70%	3.20%
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q3**	**Q4**	**Movement**
62 Day Standard	85%	1	1	82.52%	85.50%	82.95%	-2.54%
62 Day Screening Standard	90%			90.44%	94.25%	90.16%	-4.09%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	96.56%	97.87%	95.89%	-1.98%
31 Day Standard	96%	1	0	97.05%	97.83%	95.02%	-2.80%
Two Week Wait Standard	93%	1	1	87.75%	88.24%	91.72%	3.47%
Breast Symptom Two Week Wait Standard	93%	1		93.42%	93.78%	95.35%	1.58%

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Mar-16	Apr-16	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	1	1	1	0
Certfication of Compliance Learning Disabilities;							
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant	1	0	Yes	Yes	Yes	
Data Completeness Community Services:							
Referral to treatment * data is for Oct and Nov 2015	50%	1	0		54.7	54.7	0.0
Referral Information	50%	1	0		87.7	87.6	-0.1
Treatment Activity	50%	1	0		70.37	71.2	0.8
Trust Overall Quality Governance Score					**4**	**5**	1

April 2016 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 5 and Monitor have imposed additional license conditions in relations to governance.

Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- Cancelled Operations
- RTT
- Cancer Waits

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

*Cancer Data is reported a month in arrears. Q4 relates to period Jan to Mar-16.

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 2016/17: April 2016 Performance (Page 1 of 1)

RESPONSIVENESS

Metric	Standard	YTD	Mar-16	Apr-16	Movement
Referral to Treatment Admitted	90%		78.00%	75.80%	-2.20%
Referral to Treatment Non Admitted	95%		90.90%	88.80%	-2.10%
Referral to Treatment Incomplete	92%		88.02%	89.47%	1.45%
Referral to Treatment Incomplete 52+ Week Waiters	0	24	1	7	6
Diagnostic waiting times > 6 Weeks	1%		0.86%	2.03%	1.17%
A&E All Types Monthly Performance	95%	89.7%	86.5%	89.7%	3.19%
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%		15.30%	14.30%	-1.00%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Feb-16	Mar-16	Movement
62 Day Standard	85%	82.52%	81.70%	82.60%	0.90%
62 Day Screening Standard	90%	90.44%	90.30%	93.50%	3.20%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	96.5%	94%	95.2%	0.80%
31 Day Standard	96%	97.01%	97.70%	96.60%	-1.10%
Two Week Wait Standard	93%	87.75%	93.20%	91.00%	-2.20%
Breast Symptom Two Week Wait Standard	93%	93.44%	95.40%	93.70%	-1.70%

EFFECTIVENESS

Metric	Standard	YTD	Mar-16	Apr-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		87.5	86.5	-1.00
Hospital Standardised Mortality Ratio - Weekday	100	0	87.0	84.3	-2.7
Hospital Standardised Mortality Ratio - Weekend	100	0	91.0	85.0	-5.97
Summary Hospital Mortality Indicator (HSCIC)	100	0	0.90	0.91	0.0
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%	3.10%	3.30%	TBC	
Bed Occupancy - Midnight Count Generl Beds Only	85%		97.0%	97.6%	0.6%
LOS - Elective			3.68	4.6	0.9
LOS - Non-Elective			4.83	5.7	0.87

CARING

Metric	Standard	YTD	Mar-16	Apr-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		93.11%	95.75%	2.64%
A&E Scores - Friends & Family Recommendation Rate	46		80.61%	82.29%	1.68%
Complaints (1 month in arreas)			79	63	-16
Mixed Sex Accomodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Mar-16	Apr-16	Movement
Clostridium Difficile - Varience from plan	31	1	1	1	0
MRSA Bacteramia	0	0	0	0	0
Never Events	0	0	0	0	0
Serious Incidents	0	13	12	13	1
Percentage of Harm Free Care	95%		94.6%	95.1%	0.5%
Medication Errors causing serious harm	0	0	1	2	1
Overdue CAS Alerts	0	2	2	2	0
Maternal Deaths	1	0	2	0	-2
VTE Risk Assessment (previous months data)*	95%		97.00%		

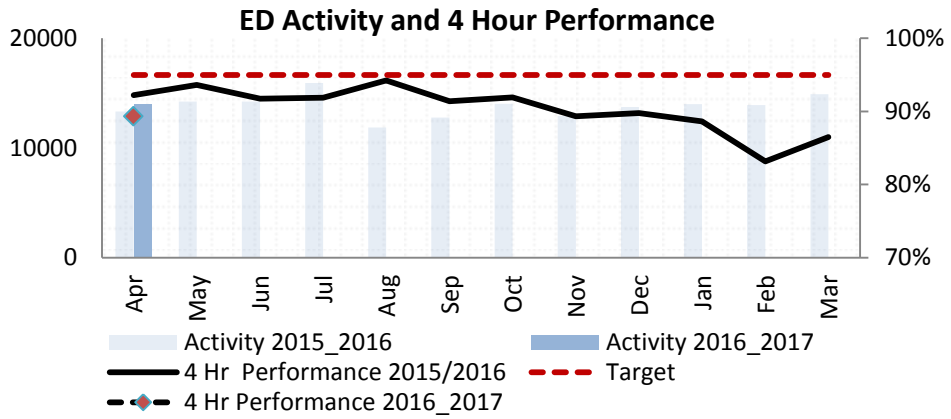
WELL LED

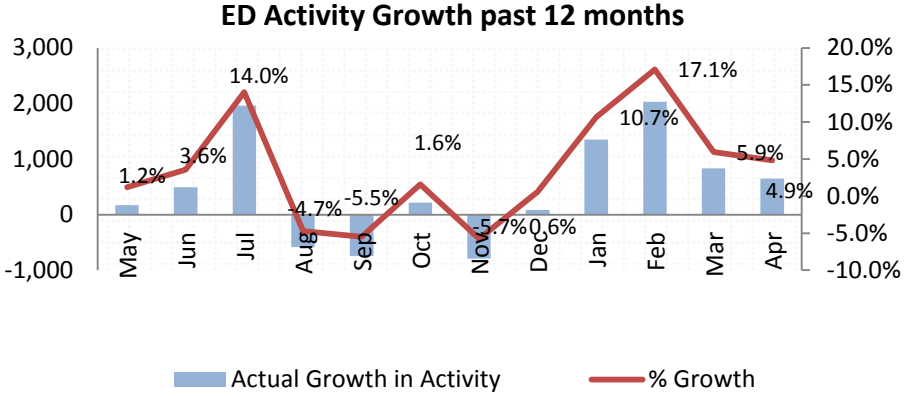
Metric	Standard	YTD	Mar-16	Apr-16	Movement
Inpatient Respose Rate Friends & Family	30%		21.1%	29.9%	8.8%
A&E Respose Rate Friends & Family	20%		25.0%	25.3%	0.3%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		18.1%	19.3%	1.2%
Trust level sickness rate	3.5%		3.7%	4.1%	0.4%
Total Trust Vacancy Rate	11%		16.7%	20.0%	3.3%
% of staff with annual appraisal - Medical	85%		84.2%	82.9%	-1.29%
% of staff with annual appraisal - non medical	85%		67.3%	66.6%	-0.71%

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.

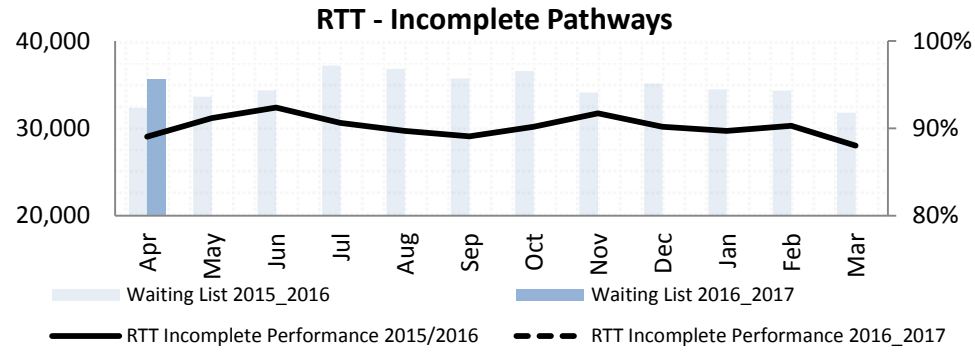
3. Trust Key Performance Areas and Activity Comparison to previous year (1 of 2)

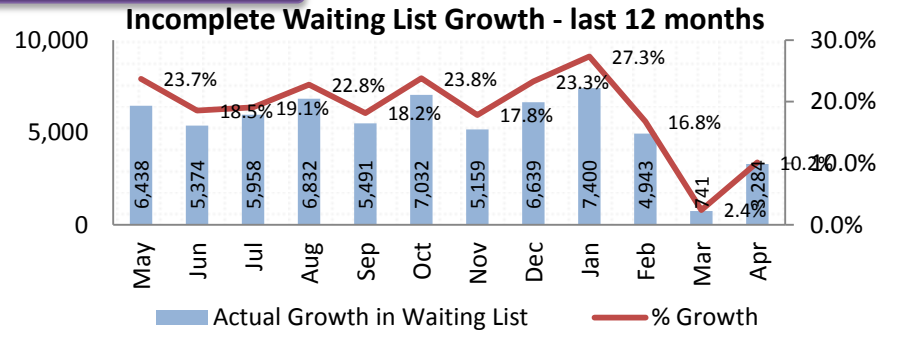
ED Performance

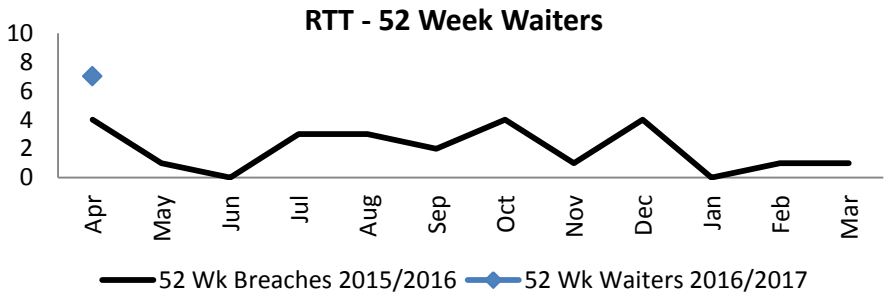


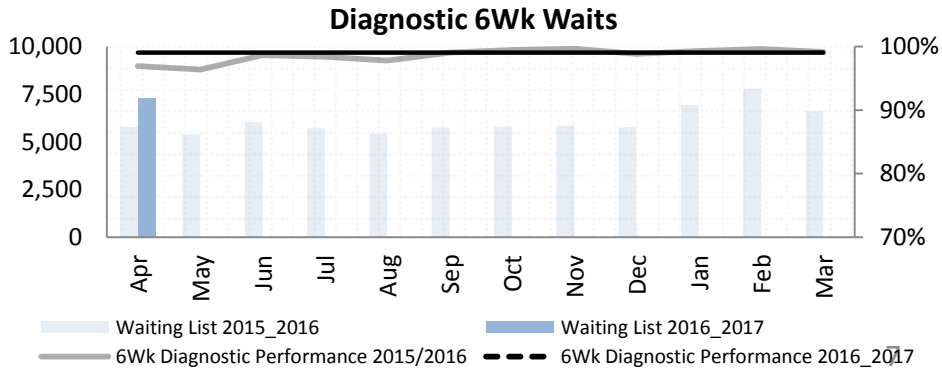


RTT & Diagnostics



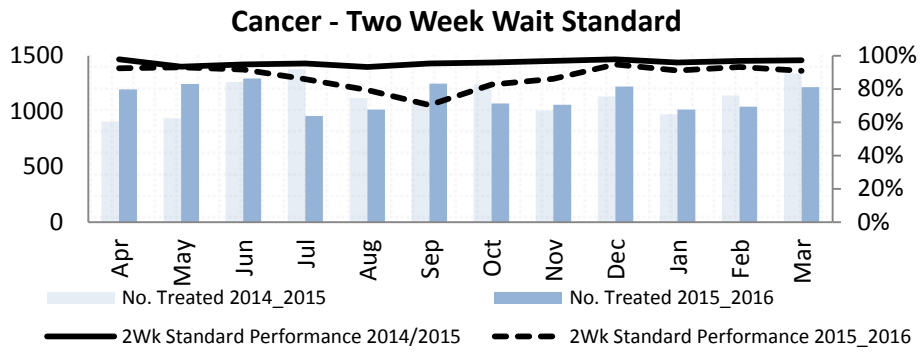


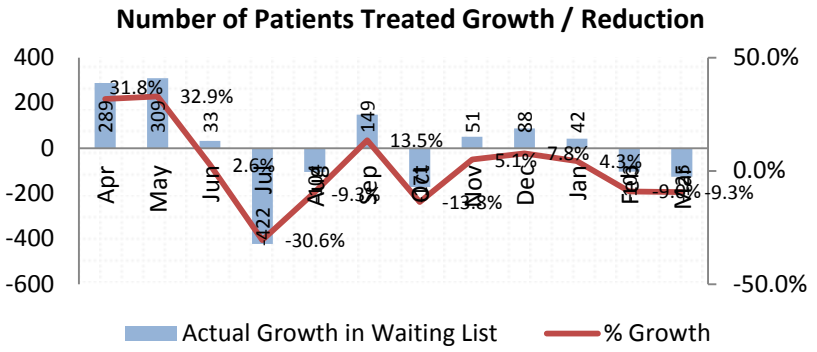




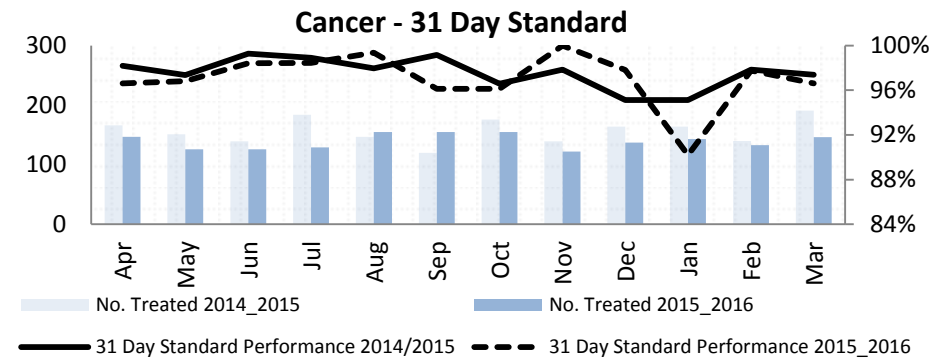
3. Trust Key Performance Indicators and Activity Comparison to previous year (2 of 2)

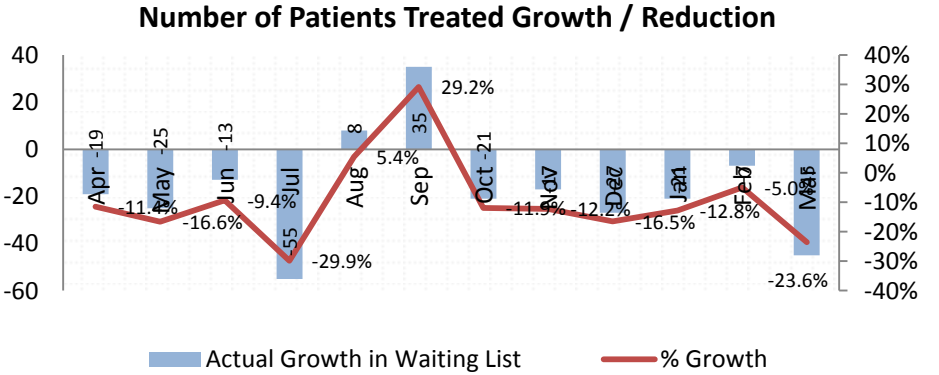
Cancer - Two Week Wait Standard



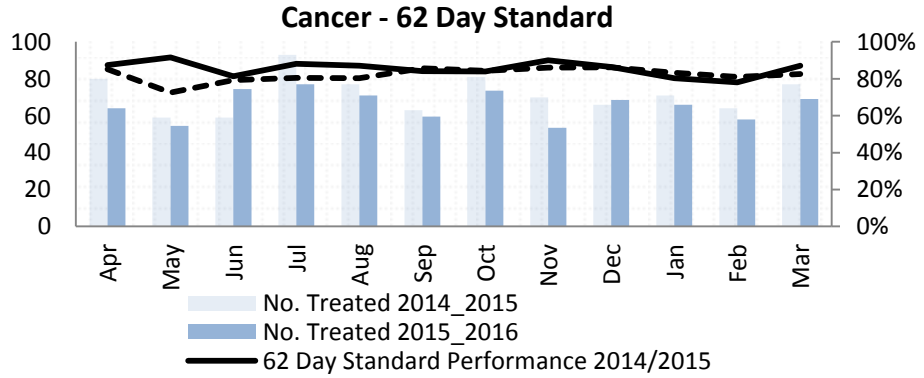


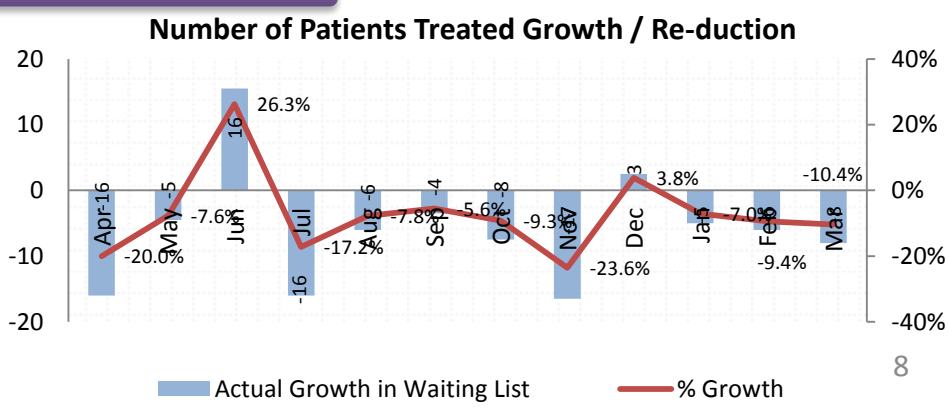
Cancer - 31 Day Standard





Cancer - 62 Day Standard





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Performance – areas of escalation

Excellence in specialist and community healthcare

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

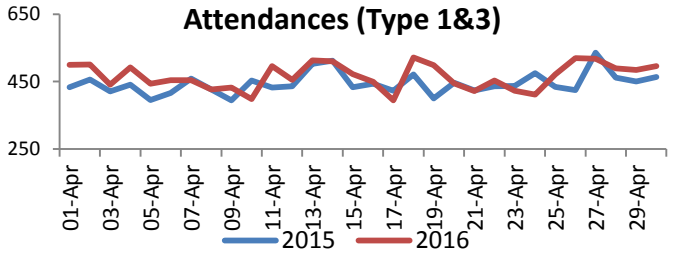
Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	Mar-16	Apr-16	Movement	2016/2017 Target	Forecast for Apr-16	Forecast for May-16	Date expected to meet standard
FA	86.50%	89.70%	⇧ 3.20%	>= 95%	R	R	TBC

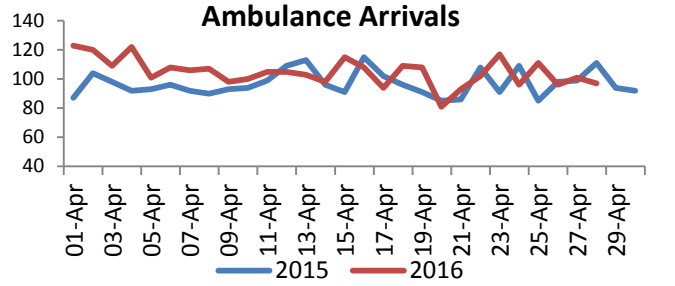
Peer Performance March 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
5	3	1	4	2
86.50%	90.60%	92.40%	81.10%	90.90%

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, however great improvement was seen in April achieving 89.70%n within 4 hours which is an increase of 3.20% compared to March.

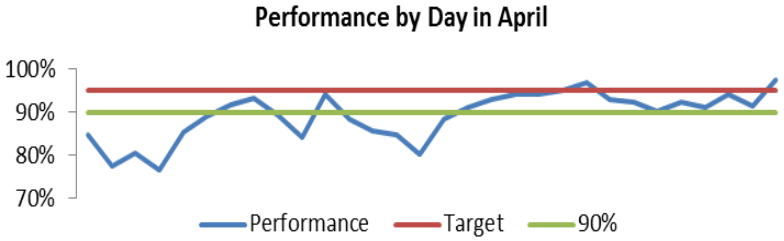
Contributing factors to ED performance were:

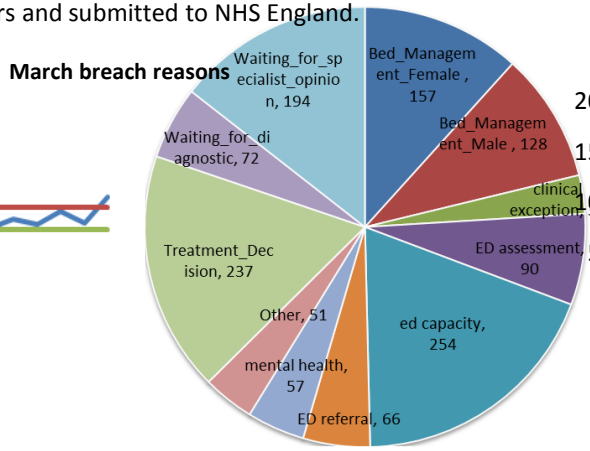
- Capacity and bed flow, with 18.9% of breach reasons attributed to ED capacity, 21.20% waiting for a bed to become available, 17.6% waiting for treatment decision and 14.4% waiting for specialised opinion as summarised in the chart below.
- An increase in the numbers of delayed transfer of care patients (DTOC) in comparison to last month and the level of delay. This 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 19/05/2016 there were 11 DTOC and 31 Non-DTOC patients.
- As at 19/05/2016 there were 71 of 614 (11.5%) patients being tracked within the organisation that were medically fit for discharge. These encompass the DTOC, NDTOC, patients awaiting transfer to another provider and patients going home that day. The trust is working with commissioners and external agencies to expedite this.

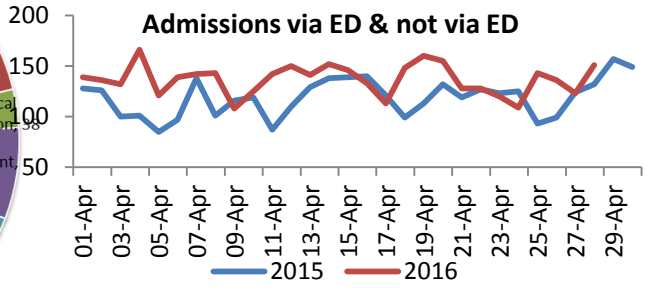




The Trust is implementing it's recovery action plan which comprises of 10 themes linked to the OVOT. A submitted trajectory has also been agreed with commissioners and submitted to NHS England.



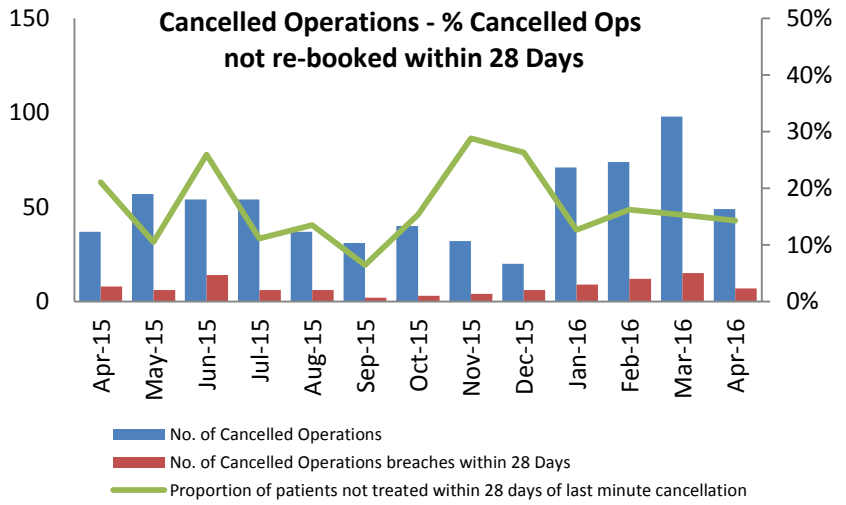


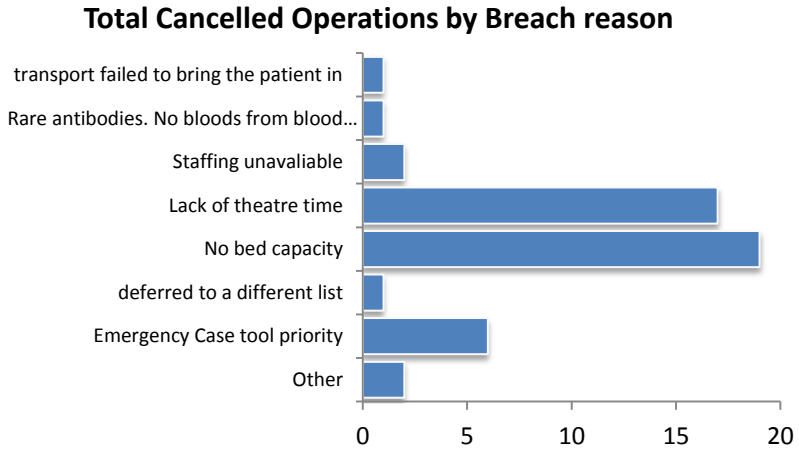


4. Performance Areas of Escalation (Page 2 of 6) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Mar-16	Apr-16	Movement	2015/2016 Target	Forecast for Apr-16	Forecast for May-16	Date expected to meet standard
CC	15.30%	14.30%	-1.00%	0%	G	G	May-16

Peer Performance Comparison – Latest Available Q4 2015/16				
STG	Croydon	Kingston	King's College	Epsom & St Helier
5	2	3	4	1
23.1%	0.0%	8.7%	11.2%	0.0%





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

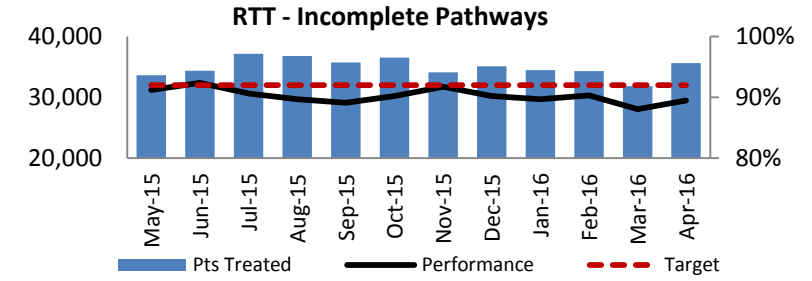
The trust had 49 on the day cancellations from 4,390 elective admissions in April. 42 of those cancellations were rebooked within 28 days with 12 patients not rebooked within 28 days, accounting for 14.3% of all cancellations. There was a decrease of 49 cancelled operations compared to the previous month. The majority of cases were cancelled due to bed availability, emergency cases, and list's over running / lack of theatre time.

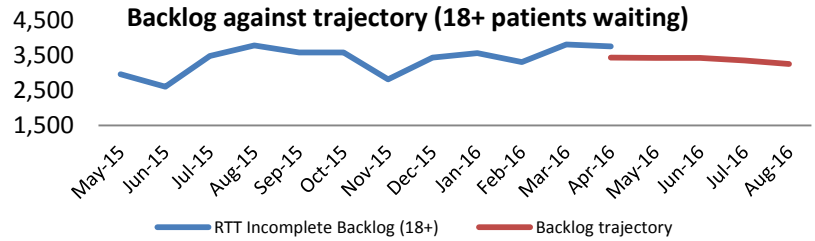
Q4 Performance for the Trust was 23.1% with a total of 58 cancelled operations not being re-booked within 28 days, the Trust reported the highest numbers compared to all London Trusts.

4. Performance Areas of Escalation (Page 3 of 6)
- RTT Incomplete Pathways

Referral to Treatment Incomplete Pathways							
Lead Director	Mar-16	Apr-16	Movement	2016/2017 Target	Forecast for Apr-16	Forecast for May-16	Date expected to meet standard
CS	88.02%	89.47%	↑ 1.45%	92%	R	R	Mar-17

Peer Performance March 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1		3
88.02%	95.40%	96.60%	80.40%	92.00%





The Trust has been non-compliant against RTT incomplete pathways for a number of months. April 2016 performance increased by 1.45% reporting 89.47% with the number of patients above 18 weeks reducing by 2% (60 patients). The total waiting list size at the end of April has seen an increase by 12%, this increase needs to be reviewed, a component to this is data quality of pathways less than 6 weeks. The increases are mainly within the Surgical specialties including Gynaecology.
There are a number of specialties shown in the table below who remain challenged with performance below target of 92%.

The number of 52 week breaches increased to 7 patients reportable in April's performance., consisting of Paediatric Surgery, Trauma & Orthopaedics, Gynaecology, Gastroenterology (3) and Thoracic. Root cause analysis investigations have commenced.

RTT remains a challenge and the trust acknowledges the importance of not just reducing long waiters but achieving a position of sustainability. The trust following work with the IST has developed a trajectory for performance recovery for 2016/17. A supporting recovery and sustainability action plan to deliver the trajectory has been developed and is currently under review with commissioners. The plan details the operational and process changes required to deliver sustainability and improve the management of patient pathways. Further to the plan the Trust is currently reviewing options for additional support to aid recovery.

	Waiting List Size						Backlog Size (18+)						Performance				
Specialty	Jan-16	Feb-16	Mar-16	Apr-16	Var	Var%	Jan-16	Feb-16	Mar-16	Apr-16	Var	Var%	Jan-16	Feb-16	Mar-16	Apr-16	Var%
Gen Surg	3,311	3062	3091	3545	454	12.8%	383	343	400	410	10	2%	88.4%	88.80%	87.06%	88.43%	1.4%
Urology	1,600	1593	1456	1664	208	12.5%	167	177	208	205	-3	-1%	89.6%	88.89%	85.71%	87.68%	2.0%
T&O	3,178	3130	2850	3298	448	13.6%	572	560	577	580	3	1%	82.0%	82.11%	79.75%	82.41%	2.7%
ENT	2,981	2960	3105	3516	411	11.7%	518	522	666	743	77	10%	82.6%	82.36%	78.55%	78.87%	0.3%
Ophthalmology	269	264	267	271	4	1.5%	2	7	25	17	-8	-47%	99.3%	97.35%	90.64%	93.73%	3.1%
Oral Surgery	1,927	2076	1987	2075	88	4.2%	39	49	42	60	18	30%	98.0%	97.64%	97.89%	97.11%	-0.8%
Neurosurgery	915	976	748	904	156	17.3%	51	37	50	59	9	15%	94.4%	96.21%	93.32%	93.47%	0.2%
Plastic Surgery	1,126	1141	1057	1060	3	0.3%	169	137	179	183	4	2%	85.0%	87.99%	83.07%	82.74%	-0.3%
Cardiothoracic	348	349	332	312	-20	-6.4%	109	119	117	103	-14	-14%	68.7%	65.90%	64.76%	66.99%	2.2%
General Medicine	617	661	630	815	185	22.7%	32	23	46	40	-6	-15%	94.8%	96.52%	92.70%	95.09%	2.4%
Gastroenterology	2,375	2402	2233	2559	326	12.7%	381	296	335	347	12	3%	84.0%	87.68%	85.00%	86.44%	1.4%
Cardiology	1,702	1656	1669	1821	152	8.3%	102	85	114	128	14	11%	94.0%	94.87%	93.17%	92.97%	-0.2%
Dermatology	2,645	2542	2503	2874	371	12.9%	279	279	276	221	-55	-25%	89.5%	89.02%	88.97%	92.31%	3.3%
Thoracic Surgery	933	1064	942	990	48	4.8%	77	119	122	73	-49	-67%	91.7%	88.82%	87.05%	92.63%	5.6%
Neurology	1,225	1171	901	968	67	6.9%	30	33	20	15	-5	-33%	97.6%	97.18%	97.78%	98.45%	0.7%
Geriatric Medicine	37	33	30	22	-8	-36.4%	0	0	1	1	0	0%	100.0%	100.00%	96.67%	95.91%	-0.8%
Rheumatology	1,031	983	849	978	129	13.2%	39	38	49	40	-9	-23%	96.2%	96.13%	94.23%	95.45%	1.2%
Gynaecology	2,903	3023	2497	3083	586	19.0%	453	328	375	297	-78	-26%	84.4%	89.15%	84.98%	90.37%	5.4%
Other	5,344	5254	4671	4871	200	4.1%	164	163	211	231	20	9%	96.9%	96.90%	95.48%	95.26%	-0.2%
Total	34,467	34340	31818	35626	3,808	10.7%	3,567	3315	3813	3753	-60	-2%	89.7%	90.35%	88.02%	89.47%	1.4%

4. Performance Areas of Escalation (Page 4 of 6) - Cancer 62 Day Pathway

Cancer Performance								Peer Performance Latest Published March 2016				
Lead Director – CC	Feb-16	Mar-16	Movement	2015/2016 Target	Forecast for Mar-16	Forecast for Apr-16	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
62 Day Wait Standard	81.70%	82.60%	-1.36%	85%	G	R	Jul-16	82.60%	89.60%	99.11%	88.06%	82.57%

62 Day Standard

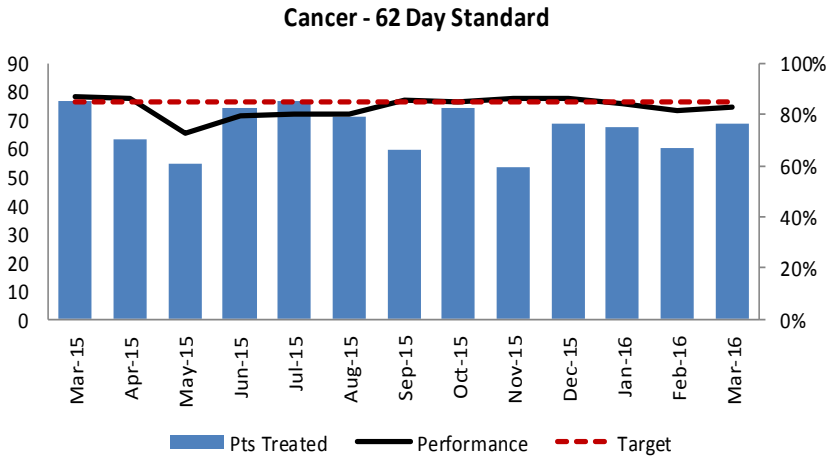
The trust was non compliant against 2 cancer target in March, the 62 Day standard and 14 Day standard.

There were a total of 12 reported breaches with the standard not being achieved in Gynae (2 breach), Head & Neck (2 breach), Lower GI (1 breach), Lung (2 breaches), Upper GI (1.5 breaches) or Skin (2 breaches).

Following continued under performance within the 62 day pathway, the Trust are in the process of revising the 62 day trajectory with NHSE and commissioners. The Trust continues to follow the agreed recovery primarily focused on enhancing PTL development, validation and improving tracking processes. Other areas of key concerns are;

- Theatre maintenance programme
- Gynae OP and Hysteroscopy capacity
- Head and Neck Diagnostic capacity
- Skin demand and minor ops (robust action plan in place to increase capacity)
- CT Colonoscopy capacity

This remains an on-going priority for the Trust and significant work in relation to PTL enhancement has been undertaken which will allow for improved tracking, expediting and forecasting. Weekly tracking meetings are in place reviewing patients to assure that timely treatment plans are in place and expedited where necessary. The Trust continues to implement its recovery and sustainability action plan, which continues to be reviewed weekly via the Trust cancer performance meeting and externally by commissioners and NHSE-London via the Elective System Resilience Group.



	Dec-15	Jan-16	Feb-16	Mar-16
All Types	86.13%	83.30%	81.00%	82.60%
Breast	100.0%	100.0%	100.0%	100.0%
Gynae	33.3%	84.6%	84.6%	60.0%
Haem	80.0%	100.0%	85.7%	92.3%
Head & Neck	50.0%	50.0%	77.8%	50.0%
Lower GI	83.3%	100.0%	75.0%	83.3%
Lung	75.0%	75.0%	70.6%	42.9%
Skin	100.0%	85.7%	66.7%	84.0%
Upper GI	66.7%	0.0%		0.0%
Urological	96.4%	90.0%	85.0%	93.1%

4. Performance Areas of Escalation (Page 5 of 6) - Cancer Two Week Wait

Cancer Performance								Peer Performance Latest Published Mar 2015- 2016				
Lead Director – CC	Feb-16	Mar-16	Movement	2015/2016 Target	Forecast for Mar-16	Forecast for Apr-16	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
14 Day GP Referral for all Suspected Cancers	93.20%	91.00%	-2.20%	93%	G	G	Apr-16	91.00%	97.30%	97.40%	93.30%	89.10%

14 Day Standard

The trust was non compliant against the two week wait target in March with performance of 91.0% against the target of 93%. There were a total of 110 reported breaches in March with the standard not being achieved in the following modalities:

- Gynaecology (27 breaches)
- Lung (3 breaches)
- Skin (36 breaches)
- Upper GI. (10 breaches)
- Children's (2 breaches)

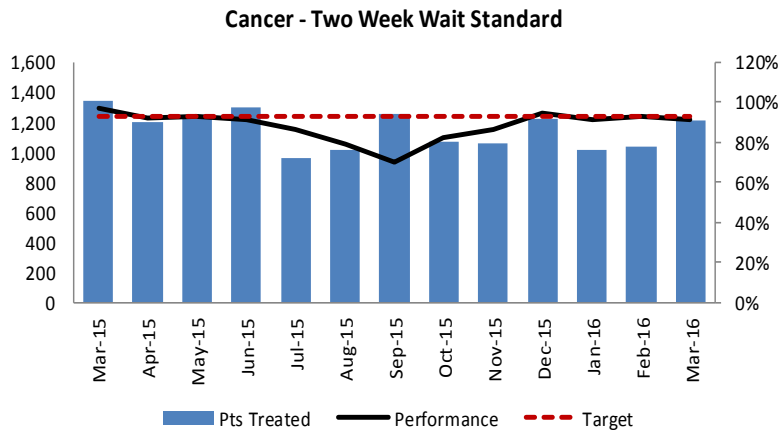
Key reasons for breaches were as follows:

- Patient choice accounting for 64% of all breaches (70 out of 110 breaches)
- Capacity constraints accounting for 35% of all breaches (39 out of 110 breaches)

This is an on-going priority area for the trust and performance is envisaged to be back on track in Q1. Weekly tracking meetings are in place support the expedition of patients where necessary. Key actions to drive performance improvement include:

- Working with NHSE to improve patient awareness and reduce patient choice breaches.
- Increase substantive capacity in key modalities such Skin and Gynae.
- Improve % of patients contacted with 48hours of referral to extend the booking window available.
- PTL development programme to enhance patient tracking and performance forecasting.
- Acquired additional resource within the TWR booking team.

Two week wait standard recovery is part of the Trusts recovery and sustainability action plan, which continues to be reviewed weekly via the Trust cancer performance meeting and externally by commissioners and NHSE-London via the Elective System Resilience Group.



	Dec-15	Jan-16	Feb-16	Mar-16
All Types	94.84%	91.13%	93.17%	90.95%
Breast	96.20%	97.64%	98.08%	93.67%
Gynae	89.00%	62.38%	90.80%	73.27%
Haem	96.15%	100.00%	92.31%	100.00%
Head & Neck	95.24%	97.96%	93.08%	94.31%
Lower GI	96.90%	99.11%	93.86%	97.16%
Lung	100.0%	97.6%	96.8%	92.5%
Skin	93.47%	87.57%	85.49%	87.14%
Upper GI	92.31%	92.68%	98.75%	91.07%
Urological	96.75%	91.38%	96.10%	96.13%
Childrens	100.0%	100.0%	66.67%	71.43%

4. Performance Areas of Escalation (Page 6 of 6) - Diagnostics 6 Week Wait

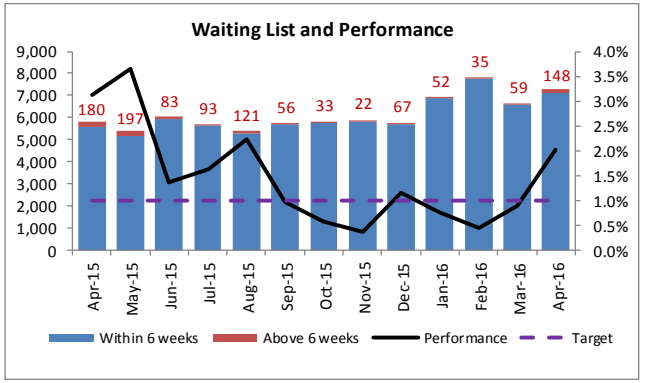
Diagnostic waiting times > 6 weeks							
Lead Director	Mar-16	Apr-16	Movement	2016/2017 Target	Forecast for Apr-16	Forecast for May-16	Date expected to meet standard
SB	0.86%	2.03%	⇩ 1.17%	1%	G	R	Jun-16

Peer Performance March 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1	5	3
0.90%	0.10%	0%	5.80%	0.70%

The Trust recovered its diagnostic performance in September 2015, and with the exception of December has been achieving the required target of 1%. However in April the Trust reported a total of 148 patient waiting greater than 6 weeks, which resulted in not meeting the national standard.

In addition the diagnostic waiting list has seen a significant increase overall since December.
The increase is predominantly within Radiology, Echocardiography and Peripheral neurophysiology.

The key modality of concern impacting on diagnostic performance is ultrasound. Particular cohorts of constraint are Paediatric Ultrasounds and Gynae non-obstetric ultrasounds.



Paeds Ultrasound – Key Issues

- Staffing Capacity (2WTE down)
- Increasing demand in comparison to Q4

Actions

- Locum appointed adding 25pts per week
- Additional WLI clinic per week by existing staff 2 half sessions (20 pts per week)

Risks

- Loss of capacity between July and August due to two SPRs rotating out

Mitigation

- Service is trying to increase capacity by utilising current resource differently.
- Two Pead Radiologist Consultants to be employed for September 2016
- Exploring opportunities for external capacity in the IS.

Gynae non-obstetric Ultrasounds – Key Issues

- Staffing capacity constraints – Staffing profile tightly in line with demand with little room for contingency .
- Capacity was being supported by use of agency staff but due to a procurement issues they temporarily withdrew capacity
- Administrative failings

Actions

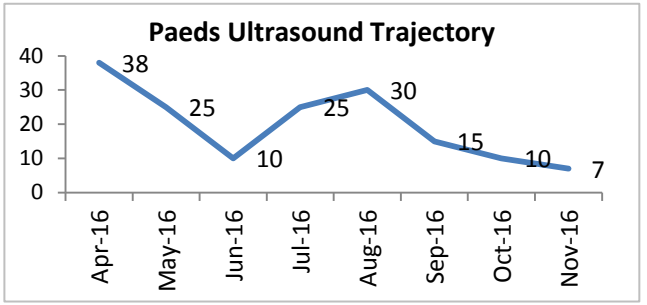
- Additional capacity is now in place.
- CBS staffing issue resolved and new communication/escalation process agreed

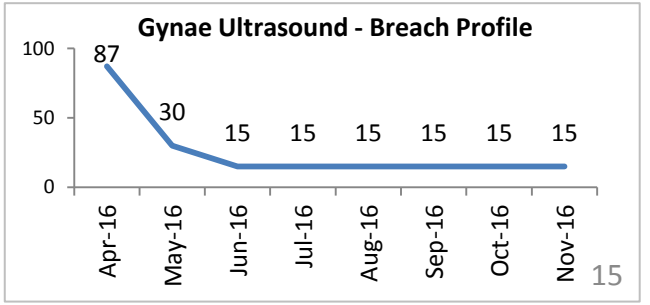
Risks

- Possible capacity constraints in the event of unexpected leave from substantive staff and if sufficient capacity from agency teams cannot be secured

Mitigation

- Pro-active recruitment drive in place
- Exploring additional capacity





5. Divisional KPIs Overview 2016/17: March 16 Performance (Page 1 of 2)

April 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 weeks - admitted waits (division level)	%	0	85.6	69.4	76.9	75.8
	18 weeks - incomplete waits (division level)	%	98.9	89.6	86.5	92.5	89.5
	18 weeks – non-admitted waits (division level)	%	100	79.5	84.9	90	88.8
	52 week waiters	No.	0	4	1	2	7
	A&E waits (4 hours)	%	100	88.6	0	0	89.7
	LAS handover within 15 mins	%					41.4
	LAS handover within 30 mins	%					94
	LAS handover within 60 mins	No.					0
	6 week diagnostic waits	%					98

Note: Cancer performance is reported a month in arrears, thus for March 2016

March 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 week gp referral to first outpatient (breast symptoms) - (division)	%	0	0	93.7	0	93.7
	2 week gp referral to first outpatient (cancer) - (division)	%	0	0	91	0	91
	31 day second or subsequent treatment (drugs) - (division)	%	0	0	100	0	100
	31 day second or subsequent treatment (surgery) - (division)	%			95.2		95.2
	31 day standard from diagnosis to first treatment - (division)	%			96.6		96.6
	62 day urgent gp referral to treatment for all cancers - (division)	%			82.6		82.6
	62 day urgent gp referral to treatment from screening - (division)	%			93.5		93.5

5. Divisional KPIs Overview 2016/17: March 16 Performance (Page 2 of 2)

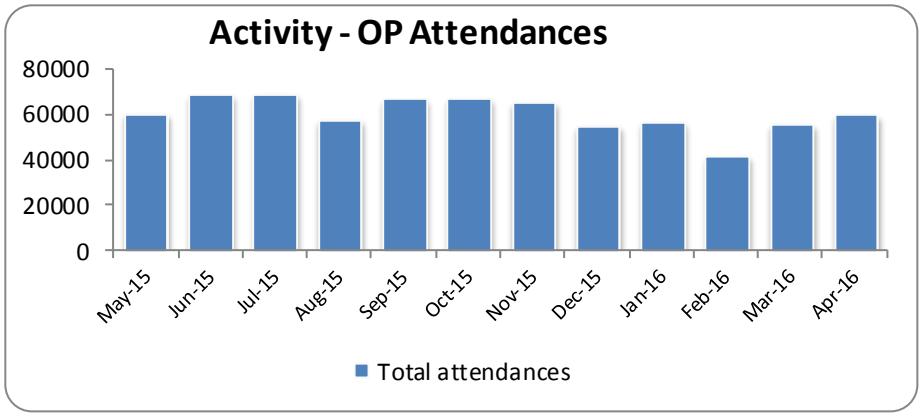
			April 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	Average LOS (elective) (division)	Ratio	0	6.3	4	4.4	4.6
	Average LOS (non-elective) (division)	Ratio	25.6	5.1	6.1	2.8	4.7
	C-sections (applicable to women & children only)	%	0	0	0	20.5	20.5
	CAS alerts	No.					2
	Falls (ward level)	No.	15	79	38	5	137
	HSMR	Ratio					86.5
	Incidence of c.difficile	No.	0	1	0	0	1
	Incidence of e-coli	No.	0	13	0	0	13
	Incidence of MRSA	No.	0	0	0	0	0
	Maternal deaths	No.	0	0	0	0	0
	Medication errors causing serious harm (division)	No.	0	1	0	1	2
	Mixed sex accomodation	No.	0	0	0	0	0
	MSSA	No.	0	0	0	1	1
	Never events	No.	0	0	0	0	0
	Serious incidents (division level)	No.	0	5	2	4	12
	SHMI	Ratio					0.91
	Trust acquired pressure ulcers	No.	0	0	0	0	0
Quality Governance Indicators	Friends & family response rate	%	57.1	40.1	38.8	12.3	38.1
	Patient satisfaction (friends & family)	%	85.7	95.7	92.5	86.7	92.9
	Percentage of harm free care	%	90	93.8	96.7	99.4	95.1
	Sickness/absence rate - (ward)	%	9.2	4	4.2	3.8	4.1
	Staff turnover - (ward)	%	18.9	21.3	20.8	16.5	19.3
	Vacancy rate - (ward)	%	4.7	23.3	27.4	12.6	20

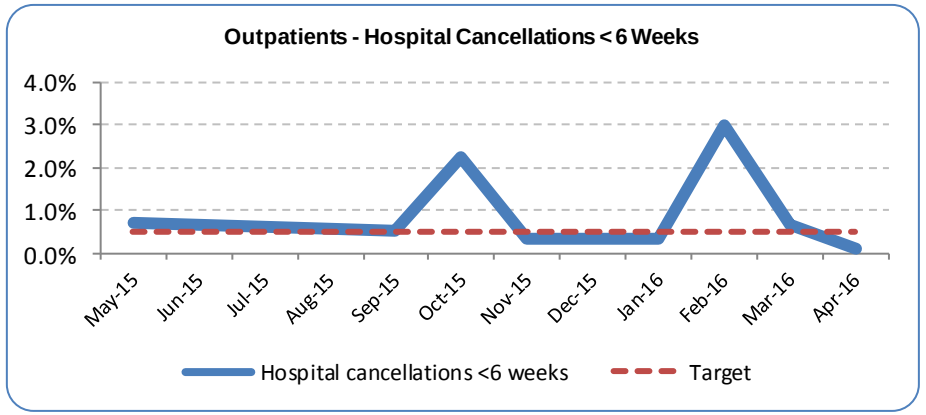
Key Messages:

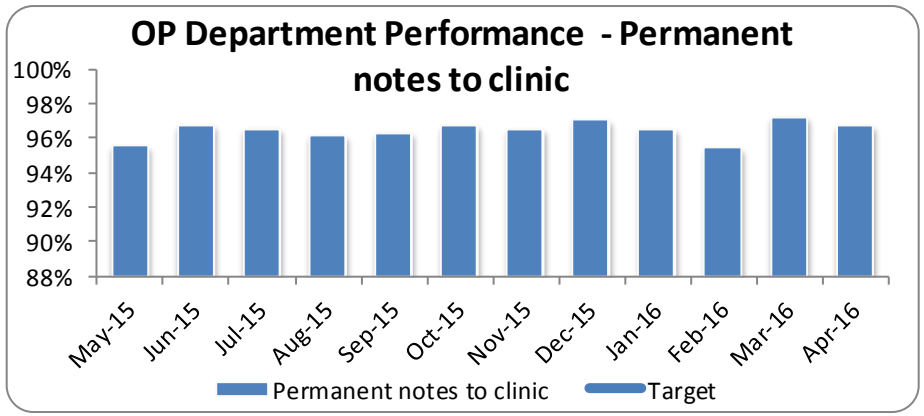
This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components,. Cancer performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of April 41.4% of patients had handover times within 15 minutes and 94% within 30 minutes, both of which are not within target. The trust had zero 60 minute LAS handover breach in March

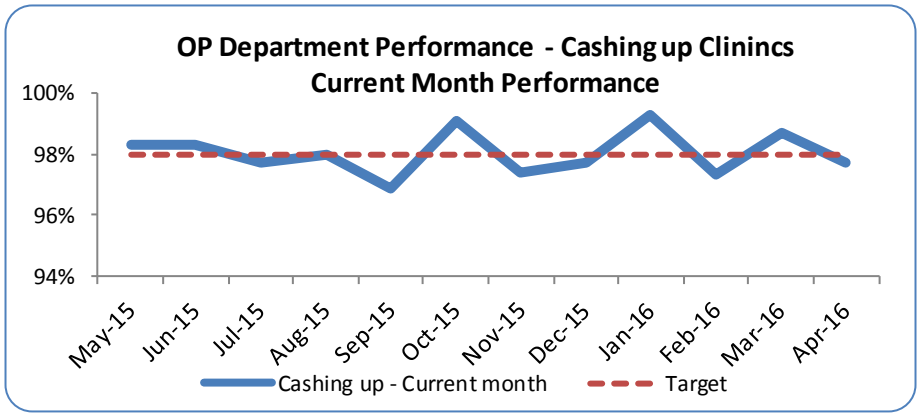
The trust has a zero tolerance on avoidable pressure ulcers and has placed significant importance on its prevention. In April the trust had no grade 3 pressure ulcer SI's and no Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

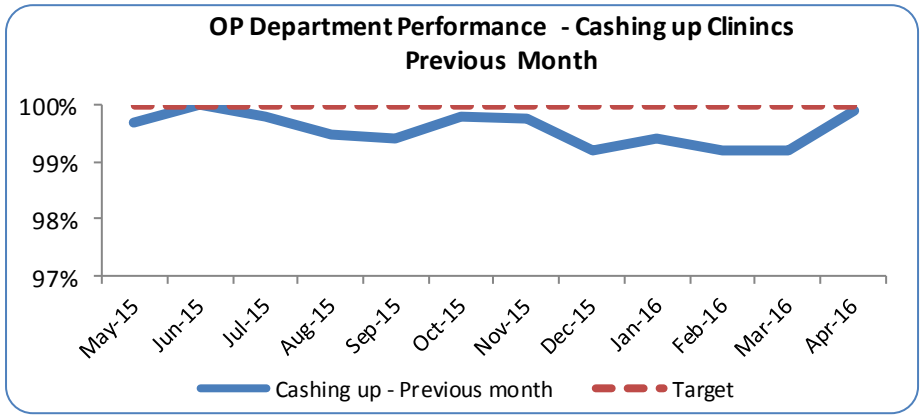
6. Corporate Outpatient Services (1 of 2) - Performance Overview

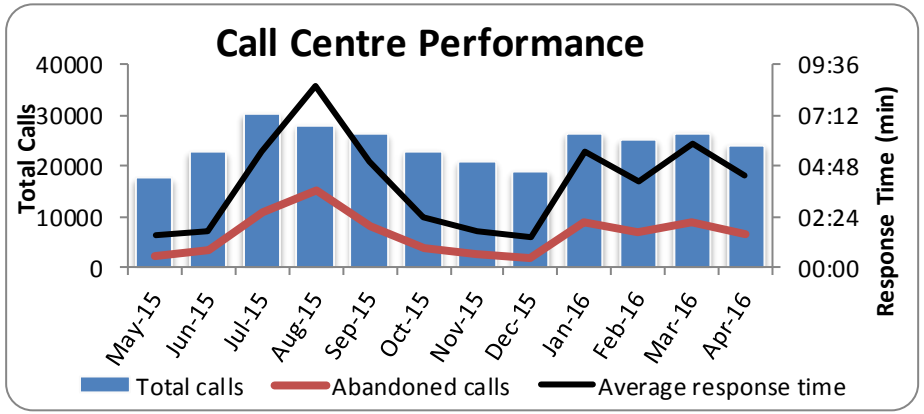












6. Corporate Outpatient Services (2 of 2) - Performance Overview

		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	Apr-16
Activity	Total attendances	N/A	60564	59841	68002	68277	57188	66271	66501	64863	54618	56239	41552	55261	59211
	Hospital cancellations <6 weeks	<0.5%	1.26%	0.74%	0.66%	0.64%	0.56%	0.54%	2.24%	0.36%	0.37%	0.35%	2.97%	0.69%	0.11%
OPD performance	Permanent notes to clinic	>98%	95.52%	95.54%	96.74%	96.54%	96.14%	96.31%	96.72%	96.52%	97.02%	96.50%	95.42%	97.20%	96.70%
	Cashing up - Current month	>98%	98.60%	98.30%	98.30%	97.70%	98.00%	96.90%	99.10%	97.40%	97.70%	99.30%	97.30%	98.70%	97.70%
	Cashing up - Previous month	100%	99.60%	99.70%	100.00%	99.80%	99.50%	99.40%	99.80%	99.75%	99.20%	99.40%	99.20%	99.20%	99.90%
Call Centre Performance	Total calls	N/A	18710	17732	22955	30426	28095	26357	23138	21082	19093	26557	25273	26674	24279
	Abandoned calls	<25%/<15%	1551	2237	3309	10828	15019	8253	3930	2756	1953	9084	6949	9055	6671
	Mean call response times	<1 m/<1m30s	01:00	01:29	01:42	05:31	08:34	04:59	02:24	01:43	01:24	05:30	04:06	05:49	04:20

Key Messages:

- Increase in activity for a second consecutive month compared to February and March. However in line with same period last year.
- Compared to April 2015 there has been a decrease in activity of 2%
- Improvement made in Hospital cancellations <6 weeks compared with March and currently 011% and achieving target.
- Permanent notes to clinic has maintained improvement since February, however still remains below target of 98%. This continues to be a priority area for the service.
- The level of call activity and the number of abandoned calls remain under target , with a some improvement in reducing the number of abandoned calls. This is primarily due to shortage in staffing levels. CBS is currently going through a transformational phase and are on a active recruitment drive to fill the staffing capacity shortfall following recent vacancies which have arisen.

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Clinical Audit & Effectiveness

Excellence in specialist and community healthcare

7. Clinical Audit and Effectiveness - Mortality

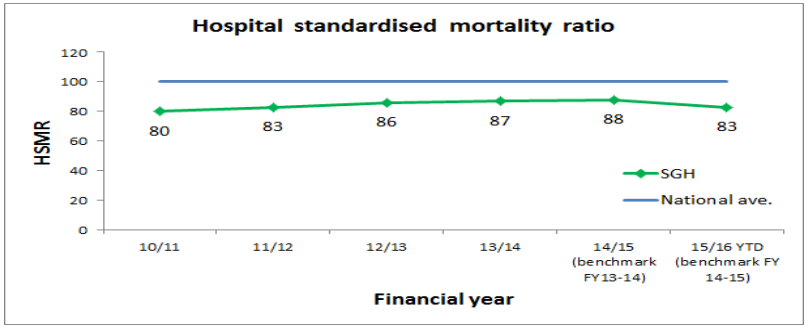
HSMR (Hospital standardised mortality ratio)							
Lead Director	March 16	April 16	May 16	Movement	2016/17 Target	Forecast March 17	Date expect to meet standard
SM	87.5	86.5	84.0	↓	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
Apr 2015	Jul 2015	Oct 2015	Jan 2016	Mar 2016
0.86	0.89	0.92	0.90	0.91

Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available (updated 19/05//16) March 2015 to February 2016, and benchmark period is the financial year 2014/15. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 23rd March 2016 relates to the period October 2014 to September 2015. The next publication is due in June 2016.

Overview:

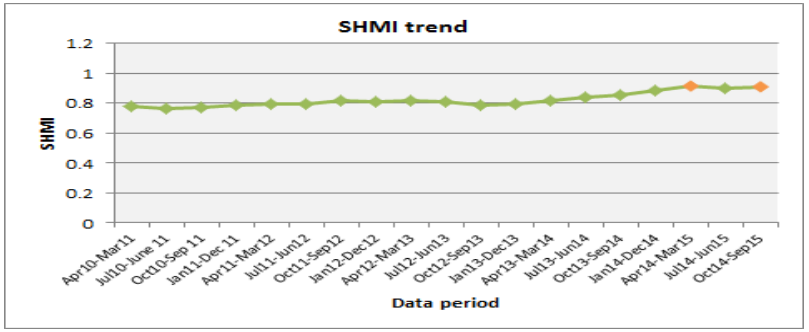
Our mortality as measured by the HSMR remains significantly lower than expected; for the period March 2015 to February 2016 our ratio is 84.0. Looking at the HSMR for emergency admissions analysed by day of admission, shows that for both patients admitted at weekends and patients admitted on weekdays, mortality is significantly better than expected at 85.03 and 84.3 respectively. Our SHMI for the period October 2014 to September 2015 is 0.91, which is categorised as 'as expected'. Raw mortality is also considered by the MMC each month, and as shown by the chart alongside, continues to be within limits.

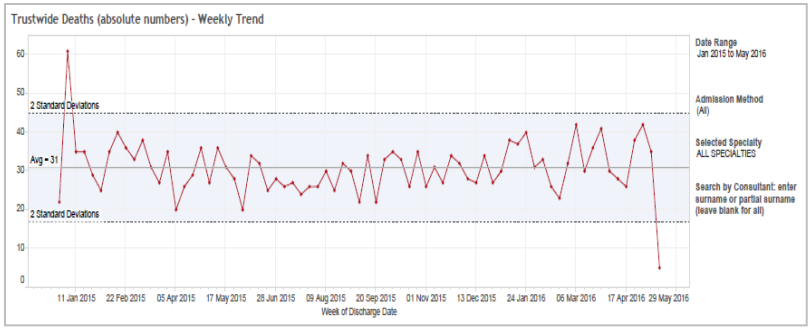


Avoidable mortality:

National debate continues around the methodology for defining and measuring avoidable mortality. St George's has been involved with this work through participation in the PRISM 2 study; our local results from external reviewers identified no avoidable mortality at that time. We are committed to full engagement in this programme and have volunteered to pilot any approach produced as part of the National Retrospective Case Record Review Programme (RRCR) which is to be managed by the Royal College of Physicians.

Locally, the Mortality Monitoring Committee continue to drive forward the proportionate review of all deaths within care groups and investigate all signals where benchmarking against national data suggests our mortality is higher than expected. A key part of these reviews is to assess whether death was expected or not, and if unexpected whether it was potentially avoidable or there were aspects of suboptimal care. We record all mortality reviews that are submitted to MMC on a database, so that we can develop an indication of the level of mortality where the outcome may have been avoidable and report trends. The focus of this work is to promote greater reflection and to better identify opportunities for learning trust-wide.





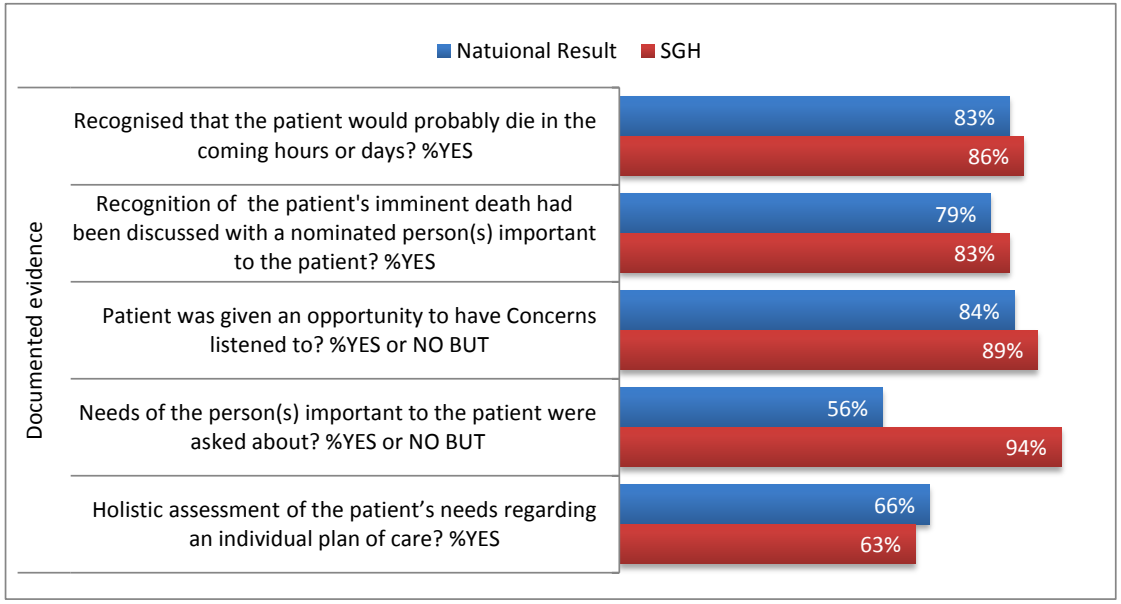
7. Clinical Audit and Effectiveness - National audit

The End of Life Care (EOLC) Audit – Dying in Hospital 2015: Page 1, Overview and results

The End of Life Care (EOLC) audit was undertaken in 2015. The audit comprised 2 sections: an organisational audit and a case note review. Results were reported against a range of activities, which reflect the 'individualised' care plans recommended by the 2013 Neuberger *More care, less pathway* review; and the 'five priorities of care for the dying person' which were published in the Leadership Alliance *One chance to get it right* report. These priorities are that, when it is thought that a person may die within the next few days or hours:

- this possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly
- sensitive communication takes place between staff and the dying person, and those identified as important to them
- the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
- the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
- an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

The clinical audit looked for documented evidence of factors directly related to the five priorities of care above and the chart below gives the results of key indicators comparing St George's to the national achievement. For 4 of the 5 indicators our performance is better than the national average.



We are currently fully compliant with 2 of the 5 indicators from the organisational audit (seeking bereaved relatives and friends views and access to palliative care) but at the time of the data collection our in-house training did not cover all staff and we did not have a lay member on the Trust board with responsibility for EOLC and did not have an EOLC facilitator.

Since the audit and since the publication of new NICE guidelines these issues have been reviewed and we aim to be fully compliant with all of the quality indicators at the end of 2016/17.

A paper providing full details of the audit results and planned actions has been prepared and discussed at the EOL committee and is summarised on the following slide.

7. Clinical Audit and Effectiveness
- National audit

The End of Life Care (EOLC) Audit – Dying in Hospital 2015: Page 2, Action plan

ACTIONS SUMMARY

The results of the audit together with the requirements of the new NICE guidelines have been discussed by the palliative care team and the End of Life Care Programme Board. Actions have been planned to address any shortfalls in both care quality indicators and organisational quality indicators. These are detailed below.

Care Quality Indicators:

- We are currently above average national average in 4 out of 5 of the clinical indicators, which is very encouraging. Guidance issued following the withdrawal of the LCP (Liverpool Care Pathway) at St. George's advised that all expected deaths should be referred to the palliative care team, so that we could write an 'individualised EOLC plan'. We have audited this twice ourselves prior to the national audit and our findings were in line with the national findings. We will continue to refer all expected deaths to palliative care team.
- To improve our Holistic Assessment of the patient's needs regarding an individual plan of care we have introduced a guidance document to support nursing staff in writing the patients EOLC plan (Daily Nursing End of Life Care Evaluation Guidance). We are also in the process of developing an electronic EOL nursing care plan to support nurses in delivering and evidencing the care that they give to dying patients and developing a medical template for EOL that will support clinicians in ensuring that the care they give is according to NICE guidance and will enable this care to be documented in a structured format, once the whole of the Trust has moved to electronic notes. It is hoped that both electronic documents can be 'rolled out' together combined with an education programme provided by the palliative care team. This will depend on the IT strategy and scheduling for the CERNER roll out.
- We will audit the use of daily nursing EOLC evaluation guidance in Q3.

Organisational Indicators:

- A board member has already been approached with a request to fulfil the role of lay lay member on the Trust Board with a responsibility for EOLC, and has now accepted.
- As part of the EOLC strategy we are developing an educational strategy, which we anticipate will be completed in Q3.
- We are also developing an educational programme for the Trust which will include releasing one CNS per month from clinical responsibilities to devote their time to Education and Training. This will include hands on support for staff caring for dying patients. We plan to implement this by Q3.
- A survey of bereaved relatives and carers is currently underway. Results will be available in Q3.

7. Clinical Audit and Effectiveness - National audit

National Audit of Percutaneous Coronary Interventions (PCI), January 2014 – December 2014

Overview

This report summarises data between January and December 2014 and assesses key aspects of the patterns and quality of care for PCI. The report looks at a number of key indicators regarding the best management and care of patients who require PCI. Data is collected from all UK centres that perform PCI's and is used to guide best practice and to monitor outcomes. The completeness and quality of data is therefore very important. Table 1 shows the percentage completeness of data collected from St George's. We are considered to be "Almost excellent" with just records of Creatinine, weight and STEMI onset location being less than 90%.

Table 1: St George's Data Completeness (%)

DOB	Sex	Med History	Pre-procedure shock	Procedure Urgency	Vessels treated	Renal Disease	Diabetes	Discharge Date	Discharge Status	PCI Hospital Outcome	NHS no.	Creatinine	Weight	STEMI Onset Location
100	99.74	95.02	91	99.93	100	94.51	98.91	95.98	96.04	99.87	94.33	89.78	58.49	88.45

NICE recommends that Coronary angiography and PCI is performed within 72 hours for patients with NSTEMI or unstable angina and that Primary PCI is carried out within 90 minutes of a patient's arrival at the hospital. Data from the audit reported that nationally these standards were achieved in 56.4% and 90.24% of cases respectively. For St George's the figure for NSTEMI patients is much better at 97.43%; however, for Primary PCI the proportion of our patients with a door to balloon time of less than 90 minutes is below the national average at 85.4%. The data also indicates that only 33% of our patient's PCIs are performed using the radial approach which is associated with a reduction in complication rate. Nationally, 75.3% of procedures use this route. Table 2 below describes actions already taken to improve on these results.

Table 2: Local Actions

Area where improvements needed	Actions taken
Door to balloon time	A local audit is underway to pinpoint exactly where delays are occuring. We expect results in Q2 and will then have a better understanding of where improvemnets are required.
Access	Practise is changing and recent data shows an improving picture: in February 2016 43% of cases used radial access, this increased to 56% in March 2016. We will continue to monitor.

Evidence suggests improved outcomes for patients treated in higher volume PCI centres. This is evident in centres such as St George's that perform over 400 procedures per annum (recommended by British Cardiovascular Intervention Society & British Cardiovascular Society). The report highlights that as PCI techniques have improved the risk of complications has reduced, but that this has also meant that the procedure can be offered to sicker patients. In 2014 the overall rate of in-hospital death following PCI was 1.9%; however, it is stressed that "The biggest predictor of mortality is how sick a patient is when they are treated, and almost invariably, a fatal outcome is a result of the patient's underlying disease, rather than due to the PCI procedure". Within St Georges any death following PCI is the subject of a review, which is in turn reported to the Trust Mortality Monitoring Committee chair. Consultant level outcomes which are derived from this national audit and reported publically show that none of the St George's operators have outcomes as measured by the major adverse cardiac and cerebrovascular event (MACCE) rate, which are outside of confidence limits.

7. Clinical Audit and Effectiveness - National audit

Sentinel Stroke National Audit Programme (SSNAP)

Table 1: Overall performances (HASU)	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Performance against previous audit round
SSNAP Level	B	A↑	A	-
Case Ascertainment (CA)	B	A↑	A	-
Audit Compliance (AC)	B	B	B	-
Combined Key Indicator (KI) Level	B↓	A↑	A	-

Table 1: Overall performances (SU)	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Performance against previous audit round
SSNAP Level	B	B	B	-
Case Ascertainment (CA)	A	A	A	-
Audit Compliance (AC)	C	B	D	↓
Combined Key Indicator (KI) Level	A	A	A	-

Table 2: Performances for Patient Centred Data (HASU)	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Performance against previous audit round
D1 - Scanning	A	A	A	-
D2 - Stroke Unit	D	C↑	C	-
D3 - Thrombolysis	B	A↑	B	↓
D4 - Specialist Assessments	C	B↑	C	↓
D5 - Occupational Therapy	A	A	A	-
D6 - Physiotherapy	A	A	A	-
D7 - Speech and Language Therapy	B↓	A↑	A	-
D8 - Multi-Disciplinary Team Working	B↓	B	B	-
D9 - Standards by Discharge	B	B	B	-
D10 - Discharge Processes	B	B	A	↑

Table 2: Performances for Patient Centred Data (SU)	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Performance against previous audit round
D1 - Scanning	B	A	A	-
D2 - Stroke Unit	C	C	C	-
D3 - Thrombolysis	B	B	A	↑
D4 - Specialist Assessments	C	B	B	-
D5 - Occupational Therapy	A	A	A	-
D6 - Physiotherapy	A	B	A	↑
D7 - Speech and Language Therapy	A	B	B	-
D8 - Multi-Disciplinary Team Working	B	B	B	-
D9 - Standards by Discharge	B	A	B	↓
D10 - Discharge Processes	B	B	A	↑

Table 3: Performances for Team Centred Data (HASU)	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Performance against previous audit round
Key Indicator Level	B↓	A↑	A	-

Table 3: Performances for Team Centred Data (SU)	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Performance against previous audit round
Key Indicator Level	B	A	A	-

Background: This is the eleventh clinical report produced under the auspices of the Sentinel Stroke National Audit Programme (SSNAP). It reports on patients admitted (or having stroke onset as an inpatient) and/or discharged from hospital.

Aims of SSNAP clinical audit: The SSNAP clinical audit collects a minimum dataset for every stroke patient, including acute care, rehabilitation, 6-month follow-up, and outcome measures in England, Wales and Northern Ireland. The aims of the audit are:

- to benchmark services regionally and nationally.
- to monitor progress against a background of organisational change to stroke services and more generally in the NHS.
- to support clinicians in identifying where improvements are needed, planning for and lobbying for change, and celebrating success.
- to empower patients to ask searching questions.

Overall Performance for Jul-Sept 2015: The Trust's score for Hyper-Acute Stroke Unit (HASU) is A and score for Stroke Unit (SU) remains at B.
Since the last audit round (Apr-Jun 2015), the following improvements have been put in place:

- Increased consultant presence in ED has reduced the waiting time for patients;
- The TIA (Transient Ischaemic Attack) clinic has increased its activity by 15% in the last year to help reduce the demand on inpatient beds;
- Continued work with radiology means most patients get a CT scan in the ED within their first hour in hospital;
- this year, the Trust expects to launch the first 24/7 thrombectomy service in the country. It took part in trials to evidence that this treatment works and have recently appointed two interventional neuroradiologists who make up a team of five specialists doing the procedure. Thrombectomy removes clots from the arteries of blocked vessels and reduces disability in severe stroke. This service will be offered to patients from SW London and our neuroscience network of partner hospitals in Surrey.

Overall Performance for Oct-Dec 2015: The Trust's score for Hyper-Acute Stroke Unit (HASU) is A and majority of the measures remain similar to the previous quarter, except for Thrombolysis (scored B compared to A) and Specialist Assessments (scored C compared to B).
The overall score for Stroke Unit (SU) remains at B, with improvement seen in Thrombolysis, Physiotherapy and Discharge processes. The scores for two measures has dropped against the previous quarter - Audit Compliance (scored D compared to B) and Standards by Discharge (scored B compared to A).

Discussion and Action Plan: Due to the huge patient turnover, the team had problems finding paper notes, which impacted on our performance in relation to 'Audit Compliance'. It is expected this will improve when all notes are accessed electronically.

7. Clinical Audit and Effectiveness - Local audit

WHO Surgical Checklist Audit 4th Quarter 2015/16 (Peer review audit round)

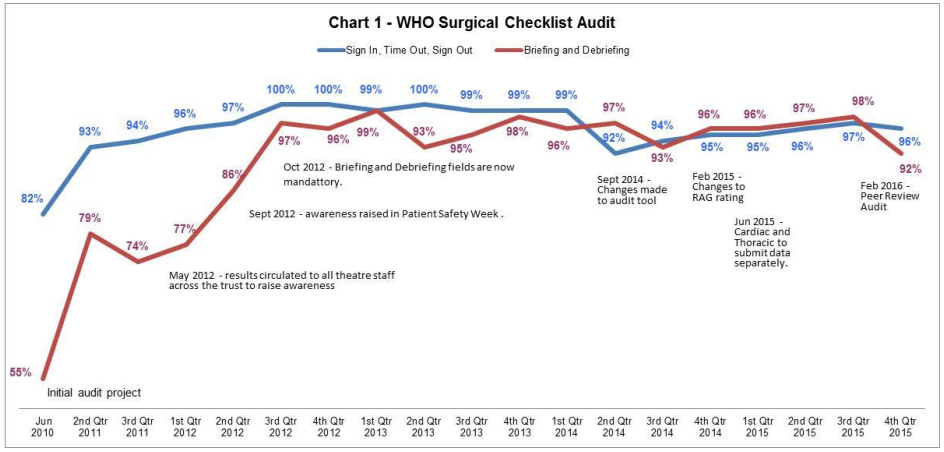


Table 1 - 2015/16	Specialty	Sign In, Time Out, and Sign Out				Briefing and Debriefing			
		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Children & Women	Gynaecology	99%	99%	99%	99%	100%	100%	100%	91%
	Obstetric - Elective	99%	97%	100%	No data	100%	98%	100%	No data
	Obstetric - Emergency	85%	98%	99%	98%	-	-	-	-
	Paediatric	97%	95%	97%	No data	100%	97%	100%	No data
Medicine & CardioThoracic	Cardiac	73%	94%	92%	94%	71%	94%	100%	91%
	Renal	100%	100%	95%	95%	100%	96%	89%	88%
	Thoracic	91%	89%	98%	97%	71%	57%	97%	93%
	Vascular	100%	100%	100%	100%	100%	100%	100%	100%
Surgery	AET/T&O	91%	97%	88%	100%	98%	94%	100%	100%
	CEPOD	98%	98%	98%	100%	100%	100%	100%	91%
	DSU	96%	98%	98%	95%	96%	96%	96%	93%
	ENT	99%	99%	100%	97%	100%	100%	100%	100%
	General Surgery	90%	92%	92%	93%	100%	91%	100%	100%
	MaxFax	100%	100%	99%	100%	100%	100%	100%	100%
	Neuro Surgery	99%	96%	100%	92%	100%	96%	100%	69%
	Plastic	92%	94%	91%	95%	97%	100%	91%	100%
	Urology	96%	99%	97%	92%	100%	100%	100%	84%

Overview:

As part of the commitment to improving patient safety, the Trust adopted the WHO Surgical Safety Checklist. Peer review audit was undertaken in this audit round to provide assurance that data submitted by specialties are in line with reported findings.

Overall Performance:

There is an overall drop in compliance rate for all fields in this peer reviewed audit round (chart 1). Sign In, Time Out, and Sign Out scored 96% (97% in the last audit round), and Briefing and Debriefing scored 92% (98% in the last audit round).

Table 1 shows the overall results. The biggest improvement is seen in AET/T&O which scored 100% for all fields (89% in the last audit round), while Neurosurgery scored 90% (100% in the last audit round, 69% for Briefing and Debriefing and 92% for Sign in, Time out and Sign out).

Recommendations and Action plans:

- ✓ Theatres Care Group Lead to circulate the report to all relevant Clinical Directors and Care Group Leads for local presentation and discussion and to agree actions for improvement in compliance.
- ✓ Summary report to be presented at Theatres Care Group meeting in April 2016 and Division Governance Board.
- ✓ Matrons and Team leaders to disseminate results and agreed actions at local team meetings.
- ✓ Assurance Oversight through the PSC, Divisional Governance Meetings
- ✓ Paediatric and Elective obstetric specialties to complete the minimum number of observations [10] for the next audit round.

7. Clinical Audit and Effectiveness - Local audit

WHO Checklist Audit for non-theatre areas, Quarter 4 2015/16

	1st Qtr 2013/14	2nd Qtr 2013/14	3rd Qtr 2013/14	4th Qtr 2013/14	1st Qtr 2014/15	2nd Qtr 2014/15	3rd Qtr 2014/15	4th Qtr 2014/15	1st Qtr 2015/16	2nd Qtr 2015/16	3rd Qtr 2015/16	4th Qtr 2015/16
WHO for theatre	99%	98%	97%	100%	99%	93%	94%	96%	96%	97%	97%	96%
WHO for non-theatres												
Cath Lab - St Georges	100%	100%	100%	100%	100%	100%	*no data*	100%	100%	100%	100%	*no data*
Day Surgery Unit (QMH)	100%	100%	100%	100%	*no data*	100%	100%	100%	100%	100%	100%	100%
Dental Procedures - St Georges	*Data collection starts in 3rd Qtr 2014/15*						50%	88%	76%	74%	99%	*no data*
Endoscopy - Nelson Hosp (start Dec 2015)	*Data collection starts in 3rd Qtr 2015/16*										98%	100%
Endoscopy - St Georges	83%	85%	83%	90%	100%	98%	96%	90%	97%	98%	100%	100%
Interventional Radiology - St Georges	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
NeuroRadiology - St Georges	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	*no data*
Radiology CT - St Georges	20%	80%	100%	100%	95%	100%	100%	83%	100%	100%	100%	100%
Radiology Ultrasound - St Georges	20%	33%	70%	50%	33%	100%	100%	100%	100%	100%	100%	100%

Overview

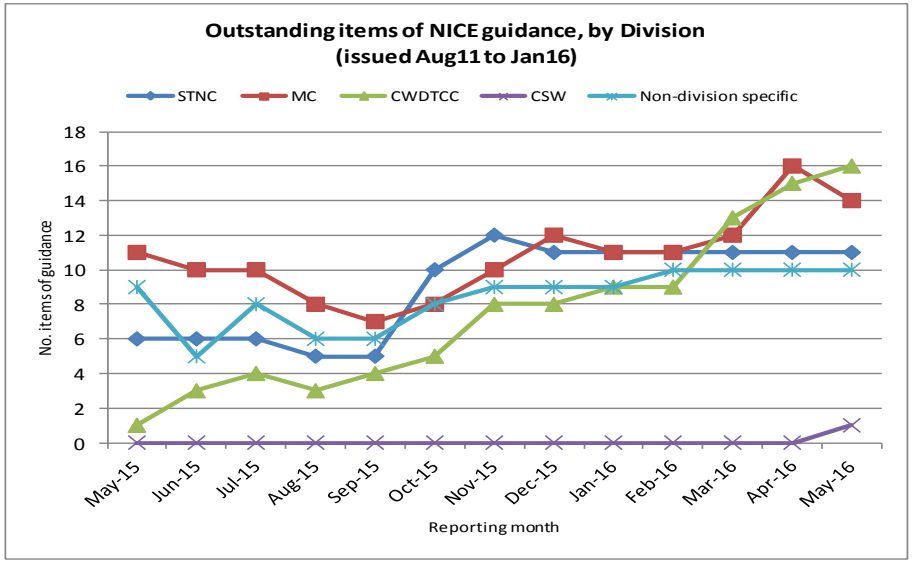
The World Health Organisation (WHO) launched the Surgical Safety Checklist in 2008 in response to an identified global risk of patient safety, with the aim to diminish the number of surgical deaths across the world. It emphasises a core of surgical safety principles to keep common problems at the front of everyone's mind. As part of the commitment to improving patient safety, the Trust adopted the WHO Surgical Safety Checklist for theatre areas and later extended the approach to non-theatre sites.

Overall Performances

Interventional Radiology (SGH), Day Surgery Unit in QMH, Radiology (CT & USS in SGH) have managed to achieve 100% throughout the financial year 2015/16. For the Endoscopy unit, the team has managed to maintain its 100% compliance since the 3rd quarter of 2015/16. Dental Procedures in SGH has shown significant improvement – 99% compared to 74% in the previous audit round.

There were no results for Cath Lab, Dental Procedure and Neuroradiology in the latest audit round, as these teams are planning to amend the audit tool to reflect their current practice and it is understood discussion is in progress. From April 2016, the WHO audit will be extended to Breast Imaging Biopsy unit, and in Q4 2016/17 similar methodology will be applied the audit of LocSIPPS (Local policies for the safe performance of invasive procedures) in any areas not already covered in the above programme of work.

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



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

Division	2010	2011	2012	2013	2014	2015
STNC (n=9)	0	1	2	1	4	1
M+C (n=17)	2	0	4	1	4	6
CWDTCC (n=16)	3	1	1	3	6	2
CSW (n=0)	0	0	0	0	0	0
Non-division specific (n=11)	0	2	0	3	1	5

Overview

The number of outstanding items of guidance remains the same at 52 this month and there are currently 53 with compliance issues. For guidance issued in the first four months of the year we have already received responses from clinicians for over 50 per cent, which is an encouraging position.

The volume of newly issued guidance and updates received from NICE each month continues to contribute to the observed increase. Since September, the audit team has continued to disseminate guidance promptly, but has had insufficient resource to follow-up those outstanding; however, a complete review is now underway. This will encompass following up historical items of guidance where we have not had a response as to implementation and those where full implementation has not been achieved. The audit team are committed to following up all items of guidance before the end of June. We are working closely with divisional colleagues, initially in Children & Women's and Medicine & Cardiovascular divisions, to address the backlog and improve the understanding of our current position. There may certain instances where consideration will need to be given to guidance where we are not fully compliant but we have assurance that services are operating at an acceptable level, agreed at divisional or corporate level.

The audit team are currently working with divisional colleagues to strengthen existing reporting processes, so that the needs of divisions and the organisation as a whole are met. Through a critical review of our reporting and the flow of information between teams, we will develop a process that delivers a clear and up-to-date picture of implementation, supporting the assessment and management of any risks associated with partial or non-compliance. The end result of this programme of work will be more efficient systems and processes and elimination of the backlog, allowing us to redirect resource to providing support to clinicians in the more timely assessment of implementation.

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Patient Safety

Excellence in specialist and community healthcare

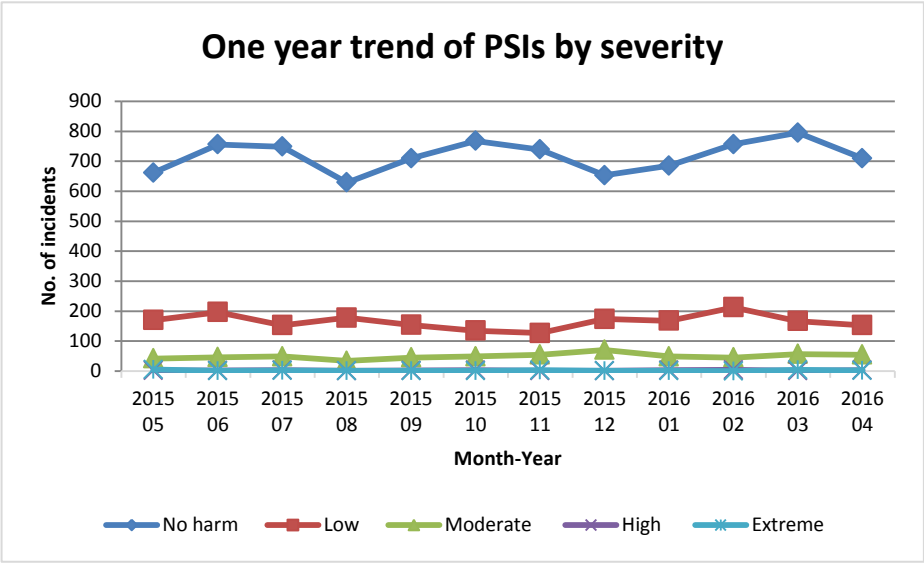
8. Patient Safety
- Incident Profile: Serious Incidents and Adverse Events

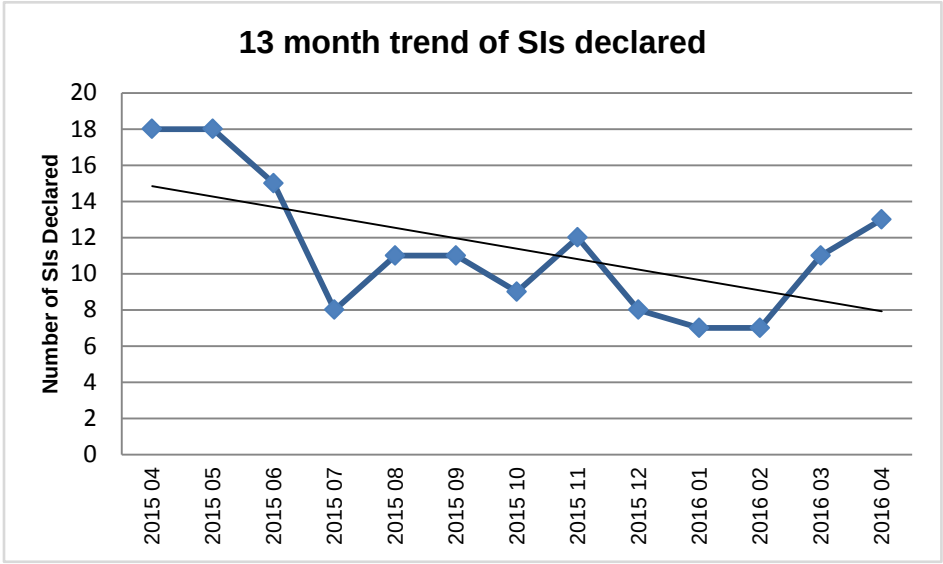
	2015/16 and 2016/17 SIs Declared by Division (incl. PUs)				
	M&C	STN&C	CSD	C&W	Corporate
February	1 (shared C&W)	3 (1 shared with C&W)	0	5 (2 shared, 1 M&C, 1 STN&C)	0
March	4 (1 shared with Corp)	2	0	4	2 (1shared with M&C)
April	5	2	0	4	1

Table 1

Closed Serious Incidents (not incl. PUs)				
Type	February	March	April	**Movement**
Total	4	4	10	➢
No Harm	2	1	5	➢
Harm	2	3	5	➢

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.

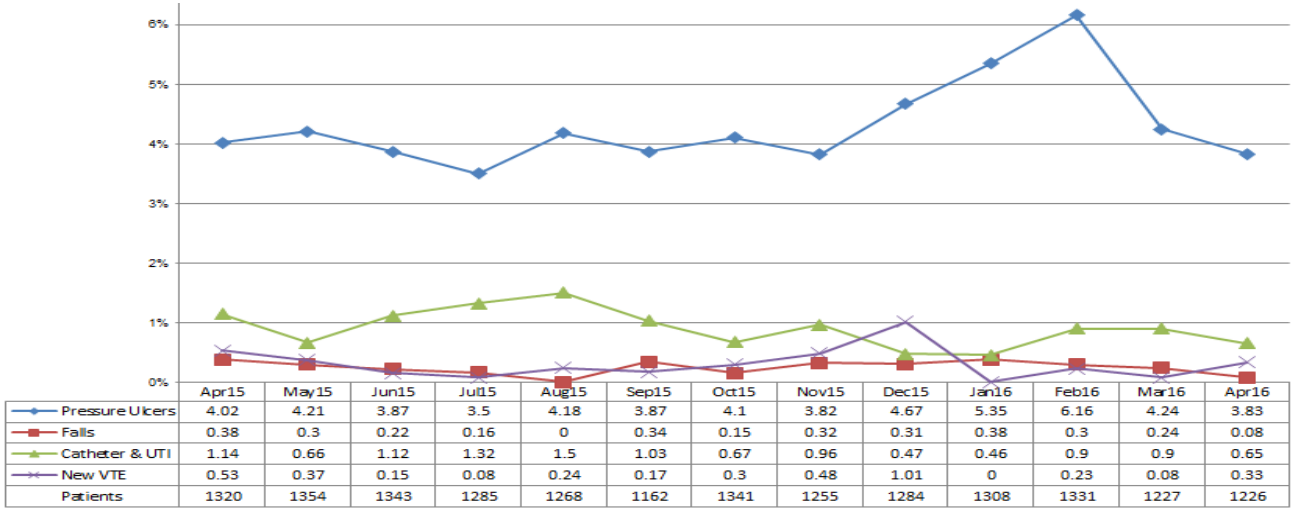
There were 13 general SIs reported in April (0 pressure ulcers) and the subjects are varied.

The 13 general SIs declared in April include the following categories:

- Medication error (2)
- Delay in treatment (3)
- Delayed diagnosis
- Missed diagnosis
- Failure to follow up (2)
- Incorrect processing of samples
- Unexpected admission to NNU
- Exposure to blood borne virus (needle stick injury)
- Patient fall

8. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	February 2016	March 2016	April 2016	**Movement**	**2016/17 Target**	**National Average April 2016**	**Date expected to meet standard**
J Hall	92.64%	94.62%	95.11%	↑	95.00%	94.16%	March 17



	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16	Apr16
Pressure Ulcers	4.02	4.21	3.87	3.5	4.18	3.87	4.1	3.82	4.67	5.35	6.16	4.24	3.83
Falls	0.38	0.3	0.22	0.16	0	0.34	0.15	0.32	0.31	0.38	0.3	0.24	0.08
Catheter & UTI	1.14	0.66	1.12	1.32	1.5	1.03	0.67	0.96	0.47	0.46	0.9	0.9	0.65
New VTE	0.53	0.37	0.15	0.08	0.24	0.17	0.3	0.48	1.01	0	0.23	0.08	0.33
Patients	1320	1354	1343	1285	1268	1162	1341	1255	1284	1308	1331	1227	1226

Pressure ulcers (47)

- 27 grade 2 (13 new, 14 old)
- 14 grade 3 (1 new, 13 old)
- 6 grade 4 (1 new, 5 old)

CAUTI (8)

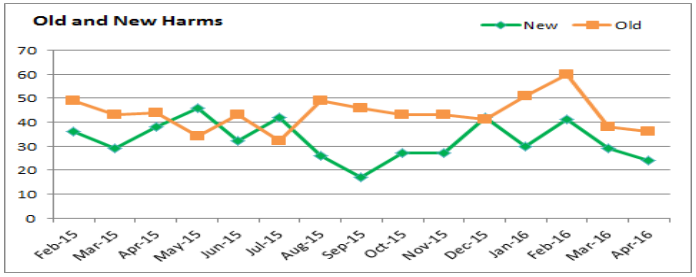
- 4 old
- 4 new

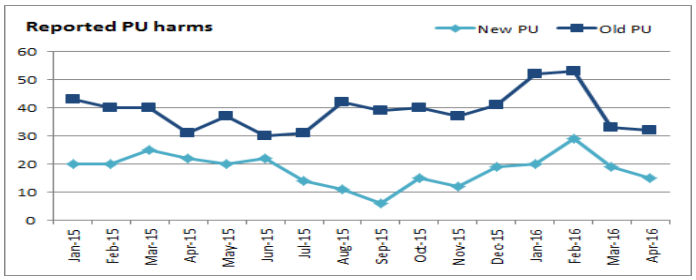
Falls (1)

- 1 low harm fall

VTE (4)

- 1 new PE
- 3 new other





The safety thermometer data represents a snapshot of harms as collected by ward staff on one nationally agreed day per month. This project measures point prevalence as opposed to the number of incidents.

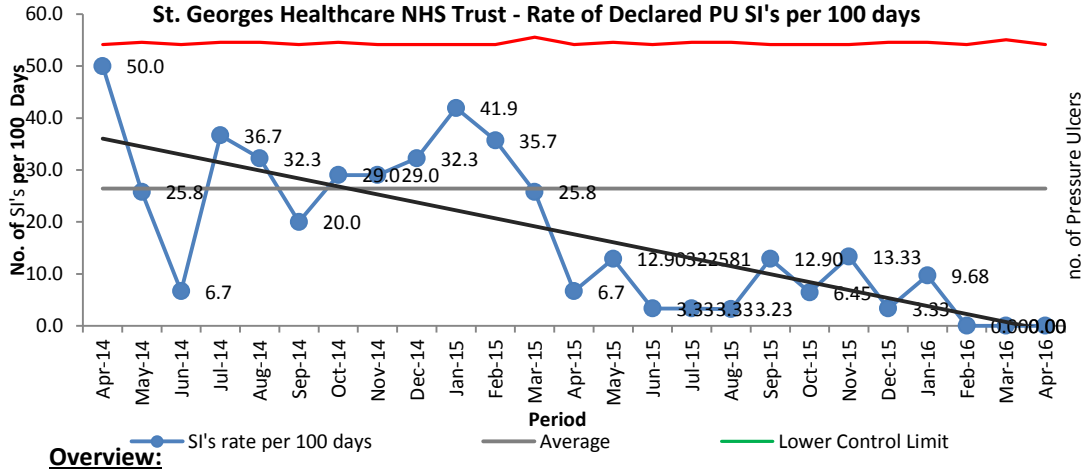
In April 2016 the proportion of our patients that received harm free care was 95.11 per cent, which is better than the national average for the month (94.16%) and is in line with our target of 95%. Sixty harms were reported for a total of 60 patients; no patients experienced more than one harm. This level of harm reflects a slight decrease in both new and old harms, at 24 and 36 respectively.

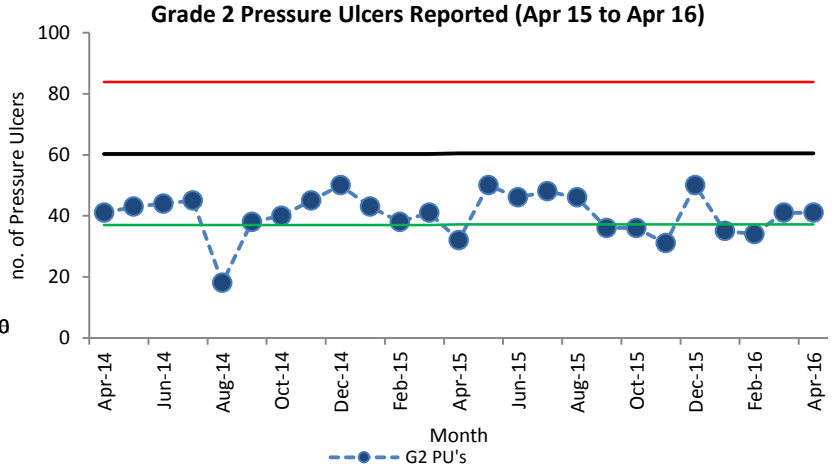
The number of old and new pressure ulcers decreased for the second consecutive month, and our level of harm is now similar to levels observed prior to December. Our mean level of PU harm for the period April 2015 to April 2016 is 4.29%, which is marginally better than the national average of 4.33%. This month also saw a reduction in the number of patients experiencing catheter associated urinary tract infections and falls. An increased number of new VTEs were reported, with a total of 4 harms recorded.

8. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Dec	Jan	Feb	Mar	Apr	YTD April – March 2017	Movement	2016/2017 Target	Forecast March 2017	Date expected to meet standard
Acute	0	2	0	0	0	**0**			G	-
Community	1	1	0	0	0	**0**			G	-
Total All	1	3	0	0	0	**0**			G	-
Total Avoidable	1	3	0	0	0	**0**		19		-
Previous Year	6	8	3	2	2	**2**				

Grade 2 Pressure Ulcers						
Dec	Jan	Feb	Mar	Apr	Movement
39	20	20	25	27	
11	15	14	16	14	
50	35	34	41	41	
50	43	38	41	32	





Overview:

In April the trust achieved its third consecutive month of zero avoidable pressure ulcer serious incidents declared, reflecting the hard work seen by staff across the trust. A target of 19 pressure ulcer declarations has been set for the 2016/17 financial year, this is based on a 10% reduction on last years total of 22 incidents. There were 41 Grade 2 pressure ulcers seen across the trust, however a reduction was seen in community services.

Actions:

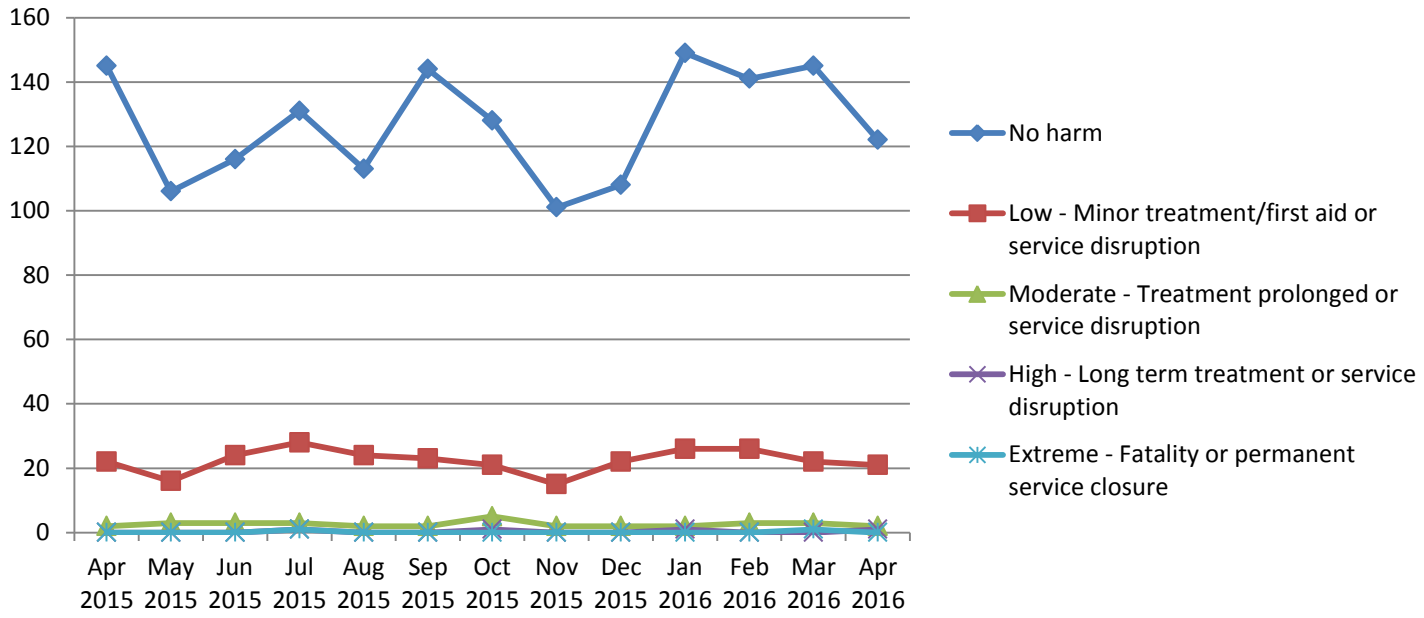
- Band 7 Interviews for Community TVN set for early June.
- Pressure Ulcer Prevention and Management Study Days fully booked for this year.
- Work with allied health professionals to audit patient seating with a view to trialling pressure relieving cushions as a way to reduce incidence rates further.
- Further roll-out of IHI work underway.

8. Patient Safety: April 2016
- Incident Profile: Falls

Falls														
Lead Director	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 16	Feb	March 16	April	Movement
	165	126	144	163	140	168	155	118	132	179	170	171	146	↓

Falls with Harm April 2015 to 2016			
No Harm	Low	Moderate	Severe
1649	290	32	2

Incidents by Incident date (Month and Year) and Severity



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 reduction in falls this month and compared to April 2015. There has been reduction in falls predominantly within the surgery and neurology division).

8. Patient Safety
- Infection Control

MRSA						
Lead Director	March	April	Movement	2016/2017 Threshold	Forecast May 2016	Date expected to meet standard
JH	0	0	⇔	0	G	31/03/17

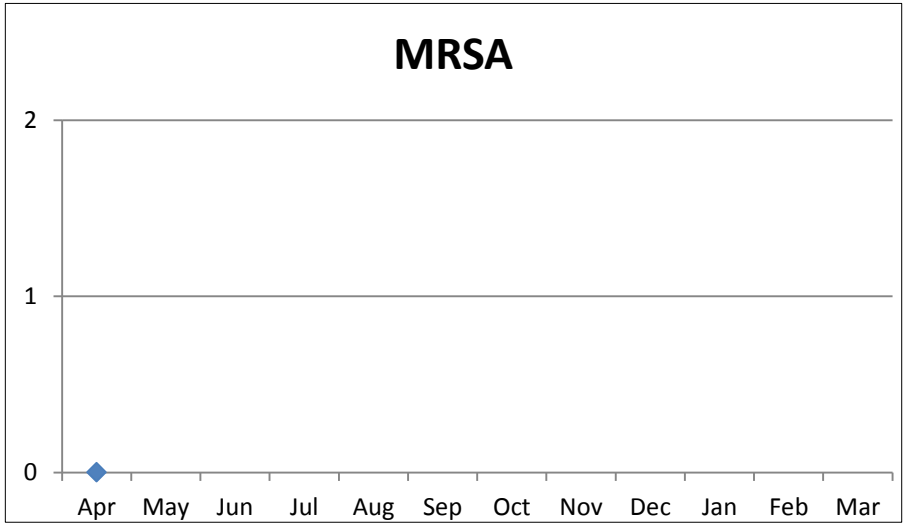
Peer Performance – YTD April 2016				
STG	Croydon	Kingston	King's College	Epsom & St Helier
0	0	0	0	0

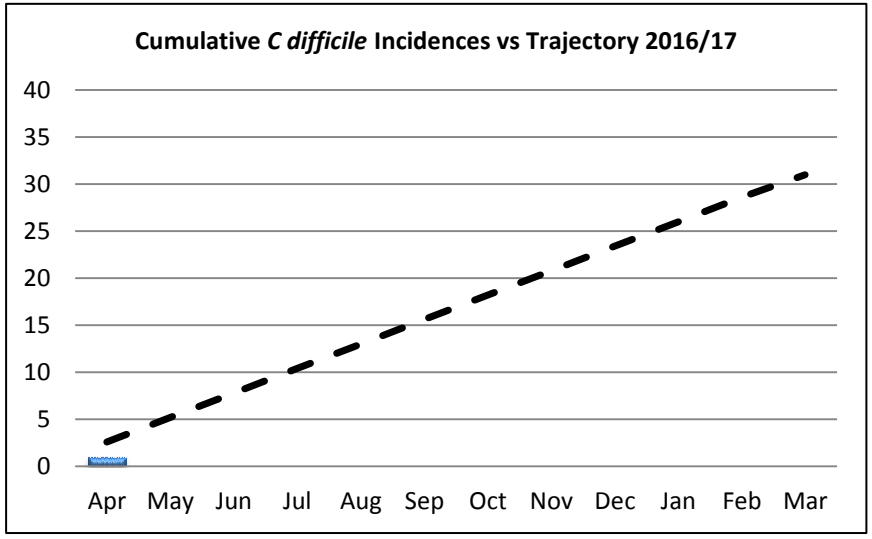
C. difficile						
Lead Director	March	April	Movement	2016/2017 Threshold	Forecast May 2016	Date expected to meet standard
JH	1	1	⇔	31	G	31/03/17

Peer Performance – YTD April 2016 (annual threshold in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
1 (31)	0 (16)	0 (9)	5 (72)	2 (39)

The MRSA bacteraemia threshold is zero. There were no MRSA Hospital-acquired bacteraemias in April 2016. The last hospital-acquired MRSA bacteraemia was on 23rd September 2015.

In 2016/17 the Trust has a threshold of no more than 31 *C. difficile* incidents. In April there was one episode. This makes a total of one for the FY to end April 2017.





8. 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	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 2016	Feb	March	April
Unify2	96.64%	96.45%	96.75%	96.56%	96.78%	97.22%	97.10%	96.8%	96.5%	96.6%	96.7%	97.04%	

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. Data is adjusted by HTG to exclude 'Not Applicable' recordings (these are validated by the team). **NB. The RAG ratings for the safety thermometer changed in April 2015 to be consistent with the UNIFY targets.**

Data Source	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 2016	Feb	March	April
Safety Thermometer	89.83%	90.19%	95.14%	94.84%	92.38%	91.28%	93.40%	93.24%	88.56%	94.10%	90.2%	94.04%	95.47%

Comparison of data streams:

There are differences in the methodology of collecting the different data streams. Data submitted to the Safety Thermometer is regularly validated by the thrombosis nursing team. The team consistently find variation in the interpretation of the audit tool across the Trust, resulting in inconsistent and sometimes inaccurate results. This problem is encountered nationally and limits the reliability and value of the data presented. 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).

2015/16 End of Year Summary:

The Trust has achieved the KPI target of >95% of patients to be risk assessed on admission to hospital consistently throughout the 2015/16 financial year (the end of year average has increased from 95.88% last financial year to 96.76% this financial year). The VTE Prevention Programme must continue to operate as it is raising awareness, identifying and resolving local issues and encouraging quality VTE prevention into the 2016/17 financial year. The Trust has the opportunity to improve quality further through optimal use of the electronic system. HTG must plan for and ensure heightened monitoring of compliance to VTE quality standards during the transition period from paper prescribing to electronic prescribing and documentation to ensure high standards are maintained and make sure the problems encountered at the last roll out are prevented from occurring again.

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. Representatives from the HTG are taking part in a working group led by Cerner UK to help co-design an improved VTE pathway for the electronic system which will support safe and effective implementation of VTE prevention guidelines.

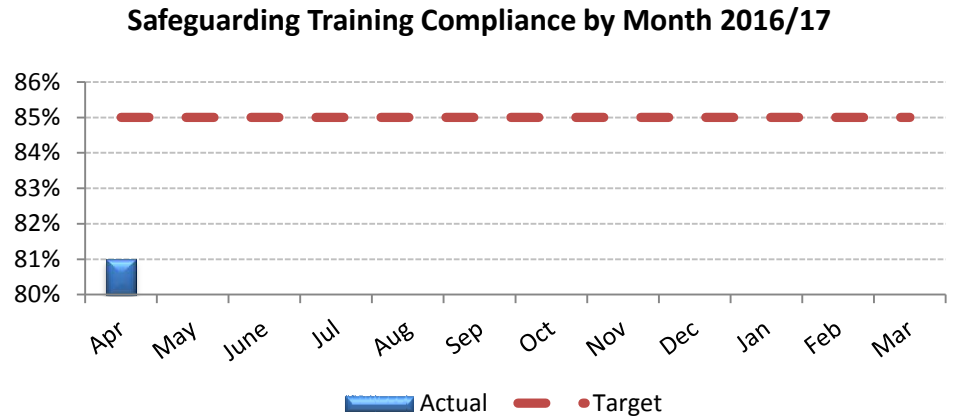
Root Cause Analysis (RCA) of Hospital Acquired Thrombosis (HAT)

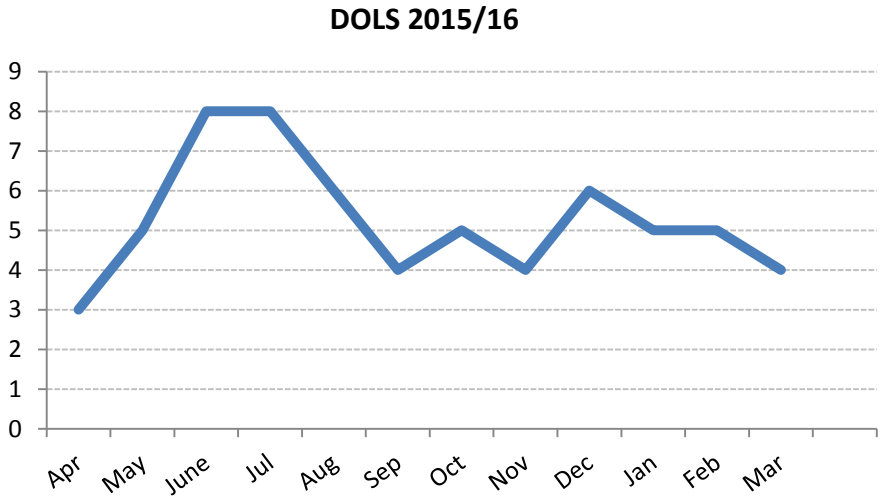
Year		2016
HAT cases identified to date (attributable to admission at SGH)		69
Mortality rate	Total	7 (10.1%)
	VTE primary cause of death	3 (4.3%)
Initiation of RCA process		100%
RCA complete		65.2% (45/69)
Cases where adequate prophylaxis was provided		41
Cases where inadequate prophylaxis was provided		4
Incidents jointly reviewed by HTG and clinical team		pending
Incidents investigated as SI		1

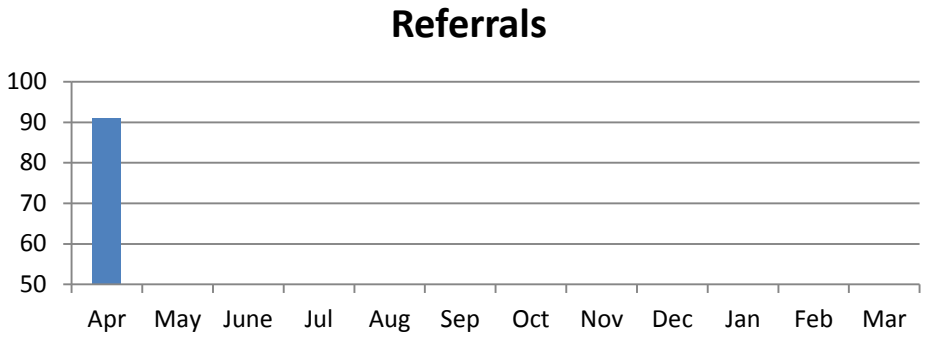
8. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Nov	Dec	Jan	Feb	Mar	April	2015/2016 Target	Forecast April 2016	Date expected to meet standard
JH	71%	70%	71%	73%	78%	81%	85%	A	-

Safeguarding Adults Training Compliance by Division – April 16				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
79%	81%	82%	82%	78%







DOLS: Since April 2014 and the Supreme Court judgement there has been a significant increase in DOLS activity which is 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. July 15 – fresh legal advice obtained around risk to organisation and patients with regard to non application of DoLs. Revised briefing paper presented for QRC July 2015.

Continue to monitor safeguarding training via ARIS and MAST steering group. Divisions to take action around low compliance

Review procedures following implementation of Care Act – Pan London procedures published Feb 2016 – local guidance completed Spring 2016

Roll out MCA training across trust, audit completed Spring 2016

8. Patient Safety
- Safeguarding Children

Division	No. requiring training	No of staff compliant	compliant %
Children and Women's Diagnostic and Therapy Services	607	508	83%
Community Services	117	115	98%
Corporate	3	3	100%
Medicine and Cardiovascular	197	153	76%
Surgery & Neurosciences	27	26	96%
Total	**951**	**805**	**85%**

Training : The Safeguarding Children team are continuing to take an in-depth look at the level 3 training figures on ARIS. It remains evident that staff who are known to be compliant are not recorded as such on ARIS. The safeguarding team are working with the MAST team re correcting the data and ensuring that staff are allocated to the appropriate level of training. The latter in conjunction with department leads and HR.

Serious Case Reviews and Internal Management Reviews: Potential SCR for a Surrey baby who was transferred from another hospital who subsequently died. He was on a Child Protection Plan for Neglect.

Other: 5 internal audits have been conducted recently: Safeguarding Issues Form and 3 for ED. In the community services a Record Keeping audit as been completed. The reports are available and are being presented at the Children and Young People's Safeguarding Committee on 11 May 2016.

2 members of the team will be attending a S11 audit interview on 11 May at Wandsworth Safeguarding Children Board.

The restructure review continues and is led by the Chief Nurse.

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9. Patient Experience
- Friends and Family Test

Service	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Average
Community Services	83% n=565	90% n=284 ^	87% n=353 v	86% n=401 v	87% n=430 ^	94% n=1213 ^	94% n=1337 –	93% n=536 v	94% n=393 ^	92% n=408 v	93% n=357 ^	93% n=369 –	91% n=6646
Medicine and Cardiovascular	93% n=837	95% n=955 ^	95% n=900 –	96% n=710 ^	94% n=807 v	96% n=687 ^	96% n=724 –	97% n=615 ^	96% n=707 v	97% n=707 ^	96% n=604 v	97% n=772 ^	96% n=9025
Surgery Anaethetics and Neuro	95% n=1152	95% n=1098 –	93% n=986 v	90% n=767 v	88% n=736 v	92% n=787 ^	90% n=709 v	91% n=642 ^	92% n=677 ^	90% n=598 v	93% n=641 ^	94% n=820 ^	92% n=9613
Women and Childrens	89% n=474	95% n=584 ^	93% n=567 v	93% n=498 –	93% n=429 –	93% n=480 –	93% n=397 –	91% n=336 v	92% n=273 ^	92% n=251 –	91% n=288 v	90% n=304 v	92% n=4881
Trust	**88% n=3028**	**94% n=2921 ^**	**93% n=2806 v**	**92% n=2376 v**	**91% n=2402 v**	**94% n=3167 ^**	**93% n=3167 v**	**93% n=2129 –**	**94% n=2050 ^**	**93% n=1964 v**	**94% n=1890 ^**	**94% n=2265 –**	**93% n=30165**

Our Friends and Family Test scores (the percentage of people who said they were “Extremely likely” or “Likely” to recommend a service to friends or relatives) are reported above by division.

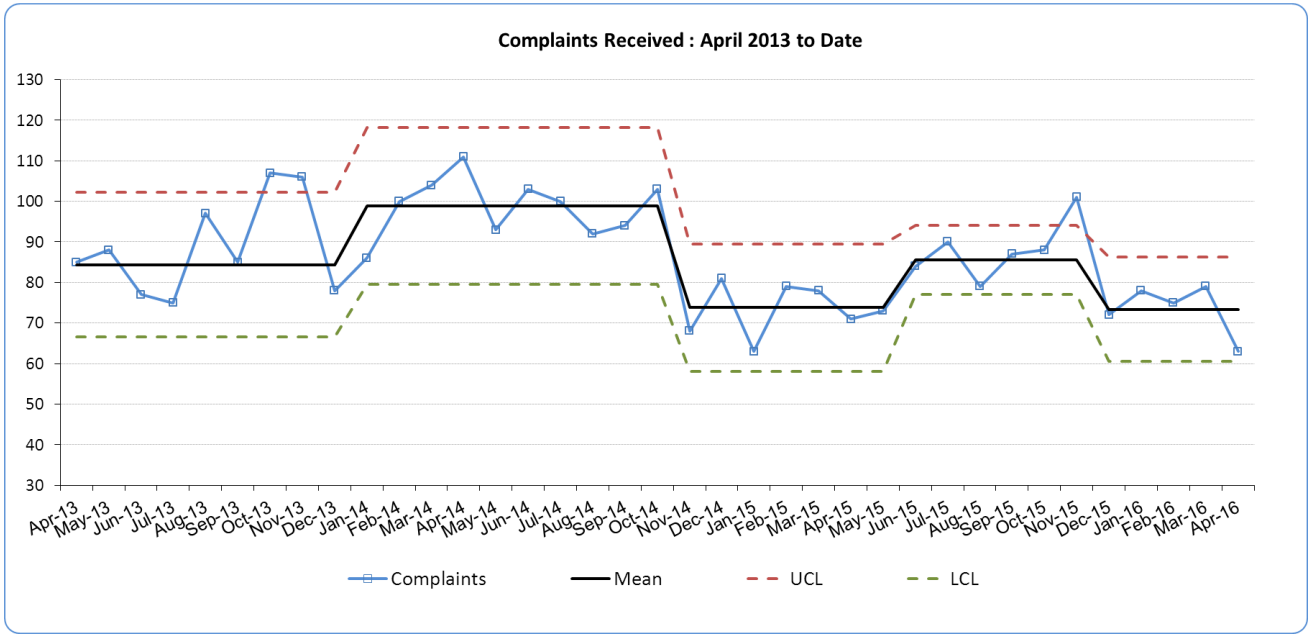
This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient or relative that would have trouble understanding the standardised survey question.

Further breakdowns are available for services and location type.

Outpatient based services underperforms all other settings in the Trust, while Critical Care and Day case services are scoring the highest.

9. Patient Experience
- Complaints Received

Complaints Received														
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	Movement
Total Number received	71	72	84	90	79	86	88	102	72	78	74	79	63	↓



Overview:

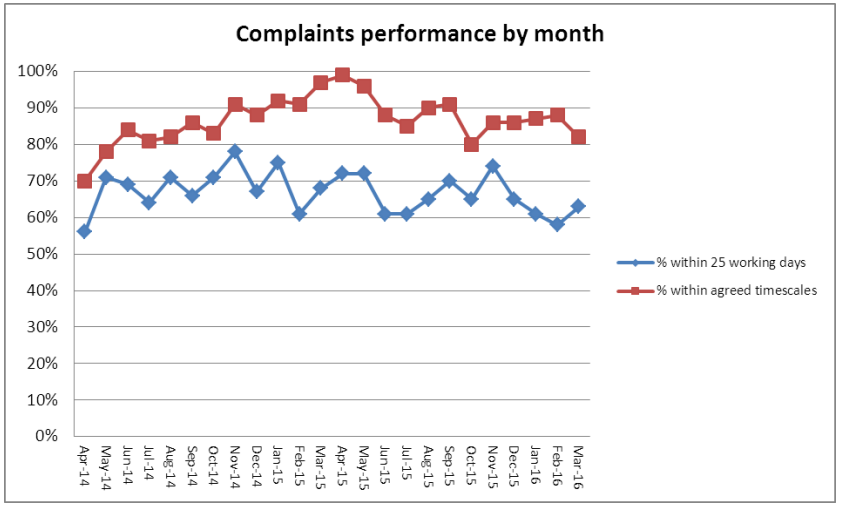
This report provides an update on complaints received in quarter 4 of 2015/2016 and information on responding to complaints within the specified timeframes for the same period, with divisional breakdowns and analysis of the data to provide some trends and themes. It also includes some actions taken and planned in quarter 4, 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 4 of 2015/2016

There were 231 complaints received in quarter 4 of 2015/2016, a reduction when compared to quarter 3 when 262 complaints were received. Complaints reduced in the Medicine and Cardiovascular and Surgery and Neurosciences Divisions and significantly so in the Children, Women's, Diagnostics and Therapeutic Division. Complaints increased slightly in the Community Services Division and Corporate Directorates.

9. Patient Experience
- Complaints Performance against targets

Performance Against Targets Quarter 4 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 and Women's	57	27	47%	(20) 82%
Medicine and Cardiovascular	77	52	68%	(20) 94%
Surgery and Neurosciences	61	37	61%	(8) 74%
Community Services	18	11	61%	(4) 83%
Director of Estates and Facilities	14	11	79%	(1) 86%
Other Corporate Directorates	4	4	100%	(0) 100%
Totals:	231	142	61%	(53) 84%



Commentary:

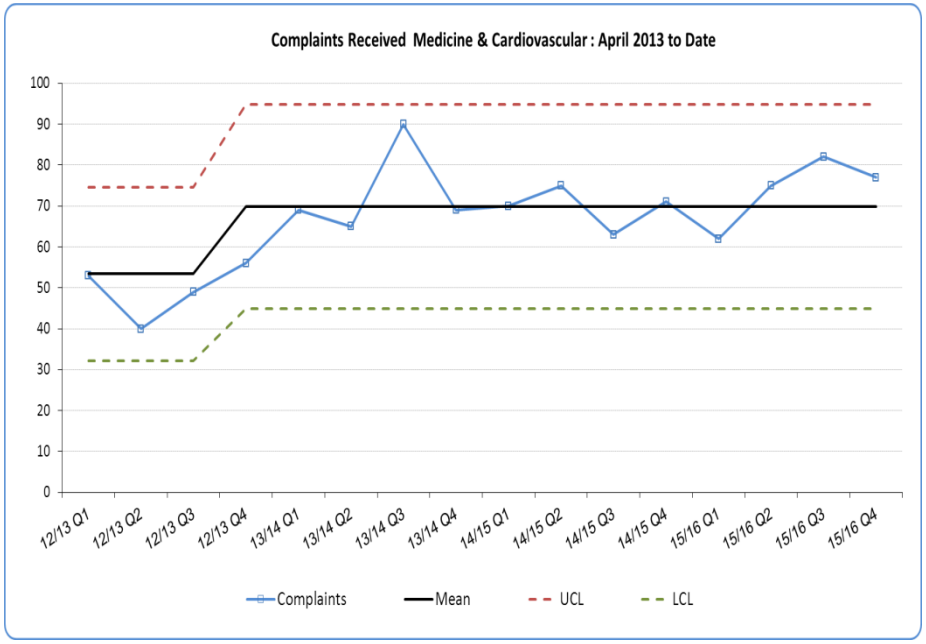
There was a decline in complaints performance against the first target in quarter 4 when compared to quarter 3. 61% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 69% in quarter 3. There was a decline in performance against the second target with 84% of complaints responded to within agreed timescales (against internal trust target of 100%) compared to 97% in quarter 3.

Other Corporate Directorates (i.e. Nursing and Finance) are the only areas where the targets were met although Medicine and Cardiovascular came very close to meeting the second target.

A workshop took place on 19 April 2016 to review how the complaints process is working and how we might go about improving performance and strengthening learning. Represented were the Corporate Nursing team, Divisional Directors of Nursing and Governance, Heads of Nursing and Matrons, General and Operational Managers, Divisional Governance Managers and the corporate Complaints and PALS teams.

Following the workshop an action plan has been developed by the Patient Experience Manager and Deputy Chief Nurse in consultation with the Divisional Directors of Nursing and Governance. This is being presented to the May Quality and Risk Committee.

9. Patient Experience
- Complaints – Q4 by Medcard division



The division has received 77 complaints in Q4 which was a reduction in complaints from Q3 when they received 82. The division has received a mean average of 69.9 complaints each quarter this year. Whilst the division has been working to achieve the 85% target of complaints responded to within 25 days and 100% in agreed timescales, this has not been achieved. The division for Q4 achieved a performance of 68% within 25 days and 94% in agreed time scales. RHO responded to 100% of complaints within 25 days for Q4. In order to monitor and improve performance the division continues to implement the following steps alongside addressing complaint actions to reduce numbers received:

- Continuation of additional support to directorates
- DDNG holds weekly review and performance meeting with HoN/GM
- Weekly follow up meeting on timescales by DDNG
- Extensions should be requested if not submitted to complaints by day 21.
- Escalation of complaints not submitted by day 20 at team meeting to DDO
- Action plan to be incorporated into response template

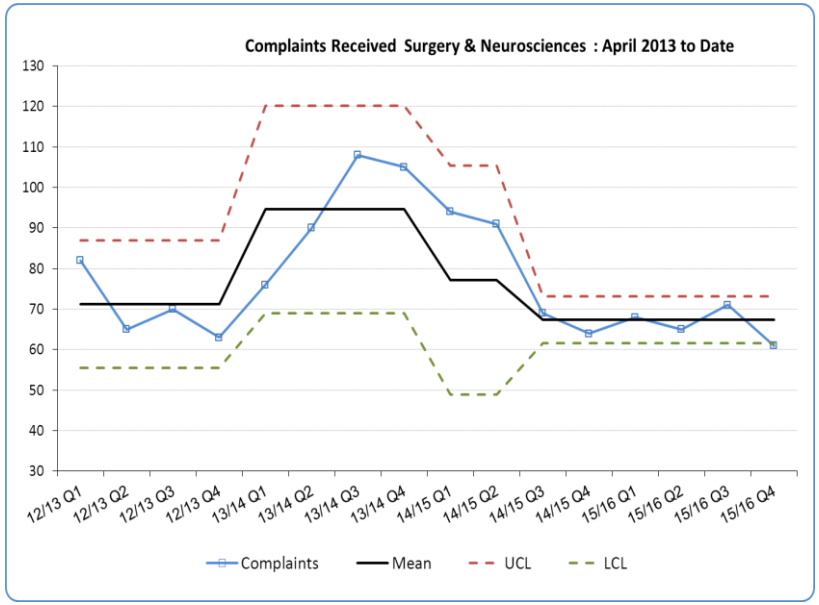
On review of the complaints received for Q4 the 3 main themes are Clinical treatment, Diagnosis Communications and Nursing care. These are predominantly spread between ED and Acute medicine, in part due to these areas receiving the most complaints due to the volume of patients cared for in these areas.

On review of the areas of concern the following actions have been taken to improve care and reduce complaints:

- A member of nursing staff has completed retraining and assessment in the management of shoulder dislocations
- Review of triage process in ED and new model of meet and greet/streaming to be implemented in Q1, including reassessment of patients waiting in waiting room
- Staff involved in complaints to complete reflective accounts and be stored in files
- Don't take your troubles home posters displayed across wards in Acute Medicine
- Action plan template to be incorporated into complaint response
- Quality Observatory implemented to monitor documentation and include patient discussions by senior member of nursing team

9. Patient Experience

- Complaints – Q4 by Surgery & Neurosciences division



General Surgery/Urology

Merlin completion - Unnecessary delays causing lack of continuity to patient pathways and poor patient experience e.g follow ups not being booked and GPs unaware of patient procedures and care plans.

Actions

Marcus Reddy, Care Group lead has discussed and re-emphasised the importance of Merlins at care meeting. complete

Implement a junior doctor rota to clear the backlog and to ensure going forward the Merlins are complete within 48 hours – complete

Consultants are not to rely on their junior doctors to complete Merlins, we have had a healthy discussion with the consultant body and they have agreed to start doing the Merlins themselves where possible.

The management team will send a weekly reminder from the generated merlin report to ensure we are capturing all patients – start week 18/5/16

Every time a merlin isn't complete a datix is being completed to reinforce the seriousness of this matter

The GM Kerry Foley and Marcus Reddy personally leading on improving this, particularly in upper GI

Volume of complaints is low and training for new starters has been well received and is building capacity into the system.

Surgical Nursing

A number of complaints regarding transport- surgery have been more rigorous around compliance with the transport policy criteria and all journeys are now authorised by the nurse in charge to ensure consistency- this has led to a number of complaints from patients whose transport requests have been legitimately turned down.

Actions

Flow chart highlighting criteria available on each ward, Nurse in charge supporting decisions and patient discussions. Training provided to facilitate this.

The flow programme are about to launch a pack of bedside patient information, have updated patient discharge leaflets and produced a poster highlighting transport criteria for all ward areas. The aim of this being to improve communication and manage patient expectation more effectively.

Neurosciences

Themes: Nursing care / attitude: OPA and waiting times: Communication

Actions

Service improvement work undertaken in Neuro out-patients to improve patient experience. Neuro out-patients has now taken responsibility for managing its own service. This has improved appointment DNA rates and provides a rapid responsive service to answering patient phone calls. Clear processes in place from admission to discharge. All nursing staff are now clear of their responsibility when communicating with patients by offering the right information at the right time enabling patients to understand their admission, in-patient and discharge pathway.

Big focus on nursing staff recruitment to decrease use of agency staff. Successful recruitment from both the recent Philippines trip and consistent advertising for band 5 nurses is proving to be effective.

Increased work to take place to ensure that awareness is raised in conjunction with communication between patients and staff. Feedback of patient complaints shared at nursing team meetings to enable shared learning.

9. Patient Experience

- Complaints – Q4 by Children's, Women's, Diagnostics and Therapy division

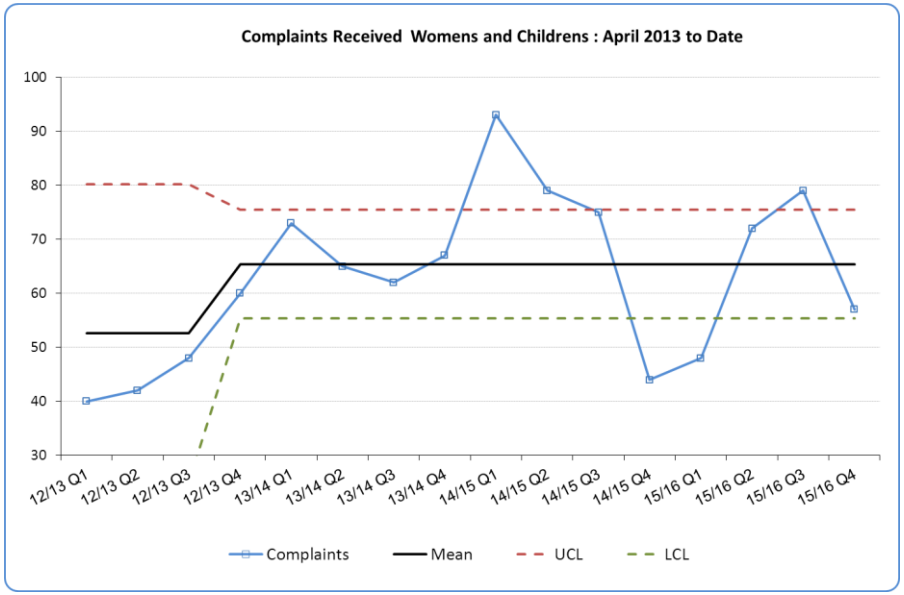
Children's, Women's, Diagnostics and Therapeutics Q4

CWDT&CC Division saw a decrease in complaints from 79 in Q3 to 57 in Q4. Women's services had the highest number of complaints in Q3 and Therapeutics in Q4, therapeutics includes pharmacy, corporate outpatients and therapies .

Themes
The top themes of complaints in the division are:

Communication
Waiting Times
Clinical Treatment
Care

Communication, waiting times and clinical treatment / care are consistent themes across the division and mirror previous quarters.



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Actions

Communication
Communication issues spreads across a broad range of services and across different professional groups. Where there are specific complaints about the attitude of staff; these are dealt with immediately by managers.

The corporate outpatients (COS) team are currently working with the education department to look at development opportunities for staff of bands 2- 4 working in COS and the Central Booking System (CBS), including the introduction of a rotation. The aim is to increase in staff satisfaction which will assist in some of the attitude /communication issues that have been highlighted in complaints.

A series of educational films which reflect actual complaints from the children's directorate are now being rolled out to the nursing staff as part of mandatory training. These will now be rolled out to a wider audience as the learning can be applied to a number of different areas within the division.

Waiting Times
The pharmacy team have reviewed the drugs that are available in the satellite pharmacies, to ensure that they can provide the patient's drugs in a timely way at the point of discharge. The pharmacy team have also revised how they communicate with the ward staff regarding patients who are being discharged. This will improve efficiency and reduce the time the patients wait

There is on-going work to ensure that patients within COS clinics are adequately informed about waiting times within clinics.

Concerns are being raised regarding the efficiency of the CBS, with patent's not receiving appointments and also the time taken to answer calls. There has recently been a change of management with all outpatient services now being managed by COS. As a result specific resource has been allocated to focus on the systems and processes within the CBS call centre; this will also include how to increase staff engagement as this also needs to be improved.

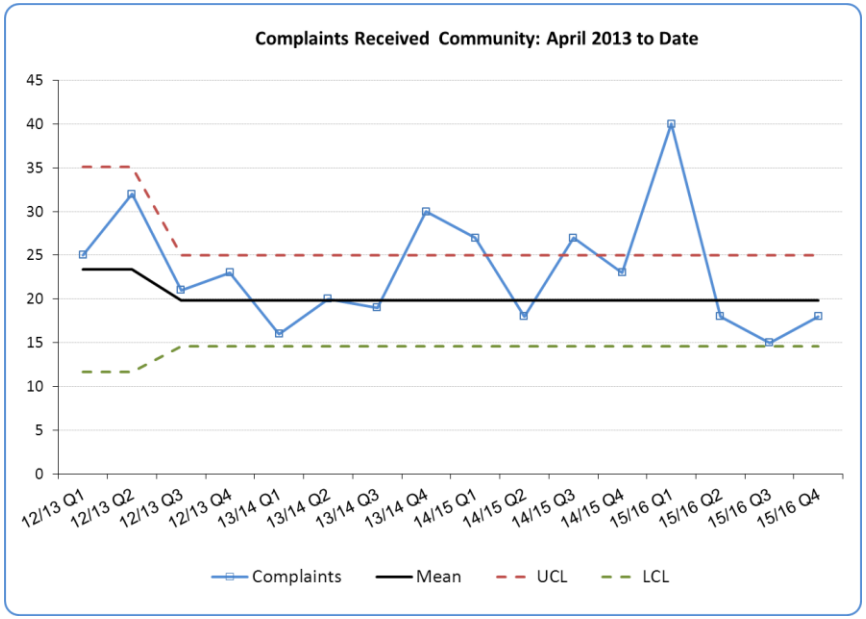
Care /Clinical Treatment
All clinical treatment concerns are addressed on a case by case basis
Maternity does however have a slightly higher proportion of complaints relating to clinical treatment and care, further analysis suggests that some complainants are unhappy with their birth experience. In recognition of this the service have now established a 'birth reflections' clinic, this enables women to review and reflect on their birth experience with the support of a member of the midwifery or obstetric team. This facility is open to all women irrespective of when they have given birth and is being offered in a proactive way.

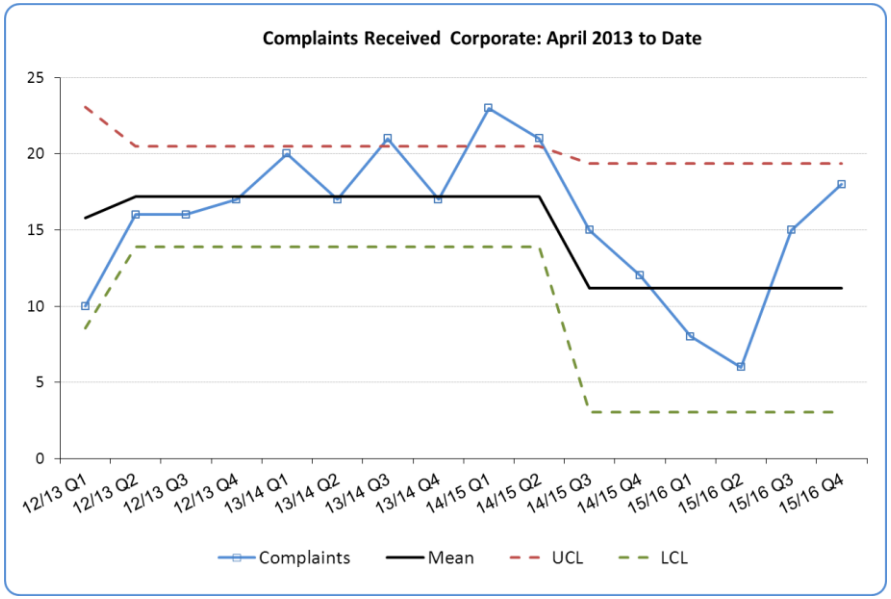
It is worth noting that there have been no complaints regarding the suspension of the urogynaecology service in this quarter.

Work has been carried out with the manufacturer of a certain cannula in paediatrics to try and reduce the risk of pressure with this particular device

9. Patient Experience

- Complaints – Q4 by Community division





Community Services Division Q4 2015/16:
CSD received 18 new formal complaints: of these one (NN 1249) remains open until extension date of 26/5/2016, so if this closes within time the Divisional performance will improve (89%).

In Q4, 11 complaints were received from OHC: the main theme of the incidents was coded to the subject theme 'clinical treatment' (8). The other 2 themes in Q4 were coded to 'communication' and 'waiting times'. These are across outpatient and diagnostic services where waiting times & clinic times/ sites have changed.

Actions to reduce further complaints include
Clinical Treatment :-
clinic appointments are triaged on clinical need to ensure those with most urgent need are treated first, additional clinic sessions are being planned.
Communication and waiting times :-
updating the information across the community Integrated Sexual Health clinic sites, updating the information on trust intranet sites. The updated service paper leaflet advises clients to telephone the clients to telephone the office prior to attending to check opening times. Where short notice cancellation and changes happen then ansa phone messages and social media will be updated with most recent news.

CSD conduct an annual review at financial year end for a paper at May DGB. OHC care group had the highest number of complaints in the 2015/16 year (36). CSD had a range of 15- 39 complaints per quarter in the 2015/16 year. Each quarter numbers and themes per Care Group are reviewed and monthly monitoring on performance of closure against target are reported at DGB.

Corporate Directorates
Complaints about Corporate Directorates increased from 15 in quarter 3 to 18 in quarter 4. 14 complaints were received about Estates and Facilities, the same number as in quarter 3. There was a reduction in complaints about Transport from 6 to 3 but an increased in complaints about car parking from 2 to 4.

Action:

Regarding catering:

In response to a complaint about the food in the restaurant being cold and a patient feeling ill after eating there, a full investigation was carried out in relation to the total food safety management system for the restaurant including the retraining of staff, checking of equipment and temperature controls. These will be continually reviewed as part of the trust's auditing processes.

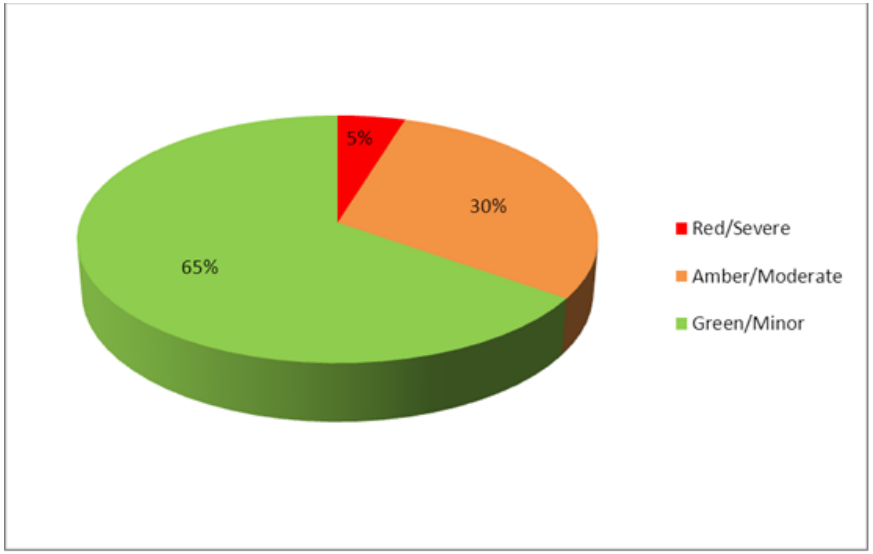
As a result of a complaint about a malfunctioning vending machine, all vending machines on site will have additional planned testing to ensure they are fully functioning and safe.

9 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 4 of 2015/2016 is presented below. A more detailed report will be presented at the Patient Experience Committee.

In Quarter 4 a total of 11 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 4 a total of 69 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 4 a total of 150 complaints were categorised as Green/Minor.

9. 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. Below are some examples of comments/stories posted on NHS Choices and Patient Opinion since the last board report. Of note only one negative comment was received out of nine posts made since the May board report.

RG gave Cardiology at St George's Hospital (London) a rating of 5 stars
emergency cardiac treatment
I attended A&E on a busy Sunday 8th May at 10pm. After 5 hour wait I was admitted to Atkinson Morley where I was stabilised prior to transfer to the new Charles Pumphrey Unit which was excellent. All the staff I came into contact with were excellent - helpful, efficient, effective and I was quickly sent for angioplasty in the very well-equipped labs. Having had 7-8 angiograms before, this was one of the best and I'd like to say thanks to the doctor and team and the cardiac nurse.

Visited in May 2016. Posted on 11 May 2016

PatientSGH reviewed St George's Hospital (London)
Excellent Patient care for MRI
I arrived for an MRI at the mobile MRI unit at St George's Hospital, Tooting, yesterday rather agitated as I had just had a rather unpleasant experience at work and I am quite claustrophobic. Pedro and his colleague (I didn't catch his name) were both extremely kind and put me at ease, both cheering me up and making the MRI experience the best I have had - I did not experience claustrophobia at all. It is a pleasure to meet clinical staff who take so much care with a patient.

Visited in April 2016. Posted on 30 April 2016 using Patient Opinion

Anonymous gave Oral and Maxillofacial Surgery at St George's Hospital (London) a rating of 1 stars
Back to the eighties
No interest in the person as a human being, shocking waiting times, worn-out interior.

Visited in May 2016. Posted on 04 May 2016

Anonymous gave Accident and emergency services at St George's Hospital (London) a rating of 5 stars
My experience
I was taken into St Georges after falling down the stairs at my sisters house.. The care that I received from everyone attending me was second to none.I cannot thank them enough after a very frightening experience.

I spent 24 hours under observation even during the night.
The hospital itself is wonderful everywhere so clean staff so kind.
I was taken straight into trauma resus unit so no waiting to be seen,
I always watch the tv programme 24 hours in a&e so felt strange to actually be there and see first hand how it all works.

Well done St Georges.

Visited in April 2016. Posted on 25 April 2016

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responsible
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WORKFORCE

Excellence in specialist and community healthcare

10. Workforce: April 2016
- 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 April 2016. 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 April 2016 the trust achieved an average fill rate of 94.52%%, a slight increase from 94.14% submitted in March 2016. The trend over the past six months is outlined below:

MONTH	NOV 15	DEC 15	JAN 16	FEB 16	MAR 16	APR
%	93.93%	95%	94.33%	93.92%	94.14%	94.52%

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 and update

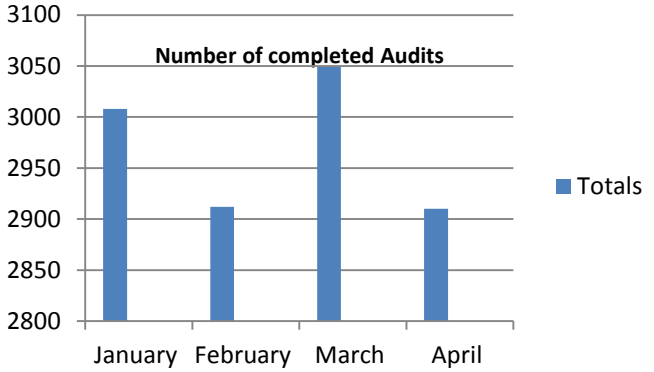
Compliance framework is to be presented to the nursing board for action in June to ensure all areas complete rosters 8weeks in advance.

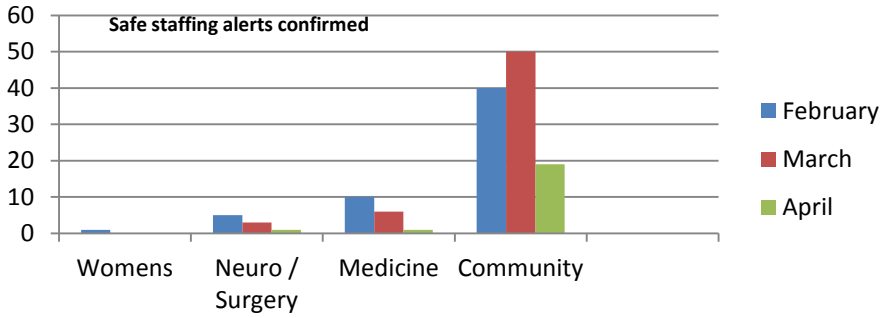
This data collection will stop and will be replaced by CHPPD – care hours per patient day. NHS Improvement are now asking for the collection of Care hours per patient day (CHPPD) monthly (beginning in April 2016) and for this to be collected daily from April 2017 as recommended by the Carter review. Recent correspondence has requested that the collection start in May (the trust was informed of this requirement on Friday 22 April 2016). CHPPD is to be developed to become the principal measure of nursing and healthcare support worker deployment. The purpose of CHPPD is to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. The tool was developed, and tested in 27 sites (St.Georges was one of these). CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight**).** CHPPD reports split out registered nurses and healthcare support workers to ensure skill mix and care needs are met. The reporting template will not be available from UNIFY until 1 June 2016. Data collection is underway for May and reporting on this new tool will begin in June 2016.

	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	92.0%	#DIV/0!	98.7%	100.0%	
Carmen Suite	127.3%	57.5%	100.1%	90.0%	
Champneys Ward	107.0%	119.6%	98.9%	100.0%	
Delivery Suite	104.4%	76.2%	109.6%	98.3%	
Fred Hewitt Ward	93.7%	87.0%	99.6%	87.5%	
General Intensive Care Unit	94.8%	49.7%	98.6%	73.9%	
Gwillim Ward	115.4%	59.9%	99.2%	90.0%	
Jungle Ward	103.9%	0.0%	#DIV/0!	#DIV/0!	
Neo Natal Unit	86.5%	#DIV/0!	87.7%	#DIV/0!	
Neuro Intensive Care Unit	91.2%	92.6%	94.4%	94.2%	
Nicholls Ward	87.7%	95.6%	98.5%	82.6%	
Paediatric Intensive Care Unit	88.7%	95.6%	91.7%	100.0%	
Pinckney Ward	112.2%	93.9%	100.0%	#DIV/0!	
Dalby Ward	94.5%	111.3%	100.0%	100.0%	
Heberden	105.6%	103.3%	85.8%	96.4%	
Mary Seacole Ward	96.1%	103.1%	99.9%	99.5%	
A & E Department	93.8%	93.7%	104.3%	85.8%	
Allingham Ward	91.8%	117.0%	98.3%	100.0%	
Amyand Ward	88.2%	109.0%	98.7%	100.1%	
Belgrave Ward AMW	87.8%	86.6%	99.9%	100.0%	
Benjamin Weir Ward AMW	85.4%	87.0%	99.2%	102.0%	
Buckland Ward	90.1%	78.4%	100.0%	100.0%	
Caroline Ward	91.7%	83.1%	99.9%	133.3%	
Cheselden Ward	89.9%	106.9%	99.1%	100.0%	
Coronary Care Unit	99.7%	270.6%	99.4%	197.8%	
James Hope Ward	84.2%	101.6%	85.7%	#DIV/0!	
Marnham Ward	89.9%	89.1%	100.0%	90.3%	
McEntee Ward	92.9%	98.7%	100.0%	102.6%	
Richmond Ward	95.2%	103.6%	98.9%	97.5%	
Rodney Smith Med Ward	94.6%	91.6%	93.6%	97.2%	
Ruth Myles Ward	100.5%	81.1%	106.0%	0.0%	
Trevor Howell Ward	99.1%	78.3%	97.8%	98.2%	
Winter Ward (Caesar Hawkins)	90.1%	107.4%	98.4%	101.5%	
Brodie Ward	95.8%	96.0%	97.0%	100.0%	
Cavell Surg Ward	85.7%	91.5%	100.0%	100.0%	
Florence Nightingale Ward	94.1%	84.7%	100.0%	106.3%	
Gray Ward	88.1%	80.3%	99.9%	93.4%	
Gunning Ward	94.9%	94.8%	100.0%	101.6%	
Gwynne Holford Ward	89.4%	86.7%	95.5%	98.2%	
Holdsworth Ward	115.6%	105.0%	86.3%	85.1%	
Keate Ward	93.6%	91.0%	98.8%	100.0%	
Kent Ward	90.3%	92.9%	99.2%	98.6%	
Mckissock Ward	89.1%	101.9%	93.5%	98.2%	
Vernon Ward	89.0%	99.5%	100.7%	107.6%	
William Drummond HASU	84.9%	85.9%	92.4%	95.2%	
Wolfson Centre	82.1%	99.3%	98.0%	100.0%	
Gordon Smith Ward	94.4%	86.7%	100.8%	100.0%	
Nightingale Step Down, Off Site Facility	27.3%	42.4%	36.1%	42.2%	
Trust Total	92.56%	93.64%	97.08%	95.73%	94.52%

Day Qual	Day HCA	Night Qual	Night HCA	Overall
92.56%	93.64%	97.08%	95.73%	94.52%

10. Workforce
April 2016 - 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: February 2912, March 3049 and April 2910. There was a significant decrease in the number of final alerts reported from 59 in March to 21 in April 2016. 13 of the alerts relate to one specific community service which has been unable to recruit and has a contingency plan in place. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) following on the day investigation over the post three months is February 33, March 13 and April 5. Of 3 nursing related safe staffing concerns raised on Datix system in April (3 in March) none matched a similar entry on the RATE system. Senior nurses are made aware of alerts and concerns at 10am. Previously only alerts were shown. Concerns have been added to the email notification and this may be a reason for the significant drop in both alerts and concerns.

Approximately 60 student nurses have accepted staff nurse posts to commence in September and a recruitment campaign to the Philippines resulted in 144 offers to nurses who will commence in post between August 2016 and January 2016. The impact on safe staffing and retention should be visible from August at the earliest.

MONTH	APRIL	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR
ALERTS	10	11	5	2	12	27	9	10	35	29	56	59	21
CONCERNS	15	18	16	17	24	14	37	13	10	18	33	13	5

Actions: Continue to raise the link between datix and the rate system with the nursing body with the aim to achieve greater consistency.
Risk: Retention is impacting on safe staffing as is the lack of registered nurses on the staff bank available to fill vacancies.

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HEATMAP DASHBOARD
WARD VIEW

Excellence in specialist and community healthcare

Nursing and Midwifery Heatmap

April 2016

Division	Ward	Incidence of c.difficile	Incidence of MRSA	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 rate - (ward)
COMMUNITY SERVICES	Mary Seacole	0.0	0.0	0.0	85.7	85.7	56.0	4.7	7.0	0.0	10.4
	Nightingale	0.0	0.0	0.0	100.0	100.0	60.0		0.0	0.0	5.1
	OPD (QMH)	0.0	0.0	0.0					6.0	0.0	
	South Locality (CCM)	0.0	0.0	0.0					0.0	0.0	
MEDICINE	ALLINGHAM	0.0	0.0	0.0	96.0	100.0	26.5	-2.5	10.0	0.0	11.6
	AMYAND	0.0	0.0	0.0	85.7	100.0	22.2	2.7	8.0	0.0	4.6
	BELGRAVE	0.0	0.0	0.0	100.0	96.9	24.1	4.3	2.0	0.0	3.2
	BENJAMIN WEIR	0.0	0.0	0.0	96.7	97.1	30.6	11.3	0.0	0.0	1.0
	BUCKLAND	1.0	0.0	0.0	81.0	97.1	50.7	-4.6	4.0	1.0	0.7
	CAESAR HAWKINS	0.0	0.0	0.0	91.3	90.0	13.9	7.1	9.0	0.0	1.0
	CARDIAC CARE UNIT	0.0	0.0	0.0	88.9	100.0	120.0	10.3	0.0	2.0	6.0
	CAROLINE	0.0	0.0	0.0	86.4	97.8	48.4	12.9	3.0	0.0	0.7
	CHESELDEN	0.0	0.0	0.0	90.9	91.2	43.0	8.5	0.0	0.0	1.9
	DALBY	0.0	0.0	0.0	91.7	100.0	28.3	3.8	8.0	0.0	3.1
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		83.0	25.3	2.3	4.0	0.0	5.0
	GORDON SMITH	0.0	0.0	0.0	100.0	92.1	82.6	10.8	0.0	0.0	3.5
	HEBERDEN	0.0	0.0	0.0	83.3	93.3	36.6	2.5	7.0	0.0	2.7
	JAMES HOPE	0.0	0.0	0.0	100.0	97.1	74.7	16.6	0.0	0.0	1.8
	MARNHAM	0.0	0.0	0.0	96.4	91.7	27.3	13.9	2.0	0.0	3.3
	MCENTEE	0.0	0.0	0.0	94.4	100.0	45.5	2.1	2.0	0.0	2.7
	RICHMOND	0.0	0.0	0.0	100.0	95.4	57.1	8.7	8.0	0.0	5.4
	RODNEY SMITH	0.0	0.0	0.0	100.0	83.3	34.0	4.6	7.0	0.0	2.6
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	100.0	100.0	50.0	6.7	0.0	0.0	4.1
	TREVOR HOWELL	0.0	0.0	0.0	93.8	97.5	52.6	3.9	5.0	0.0	5.3

April 2016

Division	Ward	Incidence of c.difficile	Incidence of MRSA	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 rate - (ward)
SURGERY	CAVELL	0.0	0.0	0.0	96.3	71.2	26.0	5.9	1.0	0.0	6.5
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	100.0	93.7	80.7	-0.5	4.0	0.0	4.6
	GRAY WARD	0.0	0.0	0.0	88.5	91.7	83.0	16.0	2.0	0.0	1.8
	GUNNING	0.0	0.0	0.0	96.0	91.7	77.4	2.1	5.0	0.0	0.0
	GWYN HOLFORD	0.0	0.0	0.0	97.7	100.0	50.0	10.1	7.0	0.0	9.2
	HOLDSWORTH	0.0	0.0	0.0	100.0	96.6	73.5	2.1	2.0	0.0	5.0
	KEATE	0.0	0.0	0.0	100.0	97.3	73.3	16.1	0.0	0.0	7.0
	KENT	0.0	0.0	0.0	100.0	100.0	37.9	6.3	5.0	0.0	1.2
	MCKISSOCK	0.0	0.0	0.0	100.0	96.6	47.0	7.7	0.0	0.0	12.9
	THOMAS YOUNG	0.0	0.0	0.0	91.7	83.3	27.3	9.5	7.0	0.0	5.4
	VERNON	0.0	0.0	0.0	90.0	95.7	30.6	8.4	2.0	0.0	2.3
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	93.4	52.1	12.9	3.0	0.0	1.4
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0	0	0	94			6	1	0	4
	CARMEN SUITE	0	0	0	100			-6	0	0	1
	CHAMPNEYS	0	0	0	100	100	8	-2	4	0	7
	DELIVERY	0	0	0	100	87		-3	0	2	6
	FREDDIE HEWITT	0	0	0				9	0	0	5
	GENERAL ICU/HDU	0	0	0	100			5	0	0	1
	GWILLIM	0	0	0	100	80		6	0	0	3
	JUNGLE	0	0	0		100	167	-2	0	0	1
	NEONATAL ICU	0	0	0	100			7	0	0	4
	NEURO ICU	0	0	0	100			6	0	0	1
	NICHOLLS	0	0	0		100	2,133	12	0	0	10
	PICU	0	0	0	100	100	0	6	0	0	6
	PINCKNEY	0	0	0	100	100	86	-2	0	0	1

12. Ward Heatmaps: Women's and Children's

April 2016

Cardiothoracic Intensive Care (CTICU)

CTICU scored 94.4% in relation to harm free care this relates to one old grade 3 pressure ulcers.

Sickness

Staff sickness amongst the nursing staff is still fairly consistent across the division with previous months. There are a number of long term sickness cases that are progressing in line with policy and the bi – monthly divisional meetings monitoring sickness and rota management continue.

Friends and Family

The Friends and Family metric remains challenging in relation to accuracy. The informatics team are now looking into this in more detail to ascertain where the discrepancies lie within the system and how this can be resolved.

Serious Incidents

There were a total of 2 serious incidents in this month, both of which relate to the delivery suite One in relation to a drug administration omission and the other relating to an unexpected admission to the neonatal unit. These incidents are being investigated and the findings will be shared at the divisional governance board.

12. Ward Heatmaps: STNC

Cavell - 2 red indicators and 1 amber indicator. The first red indicator related to 1 fall. This amount of falls should not have triggered as the monthly quota for the ward is 3. The second red indicator related to sickness absence of 6.5%. 2 staff members were on long term sickness, but have now returned to work and their absence was managed to trust policy. The amber indicator related to a F & F response rate of 26%. This has been an on-going issue and the ward matron and sister are setting objectives for the team to meet the trust target of 40%

Florence Nightingale – 2 red indicators. The first red indicator related to 4 falls; however there were only 2 falls for the month of April-one was a staff member who slipped on water, no harm and the other fall was a patient who slipped off her chair, no harm also. The second red indicator related to sickness absence of 4.6%. This is due to one member of staff on long term sickness (managed to trust policy).

Gunning – 1 red indicator relating to 5 falls. All were no harm.

Holdsworth –2 red indicators. The first red indicator was due to sickness of 5%. One staff member was on long term sickness and there was one episode of short-term sickness, both were managed to trust policy. One member of staff is also currently on maternity leave. The second red indicator is related to 2 falls, this should not have triggered a red indicator as the falls threshold for Holdsworth ward is 4 per month. All falls were low harm.

Keate- 1 red indicator sickness and absence of 7%. One staff on long term sickness (managed to trust policy) and one staff member was on maternity leave.

Gray- 2 red indicators. The first red indicator related to a harm free care percentage of 88.5%. This score was incorrect as it stated that two grade 2 pressure ulcers were attributed to Gray ward. The nurse who completed this audit has been met with and training has been completed on data input to the safety thermometer on RATE. One patient had a catheter and an old UTI, this information is correct. The second indicator related to 2 falls (should not have triggered as the monthly quota for the ward is 4). Both falls were no harm.

Vernon-1 red and 1 amber indicator. Red indicator relates to 2 falls. (should not have triggered as the monthly quota for the ward is 4 and both were no harm). The amber indicator related to harm free care of 90%. One community patient with a grade 2 pressure ulcer and one patient VTE not completed. The medical team have been informed of their duty to ensure every patient has VTE completed and updated.

Kent – 1 red indicator. The red indicator related to 5 falls. All falls were no harm. This indicator should not be red but green, as the threshold for falls is 6.

William Drummond- 1 red indicator. This related to 3 falls on William Drummond. All falls were no harm.

Thomas Young- 2 red indicators and 2 amber indicators. The first red indicator related to 7 falls. This data should be green. Current combined threshold is 11 (Brodie Stroke- 4, Thomas Young-7). TY had 6 no harm falls and 1 low harm fall. Red indicator for sickness absence of 5.4%., relates to two staff on long term sickness, one has recently returned to work and the second is due back to work at the beginning of June 2016. Sickness and absence is being proactively managed as per trust policy. The first amber indicator relates to FFT response rate of 27.3 %, - an improvement from April 2016 data at 24.1%. Staff have been reminded to capture data from F and F of patient users on TY. There will be on-going focused efforts to increase the response rate during May 2016. There have been no technical issues to explain non -compliance to discharge process. The second amber indicator related to Harms Free Care of 91.7%. This related to two acquired grade 2 Pressure Ulcers (one was related to a blister from a catheter).

McKissock- 1 red indicator which related to sickness and absence of 12.9%. There were 4 members of staff on long term sick leave .Two staff are now back on a phased return but 2 remain on long term sick leave with no return to work date as yet. There was 63.5hrs short term sick leave. All absence has been managed to trust policy.

Gwynne Holford – 2 red indicators. The first red indicator relates to falls 7. A lot of work is being done by the falls group and meet every month to discuss patients and themes regarding the reported falls. Patients are also discussed weekly at the ward rounds.

12. Ward Heatmaps: MSW

Falls: these relate to one particular patient who we are finding quite challenging and the majority of his falls are near miss or assisted. The patient has had a lot of input from the MDT and has all preventative measures in place, he is also specialled at all times. There is a behavioural element to his falls and the patient is reviewed daily at our senior meetings. This patient has been with us for some weeks now and is likely to remain for some time yet as they work on stabilising his Parkinson meds and risk behaviour.

Sickness: We have staff on both sides with long term sickness issues which are being managed as per policy. All staff who are triggering on the short term sickness scale are being managed and I have recently met with a large number of staff who were not being managed appropriately to discuss their sickness. Hopefully we will start to see an improvement over the next couple of months.

12. Ward Heatmaps: Medcard

Belgrave – There is a drop in the friends & family response rate which the Matron and Head of Nursing has addressed with the ward team and will monitor. There have been 2 falls , both of which are no harm.

CCU – 2 SI recorded against CCU however are not directly attributed to the ward as they occurred in outpatient clinic and a treatment delay. Both these SI's are currently being investigated. Sickness is reported as 6 which is being managed by the ward manager.

Caroline – They have had 3 falls all of which are low or no harm. They have scored 66.4% for harm free care, I have been into RATE and the data does not seem to tally up, there are no harms other than 1 fall recorded on the safety thermometer.

Cheselden – Have scored 90.9% for harm free care, this is linked to 1 new UTI and 1 patient not being commenced on appropriate VTE prophylaxis.

Buckland – There was 1 x C.diff infection which following an RCA showed this was due to medical/antibiotics and no infection control issues were identified. Of the 4 falls reported in month 2 were no harm falls. 1 falls was related to a sudden collapse and 1 fall resulted in a fractured NOF which is being investigated as an SI.

Ruth Myles Ward –Sickness is reported as 4.1 in month. This was due to 3 staff members being absent, 2 of which was short term sickness and 1 long term sickness which is being managed with HR in line with policy.

Trevor Howell- 5 falls were reported all on separate patient which resulted in no harm. Only 1 fall was witnessed and care bundles were started at this time and reviews following falls completed. Sickness level was elevated due to 1 long term sickness which is being managed appropriately, 1 long term sickness which has now returned to work and 3 episodes of short term sickness now resolved.

CSD scorecard April 2016

Domain	Indicator	Frequency	2015/2016 Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
				Quarter 1 2016/17			Quarter 2 2016/17			Quarter 3 2016/17			Quarter 4 2016/17		
Patient Safety	SI's REPORTED	Monthly		0											
Patient Safety	Number of SI's breached	Monthly	0	0											
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly	0	0											
Patient Safety	Grade 4 Pressure Ulcers	Monthly	0	0											
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly	0	13											
Patient Safety	Number of moderate falls	Monthly	0	0											
Patient Safety	Number of major falls	Monthly	0	0											
Patient Safety	Number of falls resulting in death	Monthly	0	0											
Patient Safety	MRSA (cumulative)	Monthly	0	0											
Patient Safety	CDiff (cumulative)	Monthly	31	0											
Patient Safety	CAS ALERTS - Number ongoing- received (Trust)	Monthly	0	2											
Patient Safety	Number of Quality Alerts	Monthly		3											
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	82.0%											
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	80.0%											
			Level 2 85%	66.0%											
			Level 3 85%	82.0%											
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100												
Patient Experience	Active Claims	Monthly		0											
Patient Experience	Number of Complaints received	Monthly		2											
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	71%											
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	86%											
	FFT Score (Mary Seacole and MIU)	Monthly Mary Seacole A		tbc											
Patient Experience		Monthly Mary Seacole B		tbc											
Patient Outcomes	Catheter related UTI (Trust)			0.65											
	Number of new VTE (Trust)		National 0.005	0.33											
Workforce	Number of DBS Request Made	Quarterly	annually	206 in 2015											
Workforce	Sickness Rate -	Monthly	3.50%	4.72% Mar16											
Workforce	Turnover Rate-	Monthly	13%	20.54% Mar16											
Workforce	Vacancy Rate-	Monthly	11%	19.43% Mar16											
Workforce	Appraisal Rates - Medical	Monthly	85%	88.89% Mar16											
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	63.25% Mar16											

11. Community heat map
- CSD Exception Report

- No serious incidents for April and no harm incidents reported.
- No. of low/no harm falls consistent (MSW A&B 6)
- Safety thermometer (March 2016): MS ward: 22 patients surveyed, harm was reported for 7 patients. There were 5 'old' PUs reported (3 x grade 2 and 2 x grade 4). 2 'new' harms were 1 new grade 3 PU (72 hr RCA showed unavoidable) and 1 new catheter associated UTI.
- Complaints closed in April (7) of which 6 were OHC (access to healthcare) (1 breached)
- 3 quality alerts: (CN x2, GUM: information), 3/3 closed
- Workforce:
  - Divisional workforce strategy refresh
  - Recruitment and retention plan refresh
  - Recruiting to R&R nurse (June 2016)
  - Turnover plan monitored at DGB

Complaints and PALS 2016/2017 action plan

The purpose of the action plan is to target four key target areas: to focus on reducing the number of complaints received, improving the current quality of responses and performance in the management of complaints, and to strengthen the learning from complaints resulting in an improved patient experience.

Aim:	Actions	By When	By Who	Progress/risks
To reduce the number of complaints received in the trust through identification of issues at an earlier point of the patient journey:				
Encourage patients to give feedback whilst they are being treated. Concerns are identified and resolved in real time.	• Email DDNGS to advise all areas to put up "Don't take your troubles home" posters and business cards • Ward / department leads to have up to date photos taken by photo media services • "Don't take your troubles home" posters and business cards to be displayed in wards and clinic areas. • Matrons roles and responsibilities to be reviewed, to be more visible on wards and in clinic areas. • Ensure that PALS leaflets and posters are available in all areas	Immediate End June 2016 July 2016 Ongoing	DCN Matrons and Senior Nurses DDNGs and Corporate Nursing PALS and ward and clinic staff	
Staff are empowered to resolve concerns as they arise rather than escalating.	• Staff to attend Customer Service Excellence training	Ongoing	Staff identified via their line managers.	Customer Service Excellence training is available to staff on a monthly basis facilitated by PALS. Courses can be booked on the Education and Development intranet site.

Increase availability of PALS resource	• Review PALS workload and make recommendations • Consider aligning PALS resource to divisions • Strengthen PALS team to enable greater support to the division	July 2016	Patient Experience Manager/Deputy Chief Nurse/Chief Nurse	Risk – No additional resource available.
To improve the quality of complaint responses				
To have a cohort of staff who can effectively write complaint responses thereby reducing the time for the trust to respond. Increase in complaints responses cleared for sending on presentation to CEO, CN.	• Ensure every staff member who has responsibility to manage complaints attends training • Divisions to identify staff who are required to attend training. • Divisions to identify "complaints champions" who can buddy up with those less confident.	Ongoing June 2016 July 2016	DDNGs, General Managers, Heads of Nursing to identify staff	Investigating and Responding to Complaints training is available to staff on a monthly basis facilitated by the Corporate Complaints Team. Courses can be booked on the Education and Development intranet site.
Access to resources and guidance to be available for staff to reference.	Complaints resources page on the intranet to be updated and publicised (pending the new intranet being build).	By end June	Patient Experience Manager and Digital Design Officer	
To improve the timeliness of our responses achieving a sustainable performance within the trust:				
Strengthen and clarify roles and responsibilities of who manages, inputs and assures timeliness and quality of complaints	• To clarify roles and responsibility and accountability within the divisions for complaints at all levels – Divisional Chair, DDO, DDNG, governance resource, HON, Matron, GM etc •	June 2016	DDNGs	Risk - Reliant on resource being identified.

	• Clarify expectations of each role within the complaints process • Identify if extra resource is required and clarify for which particular task. • Allocate tasks and hold individuals to account for delivering in a timely manner			
Strengthen Staff held to account for poor performance.	• At weekly divisional complaints meetings. • At directorate and care group meetings • At quarterly performance quality meetings	Immediate July 16	DDNGs, GMs	
To strengthen monitoring of performance	• To reset and agree divisional performance targets within 16/17 which are realistic and deliver the trust standards • To review the performance against targets and agree which meetings this review will occur • Scoping exercise regarding other trust's targets and performance.	End July 2016	Patient Experience Manager	
Strengthen learning from complaints:				
Clear visibility of actions available which were taken in response to complaints and evidence portfolio available.	Investigate capabilities/functionality of new DATIX software.	June 2016	Patient Experience Manager	

To use a range of approaches to support effective learning from complaints.	• Complaints themes and lessons learned to be presented at directorate and care group meetings as standing agenda item. • Weekly overview complaints report to include actions taken for complaints closed in previous week as well as synopses of complaints received. • Undertake scoping exercise of practice at other trusts.	July 2016 End May 2016 July 2016	DDNGs to cascade Complaints team Patient Experience Manager and Complaints team.	.

REPORT TO TRUST BOARD **Paper ref:**

Paper Title:	2016/17 Sustainability and Transformation Fund Improvement Trajectories
Sponsoring Director:	Corinne Siddall -Chief Operating Officer
Authors:	Head of Performance
	To inform Board about Sustainability and Transformation Fund improvement trajectories for 2016/17.
Action required by the board:	To note the trajectories, revisions made and risks to delivery.
Document previously considered by:	

Executive summary

One of the key objectives for access to the Sustainability and Transformation Fund for 2016/17 was the agreement and delivery against improvement trajectories on key access standards.

Improvement trajectories were required to be developed and following agreement with commissioners, NHSE and NHSI (tri-partite) they were submitted for the following key access standards:

- Emergency Department (ED) four hour waiting time
- Referral to Treatment incomplete pathways
- 62 Day cancer waiting times
- Over 6 week diagnostic waiting times
-

The trust submitted trajectories following the above process on 18th April 2016 and as detailed in last month's board report. However, there was an opportunity to review the trajectories and submit revised versions if required and agreed by the tri-partite by 23rd May 2016.

Following the 23rd May submission the "Emergency Department (ED) four hour waiting time" and "Referral to Treatment incomplete pathways" trajectories are unchanged and remains as originally submitted on 18/04/2016.

However, the "62 Day cancer waiting times" and "Over 6 week diagnostic waiting times" trajectories were revised following review and agreement with the tri-partite.

Key changes are "62 Day cancer waiting times" standard compliance is not forecasted until Q2 and "Over 6 week diagnostic waiting times" standard is forecasted to underperform in May and August with sustained compliance from September 2016. Details of the revised trajectories and rationale for revision are detailed in the report.

Risks identified:

- 62 Day cancer waiting times standard - The trust would like to highlight the potential risks to underperformance in January 2017 based on seasonal trends and associated patient choice.
- Over 6 week diagnostic waiting times standard - Loss of capacity between July and August due to two SPRs rotating out.

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

2016/17 Sustainability and Transformation Fund Improvement Trajectories

Update

Excellence in specialist and community healthcare

STF Improvement Trajectories - Overview

One of the key objectives for access to the Sustainability and Transformation Fund for 2016/17 was the agreement and delivery against improvement trajectories on key access standards.

Improvement trajectories were required to be developed and following agreement with commissioners, NHSE and NHSI (tri-partite) they were submitted for the following key access standards:

- Emergency Department (ED) four hour waiting time
- Referral to Treatment incomplete pathways
- 62 Day cancer waiting times
- Over 6 week diagnostic waiting times

The trust submitted trajectories following the above process on 18th April 2016 and as detailed in last months board report. However, there was an opportunity to review the trajectories and submit revised versions if required and agreed by the tri-partite by 23rd May 2016.

The current status of the trajectories is as follows:

- Emergency Department (ED) four hour waiting time trajectory remains as originally submitted on 18/04/2016.

	ED												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	11578	12085	13098	13286	13176	12407	13086	13252	13157	12811	13225	13081	14129
Denominator	13919	13606	14521	14523	14413	13373	14075	14317	14207	14006	14275	14197	15317
Performance	83.18%	88.82%	90.20%	91.48%	91.42%	92.77%	92.97%	92.56%	92.61%	91.47%	92.65%	92.14%	92.24%

- Referral to Treatment incomplete pathways trajectory remains as originally submitted on 18/04/2016. This will be reviewed prior to end of Q1, following the external RTT review as agreed with commissioners.

	RTT												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	30213	29526	29526	29261	29162	28956	28794	28577	28274	27932	27734	27558	27511
Denominator	33769	32957	32957	32618	32419	31985	31721	31392	30943	30504	30205	29968	29765
Performance	89.47%	89.59%	89.59%	89.71%	89.95%	90.53%	90.77%	91.03%	91.37%	91.57%	91.82%	91.96%	92.43%

- The 62 Day cancer waiting times and Over 6 week diagnostic waiting times trajectories were revised following review and agreement with the tri-partite. Details of the revised trajectories are as follows:

Cancer 62 Day Pathway Trajectory

Current Trajectory

	Cancer - 62 Day												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	9.5	10	9	11	11	11	9	10	9	10	10	10	10
Denominator	63	60	60	74	74	74	63	70	63	68	68	70	70
Performance	84.9%	83.3%	85.0%	85.1%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%

Revised Trajectory Proposal

	Cancer - 62 Day										
	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	11	12	11	11	9	10	9	10	10	10	10
Denominator	60	74	74	74	63	70	63	68	68	70	70
Performance	81.7%	83.8%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%

Rationale for Revision

- Forecasted breach numbers revised in review of outputs from PTL meetings and on-going risks around theatre capacity constraints and in particular the inability to cope with unexpected increases in demand and the increased pressure on the trust from the SWL Head and Neck Pathway.
- The Trust has undertaken a PTL reconstruction exercise in conjunction with NHSE, and following that has established senior led weekly PTL tracking assurance meetings. Success from the exercise and subsequent PTL meetings has resulted in long waiting patients being expedited and their TCIs being scheduled in May and June. This has a negative impact on performance but a positive impact on our backlog position. Furthermore the pro-active tracking of patients is also reducing the number of patients tipping into the backlog.
- Trend analysis demonstrates that TWR activity is in line with agreed contractual obligations.
- The backlog position has seen a reduction from an weekly average of 124 in March to 113 in April. As patients are being expedited and treatment dates being brought forward this will continue to decrease. Also, the trust has been reducing the average DTT backlog at a rate of 2 a month and plans to further reduce from 13 at present to the sustainable position of 8 by August.
- The trust would like to highlight the potential risks to underperformance in January based on seasonal trends. A key contributory factor being patient choice in particular within Urology pathways and around admitted diagnostics in December during the Christmas period. However, the trust are reviewing January capacity plans and also working with NHSE in relation to patient choice in order to mitigate this. The trust will achieve Q4 performance overall.

Diagnostic – waits greater than 6 weeks

Current Trajectory

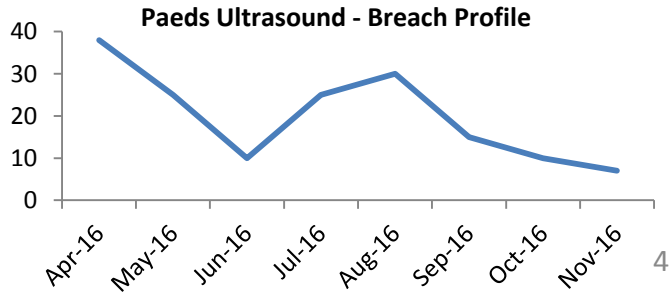
	Diagnostics												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	5772	5730	5332	5986	5661	5375	5693.0	5745	5801	5718	5755	5758	5744
Denominator	5813	5788	5386	6046	5718	5429	5750	5803	5860	5776	5813	5816	5802
Performance	99.29%	99.00%	99.00%	99.00%	99.00%	99.00%	99.01%	99.00%	99.00%	99.00%	99.00%	99.01%	99.00%

Revised Trajectory Proposal

	Diagnostics										
	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	5317	5989	5661	5359	5693	5745	5802	5719	5755	5758	5744
Denominator	5386	6046	5718	5429	5750	5803	5860	5776	5813	5816	5802
Performance	98.72%	99.06%	99.00%	98.71%	99.01%	99.00%	99.01%	99.01%	99.00%	99.00%	99.00%

Key Areas of Issue

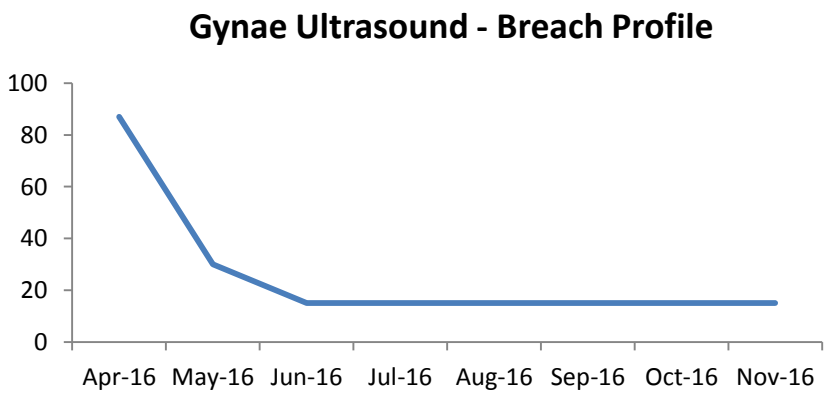
- The key modality of concern impacting on diagnostic performance are is non-obstetric ultrasound. Particular cohorts of constraint are Paediatric Ultrasounds and Gynae non-obstetric ultrasounds.
- **Paediatric Ultrasounds (supporting paper also attached)**
- Key Issues:
  - Staffing capacity (2WTE down).
  - Increased demand – Q4 referrals up 102pts in comparison to Q4 2014/15.
- Remedial Actions being undertaken:
  - Locum consultant appointed adding two sessions of capacity a week (25pts per week)
  - Additional WLI clinic being undertaken by existing staff – 2 half sessions (20pts per week)
- Risks
  - Loss of capacity between July and August due to two SPRs rotating out.
  - This is what is driving the underperformance in August.
- Mitigation
  - Service is trying to increase capacity by utilising current resource differently.
  - Two Pead Radiologist Consultants to be employed for September 2016
  - Exploring opportunities for external capacity in the IS.
  - Active management of diagnostics now in place. Diagnostic performance is being reviewed weekly as a standing agenda item at the weekly RTT recovery meetings.



Diagnostic – waits greater than 6 weeks

Key Areas of Issue

- **Gynae non-obstetric Ultrasounds**
- Key Issues:
  - Staffing capacity constraints – Staffing profile tightly in line with demand with little room for contingency in the event of unexpected sickness, staff AL, or if a member was to leave the department. Capacity was being supported by use of agency staff but due to a procurement issues they temporarily withdrew capacity.
  - Administrative failings – CBS staff member assigned to bookings for service on sick leave, no contingency in place and this was not escalated to services until it was to late.
- Remedial Actions being undertaken:
  - Procurement issue resolved and additional capacity is now in place. This capacity is also being used to drive down overall waiting list size.
  - CBS staffing issue resolved and new communication/escalation process agreed.
  - Booking window now brought down to 4 weeks.
- Risks
  - Possible capacity constraints in the event of unexpected leave from substantive staff and if sufficient capacity from agency teams cannot be secured.
- Mitigation
  - Pro-active recruitment drive in progress.
  - Exploring opportunities for additional capacity.



APPENDIX A: RTT Recovery Plan Update

RTT Recovery : May 2016

Current Position

The action plan alongside the Trust and speciality based trajectories were submitted in April. The plan was tabled at SRG, but has yet to be formally signed off by commissioners. It is recognised that any issues arising from the technical and in depth review will result in revision of the plan and the supporting trajectory. However, following the original submission the trusts in support with commissioners and NHSE have commissioned a third external review of RTT. It has been agreed that the trust will review and revise its recovery action plan and supporting trajectories following the review and have them agreed with commissioner by end of Q1.

The Trust is working through the technical review feedback following the IST review in February. From the 47 red risk pathways, 1,111 pathways were identified to have no appointment encounter: these have all been reviewed and 65 need a more in depth review. The Trust has committed to commissioners that this will be completed by the end of May. Thus far no patients have been subject to clinical harm as a result of this process.

A formal Clinical Review procedure to incorporate RTT and Cancer has been agreed with Chief Nurse and Medical Director. Clinical Review panel is to be chaired by Medical Director from NHSE.

The specification for a more in depth external review of RTT across the Trust was agreed with commissioners, NHSE and Monitor. The scope of the review is designed to cover the risks and concerns relating to RTT recovery and more recently issues that have been identified relating to PTL and operational management. MBI have been appointed to undertake the external review.

A range of meetings have been held with commissioners to support the identification of additional capacity and focus on high risk services. Clinical summits took place earlier this year and the actions of these have been re visited. In the demand and capacity exercise, a number of services identified capacity gaps across pathways which they are unable to bridge. Commissioners have been tasked by SRG to identify potential gap fill capacity and services have provided the case mix. A framework of IS capacity has been identified by commissioners in particular for ENT and T&O. The trust will now need to start utilising this capacity. To support this, the trust will need to put in formal PMO resource to manage this.

Governance

The RTT recovery meeting takes place each Thursday with service and commissioner representation in attendance. The agenda is split between performance and monitoring progression against the current action plan.

A revised weekly PTL meeting where all specialities attend , now runs over two days (Wednesday and Thursday afternoon) and covers the following :

- RTT pathway: Non Admitted and Admitted.
- Incomplete Standard
- Patients on a planned pathway.

- All patients who are at risk and in breach of the 52 week standard.
- Correspondence waiting times

Incorporated into the above is the identification of areas where additional activity is required from the IS and the identification of service risk.

Risks

There is a risk log embedded into each of the service based trajectories but in addition to those there are the following identified:

- Impact of the Junior Dr strikes – awaiting data.
- Delivery of the OP and Theatre Transformation programmes: process and improved productivity. A new OP transformation programme has now begun. There are some concerns regarding the traction and visibility of the theatre transformation programme.
- Theatres- maintenance programme now extending to end July.
- Recruitment: medical staff and secretarial and admin, the latter required to support the turnaround of letters.
- Number of patients breaching: 52 weeks due to the current process of validation.
- Ability to identify additional capacity to bridge the recovery gap. There are issues relating to procurement processes in getting contracts set-up with IS providers, to expedite that transfer process.
- As a service ENT: given the current backlog position and case mix which is predominantly Paediatrics. Summit scheduled to review hub and spoke arrangement.
- IT and Information resources required to support delivery

Performance

The Trust completed the year end validation exercise down to six weeks as agreed with SRG.

At the end of March the Trust submitted: 31818 incomplete pathways against the trajectory of 32936 of which the backlog (patients waiting greater than 18 weeks) was 3813 against a trajectory of 3433. RTT incomplete performance was 88.02% in March with one 52 week declaration.

At the end of April the Trust submitted: 35627 incomplete pathways against the trajectory of 32957 of which the backlog (patients waiting greater than 18 weeks) was 3753 against a trajectory of 3431. RTT incomplete performance was 89.47% in March with seven 52 week waiter declarations.

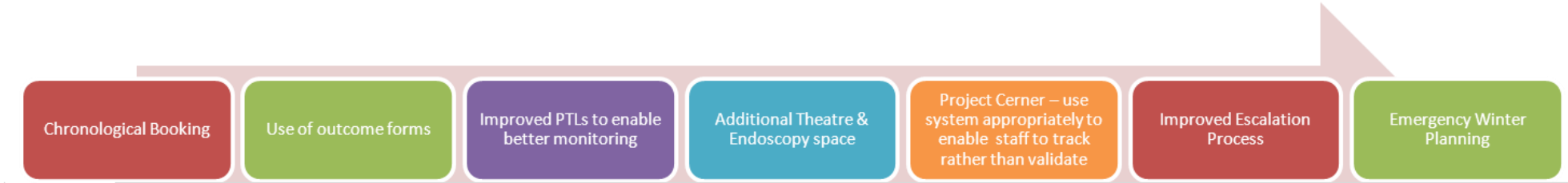
Plan

- The procurement process for the external review has been completed and a preferred bidder appointed. The external review commenced on 23rd May and is due to be completed with a final report being available on 17th June 2016.
- Continue with the delivery of actions in the submitted recovery plan and update the plan by the end of Q1 to incorporate the outputs of the external review.
- Finalise and develop a utilisation plan for additional capacity identified by commissioners.
- Agree additional performance information required weekly to monitor run rate reduction in backlog against individual trajectories.

RTT Recovery Plan Overview

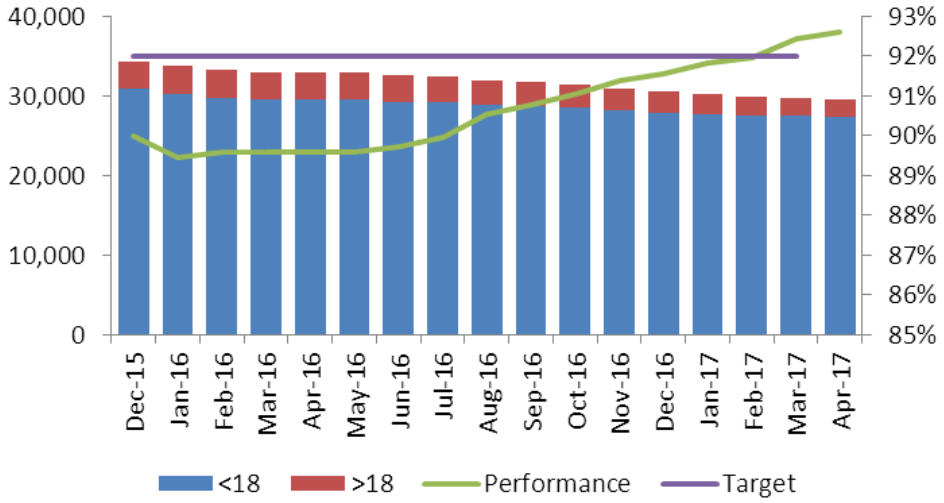
Road Map to Recovery

In addition to specialty plans, Trust wide processes and improvement will also have a positive impact on performance as documented within the action plan



	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total	34,287	33,769	33,269	32,936	32,957	32,957	32,618	32,419	31,985	31,721	31,392	30,943	30,504	30,205	29,968	29,765	29,605
>18	3,427	3,556	3,463	3,433	3,431	3,431	3,357	3,257	3,029	2,927	2,815	2,669	2,572	2,471	2,410	2,254	2,192
<18	30,860	30,213	29,806	29,503	29,526	29,526	29,261	29,162	28,956	28,794	28,577	28,274	27,932	27,734	27,558	27,511	27,413
Performance	90.0%	89.5%	89.6%	89.6%	89.6%	89.6%	89.7%	90.0%	90.5%	90.8%	91.0%	91.4%	91.57%	91.82%	91.96%	92.43%	92.6%

Trust Performance & Waiting List Trajectory



Dependencies & Risks

- Recruitment Plans
- Retention of Staff
- Winter Planning
- Outpatient Capacity / Space
- Impact of Follow ups taken trust average of follow up ratio
- Growth
- No continuing pathways mapped to sustainability planning
- D&C at specialty level not sub specialty level and QMH not calculated
- No D&C completed for follow up pathways
- Not clear of outcome of technical review and how this will impact waiting list size
- Impact of on-going validation
- Changes in revised rules in Access Policy

REPORT TO THE TRUST BOARD *June 2016*

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 April 2016.

The workforce performance report contains detail of workforce performance against key workforce performance indicators for April 2016. The report also includes available benchmark information.

Key points to note are:

- The positive movement that occurred in March has not continued with marginal deterioration in all key indicators.
- There has been progress in mandatory training compliance.
- The trust continues to benchmark reasonably well against similar London trusts for sickness absence and turnover.

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

Vacancy information

The overall number of staff in post has grown by 39 WTE but the vacancy factor has also increased. The significant reduction in vacancy factor in estates relates to the transfer of MITIE staff into the organisation. The increase in SNT relates in the establishment of the surgical assessment unit in budgets.

Turnover

After last month's reduction turnover has increased again.

Acting up arrangements

Concerns have been raised by staff about acting up arrangements in place which are felt to be unfair and which do not follow policy. In response to these concerns managers have been requested to resolve all acting up arrangements that have lasted for more than 6 months by the end of July.

Sickness absence

After an unusually long period of above average sickness absence levels, rates have now returned to slightly above average. The main reason for absence remains colds, coughs, flu and influenza. The second major reason for numbers of days lost is anxiety/stress and depression.

The trust has been pleased to be given the opportunity to develop its wellbeing programme in response to the national CQUIN. The programme will include provision of fast track musculo-skeletal physiotherapy support for staff, support for physical activity through programmes such as global corporate challenge, which begins in May, and support for mental wellbeing through the staff support service and the mental health trust IAT programme.

Agency and bank staff usage

Temporary staffing levels has reduced in April.

The trust is meeting its requirements to report breaches of the agency price cap on a weekly basis. New lower capped rates were introduced from 1st April which has led to an increased number of nursing and midwifery shifts breaching during April.

The trust is being supported by Monitor to undertake a 'deep dive' review into its management of agency staffing. It is understood that the trust benchmarks well against other similar organisations.

Mandatory training and appraisal rates

The deterioration in mandatory training compliance and rates has reversed and the trust is meeting its trajectory for improvement. The workforce and education committee considered the actions being taken to turnaround performance in mandatory training at its meeting in January. Resources have been reallocated to focus on ensuring well-defined training needs analysis, accurate and trusted monitoring of compliance and easy access to training.

Appraisal rates continue to deteriorate and a revised programme is now being introduced including briefing sessions for managers. There will be a detailed review of appraisal processes at the workforce and education committee meeting due to take place in May.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 1 - April 2016

Excellence in specialist and community healthcare

Workforce Performance Report May ‘15 - Apr ‘16

Contents

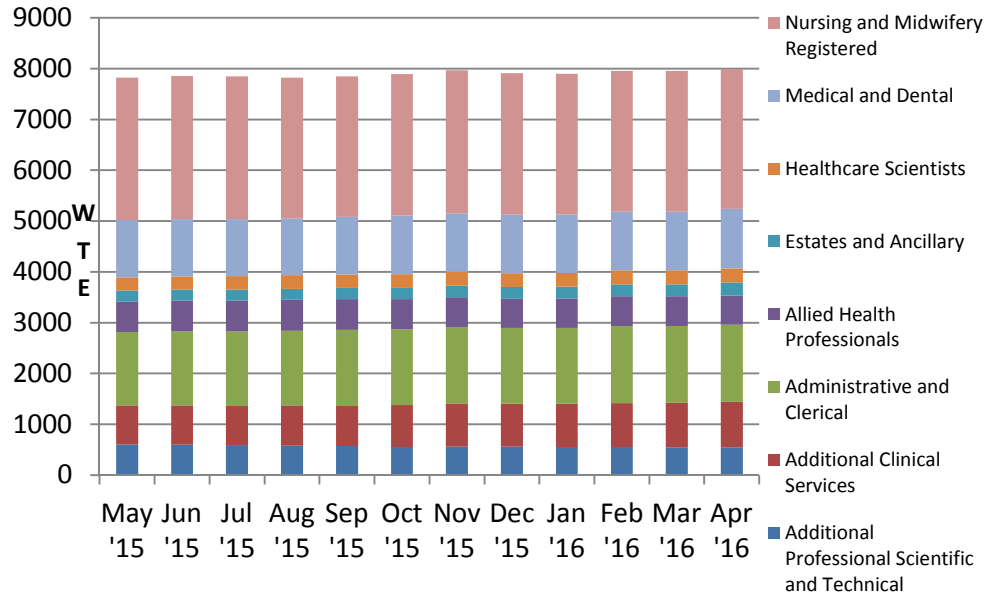
Performance Summary

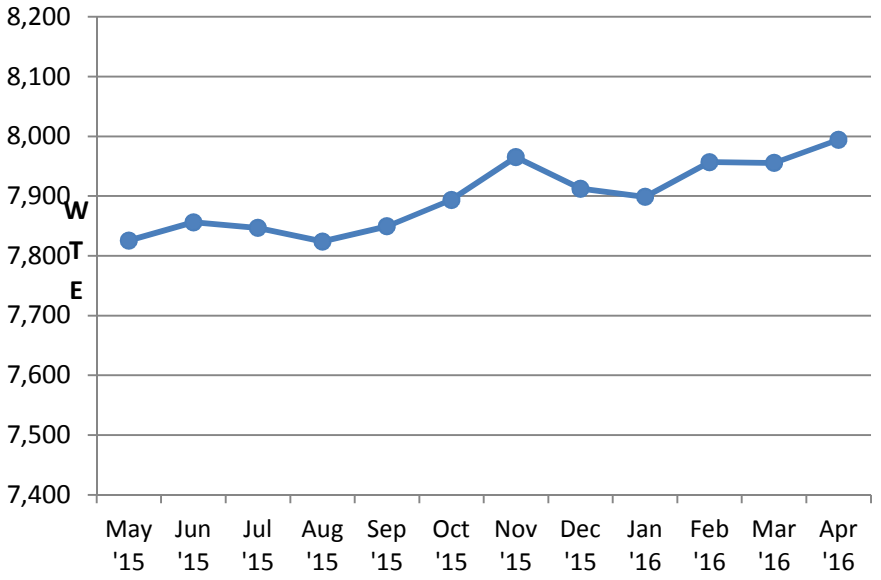
Summary of overall performance is set out below

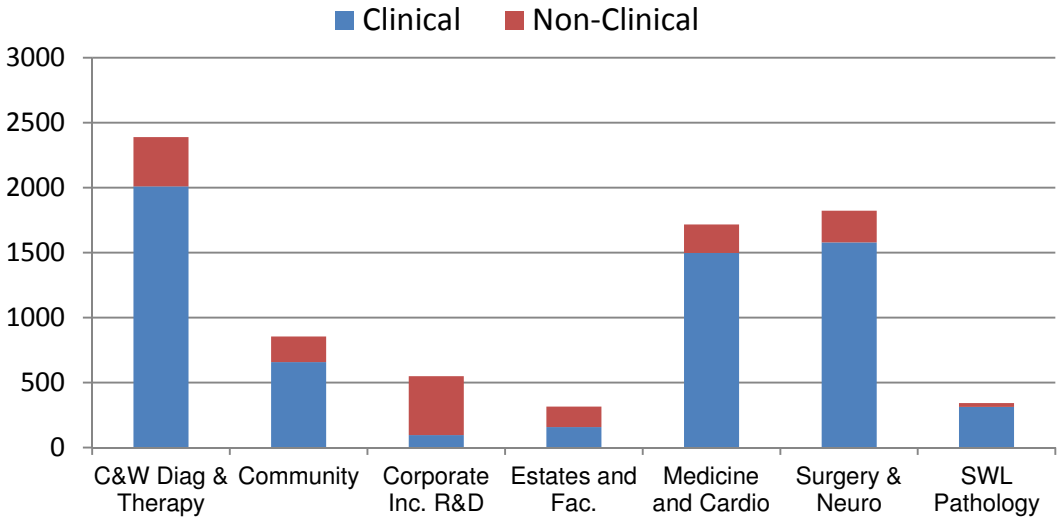
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 0.6%	14.2%	16.5%	17.1%	↗
6	Turnover	Turnover has increased by 0.1%	17.5%	17.9%	18.0%	↗
7	Voluntary Turnover	Voluntary turnover has increased by 0.2%	14.1%	14.5%	14.7%	↗
8	Stability	Stability has decreased by 0.3%	82.8%	82.4%	82.1%	↘
10	Sickness	Sickness has increased by 0.1%	3.2%	3.6%	3.7%	↗
15	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 0.8%	16.0%	16.1%	16.9%	↗
17	Mandatory Training	MAST compliance has increased by 1.2%	74.2%	76.8%	78.0%	↗
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.4%	75.2%	67.0%	66.6%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





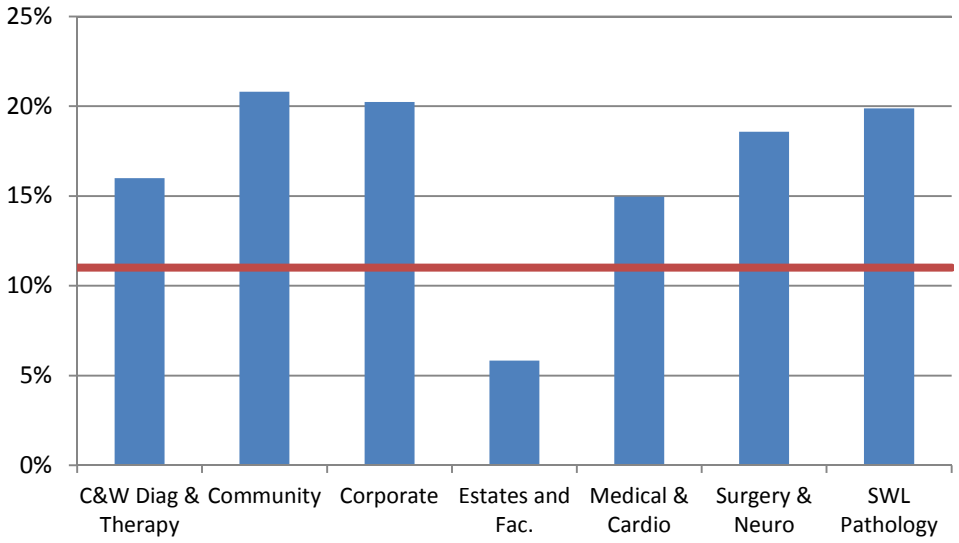


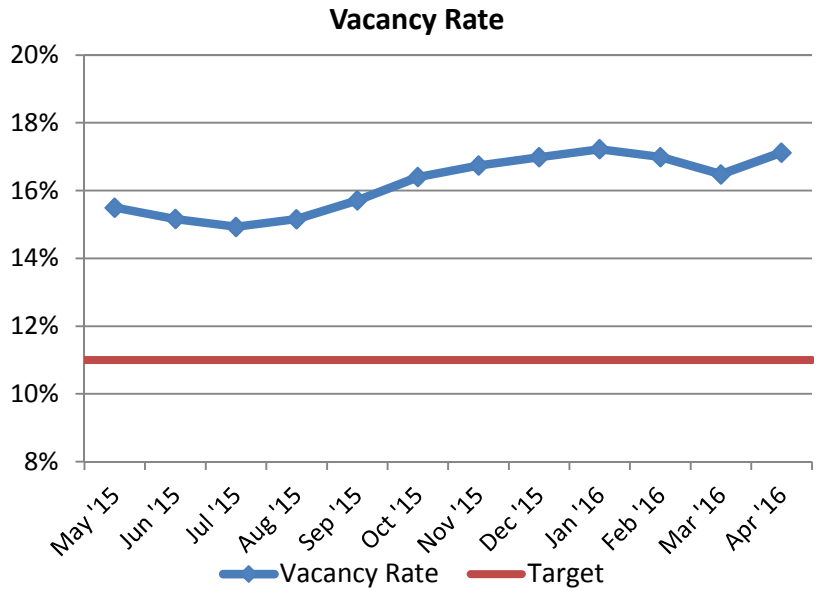
COMMENTARY

The Trust currently employs 8542 people working a whole time equivalent of 7994 which is 39 WTE higher than March. The growth rate in the directly employed workforce since April 2015 is 152 WTE or 1.9%.

The Trust also employs an additional 413 WTE GP Trainees covering the South London area, which makes the total WTE 8407.

Section 1: Vacancies





Vacancies by Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diag & Therapy	16.0%	15.3%	15.1%	16.0%	↗
Community	18.9%	18.7%	19.4%	20.8%	↗
Corporate	16.9%	16.4%	17.9%	20.2%	↗
Estates and Fac.	14.3%	13.0%	13.5%	5.8%	↘
Medical & Cardio	16.7%	16.1%	16.2%	15.0%	↘
Surgery & Neuro	16.7%	14.8%	15.6%	18.6%	↗
SWL Pathology	25.4%	35.4%	20.9%	19.9%	↘
Whole Trust	**17.2%**	**17.0%**	**16.5%**	**17.1%**	↗

Vacancies Staff Group	Jan '16	Feb '16	Mar '16	Apr '16	Trend
Add Prof Scientific and Technic	23.8%	20.4%	16.9%	15.8%	↘
Additional Clinical Services	19.4%	19.2%	12.8%	23.9%	↗
Administrative and Clerical	18.5%	16.4%	17.3%	18.2%	↗
Allied Health Professionals	15.3%	14.5%	14.4%	17.0%	↗
Estates and Ancillary	15.4%	13.8%	14.3%	4.7%	↘
Healthcare Scientists	20.5%	36.2%	35.3%	13.8%	↘
Medical and Dental	6.4%	5.7%	9.4%	5.9%	↘
Nursing and Midwifery Registered	18.5%	18.3%	17.9%	19.9%	↗
Total	**17.2%**	**17.0%**	**16.5%**	**17.1%**	↗

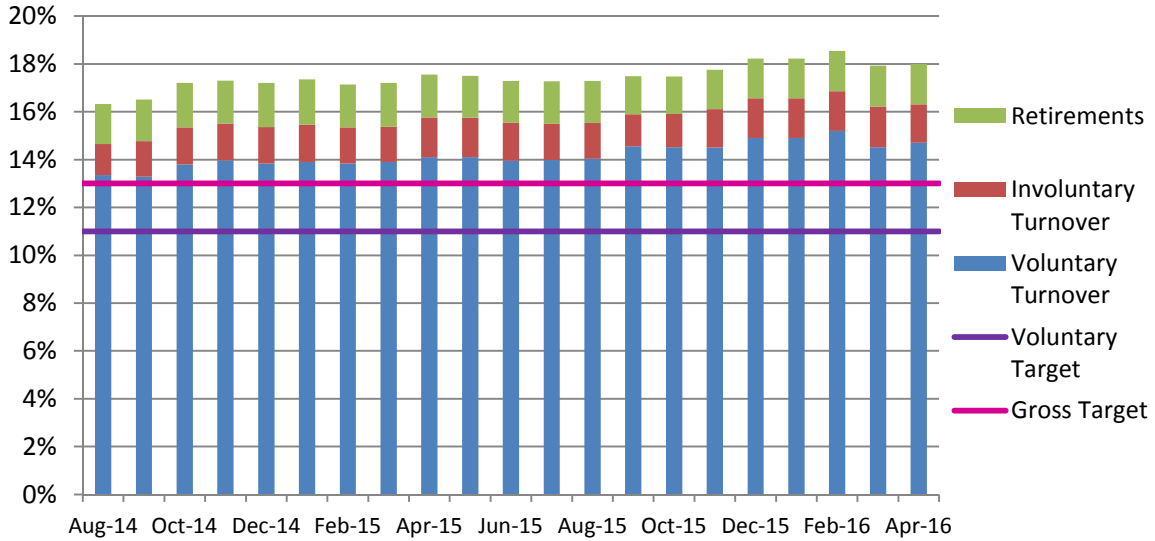
COMMENTARY

The vacancy rate has increased in April and is now 17.1%.

The highest vacancy rate is currently in the Community Services Division, the majority of which are in the Nursing & Midwifery staff group.

Section 2a: Gross Turnover

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



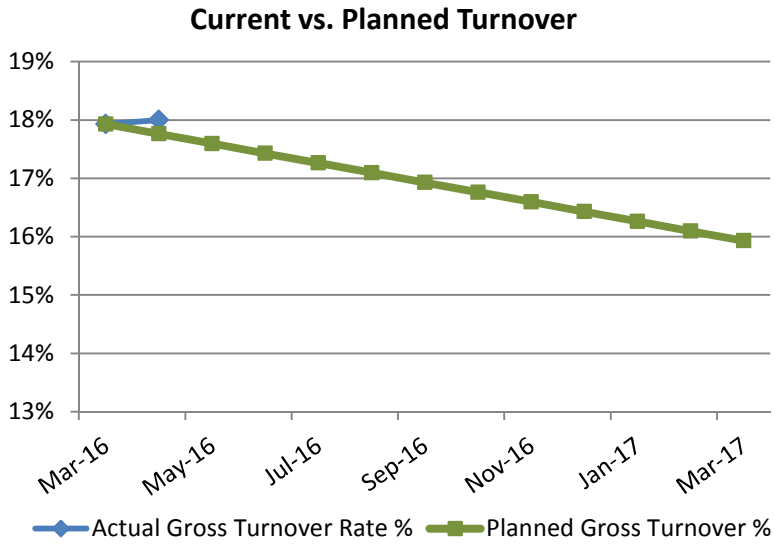
COMMENTARY

The total trust turnover rate has increased slightly this month to 18%. This is significantly above the current target of 13%. In the last 12 months there have been 1311 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	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	19.2%	19.3%	18.7%	19.2%	↗
Community Services	20.8%	21.6%	20.5%	20.3%	↘
Corporate	22.2%	22.3%	23.4%	22.0%	↘
Estates and Facilities	14.2%	14.5%	14.0%	10.9%	↘
Medical & Cardiothoracics	18.9%	18.9%	17.5%	17.7%	↗
Surgery, Neurosciences & Anaes	14.6%	15.1%	14.9%	15.4%	↗
SWL Pathology	17.2%	18.9%	17.7%	19.2%	↗
Whole Trust	**18.2%**	**18.5%**	**17.9%**	**18.0%**	↗

	All Turnover				
Staff Group	Jan '16	Feb '16	Mar '16	Apr '16	Trend
Add Prof Scientific and Technic	21.9%	21.5%	21.8%	21.8%	↔
Additional Clinical Services	20.6%	21.0%	18.4%	17.8%	↘
Administrative and Clerical	18.2%	18.2%	18.1%	17.2%	↘
Allied Health Professionals	19.7%	19.8%	19.8%	20.1%	↗
Estates and Ancillary	5.8%	6.1%	5.8%	6.6%	↗
Healthcare Scientists	16.5%	17.6%	17.9%	17.2%	↘
Medical and Dental	11.4%	11.1%	11.6%	12.6%	↗
Nursing and Midwifery Registered	18.9%	19.6%	18.7%	19.4%	↗
Whole Trust	**18.2%**	**18.5%**	**17.9%**	**18.0%**	↗



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover APR 2016	
Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	16.0%	16.1%	15.5%	15.8%	↗	1.9%	1.4%
Community Services	15.3%	16.1%	15.1%	15.1%	↔	1.7%	3.5%
Corporate	18.2%	18.3%	19.7%	18.0%	↘	2.0%	2.0%
Estates and Facilities	7.4%	7.8%	8.2%	8.6%	↗	2.0%	0.3%
Medical & Cardiothoracics	16.5%	16.4%	15.0%	15.4%	↗	1.3%	0.9%
Surgery, Neurosciences & Anaes	12.2%	12.7%	12.2%	12.6%	↗	1.3%	1.5%
SWL Pathology	14.3%	15.6%	13.7%	14.5%	↗	0.9%	3.8%
Whole Trust	**14.9%**	**15.2%**	**14.5%**	**14.7%**	↗	**1.6%**	**1.7%**

	Voluntary Turnover					Other Turnover APR 2016	
Staff Group	Jan '16	Feb '16	Mar '16	Apr '16	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	16.1%	15.7%	15.1%	15.2%	↗	5.6%	1.0%
Additional Clinical Services	17.5%	17.5%	15.5%	15.0%	↘	1.0%	1.7%
Administrative and Clerical	13.8%	13.8%	13.6%	13.2%	↘	1.7%	2.3%
Allied Health Professionals	18.3%	18.4%	18.5%	18.6%	↗	0.6%	0.9%
Estates and Ancillary	4.0%	4.3%	4.4%	5.3%	↗	0.4%	0.8%
Healthcare Scientists	13.5%	14.6%	14.5%	13.9%	↘	0.8%	2.5%
Medical and Dental	5.4%	5.3%	5.5%	5.9%	↗	5.1%	1.7%
Nursing and Midwifery Registered	16.6%	17.3%	16.3%	17.1%	↗	0.7%	1.6%
Whole Trust	**14.9%**	**15.2%**	**14.5%**	**14.7%**	↗	**1.6%**	**1.7%**

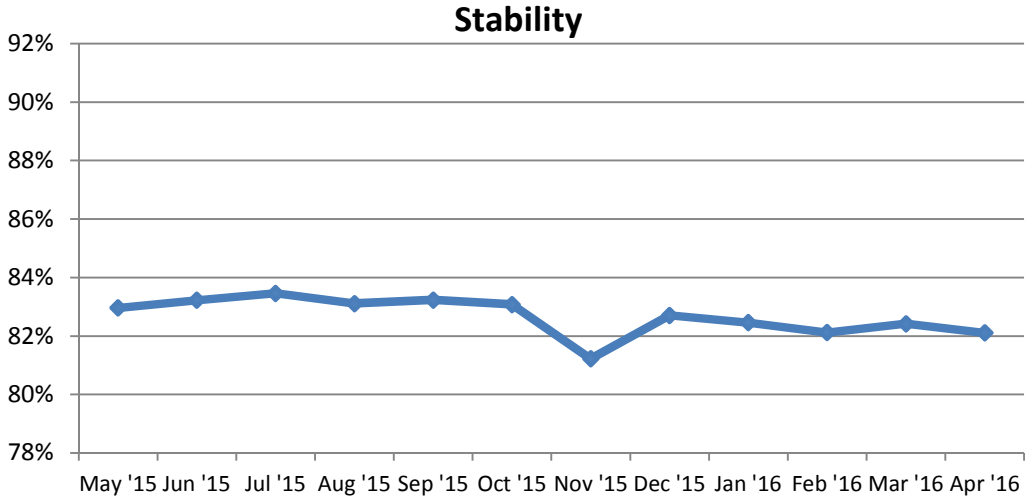
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
SWLP Microbiology	61.5	18.3	26.3%
Procurement & Materials Mgmt	38.0	10.0	25.3%
Stroke, Neurorehab, Neurophysiology	154.3	32.5	24.3%
Medical Oncology & Palliative Care	88.1	18.7	23.5%
Cardiac Surgery Thoracics	94.4	18.5	22.9%

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	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	81.8%	81.7%	82.3%	81.7%	↘
Community Services	79.1%	79.1%	79.1%	79.1%	↔
Corporate	76.0%	75.9%	78.1%	78.4%	↗
Estates and Facilities	85.9%	86.5%	87.2%	89.3%	↗
Medical & Cardiothoracics	81.9%	81.0%	81.5%	81.4%	↘
Surgery, Neurosciences & Anaes	86.0%	85.7%	85.6%	85.0%	↘
SWL Pathology	88.5%	87.0%	83.7%	81.8%	↘
Whole Trust	**82.5%**	**82.1%**	**82.4%**	**82.1%**	↘

Stability Staff Group	Jan '16	Feb '16	Mar '16	Apr '16	Trend
Add Prof Scientific and Technic	76.7%	73.8%	74.1%	71.5%	↘
Additional Clinical Services	84.7%	84.9%	86.0%	84.4%	↘
Administrative and Clerical	83.5%	83.7%	83.9%	84.2%	↗
Allied Health Professionals	80.3%	79.1%	79.8%	78.8%	↘
Estates and Ancillary	92.4%	93.2%	93.3%	92.1%	↘
Healthcare Scientists	88.3%	89.7%	88.9%	90.8%	↗
Medical and Dental	90.4%	90.2%	90.1%	89.6%	↘
Nursing and Midwifery Registered	80.2%	79.9%	80.2%	80.4%	↗
Total	**82.5%**	**82.1%**	**82.4%**	**82.1%**	↘

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.

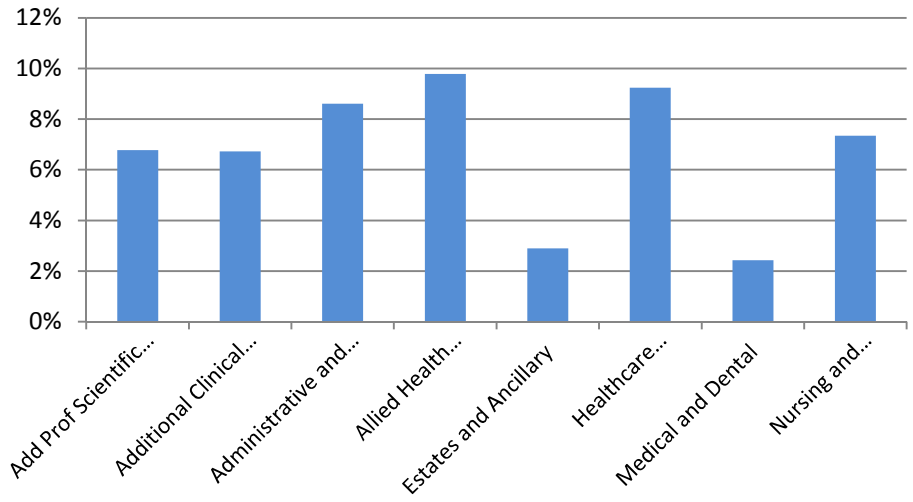
The stability rate has decreased by 0.3% this month.

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 0.7% and is now at 82.1%.

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 April 60 staff were promoted, there were 157 new starters to the Trust and 182 employees were acting up to a higher grade.

Over the last year 7.3% 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 Corporate.

Managers have been asked to resolve all long standing acting up arrangements by the end of July.

The Allied Health Professionals staff group have the highest promotion rate at 9.8% followed by Healthcare Scientists at 9.2%.

	No. of Promotions				
Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	25	9	25	22	↘
Community Services	10	4	10	14	↗
Corporate	9	2	5	5	↔
Estates and Facilities	0	0	1	0	↘
Medical & Cardiothoracics	14	1	6	8	↗
Surgery, Neurosciences & Anaes	12	9	13	8	↘
SWL Pathology	1	6	1	3	↗
Whole Trust Promotions	**71**	**31**	**61**	**60**	↘
New Starters (Excludes Junior Doctors)	**125**	**137**	**75**	**157**	↗

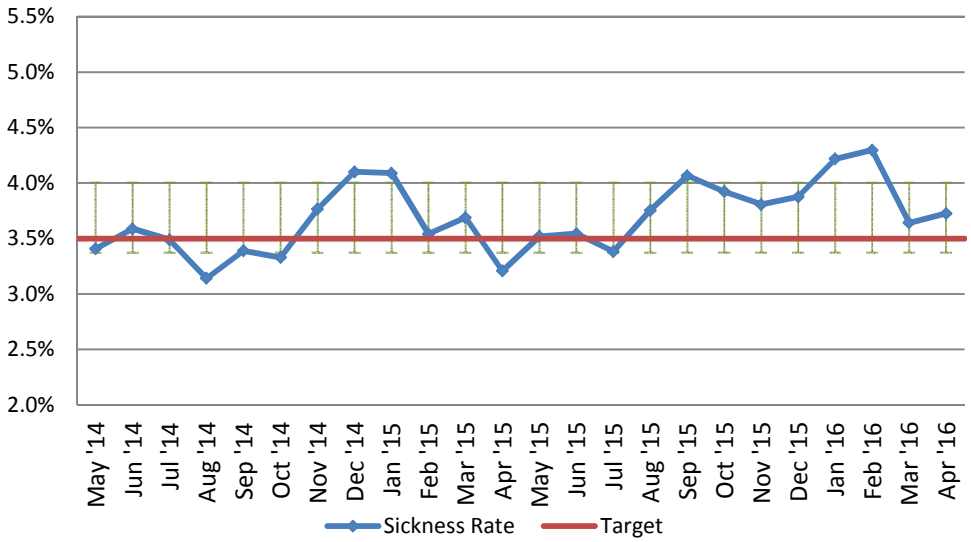
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1986	148	7.5%	85
Community Services	829	51	6.2%	7
Corporate	428	40	9.3%	22
Estates and Facilities	259	7	2.7%	6
Medical & Cardiothoracics	1245	81	6.5%	34
Surgery, Neurosciences & Anaes	1390	91	6.5%	21
SWL Pathology	304	49	16.1%	7
Whole Trust	**6441**	**467**	**7.3%**	**182**
New Starters (Excludes Junior Doctors)		**1399**		

	No. of Promotions				
Staff Group	Jan '16	Feb '16	Mar '16	Apr '16	Trend
Add Prof Scientific and Technic	4	0	6	3	↘
Additional Clinical Services	5	4	2	7	↗
Administrative and Clerical	30	8	16	15	↘
Allied Health Professionals	8	3	5	12	↗
Estates and Ancillary	0	0	1	0	↘
Healthcare Scientists	2	3	1	2	↗
Medical and Dental	0	2	0	1	↗
Nursing and Midwifery Registered	22	11	30	20	↘
Whole Trust	**71**	**31**	**61**	**60**	↘

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	472	32	6.8%	35
Additional Clinical Services	713	48	6.7%	7
Administrative and Clerical	1301	112	8.6%	60
Allied Health Professionals	552	54	9.8%	23
Estates and Ancillary	207	6	2.9%	4
Healthcare Scientists	249	23	9.2%	5
Medical and Dental	495	12	2.4%	2
Nursing and Midwifery Registered	2452	180	7.3%	46
Whole Trust	**6441**	**467**	**7.3%**	**182**

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 3.7% for April, which is a increase of 0.1% on the previous month. Analysis of reasons for absence this month shows colds and flu to be the main reason for being off work.

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 April 2016. 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	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	4.3%	4.6%	4.1%	3.7%	↘
Community Services	6.5%	6.2%	4.7%	5.7%	↗
Corporate	3.4%	4.2%	3.6%	3.4%	↘
Estates and Facilities	4.7%	5.2%	4.7%	4.5%	↘
Medical & Cardiothoracics	3.8%	3.5%	2.9%	3.2%	↗
Surgery, Neurosciences & Anaes	3.8%	3.8%	3.3%	3.3%	↔
SWL Pathology	2.8%	3.6%	2.5%	3.9%	↗
Whole Trust	**4.2%**	**4.3%**	**3.6%**	**3.7%**	↗

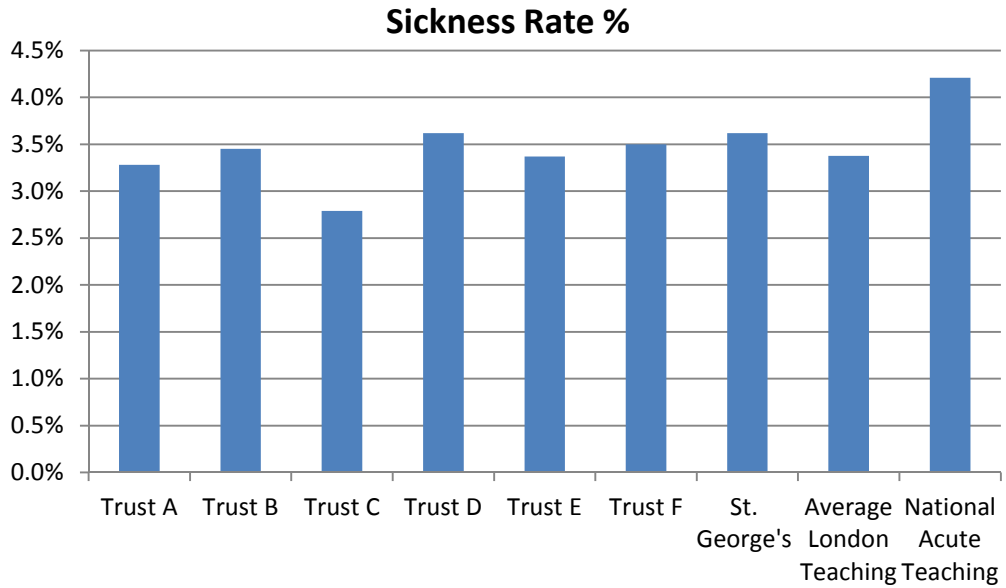
Sickness Staff Group	Jan '16	Feb '16	Mar '16	Apr '16	Trend
Add Prof Scientific and Technic	3.4%	3.0%	3.0%	2.9%	↘
Additional Clinical Services	8.1%	6.7%	5.7%	5.9%	↗
Administrative and Clerical	4.5%	4.6%	4.9%	4.5%	↘
Allied Health Professionals	3.6%	3.8%	3.7%	2.9%	↘
Estates and Ancillary	6.2%	6.3%	5.2%	5.5%	↗
Healthcare Scientists	2.4%	2.7%	2.2%	2.6%	↗
Medical and Dental	1.3%	1.6%	1.5%	1.4%	↘
Nursing and Midwifery Registered	4.5%	5.0%	3.4%	3.9%	↗
Total	**4.2%**	**4.3%**	**3.6%**	**3.7%**	↗

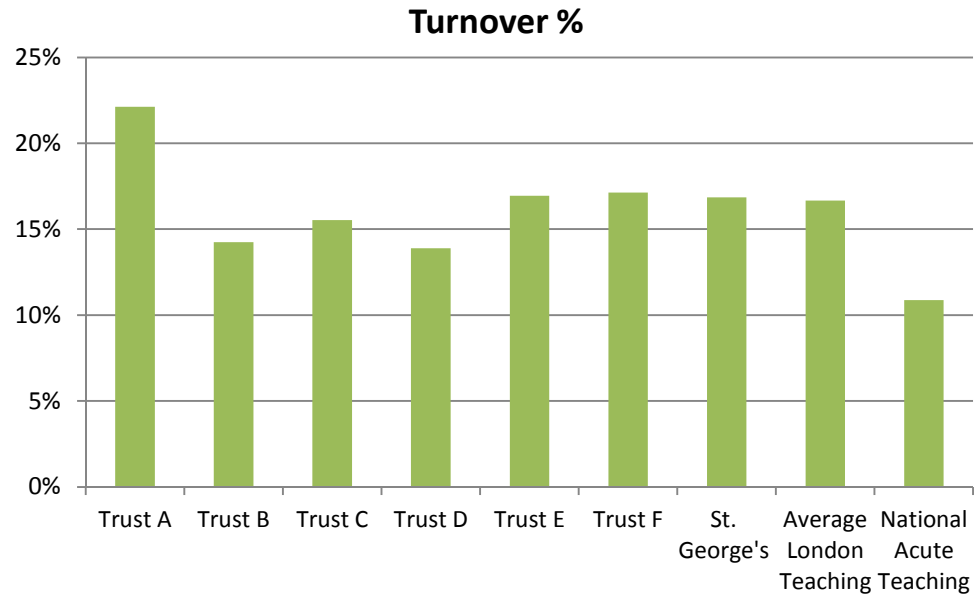
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Offender Healthcare HMPW Services	55.93	193.00	12.0%	£13,343
Energy and Engineering	53.13	174.00	10.9%	£10,663
Paediatric Surgery	58.95	132.00	8.1%	£15,507
SWLP Central Reception	59.27	140.00	7.8%	£6,337
Cardiac Directorate Overheads	23.09	50.00	7.7%	£4,299

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	30.74%
S25 Gastrointestinal problems	17.88%
S12 Other musculoskeletal problems	7.49%
S10 Anxiety/stress/depression/other psychiatric illnesses	6.83%
S16 Headache / migraine	6.47%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	18.60%
S10 Anxiety/stress/depression/other psychiatric illnesses	14.12%
S12 Other musculoskeletal problems	11.77%
S25 Gastrointestinal problems	10.22%
S11 Back Problems	7.30%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from January '15 which is the most recent available. Compared to other Acute teaching trusts in London, St. Georges had a rate higher than average at 3.38%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was lower than the national rate for acute teaching hospitals in January.

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 types of leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has a slightly higher than average turnover compared to the group (12 months to end February). Stability is lower 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 5% lower than St. Georges.

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

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	22.12%	78.06%	3.28%
Trust B	14.24%	85.29%	3.45%
Trust C	15.53%	84.04%	2.79%
Trust D	13.89%	85.61%	3.62%
Trust E	16.94%	83.07%	3.37%
Trust F	17.13%	82.84%	3.50%
St. George's	16.86%	82.94%	3.62%
Average London Teaching	16.67%	83.12%	3.38%
National Acute Teaching	10.87%	88.90%	4.21%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	1150.9	1152.9	1152.9	1156.9	↗
Community Services	598.4	598.4	598.4	598.4	↔
Corporate & R&D	67.8	61.1	63.4	64.1	↗
Medical & Cardiothoracics	1279.2	1279.2	1275.9	1275.9	↔
Surgery, Neurosciences & Anaes	1113.7	1094.0	1111.0	1196.7	↗
Total	4210.0	4185.6	4201.6	4292.0	↗

Nursing Staff in Post WTE

Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	996.4	997.7	1004.4	993.1	↘
Community Services	448.0	441.6	437.7	429.6	↘
Corporate & R&D	56.1	55.1	54.1	44.0	↘
Medical & Cardiothoracics	993.5	999.6	1003.9	1019.8	↗
Surgery, Neurosciences & Anaes	903.1	904.2	908.0	910.7	↗
Total	3397.0	3398.1	3408.0	3397.2	↘

Nursing Vacancy Rate

Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	13.4%	13.5%	12.9%	14.2%	↗
Community Services	25.1%	26.2%	26.8%	28.2%	↗
Corporate & R&D	17.3%	9.9%	14.7%	31.4%	↗
Medical & Cardiothoracics	22.3%	21.9%	21.3%	20.1%	↘
Surgery, Neurosciences & Anaes	18.9%	17.4%	18.3%	23.9%	↗
Total	19.3%	18.8%	18.9%	20.8%	↗

Nursing Sickness Rates

Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	5.0%	6.1%	4.7%	4.0%	↘
Community Services	8.7%	7.8%	5.2%	6.7%	↗
Corporate	2.5%	3.5%	2.6%	2.7%	↗
Medical & Cardiothoracics	4.7%	4.1%	3.3%	3.9%	↗
Surgery, Neurosciences & Anaes	4.8%	4.8%	3.4%	3.9%	↗
Total	5.4%	5.4%	4.0%	4.3%	↗

Nursing Voluntary Turnover

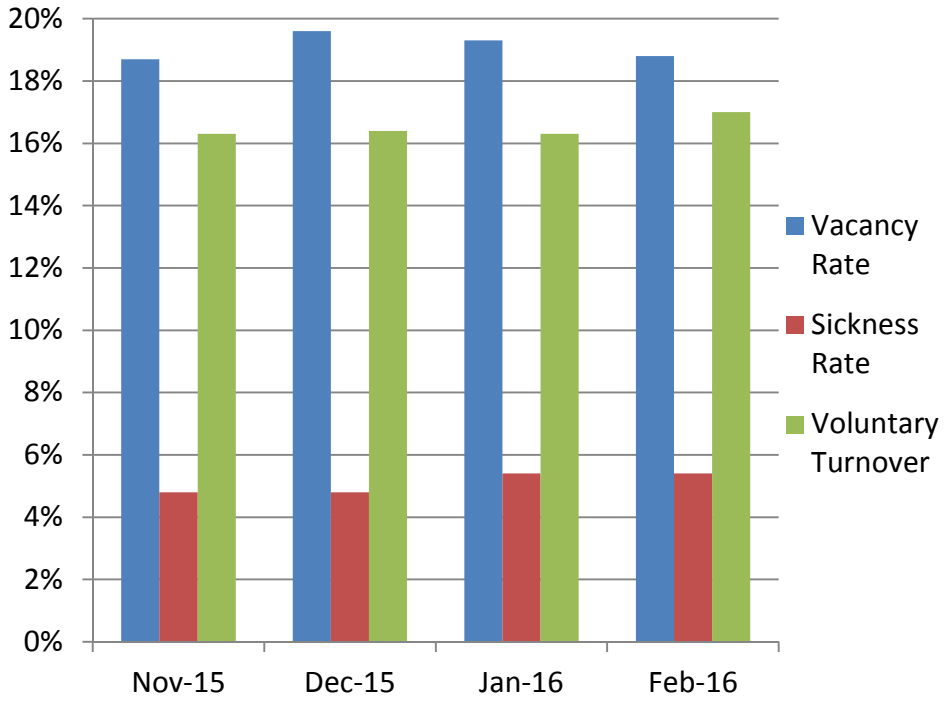
Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	15.11%	15.68%	14.07%	14.50%	↗
Community Services	16.16%	17.72%	16.82%	17.08%	↗
Corporate & R&D	12.37%	14.16%	13.05%	13.74%	↗
Medical & Cardiothoracics	19.35%	19.34%	17.96%	18.41%	↗
Surgery, Neurosciences & Anaes	14.90%	15.65%	15.03%	15.74%	↗
Total	16.4%	17.0%	15.8%	16.3%	↗

COMMENTARY

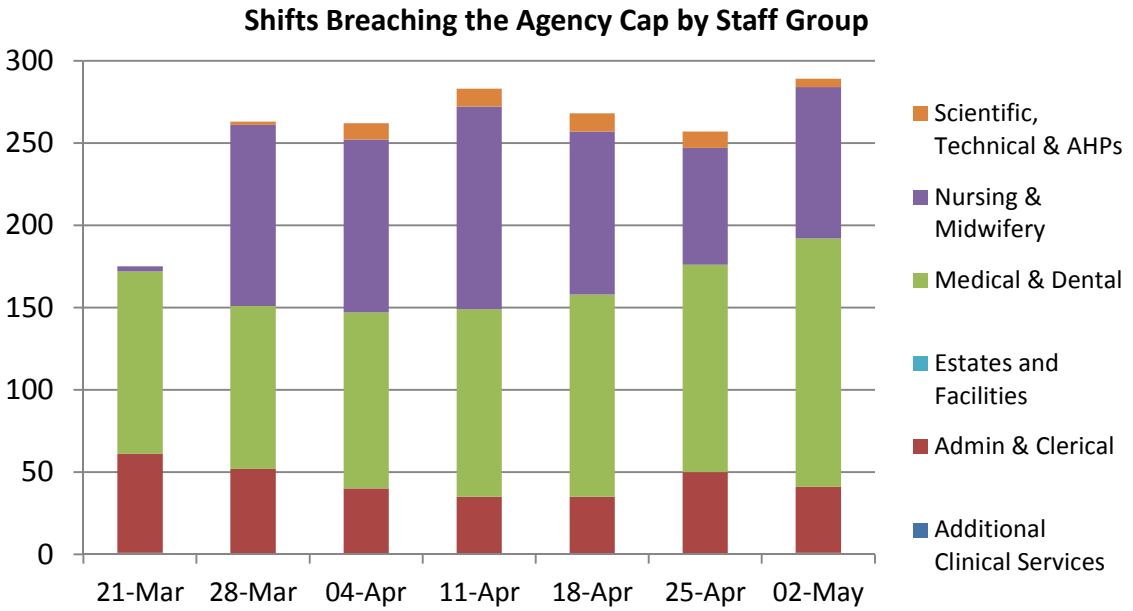
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has decreased by 11 WTE in April.

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



Section 8: Agency Cap Monitoring



Agency Cap Shift Breaches by Staff Group	21-Mar	28-Mar	04-Apr	11-Apr	18-Apr	25-Apr	02-May
Additional Clinical Services	1	0	0	0	0	0	1
Admin & Clerical	60	52	40	35	35	50	40
Estates and Facilities	0	0	0	0	0	0	0
Medical & Dental	111	99	107	114	123	126	151
Nursing & Midwifery	3	110	105	123	99	71	92
Scientific, Technical & AHPs	0	2	10	11	11	10	5
Whole Trust	175	263	262	283	268	257	289

Agency Cap Shift Breaches by Division	21-Mar	28-Mar	04-Apr	11-Apr	18-Apr	25-Apr	02-May
C&W Diagnostic & Therapy	15	33	56	71	58	41	60
Community Services	21	51	36	55	60	51	59
Corporate	74	66	55	45	55	70	64
Estates and Facilities	0	0	0	0	0	0	0
Medical & Cardiothoracics	57	74	75	73	70	65	88
Surgery, Neurosciences & Anaes	8	39	40	39	25	30	18
SWL Pathology	0	0	0	0	0	0	0
Whole Trust	175	263	262	283	268	257	289

COMMENTARY

All Trusts are now required to report weekly on the number of shifts which have breached the Agency capped rates which have been set by Monitor.

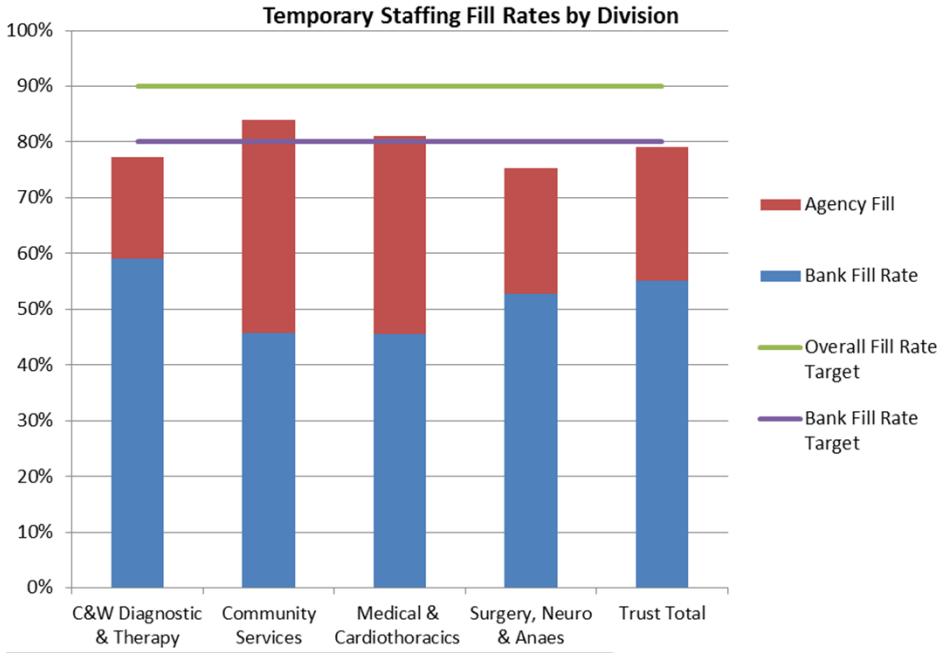
Work is on-going to stop using agencies which breach the caps where possible.

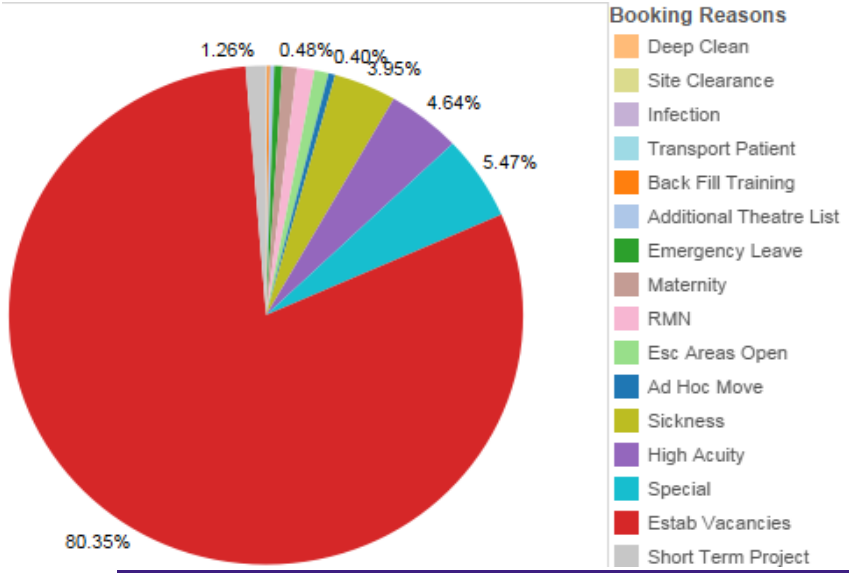
In all cases, services have confirmed there would be an adverse impact upon patient safety should the booking not go ahead.

New lower capped rates were introduced from the 1st of April which are reflected in the increased number of breached Nursing & Midwifery shifts now being reported.

For the week commencing 2nd of May, the Medical & Cardiothoracics Division had the largest number of breaches in the nursing staff group (47). Med Card also had the highest number of Medical and Dental breaches in that week (74).

Section 9: 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 April the Bank Fill Rate was reported at 55.1% which is 2.4% higher than the previous month. The Overall Fill Rate was 79% which is an increase of 1.2% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

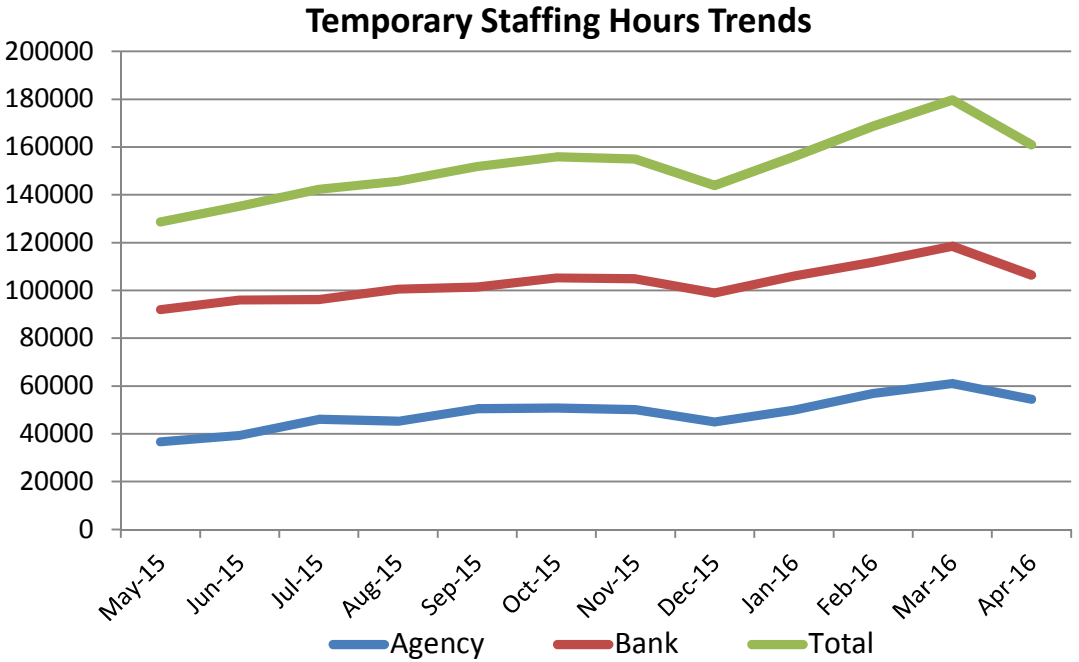
The pie chart shows a breakdown of the reasons given for requesting bank shifts in April. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	63.3%	59.2%	52.4%	59.0%	↗
Community Services	48.4%	46.2%	44.4%	45.8%	↗
Medical & Cardiothoracics	46.2%	44.5%	46.0%	45.5%	↘
Surgery, Neurosciences & Anaes	51.5%	49.1%	52.3%	52.7%	↗
Whole Trust	**56.9%**	**54.7%**	**52.7%**	**55.1%**	↗

Overall Fill Rate % by Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	80.3%	79.3%	73.7%	77.2%	↗
Community Services	86.9%	84.1%	85.1%	83.9%	↘
Medical & Cardiothoracics	81.2%	79.5%	79.4%	81.0%	↗
Surgery, Neurosciences & Anaes	70.9%	71.2%	74.2%	75.3%	↗
Whole Trust	**80.7%**	**79.6%**	**77.8%**	**79.0%**	↗

Section 10: 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. Overall Bank & agency hours have decreased across most Divisions in April.

There was a small increase in both Bank and Agency hours in the Corporate Division in areas including Finance, IT, HR and also in SWL Pathology cost centres which are currently based in the Corporate structure.

TYPE	Division	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Agency	C&W Diagnostic & Therapy	10750	8656	9638	9408	10033	11112	10724	11615	11158	14779	16404	14872
	Community Services	5769	5245	6077	6422	6421	7086	6605	6715	7298	8717	10225	8709
	Corporate	1331	949	529	46	423	402	384	541	1021	793	610	866
	Estates and Facilities	0	0	0	0	0	4	166	322	140	176	180	361
	Medical & Cardiothoracics	13202	17823	20429	20348	24428	21792	22626	19732	23154	23159	23779	21106
	Surgery, Neurosciences & Anaes	5462	6386	9195	8730	8860	9994	9362	5953	7161	9211	9885	8584
	SWL Pathology	204	241	228	245	352	267	150	143	0	0	0	0
Agency Total		**36717**	**39299**	**46097**	**45199**	**50517**	**50657**	**50017**	**45021**	**49932**	**56835**	**61083**	**54498**
Bank	C&W Diagnostic & Therapy	28714	29038	25990	26657	30745	32858	31790	30886	33343	34999	32870	31037
	Community Services	7619	7704	8252	9033	8695	9149	9133	9005	9225	9796	10885	9005
	Corporate	7165	8430	7972	7206	8828	11156	9858	8426	8674	8773	9078	10249
	Estates and Facilities	7502	8178	9216	8910	8264	8506	9423	8467	8428	10122	10078	9021
	Medical & Cardiothoracics	24829	24969	26255	29728	27842	26409	28073	25363	26990	26921	29610	25231
	Surgery, Neurosciences & Anaes	13495	14553	14740	15545	16118	16265	15754	15791	18358	20155	22946	18370
	SWL Pathology	2620	3052	3751	3389	803	821	839	998	1016	1050	3063	3463
Bank Total		**91944**	**95925**	**96177**	**100468**	**101295**	**105164**	**104870**	**98936**	**106034**	**111816**	**118530**	**106376**
Temporary Staff Total		**128661**	**135224**	**142273**	**145667**	**151811**	**155821**	**154887**	**143957**	**155966**	**168651**	**179613**	**160874**

Section 11: Temporary Staffing Weekly Tracking

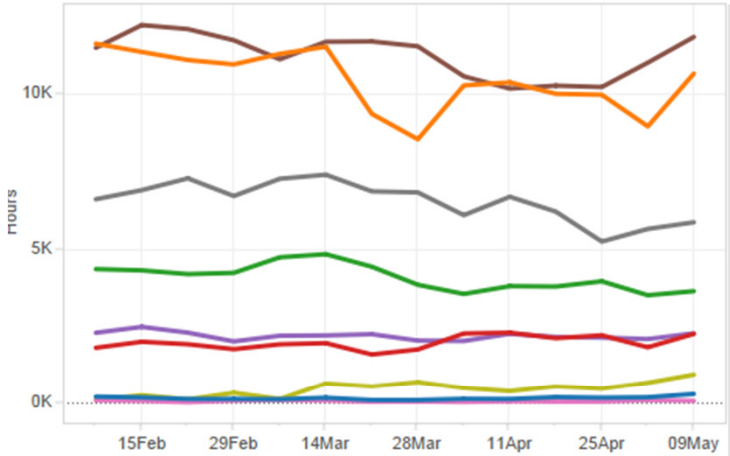
Weekly Hours Used By Division

Division	08 Feb	15 Feb	22 Feb	29 Feb	07 Mar	14 Mar	21 Mar	28 Mar	04 Apr	11 Apr	18 Apr	25 Apr	02 M..	09 M..
Capital Division	227	200	149	151	142	192	117	118	157	151	212	193	207	316
Children and Women's Diagnostic and T..	11,624	11,357	11,097	10,957	11,295	11,525	9,363	8,545	10,279	10,376	10,010	9,979	8,960	10,659
Community Services Division	4,364	4,323	4,202	4,243	4,744	4,844	4,441	3,859	3,564	3,815	3,802	3,971	3,523	3,653
Corporate Division	1,829	2,023	1,943	1,785	1,942	1,979	1,613	1,774	2,290	2,316	2,139	2,231	1,846	2,278
Estates and Facilities Division	2,313	2,503	2,318	2,035	2,219	2,229	2,268	2,062	2,050	2,282	2,176	2,159	2,111	2,295
Medicine and Cardiovascular Division	11,492	12,223	12,093	11,734	11,120	11,685	11,696	11,539	10,571	10,177	10,272	10,227	11,012	11,839
Research & Development Division	109	88	46	99	123	102	61	68	54	76	66	65	118	89
Surgery & Neurosciences Division	6,614	6,907	7,287	6,717	7,273	7,404	6,868	6,834	6,100	6,693	6,215	5,251	5,658	5,870
SWL Pathology Division	128	272	136	352	149	669	570	713	513	413	568	496	694	959
Grand Total	38,700	39,896	39,271	38,071	39,007	40,627	36,995	35,510	35,576	36,299	35,460	34,570	34,128	37,957

Type
- Agency
- Bank

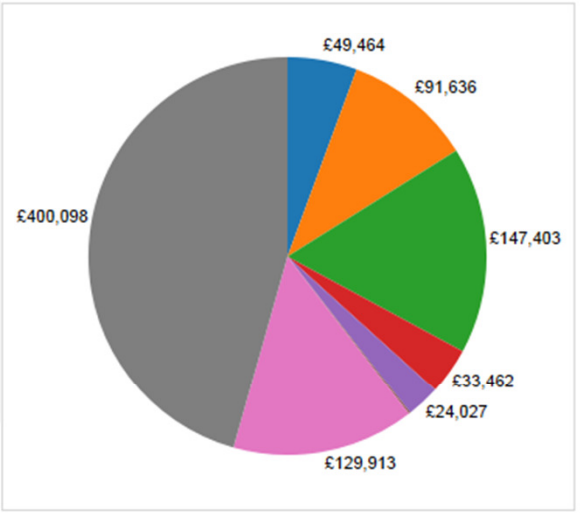
Division
- Capital Division
- Children and Women's D..
- Community Services Divi..
- Corporate Division
- Estates and Facilities Div..
- Medicine and Cardiovasc..
- Research & Developmen..
- Surgery & Neuroscience..
- SWL Pathology Division

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



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

Total Cost
£877,246

Select Date (W/C)
09/05/2016

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

Section 12: Mandatory Training

MAST Topic	Mar '16	Apr '16	Trend
Conflict Resolution	85.4	87.7	↗
Equality, Diversity and Human Rights	80.9	81.3	↗
Fire Safety	80.9	82.8	↗
Health, Safety and Welfare	81.4	83.1	↗
Infection Prevention and Control Clinical	70.8	72.9	↗
Infection Prevention and Control Non Clinical	76.0	76.7	↗
Information Governance	81.7	81.7	↗
Moving and Handling	78.4	79.9	↗
Moving and Handling Patient	63.0	67.3	↗
Resuscitation BLS	51.1	56.2	↗
Resuscitation ILS	59.4	56.4	↘
Resuscitation Non Clinical	67.4	70.1	↗
Safeguarding Adults	78.8	80.5	↗
Safeguarding Children Level 1	77.9	78.2	↗
Safeguarding Children Level 2	77.2	77.3	↗
Safeguarding Children Level 3	68.6	71.0	↗

COMMENTARY

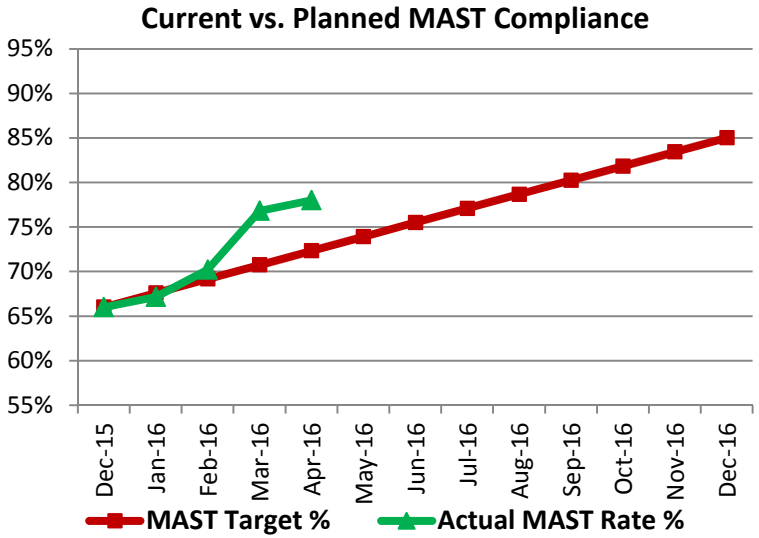
A programme of working is taking place including:

- 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.

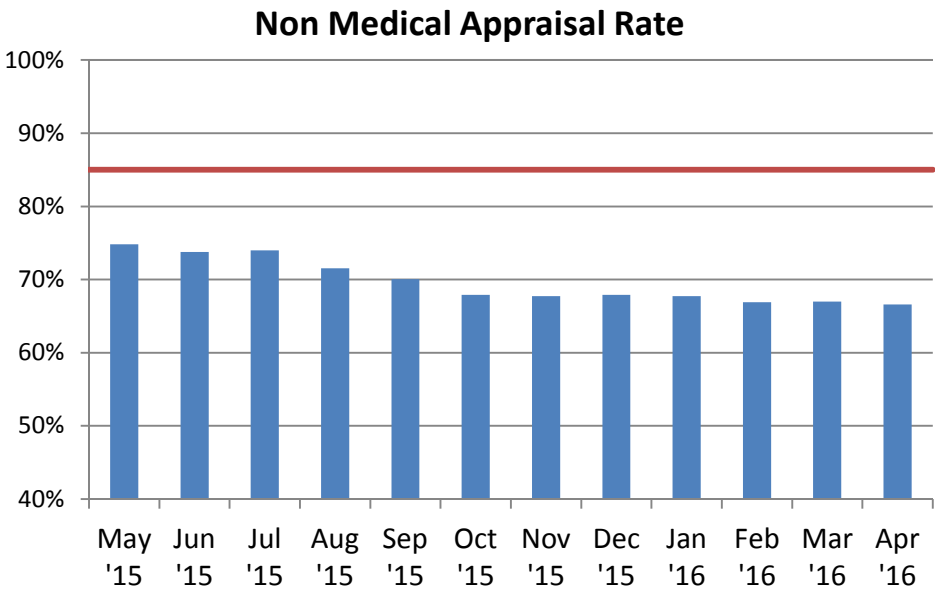
Current Issues:

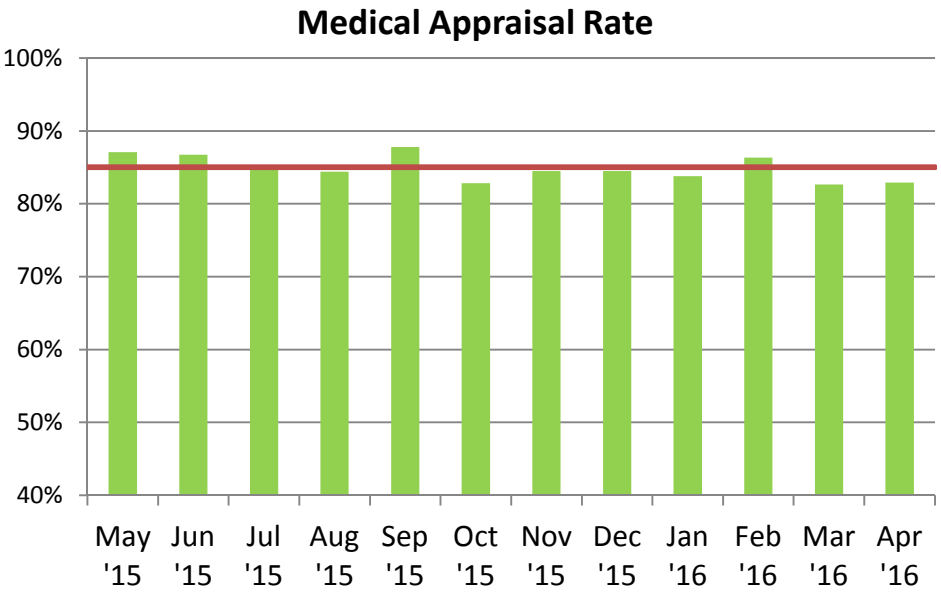
- Fall in compliance rates – largely due to staffing pressures
- Community access to Totara is on the risk register, in the interim we are visiting community sites with tablets and developing a permanent solution in parallel
- Staff unable to access training externally- Software and licencing and IG 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.

MAST Compliance % by Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	69.0%	71.9%	77.3%	77.8%	↗
Community Services	65.9%	68.4%	79.1%	81.0%	↗
Corporate	66.1%	69.5%	76.3%	77.6%	↗
Estates and Facilities	62.1%	68.6%	70.9%	70.1%	↘
Medical & Cardiothoracics	65.0%	66.9%	73.1%	75.5%	↗
Surgery, Neurosciences & Anaes	66.1%	68.4%	75.0%	76.1%	↗
Whole Trust	67.1%	70.2%	76.8%	78.0%	↗



Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 0.4% this month to 66.6%. 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 increased this month to 82.9% which is just below target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Procurement & Materials Mgmt	15.6%	38.00
Energy and Engineering	21.4%	53.13
Finance Directorate	33.7%	104.64
Dermatology & Lymphoedema	40.0%	34.06
Urology	43.9%	69.47

Non Medical Appraisals by Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	70.7%	68.3%	65.1%	63.5%	↘
Community Services	63.2%	63.5%	63.3%	64.5%	↗
Medical & Cardiothoracics	72.3%	72.0%	69.2%	68.3%	↘
Surgery, Neurosciences & Anaes	75.1%	75.0%	73.5%	73.3%	↘
Corporate	52.2%	56.8%	61.2%	62.0%	↗
Estates & Facilities	64.9%	63.0%	62.0%	64.5%	↗
Whole Trust	**67.7%**	**66.9%**	**67.0%**	**66.6%**	↘

Medical Appraisals by Division	Jan '16	Feb '16	Mar '16	Apr '16	Trend
C&W Diagnostic & Therapy	82.2%	85.9%	84.1%	85.5%	↗
Community Services	87.1%	83.9%	88.9%	92.6%	↗
Medical & Cardiothoracics	85.7%	90.5%	82.1%	85.4%	↗
Surgery, Neurosciences & Anaes	86.0%	84.1%	84.9%	83.4%	↘
Corporate	100.0%	100.0%	100.0%	100.0%	↔
Whole Trust	**83.8%**	**86.4%**	**82.7%**	**82.9%**	↗

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *June 2016*

Paper Title:	Report to the Board from Workforce and Education Committee – 31st May 2016
Sponsoring Director:	Stella Pantelides, Non-executive Director
Author:	Stella Pantelides, Non-executive Director
Purpose: *The purpose of bringing the report to the board*	To provide the Board with a summary of the proceedings from the last Workforce and Education Committee
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	To note the update
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	N/A

Summary:

Enclosed are the key messages and draft minutes from the Workforce and Education Committee on the 31st May 2016. The Board are asked to note the proceedings.

Key risks identified:
Risks are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All Corporate Objectives.
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	N/A

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes / No)
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.

Chair's Report from Workforce & Education Committee Meeting of 31 May 2016

Workforce and Staff Experience Plan 16/17
The Committee endorsed the content of the plan whose key objectives include improvement in staff experience and engagement. Wendy offered assurance that **by 30 June** and in conjunction with the Communications team, a tool will be in place that will enable the trust to take regular temperature checks of staff engagement. This will in turn be used to assess whether the various actions in the plan are working as intended.

Staff Turnover
MedCard and Surgery updated the Committee on how each division is addressing pockets of high turnover in each of its directorates using granular evidence from exit interviews, staff surveys and by listening to concerns raised about the quality of those in leadership positions. The Committee was content that both divisions have well developed programmes that are being owned and monitored by their divisional leadership. Although there is not as yet a discernible downward trend, both divisions know by now what works and spoke of a 'dogged determination' to carry on with those actions until the programmes bear fruit.

The Committee also received the annual report of the Staff Support Service (a confidential counselling and support service which also handles the bullying and harassment help line) as well as an updated report from the exit interviews that were conducted in 2015.

There is a narrative developing in the trust that staff are predominantly unhappy about Estates and IT. Whilst those are undoubtedly important factors that impact their operational effectiveness, the evidence from all the sources described above is that the key reasons that make people unhappy to the extent that they decide to leave are:

- **Managerial competence and behaviours of their immediate line manager** and the extent to which they feel understood, supported and enabled to do their work. The Staff Support Service report indicates that the proportion of staff seeking counselling support because of poor relationships with their managers has risen from 31% to 41% in the last year.
- **Consistency and continuity in line management.** Divisions could correlate directly periods of instability in ward management with rising turnover.
- **Perceived lack of scope to develop and advance their careers.** For example Band 5 nurses seeing limited opportunities for promotion or further development.

The data also show that turnover is much higher in the first couple of years since joining and that those joining from overseas are more prone to consider leaving early (and joining other trusts). All factors causing rising turnover are the focus of both divisional and corporate plans that form part of the Workforce and Staff Experience Plan referred to above. In order to address the short-service turnover, interviews are now being conducted with joiners 100 days after joining and induction and assimilation programmes are being revisited.

Leadership Development, Organisational Development, Coaching/Mentoring Support
Since Sarah James' arrival, (AD Education and Training), a considerable investment has been undertaken by the trust to develop its managers and leaders (as stated above, critical to reducing staff turnover and improving staff engagement). Investment has also been made in supporting Organisational Change and Development whilst a formal programme of mentoring and coaching is being developed to support managers and staff. Sarah has not only been successful in developing these programmes but also in securing external funding for them.
Although the programmes are too new to have yielded results, the Committee was unanimous in its support for them: they represent a long term investment in the development of our staff (part of the intangible infrastructure of the trust). Given the changes in senior leadership and the very challenging circumstances under which our managers and leaders now have to operate, Sarah was requested to:

- Renew senior leadership sponsorship of these programmes, ensuring that both the Chair and the CEO are supportive of the programmes' objectives and are prepared visibly to act as sponsors;

- Based on those conversations, recalibrate content, where necessary, to address challenges and behavioural shifts that the new leadership is aiming to bring about.

Education- Quality of Placements
Sarah James introduced a paper seeking approval from the Committee to a series of measures to assure quality and to consider capacity for additional non-medical placements following the removal of bursaries and the lifting of the cap on students studying for nursing, Midwifery and AHP degrees from September 2017. The Trust provides over 1200 student placements, 330 of which are for pre-registration nursing and midwifery students.

The Committee encouraged the Training Team to think creatively about the shape and content of these pre-registration nursing programmes so as to ensure they prepare students for the 5 Year Forward View. There was a very strong feeling that unless training delivered now prepares staff for the working models of tomorrow, staff will act as a constrain to their success. Sarah James welcomed the encouragement and it was agreed that Alison Benincasa would provide a steer to the working group that will be put together to develop these programmes.

Education-Funding
Sarah James confirmed the significant reduction in education income, down to £34.5m in 16/17 as transition funding support is gradually withdrawn. Further reductions are anticipated for 17/18 with transition funding ceasing completely in 2018-19.

The trust is pursuing a strategy of maximizing activity whilst ensuring that quality is not compromised. The trust has also made progress in ensuring that 'money follows activity' by insisting on more transparency in medical job plans. As a result, there are care groups that are likely to lose income and others that will gain as teaching activity and funding get more closely aligned.

Despite the anticipated diminishing trend, education will remain an important source of income for the trust for many years to come. This Committee has requested in the past that a commercial lens is applied to this area as this is outside its own competence. This is now long overdue.

Other Updates
In addition to the issues set out above, the Committee received updates on a number of agenda items that will be fully minuted but are only listed below for completeness:

- Performance appraisals: Limited assurance; expect a paper in July.
- MAST: Good progress, ahead of trajectory; on course to hit 85% by January.
- Wellbeing CQIN: Worth £2m; programme in development with support from the Partnership and with input from Commissioners.
- WEG/Efficiency Programme: In leadership transition, along with other transformational programmes.
- Management of bullying: Updated policy and case history in preparation for CQC.
- Inclusivity/unconscious bias: Update on take up and impact.
- Workforce planning/headcount reconciliation: Assured that the process of reconciling ESR with Agresso continue, albeit dependent on manual interventions.

Wendy Brewer
This was Wendy Brewer's last attendance before she leaves us at the end of June. The Chair, on behalf of the whole Committee, thanked Wendy warmly for her inspiring professional leadership of the HR & OD Function and for being a source of stability and emotional maturity throughout her tenure at the trust.

Stella Pantelides
31.05.16

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting: **TRUST BOARD** **June 2016**
Document Title: **Urogynaecology at St George's**
Summary: The Trust Board on the 3 March 2016 supported the proposal for the Trust to begin a process of liaison with commissioners to understand the appetite and specification for the re-establishment of a urogynaecology service at SGUH. This paper provides an update on the progress that SGUH have made with Wandsworth CCG.
Author and Date: Andrew Rhodes 26 May 2016
Presented by: Professor Andrew Rhodes **Divisional Chair, CWDT&CC**

Urogynaecology at St George's

Introduction

Urogynaecology is a subspecialty of gynaecology for the management of women with pelvic floor dysfunction. St George's University Hospitals NHS Foundation Trust (SGUH) provided an acute local and tertiary Urogynaecology service as a subspecialty within the Women's Services directorate up until June 2015 when the service was temporarily suspended for due to concerns with the safety and governance of the service.

SGUH Trust Board Decision- March 2016

The SGUH Trust Board met on 3 March 2016 and agreed the proposal put forward by the Executive Management Team on the future of the urogynaecology service at the Trust. The Board supported the proposal for the Trust to begin a process of liaison with commissioners to understand the appetite and specification for the re-establishment of a urogynaecology service at SGUH. It was made clear that any reconfigured service would need to meet the requirements of both clinical and financial sustainability in accordance with the Trust's business case process. It was agreed that any future consultation that may be required in relation to the urogynaecology service will be led by the CCG as commissioner. The service has remained in suspension during this period.

Staff Impact

There were 7 full time staff employed at SGUH who, in June 2015 were working within the urogynaecology subspecialty unit. Up until the March 2016 Trust Board these staff had been temporarily redeployed to other duties within the Women's Directorate. As a result of the decision by the board, the Trust has continued the temporary cessation of the urogynaecology service. Unlike the initial closure that could have been short term in nature, the decision that was made in March resulted in the service being closed for an extended period, likely to last for many months and, at the end of that period, may significantly change.

A redundancy situation arises when the employer "*has ceased or intends to cease to carry on the business for the purposes of which the employee was employed*". Any cessation can be "*permanent or temporary and for whatever reason*". This has therefore led to a redundancy situation at SGUH. Out of the 7 staff that were temporarily redeployed, SGUH have been able to find alternate employment for 6 of these members of staff. Sadly 1 member of staff (medical) has been served with their redundancy notice.

Current Situation

Since the Trust Board meeting on 3 March 2016, the Trust has had a series of meetings and discussions with Wandsworth CCG regarding the future provision of a urogynaecology service. Wandsworth CCG have indicated that they aim to review the clinical needs of the local population in relation to urogyanecology and also the sub speciality needs to support other services at St George's, as well as working with other local Trusts like Croydon University Hospitals (CUH) who currently provide an accredited specialised service.

Wandsworth CCG has identified a GP clinical lead who will be working closely with SGUH on the development of any potential new service specification. Building on similar models of care for patients with long term conditions, Wandsworth CCG anticipate that care will be delivered wherever possible by GPs and specialised community staff (physiotherapists and nurses) with leadership from the SGUH team and specialised support from CUH. Wandsworth CCG anticipate that this should enable patients to have care as close to home as possible, while remaining confident that the specialised input is available if required.

SGUH are working closely with Wandsworth CCG and aim to produce a service specification for testing more widely with stakeholders in the autumn. The timeline to open a re-configured urogynaecology service will be dependent on a decision about formal procurement of the new service, the ability to deliver the service within the framework of the national tariff and the timescales for recruitment of new staff.

Recommendation for the Board

The Board is asked to support the Trust's on-going liaison process with Wandsworth CCG.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
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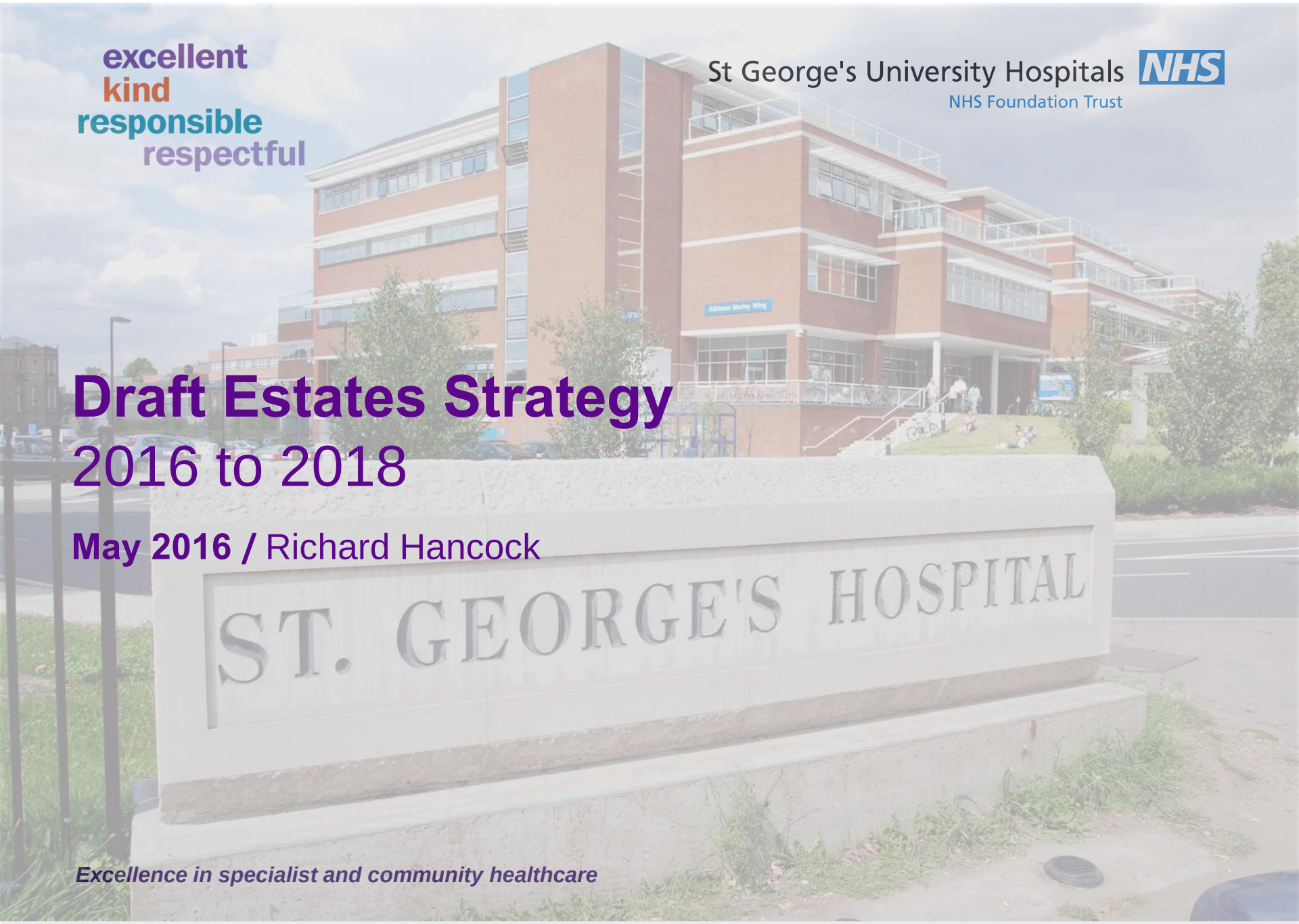


Draft Estates Strategy
2016 to 2018

May 2016 / Richard Hancock

Excellence in specialist and community healthcare

Agenda

1. Introduction
2. Current estate
3. Plans
4. Mobilisation

Introduction

The Estates Strategy Vision is:

"for the Trust to be operating from a safe, reliable estate that supports the effective, efficient delivery of services in support of the Trust's operational plan".

Supported by the Draft Estate Strategy – June 2016

To identify the estates priorities facing the Trust and outline the plan to address the issues identified.

- To be refined for July 2016 board meeting
- The final proposals will form the basis of a business case(s) that will be used to gain funding to deliver the intended improvements.

Introduction

The Estates Strategy guiding principles are:

1. Ensure that estates risks are managed and that the **estate complies with all necessary standards**.
2. Ensure that, wherever possible, appropriate **services are provided offsite** in the community, improving access for patients and relieving pressure on the main campus.
3. Ensure that there is a **more efficient use of space** on site; services must be sensibly located, supporting efficient and effective patient pathways and workflows.
4. Ensure that all the estate **provides sufficient capacity in the right locations** to meet demand for healthcare.
5. Works must be **delivered quickly, and at value for money**, requiring decisive planning and an expectation to deliver several projects in parallel (recognising that there is an urgent need for investment but that capital and revenue funding is constrained).

The Estates Strategy aims:

A. Improve infrastructure in short term to resolve safety and reliability issues

B. Develop plans to support the clinical strategy

These improvements in productivity will reduce the overall additional capacity required on the Tooting campus, thereby minimising the requirement for further capital developments.

Introduction

Context

- NHS Five Year Forward View, October 2014
- Transforming London's Health & Care Together, 2014
- London Specialist Services Redesign, ongoing 2016
- Lord Carter's Review, June 2015 and Feb 2016
- Sustainability and Transformation Plan (STP) - SW London Acute Provider Collaborative, ongoing 2016
- Trust Strategy and Clinical Strategy

Current estate

Condition

As of 2010: 20% of buildings Category C (major defects) or D (life expired).

- **Electrical**:
  - Aged electrical infrastructure (end of life)
  - Expansion of capacity needed
  - Needs to be more sustainable and efficient
- **Building / Infrastructure:**
  - Urgent roof repair or replacement needed
  - Water leaks / flooding
  - Poor condition of drainage, roads and paths
- **Mechanical systems:**
  - In breach of safety & statutory compliance
  - Energy centre in need of renewal
  - Malfunctioning lifts
- **Fire systems**
  - Poor state of repair of fire alarm systems
  - Poor fire separation provision
  - Fire awareness training requires upgrade

Impacts

Increasing number of risks to patient safety identified, arising from estates issues

- Repeated **infrastructure breakdowns**
- Lanesborough Wing has **urgent safety issues**:
  - An inspection could result in an Enforcement Notice / prosecution.
  - The Fire Authority could consider actions which would require immediate closure of the building.
  - Risk of water contamination; Legionellosis
  - Non-CQC compliant
- Staff survey raised issues about the estate **negatively affecting patient care**

Constraints

- Space on site is **cramped**
- **Lack of funding** for Infrastructure

Current estate

High risk backlog maintenance requirements 2016-2021 envisaged to be £61.5 million (£100m Gross)

Building / element	Total high-risk backlog '16-21	Proportion of backlog
Energy centre	£ 12,770,000	21 %
Lanesborough Wing	£ 12,150,000	20 %
Infrastructure	£ 11,005,000	18 %
Theatres / day surgery	£ 10,300,000	17 %
St. James Wing	£ 4,450,000	11 %
Grosvenor Wing	£ 3,700,000	6 %
Boiler house	£ 1,730,000	3 %
Education centre	£ 800,000	1 %

Draft capital programme for 2016/17 (as currently conceived) envisaged to be £37.4 million (inc. £8.1m for infrastructure)

Estates plans; with funds allocated

Infrastructure works

- Energy security
  - Energy performance contract
- Power generation
  - Standby generators
- Fire safety
- Water safety (Legionella)
- Re-roofing

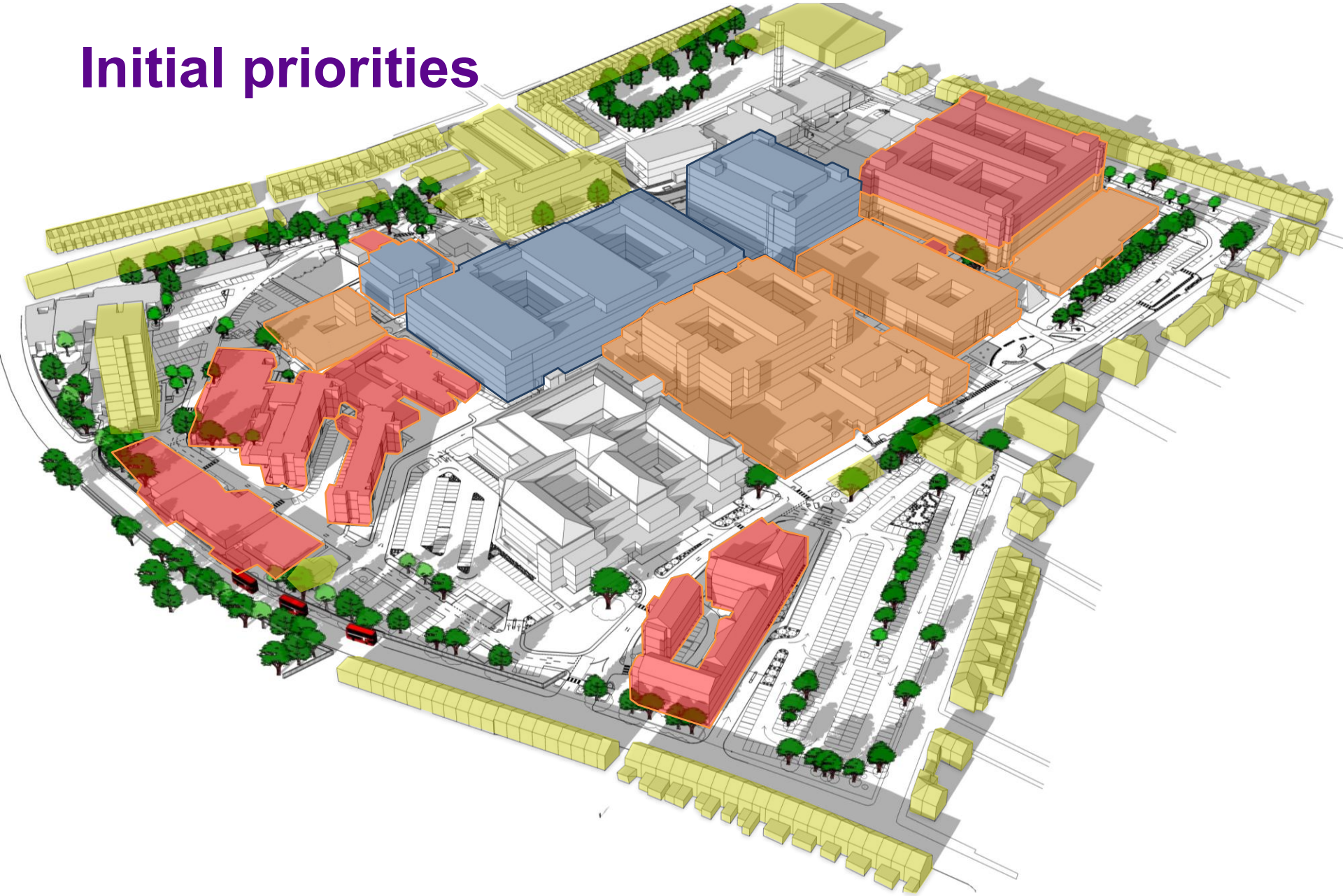
Clinical projects

- Surgical assessment unit
- Coronary care unit 2
- Endoscopy expansion
- St. James' Theatres
- Chemotherapy day care
- Genomes project
- PLACE

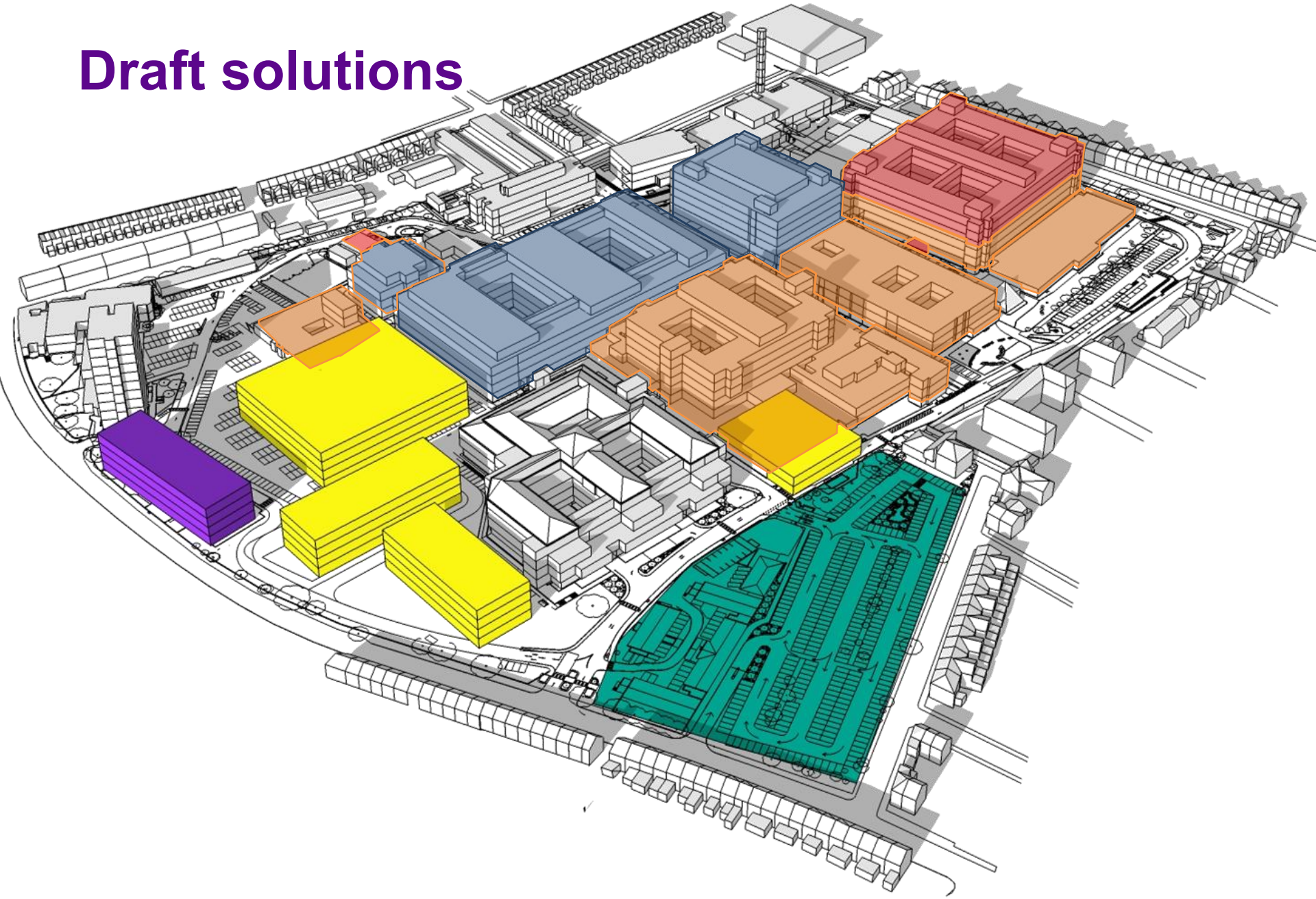
Estates plans; 2016/17 – to be Allocated

- Mortuary Phase 2
- ED capacity improvement
- Pharmacy pre pack and quality control

Initial priorities



Draft solutions



Estates plans; proposed projects 2

Vacating and removing out-of-date building stock

Project	Benefits	Priority	Cost*
Wandle annex	Removes services from poor accommodation Reduces estates cost, liabilities and risk Clears site for re-use (non-clinical)	1	£465k
Knightsbridge	Removes services from poor accommodation Reduces estates cost, liabilities and risk Clears site for re-use (clinical) Relocates services to community	1-2	£2.1m
Renal Unit relocation	Removes services from poor accommodation Reduces estates cost, liabilities and risk	1-2	£19.1m

Priority
1 = 'Step 1' / Immediate / Critical
2 = 'Step 2' / year 2
3 = 'Step 3' / year 3 (planning to start year 1)

Estates plans; proposed projects 1

Improving reliability/compliance of infrastructure/wards

Project	Benefits	Priority	Cost*
Infrastructure backlog maintenance prog.	Development of logical plan-of-works results in a safer, more reliable estate	1	£10m 'budget'

Priority
1 = 'Step 1' / Immediate / Critical
2 = 'Step 2' / year 2
3 = 'Step 3' / year 3 (planning to start year 1)

* Preliminary 'high level' cost estimation by Sweett Group

Estates plans; proposed projects 2

Vacating and removing out-of-date building stock

Project	Benefits	Priority	Cost*
Back office services	Removes services from poor accommodation Reduces estates cost, liabilities and risk Provides swing space	1	£1.5m
Bence Jones	Removes services from poor accommodation Reduces estates cost, liabilities and risk	1	£100k
Porters accommodation	Removes services from poor accommodation Reduces estates cost, liabilities and risk	1	£50k
Blackshaw annex	Removes services from poor accommodation Reduces estates cost, liabilities and risk	2	TBC

Priority
1 = 'Step 1' / Immediate / Critical
2 = 'Step 2' / year 2
3 = 'Step 3' / year 3 (planning to start year 1)

Estates plans; proposed projects 3

Increasing car parking whilst streamlining campus use

Project	Benefits	Priority	Cost*
Maybury St. car park (including demolition of Clare & Bronte)	Provides additional CP capacity Frees space for decant of clinical space Reduces non-emergency traffic on site Potentially increases income (charges)	1-2	£9m

Priority
1 = 'Step 1' / Immediate / Critical
2 = 'Step 2' / year 2
3 = 'Step 3' / year 3 (planning to start year 1)

Estates plans; proposed projects 4

Moving selected services into the community

Project	Benefits	Priority	Cost*
Genito Urinary Medicine	Clinical services in more accessible location 1,430m^2 made available on main campus	1	£4.4m
Outpatients	Frees clinical space for E.D. expansion	1-2	TBC
Pharmacy Pre pack & Quality Control	Frees up space for other, more crucial, services	2	£6m

Priority
1 = 'Step 1' / Immediate / Critical
2 = 'Step 2' / year 2
3 = 'Step 3' / year 3 (planning to start year 1)

Estates plans; proposed projects 5

Revising clinical service capacity and location

Project	Benefits	Priority	Cost*
Ward quality & compliance	Provides additional accommodation Quality improvement	1-3	£157m
St. James'	Upgrade to better quality accommodation	3	£75.6m
OPD & Therapies / ED capacity	OPD & Therapy moved off site, releases space for expanded ED capacity	1-2	£6.1m
Theatres review	Maximising existing capacity Targeting investment in priority areas	1	TBC

Priority
1 = 'Step 1' / Immediate / Critical
2 = 'Step 2' / year 2
3 = 'Step 3' / year 3 (planning to start year 1)

Estates plans; proposed projects 5

Revising clinical service capacity and location

Project	Benefits	Priority	Cost*
Education consolidation	Consolidates education services close to clinical accommodation Utilises vacant space appropriately	1	£7.9m
Children's consolidation	Easier staffing and management Better quality accommodation	3	TBC
Cancer consolidation	Easier staffing and management Upgrade to better quality accommodation	3	TBC

Priority
1 = 'Step 1' / Immediate / Critical
2 = 'Step 2' / year 2
3 = 'Step 3' / year 3 (planning to start year 1)

Estates plans; proposed projects 6

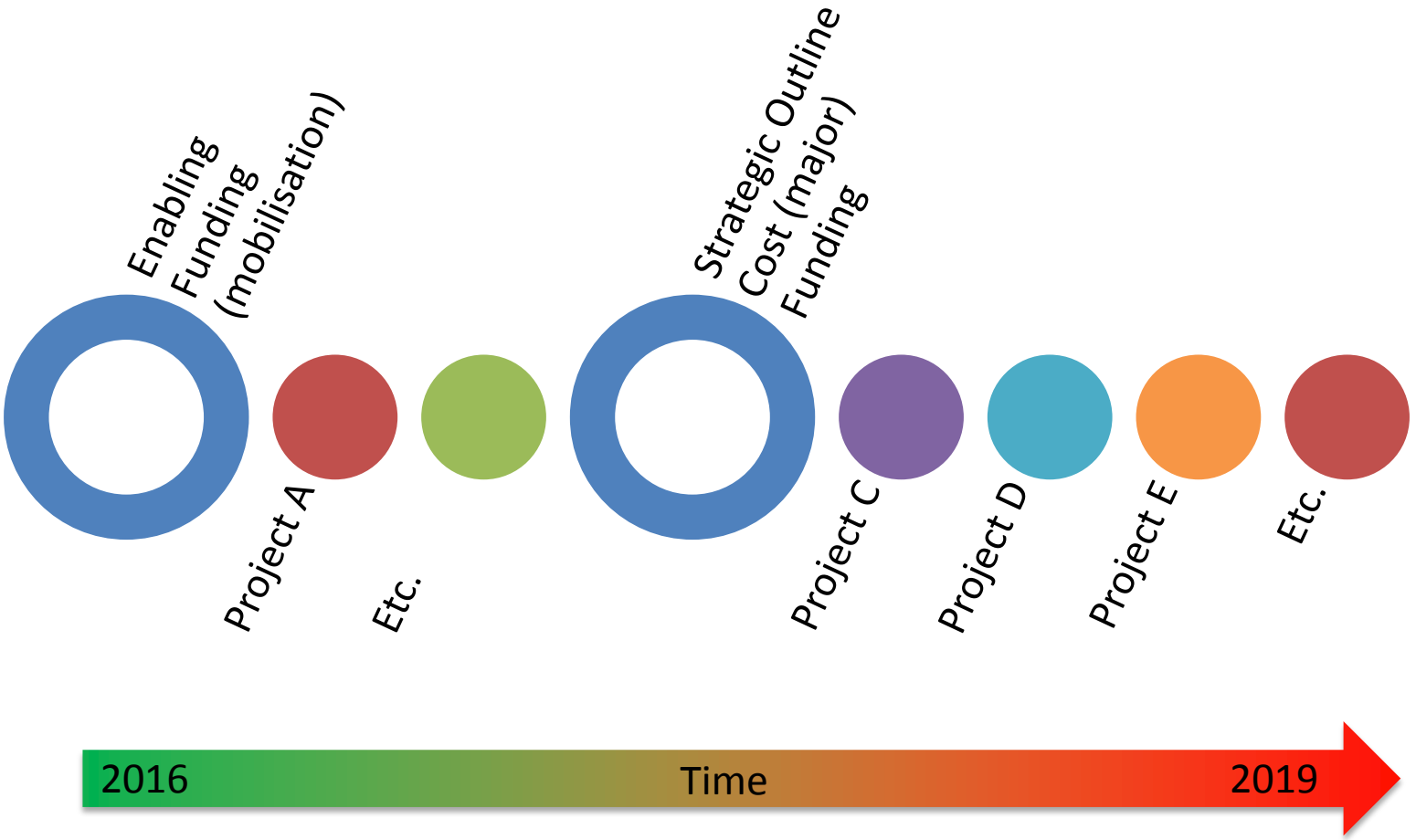
Commercial projects

Project	Benefits	Priority	Cost*
Moorfields	Revenue generation (no CapEx) Clears space for alternative use Enhanced clinical services	3	TBC
Retail development	Improved on-site facilities for staff, patients and visitors Income generation Productive use of non-clinical space	1	£2m
PPU	Revenue generation (no CapEx) Good opportunities for Consultants	2	TBC

Priority
1 = 'Step 1' / Immediate / Critical
2 = 'Step 2' / year 2
3 = 'Step 3' / year 3 (planning to start year 1)

Mobilization

Scope, programme, sequencing and funding (sources, quantity and time) need to be understood



Mobilisation

1. Refinement of estates plans
2. Development of additional Estates information
3. Funding for the redevelopment programme
4. Governance and team
5. Stakeholder engagement

Thank you

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St George's University Hospitals NHS
NHS Foundation Trust

DRAFT ESTATE STRATEGY 2016-2018





May 2016

~~Fourth~~ Fifth Draft ~~26~~ 27 May 2016

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St George's University Hospitals NHS
NHS Foundation Trust

Contents

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1. Executive Summary

This Draft Estate Strategy has been prepared in May 2016 to identify the estates priorities facing the Trust and outline the transformative plan to address the issues identified.

It is noted that the Trust is developing its own corporate and clinical strategies in the context of other emerging plans across the region that are being developed by partners in the local health and social care economy.

The Estates Strategy Vision is for the Trust to be operating from a safe, reliable estate that supports the effective, efficient delivery of services in support of the Trust's operational plan.

This strategy focuses on resolving the critical issue facing the Trust: a large backlog maintenance liability which is associated with a number of estates-related safety, reliability and compliance risks. This needs urgent resolution. It will be addressed by an increase in backlog maintenance works and works to remove some of the poorer quality buildings across the site to further reduces estates related costs and risks. It also ultimately planned to provide high quality accommodation in a new clinical block to remove inpatient areas from the upper floors of the Lanesborough Wing and enable improvements within St James WIng. This will require significant investment supported by external funding but is the most effective way of resolving the risk and constraints associated with a high proportion of the inpatient accommodation on site.

The community estate and other premised off the main campus provide part of the answer to addressing pressures on the main campus and moving clinical services to appropriate, accessible locations. It is recognised that more work is required to understand the opportunities in the community.

Preliminary works have started to begin to outline how these issues will be addressed. It should be stressed that planning work is at an early stage and the solutions need careful consideration to ensure they are right fort the Trust. The solution is complex.

This strategy seeks to provide the Trust with a flexible estate that will enable it to respond to the evolving future vision of specialist services across London. This is expected to be based around fewer specialised services and therefore could see a change in the disposition of specialist services on the St George's site. This strategy recognises these factors and gives the Trust the opportunity to prepare itself for the potential migration of some services to other Trusts and plan for expansion of other services to meet demand and fit with the plan for specialist services.

In summary, investment is urgently required in the basic infrastructure as well as in readiness for the potential wider service changes ahead.

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2. Introduction

This Draft Estate Strategy has been prepared in May 2016 to identify the estates priorities facing the Trust and outline the transformative plan to address the issues identified.

It replaces the 2010 Estate Strategy and subsequent addenda published in 2012 and January 2013.

It will be supplemented by additional scheme information to be developed during July 2016.

The proposals outlined in the final Board approved version of the Estate Strategy will form the basis of the plans to invest the allocated and budgeted funding and develop business case(s) that will be used to gain further funding to deliver the intended improvements.

In section 3 the current context and issues facing the Trust in relation to its estate are described. The Vision for the future estate is confirmed, the guiding principles and critical success factors for delivering the Estate Strategy are provided, and SMART (Specific, Measurable, Achievable, Realistic and Time-bounded) Estate Strategy Objectives are set out.

In section 4 a high level list of projects that contribute towards meeting the Estate Strategy objectives are described. The rationale for each project and its part in helping to deliver the Vision is provided. This information is supplemented by a Development Control Plan that shows how the site is planned to change on a scheme by scheme basis over the coming months and years.

Finally, in section 5, the next steps are set out explaining how the emerging ideas presented herein will be developed and implemented in line with best practice. It will set out at a high level how governance will be established to deliver the portfolio of projects envisaged in this strategy.

Alongside the development and implementation of the estates plans outlined in this document, the Trust will look to continually redesign services and pathways of care through its Improvement Programme. This programme will need to ensure that the Trust is able to reduce the number of outpatient appointments on the acute site, reduce the number of admissions and particularly re-admissions, and reduce lengths of stay. These improvements in productivity will reduce the overall additional capacity required on the Tooting campus thereby minimising the requirement for further capital developments.

Comment [WA1]: Is this still going / the right name

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3. Context

3.1 Strategic Context

3.1.1 Overview of the Trust

St George's is the largest healthcare provider in south west London, with over 8,500 dedicated staff. The Trust is the specialist regional centre for the 2.6 million people of southwest London and Surrey, and also provides a range of supra-regional services such as cardiothoracic surgery, neurosciences and renal transplantation for upwards of 3.5 million people. St George's is one of four major trauma centres in London (and one of only two in London currently with a helipad), a heart attack centre, and one of eight hyper-acute stroke units serving London. It is also the provider of community services for Wandsworth including at HMP Wandsworth. It is a diverse, complex and high quality organisation, authorised as a Foundation Trust on 1st February 2015.

~~St George's ended 2014/15 with a £16.8m deficit and its initial forecast deficit for 2015/16 was £46.2m resulting in the trust being in breach of its Foundation Trust license. This resulted in Monitor, the oversight body for Foundation Trusts, placing St George's into 'turnaround'. This involves outside support, in this case from KPMG, being brought into the Trust to help identify and address the causes and drivers for the financial position, and begin the process of returning the organisation to financial sustainability. A key output of the turnaround process has been a revised financial forecast for 2015/16 outturn of £63m and a high level financial plan for 2016/17.~~

The Trust's strategy was approved in late 2012 and was reflective of the Trust's financial performance in the previous years, its aspiration to become a Foundation Trust and set out a direction for the organisation for the ten years to 2022. The current strategy remained in force during 2015/16 as the overarching framework against which corporate objectives and other trust proposals were measured and developed against.

The mission and vision set out in this strategy were as follows:

> **Mission (the Trust's purpose):** "To provide excellent clinical care, education and research to improve the health of the population we serve."
>
> **Vision (what the trust wants to be):** "An excellent integrated care provider and a comprehensive specialist centre for south west London, Surrey and beyond with thriving programmes of education and research."

The Trust will refresh its strategy during early 2016/17. It is the expectation that the strategy will be evolutionary as opposed to revolutionary – the needs and requirements of the patients that use the Trust's services and the need to deliver a high quality service, seven days a week, being key to the strategy in development.

The refreshed strategy will take account of the financial challenges the organisation faces, the evolving needs of the health economy and the implementation of the five year forward view and the local Sustainability and Transformation Plan (STP), described further below.

3.1.2 NHS Five Year Forward View, October 2014

The Five Year Forward View was published by NHS England and identifies that the quality of care is changeable, preventable illness is widespread and health inequalities are deep rooted, patients' needs are changing, new treatment options are emerging and new challenges being faced particularly in mental health, cancer and support for frail older patients. It reported that, unless determined action was taken, the gap between need and available resources would be £30bn in 2020/21. The document describes the need to:

- Continue improving helping people lead healthier lives preventing illness;

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- Supporting the multispecialty community provider model and improving primary and acute care systems to bring together GPs, urgent care centres and hospital services;
- Consider additional approaches to creating viable smaller hospitals;
- Develop midwifery-led maternity services.

3.1.3 Transforming London's Health and Care Together , 2014

This plan was created by the office of the CCGs and NHS England and set out the joint vision to implement the Five Year Forward View in London. It set out a wide ranging transformation plan that included aspirations to create world class specialist care services and transforming London's estate to deliver high quality care. In relation to specialist services it outlined a strategy to create centres of excellence for cancer and reducing variations in quality and experience. It stated it would review pathways including specialist services and agree changes as required.

In relation to the estate it said that strategic planning and capital boards would be established, a robust asset database would be developed, an emphasis would be put on the estate meeting robust quality standards and that levers and incentives would be developed to ensure estates strategies meet clinical strategy needs.

3.1.4 London Health Plan (Specialist Services Redesign), ongoing 2016

Senior representatives of local healthcare provider organisations are currently undertaking a review of the disposition of specialist services amongst acute providers in London. This could result in a reallocation of specialist services between hospitals to provide higher quality services operating in a more sustainable model.

This could impact St George's in relation to some of the tertiary services it may be commissioned to provide in the medium to long term. It could mean the migration of some services to other Trusts and the expansion of some existing services such as Neurosciences. It would appear that the Trust's future as an emergency / trauma centre is secure and indeed there is pressure to increase the capacity of the Emergency Department to meet the .

3.1.5 Lord Carter's Review, June 2015 and Feb 2016

In response to the funding challenges faced by the NHS, Lord Carter published a report in February 2016 highlighting opportunities to improve operational productivity in NHS acute hospitals. The report identified opportunities to make estates related savings in the following areas in acute hospitals:

- Reducing estates and facilities running costs;
- Reducing the percentage of non-clinical space as a proportion of overall space; and
- Reducing unoccupied or underused space.

It recommends that Trusts should operate at or above the benchmarks agreed by NHS Improvement for the operational management of their estates and facilities functions by April 2017; with all Trusts (where appropriate) having a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner.

3.1.6 Sustainability and Transformation Plan (STP) - SW London Acute Provider Collaborative, ongoing 2016

The CCGs and providers in South West London have come together to develop a Sustainability and Transformation Plan for the area. This sets out a shift to community based services through a series of community 'hubs' based in primary care.

Given the challenges of deprivation, an aging population, increased emergency admissions, failure to meet national and local minimum standards for urgent and emergency care and a poor hospital estate, the objectives are to transform services by introducing new models of care to transform services which:

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- Deliver better health outcomes at a lower cost of provision to the system;
- Are patient centred and coordinates a wide range of services around their needs;
- Are proactive and preventative;
- Provide services at the most effective and efficient scale across the population.

The work underway is focussing on reducing cost, demand and throughput by increasing productivity, improving prevention and early intervention and looking at the configuration of hospital sites.

In finding solutions, the STP work recognises the need to have an estates strategy which ensures the best use of all assets and meets the standards of 21st century healthcare.

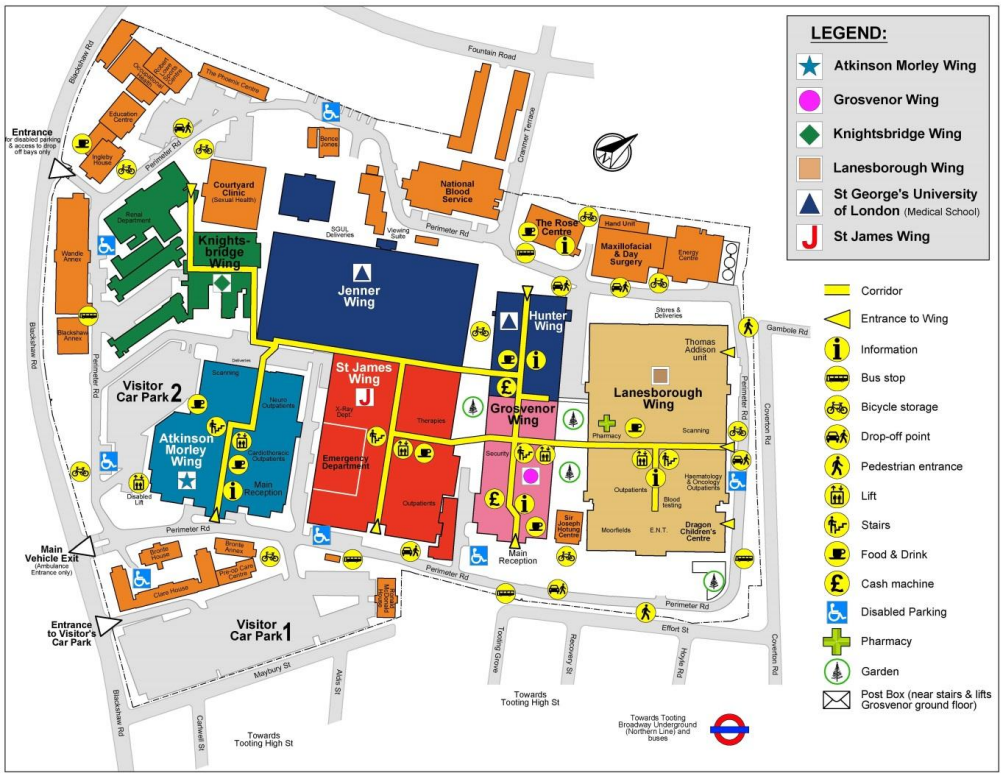
The STP is due to be completed at the end of June 2016.

3.1.7 Trust Strategy and Clinical Strategy

A new strategy is being developed by the Trust which will set out how the Trust intends to operate in the light of the context outlined in the paragraphs above.

3.2 Current Estate

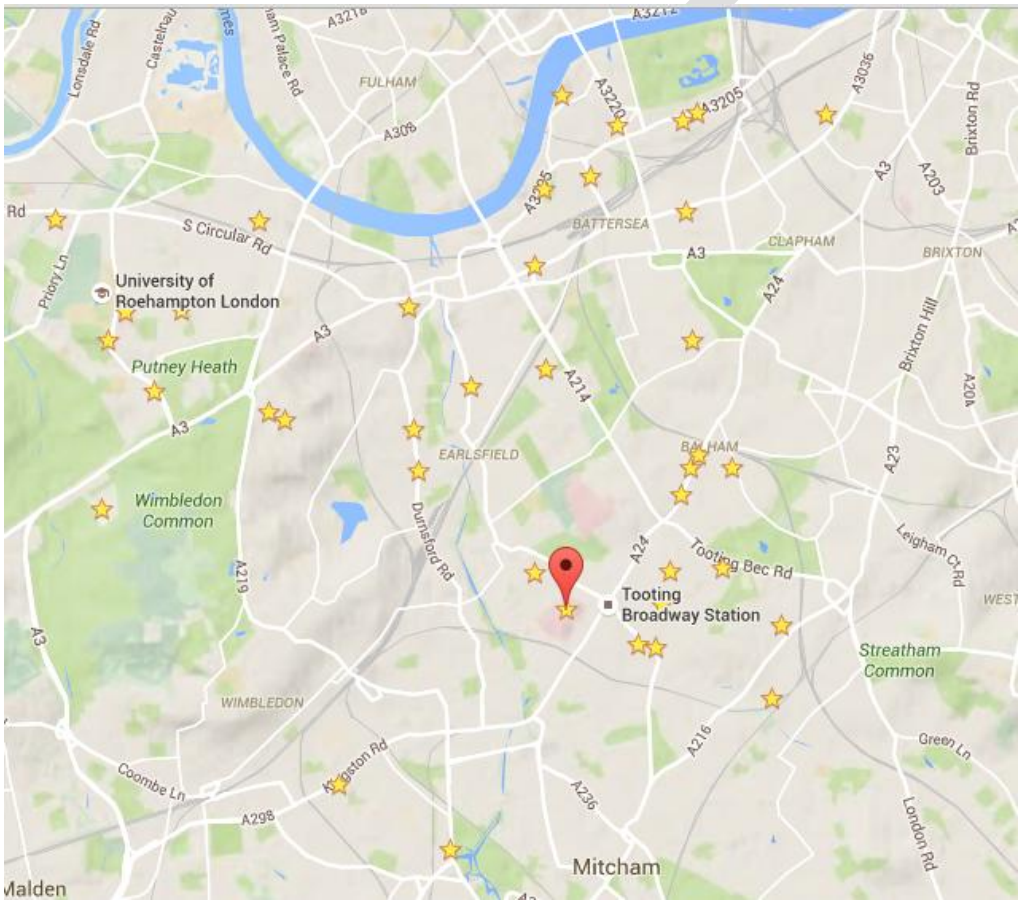
The St George's Hospital site occupies a 33 acre site in Tooting, southwest London. There is a mix of buildings ranging from blocks built in the late Victorian era to the Hotung Centre, built in 2005. The majority of the blocks were built in the 1970s, just before the St George's Hospital was moved to the site; this includes the Lanesborough, Jenner, Hunter and Grosvenor Wings. The plan below shows the main campus.



The Trust also provides services from the following locations:

- Queen Mary's Hospital
- St John's Therapy Centre
- Balham Health Centre
- Bridge Lane Health Centre
- Brocklebank Health Centre
- Doddington Health Centre
- Eileen Lecky Clinic
- Joan Bicknell Centre
- Stormont Health Centre
- Tooting Health Clinic
- Tudor Lodge Health Centre
- Westmoor Community Clinic
- Nelson Health Centre
- HMP Wandsworth
- Community services in GP surgeries, schools, nurseries, community centres and in patients' homes

The map below shows the locations of the premises where community services are provided from.



Key estate statistics include:

- A total of around 154,449m^2 is provided across 40 structures
- Most of the estate is retained; Atkinson Morley Wing is PFI
- Around 2,528m^2 of space is in portacabins – these are meant to be temporary structures and need to be removed. Portacabins tend to be very inefficient accommodation and expensive to run
- Approximately 44% of space is devoted to non-patient space; this is a high proportion

- Around 10% of the estate is leased to third parties and the Trust acts as a landlord; these include Moorfields Eye Hospital and the Pelican Hotel
- University College London and the National Blood and Transplant Service are neighbours on the site, but manage their space independently
- 968 car parking bays are available on site; of which 313 are available for staff. 200 staff bays are available via a Park and Ride at Wimbledon Greyhound Stadium. There are 53 drop-off bays and 41 disabled parking bays. There are 518 specific spaces on site for bicycle parking.

3.3 Condition

The Trust is in the planning stages to conduct a full 6-facet survey and fire, health and safety survey. This information will provide a clear and current picture of the detailed estate issues and help identify the highest priorities for expenditure. The known issues for the estate are explored briefly under the headings below. Additional detail is provided in the table of Estate-related risks and backlog.

- **Electrical** – parts of the estate (Knightsbridge, Lanesborough Wing) have an ageing electrical infrastructure which has reached the end of its life and must be replaced. Electrical infrastructure is inadequate for the needs of 21st Century healthcare and there is a need to expand the capacity of electricity on the site. Electricity generation and provision needs to be more sustainable and efficient.

- **Building / Infrastructure –** a number of buildings have urgent roof repair or replacement issues (Day Surgery, Lanesborough). Major refurbishment is required for clinical and support spaces (theatres, ward kitchens, service corridors). Infrastructure repairs are required to drainage, roads and pavements.

- **Mechanical systems –** significant renewals are needed to systems that keep the site operational and safe, including high-risk theatre ventilation (c.£9m), an energy centre renewal (c.£12m), refurbishment of lifts (c.£1m) and replacement of the Grosvenor plant room (c.£1m). A number of other projects costing up to £900k each are aimed at ensuring safety and statutory compliance (legionella, asbestos removal, steam main repairs).

- **Fire systems –** replacement or major refurbishment of fire alarm systems and improvements in the fire separation provision is needed in Lanesborough, Grosvenor and St James Wings. The site fire main requires upgrade.

The last comprehensive condition survey was conducted in 2010. At that time, almost 20% of the buildings on the site were categorised as C (exhibiting major defects) or D (life expired / failure imminent). It is anticipated that this figure will rise to nearly one-third in the 2016 condition survey. The Development Control Plan addresses the need for major renewal and development at St George's; details on the Plan are summarised in Section 4. The following buildings were identified in the 2010 survey as having particular deficiencies:

- Chest and Breast Clinic
- Wandle Annex
- Parts of Knightsbridge Wing
- Bronte House
- Bronte Annex
- Clare House
- Grosvenor Wing
- Parts of Lanesborough Wing
- Lanesborough Outpatients Department
- Education Centre
- Robert Lowe Sports Centre

3.4 Estate-related Risks

There are an increasing number of risks to patient safety and experience identified arising from issues related to estates. For example:

- There was a Serious Incident relating to infrastructure in March 2016;
- The renal unit suffered repeated infrastructure breakdowns during Q4-2015/16;

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- Lack of funding for Infrastructure projects has been identified as a key risk to achieving the 2016/17 Operational Plan, particularly regarding renal and the children and women's hospital
- The most recent staff survey (Q3 2015/16) raised issues about the estate affecting care;
- Lanesborough Wing has urgent fire safety issues. An independent report concluded that an inspection could result in an Enforcement Notice or possible prosecution. It added that the Fire Authority could consider actions which would require immediate closure of the building.

The table below summarises estate-related red risks on the Corporate Risk Register as at April 2016.

Corporate Risk Register Summary

Risk Area	Rating	Risk Description	Estates Implications / Response
Theatre capacity	20	Maintenance of theatres behind plan for a number of years, leading to a materialised risk that theatres will break down	• New hybrid theatre installation progressing • Planned maintenance, remedial works and theatre upgrade plan to be completed • Business case Cardiac 4 theatre for to be reviewed and approved
Bed capacity	16	Need for additional G&A beds despite initiatives to manage use of beds and patient flows	• Expand bed capacity
Planned & Reactive Maintenance response	16	In order to achieve identified savings targets, the Estates and Facilities Department has to reduce labour and materials expenditure on its planned and reactive maintenance service.	• Asset and PPM programme being developed for all estates assets • Staffing levels have increased to undertake additional works for CQC and other urgent works. • Materials and services procurement issues with appropriate response times
Capital Programme	16	Delay capital programme and /or maintenance activity due to clinical and capacity demands preventing access for works	• Robust monitoring of project and maintenance activity • Agreements for access to areas for remedial works, including CQC items
Patient safety	16	There is a danger of a major failure because the electrical infrastructure has reached the end of its useful life in Knightsbridge Wing. A recent major failure caused the wing to be evacuated	• Temporary repair for short term • Replacement electrical panel awaiting installation, which will work in the medium term • Identify condition and remedial actions through condition surveys
Fire safety	16	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)	• Implement action plan (fire risk assessments, training, infrastructure, governance) • Monitor progress through relevant committees • Incorporate findings of recent IFC interim audit to fire management approach • Revised Fire Safety Policy being finalised
Statutory compliance	16	There is a risk to patient safety from legionella infection. There is increased risk because legionella has been found in isolated areas in the St George's Hospital site	• Enhanced monitoring & testing • Capital funding for works to resolve
Site capacity	16	Lack of decant space will result	• Review of space and potential

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Risk Area	Rating	Risk Description	Estates Implications / Response
		in delays in delivering the capital programme	decant areas being undertaken • New Space Committee mobilised to develop the space strategy, assess the Trust space issues and requests • Use Space Committee work to agree approach to decant space issues
Capital Programme	12	Risk to the quality and safety of patient care if required works cannot be undertaken due to capital funding decisions not to fund such projects	• Preparation of new 5 year prioritised capital programme • Condition survey • Capital programme to be reviewed in line with condition surveys
Statutory compliance	12	Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation because there are gaps in mandatory documentation	• Regular updates to monitoring committees • Estates Staff training • Planned Maintenance activities being developed • Premises Assurance Model being undertaken
Adult Critical Care capacity	9	Requirement for high activity volumes to meet patient and commissioner needs, non-elective admissions, RTT standards	• Building works on CCU & Thomas Young to enable creation of 3 additional CTITU, 1 CCU & 4 Neuro HDU beds

3.5 Backlog Maintenance

An assessment of the high risk backlog maintenance projects has been undertaken by the Trust's Head of Estates. Reflecting underinvestment in infrastructure systems in recent years it identifies works to the value of £61,555,000 over the next five years including a recommended spend of £26,335m in 2016/17. When risk contingencies, fees and VAT are added the true level of expenditure would be in the region of £100m.

High risk backlog maintenance 5 year requirements 2016-2021

Element	2016/17 (£'000)	2017/18 (£'000)	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Electrical	3,425	3,605	2,825	875	75	**£10,805**
Building	3,020	3,620	520	520	100	**£7,780**
Mechanical Systems	16,220	7,400	3,700	1,200	1,000	**£29,520**
Fire Systems	3,270	4,420	1,520	1,520	1,520	**£12,250**
Estates systems & data management	400	200	200	200	200	**£1,250**
Total	**£26,335**	**£19,245**	**£8,765**	**£4,315**	**£2,895**	**£61,555**

Analysis by building shows that Lanesborough Wing has significant issues of backlog and requires major works to address these. Lanesborough Wing accounts for one-fifth of the total sum estimated as being required to address high risk backlog over the next five years. It should be noted that the items characterised as Infrastructure works were not identified by building or relate to components across a number of buildings.

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Backlog by Building

Building / Element	Total High Risk Backlog 2016-21 £ ('000)	Proportion of Total High Risk Backlog %
Energy Centre	12,770	21
Lanesborough Wing	12,150	20
Infrastructure	11,005	18
Theatres / Day Surgery	10,300	17
St James Wing	4,450	11
Grosvenor Wing	3,700	6
Boiler House	1,730	3
Education Centre	800	1

3.6 2016/17 Capital Programme

The table below summarises the draft capital programme for 2016/17 as currently allocated.

Capital Programme Summary

Element	Draft Capital Programme 16/17 (£'000)
IMT	**4,691**
Infrastructure Renewal	**8,139**
Energy	3,938
Fire safety	1,942
Other	1,937
Water	322
Energy Performance Contract	**11,552**
EPC	11,552
Major Projects	**6,070**
Medical Equipment	**4,718**
Other	**2,018**
SWL Pathology IT System	**165**
Grand Total	**37,353**

3.7 Estates Vision

The Estates Strategy Vision is for the Trust to be operating from a safe, reliable estate that supports the effective, efficient delivery of services in support of the Trust's operational plan.

3.8 Guiding Principles and Critical Success Factors

The guiding principles and critical success factors associated with delivering this estate strategy are:

1. Treasury-provided capital funding is and will remain very limited. Therefore it is only to be used for the most essential enabling activities (in-line with the developing Trust strategy);
2. Non-clinical administrative activities should be relocated offsite wherever possible or at least located outside the main clinical blocks. This will release space for decant whilst work is undertaken in line with the plan.

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3. Patients should be treated in safe, compliant facilities.
4. The plans emanating from this Estate Strategy must support the more efficient use of space more efficiently, consolidating services, supporting new ways of working and supporting logical flows to require less space overall in order to reduce capital and estates revenue costs and achieve better value for money.
5. The Trust will need to work closely with its partners in the local and regional health and social care community to achieve the transformative plans outlined herein.
6. The Trust should invest in careful planning and preparation before commencing with physical works to ensure that, wherever possible, works can be delivered quickly but also on a value for money basis, benefiting from innovative solutions and best practice. However full end to end planning may not be possible or even desirable at this stage and some flexibility will need to be allowed for.
7. The Trust recognises that in order to see a step change in the quality and reliability of the estate, the Trust must plan decisively, with determination and prepare to deliver several projects in parallel. Capital must be invested as soon as possible in order to achieve results at the earliest opportunity.

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3.9 Estates Strategy Objectives

The Estate Strategy objectives are to:

1. Ensure that estates risks are managed and that the estate complies with all necessary standards.
2. Ensure that wherever possible services are provided in the community, improving access for patients and relieving pressure on the main campus.
3. Ensure that services are sensibly located, supporting efficient and effective patient pathways and workflows.
4. Ensure that all the estate provides sufficient capacity in the right locations to meet demand for healthcare.
5. Deliver the required improvements on a rapid but cost-effective basis recognising that there is an urgent need for investment but that capital and revenue funding is constrained.

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4. Estates Plans

4.1 Introduction

This section outlines the projects currently in development and those projects proposed to be initiated in this Draft Estate Strategy. Sections 4 .3 shows how these projects align with the Trust's Estates Strategy Objectives.

4.2 Ongoing Projects

4.2.1 Infrastructure Capital Programme

The Trust's draft 2016/17 capital programme includes the following major (>£250k) elements of essential estate infrastructure spend:

- Energy Performance Contract £11,556k
- Standby Generators £3,092k
- Fire safety measures £974k
- Boiler House Roof £500k
- St James plate heat exchange £361k
- Water tank replacement £300k

Other major items of spend include the lease of two Sterliox E200 generators until 2019 at an annual cost of £450k.

In addition £525k is allocated towards funding a full 6 facet survey and fire, health and safety survey. These surveys, to be carried out in 2016 will provide an up to date picture of the condition of the Trust's estate and associated risks and enable the identification and prioritisation of investment to support the development of a high quality, reliable, safe estate. The last such comprehensive survey was carried out in 2010.

4.2.2 Major Projects (Clinical Services) Capital Programme

The projects listed below are intended to enhance the capacity and quality of clinical services. The costs shown relate to the amount of investment allocated in the draft 2016/17 capital programme. In the main these projects have had their business cases approved over the last couple of years and in most cases are well underway. If the Trust was looking to reconsider these decisions, the schemes that could be halted are the Coronary Care Unit 2 / Critical Care and CVT Theatre 4 projects although there would be operational implication associated with such a step.

Surgical Assessments Unit (Amount allocated 16/17 - £1,532k)
This £3.5m project will provide SAU capacity: waiting space, 2 x 4 bed bays, 8 trolleys, a minor procedures room and an 18 chair discharge area on the ground floor of St James Wing, collocated with the Emergency Department. This will improve ED waiting times by allowing the fast track of surgical patients from ED to SAU, where they will be assessed, treated or discharged. The project is underway and will complete in June 2016.

Coronary Care Unit 2 / Critical Care (£893k)
These projects, worth £900k which are planned to take place in Atkinson Morley Wing (first floor) will increase critical care intensive care capacity by three beds and the coronary care unit by 1 bed supporting the heart failure CQUIN. They will delivered by Blackshaw Health Services Ltd, the PFI Special Purpose Vehicle. The projects are planned to commence in July 2016, subject to approval by the PFI funders, and are expected to complete in December 2016.

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Endoscopy department expansion (£873k)
This £1.2m project, adjacent to the existing Endoscopy Department on the first floor of St James Wing, will increase the capacity of the endoscopy department by two additional endoscopy rooms to cope with additional demand created by bowel screening programme. It also provides additional office space to support the bowel screening programme. This is well underway and completes in June 2016.

Atkinson Morley Wing – Additional 7 Neuro Beds (£269k) and 7 Cardiac Beds (£673k)
This expenditure has been set aside to pay the outstanding monies on the projects to increase neuro and cardiac bed capacity in Atkinson Morley Wing by 7 beds each on the 2nd and 3rd floors. All works are complete.

St James Wing Theatres 5&6 (£671k)
This £2.35m project will refurbish two outdated theatres on the first floor of St James Wing with AHU reliability problems provide refurbished facilities with laminar flow to theatres 5 and 6 in St James Wing. It is due to be completed in July and operational in August 2016. Is the start of a programme of theatre upgrades.

CVT Theatre 4, Atkinson Morley Wing (£459k)
Cardiac theatre four has been released as a result of the new hybrid theatre redevelopment. A business case has been approved for theatre 4 to be used to provide additional cardiothoracic capacity. The capital expenditure is required to purchase essential theatre equipment.

Chemotherapy Day Care Unit (£410k)
This project, on the 3rd floor of Lanesborough Wing will increase the space allocation for patients and increase the number of chairs from 14 to 16. These improvements will improve the effectiveness of the department. This will be taken forward if additional capital funding can be secured from the Charity.

Genomes Project (£320k)
This expenditure is for equipment and software for the SWT Clinical Genetics department to support the Genomes project. It is funded by a special PDC capital allocation the Trust received last year from the Department of Health.

PLACE (£250k)
This is a charity-funded project to make environments used by elderly patients more dementia friendly through the provision of day rooms, chairs, special lighting, etc.

Emergency Department Hot Lab (£196k)
This project provides a new hot lab in the Emergency Department. This will provide fast access to a range of tests required by the department.

4.2.3 Completed projects with 2016/17 expenditure

The projects listed below are complete but have committed, outstanding monies to be paid pending agreement of the final accounts:

- Neuro-rehab re-location costs (£343k)
- Hybrid theatre (£122k)
- Non-invasive Pre-testing Laboratory (£62k)
- Gordon-Smith Ward Lanesborough Wing 3rd Floor (20 extra oncology / haematology beds) (£45k)
- Thomas Young Ward Lanesborough wing - 3rd floor - - £112k
- Mortuary Upgrade (Phase 1) (£59k)

4.3 Other Projects in Development

A number of other projects are in development but are not included on the Capital Programme.

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Mortuary Phase 2
This £174k project provides 30 body freezers to enhance capacity of the mortuary, located on the lower ground floor of Jenner Wing.

New Parent's Room in Neonatal Department
This £30k project on 1st floor of the Lanesborough Wing reprovides a parent's room that was removed in an earlier project. This is planned to be complete by the end of July 2016.

ED Capacity Improvement
This £16k project, that provides three additional trolley spaces in ED, is in development. This is due to complete in July 2016.

Clinical Research Facility
This £100k project in Jenner Wing, funded by the University and Clinical Research Facility provides improvements to a non-compliant facility Cat 2 lab.

Pharmacy Packing Unit and Pharmacy Quality Control Unit
A project to relocate the current Pharmacy Packing Unit (PPU) from St George's Hospital to an offsite warehouse location has been started in order to facilitate growth in the PPU service and realisation of other commercial opportunities. This project is being run as a Commercial Scheme under the Commercial Board. Consideration is being given to incorporating the reprovision of a compliant Pharmacy Quality Control facility into the Pharmacy Pre-Packing Unit scheme. The intention is for all works to be landlord funded and reimbursed through rent payments. These projects are currently on hold.

4.4 Proposed Projects

All of the ongoing projects have been tested against the updated Estate Strategy Objectives and will continue.

A number of new projects have been conceived that will support the Trust in achieving the Estate Strategy Objectives. The projects have been given a priority for when significant work towards either planning or implementing the changes needs to start. The rationale and high level content of these projects are outlined below and have been themed along the following lines:

- Improving the reliability and compliance of our infrastructure;
- Vacating and moving out of date building stock to reduce estates maintenance liabilities;
- Moving clinical and non-clinical services into the community;
- Ensuring clinical services have the right capacity and are sensibly located, providing efficient and effective patient pathways;
- Providing sufficient car parking whilst enabling better use of the main campus;
- Commercial projects to provide complementary services, generate income and improve the working environment.

4.4.1 Improving the Reliability and Compliance of our Infrastructure

Backlog Maintenance Programme – Year One Priority
The capital programme has allocated c£7.5m of expenditure in 2016/17 on infrastructure renewals, set against a recommended high risk backlog maintenance investment requirement of £26.335m in 2016/17. The reduction of backlog maintenance and the associated estates-related issues and risks is a top priority.

The capital programme has been reviewed in the light of the priorities outlined herein to ensure that backlog maintenance spend is targeted at elements that will resolve the highest level risks; is not carried out in buildings which will no longer be used; and that any works required in buildings where projects are planned can be implemented together, wherever appropriate, to minimise disruption and maximise value for money. Additional works to address critical infrastructure issues to be funded from budgeted expenditure have been identified as follows:

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We have prioritised the high risk backlog maintenance and identified items to be addressed within 2016/17 which fit the Trust's allocated and budgeted spend of c£18m. Additional items to be addressed from the budgeted spend include generator and electrical infrastructure upgrades in Lanesborough Wing, St James Wing, Maxillofacial, the Rose Centre and Energy Centre.

Further high risk backlog items have been prioritised and will form the basis either of a enabling business case submission and /or next year's priorities.

4.4.2 Vacating and moving out of date building stock to reduce estates maintenance liabilities

Wandle Annex - Vacation and Demolition – Year One Priority
The Wandle Annex, backing onto Blackshaw Road on the south west perimeter, houses part of the Occupational Health service, Macmillan, two managers, the CHS Team, Service Improvement and the PET Reception. The accommodation is very poor. It is proposed that the occupiers are decanted and the building is demolished to reduce estates costs and maintenance liabilities. There is very limited free space available across the campus to accommodate these services. The Trust has a temporary planning consent with c4 years remaining to build a c1,000m^2 footprint, four storey building in its place so this could provide an option to house these services. More detailed solutions will be developed.

Knightsbridge Wing Vacation and Demolition – Year One/Two Priority
The Trust plans to vacate and demolish Knightsbridge Wing as it is an old, poor quality building with a number of infrastructure issues. In addition to the renal service it accommodates:

- Medical Physics
- The Blood Pressure Unit
- Community Midwives
- Divisional Governance Office
- Legal Services
- Clinical Effectiveness
- The Plastic Dressing Clinic
- Cancer Services office
- Risk Management
- Gastroenterology
- Sewing Room
- The Norman Tanner Corridor Office
- Training and Development
- Human Resources

These services would need to be accommodated elsewhere and plans will be developed to do this on a cost effective basis.

Renal Unit – Relocation – Year One/Two Priority
The renal unit is currently provided in Knightsbridge Wing in relatively poor accommodation which has experienced problems with water quality, heating and hot water supply. There are opportunities for some renal outpatient activity and administration to be permanently relocated offsite as part of an expansion to current practice on both the Colliers Wood and Queen Mary's Roehampton (QMH) sites. This leaves the need to relocate the 24 bedded ward and adjacent 16 dialysis stations on the St George site. Dialysis provision remains necessary for patients from specialties within many other specialities as well as established links with vascular surgery and Acute Kidney Injury (AKI) provision so must remain on site. A Renal Redevelopment Project Board has been established. Approximately 2,700m^2 is required. On site relocation options currently under consideration are the use of the Courtyard, enabled by an extension. Alternatively it could be accommodated in a new building. Ideally the service needs to benefit from an internal, physical link to the rest of the hospital to support the safe and dignified transfer of patients.

Non-Clinical Office Accommodation – Year One/Two Priority
Bronte House and Bronte Annex currently house the Finance department and St George's Hospital Charity office. Clare House houses the IM&T department (in addition to Macmillan offices; adult psychiatry consulting, meeting rooms and offices; mental health liaison offices; pre-operative assessment; occupational health offices; the e-rostering team, paediatric psychiatry; child health; palliative care offices).

The accommodation is provided over several floors in cellular offices and is not an efficient, cost-effective way of providing office accommodation in line with 21st century working practices. The

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accommodation is old and unsuitable for refurbishment for modern clinical facilities. IM&T (barring on-site support staff) and Finance departments do not have to be accommodated on the site. Therefore it is proposed that modern office accommodation is sourced and leased for Finance and IM&T (barring on-site support staff). The business case will need to consider whether an off-site, leased solution would be cheaper and more beneficial than a solution that rehouses the services on site. In relation to the other services in Clare House, the Charity is considering alternative locations for its office. The Trust needs to liaise with South West London & St George's Mental Health NHS Trust to discuss the preferred future location of the mental health services. Pre-Operative assessment would need to be accommodated on site. E-rostering could go off-site. Occupational health would benefit from consolidation with the other three elements of the service that are currently dispersed across the campus.

Procurement Portacabin Vacation and Demolition – Year One Priority
The Procurement department is currently based in a portacabin on the north-west side of Lanesborough Wing. The Supply Chain team could be moved off site just leaving a management presence on site thus eliminating the costs and maintenance liabilities associated with this facility.

Bence Jones Vacation and Demolition – Year One Priority
If sufficient space can be released by other projects, consideration should be given to rehousing the occupants of the Bence Jones portacabin (Medical Records and the 18 week team) and thus eliminating the costs and maintenance liabilities associated with this facility.

Porters' Accommodation Vacation and Demolition – Year One Priority
If the pharmacy Pre-Packing and QC projects proceed and the services move off site, space will be released in Lanesborough level 0. This could accommodate the Porters' accommodation that is currently housed in a portacabin between Lanesborough and Grosvenor Wings thus eliminating the costs and maintenance liabilities associated with this facility.

Blackshaw Annex – Year Two Priority
A decision is required on whether the lease on the Blackshaw Annex portacabin, which expires in August 2016 should be extended for a further period. It is understood that this has temporary planning consent until August 2019. The building currently houses 64 staff including the Cardiac management offices, the Staff Bank, Recruitment, Workforce Intelligence, Main Booking Office and Medical Locum Administration Teams. In the short term it is probable that the lease will be extended but this needs to be kept under review in the light of emerging plans.

4.4.3 Providing sufficient car parking whilst enabling better use of the main campus

Maybury Street Car Park – Year One/Two Priority
In order to withdraw car parking from the main hospital campus to free space for additional or replacement clinical accommodation and minimise car traffic around the site perimeter road, it is intended to increase the capacity of the Maybury Street car park. This will be done as part of a phased project to create a deck on the Maybury Street site and on the sites of the Bronte and Clare buildings which will be vacated as outlined elsewhere. The Bronte and Clare buildings will be cleared and replaced with a deck car park. This will provide car parking capacity whilst a deck is created on the Maybury Street car park. Access and egress would be from Blackshaw Road. The project will be implemented in such a way to minimise the reduction of spaces available across the campus at any one time. Ultimately it will enable the decommissioning of car parks such as the Atkinson Morley Wing car park which will be available to house additional or replacement clinical accommodation with easy links into the existing clinical buildings. The proposals will require planning permission as part of a wider site masterplan.

4.4.4 Moving clinical and non-clinical services into the community

Genito Urinary Medicine - Relocation into the Community – Year One Priority
The Genito Urinary Medicine department is located in the Courtyard building. The service is commissioned by Wandsworth Borough Council who want the service to be provided from community settings. It is therefore planned that this service will move off the campus. This will require joint planning with the council and will be dependent on securing suitable premises and reaching a

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mutually acceptable commercial arrangement that enables this. This will release the Courtyard building for alternative clinical use, potentially for the Renal Unit.

Outpatients into the Community – Year One/Two Priority
A programme is underway to identify which outpatient clinics / services can be provided from community settings, making better use of facilities to provide more accessible services. This programme will free up outpatient clinic capacity and could therefore enable a redistribution of outpatient clinics on the main campus. If this is the case, consideration should be given to reallocating outpatient space in the ground floor of St James Wing to ED or associated use to help further relieve the capacity pressures on ED on a cost-effective basis. Consideration will also be given to the potential use of space at Queen Mary's Hospital, Roehampton to further free space on the St George's site.

Pharmacy Packing Unit and Pharmacy Quality Control Unit - Year Two Priority
A project to relocate the current Pharmacy Packing Unit (PPU) from St George's Hospital to an offsite warehouse location has been started in order to facilitate growth in the PPU service and realisation of other commercial opportunities. This project is being run as a Commercial Scheme under the Commercial Board. Consideration is being given to incorporating the reprovision of a compliant Pharmacy Quality Control facility into the Pharmacy Pre-Packing Unit scheme. The intention is for all works to be landlord funded and reimbursed through rent payments. These projects are currently on hold.

4.4.5 Ensuring clinical services have the right capacity and are sensibly located, providing efficient and effective patient pathway

Backlog/Compliance Programme for Wards – Year One Priority to start planning. On site by Year Three
In relation to the outcomes of the fire survey of Lanesborough Wing, the Trust is defining and agreeing a strategy to mitigate as many of the issues and implement as many of the recommendations as practicable. Part of this includes reviewing the use of the upper floors to reduce the impact of any adverse events, probably by moving inpatient services out and replacing them with more ambulant occupiers after works have been undertaken to make the building fully compliant. Currently a total of 10 inpatient wards are located above the second floor plant areas:

- Dalby (Elderly Care, 5th floor)
- Frederick Hewitt (Children, 5th)
- Pinckney (Children, 5th)
- Gwillim (Post-Op, 4th)
- Dakin (Post-Op, 4th)
- Caesar Hawkins (Medical, 4th)
- Champneys (Gynaecology, 4th)
- Heberden (Elderly Care,3rd)
- Thomas Young (Neuro-Rehab, 3rd)
- Rodney Smith (Oncology, 3rd)

There is no space available to accommodate these ten wards so consideration will need to be given to accommodating these in a new clinical block that is designed and built to the latest standards. As part of this project consideration will be given to the disposition of all wards on the site to ensure that logical flows and adjacencies are achieved. The new clinical block would need to be connected to the other clinical blocks. A high priority will be given to the scoping of these works which will then need to be the subject of funding approval through a business case process that will require DH and Treasury approval given the likely value.

St James Inpatient Accommodation – Year One Priority to start planning. On site by Year Three
The inpatient accommodation in St James Wing does not meet modern standards. Most beds are provided in 6 or 8 bed bays. A relatively low proportion of single bed rooms are provided. In modern wards 50% of beds are provided in single bed rooms. Bedrooms, in the main, do not have ensuite sanitary accommodation, necessitating the allocation of whole wards to a single gender. Bed centres are considerably less than the recommended 3.6m. Consideration needs to be given to addressing these shortcomings in order to provide a high quality, safe environment. In addition consideration will be given to whether ITU capacity is sufficient.

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Emergency Department Capacity - Year One/Two Priority
ED is short of capacity, catering for up to 30% more patients than it was designed for. This is evidenced by the 90.4% 4 hour wait performance through 2015/16. In addition to the SAU and trolley capacity enhancement projects already underway, and any space freed up by moving out any adjacent outpatient services, consideration should be given to whether all the therapies services on the ground floor of St James Wing have to be located there or could be removed to another location on the site.

Theatres Review – Year One Priority
A review of theatre activity and capacity should be undertaken to support decision-making on the number of theatres needed and where investment should be prioritised. Consideration should be given to the relocation of the day surgery centre to co-locate surgery.

Education Consolidation – Year One Priority
The planned departure of the Medical School and Faculty of Health from 2nd floor of Grosvenor Wing will release c 2,700m^2 of office/ meeting room accommodation from October 2016. This will be used to accommodate educational facilities from the Education Centre adjacent to Ingleby House. The space would help accommodated the greater workload associated with the expansion of the apprenticeship programme. The existing Education Centre would be available to accommodate other displaced services that do not need to be connected to the main clinical accommodation on the campus. Education services could be consolidated by also moving in Training facilities from Knightsbridge Wing and Resuscitation Training from the lower ground floor of Grosvenor Wing, potentially freeing up additional space for retailer use. Works required would be minimal.

Children's Services – Year One Priority to start planning. On site by Year Three
A Full Business Case was produced in January 2015 for the development of a new Children's Hospital. It sought to consolidate services on 5th floor of Lanesborough Wing. The current facilities in the Lanesborough Wing are considered inadequate for a tertiary centre which provides state of the art care for children and are incompatible with a satisfactory experience for our young patients and their families. In physical terms, the design and layout of the fifth floor are no longer suitable for modern healthcare due to the poor physical condition poor layout and departmental relationships, compromised privacy and dignity, infection control risks imposed by the lack of space between beds and inadequate sanitary facilities. It is recognised that a rationalisation and consolidation of services will be of benefit and will be explored.

Cancer Services Consolidation – Year One Priority to start planning. On site by Year Three
A review of the disposition of services on the site shows that cancer services are dispersed. With a ward on 2nd floor of St James Wing and an oncology ward and oncology day care on 3rd floor of Lanesborough Wing. Consideration should be given to co-locating these services to enhance clinical and operational effectiveness.

4.4.6 Commercial projects to provide complementary services, generate income and improve the working environment

Moorfields Development – Year One Priority to start planning. On site by Year Three
Moorfields Hospital provides outreach services from the St George hospital site to patients in south west London. It provides outpatients on level 0 and day surgery from 1.6 theatres on the 5th floor of the Lanesborough Wing. Moorfields is prepared to fund the creation of a building that will provide outpatients and theatre services in a single area. This would relieve the infrastructure pressure and risks associated with accommodating theatres on the 5th floor of Lanesborough Wing. This accommodation should be physically connected in some way to the four main clinical blocks in the event of theatre patients requiring clinical intervention by St George's teams in St George's facilities. So a location somewhere on the Knightsbridge or AMW car park site may be appropriate. Control of this project would be limited as the pace will be driven to a degree by Moorfields.

Retail Development – Year One Priority
A study has been carried out that identifies the opportunity to enhance the provision of retail facilities in the ground floor of Grosvenor Wing. Up to five additional units could be released for this purpose and the outlets would provide useful amenities for patients, visitors and staff and provide commercial revenues for the Trust, making improved use of an existing space. To accommodate these units,

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underutilised space in the Ingredients Restaurant could be adapted to house some or all of the medical records facilities currently accommodated on the ground floor of Grosvenor Wing. Consideration needs to be given as to whether identifying and releasing capital to create shell space for retailers to fit out is a priority, given the other issues outlined herein.

Private Patient Unit – Year Two Priority

The Commercial Board has confirmed that despite the recent stalled project to develop a dedicated Private Patient Unit, the development of such a unit is still the right strategy over the long term (3-5 years). A revised business case is being prepared to support the project and in the short and medium term the plan is to incrementally develop private services on site. However this is not considered to be an immediate priority.

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5. Next Steps

5.1 Refinement of estates plans

This paper represents a snapshot of the emerging thoughts underpinning the Estate Strategy. These ideas will be refined and tested during June to ensure that a more robust Estate Strategy can be developed and presented for Trust Board approval in July 2016. The revised Estate Strategy will also respond to feedback from the Board.

The next iteration will benefit from further feedback from the emerging Trust and regional clinical strategies and from interrogating the Local Estates Strategy developed by Wandsworth CCG for community-based opportunities.

A preliminary approach will be made to Wandsworth Borough Council to start to discuss and seek support for the implications of the proposals from a town planning perspective; it is anticipated that the Council will have a keen interest in parking, traffic and massing implications associated with the emerging ideas. We will build on our existing relationship and knowledge of the local planning context to ensure that plans that meet local town planning aspirations are developed collaboratively.

At the same time the draft 2016/17 Capital Programme will be reviewed to align it with the emerging approach described herein.

5.2 Developing additional Estates Information

It is recognised that in some cases the information required to support informed decision-making is not available. This will be rectified over the summer with the development of:

- The development of a schedule of “as-is” space use, risk profiles, estates issues and constraints;
- Six facet and health & safety surveys of the estate;
- Space utilisation surveys and analysis;
- More detailed information on the proposed works / projects and decants;
- Updated capital costs and development of estates revenue costs analysis including any business impact costs;
- A site wide masterplan to support a planning application
- A business case for funding the redevelopment elements ~~out~~with allocated and budgeted funding;
- Further investigation of retail development opportunities.

5.3 Funding for the Redevelopment Programme

The proposed projects outlined in this Draft Estate Strategy will be funded from the following sources.

- Allocated in year spend;
- Additional budgeted in year spend;
- Through the development and approval of (a) business case(s) for projects over and above the allocated and budgeted spending limits;
- Through charitable funding;
- Through 3rd party funding, such as from Moorfields.

Some preliminary high level costs have been developed to start to build up the potential funding requirements:

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Project	Preliminary Cost Estimate
Improving the Reliability and Compliance of our Infrastructure	
Backlog Maintenance Programme	Additional budgeted spend: £10,000,000
Vacating and moving out of date building stock to reduce estates maintenance liabilities	
Wandle Annex - Vacation and Demolition 1,468m^2 building	Demolition cost: £465,000 Decant costs not yet calculated.
Knightsbridge Wing - Vacation and Demolition 5,431m^2 building	Demolition cost: £2,078,000 Decant costs not yet calculated – solution not known.
Renal Unit – Relocation. Assumes 2,700m^2 50% in refurbishment, 50% in extension	£19,124,000
Non-Clinical Office Accommodation – 4 storey, 4,000m^2 office	£16,945,000
~~Procurement Portacabin Vacation and Demolition 635m^2 portacabin~~Back-Office Services off-siting	~~Demolition cost: £204,000~~ Decant costs not yet calculated – ~~solution not known.~~c£1.5m bases on serviced desks in rented accommodation
Bence Jones Vacation and Demolition 310m^2 portacabin	Demolition cost: £103,000 Decant costs not yet calculated – solution not known.
Porters' Accommodation Vacation and Demolition 149m^2 portacabin	Demolition cost: £49,000 Decant costs not yet calculated – solution not known.
Blackshaw Annex	No costed (leased)
Providing sufficient car parking whilst enabling better use of the main campus	
Maybury Street Car Park: Demolition of Clare House 3,275m^2 Bronte House and Bronte Annex 1,058m^2 tbc Car park – single deck, phased over Maybury Street and Clare and Bronte sites.	£9,030,000
Moving clinical and non-clinical services into the community	
Genito Urinary Medicine - Relocation into the Community. Fit out costs for 1,462m^2. Assumes fairly heavy strip out.	£4,366,000
Outpatients into the Community	Not possible to cost – no brief yet.
Pharmacy Packing Unit and Pharmacy Quality Control Unit	£5,950,000
Ensuring clinical services have the right capacity and are sensibly located, providing efficient and effective patient pathway	
Backlog/Compliance Programme for Wards – Renovation of Lanesborough or New Clinical Block: 12 x 28 bed wards @ 1,084m^2 per ward over 3 floors plus 200m^2 per floor ancillary space = 4,536m^2 x 3 = 13,608m^2 One floor of other clinical accommodation = 4,536m^2	£156,688,000

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Project	Preliminary Cost Estimate
Communication space (15%) Engineering space (6%) **Grand Total 21,954m^2**	
St James Inpatient Accommodation: Refurbishment of ward space to create more single bed rooms, ensuites and smaller bed bays. Assumes floors 1-5 inclusive(18,878m^2) will need to be refurbished	£75,645,000
Emergency Department Capacity. Assumes refurbishment / conversion of 1,000m^2 of space, phased.	£6,142,000
Theatres Review	Not possible to cost – no information yet – solution not known.
Education Consolidation 2,700m^2 GIA – low level refurb/ touch up for other offices Fit out of vacated Education Centre for misc office accommodation 860m^2	£7,930,000
Children's Services	Not possible to cost – no information yet – solution not known.
Cancer Services Consolidation	Not possible to cost – no information yet – solution not known.
Commercial projects to provide complementary services, generate income and improve the working environment	
Moorfields Development	To be funded by Moorfields
Retail Development	Not costed yet
Private Patient Unit	Not funded by Trust

More details will be provided in the next iteration of this document. It should be noted that in many cases the costs are indicative and incomplete and rely upon the identification and development of robust design solutions that can then be costed.

Initially, the following funding requirement has been identified to develop plans over the next two months:

Cost Heading	Description	Budget to mid- August 2016
Internal programme costs		
External programme costs	Watkins Gray International: Development Control Plan and outline scheme designs / proposals	
	Sweett Group: - Refinement of Estate Strategy - Development of project proposals - Capital cost estimates - Development of Enabling Business Case	
	Essentia - Estates Strategy - Provide technical support to the Trust's internal team and other third party consultants in the development, drafting, and review of the Estates Strategy including any associated presentation materials. - Act as a liaison into the ongoing	£13,200

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	remediation and broader estates condition survey programmes	
	Other external support - budget	

5.4 Governance

A Programme Initiation Document will be prepared. This will outline the scope of the programme of works, the resources required to deliver the works (including a mobilisation plan for a dedicated programme delivery team) and the proposed governance to ensure it is well run, in accordance with the Trust's systems and processes.

5.5 Stakeholder Engagement

The plans outlined herein will affect large numbers of patients, visitors and staff. We will also need to engage with other organisations to develop and deliver the plans successfully.

To maximise the chances of success it is recognised that the plans need to be communicated clearly, regularly and positively to generate support for our proposals.

A stakeholder engagement plan and associated communications plan will be developed to support the delivery of the Estate Strategy.

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Appendix 1 – Draft Development Control Plan

In the light of the proposals outlined in this document, the Trust's Development Control Plan for the main St George's Hospital Tooting Campus has been updated and is shown on the following pages.

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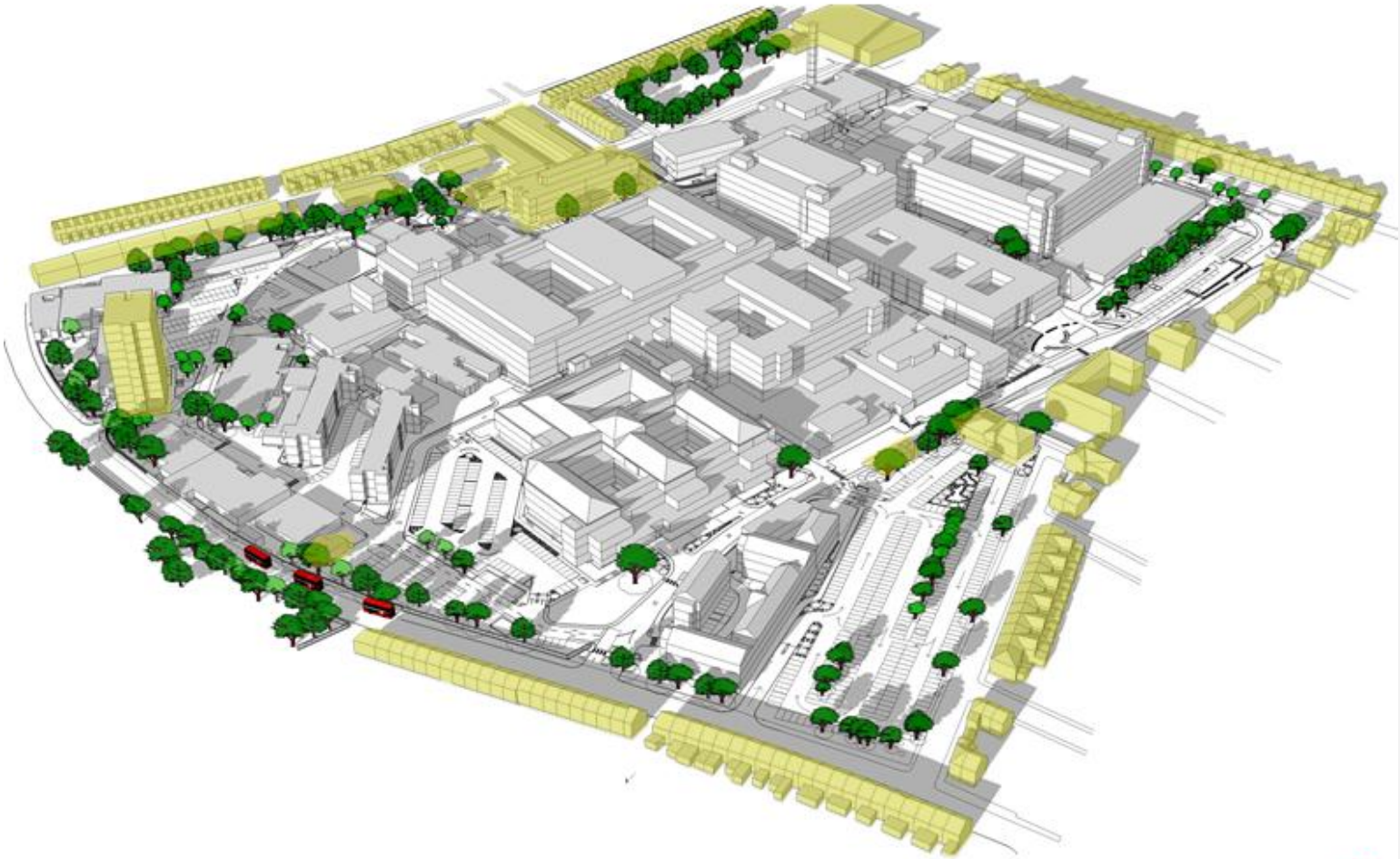

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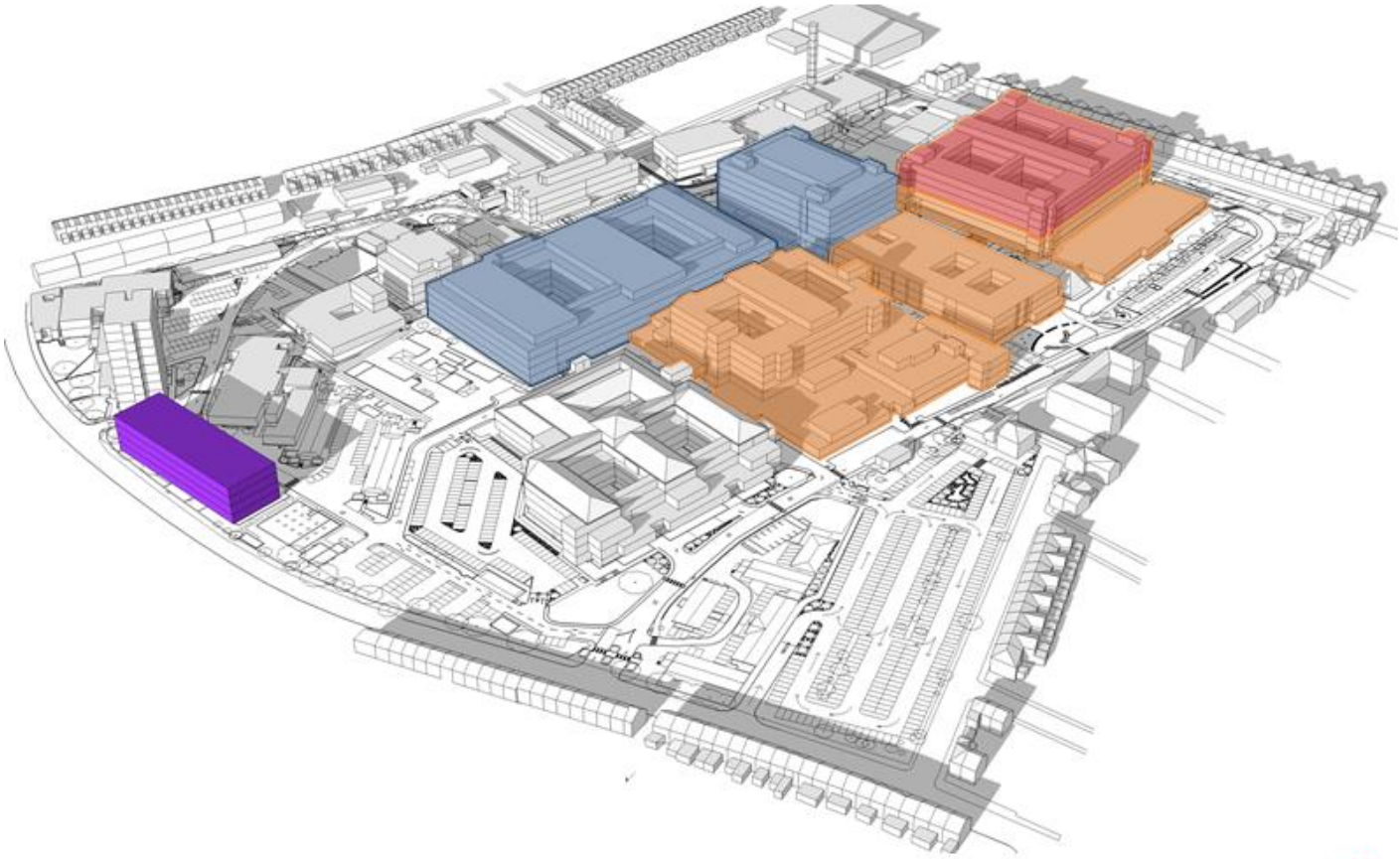

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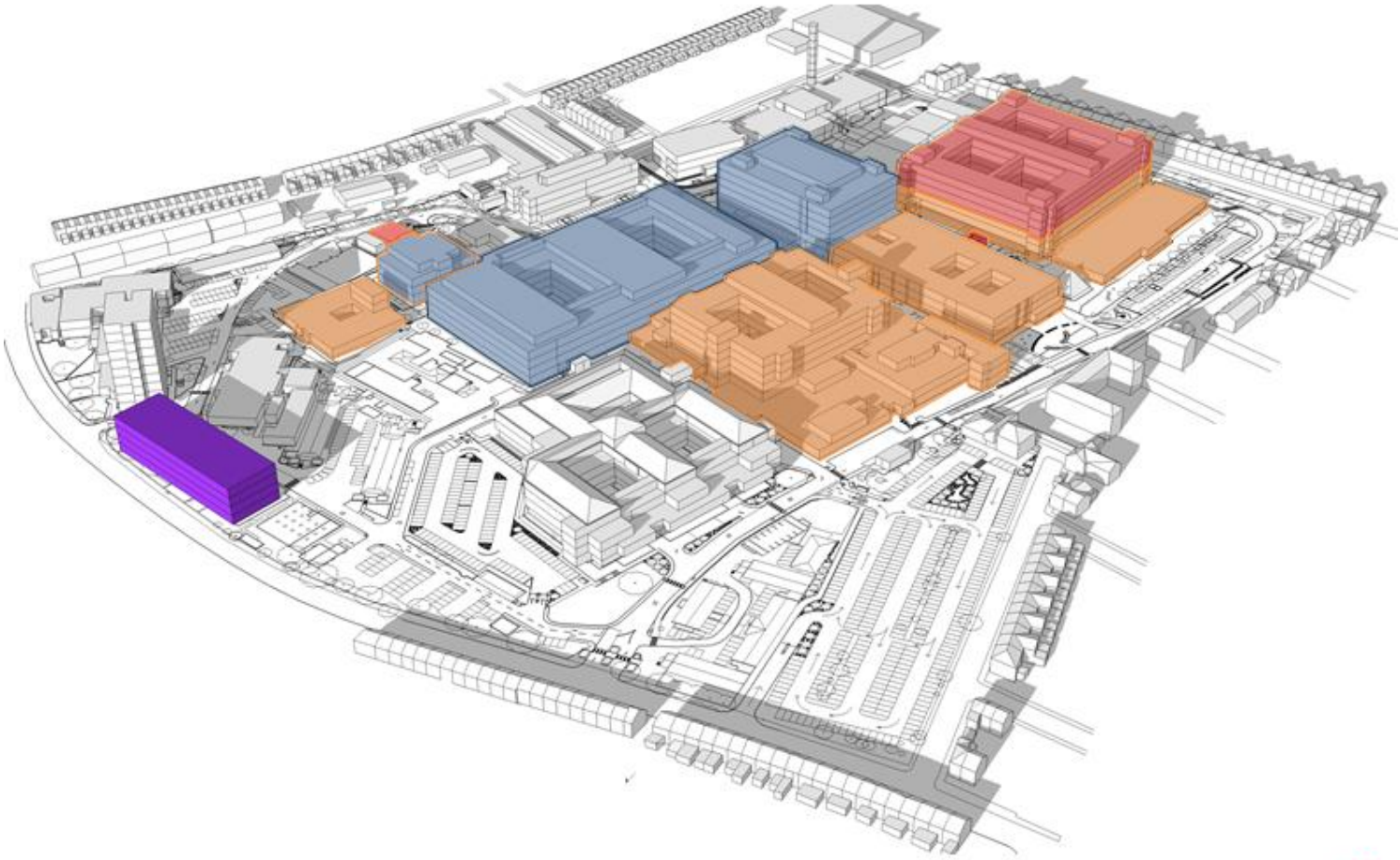

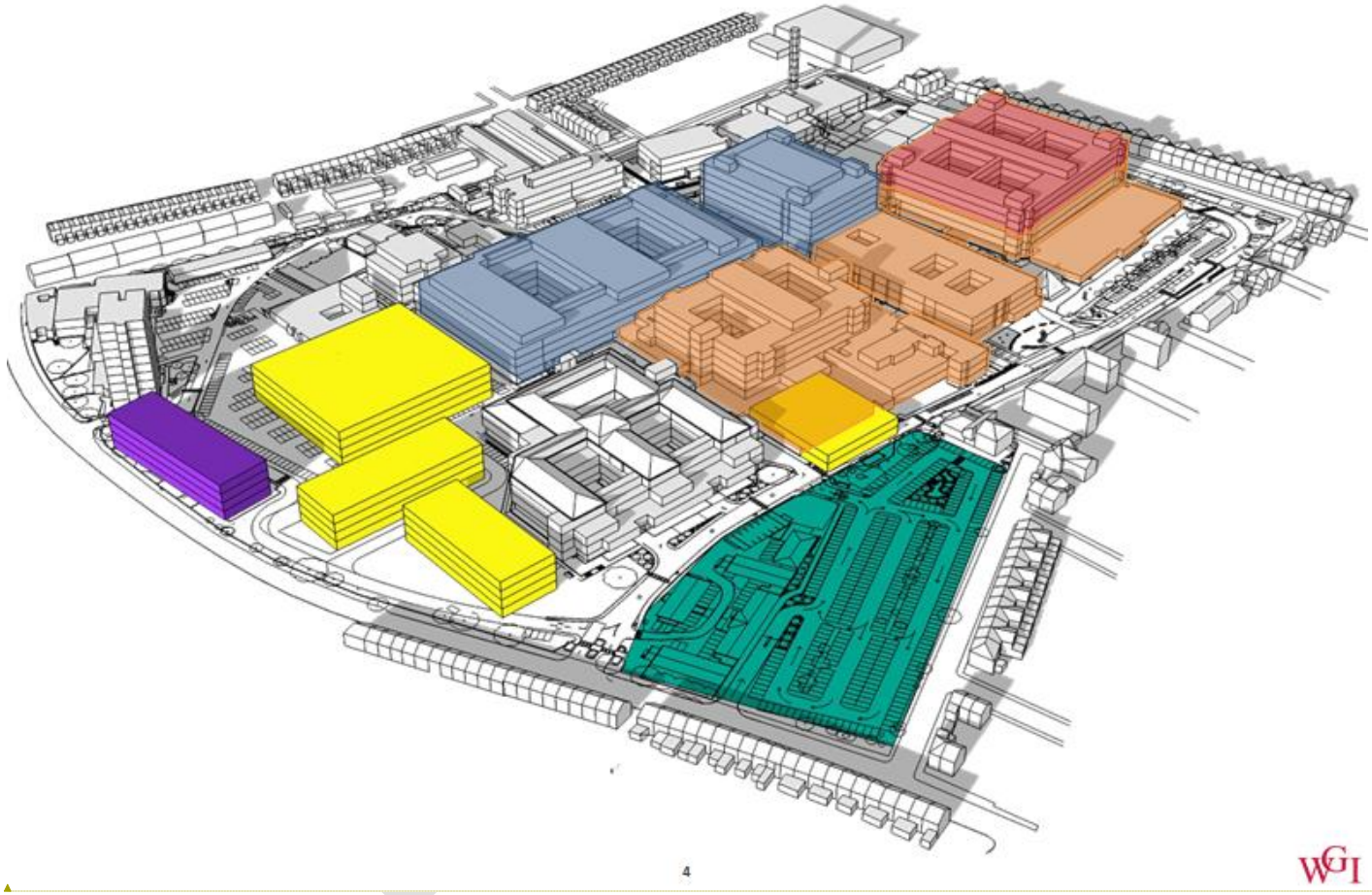

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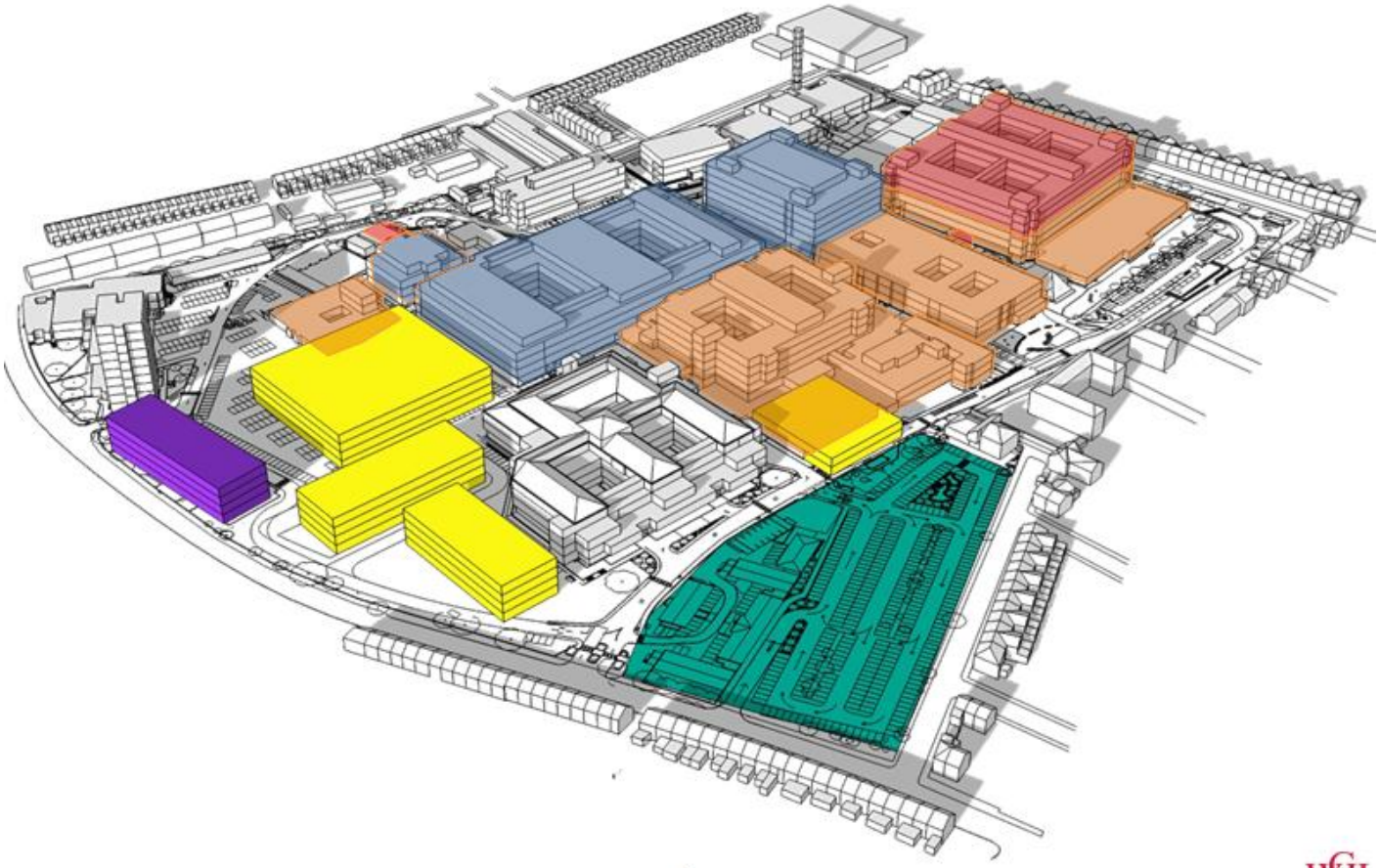

Appendix 2 – Departments under consideration for decanting

The sheets that follow outline the contents of the departments that are under preliminary consideration for decanting.

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St George's University Hospitals NHS
NHS Foundation Trust

Wandle Annexe Decant Schedule

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
Wandle Ann.	0	0.01	Occupational Health	Waiting room (13 Seats)	
Wandle Ann.	0	0.02	Occupational Health		3
Wandle Ann.	0		Occupational Health		
Wandle Ann.	0		Occupational Health		
Wandle Ann.	0	0.04	Occupational Health	Consulting Room 1	1
Wandle Ann.	0	0.05	Occupational Health	Consulting Room 6	1
Wandle Ann.	0	0.06	Occupational Health	Consulting Room 2	1
Wandle Ann.	0	0.07	Occupational Health	Consulting Room 5	1
Wandle Ann.	0	0.08	Occupational Health	Staff Room/Meeting Room/Phlebotomy	
Wandle Ann.	0	0.09	Occupational Health	Consulting Room 4	1
Wandle Ann.	0	0.11	Occupational Health	Disabled Toilet	
Wandle Ann.	0	0.85	Occupational Health	Manual Handling + Back Care	2
Wandle Ann.	0		Occupational Health		
Wandle Ann.	0	0.25	SCNT		
Wandle Ann.	0		Macmillian		
Wandle Ann.	0		Macmillian		
Wandle Ann.	0		Macmillian		
Wandle Ann.	0		Macmillian		
Wandle Ann.	0		SCNT		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0		Service Improvement		
Wandle Ann.	0	0.15	Service Improvement		
Wandle Ann.	0	0.17	CHS Team		3
Wandle Ann.	0		CHS Team		
Wandle Ann.	0		CHS Team		
Total	**Rooms: 13**				**Staff: 37**

Knightsbridge Decant Schedule

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
KNB	0	K50.33	Blood Pressure Unit	Blood Pressure Unit secretaries	
KNB	0	K40.02	Blood Pressure Unit	Blood Pressure Unit waiting room	
KNB	0	K40.02A	Blood Pressure Unit	Blood Pressure Unit	1
KNB	0	K40.03	Blood Pressure Unit	Doctors Room	
KNB	0	K40.04	Blood Pressure Unit	Examination Room	1
KNB	0	K40.05	Blood Pressure Unit	Examination Room	1
KNB	0	K40.06	Blood Pressure Unit	Examination Room	1
KNB	0	K40.08	Blood Pressure Unit	Combined Blood Screening Service	2
KNB	0		Blood Pressure Unit		
KNB	0	K40.09	Community Midwives	Community Midwifes postnatal clinic Reception	
KNB	0	K40.10	Community Midwives	Toilet	
KNB	0	K40.11	Community Midwives	Toilet	
KNB	0	K40.12	Blood Pressure Unit	Store Room	
KNB	0	K40.13	Blood Pressure Unit	Staff changing room	
KNB	0	K40.14	Blood Pressure Unit	Store Room	
KNB	0	K40.14A	Post Natal	Waste Storage area	
KNB	0	K40.15	Post Natal	Breast Feeding Support & Advice	1
KNB	0	K40.16	?	Store Room	
KNB	0	K40.17	Post Natal	Waiting Area	
KNB	0	K40.18	Post Natal	Exam Room	
KNB	0	K40.19	Post Natal	Exam Room	
KNB	0	K40.20	Community/Post Natal	Community Midwives - Ruby Team	3
KNB			Community/Post Natal	Community Midwives - Lavender Team	
KNB			Community/Post Natal	Post Natal Clinic	
KNB	0	K40.21	Community/Post Natal	Store room	
KNB	0	K40.22	Community	Divisional Governance Office	8
KNB	0		Community		
KNB	0		Community		

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
KNB	0		Community		
KNB	0		Community		
KNB	0		Community		
KNB	0		Community		
KNB	0		Community		
KNB	0	K40.23	Legal Services	Office	3
KNB	0		Legal Services		
KNB	0		Legal Services		
KNB	0	K40.24	Legal Services	Locked	
KNB	0	K40.25	Legal Services	Photocopy Room	
KNB	0	K40.26	Legal Services	Office	1
KNB	0	K40.27	Clinical Effectiveness	Office	1
KNB	0	K40.28	Clinical Effectiveness	Office	4
KNB	0		Clinical Effectiveness		
KNB	0		Clinical Effectiveness		
KNB	0		Clinical Effectiveness		
KNB	0	K40.29	Clinical Effectiveness	Storage Room	
KNB	0	K40.30	Clinical Effectiveness	Office	1
KNB	0	K40.31	Clinical Effectiveness	Office	1
KNB	0	K40.32	Nursing	Locked	
KNB	0	K40.33	Antenatal	Antenatal Booking Interview Room 2	
KNB	0	K40.34	Antenatal	Antenatal Booking Interview Room 1	
KNB	0	K40.35	GMB	Meeting Room?	
KNB	0	K40.36	Plastic Dressing Clinic		1
KNB	0	K40.37	Plastic Dressing Clinic	Store Room	
KNB	0	K40.38	Cancer Services		3
KNB	0		Cancer Services		
KNB	0		Cancer Services		
KNB	0	K40.39	Risk Management		4
KNB	0		Risk Management		
KNB	0		Risk Management		
KNB	0		Risk Management		
KNB	0	K40.40		Kitchen	
KNB	0	K40.41	Risk Management	Risk Management Office	7

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
KNB	0		Risk Management		
KNB	0		Risk Management		
KNB	0		Risk Management		
KNB	0		Risk Management		
KNB	0		Risk Management		
KNB	0		Risk Management		
KNB	0	K40.43	Risk Management	Store Room	
KNB	0	K40.44	Gastroenterology	Registrar/CNS Offices	3
KNB	0		Gastroenterology		
KNB	0		Gastroenterology		
KNB	0	K40.45	Gastroenterology	Office	2
KNB	0		Gastroenterology		
KNB	0	K40.46	Gastroenterology	Consultant Office	1
KNB	0	K40.47	Gastroenterology	Consultant Office	1
KNB	0	K40.48	Gastroenterology	Consultant Office	1
KNB	0	K40.51	Back Care Manual Handling	Manual Handling Training	
KNB	0	K40.53	Gastroenterology	Medical Secretaries	6
KNB	0		Gastroenterology		
KNB	0		Gastroenterology		
KNB	0		Gastroenterology		
KNB	0		Gastroenterology		
KNB	0		Gastroenterology		
KNB	0	K40.53A	Gastroenterology	Office	1
KNB	0	K40.54	Linen	Sewing Room	2
KNB	0		Linen		
KNB	0	K40.55	Gastroenterology	Locked	
KNB	0	K40.56	Renal	Locked	
KNB	0	K50.23		Friends of St. Georges Store	
KNB	0	K50.24	Legal Services	Store Room	
KNB	0	K50.25	Legal Services	Legal Medical Records & Storage	
KNB	0	K50.26	Legal Services	Legal Medical Records & Storage	
KNB	0	K50.27		Store Room	
KNB	0	K50.28		Store Room	
KNB	0	K50.29		Store Room	
KNB	0	K50.30		Store Room	
KNB	0	K50.58	Old CBS Office		
KNB	0	K60.01	Medical Physics	Office	3
KNB	0		Medical Physics		
KNB	0		Medical Physics		
KNB	0		Medical Physics		
KNB	0	K60.02	Medical Physics	Office	2
KNB	0		Medical Physics		
KNB	0	K60.03	Medical Physics	Store Room	

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
KNB	0	K60.04	Medical Physics	Store Room	
KNB	0	K60.05	Medical Physics	Store Room	
KNB	0	K60.06	Medical Physics	Arc Welding	
KNB	0	K60.07	Medical Physics	Store Room	
KNB	0	K60.08	Medical Physics	Medical Physics Workshop	
KNB	0	K60.18	Undergraduate Education	Locked Undergraduate Office	
KNB	0	K60.22	Medical Physics	Store Room	
KNB	0	K60.25	Medical Physics	Equipment Collection Store	
KNB	0	K60.26	Gaestronterology		2
KNB	0		Gaestronterology		
KNB	0	K60.28	Gaestronterology	Department of Gaestronterology	3
KNB	0		Gaestronterology		
KNB	0		Gaestronterology		
KNB	0	K60.29	Medical Equipment Service	Regional Radiation Protection Service	
KNB	0	K30.03	Norman Tanner	Store Room	
KNB	0	K30.04	Norman Tanner	Comms Room	
KNB	0	K30.05	Norman Tanner	Consultants Office Locked	
KNB	0	K30.07	Norman Tanner	Office	5
KNB	0		Norman Tanner		
KNB	0		Norman Tanner		
KNB	0		Norman Tanner		
KNB	0		Norman Tanner		
KNB	1	K31.73	Training & Development	Comms Room	
KNB	1	K31.01	Training & Development	Training & Development	5
KNB	1		Training & Development		
KNB	1		Training & Development		
KNB	1		Training & Development		
KNB	1		Training & Development		
KNB	1	K31.03	Training & Development	Store Room	
KNB	1	K31.05	Training & Development	Kitchen	
KNB	1	K31.06	Training & Development	Office	2
KNB	1		Training & Development		

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
KNB	1	K31.08	Human Resources	Office	5
KNB	1		Human Resources		
KNB	1		Human Resources		
KNB	1		Human Resources		
KNB	1		Human Resources		
KNB	1	K31.09	Human Resources	Office	8
KNB	1		Human Resources		
KNB	1		Human Resources		
KNB	1		Human Resources		
KNB	1		Human Resources		
KNB	1		Human Resources		
KNB	1		Human Resources		
KNB	1	K31.11	Human Resources	Meeting Room	
KNB	1	K31.15	Training & Development	Office	2
KNB	1		Training & Development		
KNB	1	K31.16	Training & Development	Mobile Medical Team Store	
KNB	1	K31.17	Training & Development	Stationary Cupboard	
KNB	1	K31.18	Training & Development	Kitchen (Do Not Enter Sign)	
KNB	1	K31.22	Training & Development	Locked	
KNB	1	K61.00	Medical Physics	Locked	
KNB	1	K61.01	Medical Physics		3
KNB	1		Medical Physics		
KNB	1		Medical Physics		
KNB	1	K61.03	Medical Physics	Store Room	
KNB	1	K61.04	Medical Physics	Workshop	5
KNB	1		Medical Physics		
KNB	1		Medical Physics		
KNB	1		Medical Physics		
KNB	1		Medical Physics		
KNB	1	K61.05	Medical Physics	Office	2
KNB	1		Medical Physics		
KNB	1	K61.06	Medical Physics	Office	3
KNB	1		Medical Physics		
KNB	1		Medical Physics		
KNB	1	K61.07	Medical Physics	Central Workshop	3
KNB	1		Medical Physics		
KNB	1		Medical Physics		
KNB	1	K61.08	Medical Physics	Office	3
KNB	1		Medical Physics		
KNB	1		Medical Physics		
KNB	1	K61.09	Medical Physics	Locked	
KNB	1	K61.10	Medical Physics	Store Room	

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
KNB	1	K61.10A	Medical Physics	Office	2
KNB	1		Medical Physics		
KNB	1	K61.11	Medical Physics	Office	2
KNB	1		Medical Physics		
KNB	1	K61.12	Medical Physics	Office	1
KNB	1	K61.14	Medical Physics	Office	1
KNB	1	K61.20/21	Medical Physics	Medical Physics Seminar Room	
KNB	1	K61.22	Medical Physics	Office	1
KNB	1	K61.23	Medical Physics	Office	1
KNB	1	K61.24	Medical Physics	Office	2
KNB	1		Medical Physics		
KNB	1	K61.25	Medical Physics	Office	1
KNB	1	K61.26	Medical Physics	Workshop	2
KNB	1		Medical Physics		
KNB	1		Medical Physics	Receipt & Distribution	
KNB	1		Medical Physics	Kitchen	
	Rms:	114			Staff: 132

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Bence Jones Decant Schedule

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
BJP	0		Medical Records	Medico-Legal	5
BJP	0		Medical Records		
BJP	0		Medical Records		
BJP	0		Medical Records		
BJP	0		Medical Records	Medico-Legal Access	
BJP	0		Medical Records	Office	2
BJP	0	020.002			
BJP	0	020.003		Meeting Room	
BJP	0	020.005		18 Week Team	18
BJP	0				
BJP	0				
BJP	0				
BJP	0				
BJP	0				
BJP	0				
BJP	0				
BJP	0				
BJP	0				
BJP	0	020.006			
BJP	0	020.007			
BJP	0	020.008			2
BJP	0				
BJP	0	020.009			2
BJP	0				
BJP	0	020.010			2
BJP	0				
BJP	0	030.001		Filing/Meeting Room	
BJP	0	030.003			
BJP	0	030.004		Shared space	
BJP	0	030.005			
BJP	0		Medical Records		
BJP	0		Medical Records	Photocopier	1
	Rms:	12			Staff: 31

Bronte Annexe Decant Schedule

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
Bronte A. P11	0	0.001	Finance		
Bronte A. P11	0	0.002	Finance		
Bronte A. P11	0	0.003	Finance	Kitchen	
Bronte A. P11	0		Finance		2
Bronte A. P11	0		Finance		
Bronte A. P11	0	0.004	Finance		
Bronte A. P11	0	0.005	Finance	Bronte Annexe Project Room	
Bronte A. P11	0	0.005A	Finance	Printing Room	
Bronte A. P11	0		Finance		5
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance	Accounts Payable	11
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0		Finance		
Bronte A. P11	0	0.006	Finance		

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
Bronte A. P11	0	0.007	Finance		
Bronte A. P11	0	0.008	Finance		
Bronte A. P11	1	1.001	Finance		
Bronte A. P11	1	1.002	Finance	Locked	
Bronte A. P11	1	1.004	Finance	Kitchen	
Bronte A. P11	1	1.005	Finance	Financial Accounts	10
Bronte A. P11	1		Finance		
Bronte A. P11	1		Finance		
Bronte A. P11	1		Finance		
Bronte A. P11	1		Finance		
Bronte A. P11	1		Finance		
Bronte A. P11	1		Finance		
Bronte A. P11	1		Finance		
Bronte A. P11	1	1.006	Finance		
Bronte A. P11	1	1.007	Finance	Printing Room	
Bronte A. P11	1	1.008	Finance	Store Room	
Bronte A. P11	1	1.009	Finance		4
Bronte A. P11	1		Finance		
Bronte A. P11	1		Finance		
Bronte A. P11	1		Finance		
Bronte A. P11	1	1.010	Finance		1
Bronte A. P11	1	1.011			
	Rms:	19			Staff: 33

Bronte House Decant Schedule

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
BRH	0	0.001	Finance	Reception	1
BRH	0	0.002	Finance	Kitchen	
BRH	0	0.003	Finance		
BRH	0	0.004	Finance		1
BRH	0	0.005	Finance		
BRH	0	0.006	Finance		1
BRH	0	0.007	Finance		1
BRH	0	0.008	Finance	Pensions Office	2
BRH	0		Finance		
BRH	0	0.009	Finance		1
BRH	0	0.011	Finance	Payroll Office	11
BRH	0		Finance		
BRH	0		Finance		
BRH	0		Finance		
BRH	0		Finance		
BRH	0		Finance		
BRH	0		Finance		
BRH	0		Finance		
BRH	0		Finance		
BRH	0		Finance		
BRH	0	0.013	Finance		4
BRH	0		Finance		
BRH	0		Finance		
BRH	0		Finance		
BRH	0	0.014	Finance		2
BRH	0		Finance		
BRH	0	0.015	Finance		1
BRH	0	0.016	Finance	Storage Room	
BRH	0	0.018	Finance		
BRH	1	1.101	Finance	Finance Office	6
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance	Commercial Directorate	
BRH	1		Finance		
BRH	1	1.102	Finance		
BRH	1	1.103	Finance	Store Room	
BRH	1	1.104	Finance	Auditor Office	5
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance		
BRH	1	1.105	Finance		

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
BRH	1	1.106	Finance		
BRH	1	1.107	Finance		1
BRH	1	1.108	Finance		9
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance		
BRH	1		Finance		
BRH	1	1.109	Finance		1
BRH	1	1.110	Finance		1
BRH	1	1.111	Finance		2
BRH	1		Finance		
BRH	1	1.112	Finance		1
BRH	1	1.113	Finance		
BRH	1	1.114	Finance		
BRH	2	2.202	Finance		
BRH	2	2.203	Finance		3
BRH	2		Finance		
BRH	2		Finance		
BRH	2	2.204	Finance		
BRH	2	2.205	Finance	Filing	
BRH	2	2.206	Finance		2
BRH	2		Finance		
BRH	2	2.207	Finance		1
BRH	2	2.208	Finance	Kitchen	
BRH	2	2.209	Finance	Vacant	
BRH	2	2.210	Finance		
BRH	2	2.211	Finance		1
BRH	2	2.212	Finance		1
BRH	2	2.213	Finance		1
BRH	2	2.214	Finance	Meeting Room	
BRH	2	2.215	Finance		
BRH	2	2.216	Finance		
BRH	2	2.217	Finance		9
BRH	2		Finance		
BRH	2		Finance		
BRH	2		Finance		
BRH	2		Finance		
BRH	2		Finance		

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
BRH	2		Finance		
BRH	2		Finance		
	Rms:	45			Staff: 69

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Clare House Decant Schedule

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	0	0.03	Surgery	Waiting Area	
CLR	0	0.05	Surgery		
CLR	0	0.06	Surgery	Waiting Area	1
CLR	0	0.09	Surgery	Healthcare Assistant Room	
CLR	0	0.10	Surgery	Healthcare Assistant Room	
CLR	0	0.11	Surgery	Medicine Closet	
CLR	0	0.12	Surgery		1
CLR	0	0.14	Surgery		1
CLR	0	0.15	Surgery	Locked	
CLR	0	0.16	Surgery	Dirty Room	
CLR	0	0.17	Surgery	Healthcare Assistant Room	
CLR	0	0.18	Surgery	Pre Op Clinical Area	1
CLR	0	0.19	Surgery		1
CLR	0	0.21	Surgery	Kitchen	
CLR	0	0.22	Surgery	Healthcare Assistant Room	
CLR	0	0.23	Surgery		2
CLR	0		Surgery		
CLR	0	0.23A	Surgery		1
CLR	0	0.24	Surgery	Healthcare Assistant Room	
CLR	0	0.25	Surgery		2
CLR	0	0.26	Surgery		
CLR	0	0.27	Surgery	Healthcare Assistant Room	
CLR	0	0.28	Surgery	Healthcare Assistant Room	
CLR	0	0.29	Surgery	Healthcare Assistant Room	
CLR	0	0.30	Surgery		1
CLR	0	0.31	Surgery	Meeting Room	
CLR	0	0.32	Surgery	Locked	
CLR	0	0.33C	Surgery	Cleaner Store	
CLR	0	0.34	IT	Kitchen	
CLR	0	0.35	IT		
CLR	0	0.36	IT	Locked	
CLR	0	0.37	IT	Filing/Storage	
CLR	0	0.39	Safeguarding		3
CLR	0		Safeguarding		
CLR	0		Safeguarding		
CLR	0		Surgery		
CLR	0		Surgery		
CLR	0	0.41	IT		1
CLR	0	0.42	IT		3
CLR	0		IT		

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	0		IT		
CLR	0	0.43	IT		6
CLR	0		IT		
CLR	0		IT		
CLR	0		IT		
CLR	0		IT		
CLR	0		IT		
CLR	0	0.44	IT		
CLR	0	0.45	IT		
CLR	0	0.46	IT		
CLR	0	0.48	IT	Network Team	
CLR	0	0.49	IT	Server Room	
CLR	0	0.50	IT	Storage Room	
CLR	0	0.50A	Adult Psychiatry	Neuro Psychiatry Office	1
CLR	0	0.50B	Adult Psychiatry		1
CLR	0	0.50C	Adult Psychiatry		
CLR	0	0.51	Adult Psychiatry		2
CLR	0		Adult Psychiatry		
CLR	0	0.52A	Adult Psychiatry	Meeting Room	
CLR	0	0.53	Adult Psychiatry	Waiting Room	
CLR	0	0.54	Adult Psychiatry	Vacant	
CLR	0	0.55	Adult Psychiatry	Consulting Room	1
CLR	0	0.56	Adult Psychiatry	Consulting Room	
CLR	0	0.57	Adult Psychiatry	Consulting Room	
CLR	0	0.58	Adult Psychiatry	Consulting Room	
CLR	0	0.65	IT		2
CLR	0		IT		
CLR	0	0.66	IT		1
CLR	0	0.67	IT	Networks KS Team	4
CLR	0	0.67A	IT	Systems Team	6
CLR	0		IT		
CLR	0		IT		
CLR	0		IT		
CLR	0		IT		
CLR	0		IT		
CLR	0	0.68	IT	Kitchen	
CLR	0	0.69	IT	IT Hub	
CLR	0	0.70	IT	VDI Team	2
CLR	0	0.71	IT	Store Room	

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	0	0.71A	IT		
CLR	0	0.72	IT	Service Desk	5
CLR	0		IT		
CLR	0		IT		
CLR	0		IT		
CLR	0		IT		
CLR	0	0.73	IT	VDI Team	2
CLR	0	0.74	IT	VDI Team	2
CLR	0	0.75	IT		2
CLR	0		IT		
CLR	0	0.76	IT	VDI Team	2
CLR	0	0.77	IT		2
CLR	0		IT		
CLR	0	0.78	IT	Drop in	2
CLR	1	1.01	Mental Health	Liaison Psychiatry Team Office	3
CLR	1		Mental Health		
CLR	1		Mental Health		
CLR	1		Mental Health		
CLR	1		Mental Health		
CLR	1	1.02	Mental Health		6
CLR	1		Mental Health		
CLR	1		Mental Health		
CLR	1		Mental Health		
CLR	1		Mental Health		
CLR	1		Mental Health		
CLR	1		Mental Health		
CLR	1	1.03	Mental Health		1
CLR	1	1.04	Mental Health		1
CLR	1	1.06	Mental Health		1
CLR	1	1.08	Mental Health		1
CLR	1	1.09	Mental Health	Kitchen	
CLR	1	1.12	Mental Health	Seminar Room	
CLR	1	1.14	Mental Health	Therapy Session Room	
CLR	1	1.15	Mental Health		2
CLR	1		Mental Health		
CLR	1	1.16	Mental Health		2
CLR	1		Mental Health		
CLR	1	1.17	Mental Health		
CLR	1	1.17A	Mental Health	Perinatal Mental Health Service	1
CLR	1	1.17B	Mental Health	Locked	
CLR	1	1.18	Occupational Health		5
CLR	1		Occupational Health		
CLR	1		Occupational Health		
CLR	1		Occupational Health		
CLR	1		Occupational Health		
CLR	1	1.19	Mental Health	Consulting Room	1

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	1	1.20	Mental Health	Neuropsychiatry Service	1
CLR	1	1.21	Mental Health	Speech & Language Therapy ENT Team	
CLR	1	1.22	Mental Health	Neuropsychiatry Service	1
CLR	1	1.23	Mental Health	Waiting Room	
CLR	1	1.24	Health Visitors	Safeguarding Children	1
CLR	1	1.25	Health Visitors		1
CLR	1	1.26	Occupational Health	Engaged	
CLR	1	1.27		Unknown	
CLR	1	1.28		Engaged	
CLR	1	1.29		Project Group Office	
CLR	1	1.31		Kitchen	
CLR	1	1.32		Therapies Stationary	
CLR	1	1.33		Locked	
CLR	1	1.34			1
CLR	1	1.36			2
CLR	1				
CLR	1	1.37		Meeting Room	
CLR	1	1.37A	Mental Health	Stroke OT	12
CLR	1		Mental Health	Stroke OT	
CLR	1		Mental Health	Stroke OT	
CLR	1		Mental Health	Stroke OT	
CLR	1		Mental Health	Stroke OT	
CLR	1		Mental Health	Stroke OT	
CLR	1		Mental Health	Stroke OT	
CLR	1		Mental Health	Stroke PT	
CLR	1		Mental Health	Stroke PT	
CLR	1		Mental Health	Stroke PT	
CLR	1		Mental Health	Stroke PT	
CLR	1		Mental Health	Stroke PT	
CLR	1	1.38	E Rostering		2
CLR	1		E Rostering		
CLR	1	1.39	E Rostering		
CLR	1	1.41	E Rostering	E-Rostering Team	
CLR	1	1.42	E Rostering	E-Rostering Training Room	
CLR	1	1.43		Reed Office	
CLR	1	1.44			1
CLR	1	1.45			1
CLR	1	1.46			1
CLR	1	1.47		Unknown	

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	1	1.48	IT	IT Service Desk	
CLR	1	1.49	IT		1
CLR	1	1.50	IT	Locked	
CLR	1	1.51	IT	Unknown	
CLR	1	1.52	IT	Empty	
CLR	1	1.53	IT	IT Trainers	2
CLR	1		IT	IT Trainers	
CLR	1	1.54	IT	Training Room	
CLR	1	1.55	IT		2
CLR	1		IT		
CLR	1	1.56	IT		
CLR	1	1.57	IT	Merge Team	3
CLR	1	1.59	IT		1
CLR	1	1.60	IT	Computer Room - Locked	
CLR	1	1.61	IT	Locked	
CLR	1	1.62	IT	Stationary Cupboard	
CLR	1	1.63	IT		2
CLR	1		IT		
CLR	1	1.64	IT		1
CLR	1	1.65	IT	Training Room	4
CLR	1		IT		
CLR	1		IT		
CLR	1		IT		
CLR	1	1.67A	IT		2
CLR	1		IT		
CLR	1	1.68	IT	Training Room	
CLR	1	1.70	IT		1
CLR	1	1.71	IT		6
CLR	1		IT		
CLR	1		IT		
CLR	1		IT		
CLR	1		IT		
CLR	1		IT		
CLR	1	1.71A	IT		
CLR	1	1.72	IT		2
CLR	1		IT		
CLR	1	1.73	IT		2
CLR	1		IT		
CLR	1	1.74	IT		2
CLR	1		IT		
CLR	1	1.75	IT		6
CLR	1		IT		
CLR	1		IT		
CLR	1		IT		
CLR	1		IT		
CLR	1		IT		
CLR	1	1.76	IT		3
CLR	1		IT		

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	1		IT		
CLR	1	1.77	IT	Filing Room	
CLR	1	1.78		Pantry	
CLR	2	2.01	Paediatric Psychology		1
CLR	2	2.02	Paediatric Psychology		1
CLR	2	2.03	Paediatric Psychology		2
CLR	2		Paediatric Psychology		
CLR	2		Paediatric Psychology		
CLR	2	2.04	Paediatric Psychology		1
CLR	2	2.05	Paediatric Psychology		2
CLR	2		Paediatric Psychology		
CLR	2	2.06	STG Charity	Store Room	
CLR	2	2.07	Theatres	Operating Theatres Education Team	2
CLR	2			Operating Theatres Education Team	
CLR	2		Paediatric Psychology		
CLR	2	2.08	Paediatric Psychology		2
CLR	2		Paediatric Psychology		
CLR	2	2.09	Paediatric Psychology	Kitchen	
CLR	2	2.10	General Surgery	Colorectal Research Registrar Office	2
CLR	2		General Surgery	Colorectal Research Registrar Office	
CLR	2	2.13	Domestic Services	Store Room	
CLR	2	2.14	Palliative Care	Unknown	
CLR	2	2.15	Nursing	St George's Nurses League	
CLR	2	2.16	Child Health	Locked	
CLR	2	2.17	Child Health		1
CLR	2	2.18	Child Health		1
CLR	2	2.19	Child Health	Community Child Health Doctors	2
CLR	2		Child Health	Community Child Health Doctors	
CLR	2	2.20	Child Health		1
CLR	2	2.21	Child Health		1

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	2	2.22	Child Health	Oncology Nurse Specialist	4
CLR	2		Child Health		
CLR	2		Child Health		
CLR	2		Child Health		
CLR	2	2.23	Palliative Care	Store Room	
CLR	2	2.26	Child Health	Locked	
CLR	2	2.27	Child Health		1
CLR	2	2.28	Child Health		
CLR	2	2.28A	Child Health	Board Room	
CLR	2	2.28	Child Health		1
CLR	2	2.29	Info & Comms	Locked	
CLR	2	2.30	Child Health	Locked	
CLR	2	2.31	Child Health	V&I Store	
CLR	2	2.32	Child Health	Store Room	
CLR	2	2.33	Child Health	Photo Copier & Loose Filing	
CLR	2	2.35	Child Health		4
CLR	2		Child Health		
CLR	2		Child Health		
CLR	2		Child Health		
CLR	2	2.36	Child Health	Development Paediatrics Team	4
CLR	2		Child Health		
CLR	2		Child Health		
CLR	2		Child Health		
CLR	2	2.37	Child Health		1
CLR	2	2.38	Child Health		1
CLR	2	2.39	Child Health		1
CLR	2	2.40	Child Health		2
CLR	2		Child Health		
CLR	2	2.41	Child Health		1
CLR	2	2.42	Palliative Care	Palliative Care	7
CLR	2		Palliative Care		
CLR	2		Palliative Care		
CLR	2		Palliative Care		
CLR	2		Palliative Care		
CLR	2		Palliative Care		
CLR	2		Palliative Care		
CLR	2	2.43	Palliative Care	Palliative Care	1
CLR	2	2.45	Palliative Care		3

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	2		Palliative Care		
CLR	2		Palliative Care		
CLR	2	2.46	Cancer Services	Cancer Referral Office	5
CLR	2		Cancer Services		
CLR	2		Cancer Services		
CLR	2		Cancer Services		
CLR	2		Cancer Services		
CLR	2	2.47	Palliative Care		3
CLR	2		Palliative Care		
CLR	2		Palliative Care		
CLR	2	2.48	Cancer Services		
CLR	2	2.49	IT		1
CLR	2	2.50	IT		1
CLR	2	2.51	IT	Contractors	4
CLR	2		IT		
CLR	2		IT		
CLR	2		IT		
CLR	2	2.52	IT		
CLR	2	2.54	Palliative Care	Palliative Care Team - Locked	
CLR	2	2.55	IT	Locked	
CLR	2	2.56	IT	Locked	
CLR	2	2.57	IT		1
CLR	2	2.58	IT		2
CLR	2		IT		
CLR	2	2.59	IT		4
CLR	2		IT		
CLR	2		IT		
CLR	2		IT		
CLR	2	2.61	IT	IT Board Room	
CLR	2	2.62	IT		1
CLR	2	2.63	IT		1
CLR	2	2.64	IT		2
CLR	2		IT		
CLR	2	2.65	IT		
CLR	2	2.66	IT		2
CLR	2		IT		
CLR	2	2.67	IT		4
CLR	2		IT		
CLR	2		IT		
CLR	2		IT		
CLR	2	2.67A	IT		2

FAC.	FLR	ROOM:	DEPARTMENT	DESCRIPTION	OCC
CLR	2		IT		
CLR	2	2.68	IT		4
CLR	2		IT		
CLR	2		IT		
CLR	2		IT		
CLR	2	2.70	IT	Printer	
CLR	2	2.71	IT	Kitchen	
	Rms:	**204**			**Staff: 230**

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Appendix 3 – Linkage of proposed projects to Estate Strategy Objectives

The Estate Strategy Objectives are to:

1. Ensure that estates risks are managed and that the estate complies with all necessary standards.
2. Ensure that wherever possible services are provided in the community, improving access for patients and relieving pressure on the main campus.
3. Ensure that services are sensibly located, supporting efficient and effective patient pathways and workflows.
4. Ensure that all the estate provides sufficient capacity in the right locations to meet demand for healthcare.
5. Deliver the required improvements on a rapid but cost-effective basis recognising that there is an urgent need for investment but that capital and revenue funding is constrained.

The tables below highlight how each of the ongoing projects and future plans supports the Trust in meeting these.

Project	Theme				
	1	2	3	4	5
Improving the Reliability and Compliance of our Infrastructure					
Backlog Maintenance Programme – Year One Priority	✓				✓
Vacating and moving out of date building stock to reduce estates maintenance liabilities					
Wandle Annex - Vacation and Demolition – Year One Priority	✓				✓
Knightsbridge Wing Vacation and Demolition – Year One/Two Priority	✓		✓		✓
Renal Unit – Relocation – Year One/Two Priority	✓	✓	✓	✓	✓
Non-Clinical Office Accommodation – Year One/Two Priority	✓	✓	✓		
Procurement Portacabin Vacation and Demolition – Year One Priority	✓	✓	✓		✓
Bence Jones Vacation and Demolition – Year One Priority	✓				✓
Porters' Accommodation Vacation and Demolition – Year One Priority	✓				✓
Blackshaw Annex – Year Two Priority	✓				
Providing sufficient car parking whilst enabling better use of the main campus					
Maybury Street Car Park – Year One/Two Priority			✓	✓	✓
Moving clinical and non-clinical services into the community					
Genito Urinary Medicine - Relocation into the Community – Year One Priority		✓	✓	✓	✓
Outpatients into the Community – Year One/Two Priority		✓	✓	✓	✓
Pharmacy Packing Unit and Pharmacy Quality Control Unit - Year Two Priority		✓			
Ensuring clinical services have the right capacity and are sensibly located, providing efficient and effective patient pathway					
Backlog/Compliance Programme for Wards – Year One Priority to start planning. On site by Year Three	✓		✓	✓	✓
St James Inpatient Accommodation – Year One Priority to start planning. On site by Year Three	✓		✓	✓	

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Project	Theme				
	1	2	3	4	5
Emergency Department Capacity - Year One/Two Priority				✓	✓
Theatres Review – Year One Priority			✓	✓	
Education Consolidation – Year One Priority			✓		✓
Children's Services – Year One Priority to start planning. On site by Year Three	✓		✓	✓	
Cancer Services Consolidation – Year One Priority to start planning. On site by Year Three			✓	✓	
Commercial projects to provide complementary services, generate income and improve the working environment					
Moorfields Development – Year One Priority to start planning. On site by Year Three	✓		✓	✓	✓
Retail Development – Year One Priority					✓
Private Patient Unit – Year Two Priority			✓		✓

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Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *June 2016* **Paper Ref:**

Paper Title:	**Outpatient Transformation Review**
Sponsoring Director:	**Professor Andrew Rhodes**
Author:	**Steve Sewell, Programme Director**
Purpose: *The purpose of bringing the report to the board*	*For information and formal approval of key Board level SRO and CRO positions.*
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**For information / For decision** *(delete as appropriate)*
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**Executive Management, Finance and Performance**

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

1. Key messages

- A review of outpatient transformation has been undertaken and a number of recommendations made with regard to:
  - The relationship between the Trust strategy and the outpatient transformation programme,
  - The fragmented leadership, governance and resource structures in the existing range of outpatient change
  - The implementation approaches within the Trust
  - The scale of the outpatient operating model changes required
  - The strategic information system (iClip), critical to the success of the outpatient service.
- EMT have accepted the review recommendations and appointed a Programme Director.
- There are plans to initiate small scale positive changes whilst also scoping and planning an integrated change programme.
- The vision for the outpatient work to optimise the existing operating model is to focus on ensuring, 'the right patient sees the right specialist, in the right place at the same time, with the right information'.
- In addition to a programme workstream that optimises the current outpatient operating model, there are two other workstreams to be established that will; design a new operating model for outpatients, and jointly develop new models of care with commissioners and other service providers.

2. Recommendation

Appoint key Board members into programme leadership roles for the outpatient transformation programme; Professor Andrew Rhodes (Medical Director) as SRO (Senior Responsible Owner) and Alison Benincasa (Divisional Chair) as CRO (Clinical Responsible Owner).

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?

In the review a number of risks are identified against the successful delivery of transformation and associated benefits within outpatients. Recommendations have been made against these.

Enclosure:

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? (~~Yes~~ / No) **If yes, please provide a summary of the key findings** **If no, please explain you reasons for not undertaking and EIA.** This paper is a review of the current position and recommendations have been made, however an appropriate EIA will be undertaken for each specific piece of project work within the 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?				
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]				

Enclosure:

2.0. Please give your reasons for this rating

Outpatient Transformation Review – Board Summary

St. George's University Hospital NHS Foundation Trust

Introduction

This summary outlines the key findings of a recent review of outpatient service change and the need to address a range of acknowledged problems and establish a transformational agenda within an outpatient programme. It outlines the key themes of the review and recommendations, early plans to achieve these and makes specific requests of the Trust Board.

Review Summary

Many external key stakeholders have described St. George's Trust as having a reputation for high quality clinical staff, but a poor and traditional outpatient service experience. The poor experience in outpatients relates to significant process issues, resulting in significant levels of wasted capacity, increasingly poor RTT performance, and frustrated patients, staff, commissioners and GPs. Some progress has been made towards addressing these issues, however, the approach to change across outpatients is driven by fragmented leadership, governance and teams, leading to a wide range of competing priorities. Work is already behind schedule.

Within the context of current national strategy (Five Year Forward View) and the increase in demand for the management of many long term conditions, there is a need to transform outpatient services in conjunction with commissioners and other providers to ensure that, in particular, long term conditions are managed more effectively within the community, reducing the need for hospital based services.

Outpatient services are critical to the success of the Trust and rapid progress needs to be made by building on work that has already been initiated. The outpatient report makes a number of recommendations, summarised into themes below:

- In the context of a changing national strategy and increasing demand for hospital services, the Trust Board needs to be clear about the strategy of the organisation and ensure there is a clear vision for outpatient services within this. Recommendations are made that require the Board to review its strategy and begin to develop, in partnership, and learn from different models of care for outpatients.
- Current planned change in outpatients has fragmented delivery, governance and leadership and a number of recommendations made relate to the need to bring all change/transformation together under a single point of leadership, governance and into an integrated team.
- The Trust doesn't have a strong record of transformational change, however the approach to change and need to build capabilities will be significantly enhanced by the development of a Trust wide change process, wider use modern tools and techniques that accelerate change and a review of some of the projects that are currently struggling to deliver benefits.

- There are a wide range of unacceptable stories from both patients and clinicians, suggesting that the range and scale of process problems in outpatients are significant, the review recommends the development of a bottom up redesign of the outpatient operating model.
- Within the current programme setup there are a limited range of defined benefits and thus the monitoring of progress is likely to be time rather than benefits driven. Recommendations are made that swap the emphasis around to focus on strategic benefits.
- There is evidence that the way in which the Cerner system is configured and used is an issue and constrains the effectiveness of the system. A diagnostic is recommended as well as senior board level operational ownership of the system and processes.

Current Situation

The full review has been assessed by the Executive Management Team and all recommendations made in the report have been accepted in full. The review is also on the Finance and Performance sub-committee agenda for 25th May 2016.

Responding to a specific recommendation, the Executive Team have appointed Steve Sewell, to the role of Programme Director for the Outpatient Transformation Programme, with responsibility to create a single programme and ensure that the benefits associated with successful change are defined and realised.

The plan is to structure the Outpatient programme around 3 workstreams:

1. Optimising the current outpatient operating model,
2. Design of a new operating model that seeks to exploit technology to achieve greater efficiency and improve experience for patients, referrers and staff and,
3. Development, with commissioners and other providers, of models of care that seek to support patients in an a more integrated environment that reduces the need for hospital based services.

Over the coming weeks the plan is focused in two areas; planning and maintaining momentum is the change work that's already begun. Within 4 to 6 weeks, the programme will have completed a number of small scale changes that begin to make an impact on patient experience and clinic capacity. Within the same timescale we also aim to have defined the wider programme ready to begin larger scale service design and implementation work.

Progress against the review recommendations is already being made in the following areas:

- Trust Board has initiated work to review the Trust strategy,
- Draft scope, governance and leadership structures have been reviewed and are due to be presented for internal approval at Transformation Board in the near future,
- Using existing resources the newly created team is mapping out and prioritising current work to produce an initial plan and resource requirement. There is also a

plan to hold two day review of all existing projects that sit within the new shape programme scope,
- A vision has been developed for the optimisation of the existing outpatient operating model and is based around ensuring the 'right patient sees the right specialist in the right place, at the same time with the right information',
- The development of a design approach for the target operating model for outpatients has begun,
- Approaches have been made to commissioners to explore new models of care and understand where St. George's Trust can best work with commissioners and other providers and,
- Discussions with the key information system supplier, Cerner, have been initiated to understand the best approach to undertaking a diagnostic on the configuration and use of the system.

Board Request

The Trust Board are requested to:

- Note the attached Outpatient Review report and recommendations,
- Endorse the approach to commissioners to begin the work of developing and understanding new models of care,
- Formally appoint the Trust COO as the system owner for the key operational system (Cerner iClip) to ensure it is managed in a way that optimises operational delivery of services and,
- Formally appoint board representatives as SRO (Senior Responsible Owner) and CRO (Clinical Responsible Owner) for the outpatients programme. The proposed SRO for this programme is Professor Andrew Rhodes (Medical Director) and for CRO, Alison Benincasa (Divisional Chair).

Steve Sewell
Outpatient Transformation Programme Director
May 2016

Outpatient Transformation Review

St. George's University Hospital NHS Foundation Trust

Review Brief

The brief for this review has been left intentionally wide in order to incorporate a range of activities, stakeholders and perspectives. The focus for the review is the proposed transformation and changes to outpatient services across the Trust, an area that is both critical to success of wider Trust transformation and has a range of acknowledged issues.

The review was carried out over a four-week period by Steve Sewell, a programme professional with experience of complex, large scale, health and social care transformation. Thanks go to all those involved in the review, for their time, patience, views and passion.

Summary

St. George's has a reputation for high quality clinicians, but a poor quality outpatient service experience. The poor quality of outpatients relates to significant process issues, resulting in significant levels of wasted capacity, increasingly poor RTT performance, and frustrated patients, staff, commissioners and GPs. Some progress has been made towards addressing these issues, with the response being shaped by Board. However, the approach to change in outpatients is driven by fragmented leadership, governance and teams leading to a wide range of competing priorities. Work is already showing signs of being behind schedule.

Despite advice to the contrary, Board made decisions to focus all outpatient transformation on the resolution of some of the processes fixes, and whilst these are important, it isn't clear what the vision for outpatients is, what the transformation will be and how this fits with the Trust Strategy and drives the future sustainability of the Trust.

St. George's has operational capabilities, however its ability to change services either incrementally or make step change is variable and dependant on individual rather than organisation capability.

Outpatient services are critical to the success of the Trust and rapid progress needs to be made by building on work that has already been initiated. This report makes a number of recommendations to the Trust Executive, focusing on the need to; develop a transformational programme, deliver a clear Trust Strategy and associated outpatient vision, create a single leadership and governance structure, and address some of the wider constraints to progress.

Current Situation

Over the past 9 months, the Trust Board have discussed, shaped and agreed an Outpatient Strategy. The early work from this strategy has formed the basis of the Outpatient Transformation Programme, part of the wider Trust Transformation Programme, and seeks to address significant operational issues in outpatient Services.

In addition to the 'Outpatient Transformation Programme' there are a number of projects or activities that target changing outpatients services and impacting on the same benefits, examples include RTT recovery plan, improvements in data quality, rollout of e-triage, Central Booking Team redesign, eDM, iClip rollout at QMH etc.

The need for change in outpatient services are driven by; Trust RTT performance, poor patient experience, staff morale, Trust financial position, loss of confidence in central outpatient services, and Trust reputation.

There are a number of acknowledged issues within outpatient services, some of the key ones being; inconsistent processes, understanding of capacity to deliver commissioner contracts, underutilised high quality outpatient facilities at Nelson and QMH, limited information system training, poor patient experience, IT Department capacity to implement and support key information systems, very low Choose and Book referral rates, poor data quality, high DNA rates, variable quality estate, and poor clinic room management and utilisation. Some examples of the impact of these are described in Appendix 1.

Review

The following outlines the key review findings and recommendations:

The **Outpatient paper discussed and decisions made at Trust Board** in December 2015 have been been **helpful in initiating the first steps** towards addressing some of the significant changes needed in Outpatients. This has led to resources being approved and secured, the development of a plan, board level leadership and governance for the changes outlined in the Outpatient DIP. One of the key achievements to date, has been the changes to management structure, which are now in place. There has been and continues to be excellent senior Clinical engagement in this work. More recently there has been Trust approval for additional resource to improve the data quality across the Trust, this is also a helpful and much needed resource. No issues relating to the quality or safety of clinical outpatient services have emerged during this review.

To address Trust challenges in outpatient services, **the Trust does need a Transformational Programme** for Outpatients, however currently planned work within the DIP, although critically important, is neither transformational nor has the features of a programme.

Transformation of Outpatient Services should be **driven by fundamental changes** in the service models and delivery methods for specialist services, for example, virtual consultations or 'one stop clinics'. The NHS 'Five Year Forward View' highlights the need for changes to care models and a more integrated approach to provision, and through a number of 'vanguards' NHS England are testing care models before wider rollout. Although not part of a vanguard community, **the Trust needs to be prepared to engage with other acute, mental health, community, primary and social care providers and commissioners in order to develop different care models**. The **current general 'all things to everyone' strategy will not serve the Trust well** in the current context of national policy and Sustainability and Transformation Planning (STP), as to achieve system sustainability

examples of emerging approaches in other parts of England are; MDT meetings across Community/Acute, redesign of OP consultations into a vertically integrated health setting, rapid access to specialist opinion, shared decision making, etc. These **service models reduce activity within the Acute sector** and for future Trust sustainability it will need to consider these models and be **clear about the capabilities** that its strategy is built on. To influence the STP across SW London a clear Trust strategy is required and within this the vision for outpatients should be evident. This outpatient vision will be key to driving work that is both transformational and programme in nature. It's worth noting that in Wandsworth, the Trust has a greater **opportunity** to drive different service models, as it has responsibility for Community Services, and if vertical integration is consistent with Trust Strategy, this opportunity is something that could be explored further. For different reasons, there is an additional **opportunity to develop integrated service models with other providers at Nelson Health Centre**.

Recommendation	Develop with Board, a Trust strategy that informs the direction of the Trust Transformation and the SW London STP process, and highlights the non-negotiables within this.		
Timescale	8 weeks	Responsibility	CEO/Director of Strategy

Recommendation	From the Trust strategy develop a Vision for Outpatients		
Timescale	3 months	Responsibility	SRO Outpatient Transformation

Recommendation	Initiate work with Commissioners and other providers to develop an integrated 'service model' for the Nelson Health Centre.		
Timescale	3 months	Responsibility	SRO Outpatient Transformation

Recommendation	Identify and redesign two vertically integrated service areas an prepare a business case for Board.		
Timescale	6 months	Responsibility	SRO Outpatient Transformation

Outside the work that forms the scope of the outpatient DIP (see Appendix 2), there are **many other streams of work** or projects that are seeking to tackle the same issues and generate the **same benefits**, examples would include the eTriage rollout, Planned Care RTT recovery, data quality improvements, central booking team redesign, eDM rollout, iClip rollout at QMH. These areas of work, also have **separate resource, governance and leadership**, some of which overlap. The delivery of change in outpatients is therefore fragmented, prioritisation of work is difficult, key operational people are being swamped, and teams are finding working together difficult. It would be much **more effective** if leadership, governance and resource were **integrated**. This would also aid the development of a **cohesive programme** that is **focused** on **strategic objectives** and **benefits**.

Recommendation	Identify the Board lead for the delivery of all strategic benefits expected from changes to or transformation of Outpatient services i.e. RTT performance, improved patient experience, reduced DNA rates, and CIP contribution. It is important that this lead is passionate about outpatient changes and will champion these within the Exec Team and at Board.		
Timescale	Immediate	Responsibility	CEO

Recommendation	To define the scope of an integrated outpatients transformation programme and workstreams within this for approval at Transformation Board.		
Timescale	2 weeks	Responsibility	SRO Outpatient Programme

Recommendation	Establish an integrated governance and organisation structure for a programme delivery team that aligns to the operational structure and is responsible for the delivery of all strategic outpatient benefits.		
Timescale	4 weeks	Responsibility	SRO Outpatient Programme

Recommendation	Develop and agree key communication messages that can underpin a consistent narrative about why change is needed, what is planned and how this will impact a range of key stakeholders.		
Timescale	4 weeks	Responsibility	SRO Outpatient Programme

The Trust **track record** in **delivering benefits** from large scale change **is limited**, but as with other organisations in the sector, **capabilities have been built around running operational services**. As the historical need for large scale change has been limited, acute sector Trusts haven't generally built the kind of capabilities around change that are prevalent in other non-health sectors. There is a need for a **different culture** around the **leadership** and **delivery of large scale change**, and whilst there are features of this, there **needs** to be more **active leadership** to drive the **culture**, **engage** internal and external **stakeholders**, **prioritise** work, **lead** an integrated team using best practice methods, **challenge** and hold disparate parts of the organisation to account, **drive** and maintain a **vision** for outpatients, oversee design and implementation activities, and resolve or escalate issues/risks, and **deliver** the strategic **benefits** required. There is currently a **gap** in this kind of **leadership** in outpatient service change work.

Recommendation	Appoint a Programme Director for Outpatient Transformation to provide active leadership and support to the SRO.		
Timescale	2 weeks	Responsibility	SRO Outpatient Programme

Currently, the focus of the work and monitoring within the DIP is **focused** on a **plan**. Whilst this process has been really **helpful** in thinking through the work that needed to be undertaken and the order of this work, there is a need for **clear**, **integrated**, **approved benefits profiles** for change projects/work within Outpatients. Timescales are important, however there is a need to drive changes through a **primary focus** on **benefits**. This would ensure that the **scope** or **quality** of work is **less likely** to be **compromised** to meet a timescale. Thus, a strong **focus on timescales** is likely to lead to the **board** receiving **false assurances** about progress towards key benefits. Although the OP Strategy paper that went to Board outlined that further work was required to define benefits and KPIs, limited progress has been made in this area.

Additionally, there are **early signs** within the DIP plan and other plans that **timescales are slipping**. This should be seen as a **warning symptom** that compromising scope/quality may become prevalent as a desirable way of catching up, and that benefits may be at risk.

Recommendation	Develop and agree initial stretch benefits around the Outpatient work, using a small number of indicators and clear realistic timescales.		
Timescale	Immediate	Responsibility	SRO Outpatient Programme

Recommendation	Develop a monitoring process in conjunction with PMO, that primarily monitors progress against benefits, but also a small number of key milestones.		
Timescale	Immediate	Responsibility	Programme Director

With slippage against activities in DIP and RTT recovery plans, and the need to **deliver in year benefits**, it is important to accelerate work across key workstreams. Looking at the wider picture of outpatient change, there are **lots of initiatives** that are implementing or planned. There is a danger that key individuals could become **bottlenecks** or that resource could be **diluted**, resulting in **slowing progress**. There is a need for **prioritisation** and a **culture**, supported by approaches (e.g. agile or rapid improvement cycles), that **create the features of accelerated change**. (See features of accelerated change - Appendix 3).

Within the various elements of work, there are clear priorities that will lead to in year benefits, however there are other pieces of work where the connection is less clear and yet further areas of work that don't yet exist, e.g. GP relationship building, Nelson/QMH clinic utilisation, standard performance reporting. An exercise in **prioritising** the various **existing and potential workstreams** within the wider programme needs to be undertaken.

Recommendation	To aid the integration of a programme team and support the use of acceleration approaches, establish an agile Physical Hub on the main St. George's site.		
Timescale	6 weeks	Responsibility	Programme Director / Estates Director

Recommendation	Prioritisation of existing and potential work, aligned to the establishment of clear programme benefits and scope.		
Timescale	4 weeks	Responsibility	Programme Director

Recommendation	Identify and introduce a small set of initial acceleration methods within the integrated programme team.		
Timescale	4 weeks	Responsibility	Programme Director

Evidence around change initiatives highlights that the organisations with the **highest success rates** are those with a **defined**, **understood** and **consistent change process** around which an **organisation change capability** is established. The Trust doesn't have such an approach built into its governance or business processes, and as such, is **dependent on individual capabilities**. Although, the DIP process has clearly been helpful in the development of some of the current set of change initiatives, it's not clear where this fits within the wider change process and the governance and assurance that will be needed going forward. **Best practice** around service change would include **engagement of patients** into the process of change, there is no indication that the Trust recognises the value of patient engagement in change, despite strong evidence of the benefits.

Within the Trust there appears to be a specific **issue** around **achievement of benefits from projects that involve IT and operations**, e.g. e-triage, and eDM. The specific issues identified with IT/Ops rollouts appear to relate to wider change processes, process design, training, resource capacity and benefits realisation. These would suggest that the **planned rollout of iClip at QMH** needs to be **carefully considered** from a number of perspectives, before committing to implementation, e.g. timing, change process, resourcing and benefits. An **unsuccessful rollout would jeopardise** one of the key areas where operational outpatient processes appear to be effective.

Recommendation	Design and approve a Trustwide change process and associated governance, tools, techniques and approach to building capability. The change process needs to include a framework that supports effective patient engagement into the process of change.		
Timescale	6 months	Responsibility	Director of Transformation

Recommendation	Design and establish an assurance review for iClip rollout at QMH. The project would need to successfully pass this assurance process before proceeding to implementation. (assumes this project would be part of Outpatient Programme)		
Timescale	Immediate	Responsibility	SRO Outpatient Programme

Recommendation	Undertake assurance reviews, focused on achievement of benefits for both eTriage and EDM. (applies if these projects are in/out of the Outpatient Programme scope)		
Timescale	Immediate	Responsibility	Programme Director

The **Cerner iClip** system is **critical to underpinning** many of the required **improved** and **consistent processes**. It is evident that the Trust **doesn't use** the Cerner system as **effectively or fully for outpatients as other Trusts**, however it's not completely clear if the reason for this sits with the system configuration (e.g access roles, templates or system rules etc.) or if this was a conscious choice not to embed some processes, e.g. clinic outcomes, within the system. There is a need to **understand** if there are **opportunities** to improve the effectiveness of the system, either through configuration changes or through digitising additional processes.

Requests to identify a **system owner** for iClip have consistently led to a mid grade IT expert undertaking an important Senior System Administrator role. Key **decisions** for a system with this level of **strategic importance** would normally be made by a **senior operational director**.

Recommendation	Appoint a senior Operational Director as the System Owner for iClip and request they establish effective design authority governance for the system.		
Timescale	Immediate	Responsibility	CEO

Recommendation	Invite another Trust using Cerner (e.g. Oxford) to undertake a diagnostic of the current configuration and RTT processes. Cost £10-15k		
Timescale	2 weeks	Responsibility	New System Owner

Outpatient Transformation Review

St. George's University Hospital NHS Foundation Trust

There are **significant issues** with existing outpatient processes, particularly at the St. George's site, with lots of evidence showing that they create rework, frustrate everyone, and are impacted by poor data. All this leads to l**imiting the effectiveness of the wealth of clinical talent** within the Trust (see Appendix 1 for examples of results of these poor processes). It also means that it is very difficult for managers to manage services, utilise capacity effectively and in some cases verges on **the edge of safety issues**. Redesigning a small number or processes, which have complex independencies will limit benefits and is a 'quick fix' approach, rather there is a need for a more **fundamental look** at the **service operating model for outpatients** i.e. a widespread redesign of outpatient processes.

Rolling out **consistent operational processes** within outpatients across the Trust will be challenging and there will be a **continuing desire** for staff to **localise operational processes** and outline why their service is a special case. The Trust needs to ensure a process to **maintain consistency** in outpatient processes and that this has the full support of the Board.

Recommendation	Identify all outpatient administrative processes and outline a plan from the redesign of each one in conjunction with IT systems that support them, and create a target operating model for central outpatient services		
Timescale	4 weeks	Responsibility	Programme Director

Recommendation	Establish a Design Authority for outpatient processes that takes responsibility for approving outpatient processes and business rules and any variances from these.		
Timescale	3 months	Responsibility	Divisional Director for Outpatients

Recommendation	Trust Board to send out a clear message to staff outlining; why the Trust needs increased consistency in OP processes, the design authority process, and their support for the process.		
Timescale	3 months	Responsibility	CEO or Chair

For the changes that are planned across outpatients, there are a number of **capability/capacity gaps** that will need to be understood, quantified and costed as scope and priorities crystallise. However, it is clear that the resource to manage the change is limited for the scale of change that is required. The currently identified gaps are;

- Business Intelligence – to support development of benefits trajectories, feedback loops and monitoring
- Subject Matter Expertise – dedicated staff from OP operations, to be a key part of the team, but also to provide a predictable resource level from operations
- Admin Support – admin expertise is required to support the programme team
- Process Design – Much of the work involves changes to processes and effective process design will be critical to success
- Trainers – Required to train large numbers of staff on new processes
- Communications expertise – to aid communication and engagement with large numbers of disparate stakeholders (GPs, staff, patients, commissioners etc.)
- Informatics – which needs to be understood in the context of wider discussions around Informatics capacity.

Much of the work around outpatients **isn't unique** to St. George's and there are many organisations, **both public and private sector**, across the UK and internationally that **demonstrate best practice** in large scale delivery of people to service points. Although some review of other models has been undertaken, this is limited to a small number and centred around healthcare in London.

Recommendation	Develop and agree resource requirements and associated benefits/timescales for the newly agreed programme scope.		
Timescale	8 weeks	Responsibility	Programme Director

Recommendation	Identify areas of good practice in outpatient delivery and develop a programme to engage with and learn from UK and international best practice.		
Timescale	10 weeks	Responsibility	Programme Director

Steve Sewell
April 2016

Appendix 1 – Example comments outlining the system problems in Outpatient Services

'… a patient having had a colectomy 18 months ago was recently re-referred to the Trust for the follow up for this surgery. The referral was necessary because the patient had had 5 follow up appointments, all cancelled by the Trust and rescheduled. The patient DNA'd for the 6th and was discharged, however the patient hadn't been aware of the 6th appointment…'

'.. it takes ages for patients to get through to the call centre, so they often don't bother, Let's ring now and see how busy it is, …. Dials number, ……. *Heard on loudspeaker*, we are experiencing high calls volumes, you are currently number 80 in the queue …..'

'… while in clinic I heard a patient, who had travelled from Cambridge, being told that their appointment had been cancelled. Their response was to ask, 'who cancelled the appointment', the receptionist response was to respond stating 'the system cancelled the appointment'…the discovery of cancellations on arrival at clinic happens a lot, I've experienced 2, just within the past few months…'

'…. I must get 10 discharge letters relating to DNAs every day, which isn't surprising as rather than book follow up appointments as patients leave the clinic, they are asked to ring the booking centre within the next 7 days and if they don't have the patience to wait for an hour and book their appointment in 7 days, they are discharged….'

'… this morning, as I didn't have any patients for a while, I rang 3 of the patients who had DNA'd to understand why this was happening. One to voicemail. Other two never received letter advising clinic appointment. One said called hospital twice most recently last week to chase appointment and was told no appointments available and would be informed of clinic appointment when one organized…'

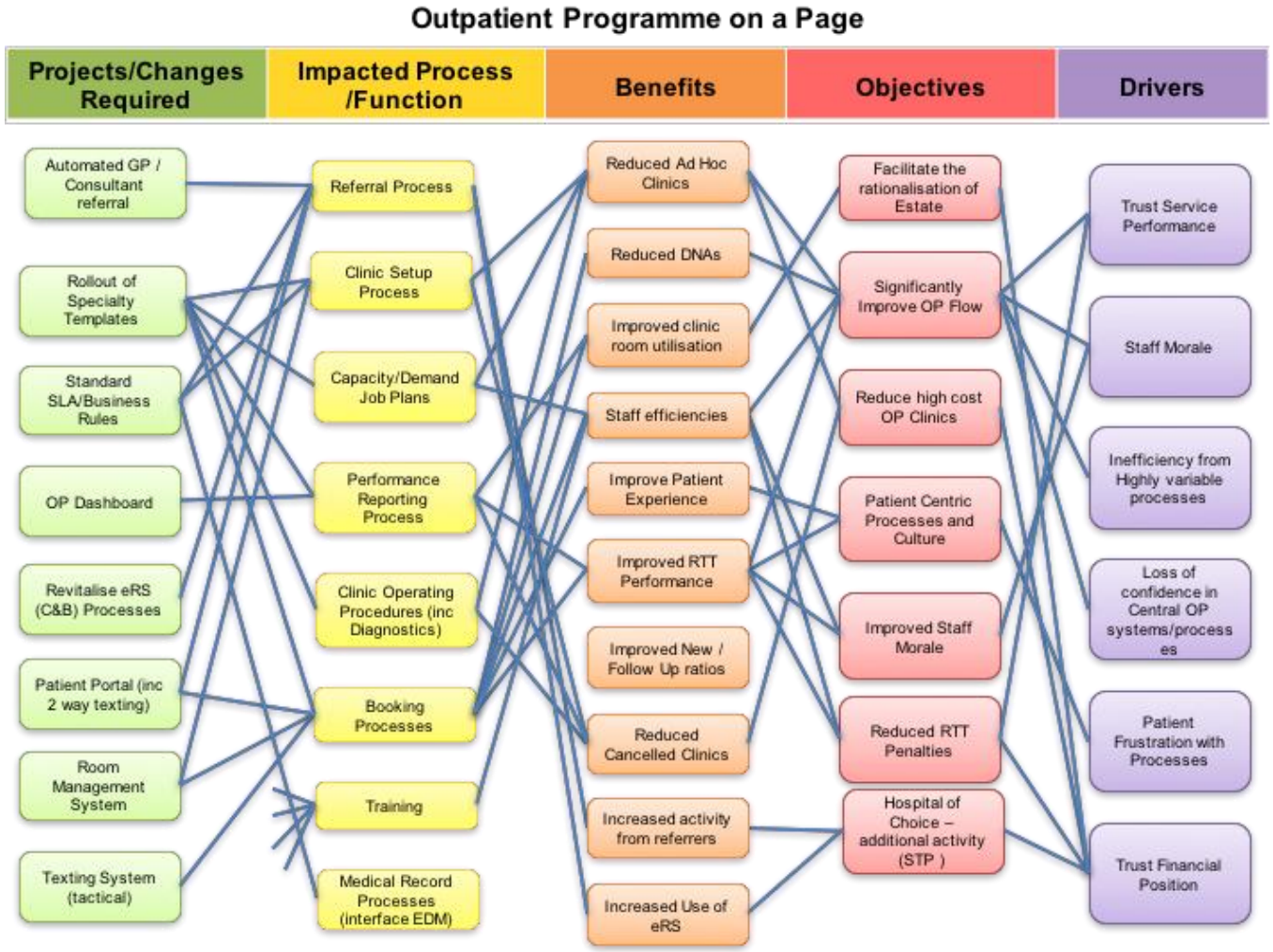
'…I know some people who bypass the processes and frustration of the booking centre by ringing the consultants medical secretary to book an appointment....'

''.. there are lots of examples of consultants who have wasted appointments in clinics as they see patients without diagnostic information being available or in some cases having been arranged, when there is a clear requirement to do so…'

'.. I spend a lot of time in the Renal unit, the staff are great, but often there isn't room and patients have to stand for long periods of time because there aren't any available seats….'

'…I happened to pop into a Urology clinic in the small outpatient suite opposite Pharmacy and it was rammed, there must have been 60 people in there, with around 25 stood up leaning against the walls of the waiting room..'

Appendix 2 – Current DIP Programme Scope and Logic



Appendix 3 – Features of accelerated change:

- everyone focused on the **vision** and **outcomes**
- clear **roles and responsibilities**
- **programme** management staff **working closely** with **operational** staff
- large numbers of engaged people taking **ownership of change**, driven by a desire to '**want to'** change
- the ability to **re-organise resources**, **funding**, **processes** and **governance** quickly in response to **changing situations**
- **devolved responsibility** for delivery
- strong **relationships** and **trust** across divisions/directorates
- **collaborative leadership** at all levels
- activities driven by a small number of **milestones** rather than **detailed activity plans**
- **knowledge and confidence** in tools and techniques that create innovation and support change
- people **making some decisions** on intuition.

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD –02 June 2016 **Paper Ref:**

Paper Title:	**Finance Report for Month 01 2016/17**
Sponsoring Director:	Nigel Carr, Chief Financial Officer
Author:	Amaka Nnadi, Finance Manager
Purpose:	To inform the Board about the Trust's financial performance in M1
Action required by the board:	To note the report
Document previously considered by:	Finance and Performance Committee

Executive summary

In April the Trust reported a deficit of £7.8m compared to a planned deficit of £6.2m. The £1.6m adverse position from plan is largely SLA income under performance while expenditure is in line with plan.

Underperformance on SLA income reflects loss of elective and outpatient activity due to the four days of junior doctor strikes, unachieved RTT targets and business case slippage. April also saw lower levels of non-elective activity than planned. Penalties for the month are broadly in line with plan.

The Trust CIP target for the year is £42.7m of which £32.7m relate to central programmes and £10m devolved to the divisions. The central target is profiled across Q1-Q4 at 13%, 23%, 30% and 37% respectively. £0.8m of CIPs were achieved this month, compared to the plan of £1.5m. The CIP programme contains significant risk as only £6.8m of the £42.7m target have schemes which have been ratified and identified to budget level.

The underlying M1 deficit after the removal of non-recurrent items was £5.3m. This was a £1.2m increase against the M12 underlying deficit of £4.1m and mainly related to inflationary increases in PAY and CNST

The cash balance at the end of April was £12.9m, £0.2m less than plan. The adverse I&E performance has not been reflected in the cash position mainly by better working capital performance and capital under spend. Capital spend in the month was £1.6m which was £0.7m less than the plan.

The Trust's overall risk rating in April was a 1 compared to the plan of 2. The adverse performance against plan is due to I&E variance of 3.1% against NHSI expectation of 1.2%

Enclosure:

Key risks identified:

The main risks identified are:

- Resource and capacity to meet the RTT trajectories and CQUINS
- Failure to meet the conditions relating to the STF funding (including RTT)
- Capacity constraints
- Fragility of the estate, especially theatres
- Delivery of the planned savings in the Transformation programme
- Insufficient liquidity

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.

Summary Finance Report
Month 1 2015/16

Trust Board 2nd June 2016

1. Month 1 Headlines & Actions – Income & Expenditure

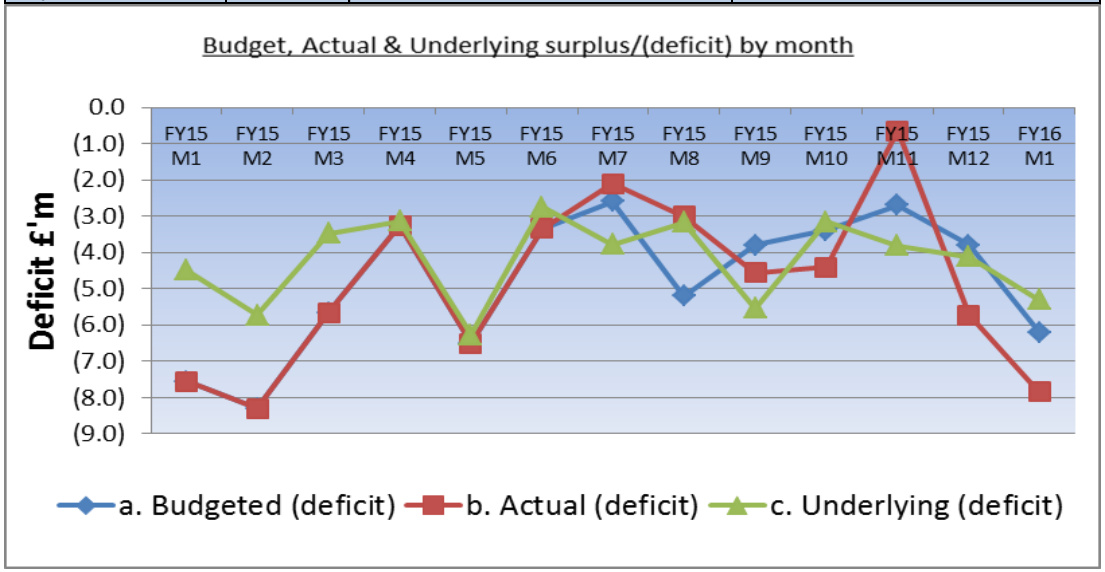
Area of Review	Metric	Key Highlights
Overall financial performance in April	Deficit of £7.8m in the month, £1.6m worse than planned	Performance is £1.6m worse than plan due to: • SLA Income: underperformance mainly attributable to 4 days junior doc tor strike action, business case slippage and unachieved growth targets • Expenditure base which is broadly on planhas not contracted to reflect activity/income underperformance
Activity/Income	SLA income is £2.2m below plan for April	Actual activity across all areas other than Non Elective is below target. A & E activity is 5% higher than last year and outpatients are 3.5% lower than last year In month £2.2m underperformance reflects income losses due to 4 days of junior doctor strikes (c£1.4m), business case slippages (Cardiac Surgery, Cardiology & T&O), and theatre sessions lost/cancelled as a result of maintenance and governance issues, and lack of ITU beds.
Expenditure- Pay	Pay spend is £0.2m below plan	• April pay is £0.2m favourable against plan. The pay underspend seen is not on comparable scale to the activity under performance, partly because impact of strike action on pay is reported a month in arrears and increases have been seen in additional sessions and use of non clinical interim s. • Actual pay spend shows an increase of £2m against 2015/16 average monthly spend. The increase comprises £1m on pay awards and loss of the pension rebate and, £1m on additional sessions, repatriated catering services, additional interim support in corporate/Trust management.
Expenditure- Non Pay	Non pay spend in April is £0.1m higher than plan	April non-pay spend is £0.1m higher than budgeted which includes £0.2m over spend for Commercial pharmacy activity for which there is offsetting other income over-performance. • Non pay variance includes £1.3m reserves budget support in month (note: 2016/17 planned reserves budget is currently £29.5m of negative budget comprising of Centralised transformational CIP targets and other unallocated budget reductions expected to be devolved over the coming months). • Non-pay includes potential duplicated costs on Unallocated creditors which will be mostly coded in M2, plus potential stocking as stock adjustments are generally done annually. • Non pay spend is £2.4m higher than the 2015/16 monthly average spend of £23.6m because of increases in CNST costs as well as rebates from 2015/16 treated as non-recurrent until confirmed.
CIP	£42.7m savings target for 2016/17. M1 delivered £0.8m savings against £1.5m target.	Trust has a total turnaround target of £42.7m made up of £32.7m on central programmes and £10m in the divisions. Month 1 target is £1.5m (NHSI APR phasing) and actual savings of £0.8m have been reported , resulting in an overall an adverse variance of £0.7m. The phasing of the central target across quarters 1-4 is 13%, 23%, 30% and 37% respectively.

2. Month 01 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights	Actions	RAG
Cash	Cash balance £12.9m	The M01 actual cash balance was £12.9m compared to £7.4m at year end which is broadly in line with plan. The cash balance increased by £5.4m in month due to lower payments to suppliers and the receipt of £8.4m Q1 monies from Health Education England.	The Trust just has sufficient secured borrowing capacity if the planned deficit of £17.2m is met however there is only £0.8m cash headroom and the Trust has requested approx £20m cash headroom to mitigate the risks relating to the receipt of the £17.6m sustainability and transformation funding (which is assumed in the £17.2m deficit plan) and the delivery of the CIP targets.	
Capital	YTD spend £1.6m, £0.7m less than plan	Capital expenditure was £1.6m in April, an under spend of £0.7m in month. Mainly relating to the energy performance contract.	Additional investment is included for infrastructure renewal in 2016/17 within the existing funded capital budget to address high priority estates areas. The Trust spent £3m on infrastructure renewal in 2015/16 and is planning to spend £7.9m in 2016/17. The new Director of Estates and Facilities is commissioning independent advisers to support the preparation of a new estates strategy which will inform investment priorities in the trust estate.	
Working Capital	+£12.7m in month, £1.4m better than plan in M01.	Working capital in April improved by £12.7m due to lower supplier payment runs following year end, the receipt in April of all £8.4m Q1 monies from Health Education England and lower capital. Cash performance was £1.4m better than plan – helping to offset the cash impact of the higher revenue deficit.	The Trust needs to continue to maintain the longer supplier payment terms and secure reductions in overdue debt to protect its working capital position in 2016/17 and help to minimise borrowing. The very long lead time for payment by NHS England of over performance debt remains the highest working capital risk to the cash position.	
FSRR	Rating of 1 compared to plan of 2	The Trust's financial sustainability risk rating for month 1 (April) is 1 which is behind plan. The rating reflects a I&E variance of 3.1% compared with an NHSI expectation of 1.2%.	Actions to deliver a more favourable variance against year to date plan in the coming months will allow this rating to improve.	

3. Overall Position for the month April 2016

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	648.3	53.1	50.8	(2.2)	53.1	50.8	(2.2)
Other Income	123.7	10.3	10.7	0.4	10.3	10.7	0.4
Overall Income	**772.0**	**63.3**	**61.5**	**(1.8)**	**63.3**	**61.5**	**(1.8)**
Pay	(491.2)	(40.7)	(40.5)	0.2	(40.7)	(40.5)	0.2
Non Pay	(262.9)	(25.9)	(26.0)	(0.1)	(25.9)	(26.0)	(0.1)
Overall Expenditure	**(754.1)**	**(66.6)**	**(66.6)**	**0.1**	**(66.6)**	**(66.6)**	**0.1**
EBITDA	17.9	(3.3)	(5.1)	(1.7)	(3.3)	(5.1)	(1.7)
Financing Costs	(35.1)	(2.9)	(2.8)	0.1	(2.9)	(2.8)	0.1
Surplus / (deficit)	**(17.2)**	**(6.2)**	**(7.8)**	**(1.6)**	**(6.2)**	**(7.8)**	**(1.6)**



Commentary

- The April deficit of £7.8m is £1.6m adverse from plan.
- **SLA income** in April is £2.2m adverse from plan mainly due to unmet growth targets, 4 days junior doctor strikes (6, 7, 26, 27th April) and business case slippages. There were also cancelled activity due to lack of ICU beds and cancelled theatre sessions due to maintenance issues.
- **Other income** in the month is higher than plan and reflects commercial pharmacy activity over performance (£0.2m) which incurs non pay overspend on drugs, and overseas income over-performance £0.2m.
- **Pay** spend this month is £0.2m lower than planned however, actual spend of £40.5m is an increase of £2m compared to the monthly average spend for last financial year.
- The increase in pay spend compared to the 2015/16 average is due to:
  - £1m increase due to changes to Pensions regime (removal of the 1.8% rebate) and 1% pay award
  - £1m other increases due to additional spend on additional session/WLI payments, 2015/16 bank staff holiday pay claimed in April and increased use of temporary staff and interims.
- **Non pay** overspend in month of £0.1m comprises of £1.3m reserves budgetary support which is offsetting adverse variances on drugs, consultancy and unallocated CIPs.
- **The M1 underlying deficit** of £5.3m, is a deterioration on the £4m average since turnaround (i.e. FY 2015 Mth 4). This reflects increased pay costs for the pay award and pension uplift, and SLA income underperformance without commensurate reduction in expenditure.
- The underlying trend continues to show the Trust variable expenditure base does not readily respond to reduction in activity.

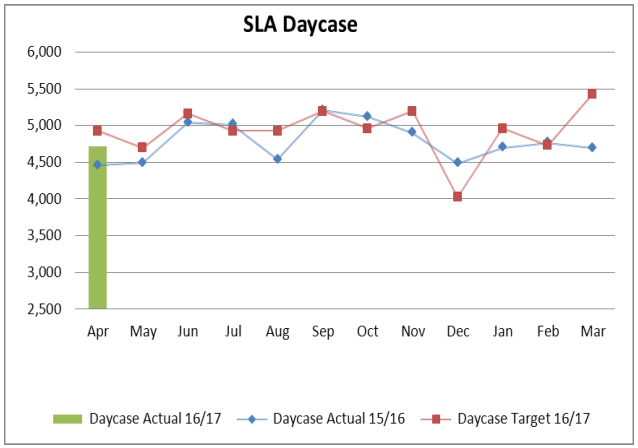
4. SLA Income for the month April 2016

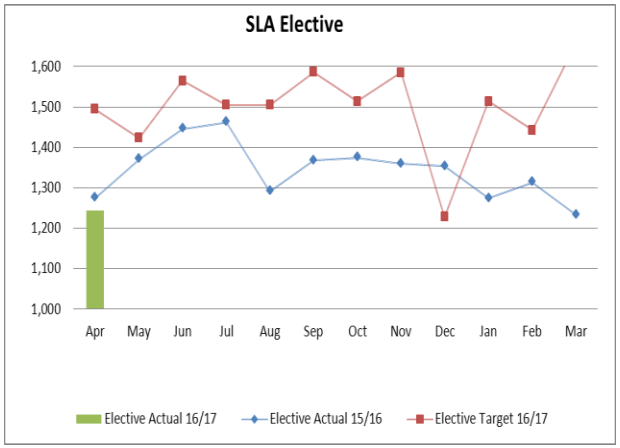
Activity	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
A&E	20.0	1.6	1.5	(0.1)	1.6	1.5	(0.1)
Bed Days	61.7	4.9	4.9	(0.0)	4.9	4.9	(0.0)
Daycase	30.9	2.6	2.6	(0.0)	2.6	2.6	(0.0)
Elective	76.3	6.3	5.0	(1.3)	6.3	5.0	(1.3)
Non Elective	133.0	10.9	10.2	(0.8)	10.9	10.2	(0.8)
Outpatients	113.5	9.3	8.7	(0.6)	9.3	8.7	(0.6)
Fixed Block (HIV)	49.3	4.2	4.2	0.0	4.2	4.2	0.0
Pass through Drugs income	47.6	4.0	4.4	0.4	4.0	4.4	0.4
Pass-through devices/programme	35.8	2.7	3.0	0.3	2.7	3.0	0.3
Diagnostics	26.1	2.2	2.2	(0.0)	2.2	2.2	(0.0)
Unbundled (Chemotherapy)	22.8	1.9	1.7	(0.2)	1.9	1.7	(0.2)
Community Block	14.1	1.2	1.2	0.0	1.2	1.2	0.0
In Patient Deliveries	13.5	1.1	1.0	(0.1)	1.1	1.0	(0.1)
Out patients - Regular Att.	4.9	0.4	0.4	(0.0)	0.4	0.4	(0.0)
Challenges/Penalties	(9.2)	(0.8)	(0.7)	0.0	(0.8)	(0.7)	0.0
CQUIN	(2.2)	(0.2)	0.0	0.2	(0.2)	0.0	0.2
Other (Ex SLA, Unallocated, CIP)	10.1	0.7	0.6	(0.1)	0.7	0.6	(0.1)
Grand Total	**648.3**	**53.1**	**50.8**	**(2.2)**	**53.1**	**50.8**	**(2.2)**

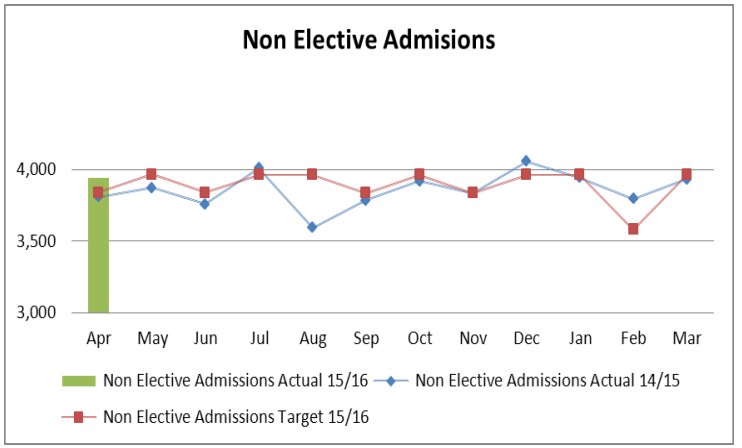
Commentary

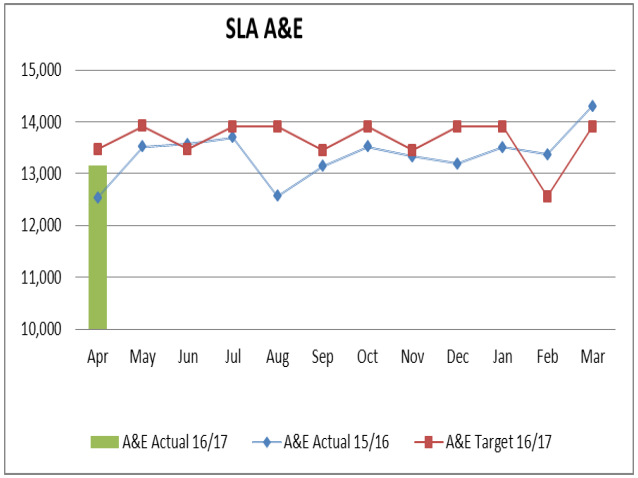
- SLA income is £2.2m under plan in the month. The main areas of underperformance are within Elective (£1.3m), Non Elective (£0.8m) and outpatients (£0.6m)
- The Elective shortfall is driven by neurosurgery (£317k), Cardiac surgery (£237k) and Trauma & Orthopaedics (£184k). The Trust has a challenging RTT target to meet in 2016-17 and in addition there have been a number of cancellations in month, dropped sessions due to theatre maintenance and the impact of the junior doctors strike which resulted in an estimated loss of. £1.4m.
- The Non Elective shortfall of £0.8m is apparent across all acute divisions, of which the Surgical division is the largest at £307k due to theatre maintenance and junior doctors strike.
- The outpatient shortfall is apparent in all Acute divisions especially Med/Card which has a shortfall of £275k .
- CQUIN:This is a provision of £2.2m (15%) to reflect prudence on achievement of the £15m CQUIN target which is budgeted for in the relevant PODs.

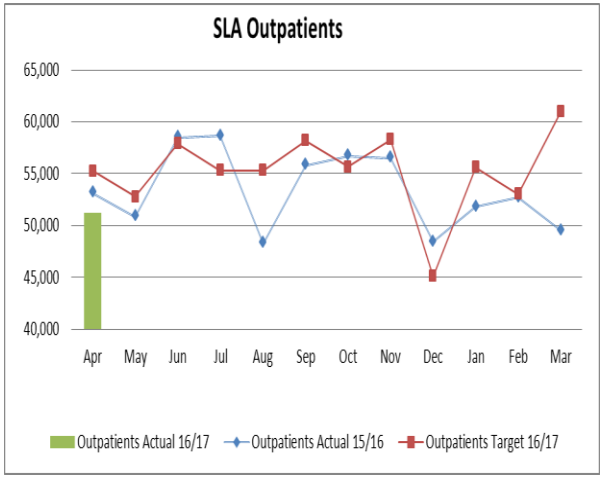
5. Patient activity compared to plan for the month April 2016











Commentary

- Actual activity across all areas other than Non Elective is below target.
- Non Elective activity is above target even though the value is below target. This is due to a case mix issue
- The shortfall in outpatients is mainly in Neuro Rehab, Gynecology and Trauma & Orthopedics.
- A & E activity is 5% higher than last year and outpatients are 3.5% lower than last year.

6. SLA Income by Commissioner for the month April 2016

St George's University Hospitals NHS
NHS Foundation Trust

Income	Annual Budget (£m)	Year to Date		
		Budget (£m)	Actual (£)	Better/(Worse) than Budget
NHSE Specialist	242,419	19,615	16,674	(2,940)
NHSE Public Health	23,656	2,003	1,954	(49)
NHSE Secondary Dental Care Services	8,956	745	695	(51)
NHSE Cancer Drugs Fund	3,833	319	280	(39)
NHSE SPECIALIST (IFR)	4	0	0	(0)
NHSE - HEPC	5,971	498	814	316
Public Health England	1,044	87	118	31
Subtotal NHSE	**285,884**	**23,268**	**20,535**	**(2,733)**
NHS Wandsworth CCG	151,111	12,446	12,699	253
NHS Merton CCG	66,178	5,433	5,396	(37)
NHS Lambeth CCG	21,758	1,785	1,632	(152)
NHS Croydon CCG	23,633	1,947	2,164	217
NHS Sutton CCG	14,314	1,181	1,312	131
NHS Kingston CCG	12,845	1,062	1,248	186
NHS Richmond CCG	12,492	1,051	1,170	118
SURREY CCG	21,628	1,785	1,984	200
Other CCGs	18,598	1,535	1,747	213
Subtotal CCGs	**342,557**	**28,224**	**29,352**	**1,128**
NCA	9,409	774	707	(68)
Other Trusts	1,249	101	83	(18)
Other Local Authority	6,677	631	643	11
Subtotal CCGs	17,334	1,507	1,433	**(74)**
Internal Targets: Growth, Business Cases etc	-4,237	-341	-986	(645)
Ex SLA Income	6,741	400	484	83
Total NHS Healthcare Income	**648,280**	**53,057**	**50,817**	**(2,241)**
Additional Income				
Private & Overseas Patient	6,247	521	789	268
Road Traffic Accidents (RTAs)	4,213	351	308	(43)
Other Healthcare Income	171	14	26	12
Education and Training Levy Income	41,188	3,432	3,432	(0)
Other Income	71,852	5,952	6,130	179
Total Other Income	**123,672**	**10,270**	**10,685**	**416**
Total income	**771,952**	**63,328**	**61,503**	**(1,825)**

Commentary

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

The Trust is over performing on local CCG (Wandsworth £253k,Croydon £217k and Kingston £186k) contracts and underperforming on NHSE £2.7m.

The Trust is below its total planned SLA activity targets by £2m year to date.

The value of contract challenges that have been assumed for month 01 are £694k. These appear under 'Internal Targets'

Other income* is the income that is generated by South West London Pathology, Pharmacy Income, R & D Project income, Donated Capital income and Parking Services income.

7. Pay costs for the April 2016

1. Pay spend against budget (In month & YTD)

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	(76.4)	(6.3)	(6.3)	0.0	(6.3)	(6.3)	0.0
Junior Doctors	(52.5)	(4.4)	(4.3)	0.1	(4.4)	(4.3)	0.1
Non Clinical	(87.1)	(7.3)	(7.1)	0.2	(7.3)	(7.1)	0.2
Nursing	(196.6)	(16.3)	(15.9)	0.4	(16.3)	(15.9)	0.4
Scientists/Technicians/Therapists	(89.4)	(7.3)	(6.9)	0.4	(7.3)	(6.9)	0.4
Other (CIP)	10.1	0.8	(0.0)	(0.8)	0.8	(0.0)	(0.8)
Unallocated (Pay Provisions)	0.8	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Grand Total	(491.2)	(40.7)	(40.5)	0.2	(40.7)	(40.5)	0.2

2015/16 → 2016/17

2. Monthly Pay trend by Staff-type	M1 £m	M2 £m	M3 £m	M4 £m	M5 £m	M6 £m	M7 £m	M8 £m	M9 £m	M10 £m	M11 £m	M12 £m	16/17 M1 £m
Consultants	(5.8)	(5.8)	(5.9)	(6.4)	(5.9)	(6.2)	(5.9)	(6.3)	(6.2)	(6.2)	(6.0)	(6.5)	(6.3)
Junior Doctors	(4.3)	(4.2)	(4.2)	(4.2)	(4.3)	(4.0)	(4.2)	(4.4)	(4.1)	(4.2)	(4.2)	(4.2)	(4.3)
Non Clinical	(6.1)	(6.0)	(6.1)	(7.5)	(6.6)	(6.3)	(6.0)	(6.5)	(6.0)	(6.2)	(6.4)	(7.0)	(7.1)
Nursing	(14.6)	(14.7)	(15.0)	(14.1)	(14.5)	(14.6)	(14.0)	(14.9)	(14.5)	(14.8)	(15.4)	(15.4)	(15.9)
Scientists/Techn & Therapists	(6.6)	(6.7)	(6.8)	(6.6)	(7.1)	(6.7)	(6.6)	(6.6)	(6.6)	(7.1)	(7.0)	(7.5)	(6.9)
Grand Total	**(37.4)**	**(37.4)**	**(38.0)**	**(38.8)**	**(38.4)**	**(37.8)**	**(36.7)**	**(38.8)**	**(37.4)**	**(38.7)**	**(39.1)**	**(40.5)**	**(40.5)**
Average per qtr :			**(37.6)**			**(38.3)**			**(37.6)**			**(39.4)**	

Note: M12 pay includes £0.7m KPMG turnaround management costs

Commentary

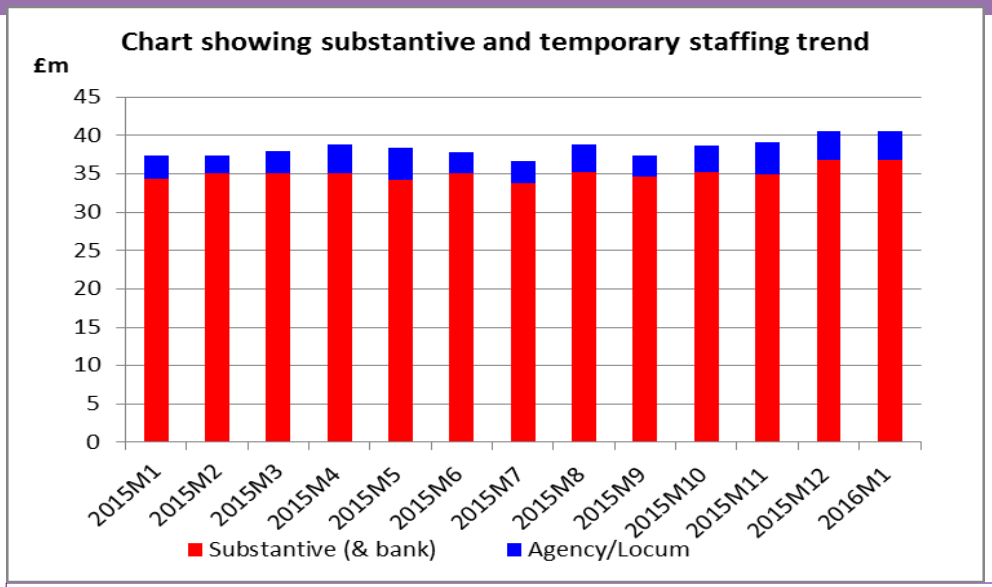
- Pay for April is £0.2m less than plan. The underspend in the month is due to vacancies held above the budgeted savings targets and vacancy factor.
- The £0.2m underspend on pay is not in line with the £2.2m SLA income under performance.
- Further workforce controls are required across the Trust to ensure pay resources employed are responsive to activity levels.
- M1 pay against the trend for 2015/16 per table 2 shows spend is c£2m more than prior year monthly average. The increase are :

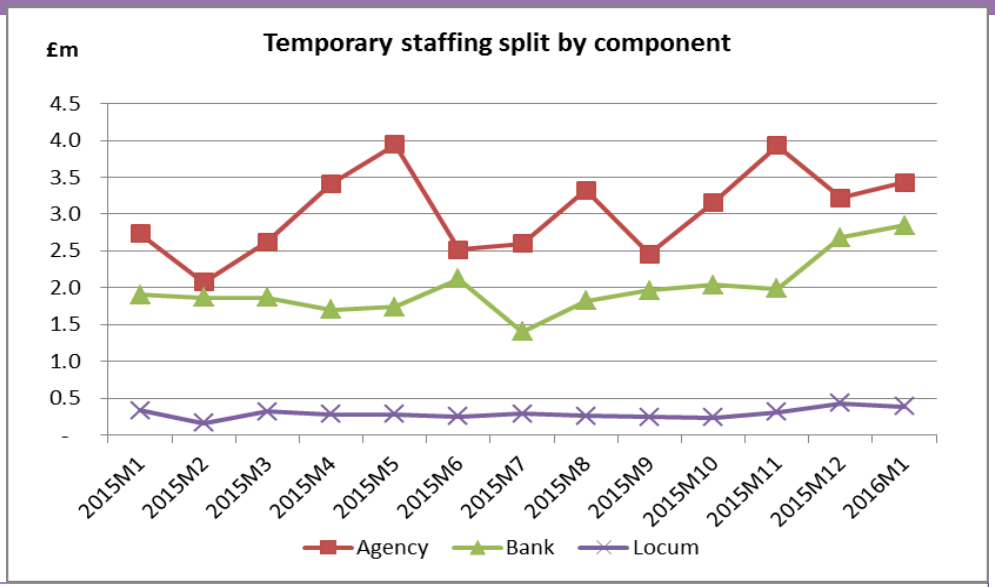
➢ £1m increase due to changes to Pensions regime (removal of the 1.8% rebate) and 1% pay award

➢ £1m other increase to pay per below:

- £0.3m additional session/WLI payments
- £0.2m staff bank holiday pay for 2015/16 claimed in M1
- £0.3m increase in temporary staff costs – mainly non clinical interims (across performance team, data quality & Trust mgmt.)
- £0.1m repatriated services & restructures (retail catering brought in-house, procurement restructure)

8. Pay trend for the 13 months to 30th April 2016





Commentary

- The proportion of total pay spend relating to use of bank staff was 7% in month. This is 2% higher than the 5% average for 2015/16 (5% average each for H1 & H2). The increase is mainly due to prior year costs relating to staff bank holiday pay, increased costs relating to the pay award and increase in pension costs.

- Agency proportion of total pay spend this month at 8% is comparable to the average for 2015/16 (8% average for each half of 2015/16) and, includes the additional spend on non-clinical interim staff,

- Department of Health caps on nurse agency spend came into effect in October 2015 . The Trust's annual agency spend target set by NHS Improvement for 2016/17 is a reduction in agency costs from prior year spend of £36m to £23m. M1agency spend increased by £0.2m compared to March meaning the Trust exceeded the planned target by £1m. The biggest area of increased spend was Non Clinical Support staff, particularly the use of Interim contractors which rose by £0.6m compared to previous month.

- Work is in progress to avoid breaching other temporary spend controls (maximum rates of pay, use of frameworks etc.) and additional enforcement protocols to achieve compliance on requirement for all departments to book agency staff via the bank office. This will improve control & reduce the estimation required each month and also allow better information on headcount.

9. Non pay costs for April 2016

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	(103.2)	(8.6)	(8.5)	0.1	(8.6)	(8.5)	0.1
Drugs	(18.4)	(1.5)	(2.6)	(1.0)	(1.5)	(2.6)	(1.0)
Drugs - Excluded (Pass-through)	(47.9)	(4.0)	(3.9)	0.1	(4.0)	(3.9)	0.1
Premises	(46.2)	(3.8)	(3.8)	0.0	(3.8)	(3.8)	0.0
Clinical Negligence	(20.4)	(1.7)	(1.7)	(0.0)	(1.7)	(1.7)	(0.0)
Establishment	(10.9)	(0.9)	(1.0)	(0.0)	(0.9)	(1.0)	(0.0)
General Supplies	(16.2)	(1.6)	(1.6)	(0.0)	(1.6)	(1.6)	(0.0)
PFI Unitary payment	(7.1)	(0.6)	(0.6)	0.0	(0.6)	(0.6)	0.0
Other non pay	(6.3)	(0.5)	(0.7)	(0.2)	(0.5)	(0.7)	(0.2)
Diagnostic tests/services	(26.4)	(2.2)	(2.2)	(0.0)	(2.2)	(2.2)	(0.0)
External Facilities	(7.9)	(0.8)	(0.6)	0.2	(0.8)	(0.6)	0.2
Other NHS Facilities	(6.0)	(0.5)	(0.5)	0.0	(0.5)	(0.5)	0.0
Consultancy	(3.7)	(0.3)	(0.5)	(0.2)	(0.3)	(0.5)	(0.2)
Reserves	29.5	(1.3)	0.0	1.3	(1.3)	0.0	1.3
Old Creditors adjustments	1.2	0.1	0.1	0.0	0.1	0.1	0.0
Unallocated creditors	0.0	0.0	(0.4)	(0.4)	0.0	(0.4)	(0.4)
SWLP reporting Offset	27.0	2.2	2.3	0.0	2.2	2.3	0.0
Grand Total	**(262.9)**	**(25.9)**	**(26.0)**	**(0.1)**	**(25.9)**	**(26.0)**	**(0.1)**

Commentary

- April spend is £0.1m higher than planed, in spite of £1.3m reserves budget supporting the position, and SLA income underperformance of £2.2m.
- Clinical consumables underspend of £0.1m does not correlate with the £2.2m SLA income underperformance . Reported April consumables costs do not reflect unused stock for cancelled clinical sessions as monthly stock adjustments are only made on very high cost items .
- Drugs overspend is partly due to £0.2m commercial pharmacy over performance (recovered via other income) and £0.8m due to negative drugs budgets in MedCard division (clinical haematology, gastro, rheumatology & diabetes) unravelled by split reporting of PbR excluded and PbR included drugs. The gap has been flagged and will be addressed in a M2 exercise to review, adjust and devolve relevant budget lines.
- Other non pay adverse variance relates to unallocated savings target and, consultancy overspend which relates to turnaround and transformation costs against which there are offsetting pay underspends on interim pay.
- Non pay spend of £26m this month is £2.4m higher than the 2015/16 monthly average spend. The increase is attributable to:

➢ £0.5m on CNST costs (£5m increase this year) > £0.6m MITIE rebates for 2015/16 unconfirmed as recurrent so accrued at original contract
➢ £0.4m drugs costs (recoverable via income) > £0.5m increase in clinical consumable costs
➢ £0.4m unallocated creditors (prudently accrued but will include disputed/duplicated elements that are corrected a month in arrears)

10. Trust CIP performance – Overall programme

Row Labels	CORPORATE EFFICIENCIES	MEDICINES OPTIMISATION	PROCUREMENT	CLINICAL TRANSFORMATION	INFRASTRUCTURE	PORTFOLIO OPTIMISATION	WORKFORCE	DIVISIONAL IMPROVEMENT	Grand Total
CORP									
CSD		0.04	0.01					0.95	0.99
CWDT		0.14	0.18					1.17	1.49
MEDCARD		1.38	0.49					1.18	3.05
SCNT		0.25	0.33					0.71	1.28
SUBMITTED	**0.00**	**1.81**	**1.00**	**0.00**	**0.00**	**0.00**	**0.00**	**4.00**	**6.81**
PIPELINE								6.00	6.00
DIPS (Savings in development)	0.00	0.00	3.76	5.39	-0.10	3.31	9.98		22.35
PLANS	0.00	1.81	4.76	5.39	-0.10	3.31	9.98	10.00	35.16
OVERALL TARGET									**42.70**
PLANNING SHORTFALL									**-7.54**

- The Trust has a total turnaround target of £42.7m with current plans targeting £35.2m, creating a current gap of £7.5m. Plans developed and identified to budget level total £6.8m.
- The central programme target is £32.7m. Plans total £25.2m are captured in the DIPs. Medicines (£1.8m) and Procurement (£1m) have been identified to budget level. The remaining £22.4m is being developed through the programmes.
- The divisions target is £10m. £4m of savings have been identified to budget level and are signed off. Divisions are developing schemes for the remaining £6m.

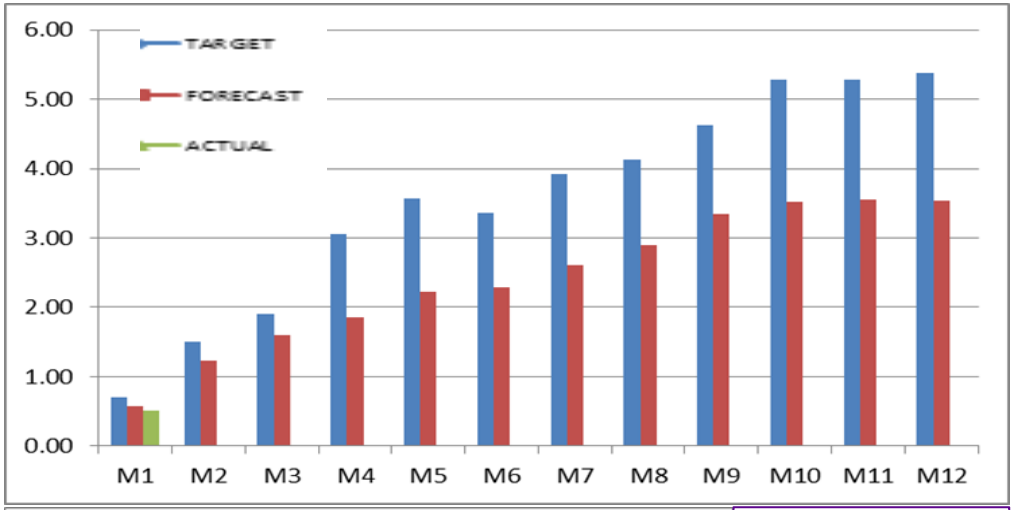
	ACTUAL MONTH 1									
	CORP	CSD	CWDT	MCDC	SCNT	SWLP	EF	TOTAL	TARGET	VAR
CORPORATE EFFICIENCIES										
MEDICINES OPTIMISATION		0.00	0.00	0.08	0.01			0.10		
PROCUREMENT		0.00	0.01	0.05	0.03			0.09		
CLINICAL TRANSFORMATION									-0.13	0.33
INFRASTRUCTURE										
PORTFOLIO OPTIMISATION										
WORKFORCE										
DIVISIONAL IMPROVEMENT		0.07	0.09	0.10	0.07			0.32	0.83	-0.51
Grand Total	**0.00**	**0.07**	**0.11**	**0.23**	**0.11**	**0.00**	**0.00**	**0.52**	**0.70**	**-0.18**

Actual performance

Month 1 target is £0.7m (NHSI APR phasing). Actual savings of £0.5m have been reported , resulting in an overall an adverse variance of £0.2m.
Within the divisions £0.32m actual has been reported against the target of £0.8m, an adverse variance of £0.51m.

The central target in M1 is negative £0.13m, being the difference between the Trust total target and the divisions £10m phased in 12ths. Central schemes (Procurement and Medicines) have delivered £0.19m actual savings in month.

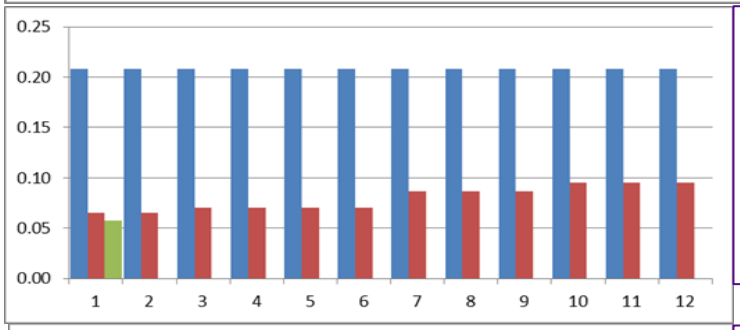
11. Trust CIP performance – Phased Programme Plans £'m



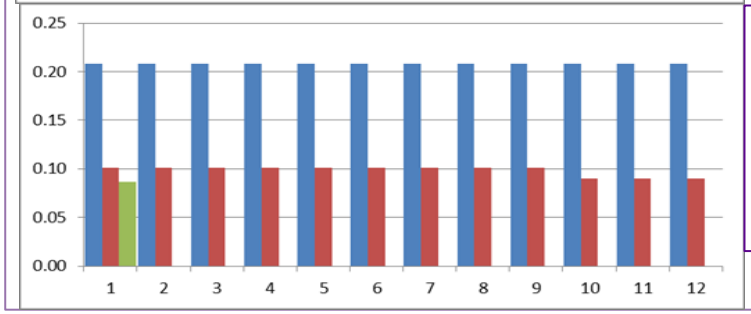
TOTAL PROGRAMME

The Trust requires an overall savings programme of £42.7m. This has been phased into the annual plan submitted to NHSI with 10% required in Q1, 23% required in Q2, 30% required in Q3, 37% required in Q4.
The forecast plans presented do not include the divisional pipeline or Red schemes.

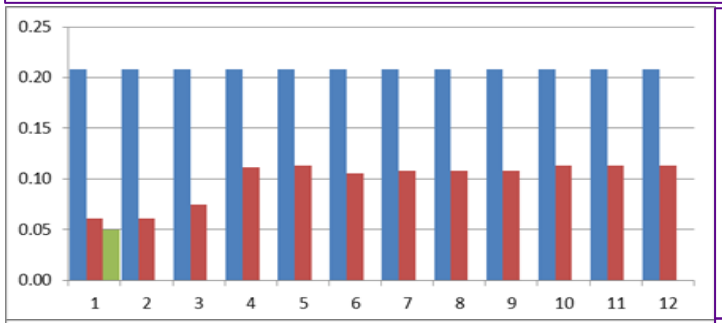
From M4 the Trust sees a planning shortfall of c£1m per month, increasing as the year progresses.
The programme contains significant risk as only £6.81m of the total plans have been identified to budget level and have passed through the governance processes.
In addition, forecast includes £2m bed closures (Flow) and £2m net additional income above RTT (Theatres). Removal of these is expected



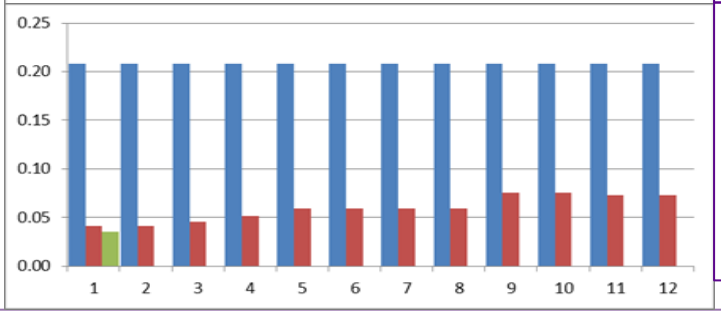
CSD has £0.95m schemes signed off against the target of £2.5m and a Pipeline of £0.1m. Significant further work will be required to close the gap.



CWDT has £1.17m signed off schemes. The division has schemes in the pipeline and anticipate that they will close the gap.

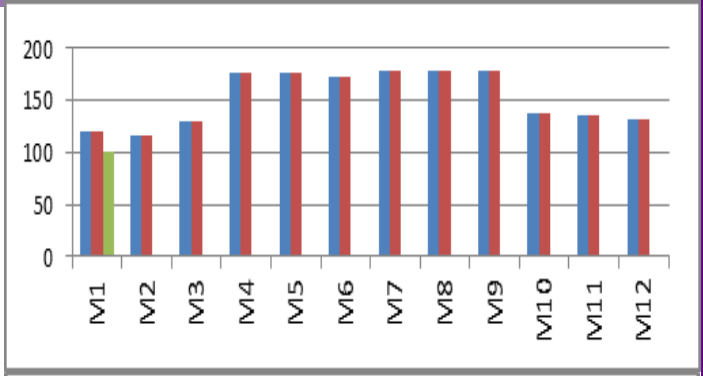


MEDCARD has £1.18m schemes signed off against a target of £2.5m. The division has schemes in the pipeline and anticipate they will close the gap.

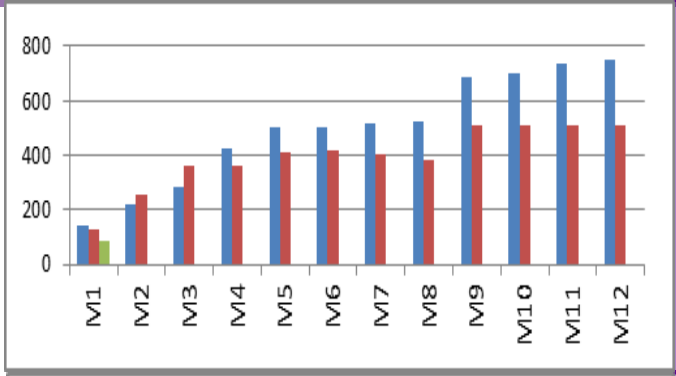


SNT has £0.71m signed off schemes and also have schemes in the pipeline, significant further work will be required to close the gap.

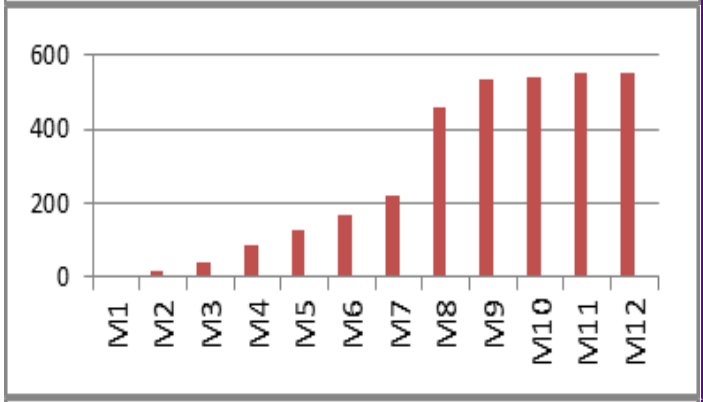
12. CIP Phased Programme Plans - Central by programme, by month £'m



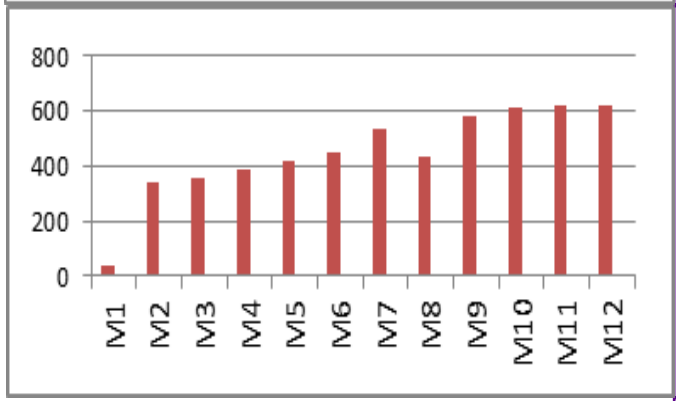
MEDICINES
Actual reported in M1 is £20k adverse to plan. This was due to reporting issues and will recover in month 2.



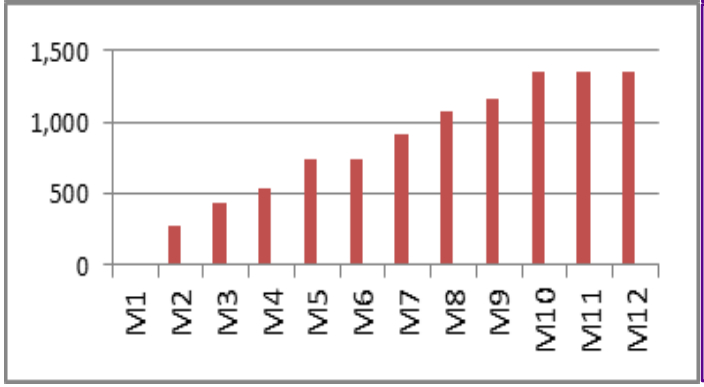
PROCUREMENT
Actual reported in M1 is £80k adverse to plan. This will recover as Procurement resolve some reporting issues. £1.2m of the £6m Procurement target has no identified plan/idea.



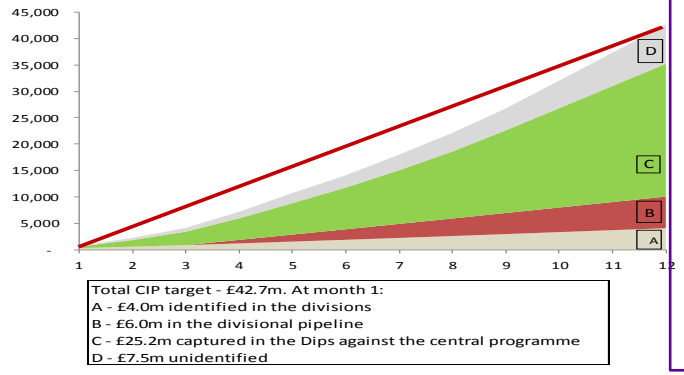
PORTFOLIO OPTIMISATION
No actual due. By M4 savings with a full year effect of £1m phase in with additional significant incremental savings thereafter. These are yet to be identified at a detailed level. High risk.



CLINICAL TRANSFORMATION
Plans totalling £5.39m start to phase in from M2. These are high risk – Flow still includes £2m bed closures to be removed and £2m benefit from Theatres represents additional income above RTT.



WORKFORCE EFFICIENCY
Plans totalling £10m start to phase in from M2. These are still at high level and are not allocated to the divisions.



UNIDENTIFIED
To reach a target of £42.7m, further plans of £6.1m are required. In addition, delivery shortfalls of £0.2m to date need to be mitigated and shortfall forecast by Procurement (£1.2m) must be recovered.

13. Divisional Summaries for April 2016 - KEY HEADLINES

Area of Review	Key Highlights
Medicine & Cardiovascular	The division's £3.7m contribution in month is £1.5m less than plan. The adverse variance mainly comprises income underperformance of £1m which is due to the 4 day junior doctor strike action, business case slippages in Cardiac surgery & Cardiology, unachieved growth targets as well as cancellations due to theatre maintenance and clinical governance issues, and lack of ITU beds. Adverse variance on pay reflects unmet CIP target while non pay adverse position is mainly due to a budgeting issue which is being investigated. Devolved divisional CIPs of £2.5m is unallocated (£2m pay and £0.5m non pay) to specific budget lines. The division will need to identify specific schemes to deliver these targets.
Surgery, Neurosciences Theatres & Cancer	The M1 contribution of £1.8m is £1.3m less than planed. The adverse position comprises of i£1.7m SLA income underperformance without proportional reduction in pay and non pay costs. Income underperformance is due to the junior doctor strike action, slippage on the T&O business case and theatre closures due to refurbishments (there is poor uptake of re-provided weekend sessions) . Devolved divisional CIPs of £2.5m includes £2m of unallocated targets which are yet to have specific and signed off schemes. The division also has £0.3m vacancy factor to achieve in order to ensure the funded establishment is not exceeded.
Community Services	The division's contribution of £0.5m is £0.1m higher than plan for April which is largely due to pay underspends over and above the vacancy factor and pay CIP targets (continuing recruitment difficulties in the CAHS service). Devolved divisional CIPs of £2.5m includes £1.5m of unallocated targets which are yet to have specific and signed off schemes. The division also has £1.7m pay run rate savings target/vacancy factor .
Children, Women & Diagnostics	M1 deficit of £1.6m is £0.5m higher than planned. This is due to SLA income under performance of £0.5m across SLA Other (in deliveries and diagnostics, plus an unmet Paediatric Oncology CIP target), non elective and outpatient activity. This is partly mitigated by £0.2m higher than planned commercial pharmacy activity income. Expenditure is £0.2m adverse from plan due to unachieved pay savings targets. Devolved divisional CIP target of £2.5m is as yet unallocated (£2.2m pay and £0.3m non pay) to specific budget lines. The division will need to identify specific schemes to deliver these targets. CWDT also has £1.7m of budgeted vacancy factor target.
Overheads	Overheads April deficit is £0.2m adverse from plan. This comprises of repatriation of loss-making retail catering in-house (£0.1m) and £0.2m overspend on corporate. Corporate overspend is in Pathology (blood issues) and Chief Operating Officer department interim support for RTT, planned care and Cancer target work streams.

Medicine & Cardiovascular - Divisional I&E for April 2016

Income & Expenditure	Annual Budget	Current Month			Year to Date		
		Budget	Actual	Better/(Worse) than Budget	Budget	Actual	Better/(Worse) than Budget
	£m	£m	£m	£m	£m	£m	£m
SLA Income							
A&E	20.0	1.6	1.5	(0.1)	1.6	1.5	(0.1)
Daycase	11.7	1.0	1.0	(0.0)	1.0	1.0	(0.0)
Elective	25.4	2.1	2.0	(0.1)	2.1	2.0	(0.1)
Pass-through devices/programme	23.3	1.7	1.6	(0.1)	1.7	1.6	(0.1)
Pass through Drugs income	30.4	2.5	2.7	0.2	2.5	2.7	0.2
Non Elective	68.2	5.6	5.4	(0.2)	5.6	5.4	(0.2)
Other (UB, DG, RA,FV, Provisions)	26.6	2.2	1.9	(0.3)	2.2	1.9	(0.3)
Outpatients	40.8	3.4	3.1	(0.3)	3.4	3.1	(0.3)
	246.3	20.2	19.2	(1.0)	20.2	19.2	(1.0)
Other Income	16.7	1.4	1.3	(0.0)	1.4	1.3	(0.0)
Overall Income	**263.0**	**21.6**	**20.6**	**(1.0)**	**21.6**	**20.6**	**(1.0)**
Pay							
Consultants	(21.5)	(1.8)	(1.7)	0.1	(1.8)	(1.7)	0.1
Junior Doctors	(18.9)	(1.6)	(1.6)	(0.1)	(1.6)	(1.6)	(0.1)
Non Clinical	(8.6)	(0.7)	(0.7)	0.0	(0.7)	(0.7)	0.0
Nursing	(58.8)	(4.9)	(5.0)	(0.1)	(4.9)	(5.0)	(0.1)
Other (Unalloc CIPs & vacancy factors)	1.1	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Scientists, Technicians, Therapists	(5.5)	(0.5)	(0.4)	0.0	(0.5)	(0.4)	0.0
Pay Unallocated (Gen pay prov)	1.0	0.1	0.0	(0.1)	0.1	0.0	(0.1)
	(111.3)	(9.2)	(9.4)	(0.2)	(9.2)	(9.4)	(0.2)
Non-Pay							
Clinical Consumables	(39.5)	(3.3)	(3.2)	0.1	(3.3)	(3.2)	0.1
Drugs	(5.1)	(0.4)	(1.2)	(0.8)	(0.4)	(1.2)	(0.8)
Drugs - PbR Excluded	(29.8)	(2.5)	(2.1)	0.4	(2.5)	(2.1)	0.4
Establishment	(1.4)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)
General Supplies	(0.4)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Other	(3.4)	(0.4)	(0.4)	(0.0)	(0.4)	(0.4)	(0.0)
Premises	(0.3)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
	(79.9)	(6.8)	(7.1)	(0.3)	(6.8)	(7.1)	(0.3)
Overall Expenditure	**(191.3)**	**(16.0)**	**(16.5)**	**(0.5)**	**(16.0)**	**(16.5)**	**(0.5)**
EBITDA	**71.7**	**5.6**	**4.1**	**(1.5)**	**5.6**	**4.1**	**(1.5)**
Financing Costs	(4.5)	(0.4)	(0.4)	0.0	(0.4)	(0.4)	0.0
Surplus / (deficit)	**67.2**	**5.2**	**3.7**	**(1.5)**	**5.2**	**3.7**	**(1.5)**

Commentary

April contribution of £3.7m is £1.5m adverse from plan. This comprises income shortfall of £1m and £0.5m expenditure overspend.

Income is £1m less than plan in month 1.

- The division reports underperformance against all SLA income categories, predominantly due to high cancellations within Cardiac and Vascular surgery. There were sessions lost due to clinical governance, theatre maintenance issues and a lack of ITU beds. In addition, April saw four days of junior doctor strikes, which resulted in a loss of £0.35m in income for the division, mainly within outpatients and elective services.
- Outpatient income underperformance is largely reported in Specialist Medicine due to vacancies in medical staff, high DNA rates and the strikes. The division has a recovery plan to improve this position over the coming months.
- The position also includes £0.1m of challenges for which the budget is held centrally.

Pay is overspent by £0.2m, largely due to nursing overspends. The reported costs include previous year invoices of £0.1m and a change to hourly rates, which had been previously understated. The in month pay overspend also includes vacancy factor and unidentified CIP of £0.2m.

Non-pay is overspent by £0.3m on drugs and use of private sector facilities to accommodate high level of cancellations reported in the month in Cardiac Surgery.
Further investigation is on-going with pharmacy to understand the drug budget shortfall.

Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for April 2016

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	5.9	0.5	0.4	(0.0)	0.5	0.4	(0.0)
Daycase	14.2	1.2	1.1	(0.1)	1.2	1.1	(0.1)
Elective	47.2	3.9	2.7	(1.2)	3.9	2.7	(1.2)
Pass-through devices/programme	6.3	0.5	0.5	0.0	0.5	0.5	0.0
Pass through Drugs income	6.0	0.5	0.7	0.2	0.5	0.7	0.2
Non Elective	55.6	4.6	4.3	(0.3)	4.6	4.3	(0.3)
Other (UB, DG, RA,FV, Provisions)	8.0	0.5	0.3	(0.2)	0.5	0.3	(0.2)
Outpatients	37.7	3.1	3.0	(0.1)	3.1	3.0	(0.1)
	180.9	14.8	13.0	(1.7)	14.8	13.0	(1.7)
Other Income	15.7	1.3	1.6	0.3	1.3	1.6	0.3
Overall Income	**196.6**	**16.1**	**14.6**	**(1.4)**	**16.1**	**14.6**	**(1.4)**
Pay							
Consultants	(27.9)	(2.3)	(2.3)	(0.0)	(2.3)	(2.3)	(0.0)
Junior Doctors	(16.2)	(1.4)	(1.4)	(0.0)	(1.4)	(1.4)	(0.0)
Non Clinical	(10.3)	(0.8)	(0.8)	0.0	(0.8)	(0.8)	0.0
Nursing	(50.8)	(4.2)	(4.0)	0.2	(4.2)	(4.0)	0.2
Other (Unalloc CIPs & vacancy factors)	1.7	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Scientists, Technicians, Therapists	(10.7)	(0.9)	(0.9)	0.0	(0.9)	(0.9)	0.0
	(114.2)	(9.4)	(9.3)	0.1	(9.4)	(9.3)	0.1
Non-Pay							
Clinical Consumables	(24.6)	(2.0)	(1.8)	0.2	(2.0)	(1.8)	0.2
Drugs	(3.6)	(0.3)	(0.3)	0.0	(0.3)	(0.3)	0.0
Drugs - PbR Excluded	(5.9)	(0.5)	(0.7)	(0.2)	(0.5)	(0.7)	(0.2)
Establishment	(0.4)	(0.0)	(0.1)	(0.0)	(0.0)	(0.1)	(0.0)
General Supplies	(0.3)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Other	(3.7)	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)	(0.0)
Premises	(0.8)	(0.1)	(0.0)	0.0	(0.1)	(0.0)	0.0
	(39.3)	(3.2)	(3.2)	0.0	(3.2)	(3.2)	0.0
Overall Expenditure	**(153.5)**	**(12.7)**	**(12.5)**	**0.1**	**(12.7)**	**(12.5)**	**0.1**
EBITDA	**43.1**	**3.4**	**2.1**	**(1.3)**	**3.4**	**2.1**	**(1.3)**
Financing Costs	(3.9)	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)	(0.0)
Surplus / (deficit)	**39.2**	**3.1**	**1.8**	**(1.3)**	**3.1**	**1.8**	**(1.3)**

Commentary

The division has delivered a net contribution of £1.8m for April 2016 which is £1.3m below plan.

Income – SLA income is significantly lower than plan in month. This is largely due to:

- 4 days Junior Doctor's strikes in April
- unplanned theatre closures due to refurbishment
- RTT targets which are phased to start in April but not resourced
- Slippage on the T&O business case

'Other' (non SLA) income over performed on private and overseas patients, including Gibraltar .

Pay – The £0.2m underspend in month is driven by vacancies in nursing and operating department practitioners (ODP's) offset by £0.1m unallocated CIP/vacancy factor.

Non-Pay – M1 spend is in line with budget. £0.2m underspend on clinical consumables is largely in Neurosurgery and offset by £0.2m pass through drugs overspend(recovered via income).

The key issues are;

- Secure resource for the RTT targets
- Improve coding of all elective activity across the division
- Catch up with the shortfall - utilise weekend capacity for reallocated weekend sessions from weekdays.

Community Services - Divisional I&E for April 2016

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	5.4	0.4	0.4	(0.0)	0.4	0.4	(0.0)
Pass-through devices/programme	4.9	0.4	0.5	0.1	0.4	0.5	0.1
Pass through Drugs income	9.4	0.8	0.9	0.1	0.8	0.9	0.1
Other (UB, DG, RA,FV, Provisions)	51.1	4.3	4.2	(0.1)	4.3	4.2	(0.1)
Outpatients	10.7	0.9	0.8	(0.1)	0.9	0.8	(0.1)
	81.5	6.8	6.9	0.0	6.8	6.9	0.0
Other Income	2.0	0.2	0.1	(0.0)	0.2	0.1	(0.0)
Overall Income	**83.5**	**7.0**	**7.0**	**(0.0)**	**7.0**	**7.0**	**(0.0)**
Pay							
Consultants	(2.1)	(0.2)	(0.2)	(0.0)	(0.2)	(0.2)	(0.0)
Junior Doctors	(2.5)	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0
Non Clinical	(8.4)	(0.7)	(0.6)	0.1	(0.7)	(0.6)	0.1
Nursing	(26.6)	(2.3)	(2.1)	0.2	(2.3)	(2.1)	0.2
Other (Unalloc CIPs & vacancy factors)	2.7	0.3	0.0	(0.3)	0.3	0.0	(0.3)
Scientists, Technicians, Therapists	(10.5)	(0.9)	(0.8)	0.1	(0.9)	(0.8)	0.1
	(47.4)	(4.0)	(3.9)	0.1	(4.0)	(3.9)	0.1
Non-Pay							
Clinical Consumables	(9.8)	(0.8)	(0.7)	0.1	(0.8)	(0.7)	0.1
Drugs	(0.5)	(0.0)	(0.1)	(0.0)	(0.0)	(0.1)	(0.0)
Drugs - PbR Excluded	(10.5)	(0.9)	(1.0)	(0.2)	(0.9)	(1.0)	(0.2)
Establishment	(1.2)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
General Supplies	(0.1)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Other	(7.7)	(0.6)	(0.7)	(0.0)	(0.6)	(0.7)	(0.0)
Premises	(0.4)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
	(30.2)	(2.5)	(2.6)	(0.1)	(2.5)	(2.6)	(0.1)
Overall Expenditure	**(77.6)**	**(6.5)**	**(6.5)**	**0.1**	**(6.5)**	**(6.5)**	**0.1**
EBITDA	**5.9**	**0.5**	**0.6**	**0.1**	**0.5**	**0.6**	**0.1**
Financing Costs	(0.2)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Surplus / (deficit)	**5.7**	**0.5**	**0.5**	**0.1**	**0.5**	**0.5**	**0.1**

Commentary

The in month divisional contribution is a surplus of £0.5m which is £0.1m better than budget.

Income – The in month position is break-even against the current budget of £7m. Small over-performances in pass through HIV drugs and prosthetic equipment are off-set by small underperformances in Prosthetics outpatients. The majority of QMH income has been transferred to the other divisions in line with Outpatients Strategy.

Pay – The in month variance is favourable by £0.1m. The budget includes a monthly vacancy target of £0.2m and an unidentified CIP target of £0.1m. The major under spending areas are in nursing, relating to CAHS and Health visiting services due to large numbers of vacancies. Other areas with a high number of vacancies include CAHS non-clinical staff and staff in the PLD service.

Non-pay – The in month overspend of £0.1m relates to pass through HIV drugs slightly off-set by underspends in the Wheelchairs service and Prosthetics (under clinical consumables).

Actions

- Transfer the Outpatients and Diagnostics costs centres in line with the new management structure.
- Continue to develop Divisional CIPs to reduce the unallocated
- Improve the Divisional forecasting for 16/17.
- Confirm the agreed SLAs for 2016/17 and understand fully the KPI and CQUIN targets.

Children, Women, Diagnostics & Therapies - Divisional I&E for April 2016

Income & Expenditure	Annual Budget	Current Month			Year to Date		
		Budget	Actual	Better/(Worse) than Budget	Budget	Actual	Better/(Worse) than Budget
	£m	£m	£m	£m	£m	£m	£m
SLA Income							
Bed Days	50.4	4.0	4.1	0.1	4.0	4.1	0.1
Daycase	4.9	0.4	0.5	0.1	0.4	0.5	0.1
Elective	3.7	0.3	0.3	(0.0)	0.3	0.3	(0.0)
Pass-through devices/programme	0.4	0.0	0.0	0.0	0.0	0.0	0.0
Pass through Drugs income	1.8	0.2	0.1	(0.1)	0.2	0.1	(0.1)
Non Elective	9.3	0.8	0.5	(0.2)	0.8	0.5	(0.2)
Other (UB, DG, RA,FV, Provisions)	45.7	3.8	3.6	(0.3)	3.8	3.6	(0.3)
Outpatients	24.3	1.9	1.7	(0.1)	1.9	1.7	(0.1)
	140.5	11.3	10.8	(0.5)	11.3	10.8	(0.5)
Other Income	25.0	2.1	2.3	0.2	2.1	2.3	0.2
Overall Income	**165.5**	**13.4**	**13.1**	**(0.3)**	**13.4**	**13.1**	**(0.3)**
Pay							
Consultants	(18.7)	(1.5)	(1.5)	0.0	(1.5)	(1.5)	0.0
Junior Doctors	(13.8)	(1.2)	(1.1)	0.1	(1.2)	(1.1)	0.1
Non Clinical	(14.3)	(1.3)	(1.1)	0.1	(1.3)	(1.1)	0.1
Nursing	(55.0)	(4.5)	(4.6)	(0.1)	(4.5)	(4.6)	(0.1)
Other (Unalloc CIPs & vacancy factors)	4.0	0.3	0.0	(0.3)	0.3	0.0	(0.3)
Scientists, Technicians, Therapists	(39.2)	(3.2)	(3.2)	0.0	(3.2)	(3.2)	0.0
Pay Unallocated (Gen pay prov)	(0.2)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
	(137.3)	(11.3)	(11.5)	(0.2)	(11.3)	(11.5)	(0.2)
Non-Pay							
Clinical Consumables	(15.2)	(1.3)	(1.1)	0.2	(1.3)	(1.1)	0.2
Drugs	(9.1)	(0.8)	(1.0)	(0.2)	(0.8)	(1.0)	(0.2)
Establishment	(0.6)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)
General Supplies	(0.5)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Other	(2.3)	(0.2)	(0.3)	(0.1)	(0.2)	(0.3)	(0.1)
Premises	(1.8)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
Drugs - PbR Excluded	(1.8)	(0.1)	(0.1)	0.1	(0.1)	(0.1)	0.1
	(31.4)	(2.6)	(2.7)	(0.0)	(2.6)	(2.7)	(0.0)
Overall Expenditure	**(168.7)**	**(14.0)**	**(14.2)**	**(0.2)**	**(14.0)**	**(14.2)**	**(0.2)**
EBITDA	**(3.2)**	**(0.5)**	**(1.1)**	**(0.5)**	**(0.5)**	**(1.1)**	**(0.5)**
Financing Costs	(6.5)	(0.5)	(0.5)	0.0	(0.5)	(0.5)	0.0
Surplus / (deficit)	**(9.7)**	**(1.1)**	**(1.6)**	**(0.5)**	**(1.1)**	**(1.6)**	**(0.5)**

Commentary

The division has a deficit of £1.6m which is £0.5m worse than planned for Month 1.

Income – SLA income has underperformed against plan by £0.5m. £0.4m due to activity underperformance and £0.1m due to case mix. Activity has underperformed in Outpatients £0.1m and Newborn £0.1m but has over-performed in Children's Day Case services by £0.1m. Case mix underperformance has effected Elective and Non-elective inpatient activity.

Other Income has over-performed by £0.2m which includes pharmacy Wholesale Dealer License income over performance of £0.2m (which has related drugs over spend) and £0.1m underperformance in the NIPT service development.

Pay is overspent by £0.2m in month. This includes £0.1m agency spend related to 2015-16. Pay spend is £0.1m under excluding prior year transactions. This is offset by unallocated CIP targets and budget setting savings requirements of £0.2m.

Non pay is £0.1m overspent in M01. Drugs overspend is due to the Wholesale Dealer License (£0.2m). Consumables has underspent on the NIPT by £0.1m (offsetting the income underperformance on this development).

Actions / Risks

- Income underperformance to be fully understood and addressed by Directorates, with recovery plans developed as necessary.
- Remaining CIP target and budget setting saving to be allocated to Directorates and further CIP schemes to be developed asap.

Overheads - Divisional I&E for April 2016

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	(21.5)	(1.8)	(1.9)	(0.0)	(1.8)	(1.9)	(0.0)
Executive Director of Nursing	(5.9)	(0.5)	(0.4)	0.1	(0.5)	(0.4)	0.1
Finance, Performance & IT	(28.6)	(2.4)	(2.4)	(0.0)	(2.4)	(2.4)	(0.0)
Human Resources Directorate	(5.5)	(0.5)	(0.5)	(0.0)	(0.5)	(0.5)	(0.0)
Service Improvement	(8.1)	(0.7)	(0.6)	0.1	(0.7)	(0.6)	0.1
Pathology - STG	(11.2)	(0.9)	(1.0)	(0.1)	(0.9)	(1.0)	(0.1)
Strategy	(1.5)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
Chief Operating Officer	(0.6)	(0.0)	(0.2)	(0.1)	(0.0)	(0.2)	(0.1)
Total Corporate	(83.0)	(6.9)	(7.1)	(0.2)	(6.9)	(7.1)	(0.2)
Estates & Facilities							
Energy & Engineering	(11.1)	(0.9)	(0.9)	0.0	(0.9)	(0.9)	0.0
Estates	(12.3)	(1.0)	(1.1)	(0.0)	(1.0)	(1.1)	(0.0)
Estates Community Premises	(17.3)	(1.4)	(1.4)	(0.0)	(1.4)	(1.4)	(0.0)
Facilities Services	(4.2)	(0.3)	(0.4)	(0.0)	(0.3)	(0.4)	(0.0)
Hotel Services	(12.4)	(1.2)	(1.3)	(0.1)	(1.2)	(1.3)	(0.1)
Medical Physics	(2.7)	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0
Project Management	(0.3)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Rates	(2.1)	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0
Total Estates & Facilities	(62.4)	(5.4)	(5.5)	(0.1)	(5.4)	(5.5)	(0.1)
Total Overheads	**(145.4)**	**(12.3)**	**(12.6)**	**(0.2)**	**(12.3)**	**(12.6)**	**(0.2)**

Overheads Summary

At Month 1, the Overheads Division showed deficit of £12.6m against a planned of £12.3m, an adverse variance of £0.2m.

Corporate

Reported variance for the department are explained below:.

- Nursing: International recruitment costs lower than the budget which is profiled in 1/12's. Pay costs lower due to vacancies.
- Service Improvement: Transformation recruitment still on-going to cover substantive vacancies.
- Pathology: Overspends relating to Blood issues.
- Chief Operating Officer: Additional cost of interims covering RTT, Planned Care and Cancer targets.
- Finance: Vacancies held in IT and Finance are above level of spend on interims covering senior roles until May.
- HR: Increased costs for agency recruitment fees are offset by increased income in Education for Simulation Services.

Estates & Facilities

Adverse variance in April of £0.1m due to:-

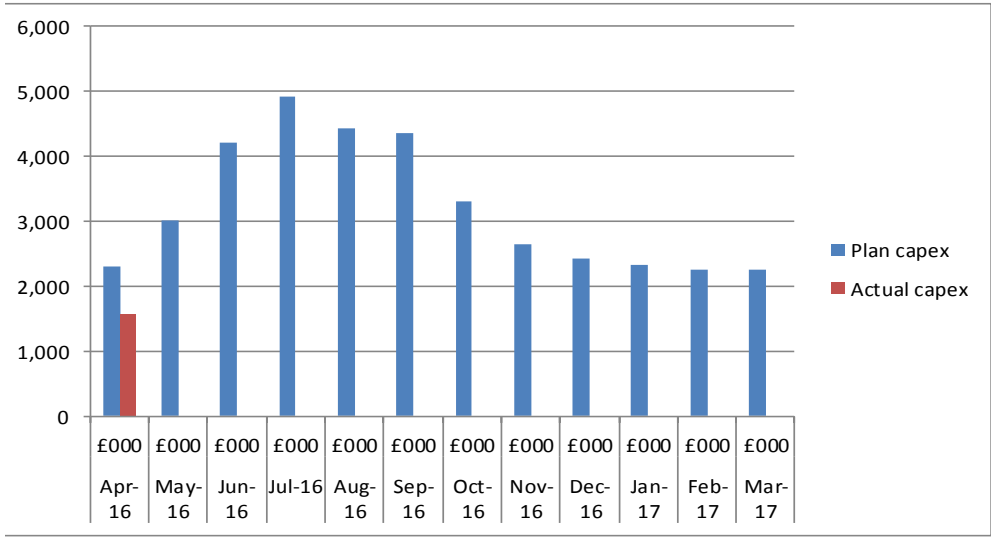
- Hotel Services: Loss in taking on new retail catering service from April 16.

Note:

- Required pay run-rate savings of 0.1m in month achieved within Corporate areas

14. Capital 2016/17

Capital programme 2016/17 - budget and actual expenditure per month



Capital programme 2016/17

Exp category	Budget Contracted £000	Budget Charity £000	Budget Essential £000	**Total Budget £000**	Actual M01 exp £000
IMT	2,617		2,554	**5,172**	580
Infra Renewal	671		7,221	**7,892**	118
Infra Renewal EPC	11,556			**11,556**	0
Major Projs	3,047	660	3,096	**6,804**	714
Med Eqpt		1,048	3,795	**4,843**	114
Other			2,031	**2,031**	0
SWL PATH			183	**183**	39
Grand Total	**17,891**	**1,708**	**18,880**	**38,480**	**1,565**

- A risk evaluation and ranking process was carried out by the Investment, Divestment and Disinvestment Group. The resulting opening draft 2016/17 draft capital programme (£30.028m) was then endorsed by the Executive Management Team (EMT) in February.
- The figures include the carry forward for 2015/16 slippage arising since the risk evaluation and ranking process was completed and the updated total budget is £38.4m.
- There is a contingency of £2m included within the overall capital programme. This is included within the spend category “Other” and is currently unallocated.£90k of the contingency has been committed to date.
- The £38.4m total includes capital value of new finance leases of £3.6m
- Capital expenditure in April was £1.6m, an under spend of £0.7m relating mainly to the energy performance contract.

15. Cash balance and WCF drawdowns vs plan

Cash balance

	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	29-Feb	31-Mar
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
2015/16 Plan cash	*13,094*	4,767	3,000	3,000	3,000	3,000	3,000	3,000	3,000	6,209	3,000	3,000
Actual/forecast cash	*12,922*											
Cash bal fav / (adv) variance to plan	*-172*											

Working Capital Facility - drawdowns within cash balance above

	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	29-Feb	31-Mar
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Plan drawdown cumulative	*0*	*0*	6,667	13,141	18,931	25,616	26,159	27,012	30,960	30,960	30,994	32,455
Actual drawdown - cumulative	*0*											
WCF cum drawdowns fav / (adv) variance to plan												

Overall Cash fav / (adv) variance to plan	***-172***											

Secured unused borrowing capacity as at 30/04/16

	Facility £000	Drawn at 31/03/16 £000	Secured borrowing capacity £000
linterim Revenue Support Loan	48,700	40,396	8,304
Working Capital Facility	25,000	0	25,000
Total	**73,700**	**40,396**	**33,304**

- The M01 actual cash balance was £12.9m which is £0.2m behind plan.
- LEEF loan impact: The cash balance at 30th April includes £11.6m unexpended LEEF loan for the energy performance contract and so the cash balance excluding LEEF would be: +£1.3m
- The Trust must maintain a cash balance > £3m under the terms of its borrowing facility.

CASH RISK

- The Trust has sufficient secured borrowing capacity ***if the planned deficit of £17.2m is met however there is only £0.8m cash headroom (£33.3m borrowing capacity - £32.5m planned borrowing requirement) and so the Trust is seeking additional borrowing facilities to provide*** approx £20m cash headroom to mitigate the risks relating to the receipt of the £17.6m sustainability and transformation funding (which is assumed in the £17.2m deficit plan) and the delivery of the 2016/17 CIP targets.

16. Analysis of cash movement

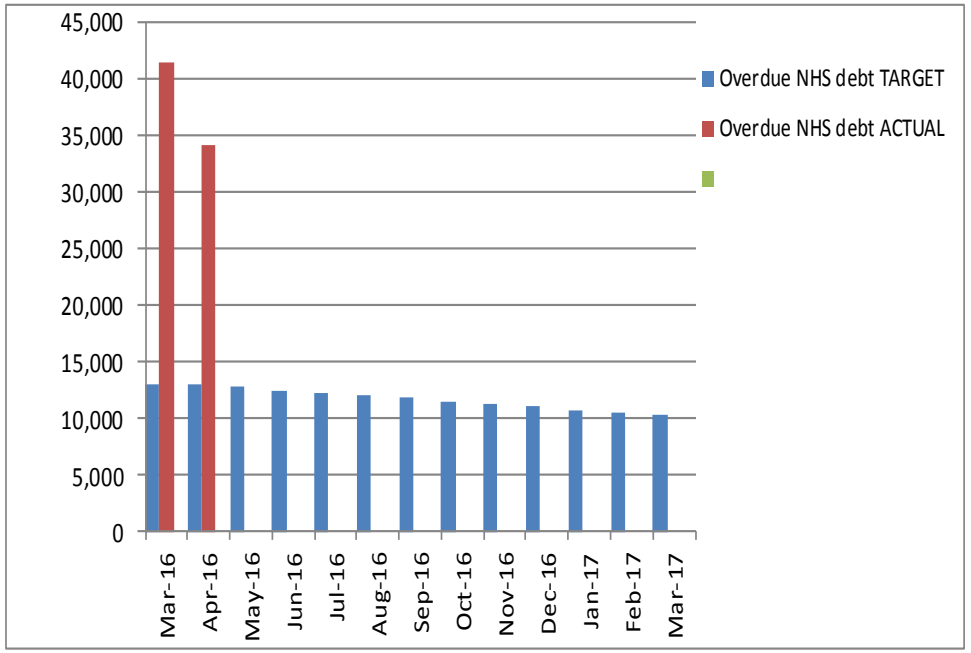
	Actual vs Plan YTD		
	Plan YTD £m	Actual YTD £m	Actual YTD VAR £m
Opening cash 01.04.16	7.4	7.4	
Operating surplus/-deficit	-3.3	-5.3	**-2.0**
Sale proceeds - asset disposals	0.0	0.0	**0.0**
Operating surplus/-deficit after disposals	**-3.3**	**-5.3**	**-2.0**
Change in stock	-0.3	-0.9	**-0.6**
Change in debtors	-0.2	-0.3	**-0.1**
Change in creditors	11.8	13.9	**2.1**
Net change in working capital	11.4	12.7	**1.4**
Capital spend (excl leases)	-1.9	-1.4	**0.5**
Other	-0.4	-0.5	**-0.1**
Investing activities	-2.3	-1.9	0.5
WCF/ISF borrowing	0.0	0.0	**0.0**
Closing cash 30.04.16	13.1	12.9	-0.2

- The cash movement table above compares the actual outturn cash movement for M01 with plan
- The better performance on working capital (+£1.4m) and cash under spend (+£0.5m) on the capital programme offset the adverse cash impact of the higher operating deficit (-£2m) enabling the Trust to maintain a cash balance at M01 broadly in line with plan.

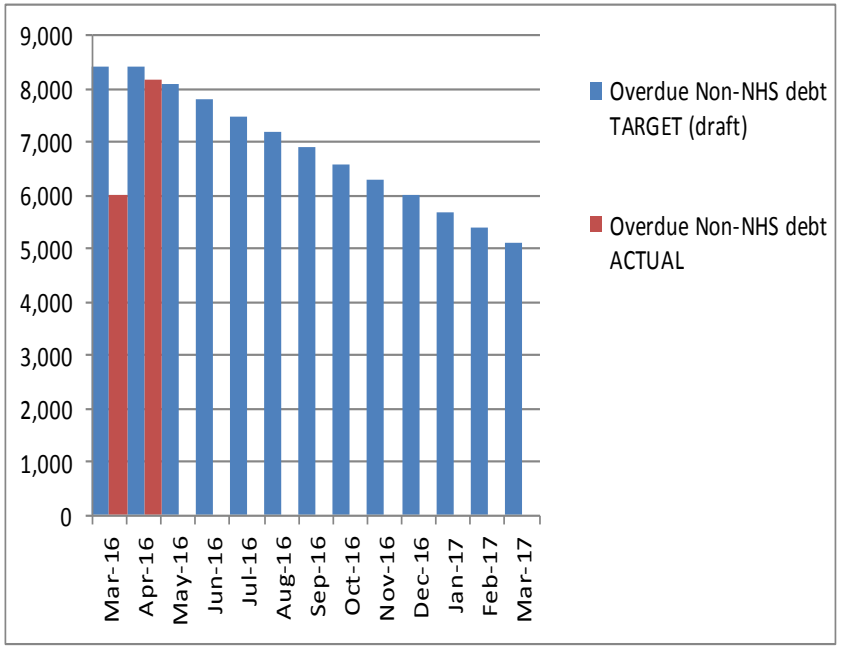
17. Debt management

- The Cash Committee has approved new "stretch" debt reduction targets for overdue debt (over 30 days old) for 2016/17.
- NHS overdue debt reduced in April by approx £7.3m however this related primarily to credit notes raised for NHS England
- The Trust is aiming to collect outstanding 2015/16 debt from NHSE by the end of June.
- Non-NHS debt increased in April but remains below the target level.
- **It should be noted the overdue debt targets below are 'stretch' targets and on the grounds of prudence the cash flow plan for the year does not assume they are met.**

Overdue NHS debt: performance vs stretch reduction targets



Overdue non-NHS debt: performance vs stretch reduction targets



18. Balance sheet as at month 01 2016/17

Balance sheet April 2016

	Apr-16 Plan £000	Apr-16 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	337,516	336,767	*749*	Lower capital expenditure than plan - so lower fixed assets
Stock	6,537	7,132	*-595*	Pharmacy increased stock after big reduction made for year end.
Debtors	67,718	67,842	*-124*	Debt balances in line with plan.
Cash	13,094	12,917	*177*	Cash in line with plan despite higher I&E deficit for M01: better performance on working capital.
Creditors	-95,353	-97,436	*2,083*	Lower supplier payment runs in April.
Capital creditors	-2,933	-3,098	*165*	
PDC div creditor	-520	-398	*-122*	
Int payable creditor	-378	-372	*-6*	
Provisions< 1 year	-512	-512	*0*	
Borrowings< 1 year	-6,419	-6,360	*-59*	
Net current assets/-liabilities	**-18,766**	**-20,285**	*1,519*	
Provisions> 1 year	-1,036	-1,058	*23*	
Borrowings> 1 year	-131,249	-130,837	*-412*	Includes £40.4m ISF borrowed in 2015/16.
Long-term liabilities	**-132,285**	**-131,895**	*-390*	
Net assets	**186,466**	**184,587**		
Taxpayer's equity				
Public Dividend Capital	129,520	129,520	*0*	
Retained Earnings	-42,686	-44,431	*1,745*	Higher I&E deficit than plan
Revaluation Reserve	98,482	98,348	*134*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**186,466**	**184,587**		

19. Borrowings analysis at M01

Borrowings summary - APRIL 2016

	Lender	Description	Interest rate fixed/variable	Interest rate pa	Term	Repayment terms	Maximum Facility value £000	Borrowings repay<1 yr at 30/04/16 £000	Borrowings repay>1 yr at 30/04/16 £000	Borrowings at 30/04/16 £000
	Loans									
1	Dept of Health	Capital loan	Fixed	2.20%	25 yrs	Repayable in bi-annual instalments	-14,747	-601	-13,850	-14,451
2	Dept of Health	Working capital loan	Fixed	1.38%	15 yrs	Repayable in bi-annual instalments	-15,000	-999	-13,002	-14,001
3	Dept of Health	Working cap facility	Variable: base rate+1%	1.50%	5 yrs	100% repayable on 18/04/20	-25,000	0	0	0
4	Dept of Health	Working cap facility	Variable: base rate+3%	3.50%	5 yrs	100% repayable on 21/09/20	-19,600	0	0	0
5	Dept of Health	Interim revenue support facility	Variable: base rate+1%	1.50%	2 years	100% repayable March 2018	-48,700	0	-40,396	-40,396
6	London Energy Effic. Fund	Capital loan	Fixed	1.50%	10 yrs	Repayable in bi-annual instalments	-13,303	-1,478	-11,086	-12,564
	Loans - total							-3,078	-78,334	-81,412
	Leases									
7	Blackshaw Health. Servs PL	PFI scheme	Implicit rate	7.50%	35 yrs	Repaid monthly in unitary charge	N/A	-933	-44,576	-45,509
8	Various lessors	Finance leases	Implicit rates	3%-7.5%	Various	Repaid quarterly or annually	N/A	-2,349	-7,927	-10,276
	Leases - total							-3,282	-52,503	-55,785
	Total Borrowings							-6,360	-130,837	-137,197

Notes

1 DH capital loan £14.747m approved in 2014 for bed capacity projects, hybrid theatre, surgical assessments unit etc.

2 Working capital loan £15m: approved in January 2015 on licensing of Foundation Trust status to boost Trust's working capital resilience. Drawn down in full in March 2015

3 Working capital facility £25m approved in January 2015 on assumption of Foundation Trust status. Drawn down in tranches July - Sept 2015 inclusive.
This facility was repaid in full on 15th February 2016 using funds drawn from the interim revenue support facility (see no. 5). The facility remains available.

4 Working capital facility £19.6m approved in September 2015 to provide cash support for period October 2015-January 2016 inclusive pending agreement of interim revenue support funding.
This facility was repaid on 15th February 2016 usinhg funds drawn from the interim revenue support facility (see no. 5). This facility is not currently available.

5 Interim revenue support facility £48.7m approved in February 2016.
The Trust drew down £36.396m from this facility on 15th February 2016 and repaid the amounts drawn under the working capital facilities per 3. and 4. above as set out in the paper approved by the board on 4th February.

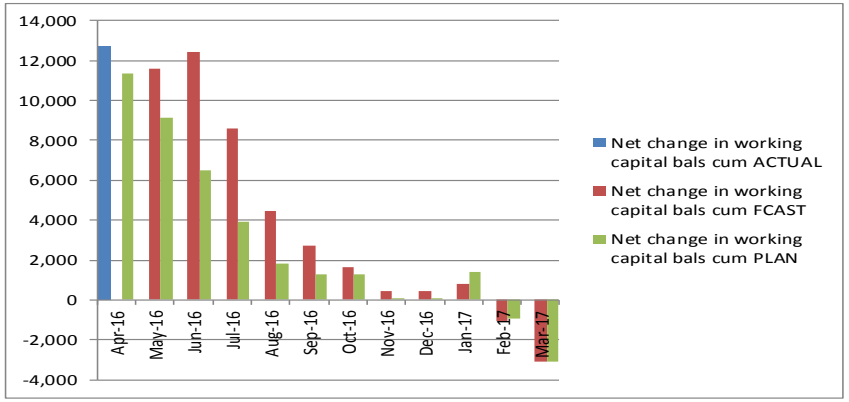
6 London Energy efficiency Fund loan for the energy performance contract.

7 AMW PFI building is accounted as on-balance sheet. The 'borrowing' figure for the lease represents the capital value of the building, fixtures and fittings encompassed in the PFI contract.

8 Finance leases for medical equipment - eg major diagnostic equipment. The capital value of new finance leases represents capital investment and is reported as such in the capital programme.

20. Working Capital – cumulative position at M01

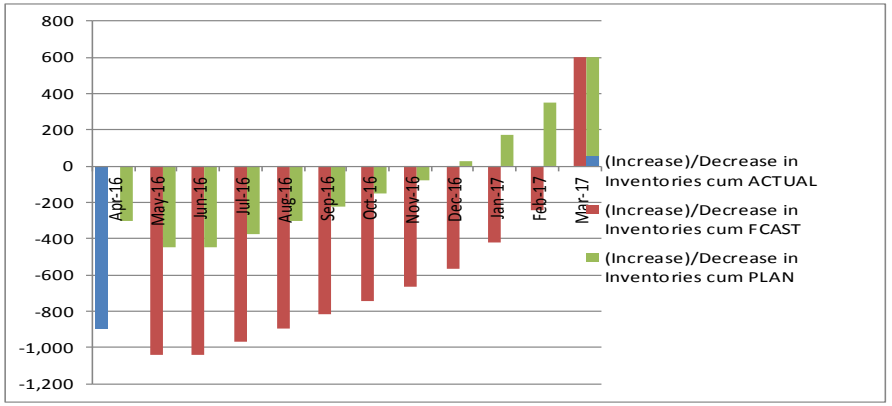
Change in all working capital balances 2016/17 actuals vs plan



£1.4m BETTER than Plan. Lower payment runs to suppliers and receipt of £8.4m HEE Q1 monies in April.

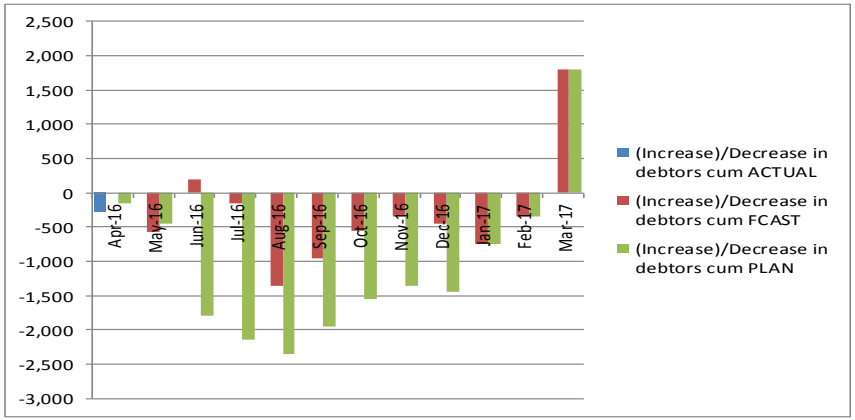
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories (stock) 2016/17 actuals vs plan



£0.6m WORSE than Plan. Stock increased by Pharmacy after significant year end reduction.

Change in debtors 2016/17 actuals vs plan



IN LINE WITH PLAN.

Trust is seeking 'early' settlement of outstanding 15/16 NHSE debt by 30th June.

Change in creditors 2016/17 actuals vs plan

£2.1m BETTER than Plan.

Lower payments to suppliers in April and trust has re-negotiated deferral of CNST premiums with NHSLA again this year (payment holiday in Q1)

21. Financial Sustainability Risk Rating (FSRR)

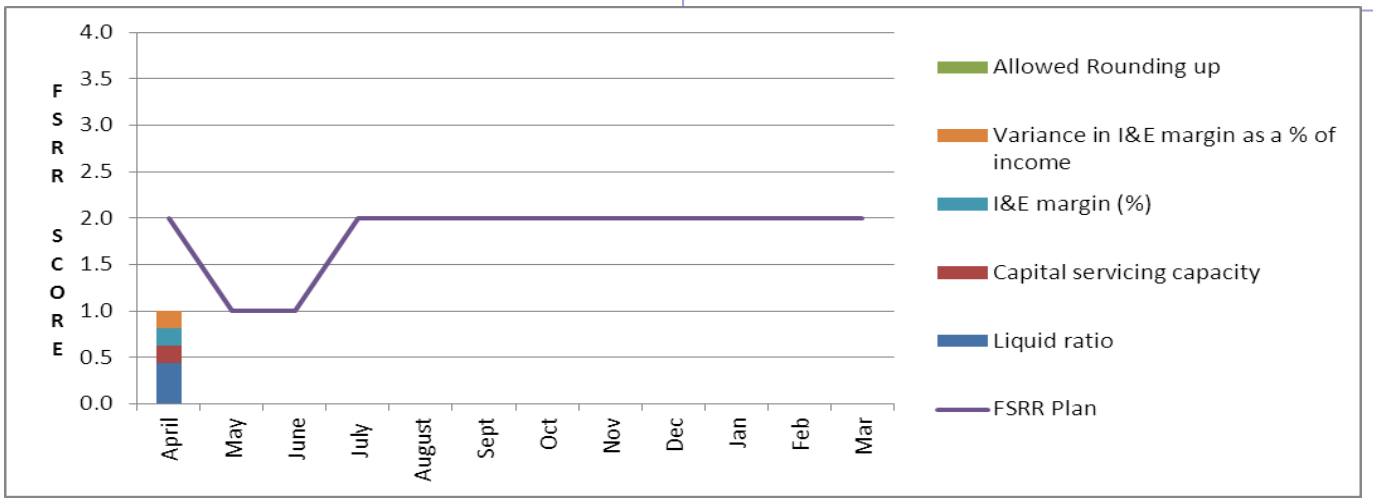
2016/17 ACTUALS	Month
Metric Scores (4 best, 1 worst)	April
Liquid ratio	2
Capital servicing capacity	1
I&E margin (%)	1
Variance in I&E margin (%)	1
Weighted Average	1.3
Overriding Score (with rounding)	1

2016/17 PLAN	2

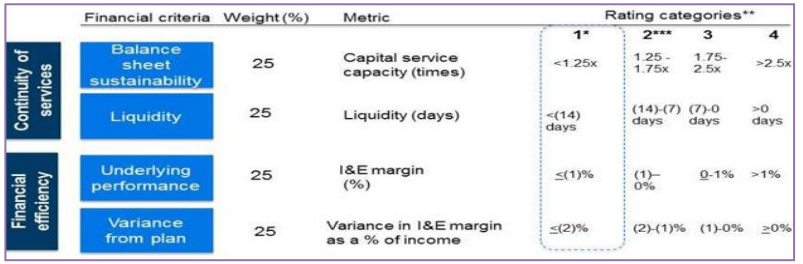
In April the Trust achieved a score of 1 for its risk rating which is behind the planned rating of 2.

Ratings for capital servicing, I&E margin and liquidity are in line with planned scores of 1,1 and 2 respectively.

The Variance against plan for April is 3.1% of Income. The NHSI plan reflects an expected variance of 1.2% based on last year's performance against the original plan submitted.



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%

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***June 2016***

Paper Title:	Risk and Compliance report for Trust Board incorporating: 1. Corporate Risk Register 2. External assurances
Sponsoring Director:	Jennie Hall, Chief Nurse/DIPC
Author:	Maria Prete, Risk Manager Sal Maughan, Head of Risk/ Governance
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.
- There are currently two new risks under risk assessment
- Controls are developed for all risks, with a rolling programme of review by QRC

Assurance:

- Details of external assurances are included within the report
- The Trust is currently preparing for re-inspection by the Care Quality Commission in June 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.

Table one: highest rated risks (detailed controls at appendix 2)

Ref	Description	C	L	Rating ↓↑
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 →**
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	**4**	**5**	**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 →**
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 →**
5.1-03	Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes	**5**	**4**	**20 →**
A520-04	Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	**4**	**5**	**20 →**
5.1-06	Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce	**4**	**5**	**20 →**
3.13-05	Working capital – the trust will not be able to secure the working capital necessary to meet its current plans	**5**	**4**	**20 →**
3.18-05	Cost pressure – the trust faces higher than expected cost	**4**	**5**	**20 →**
05-07	Risk to the success of the turnaround and the transformation programme in the event that there is a lack of engagement across the workforce	**5**	**4**	**20 →**
05-06	Risk of loss of Trust data due to malware known as 'Ransom ware'	**4**	**5**	**20 →**

1.1 New risks proposed for inclusion on the CRR

There are two risks previously identified which are currently undergoing risk assessment:

- Resource and capacity to support women of non-child bearing age subject to FGM (Corporate Nursing)
- Resource and capacity to support Safeguarding Adults (DOLS) agenda: escalated via Patient Safety Committee (Corporate Nursing)

A further potential risk has been identified via the Quality and Risk Committee (26th May) in relation to Consultant attribution and a risk assessment will be undertaken.

At the previous meeting, the board queried whether the closing of the risk was appropriate in view of the discussion on 2016/17 financial plan:

- 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

The Director of Finance has confirmed it is appropriate to close this risk and to open a new risk, a risk assessment is also underway.

1.2 Risks proposed for closure

Two risks have been proposed for closure, the rationale is included at Appendix 1:

Table four: closed risks

Ref	Risk
01-18	**Blood track system** - Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products
01-21	**Draft discharge summaries sent to GPs** - Patient care is compromised and incorrect prescribing occurs because General Practitioners receive draft copies of discharge summaries

1.3 Change to risk description/scores

At the previous meeting, the board required for the risk description of risk 01-13 to be reviewed:

Previous risk description (01-13)	Reviewed risk description (01-13)
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	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. Backlog maintenance issues, ventilation and heating unreliability and low levels of theatre utilisation all driving efficiency issues and therefore reducing available capacity. Potential for commissioner challenges and financial penalties Adverse reputation

In addition, the previous meeting, the board requested that the scoring for the following risk be reviewed.

- 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) (C4xL4 = 16)

This review has now been undertaken by the Director of Estates and Facilities who has confirmed the current risk scoring and profile is unchanged and that there is a mitigation plan which the team are working to deliver.

1.4 Summary of risks by score and domain

There are 54 risks on the CRR of which 35 are extreme (a score of 15 or above). Of these extreme risks, 11 sit within the domain of Quality and seven within Finance and Operations. Of the total risks on the CRR, 62% relate to Quality.

Fig 1&2: CRR Risks by score and domain

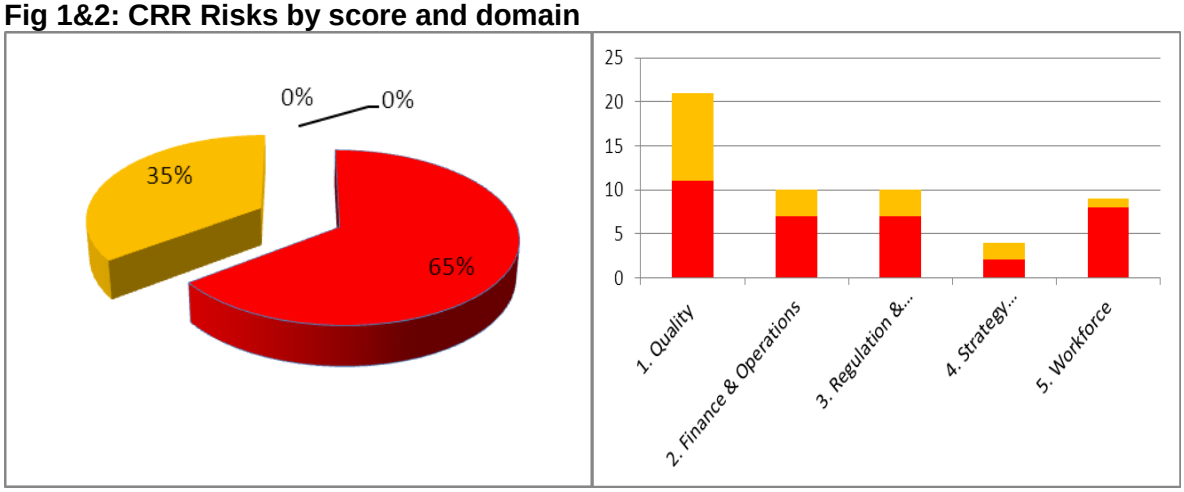


Table five: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Mod)	0-3 (low)	Total
1. Quality	11	10	0	0	21
2. Finance & Operations	7	3	0	0	10
3. Regulation & Compliance	7	3	0	0	10
4. Strategy Transformation & Development	2	2	0	0	4
5. Workforce	8	1	0	0	9
Total	**35**	**19**	**0**	**0**	**54**

2. Assurance Map

2.1 Care Quality Commission (CQC) – preparation for inspection

The Trust will undergo a full announced inspection by the CQC on 21st – 23rd June 2016. A core delivery team is in place with work stream and core service leads reporting to a weekly steering group meeting. A project team is also in place to support the readiness project with support from the KPMG team. Identified work stream leads are in place for Governance, Quality, Communications, Estates and Environment, ICT, HR and Medicines Safety.

In addition there are dedicated divisional leads and core service leads for each of the 12 core services to be inspected across acute and community sites.

The work being undertaken by the trust includes the following:

- Programme of IT works focusing on improving infrastructure in wards and departments, and clearing a backlog of issues
- Increased leadership of senior nursing staff through a back to the floor programme and increased quality inspections with executive input on a daily basis
- Enhanced ward leadership support to ward managers and matrons to ensure they are supported to demonstrate the characteristics of well led
- Focussed medicine safety programme with weekly audits covering key areas for improvement
- End of Life Care strategy and a 'Dying Matters' week of focussed activity
- Programme to enhance incident reporting and feedback mechanisms including focus upon Duty of Candour with bespoke training
- Trust wide programme to ensure all policies and procedures are in date and fir for purpose with newly built micro-site to ensure accessibility for all staff
- Mandatory training improved from around 50% to 78% to date with the aim to reach 85% compliance by June

The corporate team are now undertaking a programme of re-visits to ward sand departments previously inspected to ensure actions have been addressed and to support ward managers and teams to address any outstanding issues not yet resolved.

2.2 External assurance and third party inspections: May 2016

2.2.1 OFSTED Inspection

From 1st May 2016, Ofsted and CQC will start to carry out inspections regarding services efficacy in identification, meeting needs and improving outcomes for children and young people with special educational needs and or disabilities. It is expected that the London Boroughs will be the first to be

inspected. The Trust has provided the required information for the Special Education Needs and Disability (SEND) to WCCG as directed. The final report is expected.

2.2.2 Patient Led Assessment of the Care Environment (PLACE)

The PLACE assessments took place on Friday 6 May and Monday 9 May. There were 11 teams who assessed several areas (wards, outpatients, communal areas / grounds and gardens including the walk in the wild side garden, departure and transport lounge) within Atkinson Morley Wing, Lanesborough Wing, St. James Wing, Knightsbridge Wing as well as External areas. The final report is expected in a few months.

2.2.2 Environment Agency (EA) – Environment Permitting Regulation (EPR 2010)

EA inspects the safety of working environments and compliance with Trust radioactive materials permits and compliance with EPR 2010. The inspection was undertaken on 19th May 2016. No non-compliances were reported. The final report is expected

2.3 Statutory Notifications - External reporting

2.3.1 Radiation incident

On 6th May 2016 an incident was reported to the CQC as required under Regulation 4(5) of the Ionising Regulation (Medical Exposure) Regulations 2000.

A patient receiving a radiation dose much greater than intended due to identification checks not being fully carried out as per policy. The unintended dose is equivalent to approximately 10 months of exposure to natural background radiation, based on the UK average.

A RCA investigation was carried out and the report was sent to the CQC. The CQC has closed its file on this incident on the understanding that the recommendations from the investigation have been, or are being, implemented and that on-going monitoring is in place to minimise the risk of a similar incident occurring in the future.

The Board should note that this additional notifiable incident under IRMER regulations may invite additional scrutiny when under CQC inspection, when viewed in conjunction with the concerns the CQC are already aware of in relation to radiation safety arising from the HESL visit late 2015.

3. Conclusion

The programme of detailed review of risks included on the Corporate Risk Register continues in order to provide stronger assurance to the Board around the management of risks. There are an increasing number of risks to patient safety and experience identified arising from issues related to estates management and IT infrastructure.

The overall long-term risk profile for the trust continues to be driven by the continued financial and operational pressures faced by the trust and the transformation programme

There have been no significant issues highlighted as a result of external inspections or reviews, however an extensive preparation project ahead of CQC inspection in June 2016 is underway, supported by a small team from KPMG; this encompasses an intensive internal inspection programme which will be triangulated with external inspection findings on an on-going basis.

Appendix 1: Executive Overview of Corporate Risk Register
Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Start date	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	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	CS	11/2012	20	20	20	20	**16**	**16**	→	
01-13 Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	CS	11/2014	20	20	20	20	**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	CS	11/2014	16	16	16	16	**9**	**9**	→	
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	05/2010	12	12	12	12	**12**	**12**	→	
01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	RH	07/2013	9	9	9	9	**9**	**9**	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	RH	01/2014	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	05/2014	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	05/2014	12	12	12	12	**12**	**12**	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	CS	05/2014	20	20	20	20	**10**	**10**	→	
01-07 Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	CS	06/2014	20	20	20	20	**16**	**16**	→	

01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	AR	07/2014	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	RH	10/2014	12	12	12	12	**12**	**12**	→	
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments	CS	06/2015	16	16	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	AR	07/2015	20	16	16	16	**16**		**Closed**	Proposed closure. New blood track system put in place and working
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.	RH	07/2015	16	16	16	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.	RH	07/2015	12	12	12	12	**12**	**12**	→	
01-19 Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment	JH	11/2015		20	20	20	**15**	**15**	→	
01-20 Potential risk to staff and patient safety in the event of a failure of the Trust to meet its requirement of IR(ME)R or other IRR requirements.	AR	01/2016				12	**12**	**12**	→	
01-21 Patient care is compromised and incorrect prescribing occurs because General Practitioners receive draft copies of discharge summaries	AR	03/2016				15	**15**		**Closed**	Proposed closure. Control put in place. Drafts are no longer sent to the GP as they are blocked
01-22 Potential risk to patient safety due to a failure to ensure all Trust policies are up to date and available to all staff	LE	03/2016				16	**16**	**16**	→	
01-23 Patient Safety risk due to electrical infrastructure in Knightsbridge Wing in danger of major failure. A recent large	RH					16	**16**	**16**	→	

failure of an electrical panel caused the wing to be evacuated										

Strategic Objective/Principal Risk	Lead	Start date	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	In month change	Change/progress
1.2 Patient Experience									↓↑	
A410-O2: Failure to sustain the trust response rate to complaints	JH	04/2009	16	16	16	16	**16**	**16**	→	
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	AR	07/2013	16	16	16	16	**16**	**16**	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	Lead	Start date	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	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	NC	07/2015	10	10	10	10	**20**	**20**	→	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.	NC	07/2015	10	10	10	10	**10**	**10**	→	
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives	NC	07/2015	15	15	15	15	**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	NC	07/2015	16	16	16	16	**20**	**20**	→	

3.19-05 Cash-flow Risks – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends	NC	07/2015	16	16	16	16	**16**	**16**	→	
3.20-05 Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.	NC	07/2015	20	20	20	20	**20**	**20**	→	
3.21 Transformation resources are of insufficient capacity and/or capability to deliver the expected benefits in 16/17	IL	03/2016				16	**16**	**16**	→	

Strategic Objective/Principal Risk	**Lead**	**Start Date**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**May 2016**	**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:	SM	05/213	20	20	20	20	**20**	**20**	→	
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	IL	06/2013	12	12	12	12	**12**	**12**	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	IL	07/2014	12	12	12	12	**12**	**12**	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	**Lead**	**Start date**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**May 2016**	**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	10/2010	5	15	15	15	**15**	**15**	→	
A537-O6:Confidential data reaching unintended audiences	AR	10/2010	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	AR	10/2011	15	15	15	15	**12**	**12**	→	
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)	RH	03/2013	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	RH	10/2012	12	12	12	12	**12**	**12**	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	RH	05/2014	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.	RH	05/2014	16	16	16	16	**16**	**16**	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	RH	05/2014	12	12	12	16	**16**	**16**	→	
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	08/2015	15	15	15	15	**15**	**15**	→	
03-07 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)	LE					15	**15**	**15**	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	**Lead**	**Start Date**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**Apr 2016**	**May 2016**	**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	09/2010	12	12	12	12	**10**	**10**	→	

Strategic Objective/Principal Risk	Lead	Start Date	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	In month change	Change/progress
4.4 Provide excellent & innovative education to improve patient safety, experience & outcome									↓↑	
05-07 Risk to the success of the turnaround and the transformation programme in the event that there is a lack of engagement across the workforce	RE	05/2016					**20**	**20**	→	

Strategic Objective/Principal Risk	Lead	Start date	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	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.	AR	03/2013	8	8	8	8	**8**	**8**	→	

Strategic Objective/Principal Risk	Lead	Start date	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	In month change	Change/progress
4.6 Improve productivity, the environment & systems to enable excellent care									↓↑	
05-06 Risk of loss of Trust data due to malware known as 'Ransom ware'	IL	07/04/2016					**20**	**20**	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Start date	Oct 2015	Nov 2015	Jan 2016	Mar 2016	Apr 2016	May 2016	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	05/2010	16	16	16	16	16	**16**	→	
A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	WB	11/2012	9	9	9	12	12	**12**	→	
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	05/2010	16	16	16	20	20	**20**	→	
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	11/2015	16	20	20	20	20	**20**	→	
5.1-02 Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.	WB	12/2015		15	15	15	**15**	**15**	→	
5.1-03 Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes	WB	12/2015			20	20	**20**	**20**	→	
5.1-04 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	WB	12/2015			16	16	**16**	**16**	→	
5.1-05 Lack of success of the transformation programme without sufficient organisational support	WB	03/2016				16	**16**	**16**	→	
5.1-06 Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce	WB	04/2016				20	**20**	**20**	→	

JH	Jennie Hall	Chief Nurse (DIPC)	RH	Richard Hancock	Director of Estates & Facilities
AR	Andrew Rhodes	Medical Director	RE	Rob Elek	Director of Strategy
CS	Corinne Siddall	Chief Operating Officer	WB	Wendy Brewer	Director of Human Resources
NC	Nigel Carr	Director of Finance	IL	Iain Lynam	Chief Restructuring Officer
LE	Luke Edwards	Head of Corporate Governance	SM	Simon Mackenzie	CEO

Appendix 2: Significant CRR risks (Score >20): detailed controls

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. Backlog maintenance issues, ventilation and heating unreliability and low levels of theatre utilisation all driving efficiency issues and therefore reducing available capacity. Potential for commissioner challenges and financial penalties Adverse reputation				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	Update April 2016	**Exec Sponsor**	Chief Operating Officer, Corinne Siddall
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:** Appointed Chief Operating Officer Flow programme in place with 10 work streams Undertaken a deep dive diagnostic into all major performance areas which has resulted in action plans with performance trajectories Current programme of bed-remodelling designed to ensure correct distribution of beds in order to increase efficiency of bed use leading to greater flow and reduced bed occupancy rates New ways of managing flow have been introduced with changes to way sin which site management team operate and three times daily safety huddles focussing on timely discharge	**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.
Gaps in controls	Maintenance of theatres behind plan for a number of years, leading to a materialised 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		

Finance & Performance Domain 2.1 Meet all financial targets

Principal Risk	**3.13-05 - Working capital** – the Trust will not be able to secure the working capital necessary to meet its current plans				
Description	The Trust's current income and expenditure plans will require more cash than can be met from the current loan/ working capital facility arrangement				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Nigel Carr
Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	2	4	**Date closed**	
Score	20	10	20		
Controls & Mitigating Actions	Working Capital Management, reporting and forecasting • Monthly Cash flow forecasts report the impact of the Trust's financial performance on the Trust's cash position **Distressed Trust Regime** • The current provider management regime allows for FTs to seek interim Support when in financial difficulty. • Such support is defined within Secretary of State's guidance under section 42A of the National Health Service act 2006 (Section 42A Guidance - https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts). It is used to provide transitional financial support to an FT or NHS			**Assurance**	No identified assurance

	Trust in financial difficulty where it is necessary to support the continued delivery of services for a period during which an assessment of the underlying problem is carried out and a Recovery Plan is developed which forecasts a return to a financially sustainable position. **Mitigating Actions:** Minimising Support requirement • Through the cost pressure process, the Trust is endeavouring to ensure that increases in the requirement for new revenue expenditure are minimised – in progress – managed by Investment Divestment and Disinvestment Group (IDDG) • 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.		
Gaps in controls	As yet there is no application for interim financial support	**Gaps in assurance**	
Actions next period:	Update financial plan to F+P in April 2016 and Trust Board (TB) May 2016		

Principal Risk	**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				
Description	▪ The Trust has to meet costs of unforeseen changes in service requirements for example the on-going and evolving understanding of meeting requirements associated with Francis Report outcomes or other compliance requirements. The cost of meeting new and existing service standards are higher than expected. ▪ Inflationary cost pressures are greater than expected e.g. changes in energy prices, impact of incremental drift etc. ▪ Premium costs related to the supply of scare resources e.g. cost of agency nurses due to nursing staff shortages				
Domain	**2.Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Nigel Carr
Consequence	4	4	4	**Date opened**	20/07/15
Likelihood	4	4	5	**Date closed**	

Score	16	16	20		
Controls & Mitigating Actions	**Controls** ▪ Business Planning Process and Business planning steering group - the expected impact of cost pressures on financial performance is considered and robust provisions are made for future increases in cost in line with high level Guidance from Monitor. ▪ IDDG taking role of managing cost pressures ▪ Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover ▪ EMT and Business Planning Steering Group oversight of the business planning process. ▪ Monitoring of cost pressures in-year through the financial reporting regime. New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee. ▪ Vacancy control panel ▪ Costs are based on data from robust historical costing systems including PLICS and Reference Costs which have been calculated in line with national guidance. **Mitigating actions** ▪ Reduced use of external capacity by better capacity planning and management of internal resources. ▪ Detailed Agency expenditure tracking ▪ The Trust has a number of actions it can deploy to recover its financial position if it is adversely affected by cost pressures, e.g. vacancy freezes, controls on discretionary expenditure, etc.			**Assurance**	Monthly financial reporting of performance to the Board Identification and review of cost pressures through the Business Planning cost pressure review process.
Gaps in controls	Workforce and financial plans do not explicitly reflect the level and premium costs of agency staffing.			**Gaps in assurance**	

Actions next period:	▪ Completion of 2016/17 Reforecasting process and 2017/18 business planning process ▪ Paper to F+P in April 2016 and Trust Board in May 2016

Principal Risk	**3.20-05 Income Volume Risk (Capacity and Trajectory)** – 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 ▪ Impact of Estate problem and maintenance programme ▪ Impact of industrial action on clinical capacity ▪ Performance against access target trajectory (RTT – A&E) where S+F funding is at risk				
Domain	**2.Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Apr 2016**	**Exec Sponsor**	Nigel Carr
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 ▪ OMT, EMT, TAB and Trust board oversight of Flow and Capacity plans and delivery **Mitigating actions:** ▪ Transformation plans / capacity and flow programme	**Assurance**	▪ Reporting of performance against planned SLA income and activity targets ▪ Live activity tracking via tableau ▪ Development of integrated demand and capacity model with scenario capabilities

Gaps in controls	▪ Integrated demand and capacity model	**Gaps in assurance**	Integrated demand and capacity model outputs to confirm capacity requirements
Actions next period:			

Finance & Performance Domain: 2.2 Meet all operational & performance requirements

Principal Risk	3.7-06 Failure to meet the minimum requirements of the NHSI Risk Assessment Framework may result in reputational damage or regulatory action.				
Description	There is a risk to patient safety and the Trust's reputation should it fail to perform against the Access Metrics set out by NHSI 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**	CEO, Simon Mackenzie
Consequence	4	4	4	**Date opened**	30/05/2013
Likelihood	4	5	5	**Date closed**	
Score	16	20	20		
Controls & Mitigating Actions	Chief Operating Officer appointed Weekly monitoring of ED, RTT and Cancer undertaken at Access board – now established Agreed trajectory with NHSE and NHSI and commissioners in place			**Assurance**	Positive assurance •Internal audit Following a period of joint investigation with commissioners, remedial action plans have been agreed for performance improvement in ED and RTT. Contract query notice served for cancer performance. 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 Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised
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

Strategy, transformation & development Domain: 4.4 Provide excellent & Innovative education to improve patient safety, experience & outcome

Principal Risk	05-07 Risk to the success of the turnaround and the transformation programme in the event that there is a lack of engagement across the workforce				
Description	Any transformation process or process of cultural and organisational change is dependent upon the workforce being engaged. A failure to ensure support systems for staff, through leadership and management actions and behaviours may result in derailment of the transformation programme or may limit the success.				
Domain	**4. Strategy Transformation & Development**			**Strategic Objective**	**4.4 Provide excellent & innovative education to improve patient safety, experience & outcome**
	Original	**Current**	**Update**	**Exec Sponsor**	Rob Elek
Consequence	5	5		**Date opened**	1.5.2016
Likelihood	4	4		**Date closed**	
Score	20	20			
Controls & Mitigating Actions	Engagement programme developed encompasses a number of actions to increase staff engagement across the trust in the short term in preparation for wider transformation change programme. Transformation change campaign has been developed about getting staff ready for the challenges and changes that the transformation programme will bring. Change campaign encompasses an organisational wide aspect and segment level (job role) aspect.			**Assurance**	Chair has signed off the engagement programme. Campaign to TAB on 15th February.
Gaps in controls	Overall budget and resource requirement not yet formally approved to support the campaign. Current resource to support project is limited. Success of project not solely within control of project/campaign team and is dependent upon wider management engagement and behaviours.			**Gaps in assurance**	No established KPIs/or framework to measure success Because there has been no opportunity to yet fully implement controls and roll out campaign, risk remains high
Actions next	Secure funding and resource for project				

period:	Develop of measurement and analysis framework/KPIs

Strategy, transformation & development Domain: 4.6 Improve productivity, the environment & systems to enable excellent care

Principal Risk	05-06 Risk of loss of Trust data due to malware known as 'Ransom ware'				
Description	A large increase in the computer malware known as "Ransom ware" is affecting Trust computer data. There is a high risk that data that has been affected will be lost if the affected files are not identified and restored within a short time frame.				
Domain	**4.Strategy Transformation & Development**			**Strategic Objective**	**4.6 Improve productivity, the environment & systems to enable excellent care**
Score	**Original**	**Residual**	**Updated Nov 2015**	**Exec Sponsor**	Ian Lynam
Likelihood	4			**Date opened**	07/04/2016
Consequence	5			**Date closed**	
Score	20				
Controls & Mitigating Actions	NHS N3 gateway anti malware software Local Websense anti malware software. Local Anti-virus software. User education and communication.			**Assurance**	ICT systems team restoring identified corrupt files from back-ups. Supplier informed and anti-malware suite security controls increased. Continuous monitoring of reported infections. Minimal data loss reported
Gaps in controls	Ransom ware infections continue to be reported			**Gaps in assurance**	
Actions next period:	Increase logical security of anti-malware applications. Trust wide comms campaign educating users not to open suspect or unexpected attachments in email.				

Workforce domain: 5.1 Develop a highly skilled & engaged workforce championing our values

Principal Risk	A520-04: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)				
Description	Loss of momentum caused by inability to release staff for training. Managers unable to ensure staff attending or undertaking eMast				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Updated Mar 16**	**Exec Sponsor**	Wendy Brewer
Consequence	4	3	4	**Date opened**	31/05/2010

Likelihood	3	4	5	**Date closed**	
Score	12	12	20		
Controls & Mitigating Actions	1. eMAST in place across the Trust. All managers are currently engaged in achieving compliance with target (all managers receive monthly reports on Core MAST take up and take action accordingly). New e-learning package being implemented and a new system for recording MAST will help ensure that all compliance activity is recorded. 2. eMAST training in place 3. Quarterly Mandatory training governance meeting includes Chief Nurse, Medical Director and Director of HR/OD to review content and staff cohorts of mandatory training 4. Implementation of new e-learning package and reporting systems. 5. Plan in place to deliver: • easy access to training • Well defined TNA • Accurate and trusted monitoring			**Assurance**	1. MAST policy Regular reports to ORC. Mandatory training rates to be reported on an individual subject basis in line with National Framework recommendations. 2. Uptake of eMAST training reports presented to ORC. 3. A report regarding the transition to the national framework has been presented to the Workforce Committee. 4. New subjects have been added to the requirements, which has had an impact on overall numbers but provides assurance that all nationally recognised mandatory items are now included in St George's mandatory training. 5. Internal Audit report received
Gaps in controls	Lack of capacity to deliver identified training – in particular face to face sessions e.g. Manual handling, Resus and Child safeguarding Level 3 Can't release the new e-learning system in Community			**Gaps in assurance**	
Actions next period:	New MAST Steering Group set up as task force to address continued risk to non- compliance with target Include mandatory training in the regular workforce meetings with Divisions as well as appraisal rates. Recovery trajectory managed through Workforce and education committee – 75% compliance by June and 85% by December - to be reported to Trust Board and Workforce education Committee				

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	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Director of Workforce and Organisational Development Chief Nurse for nursing workforce
Consequence	4	4	4	**Date opened**	10/2015
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 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.			**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 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

	Workforce plans form part of the annual business planning round.		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. The workforce and education committee: • Routinely review turnover plans form divisions review progress with the workforce plan including progress with reconciling the ledger to ESR. • Review progress on the nursing recruitment plan.
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:	Business case approved to recruit 150 nursing staff from Philippines. Complete medical establishment review – now underway Routine review of turnover plans form divisions at workforce and education Committee		

Principal Risk	5.1-03 Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes				
Description	Patient safety and experience may be negatively affected if the trust fails to adequately plan for junior doctor strikes. This may impact upon waiting times and ability to meet performance targets.				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Update Mar 2016**	**Exec Sponsor**	Wendy Brewer
Consequence	5	5	**5**	**Date opened**	1/12/2015
Likelihood	5	4	4	**Date closed**	
Score	25	20	20		
Controls & Mitigating Actions	Planning meetings underway for strikes – led by Chief Operating Officer. All Divisional plans from previous industrial action planning in December 2015 are being reviewed in preparation for new dates. Plans have been put in place for consultants and junior doctors not taking part in strike action to cover strike periods in order to maintain safe services. Where there is insufficient cover services will be cancelled. Decisions around whether to limit or cancel elective services and outpatient clinics are being communicated to patients but will remain under review in case the industrial action is called off at the last minute			**Assurance**	Divisional representatives are satisfied their plans are robust. Agreement with the BMA that their members will leave the picket line to provide help should there be an issue of patient safety. Strike action has been managed with no perceivable negative impact on business continuity
Gaps in controls	Future strike dates planned for January and February 2016. Limited ability to influence response to national agenda			**Gaps in assurance**	Uncertainty around effectiveness of actions until fully tested
Actions next period:	Continue on-going planning in relation to the recently announced industrial action dates. Risk remains given uncertainty around further strike action				

Principal Risk	5.1-06 Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce		
Description	Staff survey and medical engagement scores and results indicate a significantly reduced level of engagement amongst staff		
Domain	**5.Workforce**	**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**

	Original	Current	Update	Exec Sponsor	Wendy Brewer
Consequence	4	4		**Date opened**	1/4/2016
Likelihood	5	5		**Date closed**	
Score	20	20			

Controls & Mitigating Actions	Delivery of workforce action plan for 16/17 themes focus upon: - Staff feeling able to report concerns - Pressure felt by staff - Engagement & communication with leaders - Appraisal - Fairness - Bullying Support from staff side representatives and governors in engaging staff	**Assurance**	Negative Staff survey results and medical engagement score Progress against workforce action plan reports to Workforce and Education Committee
Gaps in controls	Limited ability to influence or mitigate external factors including; London wide issues of staff turnover, turnaround and financial position Levels of disengagement amongst managers make it difficult to effectively deliver the programme	**Gaps in assurance**	Difficult to ascertain level of management engagement
Actions next period:	Staff survey open session Review bullying and harassment policy Recruit from Philippines to alleviate staffing pressures		

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD - May 2016

Paper Title:	Board governance statements
Sponsoring Director:	Luke Edwards, Head of Corporate Governance
Author:	Luke Edwards, Head of Corporate Governance
Purpose:	To provide a summary of assurances available to inform the board's judgement of compliance with governance statements For the board to assess whether it can confirm compliance with annual governance statements, for submission to NHSI.
Action required by the committee:	To agree the level of compliance with the two governance statements outlined due to be submitted by 29th May or provide a commentary if the Board feels unable to do so.
Document previously considered by:	N/A

Key Messages

The Risk Assessment Framework (RAF) requires Foundation Trusts to submit a series of governance statements as part of the annual planning process. NHSI uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. Monitor will also assess the quality of the underlying planning processes.

NHS Foundation Trusts are required to make the following annual declarations to Monitor:

1 & 2 Systems for compliance with licence conditions – in accordance with General condition 6 of the NHS provider licence;

3 Availability of resources and accompanying statement – in accordance with Continuity of Services condition 7 of the NHS provider licence;

4 Corporate Governance Statement – in accordance with the Risk Assessment Framework;

5 Certification on AHSCs and governance – in accordance with Appendix E of the Risk Assessment Framework;

6 Certification on training of governors – in accordance with s151(5) of the Health and Social Care Act

For 2015/16 these statements are made in several submissions:
Declarations 1& 2 are to be submitted by 29th May;
Declaration 3 has been submitted as part of the annual planning process and agreed by the Board at 5th May.

Declarations 4, 5 and 6 are required to be submitted by 30th June.

These statements replace the board statements that NHS foundation trusts were previously required to submit with their annual plans under the Compliance Framework. Where facts come to light that could call into question information in the corporate governance statement, or indicate that an NHS foundation trust may not have carried out planned actions, NHSI is likely to seek additional information from the NHS foundation trust to understand the underlying situation. Depending on the trust's response, NHSI may decide to investigate further to establish whether there is a material governance concern that merits further action.

This paper therefore sets out the two statements required to be submitted by 29th May, along with assurance statements which should inform the board's opinion on its declaration as to whether it can confirm or not compliance with the respective statements. Where the board determines that it cannot confirm compliance with a specific statement, it should declare 'not confirmed' and provide commentary to explain the reason for the non-compliance.

The two statements and assurance statements are attached at Appendix A. The board is required to consider and certify whether or not it can confirm compliance with each statement.

Statement 1: The Board is satisfied that the trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

Statement 2: The Board has regard to such guidance on good corporate governance as may be issued by Monitor/NHSI from time to time

There is an established governance framework, supported and maintained by a framework of committees. The board has standing orders, reservation and delegation of powers and standing financial instructions in place which are reviewed annually. The Head of Internal Audit has provided reasonable assurance that both controls are generally sound and operating effectively and that the internal controls are operating effectively within the fundamental financial systems. The trust has completed 62 of the 76 PWC actions with 13 remaining open. A number of the open actions relate to governance improvements.

We have identified significant governance challenges as a trust, including around corporate governance, and we have recognised that these will need to be strengthened including in our annual governance statement. We do not currently have a senior independent director following Mike Rappolt retirement and this will need to be addressed.

The Board may wish to consider whether it is able to confirm compliance with the first of these statements, particularly in view of the forthcoming CQC Inspection and the identified weaknesses in the corporate governance framework. It is recommended that compliance with the second statement is confirmed.

If you do not consider that we are not compliant with the first statement then we are asked to provide a short statement. If this is the case I propose the following draft text:

The Trust has an established governance framework, supported and maintained by a framework of committees. There are internal controls in place and risk management is embedded throughout all levels of the organisation. Internal assurance has provided reasonable assurance that controls are generally sound and operating effectively. The trust has implemented the majority of the PWC recommendations however 13 remain open and continue to be monitored.

However, given the challenges that the trust faces across finance, estates, performance and managing risk the governance structures and framework will require strengthening. This will be a key priority over the coming months

The assurances for declarations 4, 5 and 6 will be presented to the next board meeting in June.

Recommendation
Board members are invited to consider and certify each statement, informed by the summary of controls and assurances outlined in appendix A. If unable to do so, the board should agree what supporting commentary it wishes to submit based on the initial draft provided.

Risks

If the board identifies a gap in compliance with the governance statements and therefore in the trust's corporate governance arrangements, then actions will need to be agreed to address that gap through the development of the trust's assurance framework.

No such gap has been identified in this assessment.

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, but particularly the 'well led' domain.

Equality Impact Assessment (EIA): Has an EIA been carried out? No

If yes, please provide a summary of the key findings

Appendix A: Proposed evidence for self-certification

Self-certification statement	Assurance statement
1. The Board is satisfied that the trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Internal controls and assurance** • Standing orders and scheme of delegation in place setting out standard operating procedures for the Board and sub-committees but these need to be reviewed; • Self-evaluation of the effectiveness of board sub-committees completed annually; • Terms of reference for board sub-committees reviewed annually; • Board composition consists of a majority of independent non-executive directors; • Trust Secretary in post to advise the board on good corporate governance; • Trust constitution approved by Board of Directors and Council of Governors; • Corporate Governance section of Annual Report outlining Code of Governance compliance which was presented to the Board in May; • Audit & Board approved Annual Governance Statement and Auditors' opinions; • Board agendas and sub-committees covers all domains of performance – quality, finance, workforce, operations and risk; • Board and QRC review of risk register each month however risk process and BAF identified as areas that require strengthening • Information Governance Toolkit self-certification and implementation work; • Standards of Business Conduct policy in place but requires updating • Review of whistleblowing procedures planned by audit committee every six months but has not been fully undertaken. Speak Up Guardian not yet in place; • Internal audit plan and audit committee workplan approved by audit committee and board; • Revised risk management strategy approved by QRC and board but not yet implemented; • Board completion of declarations of interest annually and at each board meeting; **External assurance** • External Audit Opinion – annual report and quality accounts. The AGS is considered to be a balanced reflection of the trust position. • Head of Internal Audit Opinion and audit of quality indicators • PWC Review completed and majority of actions completed

2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	• NHSI monthly bulletin circulated to all executive directors; • Board performance reports reviewed against Monitor's Risk Assessment Framework; • Trust annual report includes statements of compliance against Monitor's Code of Governance; • Trust's assurance framework will be redeveloped over 16/17 supported by additional senior resources

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – MAY 2016

Paper Title:	2016/17 Annual Plan
Sponsoring Director:	Nigel Carr, Chief Financial Officer
Author:	Tom Ellis, Head of Business Planning
Purpose:	The trust is required to submit an annual plan to NHSI each year. The trust submitted its annual plan, and associated Annual Planning Return (APR) which details the trust's financial and activity plans, on the 11th May. The final version of the attached document was approved by Trust directors prior to submission. The financial section reflects at a high level, the content of the APR.
Action required by the board:	The final version of the plan is presented for information.
Document previously considered by:	The Annual Plan was considered at EMT on 25th April and by trust Directors up until submission on the 11th May

The trust is required to submit to NHS Improvement (NHSI) a narrative annual plan and a set of Annual Planning Return (APR) templates that detail the financial plan and other key operational parameters for the organisation for the upcoming year.

The plan is presented in the format required by NHSI, which is highly prescriptive about the content and length of the document and the sections within it. The plan needs to be read with that understanding.

The document is set out in the following sections:

1. Executive Summary – which outlines the estate, ICT and financial pressures on the trust
2. Strategic context and the emerging Sustainability & Transformation Plan
3. St. George's corporate objectives 2016/17 – draft as per previously presented to the board
4. 2016/17 Activity and Capacity Plans – including meeting STF access trajectories
5. Quality Planning – including CQC and 7 day working
6. Approach to Workforce Planning
7. Financial Planning
8. Risks to delivering the 20156/17 Operational Plan
9. Foundation trust membership and elections

The plan will be published on the trust website following the Board.

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?

Risks are identified in the plan and will be triangulated against the trusts current risk registers

Related Corporate Objective: *Reference to corporate objective*	None – the production of the annual plan will inform the finalised corporate objectives for 2016/17

that this paper refers to.	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	None

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

If yes, please provide a summary of the key findings

No specific groups of patients or community will be affected by the content of the annual plan. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

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

The annual plan is a high level document that does not detail individual proposals that will require an EIA. As the plan moves to implementation then any actions within the plan that necessitate a EIA will have one taken as part of the business as usual development and implementation of proposals and initiatives within the trust.

St George's University Hospitals NHS
NHS Foundation Trust

St. George's University Hospitals NHS Foundation Trust

2016/17 Operational Plan

V4

Excellence in specialist and community healthcare

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1. Executive Summary

The trust had a deficit of £16.8 million in 2014/2015, and £55.1 million in 2015/2016. The plan is to achieve a reduced deficit of £17.2 million, which is also the currently agreed control total.

This figure of £17.2 million deficit specifically excludes:

- Any exceptional expenditure to catch up the capital and maintenance backlog on the St George's hospital site estate and IT infrastructures;
- Any consequential effects on clinical activity caused by construction work involved in catching up this capital and maintenance backlog;
- Any proceeds from asset sales;
- Any impairment of the balance sheet (some £4 million) with regard to costs on future redevelopments that will not now go ahead.

The task of achieving this smaller 2016/2017 deficit will be very demanding and tough. The trust is starting behind the timetable and still does not yet have the skilled resources in place to deliver the CIPs required.

The main hospital site is deceptive, on a sunny day it looks credible and functional, but in reality it is largely over 40 years old. Significantly, some 15 years ago preventative maintenance ceased, generating significant cost savings over the years, and was replaced by a regime of maintain on failure. Today the consequences of this policy are evident in the many single points of failure that exist and the growing number of incidents of basic infrastructure failure. The site does not have an adequate level of basic heat, water, light, roof and fire integrity and IT systems. Several buildings are well beyond their useful life and will soon become unfit for occupation. Furthermore to achieve adequacy a disruptive programme of construction work will be required.

It is also clear with hindsight that the trust embarked on a dash for growth, as it sought and then built on FT status. The outcome was a strategy to acquire a range of services with no discernible overview of the cumulative impact or benefits of so doing. Subsequent poor implementation has left the trust with hugely increased costs. Inadvertently this also maximised load on the infrastructure at precisely the time it could not cope.

One encouragement in this is that a return to focus offers a real opportunity for genuine efficiency increases delivering a better and safer patient experience for less cost, whilst releasing infrastructure and clinical capacity on the over stretched hospital site. Eliminating wasteful procedures and identifying true profitability on much of what we now do will enable dialogue with commissioners, staff and other stakeholders as to how we transform outcomes to the satisfaction of all parties.

The turnaround and transformation process that is now required will require a sustained 3 to 5 year programme coupled with sustained external support and cash resource to achieve.

2.0 The strategic context and the emerging local Sustainability & Transformation Plan

St. George's is located in south Wandsworth, in the centre of the south west London health economy. The health economy has been financially challenged for a number of years and there have been two major sector wide reviews in recent years, neither of which have been implemented. In both reviews, however, St. George's has remained as a fixed point in the health landscape as the tertiary provider for the sector. The health economy remains financially challenged, and the requirement for service change and reconfiguration recognised as a key requirement in order to deliver long term service and financial sustainability in south west London.

St. George's is in the South West London Sustainability & Transformation Plan (STP) area. This annual plan is closely aligned with the Sustainability and Transformation Plan that is being produced across SWL.

Section 7 outlines St. George's financial projections for 2016/17. These should be read within the context of the other submissions from the South West London acute provider trusts (Epsom and St Helier University Hospitals NHS Trust, Croydon Health Services NHS Trust, and Kingston Hospital NHS Foundation Trust) as well as the SWL CCGs (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth) which form the STP.

The trust's development of its Transformation Programme and its overall strategic direction is taking place in the context of wider discussion between commissioners and providers around the development of the STP. There are a number of strands which St. George's is actively participating in, which will come together to shape the future of south west London for the next 5 years. The first draft STP was submitted to NHSI on 15th April, with the document having a very strong focus on primary and community services. The trust will engage constructively with the further development of the plan leading up to the submission at the end of June of the full STP.

The following points within the initially submitted STP will be developed further, and which have implications for the range of services – community to tertiary – that the trust provides:

1. The sector is failing to meet standards for urgent and emergency care, 7 days services and that there is not the workforce to deliver 24/7 care for all services on all sites (though St. George's is currently better placed than most trusts in delivering 7 day services, as outlined in section 5.3)
2. Demand is increasing, as the population and the age of that population increases, placing a particular burden on long term condition management
3. Not all hospital estate is fit for purpose and significant investment is required in health infrastructure in south west London
4. The current model of care is financially unviable, with the funding gap identified as £864m by 2020/21 in the "Do nothing" scenario
5. More care needs to be delivered outside of hospitals and new models of care need to be introduced that will transform service delivery.
6. Effort is going to be focused on reducing cost, demand and increasing throughput

The emerging solution hypotheses are based on:

1. Prevention and early intervention to reduce demand on hospitals, and build health and social care services in the community
2. Right care in the best setting – indicating breaking down of and between organisational barriers
3. Site configuration & Clinical networking – Four A&E site model for the sector and reconfiguration between sites of the current clinical service portfolio, linking to St. George's Portfolio Optimisation Transformation project as well as the development of shared staff banks, also in the trusts Transformation Programme
4. Focussing on population cohorts, and developing sector wide responses to variation in care
5. The development of place based organisational structures, implying increased vertical and horizontal integration between clinical and social care teams

The June submission will be a development of the above hypotheses into initial plans, areas of agreement, and the identification of areas needing further work. The longer term implementation of the five year plan, including any consultation on reconfiguration options, will be taken forward through the South West London and Surrey Downs Healthcare Partnership. St. George's will work constructively and transparently with our partners in the sector to ensure the plans are robust and deliverable, and the deadline of June is met.

3.0 St. George's Corporate Objectives 2016/17

The operational plan needs to reflect St. George's corporate and organisational priorities for the coming year. 2015/16's plans articulated these within the seven strategic themes developed in 2012, but were not widely thought to enable a holistic view of organisational performance.

The trust has clearly stated its desire to refresh the overarching strategy, both as a pre-requisite to the wider health economy plan, but more importantly to ensure that the route to the future sustainability of the organisation is robustly planned and executed. Through the board strategy sessions, interactions with Monitor, consideration of guidance, internal and external issues, and participation in the SW London and Surrey Downs Health partnership, the following statement, updated since the 8th February submission, encapsulates the required direction for the organisation in the coming year:

"To support our committed staff to focus on getting the basics right, particularly by investing in our estate and IT infrastructure, ensuring the continued excellence of clinical services for our patients; and to address operational and financial performance challenges, through the implementation of the Transformation Programme"

To do this the trust will:

1. Ensure the trust has an unwavering focus on all measures of quality and safety, and patient experience.
2. Ensure our workforce is supported and motivated, and that they understand, and are engaged with, the challenges facing the organisation
3. Deliver our Transformation Programme enabling the trust to meet its operational and financial targets
4. Refresh the trust's strategy, to develop a sustainable service model with a clear and consistent message
5. To develop and deliver programmes of education and research that attract students and grow the St. George's brand
6. Ensure we make the most of our buildings and estate and maximise efficiency through improving back office and corporate functions.

The above have been updated and refined since the draft submission, and work is on-going to agree the individual actions that sit under each of these statements, delivery against which will be used to measure achievement. The Corporate Objectives are in the process of being finalised, and it is not anticipated that they will change significantly.

A major strategy refresh, as outlined in point 4 above, has the potential to seriously alter the direction of travel on individual services, transformation programmes, or the trusts stance on wider STP questions. The content of this Annual Plan therefore, whilst accurate at the point of submission, may be superseded by the content of the new strategy, and the content needs to be viewed with that understanding.

Forming part of the proposed corporate objectives are five key issues and challenges that the trust needs to address in 2016/17. These are:

Challenge	Current Status	The challenge for 2016/17
Finding a sustainable solution to core estate and infrastructure problems	The trust has experienced a number of core systems failures, for example loss of heating, steam supply, water ingress during 2015/16, which has resulted in patient evacuation on two occasions and an unacceptable impact on patient safety and overall experience of care delivered on the St. George's site. A key issue that needs to be addressed is the condition of renal estate, which has been a longstanding issue for the trust and which is beyond its working life and no longer appropriate for delivering patient care. The estate for children and women's services is poor. The trust had major plans to redevelop the Lanesborough Wing into a Children & Women's Hospital, but the proposal requires very significant capital finance and the funding for this is currently not identified.	The trust is undertaking a Six Facet Survey to ensure that it has a comprehensive understanding of the current pressures on estate and infrastructure in the trust. The trust has already allocated the vast majority of its capital funding to address a proportion of backlog maintenance and priority projects but is clear that more significant funding needs to be identified to ensure the St. George's site is safe and reliable in the delivery of core support services. With regard to renal services, the trust has to ensure that immediate risks are controlled and minimised whilst at the same time making swift progress to identify a long term solution. There is insufficient internal funding to build a new unit so innovative solutions (modular builds, moving other services to accommodate, using satellite dialysis space) are being considered. The solution will require external funding support to deliver, including funding any I&E impact from disrupted services. The Children & Women's Hospital build, and the first stage of it – the redevelopment of the 5th floor – are both at a halt due to the trusts current financial position. However, the current facilities are not fit for purpose and a solution needs to be developed that allows the trust to address the condition of the wing.
Addressing long term under-investment in ICT	The current information technology infrastructure in the trust is sub-optimal with a significant backlog of work requiring potentially significant financial investment. The weaknesses in the trusts ICT is impacting on the day to day delivery of trust operations and needs to be addressed	The trust is in the process of reviewing its ICT programme for 2016/17 and gaining a fuller understanding of the backlog in core ICT systems and hardware. Once this process has been agreed the trust will need to consider funding requirements and options to meet that funding requirement.
Delivering Access Targets	18 week RTT, A&E 4 hour and 62 day cancer target delivery are 'must-do's' for the NHS for 2016/17 and the trust	The trust has trajectories and associated plans for recovering its position against all three key targets

	needs to improve performance during 2016/17. The trust has had significant problems in a number of specialties in meeting the 18 week access target, as well as failing to meet the 4 hour A&E standard and some cancer targets. Delivery of these targets is also a key component in ensuring the trust receives its full STF funding allocation.	and has agreed these with Commissioners. However, all targets are at risk from external pressures e.g. a harsh winter increasing the number of non-elective admissions, and internal challenges e.g. delivering the Flow programme to streamline the patient journey, as well as the risk of infrastructure failure. There also remain considerable capacity constraints. Delivering these targets will be challenging.
Addressing the wider demand and capacity challenge	The trust has a very high level of occupancy (in Q3 at 97%) and a shortage of capacity to deliver the demand for the services on site. However, it is not just inpatient beds that there are capacity constraints in – outpatient, theatres and diagnostics have their own challenges which have the potential to reduce the operational efficiency of the hospital.	There are limited opportunities to increase inpatient or diagnostic capacity on site in 2016/17 and no plans for additional theatre capacity. Various elements of the Transformation Programme will help address the capacity gap, through looking at patient flow, theatre and diagnostic systems and practices. However, the scale and ambition of the programme bring with it inherent risks to delivery The on-going challenge to the organisation is to identify better ways to work to free up capacity, whilst delivering targets and ensuring the workforce remains engaged, motivated and supported to deliver in a challenging environment.
Meeting the workforce challenge	A hospital such as St. George's, with the complex range of clinical services it provides, is reliant on having a highly trained, committed, motivated and satisfied workforce. The Annual Staff Survey, and Medical Scale Engagement Survey, the results of which have both recently been received by the trust, indicate that the trust has significant and systemic issues to address with its workforce and any failure to do so will impact on the trusts ability to deliver its complex mandate in 2016/17. High rates of staff vacancies, and high	In common with many trusts, St. George's has had significant workforce challenges and pressures during 2015/16. Rates of turnover have risen from the historical average of 13% to 17%+ and vacancy rates have risen also. The trust needs to work to retain its current workforce, and actively fill, for example through its planned International Nurse Recruitment project, its vacancies. Furthermore the trust needs to actively and meaningfully respond to the findings of the Staff Survey and the

	staff turnover, present problems in terms of continuity of care and service delivery, increase pressure on other permanent members of staff and a difficult in planning or implementing the Transformation programme and other workforce related developments during the year.	Medical Scale Engagement reports.

4.0 2016/17 Activity and Capacity Plans

4.1 St. George's capacity

St. George's is a large hospital, but has significant demand and capacity issues. Quarter 3 2015/16 bed occupancy for acute beds stood at 97%, which is well above the national guideline of 90%, and was the highest quarterly figure for 4 years at St. George's. This level of occupancy leads to delays in patient flow through hospital, with negative impacts on Referral to Treatment, A&E and Cancer target achievement.

The following table shows the bed and theatre stock available to the trust. This data has been shared with other local stakeholders in line with the open book requirements of the guidance.

Category	Position 01/04/15	FY 2016/17 Baseline bed position	Planned 2016/17 extra capacity	Projected – 31/03/17
Acute beds	919	960	29 beds*	989
Adult ICU	53	56	-	56
Paed and Neo-natal ICU	45	45	-	45
Community / Intermediate Care / Hospital at home beds	82	94	+12	106
TOTAL BEDS	**1,099**	**1,155**	**+41**	**1,196**
Theatres	29	30	0	30

*includes recovery at home beds

During 2016/17 the trust expects to increase its bed capacity by 3.5%, which along with the 13% increase in non-acute beds, is hoped will help reduce the bed occupancy rate, and contribute to addressing the significant capacity shortfall the trust faces.

4.2 St. George's activity plans and SLA proposal

The trust's activity plans are considered to be realistic and deliverable. It has used as the basis for its activity assumptions and initial SLA proposal the following methodology:

- M6 2015/16 activity doubled plus seasonality
- The impact of demographic growth, developed at Speciality and POD level.
- The impact of business cases which detail the anticipated additional activity and are clear on where the physical capacity is to deliver the activity.

There has been constructive and on-going dialogue with both CCGs and NHSE since 8th February. The trust has agreed and signed the CCG contract and has also agreed Heads of Terms with NHSE, including the quantum of income across Specialised, Public Health, Dental and Offender Health. This represents a significant improvement on last year in terms of the early agreement of activity and associated income. The NHSE contract is expected to be signed by 13th May.

CCGs/NHSE have agreed to invest £15.5m to include growth, full year effect of 2015/16 business cases and a few specific agreed 2016/17 developments. The CCGs have also agreed to fund some capacity schemes including the new Surgical Assessment Unit which will assist in flow within the trust and also deliver an outstanding gap in the London Quality Standards.

Commissioners have submitted QIPP schemes to the value of £10m relating to demand management and other measures to reduce activity or spend within the trust. If these schemes are not successful the risk will lie with the commissioner of overperformance on the contract level. Penalties and fines are budgeted to fall by £3m on 2015/16 due to the removal of national fines for RTT, ED and Cancer. No allowance has been made for financial penalties associated with the STF but which have not yet been defined.

The following table illustrates at a POD level the outputs of this work and show the St. George's SLA position going into 2016/17. These figures include 18 week activity when it can be delivered within current or planned capacity. Where 18 week activity cannot be delivered on site, commissioners understand that they will need to make appropriate alternative provision, and the trust will work constructively to support the commissioners in the development of these plans

POD	15/16 actual Activity	15/16 actual Income (£m)	16/17 current proposal Activity	16/17 current proposal Income (£m)	% Activity Change 15/16 – 16/17	£m change 15/16 – 16/17
A&E	160,267	18.248	163,742	19.954	2%	1.706
Bed Days	68,058	56.889	71,585	61.721	5%	4.832
Daycase	34,088	31.140	34,499	30.900	1%	-0.240
Deliveries	5,005	10.810	5,307	13.493	6%	2.683
Diagnostics	8,452,840	26.038	8,122,468	26.150	-4%	0.112
Elective	16,121	66.588	18,020	76.277	11%	9.689
Emergency	39,809	106.093	37,371	114.868	-7%	8.775
Emergency short stay	4,713	2.967	7,016	3.366	33%	0.399
Other non-elective	1,790	11.066	2,280	14.760	21%	3.694
Outpatient	608,514	106.530	639,526	113.714	5%	7.184
Other Outpatients	32,206	4.035	26,616	3.702	-21%	-0.333
Programme	81,191	16.769	82,788	17.598	2%	0.829
Regular Attenders	23,307	4.278	24,650	4.904	5%	0.626
Unbundled	119,222	20.804	118,697	22.833	0%	2.029
Value Fixed	62,032,210	62.383	63,532,722	69.896	2%	7.513
Variable Value	6,413,707	69.117	3,197,241	59.351	-101%	-9.766
Other	132,830	-7.367	130,985	-6.355	-1%	1.012
Total		**606.388**		**647.133**		**40.744**

In previous years the trust has on occasion included significant local income targets (LITS) which have not always been underpinned by a robust capacity plans. This year the trust has been very careful in developing an activity plan that does not include significant LITs. This has led to a conservative set of activity assumptions, the key driver of which has been previous year's delivered activity – which provides a key assurance around deliverability.

South West London CCGs have invested in reasonable levels of growth for 2016/17 and these have been triangulated with the trust so we have a common view going forwards. NHSE (Specialised) has also commissioned a reasonable level of growth and so the specialised contract level for 2016/17 is a more reasonable starting point from the trust's perspective than in 2015/16.

The trust is still working through the details of the CCG and NHSE CQUINs with commissioners. A number of these schemes are high value and complex to deliver so detailed plans for delivery will be required.

4.3 Delivering access targets

The NHS Mandate and planning guidance make clear the requirement for trusts to meet key access targets. St. George's major trauma centre, helipad, heart attack and HASU status, alongside its delivery of core local district general hospital services, has led to an increase in demand, and the acuity of that demand, on the site. This increase, coupled with the previously detailed capacity constraints, has directly contributed to the difficulty that St. George's has experienced in delivering access targets.

The challenge the organisation will seek to tackle head on in 2016/17 is ensuring there is sufficient capacity to deliver an improving trajectory within the current bed base and a capital programme that currently has no ability to fund new capacity.

4.3.1 18 week referral to Treatment (RTT)

The trust not been delivering performance against the incomplete pathway standard since August 2014. Performance fell significantly to 89% in April 2015 and although performance improved subsequently in June 2015 to 92.38% since then the waiting list has increased substantially and performance has been below target.

Overall the trust has averaged 90% - 91% RTT performance during the first three quarters against the 92% target. However, this masks the fact that the trust has significant challenges to meet the 18 week RTT target in a number of specialties, particularly Cardiac Surgery, ENT, Gastroenterology, General Surgery, Gynaecology, Plastic Surgery, Trauma & Orthopaedics and Urology. Meeting and maintaining the 18 week target in these services presents physical, human and logistical capacity challenges.

The trust has focused during Q4 on developing a clear picture, at a clinical service level, of the backlog it faces, the nature of the backlog and developing a plan, agreed with commissioners, for its clearance and long term sustainability. Predominantly the backlog lies within outpatient services. NHSE recommend that, as a rule of thumb, the backlog size for each specialty should be no greater than three quarters of a week's activity. Historically, when undertaking RTT recovery in the trust, the focus has been on inpatients. However key to achieving sustainable delivery is in reducing the outpatient backlog in the first instance.

The trust's plans, though specialty specific, have a number of core elements including:

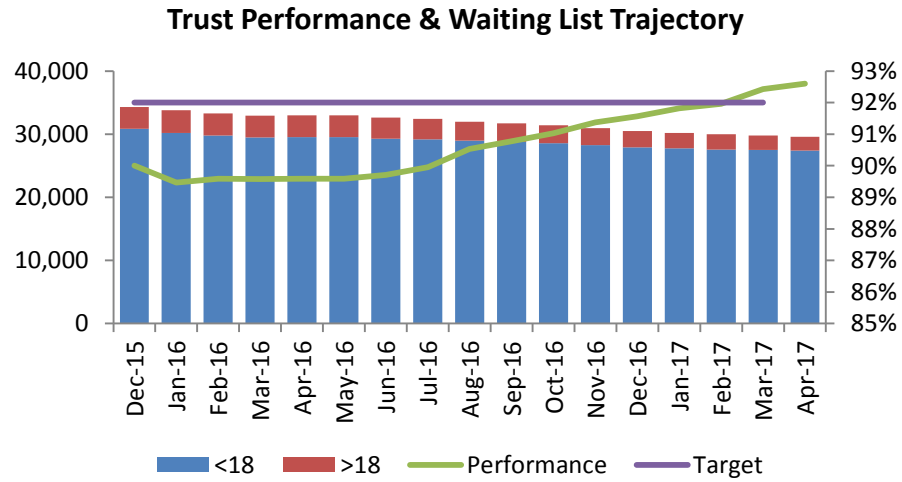
- Undertaking additional clinics and maximising utilisation of all available clinics
- Chronological booking of patients

- Utilisation of capacity at other sites, such as Queen Mary's Hospital, and the Nelson
- Utilisation of capacity on evenings and weekends as well as independent sector for some specialties

Taken together the trust believes that its plans are realistic and deliverable. The trust has been clear with commissioners where it does not believe it will be possible to deliver the 18 week RTT target, to ensure that they have the ability to formulate plans early in the year utilising alternative providers etc.

The following table and graph shows the numbers in the plan agreed with commissioners. This shows the trust meeting the target overall by March 2017, with the numbers waiting over 18 week falling from 3,556 to 2,254 during the course of the year. It is worth noting that individual specialties will be achieving the target earlier than that as the performance of the trust improves through the year.

	RTT												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	30213	29526	29526	29261	29162	28956	28794	28577	28274	27932	27734	27558	27511
Denominator	33769	32957	32957	32618	32419	31985	31721	31392	30943	30504	30205	29968	29765
Performance	89.47%	89.59%	89.59%	89.71%	89.95%	90.53%	90.77%	91.03%	91.37%	91.57%	91.82%	91.96%	92.43%
>18 Weeks	3556	3431	3431	3357	3257	3029	2927	2815	2669	2572	2471	2410	2254



It is worth noting that the delivery of the RTT trajectory has a number of dependencies and risks, key to these being

- The ability to recruit and retain skilled staff in line with the services' individual plans
- Adequate winter planning
- Outpatient Capacity / Space becomes available as planned
- Growth not exceeding agreed levels of activity and referrals and therefore trust capacity
- Unclear outcome of technical review of waiting list management and how this will impact waiting list size, as well as the impact of on-going validation and changes to the rules in the Access Policy

4.3.2 A&E Target

The Emergency Department (ED) provides non-elective care to around 400 patients per day. The ED aims to assess, treat, and discharge or admit 95% of patients within four hours, in line with national emergency access standards. The trust has struggled to meet this target with performance during

the first three quarters of 2015/16 was 93%, 92% and 90% respectively. This is part of a long term trend of increased pressure on ED and a related decrease in operational performance.

It is clear to the trust that its current systems are not capable of delivering the target on a consistent basis, and the SRG commissioned McKinsey to review the operating model in the ED and recommend how ED can improve its current systems and practices – this resulted in the "One Version of the truth" (OVOT) report. OVOT identified key drivers and issues, none of which are easy or quick to address.

The report showed that St. George's 2014 performance against the 4-hour A&E target was frequently between 92% and 96%. Since November 2014, however, the 95% threshold has been missed consistently. Over the winter of 2014/15, performance dropped significantly with periods at 80-85%; ED attendances remained at the long term average but medical bed midnight occupancy rose steeply and held at 93-95%. 2015 has seen a further 3% increase in ED attendance.

Using a new approach to validate reasons for breaches an estimated 52% of all breaches are caused by lack of 'bed flow'. This includes patients directly delayed by lack of available bed capacity or the knock on effect in ED of reaching capacity constraints in cubicles where patients are unable to move to beds in the hospital. It needs to be noted that many of the ED problems are downstream and linked to the capacity issue previously noted, including those outside of our control, for example the 20 – 30 patients regularly ready for repatriation to other trusts but blocking beds at St. George's.

The work also showed that 20% of the breaches were due to delays within ED processes and 15% due to delays in specialty review in ED. The trust has also found the acuity of A&E patients increasing, even though numbers attending A&E are relatively stable, the length of stay of those admitted through A&E is increasing. The report identified nine route causes and the following solutions were proposed:

- Manage patient flow through trust and primary care action
- Streamline ED processes and review capacity
- Improve clinical specialty response and engagement
- Re-evaluate the use of short stay and assessment units
- Improve flow and occupancy of inpatient wards
- Improve the complex discharge process
- Improve out of hospital capacity
- Reduce delays due to repatriation to other hospitals
- Implement a sustainable performance management structure across the system

The trust has agreed the following trajectory with commissioners for the delivery of the A&E target during 2016/17.

	ED												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	11578	12085	13098	13286	13176	12407	13086	13252	13157	12811	13225	13081	14129
Denominator	13919	13606	14521	14523	14413	13373	14075	14317	14207	14006	14275	14197	15317
Performance	83.18%	88.82%	90.20%	91.48%	91.42%	92.77%	92.97%	92.56%	92.61%	91.47%	92.65%	92.14%	92.24%
>4hours	2341	1521	1423	1237	1237	966	989	1065	1050	1195	1050	1116	1188

As can be seen from the above, the trust does not anticipate being able to meet the 95% A&E target during 2016/17, but commissioners have agreed the above as deliverable and robust and the trust will be working hard to ensure that it both meets the agreed trajectory, and where possible, exceeds

it. Delivery of this trajectory is based on assumptions and constraints including: no further growth in attendances or admissions beyond forecast; the delivery of external system workstream initiatives which will contribute to a reducing demand/attendance; improving flow by facilitating discharge and releasing occupancy as well as no unexpected/out of variation winter pressures.

4.3.3 Cancer Targets

The trust provides a comprehensive cancer service with significant surgical and oncological sub-speciality services. The trust has struggled to meet the two week wait and 62 day cancer standards in 2015/16 and in response a "Cancer Action Plan" has been agreed with commissioners and is currently being implemented. It is designed to improve all aspects of a patient's journey and experience, including meeting the access targets.

Key actions have included recruiting additional staff and increased staff training, undertaking demand and capacity modelling, more senior oversight and escalation, and weekly conference calls with referring trusts to discuss shared pathways and compliance.

The introduction of best practice pathways in breast, urology and lower GI (one stop clinics for first OP appointment) has greatly reduced the diagnostic waiting times for these higher volume tumour types, helping the trust achieve the NHS Mandate deliverable around achievement measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test.

The trust has signed up to joining a 3 year pilot aiming to improve cancer care led by the Royal Marsden, as part of a Cancer Vanguard. The initial stakeholder meetings are underway. An internal steering group has been set up at a senior level to co-ordinate our relationship with the new network. The agenda for the work of the network is expected to emerge over the next few months.

The following trajectory has been agreed with commissioners for the delivery of the Cancer 62 day target, with the trust meeting and then maintaining the target from May 2016 onwards:

	Cancer - 62 Day												
	Baseline	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Numerator	9.5	10	9	11	11	11	9	10	9	10	10	10	10
Denominator	63	60	60	74	74	74	63	70	63	68	68	70	70
Performance	84.9%	83.3%	85.0%	85.1%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%
	53.5	50	51	63	63	63	54	60	54	58	58	60	60

4.4 Delivering other aspects of the 2016/17 NHS Mandate

As well as the 'must-do's' relating to access target achievement and aggregate financial balance across health economies, the NHS Mandate has a number of requirements for providers. The trust is already meeting or has plans to meet many of the elements of the NHS Mandate. The following shows the trust position or plans against some of the targets more related to direct clinical care and patient experience, where these are not covered elsewhere within the plan:

Requirement	Position
Maternity services Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety	The review was published in February 2016. The trust is reviewing the recommendations and is currently developing a strategy in response.
Obesity & Diabetes Contribute to the agreed Child	This is key target for school nursing service. School nurses will now be responsible for following up overweight / obese

obesity implementation plan	children in partnership with other services in Wandsworth.
Dementia Maintain a minimum of two thirds of diagnosis rates for people with dementia	All staff are expected to do basic dementia training as part of MAST and the trust will offer more in depth training for those who need it. St. George's welcomes enquiries from relatives about staying overnight with patients and will be gauging interest in this and seeking feedback on our offer via the Dementia Carers Questionnaire. The trust is committed to being more dementia friendly, as set out in its Dementia Strategy
People with Learning difficulties Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 206/17 actions for Transforming Care	In accordance with the Transforming Care Programme a multi-agency Transforming Care Group has been established in Wandsworth. The responsibility of the group will be to reduce the number of learning disability patients in inpatients beds and put in place recovery plans for any failed discharges. The Transforming Care Group has established a register of individuals who are at risk of community breakdown. The Community Learning Disability Health Team (CLDHT) has a 2016/17 KPI around avoiding unnecessary hospital admissions and out of borough placements - all people at risk and known to the CLDHT will be reviewed and a plan to avoid unnecessary hospital admission will be implemented.

4.5 Demand and Capacity Modelling

Demand and capacity planning and modelling is not new to St George's and has been undertaken using a variety of tools over recent years. Typically tools have been based around a single activity type (e.g. outpatients, inpatients, diagnostics or theatres) and have found it easier to forecast demand (current activity + demographic growth + service developments) than to model capacity (because this is complicated to measure) or expected key performance impacts

In the run up to 2015/16 and recognising the capacity pressures facing the organisation, the trust increased its understanding and presentation of demand and capacity information across inpatients (activity, length of stay, capacity and occupancy) and theatres (timetable and session utilisation). It identified a shortfall of circa 90 beds to meet expected demand and deliver targets etc. Whilst progress has been made in increasing capacity there remains a shortfall, and there are no plans to increase that capacity in 2016/17, driven by the trust's overall financial position and the lack of capital funds.

As part of the Turnaround process the trust commissioned KPMG to develop a modelling workstream to *"Support the trust to develop an integrated activity and capacity model. For a five year period, the model shall seek to take forecast activity as an input and convert into capacity required and compare to capacity available."* The inpatient element of the model is functioning, and work continues to complete the outpatient, diagnostic and theatre elements of the model.

The trust remains very focussed on demand and capacity, and specialties have reviewed and considered their capacity when developing their 18 week RTT recovery plans. However, with regard to assurance regarding the delivery of the plan the trust would note:

- The agreed SLA has been run through the inpatient function and it shows that the proposal is deliverable based on Q3 occupancy of 96.8%, though with some pinch points identified and discussions about how these are addressed are underway
- That the SLA broadly reflects the same level of activity undertaken in 2016/17, as it has in 2015/16, apart from where there are known service developments that include appropriate capacity increases.
- The other major driver of increase has been demographic growth, which inevitably increases the background demand year on year, and has been agreed at between 1% and 2% depending on specialty and POD
- The Transformation programme includes various elements that will help improve the efficiency of the trusts bed base and flow through the hospital, increasing capacity, albeit such capacity improvements are back ended.

5.0 Quality Planning

5.1 Approach to quality planning and improvement

The Chief Nurse/ DIPC and Medical Director are the executive leads for the delivery of the Quality Improvement plan.

The trust has a Quality Improvement Strategy, which is refreshed annually and outlines the trust's vision for quality improvement over a 5 year period (2012 – 2017), detailing key priority areas and planned action to promote continuous improvement in the safety and quality of services provided by the trust. The Quality Improvement strategy will be reviewed in parallel with the overall trust Strategy during 16/17 to support work beyond 2017.

The strategy implementation is monitored quarterly by the trust Patient Safety Committee. Patient Experience and Clinical Audit and Outcomes Committees both feed into the Quality and Risk Committee, the board sub-committee with over-arching responsibility for quality where progress against objectives is challenged and scrutinised.

Each clinical division will have an annual quality improvement strategy which is aligned to the overarching trust strategy and implementation of these is also monitored by the Quality and Risk Committee bi-annually. Clinical divisions also drive implementation of their quality strategies through Divisional Governance Board meetings.

The principles of ensuring St. George's delivers high quality, safe compassionate, care, through an effective productive and well led workforce underpins all quality improvement work. There is an assigned SRO for each of the CQC fundamental standards and these have been reviewed and mapped, alongside work to understand the core services profile to existing governance and monitoring structures, with action plans being finalised to address any gaps which have been identified.

In order to ensure a transparent a robust quality assurance process, a revised care audit tool has been developed which is completed monthly by the matrons, the results of which are available to each ward manager to review their ward performance, alongside the divisions and board. To ensure parity, a quality inspection process is undertaken at corporate level, with each inspection team comprising a trust, clinical and patient representative lead. This inspection frequently includes a commissioner attendee. Existing governance structures receive regular reporting and updates, and in addition, changes to systems and processes to ensure maximum efficiency are being monitored in terms of impact on patient care.

St. George's, through its Quality Improvement Annual Plan and Transformation Programme for 2016/17, will focus on fundamental aspects of care within its annual improvement plan to ensure that safe and effective care is being provided during a period of significant transformational change. The priorities have been identified from Clinical outcome, incident, claims and patient feedback data to determine the programme.

The programme is being expanded to include organisational development in relation to quality including the development of a Quality Improvement faculty alongside the existing safety, experience and outcome domains.

Working to both build on and improve outcomes of care including providing transparency on outcomes, key quality priorities are anticipated to be:

- Ensuring that we are getting patients in the right place first time to improve safety of care and reduction in length of stay through the trusts flow programme, review of specific clinical pathways, management of cancer pathways and the outpatient programme.
- Agreeing and embedding high quality standardised processes 7 days a week through building on existing processes within the trust for the management of deteriorating patient's use of National Early Warning Scoring system, management of sepsis and management of results.
- Investing capital resource to reduce clinical risks through the delivery of an environmental programme that addresses both small and large scale projects during 2016/17 including the provision of dementia friendly environments.

The trust has considered the recommendations from the Association of Medical Royal Colleges guidance on the responsible consultant and is committed to ensure all patients have a 'responsible' consultant, and this is clearly indicated in the patient record and on the ward.

The responsible consultant is usually determined at the point of admission, but may be changed if the patient's needs are better met by another consultant's experience or team. The responsible consultant is identified to staff on the ward patient board and currently there is roll out of electronic boards to display this information. For patients admitted to critical care environments the responsible consultant is allocated to the patient for the period of their admission to a specialised unit, and then this responsibility explicitly returned to the responsible consultant overseeing ward care. Not all wards display the responsible consultant on bed boards at this point and the trust is working to address this. The responsible consultant has overall responsibility for management and coordination of patient care.

5.2 CQC Inspection

The trust will be formally inspected by the CQC in late June 2016. Whilst the trust seeks to meet all the CQC's standards of care at all times, there is no doubt that an inspection sharpens the focus and provides the opportunity for St. George's to take an objective review of its position and seek to address areas requiring remedial work. St. George's has invested £180k in staff costs to oversee and implement a comprehensive programme to ensure the trust is ready for the rigours of a CQC inspection, though this is against a background of limited funds being available due to the overall financial position.

The trust had commenced work in 2015 in relation to its position against CQC fundamental standards, use of Quality Inspections, self-assessment of Divisions until Quarter 2 and then a revised approach for Q4 and on-going oversight through other governance forums. A quality fundamental standards group was also established in Q3 of 15/16.

Following the formal notification of the inspection the trust has taken the following key actions:

- A trust wide programme of work led by the Chief Nurse/ DIPC to prepare for the inspection. This is supported by a small programme team
- Completion of an external inspection programme which covered 50 areas within the trust. In addition the on-going internal inspection programme covering the acute and community sites. This involves Governors, Patient reps, Board members and CCG colleagues. Feedback from this work going directly back to clinical areas
- Further external inspection by another trust will occur in May for three key core services across community and acute sites
- Completion of KLOE for all core services and self-assessment prior to the CQC Inspection
- Key work streams have been established to address the preparatory work for the inspection with the existing Quality Improvement Strategy for 16/17 including actions for medium and longer term. The final version will be signed off by the board in May.

The work being undertaken by the trust in preparation for the CQC inspection includes the following:
- Programme of IT works focusing on improving infrastructure in wards and departments, and clearing a backlog of issues
- Increased leadership of senior nursing staff through a back to the floor programme and increased quality inspections with executive input on a daily basis
- Enhanced ward leadership support to ward managers and matrons to ensure they are supported to demonstrate the characteristics of well led
- Focussed medicine safety programme with weekly audits covering key areas for improvement
- End of Life Care strategy and a 'Dying Matters' week of focussed activity
- Programme to enhance incident reporting and feedback mechanisms including focus upon Duty of Candour with bespoke training
- Trust wide programme to ensure all policies and procedures are in date and fir for purpose with newly built micro-site to ensure accessibility for all staff
- Mandatory training improved from around 50% to 78% to date with the aim to reach 85% compliance by June

The trust's capital programme for 2016/17 includes £19.4m investment to ensure that core infrastructure, essential for the day to day delivery of safe care and a positive patient experience, is fit for purpose. The total capital programme for 2016/17 is £38m, and includes a wide range of projects, both big and small, that will improve the estate. It is not easy to identify within this figure projects that are triggered by the CQC inspection – the trust considers all projects identified for investment as necessary, and which would have been invested in, notwithstanding the CQC inspection.

It should be noted that the £38m the trust has allocated is inadequate to address the extent of the estate and infrastructure, and I.T. backlog within the trust. To make a step change in the quality and condition of these key enablers, the trust will need to identify and access additional capital funding.

5.3 Seven Day Services

The trust has been working to strengthen 7 day services throughout the organisation, and has been working on delivering the London Emergency standards. Key points of the trust position are:
- The trust has 24/7 ED consultant cover and high levels of labour ward consultant cover 7 days a week.
- The London emergency standard *"All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital"* is met 7 days a week in surgery with a consultant on-site free of elective commitments between 08:00 and 20:00 7 days a week, to ensure patients are seen and assessed within 12 hours of the decision to admit.

- In medicine, the standard is met Monday – Saturday a.m. but not fully across the weekend. The appointment of the 2 new posts is underway to allow this standard to be met.
- In terms of diagnostic service, access to imaging is met within the timescales for critical and urgent diagnostic tests 7 days a week. Routine diagnostics are not all carried out 7 days a week. The trust has enhanced diagnostic services out of hours with trauma patients have 24/7 access to CT and radiology.
- As a Heart Attack centre, the trust has 24/7 services fully supported by appropriate diagnostic support.

The trust is committed to detailed mortality monitoring and our published risk adjusted mortality does not demonstrate a significant weekend difference; we continue to monitor this and embrace the national drive for detailed case note review, and oversight, to ensure learning.

5.4 Quality impact assessment process

The trust is working on finalising and delivering a significant transformation programme based on six key themes including clinical transformation. Each SRO for the work streams is required to complete a Quality Impact Assessment (QIA) for the overall work stream with individual smaller work stream completing a standardised QIA template which focusses on all aspects of quality. Each work stream is required to achieve sign off by the Medical Director and Chief Nurse/ DIPC prior to the work stream commencing.

The Clinical Divisions also are required to follow this process for any cost improvement schemes over and above those within the trust programme. The QIA needs to be approved by the clinical Divisional Chair, Divisional Director of Nursing and Governance and Divisional Director of Operations before submission to Chief Nurse and Medical Director.

QIA s are completed by the Divisions and collated by the PMO. These are reviewed through a single point electronic database by the Chief Nurse and Medical Director.

All Transformation Programme projects and divisional CIP projects now have a “Clinical Responsible Officer” (CRO) who is responsible for insuring on an on-going basis that the quality of a service is not adversely affected by the implementation of the programme. There is a continuous review loop where the CRO reviews the impacts of a project as it is implemented, raising, addressing or escalating concerns as appropriate.

Overseeing the overall programme is the “Transformation Quality Governance Group” (TQCG) which has been established to provide assurance to the board that the Transformation Programmes are not adversely impacting patient safety, patient experience, clinical outcomes and performance KPI’s.

The TQCG tests in depth whether the QIA process and on-going risk management processes being run by each programme are effective and robust. This includes a review of trending KPIs for each programme and a review of the cumulative effect of the programme on the organisation. The TQCG will receive assurances from each programme and sign off the clinical risks within the programme. The TQCG reports to the trust Turnaround Board on the top clinical risks within the programme, and also reports to the Quality & Risk Committee on an exception basis, escalating any significant risks or issues.

The TQCG will aim to be firm at which the cross-programme clinical impact of all the changes is reviewed in one forum.

5.5 Triangulation of indicators

The trust triangulates quality, workforce and financial on a monthly and quarterly basis and via a number of forums. The process is comprehensive and robust

As part of the trust performance framework, St. George's undertakes quarterly executive performance reviews where a series of indicators and their interdependencies in relation to performance, finance, quality, workforce, and risk are reviewed and key items for escalation are addressed. Areas of underperformance are reviewed in terms of delivery against national/internal standards, financial implications, impact on quality and patient care and experience, and workforce implications associated with it. In addition to this the impact of potential workforce issues are discussed and their impact on respective areas, both short and long term with remedial proposals for action.

Some of the key indicators reviewed at the quarterly meeting include:

- National access and cancer targets
- Quality targets associated to CQC domains of Safe (e.g. infection control, harm free care), Effectiveness (e.g. Mortality Bed Occupancy, re-admissions), and Caring(e.g. FFT /complaints)
- HR Targets in relation to CQC Well Led domain, to include Friends & Family Tests, turnover, sickness, vacancy and training/appraisal compliance rates.
- Finance – activity, divisional financial positions, fines
- CQC compliance and internal mock inspection results

Key actions from reviews are also discussed and monitored at various forums in relation to key domains, namely: Finance and Performance Committee, Quality and Risk Committee, Workforce and Education Committee and Monthly Finance and Performance Reviews.

Further triangulation and board scrutiny of key areas is undertaken at monthly trust Board and key indicators from all domains are reported in the monthly trust Board Performance and Quality Report. The Board scrutinise indicators/performance, request further details or recovery action plans where required. Also, in relation to particular areas the board may request specific thematic analysis and forecast for future performance and any associate implications. The board will then use this data to identify key priority and development areas for the trust for both the immediate term and strategic long term. The trust is currently reviewing its Performance Framework and it performance report in Q4, to align it to key quality priority for the forthcoming year and to make further enhancements in relation to benchmarking, trend analysis and triangulation.

In addition to the above and as the trust is in financial turnaround and impacted by a number of workforce and operational pressures. Weekly impact of quality is monitored via the Chief Nurse Quality Dashboard which shows weekly trends for the following areas: Crude Mortality, Falls, Pressure Ulcers, SIs, Complaints, Staffing Fill rates, Safe Staffing Alerts, and Staffing incidents. These metrics are also reviewed by the executive team bi-weekly at the Executive Management Committee.

5.6 Specific Quality Risks

The trust has a risk management process (which it is currently reviewing) in place but given the challenges articulated in this document there are a number of specific quality risks that have been identified, and which the trust will seek to address through its Quality Improvement Strategy Annual Plan 2016/17 and Workforce Plan. It is worth noting that although 2015/16 was a challenging year in many respects, there has not been a marked deterioration in any key quality metrics reported to the board although the Trust would recognise the impact of challenging operational performance on patients and it has addressed specific quality issues which arose during 2015/16. St. George's will

approach 2016/17 knowing that it whilst there are a number of areas where performance is consistent in relation to quality there are a number of areas impacting on quality where focus will be placed. The key issues identified include:

- Estate and infrastructure impacting on patient care and experience – the annual plan makes clear the need to invest capital resource to reduce clinical risks. This would be through the delivery of an environmental programme that addresses both small and large scale projects during 2016/17
- Staff engagement – the staff survey raised serious issues for the trust, for example a lack of confidence in raising issues, and the more recent medical engagement survey identified significant problems also. The trust needs to ensure that its workforce is fully engaged and that the organisation is seen by its staff as supportive and open.
- Overall quality focus during financial turnaround – though the trust has maintained quality as measured by KPI's, and has in place a comprehensive architecture to identify problems, but the trust needs to ensure that the board to ward process continues to function appropriately

6.0 Approach to Workforce Planning

6.1 St. George's workforce

Staff costs account for 61.9% of St. George's expenditure. Recent years have seen a steady growth in workforce numbers, and this growth has been a contributory factor to the deficit in both 2014/15 and 15/16. The drivers for this increase include:

- Safe staffing and nursing establishment review in part driven by delivering locally the recommendations of the Francis report
- Planned growth in line with agreed service developments
- Nelson hospital development
- Gordon Smith ward staffing and other incremental increases in capacity

The following table illustrates the changes in workforce over the past two years:

	Staff In Post		Establishment	
Staff Group	**31-Dec-14**	**31-Dec-15**	**31-Dec-14**	**31-Dec-15**
Add Prof Scientific and Technic	611	561	731	737
Additional Clinical Services	719	842	840	1,034
of which Healthcare Assistants	484	584	619	757
Administrative and Clerical	1,441	1,490	1,773	1,832
Allied Health Professionals	585	579	622	685
Estates and Ancillary	215	231	263	275
Healthcare Scientists	268	270	315	339
Medical and Dental	1,134	1,152	1,139	1,222
of which Consultants	456	477	456	503
Nursing and Midwifery Registered	2,740	2,786	3,192	3,407
of which Midwives	203	191	209	231
Total	**7,712.34**	**7,912.39**	**8,875.44**	**9,531.54**

The trust is fully cognisant of the need to manage its workforce, to deliver productivity and efficiency savings, and to triangulate its workforce, activity and clinical plans.

Key challenges for the trust with regard to workforce has been a very high turnover rate, at 17% , with the impacts on patient care, continuity of care, remaining staff morale, and bank and agency

expenditure. The position at St. George's is reflective of other London trusts, particularly with regard to nursing and AHPs, and is in part reflective of the high cost of housing in the capital and other complex causal factors. The challenge will be on-going through 2016/17 and beyond.

6.2 Workforce Planning Process

The workforce planning process both a bottom up and top down. The trust requires every clinical service to produce a workforce plan for the coming year, which clearly outlines the workforce challenges faced, the plans to address those challenges, and the resultant expected changes and movements in a service's staffing requirements over the coming 12 months. Workforce plans are reflective, where appropriate, to local commissioning strategies e.g. additional Chest Medicine & Dermatology consultants to help address on-going 18 week challenges in both services. The trust has a more limited investment programme than in recent years but the following four service developments, all agreed with local CCGS for 2016/17, have significant workforce implications:

- Surgical Assessment Unit
- Cardiac intensive care unit development (4 beds)
- Thrombectomy business case
- Cardiac Theatre 4

The plans are cross-referenced against the care groups clinical plans and proposed service developments to ensure appropriate triangulation between these key planning documents. Both Care Group plan and Workforce Plan are reviewed, approved and signed-off by the Care Group Clinical Lead, ensuring the clinical workforce is appropriately engaged with the development of plans and their implications for each services workforce.

Workforce data is also considered and reviewed by the workforce planning group, which meets weekly and includes clinical membership. The workforce planning group reports to the workforce and education committee, which is a sub-committee of the trust board. The committee meets every two months and reviews workforce risks at each of its meetings. Trust board reports include workforce and quality detail on a ward by ward basis, enabling triangulation of key metrics supporting the identification of areas of risk.

The workforce plans are included in the annual business plan that is presented to the board. The annual workforce action plan is managed through the workforce and education committee, which is a sub-committee of the board. The workforce planning meeting reports into the workforce and education committee.

The individual workforce plans inform the trusts "Workforce and Organisational Development Plan", which will be approved by both the Workforce & Education Committee and the Trust Board. The totality of these plans are then used to support the submission to Health Education South London, the local LETB. High levels of turnover are a key risk for the trust along with all over major London teaching hospitals. The situation is particularly acute with band 5 nurses, specialist AHPs and specialist nursing such as paediatric nurses, prison nurses, community nurses and oncology nurses. Divisions each have plans to reduce staff turnover, which are monitored through the workforce efficiency programme.

The trust works closely with external bodies such as Health Education South London, St George's University of London, King's College and Kingston University to ensure that the trust is able to help shape the supply of the future workforce. This joint working includes developing a shared education strategy with St George's University of London that focuses on the delivery of high quality undergraduate placements and on strategically positioning the trust in order to maximise the opportunities from the changed commissioning and funding arrangements for nursing and AHP staff.

In response to the significant trust deficit in 2015/16 and the planned deficit position for 2016/17, the trust has also endeavoured to ensure that a robust process of review and challenge has been put in place with regard to workforce. Key elements of this have been:

- The review of all divisional and corporate establishments, with all vacant posts being challenged, and where appropriate permanently removed from the establishment. This is a live process, and to date has taken over £2m of pay costs recurrently out of budgets.
- The on-going Vacancy Control Panel process, to challenge and provide assurance that all posts being filled are absolutely required for the delivery of core trust functions
- The removal from budgets of short term external funding, with the services affected making decisions about whether and how the role is necessary and should be funded going forward.

6.3 Workforce Plan 2016/17

Overall, the focus for the workforce plan in 2016/17 will be:

- reducing staff turnover
- workforce efficiency
- Supporting high quality educational placements.

Workforce is one of one of the seven Transformation programmes. The programme includes the following projects.

Project	Description
Temporary staffing, staff benefits and apprentices	This scheme is about reducing the reliance on temporary staffing across all staff groups, with a focus on areas which are breaching the agency caps. Support is being provided by the NHSI team with this piece of work. The project is also focusing on increasing the number of apprentices, from their current levels of circa 40 WTE to 200 WTE by 2017 Nursing temporary staffing – this project is focusing on the nursing percentage and price caps and ensuring controls are in place to manage these. The programme includes a HESL funded project to support acute nursing with mental health skills in order to reduce the demand for mental health 'specials' The trust has an agency cap target of £24m and intends to meet this target.
SWL Bank	St George's is leading on the formation of the development of a process to enable sharing of staff bank staff amongst the four acute trusts and the mental health trust in South West London.
Organisational shape	In line with the Carter recommendations, the trust is reviewing the number of management layers and the span of management control with a view to ensuring that the organisation can function effectively with speedy and effective communication and accountability.
Medical establishment	This is a review of the job plans for all consultant staff, linking plans closely with activity and ensuring the delivery of 42 weeks' worth of activity for all consultant staff. There will also be a review of the junior doctor establishment to ensure that there are sufficient clinical staff available, especially out of hours and that the trust is making the most appropriate use of alternative roles such as physician associates, prescribing pharmacists and surgical nurse associate practitioners
Nursing establishment	This second part of the nursing establishment review is focusing on the specialist nurse practitioners and the shape of nursing management layers and spans of control.

As well as the Transformation Programme, the following areas of workforce development and focus are planned for 2016/17

Area of focus	Description
Triangulation of quality and safety metrics with workforce indicators to identify areas of risk	In the monthly quality report to the trust board there is ward 'heat map' that reports on areas of risk which have been produced through triangulating the workforce, quality and safety data.
Plans for any new workforce initiatives agreed with partners and funded specifically for 2016/17 as part of the Five Year Forward View	Additional workforce that is required through newly commissioned activity is set out in the workforce plans. The trust welcomes the opportunity to invest in staff wellbeing in accordance with the newly published CQINN details.
Balancing of agency rules with the achievement of appropriate staffing levels	There is a weekly meeting of the nursing senior team to review nursing agency and bank requirements alongside patient safety. There is a daily safe staffing alert system.
Systems in place to regularly review and address workforce risk areas.	Workforce risks are reported and regularly reviewed at the workforce and education committee meeting. The agenda is organised in response to the key risks.

Finally, and crucially, the trust will be putting in place a comprehensive response to the outcomes of the 2015 NHS Staff Survey, which saw the trust score poorly across many of the parameters tested, and the recent Medical Scale Engagement report, which showed a clinical workforce disengaged and feeling marginalised from the key decisions the trust is currently taking. The leadership of the trust is very aware that the difficult challenges currently faced by the organisation are better addressed when the workforce is positively engaged with, and understand and input into developing the solutions the trust needs.

6.4 The workforce in 2016/17

The trust is aiming for a reduction in its workforce during 2016/17, after a number of years of rising staff costs. There are a number of drivers for this, key amongst them being:

- The impact of the Transformation Programme, reducing the headcount as the trust identifies and implements more efficient ways of working
- The renewed focus on the need and requirement for all posts in the current establishment, and the cumulative impact of the trust turnaround plan
- A reduction in agency usage, with bank numbers increasing to reflect this, helping the trust meet the agency cap. This accounts for the single biggest reduction in WTE anticipated for 2016/17
- The impact of skill mix changes and new roles as the trust seeks to modernise its workforce

All Transformation schemes have to have a Quality Impact Assessment completed and approved by the Medical Director and Chief Nurse, and overseen on an on-going basis by the Transformation Quality Governance Group, referred to in 5.4 above. The trust is finalising its Transformation Programme and the final numbers are still being developed.

7.0 Financial Planning

7.1 Financial forecasts and modelling

2015/16 was a challenging year financially for the trust and, after going into turnaround in the summer, and a detailed reforecasting exercise, the trust delivered £41.5m of savings and a year-end deficit of £55.1m, which was £1m better than the revised budget deficit agreed in January. 2015/16 outturn and the 2016/17 reforecast (TRP2) form the starting point for 2016/17 plans.

The reforecasting exercise for 2015/16 was completed with extensive input from budget holders. Divisional management teams and managers welcomed the opportunity to correct anomalies in their budgets and make them more realistic. Inevitably lessons have been learned from the process and these have been applied to finalising the plan for the new year. In particular it was clear that the 2015/16 spend forecasts erred on the side of caution, especially on pay, and as a result there were pay underspends across the trust. Pay budgets for 2016/17 have been reviewed in detail to ensure that budgets are based on realistic assessments of recruitment.

Overall St. George's is working on a plan to achieve a deficit of £17.2m, excluding any profits from asset sales, and potential impairments for costs capitalised in respect of the future development of the site. This is the control total made as a condition for the receipt of Sustainability and Transformation Funding of £17.6m. This aim is the same as that in the draft Operational Plan submitted in February. The trust has carefully considered the request to improve on this position but at present the board is not able to sign up to a plan for a lower deficit.

The table below provides a bridge between 2015/16 outturn and the 2016/17 plan. The table shows a baseline deficit of £70.8m before savings of £36m (net of costs of £6.7m) and STF funding of £17.6m. After adjusting for non-recurrent items in 2015/16, the largest of which, £6.7m, mainly relates to turnaround costs, the recurrent outturn is only £0.6m less than the actual outturn reported for the year.

Income has changed primarily for tariff inflation, CQUIN payments for which the trust was not eligible last year, and commissioner QIPP plans. There is also an expectation that income will exceed agreed contract values and so a local income target has been included.

Expenditure is expected to increase by inflation of £20.3m and cost pressures of £5.9m, changes in business cases are more or less neutral and a 1% contingency is included in the plan. Work is on-going to achieve the £36m net savings in the plan.

FINANCIAL BRIDGE 2015/16 Out-turn - 2016/17 Plan	**£m**	**£m**
Out-turn 15-16		**(55.1)**
Non Recurrent adjustments		
Cap/Rev Transfers	(4.6)	
Charitable income	(1.5)	
Other Income	(2.0)	
Prior year costs	5.0	
Expenditure	6.7	3.7
Full Year Effects		
Business Cases	(1.5)	
Nursing Establishment Review	(3.0)	
Other	0.1	(4.3)
Recurrent Out-turn 15-16		**(55.7)**

Inflation		
Tariff inflation	8.3	
Pay inflation	(12.3)	
Non Pay inflation	(2.5)	
CNST inflation	(5.5)	(11.9)
Other Price changes		
CQUIN	12.5	
Other Tariff changes	(5.8)	
Penalties, fines & challenges	3.0	9.8
Volume		
RTT Improvement	4.6	
Commissioner QIPP	(10.0)	
SLA Disinvestments	(1.0)	
Local Income Targets	6.3	(0.1)
Business Case investments		
Funded Developments	8.0	
Unfunded Developments	(5.2)	2.8
Other		
Cost Pressures	(5.9)	
Non Operating Costs	(2.2)	
Contingency	(7.5)	(15.6)
Baseline before savings & STF		**(70.8)**
Savings / Efficiencies		36.0
Sustainability and Transformation Funding		17.6
		(17.2)

7.2 2016/17 Service Developments & SLA negotiations

As well as the focus on transformation and savings, a number of business cases that will make a positive financial contribution to the trust are included in plans for 2016/17 and several went live in the last quarter of 2015/16. Commissioners have expressed support for these developments. These include:

- Cardiovascular – additional capacity for elective & non elective cardiology
- Neurosciences gym – increase in elective neurosurgery capacity
- Recovery at home - patients continuing their recovery at home rather than in hospital but are being visited by nurses/therapists in the community
- T&O consultants – 5 extra posts to provide a 2 tier trauma rota and extra operating sessions for trauma and elective cases
- Spinal Cord injury beds

Local CCGs have also agreed the funding of the Surgical Assessment Unit due to open in the summer 2016.

Contracts have now been agreed with local CCGs and NHSE. These include assumptions about local growth related to demographic change etc. and QIPP proposals. The trust has also set an additional income target of £12.7m to cover activity expected over and above agreed contracts with commissioners.

The agreed contracts include funding for CQUIN schemes from both NHSE and CCGs although the details of the schemes and the means by which they are going to be delivered within the trust is being reviewed.

7.3 The Sustainability & Transformation Fund

The government is investing £1.8bn of additional provider support next year, through a new STF fund. St. George's proportion of this is £17.6m through general STF funding, and potentially more through target funding. This offer is made on the basis that St. George's will deliver a deficit of no more than £17.2m in 2016/17. It should also be noted this offer is contingent on the NHS 15/16 provider sector deficit being £1.8bn. If it is higher than that, it is likely that this additional overspend will be top sliced from the STF fund, reducing the offer to each trust.

The release of STF funding is contingent on achieving recovery milestones for deficit reduction, access standards, and progress on transformation. Where trusts default on the conditions access to the fund may be restricted and sanctions will be applied.

7.4 Cashflow and financial support

The trust made significant progress in improving its cash management during 2015/16 e.g. through longer supplier payment terms, credit control actions to reduce overdue debt and a managed slowing down of capital expenditure and stock reductions. The combined impact of these cash benefit measures enabled the trust to finance a higher income and expenditure deficit than original plan and at the same time borrow less than planned under its working capital facilities.

In early February the trust agreed to the terms of a loan facility of £48.7m to replace previous interim cash support and it will maintain the ability to access a working capital facility of £25m in 2016/17. The trust's cash balance on 31 March 2016 was £7.4m after loan drawdowns of £40.4m.

The trust has access to approx. £33.4m additional cash under secured borrowing facilities to finance a revenue deficit of £17.2m in 2016/17 – comprising the £8.3m undrawn balance of its interim revenue support loan and £25m from its working capital facility. This is based on a 2016/17 year end deficit of £17.2m, capital cash spend of £33.4m and a £3.1m deterioration in working capital due to some shortening of creditor payment terms.

The I&E position contains significant risk in respect of CIP delivery and the £17.6m Sustainability and Transformation funding which is conditional on the trust's achievement of specific financial and performance objectives. Therefore the trust's current assessment is that additional borrowing facilities of approx. £20m over and above the £33.4m already secured should be sought to provide sufficient resilience to manage these risks to the cash position.

The trust finished 2015/16 with a risk rating of 2 due to its improved liquidity and a positive variance on its I&E margin. A rating of 2 is expected at the end of 2016/17.

7.5 Capital Planning

The trust acknowledges the requirement to generate internally the majority of its capital expenditure. The trust has been through a rigorous and on-going process to finalise its 2016/17 capital programme. Executive directors and other key staff have met to challenge, risk-assess and prioritise each of the originally proposed 205 line items. The process has worked as follows:

- Clarification on the available funding for the capital programme was given based on the forecast deficit for this year and next.
- All major strategic schemes were excluded and associated DH Loan funding removed, such as the Children's 5th Floor and General Critical Care build, following guidance on DH capital funding. The trust does need to progress this project however, as detailed in section 3.
- The master list was checked to ensure all items were captured and risk assessed, with risk description and mitigation should the item not be prioritised.
- Following this, items were reviewed line by line and prioritised into individual categories- 'Contractual', 'Charity-funded', 'Essential', 'Priority' and 'Desirable', and ranked by expenditure category.
- In the latest draft iteration, based on the level of funding available, only 'Contractual', 'Charity-funded' and 'Essential' categories have been approved as budgets for 2016/17. A final review checked items in the 'Priority' column to see if they were suitable to leave unfunded.

The major difference between the figures below and those presented in the 8th February submission has been the inclusion of circa £7m of capital slippage from 2015/16, which is now included in the 2016/17 capital budget.

As a result of this process, the trust has finalised its capital programme. The programme currently is formulated as follows – all figures £,000's.

Category	Contractually committed £000	Charity funded £000	Essential exp £000	Agreed Funding £000
IMT	2,617		2,554	**5,172**
Infra renewal	671		7,221	**7,892**
Infra Renewal - Energy centre	11,556			**11,556**
Major Projects	3,047	660	3,096	**6,804**
Medical Equipment		1,048	3,795	**4,843**
Other			2,031	**2,031**
SWL PATH			183	**183**
Grand Total	**17,891**	**1,708**	**18,880**	**38,480**
Less capital value of new finance leases			**-3,604**	**-3,604**
Capital Expenditure (cash)	**17,891**	**1,708**	**15,276**	**34,877**

Based on the above, the trust has undertaken the trust is looking to invest in the following major programmes during 2016/17.

- **IM&T** – Major areas of investment are around basic infrastructure renewal – implementing changes to the trusts main PAS system and electronic document management and prescribing systems, which improve patient safety.
- **Infrastructure Renewal** – Major expenditure on generator renewal and fire safety projects, lift upgrades and theatre refurbishment

- **Energy Contract** – the trust is committing £11.6m to the renewal of its energy centre, the plant that supplies the energy to the main site. This project is financed by a secured loan from the London Energy Efficiency Fund (LEEF).
- **Major projects** – Developing the Surgical Assessment Unit, in line with commissioner requirements and funding, developing endoscopy services to cope with additional demand, and costs associated with enhancing theatre capacity for cardiac and neurosurgery on site are major developments this year.
- **Medical equipment** –funded by finance leases, along with £1m investment in replacing equipment at the end of its working life.

The trust is exploring ways of better using assets, including:
- Exploring a managed equipment solution to the catheter laboratories upgrade that is required in the coming year
- Extending asset lives where risk is low
- Reviewing the community estate currently owned and managed by the trust, and looking to reduce the total number of bases within the community, whilst still delivering a high quality community service.

7.6 Transformation Programme and efficiency savings 2016/17

The trust established a Transformation Programme with the aim of fundamentally changing elements of the way the trust works, and through that to release significant savings. The initial aspiration for the programme was that it would save £50m net during 2016/17, and although plans are still being developed and refined, the current expected net saving is £36.2m, excluding income from any asset disposals. As the plans get finalised, the trust is working to ensure that any double-counts of savings are identified and removed.

The trust expects benefits from the programme to include:
- The transformation programme will help us address the current ways of working so that we can reduce waste, delays and confusion for patients, whilst saving money and enabling us to treat more patients.
- The transformation programme will engage staff in having a greater positive impact in their work and build their transferable skills as we improve services.
- The transformation programme offers them the opportunity to work together to improve the value of the services they provide, giving us a sense of shared purpose, collective success, and real team pride.
- We want St. George's to top the rankings in patient care and quality, as well as staff satisfaction and financial success.
- By improving our services and reducing our costs, we will help make sure the NHS is there for generations to come.

There are five main transformation workstreams, each led by an executive director. These workstreams are detailed below:

7.6.1 Workforce efficiency

The workforce accounts for 61.9% of the trust expenditure. Tight management and control on staff numbers, roles and responsibilities is therefore a crucial transformation programme requirement. The trust has a number of efficiency and productivity schemes linked to this workstream. All workforce savings schemes are subject to the quality impact assessment process, which is led by the Chief Nurse and the Medical Director.

This workstream covers realigning the size and shape of the organisation, finalising the second stage of the nursing establishment review, reviewing the medical staff establishment, improving productivity and further reducing spend on temporary staff to ensure the workforce is better positioned to deliver the trust's strategy and turnaround. The following table details the key elements of the programme, and current anticipated saving from each element.

Project Name & Summary	2016/17 Anticipated net Saving £,000's
Reducing Pay Costs This workstream will support the trust in reducing the average unit pay cost of its workforce. This project is made up of five work streams including: 1.Extending temporary staffing controls successfully implemented in 2015/16 across all non-nursing staffing groups in 2016/17 2.Review and implementation of actions to address payroll review findings within key domains including 3.Expansion of the apprenticeship scheme at St. George's 4.Expansion of the salary sacrifice programme 5.Review of the level of new Local CEAs awarded during the annual round	**3,156**
Reduction in medical secretaries and clinical admins costs The letters and other dictated clinical correspondence we produce are important to patients, staff and the trust. They are essential in providing high quality care, keeping people up to date with what is happening, the organisation of future tests and treatments, accurate record keeping and ensuring that the trust is properly paid. The project improve service and save money through: 1. Reduce delays in the current process, through the adoption of a single framework 2. Reduction in human error through automation etc. 3. Usage of IT to distribute letters, moving away from paper versions 4. Centralised filing and automatic filing of clinical correspondence.	**163**
Medical Workforce Review The Project is a review of the medical workforce looking at four workstream, the two main ones being: To review the medical workforce and job plan the Consultant workforce to the activity demand of the service including a review of education, research and off site cover. Currently not all consultants have a signed job plan. The pay bill for the trust Consultant workforce is: Employed Consultants £61,421,018, Budgeted Agency Consultants £380,295, Budgeted Locums £3,006,028. To review all junior doctor rotas for gaps and to ensure optimum rota design and a review of the hospital at night. This will provide the trust with assurance that the actual distribution of staff is optimised to provide safe patient care.	**1,822**
Nursing Establishment Review To implement a review of senior nurses/ Midwives in order to minimise the non-patient facing tasks which could be carried out by staff at a lower grade and as such secure best value from staff, integrated with workforce, financial and service business planning. In preparation diary cards have been completed by senior nurses/ Midwives within St. George's highlighting a number of issues including: 1) Overall compliance with assumed senior role in patient facing time ratios are not in place 2) Admin appears be taking up a proportion of the role (which includes telephone calls) some of these duties could be managed by a lower grade of staff	**2,621**

Est. benefit: release approx. 7-10% of Senior Nursing time to be released through vacancy or natural staff turnover To complete a review of AHP staff to meet Operational/ Service profiles whilst reducing WTE to benchmarked peer proportions	
Nursing Temporary Staffing St. George's has the opportunity to reduce the overall average unit pay cost for the nursing workforce by taking the necessary actions to implement National guidance in relation to further bank and agency controls. Implementation of this project will support the trust in reducing the current performance against monitors cap to delivering the 8% compliance cap in FY16. The reducing average unit pay costs - Nursing and Midwifery project is made up of five work streams including: 1) Delivery of the aggregated qualified Agency caps to 8 % by April '16 2) Overseas recruitment of 125 nurses to replace Agency usage by Dec' 16 3) Enforcement of e-rostering management SOPs across St. George's by April '16 4) Reduction in RMN usage by 50% in Q1 '16 5) Delivery of 85% student nurses direct entry by Sep '16 for students from Kingston and Kings`	**1,492**
South West London Staff Bank Establishing the SW London Bank is expected to help to attract staff to work for the local NHS directly, rather than through an agency. This project aims to bring the capacity of 5 staff banks (St George's, SWL Mental Health, Kingston, Epsom and St. Helier and Croydon) together to improve bank fill rates and reduce reliance on agency staff. This is not a merger of bank teams but a sharing of bank staff. To achieve this the trust's involved need to; ▪ harmonise roster policies ▪ harmonise bank rates ▪ implement a technology platform to share shifts with bank staff members across the 5 organisations	**174**
Spans and Layers This workstream seeks to support St. George's in realigning the size and shape of the organisation to reduce the pay costs of the workforce by reducing inefficiency and duplication in management spans and layers. The trust management roles and responsibilities have largely grown organically, with limited consistency across divisions in terms of management layers and spans of control. Indicative findings suggests that: ▪ there are 14 layers of management in the trust, i.e. from CEO to the most junior employees. This is high compared to benchmarks and good practice set at 8 layers. ▪ there are 120 managers with a 1:1 management relationships (17%) and 261 managers listed as having fewer than four direct reports (37%) suggesting the trust is not maximising its investment in the existing management layers. The next two phases of this project will re-design management spans and layers and will roll out the new approach across the trust.	**555**
Total anticipated Workstream savings	**9,984**

7.6.2 Clinical Transformation

One focus of this workstream is on improving theatre utilisation and productivity and minimising the need for extra physical capacity as well as looking at how theatre consumables and equipment are utilised and managed. The other aspect is improving length of stay to speed up patient pathways and reduce the use of the private sector.

Project Name & Summary	2016/17 Anticipated net Saving £,000's
Diagnostics Currently the Diagnostic Service is experiencing operational challenges to manage capacity and demand. There have been challenges during the financial year because of reduced staffing levels (e.g. current vacancy factor radiographers approx. 25%), ultrasound equipment, requirements to upgrade plain film x-ray equipment and potential lack of capacity for MRI to meet any growth in demand. The Diagnostics Directorate have proposed an aspirational plan to create sustainability for the longer term through an integrated approach. Expected benefits: (1) Improved quality and focus on reduced error reporting (2) grow activity/demand in the service, by: increasing productivity, increase capacity (staff and/or modalities), and managing demand. (3) become a more integrated Diagnostic Service, building on the work the trust has undertaken to integrate STGH, QMH and the Nelson Diagnostics (4) Improved patient flow through the hospital and reduction in the length of stay.	**1,383**
Flow Programme Over the last 18 months, the trust's Flow Programme has focused on reducing length of stay in adult beds. Specific areas of focus were: ▪ working with 29 wards to identify address issues around earlier discharge ▪ implementing iClip 5 a day to give a trust-wide view of patients' EDDs and PDDs and reasons for delay ▪ Improving DTOC and NDTOC management to reduce delays ▪ Improving management of internal transfers from AMU to downstream wards ▪ Opening and utilisation of a Departure Lounge to release beds earlier There are 4 key breakthrough objectives for 16/17: (i) Fully embedding and augmenting existing flow initiatives (ii) Broadening core discharge practices across all adult and paediatric acute wards (iii) Prioritising new initiatives, with an emphasis on implementing high impact interventions suggested by OVOT and MADE (iv) Building a robust performance management framework to drive sustained improvement	**2,200**
Theatre Productivity There is a significant opportunity to improve theatre productivity at St George's, specifically the number of operations per list, by raising the current in session utilisation of certain specialities to the UK national average or upper quartile in comparable acute hospitals, and overall session utilisation By raising Main theatre [79%] and Day Surgery Unit utilisation [77%] to 85% the trust will generate [774] theatre sessions for an additional [1,560] elective cases	**1,900**
Outpatients The trust sees in excess of 800,000 outpatient appointments a year, generating over £110m in income each year. Outpatients are currently managed across two divisions, by three management teams using two different income models. There are currently multiple processes and methods of reporting and managing outpatient services. Proposal ▪ Align the current outpatient models to develop a unified and standardised approach to	**TBC**

delivery of outpatients ▪ Core business rules, processes and IT systems in place to support central management team ▪ Review ways of working, capacity & demand to ensure the OP service is efficient and high quality ▪ Centralised approach to management of all outpatient rooms to ensure fully utilised, through the introduction of room management system.	
Total anticipated Workstream savings	**5,484**

7.6.3 Portfolio optimisation

This workstream will assess the clinical services portfolio and the scope to improve efficiency and effectiveness; and will seek to increase the contribution from private patient and commercial activities.

Project Name & Summary	2016/17 Anticipated net Saving £,000's
Fix, Close, Transfer For the 15/16 financial year, clinical services delivered a gross margin (income less direct costs) of circa 12% of income. This gross margin is insufficient to cover overheads. The position is not equally shared across services, however, with some making a significant gross margin, while others are failing to cover even direct costs. There is a need to understand both financial performance and the reasons underpinning financial performance at service level to ensure that the correct measures can be taken to address service specific issues.	**3,025**
Commercial To increase private patient income and activity undertaken at St. George's in Neurology, Cardiology and Cardiac Surgery so as to generate additional income. This project is an element of the wider private patient strategy for the trust. The trust currently undertakes work on behalf of Gibraltar. This project aims to increase Gibraltar activity above and beyond forecast 16/17 plan to bring the activity more in line with contractual obligations.	**484**
Total anticipated Workstream savings	**3,509**

7.6.4 Divisional / functional improvement

Project Name & Summary	2016/17 Anticipated net Saving £,000's
Divisional Savings Projects The trust will expect its clinical divisions and support and corporate functions to continue to make business as usual improvements in the delivery of healthcare. The target for the departments is significantly reduced from previous years, as the focus of the trusts CIP programme moves to more transformational projects.	**10,000**
Medicine Optimisation Pharmacy has a proven track record of achieving significant savings through Medicines Management Cost Improvement programs. The target will be achieved through a number of schemes including contract updates, generic medicine switches, biosimilar medicine introductions, prescribing policy changes and reduced waste.	**1,831**
Total anticipated Workstream savings	**11,831**

7.6.5 Corporate efficiencies

This is focusing on improving the performance of corporate departments and reducing costs as well as securing procurement savings associated with the Carter review and other opportunities.

Project Name & Summary	2016/17 Anticipated net Saving £,000's
Procurement Procurement is to deliver a recurring benefit to the trust, via cost improvement, cost pressure avoidance and cost recovery for 2016/17, and on-going stock reduction. Projects are subject to on-going review and change but are likely to comprise: 1. CIPs already identified and included in the Procurement programme for 16/17 2. New 'ordinary course' CIPs - better prices on existing products, substitution for cheaper products, better ways of working; to include increased collaboration with SWL APs and other trusts. 3. Improved consumption management (behavioural change) on key categories of spend (e.g. legal services, translation); 4. Historic consumption/compliance review; 5. Permanent inventory reduction; 6. Reduced use of consignment stocks.	**6,000**
Back office modernisation The objective of the project is to design and implement new ways of working which achieve a reduction in Finance, Estates, HR and IT operating costs, whilst at the same time maintaining and preferably enhancing service delivery. The solutions for each function will vary and may include process and systems improvements, the development of a unified internal support function(s) and outsourcing, or a combination of two or more. The final solution for each function will be determined following the development of a robust baseline and options appraisal.	**TBA**
Implementing Lord Carter Report The trust transformation plan sets out the actions we are taking to realise the savings outlined in Lord Carter's report across areas such as workforce efficiency, clinical transformation portfolio optimisation, infrastructure etc. In developing the plan the trust has benchmarked improvement opportunities from a number of sources, including the Carter review which indicated a £55m opportunity over 3-5 years. As the Carter Model Hospital analyses are completed nationally, the trust will look to incorporate these findings into the trust's transformation programme, supporting each service to improve their productivity and efficiency still further.	**TBA**
Total anticipated Workstream savings	**6,000**

8.0 Risks to delivering the 2016/17 Operational Plan

The trust has a comprehensive governance process that identifies and manages risk within the trust. A number of the challenges, or actions to address those challenges, are covered by the trust's various risk registers and particularly the Corporate Risk Register.

For clarities sake, however, the following key risks to the delivery of the operational plan have been identified.

Risk	Risk Description	Potential impact	Mitigation
Plan Delivery	The 16-17 Plan is not achieved. The financial plan could be destabilised by "must-dos" including patient safety, leading to slippage on recovery plans, pressure on cash; and non-achievement of in-year plans.	Key stakeholders lose confidence in the trust and its leadership team.	Focussed strengthening of management capacity and capability to assure delivery Continuing emphasis on the continuing need to proceed at pace to deliver change; Continuing dialogue with stakeholders to ensure shared approaches to challenges.
Income & Activity	Expenditure reductions and regulatory risks impact on the trust's ability to deliver planned activity. The trust has insufficient capacity to deliver expected levels of activity	Strategic Transformation and other budgeted income funding are not achieved. The financial plan is not achieved	Careful balancing of income and expenditure priorities to ensure that activity is delivered. Continuing dialogue with stakeholders including support to commissioner QIPP plans (demand management.)
Expenditure	Efficiency programmes will not be sufficient to deliver savings assumed within budgets. Staff do not buy in/ understand the requirement to deliver agreed expenditure budgets. Risk that the expenditure budgets after efficiency gains are seen as incompatible with the achievement of income targets; and/or central/local savings targets are double counted, giving the Board a false sense of assurance	CIP targets are not achieved. The expenditure plan is not achieved.	Minimise risk of double counting by devolving financial targets to divisional levels; Stronger performance management and follow-through of actions; Increase assurance through robust data quality; tight management of vacancies and staff costs.
Regulatory Risk	The financial plan is not accepted by NHS Improvement. Care Quality Commission, Royal Colleges and other regulators may require additional investment NHS Improvement may increase controls over agency and premium costs, leading to staffing constraints.	The trust does not achieve its income target. The trust is required to invest more than its budgeted expenditure plans (capital and/ or revenue) The trust is unable to manage within the cash resources available. The trust's financial plan is not achieved	Raise awareness within divisions and develop locally-owned mitigation plans; Develop active communication plans for stakeholders and patients about responses to risks and mitigating actions; More robust performance management to promote improved ownership and mitigations.

These further risks were identified in the 8th February submission and remain relevant, though many form a sub-set of the key headings above.

1. That the lack of capital funding, internal or external, does not allow the trust to progress major infrastructure projects outlined in section 3, particularly the renal re-provision and children & women's hospital
2. That unexpected infrastructure failure forces the trust to spend additional monies on the capital programme, so risking delivery of the trusts financial targets
3. That unexpected additional constraints on capacity mean that plans to improve access target performance as outlined in the plan are not delivered
4. That staff turnover and vacancy rates remain unchanged or worsen, impacting on the continuity of patient care, the ability to meet the agency cap, and impact on the ability to deliver the workforce savings outlined in this plan

9.0 Foundation Trust Membership and elections

As a relatively new FT, the trust is working with its Council of Governors to define their role, the relationship between trust and Council, and how both engage with the wider membership.

As at January 2016, the trust has a total membership of 20,383, made up of 12,304 public members and 8,079 staff members. The trust is aiming for a stable membership at or around this number and will be agreeing with Governors, future target membership.

Governor elections were held in July 2014. Governors all received an induction after election and at least a third attend the monthly board meetings as observers on a regular basis, and three rotating Governors are allowed to observe board committee meetings.

There are currently five staff governors, eight nominated from key local stakeholder organisations and 15 public governors from primarily south west London and Surrey, reflecting the tertiary nature of the services the trust provides. The next elections are planned for February 2017, two years from authorisation as an FT.

The trust has undertaken a number of activities to engage, support and provide education for Governors, to enable them to fulfil their role as democratically elected public representatives. Examples include:

- A Finance Workshop in June 2015, delivered by the Chief Financial Officer and Wandsworth CCG's Finance Director, to give an insight into the challenges facing NHS and St. George's funding and demands, legal and other requirements on those monies.
- The trust has held workshops and training on the following
    - Protocols regarding Governor attendance at Board Committee Meetings
    - Their role in Quality Inspections, which is a key programme of inspection and review of all clinical areas which runs on an on-going basis. This included training on infection control, speaking to patients and how to escalate any problems that are highlighted. To date seven governors have taken part in these inspections
- The Council of Governors are well attended by trust Directors, including the CEO, whom update them on key plans and developments and are subject to challenging scrutiny from the council.

The first Annual Members Meeting was held in July 2015 where Governors met public and staff and took part in escorted 'wellbeing walkabouts' beforehand around the hospital. Governors are invited to all staff briefings and receive information about public consultations and also receive the weekly media update so are aware of anything mentioning the trust in the media (including social media).

The trust engages with the various communities that utilise our services, including local community and faith groups such as Healthwatch, the Tooting Islamic community centre, school sixth forms etc. The trust undertakes monthly talks out in the community covering different health topics which the Governors also attend, as well as talks to Students of the associated St. George's University of London students union.

In addition to face to face activities, the trust actively uses social media – Facebook, Twitter and websites to keep members and the public more generally informed about current issues. This includes sending a month e-mail bulletin to over 6,500 users for whom we have an e-mail address.