St George's University Hospitals NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: 3rd March 2016
Time: 9.00 – 1.00
Venue: H2.5, 2nd Floor Hunter Wing, Boardroom 5

	Time	Item	Paper
1.	9.00	**Welcome**	Chair
2.		**Apologies for absence/changes in membership**	Chair
3.		**Declarations of Interest** To declare any pecuniary or non pecuniary interests	Chair
4.		**Minutes of the meeting** Held on 4th February 16 to be confirmed as an accurate record	Encl: 01
5.		**Schedule of Matters Arising**	Encl: 02
6.		**Chief Executives Report** Report of the Chief Executive	Encl: 03
7.	9.40	**Urogynaecology Report** Report of the Divisional Director of Children's, Women's, Diagnostic, Therapeutics Critical care	Encl: 04 (To follow)
Patient Safety Quality and Performance			
8.	10.10	**Performance & Quality Report** Report of the Director of Nursing	Encl:05
9.		**Turnaround Board update (verbal)** Turnaround Director / Interim Director of Finance, Performance & Informatics	verbal
10.		**Workforce Report** Report of the Joint Director of Workforce Organisation Development	Encl:06
Strategy			
11.	10.55	**SWLP Post Implementation Review** Report of the Managing Director SWLP	Encl:07
12.		**Outpatient Recovery Plan update** Report of the Chief Operating Officer	Verbal
13.		**Annual plan 16/17 progress update including budget setting** Director of Strategy	Encl: 08
Finance and Performance			
14.	11.35	**Finance Report – month 10** Report from the Interim Director of Finance, Performance & Informatics	Encl: 09
15.		**Report from the Finance & Performance Committee (verbal)** Report from the Chair	

	Time	Item	Paper
Governance and Risk			
16.	12.05	**Risk and Compliance Report** Report from the Chief Nurse, Director of Infection Control	Encl: 10
Items for Information			
17.	12.35	**Use of the Trust Seal –** To note use of the Trust seal in February 2016 The seal was used: • 02.02.16 – Purley War Memorial Hospital Breast Screening • 02.02.16 – Bed Capacity Scheme (Option 5+18) • 04.02.16 – Trinity Fire, Lanesborough Wing • 09.02.16 – Estates Areas Lease SGH	
18.		**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*	
19.		**Points of Reflection**	
20.		**Date of next meeting** The next scheduled meeting of the Board to be held in public will be 7th April 2016	
		Exclusion of the Press and Public **RESOLUTION** **That under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of business to be transacted.**	
		Close	

St George's University Hospitals NHS
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Minutes Trust Board

Minutes of the meeting Trust Board of St George's University Hospitals NHS Foundation Trust, held on Thursday 4 February 2016 in the Seminar Room, Rose Centre, St George's Hospital, commencing at 9am and concluding at 12.10pm.

MEMBERS PRESENT

Sarah Wilton	SW	Acting Chair
Mike Rappolt	MR	Deputy Chair, Non-Executive Director
Kate Leach	KL	Non-Executive Director
Stella Pantelides	SP	Non-Executive Director
Prof Jenny Higham	JMH	Non-Executive Director
Miles Scott	MS	Chief Executive
Jennie Hall	JH	Chief Nurse
Simon Mackenzie	SM	Medical Director
Steve Bolam	SB	Chief Finance Officer
Wendy Brewer	WB	Director of Workforce
Martin Wilson	MW	Director of Delivery & Improvement
Rob Elek	RE	Director of Strategy
Paula Vasco-Knight	PVK	Chief Operating Officer
Eric Munro	EM	Director of Estates and Facilities
Jill Hall	JHA	Interim Trust Secretary
Andrew Burn	AB	Director of Transformation
Lisa Pickering	LP	Divisional Chair, Medicine and Cardiology
Paul Alford	PA	Divisional Chair, Community Services
Tunde Odutoye	TO	Divisional Chair, Surgery
Andy Rhodes	AR	Divisional Chair, Women and Children

Agenda Item	**Action**

1 Chairman's opening remarks

The Chair welcomed everyone to the meeting

2 Apologies for Absence

There were none.

3 Declarations of Interest

Mike Rappolt, Non-Executive Director, declared an interest in agenda item 9.2 Charity Independence Report as he is a Trustee of the St George's Charity.

4. **Minutes** of the meeting held on 14 January 2016 were approved as an accurate record subject to the following:

COO was looking at the call centre performance to aim to reduce the number of abandoned calls — PKV
Finance report – add – MR asked why performance had dipped in November….

RESOLVED
That the minutes of the meeting held on 16 January 2016 were approved.

5 Matters Arising

All matters arising were either on the agenda or being actioned:

Action 7 – Mental health in ED – CSU had produced a review and evaluation which will be included in the April performance report — PVK
Action 7 – Outpatients appointments – 18 week position will be included in the April performance report — PVK
Action7 – Bed occupancy rates it was noted the calculation for October/November was incorrect.
Action 7 – Mental Health mortality issues – due to be reported to Board on 7 April 2016 — PVK
Action 7 – Complaints – will be reported to Board on 7 April 2016 — JH
Action 8.3 – Outpatient additional activity income – move due date to 7 April 2016.

6 Chief Executives Report

The Board received the regular report of the Chief Executive which gave an update on key developments within the Trust. In particular highlighting the recent acknowledgement by the Sentinel Stroke National Audit Programme (SSNAP) which rated the Trusts Hyper Acute Stroke Unit an 'A' grade and the 24/7 thrombectomy service, the first in the Country, which the Trust expects to launch this year.

The Board noted the positive media coverage in the Guardian following interviews with staff on two occasions and the positive social media comments.

The Board were updated on the urogynaecology consultation noting that to ensure all comments from stakeholders and the public had been analysed a report would be submitted to the Board at its March meeting for decision..

It was noted that there had been growing interest in the PAG service and three members of the Executive team would be attending OSCs in South West London over the next week. The Chief Executive reiterated that the PAG service had not been closed.

In response to a question on primary care and GP involvement and views on strategic development it was noted that a report would be brought to the Boards meeting on 7 April 2016. — RE (7 April 2016)

7 Quality and Performance

7.1 Quality & Performance Report

The Chief Operating Officer (COO) introduced the report had highlighted that Emergency Department (ED) performance remained challenging in January with an increase of 12% in attendances and 16% increase in ambulances, this mirrored the picture across London. It was noted that McKinsey had been engaged and would work with the Trust over five weeks to implement One Version of the Truth and look at onward care. It was reiterated that this was a system wide issue that required a system wide approach and action plan. The Chief Nurse was the Senior Responsible Officer (SRO) for this work.

It was noted that although the RTT standard had not been achieved, progress on patients waiting over 18 weeks was being made. A new plan to replace the Health Commissioners Plan, which no longer applied, would look at planned and unplanned care. Timescales had been agreed with commissioners and a sustainable action plan was due for submission at the end of March.

The Board welcomed the news that in December both the 14 day and 62 day cancer targets had been achieved. A lot of work to support patients waiting over 104 days was noted. The cancer plan was continuing to be delivered with patients referred via the 14 day referral process now being seen within 7 days.

Discussing delayed discharge of care (DTC) and stakeholder engagement it was noted that this remained a problem with 86 patients currently delayed. It was noted that there had been a two day multidisciplinary event with representatives from the local authorities, commissioners, GPs and staff, which had reviewed all wards and patients and came up with a number of actions. Domiciliary and onward care had been highlighted as a problem for local authorities and it was recognised that the system needed to work collectively. Future monitoring would be through the System Resilience Plan.

The Chief Nurse reported that the Flow Programme would be supported by McKinsey over the next five weeks. She would be co-chairing the group with a CCG representative, still to be appointed, which meant that both organisations could hold each other to account. KL asked for assurance on the commitment of the co-chair, it was noted that the appointment would be confirmed later that day.

It was agreed that as this was an important piece of work the Flow Programme would be circulated to the Board. The Chief Executive reported it was also part of the Transformation Programme. — JH by end of the week

The Board also noted that the surgical virtual assessment unit was open and was working well.

The Chief Executive reported that Commissioners required assurance on the Boards, and clinical services, commitment to achieve RTT performance standards, it was agreed that the RTT Plan would be

submitted to the Board at its meeting on 7 April to ensure the Board had a good understanding.

The Chief Executive also explained that Commissioners could impose a fine for failing to achieve RTT, however, an agreement had been reached that if the standard was met by 31 March 2016 then no fines would be levied and an agreed amount would be refunded back to the Trust.

In response to a comment on cancelled operations performance it was noted that performance looked worse due to the small numbers of patients involved. It was further noted that operations cancelled before the day were not counted.

Mortality
The Chief Nurse reported that SHMI numbers had returned to lower than expected levels.

Safety
It was noted that the SI trend charts had been amended as requested by the Board.

There had been no reported cases of MRSA and to the end of December 24 cases of C-Diff had been reported. The Trust remained on trajectory for C.Difficile.

Safeguarding Training
It was noted that the Safeguarding Manager was working to improve rates across the Trust.

Patient Experience
FFT performance continued to underperform against the target for response rates in outpatient settings, it had been agreed that the method used to collect responses would be reviewed.

Complaints
The number of complaints had decreased in November and response rates had improved. The Chief Nurse addressed the points raised in the internal audit report and said that the Policy did include tracking complaints but this would be amended to include themes. It was further reported that a workshop was being held in March on lessons learnt from complaints.

The Board noted issues with the infrastructure on Knightsbridge Wing and Buckland Ward with interruptions in the electricity supply and failure of the heating system which led to temperatures dropping in some clinical areas, with disruption to some services.

In response the Director of Estates and Facilities reminded the Board of the age of Knightsbridge Wing and that to run a clinical service in that area required a lot of work to upgrade the infrastructure. Due to the age of the systems replacement parts had to be custom made.

SW referred to WHO non-compliance and sought assurance that where compliance was low Divisional Chairs and DDO's had clear action plans in

place to improve performance. Where areas required support this would be given.

SP referred to safe staffing and queried the comments on robustness of recruitment plans. In response the Chief Nurse confirmed that plans were in place. However the current job environment was challenging alongside turnover rates.

The Board commented on the low levels of Safeguarding Children training, which was currently at 43% trained and how this looked across the Divisions. The Director of Workforce commented on the importance of ensuring the ARIS system was up to date with staff in post.

7.1.1 **Quality and Risk Committee update report**

The Chair of the Quality and Risk Committee provided a verbal update on the recent meeting of the Committee. In particular the following was highlighted:

- Medical Records data had improved from 90% to 97%, a significant improvement;
- The committee noted the progress on SAP Committee for diagnostic, this was still not satisfactory but processes were being put in place, the QRC would continue to monitor progress monthly.

The Board noted the update.

7.2 **Finance Report**

The Chief Finance Officer presented the Month 9 finance report and reminded the Board that at its meeting on 14 January it had agreed the revised budget of £56.1m.

The Board noted that the cumulative deficit was £1.8m better than plan mainly due to a underspend on pay budgets because recruitment to posts had been slower than planned. Pay spend had improved following better control of agency and recruitment processes. It was noted that the underspend had been partially offset against underperformance on SLA income, particularly in outpatients and non-elective admissions and higher than expected SLA penalties.

The Board noted that the Trust would continue to work to improve the financial position against the £56.2m. Reporting on the recent meeting with Monitor and the TDA it was noted there was now evidence in the numbers of the improving position, recognised by the regulators.

Other areas that would contribute positively included delaying capital projects, converting capital to revenue, this would deliver approximately £2.2m. The Board also noted the good news on delivery of CIP with 98% reported green.

In response to comments on NHS debt and progress on debt recovery, it was noted that the 2014/15 debt would be recovered by the end of February. There had been no payment on the 2015/16 contract which was currently £9m and increasing, this would be escalated during February. It was also noted that the Trust was actively pursuing all debt.

Discussing NHS England (NHSE) debt it was noted their payment terms were 3 months in arrears and would challenge back to the Trust any invoices it deemed were outside of the contract terms. NHSE then had to follow their local approvement procedures prior to payments being made. It was noted that the total debt owed by NHSE was £14m.

In response to KL's comment on the estate infrastructure and particularly Knightsbridge Wing issues reported earlier, it was noted that high risk areas were being addressed and resources identified.

The Board also discussed outpatient activity, which now had plans and a strategy to deliver against. DNA rates continued at 13%, a lot of work was being done to reduce this down to 10%.

RESOLVED
That the Board NOTED the financial performance for month 9.

7.3 **Workforce and Performance Report**

The Board received the report of the Director of Workforce who highlighted the following:

- Turnover had increased again in clinical roles
- There had been a net reduction in vacancy rates in December
- Sick absence levels remained above target at 3.5%, at this time of year levels were expected to peak, however, the spike was holding for longer that expected
- Bank/agency staffing rates had increased in December but was now showing a return to October/November levels
- Agency price cap breeches were being reported
- MAST training and appraisal rates remained static

MR asked what the Trust was doing about framework agreements for agency staff which were above the price cap set by Monitor, in response it was noted that the framework was set below caps. It was still unclear what penalties would be imposed; Monitor was in the process of collecting information. HR Directors were working together to ensure there were no breeches and Trusts continued to provide safe patient care. There would continue to be a need to bring in staff urgently but with better planning better rates could be achieved. The focus was now on working with South West London Bank but with a recognition that there would be times when premium rate staff would be needed.

MR referred to Safe Staffing and asked what the implications would be if a further review was carried out by the regulators and Government. In response the Chief Nurse reported that next year a workforce redesign would be undertaken. It was noted that a review of skill mix had already been completed. The Carter review was recommending that staffing should be looked at by nursing hours per patient in a day. The Board were reminded the Trust had been part of the pilot and had some data available to it. It was felt that next year the Trust would be reporting nurse : patient hours.

In response to comments on sick absence rates and concerns on the number of day lost due to stress and anxiety, the Director of Workforce

recognised that this was an issue of concern. She reported that there was a framework of support mechanisms in place for staff to access.

Discussing how workforce data reflected in the financial position and particularly the impact of £43m savings needed to be achieved in 15/16 and £50m in 16/17 and staff taking on more work. SP reiterated that 16/17 savings must be transformative and not just about taking people out.

The Chief Executive agreed that staffing issues were a concern, particularly the continuing high levels of staff turnover. He recognised that benchmarking data available tended to related to performance of more than 3 months previously. He asked the Director of Workforce if she could contact peer trusts to find out if there was a similar situation. WB

RESOLVED
That the Board NOTED and DISCUSSED the report.

7.3.1 **Update of the Workforce Committee**

The Chair of the Workforce Committee reported on the meeting held on 26 January 2016. In particular:

- A review on the progress to date on appraisal process and review of past performance
- Noted that workforce efficiency and the efficiency project were monitored at TAB
- It could not give the Board assurance on the Community Service action plan due to a lack of evidence, the Director of Workforce would support the service with developing more specific actions.
- When securing savings Divisions should do this alongside maintaining quality and staff experience
- There had been a report on undergraduate education. The committee had requested more information about resourcing and proposals about the strategic direction.
- A review had been undertaken of the trust's policy on bullying and and harassment and, it was clear that some other Trusts were doing taking a more proactive approach. The trust's policy and approach would be revised to reflect this feedback.
- A business case to expand the recruitment team and purchase new software systems was endorsed
- Targets and plans to achieve 85% MAST compliance by June had been received.

MR suggested that the Trust think about outsourcing recruitment, in response, the Chair of the Workforce Committee reported the current approach was to develop the internal team.

JMH referred to training and asked who owned the St George's brand, it was agreed this should be a discussion between the trust and the university.

MR requested a report on training be submitted to a future Trust Board meeting. Director of Workforce – date to be agreed

7.4 **Junior Doctors Update**

The Chief Executive gave an update on the position of the Junior Doctors industrial actions. Further action was due to take place on 10th February.

The Medical Director reported that many Consultants and senior doctors supported the Junior Doctors action. He added that the outcome of the strikes would likely be a government imposed solution. The Divisional Chair for Surgery added that junior doctors accepted Saturday working was coming but were unhappy with the proposed rate of pay remaining the same as week day pay.

The Chief Operating Officer reported that letters were going out to patients in preparation as some outpatient appointments would be cancelled.

7.5 **Audit Committee Report**

The Board received and noted the report of the Chair of the Audit Committee. In particular it was noted that the internal audit into discharge summaries had been delayed by 5 months due to no clinical expert being available, the new internal auditors had been asked to help. The external auditors as part of the annual accounts had recommended reducing the level of materiality to 1.2%, the Committee had asked for further clarity.

TIAA had begun the handover process from LAC. The Committee had thanked LAC for their services to the Trust.

The committee had also thanked Judith Hulf and Sarah Wilton for their contribution and support.

The report highlighted changes made to the Audit Plan 15/16 and sought the Boards approval.

RESOLVED
That the Board NOTED the report and ENDORSED the changes to the Audit Plan 15/16.

7.6 **Transition Plan**

The Transformation Director reported on the work being done to ensure a smooth transition once KPMG had exited the Trust. It was noted that the Director of Delivery and Improvement was the responsible officer for driving this forward. The SRO's had identified 50 WTE to ensure business as usual (BAU). The list would be reviewed and would be part of the process to look at relocating internal staff whilst a recruitment process was undertaken or aspect of the work required were tendered out. Final plans and numbers would be reported to Finance and Performance Committee and Board for approval.

7.7 **2015/16 Working Capital Loan Agreement Authorisation**

The Chief Finance Officer presented the report which set out in detail the current loan agreement arrangements and the need to secure a new permanent facility with a lower interest rate. He reported that the Trust expected to draw another £9.7m in March from the temporary facility.

SP asked if disposal of assets would breech the agreement, in response it was noted that the Trust would need to seek approval.

In response to a comment on cash flow it was noted that the Trust needed to focus on cash during quarter 4 to ensure it didn't experience the similar issues going forward in 2016/17.

7.8 **Monitor Update**

The Board noted the verbal update which highlighted the following for the board to note:

1. Positive progress was being made on identifying the £50m savings target for 16/17
2. The Board had accepted the proposal regarding transitional funding with NHSI to get to £17.5m

8 Strategy

8.1 **2015/16 Annual Report Process**

The Board received and noted the report of the Director of Strategy on this years process for the preparation of the Annual Report. The Board noted the key dates and that additional meetings of the Audit Committee and Trust Board were required.

8.2 **Annual Operating Plan and Corporate Objectives 2016/17**

The Director of Strategy presented the report which set out progress against the current business planning round and some of the key assumptions underpinning the draft.

It was noted that the process had begun early off the back of the turnaround process. This was an early first draft that was required by Monitor to be submitted to them by 8 February.

The Board discussed the report and highlighted the need for the plan to be aligned with other 16/17 plans. The Director of Strategy reminded that Board that there were a number of holding pages that would be completed once the Challenge Sessions with Divisions had been completed.

The Board approved the recommendations and agreed that the Chair should be included in the delegated authority.

RESOLVED
That the Board:

a. **AGREED to delegate authority to the Chair, Chief Executive and Chief Finance Officer to authorise the completed operational plan and financials to Monitor on 8 February 2016; and,**
b. **APPROVED the proposed framework for the development of corporate objectives for 2016/17**

8.3 **Annual (Operational) Plan Q3 monitoring report**

The Board received and noted the report.

9 Governance

9.1 Procurement Policy

The Board received and noted the policy. It was noted that the policy was not just addressing procurement but also behaviour around the Trust. A communications plan would be run alongside the policy implementation and monitored by Finance and Performance Committee.

9.2 Charity Independence Report

The Chief Executive presented the report and explained the proposal to support the charity for independence highlighting that this would not affect the Trust.

KL highlighted the importance of knowing who the Trustees were so as not to loose sight and cause problems in the future. It was noted that a NED would sit on the Charity Board, currently this was Mike Rappolt.

RESOLVED
That the Board:

a. **NOTED and DISCUSSED the two options set out in the report;**
b. **AGREED to register its agreement for St George's Hospital Charity to form as a new charity independent of the Department of Health and unaffected by the NHS Act 2006.**

9.3 Risk and Compliance Report

The Chief Nurse presented the report and highlighted the new risks as set out in the report.

10 General Items for information

10.1 Care & Environment Report – Arts Strategy

The report of the Director of Estates and Facilities provided an update on progress with improving care and the environment across the Trust. It was noted that a number of the schemes had been supported by the Charity.

10.2 Use of the Trust Seal

The Seal had not been used in January 2016.

10.3 Questions from the public

a. A member of the public stated they hoped the Junior Doctors industrial action would not take place and therefore ensure no operations were cancelled.

b. A member of the Council of Governors suggested that there were a number of ways Governors could be used including links to wards and supporting staff welfare.
In response the Chief Executive reported that currently governors were involved in the Boards Sub-committees and its strategic agenda.

Governor involvement would be picked up in more detail with governors.

c. A member of the public asked it the Trust and University held joint Board meetings. In response it was noted that the there was a joint meeting, JIB, which discussed finance and operational issues.

11. **Meeting evaluation**

12. **Date of next meeting**
Thursday 3 March 2016

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
3 March 2016

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 3 March 2016
7.	14 Jan 16	Quality & Performance Report	**Death of people with mental capacity issues** – identify this group in the mortality figures	7 April 16	P Vasco-Knight	Due April 2016
7.1	14 Jan 16	Quality & Performance Report	**Complaints** – Q3 report to include themes, learning and actions and improvements	7 April 16	Jennie Hall	Not due until April, part of routine reports so can be closed.
8.4	14 Jan 16	One Version of the Truth	6 month update	July.16	P Vasco-Knight	Due April 2016
7.3	14 Jan 16	Workforce & Performance Report	South West London Trusts – Set up shared Bank Agency. Report on the setting out the plans with a statement of memorandum	April 16	W Brewer	The project is on track to bring proposals to the April board.
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 .	April 16	P Vasco - Knight / R Elek	Should sit within the outpatient strategy update for April 16
4.	4 Feb 16	Minutes of previous meeting 14 Jan 16 (amendment)	Call centre performance to be looked at to aim to reduce the number of abandoned calls	TBC	P Vasco-Knight	
6	4 Feb 16	Chief Executives Report	In response to a question on primary care and GP involvement and views on strategic development it was noted that a report would be brought to the Boards meeting on 7 April 2016	7 April 16	R Elek	Due April 2016
7.	4 Feb 16	Quality Report	Flow programme to be circulated to the Board. (Also be part of the Transformation Programme)	Feb 16	J Hall	This is OVOT which the Board have been briefed about, PID will be presented at the challenge session.
7.	4 Feb 16	Quality Report	RTT plan to be submitted to the Board to ensure the Board have a good understanding.	7 April 16	P Vasco-Knight	Due April 2016
7.	4 Feb 16	Quality Report - Mortality	SHIMI numbers had returned to lower than expected levels, a full report would be submitted to the Boards	7 April 16	J Hall	Already reported to QRC so can be closed
7.3	4 Feb 16	Workforce & Performance Report	High levels of staff turnover – WB to contact peer trusts to ascertain if in similar/same position.	TBC	W Brewer	

7.3.1	4 Feb 16	Update of the Workforce Committee	Training report to be submitted to Board	TBC	W Brewer	

St George's University Hospitals NHS
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REPORT TO THE TRUST BOARD – MARCH 2016

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

Executive summary

1. Key messages

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

- Quality & Safety
- Strategic developments
- Management arrangements

2. Recommendation

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

Key risks identified:

Risks are detailed in the report under each section.

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

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

If yes, please provide a summary of the key findings

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

1. Health Sector Developments

1.01 Launch of NHS Improvement – 11 February 2016

11 February 2016 saw the official launch of NHS Improvement (NHSI), the new body in charge of improvement in the NHS. NHSI also set out its vision for providers and the support it will offer the health service. It published the first of a series of 'roadmaps' from national health bodies, intending to facilitate the attainment of the Five Year Forward View. The document outlined the key priorities for NHS provider organisations in delivering high quality health and care this year and beyond.

For the full document, please follow the link below.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499663/Provider_roadmap_11feb.pdf

2. Strategy

2.01 Primary Care Engagement and Strategic Development

The third edition of our newsletter for colleagues in primary care was published in February 2016 and is available via this link https://www.stgeorges.nhs.uk/gps-and-clinicians/intouch-gp-newsletter/

3. Academic Developments

3.01 Research

A Pre-Qualifying Questionnaire (PQQ) was submitted on 15 February 2016, as part of a bid to the National Institute for Health Research (NIHR) for a Biomedical Research Centre (BRC). We will not hear the outcome of this stage until April 2016, and if successful will need to submit a full bid by 6 June 2016.

The NIHR has also just announced a national competition for Clinical Research Facilities (CRFs). This is a one-stage process and we will be looking to submit a bid, in line with the deadline of 22 June 2016.

3.02 Clinical Academic Groups

At the Joint Implementation Board (JIB) held on 23 February 2016, we agreed to the proposal for the development of a Neurosciences Clinical Academic Group (CAG). Further to this, a proposal for a Women's Health CAG was commissioned: potentially the third CAG to be established by the university and the trust.

4. Operational Developments

4.01 Junior Doctors' Contract

Following a breakdown in negotiations, the Secretary of State decided to proceed with the implementation of the junior doctors' contract from 1 August 2016. Trusts received a letter from Jim Mackey the CEO of NHS Improvement, confirming the expectation of consistent implementation of the new contract across the NHS. Further to this, Professor Ian Cumming the CEO of HEE wrote a letter informing trusts that the contract's implementation would be a key criterion for HEE in making its decisions on investment in training posts.

The BMA has also announced three more 48 hour strikes, taking place on:

- Wednesday 9 March from 8am
- Wednesday 6 April from 8am
- Tuesday 26 April from 8am

Emergency cover will be provided for all three.

Within the trust we have held a series of open meetings with junior doctors, consultants and clinical managers. Any local engagement has been taking place via the Local Negotiating Committee, and our Medical Director, Simon Mackenzie, is chairing a working group overseeing the process.

5. Board Appointments

Chief Financial Officer

I am sorry to announce that Steve Bolam has stepped down from his role as CFO, and will be taking up a new national role at NHS Improvement, the successor body to Monitor and the Trust Development Authority. Steve has served St George's for over three and a half years with great distinction, imagination and commitment. We wish him every success and fulfilment in his new role. His last day at the trust was on 12 February 2016.

In light of this, Iain Lynam has been appointed Interim Chief Financial Officer. Iain is a very senior and experienced finance professional with particular expertise in corporate and financial restructuring in both the NHS and the private sector. He formally took over the reins from Steve on 15 February.

Director of Transformation

I would like to congratulate Martin Wilson on being appointed Director of Transformation for the trust. Martin has been the Director of Delivery and Improvement for St George's since August 2014, and has great experience of transformational roles; in the private sector as well as in the NHS.

Divisional Chair Community Services Division

Finally, I would like to announce that Paul Alford's term as Divisional Chair of the Community Services Division has come to an end and that the trust will be interviewing candidates on 1st March 2016. An announcement regarding Paul's successor will be made in the next CEO's report.

6. Communications

3.01 Media update

The February/March edition of *By George!* has been distributed around the trust and is on the intranet. It features articles on staff health and wellbeing, a remarkable patient recovery and celebrating our successes.

A protest over the closure of our urogynaecology services coincided with International Day of Tolerance for Female Genital Mutilation Day on Saturday 6th February. The story was picked up by the Guardian and the Wandsworth Guardian. The majority of articles published have incorrectly reported the services affected. We contacted the Guardian for a correction and published a statement to the trust's website.

Miles Scott was referenced in several articles across traditional and social media regarding the junior doctors' contracts. A statement is on our website to illustrate Miles' position.

The pioneering work of Matthew Crocker in neurosurgery was highlighted in the Daily Mail's Me and My Operation section and focused on how new surgical techniques were greatly improving outcomes for patients who had suffered spinal cord injuries.

The HSJ published a second article relating to the findings of the trust's PwC report. The trust published a response to our website.

Our resident emergency department GP, Dr Hamed Khan, was mentioned in the Huffington Post in an article on childhood obesity. Dr Khan was strongly in favour of a sugar tax as a disincentive to parents to buy foods with high sugar content.

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting: **TRUST BOARD** **March 2016**
Document Title: **Urogynaecology at St George's**
Summary: The urogynaecology service was suspended due to safety concerns in June 2015. This paper describes the consultation process that has been followed since the suspension. The consultation process has concluded that the original grounds for suspending the service remain and that there was a need for SGUH to re-explore how the service could be re-provided in a clinically and financially sustainable fashion. This paper recommends that the Trust works with commissioners to explore how to re-provide the urogynaecology service in the future.
Author and Date: Andrew Rhodes 26 February 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.

The following conditions were treated at SGUH

- Primary incontinence and prolapse
- Recurrent incontinence and prolapse
- Postpartum pelvic floor problems Tertiary Acute Conditions:
- Combined Pelvic floor clinic
- Complex Urology
- Neuro-urology

The service was provided and supported by

- 1 x clinical lead (2 sessions per week)
- 1.7 x consultants
- 1 x associate specialist
- 2 x clinical fellow
- 2 x clinical nurse specialist
- 3 x administrators

Suspension of Urogynaecology Service at SGUH

The Urogynaecology service was suspended in June 2015 due to concerns about the safety and governance of the service. The Women's Directorate approached the CWDT Divisional leadership team as they no longer had confidence in the quality being provided by the urogynaecology service and raised issues with regards to patient safety. This was on the background of many longer term issues (HR and clinical) that the Directorate had been trying to resolve with the service for a number of years (Appendix 1). External professional organizations had tried to intervene on these issues without success. Following review by the Division, the Medical Director and a number of external parties a decision was therefore taken to suspend the service in order to give time to better understand the available options that would re-assure the Trust that quality, safety and governance could be restored.

Current Status of Suspension

The service currently remains in suspension as has been unable to resolve the quality, safety and governance issues.

As a consequence of the decision to suspend the service a number of steps had to be taken with immediate effect. These included the need to:

1) Find suitable alternative provision for the patients;
2) Understand and manage the related impact on other services;
3) To ensure adequate engagement with key stakeholders with appropriate consideration afforded to equality issues to guide future decision making.

Suitable Alternative Provision

The subspecialty provided for patients from the boroughs of Wandsworth and Merton in the main. During the period of suspension, 170 patients from the borough of Wandsworth remained on a continuing RTT (referral to treatment) pathway, and 109 remained from Merton. In order to secure continuity of care for these aforementioned patients, the Trust took the decision to offer patients the opportunity to move their care to an alternative provider (Croydon University hospital).

Croydon University Hospital (CUH) is a tertiary level provider of urogynaecology and is the only provider in the SW London region to have received British Society of Urogynaecology (BSUG) accreditation. All patients affected were contacted to explain the movement of their transfer of care to CUH. Those patients who did not wish to move their care were provided with details of the following alternative providers in London to be referred to by their GP.

- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- Kings College Hospital NHS Foundation Trust
- Guys and St Thomas' NHS Foundation Trust

Following suspension of the urogynaecology service the trust acted in conjunction with Wandsworth CCG to agree that all of the patients who were using the service at the point of suspension were followed up or treated by either CUH or another provider. The trust is satisfied that CUH provides a suitable alternative provision of urogynaecology with the appropriate level of specialised skills and treatment available. CUH is one of two independently recognised subspecialty urogynaecology units in South London, accredited by the British Society of Urogynaecologists. Details of other providers of urogynaecology have been provided to both GP's and patients.

Understand and manage impact on other services

As a consequence of the suspension of the urogynaecology subspecialty service the following services were impacted:

- **Maternal Perineal Service.** The service remains in operation, although its overall management is now under the care of the consultant obstetric team.
- **Pessary Management Clinic.** The service remains in operation, although its overall management is now under the care of the consultant gynaecology team.
- **Neuro-Urology and Complex Urology Service.** The service remains in operation, although its overall management is now under the care of the consultant urology team.
- **Post natal patients requiring perineal care** continue to be treated at SGUH.
- **Adult Female Genital Mutilation.** The service remains in operation, although its overall management is now under the care of the consultant gynaecology team.
- **Paediatric and Adolescent Gynaecology (PAG) Clinic.** The PAG service was a relatively small (but very important) service for children and adolescents. It was predominantly run by one of the consultants who practised in urogynaecology. As a consequence of the decision to suspend adult urogynaecology, and due to a number of HR issues, a new clinical pathway for the delivery of this service had to be created. This new pathway has had to take into account both clinical and safeguarding provision issues. The new clinical pathway has been reviewed by the CQRM and the safeguarding issues have been reviewed by Jenny Hall (Chief Nurse and lead for Safeguarding to the Trust board), Dr. Sarah Thurlbeck (Designated Doctor for safeguarding) and Dr. Peter Green (Safeguarding lead for CCG). Further details of this PAG service are provided in Appendix 2.

There has been adequate engagement with key stakeholders and appropriate consideration has been afforded to equality issues.

The Trust undertook a consultation process in order to understand future options for the re-provision of this service. This included discussions with commissioners, staff and the wider public (Appendix 3 and 4).

1. Discussions with Commissioners

The Trust met with Wandsworth Clinical Commissioning Group (CCG) to inform them of the developing situation and to seek their guidance and support for the approach proposed. The CCG supported the Trust's decision to suspend the service and agreed with the approach to moving patients to CUH, but requested that on occasions whereby the patient in discussion with their GP elected to be referred to an alternative provider, that this would be facilitated.

During the period of June 2015 – December 2015, 1300 patients have had their care moved to CUH. Throughout this period, the Trust engaged with patients via telephone and written queries and assisted with any concerns as required.

2. Internal staff consultation

A staff consultation process took place in August 2015. A range of potential options were obtained from the staff to be considered by the Clinical Management teams. None of these options provided an obvious solution to the original concerns. Following consultation with the Trust Board a public consultation was commenced in order to widen the views as to the potential future options for the service.

3. Public Consultation

To further inform the Trust's Board and to enable better decision-making, a public consultation was commenced from 12 October 2015. The trust consulted on the proposal that the unit remains closed and that the Urogynaecology service is not provided by St George's, but by other local hospitals.

During this period of the consultation, the subspecialty remained in suspension. As part of this process the Trust consulted with the Health Oversight and Scrutiny committees of Wandsworth, Merton, Kingston and Sutton Councils, Healthwatch Wandsworth, local commissioning groups and the general public. Healthwatch Wandsworth informed the process to enable wider consultation with special interest groups in particular to ensure appropriate equality and diversity issues were taken into account.

4. Equality issues

Equalities issues have been considered and work has been done to mitigate inequalities, as is detailed in Appendix 5.

<u>Conclusions from public consultation</u>

The public consultation process provided a wide and extensive series of views as to potential options for the reconfiguration of the service. These views were all considered in detail. None of the proposals could be implemented with immediate effect or would mitigate the previous safety concerns that led to the service being suspended. There was a clear view expressed that SGUH should re-explore the provision of urogynaecology for the local population. After taking these views into account, the original proposal of closing the service has been re-considered. The Trust now proposes to further explore options to provide a secondary care urogynaecology service.

Proposals for the future

The original proposal was to close the urogynaecology service at SGUH. In response to the public consultation significant feedback has been given to re-look at this and to re-assess how the service could be provided in the future. We now propose to begin a process of liaison with commissioners to understand the appetite and specification for the re-establishment of a urogynaecology service at SGUH. The proposed models arising from the consultation will be fed into this discussion and evaluated should the CCGs indicate that they wish to commission a service from St George's. Any reconfigured service would need to meet the requirements of both clinical and financial sustainability in accordance with the trust's business case process. The Trust will also have to do further work to understand the equalities issues (including around access) and further consultation may be required. The service would have to remain in suspension during this period.

Recommendation for the Board

The Board is asked to support this proposal.

Appendix 1

History of Issues

In early 2014, a senior consultant Urogynaecologist from Croydon University Hospital NHS Trust (CUH) was appointed as a Clinical Director for two programmed activities (PAs), to provide leadership to the unit following difficulties in cohesive working between the two Consultants. The appointment to the Clinical Director (CD) role was for a fixed term period of one year. The Directorate heavily invested and supported the two consultants to engage with mediation and professional relationship coaching to improve the unit's viability, without demonstrable improvements.

The CD was asked to establish an appropriate governance structure including the multi-disciplinary team process (MDT) for complex cases, to assist the unit's British Society of Urogynaecologist (BSUG) application and to act as a lead expert and accountable decision maker where differences of clinical opinion between the medical staff in the sub-specialty occurred. However, the CD reported that due to a heavy reliance placed on her by the urogynaecology team members from the start of her appointment, she was regularly working in excess of the two PA allocation, which she found to be unsustainable. She further reported that due to further governance concerns, along with clinical disagreements in the management of both primary and complex cases, and on-going disputes raised by each consultant against one another, she was unable to provide the level of supervision required to the team as a whole and therefore could not continue as responsible governance lead. The CD requested to leave her position following a three month extension between March – May 2015.

The 2013 NICE Incontinence Guideline recommends that all invasive treatments for over active bladder and stress urinary incontinence need to be discussed between clinicians at an MDT (multi-disciplinary team) meeting, prior to treatment, to help ensure optimal management. However, in the absence of the external CD, and without resolution of the on-going clinical governance, leadership and relationship issues within the department, it was evident that there was no lead clinician internally to take forward appropriate leadership of the unit and effective Chair of the local MDT. As effective governance requires discussion between appropriate clinicians, a single operating consultant provider cannot also act in the role of Chair.

The directorate of Women's Services reviewed the pool of alternative Consultant Urogynaecologists across the region who were of sufficient experience and seniority to recruit to the role of CD, however there was no suitable successor identified. Of note, this arrangement is exceptional to that of any similar sized tertiary unit with two senior consultants where it would ordinarily be an expectation that leadership is managed internally, without the need for additional supervision.

In May 2015, the Medical Director, Clinical Director for Women's services, Care Group Lead for Gynaecology, Divisional Director, Divisional Chair and General Manager for Women's Services met to discuss the operational impact of the CD's resignation and the concerns regarding the on-going insufficient clinical governance arrangements to support the safe delivery of patient care. Upon hearing all of the information presented, the Medical Director decided that without a senior clinical lead the subspecialty could not run a functioning multidisciplinary team meeting (MDT) where treatment plans are discussed and agreed. This posed a clinical governance risk and was not compliant with current guidelines.

In response, the trust therefore had to take the decision to suspend the service to new referrals and in the interest of patients provide an alternative care provider for those on a continuing pathway from Monday 8 June 2015, until such time as there has been a full review of the options and the service.

Appendix 2

Paediatric Adolescent Gynaecology

Background

In June 2015, the subspecialty of Urogynaecology was suspended on safety and governance grounds. At the point of suspension, a clinician for urogynaecology who also managed the Paediatric and Adolescent Gynaecology (PAG) clinic went on sick leave. On their return the individual in question has been on restricted duties and has not been working clinically. As a consequence the trust has needed to provide continuity of care for patients already in the service, and to establish an appropriate service for new referrals.

Safeguarding Review

All of the 10 GP referrals and case notes of the patients who were not under acute care have been reviewed by Dr Sarah Thurlbeck, Consultant Paediatrician and Safeguarding lead doctor who confirmed that they are appropriate for gynaecological review and that there are no specific safeguarding concerns of a child maltreatment type identified. The remaining 28 are all under the care of a Consultant Paediatrician referred in for specific gynaecology treatment. To address any concerns had around safeguarding: all of these patients are general gynaecology referrals or female urology, and none have been referred as part of an active safeguarding investigation. Each of the cases has also been clinically reviewed and assurance provided that no safeguarding issues have arisen from the length of wait some of the patients experienced to be seen.

Revised PAG Clinic

The revised PAG clinic has moved to the management of Children's Services. The clinic will be led by Miss Evans, Consultant Paediatric Urologist and Mr Murphy, Consultant Paediatric Urologist with gynaecology support from Dr Franco, Associate Specialist in Gynaecology and nursing support from CNS Affleck, Clinical Paediatric Nurse Specialist. All of the staff have received Level 3 Child Safeguarding training (February 2016) and have experience working with children and adolescents particularly in gynaecology and female urology. Recommendations from the Royal College regarding specific PAG qualifications will be explored and supported for the staff over the next three months. The clinic will be held and based in the Children's Dragon Outpatient Centre. The clinic will accept referrals from both GP and secondary consultants. The service has been reviewed by Jennie Hall, Chief Nurse, Dr Thurlbeck, Named Doctor for Child Safeguarding and CNS Hogan, Paediatric Clinical Nurse Specialist and Named Nurse for Child Safeguarding.

Appendix 3

Public Consultation

The process of public consultation has included:

- Engagement with Healthwatch Wandsworth
- Engagement with the following 7 community groups, who were sent the original consultation document as well as translations in Polish, Urdu and Tamil where appropriate. (They were also sent an invitation to the public open evening held on 1 December 2015):
    - Age UK
    - Wandsworth Older People's Forum
    - Somali Community Advancement Organisation (SCAO)
    - Women of Wandsworth
    - South London Polish Ladies Circle
    - South London Tamil Welfare Group
    - Wandsworth Asian Women's Association
- Engagement with the trust's Governors and Patient Representatives
- The trust writing directly to 900 users of the service asking them to provide their views
- A public open evening held on 1 December 2015, at which the Chief Executive was present.
- Attendance at the following Health Overview and Scrutiny Committees (OSCs):
    - Wandsworth on 12 November 2015
    - Sutton on 20 January 2016
    - Kingston on 26 January 2016
    - Merton on 9 February 2016
    - Wandsworth on 9 February 2016 (at which an update will be provided)

Responses in public consultation

Number of formal responses received

Format	**Number**
Email	78
Post	20
Petition signatures	654

Appendix 4

Methods used to publicise consultation

Method	Details	Area/numbers covered
Letter sent with consultation document	Details of consultation plus how to send views on proposal	Hard copy sent to 900 users of the service
Letter emailed with consultation document (including translations in Urdu, Tamil and Polish as appropriate)	Details of consultation plus how to send views on proposal	• Age UK Wandsworth • Wandsworth Older People's Forum • Somali Community Advancement Organisation (SCAO) • Women of Wandsworth • South London Polish Ladies Circle • South London Tamil Welfare Group • Wandsworth Asian Women's Association
Support publicity in partner publications (websites, intranets and newsletters)	Details of consultation (including translations and consultation extension) plus how to send views on proposal	Healthwatch Wandsworth website
Twitter and Facebook	To say that consultation documents available in Tamil, Urdu and Polish with links to them	The trust has 10,000 twitter followers
Trust website	Consultation documents (plus translations) and details of consultation extension	1,607 total page views for this story
Governor letters	Publicised the consultation, plus how to send views on proposal	All 28 trust governors
Dedicated consultation email address set up	For official responses	78 responses received via email
Direct communication with service users via	Provided by the Women's Services Management Team	Approximately 60 calls

telephone		

Meetings

Meeting type: patient group	**Details**	**Area/numbers covered**
Meeting with St George's patient reference group	15/10/2015: St George's Patient Reference Group	Wandsworth

Meeting type: partner organisations	**Details**	**Area/numbers covered**
Clinical Commissioning Group	19/08/2015 & 21/10/15	Wandsworth
Wandsworth Council Health Scrutiny and Overview Committee	12/11/2015: The committee received a deputation on the urogynaecology consultation and asked questions to both the deputation and the trust. The trust informed the committee that that the consultation period on the proposed changes had been extended and that the trust would then take a further month to consider all responses and proposals received. Healthwatch offered to help advise the trust on the consultation process. The trust accepted this offer and acted on the advice of Healthwatch to reach residents and patients who had not been engaged in the consultation so far.	Wandsworth Council
Sutton Council Health Scrutiny and Overview Committee	20/01/16: Update given to the committee on the provision of urogynaecology for affected Sutton patients. Questions raised regarding the provision of the Paediatric Adolescent Gynaecology (PAG) Clinic responded to.	Sutton Council
Kingston Council Health Scrutiny and Overview Committee	26/01/16: Update given to the committee on the provision of urogynaecology for affected Kingston patients. Questions raised regarding the provision of the Paediatric	Kingston Council

	Adolescent Gynaecology (PAG) Clinic responded to.	
Merton Council Health Scrutiny and Overview Committee	09/02/16: Update given to the committee on the provision of urogynaecology for affected Merton patients. Questions raised regarding the provision of the Paediatric Adolescent Gynaecology (PAG) Clinic responded to.	Merton Council
Wandsworth Council Health Scrutiny and Overview Committee	09/02/16: Update given to the committee following recommendations to the trust regarding the consultation process in November 2015. Questions raised regarding the provision of the Paediatric Adolescent Gynaecology (PAG) Clinic responded to.	Wandsworth Council

Meeting type: public	**Details**	**Area/numbers covered**
Open public meeting	For the public to ask any questions from service leads and provide views face to face	6 attendees
Publicity for open meeting:	**Details**	**Area/numbers covered**
Consultation document (translations where appropriate) and invitation to open public meeting	Emailed to seven community groups	• Age UK Wandsworth • Wandsworth Older People's Forum • Somali Community Advancement Organisation (SCAO) • Women of Wandsworth • South London Polish Ladies Circle • South London Tamil Welfare Group • Wandsworth Asian Women's Association

Twitter and Facebook	To advertise open public meeting	Messages were retweeted by: • Merton CCG • High Path Community Association • Healthwatch Merton • Healthwatch Wandsworth • Healthwatch Kingston • Tamilelamm • Tooting Press
Tooting Press website	To advertise public meeting	1000 views per week not including traffic generated from social media
Trust website	To advertise public meeting	Trust website attracts approximately 80,000 visits per month
Healthwatch Wandsworth website	To advertise public meeting	Healthwatch staff, members and interested public in Wandsworth

Appendix 5

Equalities Issues

During the meeting with Wandsworth Council on 12 November 2015, Healthwatch raised issue in response to the trust's public engagement process as the consultation document was not presented in languages other than English and it was not felt to have been communicated to vulnerable groups.

In response to the equalities issues raised by Healthwatch, the consultation document was translated and made available in Urdu, Tamil and Polish and local groups were invited to attend the trust's open evening on 1 December 2015.

Croydon University Hospital – The Trust provides comprehensive and professional interpreting services in more than 50 languages - either over the telephone or in person, and including British Sign Language. The trust has good public transport links and works with local primary care to provide patient transport when needed.

REPORT TO TRUST BOARD **Paper ref:**

Paper Title:	Performance and Quality Report to Month 10. January 2016
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director
Authors:	Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Head of Performance
Purpose:	To inform Board about Quality Performance for Month 10.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	EMT

Executive summary

Performance

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

The trust has seen positive performance improvement in Diagnostics with number of patients waiting greater than 6 weeks reducing significantly and has also seen marked improvement with regards to cancelled operations and the number of patients not re-booked within 28 days. Diagnostic performance issues from December relating to the breakdown of a scanner are now resolved, and the trust is back on track.

The Trust has undertaken a One Version of The Truth (OVT) diagnostic exercise which has reviewed emergency care across the system and identified 11 key work streams to action to transform the unplanned care system for the local health and social care economy. Following the OVT review an implementation plan addressing key work streams has been developed and agreed with commissioner and the System Resilience Group (SRG). The SRG have appointed McKinsey to lead the implementation of the unplanned care system re-design plan following the OVT diagnostic exercise. There are 6 key workstreams required to transform emergency care across the system, to include: ED, Shortstay wards, Internal processes, discharge processes, admission avoidance and discharge pathways.

The trust met all cancer targets in December and continues the implementation of its recovery plan to achieve long term sustainability. Performance against trajectories and implementation of the plan continue to be monitored both internally and externally by the SRG via weekly Elective care recovery meetings, chaired by the CCG CCO.

The trust continues to show the quality governance score against the Monitor risk assessment framework of 4 following the Monitor imposed additional license conditions in relation to governance.

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

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

. In addition the Board needs to be aware of some environmental challenges experienced in the last month both within Knightsbridge and Lanesborough Wings which impacted on the delivery of clinical services. These arose mainly from failure of infrastructure which led to some clinical areas being very cold and unable to be used to provide clinical care.

The report highlights the key quality metrics which have been reported during 2015/16 In terms of Quality Metrics, the Overall position in January remains consistent with the previous two quarters in terms of the trends for the metrics with some moderate improvement across a number of indicators. Serious Incident numbers remain an area of focus in relation to themes seen and actions being taken. Routine oversight of serious incidents continues to be monitored through the Patient Safety Committee and SIDM.

Effectiveness Domain:

- Mortality performance remains statistically better than expected for the Trust. Mortality remains in line with expected for admissions at the weekend and for emergency weekday admissions is better than expected. The SHMI position has returned to better than expected. Despite this encouraging position we continue to proactively investigate mortality signals at procedure and diagnosis level.
- National Audits within the report: The results of the National Pregnancy in Diabetes audit are described at a national and regional level, local data is being sought. The results of the National head and Neck Cancer audit is positive with a number of actions for the single metric where the Trust did not score highly.
- The Local Audit in relation to Controlled drug stock and check audit indicates generally an improvement in overall standard, the summary also indicates where immediate action was taken for areas of non-compliance.
- The report indicates the position with compliance with NICE guidance for the period June 2010 to August 2015. The number of outstanding areas of non-compliance has increased, however actions have been put in place to recover this position. Detail is available of all areas where we have declared noncompliance, the reasons for this position and action being taken. Further assurance is being sought in relation to the risk profile; any findings of note will be reported back to the board following the DGB meetings at the end of this month.

Safety Domain:

- The number of general reported incidents in January indicates a similar trend in terms of numbers and level of harm.
- Safety Thermometer performance is 93.96% slightly below the national average for that month. There is a reduction in new harms from the previous months although the board will note the pressure ulcer and Cauti profile. The Trust continues to participate in the HIN CAUTI work with baseline audits now completed.
- No further MRSA bacteraemia cases were reported for January, the total to 3 cases year to date and no cases since Mid-September. There are now a total of 25 C-Difficile cases to the end of January. Therefore we remain on target to meet the annual Trajectory for C Difficile which is set at 31 cases for 15/16. All cases are currently subject to an RCA process.
- Safeguarding Adults compliance for training remains a key area of focus. The Trust is now demonstrating a compliance of 71% for adult training. The board will note that the numbers of staff to be trained is known and there are agreed actions both for adult safeguarding which is being monitored by the respective safeguarding Committee. Following validation of the Safeguarding Children data the compliance for the Trust is now 75% at level 3, with Surgery an outlier in relation to Training performance. Given small numbers of personnel for this Division it is required that compliance is achieved

before the end of the financial year.

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 complaints profile in relation to numbers has increased slightly from December to January by 6. The quarter three position for complaints indicates a consistent picture in terms of overall numbers with 262 for Quarter 3**.** In relation to turnaround times of complaints an improvement can be seen in % within 25 days, although within the agreed timescale the performance has slightly deteriorated in December compared to November. Detail about Divisional improvement actions are included in the report. A complaints workshop is being held on 7th March to review the complaints process end to end.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 94.33 % 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 January is included this month for both Acute and Community services. During this month one clinical ward area was placed 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.

In addition the Board should be aware that there have been some challenges in relation to the Environment which have led to a lack of heating within some clinical areas for a period of time and resulted in the requirement to review delivery of some clinical services with areas closed. There were further problems within Knightsbridge Wing in relation to electrical infrastructure on Buckland ward. Business continuity arrangements were put in place to support safety of patient care.

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

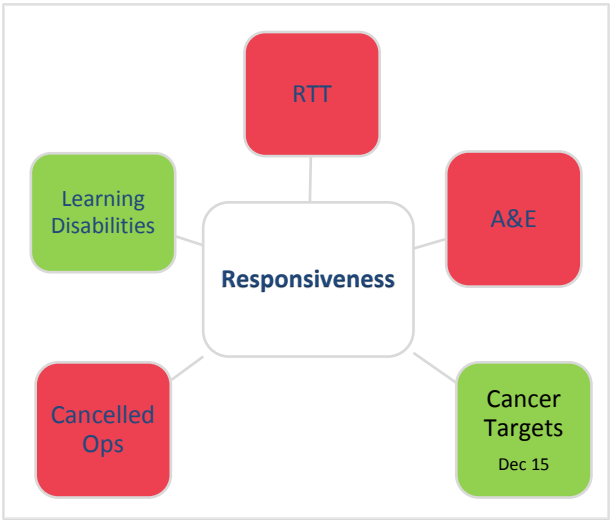
For Trust Board

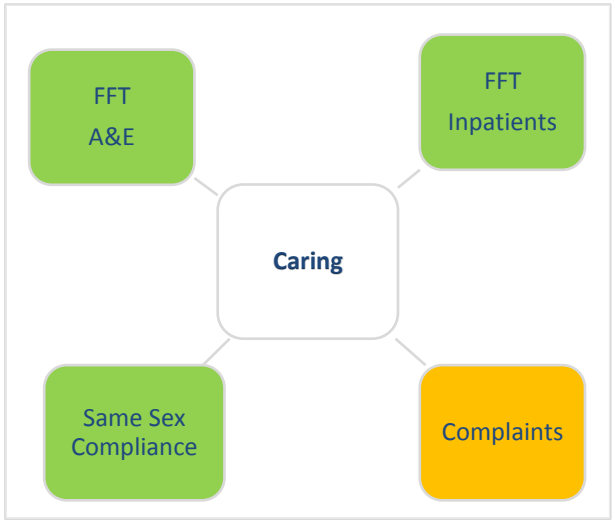
Month 10 – January 2016

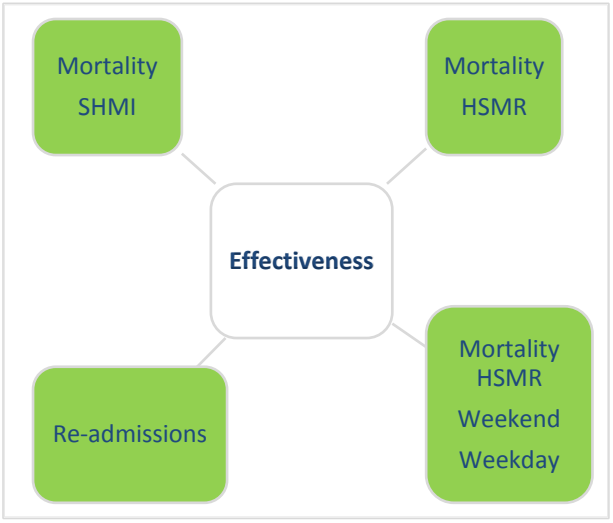
Excellence in specialist and community healthcare

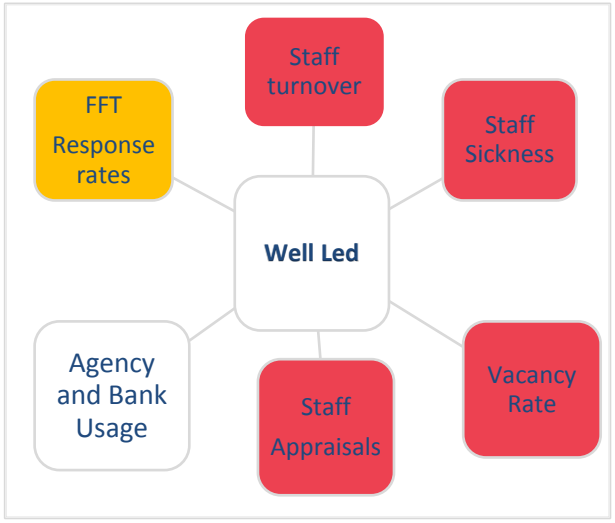
CONTENTS

1. Executive Summary - Key Priority Areas January 2016*









The above shows an overview January 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 December 2015 as reported one month in arrears)

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

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St George's University Hospitals NHS
NHS Foundation Trust

Performance against Frameworks

Excellence in specialist and community healthcare

2. Monitor Risk Assessment Framework KPIs 2015/16: January 2016 Performance (Page 1 of 1)

ACCESS

Metric	Standard	Weighting	Score	YTD	Dec-15	Jan-16	Movement
Referral to Treatment Admitted	90%	N/A	N/A		81.50%	78.20%	-3.30%
Referral to Treatment Non Admitted	95%	N/A	N/A		89.80%	91.00%	1.20%
Referral to Treatment Incomplete	92%	1	1		90.20%	89.70%	-0.50%
A&E All Types Monthly Performance	95%	1	1	91.71%	89.80%	88.66%	-1.14%

Metric	Standard	Weighting	Score	YTD	Q2	Q3	Movement
62 Day Standard	85%	1	1	82.21%	81.93%	84.35%	2.43%
62 Day Screening Standard	90%			90.48%	92.68%	90.20%	-2.48%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	96.67%	97.50%	100.00%	2.50%
31 Day Standard	96%	1	0	97.68%	97.95%	96.13%	-1.82%
Two Week Wait Standard	93%	1	1	86.50%	77.85%	82.73%	4.87%
Breast Symptom Two Week Wait Standard	93%	1		92.73%	94.48%	89.55%	-4.92%

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Dec-15	Jan-16	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	25	1	2	1
Certfication of Compliance Learning Disabilities;							
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant	1	0	Yes	Yes	Yes	
Data Completeness Community Services:							
Referral to treatment * data is for Oct and Nov 2015	50%	1	0		55.7	55.6	-0.1
Referral Information	50%	1	0		88	87.9	-0.1
Treatment Activity	50%	1	0		71.19	69.92	-1.3
Trust Overall Quality Governance Score					4	4	0

January 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 4 and Monitor have imposed additional license conditions in relations to governance. (further details in appendix 1.)

.

Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- 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. Q3 relates to Oct-Dec.

Legend	
⇧	Positive Performance Change
⇩	Negative Performance Change
⇨	No Performance Change

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

2. Trust Key Performance Indicators 2015/16: January 2016 Performance (Page 1 of 1)

RESPONSIVENESS

Metric	Standard	YTD	Dec-15	Jan-16	Movement
Referral to Treatment Admitted	90%		81.50%	78.20%	-3.30%
Referral to Treatment Non Admitted	95%		89.80%	91.00%	1.20%
Referral to Treatment Incomplete	92%		90.20%	89.70%	-0.50%
Referral to Treatment Incomplete 52+ Week Waiters	0	22	4	0	-4.00
Diagnostic waiting times > 6 Weeks	1%		1.16%	0.75%	-0.41%
A&E All Types Monthly Performance	95%	91.71%	89.80%	88.66%	-1.14%
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%	17.31%	26.32%	12.68%	-13.64%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Nov-15	Dec-15	Movement
62 Day Standard	85%	82.21%	85.98%	86.13%	0.15%
62 Day Screening Standard	90%	90.48%	98.70%	91.07%	-7.63%
31 Day Subsequent Drug Standard	98%	100%	100%	100.0%	0.00%
31 Day Subsequent Surgery Standard	94%	97%	100%	96.0%	-4.00%
31 Day Standard	96%	97.68%	100.00%	97.81%	-2.19%
Two Week Wait Standard	93%	86.50%	86.20%	94.84%	8.64%
Breast Symptom Two Week Wait Standard	93%	92.73%	93.71%	97.11%	3.40%

EFFECTIVENESS

Metric	Standard	YTD	Dec-15	Jan-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		91.8	90.9	-0.9
Hospital Standardised Mortality Ratio - Weekday	100	0	92.9	89.7	-3.2
Hospital Standardised Mortality Ratio - Weekend	100	0	96.1	92.5	-3.6
Summary Hospital Mortality Indicator (HSCIC)	100	0	92	90	-2.00
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%	3.10%	2.20%	1.50%	-0.7%
Bed Occupancy - Midnight Count Generl Beds Only	85%		97.8%	99.7%	2.0%
LOS - Elective			4	3.7	-0.3
LOS - Non-Elective			4.9	4.6	-0.30

CARING

Metric	Standard	YTD	Dec-15	Jan-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		93.67%	93.23%	-0.44%
A&E Scores - Friends & Family Recommendation Rate	46		82.37%	83.21%	0.84%
Complaints (1 month in arreas)			72	78	6.0
Mixed Sex Accomodation Breaches	0	5	0	0	0.0

SAFE

Metric	Standard	YTD	Dec-15	Jan-16	Movement
Clostridium Difficile - Varience from plan	31	25	1	2	1
MRSA Bacteramia	0	3	0	0	0
Never Events	0	8	1	0	-1
Serious Incidents	0	123	10	7	-3
Percentage of Harm Free Care	95%		92.8%	93.7%	0.009
Medication Errors causing serious harm	0	3	1	1	0
Overdue CAS Alerts	0	2	2	2	0
Maternal Deaths	1	1	1	0	-1
VTE Risk Assessment (previous months data)*	95%		96.76%	96.51%	-0.003

WELL LED

Metric	Standard	YTD	Dec-15	Jan-16	Movement
Inpatient Respose Rate Friends & Family	30%		20.4%	20.1%	-0.3%
A&E Respose Rate Friends & Family	20%		21.5%	23.7%	2.2%
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%		18.4%	18.5%	0.0%
Trust level sickness rate	3.5%		3.9%	4.3%	0.5%
Total Trust Vacancy Rate	11%		17.0%	16.7%	-0.2%
% of staff with annual appraisal - Medical	85%		84.2%	85.2%	0.99%
% of staff with annual appraisal - non medical	85%		69.4%	69.4%	-0.07%

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. Performance Areas of Improvement (Page 1 of 1) - Cancer Performance - Update

Care Quality Commission Target	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
14 Day GP Referral for all Suspected Cancers	Seen Within Target	1108.0	1160.0	1188.0	824.0	806.0	880.0	886.0	912.0	1159.0
	Total Referral	1198.0	1247.0	1296.0	958.0	1016.0	1250.0	1071.0	1058.0	1222.0
	93%	92.5%	93.0%	91.7%	86.0%	79.3%	70.4%	82.7%	86.2%	94.8%
14 Day Breast Symptomatic Referral	Seen Within Target	109.0	152.0	184.0	120.0	107.0	115.0	120.0	149.0	168.0
	Total Referral	139.0	166.0	187.0	127.0	114.0	121.0	134.0	159.0	173.0
	93%	78.4%	91.6%	98.4%	94.5%	93.9%	95.0%	89.6%	93.7%	97.1%
31 Day First Treatment	Treated Within Target	142.0	122.0	124.0	127.0	154.0	149.0	149.0	122.0	134.0
	Total Treated	147.0	126.0	126.0	129.0	155.0	155.0	155.0	122.0	137.0
	96%	96.6%	96.8%	98.4%	98.4%	99.4%	96.1%	96.1%	100.0%	97.8%
31 Day Subsequent Surgery Treatment	Treated Within Target	31.0	22.0	26.0	23.0	26.0	29.0	6.0	16.0	24.0
	Total Treated	32.0	25.0	26.0	24.0	26.0	30.0	6.0	16.0	25.0
	94%	96.9%	88.0%	100.0%	95.8%	100.0%	96.7%	100.0%	100.0%	96.0%
31 Day Subsequent Drug Treatment	Treated Within Target	36.0	23.0	22.0	21.0	31.0	47.0	19.0	45.0	31.0
	Total Treated	36.0	23.0	22.0	21.0	31.0	47.0	19.0	45.0	31.0
	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 day GP Referral to Treatment	Treated Within Target	55.0	39.5	59.0	62.0	57.0	51.0	63.0	46.0	59.0
	Total Treated	63.5	54.5	74.5	77.0	71.0	59.5	74.5	53.5	68.5
	85%	86.6%	72.5%	79.2%	80.5%	80.3%	85.7%	84.6%	86.0%	86.1%
62 Day Screening Referral to Treatment	Treated Within Target	13.5	16.0	14.0	19.5	16.5	21.0	18.5	38.0	25.5
	Total Treated	15.0	22.0	16.0	21.5	18.0	22.0	20.5	38.5	28.0
	90%	90.0%	72.7%	87.5%	90.7%	91.7%	95.5%	90.2%	98.7%	91.1%
62 Day Consultant Upgrade to Treatment	Treated Within Target	0.5	0.0	0.0	2.0	0.5	5.5	1.0	2.5	2.0
	Total Treated	0.5	0.0	0.0	2.5	0.5	7.0	1.0	3.0	2.0
	85%	100.0%			80.0%	100.0%	78.6%	100.0%	83.3%	100.0%

All cancer performance targets were met in December, with significant improvements made within challenged specialties.

The improvements are in line with the trusts recovery action plan.

December 2015 performance against national cancer targets by tumour type.

Cancer Indicator	All Types	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Skin	Upper GI	Urological
14 Day GP Referral for all Suspected Cancers	94.80%	96.20%	89.00%	96.20%	95.20%	96.90%	100.00%	93.50%	92.30%	96.80%
14 Day Breast Symptomatic Referral	97.10%	97.10%								
31 Day First Treatment	97.80%	100%	100%	100%	100%	100%	100%	87.50%	100%	97.40%
31 Day Subsequent Surgery Treatment	96.00%	100%			100%	100%		100%		100%
31 Day Subsequent Drug Treatment	100.00%	100%		100%	100%	100%		100%	100%	100%
62 day GP Referral to Treatment	86.10%	100%	33.30%	80.00%	50.00%	83.30%	75.00%	100%	66.70%	96.40%
62 Day Screening Referral to Treatment	91.10%	91.70%				87.50%				
62 Day Consultant Upgrade to Treatment	100%			100%			100%			100%

Performance against agreed trajectory

Cancer Standard	Apr-15	May-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
14 Day Standard	92.49%	93.02%	85.89%	79.06%	70.27%	82.71%	86.20%	94.80%			
							83.76%	91.08%	93.06%	93.56%	94.14%
	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

	Apr-15	May-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
62 Day Standard	86.61%	72.48%	80.52%	80.28%	85.71%	84.35%	85.80%	86.10%			
							85.14%	85.51%	86.09%	87.24%	88.96%
	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

TWR

Breast – treated 60 more patients within target compared to November, with the highest volume of referrals in month YTD, achieving target for the first time this year

Head & Neck

Increase of 6.4% and achieving target, treating more patients than previous months.

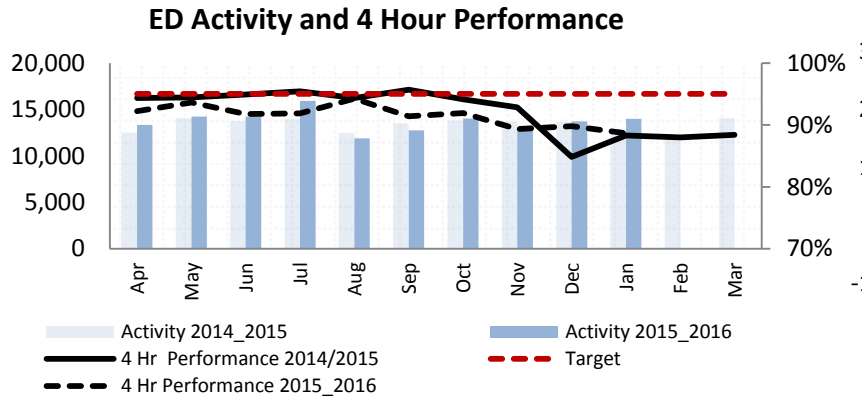
Skin

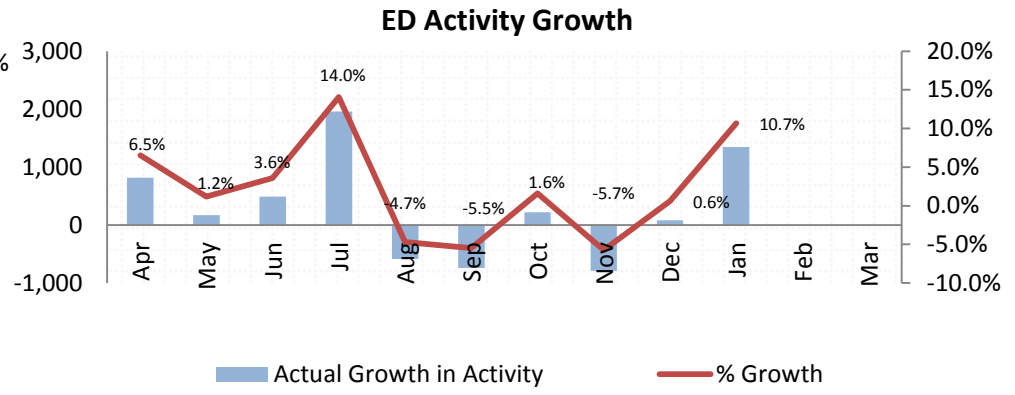
Significant increase in performance + 16.9% compared to November treating 45% more patients within target.

Although Upper GI and Gynae are not yet meeting 93%, significant increases have been seen in December

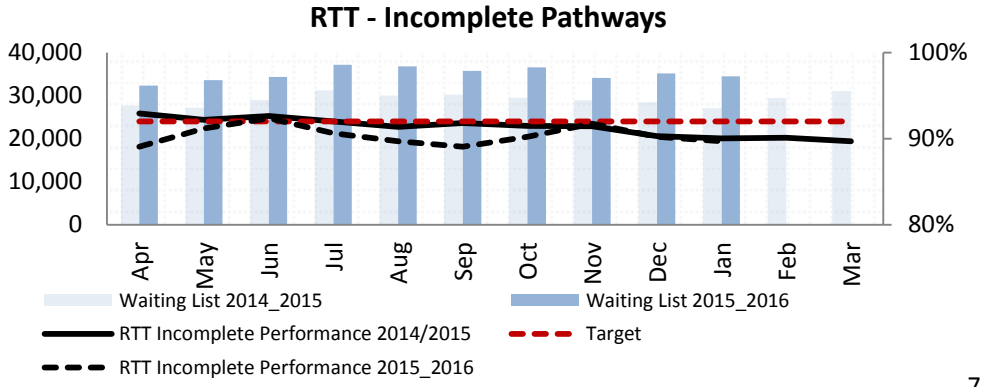
4. Trust Key Performance Areas and Activity Comparison to previous year (1 of 2)

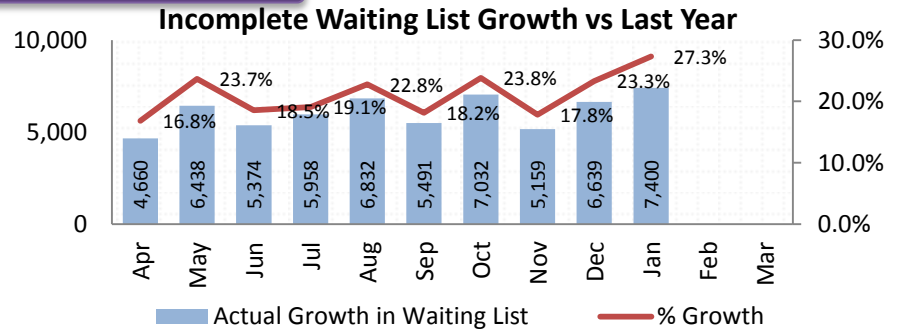
ED Performance

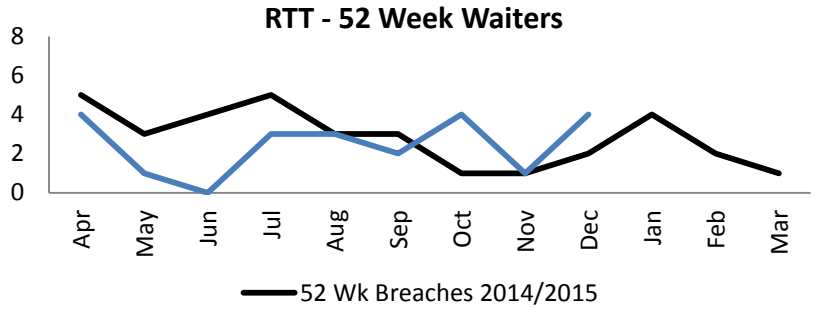


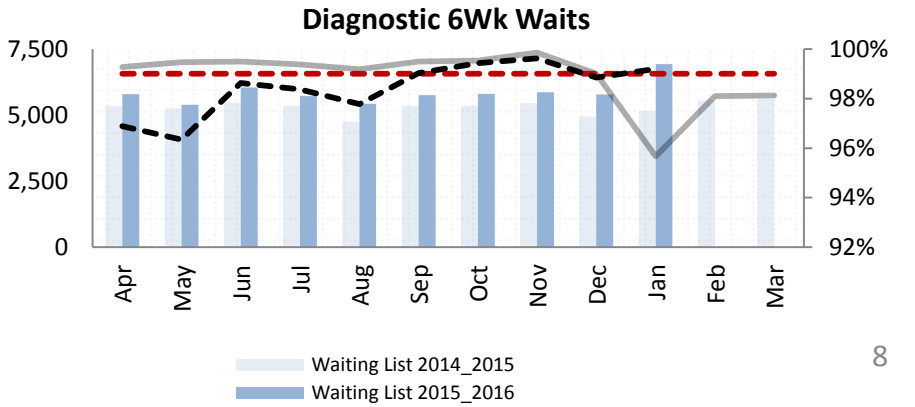


RTT & Diagnostics



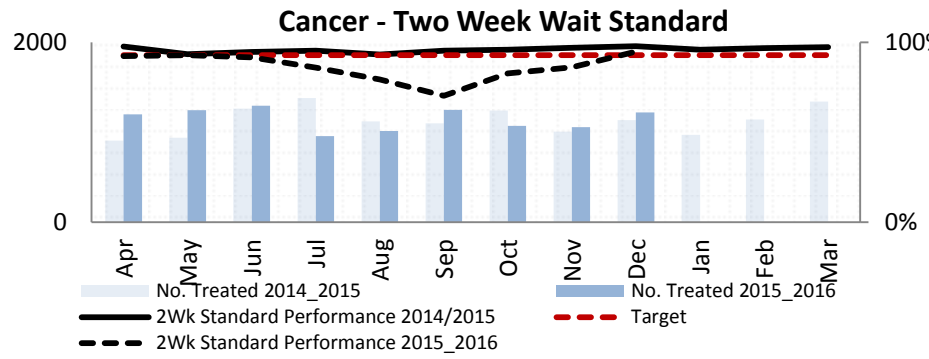


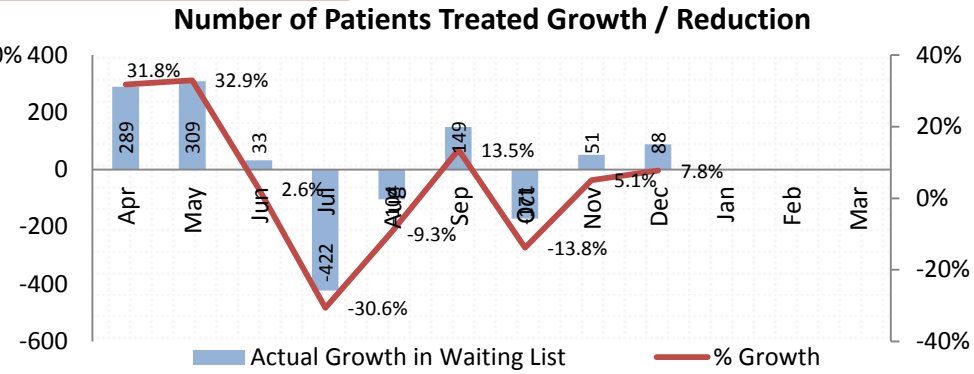




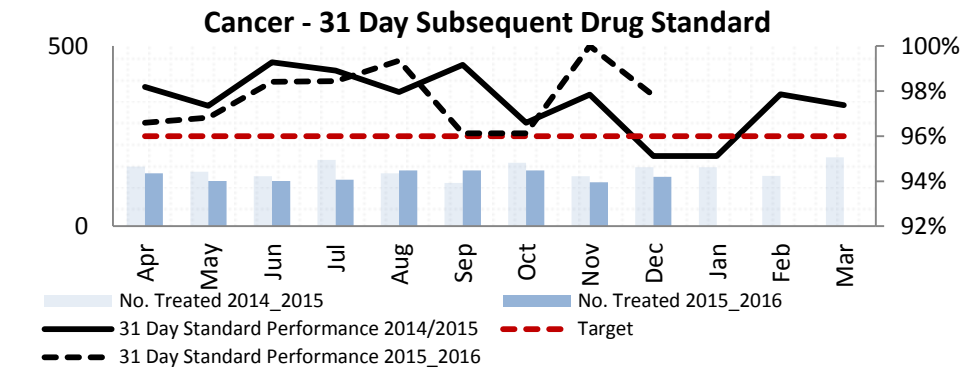
4. Trust Key Performance Indicators and Activity Comparison to previous year (2 of 2)

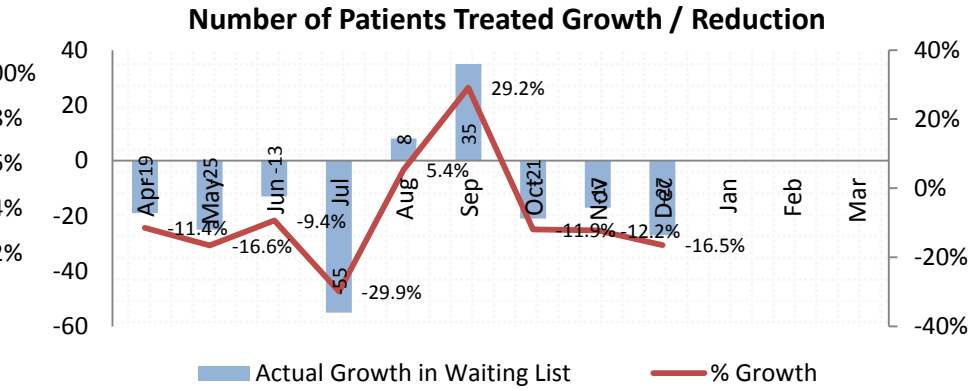
Cancer - Two Week Wait Standard



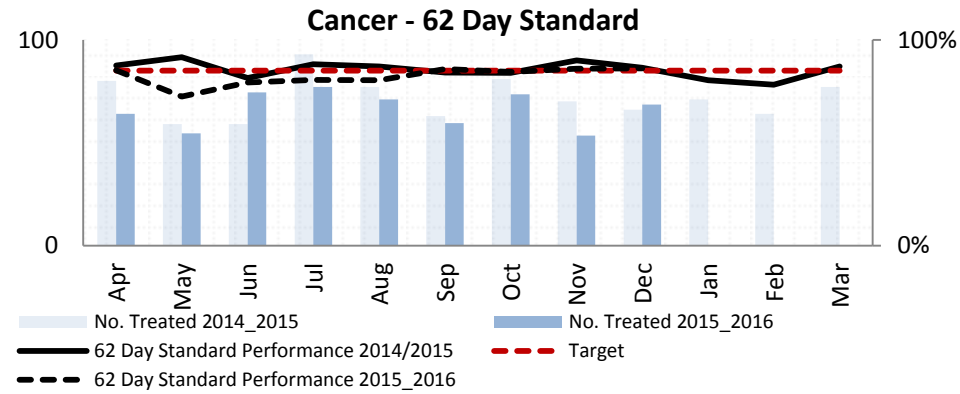


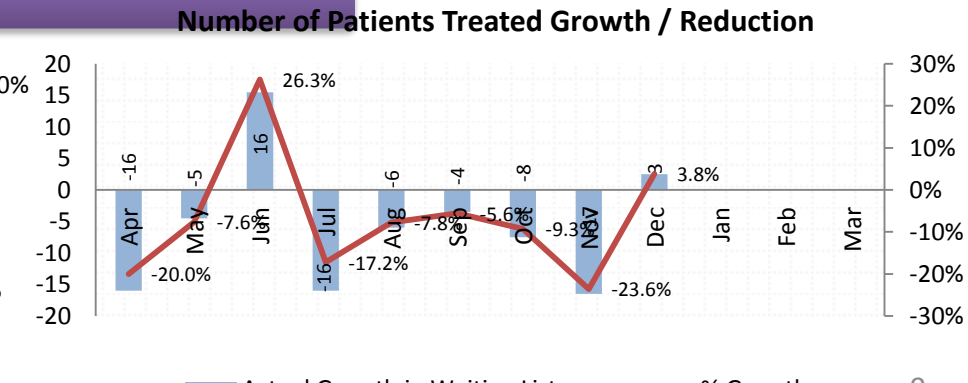
Cancer - 31 Day Subsequent Drug Standard





Cancer - 31 Day Subsequent Drug Standard





excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Performance – areas of escalation

Excellence in specialist and community healthcare

5. Performance Area of Escalation (Page 1 of 2) - A&E: 4 Hour Standard

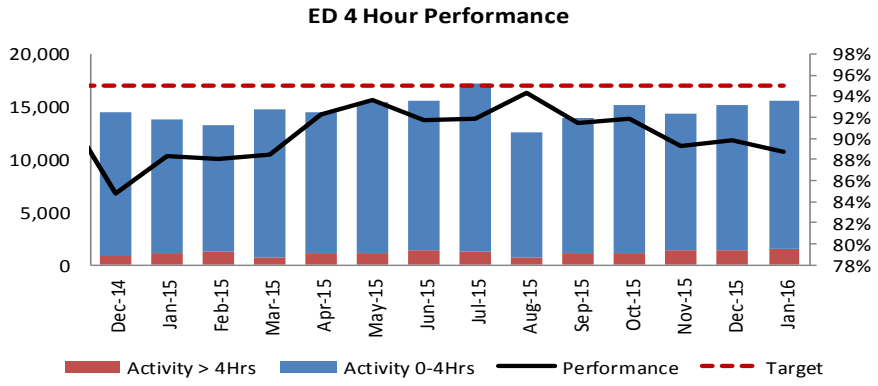
Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	Dec-15	Jan-16	Movement	2015/2016 Target	Forecast for Jan-16	Forecast for Feb-16	Date expected to meet standard
FA	89.80%	88.66%	-1.14%	>= 95%	R	R	TBC

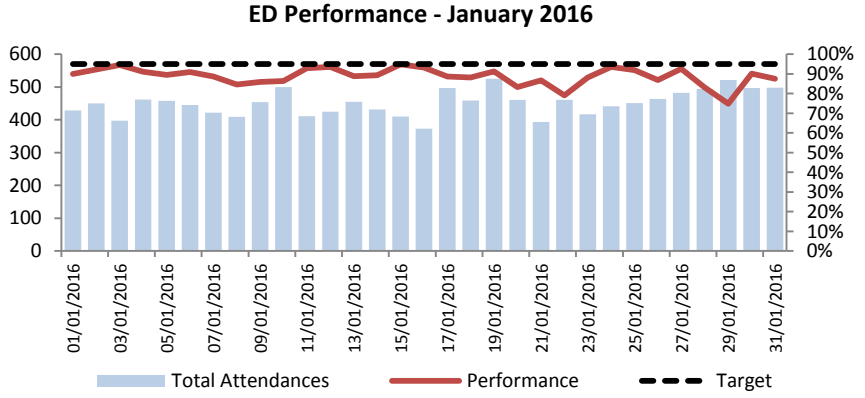
Peer Performance December 2015 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	3	1	5	2
89.80%	93.20%	94.20%	87.50%	93.40%

The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. Performance remains challenged being below the target at both the weekly and monthly level. In January 88.66% of patients were seen within 4 hours which was 1.14% lower than December 15.

Factors that continue to affect performance include:

- **Capacity pressures within the Emergency Department**
- **Decrease in the numbers of delayed transfer of care patients (DTOC) and the level of delay remains a focus area for the organisation as this has a significant impact on flow through the hospital and impact upon ED flow into the organisation. As at 15/02/2016 there were 15 DTOC and 19 Non-DTOC.**
- **As at 15/02/2016 there were 44 of 587 (7.4%) 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 has appointed McKinsey and Co. to lead the implementation of the unplanned care system re-design plan following the OVT diagnostic exercise. There are 6 key workstreams required to transform emergency care across the system, to include: ED, Shortstay wards, Internal processes, discharge processes, admission avoidance and discharge pathways.**

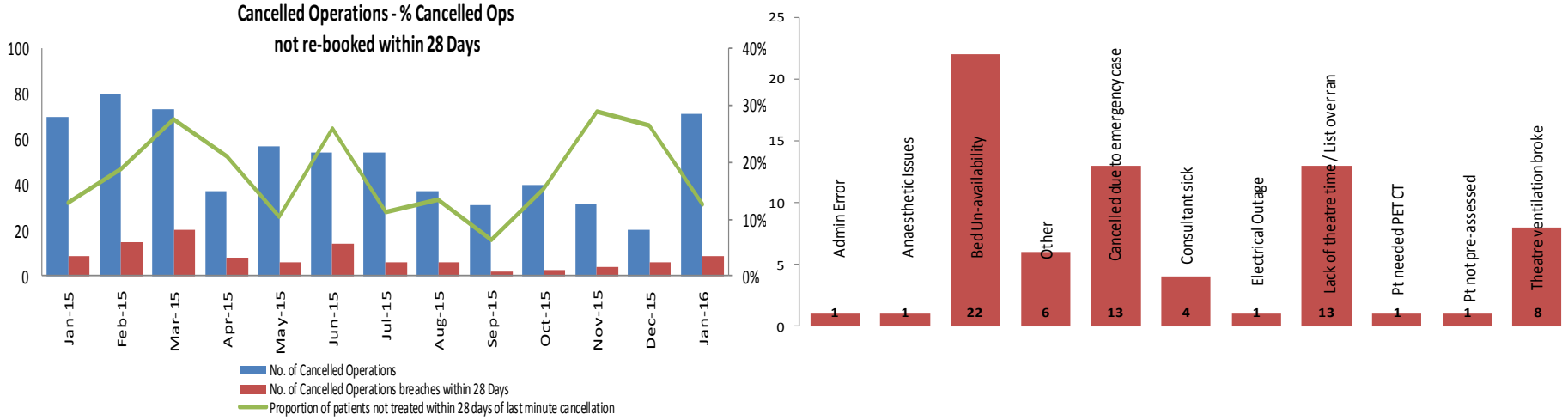




5. Performance Areas of Escalation (Page 2 of 2) - Cancelled Operations

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Dec-15	Jan-16	Movement	2015/2016 Target	Forecast for Jan-16	Forecast for Feb-16	Date expected to meet standard
CC	26.32%	12.68%	⇧ -13.64%	0%	G	G	Feb-16

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



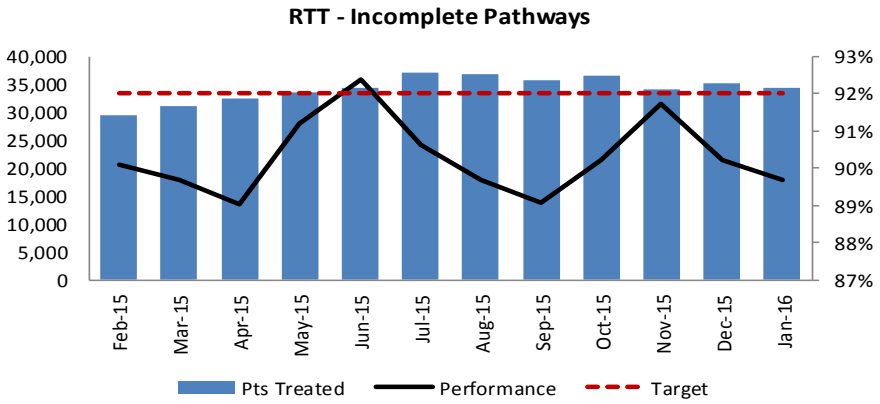
The national standard is that all patients whose operation has been cancelled for non clinical reasons should be treated within 28 days.

The trust had 71 cancelled operations from 4,440 elective admissions in January. 62 of those cancellations were rebooked within 28 days with 9 patients not rebooked within 28 days, accounting for 12.67% of all cancellations. There was a significant increase in the number of cancelled operations compared to the previous month although this was similar to performance last January. As the chart above shows the majority of cases were cancelled due to bed availability, emergency cases and list's over running, added to this the theatre ventilation system broke cancelling 8 patients scheduled for the 20/01/2016.

5. Performance Areas of Escalation (Page 2 of 2) - RTT Incomplete Pathways

Referral to Treatment Incomplete Pathways							
Lead Director	Dec-15	Jan-16	Movement	2015/2016 Target	Forecast for Jan-16	Forecast for Feb-16	Date expected to meet standard
PVK	90.20%	89.70%	-0.50%	92%			TBC

Peer Performance December 2015 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1		3
90.20%	94.30%	96.30%	-	92.00%



The Trust has been non-compliant against RTT incomplete pathways for a number of months with a decreasing performance in January of 89.7%.

As part of the trust RTT recovery and sustainability programme, through validation at month end the waiting list size reduced by 2%, with the biggest decrease in T&O (-216 pts) and Gynae (-156 pts). There are a number of specialties shown in the table below who remain challenged with performance below target of 92%. However Dermatology and Thoracic Surgery have seen a dip in the last 2 months.

The Trust acknowledges the poor performance and there remains a challenge in increasing performance and reducing long waiters to achieve a position of sustainability. The trust are currently working with the IST in undertaking a demand and capacity exercise to identify and understand the gap that needs to be bridged to achieve sustainability. The trust are pro-actively developing a RTT recovery and sustainability plan to deliver this and to address the operational and process changes required to deliver sustained performance and improved management of patient pathways.

	Waiting List Size					Backlog Size (18+)					Performance 92% Target			
Specialty	Nov-15	Dec-15	Jan-16	Var	Var%	Nov-15	Dec-15	Jan-16	Var	Var%	Nov-15	Dec-15	Jan-16	Var
Gen Surg	3,334	3,392	3,311	-81	-2%	373	383	383	0	0.0%	88.8%	88.7%	88.4%	-0.3%
Urology	1,493	1,608	1,600	-8	0%	146	176	167	-9	-5.1%	90.2%	89.1%	89.6%	0.5%
T&O	3,158	3,394	3,178	-216	-6%	433	580	572	-8	-1.4%	86.3%	82.9%	82.0%	-0.9%
ENT	2,996	3,026	2,981	-45	-1%	482	536	518	-18	-3.4%	83.9%	82.3%	82.6%	0.3%
Ophthalmology	231	262	269	7	3%	0	1	2	1	100.0%	100.0%	99.6%	99.3%	-0.3%
Oral Surgery	1,986	2,048	1,927	-121	-6%	14	39	39	0	0.0%	99.3%	98.1%	98.0%	-0.1%
Neurosurgery	887	944	915	-29	-3%	34	58	51	-7	-12.1%	96.2%	93.9%	94.4%	0.5%
Plastic Surgery	1,135	1,143	1,126	-17	-1%	160	183	169	-14	-7.7%	85.9%	84.0%	85.0%	1.0%
Cardiothoracic	265	302	348	46	15%	65	93	109	16	17.2%	75.5%	69.2%	68.7%	-0.5%
General Medicine	682	622	617	-5	-1%	23	27	32	5	18.5%	96.6%	95.7%	94.8%	-0.9%
Gastroenterology	2,339	2,461	2,375	-86	-3%	331	381	381	0	0.0%	85.8%	84.5%	84.0%	-0.5%
Cardiology	1,594	1,728	1,702	-26	-2%	46	74	102	28	37.8%	97.1%	95.7%	94.0%	-1.7%
Dermatology	2,677	2,610	2,645	35	1%	177	249	279	30	12.0%	93.4%	90.5%	89.5%	-1.0%
Thoracic Surgery	958	986	933	-53	-5%	61	79	77	-2	-2.5%	93.6%	92.0%	91.7%	-0.3%
Neurology	1,218	1,175	1,225	50	4%	13	25	30	5	20.0%	98.9%	97.9%	97.6%	-0.3%
Geriatric Medicine	31	33	37	4	12%	31	0	0	0		100.0%	100.0%	100.0%	0.0%
Rheumatology	966	989	1,031	42	4%	0	25	39	14	56.0%	96.8%	97.5%	96.2%	-1.3%
Gynaecology	2,870	3,059	2,903	-156	-5%	313	389	453	64	16.5%	89.1%	87.3%	84.4%	-2.9%
Other	5,229	5,345	5,344	-1	0%	113	143	164	21	14.7%	97.8%	97.3%	96.9%	-0.4%
Total	34,049	35,127	34,467	-660	-2%	2,815	3,441	3,567	126	3.7%	91.7%	90.2%	89.7%	-0.5%

6. Divisional KPIs Overview 2015/16: January 16 Performance (Page 1 of 2)

Monthly View

			January 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 weeks - admitted waits (division level)	%		85.5	72.5	84.1	78.2
	18 weeks - incomplete waits (division level)	%	99.5	89.2	87.9	90.3	89.6
	18 weeks – non-admitted waits (division level)	%	100	86.7	85.5	93.6	91
	52 week waiters	No.	0	0	0	0	0
	A&E waits (4 hours)	%	99.9	87.6			88.7
	LAS handover within 15 mins	%					38.9
	LAS handover within 30 mins	%					91
	LAS handover within 60 mins	No.					1

Monthly View

Note: Cancer performance is reported a month in arrears, thus for December2015

			December 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 week gp referral to first outpatient (breast symptoms) - (division)	%			97.1		97.1
	2 week gp referral to first outpatient (cancer) - (division)	%			94.8		94.8
	31 day second or subsequent treatment (drugs) - (division)	%			100		100
	31 day second or subsequent treatment (surgery) - (division)	%			96		96
	31 day standard from diagnosis to first treatment - (division)	%			97.8		97.8
	62 day urgent gp referral to treatment for all cancers - (division)	%			86.1		86.1
	62 day urgent gp referral to treatment from screening - (division)	%			91.1		91.1

6. Divisional KPIs Overview 2015/16: January 16 Performance (Page 2 of 2)

Monthly View

Outcome Metrics

January 2016

		COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
30 day emergency re-admissions (from elective) (division)	%	0	0.4	1.1	0.4	0.6
30 day emergency re-admissions (from non-elective) (division)	%	0	4.3	2.2	0.3	2.8
Average LOS (elective) (division)	Ratio		3.7	3.7	4	3.7
Average LOS (non-elective) (division)	Ratio	16.5	4.4	7.1	2.7	4.5
C-sections (applicable to women & children only)	%				27	27
CAS alerts	No.					2
HSMR	Ratio					91
Incidence of c.difficile	No.	0	2	0	0	2
Incidence of e-coli	No.	0	1	1	1	3
Incidence of MRSA	No.	0	0	0	0	0
Maternal deaths	No.	0	0	0	0	0
Medication errors causing serious harm	No.	0	0	0	0	0
MSSA	No.	0	0	0	0	0
Never events	No.	0	0	0	0	0
Serious incidents (division level)	No.	1	5	0	0	7
SHMI	Ratio					0.9
Trust acquired pressure ulcers	No.	1	2	0	0	3
VTE risk assessment (data submitted to unify)	%					96.5

Quality Governance Indicators

		COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Patient satisfaction (friends & family)	%	90	94.5	90.3	91.1	92
Percentage of staff appraisal (medical) - (division)	%	87.1	85.7	86	82.8	85.2
Percentage of staff appraisal (non-medical) - (division)	%	63.2	72.2	75.1	70.7	69.4
Sickness/absence rate - (division)	%	6.5	3.8	3.8	4.3	4.3
Staff turnover - (division)	%	20.8	18.9	14.6	19.2	18.5
Vacancy rate - (division)	%	18.9	16.7	16.7	16	16.7
Voluntary staff turnover - (division)	%	15.3	16.5	12.2	16	15.3

Key Messages:

This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components, as Cancer metric and complaints performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of January 38.9% of patients had handover times within 15 minutes and 91% within 30 minutes. both of which are not within target. The 30 minute handover data is currently being validated and is envisaged to increase post validation. The trust had zero 60 minute LAS breaches in January although this is an unvalidated position

The trust has a zero tolerance on avoidable pressure ulcers and has placed significant importance on its prevention. In January the trust had 2 grade 3 pressure ulcer SI's and one Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full investigation and Root Cause Analysis will be produced for each PU and reviewed at the Pressure Ulcer Strategy group, chaired by the Deputy Chief Nurse

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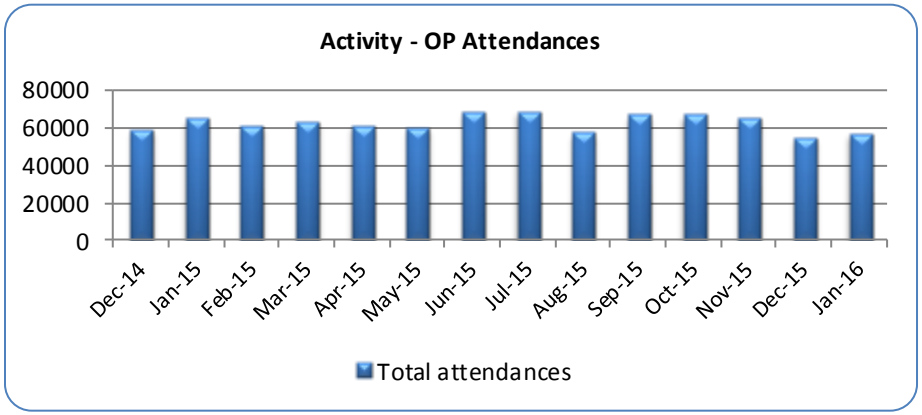
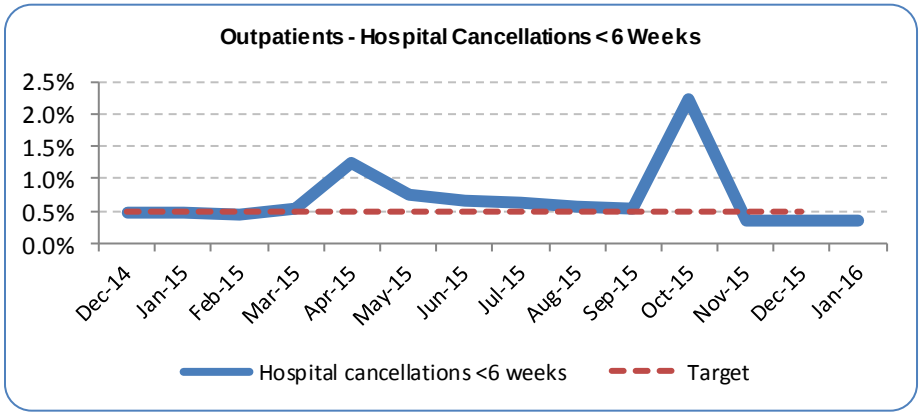
St George's University Hospitals NHS
NHS Foundation Trust

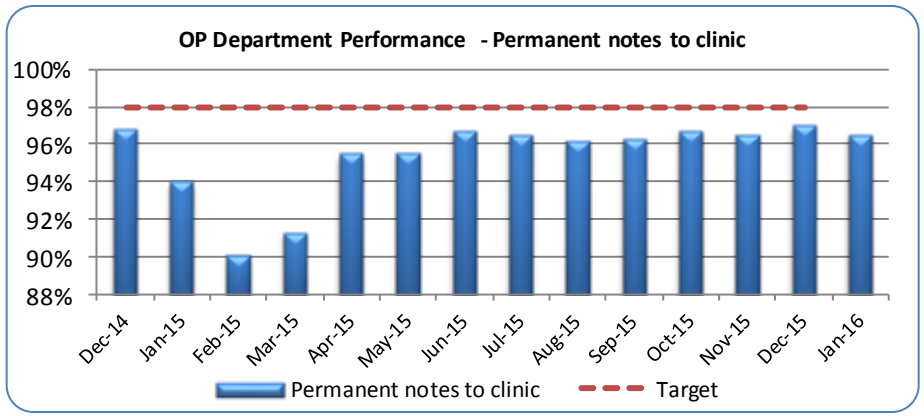
Corporate Outpatient Services Performance

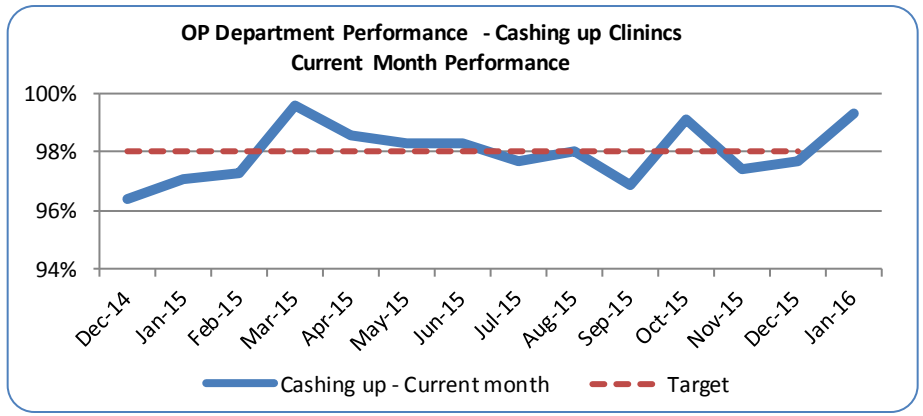
Excellence in specialist and community healthcare

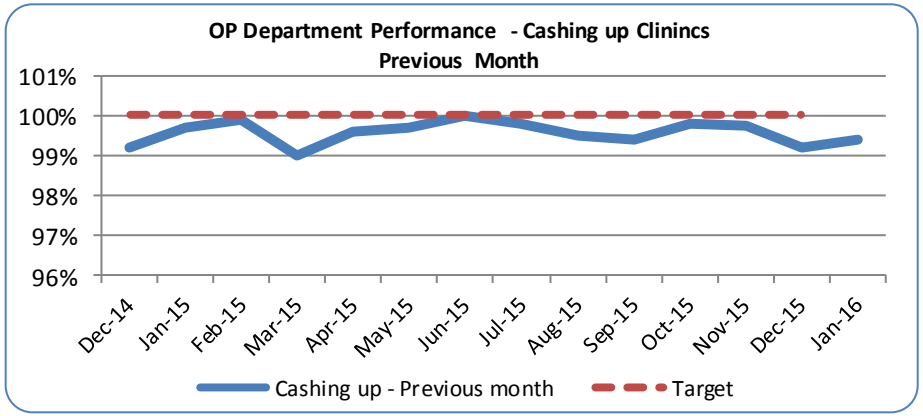
7. Corporate Outpatient Services (1 of 2) - Performance Overview

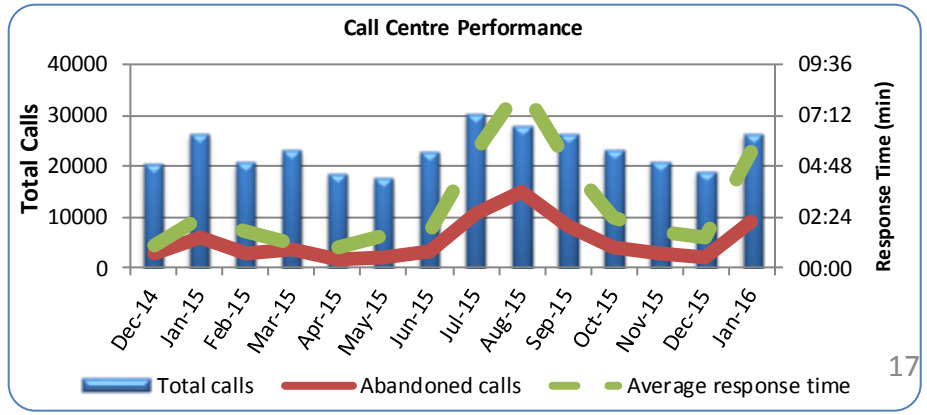












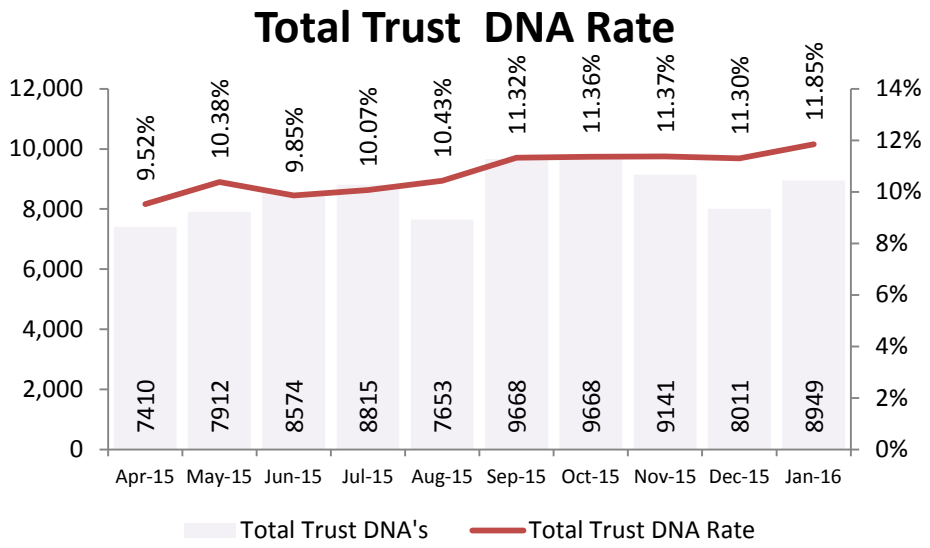
7. Corporate Outpatient Services (2 of 2) - Performance Overview

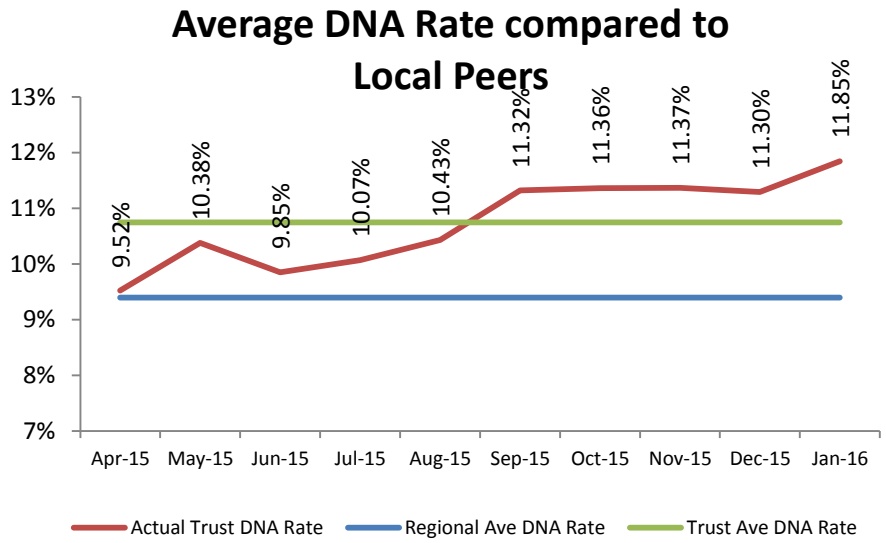
		Target	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
Activity	Total attendances	N/A	58659	64609	60659	62946	60564	59841	68002	68277	57188	66271	66501	64863	54618	56239
	Hospital cancellations <6 weeks	<0.5%	0.48%	0.47%	0.45%	0.54%	1.26%	0.74%	0.66%	0.64%	0.56%	0.54%	2.24%	0.36%	0.37%	0.35%
OPD performance	Permanent notes to clinic	>98%	96.77%	94.05%	90.12%	91.32%	95.52%	95.54%	96.74%	96.54%	96.14%	96.31%	96.72%	96.52%	97.02%	96.50%
	Cashing up - Current month	>98%	96.40%	97.10%	97.30%	99.60%	98.60%	98.30%	98.30%	97.70%	98.00%	96.90%	99.10%	97.40%	97.70%	99.30%
	Cashing up - Previous month	100%	99.20%	99.70%	99.90%	99.00%	99.60%	99.70%	100.00%	99.80%	99.50%	99.40%	99.80%	99.75%	99.20%	99.40%
Call Centre Performance	Total calls	N/A	20639	26565	20842	23235	18710	17732	22955	30426	28095	26357	23138	21082	19093	26557
	Abandoned calls	<25%/<15%	2681	5923	2908	3782	1551	2237	3309	10828	15019	8253	3930	2756	1953	9084
	Mean call response times	<1 m/<1m30s	01:02	02:24	01:43	01:08	01:00	01:29	01:42	05:31	08:34	04:59	02:24	01:43	01:24	05:30

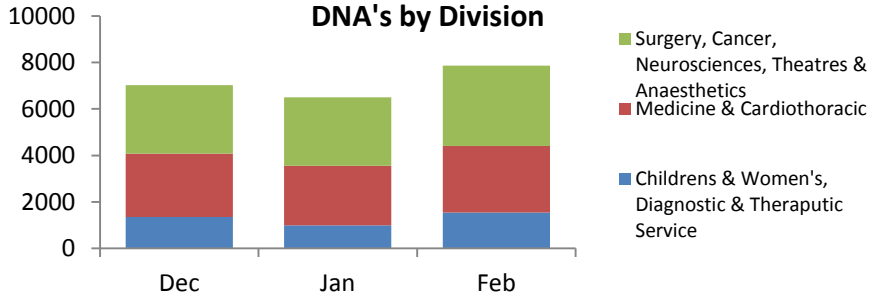
Key Messages:

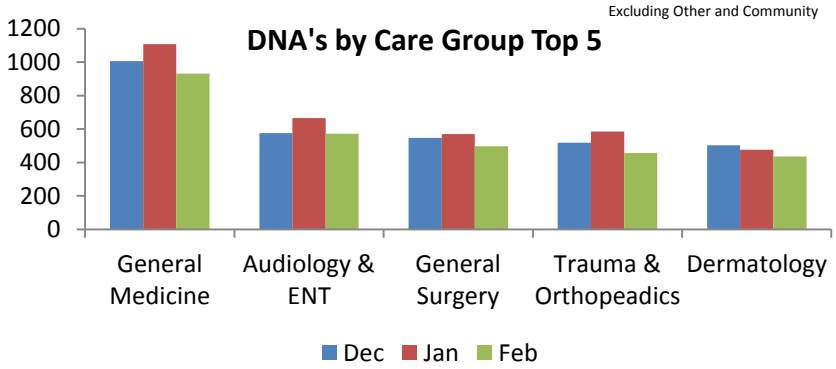
- Decrease in activity in December in line with previous years decrease due to seasonal variation. January has increased to 56,239.
- Hospital cancellations continue to be within target at 0.35%.
- Performance of permanent notes to clinic has slightly decreased to 96.50% however remains below target . This remains a priority area for the service.
- The level of activity and the number of abandoned calls significantly decreased between Oct and Dec 2015, however this significantly dropped in January, along with a drop in mean call response times.
- Due to issues with the telephone service provider, to note this is a Trust wide issue, there had been numerous issues in January with call connections and also in reporting ability. This is an issue that has been escalated and is being dealt with centrally by IT

8. Trust DNA Rates (1 of 1)









- The Trust has a current DNA Rate of 10.75% compared to a regional average of 9.4%
- There has been a significant increase in the rate of DNA's however total number of DNA's vary month on month particular around holiday periods where the total booked is less
- The highest rate of DNA's are within follow up appointment's however the recent increase has been due an increased number of patients within first appointments not attending
- Surgery, Cancer, Neurosciences, Theatres & Anaesthetics have the highest number of DNA's per month

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St George's University Hospitals NHS
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Clinical audit & effectiveness

Excellence in specialist and community healthcare

9. Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)							
Lead Director	November 15	December 15	January 16	Movement	2015/16 Target	Forecast March 16	Date expect to meet standard
SM	91.8	92.6	90.9	↓	<100	G	Met

SHMI (Summary hospital-level mortality indicator)				
Jan 2015	Apr 2015	Jul 2015	Oct 2015	Jan 2016
0.84	0.86	0.89	0.92	0.90

Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available (updated 18/02/16) December 2014 to November 2015, 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 27th January 2016 relates to the period July 2014 to June 2015. The next publication is due in April 2016.

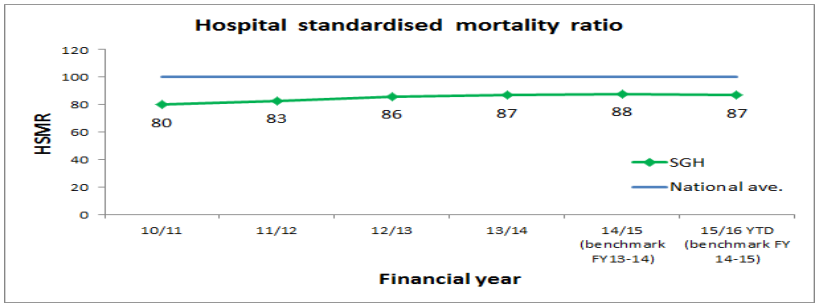
Overview:

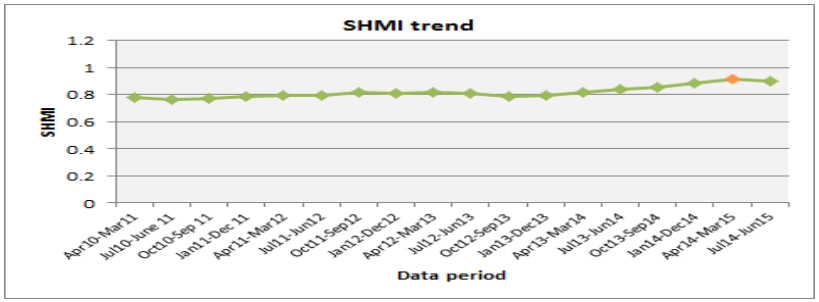
Our mortality as measured by both the HSMR and the SHMI is significantly lower than expected. The trust's most recent HSMR is 90.9, which is statistically significantly better than expected. Looking at the HSMR for emergency admissions at weekends, our mortality is in line with expected at 92.5 and for emergency weekday admissions it is better than expected at 89.7.

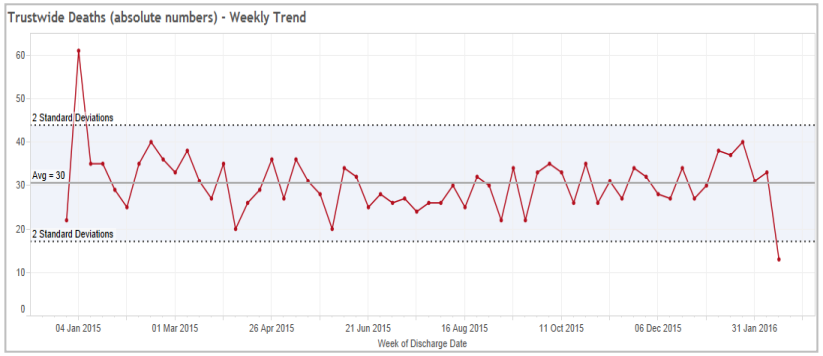
The Health and Social Care Information Centre published the latest SHMI for the period July 2014 to June 2015 on the 27th January. Our score has improved and is categorised as 'lower than expected'. For this period 109 of 136 non-specialist acute trusts are categorised as 'as expected', 14 as 'higher than expected' and 13 as 'lower than expected'. Of these 13 trusts, St George's was one of 9 that also has a 'lower than expected' SHMI for the same period a year previously.

The quarterly data release includes observed and expected deaths by trust for each of the 140 diagnosis groups that make up the SHMI. For St George's there are 46 groups where observed deaths are lower than expected, ranging from a difference of 0.04 to 68.5. For 59 groups the difference cannot be calculated as the number of events is too small. There are 36 diagnosis groups where observed deaths exceed expected, with a difference ranging from 22.2 to 0.3. The Mortality Monitoring Committee will consider the SHMI in detail at the meeting on 24th February and will identify any diagnosis groups where it is felt that further investigation is required. The committee will also receive an update on the 2 SHMI diagnosis groups prioritised for investigation following the October publication; these were wide groupings related to T&O and vascular.

Over the winter, members of the MMC have been monitoring raw mortality on a daily basis, using the report available in Tableau. As shown by the chart alongside there has not been a repeat of the increased mortality that was observed in January 2015.







9. Clinical Audit and Effectiveness - National audit

National Pregnancy in Diabetes Audit 2014

Table: First trimester HbA1c measurement 2014

	All pregnancies		Pregnancies in women with Type 1 diabetes		Pregnancies in women with Type 2 diabetes	
	London	England and Wales	London	England and Wales	London	England and Wales
	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage
Result < 43 mmol/mol (6.1%)	18.5	14.6	14.1	7.9	20.1	21.7
Result < 48 mmol/mol (6.5%)	35.2	25.9	23.7	15.4	37.3	35.8
Result < 58 mmol/mol (7.5%)	61.6	51.6	46.7	40.1	65.7	62.9
Result ≥ 86 mmol/mol (10.0%)	8.6	9.7	12.6	11.6	7.8	8.1

Source: HSCIC

The National Pregnancy in Diabetes audit is part of the National Diabetes Audit (NDA) programme. The project aims to measure whether:

- Women were adequately prepared for pregnancy;
- Adverse maternal outcomes were minimised;
- Adverse fetal/infant outcomes were minimised.

The audit measures quality of care received by women with diabetes who become pregnant using national standards detailed in NICE guidance.

Nationally the results show that women generally enter pregnancy poorly prepared and that outcomes have changed little since the confidential enquiry into pregnancy in women with diabetes in 2002-03. Local unit reports are not provided; however, the results for London generally compare favourably when viewed against national results, as shown in the table above.

The main report recommendations are:

1. Develop strategic focus to improve preparation for pregnancy. Engage with primary care to raise awareness & planning.
2. Develop plans to incorporate training about pregnancy into patient education especially for women with Type 2 diabetes.
3. Focus on improving glycaemic control during pregnancy for women with both Type1 and Type 2 diabetes to avoid late adverse fetal outcomes.
4. A coordinated approach from commissioners, healthcare providers and professional bodies will be needed if outcomes are to be improved.

Local actions to date:

1. We have contacted the national project team and HQIP (Healthcare Quality Improvement Partnership) who commissions the audit, to request local unit reports (with or without benchmarking) to inform local action planning.
2. In 2013/14 a process was agreed with community retinal screening clinics to improve access to information of in-pregnancy retinal screening test results, however this did not work as planned. Three clinics provided information upon request which was then submitted to the audit.
3. Improved processes for consenting women to increase the number of cases submitted by St George's. The numbers of women consenting to participate has substantially improved on the first year and the data submission for the 2014 round of the audit is imminent.

9. Clinical Audit and Effectiveness - National audit

National Head and Neck Cancer Audit 2014

Table 1 - Results from reports which show MDT Host data	National score	LCA score	St George's score	Previous audit round (St George's)
Count of tumours recorded with performance status - by first MDT organisation (Report 19)	76.8%	74.7%	100%	100%
Count of co-morbidity by level of decompensation for summated site groups - by MDT organisation (Report 20)	61.2%	48.4%	100%	100%
Percentage of patients seen by Clinical Nurse Specialist prior to commencement of first treatment - by MDT (Report 27)	62.9%	61.3%	50.8%	65.5%
Has a 'Patient Concerns Inventory' been carried out after treatment has been completed and within 6 months of diagnosis? (Report 34)	40.8%	11.0%	100%	No Data
Interval from biopsy to reporting - by first diagnosing organisation - <10 days (Report 35)	65.4%	58.0%	97.0%	97.1%
Percentage with pre-treatment chest imaging - by diagnosing trust (Report 38)	71.4%	82.9%	95.1%	92.2%
Analysis of multi-disciplinary discussion for index year (Report 39)	97.0%	98.2%	100%	100%
Analysis of multi-disciplinary discussion of resective pathology in those patients (Report 51)	77.6%	65.8%	98.3%	No Data

Background After more than ten years, the provision, development and management of the National Head and Neck Audit has moved from the Health and Social Care Information Centre to Saving Faces – The Facial Surgery Research Foundation. The new contract commenced on 1st July 2015. Under the new management the audit will be named the Head and Neck Cancer Audit (HANA) and the informatics element will be provided by Dendrite Clinical Systems. The audit will continue to be commissioned by the Healthcare Quality Improvement Partnership, on behalf of NHS England and the Welsh Government and as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

Data Period
Key findings for England and Wales for the audit period November 2013 to October 2014

Audit aims
The aim of the audit is to improve quality of care to those patients with head and neck cancer by raising standards of care to match those of the best performing teams.

Results
Eight measures were identified in this report and the trust scores were above the national and London Cancer Alliance (LCA) scores for 7 of these measures. One measure which relates to patient seen by CNS prior to 1st treatment by MDT scored 50.8% which is lower than the national score (62.9%) and London Cancer Alliance score (61.3%). See Table 1.

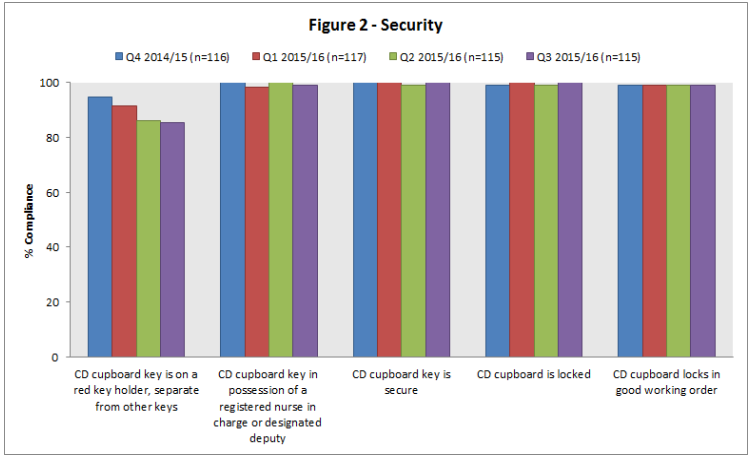
For the section relating to Clinical Nurse Specialist (CNS), discussion is currently on going as to the reasons for this and how to improve. Some possible factors were identified which can influence this:

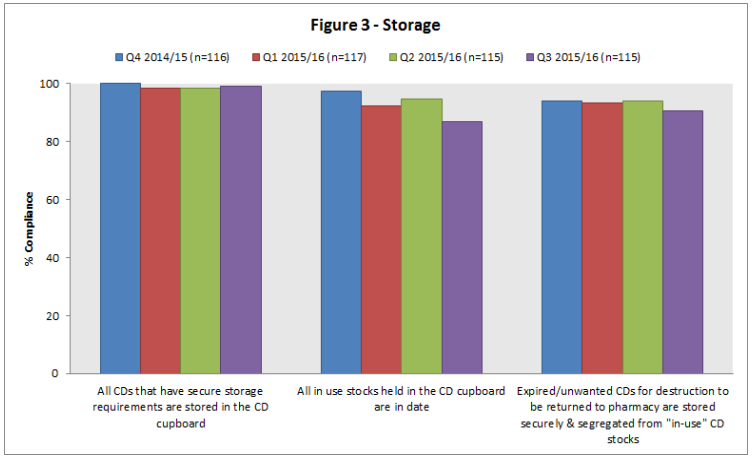
1. The CNS seeing patients before treatment is dependent on whether they are referred the patients in a timely fashion. The MDT is to encourage all clinicians to refer patients to the CNS team as early in the pathway post diagnosis as possible.
2. CNS access to and contemporaneous entry onto Infoflex must be a priority.
3. Some patients may get their diagnosis and treatment plan the same day and go to RMH (Royal Marsden) for first definitive treatment. Sometimes the CNS's would not get to see the patients in clinic as they see the RMH doctors.
4. This situation could be mitigated by the presence of the CNS from the RMH in the H&N clinic at St George's and register the patients as seen here prior to transfer for RT/CRT.

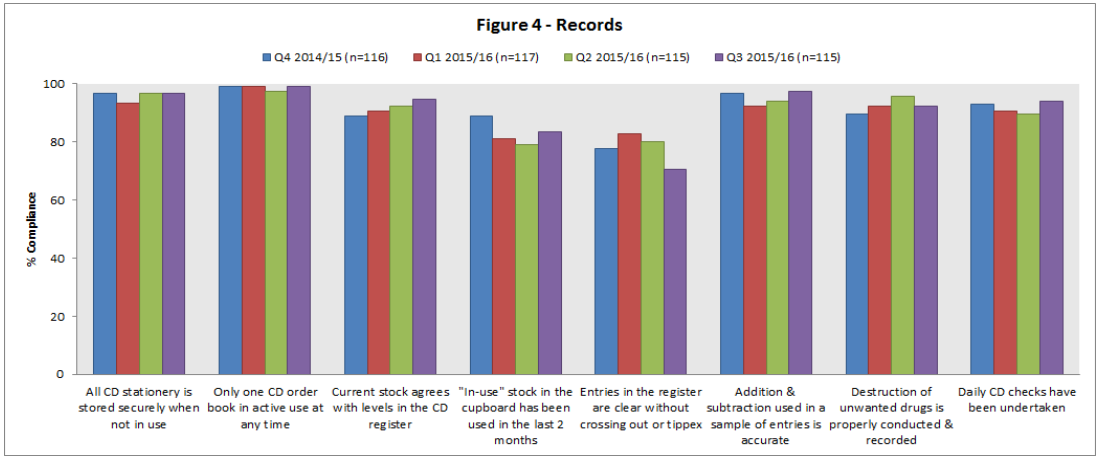
9. Clinical Audit and Effectiveness - Local audit

Controlled Drugs Check & Stock Audit Quarter 3 2015/16 (DB1321)

The quarterly controlled drugs (CD) audit is conducted jointly by pharmacy and ward/department staff and measures compliance against the Trust's CD Policy. The audit being completed across all 115 clinical areas that stock CDs.







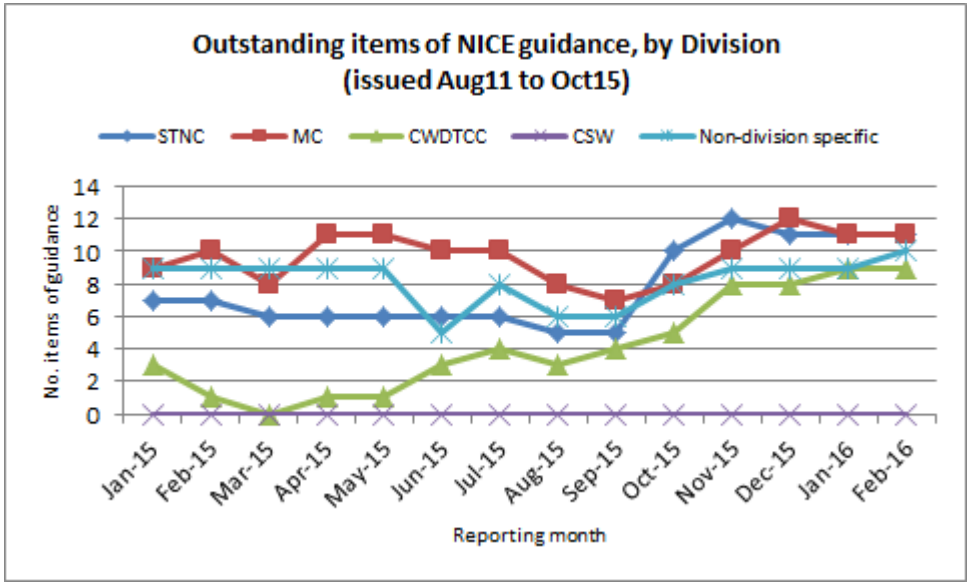
High compliance with the security of CDs was maintained with performance for 4 out of 5 measures at 99% or above. However, in a small number of areas (n=17) the CD keys were not held on a red key holder, separate to other medication cupboard keys. This practice was addressed at the time of the audit and highlighted to clinical teams. This has been reported to divisions to ensure compliance is achieved and maintained.

The storage of CDs was generally good, however the need to proactively ensure prompt removal or disposal of expired/unwanted CDs was identified in 11 areas. Corrective action including immediate returning of expired/unwanted CDs to pharmacy, was taken at the time of the audit and this has been reported to divisions for ongoing support.

It is very positive to note that practice related to record keeping improved or was sustained in 6 of the 8 standards audited, and compliance was above 90 per cent for 6 measures.

The trust-wide report was presented to the Medications Risk Management Committee meeting in January 2016 and action planning at an organisational level is on-going, informed by divisional level reports. Where non-compliance with any measure has been observed in consecutive quarters this is highlighted so that support can be targeted appropriately. It should be noted that pharmacists carried out local education and training of ward staff as issues were identified during the audit process. Additionally, where pharmacists have identified the need for CD training, to include how to order CDs, entering CDs into registers and managing stock held, mini training sessions are being held to address these issues.

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



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

Division	2010	2011	2012	2013	2014	2015
STNC (n=8)	0	1	2	1	4	0
M+C (n=16)	2	2	4	1	2	5
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	4	1	4

Overview

The overall number of outstanding items of guidance remains largely unchanged since the last report. There are 41 items of guidance for which we have not received responses as to implementation. The number of items of guidance where we are not fully compliant has also remained fairly stable, and stands at 51 in total.

Although all new guidance is being disseminated there has been limited follow up of outstanding guidance due to a lack of resource in the clinical effectiveness team. It is anticipated that the team will return to full staffing levels in April, and managing this backlog will be made a priority. In the meantime we will try and follow up as many items of guidance as possible and will endeavour to complete the review of guidance with compliance issues before year end.

Compliance reports have been prepared at the request of Medicine & Cardiovascular and Children & Women's divisions for discussion at their most recent Divisional Governance Boards and it is hoped that this focus and support will also help in reducing the items outstanding and in providing a more comprehensive picture of compliance and any associated risks.

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Patient Safety

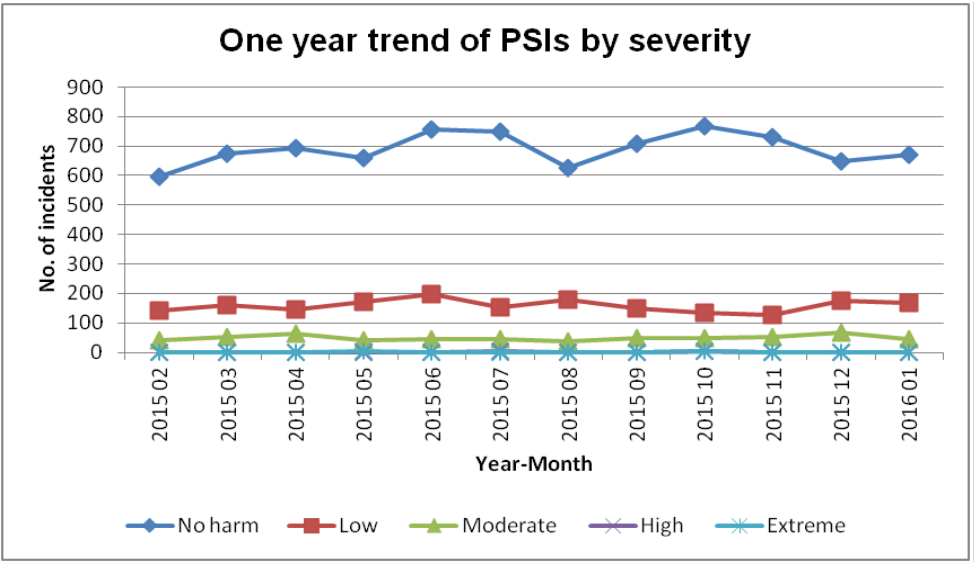
Excellence in specialist and community healthcare

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

	2015/16 SIs Declared by Division (incl. PUs)				
	M&C	STN&C	CSD	C&W	Corporate
November	5	3	3	1	0
December	2	2	1	2	1
January	5	0	1	0	1

Closed Serious Incidents (not incl. PUs)				
Type	November	December	January	**Movement**
Total	8	10	4	⮟
No Harm	2	3	3	➤
Harm	7	7	1	⮟

Table 1



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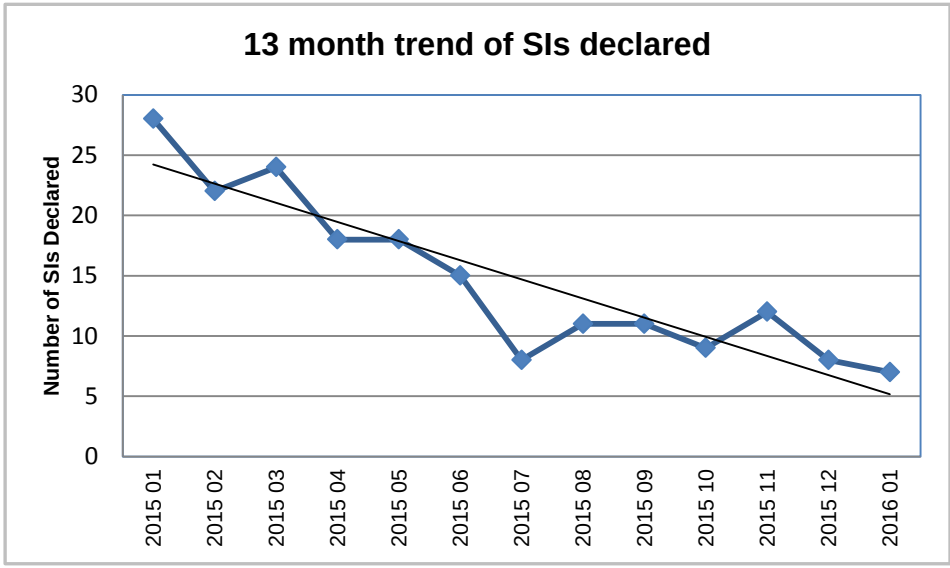


Overview:
The numbers of general reported incidents are shown in Table 1. This trend should be observed carefully in conjunction with the trends and profile of SIs. High reporting of low or no harm incidents is generally felt to be an indication of a good reporting culture.

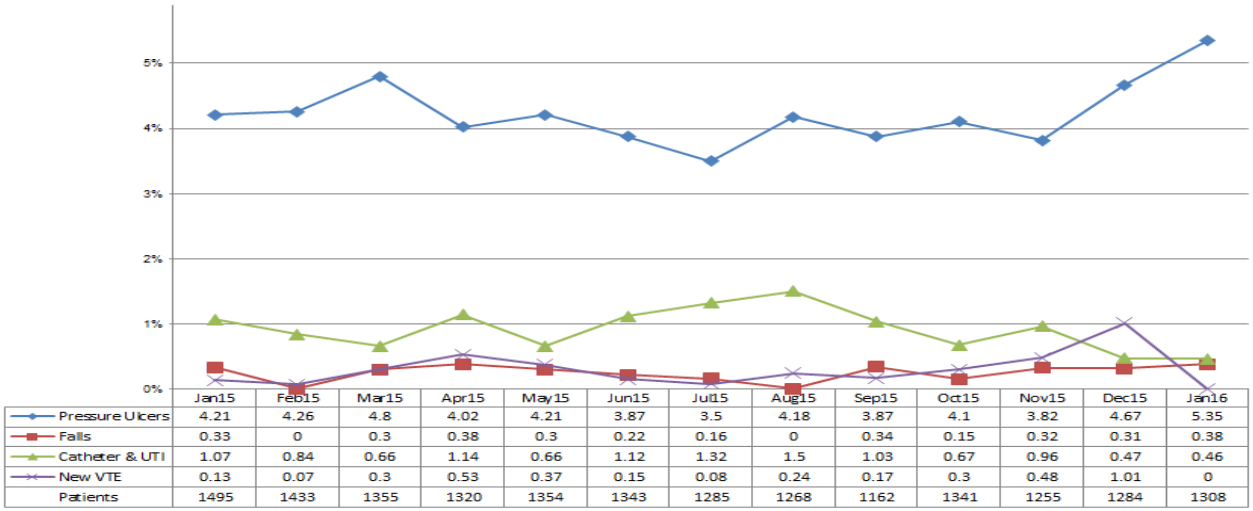
There were 4 general SIs reported in January (+3 pressure ulcers) and the subjects are varied.

The 4 general SIs declared in January relate to a range of issues. They include the following categories:

- Unforeseen complications
- Patient fall
- Patient absconded
- Appointment delay

10. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	November 2015	December 2015	January 2016	**Movement**	**2015/2016 Target**	**National Average December 2015**	**Date expected to meet standard**
J Hall	94.50%	93.69%	93.96%	↑	95.00%	94.15%	March 16



	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16
Pressure Ulcers	4.21	4.26	4.8	4.02	4.21	3.87	3.5	4.18	3.87	4.1	3.82	4.67	5.35
Falls	0.33	0	0.3	0.38	0.3	0.22	0.16	0	0.34	0.15	0.32	0.31	0.38
Catheter & UTI	1.07	0.84	0.66	1.14	0.66	1.12	1.32	1.5	1.03	0.67	0.96	0.47	0.46
New VTE	0.13	0.07	0.3	0.53	0.37	0.15	0.08	0.24	0.17	0.3	0.48	1.01	0
Patients	1495	1433	1355	1320	1354	1343	1285	1268	1162	1341	1255	1284	1308

Pressure ulcers (70)

- 41 grade 2 (18 new, 23 old)
- 22 grade 3 (2 new, 20 old)
- 7 grade 4 (0 new, 7 old)

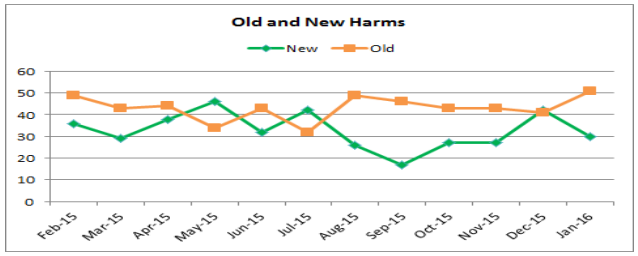
CAUTI (6)

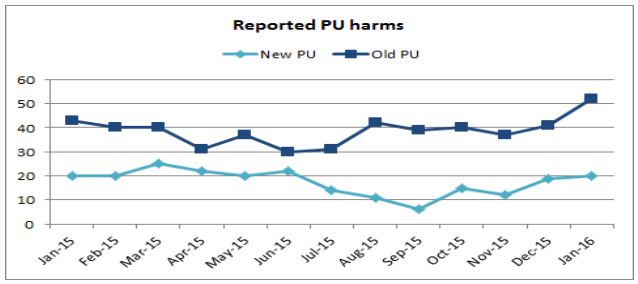
- 1 old
- 5 new

Falls (5)

- 4 low harm falls
- 1 moderate harm fall

VTE (0)





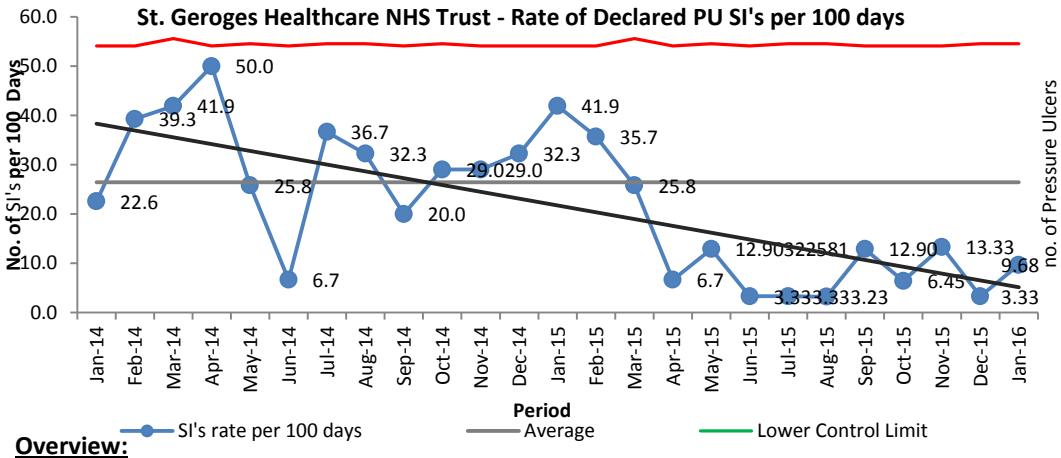
The safety thermometer data represents a snapshot of harms as collected by ward staff on one nationally agreed day per month. This point prevalence audit shows that in January 2016 the proportion of our patients that received harm free care was 93.96 per cent, which is below our target and marginally lower that the national average of 94.15%.

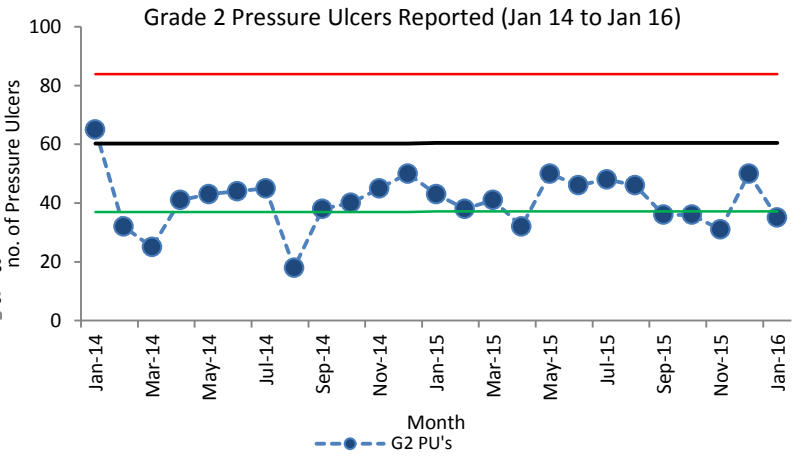
In January we reported 81 harms to 79 patients; 77 patients experienced one harm and 2 patient had 2 harms. 30 harms are categorised as new, meaning that they either developed, or treatment began, whilst under our care, which is a significant decrease from the previous month as shown in the chart alongside.

The reduction in new harms can be attributed in large part to the absence of any VTE harms. The increase in old harms reported is predominantly old pressure ulcers as shown in the second small chart. Old harms are defined as harms that did not develop whilst the patient was under our care.

10. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers											Grade 2 Pressure Ulcers					
Type	Sep	Oct	Nov	Dec	Jan	YTD April – May 2016	Movement	2015/2016 Target	Forecast March 2016	Date expected to meet standard	Sep	Oct	Nov	Dec	Jan	Movement
Acute	2	1	3	0	2	**14**			G	-	21	21	11	39	20	
Community	2	1	1	1	1	**8**			G	-	15	15	20	11	15	
Total All	4	2	4	1	3	**22**			G	-	36	36	31	50	35	
Total Avoidable	4	2	4	1	3	**22**		40		-						
Previous Year	3	6	8	6	8	**52**					**38**	40	45	50	43	





Overview:

In January there was a rise in the total number of pressure ulcer serious incidents across the organisation, with 3 declarations- these were acquired on Richmond Ward, Allingham Ward and Community CSD. Year-on-year there was a reduction from 8 incidents in 2015, this is a reflection of the increased awareness and hard work seen across all divisions. There was a reduction in the number of Grade 2 pressure ulcers from December, as well as a year-on-year decrease. At present the trust is set to achieve its target of 40 avoidable pressure ulcers for the financial year 2015/16.

Actions:

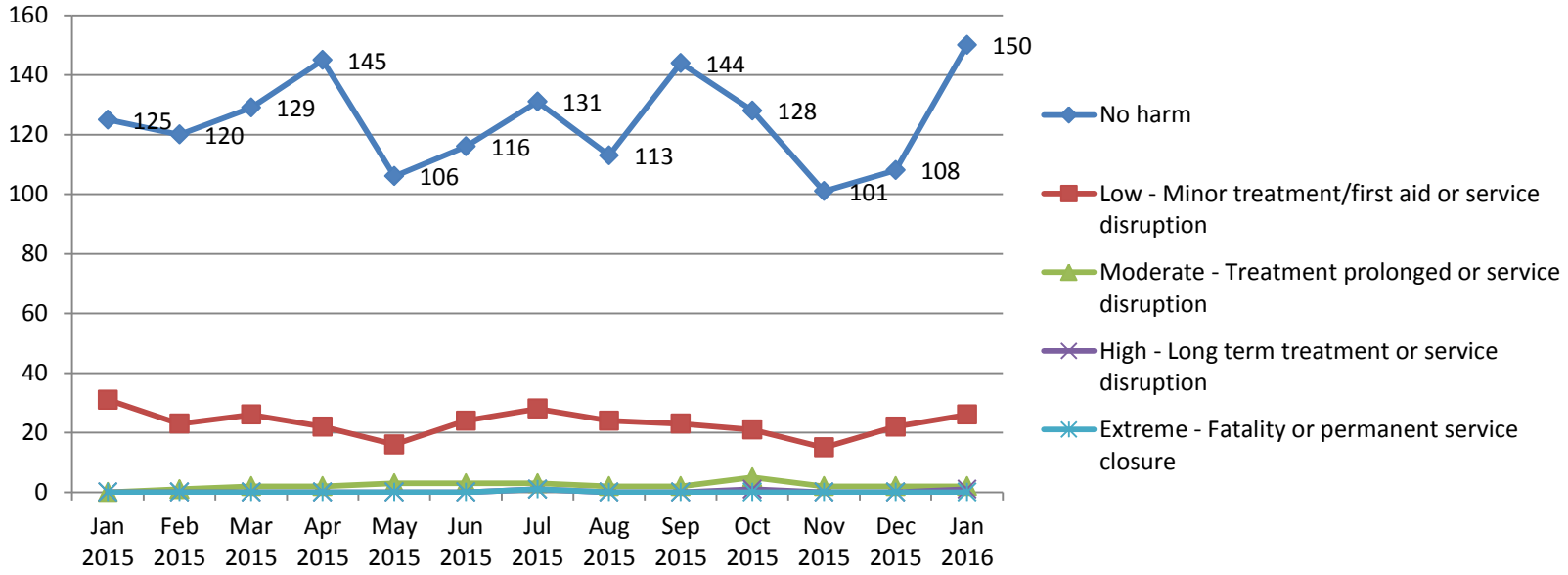
- No suitable applicants for Band 7 community TVN post following advert, a 'deep dive' meeting scheduled in March to look at current provision of service in this field.
- Work across the community division to review the current spend on pressure relieving equipment commences on 24th February 2016. Safe and effective care for clients will remain a priority.
- Quality Improvement programme to begin on Dalby Ward starting in March, initial focus will be patient repositioning. Roll out plan to be developed to demonstrate how this programme will be delivered across the trust.

10. Patient Safety: January 2016
- Incident Profile: Falls

Falls														
Lead Director	Jan 15	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 16	Movement
	154	144	157	165	126	144	163	140	168	155	118	132	179	↑

Falls with Harm Jan 2015 to date		
No Harm	Moderate	Severe
1875	32	4

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 significant spike in the incidence of falls this month which is related to an increase particularly in the medical/cardiac division. Focused work in the AMU and gastro-intestinal medical ward to identify specific areas of improvement is recommended.

10. Patient Safety - Infection Control

MRSA						
Lead Director	December	January	Movement	2015/2016 Threshold	Forecast February- 16	Date expected to meet standard
JH	0	0	⇔	0	G	-

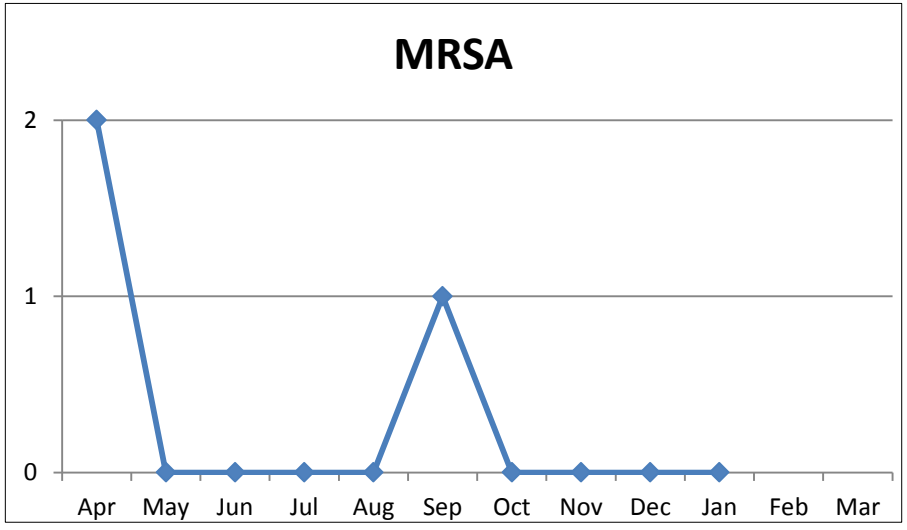
Peer Performance – YTD December 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	2	1	2	4

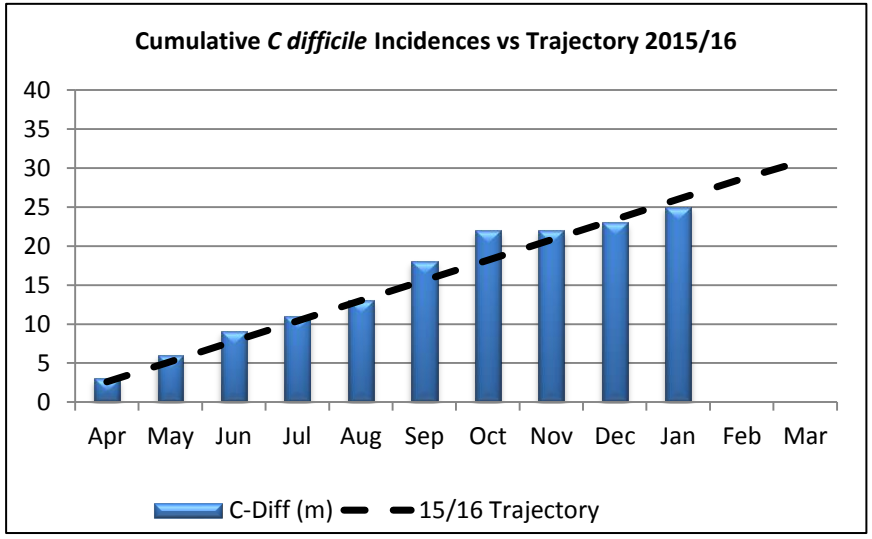
C-Diff						
Lead Director	December	January	Movement	2015/2016 Threshold	Forecast February - 16	Date expected to meet standard
JH	1	2	↑	31	G	-

Peer Performance – YTD December 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
25 (31)	17(16)	14(9)	77(72)	25(39)

The MRSA bacteraemia threshold is zero. There were no MRSA Hospital-acquired bacteraemias in December or January. The last hospital-acquired MRSA bacteraemia was on 23rd September 2015. The Trust is non-compliant , with 3 incidents in total against a target of zero.

In 2015/16 the Trust has a threshold of no more than 31 *C. difficile* incidents. In December there was one episode and two in January. This makes a total of 25 for the FY to end January 2016. This means that the Trust is currently on trajectory and can still achieve the target at the end of the FY 2015/16.





10. 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	Jan 2015	Feb	Mar	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 2016
Unify2	95.94%	96.03%	96.27%	96.64%	96.45%	96.75%	96.56%	96.78%	97.22%	97.10%	96.8%	96.5%	

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

Data Source	Jan 2015	Feb	Mar	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 2016
Safety Thermometer	79.08%	83.89%	85.74%	89.83%	90.19%	95.14%	94.84%	92.38%	91.28%	93.40%	93.24%	88.56%	
National average	84.69%	84.82%	84.69%										

Comparison of data streams:

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

Current and Future developments:

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

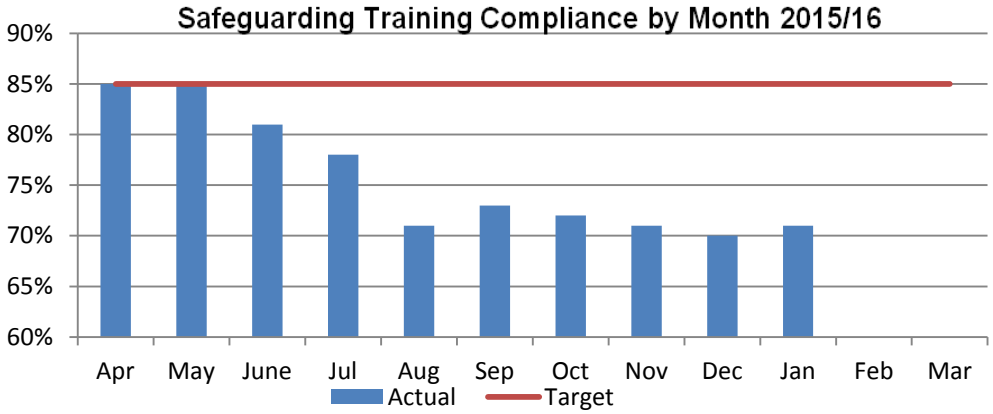
Year		2015
HAT cases identified to date (attributable to admission at SGH)		196
Mortality rate	Total	15.3% (30/196)
	VTE primary cause of death	4.1% (8/196)
Initiation of RCA process		100% (196/196)
RCA complete		90.8% (178/196)

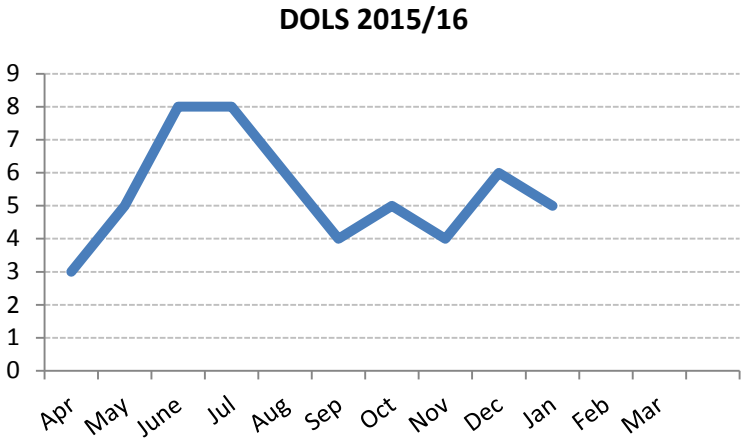
Year		2016
HAT cases identified to date (attributable to admission at SGH)		13
Mortality rate	Total	0
	VTE primary cause of death	0
Initiation of RCA process		100%
RCA complete		30.8% (4/13)

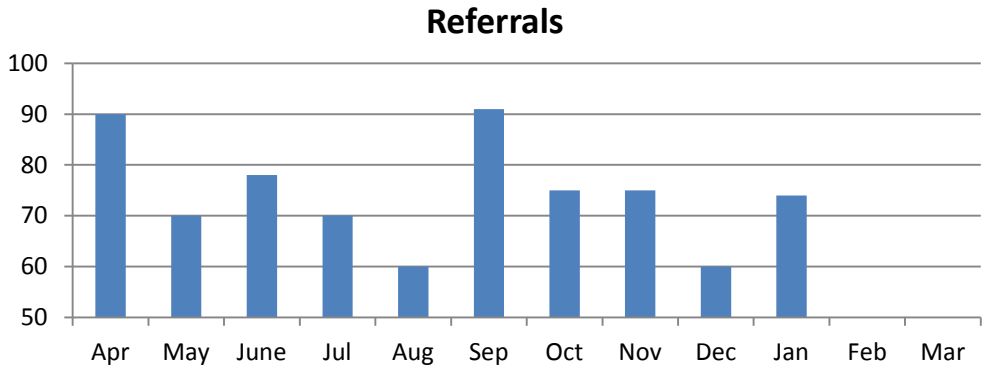
10. Patient Safety
- Safeguarding: Adults

Safeguarding Training Compliance - Adults									
Lead Director	Aug	Sep	Oct	Nov	Dec	Jan	2015/2016 Target	Forecast April 2016	Date expected to meet standard
JH	71%	73%	72%	71%	70%	71%	85%	A	-

Safeguarding Adults Training Compliance by Division – Jan 16				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
70%	71%	70%	74%	68%







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 - Awaiting revision of Pan London Procedures due Jan 2016

Roll out MCA training across trust, audit due Winter 2015/16

10. Patient Safety - Safeguarding Children

Data extracted from ARIS 19/02/2016			
Division	**No. requiring training**	**No of staff compliant**	**Manual system compliant %**
Children and Women's Diagnostic and Therapy Services	615	502	82%
Community Services	124	99	80%
Corporate	3	3	100%
Medicine and Cardiovascular	189	150	79%
Surgery & Neurosciences	16	10	62%
Total	**947**	**764**	**81%**

Training : The trend analysis this month shows that the highest number of staff ever are compliant with level 3 safeguarding training which is good news. Training remains on the Trust's Risk Register.
Work is underway to determine the optimal way forward in delivering both the PREVENT and FGM training requirements.

Serious Case Reviews and Internal Management Reviews: There are no new SCR's or IMR's this month. Wandsworth Safeguarding Children Board are organising a Learning event in April to combine learning from the Family A SCR and Family J review. The Acute and Community services are both involved in these cases.

SI – The process of escalation of safeguarding children incidents to SI status is under review.

Other: LB Wandsworth underwent an OfSTED inspection in December 2015, the outcome was published on 16th February and services were graded as Inadequate. St George's as a multi-agency partner are working to support the action plan for improvement .

Section 11 annual self assessment audit is currently being implemented. For the first time it is being disseminated electronically via Survey Monkey.

We are also part of the WSCB Multi-agency audit programme and are currently completing case audits on the "Step up/Step down" process.

The review of the safeguarding team is on going being led by the Chief Nurse.

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Patient Experience

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11. Patient Experience - Friends and Family Test

Service	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Average
Community Services	86% n=292	88% n=518 ^	95% n=539 ^	96% n=565 ^	90% n=284 v	87% n=352 v	86% n=401 v	87% n=430 ^	94% n=1223 ^	94% n=1337 -	93% n=532 v	94% n=358 ^	90% n=6539
Medicine and Cardiovascular	95% n=769	96% n=896 ^	96% n=808 ^	94% n=837 v	94% n=872 -	94% n=752 -	96% n=580 ^	93% n=628 v	95% n=555 ^	95% n=649 -	96% n=513 ^	96% n=581 -	95% n=7671
Surgery Anaethetics and Neuro	95% n=842	96% n=917 ^	95% n=1016 ^	96% n=1152 ^	95% n=1098 v	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 ^	92% n=9487
Women and Childrens	93% n=303	93% n=440 -	91% n=480 ^	92% 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=269 ^	92% n=4954
Trust	**93%**	**94% n=2771 ^**	**95% n=2843 ^**	**95% n=3028 -**	**94% n=2838 v**	**93% n=2657 v**	**92% n=2246 v**	**90% n=2223 v**	**93% n=3045 ^**	**93% n=3092 -**	**93% n=2023 -**	**93% n=1885 -**	**92% n=28651**

We can now report 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) by division.

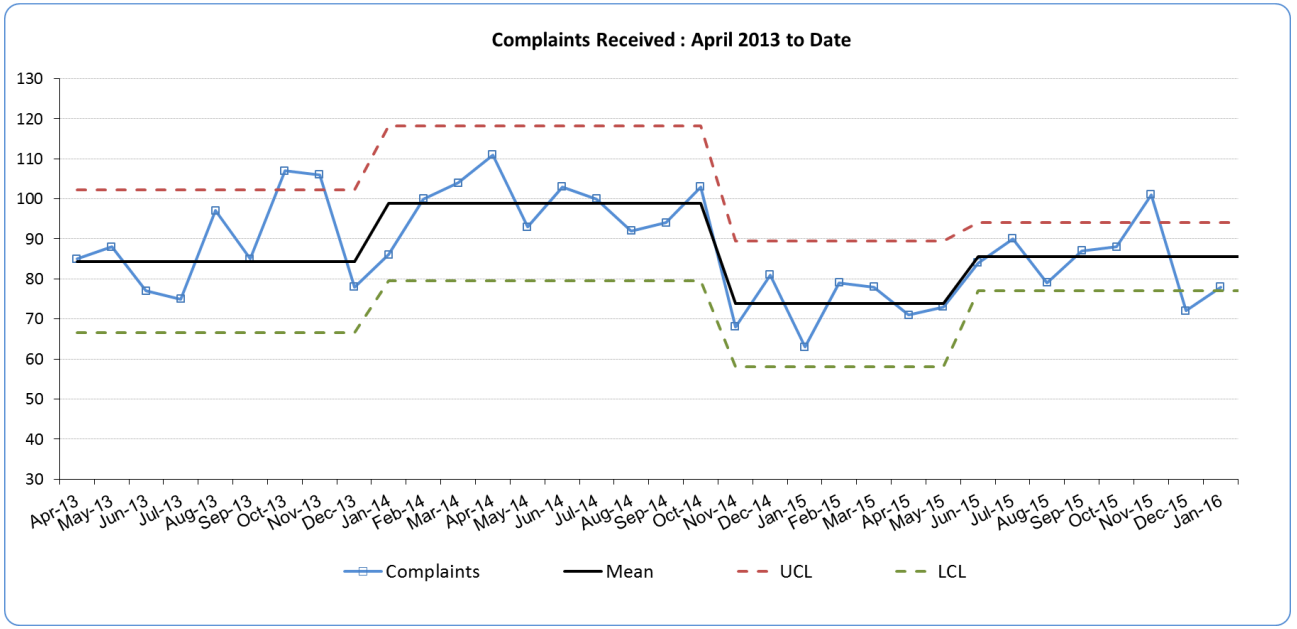
This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient that would have trouble understanding the standard survey question.

Further breakdowns are available for services and location type.

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

11. Patient Experience - Complaints Received

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



Overview:

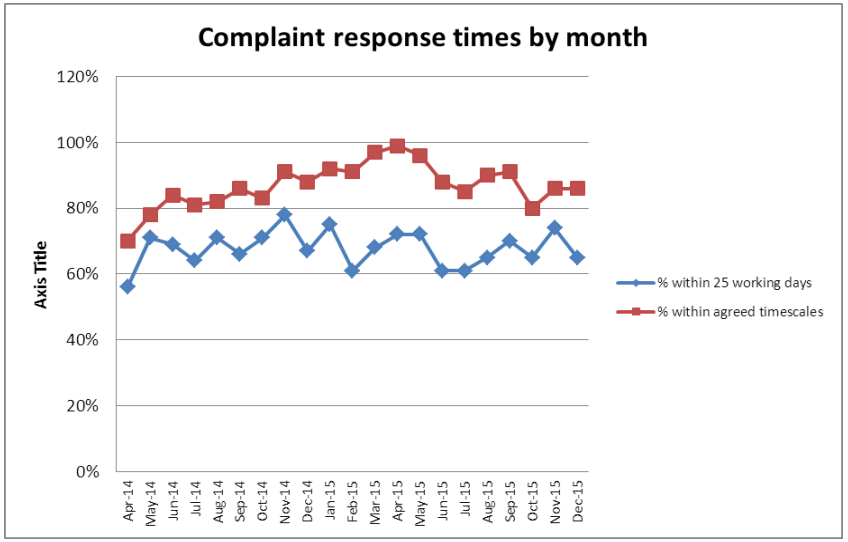
This report provides an update on complaints received in quarter 3 of 2015/2016 and information on responding to complaints within the specified timeframes for the same period, with divisional breakdowns and analysis of the data to provide some trends and themes. It also includes some actions taken and planned in quarter 3, 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 3 of 2015/2016

There were 262 complaints received in quarter 3 of 2015/2016, not a significant change when compared to quarter 2 when 255 complaints were received. Complaints remained stable in the Surgery and Neurosciences Division and reduced in the Community Services Division and Corporate Directors but rose in Medicine and Cardiovascular and Women's and Children's Divisions.

11. Patient Experience
- Complaints Performance against targets

Performance Against Targets Quarter 3 of 2015/2016				
Division	**Total number of complaints received**	**Number within 25 working days**	**% within 25 working days**	**% within 25 working days or agreed timescales**
Children's & Women's	79	51	65%	(16) 85%
Medicine and Cardiovascular	82	53	65%	(20) 89%
Surgery & Neurosciences	71	50	70%	(9) 83%
Community Services	15	13	87%	(1) 93%
Corporate Directorates	15	14	93%	(1) 100%
Totals:	262	181	69%	(46) 87%



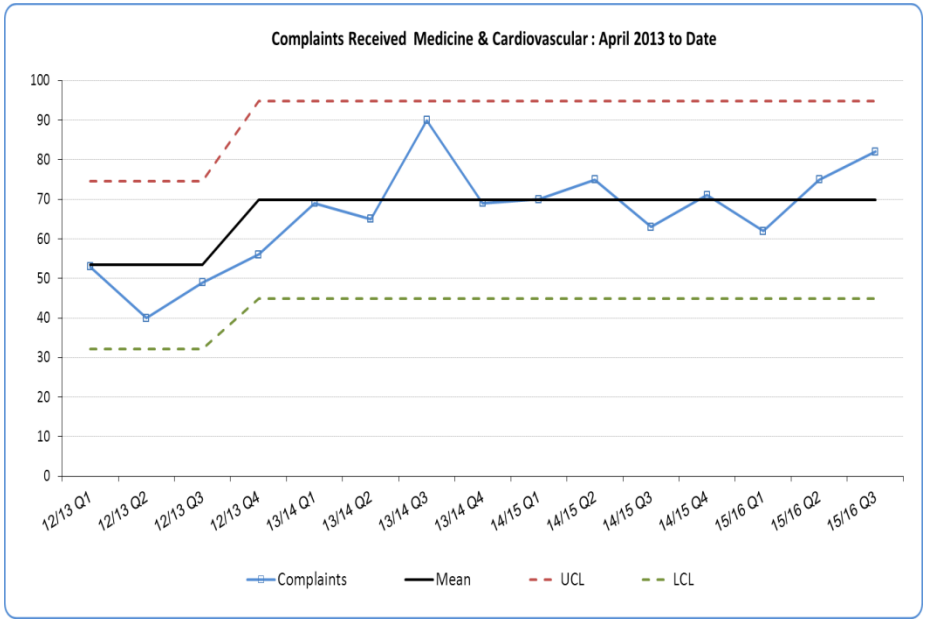
Commentary:

There was a slight improvement in complaints performance against the first target in quarter 3 when compared to quarter 2. 69% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 65% in quarter 2. There was a decline in performance again the second target with 87% of complaints responded to within agreed timescales (against internal trust target of 100%) compared to 90% in quarter 2.

Estates and Facilities Directorate was the only area which reached both targets but Community Services was very close. Action plans are in place in divisions to improve and to deliver performance against internal standards.

A workshop is taking place on 7 March 2016 to review how the complaints process is working from beginning to end and the governance/reporting/performance management. Participating will be the Deputy Chief Nurse, Divisional Directors of Nursing and Governance, Heads of Nursing, General Managers, Divisional Governance Managers and the corporate complaints and PALS teams.

11. Patient Experience
- Complaints – Q3 by division



Attitude and Communication

Band 7 development day for Sisters initiated across division. This covers expectations, challenging behaviours and difficult conversations

Standards of behaviour implemented within ED and 2 Acute Medical wards. To be implemented across division

Learning from complaints is now a standard part of directorate meeting

Communication Regarding Clinical Care

PALS and Senior Leaders contact posters to be displayed on all wards

Relative engagement at ward rounds to be initiated through inviting relative at ward round. To be trailed on Dalby and AMU March 2016.

Quality Observatory piloted in division allowing visible leadership and engagement with patents

Waiting time for appointments

Change in outpatient booking process to chronological order from February 2015

Weekly review of patient tracking lists

Triage and patient contact system in place for patient waiting for prolonged periods within Cardiac Services.

Actions to improve performance and learning

Twice weekly review of outstanding complaints by directorate initiated.

Face to face meeting already established and verbal review of actions implemented from 23rd February 2016

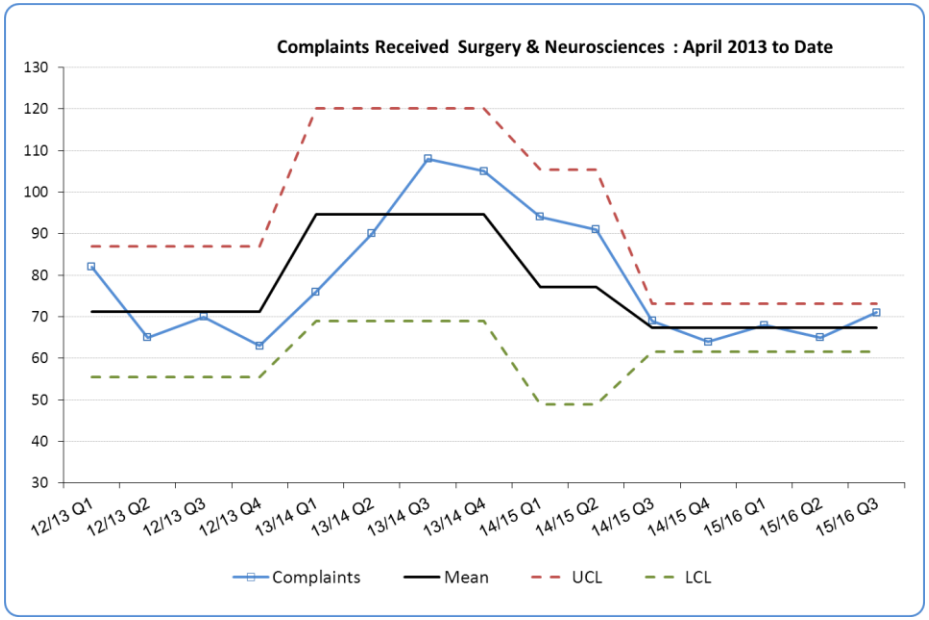
Complaints action plan and learning from complaints to be incorporated into responses and loaded onto datix centrally. This will allow greater visibility of actions and learning. To be implemented from March 2016

Additional senior nursing support provided to directorates with high number of complaints. Support in place and extended.

Promote local resolution of complaints and de-escalation through identification of leads for each complaint to contact complainant. Replicating work seen in ED. February 2016.

Divisional Participation in Trust complaints meeting to review learning and review process March 2016

11. Patient Experience
- Complaints – Q3 by division



STNC Directorate:

- The division had a slight increase in the complaints they received in Q3.
- Currently in the SNTC division we have a total of 29 complaints to respond to and 6 of those have extensions agreed due to the complexity of the response needed.
- The Trauma and Orthopaedic care group have 17 out of the 29 complaints
- Theatres have zero complaints

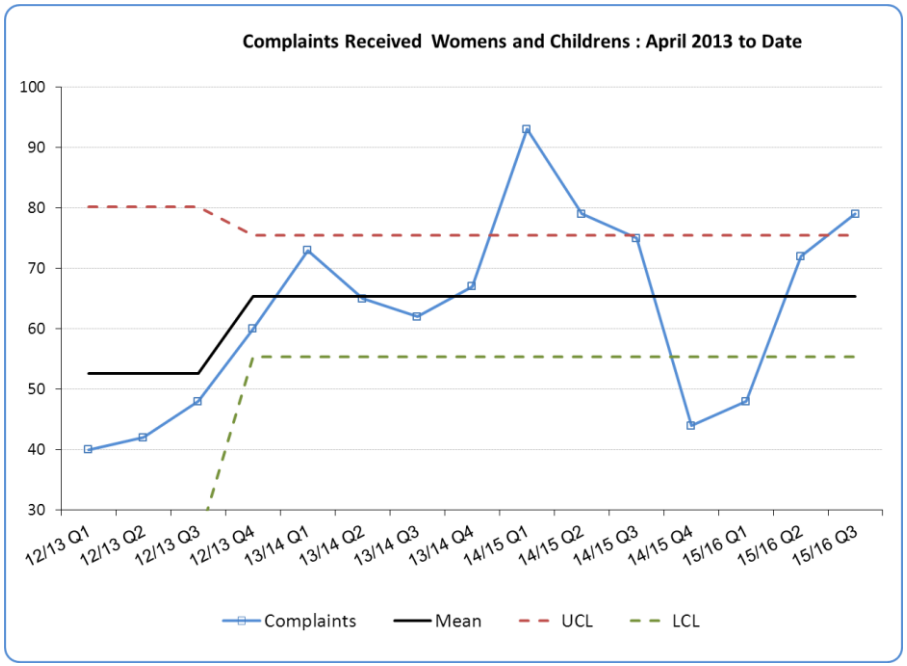
Themes

- The common theme in all these complaints relates to poor communication by our administrative and clinical consultant teams.

Action plan.

- The Trauma and Orthopaedic care group have had a large vacancy gap of administrative staff; however, the management team have recently recruited into all their vacant positions.
- A Listening in Action programme has been set up for the Trauma and Orthopaedic outpatients department, which is currently looking at the processes and patient flow in this area and how we can improve patient's experience.
- An additional member of temporary staff has been recruited to help with this large volume of complaints

11. Patient Experience
- Complaints – Q3 by division



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

The Children's, Women's, Diagnostics & Therapeutics Division saw a slight increase in complaints received between Q2 where 72 were received to 79 in Q3. Women's services as a directorate continue to have the highest number of complaints within the division.

The top themes of complaints in the division are:

Communication
Clinical Treatment
Attitude / Care

Communication and clinical treatment are themes that reflect the previous quarter, with the addition of attitude as another area of concern for patients this quarter. It is however encouraging to see that waiting times did not feature as a theme in Q3, this is largely attributed to actions that have been implemented within services; this will however continue to be monitored to ensure that this improvement is sustained.

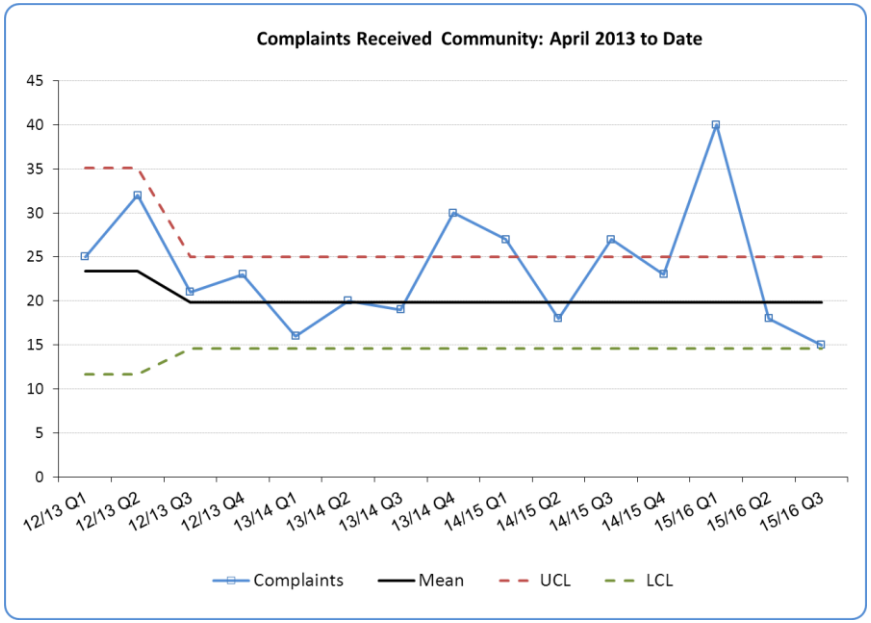
The following actions are being taken to address the top themes in the division:

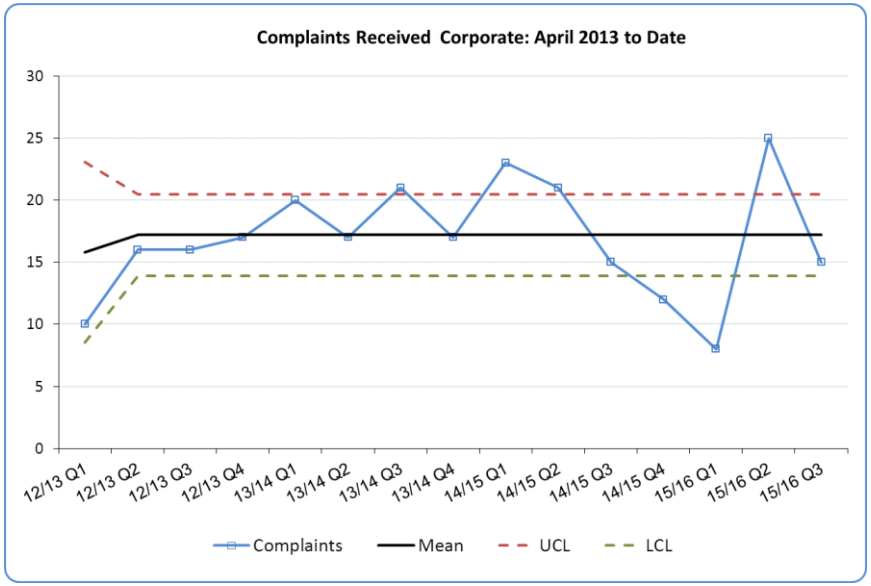
Communication / Attitude
Customer care training continues in outpatients is being expanded to include the use of a short film made in the Trust, by staff and patients, in addition one of the service managers is providing customer service training directly to the administrative staff in corporate outpatients.
The educational films which re-enact real complaints are being utilised within children's services and an additional piece of work is being delivered to improve the communication to adolescents.

Clinical Treatment
The suspension of the urogynaecology service has featured again in this quarter. As in previous quarters there is a consistent approach to the complaints related to this service, which is also being managed via a public consultation. All patients have been offered alternative hospitals for treatment.

Within obstetrics a birth reflections clinic has been established; through this it is hoped the number of complaints will be reduced as this clinic will give women the opportunity to discuss their birth experiences with a midwife. This clinic is being held on a monthly basis and will be open to all women irrespective of when they gave birth.

11. Patient Experience
- Complaints – Q3 by division





Community Services Division

The community Services Division saw a reduction in complaints being received in quarter 3 when 15 complaints were received compared to 18 in quarter. In year to date most complaints are received for Adult Services (ADS) followed by the Offender Healthcare Care (OHC) Group.
In OHC & ADS the majority of complaints are about the subject of clinical treatment.

Action:

As a result of a complaint where a patient was unhappy with the length of time it took to have radiotherapy after being diagnosed service are now putting a copy of the fax receipt in the medical notes and are sending emails via NHS.net to ensure there is a record of any referral made.

Corporate Directorates

Complaints about Corporate Directorates reduced from 25 in quarter 2 to 15 in quarter one. Complaints about Estates and Facilities (mainly transport) reduced from 19 to 14 and there were no complaints received about Finance compared to 4 in quarter 2.

Action:

In the transport service:

Two new team leaders have been recruited and will be based in the transport lounge. They will also be tasked with overseeing renal patient transport.

The trust is planning to re-tender the patient transport service this year as part of a South West London service. This is a completely new way of working and the provision of renal transport is a top priority.

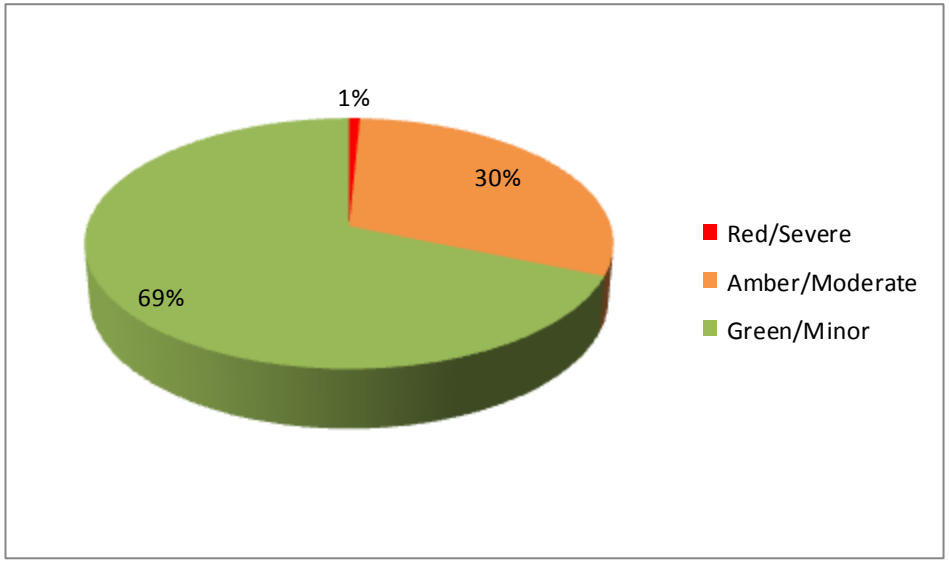
Waits will be monitored at the weekly meeting and the renal staff will work on ensuring she is booked ready to return home to travel with the patients she travelled in with. This will reduce the waiting times.

11. 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 3 of 2015/2016 is presented below. A more detailed report will be presented at the Patient Experience Committee.

In Quarter 3 a total of 2 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 3 a total of 80 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 3 a total of 180 complaints were categorised as Green/Minor.

11. 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 February board report.

Anonymous *gave St George's Hospital (London) a rating of 5 stars*
Great experience with the staff at this hospital
I've had to use various services at this hospital over the last 4 weeks and the people working here continually leave me impressed. They are kind, caring and most importantly very professional.

I would definitely recommend St. Georges to my loved ones and feel secure in my treatments here.

Visited in January 2016. Posted on 29 January 2016

Anonymous *gave Cardiology at St George's Hospital (London) a rating of 5 stars*
Wonderful care during my angiogram
Many thanks to the staff of James Hope ward for the wonderful care that I received on the ward and also during the procedure. Everyone was so kind and efficient.

Visited in February 2016. Posted on 03 February 2016

Anonymous gave *Queen Mary Hospital a rating of 1 stars*
Receptionists are extremely rude
The receptions were very rude, they asked me 'what's the problem' rather than 'how can we help'. They didn't make me feel welcome or comfortable even though I was suffering from so much pain. I went a previous time with friend as she hurt her wrist. We arrived 5 mins after closing, the doors were locked so we rang the phone, the receptionist ignored our call even though they could see us standing outside.

Visited in January 2016. Posted on 21 January 2016

Rianjongdee *gave Queen Mary Hospital a rating of 5 stars*
Pharmacy
I would like to thank the Pharmacy staff for such an efficient and friendly service.
They were very helpful with my daughter's prescription and I would like to thank them on her behalf too.
Best Wishes
Daniela

Visited in January 2016. Posted on 18 January 2016

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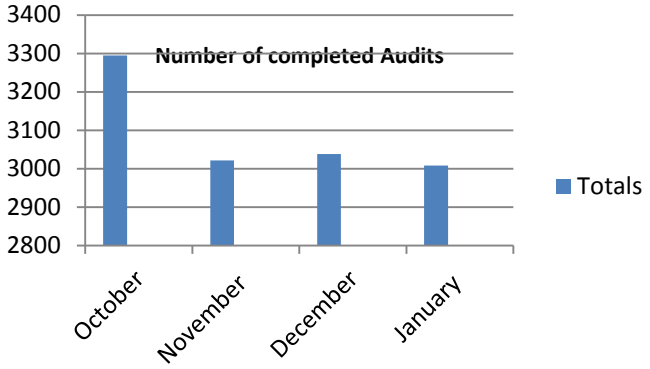
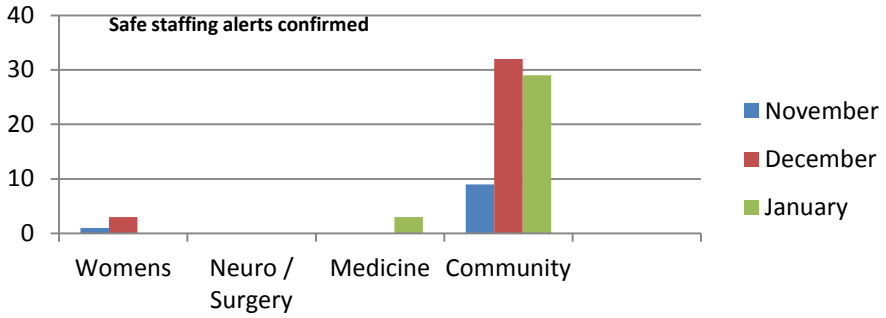
St George's University Hospitals NHS
NHS Foundation Trust

Workforce

Excellence in specialist and community healthcare

12. Workforce
January 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: November 3021, December 3038 and January 3008. There was a slight decrease in the number of final alerts reported from 35 in December 2015 to 32 in January 2016. 29 of the alerts relate to community services. 15 alerts were registered by the tissue viability service, a similar number to last month. Recruitment to this service has been challenging. Care is prioritised to ensure patients are safe. Community services have a robust recruitment plan, although recruitment remains challenging in this area. 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 November 13, December 10 and January 18. 3 nursing related safe staffing concerns were raised on Datix system in January compared to 5 in December. None of the alerts and none of the concerns matched a similar entry on the RATE system.

MONTH	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN
ALERTS	11	13	8	10	11	5	2	12	27	9	10	35	29
CONCERNS	19	32	25	15	18	16	17	24	14	37	13	10	18

Actions: 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.

12. Workforce: January 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 January 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 December the trust achieved an average fill rate of 94.33%, a slight decrease from 95% submitted in December 2015. The trend over the past six months is outlined below:

MONTH	AUG 15	SEPT 15	OCT 15	NOV 15	DEC 15	JAN 16
%	93.99%	94.6%	94.4%	93.93%	95%	94.33%

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

On going review of temporary staffing

On-going review of rostering compliance – waiting for this to be included in the heatmap

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	94.2%	#DIV/0!	99.4%	169.2%
Carmen Suite	130.9%	67.2%	99.3%	86.2%
Champneys Ward	104.6%	113.0%	101.1%	100.0%
Delivery Suite	104.0%	66.8%	107.5%	96.7%
Fred Hewitt Ward	93.7%	107.1%	96.8%	94.1%
General Intensive Care Unit	96.0%	74.7%	99.8%	79.7%
Gwillim Ward	112.4%	55.6%	99.5%	85.0%
Jungle Ward	100.1%	0.0%	#DIV/0!	#DIV/0!
Neo Natal Unit	87.8%	#DIV/0!	95.2%	#DIV/0!
Neuro Intensive Care Unit	94.4%	75.7%	97.8%	78.3%
Nicholls Ward	90.6%	87.2%	98.0%	44.4%
Paediatric Intensive Care Unit	94.6%	96.3%	97.0%	100.0%
Pinckney Ward	112.8%	64.3%	98.1%	#DIV/0!
Dalby Ward	96.5%	110.6%	99.9%	99.2%
Heberden	83.1%	102.2%	100.0%	100.0%
Mary Seacole Ward	95.5%	100.0%	98.4%	99.4%
A & E Department	93.4%	67.3%	102.2%	69.7%
Allingham Ward	87.1%	116.3%	99.1%	99.0%
Amyand Ward	80.3%	103.1%	97.5%	99.0%
Belgrave Ward AMW	94.3%	94.8%	99.4%	98.1%
Benjamin Weir Ward AMW	88.1%	74.5%	98.6%	95.9%
Buckland Ward	83.9%	57.5%	98.9%	93.8%
Caroline Ward	87.5%	79.7%	97.6%	#DIV/0!
Cheselden Ward	91.8%	110.2%	98.9%	97.7%
Coronary Care Unit	97.7%	#DIV/0!	102.1%	#DIV/0!
James Hope Ward	82.2%	90.9%	94.8%	#DIV/0!
Marnham Ward	85.7%	92.4%	96.3%	97.5%
McEntee Ward	90.1%	105.4%	99.4%	100.0%
Richmond Ward	88.8%	97.5%	97.1%	97.7%
Rodney Smith Med Ward	90.0%	94.2%	100.0%	98.9%
Ruth Myles Ward	107.7%	105.0%	100.0%	92.6%
Trevor Howell Ward	97.4%	121.8%	108.1%	75.7%
Winter Ward (Caesar Hawkins)	84.7%	102.1%	99.3%	96.7%
Brodie Ward	89.7%	89.1%	96.5%	98.4%
Cavell Surg Ward	78.7%	85.8%	97.7%	100.0%
Florence Nightingale Ward	91.2%	71.2%	99.9%	#DIV/0!
Gray Ward	83.3%	67.8%	99.9%	92.2%
Gunning Ward	89.6%	91.8%	100.0%	98.4%
Gwynne Holford Ward	87.3%	86.7%	92.8%	100.8%
Holdsworth Ward	89.1%	82.8%	100.0%	95.9%
Keate Ward	95.3%	75.5%	100.0%	100.0%
Kent Ward	85.2%	88.2%	99.1%	98.5%
Mckissock Ward	88.5%	98.3%	96.5%	96.7%
Vernon Ward	81.0%	84.8%	99.1%	100.0%
William Drummond HASU	86.5%	90.4%	92.6%	98.6%
Wolfson Centre	79.9%	100.6%	94.8%	104.3%
Gordon Smith Ward	84.5%	86.2%	100.0%	93.9%
Trust Total	91.73%	91.09%	98.84%	95.31%
	Day Qual	Day HCA	Night Qual	Night HCA
	91.73%	91.09%	98.84%	95.31%

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St George's University Hospitals NHS
NHS Foundation Trust

Heatmap Dashboard
Ward view

Excellence in specialist and community healthcare

January 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	94.1	53.7	29.3	13.6	4.0	0.0	11.9
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	100.0	93.9	70.6	9.5	1.0	0.0	6.6
	GRAY WARD	0.0	0.0	0.0	93.3	97.1	63.6	14.9	1.0	0.0	0.5
	GUNNING	0.0	0.0	0.0	96.2	92.9	47.8	6.5	4.0	0.0	0.2
	GWYN HOLFORD	0.0	0.0	0.0	97.7	100.0	88.9	9.5	10.0	0.0	2.0
	HOLDSWORTH	0.0	0.0	0.0	100.0	89.5	34.5	8.2	7.0	0.0	8.5
	KEATE	0.0	0.0	0.0	94.7	93.9	76.6	6.5	0.0	0.0	4.3
	KENT	0.0	0.0	0.0	100.0	77.8	11.3	8.5	9.0	0.0	0.8
	MCKISSOCK	0.0	0.0	0.0	100.0	100.0	61.1	6.5	3.0	0.0	11.7
	THOMAS YOUNG	0.0	0.0	0.0	88.5	66.7	14.3	7.8	4.0	0.0	1.2
	VERNON	0.0	0.0	0.0	100.0	96.4	35.0	11.9	2.0	0.0	5.1
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	93.8	95.5	25.6	9.6	2.0	0.0	3.4
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0	92.9		0.0	2.5	0.0	0.0	1.7
	CARMEN SUITE	0.0	0.0	0.0	100.0			-5.3	0.0	0.0	2.8
	CHAMPNEYS	0.0	0.0	0.0	100.0	90.9	11.2	-3.6	2.0	0.0	1.0
	DELIVERY	0.0	0.0	0.0	100.0	100.0	25.0	-1.5	0.0	0.0	8.4
	FREDDIE HEWITT	0.0	0.0	0.0			12.5	4.1	0.0	0.0	3.6
	GENERAL ICU/HDU	0.0	0.0	0.0	87.5			2.5	1.0	0.0	3.9
	GWILLIM	0.0	0.0	0.0	100.0	90.0	42.4	4.8	0.0	0.0	4.7
	JUNGLE	0.0	0.0	0.0			28.6	2.0	0.0	0.0	1.6
	NEONATAL ICU	0.0	0.0	0.0	100.0		0.0	8.7	0.0	0.0	6.1
	NEURO ICU	0.0	0.0	0.0	92.3			5.8	0.0	0.0	2.9
	NICHOLLS	0.0	0.0	0.0			0.0	9.9	1.0	0.0	10.7
	PICU	0.0	0.0	0.0		100.0		4.0	0.0	0.0	1.2
	PINCKNEY	0.0	0.0	0.0			0.0	-2.6	0.0	0.0	2.4

January 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	94.7	90.0	64.9	1.7	8.0	0.0	5.2
	South Locality (CCM)	0.0	0.0	1.0					0.0	0.0	
MEDICINE	ALLINGHAM	1.0	0.0	1.0	84.6	78.9	30.2	2.4	10.0	2.0	12.4
	AMYAND	0.0	0.0	0.0	96.9	100.0	15.3	7.5	6.0	0.0	5.9
	BELGRAVE	0.0	0.0	0.0	96.9	93.4	39.6	3.8	12.0	0.0	0.4
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	96.8	38.3	9.8	4.0	0.0	4.0
	BUCKLAND	0.0	0.0	0.0	95.0	100.0	67.9	15.3	4.0	0.0	4.1
	CAESAR HAWKINS	0.0	0.0	0.0	69.6	77.8	11.3	6.1	8.0	1.0	12.2
	CARDIAC CARE UNIT	0.0	0.0	0.0	85.7	100.0	100.0	-0.2	0.0	1.0	3.4
	CAROLINE	0.0	0.0	0.0	100.0	95.6	39.3	10.5	2.0	0.0	9.3
	CHESELDEN	0.0	0.0	0.0	95.5	97.1	44.3	3.1	6.0	0.0	0.1
	DALBY	0.0	0.0	0.0	74.1	100.0	38.7	-2.1	9.0	0.0	6.3
	EMERGENCY DEPARTMENT	0.0	0.0	0.0				7.6	1.0	0.0	4.3
	GORDON SMITH	0.0	0.0	0.0	100.0	96.3	57.4	10.1	4.0	0.0	0.4
	HEBERDEN	0.0	0.0	0.0	91.7	100.0	14.3	3.8	2.0	0.0	8.9
	JAMES HOPE	0.0	0.0	0.0			0.0	14.1	1.0	0.0	2.5
	MARNHAM	0.0	0.0	0.0	89.3	100.0	15.4	8.5	4.0	0.0	4.3
	MCENTEE	1.0	0.0	0.0	88.2	86.7	43.5	2.7	2.0	0.0	1.7
	RICHMOND	0.0	0.0	1.0	92.0	95.3	15.4	5.4	0.0	1.0	6.1
	RODNEY SMITH	0.0	0.0	0.0	88.9	95.2	45.7	5.2	6.0	0.0	3.4
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	76.9	100.0	75.0	-3.5	1.0	0.0	1.9
	TREVOR HOWELL	0.0	0.0	0.0	100.0	92.3	29.2	0.2	2.0	0.0	6.6

13. **Ward** heatmap
CWDT&CC Division

Cardiothoracic Intensive Care (CTICU)
92.9% scored for harm free care. 14 patients were surveyed with 1 reported harm, which was a patient with an old pressure ulcer.

General Intensive Care (GICU)
87.5% scored for harm free care. 16 patients were surveyed with 2 patients recorded as having harms; both of these patients had new grade 2 pressure ulcers.

Neuro Intensive Care (NICU)
92.3% scored for harm free care. 13 patients were surveyed, with 1 patient found to have an old grade 2 pressure ulcer and a d new grade 2 pressure ulcer.

There has been significant focus on pressure ulcer prevention in the adult critical care areas; particularly in relation to preventing grade 2 pressure ulcers from further deterioration. This is highlighted in the fact there has only been 1 grade 3 pressure ulcer across the units in Q2/3, which is a much improved and sustained position.

Sickness
The staff sickness profile continues to improve across the division. Further work is required in specific areas to drive this down further such as Nicholls ward and Delivery suite. Divisional meetings that will review rota compliance and sickness are due to commence at the end of March 2016.

Friends and Family
The situation with Friends and Family reporting remains the same as in January 2016; there are significant data errors for the metric. The Divisional Director of Nursing and Governance has escalated the concerns regarding this to the informatics team.

Falls
December 2015 saw an increase in falls on Champneys ward due to the change in patient type on the ward; this has reduced by 50 % in January 2016 which is positive, the challenge is now to sustain this which the ward team are working to achieve.

13. **Ward** heatmap
SNCT

There are 19 red alerts for January 2016 compared to 14 for the previous reporting period. Last reposting period did not include ward staffing unfilled hours and sickness absence in its data report. There is also an increase in the overall number of alerts from 15 to 23, however again it should be noted that sickness absence / ward staffing unfilled hours were not included in Jan report - difficult to monitor the alert trend for this period.

Florence Nightingale – 1 red indicator due to sickness of 6.6%. (one member of staff on long term sickness - some short term sickness-all managed to policy.
Gunning – 1 red indicator due to falls x 4 – all falls were no harm. The falls threshold per month should be 4, but on the scorecard it is one. This needs amending
Holdsworth – 2 red indicators – The first red indicator was due to sickness of 8.5%. Two staff members were on long term sickness and were managed to policy
The second red indicator related to 7 falls –all were no harm and one patient fell twice. All risk assessments were completed. The falls threshold per month should be 4 but on the scorecard it is 1.5, this needs amending. An environmental risk assessment requested due to the amount of falls.
Cavell - 3 red indicators ad 1 amber indicator.
The first red indicator related to sickness of 11.9 %. This was due to 2 staff members on long term sickness and the ward also had three episodes of short term sickness and all were managed to policy. The second red indicator was due to 4 falls. One patient fell twice and all falls were no harm. The third red indicator related 13.6% of unfilled hours. This was due to vacant duties that were not filled by bank and agency. One amber indicator related to 94.1% Harm free care. This was due as a patient was admitted to the ward with an old grade 4 pressure ulcer from an external organisation.
Keate- 1 amber indicator and 1 red indicator. The amber indicator related to 94.7% of Harm Free care. This was due to one old grade 2 pressure ulcer, admitted to the ward from an external organisation.
The red indicator related to sickness absence of 4.3%. This was due to one staff member being on long term sickness and some short term sickness; all have been managed to policy.
Gray- 1 red indicator and 1 amber indicator. The red indicator was due to 14.9% unfilled hours as vacant duties were not filled by bank or agency. The amber indicator related to 93.3% of Harm Free Care. This was due to 1 patient who had an old grade 4 pressure ulcer and another patient who had an old grade 2 pressure ulcer. Both patients were admitted to the ward from external organisations
Vernon-2 red indicators. 1st related to sickness of 5.1%, this was due to two members of staff who were on long term sickness. All sickness managed to policy.
The second red indicator was related to 11.9% of unfilled duty hours as the vacant duties were not filled by bank or agency.
Brodie - data appears to be missing
McKissock – 2 red flags due to 3 falls. (below the agreed threshold for McKissock (4) will be adjusted. The falls were x1 patient fainting and x2 controlled falls where patient mobilising and became unsteady. All no harm
11.3% sickness. X2 nurses on long term sick leave and small amount of short term sick leave. X1 nurse on long term sick will be returning at the end of Feb and the other is being managed as per sickness policy and will be going to a final sickness hearing shortly.
Kent – 2 red flags. 9 falls, all no harm and all different patients. The falls were either unseen where patients were attempting to mobilise without asking for assistance or controlled falls when having therapy sessions. 11.3% friends and family response rate. All staff have been reminded to ensure that the friends and family test is completed on discharge
William Drummond – 2 amber indicators– relates to 93.8% Harms Free Care, 1 x old grade 2 pressure sore present on patient's admission. FFT= 25.6% of discharges audited, this relates to patient cohort however of the patients audited 100% would recommend the service as extremely likely or likely
Thomas Young - 3 reds indicators- relates to 88.5 % Harms Free care, 1 x new grade 2 pressure ulcer, 1 x patient old grade 3 pressure ulcers present on admission, 1 x patient fall low harm. FFT= 14.3% only 3 patient's discharged were audited of these three 1 was extremely likely and 1 was likely to recommend. 1 patient was unlikely to recommend although all comments were positive. The tablet was also broken for a couple of weeks
Falls= 4, threshold is for 11. All falls were no harm and appropriate falls and post falls risk assessments were completed.
Gwynne Halford - X1 Red flag due to 10 falls. Falls - no harm and due to patients having therapy sessions. New matron concentrating on reducing number of falls

13. **Ward** heatmap
Medcard (1)

Dalby – 2 members of staff on long term sick which is being managed with HR. Harm Free Care – This is due to multiple patients having non acquired hospital pressure ulcers

Heberden - FFT- Poor response rate due to staff compliance issues. The Ward Manager has been off on long term sick and now has a plan in place to increase response rate. Sickness – 1 member of staff on long term sick, managed in line with policy and is now on a phased return.

Amyand - FFT– work is on-going to remind staff and raise awareness of the importance of competing the FFT. In January there were a number of patients due to their medical conditions who were unable to complete the survey.Sickness – 1 long term sickness which is being managed in conjunction with HR, short term sickness managed locally with no staff member triggering for formal management.

Richmond - Grade 3 pressure sore currently being investigated as a Serious Incident, following which the learning will be shared across the nursing teams. FFT: The Matron is working with the band 6 and 7 as part of the development days on the ward to improve completion of the FFT. Additionally this is being allocated to the house keeper and patient flow coordinator to assist with completion. Serious Incident : This incident relates to a Grade 3 pressure ulcer which is being investigated. Sickness: 3 staff on LTS, these have been managed with HR and 2 have return to work dates established.

Allingham ward- C.Diff: A RCA was completed for this patient which showed the patients was on laxatives and intravenous antibiotics and developed type 7 stool. Pressure Ulcer: Grade 1 acquired ulcer that was treated by the ward team and subsequently healed prior to the patients discharge. Falls: 6 falls were attributed to one patient, who subsequently received 1:1 care with a HCA until discharge. 4 individual patients resulted in low or no harm. Serious Incidents: 2 incidents currently being investigated. 1st patient transferred to Buckland ward on 30/11/15 with Grade 3 sacral sore. 2nd relates to a fall resulting in a fractured NOF which is currently being investigated and a 72 hour report has been completed. Sickness 12.4%: 3 members of staff currently on LTS and multiple episodes of short term sickness. Meetings now established with HR to support ward manager in the management of these cases. Harm Free Care 84.6%, 26 patients surveyed. 4 harms reported. 2 patients had old grade 3 pressure ulcers, 1 patient had an old grade 4 pressure ulcer and 1 patient had a fall with a low harm.

Marnham ward – FFT response rate 15.4%. Staff have been reminded at handovers to ensure that this is completed prior to discharge. The Ward sister has now returned from Maternity leave and has a plan in place to monitor and ensure improvement. Harm free care- 89.3% due to one Grade 3 pressure ulcer which was old and 2 patients had new catheters with a new diagnosis of UTI. Sickness is currently recorded as 4.3% and the ward sister is managing this with support of HR. Falls: 4 falls were reported during this period, all were low or no harm falls, on individual patients.

Rodney smith- Harm free care 88.9% 1 patient had a new grade 2 pressure ulcer, 1 patient had an old grade 3 pressure ulcer and 1 patient had a catheter and new UTI. Falls x6: Of the falls recorded 4 falls relate to the same patient who was specialled. The remaining falls relate to individual patients and were low harm falls.

13. **Ward** heatmap
Medcard (2)

Caesar Hawkins- Harm free care –23 patients surveyed. 7 patients had harms reported. 2 patients had old grade 2 pressure ulcers, 2 patients had old grade 3 pressure ulcers, 1 patient had a new grade 2 pressure ulcer, 1 patient had a new grade 3 pressure ulcer and 1 patient had a fall with low harm.
FFT– The ward sister will be meeting with the discharge co-ordinator, House keeper and senior team to discuss this issue and increase compliance.
Falls – The ward had 8 falls during the month. These falls were low and no harm falls. The ward sister has met with the nurse staff and informed them of the need to identify high risk falls patients and the need for accurate reassessment of patients on transfer to the ward to be completed.
SIs– This incident is currently being investigated and relates to a patient who absconded from the ward.

Ben Weir - Sickness at 4% in month, this relates to short term sickness that is being appropriately managed.

CCU - Harm free care 85.7% 7 patients surveyed. 1 patient had a harm reported. Patient had an old grade 2 pressure ulcer. There is 1 SI attributed to CCU which is currently being investigated and relates to the management of a patient following a TAVI procedure.

Caroline - 10.5% unfilled hours, currently we have significant vacancy on the ward, the roster is created within agreed timescales and shifts requested to bank. Staffing is reviewed on a daily basis and moved across the units as appropriate. The ward have appointed 3 nurses and await start dates, and are actively recruiting to vacancies.

James Hope / CPU - 14.1% unfilled roster, the ward has significant vacancy. The roster is created within agreed timescales and shifts requested to bank. Staffing is reviewed on a daily basis and moved across the units as appropriate.

Buckland – Red for 'unfilled duty hours' – percentage of fill rate was only 58%. The Roster has been created and approved within timescales and all outstanding shifts sent to bank. Red for sickness at 4.1% - this is due to 183.5 hours of STS, with a mix of B6, Band 5's and a Band 2 – This is being managed in line with policy, one HCA on stage 1 and one band 5 on stage 2.

Gordon-Smith –Red for 'unfilled duty hours' – for January, 74% fill rate. The Roster has been created and approved within timescales and all outstanding shifts sent to bank.

Ruth Myles ward- Red for Percentage of harm free care- this reflects 3 patients who came in with old pressure ulcers, one had a grade 3 and two had a grade 2 PU.

Trevor Howell- Red for sickness at 6.6% - this is due to LTS for B7 / 63 hours in January, and 113 hours of STS/0.61wte– all being managed appropriately in line with policy.

McKentee – C Dif. –an RCA was completed unavoidable. The patient had multiple medical issues and antibiotics as they had CMV colitis.
Harm Free Care – 1 Grade 2 pressure ulcer acquired, 1 fall, and 1 catheter longer than 28 days and 1 VTE with no prophylaxis prescribed. Nursing staff have been made aware of G2 learning and the importance of VTE is was discussed at Clinical Governance and fed back to medical staff.

13. **Ward** heatmap
Mary Seacole

Harm Free Care: 94.7, this figure relates to patients with Old Pressure Ulcers and 1 acquired grade 2. We continue to work hard to reduce incidence of PU, all patients have senior review twice weekly, ward Sisters monitor staff performance in relation to Turning charts and completion of PUP twice weekly.

Falls: 8.0 We work alongside our therapy colleagues to reduce risk of falling in patients, all patients have Falls risk assessment completed and reviewed, patients at high risk are assessed for need for 1:1 supervision and this is monitored by ward sisters daily. In handovers and team meetings the level of falls will be discussed and we will continue to review all falls and action ones where we consider there was a failure in correct action being taken to prevent.

Sickness 5.2, there have been challenges around sickness with some long term sickness. I am confident that all staff are managed appropriately through the sickness policy and referred for OH when required. I work with the ward sisters to ensure this happens and will review all staff with the sisters as part of their supervision to ensure this is happening.

14. Community Services Scorecard

Domain	Indicator	Frequency	2015/2016 Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16		
Patient Safety	SI's REPORTED	Monthly		1	1	2	0	1	4	1	3	1	1		
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0	0	0	0	1	0	0		
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0	0	1	2	1	1	0	1		
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0	0	0	0	0	0	0	1	1		
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7	4	12	8	13	10	11	13	10		
Patient Safety	Number of moderate falls	Monthly	0	2	1	0	1	0	0	0	2	1	0		
Patient Safety	Number of major falls	Monthly	0	0	0	0	0	0	0	0	0	0	0		
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0	0	0	0	0	0	0	0		
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0	0	0	0	0	0		
Patient Safety	CDiff (cumulative)	Monthly	31	1	0	0	0	0	0	0	0	0	0		
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2	2	2	2	2	2	2	2	2		
Patient Safety	Number of Quality Alerts	Monthly		3	5	2	9	11	4	6	7	4	7		
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	89.0%	86%	85%	84%	81%	81%	77%	74%	70.0%	70.0%		
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	90.0%	90.0%	85%	82%	79%	88%	89%	86%	85%	89%		
			Level 2 85%	84.0%	84.0%	82%	82%	74%	66%	67%	63%	83%	80%		
			Level 3 85%	69.0%	69.0%	82%	90.00%	70%	85%	87%	84%	84%	84%		
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.86	0.86	0.9	0.9	0.9	0.9	0.9		
Patient Experience	Active Claims	Monthly		0	0	1	3	1	0	1	0	0			
Patient Experience	Number of Complaints received	Monthly		16	18	6	5	2	5	5	5	5	4		
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	88% April 2015	78% May 2015	100%	100%	85%	100%	100%	89%	100.0%		
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100% April 2015	100% May 2015	100%	100%	92%	100%		78%	100%		
	FFT Score (Mary Seacole and MIU)	Monthly Mary Seacole A		97.0%	94.7%	77.7%	71.0%	97.3%	84.2%	94.4%	94.4%	100%	90%		
Patient Experience		Monthly Mary Seacole B		81.20%	90.90%	75.00%	95.40%	90.90%	75%	90%	94%		85%		
Patient Outcomes	Catheter related UTI (Trust)			1.14	0.66	1.12	1.32	1.50	1.03	0.67	0.96	0.47	Data available after 17th Feb		
	Number of new VTE (Trust)		National 0.005	0.53	0.37	0.15	0.08	0.24	0.17	0.30	0.48	1.03			
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	6.04%	6.00%	4.69%	5.75%	5.53%	5.90%	5.71%	6.00%			
Workforce	Turnover Rate-	Monthly	13%	19.64%	19.94%	20.40%	20.08%	21.00%	21.15%	20.75%	20.76%	21.20%			
Workforce	Vacancy Rate-	Monthly	11%	19.41%	19.06%	19.40%	12.60%	13.42%	12.59%	15.67%	18.50%	19.40%			
Workforce	Appraisal Rates - Medical	Monthly	85%	66.67%	72.73%	69.57%	69.57%	84.00%	84.00%	79.41%	81.26%	87.10%			
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	77.25%	76.80%	75.84%	75.42%	76.02%	68.22%	64.91%	62.92%	62.40%			

CSD Quality scorecard exception report

Serious Incidents: In Jan 2016: 1 PU Grade Community nursing

Quality alerts:

7 reported in Jan 2016 (2 remain open) (Community nursing: Access) (QMH MIU, OPD access)

Workforce data:

Vacancy and sickness rates increased on last month. workshop Feb 2016 to review recruitment, retention and foreword planning.

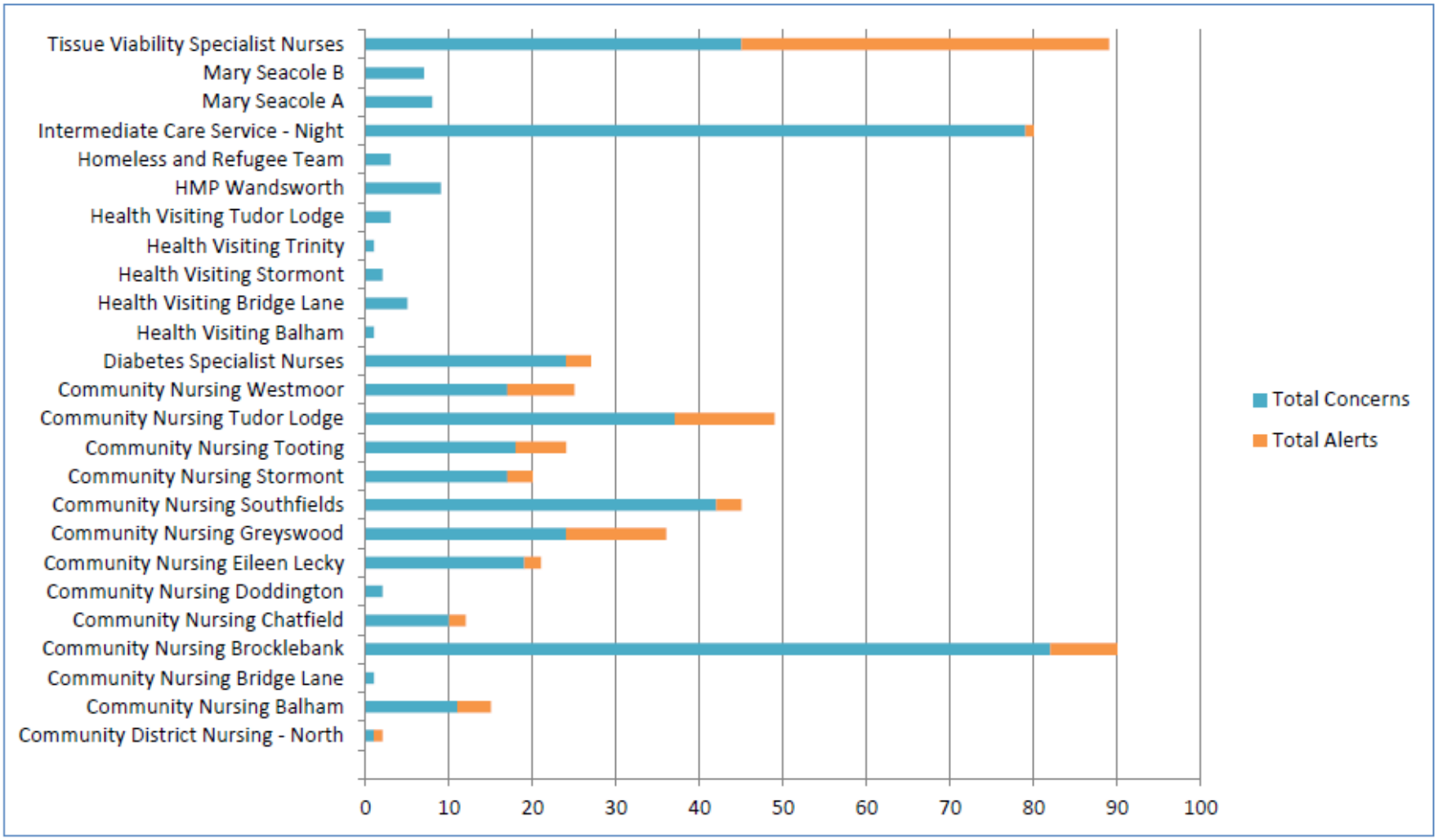
Safe staffing alerts:

Brocklebank community nurses have highest number of safe staffing concerns overall. TVN service remains high alert due to vacancy Overall report remains in development. a daily CAHS sit rep report has been introduced to monitor staffing and patient dependency and to provide support to CTLs and teams.

Key areas of concern for workforce:

Recruitment and retention: particularly offender healthcare, Mary Seacole ward (QMH), community nursing, school nursing, specialist nursing an therapy posts

Safe staffing report (Oct – Feb 2016)



REPORT TO THE TRUST BOARD *March 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 January 2016
- Staff survey results 2015

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

Key points to note are:

- Staff turnover has remained at the level to which it increased in December. Staff groups with increasing turnover rates are therapists, scientists and clinical technical roles. Nursing turnover is marginally decreasing.
- Sickness absence has increased again and has now been above target for longer than is usual in the winter.
- The trust continues to benchmark well against similar London trusts.

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

Turnover

The key message from the January workforce data is that turnover has remained at high levels specifically in therapy and clinical scientist and technical roles. Nursing turnover has reduced marginally. Although the trust continues to benchmark well against other London teaching trusts, high levels of staff turnover put significant pressure on the organisation.

Vacancy rate

There is a continued net reduction of staff in post with a reduction of 14 WTE since December.

Sickness absence

Sickness absence levels have increased marginally and the trust has now been above its target of 3.5% for five months in a row. Although there would normally be a spike in the winter period it would be normal to see this reducing by now. Some comfort can be drawn from the fact that the most common reason for absence is seasonal colds and flu.

Agency and bank staff usage

Temporary staffing levels returned to pre-Christmas levels in January.

The trust is meeting its requirements to report breaches of the agency price cap on a weekly basis. The greatest challenges remain with sourcing medical staff at prices that are below the agency caps. A report listing all interim management staff that breach the cap has been considered by the remuneration committee and will the list of breaches will be reported on a six-monthly basis to the committee.

The trust is being supported by Monitor to undertake a ‘deep dive’ review into its management of agency staffing.

Mandatory training and appraisal rates

The deterioration in mandatory training compliance and rates has reversed and the trust is currently 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 further focus will be given to this area. There will be a detailed review of appraisal processes at the workforce and education committee meeting due to take place in March.

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St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 10 - January 2016

Excellence in specialist and community healthcare

Workforce Performance Report Feb ‘15 - Jan ‘16

Contents

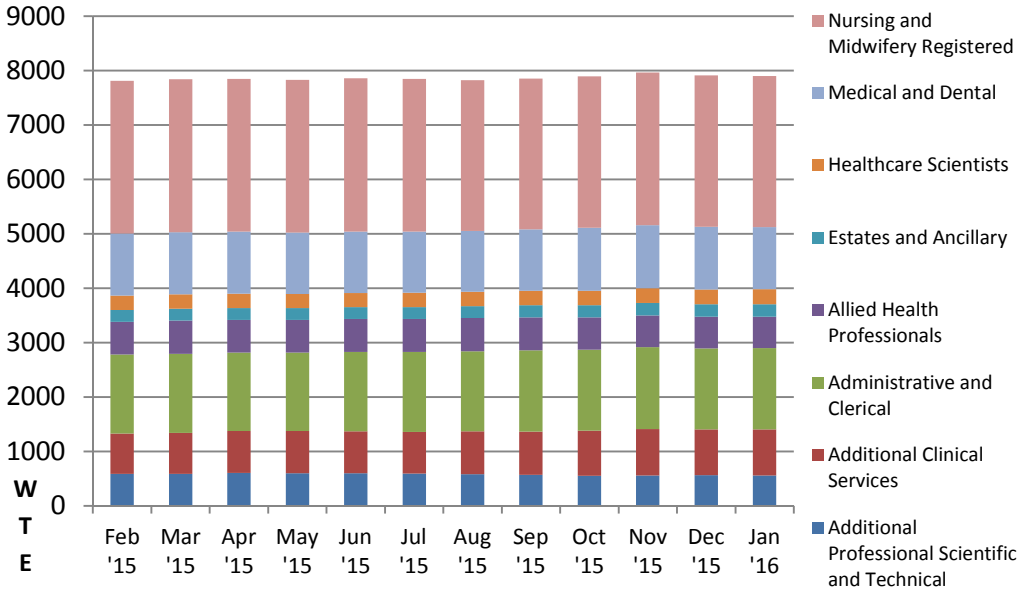
Performance Summary

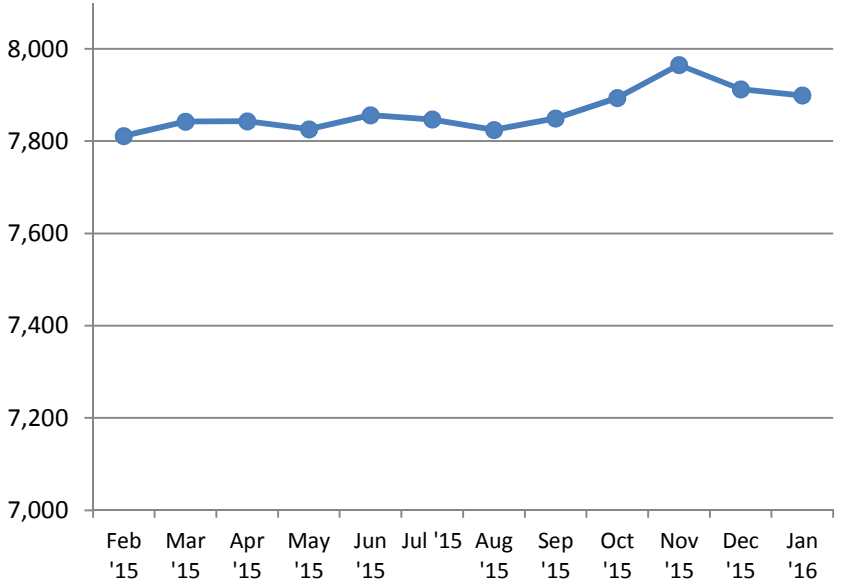
Summary of overall performance is set out below

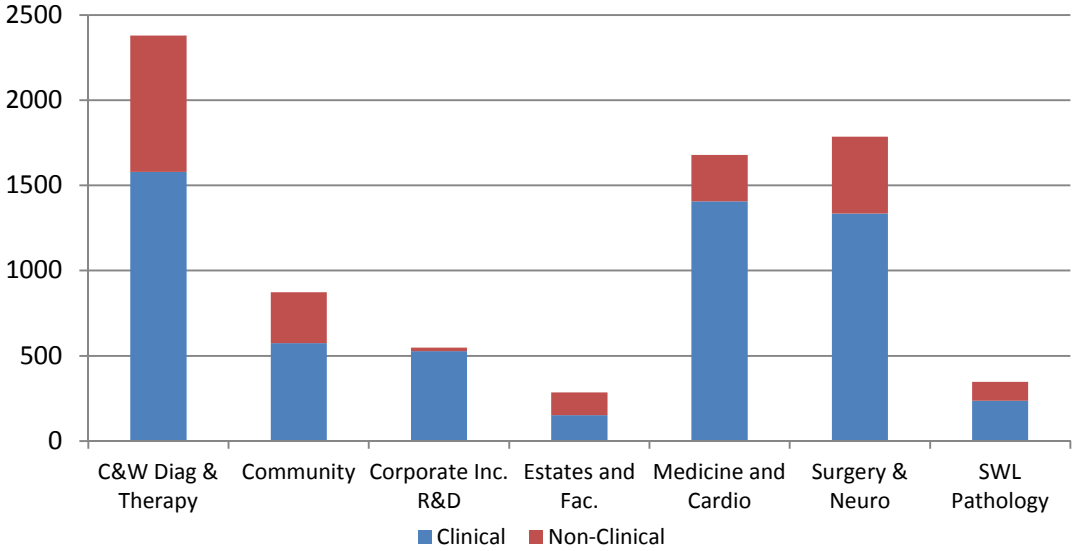
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 0.2%	13.7%	17.0%	17.2%	↗
6	Turnover	Turnover has reamained the same	17.3%	18.2%	18.2%	↔
7	Voluntary Turnover	Voluntary Turnover has remained the same	13.9%	14.9%	14.9%	↔
8	Stability	Stability has decreased by 0.2%	83.8%	82.7%	82.5%	↘
10	Sickness	Sickness has increased by 0.3%	4.1%	3.9%	4.2%	↗
15	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 2.1%	17.0%	12.8%	14.9%	↗
17	Mandatory Training	MAST compliance has increased by 1.1%	74.4%	66.0%	67.1%	↗
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.2%	80.4%	67.9%	67.7%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





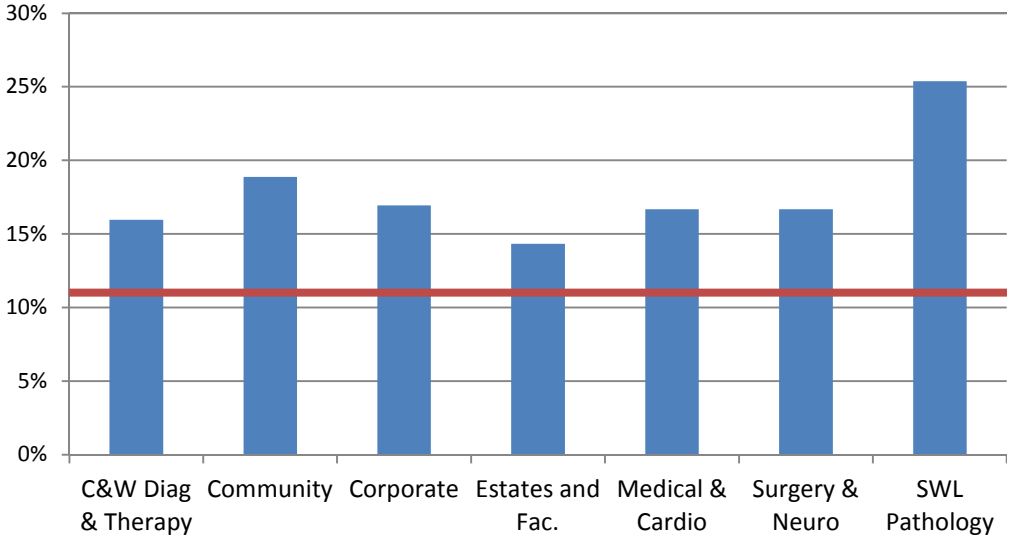


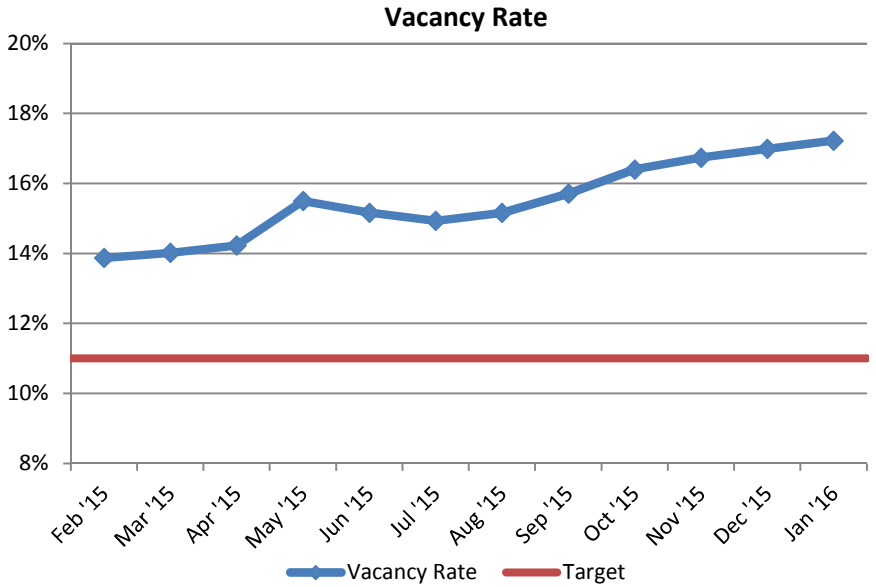
COMMENTARY

The Trust currently employs 8444 people working a whole time equivalent of 7899 which is 14 WTE fewer than December. The growth rate in the directly employed workforce since January 2015 is 159 WTE or 2.0%.

The Trust also employs an additional 462 WTE GP Trainees covering the South London area, which makes the total WTE 8361.

Section 1: Vacancies





Vacancies by Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diag & Therapy	12.4%	13.6%	15.1%	16.0%	↗
Community	15.7%	18.5%	19.4%	18.9%	↘
Corporate	14.5%	15.8%	16.3%	16.9%	↗
Estates and Fac.	16.7%	16.3%	15.3%	14.3%	↘
Medical & Cardio	16.4%	16.6%	17.3%	16.7%	↘
Surgery & Neuro	18.4%	17.9%	15.9%	16.7%	↗
SWL Pathology	25.5%	22.8%	23.8%	25.4%	↗
Whole Trust	**16.4%**	**16.7%**	**17.0%**	**17.2%**	↗

Vacancies Staff Group	Oct '15	Nov '15	Dec '15	Jan '16	Trend
Add Prof Scientific and Technic	22.7%	23.8%	23.9%	23.8%	↘
Additional Clinical Services	19.3%	18.2%	18.5%	19.4%	↗
Administrative and Clerical	17.0%	18.4%	18.7%	18.5%	↘
Allied Health Professionals	14.0%	14.1%	15.4%	15.3%	↘
Estates and Ancillary	19.3%	17.7%	15.8%	15.4%	↘
Healthcare Scientists	19.4%	20.1%	20.4%	20.5%	↗
Medical and Dental	4.4%	5.3%	5.7%	6.4%	↗
Nursing and Midwifery Registered	18.1%	18.1%	18.2%	18.5%	↗
Total	**16.4%**	**16.7%**	**17.0%**	**17.2%**	↗

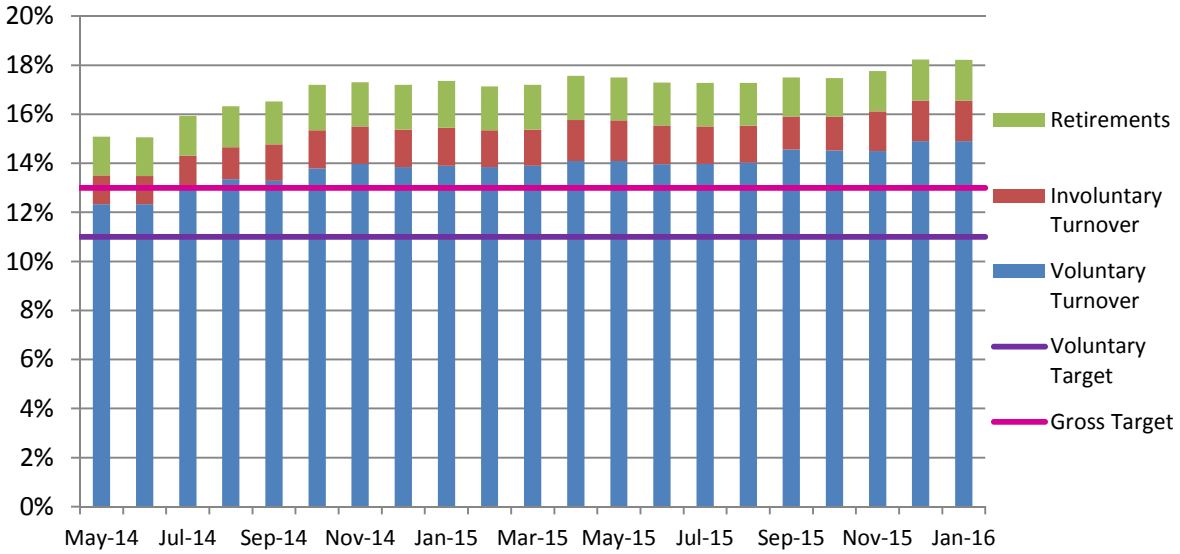
COMMENTARY

The vacancy rate has increased in January in line with a reduction in WTE staff in post and is now 17.2%.

Monthly reconciliation meetings to ensure that the establishment is maintained effectively on ESR have now commenced.

Section 2a: Gross Turnover

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



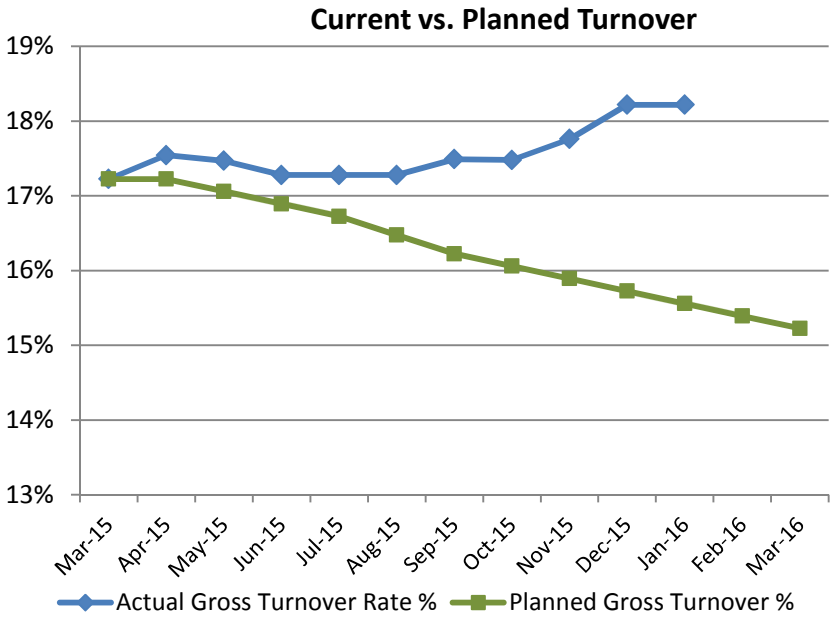
COMMENTARY

The total trust turnover rate has remained the same this month at 18.2%. This is significantly above the current target of 13%. In the last 12 months there have been 1310 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	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	18.0%	18.4%	19.3%	19.2%	↘
Community Services	20.8%	20.8%	21.2%	20.8%	↘
Corporate	20.1%	20.6%	21.1%	22.2%	↗
Estates and Facilities	16.0%	16.3%	15.9%	14.2%	↘
Medical & Cardiothoracics	19.1%	19.3%	19.3%	18.9%	↘
Surgery, Neurosciences & Anaes	13.3%	13.9%	13.9%	14.6%	↗
SWL Pathology	14.8%	15.0%	16.6%	17.2%	↗
Whole Trust	**17.5%**	**17.8%**	**18.2%**	**18.2%**	↔

	All Turnover				
Staff Group	Oct '15	Nov '15	Dec '15	Jan '16	Trend
Add Prof Scientific and Technic	20.2%	17.9%	21.3%	21.9%	↗
Additional Clinical Services	19.2%	20.1%	20.4%	20.6%	↗
Administrative and Clerical	16.2%	17.1%	17.7%	18.2%	↗
Allied Health Professionals	17.5%	17.0%	19.2%	19.7%	↗
Estates and Ancillary	8.6%	8.7%	8.0%	5.8%	↘
Healthcare Scientists	14.0%	14.4%	16.3%	16.5%	↗
Medical and Dental	10.6%	12.5%	11.8%	11.4%	↘
Nursing and Midwifery Registered	19.4%	19.7%	19.3%	18.9%	↘
Whole Trust	**17.5%**	**17.8%**	**18.2%**	**18.2%**	↔



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover JAN 2016	
Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	14.9%	15.1%	15.9%	16.0%	↗	1.9%	1.3%
Community Services	16.2%	16.0%	16.2%	15.3%	↘	1.7%	3.8%
Corporate	15.7%	16.2%	17.0%	18.2%	↗	2.0%	2.0%
Estates and Facilities	8.1%	8.4%	8.0%	7.4%	↘	5.5%	1.3%
Medical & Cardiothoracics	17.1%	16.8%	16.9%	16.5%	↘	1.3%	1.1%
Surgery, Neurosciences & Anaes	11.8%	11.9%	11.7%	12.2%	↗	1.0%	1.4%
SWL Pathology	13.2%	12.7%	14.1%	14.3%	↗	0.6%	2.2%
Whole Trust	**14.5%**	**14.5%**	**14.9%**	**14.9%**	↔	**1.7%**	**1.7%**

	Voluntary Turnover					Other Turnover Jan 2016	
Staff Group	Oct '15	Nov '15	Dec '15	Jan '16	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	15.5%	13.4%	15.8%	16.1%	↗	5.1%	0.7%
Additional Clinical Services	16.5%	16.8%	17.4%	17.5%	↗	0.9%	2.2%
Administrative and Clerical	12.4%	13.1%	13.4%	13.8%	↗	2.1%	2.3%
Allied Health Professionals	16.8%	16.1%	17.7%	18.3%	↗	0.6%	0.8%
Estates and Ancillary	5.4%	5.3%	4.8%	4.0%	↘	0.4%	1.3%
Healthcare Scientists	11.5%	11.6%	13.2%	13.5%	↗	0.7%	2.3%
Medical and Dental	5.8%	6.3%	6.0%	5.4%	↘	4.6%	1.4%
Nursing and Midwifery Registered	17.1%	17.1%	16.8%	16.6%	↘	0.8%	1.6%
Whole Trust	**14.5%**	**14.5%**	**14.9%**	**14.9%**	↔	**1.7%**	**1.7%**

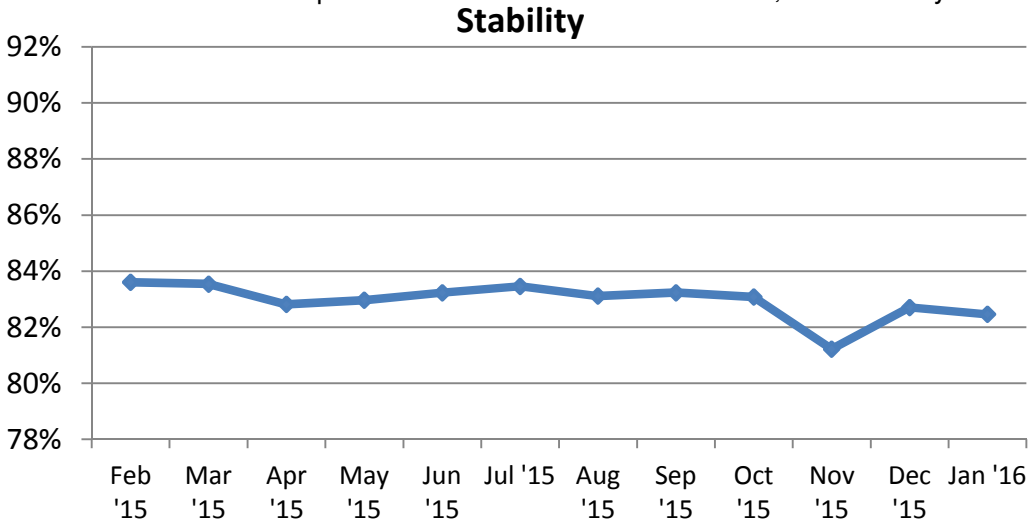
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Procurement & Materials Mgmt	37.0	12.0	30.4%
Offender Healthcare HMPW Services	55.7	15.8	27.9%
Human Resources Directorate	89.0	25.1	27.3%
Cardiac Surgery	95.7	21.3	27.1%
Medical Oncology & Palliative Care	86.6	20.8	26.2%

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	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	83.0%	80.1%	81.3%	81.8%	↗
Community Services	79.8%	78.0%	79.3%	79.1%	↘
Corporate	78.4%	75.5%	78.0%	76.0%	↘
Estates and Facilities	85.1%	84.0%	85.0%	85.9%	↗
Medical & Cardiothoracics	81.2%	80.0%	81.4%	81.9%	↗
Surgery, Neurosciences & Anaes	86.4%	84.6%	86.8%	86.0%	↘
SWL Pathology	91.0%	89.7%	89.5%	88.5%	↘
Whole Trust	**83.1%**	**81.2%**	**82.7%**	**82.5%**	↘

Stability Staff Group	Oct '15	Nov '15	Dec '15	Jan '16	Trend
Add Prof Scientific and Technic	69.8%	50.4%	73.4%	76.7%	↗
Additional Clinical Services	87.0%	90.1%	85.9%	84.7%	↘
Administrative and Clerical	85.9%	83.2%	84.6%	83.5%	↘
Allied Health Professionals	81.3%	78.7%	80.6%	80.3%	↘
Estates and Ancillary	88.6%	104.0%	89.3%	92.4%	↗
Healthcare Scientists	93.9%	90.3%	89.0%	88.3%	↘
Medical and Dental	90.1%	89.4%	90.1%	90.4%	↗
Nursing and Midwifery Registered	81.3%	84.6%	80.9%	80.2%	↘
Total	**83.1%**	**81.2%**	**82.7%**	**82.5%**	↘

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.

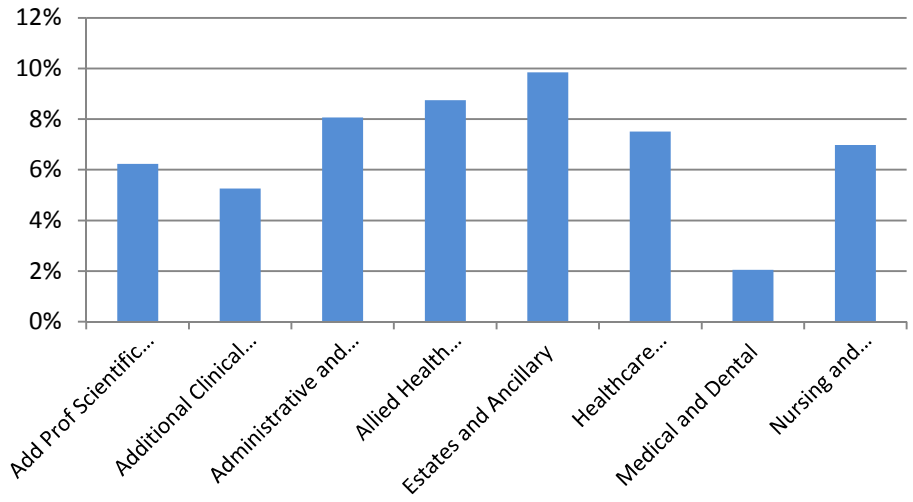
The stability rate has increased by 0.2% this month.

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

Over the last 12 months the stability rate has declined by 1.4% and is now at 82.5%.

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 January 71 staff were promoted, there were 125 new starters to the Trust and 178 employees were acting up to a higher grade.

Over the last year 6.9% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the SW London Pathology Division followed by the Corporate and Estates & Facilities Divisions.

The graph shows that Estates & Ancillary staff were most likely to be promoted over the last year followed by Allied Health Professionals.

	No. of Promotions				
Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	21	28	12	25	↗
Community Services	2	10	10	10	↔
Corporate	3	11	5	9	↗
Estates and Facilities	0	0	0	0	↔
Medical & Cardiothoracics	6	9	12	14	↗
Surgery, Neurosciences & Anaes	9	4	6	12	↗
SWL Pathology	23	2	0	1	↗
Whole Trust Promotions	**64**	**64**	**45**	**71**	↗
New Starters (Excludes Junior Doctors)	**144**	**146**	**47**	**125**	↗

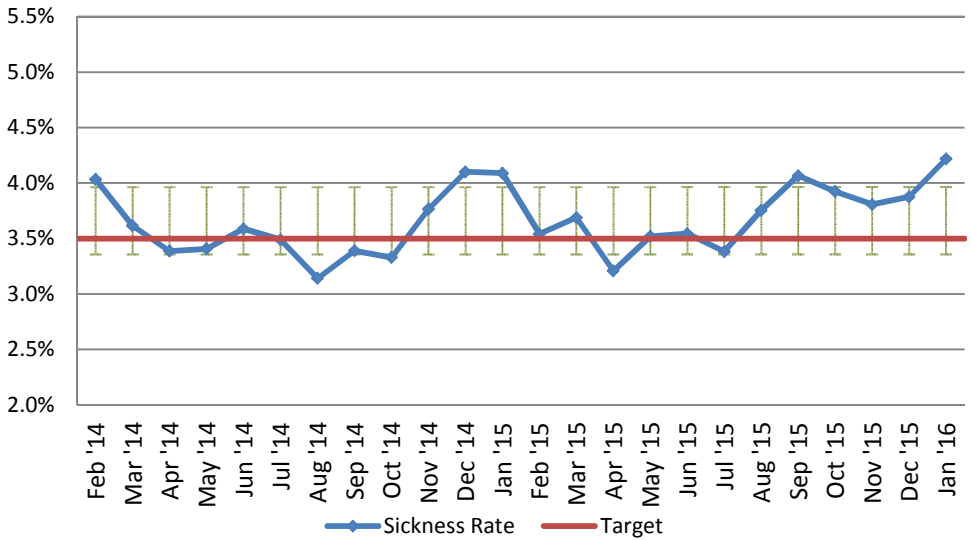
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1987	140	7.0%	80
Community Services	813	40	4.9%	6
Corporate	436	39	8.9%	25
Estates and Facilities	253	20	7.9%	9
Medical & Cardiothoracics	1204	77	6.4%	36
Surgery, Neurosciences & Anaes	1367	77	5.6%	15
SWL Pathology	317	44	13.9%	7
Whole Trust	**6377**	**437**	**6.9%**	**178**
New Starters (Excludes Junior Doctors)		**1417**		

	No. of Promotions				
Staff Group	Oct '15	Nov '15	Dec '15	Jan '16	Trend
Add Prof Scientific and Technic	2	1	2	4	↗
Additional Clinical Services	19	2	3	5	↗
Administrative and Clerical	12	23	14	30	↗
Allied Health Professionals	6	11	11	8	↘
Estates and Ancillary	0	0	0	0	↔
Healthcare Scientists	1	3	1	2	↗
Medical and Dental	2	0	0	0	↔
Nursing and Midwifery Registered	22	24	14	22	↗
Whole Trust	**64**	**64**	**45**	**71**	↗

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	481	30	6.2%	36
Additional Clinical Services	685	36	5.3%	2
Administrative and Clerical	1301	105	8.1%	62
Allied Health Professionals	560	49	8.8%	16
Estates and Ancillary	203	20	9.9%	5
Healthcare Scientists	253	19	7.5%	6
Medical and Dental	488	10	2.0%	1
Nursing and Midwifery Registered	2406	168	7.0%	50
Whole Trust	**6377**	**437**	**6.9%**	**178**

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 4.2% for January, which is an increase of 0.3% on the previous month. Analysis of reasons for absence this month shows a large increase in seasonal colds and flu.

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 January 2015. Below that is a breakdown of the top 5 reasons for absence, both by the number of episodes and the number of days lost.

Sickness by Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	3.9%	3.4%	3.4%	4.3%	↗
Community Services	5.9%	5.7%	6.0%	6.5%	↗
Corporate	3.7%	3.7%	3.7%	3.4%	↘
Estates and Facilities	2.2%	4.7%	5.4%	4.7%	↘
Medical & Cardiothoracics	4.1%	4.2%	4.0%	3.8%	↘
Surgery, Neurosciences & Anaes	3.5%	3.2%	3.3%	3.8%	↗
SWL Pathology	2.1%	2.5%	3.3%	2.8%	↘
Whole Trust	**3.9%**	**3.8%**	**3.9%**	**4.2%**	↗

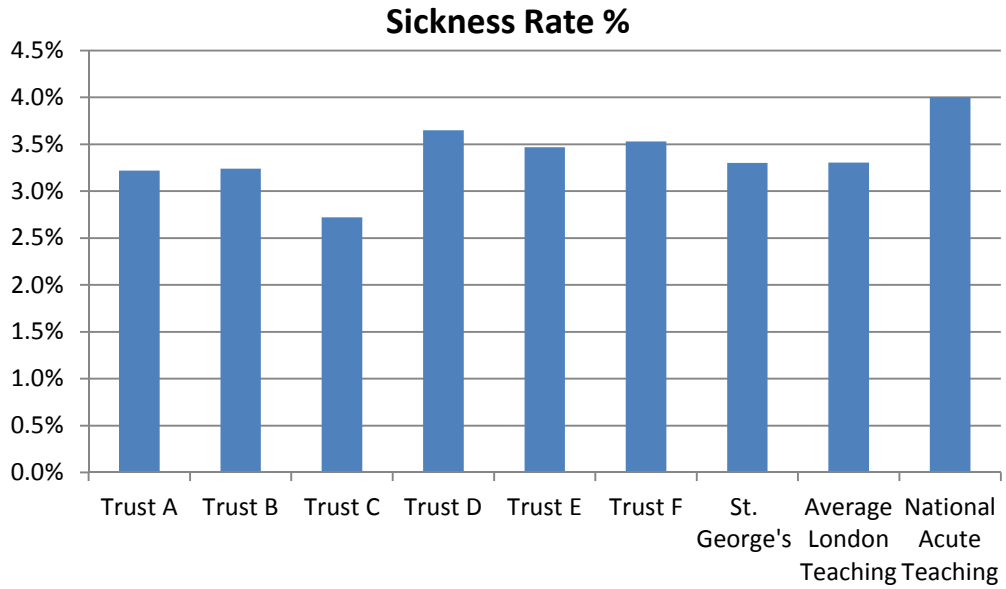
Sickness Staff Group	Oct '15	Nov '15	Dec '15	Jan '16	Trend
Add Prof Scientific and Technic	4.1%	3.3%	2.9%	3.4%	↗
Additional Clinical Services	6.4%	6.4%	7.4%	8.1%	↗
Administrative and Clerical	3.9%	4.1%	4.5%	4.5%	↔
Allied Health Professionals	2.5%	2.5%	3.2%	3.6%	↗
Estates and Ancillary	3.2%	5.8%	7.4%	6.2%	↘
Healthcare Scientists	2.4%	2.9%	2.4%	2.4%	↔
Medical and Dental	1.7%	1.3%	0.8%	1.3%	↗
Nursing and Midwifery Registered	4.6%	4.2%	4.0%	4.5%	↗
Total	**3.9%**	**3.8%**	**3.9%**	**4.2%**	↗

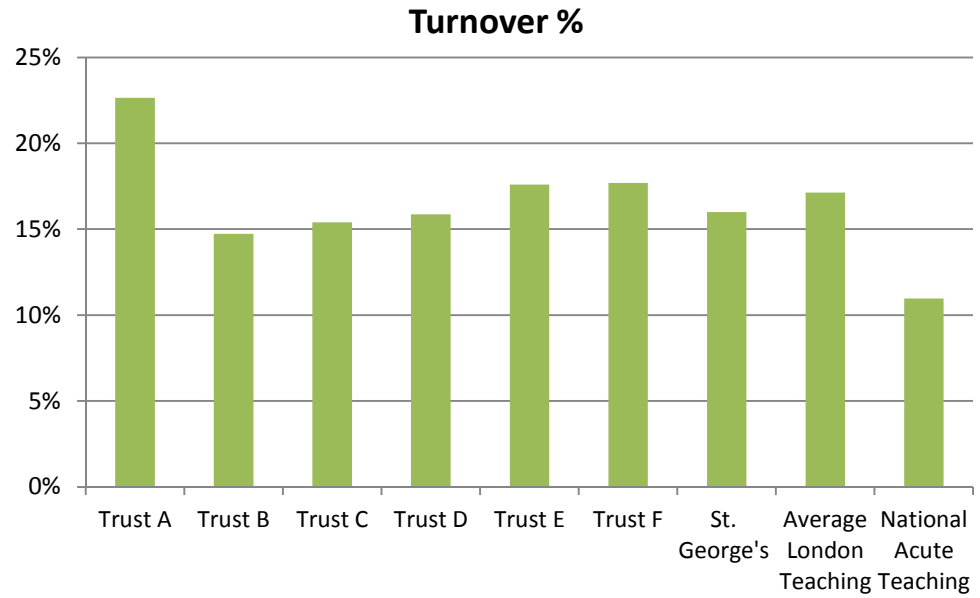
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Offender Healthcare HMPW Services	55.68	220.53	12.7%	£16,570
Paediatric Surgery	60.47	240.48	12.4%	£20,422
Energy and Engineering	51.70	199.00	12.4%	£16,699
Cancer	22.60	60.00	8.6%	£2,781
Procurement & Materials Mgmt	37.00	98.00	8.1%	£7,618

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	39.70%
S25 Gastrointestinal problems	13.00%
S12 Other musculoskeletal problems	6.37%
S10 Anxiety/stress/depression/other psychiatric illnesses	5.91%
S15 Chest & respiratory problems	5.52%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	24.36%
S10 Anxiety/stress/depression/other psychiatric illnesses	14.32%
S12 Other musculoskeletal problems	10.84%
S25 Gastrointestinal problems	9.49%
S28 Injury, fracture	6.20%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from October '15 which is the most recent available. Compared to other Acute teaching trusts in London, St. Georges had a rate equivalent to the average at 3.3%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was significantly lower than the national rate for acute teaching hospitals in October.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has a lower than average turnover compared to the group (12 months to end November). Stability is also slightly higher than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is 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	22.64%	77.61%	3.22%
Trust B	14.72%	84.84%	3.24%
Trust C	15.40%	84.11%	2.72%
Trust D	15.86%	83.72%	3.65%
Trust E	17.59%	82.42%	3.47%
Trust F	17.69%	82.20%	3.53%
St. George's	15.99%	83.68%	3.30%
Average London Teaching	17.13%	82.65%	3.30%
National Acute Teaching	10.97%	88.80%	4.00%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	1094.9	1105.4	1110.4	1150.9	↗
Community Services	596.4	613.5	614.5	598.4	↘
Corporate & R&D	94.2	95.2	95.2	67.8	↘
Medical & Cardiothoracics	1246.1	1253.7	1253.7	1279.2	↗
Surgery, Neurosciences & Anaes	1151.0	1151.0	1151.0	1113.7	↘
Total	4182.6	4218.8	4224.8	4210.0	↘

Nursing Staff in Post WTE

Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	1007.4	999.5	980.6	996.4	↗
Community Services	441.6	452.9	452.9	448.0	↘
Corporate & R&D	52.5	70.6	72.5	56.1	↘
Medical & Cardiothoracics	986.0	995.4	982.9	993.5	↗
Surgery, Neurosciences & Anaes	906.5	910.9	909.0	903.1	↘
Total	3394.0	3429.3	3397.9	3397.0	↘

Nursing Vacancy Rate

Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	8.0%	9.6%	11.7%	13.4%	↗
Community Services	26.0%	26.2%	26.3%	25.1%	↘
Corporate & R&D	44.2%	25.8%	23.8%	17.3%	↘
Medical & Cardiothoracics	20.9%	20.6%	21.6%	22.3%	↗
Surgery, Neurosciences & Anaes	21.2%	20.9%	21.0%	18.9%	↘
Total	18.9%	18.7%	19.6%	19.3%	↘

Nursing Sickness Rates

Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	5.6%	4.7%	4.2%	5.0%	↗
Community Services	6.7%	6.6%	7.5%	8.7%	↗
Corporate	8.4%	5.3%	3.2%	2.5%	↘
Medical & Cardiothoracics	4.6%	4.8%	4.8%	4.7%	↘
Surgery, Neurosciences & Anaes	4.2%	3.9%	4.2%	4.8%	↗
Total	5.1%	4.8%	4.8%	5.4%	↗

Nursing Voluntary Turnover

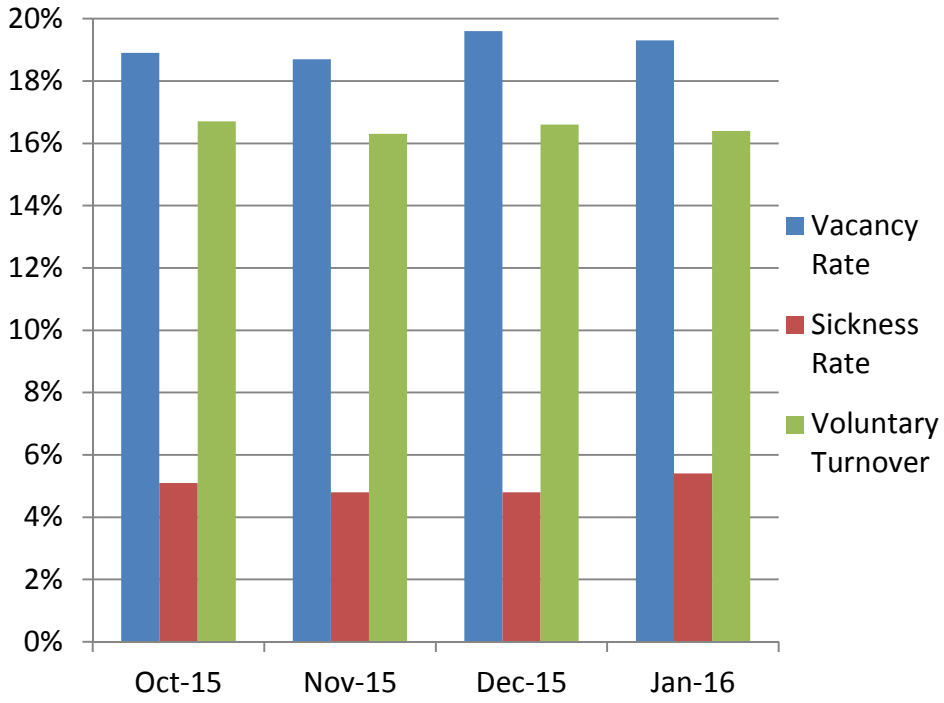
Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	15.43%	15.03%	15.75%	15.11%	↘
Community Services	18.14%	18.09%	17.52%	16.16%	↘
Corporate & R&D	13.53%	9.47%	10.98%	12.37%	↗
Medical & Cardiothoracics	20.01%	19.15%	19.44%	19.35%	↘
Surgery, Neurosciences & Anaes	13.70%	13.84%	14.27%	14.90%	↗
Total	16.7%	16.3%	16.6%	16.4%	↘

COMMENTARY

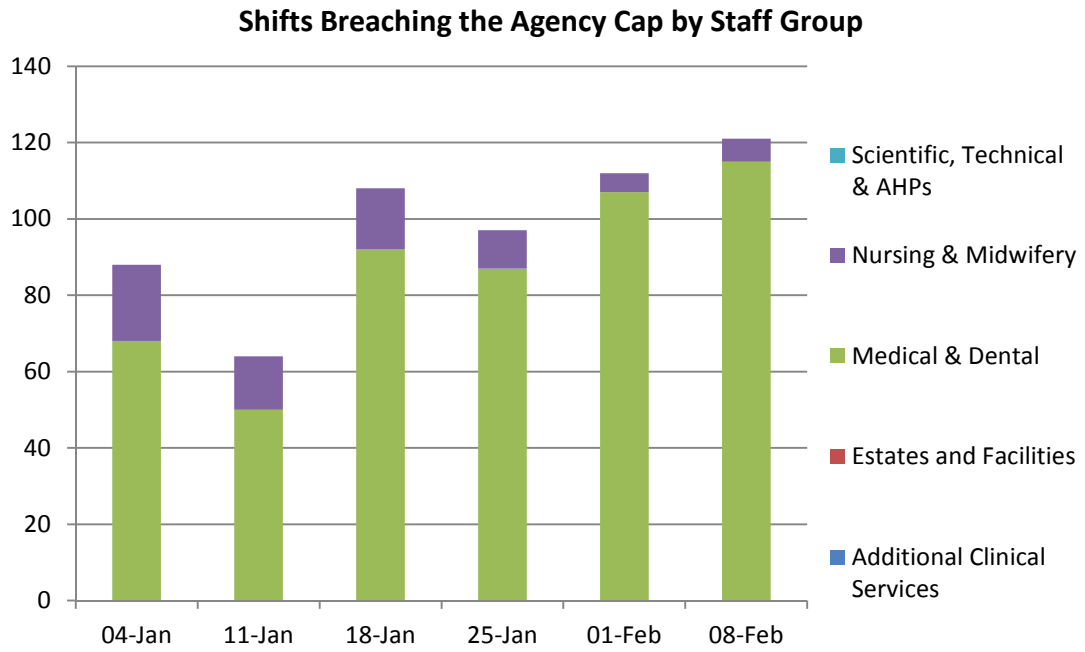
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has decreased by 0.9 WTE in January.

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	04-Jan	11-Jan	18-Jan	25-Jan	01-Feb	08-Feb	Trend
Additional Clinical Services	0	0	0	0	0	0	↔
Estates and Facilities	0	0	0	0	0	0	↔
Medical & Dental	68	50	92	87	107	115	↗
Nursing & Midwifery	20	14	16	10	5	6	↗
Scientific, Technical & AHPs	0	0	0	0	0	0	↔
Whole Trust	**88**	**64**	**64**	**97**	**112**	**121**	↗

Agency Cap Shift Breaches by Division	04-Jan	11-Jan	18-Jan	25-Jan	01-Feb	08-Feb	Trend
C&W Diagnostic & Therapy	18	16	16	6	4	6	↗
Community Services	14	10	15	15	16	12	↘
Corporate	10	10	15	15	15	15	↔
Estates and Facilities	0	0	0	0	0	0	↔
Medical & Cardiothoracics	37	22	46	45	61	75	↗
Surgery, Neurosciences & Anaes	9	6	16	16	16	13	↘
SWL Pathology	0	0	0	0	0	0	↔
Whole Trust	**88**	**64**	**64**	**97**	**112**	**121**	↗

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.

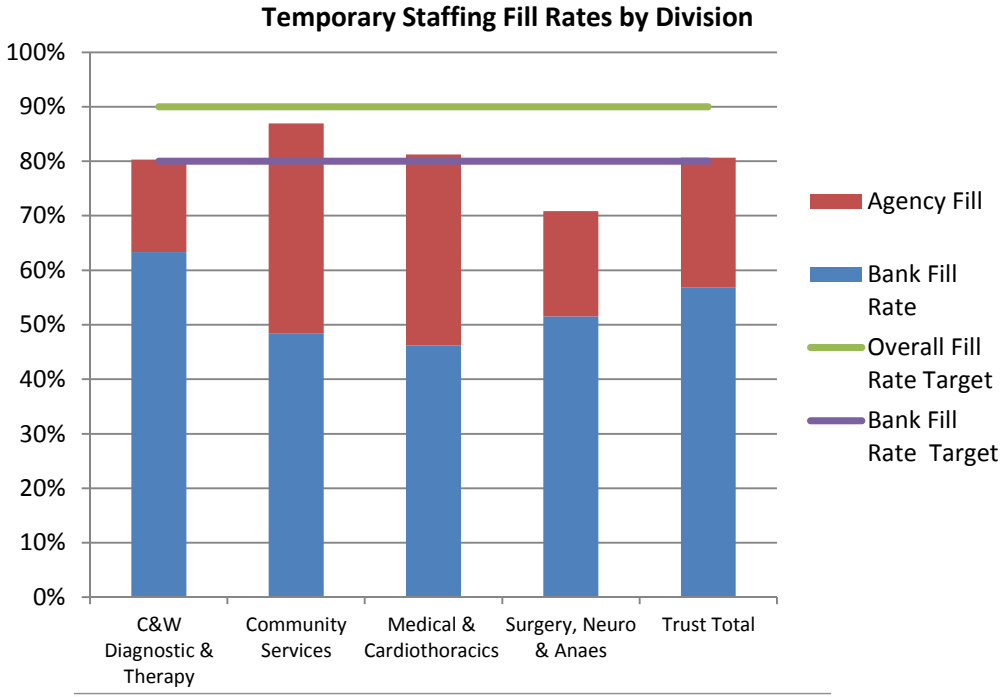
Work is on-going to stop using agencies which breach the caps where possible.

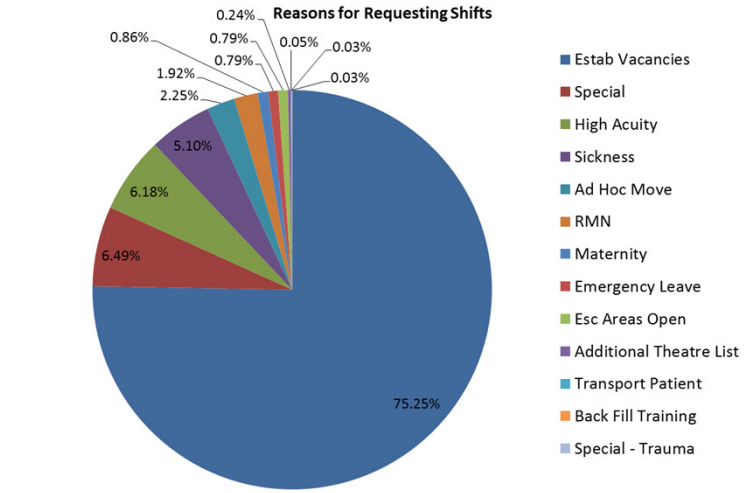
In all cases, services have confirmed there would be an adverse impact upon patient safety should the booking not go ahead.

Most breaches are currently for medical and dental shifts, many of which are currently in the Medicine & Cardiothoracics Division in specialities including Haemotology and Oncology. Almost all Nursing breaches are for specialist Paediatric nurses.

New reduced capped rates were introduced by Monitor in February. Negotiating improved rates for Nursing has enabled the Trust to maintain only a small number of breaches for this staff group.

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 January the Bank Fill Rate was reported at 56.9% which is 0.7% lower than the previous month. The Overall Fill Rate was 80.7% which is an decrease of 0.1% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

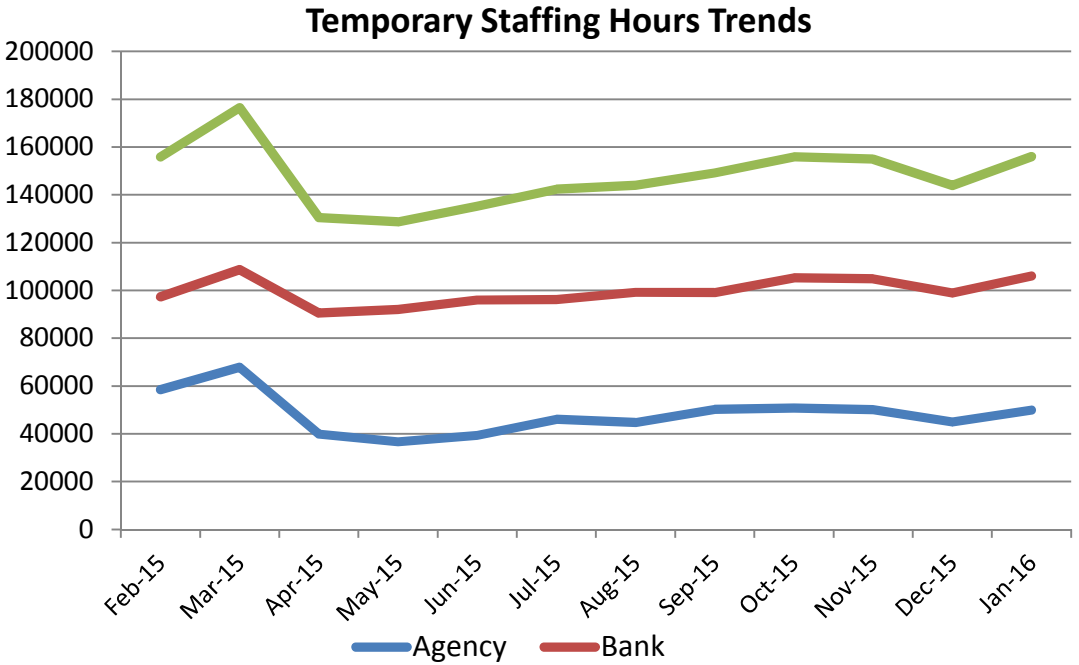
The pie chart shows a breakdown of the reasons given for requesting bank shifts in January. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	65.3%	65.9%	60.0%	63.3%	↗
Community Services	49.7%	51.0%	48.1%	48.4%	↗
Medical & Cardiothoracics	46.2%	48.4%	47.7%	46.2%	↘
Surgery, Neurosciences & Anaes	50.3%	50.8%	56.3%	51.5%	↘
Whole Trust	**58.1%**	**59.2%**	**57.6%**	**56.9%**	↘

Overall Fill Rate % by Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	81.9%	81.9%	77.7%	80.3%	↗
Community Services	88.2%	88.7%	84.1%	86.9%	↗
Medical & Cardiothoracics	79.4%	83.5%	81.2%	81.2%	↗
Surgery, Neurosciences & Anaes	76.8%	75.7%	76.2%	70.9%	↘
Whole Trust	**81.6%**	**83.2%**	**80.8%**	**80.7%**	↘

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 both increased in January in most areas.

There was an increase in agency hours in the Medical and Cardiothoracics Division across acute medical wards and in both cardiac and vascular surgery.

Bank hours increased in General Surgery and supporting Theatres staffing, also in Paediatrics (PICU, Nicholls Ward) and in Neuro (Kent Ward).

TYPE	Division	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
Agency	C&W Diagnostic & Therapy	15363	16791	9525	10750	8656	9638	9210	9921	11112	10724	11615	11158
	Community Services	7800	9890	7938	5769	5245	6077	6422	6421	7086	6605	6715	7298
	Corporate	2763	3488	1246	1331	949	529	32	423	402	384	541	1021
	Estates and Facilities	0	0	0	0	0	0	0	0	4	166	322	140
	Medical & Cardiothoracics	21773	25876	14492	13202	17823	20429	20285	24408	21792	22626	19732	23154
	Surgery, Neurosciences & Anaes	10809	11833	6582	5462	6386	9195	8560	8620	9994	9362	5953	7161
	SWL Pathology	0	0	119	204	241	228	237	352	267	150	143	0
Agency Total		**58508**	**67877**	**39901**	**36717**	**39299**	**46097**	**44746**	**50145**	**50657**	**50017**	**45021**	**49932**
Bank	C&W Diagnostic & Therapy	27388	31536	27789	28714	29038	25990	26258	28178	32858	31790	30886	33343
	Community Services	9360	10560	8379	7619	7704	8252	9030	8659	9149	9133	9005	9225
	Corporate	7248	7922	7424	7165	8430	7972	7321	11048	11156	9858	8426	8674
	Estates and Facilities	6807	7744	6885	7502	8178	9216	8910	8264	8506	9423	8467	8428
	Medical & Cardiothoracics	25083	27553	23755	24829	24969	26255	29159	26958	26409	28073	25363	26990
	Surgery, Neurosciences & Anaes	18438	20376	13521	13495	14553	14740	15202	15268	16265	15754	15791	18358
	SWL Pathology	2947	2953	2753	2620	3052	3751	3314	638	821	839	998	1016
Bank Total		**97272**	**108643**	**90507**	**91944**	**95925**	**96177**	**99193**	**99013**	**105164**	**104870**	**98936**	**106034**
Temporary Staff Total		**155780**	**176520**	**130408**	**128661**	**135224**	**142273**	**143940**	**149157**	**155821**	**154887**	**143957**	**155966**

Section 11: Temporary Staffing Weekly Tracking

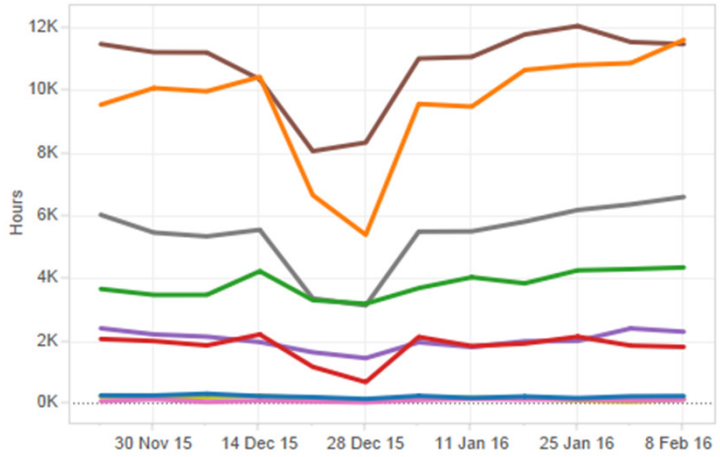
Weekly Hours Used By Division

Division	23 Nov	30 Nov	07 Dec	14 Dec	21 Dec	28 Dec	04 Jan	11 Jan	18 Jan	25 Jan	01 Feb	08 Feb
Capital Division	248	245	301	224	192	133	233	168	214	162	218	227
Children and Women's Diagnostic and Th..	9,558	10,089	9,985	10,445	6,671	5,405	9,583	9,496	10,665	10,822	10,884	11,624
Community Services Division	3,678	3,489	3,490	4,245	3,322	3,206	3,706	4,051	3,856	4,273	4,311	4,364
Corporate Division	2,082	2,017	1,875	2,225	1,193	704	2,148	1,855	1,935	2,155	1,870	1,829
Estates and Facilities Division	2,423	2,228	2,155	1,984	1,658	1,470	1,977	1,826	2,009	2,020	2,419	2,313
Medicine and Cardiovascular Division	11,493	11,232	11,224	10,367	8,077	8,351	11,031	11,084	11,799	12,070	11,559	11,492
Research & Development Division	58	127	35	80	53	24	101	132	116	124	93	109
Surgery & Neurosciences Division	6,043	5,477	5,356	5,567	3,375	3,154	5,507	5,515	5,827	6,199	6,376	6,614
SWL Pathology Division	206	181	196	228	161	85	167	165	168	91	44	128
Grand Total	35,788	35,084	34,616	35,364	24,701	22,532	34,451	34,293	36,589	37,916	37,774	38,700

Type
- Agency
- Bank

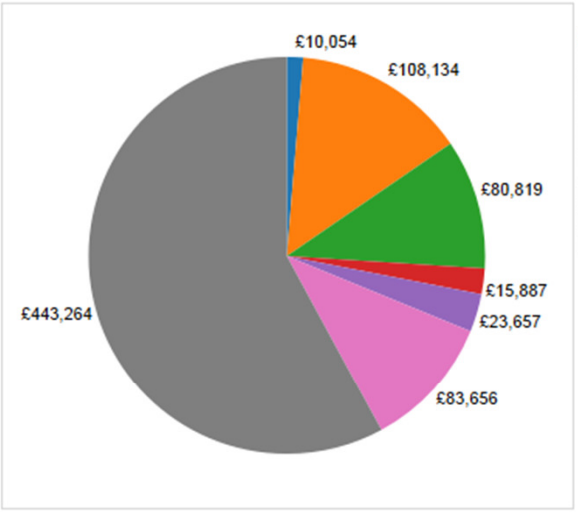
Division
- Capital Division
- Children and Women's D..
- Community Services Divi..
- Corporate Division
- Estates and Facilities Div..
- Medicine and Cardiovasc..
- Research & Developmen..
- Surgery & Neuroscience..
- SWL Pathology Division

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
£765,471

Select Date (W/C)
08/02/2016

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

Section 12: Mandatory Training

MAST Topic	Dec '15	Jan '16	Trend
Conflict Resolution	74.9	76.2	↗
Equality, Diversity and Human Rights	74.7	75.8	↗
Fire Safety	71.8	71.9	↗
Health, Safety and Welfare	72.7	73.5	↗
Infection Prevention and Control Clinical	58.9	59.6	↗
Infection Prevention and Control Non Clinical	63.7	64.6	↗
Information Governance	60.7	60.8	↗
Moving and Handling	66.6	68.6	↗
Moving and Handling Patient	51.2	61.3	↗
Resuscitation BLS	43.7	44.0	↗
Resuscitation ILS	50.1	50.6	↗
Resuscitation Non Clinical	59.1	59.7	↗
Safeguarding Adults	69.9	70.8	↗
Safeguarding Children Level 1	68.3	68.5	↗
Safeguarding Children Level 2	70.0	71.7	↗
Safeguarding Children Level 3	66.7	67.6	↗

COMMENTARY

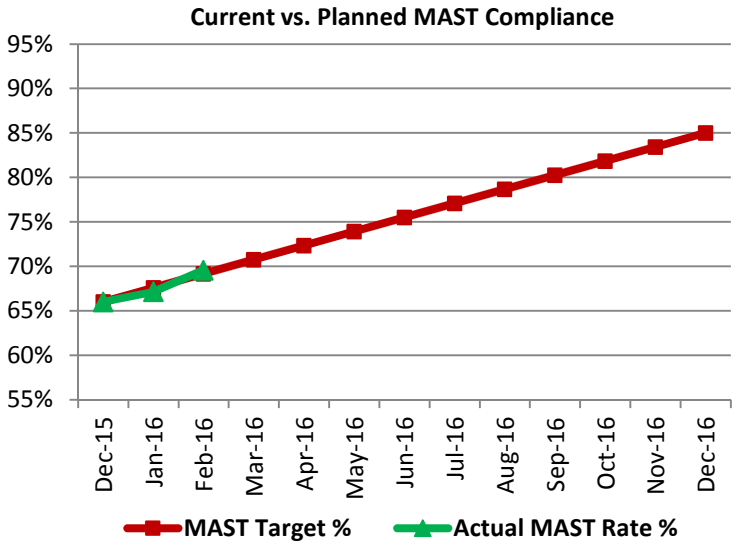
A programme of working is taking place including:

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

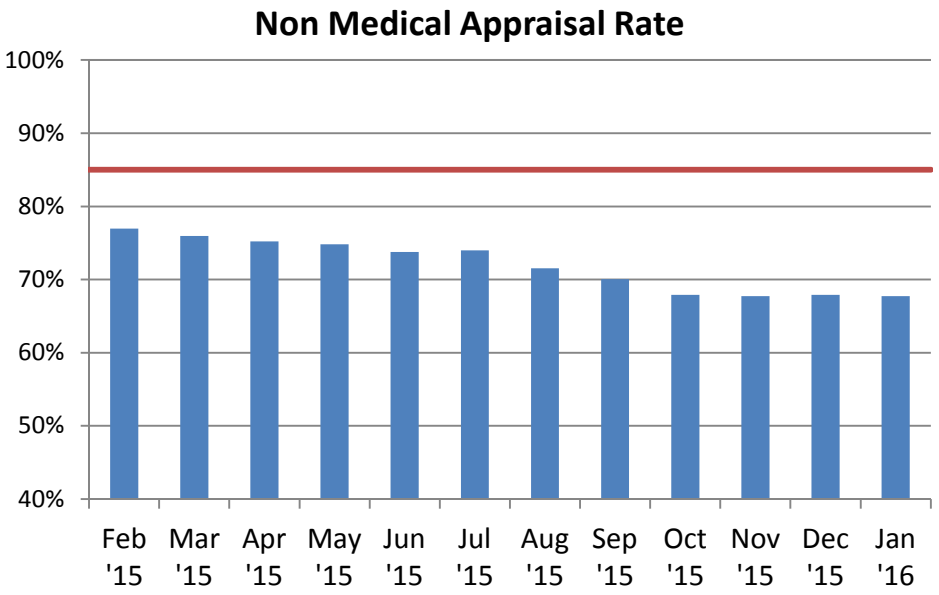
Current Issues:

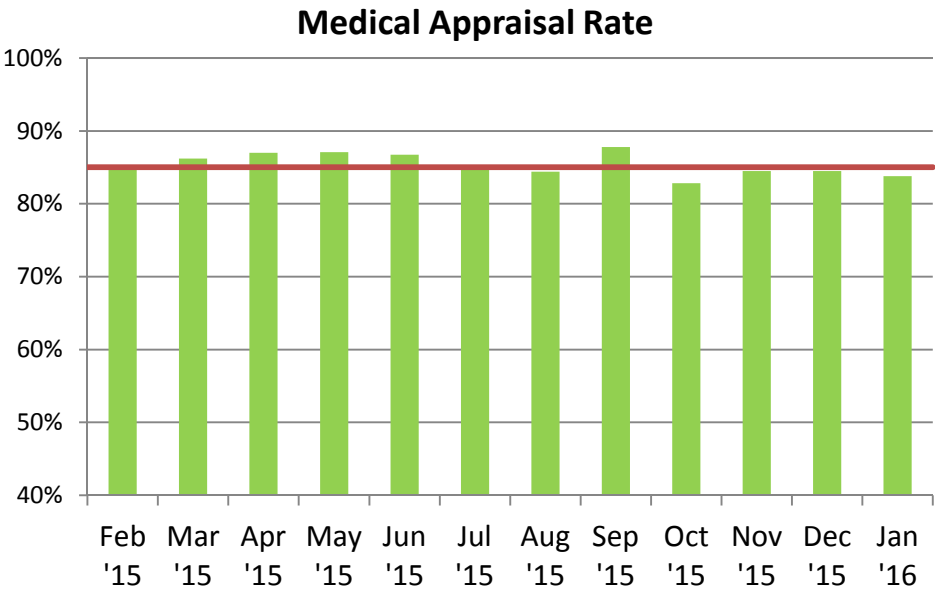
- Fall in compliance rates – largely due to staffing pressures
- Community access to Totara is on the risk register, in the interim we are visiting community sites with tablets and developing a permanent solution in parallel
- Staff unable to access training externally- Software and licencing and IG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

MAST Compliance % by Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	67.8%	65.7%	67.3%	69.0%	↗
Community Services	68.8%	65.7%	65.6%	65.9%	↗
Corporate	66.1%	62.9%	65.5%	66.1%	↗
Estates and Facilities	61.9%	62.4%	62.5%	62.1%	↘
Medical & Cardiothoracics	61.4%	61.2%	63.5%	65.0%	↗
Surgery, Neurosciences & Anaes	65.2%	63.9%	64.9%	66.1%	↗
Whole Trust	66.6%	64.5%	66.0%	67.1%	↗



Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 0.2% this month to 67.7%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

Medical appraisal rate compliance has decreased this month to 83.8% which is below target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Information Directorate	16.7%	33.80
Energy and Engineering	18.4%	51.70
SWLP Central Reception	22.0%	51.87
SWLP Biochemistry	22.8%	61.27
SWLP Haematology	24.6%	66.68

Non Medical Appraisals by Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	68.1%	69.7%	71.8%	70.7%	↘
Community Services	64.9%	62.9%	62.4%	63.2%	↗
Medical & Cardiothoracics	71.6%	74.6%	73.7%	72.3%	↘
Surgery, Neurosciences & Anaes	76.2%	74.9%	74.0%	75.1%	↗
Corporate	53.7%	51.5%	50.2%	52.2%	↗
Estates & Facilities	64.0%	66.9%	66.1%	64.9%	↘
Whole Trust	**67.9%**	**67.7%**	**67.9%**	**67.7%**	↘

Medical Appraisals by Division	Oct '15	Nov '15	Dec '15	Jan '16	Trend
C&W Diagnostic & Therapy	83.5%	84.4%	86.0%	82.2%	↘
Community Services	79.4%	81.3%	87.1%	87.1%	↔
Medical & Cardiothoracics	83.5%	87.8%	87.7%	85.7%	↘
Surgery, Neurosciences & Anaes	81.4%	82.0%	79.9%	86.0%	↗
Corporate	75.0%	75.0%	75.0%	100.0%	↗
Whole Trust	**82.8%**	**84.5%**	**84.5%**	**83.8%**	↘

2015 National NHS Staff survey

Introduction

There has been a significant deterioration in the staff survey results in 2015. This is an issue of grave concern but it is not a surprise to the trust as we have seen deterioration in the Friends and Family staff survey results over the past year as the trust has been in turnaround.

Comparative information

The comparison group used by the NHS is combined acute and community trusts. As this may not provide a true picture of St George's compared to similar London teaching hospitals, the comparator data on key indicators with our peer group is set out below.

NHS Staff survey/ London teaching trusts								
Trust's Name	**St Georges**	**King's**	**Barts**	**Royal Free**	**Imperial**	**UCLH**	**GSTT**	**Average**
Staff recommendation of the organisation as a place to work or receive treatment	3.66	3.69	3.49	3.77	3.61	3.91	4.22	3.76
Staff motivation at work	3.85	3.97	3.89	3.96	3.89	3.89	4.03	3.93
% reporting good communication between senior management and staff	27	34	28	31	33	33	42	32.57
% able to contribute towards improvements at work	68	74	68	66	70	72	75	70.43
% experiencing harassment, bullying or abuse from staff in last 12 months	33	29	37	34	32	31	24	31.43
Overall staff engagement	3.72	3.81	3.68	3.79	3.71	3.84	4.03	3.80

Workforce department programme of activity

The Workforce department has reported to the Workforce and Education Committee throughout the year on a programme of activity that is aimed to reduce turnover and to support staff. The programme includes:

- Developing leadership behaviours to deliver high quality care including an executive leadership assessment, the development and implementation of a leadership development programme and agreement with trade unions on an appraisal system that recognises achievement and contribution.
- Embedding the trust's values including a systematic staff awards programme, the further development of the Liaise service, providing additional resource to the staff support service, establishing a St George's as One, diversity group, implementing a wellbeing strategy including taking part in the Global Corporate Challenge, having a New Year New You day, introducing a staff physiotherapy service and reviewing our approach to managing bullying.

Action in response to the 2015 service

The workforce and education committee will use its meeting on 29th March to hold a workshop with staff to work with them on the issues that really need to be resolved in order for staff to feel confident about St George's as a place to work.

The survey has been disseminated to all senior leaders within the trust with an expectation that all leaders are involved in engaging with and responding to how staff feel.

It is essential that the whole board considers the messages that members of staff are telling us and sets out clear responses that address members of staff's concerns particularly in relation to resources and infrastructure. We need to take very seriously the concerns that members of staff are raising regarding the deterioration in engagement and in their willingness to recommend the trust as a place to receive treatment or to work.

2015 National NHS staff survey

Brief summary of results from St George's University Hospitals NHS Foundation Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2015 national NHS staff survey conducted in St George's University Hospitals NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured around four of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus three additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme: Equality and diversity
- Additional theme: Errors and incidents
- Additional theme: Patient experience measures

Please note, the questionnaire, key findings and benchmarking groups have all undergone substantial revision since the previous staff survey. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2015 survey results for St George's University Hospitals NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

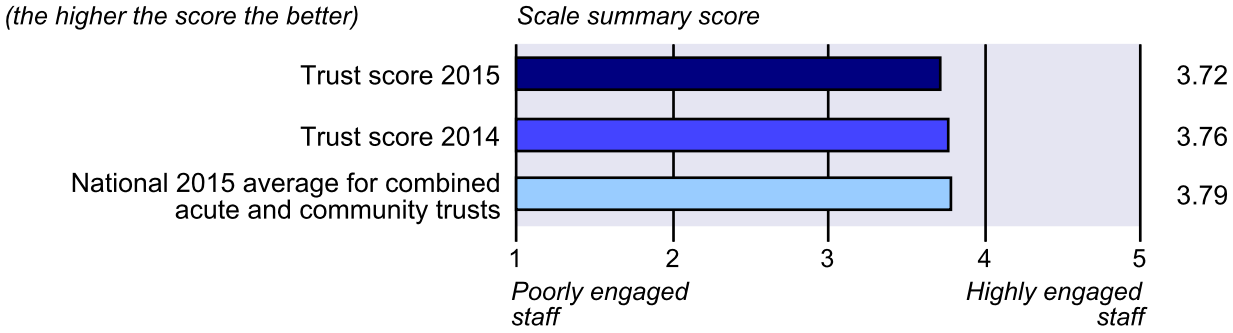
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2015	Average (median) for combined acute and community trusts	Your Trust in 2014
Q21a	"Care of patients / service users is my organisation's top priority"	71%	73%	74%
Q21b	"My organisation acts on concerns raised by patients / service users"	68%	72%	74%
Q21c	"I would recommend my organisation as a place to work"	55%	58%	62%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	71%	67%	73%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.66	3.71	3.78

2. Overall indicator of staff engagement for St George's University Hospitals NHS Foundation Trust

The figure below shows how St George's University Hospitals NHS Foundation Trust compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.72 was below (worse than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how St George's University Hospitals NHS Foundation Trust compares with other combined acute and community trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2014 survey.

	Change since 2014 survey	Ranking, compared with all combined acute and community trusts
OVERALL STAFF ENGAGEMENT	! Decrease (worse than 14)	! Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	! Decrease (worse than 14)	• Average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	! Below (worse than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Below (worse than) average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

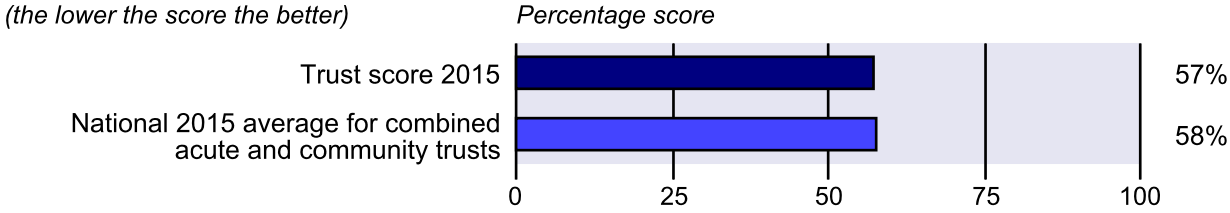
3. Summary of 2015 Key Findings for St George's University Hospitals NHS Foundation Trust

3.1 Top and Bottom Ranking Scores

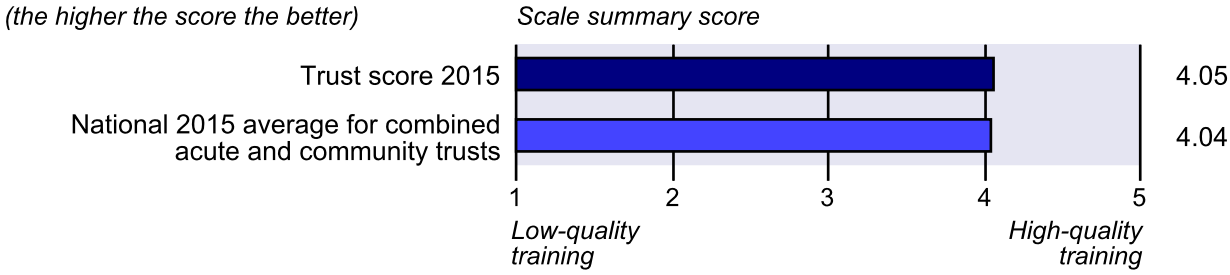
This page highlights the five Key Findings for which St George's University Hospitals NHS Foundation Trust compares most favourably with other combined acute and community trusts in England.

TOP FIVE RANKING SCORES

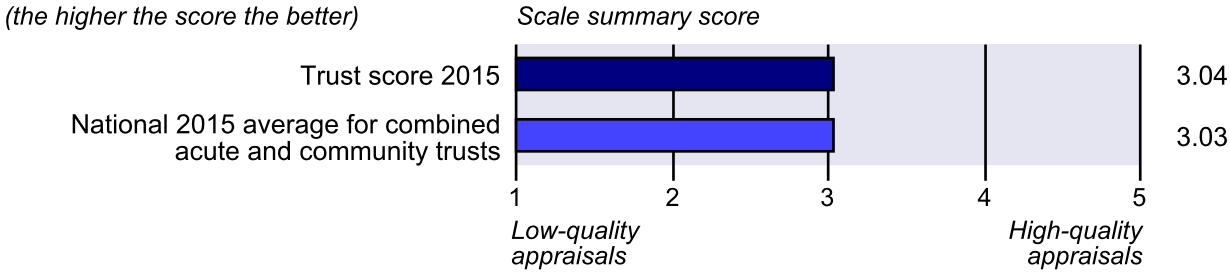
✓KF18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell



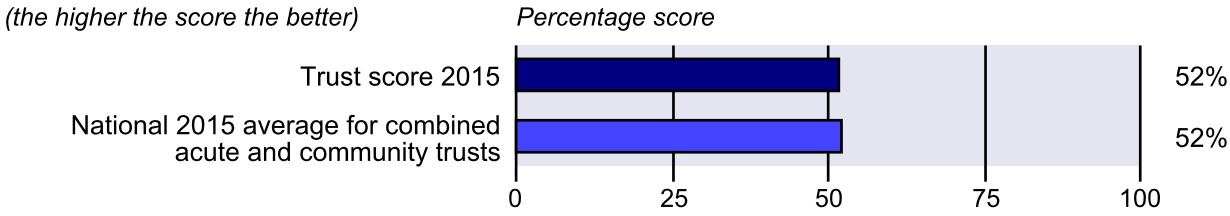
✓KF13. Quality of non-mandatory training, learning or development



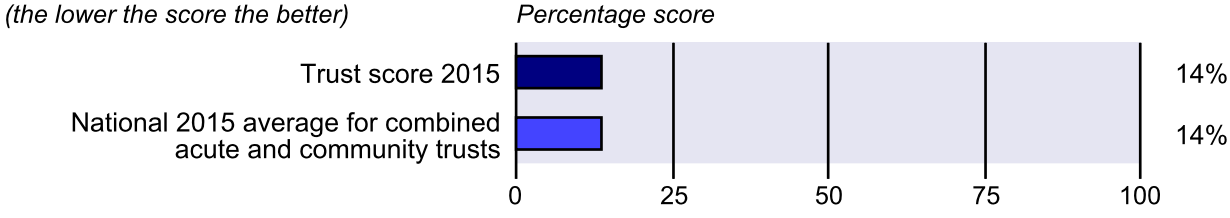
✓KF12. Quality of appraisals



✓KF24. Percentage of staff / colleagues reporting most recent experience of violence



✓KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months



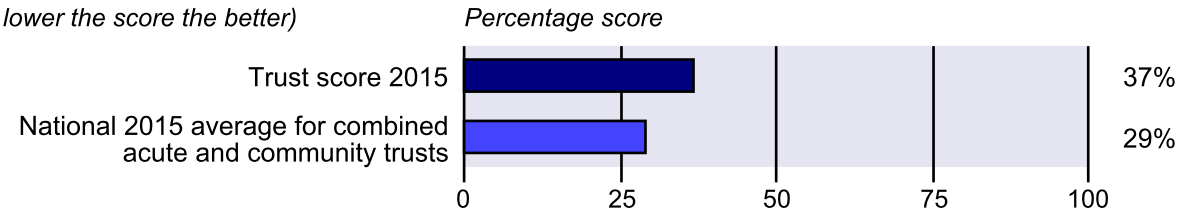
For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 39 (the bottom ranking score). St George's University Hospitals NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which St George's University Hospitals NHS Foundation Trust compares least favourably with other combined acute and community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

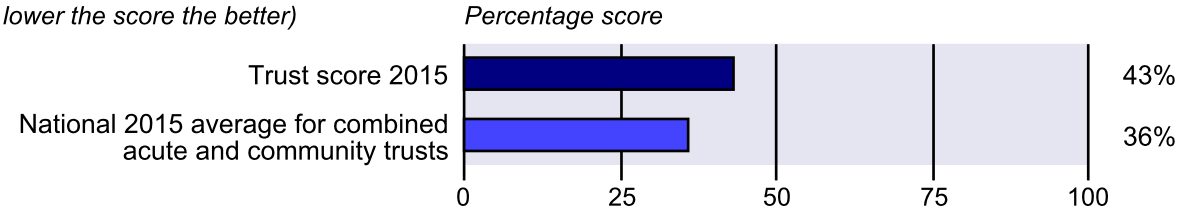
! KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



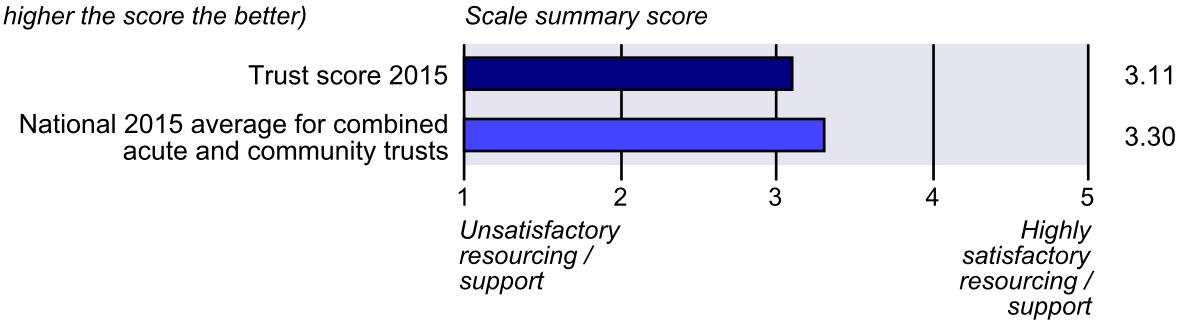
! KF17. Percentage of staff suffering work related stress in last 12 months

(the lower the score the better)



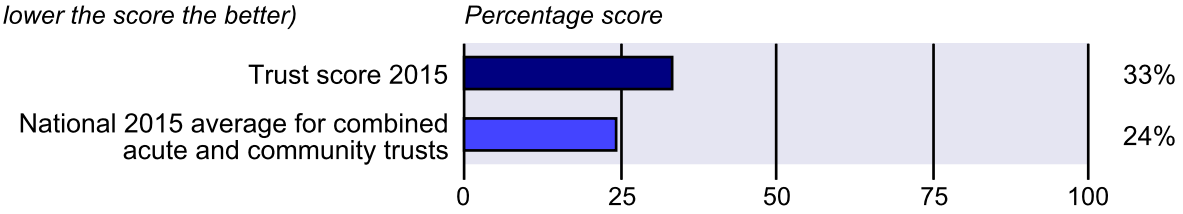
! KF14. Staff satisfaction with resourcing and support

(the higher the score the better)



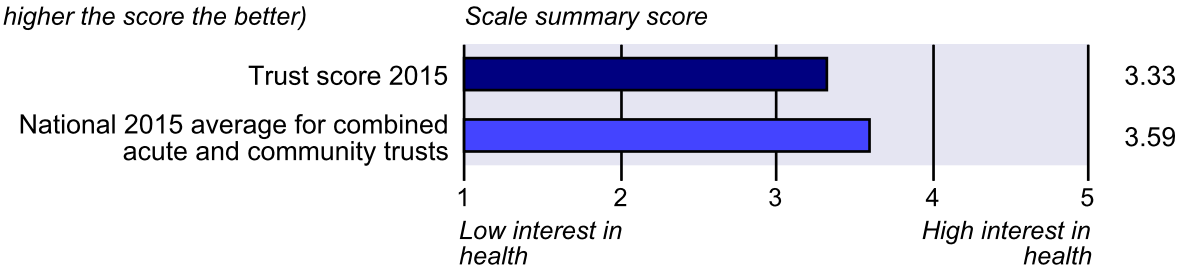
! KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



! KF19. Organisation and management interest in and action on health and wellbeing

(the higher the score the better)



For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 39 (the bottom ranking score). St George's University Hospitals NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 39. Further details about this can be found in the document ***Making sense of your staff survey data***.

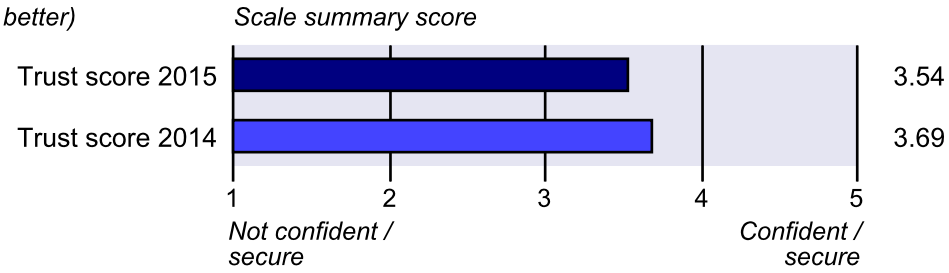
3.2 Largest Local Changes since the 2014 Survey

This page highlights the five Key Findings where staff experiences have deteriorated since the 2014 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

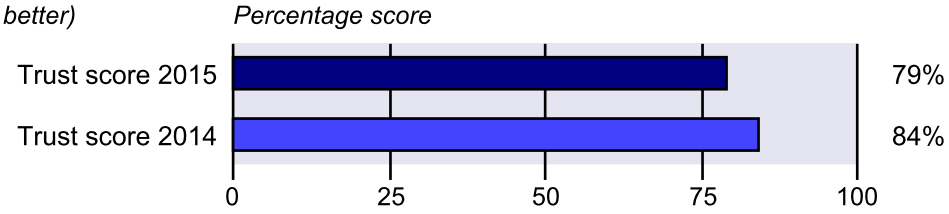
! KF31. Staff confidence and security in reporting unsafe clinical practice

(the higher the score the better)



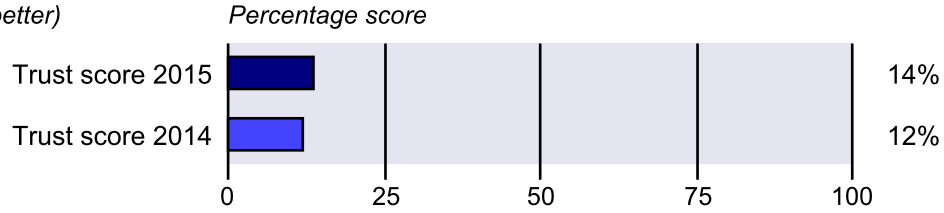
! KF11. Percentage of staff appraised in last 12 months

(the higher the score the better)



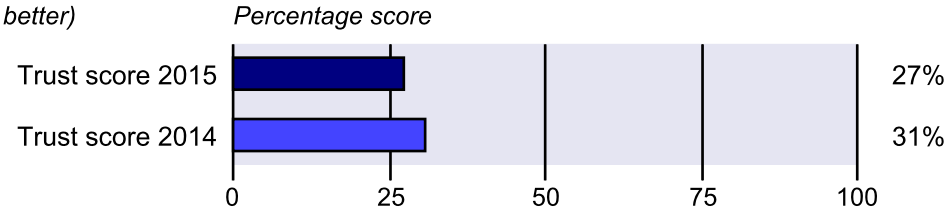
! KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



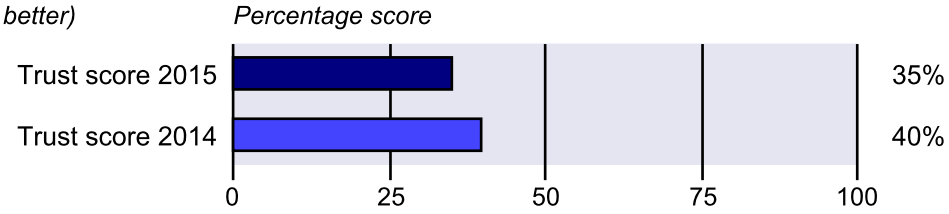
! KF6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



! KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



3.3. Summary of all Key Findings for St George's University Hospitals NHS Foundation Trust

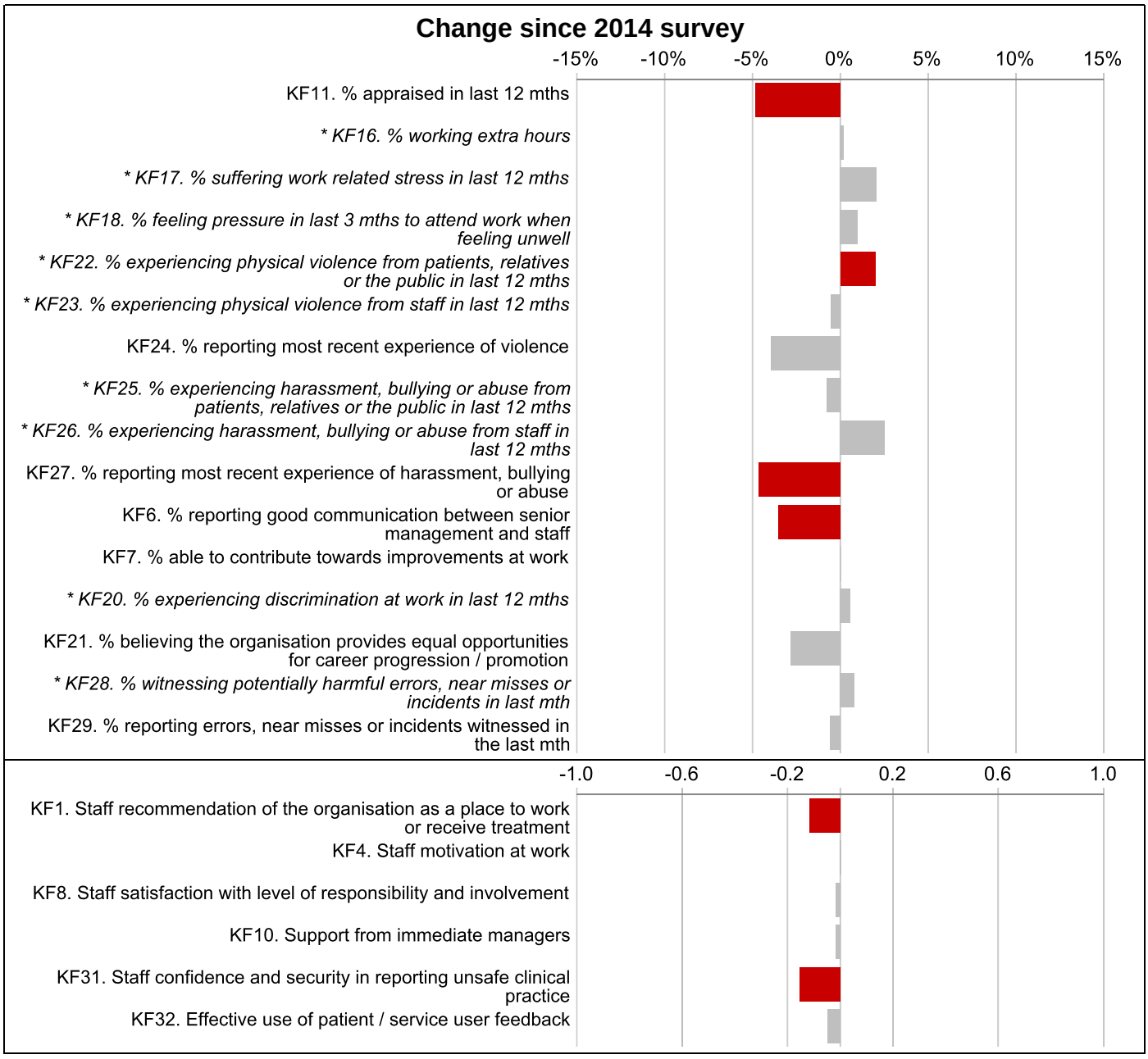
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2014 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2014 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2014 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for St George's University Hospitals NHS Foundation Trust

KEY

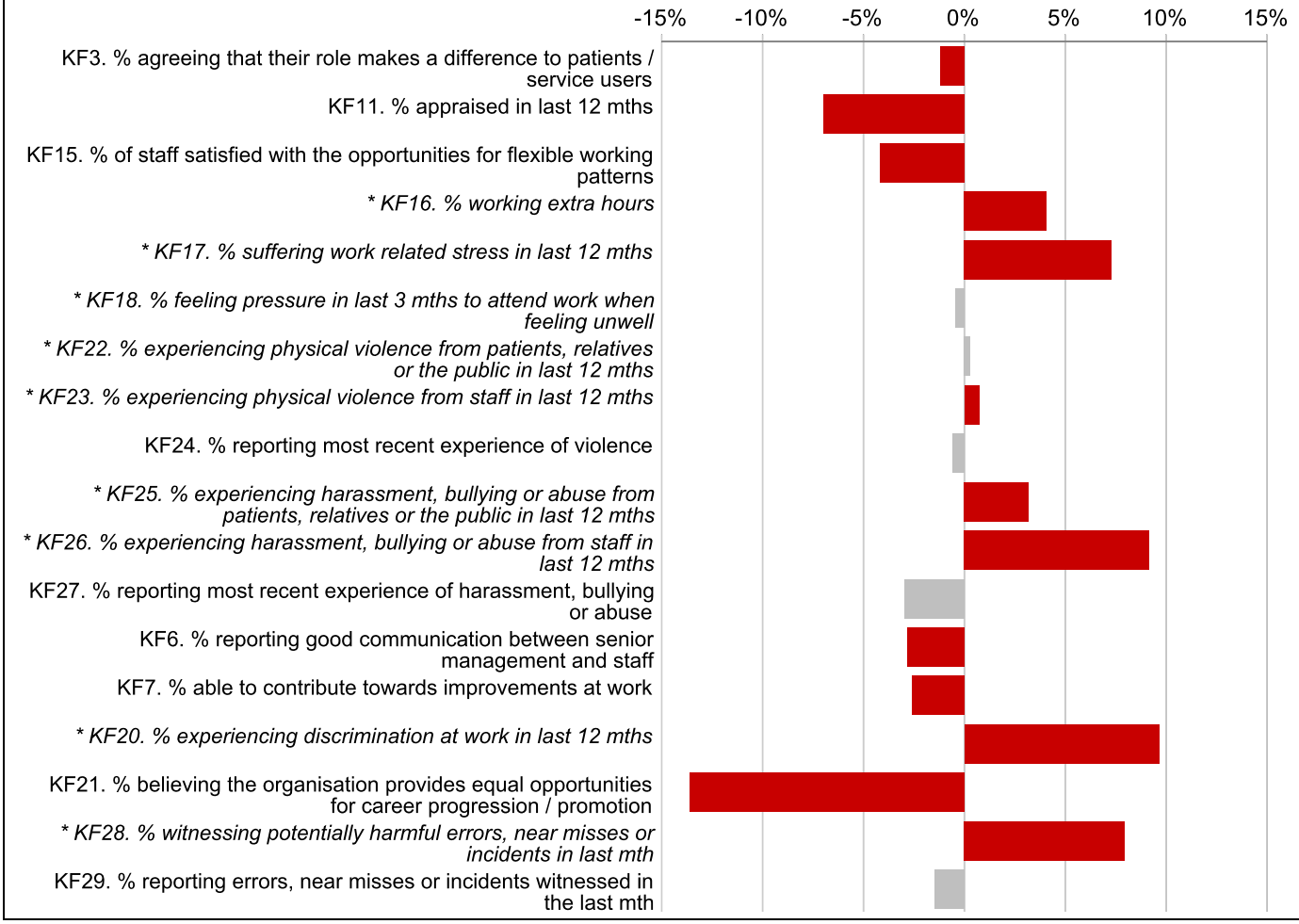
Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all combined acute and community trusts in 2015



3.3. Summary of all Key Findings for St George's University Hospitals NHS Foundation Trust

KEY

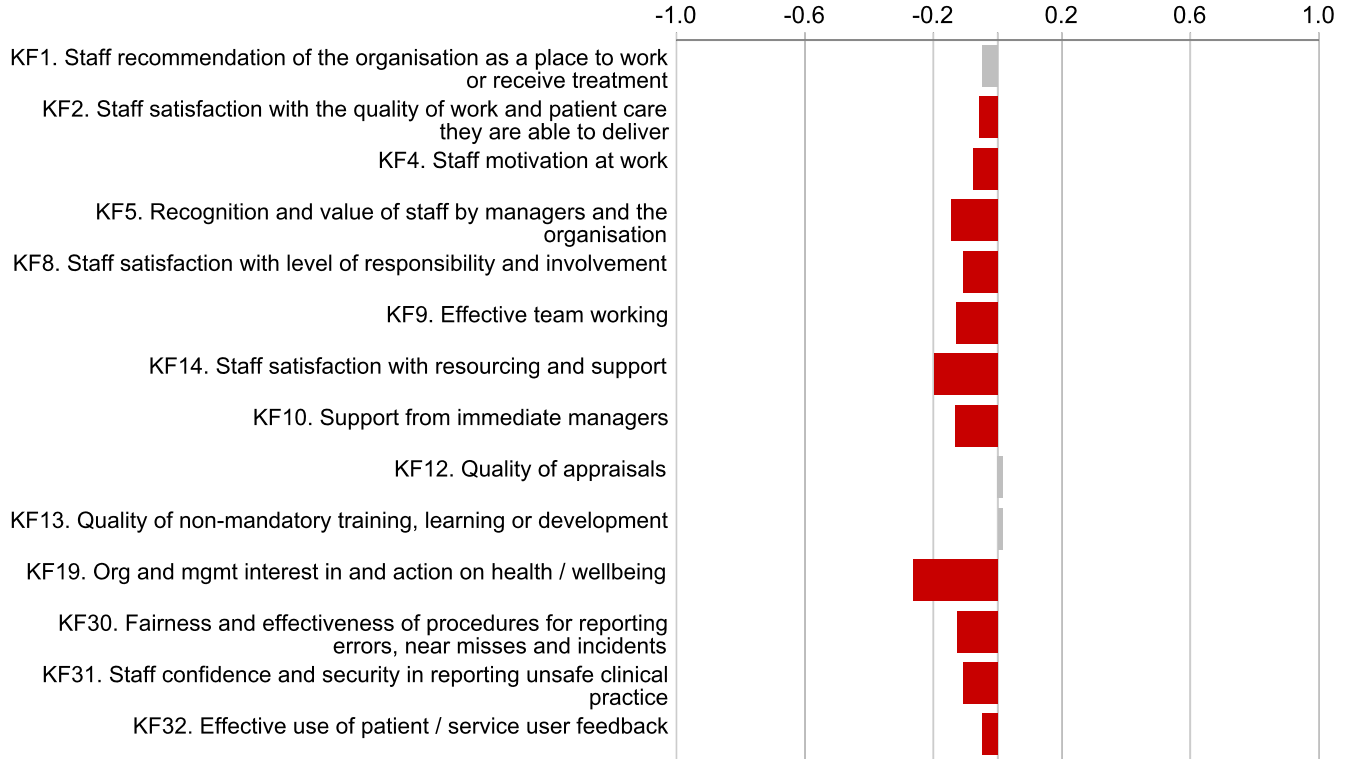
Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all combined acute and community trusts in 2015 (cont)



3.4. Summary of all Key Findings for St George's University Hospitals NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2014.

! Red = Negative finding, e.g. worse than average, worse than 2014.

'Change since 2014 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2014 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2014 survey	Ranking, compared with all combined acute and community trusts in 2015
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	! Decrease (worse than 14)	• Average
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver	--	! Below (worse than) average
KF3. % agreeing that their role makes a difference to patients / service users	--	! Below (worse than) average
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF5. Recognition and value of staff by managers and the organisation	--	! Below (worse than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	! Below (worse than) average
KF9. Effective team working	--	! Below (worse than) average
KF14. Staff satisfaction with resourcing and support	--	! Below (worse than) average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF10. Support from immediate managers	• No change	! Below (worse than) average
KF11. % appraised in last 12 mths	! Decrease (worse than 14)	! Below (worse than) average
KF12. Quality of appraisals	--	• Average
KF13. Quality of non-mandatory training, learning or development	--	• Average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Health and well-being		
KF15. % of staff satisfied with the opportunities for flexible working patterns	--	! Below (worse than) average
* *KF16. % working extra hours*	• No change	! Above (worse than) average
* *KF17. % suffering work related stress in last 12 mths*	• No change	! Above (worse than) average
* *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	• Average
KF19. Org and mgmt interest in and action on health / wellbeing	--	! Below (worse than) average

3.4. Summary of all Key Findings for St George's University Hospitals NHS Foundation Trust (cont)

	Change since 2014 survey	Ranking, compared with all combined acute and community trusts in 2015
Violence and harassment		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	! Increase (worse than 14)	• Average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	! Above (worse than) average
KF24. % reporting most recent experience of violence	• No change	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	! Decrease (worse than 14)	• Average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF6. % reporting good communication between senior management and staff	! Decrease (worse than 14)	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	! Below (worse than) average
ADDITIONAL THEME: Equality and diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	! Below (worse than) average
ADDITIONAL THEME: Errors and incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Above (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in the last mth	• No change	• Average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	--	! Below (worse than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	! Decrease (worse than 14)	! Below (worse than) average
ADDITIONAL THEME: Patient experience measures		
KF32. Effective use of patient / service user feedback	• No change	! Below (worse than) average

4. Key Findings for St George's University Hospitals NHS Foundation Trust

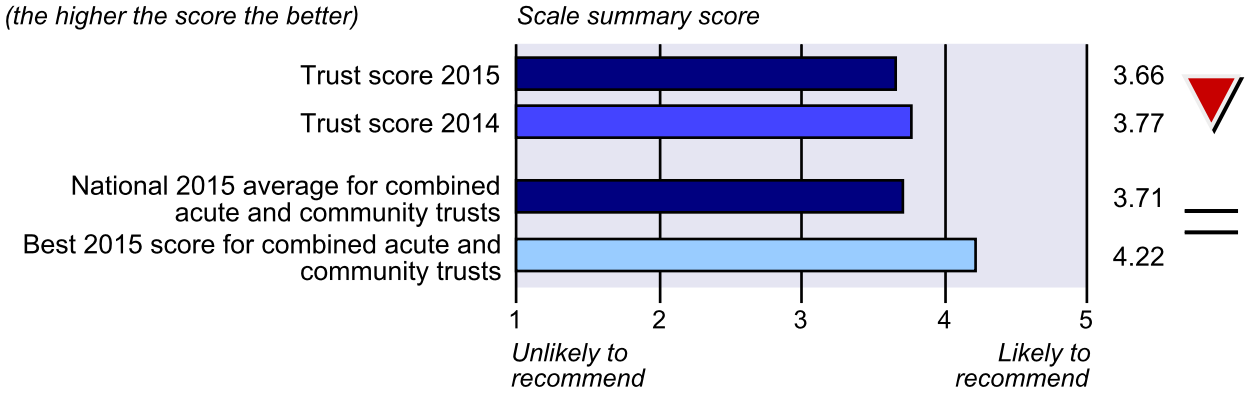
2552 staff at St George's University Hospitals NHS Foundation Trust took part in this survey. This is a response rate of 31%[1] which is below average for combined acute and community trusts in England, and compares with a response rate of 39% in this trust in the 2014 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2015 survey, and compares these to other combined acute and community trusts in England and to the trust's performance in the 2014 survey. The findings are arranged under seven headings – the four staff pledges from the NHS Constitution, and the three additional themes of equality and diversity, errors and incidents, and patient experience measures.

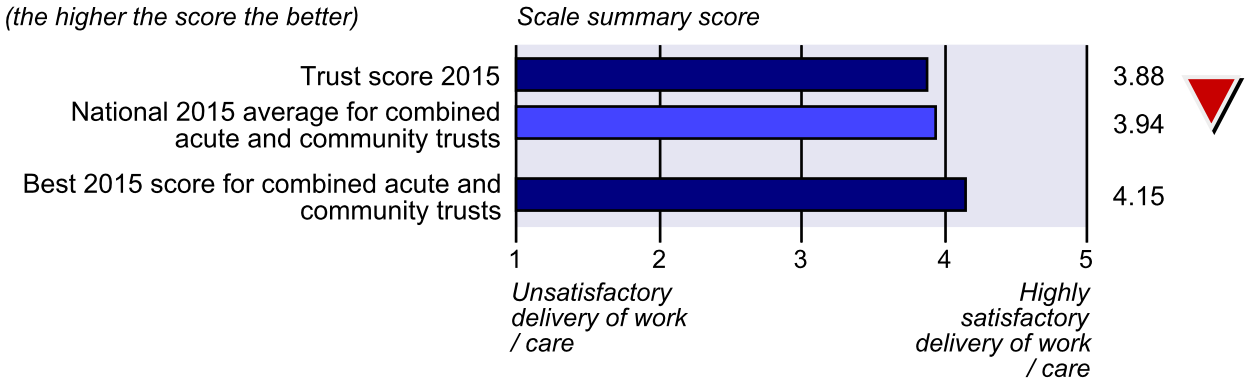
Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2014). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2014). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

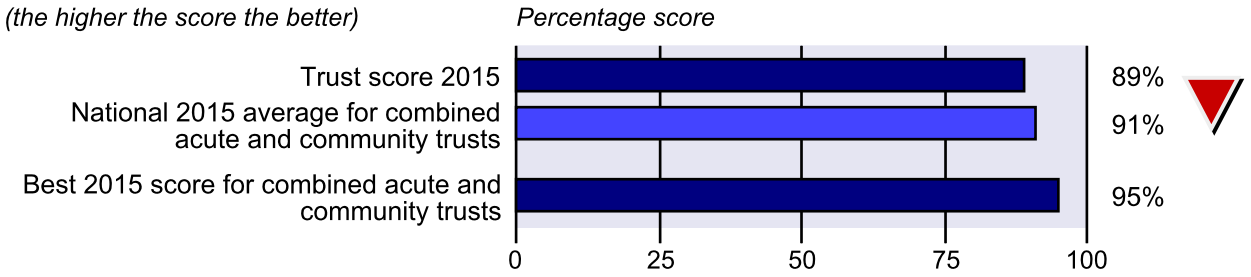


KEY FINDING 2. Staff satisfaction with the quality of work and patient care they are able to deliver

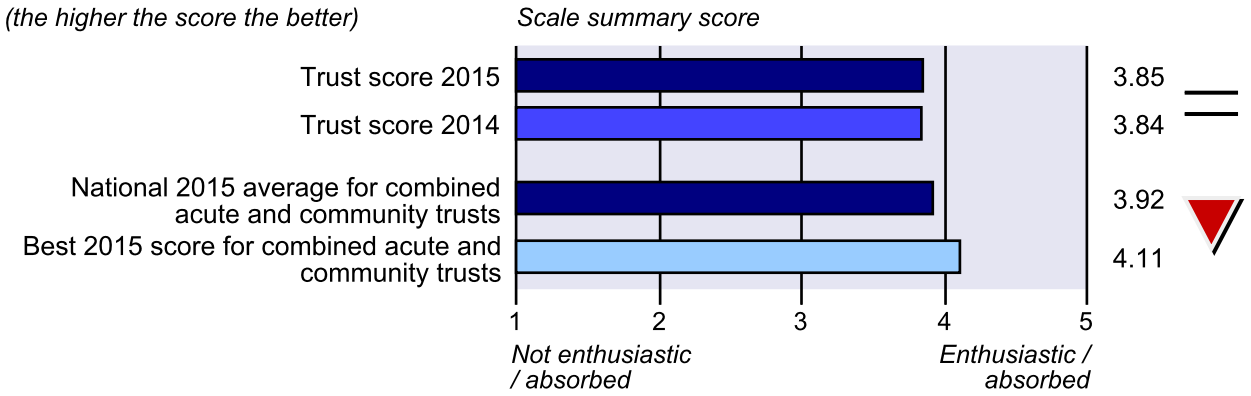


[1]Questionnaires were sent to all 8283 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

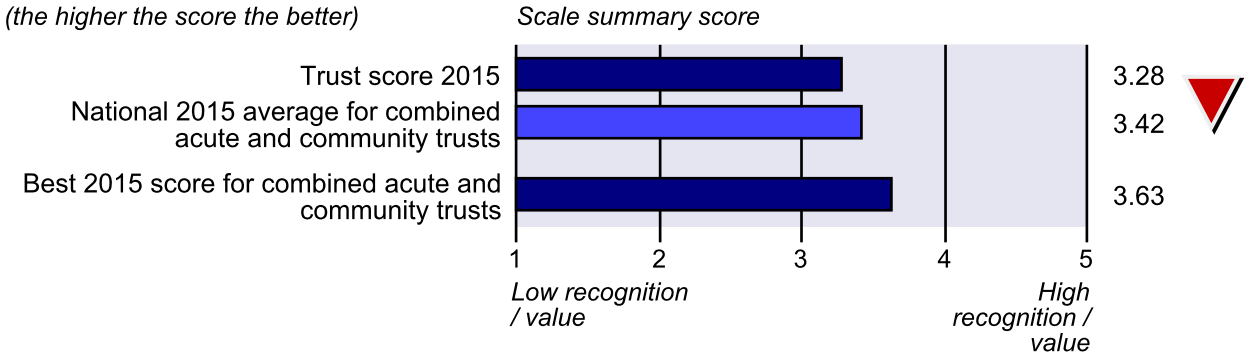
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users



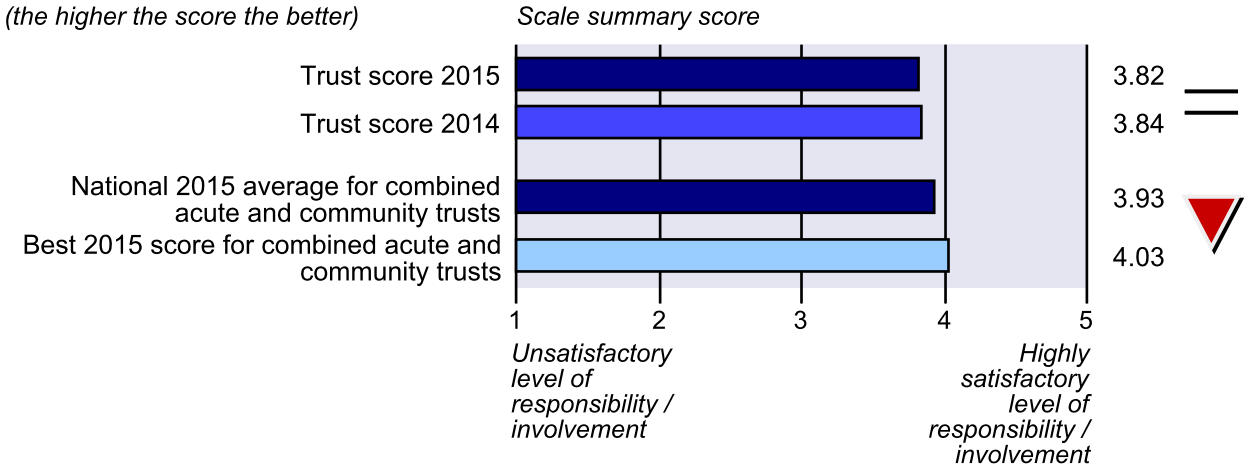
KEY FINDING 4. Staff motivation at work



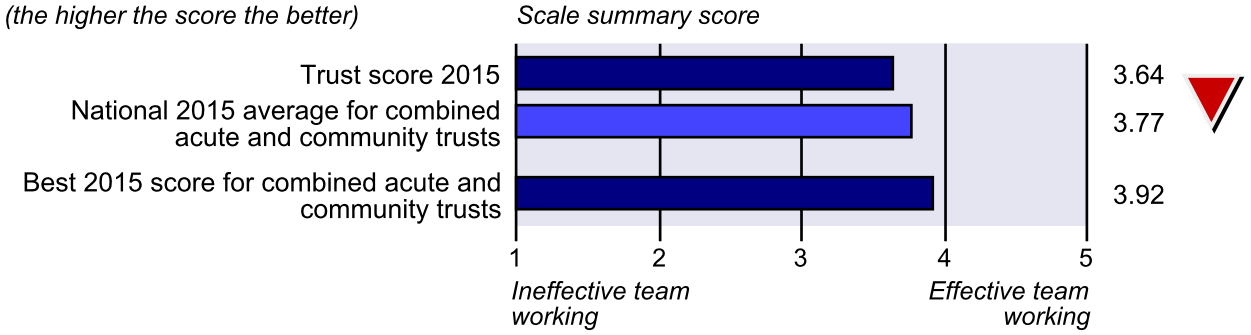
KEY FINDING 5. Recognition and value of staff by managers and the organisation



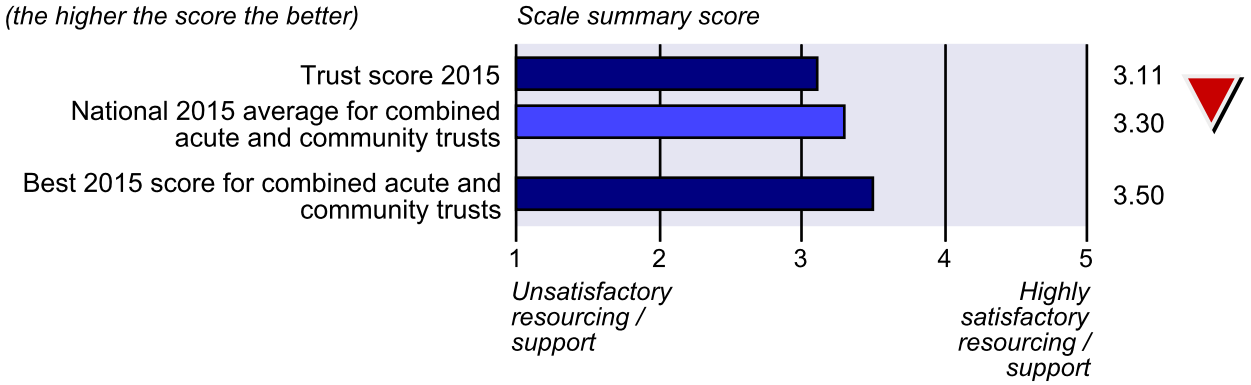
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement



KEY FINDING 9. Effective team working

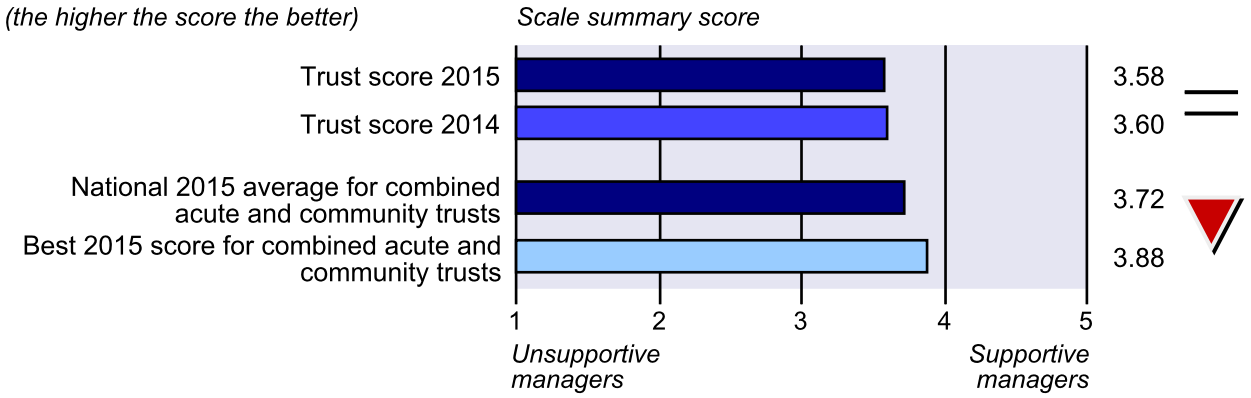


KEY FINDING 14. Staff satisfaction with resourcing and support

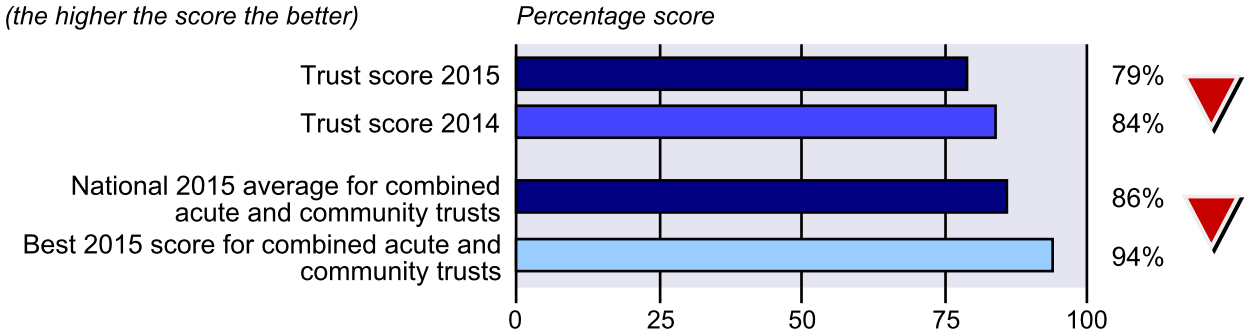


STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

KEY FINDING 10. Support from immediate managers

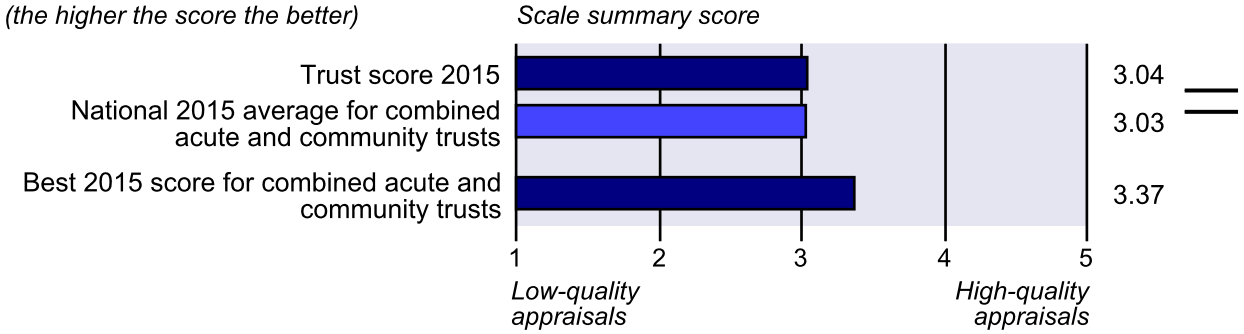


KEY FINDING 11. Percentage of staff appraised in last 12 months



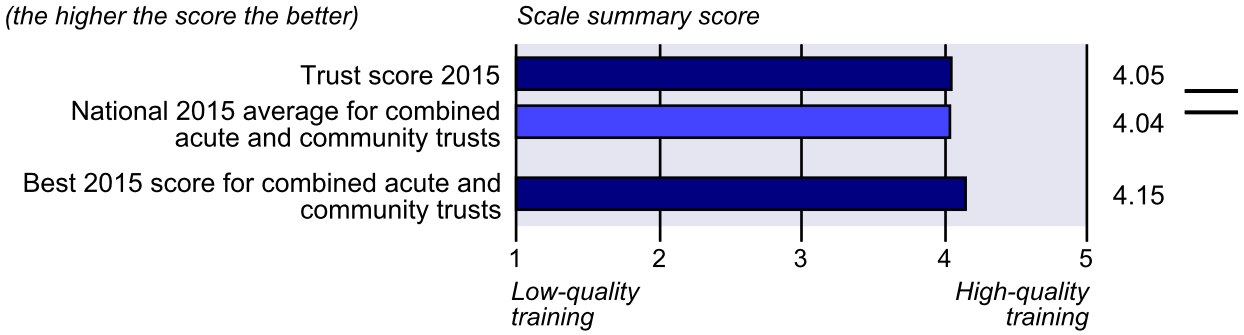
KEY FINDING 12. Quality of appraisals

(the higher the score the better)



KEY FINDING 13. Quality of non-mandatory training, learning or development

(the higher the score the better)

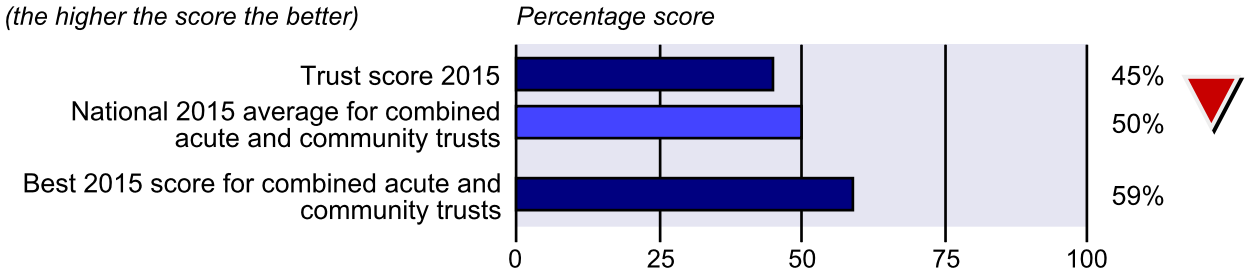


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Health and well-being

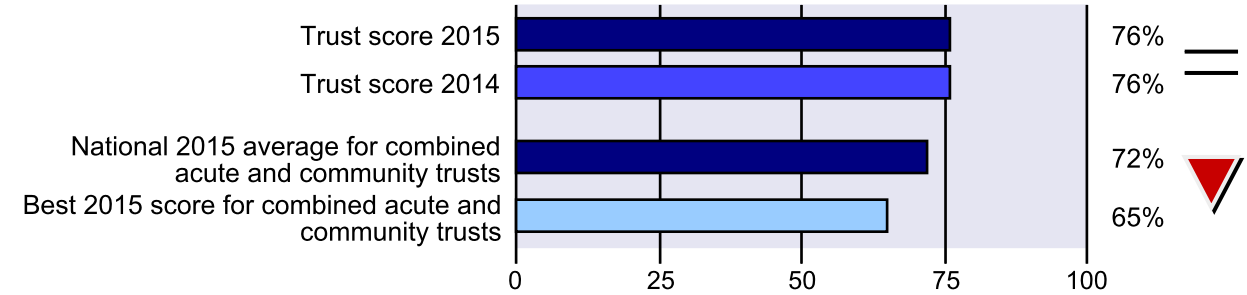
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)

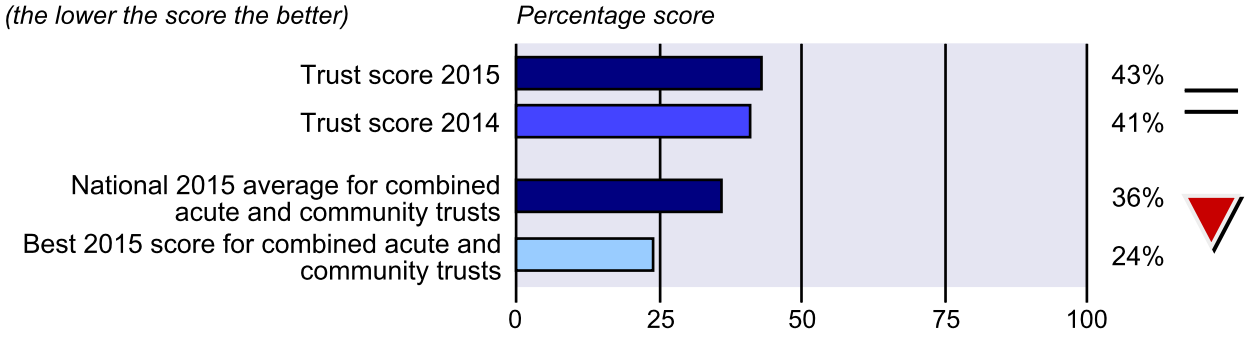


KEY FINDING 16. Percentage of staff working extra hours

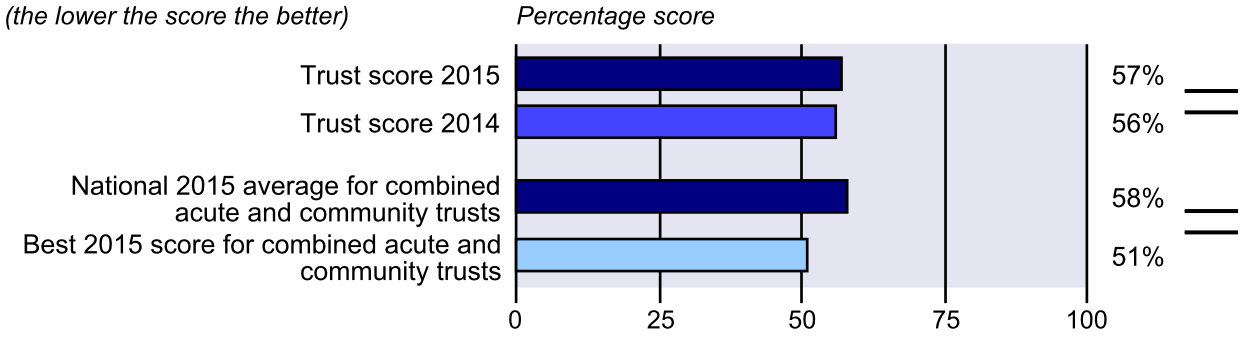
(the lower the score the better)



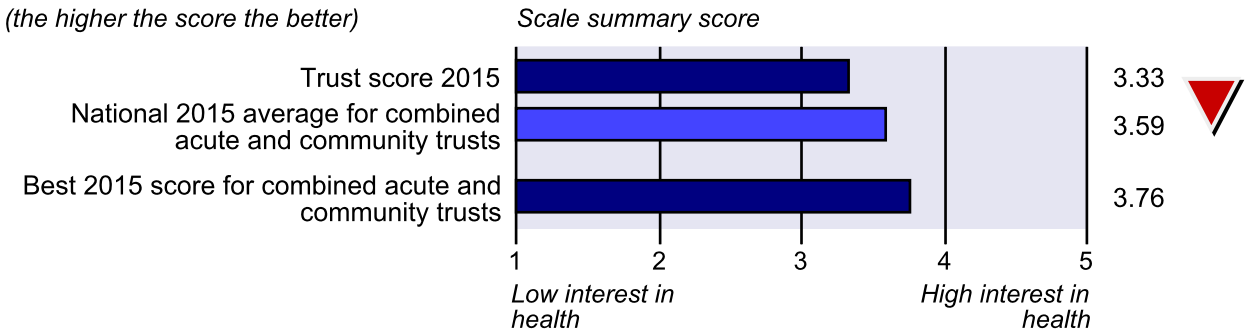
KEY FINDING 17. Percentage of staff suffering work related stress in last 12 months



KEY FINDING 18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell

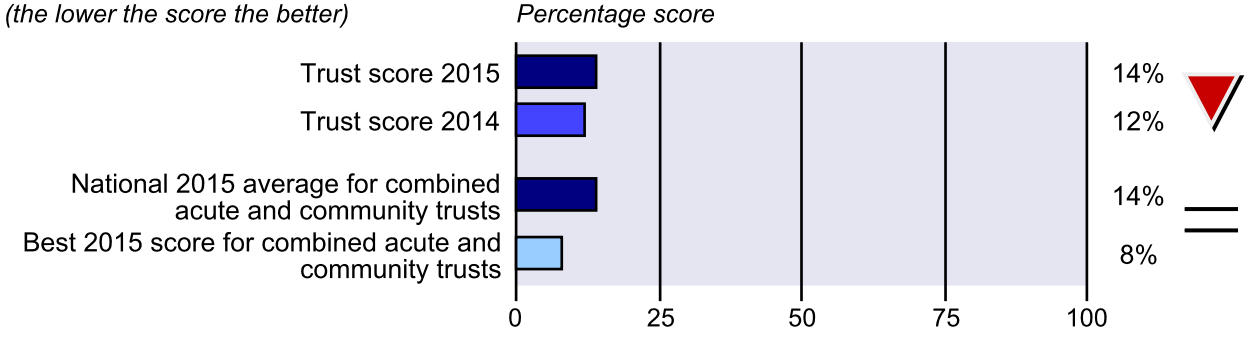


KEY FINDING 19. Organisation and management interest in and action on health and wellbeing



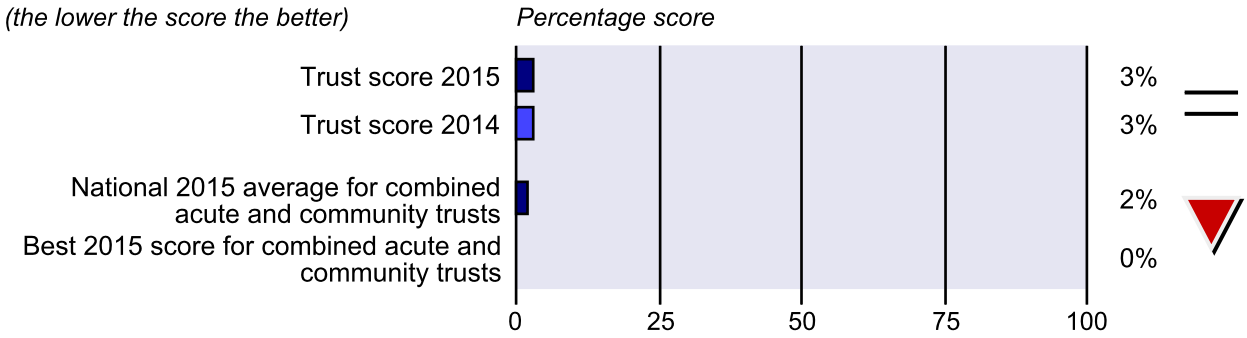
Violence and harassment

KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months



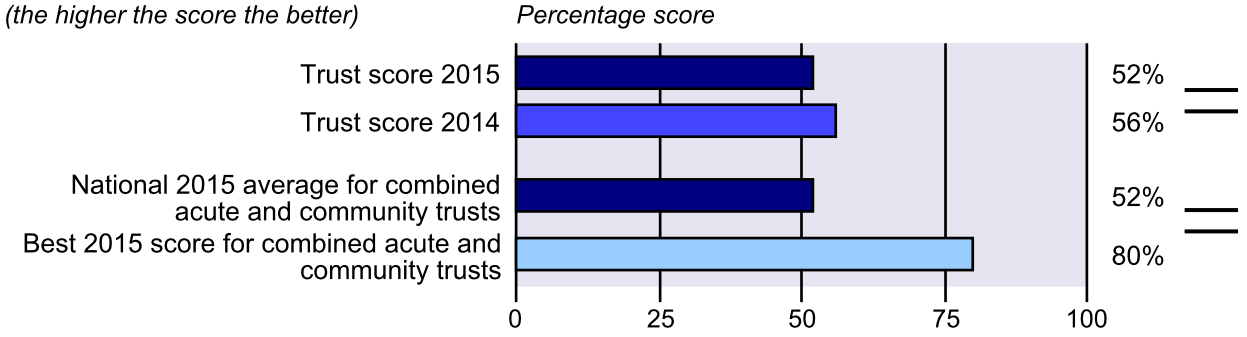
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



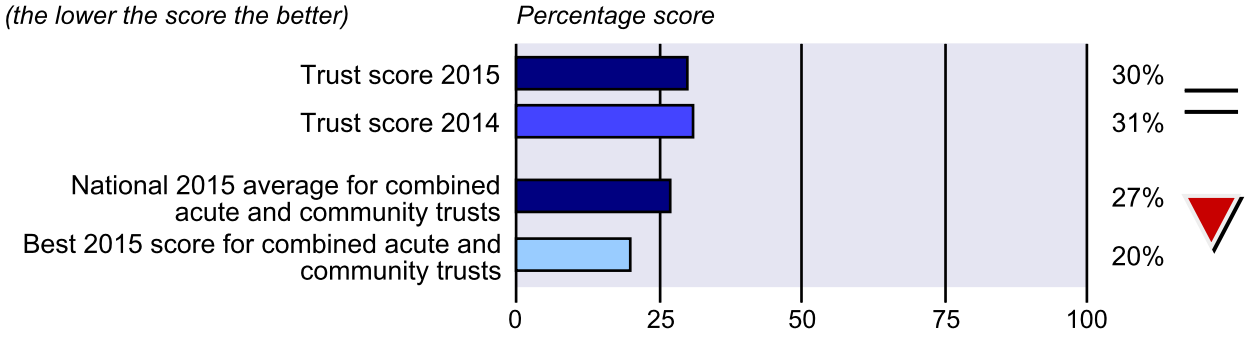
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



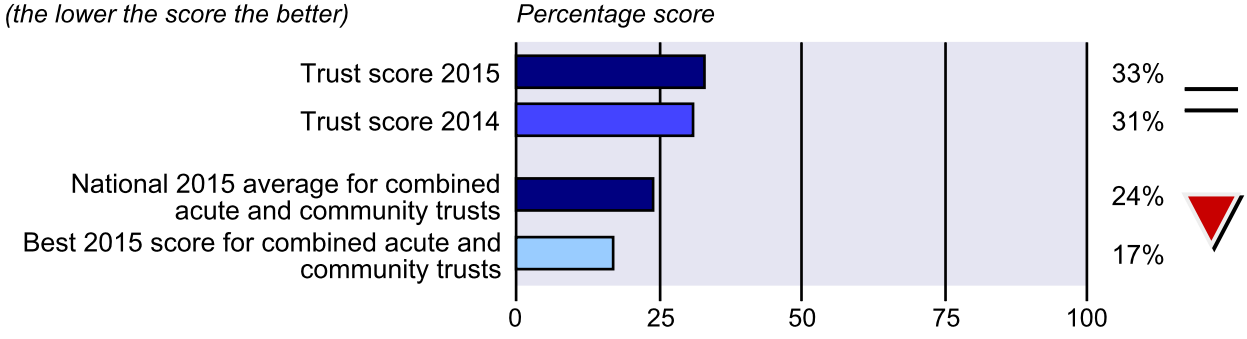
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



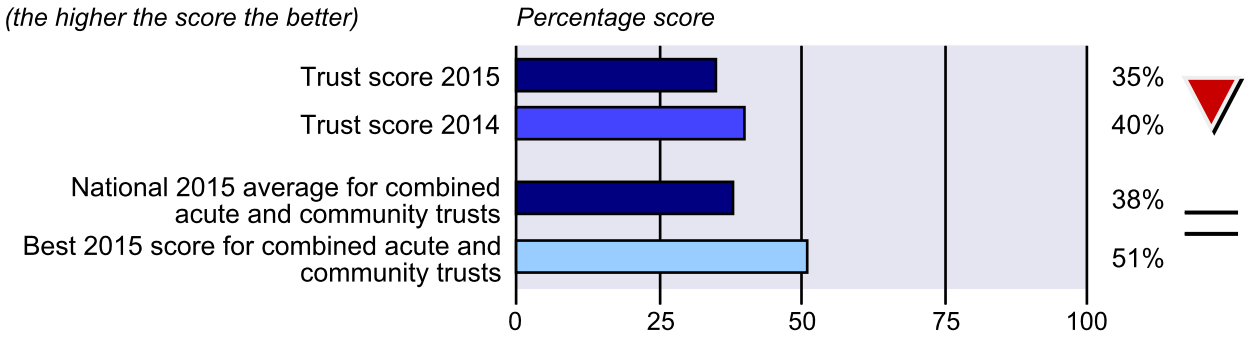
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

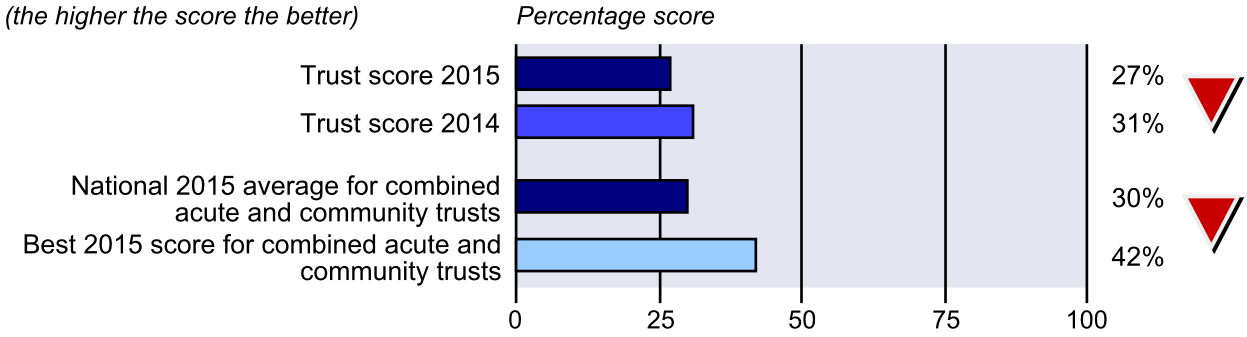
(the higher the score the better)



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

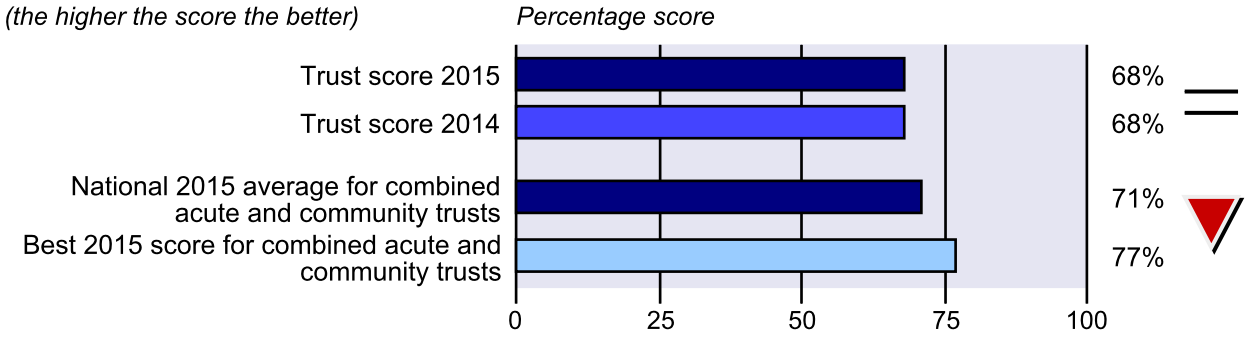
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

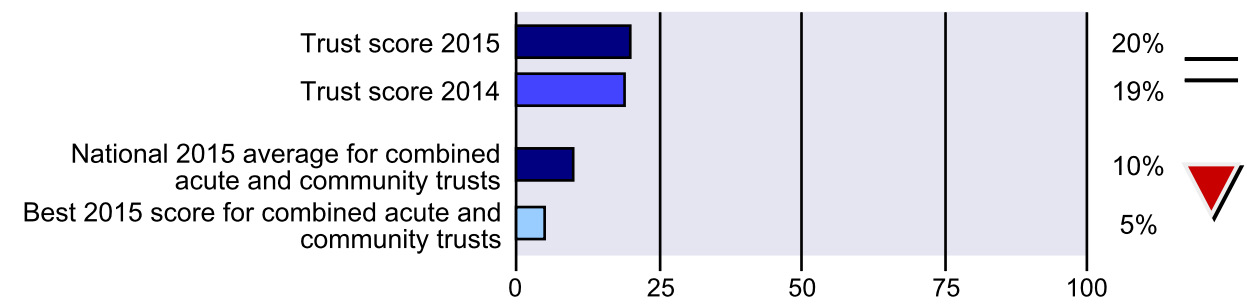
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

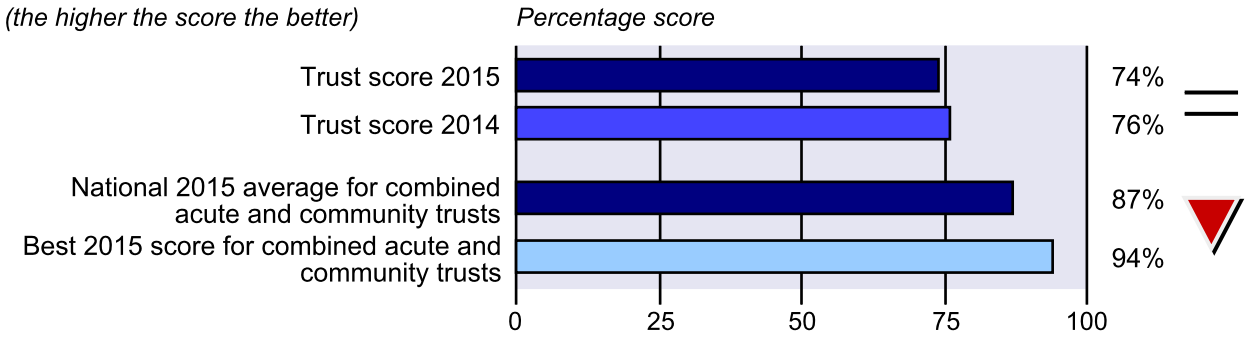
KEY FINDING 20. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

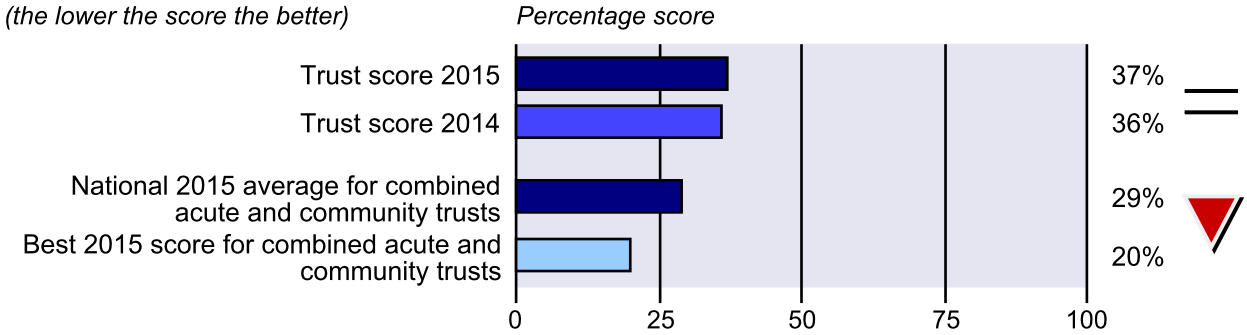
(the higher the score the better)



ADDITIONAL THEME: Errors and incidents

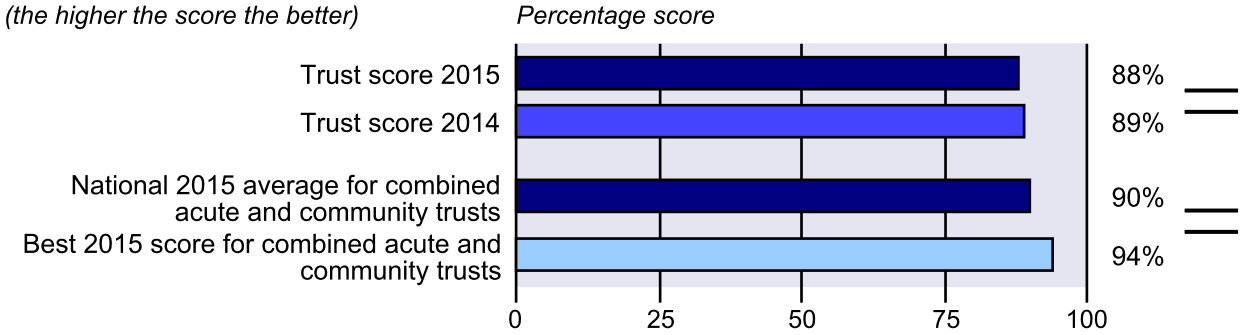
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



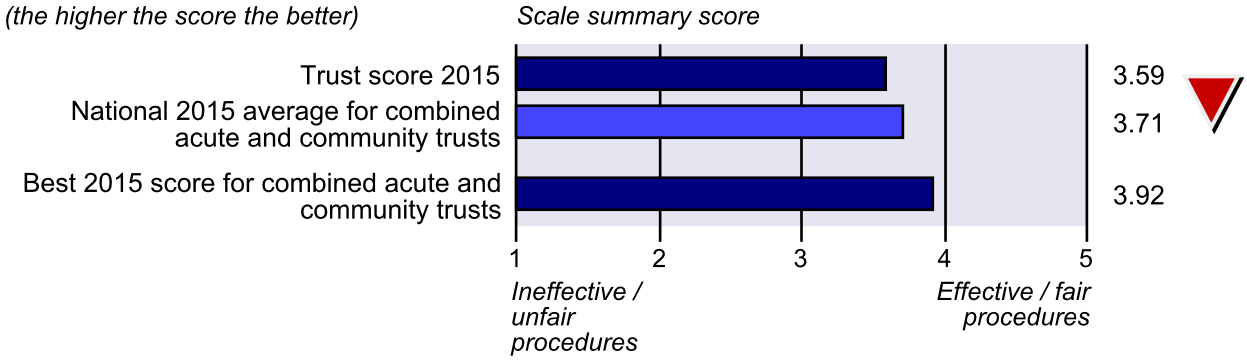
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)

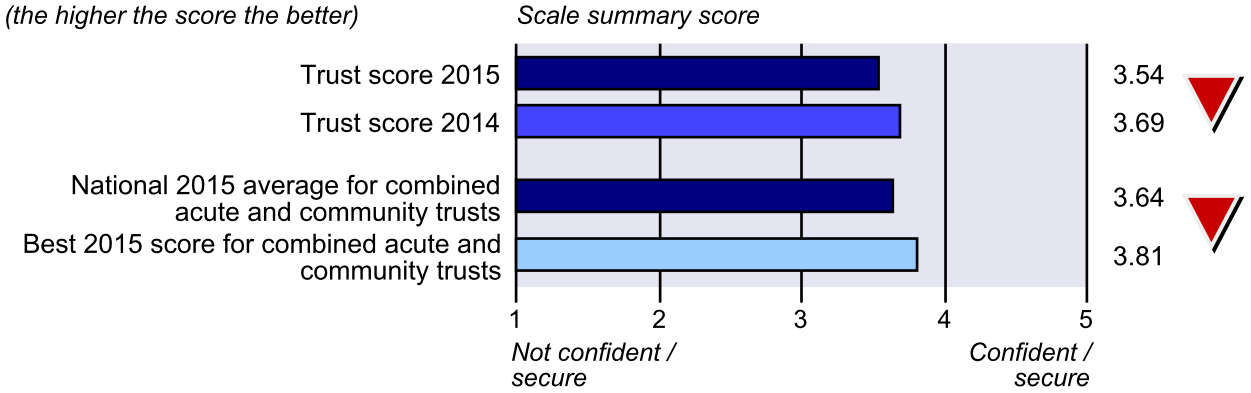


KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)

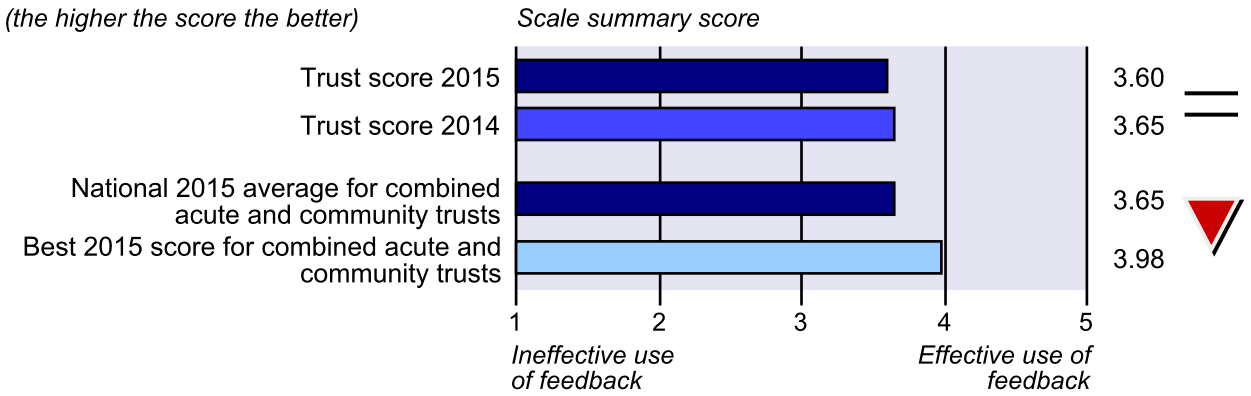


KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice



ADDITIONAL THEME: Patient experience measures

KEY FINDING 32. Effective use of patient / service user feedback



excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

2015 Staff Survey

Wendy Brewer

Excellence in specialist and community healthcare

Key message

- St George's is most usefully compared to other large London teaching hospitals.
- In previous years the trust has benchmarked well against this group.
- In particular the trust has always done well for staff recommendation of the trust as a place to work or to receive treatment – this year our performance is only average.
- In 2015 the trust deteriorated in its overall performance and has done less well compared to the overall group.
- This is a clear message to trust leaders to deal with the concerns that staff are raising

Comparison to London teaching hospitals

NHS Staff survey/ London teaching trusts								
Trust's Name	St Georges	King's	Bart's	Royal Free	Imperial	UCLH	GSTT	Average
Staff recommendation of the organisation as a place to work or receive treatment	3.66	3.69	3.49	3.77	3.61	3.91	4.22	3.76*
Staff motivation at work	3.85	3.97	3.89	3.96	3.89	3.89	4.03	3.93*
% reporting good communication between senior management and staff	27	34	28	31	33	33	42	32.57*
% able to contribute towards improvements at work	68	74	68	66	70	72	75	70.43*
% experiencing harassment, bullying or abuse from staff in last 12 months	33	29	37	34	32	31	24	31.43**
Overall staff engagement	3.72	3.81	3.68	3.79	3.71	3.84	4.03	3.80*
	*higher = better **lower=better							

Key areas of concern

- Willingness to report concerns
- Pressure felt by staff
- Engagement and communication with leaders
- Appraisal
- Fairness
- Bullying

Willingness to report concerns

What we have done

- Established a Listening into Action Liaison role – a staff champion to hear staff concerns and to resolve them.

What we will do

- Invest in estates and IT infrastructure

Pressure felt by staff

What we have done

- Invested more financial resources into the staff support service.
- Developed coaching programmes for line managers.
- Values Awards
- A programme of wellbeing events – New Year, New You, Global Corporate Challenge

What we will do

- Recruit 125 nurses from the Philippines
- Invest in Swartz rounds
- Introduce a credit union for staff
- Introduce a staff physiotherapy service

Engagement and communication with leaders

What we have done

- Trust wide Listening into Action staff engagement programme
- Senior leaders and Ask Miles forums
- Developed a leadership development programme

What we will do

- Agree our priorities and communicate these clearly
- Implement the leadership development programme for all leaders

Appraisal

What we have done

- Quality of appraisals is well received
- Agreed a rating system and link to performance with staff side

What we will do

- Introduce electronic system for appraisals
- Roll out nursing revalidation
- Reintroduce monitoring of appraisal completion
- Introduce talent management processes

Fairness

What we have done

- Rolled out a programme of unconscious bias training
- Held Listening into Action inclusivity events
- Set up a St George's as One group

What we will do

- Review & change process for acting up
- Review & change process for internal promotions
- Require all line managers to attend unconscious bias training

Bullying

What we have done

- Reviewed our policy and practice compared to The Royal Free and GSTT and identified weaknesses in our policy
- Programme of work to deal with bullying behaviour identified by CQC in 2014
- Provided support to managers in how to manage challenging staff
- Taken action against staff proven to be bullies

What we will do

- Amend our policy to include more opportunities for early and informal resolution
- Introduce new policy through briefing sessions led by Miles
- Take advice on publicising action taken against staff proven to be bullies

St George's University Hospitals NHS
NHS Foundation Trust

February Trust Board
3rd March 2016

Business Planning and Budget setting 2016/17

1. Introduction

The trust is part way through its annual business planning and budget setting cycle. This year's process is different from previous years, with new demands and requirements of the trust and the wider health economy. The trust submitted its draft annual plan to Monitor on 8th February.

This paper updates the Trust Board on the following key issues and next steps for each.

1. A summary of significant elements of the submitted draft annual plan and the additional work required for the 11th April submission
2. The associated budget setting process
3. The format and development of the Corporate objectives for 2016/17
4. More detail on the emerging 5 year Sustainability & Transformation Plan for south west London

2. The draft 2016/17 Annual Plan

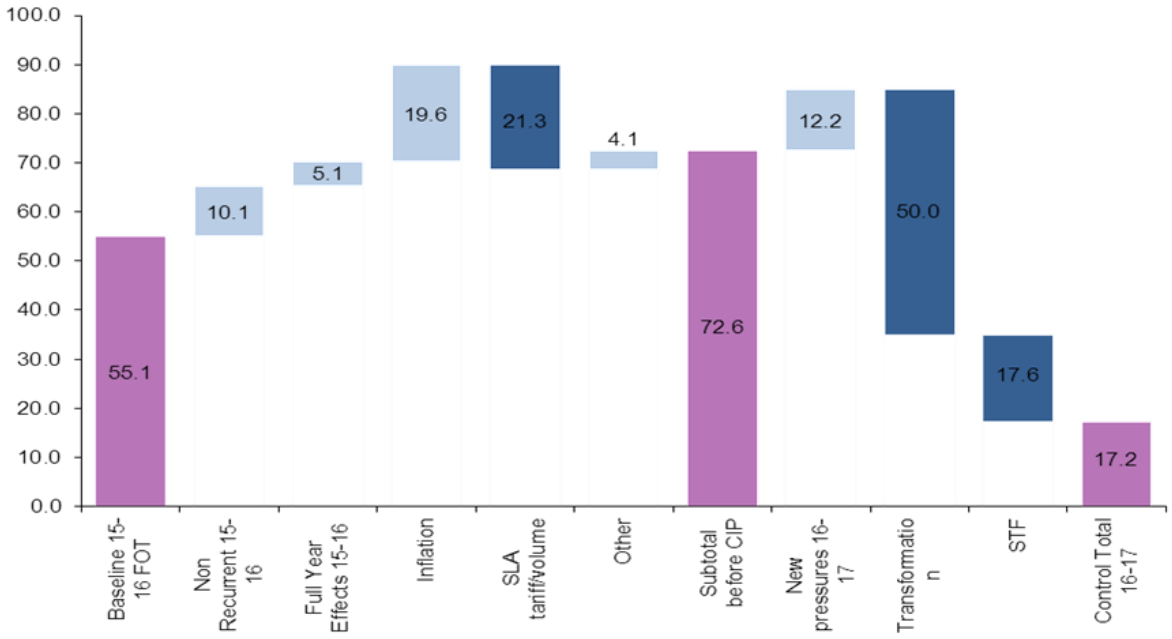
Key elements or points to note relating to the draft plan are:

- Monitor were very prescriptive about the format and content. The trust has met these requirements whilst at the same time highlighting key messages it wants to give Monitor.
- The plan signposts the requirement for a strategy refresh which has the potential to alter the plan
- It outlines five key challenges the trust needs to address:
    - Finding a sustainable solution to renal infrastructure problems
    - The Children and Women's Hospital development
    - Delivering access targets
    - Addressing the trusts wider demand and capacity challenge
    - Meeting the workforce challenge of staff recruitment and retention
- There is a focus on the current position relating to 18 week Referral to Treatment (RTT), A&E 4 hour, and Cancer waits, as these are three of the nine 'must-do's' that the guidance is clear all acute trusts have to deliver against in 2016/17
- The plan provides detail on the Transformation programme content, given its importance to delivering the financial plan in 2016/17
- The document is clear on the risks to delivering the proposed plan.

The other key requirement in the guidance is for the overall system to return to aggregate financial balance. The trust has accepted the Sustainability and Transformation Fund (STF) offer of £17.6m, which is predicated on the trust delivering a control total deficit of £17.2m in 2016/17. It should be noted that the STF offer is linked to the NHS's England's forecast deficit for 2016/17 being £1.8b. Any overspend on that amount may result in the STF offer being reduced.

It should be noted that STF funding is paid quarterly in arrears and is contingent on delivering agreed access targets and financial trajectories, as well as the development of the wider STP. Failure to meet those trajectories will result in significant financial penalties.

The following bridge between the forecast 2015/16 outturn and the 2016/17 plan is in the submitted plan and shows the positive and negative financial drivers that take us from a forecast outturn of £55.1m deficit in 2015/16 to a control total deficit of £17.2m for 2016/17. The left axis are deficit £m's.



The trust is required to submit a full annual plan on the 11th April 2016. This submission will need to have greater clarity on the following issues, and these will be the focus of work over the coming weeks. The trust will also need to understand the risks inherent in delivery associated with these issues.

1. Clear trajectories, agreed by commissioners, for all access targets.
2. Agreeing SLA agreements with CCGs and NHSE – the guidance states contracts should be signed by 31st March. A key area of focus is the additional activity required to sustainably deliver access targets.
3. Linked to the discussion about access targets, a clear understanding of our capacity, and our ability to deliver additional required work, both on-site and off-site, linking to Transformation Programmes.
4. More detail on the Transformation programmes, in particular allocating the £50m savings to budgets
5. Greater detail on the trusts response to the Lord Carter review
6. From all of the above, a robust financial plan for achieving, as a minimum, the £17.2m control total.

3. Budget Setting 2016/17

The trusts budget setting process for 2016/17 builds on the outputs of TRP2, which forms the baseline for work underway. Key deadlines or issues are:

- Wk beginning 29th Feb
    - Agreement about how agency premiums and vacancy factors are incorporated
    - SLA updated to reflect 16/17 tariffs and shared with commissioners
    - Budget setting resource model being updated with SFM support to reflect SLA Volume, agreed business cases and known and approved cost pressures.
- 4th March – baseline 2016/17 budgets agreed by SFMs and GMs at cost centre and account code
- Wk beginning 4th March – Trust makes decision on how Transformation Programmes that cannot be allocated to a cost centre and account code by 31st March will be managed and accounted for in the overall trust budget.
- 17th March – set out final budget setting assumptions for agreement
- 21st March – set out consolidated financial risks and cost pressures for review and agreement
- 24th March – submit Final Budget Strategy/Plan Papers for F&P
- 31st March – submit Final Budgets & Annual Operational Plan to Board
- 31st March – sign SLA's with commissioners
- 11th April – submission of APR and Operational plan to NHSI
- 25th April – upload I&E Budgets Journals and Agresso

4. Corporate Objectives 2016/17

The draft plan, and previous EMT and Trust Board papers before that, stated that the trusts focus for 2016/17 would be:

"To maintain the quality of care for our patients whilst delivering sustainable operational and financial performance, alongside a strategic repositioning of the organisation to ensure that it is fit for the future"

To deliver this it proposed the following framework, explicitly linked the Transformation programme structure, for the Corporate Objectives for 2016/17:

1. Refresh the organisational strategy to inform the strategic plan submission in June, ensuring that we maximise internal and external strategic opportunities.)
2. Engage with our workforce, and other stakeholders, to develop new models of care and new ways of working, ensuring that our staff are supported, motivated and engaged to deliver our revised strategy, through the workforce efficiency programme supported by a reinvigorated communications strategy.
3. Deliver our transformational change programme, predominately focussing on improving clinical and operational productivity and efficiency through our theatre productivity, outpatient strategy, diagnostic review and flow workstreams
4. Review how we utilise our estate and corporate resources, to ensure that we maximise the value of the estate and the effectiveness of our support services, through the procurement, infrastructure and back office workstreams.
5. Maintain quality and safety by strengthening our assurance processes and focusing resources appropriately, ensuring that we deliver the NHS Mandate and 7 day working requirements.
6. Continuing to invest in clinical, research or educational services to deliver operational improvement or financial benefits, and disinvest from those that do not contribute to organisational quality or financial performance.

Over the coming weeks, the trust will need to develop against each of the six points above:

1. A limited set of focussed, specific and measurable actions/objectives
2. Bring those draft Corporate objectives to the March Trust Board for discussion and approval
3. Develop and approve a series of individual Corporate Plans (e.g. Estates & Facilities, IM&T) which triangulate with all other plans being developed by the trust.

5. The Sustainability and Transformation Plan

Sustainability and Transformation Plans are a crucial development in the planning and delivery infrastructure of the NHS. All health economies must agree their local STP footprint, and then deliver by June 2016 a five year plan to 2021. The trusts 2016/17 Annual Plan is year one of this five year plan.

Discussions around the STP are obviously at a very early stage but the following emerging governance structure has been agreed:

- St. George's has agreed that it will be in the South West London STP.
- Within the STP there will be three sub-regional STP groups, and St. George's will be in one with Wandsworth CCG, Merton CCG, Sutton CCG and Epsom & St. Helier NHS Trust.
- Miles Scott has agreed to chair the weekly working group that co-ordinates the overall process
- A programme board will meet on a 6 weekly basis with overall responsibility for the process, as well as monthly CO/CEO meetings, a Transformation group (which Miles will also be attending), a Finance and Activity committee and a clinical group.

5a) Financial Diagnostic exercise

There is work already underway on a financial diagnostic to understand the scale of the sector wide financial challenge faced over the next five years, which will be co-opted into the STP framework.

The financial diagnostic will develop an integrated baseline normalised 5-year activity/capacity/finance model to generate a forecast baseline position that is owned by all STP stakeholders. Each organisation within the economy has been asked to prepare a "Do Minimum" case, which will show the accumulated deficit position of the STP if no significant action is taken.

Work on the model is being co-ordinated by a finance technical group on behalf of the CFOs and FDs of the economies organisations, who are expected to sign off the baseline financial diagnostic models on the 11th March. A detailed set of assumptions and how they have been reflected in the Trust's financial diagnostic submission will be shared with EMT for approval on 7th March.

5b) Guidance on the 5 year plan

STP guidance is still evolving, with a further tranche released on 16th February. The guidance is entitled "Supporting Providers to Deliver" and has the following opening statement:
"The challenge facing providers to 2020 is to deliver patient care of outstanding quality, regain NHS constitution access standards, return to financial balance and eliminated unwarranted variation across all these areas, whilst at the same time making the transformation needed to ensure long term sustainability."

At this stage the guidance is still high level and NHSI accept that this is an *"ambitious and stretching task".* The submitted STP will need to show how the following will be delivered by 2020 (not exhaustive):

- All hospitals to be rated 'Good' or 'Outstanding' by the CQC with no trusts in special measures
- All trusts to have made improvements specified by national taskforces on cancer, mental health, dementia, maternity and urgent and emergency care
- Significant progress in eliminating unwarranted variation in clinical performance
- Consistently improve patient safety will all trusts delivering seven day services.
- All trusts delivering agreed access standards
- Better demand and capacity modelling, quality data, operational management
- All providers balance their books and will have released significant efficiency savings
- Acute trusts plan to achieve savings of up to 10% of the expenditure as identified by Lord Carter
- Movement from focus on individual organisations to performance of the whole health and care system
- Clear plans to move to new care models, and to reconfigure services where required

The challenge to produce a robust and coherent plan containing real actions and solutions, that all stakeholders within the STP can sign up to, which addresses all of the above, by June 2016 is a substantial challenge and one that will require input from a range of staff at St. George's to help deliver.

6) Summary and recommendations

The trust has submitted its draft annual plan and accompanying financials to Monitor on 8th February. The trust has to deliver its final plan on the 11th April, and this paper details both the areas that need additional focus between now and then, and the associated budget setting process.

The trust needs to develop its Corporate Objectives for next year. Work needs to happen to develop granular actions that will allow the trust to monitor whether the objectives are being met.

The trust is working with partner organisations in the SW London STP and a governance structure is emerging to underpin this work. The vision against which the STPs will be expected to deliver is very challenging and will require innovative and sector wide change. The submission of the annual plan on the 11th April is year one of the STP's. To deliver the full STP plan by June 2016 significant work is required, and this will require input of time, energy and commitment from trust staff.

The Trust Board is asked to note the:

1. Additional actions, and potential risks, associated with completing the final operational plan for 2016/17 for 11th April submission
2. Key dates from the budget setting timetable and the need to resolve how the £50m transformation programme is shown within the overall trust budget for 2016/17
3. Framework for Corporate Objectives for 2016/17.
4. Wide-ranging and significant change anticipated and outlined in the STP guidance, the emerging governance process to oversee the development of the STP, and the likely requirement for senior trust staff to take forward elements of STP work up to and post submission in June.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – JANUARY 2016

Paper Title:	Business Planning and Budget setting 2016/17
Sponsoring Director:	Rob Elek, Director of Strategy
Author:	Tom Ellis, Head of Business Planning
Purpose:	To inform the Trust board of progress of the 2016/17 Business planning round and Corporate Objective development and confirm the next stages for both. To confirm the timeline and actions associated with developing robust budgets for 2016/17 To update the board of the content of recent guidance relating to the required content of Sustainability & Transformation Plans
Action required by the board:	For information
Document previously considered by:	Earlier versions of this paper were presented to EMT on 22nd February and F&P on 1st March

Executive summary

The trust has submitted its draft annual plan and accompanying financials to Monitor on 8th February. The trust has to deliver its final plan on the 11th April, and this paper details both the areas that need additional focus between now and then, and the associated budget setting process.

This paper updates the Trust Board on the following key issues and next steps for each.

1. A summary of significant elements of the submitted draft annual plan and the additional work required for the 11th April submission
2. The associated budget setting process
3. The format and development of the Corporate objectives for 2016/17
4. More detail on the emerging 5 year Sustainability & Transformation Plan for south west London

The Trust Board is asked to note the:

1. Additional actions, and potential risks, associated with completing the final operational plan for 2016/17 for 11th April submission
2. Key dates from the budget setting timetable and the need to resolve how the £50m transformation programme is shown within the overall trust budget for 2016/17
3. Framework for Corporate Objectives for 2016/17.
4. Wide-ranging and significant change anticipated and outlined in the STP guidance, the emerging governance process to oversee the development of the STP, and the likely requirement for senior trust staff to take forward elements of STP work up to and post submission in June.

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 will be identified in the plan and are noted in the paper e.g. around capacity to deliver 18 week activity.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	None – the production of the annual plan and corporate objectives will deliver a refreshed set of corporate objectives for 2016/17
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 initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

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

No, not at this stage. Once they have been completed a decision will be taken in association with appropriate trust leads about whether it is required and if so how it should be progressed.

Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – 3 March 2016 **Paper Ref:**

Paper Title:	**Finance Report for Month 10 2015/16**
Sponsoring Director:	Iain Lynam, Interim Chief Financial Officer
Author:	Anna Anderson, Interim Director of Financial Performance
Purpose:	To inform the Board about the Trust's financial position at the end of January 2016
Action required by the board:	For review and to identify where further action or assurance is required
Document previously considered by:	Finance and Performance Committee

Executive summary

Performance is reported against the revised budget, with a target year end deficit of £56m, agreed by the Board in January. The Trust's aim is to improve outturn beyond this.

The cumulative deficit to the end of January was £48.7m, £0.8m better than plan. The main reason for this positive position is £4.2m of underspending on pay budgets largely because the pace of recruitment, eg to posts covered by business cases and winter capacity increases, has been slower than planned. These underspends have been partially offset by continuing underperformance on SLA income, particularly for outpatients, a low level of elective income in the month, and higher than expected SLA penalties. The reason that performance in the month of January was worse than plan was because of budget adjustments, some of which relate to previous months. These relate savings expected in the 'bridge' from the baseline budgets, issued in November, to the current, improved, plan.

£32.7m of CIPs have been achieved to date. The Trust has savings plans totalling £41.6m for the year and 90% of these are green rated.

The cash balance at the end of January was £22m, £19m more than in the original plan. In addition, use of the working capital facility was £11m lower than expected so overall the cash position was £30m better than plan. This is due to strong cash management and slow down of the capital programme.

The continuing improved cash position and the improved variance in I&E margin are the main factors which have maintained the improvement in the Trust's overall risk rating from a 1 to a 2 for a fifth month.

Capital spend is continuing to be slowed down as part of the overall cash management plan and to date spend has been £25.8m, £18.4m less than the revised plan.

Based on bottom up forecasts by Divisions, the year end outturn is expected to improve to a £54m deficit. This could improve further if additional capital to revenue transfers are agreed and if positive progress is made on discussions about the return/capping of contract fines.

The focus now has to be on maximising the improvement in the Trust's financial position to reduce the year end deficit as much as possible and to further develop budgets and transformation plans for 2016/17

Enclosure:

Key risks identified: The need to balance financial measures with maintaining the quality of patient care. The impact of one off measures this year on 2016/17. The tension between reducing capital spend and addressing urgent needs for capital investment.

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

Equality Impact Assessment (EIA): Has an EIA been carried out? No
No specific groups of patients of communities will be affected by the items in this report. Where there may be an impact on patients consultation will be managed as part of that specific programme.

St George's Healthcare NHS
NHS Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
				15 Oct 2010

1.1 Who is responsible for this service / function / policy?
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

Enclosure:

1.6 If yes, please describe current or planned activities to address the impact.
1.7 Is there any scope for new measures which would promote equality?
1.8 What are your monitoring arrangements for this policy/ service
1.9 Equality Impact Rating [low, medium, high] **2.0. Please give your reasons for this rating**

Summary Finance Report
Month 10 2015/16

Trust Board meeting 3 March 2016

1. Month 10 Headlines & Actions – Income & Expenditure

Area of Review	Metric	Key Highlights	Actions	RAG
Overall financial performance in January	Deficit of £4.4m in the month, £1m worse than reforecast	Performance is £1m worse than plan in the month due to retrospective budget adjustments of £2.5m for pay and non-pay CIPs which are mainly non-recurrent /slippage schemes. Despite these, expenditure budgets broke even overall. Income was again below plan, by £1.3m.	• Assess likely impact of trends to date on the forecast year end position and take action to manage risks and achieve final improvements in the remainder of 2015/16. • Ensure remedial action taken to resolve problems e.g. RTT penalties. • Conclude negotiations with commissioners about penalties, and reinvestment of fines.	
Overall financial performance - year to date and forecast outturn	Year to date deficit of £48.7m against plan of £49.6m i.e. £0.8m better	Month 10 cumulative performance is better than budget primarily because of pay underspends as assumptions about recruitment in the reforecast were, with hindsight, too optimistic. Income continues to be below plan despite a lower reforecast.	Based on year end forecasts prepared by divisions and an assessment of risks, eg additional NHSE contract penalties and the last junior doctors strike this month (and a possible upside from continuing caution about the rate of pay spend) the year end outturn is estimated to be c £54m. It is possible that this will improve further if capital to revenue transfers are increased and contract penalties are capped.	
Activity/Income	Income is £1.9m below plan for the year to date	Actual activity across all areas other than elective and non elective improved this month compared to December. Elective income fell significantly partly due to unplanned theatre closures, changes to theatre schedules and adjustment to marginal rate calculations for neuro rehab Outpatient activity continues to underperform against plan and penalties continue to be high and a risk to the Trust	• Identify ways to minimise the negative impact of theatre changes and closures for unplanned maintenance • Assess scope to ameliorate further commissioner challenges and negotiate reduction of fines • Complete work to address RTT pressures	
Expenditure-Pay	Pay budgets are £4.2m below plan for the year to date (£0.2m worse than plan in month)	Pay spend in month 10 shows an increase in agency spend compared to the earlier parts of the year. This is due to a combination of higher usage and data issues. The £4.2m underspend is mainly in three areas: nursing, non clinical and scientists/ therapists and is due to recruitment difficulty, slippage on implementation of plans to increase capacity and other business cases.	• Continue work to remove agency use in non nursing areas and/or switch to bank or permanent appointments • Continue work to improve accuracy of pay spend reporting • Continue challenging all new appointments through the vacancy panel	
Expenditure-Non Pay	Non pay for the year to date is £1.9m worse than plan (£0.2m better than plan in month)	Month 9 adverse variance reflects £0.8m budget reductions for CIPs. The cumulative position is mainly due: • Drugs overspend due to use of more high cost drugs and greater commercial pharmacy activity (matched by extra income). • Clinical consumables under plan due to lower SLA activity levels	• Continue grip actions to ensure compliance with SFIs in the procurement of goods and services. • Continue Implementing bold non pay proposals	
CIP	£32.7m savings delivered to date against plan of £31.8m	Of the £32.7m delivered to date £17.3m is CIPs and £15.3m is non recurrent or run rate savings. Of the £41.6m total schemes expected to be delivered this year £37.5m, or 90%, are green .	• Continue to work on remaining schemes as well as developing transformation/divisional CIPs for 2016/17	

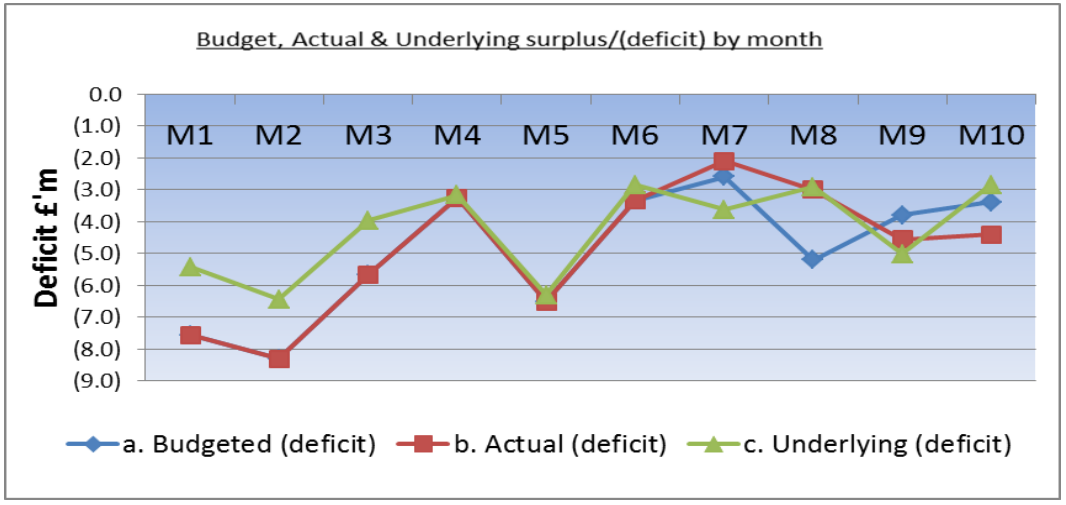
2. Month 10 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights	Actions	RAG
Cash	Cash balance £22m	The month10 cash balance was £22m (£19m higher than original plan). This was after cumulative WCF drawdowns of £36.4m (£11m less than plan) and meant that the overall cash position was £30.2m better than expected. The receipt of all the Q4 monies from Health Education England, combined with lower level of payments to suppliers in January boosted cash to its highest level since April. However it should be noted the cash balance will reduce markedly in February and March as a number of cash actions taken before Christmas will be reversed.	The Trust board approved the loan agreement from the ITFF for the total £48.7m interim support funding on 4th February. The Trust drew down £36.4m on 15th February to repay its two working capital facilities to reduce interest costs. The Trust is continuing to implement savings to reduce the I&E deficit and cash actions to minimise further borrowings.	
Capital	YTD spend £25.8m, £18.8m less than plan	Capital expenditure was £2.1m in January. Year to date expenditure is £25.8m which is £18.4m less than the revised budget – contributing significantly to the favourable cash position reported above.	The Trust is continuing to slow down the rate of capital expenditure where possible to support the cash position and minimise borrowing. The lower forecast outturn for the year has resulted in a reduction in the forecast borrowing requirement for March of £1.6m.	
Working Capital	YTD movement -+£10.3m, £19m better than Plan	Working capital improved by £11.3m (YTD +£10.3m) in month due primarily to the receipt of all Q4 monies in January from Health Education England (HEE) and also a reduction in current NHS debt. Overdue NHS debt remains very high mainly as NHSE has not paid for any over performance on contracts. Stock reduced by approx £0.3m in month 10.	Longer supplier payment terms need to be maintained and reductions in overdue debt need to be achieved to build on the improvements made this year on working capital. NHS England over performance debt remains the highest risk to the year end working capital position. Stock needs to reduce by approx £1.5m in February and March to achieve the year end target.	
FSRR (formally COSRR)	Rating of 2 compared to plan of 1	The Trust's financial sustainability risk rating for month 10 (January) is 2 which is ahead of plan. The rating reflects a better than planned cash balance and deficit position.	With continuing efforts to deliver savings and strong cash management the forecast year end rating for the Trust is 2.	

3. Overall Position for the 10 months to 31st January

Note: YTD variances reflect variances from Oct (M7)

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
SLA Income	614.9	52.4	50.4	(1.9)	507.2	503.5	(3.7)
Other Income	106.4	9.3	9.9	0.7	87.5	89.4	1.9
Overall Income	**721.3**	**61.6**	**60.4**	**(1.3)**	**594.8**	**592.9**	**(1.8)**
Pay	(463.5)	(38.4)	(38.7)	(0.2)	(383.5)	(379.3)	4.2
Non Pay	(279.5)	(23.7)	(23.5)	0.2	(232.2)	(234.1)	(1.9)
Overall Expenditure	**(743.0)**	**(62.1)**	**(62.1)**	**(0.0)**	**(615.7)**	**(613.4)**	**2.3**
EBITDA	(21.7)	(0.5)	(1.8)	(1.3)	(21.0)	(20.5)	0.5
Financing Costs	(34.4)	(2.9)	(2.6)	0.3	(28.6)	(28.2)	0.4
Surplus / (deficit)	**(56.1)**	**(3.4)**	**(4.4)**	**(1.0)**	**(49.6)**	**(48.7)**	**0.8**



Commentary

- Budgets were amended in month 8 to the baseline reforecast £63m deficit budget and reduced in M9 to an annual plan for a deficit of £56.1m reflecting the board's decision in January. £3m of this £7m reduction was reflected in detailed budgets last month and £4m of the balance has been adjusted in detailed budgets this month which includes a small positive balance of £1.5m centrally.

- January deficit reported is £4.4m, a £0.2m improvement on the M9 deficit.
- The in month position is £1m worse than budget due to further retrospective budget adjustments for CIPs, mostly relating to benefits reported last month.

- The cumulative deficit is £48.7m, which is £0.8m better than plan due to pay underspends.

- M10 income although £1m up on last month, is £1.3m worse than plan.

- **SLA income** in January is £1.9m below plan and £3.7m below plan year to date. This is due to higher income challenges/penalties than expected and under performance on outpatient, elective and non elective activity.
- **Pay** was £0.2m above plan this month due to c£1.6m of retrospective pay CIP budget adjustments. Cumulative pay budgets are £4.2m underspent mainly due to slippage on business cases and, slower than expected recruitment . This has contributed to the £3.7m SLA income shortfall.
- **Non pay** overspend to date relates to high cost drugs and commercial pharmacy spend above plan.

- Monthly underlying deficits shown in the graph are updated monthly to reflect any new information. The M10 underlying deficit is £2.9m, which is better than the £4.7m average for the first 6months.

- The improvement in underlying deficit in the second half of the year is mainly due to higher income as the expenditure trend is largely unchanged .

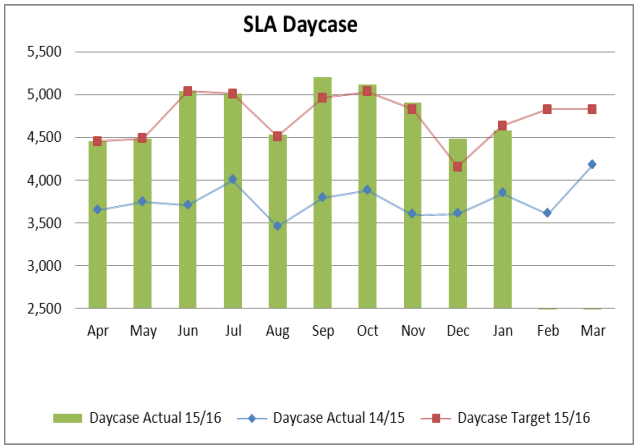
4. SLA Income for the 10 months to 31st January

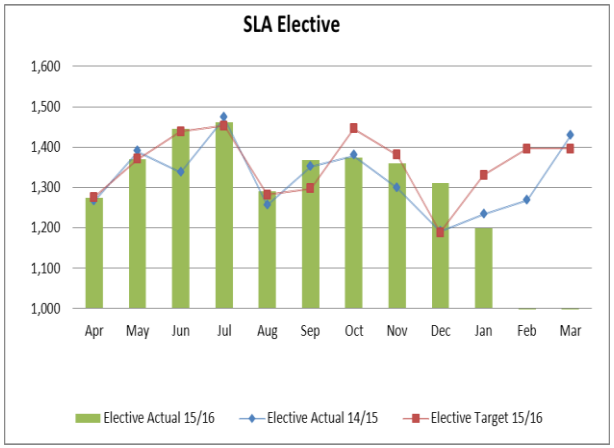
Activity	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
A&E	18.5	1.6	1.5	(0.0)	15.4	15.3	(0.1)
Bed Days	59.0	5.2	4.7	(0.5)	48.4	47.8	(0.6)
Daycase	30.6	2.5	2.7	0.2	25.3	25.6	0.3
Elective	67.1	5.5	4.8	(0.7)	55.6	54.6	(1.0)
Non Elective	121.2	10.4	10.1	(0.3)	101.0	100.1	(0.9)
Outpatients	139.1	11.6	11.0	(0.6)	114.7	113.2	(1.5)
Pass-through drugs & devices income (HCD)	74.6	6.3	6.8	0.5	62.1	63.8	1.7
Community Block	49.7	4.2	4.2	0.0	41.4	41.6	0.2
Fixed Block (HIV)	21.7	1.8	1.8	0.0	18.1	18.2	0.0
Unbundled (Chemotherapy & Diagnostics)	20.8	1.7	1.6	(0.1)	17.3	17.2	(0.1)
In Patient Deliveries	11.1	0.9	0.8	(0.1)	9.2	9.1	(0.1)
Out Patient Regular Attenders	4.2	0.3	0.3	(0.0)	3.5	3.6	0.1
Challenges/Penalties	(10.6)	(0.9)	(1.3)	(0.4)	(7.2)	(8.8)	(1.6)
Other (Ex SLA)	4.4	1.2	1.4	0.1	2.3	2.2	(0.1)
Grand Total	**611.3**	**52.4**	**50.4**	**(1.9)**	**507.2**	**503.5**	**(3.7)**

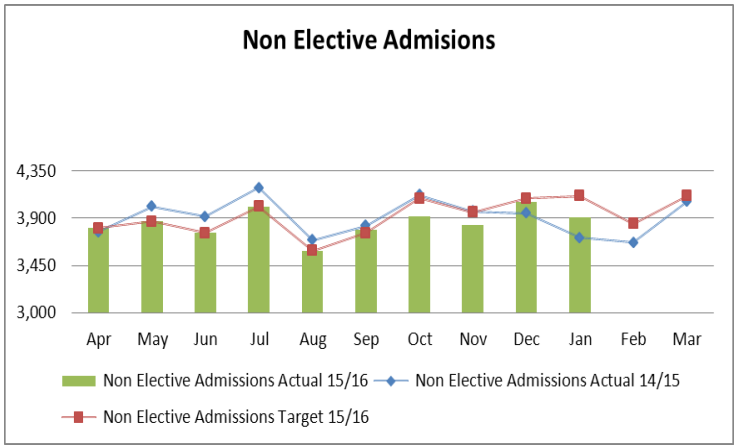
Commentary

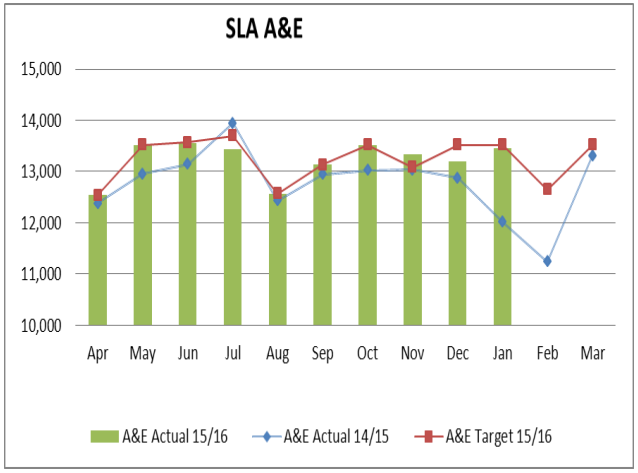
- The January income budget was £2.7m more than in December reflecting a higher number of working days in the month.
- SLA income was £1.9m under plan in the month and £3.7m below plan for the year to date. Penalties account for £1.6m of the shortfall to date, elective activity £1m and outpatient activity £1.5m. In contrast pass through income for drugs and devices is £1.7m higher than expected.
- Admitted elective income has underperformed in the month especially within neuro-rehabilitation (CCG commissioned activity at Queen Mary's), neurosurgery (due to slippage on the gym business case) and cardiac surgery (general underperformance) and outpatients have not performed as expected in the reforecast.
- Activity trends are shown on the next slide

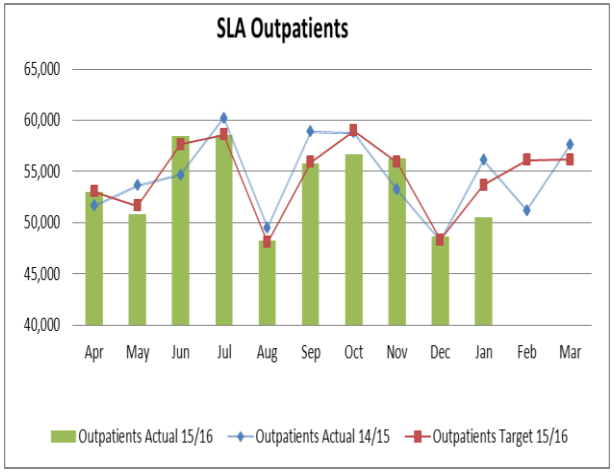
5. Patient activity compared to plan for the 10 months to 31st January











Commentary

- Budgeted activity numbers reflect those in the reforecast plan.
- Actual activity for elective work and non elective admissions has fallen in January compared to December.
- Daycases and A&E attendances are in line with the reforecast plan whilst other areas are below.
- The shortfall in outpatient attendances is mainly within the Surgery division, especially in Neurosciences and T&O partly driven by in year business cases which have had a slower start than intended.
- A & E activity is 3% higher than last year and outpatient attendances are 1% lower than last year.

6. SLA Income by Commissioner for the 10 months to 31st January

Income	Annual Budget (£m)	Year to Date		
		Budget (£m)	Actual (£)	Better/(Worse) than Budget
NHSE Specialist	212,854	175,413	188,285	12,873
NHSE Public Health	23,434	19,527	19,484	(43)
NHSE Secondary Dental Care Services	8,708	7,233	7,154	(79)
NHSE Cancer Drugs Fund	2,882	2,329	3,485	1,156
NHSE SPECIALIST (IFR)	0	0	13	13
Public Health England	422	352	852	501
Subtotal NHSE	**248,299**	**204,853**	**219,273**	**14,420**
NHS Wandsworth CCG	146,926	122,180	123,633	1,453
NHS Merton CCG	58,570	48,709	52,193	3,484
NHS Lambeth CCG	19,964	16,607	17,063	455
NHS Croydon CCG	21,334	17,725	18,971	1,246
NHS Sutton CCG	13,449	11,176	11,307	132
NHS Kingston CCG	12,912	10,736	10,432	(305)
NHS Richmond CCG	11,818	9,827	10,079	252
SURREY CCG	19,892	16,523	16,675	152
Other CCGs	20,871	17,250	15,359	(1,891)
Subtotal CCGs	**325,737**	**270,733**	**275,711**	**4,978**
NCA	8,302	6,902	6,399	(503)
Other Trusts	1,060	877	1,032	154
Other Local Authority	7,976	6,639	7,010	371
Subtotal CCGs	**17,337**	**14,419**	**14,441**	**22**
Internal Targets: Growth, Business Cases etc	14,012	13,438	(9,732)	(23,169)
Ex SLA Income	5,930	3,803	3,829	26
Total NHS Healthcare Income	**611,315**	**507,245**	**503,521**	**(3,723)**
Additional Income				
Private & Overseas Patient	5,459	4,522	5,528	1,006
Road Traffic Accidents (RTAs)	4,182	3,480	3,109	(371)
Other Healthcare Income	237	209	203	(6)
Education and Training Levy Income	44,219	36,894	37,002	107
Other Income	55,903	42,418	43,525	1,107
Total Other Income	**110,000**	**87,523**	**89,366**	**1,844**
Total income	**721,315**	**594,768**	**592,888**	**(1,879)**

Commentary

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

The Trust is over performing significantly on the NHSE and local CCG (Wandsworth, Merton and Croydon) contracts. The NHSE specialist over performance mainly relates to High Cost Drugs.

At the start of the year the Trust set an additional internal target of £26.6m to reflect patient activity that was expected over and above agreed contract values, this was reduced to £14m in the reforecast exercise.

The Trust is below its reforecast total SLA activity targets by £3.7m year to date.

The actual value shown on the internal target line is mainly contract penalties (shown separately for transparency and allocated to CCG upon agreement). All other income is shown by CCG hence the negative variance on this line.

Other income* is the income that is generated by South West London Pathology, pharmacy Income, R & D project income, donated capital income and parking services income.

7. Pay costs for the 10 months to 31st January

1. Pay spend against budget (In month & YTD)

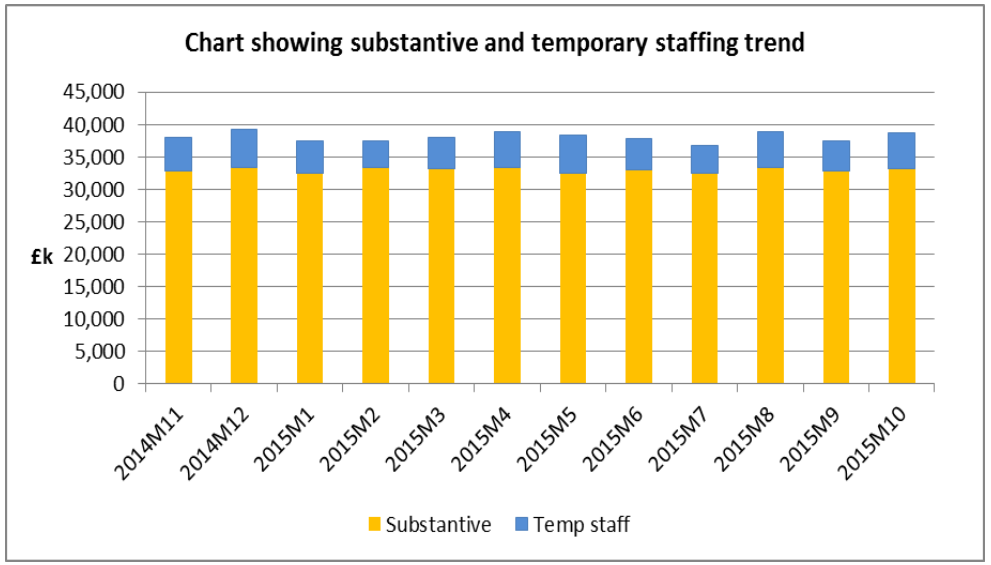
Pay Summary by Staff Type	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Consultants	(72.7)	(6.2)	(6.2)	(0.1)	(60.3)	(60.6)	(0.4)
Junior Doctors	(50.6)	(4.2)	(4.2)	(0.0)	(42.1)	(42.1)	0.0
Non Clinical	(78.1)	(6.4)	(6.2)	0.2	(64.8)	(63.3)	1.5
Nursing	(178.8)	(14.7)	(14.8)	(0.2)	(147.5)	(145.8)	1.7
Scientists, Technicians, Therapists	(82.6)	(6.8)	(7.1)	(0.3)	(68.3)	(67.5)	0.9
Unallocated (Pay Provisions)	(0.8)	(0.1)	0.0	0.1	(0.5)	0.0	0.5
Grand Total	(463.5)	(38.4)	(38.7)	(0.2)	(383.5)	(379.3)	4.2

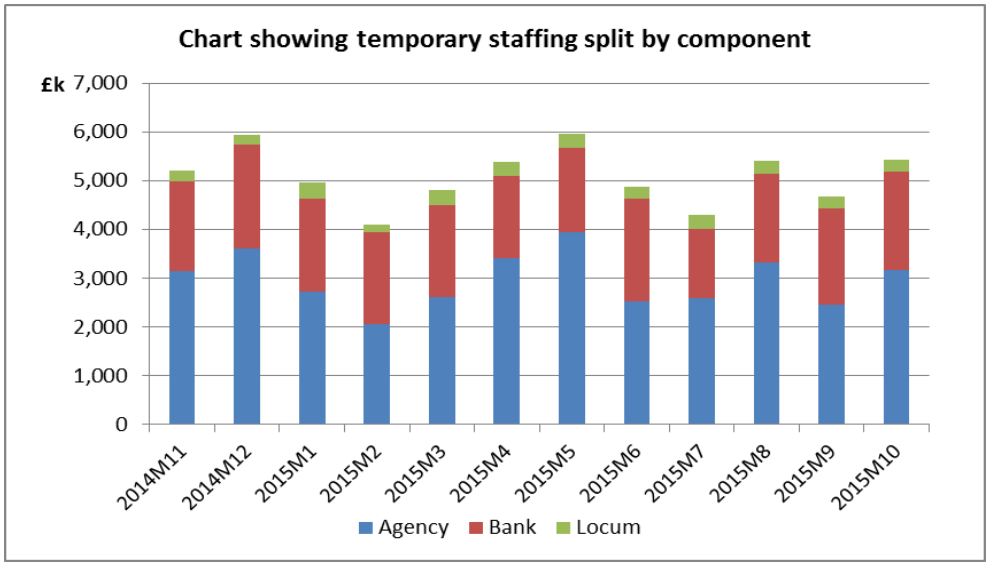
Monthly Pay trend by Staff Type	M1 £m	M2 £m	M3 £m	M4 £m	M5 £m	M6 £m	M7 £m	M8 £m	M9 £m	M10 £m	Total £m
Consultants	(5.8)	(5.8)	(5.9)	(6.4)	(5.9)	(6.2)	(5.9)	(6.3)	(6.2)	(6.2)	(60.6)
Junior Doctors	(4.3)	(4.2)	(4.2)	(4.2)	(4.3)	(4.0)	(4.2)	(4.4)	(4.1)	(4.2)	(42.1)
Non Clinical	(6.1)	(6.0)	(6.1)	(7.5)	(6.6)	(6.3)	(6.0)	(6.5)	(6.0)	(6.2)	(63.3)
Nursing	(14.6)	(14.7)	(15.0)	(14.1)	(14.5)	(14.6)	(14.0)	(14.9)	(14.5)	(14.8)	(145.8)
Scientists, Technicians, Therapists	(6.6)	(6.7)	(6.8)	(6.6)	(7.1)	(6.7)	(6.6)	(6.6)	(6.6)	(7.1)	(67.5)
Other	(0.0)	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	0.0	(0.0)
Grand Total	**(37.4)**	**(37.4)**	**(38.0)**	**(38.8)**	**(38.4)**	**(37.8)**	**(36.7)**	**(38.8)**	**(37.4)**	**(38.7)**	**(379.3)**
Average per qtr :			**(37.6)**			**(38.3)**			**(37.6)**		

Commentary

- Pay this month is £0.2m higher than plan. £1.5m retrospective budget adjustments for pay CIPs have offset continuing underspends but cumulatively pay spend is still £4.2m below plan.
- Nursing budgets are underspent across all clinical divisions as planned extra winter bed capacity has not all been used and there has been slippage on various business cases. There are also cumulative underspends in non clinical and scientific/therapeutic staff for the Children's and Women's division which reflect the fact that planned extra outpatient clinics have not been used, and there are continuing difficulties in recruiting scientific & therapeutic staff.
- Actual pay spend in January was £0.8m (2.1%) more than monthly average spend for the previous 3 quarters. This is due to:
  - Reopening of beds closed over Christmas
  - In December non clinical temporary staff were off for two weeks and have now returned
  - £0.3m increase in scientific/technical pay spend is due to correction of costs previously coded as non-pay (SWLP at Croydon)
  - £0.2k medical agency spend from last financial year (MedCard)

8. Pay trend for the 10 months to 31st January





Commentary

- Pay spend remains significantly below budget due to slippage on various business cases, recruitment difficulties and a mild winter. Partly as a a result, SLA income is under-plan.
- The bank spend proportion remains at 5%.
- The Department of Health caps on nurse agency spend over the next three years came into effect in October. The nursing agency cap for the Trust for Q3 & Q4 is 10% of total nursing spend. The M10 actual nurse agency spend was 10.9% against an internal target of 11% for the month. October to January agency spend is 11% of nursing total pay. The Trust is working on reducing agency spend down to the cap.
- Work is also in progress to avoid breaching other temporary spend controls eg on maximum rates of pay and use of frameworks.
- Improvements to processes to report temporary pay accurately are now having a positive effect on the quality of information available. Any reporting/accounting issues discovered are being addressed to get to the root of problems and prevent them recurring.
- The work of the HR team to ensure the bank is used by all departments to book agency staff is continuing and will improve control and reduce the amount of estimation required each month.

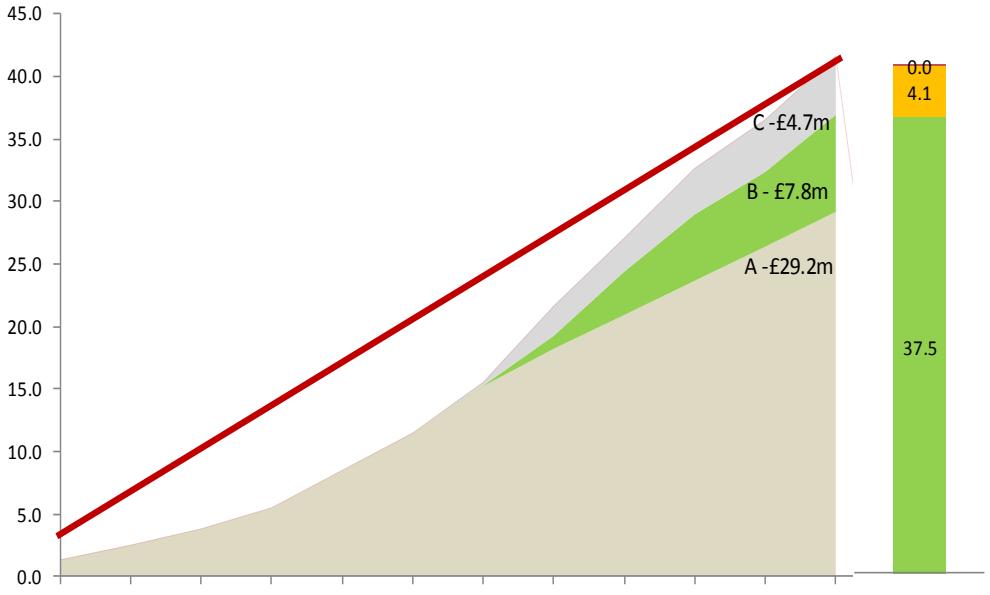
9. Non pay costs for the 10 months to 31st January

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	(98.0)	(8.2)	(7.5)	0.7	(81.1)	(79.1)	2.0
Drugs	(61.3)	(5.2)	(5.2)	0.0	(51.0)	(53.8)	(2.8)
Premises	(43.7)	(3.4)	(3.7)	(0.3)	(35.9)	(36.1)	(0.1)
Clinical Negligence	(15.1)	(1.2)	(1.2)	(0.0)	(12.6)	(12.8)	(0.3)
Establishment	(11.2)	(0.9)	(0.9)	0.0	(9.3)	(9.3)	(0.0)
General Supplies	(14.6)	(1.4)	(1.3)	0.1	(12.3)	(11.9)	0.4
Non Pay Unallocated	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
PFI Unitary payment	(7.0)	(0.6)	(0.6)	(0.0)	(5.8)	(5.8)	(0.0)
Reserves	(0.2)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Prior Year Costs	(1.3)	0.0	0.0	0.0	(1.3)	(1.3)	0.0
Old Year Creditor Adjustments	1.4	0.2	0.0	(0.2)	1.0	0.8	(0.3)
Consultancy	(7.3)	(0.6)	(0.8)	(0.1)	(6.0)	(5.8)	0.1
External Facilities	(7.9)	(0.9)	(0.9)	(0.1)	(6.1)	(5.8)	0.2
Other NHS Facilities	(6.4)	(0.5)	(0.4)	0.1	(5.4)	(4.9)	0.4
Other	(7.2)	(0.9)	(1.0)	(0.1)	(6.3)	(8.0)	(1.6)
Grand Total	**(279.5)**	**(23.7)**	**(23.5)**	**0.2**	**(232.2)**	**(234.1)**	**(1.9)**

Commentary

- M10 non pay spend is £0.2m below plan and includes CIP budget reductions of £1.1m and a £0.4m budget increase for turnaround support and the McKinsey diagnostic work (quoted figures are in month impact). In M10 £0.3m SWLP costs were transferred from non-pay to pay (improved data from partner) and prosthetic costs (Opcare contract) in Community Services were reduced following a full data review.
- Cumulatively, non pay is £1.9m worse than plan due to drug overspends which relate to high cost drugs and commercial pharmacy activity over performance (both are fully offset by additional income). Some of the drugs over spend is mitigated by clinical consumables underspend as a result of slippage against various business cases and winter capacity schemes.
- The adverse variance against 'Other' is due to cross charges for which there is offsetting favourable income (relates to cross charges for SWLP).
- The £23.5m non-pay spend in month is higher than the average for quarters 2 and 3(£23.0m & £23.1m respectively) but in line with plans for the winter months.

10. Trust CIP performance



Total CIP schemes reported to date - £41.6m. Of which -
A - £29.2m forecast against £30.7m embedded in reforecast £63m deficit plan
B - £7.8m new schemes which will improve the reforecast £63m deficit plan
C - £4.7m schemes reported as CIP but are embeddedin the £63m reforecast deficit plan

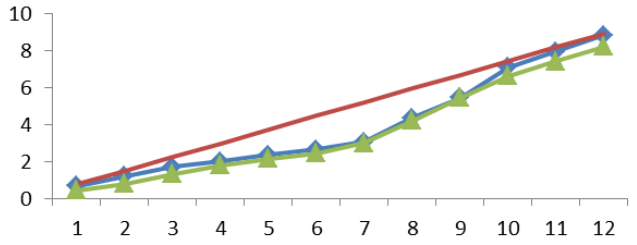
Commentary

- The original CIP target for 2015/16 was £38.1m. The chart alongside shows CIP plans and delivery against the £38.1m target
- In the year to date the Trust has delivered £32.7m of savings compared to a plan of £31.8m. Of the £32.7m delivered so far, £17.3m is CIPs and the balance of £15.3m is non-recurrent run rate/vacancy control savings
- The baseline forecast £63m deficit plan required delivery of £30.7m CIP embedded in the revised plan. The forecast against this is currently at £29.2m as forecasts for a number of schemes have been reduced.
- £7.8m CIP has been added to the forecast and will improve the trust position – this includes SWLEOC (£0.7m) and Mitie contract renegotiation (£2.2m non-recurrent), delays in opening winter capacity and funding from the St George's charity. These new schemes have been removed from the budgets.
- A further £4.7m is reported as CIP but will not impact the forecast plan as these schemes are already embedded in the trust's reforecast plan.
- Of the total £41.6m CIP reported, £37.5m is Green
- Looking to 2016/17 the extra full year effect of 2015/16 schemes is £5.2m however this is more than offset by the loss of 2015/16 non recurring schemes of £17.3m. In addition £7.3m of new CIPs have so far been identified for 2016/17.

11. Trust CIP performance - divisions

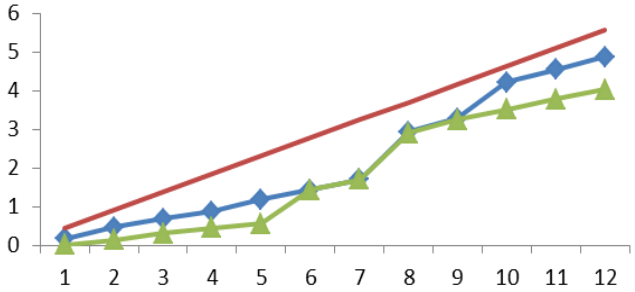
Children and Women

£8.8m schemes have been developed against the £8.9m target so there is a gap of £0.1m. To date £0.4m less than plan has been saved, although this gap is expected to reduce further with run rate schemes. Green schemes are 93.2% of the total identified so far.



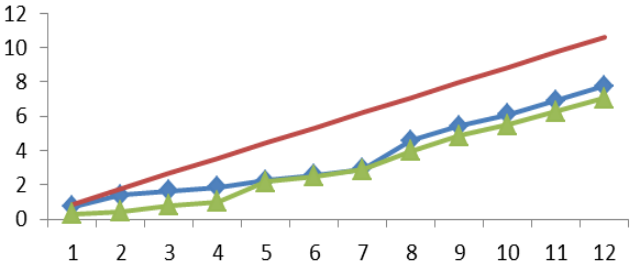
Community Services

£4.9m schemes have been developed against the £5.6m target, the gap is £0.7m and is not expected to be eliminated but is being covered through run rate schemes. Year to date underperformance is £0.4m. Green schemes are 82.7% of the total.



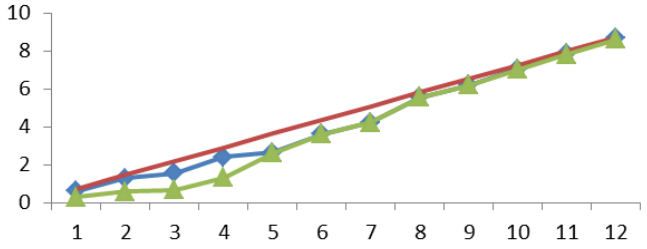
Medicine & Cardiovascular

£7.7m schemes have been developed against the £10.6m target. The gap is £2.9m. Year to date underperformance is £2.7m. Green schemes are 91.2% of the total.



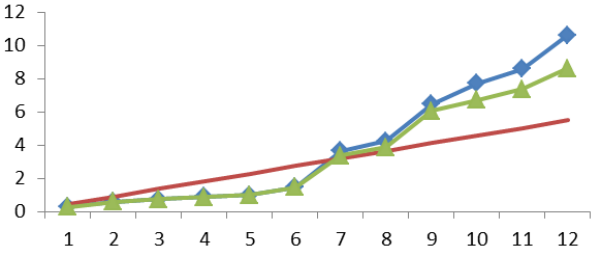
Surgery and Neurosciences

£8.7m schemes have been developed against a £8.7m target. The gap is £45k. Year to date savings are £0.2m below plan. Green schemes are 99.5% of the total. The division expects to close the gap with run rate schemes.



Overheads

£10.6m schemes have been developed against a £5.5m target. In the year to date £3.1m more than plan has been saved. Green schemes are 81.1% of the total. Corporate functions have closed the gap with the schemes submitted recently. Estates & Facilities have closed the gap through run rate savings and renegotiation of the Mitie contract.



Commentary

- Divisional targets are based on the original £38.1m target phased in 1/12s.The 10% CIP provision built into the budget is held centrally.
- Overhead departments' performance has improved significantly.
- The biggest forecast shortfall is £2.9m in Medicine.
- Further work is on-going to firm up on red/amber schemes and to complete governance processes so they can become green.
- Focus is now on the 16/17 programme

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

12. Divisional Summaries for the 10 months to 31st January KEY HEADLINES

Area of Review	Key Highlights
Medicine & Cardiovascular	The division's performance this month £0.4m worse than planned £3.9m contribution however, cumulative contribution of £40.9m is £0.2m better than plan. The adverse in month position is due retrospective budget adjustments for CIPs (mainly pay) and credit notes raised in month for withdrawn prior year RTA income. Year to date favourable position is attributable to less spend than expected on specialling, and more efficient management of rotas through the winter period (emergency department).
Surgery, Neurosciences Theatres & Cancer	The division's contribution of £1.5m in month is £0.3m less than planned contribution. The cumulative contribution is £19.7m which is £0.2m below budget. The adverse position is the result of income underperformance attributable to increase in penalties, the impact of theatre closures on elective work and delays to the Neuro gym business case. Some of the SLA income underperformance is mitigated by associated expenditure under spends, less use of the private sector for general surgery activity and more 'other' income than planned (Gibraltar income & private patient income).
Community Services	The division is £0.7m above its planned year to date contribution of £18.8m. This is due to pay underspends against the reforecast budget as a result of recruitment difficulties in the CAHS service.
Children, Women & Diagnostics	The £8.6m cumulative divisional deficit is £1.3m better than plan and the January deficit is £0.2m worse than plan due to retrospective CIP budget adjustments. This favourable variance to date is due to pay underspends as expected additional outpatient clinics have not been used and recruitment to therapy vacancies has been slower than planned. The lack of uptake of outpatient additional clinics is reflected in outpatient income under performance across the acute clinical divisions.
Overheads	Overhead costs were £0.3m higher than plan in January and £0.3m better than plan for the year to date. The adverse M9 position reflects higher turnaround spend the original 2015/16 plan of £4.6m was increased by £1.1m in December following extension of the contract. Cumulative turnaround spend stands at £5.1m and the forecast for the year is £6.3m. The cumulative overheads underspend is due to Estates & Facilities favourable position from higher recharges for use of premises by Moorfields, and an underspend on domestic & catering services due to lower patient volumes and a mild winter so far.

Medicine & Cardiovascular - Divisional I&E for the 10 months to 31st January

Medicine and Cardiovascular

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
A&E	17.4	1.5	1.5	(0.0)	14.5	14.4	(0.1)
Daycase	11.8	1.0	1.1	0.1	9.7	10.0	0.2
Elective	23.8	1.9	1.7	(0.2)	19.9	19.9	(0.0)
Pass-through drugs/devices/programme	48.2	4.1	4.4	0.3	39.7	41.1	1.4
Non Elective	64.6	5.5	5.6	0.2	54.0	54.3	0.3
Other	17.6	1.5	1.3	(0.2)	14.7	14.2	(0.5)
Outpatients	35.6	2.9	2.6	(0.4)	29.5	29.0	(0.4)
	218.9	18.3	18.2	(0.1)	182.0	182.9	0.9
Other Income	17.8	1.5	1.2	(0.3)	14.8	14.3	(0.5)
Overall Income	**236.7**	**19.8**	**19.4**	**(0.4)**	**196.8**	**197.2**	**0.4**
Pay							
Consultants	(19.7)	(1.7)	(1.8)	(0.1)	(16.3)	(16.5)	(0.1)
Junior Doctors	(18.6)	(1.5)	(1.6)	(0.0)	(15.6)	(15.6)	(0.0)
Non Clinical	(8.7)	(0.7)	(0.7)	0.1	(7.2)	(7.0)	0.2
Nursing	(53.9)	(4.4)	(4.5)	(0.1)	(44.6)	(44.3)	0.3
Scientists, Technicians, Therapists	(5.3)	(0.5)	(0.4)	0.1	(4.4)	(4.1)	0.2
Pay Unallocated	(0.0)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
	(106.3)	(8.9)	(9.0)	(0.1)	(88.1)	(87.5)	0.6
Non-Pay							
Clinical Consumables	(38.6)	(3.2)	(3.3)	(0.1)	(32.2)	(32.5)	(0.3)
Drugs	(31.5)	(2.8)	(2.8)	(0.1)	(26.0)	(26.9)	(0.9)
Establishment	(1.6)	(0.1)	(0.1)	(0.0)	(1.3)	(1.4)	(0.0)
General Supplies	(0.4)	(0.0)	(0.0)	(0.0)	(0.4)	(0.4)	(0.0)
Other	(5.1)	(0.5)	(0.2)	0.3	(4.1)	(3.6)	0.5
Premises	(0.3)	(0.0)	(0.0)	0.0	(0.3)	(0.2)	0.0
	(77.6)	(6.7)	(6.5)	0.2	(64.2)	(65.0)	(0.8)
Overall Expenditure	**(183.9)**	**(15.6)**	**(15.5)**	**0.0**	**(152.3)**	**(152.5)**	**(0.2)**
EBITDA	**52.8**	**4.2**	**3.8**	**(0.4)**	**44.5**	**44.7**	**0.2**
Financing Costs	(4.5)	(0.4)	(0.4)	(0.0)	(3.8)	(3.8)	(0.0)
Surplus / (deficit)	**48.3**	**3.9**	**3.5**	**(0.4)**	**40.8**	**40.9**	**0.2**

Commentary

The year to date contribution at month 10 is £0.2m better than plan.

Income is £0.4m above cumulative plan due to higher than planned income for pass through drugs, which is matched by non-pay (drugs) overspend. Outpatient income is £0.4m adverse in month and to date due to missing diagnostics activity from M8 in Cardiology. This will be corrected in month11 reporting.
Other income is £0.5m adverse to date due to credit notes raised for RTA income this month (relates to prior year claims).

Pay is £0.6m favourable to date. Ward nursing is underspent due to lower than planned specialling. ED are also underspent as a result of more efficient management of rotas through the winter period. In addition, costs forecast for additional Champneys beds are currently within CWDT division.

Non-pay is £0.8m overspent and relates to high cost drugs & devices. Both are both pass through costs and offset by additional income. In addition, there is a cost pressure emerging in Oncology for high cost cancer drugs that are not fully covered by the unbundled tariff.

Actions

- Minimise Cardiac Surgery activity sent to the private sector.
- Extensive input into DIP's ahead of 16/17 to deliver significant efficiencies as part of the work streams.
- Continue flow programme work to minimise extra winter costs.

Forecast The current better than plan performance may be eroded by the following risks:

- Cardiac Surgery (ability to continue on site due to cancellations)
- Vascular surgery (loss of junior doctors)
- ED (winter pressures), Haematology (marginal rates may apply to income), and Oncology (drugs mentioned above).

Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for the 10 months to 31st January

Surgery and Neurosciences

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	5.2	0.5	0.4	(0.1)	4.3	4.2	(0.2)
Daycase	14.2	1.2	1.2	(0.0)	11.7	11.6	(0.1)
Elective	39.1	3.3	2.7	(0.6)	32.2	31.3	(0.9)
Pass-through drugs/devices/programme	11.5	0.9	1.0	0.0	9.8	10.2	0.4
Non Elective	49.5	4.3	3.9	(0.4)	41.1	40.1	(1.0)
Other	1.8	0.3	0.0	(0.3)	1.6	0.6	(0.9)
Outpatients	32.5	2.8	2.6	(0.2)	26.7	26.2	(0.5)
	153.8	13.2	11.8	(1.5)	127.4	124.2	(3.2)
Other Income	16.0	1.3	1.7	0.4	13.3	14.0	0.7
Overall Income	**169.8**	**14.6**	**13.5**	**(1.1)**	**140.7**	**138.3**	**(2.5)**
Pay							
Consultants	(26.8)	(2.3)	(2.2)	0.1	(22.1)	(22.0)	0.1
Junior Doctors	(15.4)	(1.3)	(1.3)	(0.0)	(12.9)	(13.1)	(0.2)
Non Clinical	(9.3)	(0.8)	(0.7)	0.0	(7.8)	(7.7)	0.0
Nursing	(43.7)	(3.7)	(3.6)	0.1	(35.9)	(35.2)	0.7
Scientists, Technicians, Therapists	(11.0)	(1.0)	(0.9)	0.1	(9.1)	(8.9)	0.2
	(106.2)	(9.1)	(8.8)	0.3	(87.8)	(86.9)	0.9
Non-Pay							
Clinical Consumables	(22.0)	(1.9)	(1.6)	0.3	(18.1)	(17.1)	1.0
Clinical Negligence	(0.0)	(0.0)	0.0	0.0	(0.0)	(0.0)	0.0
Drugs	(9.0)	(0.7)	(0.7)	0.0	(7.5)	(7.7)	(0.2)
Establishment	(0.4)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	(0.0)
General Supplies	(0.3)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Other	(3.9)	(0.4)	(0.3)	0.1	(3.0)	(2.5)	0.5
Premises	(0.8)	(0.1)	(0.1)	0.0	(0.5)	(0.5)	0.0
	(36.5)	(3.3)	(2.8)	0.5	(29.8)	(28.5)	1.4
Overall Expenditure	**(142.7)**	**(12.4)**	**(11.6)**	**0.8**	**(117.6)**	**(115.3)**	**2.3**
EBITDA	**27.1**	**2.1**	**1.9**	**(0.3)**	**23.1**	**23.0**	**(0.2)**
Financing Costs	(4.0)	(0.3)	(0.3)	(0.0)	(3.3)	(3.3)	(0.0)
Surplus / (deficit)	**23.2**	**1.8**	**1.5**	**(0.3)**	**19.8**	**19.7**	**(0.2)**

Commentary

The division has delivered a net contribution of £19.7m year to date which is £0.2m adverse compared to plan for 15/16.

Income - Elective income is significantly lower than plan year to date largely due to theatre closures and delays to implementation of the Neuro Gym business case. Outpatient income is underperforming within T&O due to a delay in the approval of the consultant business case and overstated Neurology income target in the reforecast. Other SLA income is significantly adverse due to an increase in the value of challenges and fines. Other income is better than plan as Gibraltar income is now reflected in the position and private patient invoicing has caught up in Month 10.

Pay - £0.9m cumulative pay underspend reflects nursing and theatre technician vacancies due to theatre downtime and bed closures in December. Winter pressure costs have so far been lower than expected.

Non-Pay - £1.4m better than budgeted and relates to lower clinical consumables mainly in Neurosurgery, due to lower activity than planned and within T&O due to non pay controls and greater clinical engagement. There has been less reliance on spend in the private sector for General Surgery and T&O use of the Clavadel private unit.

Actions to Improve Position

- Implement bold schemes in full
- Ensure all high cost activity is correctly recorded in SLAM
- Review contract challenges and validate the PTL to minimise penalties

Forecast - The division is forecasting a contribution of £22.7m which is £0.4m adverse to plan. This is due to delay of the Neuro Gym business case and unplanned theatre downtime.

Community Services - Divisional I&E for the 10 months to 31st January

Community Services

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
A&E	1.2	0.1	0.1	(0.0)	1.0	0.9	(0.0)
Bed Days	5.6	0.5	0.5	(0.0)	4.6	4.5	(0.2)
Exclusions	8.6	0.7	0.8	0.1	7.4	7.3	(0.1)
Other	59.3	4.9	4.9	0.0	49.3	49.2	(0.1)
Outpatients	24.2	2.0	2.0	(0.0)	20.0	20.2	0.2
	98.8	8.2	8.2	0.0	82.3	82.1	(0.2)
Other Income	1.9	0.2	0.2	0.0	1.6	1.7	0.1
Overall Income	**100.7**	**8.4**	**8.4**	**0.1**	**83.9**	**83.9**	**(0.0)**
Pay							
Consultants	(2.4)	(0.2)	(0.2)	(0.1)	(1.9)	(2.0)	(0.0)
Junior Doctors	(2.7)	(0.2)	(0.2)	0.0	(2.2)	(2.0)	0.2
Non Clinical	(7.6)	(0.6)	(0.6)	0.1	(6.3)	(6.1)	0.2
Nursing	(24.1)	(1.6)	(1.9)	(0.3)	(19.7)	(19.5)	0.2
Scientists, Technicians, Therapists	(10.1)	(0.8)	(0.8)	0.0	(8.4)	(8.2)	0.2
	(46.8)	(3.5)	(3.7)	(0.2)	(38.5)	(37.7)	0.7
Non-Pay							
Clinical Consumables	(9.4)	(0.8)	(0.9)	(0.1)	(7.8)	(8.1)	(0.3)
Clinical Negligence	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Drugs	(11.8)	(1.0)	(0.6)	0.4	(9.9)	(9.8)	0.1
Establishment	(1.2)	(0.1)	(0.1)	0.0	(1.0)	(0.9)	0.0
General Supplies	(0.1)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Other	(8.6)	(0.6)	(0.8)	(0.2)	(7.1)	(7.0)	0.1
Premises	(0.7)	0.1	(0.1)	(0.2)	(0.6)	(0.6)	(0.0)
	(31.9)	(2.5)	(2.6)	(0.1)	(26.4)	(26.5)	(0.0)
Overall Expenditure	**(78.7)**	**(6.0)**	**(6.3)**	**(0.3)**	**(64.9)**	**(64.2)**	**0.7**
EBITDA	**21.9**	**2.4**	**2.2**	**(0.2)**	**19.0**	**19.7**	**0.7**
Financing Costs	(0.2)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.0)
Surplus / (deficit)	**21.7**	**2.4**	**2.1**	**(0.3)**	**18.8**	**19.5**	**0.7**

Commentary

The division has a £19.5m surplus to date which is £0.7m better than the reforecast plan. This month the budget was reduced by £0.9m in relation to the Nightingale slippage (£0.6m) and pay CIPs (£0.3m).

Income – Overall the income position is break-even with small underperformance in SLA income, due to additional penalties, are off-set by favourable other income.

Pay – Although budget was reduced by £0.7m in the month, the January position only shows an overspend of £0.2m due to continued recruitment challenges in the CAHS services and vacancies in a number of Community services.

Non-pay – Non-pay spend in January was under budget, mainly due to volume related decrease in GU drugs spend in the month (£0.4m) off-set by budget reductions (£0.2m) and Bed-watch costs.

Actions

- Continue to monitor and deliver recovery plans for Outpatients & Diagnostics, Rehabilitation & Therapies, GU Medicine.
- Continue monitoring the GU Medicine drugs expenditure reporting and forecasting.

Forecast

The overall forecast of a £22.7m surplus includes additional costs relating to the opening of the Nightingale unit and recruitment to a number of vacancies.

Children, Women, Diagnostics & Therapies - Divisional I&E for the 10 months to 31st January

C&W, Diagnostics, Therapies

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
Bed Days	48.2	4.2	3.9	(0.4)	39.4	39.2	(0.2)
Daycase	4.6	0.4	0.4	0.1	3.9	4.1	0.2
Elective	4.2	0.3	0.4	0.1	3.5	3.4	(0.1)
Pass-through drugs/devices/programme	2.3	0.2	0.2	0.0	1.9	1.9	(0.0)
Non Elective	8.4	0.7	0.7	0.0	7.1	7.2	0.1
Other	25.7	2.1	2.2	0.1	21.5	21.8	0.3
Outpatients	38.4	3.2	3.2	0.0	31.6	31.0	(0.5)
	131.8	11.1	11.0	(0.1)	108.9	108.7	(0.2)
Other Income	21.8	1.9	2.2	0.3	17.7	19.6	1.9
Overall Income	**153.6**	**13.0**	**13.2**	**0.2**	**126.6**	**128.3**	**1.7**
Pay							
Consultants	(16.9)	(1.4)	(1.4)	(0.0)	(14.1)	(14.4)	(0.3)
Junior Doctors	(12.9)	(1.1)	(1.1)	(0.0)	(10.7)	(10.7)	0.0
Non Clinical	(14.2)	(1.2)	(1.1)	0.1	(11.8)	(11.3)	0.6
Nursing	(52.2)	(4.5)	(4.4)	0.1	(43.3)	(43.0)	0.3
Scientists, Technicians, Therapists	(34.9)	(2.8)	(2.9)	(0.1)	(28.6)	(28.0)	0.5
	(131.1)	(10.9)	(10.9)	0.0	(108.5)	(107.4)	1.1
Non-Pay							
Clinical Consumables	(13.4)	(1.1)	(0.9)	0.2	(10.9)	(10.5)	0.4
Drugs	(8.8)	(0.7)	(1.0)	(0.3)	(7.4)	(9.3)	(1.8)
Establishment	(0.7)	(0.1)	(0.1)	0.0	(0.6)	(0.5)	0.1
General Supplies	(0.5)	(0.1)	(0.0)	0.0	(0.4)	(0.4)	0.1
Other	(2.5)	(0.2)	(0.5)	(0.3)	(2.1)	(2.4)	(0.3)
Premises	(1.5)	(0.0)	(0.1)	(0.1)	(1.2)	(1.0)	0.2
	(27.5)	(2.1)	(2.6)	(0.5)	(22.6)	(24.1)	(1.5)
Overall Expenditure	**(158.6)**	**(13.1)**	**(13.5)**	**(0.4)**	**(131.1)**	**(131.5)**	**(0.4)**
EBITDA	**(5.0)**	**(0.1)**	**(0.3)**	**(0.3)**	**(4.5)**	**(3.2)**	**1.3**
Financing Costs	(6.5)	(0.6)	(0.5)	0.0	(5.4)	(5.4)	0.0
Surplus / (deficit)	**(11.6)**	**(0.6)**	**(0.9)**	**(0.2)**	**(9.9)**	**(8.6)**	**1.3**

Commentary

The division has a cumulative deficit of £8.6m which is £1.3m better than the reforecast. The budgets were reduced by £0.9m to close the CIP gap for the Division which has reduced the variance compared to month 9

Income – Current month variances have improved other than bed days which is mainly due to the correction of income overstated in month 9 for neonatal intensive care unit. Outpatient underperformance to date is due to an error in TRP relating to antenatal income. Breast Screening is also under plan.
Other income over performance of £1.9m reflects the success of pharmacy commercial operations (associated increase in drug spend is £1.8m).

Pay spend is £1.1m better than the year to date plan. Outpatient budget underspends have contributed to the non clinical and nursing variances reported as additional planned capacity has not been used by specialties. The underspend on the scientist line largely reflects the slower than expected pace of recruitment for therapists.

Non pay – The drugs overspend of £1.8m relates to pharmacy commercial operations referred to above.

Actions / Risks

- The delayed development in critical care beds will lead to an underperformance in bed days for the last two months of 2015/16.
- The outpatients service will continue to underspend due to the under utilisation of capacity.
- Pharmacy Lab outstanding repairs are a risk to income

Forecast Position

The division expects to end the year £1.6m better than budget.

Overheads - Divisional I&E for the 10 months to 31st January

Overheads

Income & Expenditure	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Corporate Directorates							
Chief Executive & Governance	(22.4)	(1.9)	(2.1)	(0.3)	(18.6)	(19.0)	(0.3)
Executive Director of Nursing	(4.9)	(0.3)	(0.3)	0.0	(4.2)	(3.9)	0.2
Finance, Performance & IT	(26.2)	(2.2)	(2.3)	(0.0)	(21.7)	(21.9)	(0.2)
Human Resources Directorate	(4.8)	(0.4)	(0.5)	(0.1)	(3.9)	(3.9)	(0.1)
Ops & Service Improvement	(1.6)	(0.2)	(0.1)	0.0	(1.2)	(1.1)	0.1
Pathology - STG	(12.1)	(0.9)	(1.0)	(0.1)	(10.2)	(10.1)	0.1
Strategy	(1.5)	(0.1)	(0.0)	0.1	(1.2)	(1.2)	(0.0)
Total Corporate	(73.3)	(6.0)	(6.4)	(0.3)	(60.9)	(61.2)	(0.2)
Estates & Facilities							
Energy & Engineering	(11.0)	(0.8)	(0.9)	(0.1)	(9.1)	(9.1)	(0.0)
Estates	(11.7)	(1.1)	(1.1)	0.1	(9.9)	(9.7)	0.2
Estates Community Premises	(16.4)	(1.2)	(1.2)	(0.0)	(13.5)	(13.6)	(0.0)
Facilities Services	(4.7)	(0.4)	(0.3)	0.0	(4.0)	(3.9)	0.1
Hotel Services	(11.6)	(1.2)	(1.1)	0.1	(9.8)	(9.5)	0.3
Medical Physics	(2.2)	(0.2)	(0.3)	(0.1)	(1.8)	(1.8)	0.0
Project Management	(0.4)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Rates	(2.0)	(0.1)	(0.1)	(0.0)	(1.7)	(1.7)	(0.0)
Total Estates & Facilities	(60.2)	(5.1)	(5.0)	0.0	(50.2)	(49.6)	0.6
Total Overheads	**(133.5)**	**(11.1)**	**(11.4)**	**(0.3)**	**(111.1)**	**(110.8)**	**0.3**

Overheads Summary

Corporate Services spend to date is £0.2m worse than plan while Estates & Facilities is £0.6m better.

Corporate

Chief Executive – over spend due to higher costs for turnaround and recruitment fees not in the reforecast.

Executive Director Nursing - break-even in month, year to date underspend is mainly due to the lower costs for the Productive Ward which is not expected to be fully running in 15/16.

Finance, Performance & IT – The cumulative overspend relates to higher than expected costs of staff embedded in divisions working on the reforecast. IT showed an underspend in month while Procurement expenditure increased through agency catch up.

Strategy: Better than plan in month due to expenditure transfer to capital for PPU costs.

Estates & Facilities

The budget broke even in month 10 despite a £0.1m loss on sale of a CHP boiler.

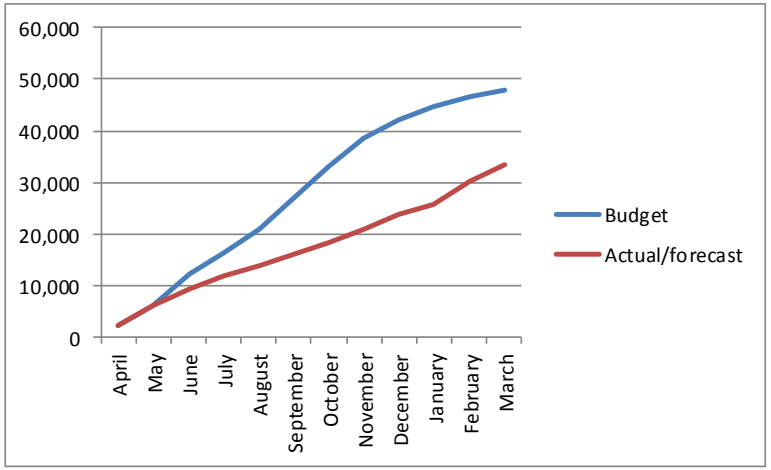
Risks

- Estates backlog maintenance jobs continue to increase
- Energy income from the Medical School being accrued as invoices not raised since July.

13. Capital

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

Actual/forecast cumulative capital expenditure 2015/16 at M10



Summary cap exp by spend category	New Budget £000	YTD Budget £000	YTD Actual £000	YTD Var £000	F'cast Outturn £000	F'cast U/spend £000
Infrastructure renewal	9,680	7,501	3,611	3,890	4,069	5,611
Medical equipment	12,412	12,027	6,830	5,197	9,857	2,555
IMT	6,526	6,526	4,306	2,220	5,415	1,111
Major Projects	18,137	17,467	10,316	7,151	13,233	4,904
Other	772	657	608	49	723	49
SWL Path	500	437	99	338	139	361
Total	48,027	44,615	25,770	18,845	33,436	14,590

- Capital expenditure in January was £2.1m and year to date expenditure is £25.8m, £18.8m less than budget.
- The Trust is deliberately slowing down capital expenditure where appropriate to support the cash position. The forecast outturn under spend is approximately £14.6m (M09 £12.6m) and therefore it is expected that there will be an increase in monthly spend in the last 2 months of the year – particularly in medical equipment (replacement of AMW 1.5t MRI scanner and hybrid theatre equipment) and major projects (SAU, hybrid theatre works and AMW bed schemes).
- The under spend on the capital programme has enabled the Trust to agree with Monitor and DH a capital to revenue transfer which will reduce the reported I&E deficit by £4.6m in February.
- The cash benefit of this forecast outturn underspend is estimated at £13m (excluding leases).

14. Cash balance and WCF drawdowns vs plan

Cash balance

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast
	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000	30-Sep £000	31-Oct £000	30-Nov £000	31-Dec £000	31-Jan £000	*29-Feb £000*	*31-Mar £000*
2015/16 Plan cash (May 2015)	n/a	14,200	6,187	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Actual/forecast cash	24,179	14,188	7,925	7,265	6,175	6,097	8,258	12,846	9,252	15,236	22,036	*8,040*	*3,000*
Cash bal fav / (adv) variance to plan	0	-12	1,738	4,265	3,175	3,097	5,258	9,846	6,252	12,236	19,036	*5,040*	*0*

Working Capital Facility - drawdowns within cash balance above

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast
	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000	30-Sep £000	31-Oct £000	30-Nov £000	31-Dec £000	31-Jan £000	*29-Feb £000*	*31-Mar £000*
Plan drawdown (May 2015)	0	0	0	2,138	6,991	14,625	24,483	29,807	34,900	42,544	47,618	*49,892*	*52,185*
Actual drawdown - in-month						7,909	9,420	1,256	0	10,140	0	*0*	*8,164*
Actual drawdown - cumulative	0	0	0	0	7,671	15,580	25,000	26,256	26,256	36,396	36,396	*36,396*	*44,560*
WCF cum drawdowns fav / (adv) variance to plan	0	0	0	2,138	-680	-955	-517	3,551	8,644	6,148	11,222	*13,496*	*7,625*

Overall Cash fav / (adv) variance to plan	0	-12	1,738	6,403	2,495	2,142	4,741	13,397	14,896	18,384	30,258	*18,536*	*7,625*

- The **cash balance** table above compares the actual cash balance and WCF drawdowns with the May plan.
- The M10 actual cash balance was £22m which is £19m ahead of plan. Cumulative WCF/ISF drawdowns to 31st January are £36.4m which is £11.2m lower than plan.
- LEEF loan impact: The cash balance includes £11.6m unexpended LEEF loan for the energy performance contract and so the cash balance excluding LEEF would be: +£10.4m.
- The forecast cash balances for February and March are £8m and £3m respectively. The reversal of cash management actions taken before Christmas will reduce the cash balance markedly – most significantly the payment of deferred £4.2m CNST instalments, £10.5 rental charges to NHS Property Services and the £3.5m dividend payment.
- The forecast year end cash balance includes a forecast drawdown of £8.2m in March (M09 forecast £9.8m) from the recently approved interim revenue support facility. This forecast drawdown is £1.6m lower than forecast last month due to a reduction in the forecast outturn capital expenditure total.

15. Analysis of cash movement YTD and year end forecast

Cash movement: M10 YTD and forecast outturn vs Plan

	Plan M10 YTD £m	Actual M10 YTD £m	Actual M10 YTD VAR £m	*Plan M12 YTD £m*	*Forecast M12 YTD £m*	*Forecast M12 YTD VAR £m*
Opening cash 01.04.15	24.2	24.2		*24.2*	*24.2*	
Operating surplus/-deficit	-19.4	-27.4	**-8.0**	*-21.6*	*-32.1*	***-10.5***
Sale proceeds - asset disposals	0.0	0.0	**0.0**	*2.5*	*0.2*	***-2.4***
WCF/ISF borrowing	47.6	36.4	**-11.2**	*52.2*	*44.6*	***-7.6***
			-19.2			***-20.5***
Net change in working capital	-8.7	10.4	**19.1**	*-7.4*	*-0.5*	***6.9***
Capital spend (excl leases)	-40.8	-22.4	**18.4**	*-45.6*	*-28.0*	***17.6***
Other	0.1	0.8	**0.8**	*-1.3*	*-5.3*	***-4.0***
Sub-total			**38.2**			***20.4***
Closing cash 31st Jan	3.0	22.0	**19.0**	*3.0*	*3.0*	***0.0***

- The cash movement table above compares the month 10 cumulative and forecast outturn cash movement with the original plan
- At M10 the Trust has more than offset the adverse cash impact of £19.2m relating to the higher operating deficit and lower WCF/ISF borrowing with the positive movement in working capital and the capital under spend.
- The year end forecast includes a marked reduction in the working capital benefit (£10.4m movement reduces to -£0.5m) as a number of cash actions taken earlier in the year reverse. However the forecast outturn working capital movement would still be £6.9m better than plan.
- The forecast indicates the Trust will need to draw down £8.2m borrowing in March bringing total WCF/ISF borrowing for the year to £44.6m which would be £7.6m lower than plan.

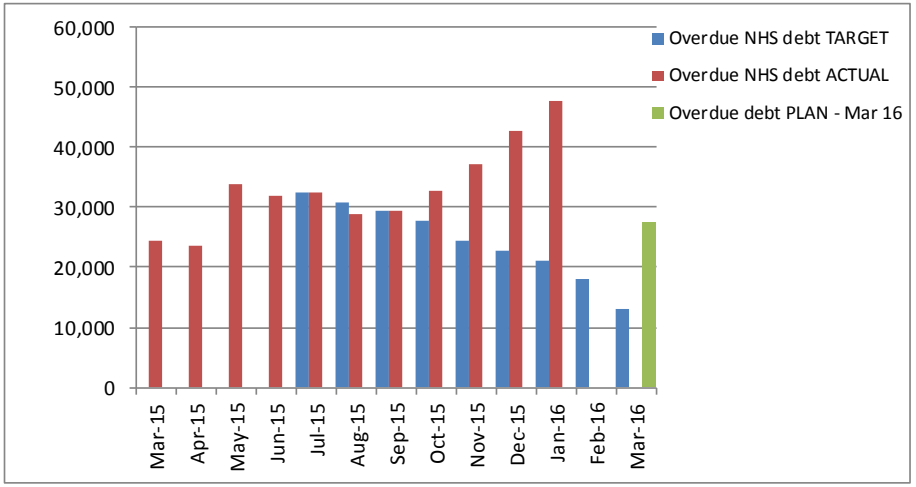
16. Debt management

- The Cash Committee approved 'stretch' debt reduction targets for 2015/16 and the baseline is the level of overdue debt (over 30 days old) as at M04.
- Current debt reduced - by £6.8m in January however overdue debt remains significantly behind target. The increase relates primarily to NHSE, CCG over performance, GP Leo hosting services, fetal medicine unit/maternity pathway and local authority GUM debt. The Trust is pursuing a 'hit list' of key overdue debts with CCGs and NHS Trusts and received £1.5m from NHSE on 15th Feb in respect of overdue debt. It should be noted the overdue debt targets below are 'stretch' targets and on the grounds of prudence the year end cash forecast does not assume they are met.
- Also the Trust continues to press NHS England for an agreement for a payment on account arrangement for in-year over performance similar to the arrangement already in place with SWL CCGs.

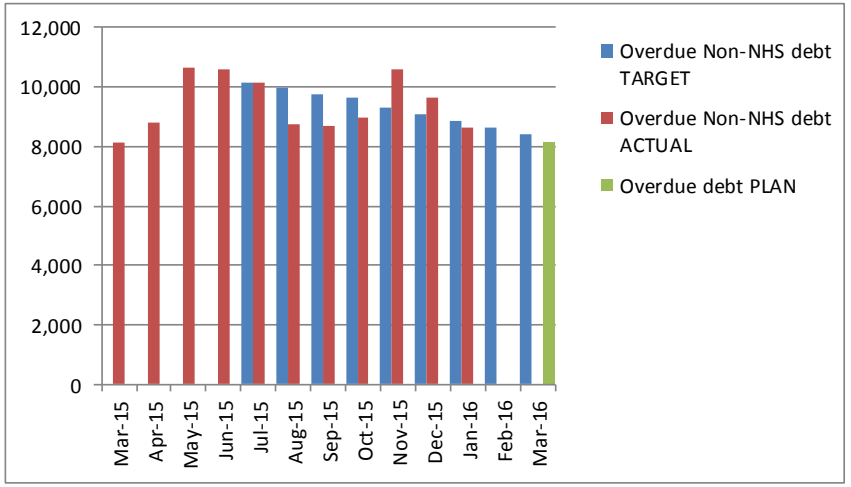
Debtor days	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
NHS income debtor days	18.5	18.8	19.5	19.4	19.4	20.1	21.6	22.1	30.7	29.1	26.9
Non-NHS income debtor days	204.9	202.0	219.3	229.0	205.1	199.2	198.4	190.9	256.1	204.9	205.3
DWP/CRU debt	981.1	986.8	1,000.1	1,029.1	1,077.7	1,019.2	1,038.3	1,080.3	1,083.9	1,072.1	1,211.6
Overseas patient income	807	789	769	753	761	740	677	793	810	778	690

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

Overdue NHS debt: performance vs stretch reduction targets



Overdue non-NHS debt: performance vs stretch reduction targets



17. Balance sheet as at month 10 2015/16

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department
Balance sheet January 2016

	Jan-16 Plan £000	Jan-16 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	360,949	337,110	*23,839*	Much lower capital expenditure than plan - so lower fixed assets
Stock	6,548	8,055	*-1,507*	Stock action group formed to progress safe reductions in levels. Reduction of £0.3m in Jan.
Debtors	81,233	72,145	*9,088*	Current debt reduced again in M10 but overdue debt higher than target.
Cash	3,000	22,035	*-19,036*	Lower capex, and better working capital performance has enabled Trust to finance higher deficit and borow less than planned. Cash is £19m better than Plan.
	0	0		
Creditors	-83,802	-95,316	*11,514*	Longer supplier payment terms since July. Also CNST & NHSPS liabilities deferred till Q4.
Capital creditors	-3,476	-2,463	*-1,013*	
PDC div creditor	-2,360	-2,234	*-126*	
Int payable creditor	-289	-447	*158*	
	0	0		
Provisions< 1 year	-602	-512	*-90*	
Borrowings< 1 year	-55,388	-6,206	*-49,182*	(NB: WCF is classified as non-current liability c/f Plan)
Net current assets/-liabilities	**-55,137**	**-4,942**	*-50,194*	
Provisions> 1 year	-1,181	-1,110	*-71*	
Borrowings> 1 year	-93,794	-126,830	*33,036*	(NB: WCF is classified as non-current liability c/f Plan)
Long-term liabilities	**-94,975**	**-127,940**	*32,965*	
Net assets	**210,838**	**204,228**		
Taxpayer's equity				
Public Dividend Capital	133,761	133,761	*0*	
Retained Earnings	-25,433	-30,630	*5,197*	YTD I&E deficit worse than plan
Revaluation Reserve	101,360	99,947	*1,413*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**210,838**	**204,228**		

18. Borrowings analysis at M10

Borrowings summary - January 2016

	Lender	Description	Interest rate fixed/variable	Interest rate pa	Term	Repayment terms	Maximum Facility value £000	Borrowings repay<1 yr at 31/01/16 £000	Borrowings repay>1 yr at 31/01/16 £000	Borrowings at 31/01/16 £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	-13,502	-14,501
3	Dept of Health	Working cap facility	Variable: base rate+1%	1.50%	5 yrs	100% repayable on 18/04/20	-25,000	0	-25,000	-25,000
4	Dept of Health	Working cap facility	Variable: base rate+3%	3.50%	5 yrs	100% repayable on 21/09/20	-19,600	0	-11,396	-11,396
5	Dept of Health	Interim revenue support facility	Variable: base rate+1%	1.50%	2 years	100% repayable March 2018	-48,700	0	0	0
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	-74,834	-77,912
	Leases									
7	Blackshaw Health. Servs PL	PFI scheme	Implicit rate	7.50%	35 yrs	Repaid monthly in unitary charge	N/A	-918	-44,813	-45,731
8	Various lessors	Finance leases	Implicit rates	3%-7.5%	Various	Repaid quarterly or annually	N/A	-2,210	-7,183	-9,393
	Leases - total							-3,128	-51,996	-55,124
	Total Borrowings							-6,206	-126,830	-133,036

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 will be repaid in full on 15th February 2016 when the drawdown is made from the recently approved interim revenue support facility (see no. 5)

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 for 2015/16.
This facility will also be repaid in full on 15th February 2016 when the drawdown is made from the recently approved interim revenue support facility (see no. 5)

5 Interim revenue support facility £48.7m approved in February 2016.
The Trust will draw down £36.396m from this facility on 15th February 2016 and repay 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.

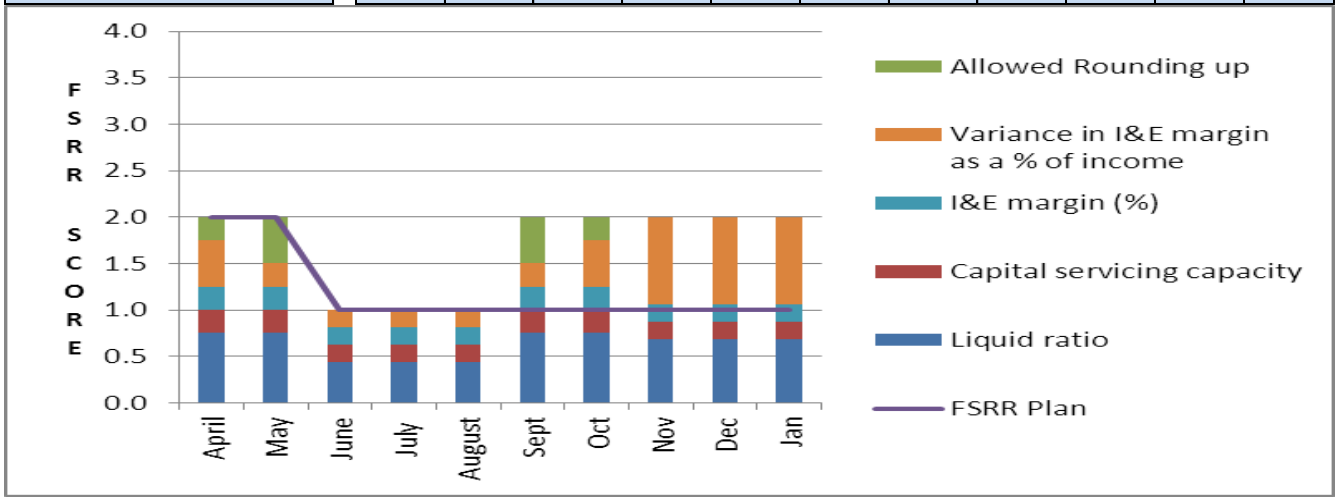
6 London Energy efficiency Fund loan for the energy performance contract.

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.

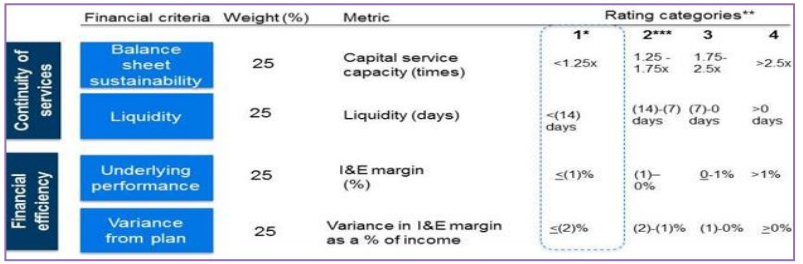
8 Finance leases for medical equipment - eg major diagnostic equipment. The capital value of new finance leases represents capital investment and is reported as such in the capital programme.

19. Financial Sustainability Risk Rating (FSRR)

2015/16 ACTUALS	Month										
Metric Scores (4 best, 1 worst)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Out-turn
Liquid ratio	3	3	2	2	2	3	3	3	3	3	2
Capital servicing capacity	1	1	1	1	1	1	1	1	1	1	1
I&E margin (%)	1	1	1	1	1	1	1	1	1	1	1
Variance in I&E margin (%)	2	1	1	1	1	1	2	4	4	4	4
Weighted Average	1.8	1.5	1.3	1.3	1.3	1.5	1.8	2.3	2.3	2.3	2.0
Overriding Score (with rounding)	2	2	1	1	1	2	2	2	2	2	2
2015/16 PLAN	2	2	1	1	1	1	1	1	1	1	1



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%

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

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

Last month's stronger cash position has been maintained resulting in an actual liquid ratio metric of 3.

The I&E variance of +0.1% as a percentage of income to date is within the range for a score of 4 due to improved performance against the I&E plan to January.

The forecast out-turn score is currently a 2 overall. The only change expected between January and the year end is an adverse moment in the liquidity metric from 3 to 2.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD ***March 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 / Gill Hall, Interim Trust Secretary
Author:	Sal Maughan, Head of Risk/ Corporate Governance
Purpose:	To highlight key risks and provide assurance regarding their management.
Action required by the committee:	The board are asked to discuss and agree - if the risk profile as set out in the report this report reflects the range of current risks to the organisation, including its external environment - If there is sufficient and robust challenge around the management of these risks and; To make recommendations for future changes and /or inclusions in the CRR

Executive summary

Key messages:

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- Controls are developed for all risks, with a rolling programme of review by QRC

Assurance:

- Details of external assurances are included within the report
- The Trust is currently preparing for re-inspection by the Care Quality Commission in Q1 2016/17.
- The Board Assurance Framework (aligned to the CQC Well Led domain and KLOEs) is currently being populated by the Executive team.

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. The detailed controls for all risks can be found at appendix 2.

Table one: highest rated risks

Ref	Description	C	L	Rating ↓↑
01-12	Bed capacity for adult G&A beds may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	5	4	20 →
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	5	4	20 →
01-07	Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	4	5	20 →
01-06	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	5	4	20 →
01-18	Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	5	4	20 →
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	4	5	20 →
3.14-05	Working capital – the trust will require more working capital than planned due to: Adverse in year I&E performance Adverse in year cash-flow performance	5	4	20 →
3.15-05	Risks to income – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust.	5	4	20 →
3.20-05	Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.	5	4	20 →
01-19	Risk to patient safety arising from delays and/or failures to ensure the correct medical equipment is available	5	4	20 →
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 ↑

1.1 New risks proposed for inclusion on the CRR

There are six new risks proposed for inclusion on the CRR which are currently undergoing risk assessment:

- Transformation programme – 4 x associated risks
  - Communications and engagement with staff (Director of Strategy)
  - Organisational design and development (Director of HR & OD)
  - Resourcing (Director of Transformation)
  - Translation into contracts (Chief Financial Officer)
- Risk to patient safety arising from inconsistent and/or multiple issues of discharge summaries to GP surgeries.
- Electrical infrastructure in Knightsbridge Wing is in danger of major failure. A recent large power failure caused the wing to be evacuated.

In addition the following risks held on the Corporate Affairs directorate risks have been escalated via the Executive team for inclusion on the CRR:

- CORP03: Potential risks to ensure correct Trust processes and procedures are followed due to a failure to ensure all Trust policies are up to date (4x4=16)
- CORP02: Risk of regulatory action or penalties upon the Trust in the event of a failure to comply with the legislative requirements of the Freedom of Information Act (2000) (5x3=15)

A further risk has now undergone a risk assessment and has been included on the CRR - full details at appendix 2:

Table two: newly included risks

Ref	Risk	Score
01-20	Radiation protection and governance issues as identified by the recent HESL visit and subsequent risk summit	4 x 3 = 12

1.2 Changes to risks scores

There have been changes to risk scores in three risks as detailed in table three, the rationale for each change is included at appendix 1.

Table three: changes to risks scores

Ref	Risk	Previous (C x L)	Updated (C x L)
A516-04	Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas	**3 x 3 = 9**	**3 x 4 =12**
A520-04	Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	**4 x 4 = 16**	**4 x 5 = 20**
03-05	Risk to patient safety as a result of legionella infection	**3 x 4 = 12**	**4 x 4 = 16**

1.3 Risks proposed for closure

There are two risks proposed for closure, the rationale for closure is included at appendix 1:

Table four: risks proposed for closure

Ref	Risk
01-10	Risk to patients, staff and public health and safety in the event the trust has failed to prepare adequately for an Ebola incident.
01-01	A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.

1.4 Summary of risks by score and domain

There are 50 risks on the CRR of which 32 are extreme (a score of 15 or above) this equates to 64% of the total risks, which compares with 62% in Jan 2016. Of these extreme risks, 12 sit within the domain of Quality and seven within Finance and Operations. Of the total risks on the CRR, 40% relate to Quality.

Fig 1&2: CRR Risks by score and domain

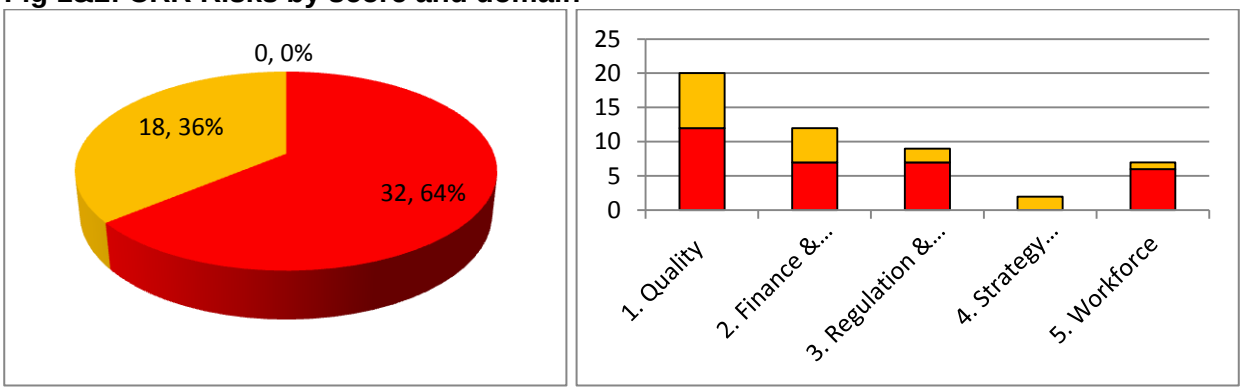
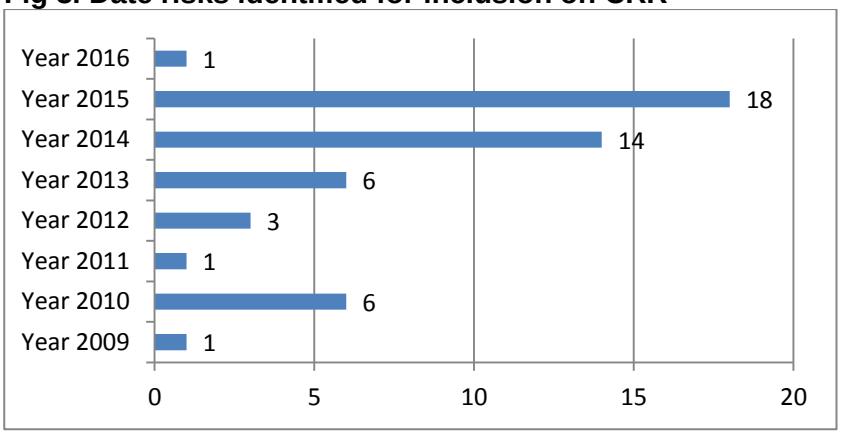


Table three: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Mod)	0-3 (low)	Total
1. Quality	12	8	0	0	20
2. Finance & Operations	7	5	0	0	12
3. Regulation & Compliance	7	2	0	0	9
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	6	1	0	0	7
Total	**32**	**18**	**0**	**0**	**50**

The following chart illustrates the duration each risk has been included on the CRR and demonstrates that 34% of the risks on the CRR were identified are more than 2 years ago. The details of the start date of each risk and changes over the previous six month period are included at appendix one.

Fig 3. Date risks identified for inclusion on CRR



1.5 QRC Deep dive

On 24th February 2016 two risks underwent a deep dive at the Quality and Risk Committee:

- A537-06:Confidential data reaching unintended audiences
- A610-06: The trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training

The QRC agreed that scores for both risks were accurate but noted that in relation to risk ref A610-06: IG Training rates, that it is unlikely the Trust will be able to recover its position and achieve 95% of staff trained by the end of March 2016, when the IG toolkit submission is due. Actions

underway to rapidly improve training rates were noted and further gaps in controls and assurance were identified in relation to training temporary staff. These changes are reflected in the risk update as included at appendix 2.

2. Assurance map

2.1 Care Quality Commission (CQC) – preparation for inspection

The Trust is anticipating an inspection by the CQC during Q1 2016/17. Work is underway to prepare for inspection with a core delivery team identified, a steering group established and a programme of work to identify and address key risks at corporate and service level.

2.2 Summary of external assurance and third party inspections – Feb 2016

2.1.1 National Joint Registry (performance for hip and knee replacements)

This report includes statistical analysis of the relative performance of surgeons (revision rate) and units (revision rate, 90-day mortality) after primary joint replacement. There are 9 indicators:

Trust compliance		
Indicator 1	Compliance rate	**Amber**
St. George's Hospital		
Indicator 2	Hospital consent rate	**Green**
Indicator 3	Hospital data linkability	**Green**
Indicator 4	Hospital Standardised Revision Ration (SRR) (Hips	**Green**
Indicator 5	Hospital SRR (Knees)	**Green**
Indicator 6	Hospital Standardised Mortality Ration (SMR) (Hip)	**Green**
Indicator 7	Hospital SMR (Knee)	**Green**
Trust Surgeon		
Indicator 8	Surgeon SRR (Hip)	**Red**
Indicator 9	Surgeon SRR (Knee)	**Green**

The report has been considered by the T&O service who have requested more data to understand in detail the amber/red areas. Indicator eight refers to an inactive surgeon. All other performance for active surgeons is acceptable.

2.1.2 Peer review visit to the Cancer unknown primary (CUP) service

This peer review within the Cancer/Oncology services has raised two serious concerns which will require an action plan from the Trust:

- CNS service and cover – no cover for leave and as current CNS is leaving, not assured that there is action in place to cover the service and provide patients with key worker in the interim
- Not assured that all CUP patients are being captured and logged at the CUP MDT – require an audit to see if some patients are being kept by site specific MDTs

An action plan is being drafted by the team.

2.1.3 Notification of Contravention of Health and Safety Act

The Trust has received notification from the HSE of the HSE about the incident on Richmond Ward in March 2015: Failure of Phillips Trilogy 202 Ventilator due to lack of power.

This was investigated as a Serious incident and an action plan is in way to address the failing identified. A full response has been provided to the HSE setting out the urgent and on-going action being taken, this has been reported through the Quality and risk Committee.

2.2 Summary of future external assurance and third party inspections

2.2.1 Patient Led Assessment of the Care Environment (PLACE)

Expected in Spring 2016 and preparations are underway.

3. Conclusion

The programme of detailed review of risks included on the Corporate Risk Register continues in order to provide stronger assurance to the Trust Board around the management of risks.

The overall long-term risk profile for the trust continues to be driven by the continued financial and operational pressures faced by the trust.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 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	MW	11/2012	20	20	20	20	20	20	→	
01-13 Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	11/2014	20	25	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	MW	11/2014	20	16	16	16	16	16	→	
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	05/2010	12	12	12	12	12	12	→	
01-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.	JH	-	12	12	9	9	9			Propose closure as this is now being managed through business as usual.
01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	EM	07/2013	9	9	9	9	9	9	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	EM	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	PVK	05/2014	15	20	20	20	20	20	→	

18 weeks on elective waiting lists										
01-07 Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	PVK	06/2014	20	20	20	20	20	20	→	
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	SM	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	EM	10/2014	12	12	12	12	12	12	→	
01-10 Risk to patients, staff and public health and safety in the event the trust has failed to prepare adequately for an Ebola incident.	JH	-	10	10	10	10	10			Propose closure as this is now being managed through business as usual.
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments	PVK	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	SM	07/2015	20	20	20	16	16	16	→	
01-16 There is a potential risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of run rate schemes.	EM	07/2015		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.	EM	07/2015		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	→	
01-20 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.	SM	01/2016						12	**NEW**	

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 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)	JH	07/2013	16	16	16	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	mar 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	IL	07/2015	20	20	10	10	10	10	→	
3.14-05 Working capital – the trust will require more working capital than planned due to: - Adverse in year I&E performance - Adverse in year cash-flow performance	IL	07/2015	20	20	20	20	20	20	→	
3.15-05 Risks to income – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust	IL	07/2015	20	20	20	20	20	20	→	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and income.	IL	07/2015	20	20	10	10	10	10	→	
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives	IL	07/2015	20	20	15	15	15	15	→	
3.18-05 Cost Pressures - The trust faces higher than	IL	07/2015	16	16	16	16	16	16	→	

expected costs due to:- - unforeseen service pressures - higher than expected inflation - higher marginal costs or costs required to deliver key activity										
3.19-05 Cash-flow Risks – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends	IL	07/2015	12	12	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.	IL	07/2015			20	20	20	20	→	

Strategic Objective/Principal Risk	Lead	Start Date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 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:	PVK	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	SB	06/2013	16	16	12	12	12	12	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	07/2014	12	12	12	12	12	12	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 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	5	5	15	15	15	→	
A537-O6:Confidential data reaching unintended audiences	SM	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	SM	10/2011	15	15	15	15	15	15	→	
03-01: Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	EM	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	EM	10/2012	16	16	12	12	12	12	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM	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.	EM	05/2014	16	16	16	16	16	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM	05/2014	12	12	12	12	12	16	↑	Increased risk due to legionella having been found outside of previous isolated area
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		20	15	15	15	15	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Start Date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 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	12	12	→	

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 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.	SM	03/2013	8	8	8	8	8	8	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 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	12	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	6	9	9	9	9	12	↑	Impact of new junior doctor contrac be highly contentious and it is poss this will have a negative impact on wishing to be employed at StG.
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	05/2010	12	16	16	16	16	20	↑	Rates of mandatory training have decreased therefore increasing the likelihood to 5
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	16	16	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	→	
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	→	

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						16	16	→	

JH	Jennie Hall	Chief Nurse (DIPC)	EM	Eric Munro	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
PVK	Paula Vasco-Knight	Chief Operating Officer	WB	Wendy Brewer	Director of Human Resources
IL	Iain Lineham	Director of Finance Performance & Information	MW	Martin Wilson	Director of Transformation

Appendix 2: Corporate Risk Register

Appendix 2 Corporate Risk Register – detailed controls

Quality Domain: 1.1 Patient Safety

Principal Risk	**01-12 Bed capacity** for adult G&A beds may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Root cause: Requirement for high activity volumes in order to meet patient and commissioner needs, and to deliver income margin as part of Trust Cost Improvement Programme. Unlimited demand on A&E which impacts on increase in emergency admissions & capacity for elective admissions affecting 28 day rebook timeframes. Delayed patient repatriation to host hospitals block beds for emergency/elective activity. 14.2% increase in emergency admissions in patients over 70 Challenges in both delivering addition capacity and releasing capacity through flow, to agreed timelines Impact: Potential for commissioner challenges and financial penalties due to breach of ED and RTT targets Potential subsequent impact on patient pathways & patient safety. Adverse reputation				
Domain	1. **Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Nov 15**	**Exec Sponsor**	Martin Wilson
Consequence	5	4	4	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	5	5	5	**Date closed**	
Score	25	20	**20**		
Controls & Mitigating Actions	**Controls:** Overall: Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Manager dedicated to capacity. Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Existing capacity: Maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved			**Assurance**	Negative assurance: - 4 hour operational standard performance - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 Internal capacity assurance: Joint trust & CCG capacity planning for 15/16 undertaken and approved by SRG Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. Follow-up capacity audit is to be completed in Q4 Flow programme dashboard provides real-time analysis of performance against

	New capacity: Business Planning identified ~72 beds are required in 15/16 to deliver required activity volumes based on 13/14 length of stay. Analysis of 13/14 LOS indicates 8% increase which is driving an additional 70 bed gap Proposals for additional bed capacity agreed with commissioners Risks exist with respect to the timing and delivery of plan. To control these risks, we have increased capital project management capability **Mitigations:** • Build/commission additional 70 beds of capacity • Cap demand for services • Increased command and control of bed management and hospital flow Work with SRG to produce system-wide solutions Development of critical path for all forecast building schemes, and embedding the holding to account of Senior Responsible Owners for delivery of agreed schemes. •		targets External assurance: ALOS benchmarking will provide insight into areas of strong and weak patient flow
Gaps in controls	Ability to deliver agreed additional capacity schemes to agreed timelines remains a challenge	**Gaps in assurance**	
Actions next period:	Realisation of new physical bed capacity New integrated demand & capacity model being developed for 5 year view by KPMG		

Principal Risk	**01-13 Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to deliver 18 week RTT standards, and to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties Adverse reputation				
Domain	1. **Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Nov 15**	**Exec Sponsor**	Martin Wilson
Consequence	5	5	5	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	**Controls:** Overall: Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity. Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Theatre Capacity Plan for 2015 to 2018 developed by Director of Delivery and Improvement with senior leadership from SNCT leadership team. Plan reviewed by extraordinary OMT and regularly reviewed by EMT. Existing capacity: Business Planning for 2015/16 increased alignment between divisional activity and capacity plans. Star chamber held by Director of Finance and Director of Delivery and Improvement with each divisional leadership team to ensure that planned activity numbers are robust. Additional capacity being realised through: • Increased in session utilisation within existing theatre sessions • All day operating sessions within day surgery • Extended day operating in main theatres • Commissioning the planned Hybrid theatre as an additional theatre	**Assurance**	Negative assurance: - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 - Cancelled elective surgery Aug 15 due to loss of air pressure and ventilation Internal assurance: Internal theatres capacity plan and tactical implementation plan Approved by Executive Management Team. Reported to Finance and Performance committee. Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. 6 of the 13 Day Surgery Unit extended day, (including reallocating sessions of activity from main theatres) Theatres dashboard in use – enables tracking of theatres throughput and utilisation External assurance: Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 elective RTT funds.

	• Offsite capacity options (NHS and independent sector) • Business case developed for opening Cardiac 4 as additional theatre • Expert external engineers developing plans for planned preventative maintenance, remedial works and theatre upgrades to minimise loss of capacity Specific theatre capacity analysis and plan developed linked to a longer term theatres strategy currently in development.. A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway. **Mitigations:** • Seek additional external capacity • Cap demand for services • Divisional management teams & boards to monitor activity against plan ensuring full use of allocated capacity, driving productivity improvements within sessions and outsourcing activity to other providers		Score increased – based upon recently materialised risk regarding theatre ventilation and maintenance
Gaps in controls	Maintenance of theatres behind plan for a number of years, leading to a 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		

Principal Risk	**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
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to support emergency services and deliver 18 week RTT standards. Also any shortage in critical care capacity will impact on trust's ability to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties and adverse reputation

Domain	1.Quality			Strategic Objective	1.1 Patient Safety
	Original	**Residual**	**Updated Mar 16**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	5	4	4	**Date closed**	
Score	20	16	16		

Controls & Mitigating Actions	**Controls:** Overall: Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity. Critical Care Business Cases for 3 additional CTITU, 1 CCU & 4 Neuro HDU beds approved – to be operational Q4 Trust Capacity Plan for 2015 to 2018 developed by Director of Delivery and Improvement with senior leadership from SNCT leadership team. Plan reviewed by extraordinary OMT and regularly reviewed by EMT. **Mitigations:** • Seek additional external capacity • Cap demand for services	**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 Internal assurance: 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. External assurance: ICNARC benchmarking analysis provided to adult critical care monthly showing delays in discharging patients to acute beds due to bed occupancy pressures. Exec DoDI assures capacity delivery with reporting via EMT
Gaps in controls		**Gaps in assurance**	
Actions next period:	Building works on CCU & Thomas Young to enable creation of 3 additional CTITU, 1 CCU & 4 Neuro HDU beds		

Principal Risk	A513-O1: Failure to achieve both National HCAI targets for MRSA and C Diff				
Description	The HCAI target for MRSA is set at 0 cases (zero tolerance) and 31 cases for *C. diff* for year 2015/16. Failure to achieve both may adversely affect the Trust's reputation resulting in a loss of patient & public confidence in the Trust and risk of patient harm.				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	31/05/2010,
Likelihood	4	3	3	**Date closed**	
Score	16	12	12		

Controls & Mitigating Actions	Infection Control score card used to monitor monthly progress, monthly review at HCAI taskforce Regular communications sent to support practice and raise awareness to ensure staff adhere strictly to diarrhoea protocol and other infection prevention and control issues. Divisional action plans presented to the taskforce as required Zero Tolerance statement on the Trust intranet Bi-monthly antimicrobial steering group chaired by Medical Director Consultant level information circulated on a regular basis RCA carried out for each infection (MRSA, MSSA & *C.diff*) Infection Control Policy in place Weekly line care rounds & *C.diff* rounds on-going. Competence assessment document for taking blood cultures in place Best practice visit to Southampton, Royal Free and west Hertfordshire Aseptic non-touch technique roll-out in AMW Chloraprep single use applicators being adopted across the organisation for insertion and ongoing care of lines. Cannulation packs in place in many areas of the trust New Surewash hand hygiene training machines in use at trust induction and across the organisation. Analysis and actions in relation to latest audit of line care undertaken.	**Assurance**	Beyond trajectory for MRSA– 3 MRSA (one case was removed from our trajectory after arbitration). Last case was in September 2015. 25 *C. diff* at end of January 2016. This means we are within the trajectory and on line to meet the target at the end of march 2016. CQC Compliance with Regulation 12 and 15 The Health and Social Care Act 2008 (July 2015) MRSA – 3 cases, have been investigated via RCA –and discussed at HCAI taskforce. Infection control action plans reviewed by internal audit – reasonable assurance. RCA process currently being audited by internal audit Peer review of infection control nursing team (By Barts & the London Trust) recommendations implemented Bi-weekly taskforce meeting and bi-monthly Infection Control Committee meeting. Scorecard and line care rounds presented/discussed at taskforce. Regular reports to the Patient Safety Committee, EMT & Trust Board

Gaps in controls	BAF risk 01-01 Informatics to support production of real time data	**Gaps in assurance**	
Actions next period:	Continual revision of infection control action plan Increasing number of consultants champions for infection control. Trust wide environmental audit to re-commence using improved audit tool. Focus on areas where IPC and cleaning inspections demonstrate need to improve. Saving Lives and Environmental audits to be carried out on RaTE to streamline and improve efficacy of process. Obtain business case approval for SSI team Refresh Communications strategy		

Principal Risk	01-02 Risk to patient safety arising from variable provision of Pressure Relieving Mattresses out of office hours (Monday to Friday 0900 – 1700)				
Description	Delivery and collection of Pressure Relieving Mattresses is only staffed Monday to Friday 0900 – 1700. Out of hours delivery by porters results in variable availability, especially when stock runs out over weekends due to lack of collection. Potential factor in increased numbers of patients sustaining pressure ulcers and infection. (Cross Ref A513-O1)				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Eric Munro
Consequence	3	3	3	**Date opened**	11/07/2013
Likelihood	4	3	3	**Date closed**	
Score	12	9	9		
Controls & Mitigating Actions	Additional initial resources approved at EMT. 32 new PRMs, 200 new top covers and band 3 post to cover 6 days per week. PRM are being cleaned following manufacturer's procedures between patients. Facilities for handling PRM are being upgraded, and procedures are planned to be brought under BS13485 quality system, requiring an upgrade to the current handling location to improve the facilities. The request to fund this is within the business case being submitted Q1 2015. Out of hours delivery significantly improved by change to access for portering staff, but stock does run out on occasions since there is no weekend collection and cleaning service. **Mitigating Actions** Service improvements as part of an on-going process.			**Assurance**	Improved monitoring of availability and delivery times. Most recent data showing improved delivery times, achieving an average since April 2014 of 99.5 % delivery in under 4 hours within 0900-1700 weekdays. Stock availability has been improved out of hours due to altered access for porters, but stock does run out occasionally, and we have no figures on the out of hours delivery delays. All but one Datix in the past year are for out of hours lack of availability. Mattresses are being cleaned following manufacturers guidance, and . Decontamination of PRM contaminated or identified as potentially contaminated is by off-site decontamination.

	Implementing electronic requesting of PRMs.		
Gaps in controls	The known gap is in the out of hours delivery. We are aiming to collect more data on the stock availability (ie how many PRM are available at the end of each day), especially to cover weekends. Collection would be needed to aid this, allied with the removal of PRM from patients that do not need one.	**Gaps in assurance**	
Actions next period:	Collect better data on out of hours availability. Business Case to be finalised for re-submission to IDDG. Once approved risk will be closed and will revert to being managed as Business as usual		

Principal Risk	01-03 Risk to patient safety arising from bed rails not being available to be deployed when required on beds which have removable rails.				
Description	The Trust has around 700 beds without in-built bed rails, and if rails are required there may be a delay in fitting these if an available set cannot be located. This delay may be from a few minutes to hours, with the risk of a fall being significant for some patients even with a few minutes delay, and the resulting harm can be extreme. In addition rails provided may not always fit for purpose, since they are specific to each bed model, and not always correctly applied. There is a dedicated bleep and support for rails provision, repair and fitting during office hours, with cover by porters out of hours, which is of necessity less specialised and they may not be able to find suitable rails. Absence of programmed maintenance potentially results in faulty equipment, though incorrect fitting of rails is considered to be a more important factor. .The above factors have been identified by the Trust as contributing to patients sustaining harmful or fatal falls.				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Eric Munro
Consequence	3	3	3	**Date opened**	1.1.2014
Likelihood	4	3	3	**Date closed**	
Score	12	9	9		
Controls & Mitigating Actions	Has been included into work reviewing beds and mattresses as part of a business case being prepared. Likely additional resources required approved at EMT, and additional rails have been purchased. Also a technician and a bleep provided to deal with delivery and maintenance requirements. **Mitigating Actions** If demand exceeds supply additional rails will be rented or purchased urgently. Review of training and risk assessment			**Assurance**	Datix reported incident July 2014 describes a patient fall, when no rails available overnight.

	tool underway by falls Lead, Consultant Physio.		
Gaps in controls	Currently no robust process of managing and maintaining equipment.	**Gaps in assurance**	
Actions next period:	Continue to monitor availability and Datix reporting. Business Case to be finalised for re-submission to IDDG. Procurement process then to start.		

Principal Risk	01-04 There is a potential 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.				
Description	Risk of staff not having required knowledge to safeguard children due to the required safeguarding children training not consistently being undertaken. Staff may not recognise a potential safeguarding issue, putting a vulnerable child at risk of harm.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	1.1.14
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	Training sessions in safeguarding children at all levels are held on a regular basis. Sessions are advertised in advance and training at a basic level is included the annual MAST update. A review by the safeguarding team of current training data takes place on a quarterly basis and a 'deep dive' into the data has revealed some anomalies in the availability of the MAST training to new staff. This is being addressed by proposed changes to the induction programme led by HR training department. All managers have been contacted by the Safeguarding Nurse and the DDNG for CWDT&CC reminding them of their obligations under Section 11. Divisional training performance is reported at the quarterly performance reviews.			**Assurance**	Levels of Child Safeguarding training as reported on ARIS 16/07/2015: Safeguarding Children level 1 - 69% Safeguarding Children level 2 - 70% Safeguarding Children level 3 - 75% Levels of training compliance at level 3 in high risk areas are high. Findings from the safeguarding review are being reviewed by the Chief Nurse – as yet it is not clear what the implications from this will be in respect of training.

Gaps in controls	The ARIS system data is still not totally accurate and this has been confirmed by a manual exercise to check the data shown.	**Gaps in assurance**	Data is not robust – manual data showing discrepancies i.e maternity shown below
Actions next period:	The safeguarding children training compliance action plan is being implemented and reviewed at trust-wide Strategic SGC committee. Continue to target level 3 by department. As a result of the peer review a decision has been made to bring together the community and acute safeguarding children team and to be line managed within the corporate nursing directorate. This is being led by the Chief Nurse		

Principal Risk	01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust				
Description	Risk escalated from Surgical divisional risk register: A number of services continue to decontaminate equipment locally:- • ENT- Nasendoscopes • Gen Surg- Anal probes • Cardiac- TOE probes • ITU - Bronchoscopes The practice is no longer compliant with new guidance. The risks relate to the environment, process and tracking of equipment, which currently place staff and patients at potential risk of chemical toxicity and cross contamination.				
Domain	**2. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update Mar 16**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	31.5.2014
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	The Decontamination Committee oversee maintenance of relevant standards/guidance in line with local departmental experts. Drying cabinets have been locked and a new escalation policy is in place to prevent further instruments from being quarantined due to poor /no tracking**.** Cardiac to comply with centralised decontamination for TOE probes: a new re-processor has been leased and was recently installed, although not yet operational & awaiting an estates update on plan to achieve this. Interim solution to use of Tristal wipes system Reduced capacity in SSD secondary to the DSU machines being out of action since Jan ’14- reliant upon this capacity			**Assurance**	Positive assurance: There have been no incidents of cross contamination Health edge electronic tracking system now in place and training rolled out to all areas. Compliance is consistent although relies upon nursing to police - there have been no further incidents of instruments being quarantined. Cardiac compliant with Tristal wipe system until such a time that the new reprocesser is operational and the service move to full centralisation On-going issues requiring estates input escalated via Trust Decontamination meetings, organisational risk and decon reports and individual communication with the estates department- awaiting a timeline and plan of works

	being back in place to enable the replacement of the St James wing machines which are now in the country as well permanent repairs to the leak in the SSD packing room. Tristal wipe system now in place for nasendoscopes and training on this and tracking fully rolled out. Increased staff support for busy OPD clinics in place to facilitate this process and work completed to separate clean and dirty clinical areas. Endoscopy have been describing mechanical issues with their drying cabinets, which are over ten yrs old and the decon committee await a full description of the risks and proposed options for a solution. Agreed Clinical Pathway in place for the decontamination of nasoendoscopes , work to be concluded regarding the long term framework for the decontamination of this equipment. Progress has been made. This includes work to ensure that surface decontamination of nasendoscopes is correctly performed. Surface decontamination is an accepted practice and included in the national guidelines. This will be monitored closely by the Infection Control Team. A business case has been made to increase the number of nasendoscopes. Initially the number purchased will ensure that scope used out of hours will have be centrally decontaminated and not by surface decontamination. Subsequent plan is to increase number so that all nasendocsopes are centrally processed.		
Gaps in controls		**Gaps in assurance**	
Actions next period:	ITU will tighten up their practice in relation to Bronchoscopes: a written process to be put in place. The rationale of the indicative cost pressure of the funding to lease an additional washer processor (1K per month) to enable decontamination to be carried out centrally has been drafted and to be signed off by each division. Explore long term solution to provide alternative centralised decontamination services which will entail a full business case and capital build		

Principal Risk	01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists
Description	Risk to patient safety and patient experience as patients waiting greater than 18 weeks on elective waiting lists.

	Possible impact that patient's condition deteriorates. Specific issues regarding cardiothoracic surgery waiting lists in particular.				
Domain	**3. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Nov 15**	**Exec Sponsor**	Paula Vasco-Knight
Consequence	5	5	5	**Date opened**	31.5.2014
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	Management of the RTT 18 week standard is the responsibility of clinical divisions and their general management teams. They are supported in their work by the Information Team and the 18 Week Validation Team which reports into Deirdre Baker – Assistant Director of Finance. Governance arrangements are: Executive leadership for RTT transferred to the Director of Delivery & Improvement Joint trust & CCG contractual investigation to develop and deliver RTT sustainability plan completed June 2015 overseen by DoDI, Surgical Divisional Chair and GP CQR lead (Dr T Coffey). Joint Trust & CCG RTT action plan in place with fortnightly reporting to joint trust & CCG action planning performance group. Compliance Meeting chaired monthly by the Director of Delivery & Improvement, attended by General Managers, Information Team and the 18 weeks team Sub groups for admitted and non- admitted pathways which involve service managers and the 18 weeks team. RTT performance is reported to the FPI Committee on a monthly basis and the issues concerning any particularly challenged specialty are discussed in detail. Performance is also monitored by commissioners at the monthly commissioner/SGH meeting and any clinical quality issues discussed at the monthly commissioner/SGH Clinical Quality Review meetings. RTT performance delivery plan to ensure full chronological	**Assurance**	Negative assurances Identified system wide gap of £12-14m of activity required to deliver RTT sustainability Some cancellations in routine elective surgery due to bed pressures Some cancelled patients are not able to be rebooked within 28 days target (7 out of 90 in January) RTT backlog rising in Q4 and now back to end of 2013/14 level of circa 800 patients. Whole system does not yet have a plan for sustainable delivery of RTT standard – specialty summits to address this

	booking and achievement of RTT aggregate trust levels standards agreed with commissioners. Divisions have reviewed clinical review of waiting lists to ensure any clinical risks due to waiting are reviewed and managed. Approach reviewed by QRC and CQRM committees. Trust data quality group established 1. Specialty based clinical summits to be held with Trust & Commissioner led clinicians and managers to review the RTT position and agree actions to improve performance. To include potential increases in commissioned activity, altered pathways and diversion of referrals to other providers 2. RTT internal improvement plan developed		
Gaps in controls	Delivery on action plan	**Gaps in assurance**	
Actions next period:	1. Develop specialty level sustainability plans for all RTT specialties 2. RTT programme manager to be appointed 3. Move to use of patient tracking lists for booking all outpatient appointments in sequential order 4. Data quality board established		

Principal Risk	01-07 Risk to patient experience and safety as a result of potential Trust failure to meet 95% Emergency Access Standards				
Description	Should the Trust recurrently fail to meet 95% Emergency Access Standards there would be a risk to: - *Patient experience whereby patients would not be treated or transferred within four hours* - *Patient safety – delays in patients receiving ED or specialist senior clinical input* - Risk of regulatory action including from commissioners and regulators - Trust reputational damage of failure to deliver the 95% clinical standard				
Domain	**4. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Nov 15**	**Exec Sponsor**	Paula Vasco- Knight
Consequence	4	4	4	**Date opened**	1/6/2014
Likelihood	5	5	5	**Date closed**	
Score	20	20	20		
Controls &	Trust and CCG Joint Investigation Action Plan developed covering capacity, pathway improvement and performance			**Assurance**	Q4 and Q1 performance standard has not been met

Mitigating Actions	management in three areas: 1. Emergency department actions – led by DDO and Clinical Director for ED 2. Whole hospital actions – led by Chief Nurse through 'Flow' programme 3. Wider system actions – led by SRG Progress in delivering action plan regularly reviewed: • ED action plan via ED Senior team meeting weekly • Whole hospital actions via OMT fortnightly • Wider system actions via System Resilience Group performance meeting monthly • Overall the plan is reviewed with the CEO and Director of Delivery and Improvement on a fortnightly basis Continued close and pro-active working with ECIST ED dashboard and operational standards agreed, finalised and in place 4. Increases in bed capacity (72 beds) 5. Investments in patient flow schemes (£4m) including ED hot lab		2015/16 performance forcast under delivery with trajectory of circa 93% Daily reporting to Exec team Escalation meetings between division & DoDI Joint Trust & CCG Investigation completed
Gaps in controls		**Gaps in assurance**	
Actions next period:	Continue implementation of improvement plan (particularly focussed on whole hospital and wider system actions)		

Principal Risk	01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results				
Description	Should the Trust fail to ensure robust mechanisms for the timely and appropriate follow up of all diagnostics tests undertaken and critical test results eg blood tests , cell path and radiology this may result in adverse impact upon patient care in terms of delays in treatment				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Simon Mackenzie
Consequence	4	4	4	**Date opened**	16.7.14
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	• All doctors have been reminded of their responsibility for ensuring that tests that they order are followed up. • All Care Groups have been asked to develop Standard Operating Procedures to ensure that this happens. • All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions. • Radiology have strengthened their safety net system. This now includes e mail to MDT for unexpected cancer (cancer MDTs have instituted a red flag system to ensure oversight). • Project group set up including IT, operations and service improvement to improve process of results endorsement on Cerner and roll it's use out in Trust. EMT has agreed that from Sept 2015 all radiology and histopathology will be endorsed in Cerner and this will be monitored. Policy for Acting on Diagnostic test Results ratified	**Assurance**	Whilst actions have been taken as described, and most Care Groups have SOPS in place, there have been further instances of serious incidents due to failure to follow up test results. This indicates that significant risk continues. Internal reporting via PSC and externally through CQRM Internal audit report received in draft format - scope to review ;– - If there's an effective safety net in place - That SOPs are in all areas - That actions from an overarching review have been implemented Findings is of 'limited assurance' with a number of recommended actions Electronic sign off from September 2015 is anticipated to substantially reduce this risk.
Gaps in controls	Some SOPs are outstanding and the effectiveness of others has not been verified. Electronic sign off will not be fully established until September 2015	**Gaps in assurance**	Some Care Groups have not developed SOPs and implementation is not confirmed.
Actions next period:	Audit of SOPs by Care Group (AMD) Update consultant lists to ensure selection of correct care episodes (CCIO)		

Principal Risk	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
Description	Competence in the use of Medical Equipment is a personal responsibility of professional staff, many of whom are professionally registered and presentation of evidence of their maintenance of competency is part of the registration renewal process. The Trust has a responsibility to ensure that it

	has processes for identifying staff authorised to use equipment, and for identifying the training needs of staff related to Medical Equipment. This may be being carried out by local supervisors and managers, but the Trust needs assurance through having visibility of the training needs and the degree to which those needs have been met. There is currently no system to identify and report Trust wide medical equipment training needs, and to report the degree of compliance with those needs. This has the risk that the Trust cannot show that it has good management of staff with proper consideration of their competence and training needs relating to Medical Equipment. This was the subject of an audit in 2013.					
Domain	**1. Quality**			**Strategic Objective**		**1.1 Patient Safety**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**		Eric Munro
Consequence	3	3	3	**Date opened**		1-10-2014
Likelihood	4	4	4	**Date closed**		
Score	12	12	**12**			
Controls & Mitigating Actions	Many areas, particularly high acuity areas, have training and some records, but generally records are incomplete. For some equipment there is well controlled training linked to authorisation (eg glucometers, blood gas meters). The Trust has a policy of equipment standardisation where possible, and this is linked to organised training on implementation (eg Smart pumps, glucometers, defibrillators, anaesthetic machines, patient monitors etc). The training requirements are also considered during the preparation for capital equipment purchases.				**Assurance**	Centralised records for glucometer training, and records of training for major standardisation projects. Records for some areas can be inspected (eg GICU), anaesthetics, but we know that record keeping is incomplete in many areas. Professional staff work under responsibility to maintain their professional competence, and to work within that competence, with many groups submitting evidence to satisfy continuing professional development requirements and within this many should be prompted to consider their competence with medical equipment that they use. This means that the extent of competence will be wider than the availability of records, and this gives some assurance of safety, though positive records are what are needed.
Gaps in controls	The majority of areas cannot show records for all staff for all equipment training needs				**Gaps in assurance**	Clear lack of complete records
Actions next period:	Trials in PICU and anaesthetics have resulted in a final specification for the system. This is being written by the provider, with completion expected by the end of February. There will then be a trial roll out in PICU and anaesthetics, followed by a Trust wide roll out, expected to take around one year, and requiring an additional staff member to lead the roll out.					

Principal Risk	01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments
Description	There is a risk to patient safety where full permanent sets of medical records are not available to clinicians for scheduled outpatient appointments. This may also adversely impact upon patient experience. The Trust target is to achieve >98% of all permanent notes available in clinic.

Domain				Strategic Objective		
	Original	**Residual**	**Update Nov 15**	**Exec Sponsor**		Paula Vasco-Knight & Rob Elek
Consequence	3	4	4	**Date opened**		1 Jun 2015
Likelihood	4	4	4	**Date closed**		
Score	12	16	16			
Controls & Mitigating Actions	Trust wide outpatient improvement programme focus on medical records availability Exec Director spot checks on Medical records and outpatients Trust outpatient strategy developing recommendations for board on Trist strategy towards medical records usage and storage EMT quality risk session held on medical records availability Perfect week held w/comm 11th May Recommendation developed around electronic document management regarding what to scan, what to shred. Developed with DMBs. Proposal coming to EMT for approval, with intention to decrease volume of notes stored and therefore increase availability of notes electronically to clinic. Electronic document management roll out plan agreed with all new: new patients to be on EDM notes by Oct 2015 and all patients on EDM notes by July 2016 Medical Director and Divisional Chairs to agreed Trust policy on retention periods and volume of history of clinical correspondence which should be scanned into EDM in order to accelerate EDM roll out and to reduce volume of medical records retained.			**Assurance**		Report on availability of notes produced and circulated: Data reported to QRC and Board through Quality and performance report. Data reported externally on a monthly basis to commissioners. Reduced performance in Q4 with improvement in May 2015: Jan - 94.05% Feb - 90.12% Mar - 91.32% Apr - 90.45% May - 95.54%. June – 96.74% Jul 96.54% CQC compliance action plan closed by Commissioners Risk score increased to align with divisional risk in the interim until solution achieved.
Gaps in controls				**Gaps in assurance**		
Actions next period:	Continue EDM implementation					

	Outpatient Strategy to be reviewed by Trust Board

Principal Risk	01-18 – Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products				
Description	Kiosks are old and are breaking down on a daily/weekly basis Trust virus scanner impacts on system responsiveness Loss of Connectivity which results in gaps to Cold Chain records Current version not compatible with Windows Operating System 7 and there is no possibility of development of functionality to system Loss of System leads to unrestricted access to blood fridge and incomplete cold chain records				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Simon Mackenzie/Jennie Hall
Consequence	4	4	4	**Date opened**	1.7.2015
Likelihood	5	5	4	**Date closed**	
Score	20	20	16		

Controls & Mitigating Actions	Kiosks are sent for repair When system fails manual/papers based system is used. On-going monitoring of failures Functionality complies with current BSQR - but may not be compliant if future changes are required Paper records can be introduced that will satisfy BSQR, but increased risk of non-compliance with recording requirements 03/02/2015 - SWLP met with SGH Director IM&T - Recognised that full mitigation will require system upgrade. Business case prepared. A preliminary business proposal for the Trust to financially support a system upgrade was presented to CIOC and a full business case is being prepared for presentation at the Capital Bids Meeting	**Assurance**	Repair times for kiosks are adequate, however breakdown is now happening far more frequently (increased over last 6 months) and time to repair increases. Number of failures and several clinical incidents related to delays in providing blood. Failures are happening on a daily/weekly basis. Presented to Organisational Risk Committee in July 2015;agreement to escalate to CRR. £50K of the required capital agreed and identified from IM&T; remaining amount to be confirmed from finance therefore risk is anticipated to be closed imminently once new system procured. Lead time for the upgrade: it is likely to take at least 12 weeks at which time the risk will be removed.

Gaps in controls		**Gaps in assurance**	
Actions next period:	Procure new system Implement new system		

Principal Risk	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.				
Description	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.				
Domain				**Strategic Objective**	
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Eric Munro
Consequence	4	4	4	**Date opened**	1 July 2015 (Identified by ORC)
Likelihood	5	4	4	**Date closed**	
Score	20	16	16		
Controls & Mitigating Actions	Revised estates permanent management structure is in place including Maintenance Manager. Health and Safety management function closely involved in maintenance service. Planet FM system (the estates helpdesk and job request system) is being upgraded to allow prioritisation and work backlog to be monitored. Works procurement and prioritisation process implemented in September 2015.			**Assurance**	Works procurement and prioritisation process being assembled. Action plan being monitored and progress updates to the Operational Management Team. This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee.
Gaps in controls	The action plan will be further developed as higher risk items are closed.			**Gaps in assurance**	Quality Impact assessment process of run rate schemes. QFS assessment still to be completed in advance of CQC inspection
Actions & timescale:					

Principal Risk	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.				
Description	Reduction of the scale of the Trust's capital programme means that not all of the Trust's high priority projects can be funded at the time they are needed.				
Domain				**Strategic Objective**	
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Eric Munro
Consequence	4	4	4	**Date opened**	1 July 2015 (identified via ORC)
Likelihood	4	3	3	**Date closed**	
Score	16	12	12		
Controls & Mitigating Actions	Risk assessments undertaken for each project. Monitored through the Capital Programme Board & Project Programme Board. Engage with the department early in the capital scheme and jointly agree how this can be managed. Delivery of Hybrid theatres and completion of Bed capacity Project will provide further mitigations.			**Assurance**	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards. IDDG has representation from all Divisions and quality and safety of patient care is the highest prioritisation for all capital projects.
Gaps in controls	None identified			**Gaps in assurance**	Quality Impact assessment process of schemes
Actions & timescale:	Preparation of new 5 year capital programme by 1 October 2015 with prioritisation from quality and safety leads.				

Principal Risk	01-19: Risk to patient safety arising from delays and/or failures to ensure the correct medical equipment is available
Description	Risk to patient safety due to problems with interface between wards and departments and finance/procurement/supply chain which in turn results in a

	failure to ensure the correct medical equipment is tin the right place at the right time. Escalated through the Quality Fundamental Standards group, incident reporting and escalated concerns to managers.				
Domain				**Strategic Objective**	
	Original	**Current**	**Update Mar 16**	**Exec Sponsor**	Jennie Hall
Consequence	5	5	5	**Date opened**	1 Nov 2015
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		
Controls & Mitigating Actions	Clinical products procurement group set up – chaired by Assoc medical director More robust reporting categories introduced on Datix to allow closer monitoring Quality Fundamental Standards (QFS) Group regular agenda item with regular attendance and reports from Finance/procurement QFS email alert group in place and extended to include finance/procurement staff Serious Incident Declaration Meeting monitoring weekly data Regular trust communications through eGazette to update staff and support timely planning & ordering of items			**Assurance**	High turnoff staff in procurement Incidents still being reported with no reduction in volume or frequency Recent further delays in supplies due to manufacturers not wishing to adhere to new 60 day terms of payment
Gaps in controls	Processes for procurement still not robust No second/alternate suppliers lists Critical list of equipment still not agreed			**Gaps in assurance**	High turnoff staff in procurement – lack of access to Datix for new starters means an inability to monitor incident reports Often clinical staff too busy to report as an incidents and info/feedback can get lost
Actions next period:	Resolve access to Datix issues Commence work on alternate suppliers list Review TOR and scope of Clinical products procurement group Gain clarity around roles and responsibilities in procurement/supply chain with a dedicated 'trouble-shooting' role put in place to resolve urgent issues Communications to all staff around what to do out of hours and under normal circumstances				

Principal Risk	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.
Description	Recent issues identified by HESL visit and subsequent risk summit have revealed that governance process across the trust for ensuring the requirements of IRMER (Ionising Radiation (Medical Equipment) Regulations) are not robust. Should plans to address this be inadequet this may place patinets and

	staff at risk of higher levels than necessary of exposure to radiation.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update**	**Exec Sponsor**	Simon Mackenzie
Consequence	4	4		**Date opened**	01/2016
Likelihood	4	3		**Date closed**	
Score	16	12			
Controls & Mitigating Actions	Action to address failings and issues highlighted by the HESL visit and the subsequent risk summit are being managed through an overarching project board with the following work streams: Safety and Governance (Chair Head of Risk/AMD) Behaviour (Chair Dep Dir HR) Training (Chair AMD – Educ) Operational (Chair Consultant Surgeon) Project board chaired by Medical Director and delivery groups meet weekly – attendance defined at DDO/Div Chair level. Dedicated project manager in place (10.2.16) Additional Medical Physics resource secured for 3 months to carry out compliance checks acroiss all areas using radiation External invited review by Royal Colleges of radiology/Surgeons to commence Feb 2016.			**Assurance**	Monthly reports to the Joint Oversight Group – chaired by Wandsworth CCG and attended by NHSE/Monitor and other CCG commissioner representatives. Internal reporting through EMT Weekly highlight reports from work stream delivery groups 19 of 29 areas now reviewed with oly minor gaps identified – with the exception fo one area where operator training is not I place – to be addressed.
Gaps in controls	Project methodology not yet fully agreed			**Gaps in assurance**	No clear map of areas across Trust using ionising radiation across Trust hence unable to provide full assurance that all areas have robust governance around radiation procedures Gaps in governance structures around radiation protection revealed and need for wider governance/ committee review
Actions next period:	Within February 2016: Newly appointed Project Manager to confirm project methodology urgently Training for operators is identified risk area to be provided 14 march Review of Radiation policy IRMER regs on intranet				

Domain 1.2 Patient Experience

Principal Risk	A410-O2: Failure to sustain the Trust response rate to complaints				
Description	Risk of failure to deliver a sustained ability to turnaround of complaints within agreed timescales, also to maximise the learning from complaints. Negative impact on the Trust's reputation and loss of patient and public confidence				
Domain	**1.Quality**			**Strategic Objective**	**1.2 Patient Experience**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Jennie Hall
Consequence	4	4	4	**Date opened**	30/04/2009
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	Weekly email detailing open complaints by division and trust response time quarter to date circulated. Included as a measure within the divisional performance scorecard. Greater oversight of complaints by DDNGs Regular reporting via PEC, QRC & Trust Board. Use of a risk rating system to identify high risk complaints.			**Assurance**	There was a slight improvement in complaints performance against the first target in quarter 3 when compared to quarter 2. 69% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 65% in quarter 2. There was a decline in performance again the second target with 87% of complaints responded to within agreed timescales (against internal trust target of 100%) compared to 90% in quarter 2. Action plans in place in divisions to improve and to deliver performance against internal standards. Trust performance reviewed by PEC every 2 months Reported to TB monthly
Gaps in controls				**Gaps in assurance**	
Actions next period:	Divisions to advise on and improve action monitoring processes. All divisions to continue to implement improvement plan (with trajectory) to improve response rate LEAN review of complaints process – workshop planned for 7 March 2016 to develop new action plan.				

Principal Risk	02-01 Risk of diminished Quality: patient safety, patient experience and patient outcomes, as a result of Cost Improvement Programmes (CIPs*)*		
Description	As Cost Improvement Programmes continue to be rolled out, there is a potential risk that inadequate identification, monitoring and mitigating actions will fail to ensure that quality of care is preserved. CIPs include run-rate schemes and service improvement projects		
Domain	**1.Quality**	**Strategic Objective**	**1.2 Patient Experience**

	Original	Residual	Updated Mar 16	Exec Sponsor		Jennie Hall/Simon Mackenzie
Consequence	4	4	4	**Date opened**		01/07/2013
Likelihood	4	4	4	**Date closed**		
Score	16	16	16			
Controls & Mitigating Actions	All combined schemes (divisional improvement programmes, run rates) must have a Quality Impact Assessment covering 5 dimensions (5x5 risk scoring): - Patient Safety - Patient Outcome - Patient Experience - Staff welfare - Financial impact Combined schemes are subject to local governance scrutiny and approval, at care group, directorate and divisional level; overseen by Divisional triumvirate including Divisional Chair, Divisional Director of Operations and Divisional Director of Nursing & Governance. CGG chaired by Medical Director – all schemes with risk score over 12 also referred for consideration for approval by CGG. CGG is dynamic. CGG reports exceptional risks to QRC. Divisions make a self-declaration upon management of schemes not presented to CGG Process continues to evolve to encompass all schemes				**Assurance**	Positive assurance: External scrutiny of process by commissioners. Evidence that this mechanism has led to review and modification or rejection of proposals **Internal – quantitative assurance:** Weekly quality oversight Quality KPIs – via Quality report Mortality monitoring **Internal – qualitative** Complaints/concerns/AIs/SIs – thematic review Risk register reviews at ORC **External – quantitative** HSCIC data including mortality KPIs reported to commissioners via Quality report **External – qualitative** CQC (Incl Intelligent Monitoring)/ Monitor Reports CQR – Commissioner
Gaps in controls	Potential that not all risks are recognised and that 5x5 risk scoring application is inconsistent across divisions. Reliance upon divisions recognising clinical risks Insufficient mitigations & increased pressure to deliver CIPs may result in less rigorous application of QIA process. Not picking up cross Trust schemes adequately – these to commence coming to CGG i.e. capacity				**Gaps in assurance**	Quality measures often lagging indicators hence risks may not be identified in a timely manner

	It is possible that cumulative impact of schemes might not be recognised Decisions largely anticipatory. No sense of real terms impact of a schemes – needs to be linked to consequence of implementing Oversight of interdependency of schemes inadequate – need to understand the cumulative impact : - Of short term schemes which by default ensure for longer - Of cross divisional/services schemes Timeliness of identification of risks -requires enhanced quality oversight		
Actions next period:	Continued oversight by CGG and refinement of CGG process Trust wide scheme to come to CGG Include feedback from re-established Quality inspections Larger themes will allow higher quality QIAs and assessment		

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 £25m working capital facility				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Iain Lineham
Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	2	2	**Date closed**	
Score	20	10	10		

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**	Monitor have agreed to submit an application for Interim financial support to the ITFF on the Trust's behalf, once the Trust has submitted its Financial Turnaround plan in November. The ITFF approved the Trust's application for a temporary loan facility submitted at the end of September to cover the Trust's working capital requirements for the period up to the end of January.

	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 • Trust has reviewed the commitments against the current capital programme to ensure that the Trust does not need to make an application for capital interim support • Through the cost pressure process, the Trust has ensured that increases in the requirement for new revenue expenditure have been minimised. • The Trust is reviewing its working capital management processes to maximise liquidity; extending creditor payment terms to 60 days; setting targets for debt reduction; and plans to reduce stock. Interim Financial Support application • Through the APR submission, the Trust has advised Monitor of its financial difficulties. • Monitor has agreed to prepare a submission to the ITFF for Interim Financial support on behalf of the Trust once a Turnaround plan has been submitted. • The Trust has engaged KPMG to assist in preparing a Turnaround plan for submission to Monitor in November. • The Trust has also applied directly to the ITFF for a temporary loan facility at the end of September to cover the Trust's working capital requirements for the period up to the end of January.		
Gaps in controls		**Gaps in assurance**	
Actions next period:			

<table>
<tr><td>Principal Risk</td><td colspan="5">3.14-05 Working capital – the Trust will require more working capital than planned due to:
Adverse in year I&E performance
Adverse in year cashflow performance</td></tr>
<tr><td>Description</td><td colspan="5">The Trust's working capital requirement will increase further due to a deterioration in the income and expenditure plans and adverse cashflow movements
Details of the contributory risks to working capital from the Income and Expenditure performance are provided under the following financial risks:
• Income - Tariff
• Income - Capacity
• Income - Market Share
• Cost Pressures
• Cost Improvement Programme
Details of the additional risks to working capital due to other cashflow changes are set out in the cash flow risk.</td></tr>
<tr><td>Domain</td><td colspan="3">2. Finance & Operations</td><td>Strategic Objective</td><td>2.1 Meet all financial targets</td></tr>
<tr><td></td><td>Original</td><td>Residual</td><td>Update Mar 16</td><td>Exec Sponsor</td><td>Iain Lineham</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td>Date opened</td><td>20/07/15</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td colspan="2"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Mitigating Actions:

Minimising Support requirement
• Trust has reviewed the commitments against the current capital programme to ensure that the Trust does not need to make an application for capital interim support
• Through the cost pressure process, the Trust has ensured that increases in the requirement for new revenue expenditure have been minimised.
• The Trust is reviewing its working capital management processes to maximise liquidity; extending creditor payment terms to 60 days; setting targets for debt reduction; and plans to reduce stock.
Interim Financial Support application
• Through the APR and monthly monitoring discussions, the Trust</td><td>Assurance</td><td>Monitor have agreed that the Trust should submit a provisional application for Interim financial support to the ITFF in September and intend to submit a further application once the Trust has revised its financial plans in November.</td></tr>
</table>

	has advised Monitor of the uncertainty of its financial difficulties. • Monitor has agreed to prepare a submission to the ITFF for Interim Financial support on behalf of the Trust once a Turnaround plan has been submitted. • The Trust has engaged KPMG to assist in preparing a Turnaround plan for submission to Monitor in November. • The Trust has also applied directly to the ITFF for a temporary loan facility at the end of September to cover the Trust's working capital requirements for the period up to the end of January.		
Gaps in controls	The PWC review identified a number of weaknesses in the Trust's forecasting processes, which the Trust is currently working through to address.	**Gaps in assurance**	Monitor will only approve the Trust Forecasts once the Trust has submitted its re-forecasting exercise and Turnaround Plan
Actions next period:	**Reforecasting Exercise** • Trust will submit the results of the 2015-16 re-forecasting exercise to monitor. • The Trust will develop additional cash mitigation plans to address the impact on cash where the planned deficit is exceeded		

Principal Risk	**3.15-05 Income Tariff Risk** – that national and local tariffs do not deliver the required income
Description	A key determinant of Trust overall financial position is the tariff that the trust receives for its clinical work and the business rules that govern the application of the tariff. There is the potential for the income position for the trust to worsen due to a range of factors linked to the tariff and application of tariff business rules. Key issues are: ▪ The impact of the Non-Elective Threshold Adjustment (NETA) on the value of increases in non-elective work, where the trust is only paid a proportion of the tariff (currently 30%) ▪ The impact of alternative contract arrangements eg the introduction of the block contract to cover non-elective work, with the associated transfer of risk to St. George's ▪ The reduction in Trust income due to contractual penalties related to poor performance against quality standards and KPIs- payment challenges e.g. RTT performance or 1st to follow up ratios; failure to achieve best practice tariffs and non-payment by CCGs of coding related improvements

<table>
<tr><td></td><td colspan="5">▪ That proposed changes in the national tariffs and business rules may adversely impact the trust financial position from 2016-17 eg
○ the introduction of HRG4+ from 2016/17
○ changes in best practice tariffs
○ reinstatement of CQUIN income
○ changes in application of marginal rates to non-elective work / specialist work</td></tr>
<tr><td>Domain</td><td colspan="3">Finance & Operations</td><td>Strategic Objective</td><td></td></tr>
<tr><td></td><td>Original</td><td>Residual</td><td>Update Mar 16</td><td>Exec Sponsor</td><td>Iain Lineham</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td>Date opened</td><td>20/07/15</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td colspan="2"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Controls
▪ Engagement with and development of good and positive relationships with all main commissioners.
▪ Proactive identification of changes to patient pathways which impact on the level of emergency admissions
▪ Good clinical engagement to ensure that services maximise income e.g. by not incurring payment or performance penalties
▪ Negotiation of appropriate and realistic thresholds and targets with local CCG’s to minimise trust exposure to challenges.
▪ Robust assumptions in business planning and income targets with respect to NETA impacts, Commissioner challenges etc
▪ Mechanisms for the accurate coding and appropriate charging for all activity
▪ Central role played on System Resilience Working Group will allow St. George’s to influence the local health economy
▪ Active membership of Project Diamond provides the Trust with a London wide voice to reflect Tertiary Hospital views in the development of the tariff.
▪ Active membership of FT Network to influence tariffs at a national level.
▪ Engagement with Consultation on changes to National Tariff / assessment of impact
▪ Participation with and through South West London Collaborative Commissioning to influence and mitigate the impact of the BCF on St. George’s.
▪ Monthly SLAM review group is using SLAM to monitor the</td><td>Assurance</td><td>▪ Role on System Resilience Working Group to positively influence how emergency care is managed in the local health economy and how retained funds are spent
▪ Reported value of emergency threshold tariff loss
▪ SWL system receiving support from PWC as part of 5 year planning process to ensure plans are coherent, consistent and deliverable.
▪ Annual business plans and business planning process though to Finance & Performance Committee and Trust Board</td></tr>
</table>

	benefit/disbenefit of the block contract arrangement. **Mitigating actions:** ▪ Support commissioners to develop realistic and deliverable QIPP plans to manage demand for emergency services ▪ Development of admissions avoidance projects in-year which reduce the total number of patients being admitted to the trust ▪ Year End Settlement discussions to mitigate income losses by agreement with commissioners to a year-end settlement through the SLA negotiation process.		
Gaps in controls	▪ Inability to influence QIPP schemes or lack of delivery of those QIPP schemes ▪ The Trust needs to more pro-actively identify specific areas of risk ahead of payment/performance challenges	**Gaps in assurance**	Access to representation on System Resilience Working Groups outside of Wandsworth/ Merton/Lambeth where significant level of STG funding sits
Actions next period:	▪ Robust dialogue and negotiations with commissioners for additional funding through 2016/17 ▪ Discuss NHSE NETA reinvestment at Finance & Recovery Group ▪ Review local tariffs as part of 16/17 contracting round		

Principal Risk	**3.16-05 Income Volume Risk (Market Share)** – that the trust loses market share, 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. Income is received from NHSE (the single biggest commissioner of St. George's activity) and CCG's, of which Wandsworth, as our local commissioner is the biggest. The other south west London CCG's and Surrey form the core of other CCG income. 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 referred to the Trust. Key issues are: ▪ Competition with other providers. Activity and associated income/contribution will be lost due to competition from other service providers resulting in reductions in market share in areas that St. George's, for financial or strategic reasons, wishes to grow activity in. For example, Cardiology going to GSTT from SWL and Surrey, or Neuroscience activity going to inner London providers. ▪ That the impact of potential decommissioning of services will reduce the trusts market share and hence income. ▪ That the trust makes a nuanced judgement about which services to tender for (or not e.g. Merton community services) and then actively aims to

	win all those services which are tendered				
Domain	**Finance & Operations**			**Strategic Objective**	
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Iain Lineham
Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	2	2	**Date closed**	
Score	20	10	10		

Controls & Mitigating Actions	**Controls** ▪ Engagement with, and development of good and positive relationships with all main commissioners to help ensure that St. George's remains referral unit of choice in south west London ▪ Commercial board oversight of understanding of market share, competitors for services, tendering exercises and development of marketing plans. ▪ Development of GP liaison role to market to individual referrers ▪ Development of marketing plans for individual services e.g. Cardiology ▪ Benchmark for quality and performance to understand how the St. George's service compares to competitors ▪ On-going improvement in service quality, to maintain market share and encourage patients to actively choose St. George's. ▪ Divisional annual business plans to identify threats in the market, and how the service will respond to those issues ▪ Business Case Assurance Group (BCAG) – reviewing all tender submissions ▪ Decision to enter tender process for each invitation received, based on current strategic and service fit and financial contribution/profitability. ▪ Win new tenders e.g. Nelson Local Care Centre, to maintain and expand market share **Mitigating actions:** ▪ Develop deliverable and measurable action plans in response to any significant loss of market share, focusing on reclaiming lost referrals	**Assurance**	▪ On-going market share monitoring via SLAM and Dr. Foster data. ▪ Business planning processes to identify risks and market strategy ▪ Trust has won the Nelson Tender. This follows on from the winning of the Prison Tender. Winning both these illustrate and demonstrate that the trust has a track record on winning tenders, and has confidence that it can produce robust and innovative responses to any future tender of services ▪ Decision not to bid for Merton Community Services ▪ Limited evidence of material reductions in referred activity and apparent shortage of capacity to deliver current demand for services

	▪ To develop action plan to develop new markets, focussing on Surrey referrals and south west London activity currently going out of sector. ▪ Cost removal – assuming that substitute activity cannot be grown to detail where cost will be taken out ▪ That St. George's wins any tenders that it chooses to bid for, negating the need for other mitigating actions ▪ Lost service Line Tenders: TUPE of all staff involved. Identification of any potential substitution activity that retained assets – staff or facilities – can undertake service lines are lost in tender process		
Gaps in controls	▪ Lack of highly developed marketing plans for many services ▪ ▪ ▪ Absence of routine market share analysis	**Gaps in assurance**	▪ Absence of routine market share analysis reporting
Actions next period:	▪ Completion of 2015-16 Reforecasting process and 2016-17 business planning process ▪ Issue of "Six month notice letter" to Commissioners ▪ Robust dialogue and negotiations with commissioners for additional funding through 2016/17		

Principal Risk	**3.17-05 Cost Improvement Programme slippage -** The Trust does not deliver its cost improvement programme objectives				
Description	▪ Opportunities for savings schemes are not identified ▪ Opportunities to save are not sufficiently developed to deliver the value required ▪ Savings identified within schemes are overoptimistic / savings are double counted ▪ Savings are redeployed ▪ Savings schemes are not delivered as planned or are delivered late ▪ Capacity constraints prevent delivery of activity plans ▪ Savings identified are only non-recurrent				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Iain Lineham
Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	3	3	**Date closed**	
Score	20	15	15		

Controls & Mitigating Actions	Controls ▪ Turnaround Board to oversee Trusts response to 2015/16 financial challenge by taking a lead role in developing, driving and delivering a robust CIP programme for 2015/16 and subsequent years ▪ Benchmarking St. George's services to ensure that opportunities are found ▪ Role of PMO in managing CIP programme. ▪ Rigorous PID development to support projects to be delivered ▪ Divisional finance managers signoff financial scoping for each scheme ▪ HR sign off WTE impacts on each scheme ▪ QIA sent to Medical Director and Chief Nurse on each scheme ▪ Divisional steering groups, meet fortnightly and approve all schemes ▪ Workstream fortnightly steering groups developing opportunities which are appropriately tagged to prevent double counts Mitigating Actions ▪ To develop further in-year non-recurrent CIP schemes to offset the non-delivery of the full CIP programme. These would include: o Vacancy freezes o Reductions in procurement spend o Slowing of in-year capital programme	**Assurance**	▪ KMPG baselined CIP programme and are developing the pipeline ▪ Extensive governance across workstreams and divisions is in place ensuring ownership and accountability, with a report into the Turnaround Board every month ▪ Finance review the financials for every scheme to ensure its validity and its link back to the budget ▪ Finance must sign off a milestone on every scheme stating that they have seen the step change / impact in the financial position when they start to record actuals
Gaps in controls	▪ A significant proportion of the schemes are non-recurrent leaving a significant problem for 16/17 ▪ Majority of schemes are budgetary management (runrate) rather than significant pathway changes. ▪ Service Improvement scheme benefits assumed in the planned I&E and cannot therefore be counted in the £38m CIP target and are therefore subject to less rigorous assurance	**Gaps in assurance**	▪ Potential shortfall on total impact of schemes delivered to meet the £38m ▪ Limited ability to measure the success of the impact of Service Improvement projects as the changes to KPIs could be due to a number of drivers not just the project change ▪ The CIP target was changed from £43.2m to £38.1m to reflect the movement of the income schemes to the divisions. The ability to achieve this is linked to the Capacity and Flow programmes led by

			Service Improvement, which have been subject to slippage and are unlikely to deliver. However, the additional £5m is not subject to same monitoring as the £38.1m
Actions next period:			

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 incurred from the usage of private sector capacity to deliver waiting time targets or services out of hours, will increase marginal costs and decrease contribution from individual services e.g. Cardiology and Cardiac Surgery ▪ Premium costs related to the supply of scare resources eg cost of agency nurses due to nursing staff shortages ▪ That extra activity costs more than anticipated due to poor cost estimation or that capacity secured off site costs more than anticipated in business planning / budget setting process				
Domain	**Finance & Operations**			**Strategic Objective**	**Meet all financial targets**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Iain Lineham
Consequence	4	4	4	**Date opened**	20/07/15
Likelihood	4	4	4	**Date closed**	
Score	16	16	16		
Controls & Mitigating Actions	**Controls** ▪ KPMG input into increasing robustness of trust finance function ▪ Business Planning Process - 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. ▪ Contingency Reserves are set aside in line with NHS			**Assurance**	Monthly financial reporting of performance to the Board Identification and review of cost pressures through the Business Planning cost pressure review process.

	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** ▪ Deployment of Turnaround team to provide greater grip on expenditure controls. ▪ 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.		
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 2015-16 Reforecasting process and 2016-17 business planning process		

Principal Risk	**3.19-05 Cash-flow Risks** – Cash balances will be depleted due to: Delays in receipt of SLA funding from Commissioners Capital overspends				
Description	The Trust's cash balances will be significantly depleted due to delays in receipt of commissioner funding. Risk is currently greater due to high level of over-performance above agreed SLA values assumed in the Trust's plans and recent data quality issues				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update**	**Exec Sponsor**	Iain Lineham

			Mar 16		
Consequence	4	4	4	**Date opened**	20/07/15
Likelihood	3	4	4	**Date closed**	
Score	12	16	16		

Controls & Mitigating Actions	**Working Capital Management** • The Trust Cash Position is reported to the Board each month as part of the finance report, including detailed cash flow statements and 2-3 year cash projections. • Changes in debtors, stock and creditors reported and explained within finance report to Finance and Performance Committee and Board. • Trust has set month-end cash balance target against which cash performance is measured: £5m minimum in line with the terms of the current working capital facility. • SLA interim invoicing – as above. **Contract Documentation** • SLAs include special clause for interim invoicing of over-performance in advance of freeze date - enhances cash flow. **Controls:-Capital Expenditure Management** • Capital Programme Group (CPG) oversees the planning and monitoring of the annual and five year capital programme, which reports to Executive Management Team • Monthly capital finance reports on funding and expenditure are submitted to the CPG for review and forecasts updated. The Finance and Performance Committee and Trust Board receives a summary financial report on the capital programme as part of the finance report and significant variances and changes to plan explained. • Maintain reasonable and prudent capital cash flow projections based on detailed returns from capital budget holders commensurate with agreed funding and ensuring they are updated regularly to reflect changes in project timescales and in the receipt of external funding. **Mitigating actions:**	**Assurance**	Detailed monitoring and forecasting of cash flow and agreed debt through Finance and Performance Committee. HDD3 working capital reviews Previous track record in managing capital programme within plan Capital programme is currently underspending against the reduced plan Contract query notice served by CCGs in Q3 2014/15 has been lifted (March 2015) following implementation of actions outline under controls

	Manage Working Capital
	• Improve Debt Collection
	• Delay payment of creditors / manage balances with major creditors e.g. SGUL
	• Reduce stock levels e.g. extend scope of consignment stock to deliver one-off improvement in liquidity – subject to VFM and affordability tests (i.e. higher unit costs)
	• Delay capital investments in line with reduced funding
	
	Address Data Quality issues
	• Agreed additional investment in Data Quality Team as part of 15/16 cost pressure funding
	• Action plan in place to address issues with data quality - actions include:
	  • Ensuring fields in minimum data set (Monthly SLAM/SUS reconciliations) are completed
	  • Rolling programme of monthly locking down data
	  • Strengthened process of ensuring "flex" and 'freeze' reports to commissioners as per contract
	  • Future upgrades to Cerner will first be tested in a test environment before going live		

Gaps in controls	Contract with NHSE likely to include unidentified QIPP leading to over performance on contract maybe c£1m per month & cash flow problems	**Gaps in assurance**	Data quality risks: Potential new data challenges from commissioners which have not yet surfaced Whilst resource focused on ensuring recording of data may limit capacity to understand scope of problem to treat and ensure no recurrence Future issues with data capture occurring or being revealed by subsequent Cerner system upgrades New Contract query notice has been served
Actions next period:	• Seek to agree payment for over-performance in the contract with NHSE • Agree loan draw down with DH to ensure no cashflow risks from major loan funded projects • Cash management review by external audit • Further escalation through NHSE • Resolve outstanding data quality problems delaying payment		

<table>
<tr><td>Principal Risk</td><td colspan="5">3.20-05 Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.</td></tr>
<tr><td>Description</td><td colspan="5">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</td></tr>
<tr><td>Domain</td><td colspan="3">Finance & Operations</td><td>Strategic Objective</td><td></td></tr>
<tr><td></td><td>Original</td><td>Residual</td><td>Update Mar 16</td><td>Exec Sponsor</td><td>Iain Lineham</td></tr>
<tr><td>Consequence</td><td>5</td><td>5</td><td>5</td><td>Date opened</td><td>30/09/15</td></tr>
<tr><td>Likelihood</td><td>4</td><td>4</td><td>4</td><td>Date closed</td><td></td></tr>
<tr><td>Score</td><td>20</td><td>20</td><td>20</td><td colspan="2"></td></tr>
<tr><td>Controls & Mitigating Actions</td><td colspan="3">Controls
▪ Business planning process – development of annual capacity plan, agreeing service volumes, capacity utilisation rates and identifying capacity requirements
▪ Benchmarking and monitoring of capacity related performance measures: i.e. capacity availability, productivity and length of stay
▪ Business Case Assurance Group (BCAG) and the business case process for approval of all investments in capacity
▪ OMT, EMT, TAB and Trust board oversight of Flow and Capacity plans and delivery

Mitigating actions:
▪ Sourcing additional capacity in independent sector at tariff to minimise loss of income associated with performance fines
▪ Ring-fencing elective beds to secure elective income
▪ Developing outpatient recovery plans to mitigate under delivery M1-6</td><td>Assurance</td><td>▪ 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</td></tr>
</table>

Gaps in controls	▪ Integrated demand and capacity model	**Gaps in assurance**	Integrated demand and capacity model outputs to confirm capacity requirements
Actions next period:	▪ Completion of 2015-16 Reforecasting process and 2016-17 business planning process including development of integrated demand and capacity model		

Finance & Performance Domain: 2.2 Meet all operational & performance requirements

Principal Risk	3.7-06 Failure to meet the minimum requirements of the Monitor Risk Assessment Framework may result in reputational damage or regulatory action.				
Description	There is a risk to the Trust's authorisation should it fail to perform against the Access Metrics set out by Monitor Performance Framework particularly in relation to:- 18 weeks- A&E Waits (4 hours)- Cancer waits (TWR, 31 & 62 day targets).Individual risks, controls and actions to mitigate are set out in Divisional risk registers				
Domain	**2. Finance & Operations**		**Strategic Objective**		**2.2 Meet all performance targets**
	Original	**Residual**	**Update Nov 15**	**Exec Sponsor**	Paula Vasco-Knight
Consequence	4	4	4	**Date opened**	30/05/2013
Likelihood	4	5	5	**Date closed**	
Score	16	20	20		
Controls & Mitigating Actions	Management framework in place which measures performance across key domains including operational performance. Divisions are held to account through formal quarterly performance reviews, monthly reporting and monitoring and escalation where required through the DoFPI The Trust has a performance management framework A&E performance meeting is held routinely within the Med/Card division to scrutinise and review ED performance Finance & Performance Committee meets monthly to review in detail the performance report including all areas of the TDA accountability framework Reporting to F&P includes description of key actions and sharing of recovery plans where necessary e.g. cancer recovery plan 12/13 Q4 Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train External scrutiny: Performance is reviewed by the TDA as part of the Accountability Framework and the Trust is held to account at a monthly meeting of senior			**Assurance**	Positive assurance •HDD, BGAF and QGAF assessments •Internal audit Following a period of joint investigation with commissioners, remedial action plans have been agreed for performance improvement in ED and RTT. Negative assurance Worsening ED performance across Q1 and continued under-delivery in Q2 – cross ref BAF Risk 01-07 RTT performance issues in relation to the incomplete pathway target. Contract query notice served for cancer performance. Tripartite meeting with NHSE & Commissioners held and a recovery plan presented. Weekly performance recovery

	teams Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action is further scrutinised **Mitigating Actions** •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads •Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train •Developmental work in place to introduce formal monthly scoring system for Divisions within the performance framework to improve visibility over performance risks and the effectiveness of remedial action •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads		meetings in place both internally and a separate meeting being chaired by commissioners
Gaps in controls	Absence of risk forecasting which is in development	**Gaps in assurance**	
Actions next period:	• Recruit to staff new capacity • Continue to implement joint I investigation actions • Implement cancer recovery plan • Cancer PTL development • Waiting list improvement programme – present proposal to TB and gain agreement		

Principal Risk	3.8-06 Low compliance with new working practices introduced as part of new ICT enabled change programme				
Description	Partial adoption of new working practices could lead to inconsistencies in management of patient care. Failure to conform to new operational procedures could lead to decrease in organisational efficiency.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.2 Meet all performance targets**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Martin Wilson
Consequence	4	4	4	**Date opened**	02/06/2013
Likelihood	3	3	3	**Date closed**	

Score	12	12	12		
Controls & Mitigating Actions	Each project within ICT programme is:- Managed using PRINCE methodology- Has a clinical lead- Reports to clinical systems programme board- Has individual risks and issues register managed on-going Director of FPI is SRO and sits on programme board. Regular programme board reports to Executive Management team Programme board highlight reports to EMT include RAG status and provides assurance project on track – this reporting mechanism promotes transparency and challenge Chief Clinical Information Officer in post 18 Champion Users seconded to support deployment Mitigating actions centre upon phases of engagement:- Involve clinical staff/health care groups in system design- Healthcare groups involved in implementation- H/care groups involved in endorsement of new working practices Weekly (monday) i-clip meeting now takes place and all issues fed back live			**Assurance**	Programme Board highlights reports to EMT to include RAG status and provides assurance project on track. Chief Information Officer in post 18 Champion users seconded to support development Now over-arching clinical governance in place, including clinically led gateway review of ICT clinical programme 15 of the secondments have ended with clinical champions returned to their substantive roles External post implementation benefits review to be completed by Nov 2015 Consolidation programme progress to be reported to October CSPB Recommendations on completion of deployment to be made to October CSPB meeting Bi weekly report on discharge summaries and VTE sent to speciality leads Revised diagnostic results endorsement policy adopted by the Trust with new process implemented from mid-September 2015
Gaps in controls	Ensuring full and representative health care professionals' input into key areas Some constraints of operating within national programme for IT framework			**Gaps in assurance**	
Actions next period:	Development of process for transition of clinical information projects into business as usual via the ICT Service Improvement Programme. Ensure lessons learned during pause period are documented and reported back to Clinical Systems programme Board in Oct 15				

Principal Risk	3.9-06- Risk of inappropriate deployment of e-prescribing and electronic clinical documentation				
Description	There is a risk that if e-prescribing and electronic documentation is inappropriately deployed this will have an adverse impact on patient care and clinical continuity.				
Domain	**2. Finance & Performance**			**Strategic Objective**	
	Original	**Residual**	**Update**	**Exec Sponsor**	Martin Wilson

			Mar 16		
Consequence	4	4	4	**Date opened**	1.7.14
Likelihood	3	3	3	**Date closed**	
Score	12	12	12		
Controls & Mitigating Actions	Deployment project being managed with PRINCE 2 methodology Clinical lead in place to ensure clinical input on programme board Gateway thresholds established for technical readiness and staff readiness Each clinical area has a task group with a clinical lead who has power to sign off to roll out in their area Overall deployment is subject to regular gateway reviews.			**Assurance**	Reporting on progress of project to Clinical Information Systems Programme Board On-going modification of deployment plan in response to lessons learned from early adoption means project is flexible and responsive to ensure success. Deployment model broadly successful but sustainability to end point currently not viable Early indications are that in areas where deployment has taken place quality has improved as well as revealing/creating challenges to existing practice Deployment system paused until 2016/17 which brings further risk of operating dual systems for longer than planned Clinical systems Programme Board reviewed lessons learnt and made recommendation to EMT in October regarding deployment options. A business case was subsequently presented to Investment Case Assurance Group (formally BCAG) on 16th November 2015 and will considered in the prioritisation exercise being conducted by the Trust for next year's capital investment programme Risk lowered as active monitoring of Datix and SIs has revealed no significant variation between areas where e-doc hs been deployed
Gaps in controls				**Gaps in assurance**	None identified
Actions next period:	Progress on approval process to be reported via the Clinical System Programme Board to EMT – Dec 2015				

Regulation and compliance Domain: 3.1 maintain compliance with all statutory and regulatory requirements

Principal Risk	A534-07:Failure to demonstrate full compliance with the CQC Fundamental Standards				
Description	Lack of a sufficiently robust approach to self-assessment and subsequent actions to ensure compliance may lead to a CQC inspection finding of non-compliance. Improvement and/or enforcement action imposed by the CQC with associated reputational risk and risk to the FT application Ref BAF Risk A509. Ultimate risk of loss of licence to operate certain services.				
Domain	**3. Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Jennie Hall
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	1	1	3	**Date closed**	
Score	5	5	15		

Controls & Mitigating Actions	**Controls:** Quality inspections programme underway Quality Fundamental standards meeting established, chaired by Chief Nurse/Deputy Chief Nurse with clear programme of meetings to review each fundamental standard and regulation across a rolling programme Regulation leads established for each regulation New quality intelligence framework in development with clear audit cycles and review at all levels within organisation- developed on electronic rate system Regular reports to QRC/Trust Board Steering group established- first meeting held 24.2.16 Core service leads appointed Self-assessment by division underway	**Assurance**	Chief Inspector of Hospitals inspection report published 24th April 2014, with overall rating of 'Good'. Two compliance actions identified. All actions on compliance action plan completed and presented to commissioners and CQC in June 2015. Commissioners are content to close the action plan in July subject to the on-going monitoring around two actions reverting to business as usual monitoring. Quality Inspection programme has recommenced on 1st June 2015 following a pause. Deep dive into risk and programme of work underway to assess compliance with standards GAP analysis undertaken against recently inspected trusts to highlight key areas of focus for StG
Gaps in controls	Resource to deliver readiness programme for re-inspection	**Gaps in assurance**	Need to understand divisional gaps
Actions next period:	Continue to develop the quality inspection programme to further align to CQC inspection frameworks and KLOEs Complete self- assessment against Well Led domain and Kloes for each division and core service Pilot new quality intelligence audit in adult in patient areas (Med- Card) throughout March Recruit PM to manager readiness project – in a way which delivers sustainable quality assessment and improvement processes		

Principal Risk	A537-06:Confidential data reaching unintended audiences				
Description	Inability to control all electronic methods of data transfer (USB sticks, laptops, e mails etc) Also paper records vulnerable to loss. Data loss can result in data reaching unintended audiences (e.g. public), loss of reputation, SUIs and restrictions from information commissioner including financial fines.				
Domain	**3. Regulation & compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Residual**	**Updated Mar 16**	**Exec Sponsor**	Simon Mackenzie
Consequence	5	4	4	**Date opened**	31/10/2010
Likelihood	3	3	3	**Date closed**	
Score	15	12	12		
Controls & Mitigating Actions	Policies on data protection, information security, medical records and corporate email reviewed and disseminated through IG training, MAST, Trust Induction and Trust Intranet. Technical controls - All Trust laptops encrypted. USB port blocking implemented. Trust known devices whitelisted. Encrypted USB sticks distributed and available to Trust. Non encrypted USB sticks read only. Encrypted external drives available. Roll out of Virtual Desktop Infrastructure and single sign on in progress. Remote access 2 factor authentication complete. Electronic data management project in progress [paper light environment, RFID tracking]. Reviewed medical storage – updated guidance and auditing practice. On-going communication to staff on IG matters through eG IG Manager has now commenced and will continue monitoring “High” alerts in the external email monitoring software prompting email notices to members of staff Monitoring of sensitive data being sent from non-secure commercial email accounts – in progress. Letters to those staff who repeatedly deviate from guidance and Trust policy are being sent.			**Assurance**	Reduction in recent incidents involving data loss. On-going monitoring of any new removable storage devices with a view to blocking all such devices when greater assurance obtained that there is no clinical risk. CQC report at inspection Feb 2014 provides assurance of compliance on inspected wards in relation to secure storage of patient records. RFID case-note tracking. is being audited locally with improving results month on month

Gaps in controls	No method of control of stopping paper records being removed.	**Gaps in assurance**	
Actions next period:	Web based email (e.g. gmail, Hotmail) traffic is being monitored – "high risk" flagged email is being further investigated for potential policy breaches.		

Principal Risk	A610-06: The Trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training				
Description	Failure to reach the target will result in an 'unsatisfactory' score for the IG toolkit submission for the Trust.				
Domain	**3. Regulation & compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Current**	**Updated Mar 16**	**Exec Sponsor**	Simon Mackenzie
Consequence	3	3	3	**Date opened**	31/10/2011
Likelihood	5	5	5	**Date closed**	
Score	15	15	15		
Controls & Mitigating Actions	Information governance is a mandatory module in Trust induction training, MAST training and Cerner Training. E-Learning platform for MAST. Review of attendance at HR and Workforce and IG Committee. Management procedures to follow up of non-attendance in place. New e-learning and e- assessment modules have gone live and continues to roll out. IG Manager continuously monitoring IG training compliance.			**Assurance**	As reported on central Trust system IG training compliance at 65% as at end of Feb 2016 Nationally mandated target of 95% was not met for 2014/15. MAST training committee established Inclusion of MAST training to monthly performance review meetings with Divisions in addition to Appraisal rates
Gaps in controls	Possibility that financial pressures will reduce focus on training due to run-rate controls – currently being monitored Temporary staff not requested to complete training			**Gaps in assurance**	Lack of reliability on central mandatory training reporting system hence true percentage trained could differ from that reported. Uncertainty around numbers of temp staff who require training
Actions next period:	Face to face drop in session arranged for delivery throughout March 2016 session to be arranged for hard to reach staff groups				

Principal Risk	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)

Description	Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Residual**	**Updated Nov 2015**	**Exec Sponsor**	Eric Munro
Likelihood	5	3	4	**Date opened**	14/03/2013
Consequence	4	4	4	**Date closed**	
Score	20	16	16		

Controls & Mitigating Actions	Robust action plan in place being led by the fire safety team and monitored through the Health, Safety & Fire Committee. Regular meetings/communication with Fire Brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety. Fire risks assessments (FRAs) prepared by Fire Safety Specialists and issued to space/premises managers Head of Estates Compliance in post Two permanent Fire Officers in post reporting to Head of Estates Compliance Established "Responsible Fire Persons" email circulation list to send personal emails to ward/area managers There are responsible persons identified for all individual areas subject to FRAs.	**Assurance**	Internal Reporting on fire risk assessments to Health, Safety and Fire Committee and escalate any issues to the Organisational Risk Committee. Fire risk assessments and fire safety audits External LFEPA regularly visit usually on a quarterly basis Internal Audit Fire safety Update Report Aug 2015: 7 out of 13 previous recommendations partially implemented, four fully implemented and two not implemented. Fire Warden training records loaded onto MAST (Totara) in December 2015. Fire Marshall training increased from 27 to 77% in the last 6 months.
Gaps in controls	Comprehensive surveys and assessments of compartmentation.	**Gaps in assurance**	90% all staff appropriately trained to increase rate of compliance • General staff • Fire Marshalls Key performance indicators are required for reporting to Health safety and Fire committee, ORC and QRC.
Actions next period:	Implement action plan in period. (Fire risk assessments, training, infrastructure, governance). Monitor progress through Health, Safety & Fire Committee and via Organisational Risk Committee.		

Principal Risk	03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation

Description	There are gaps in the mandatory and statutory estates compliance documentation.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Residual**	**Updated Nov 2015**	**Exec Sponsor**	Eric Munro
Likelihood	4	3	4	**Date opened**	October 2012
Consequence	4	4	4	**Date closed**	
Score	16	12	16		
Controls & Mitigating Actions	Revised estates permanent management structure is in place this includes a compliance manager. Management structure which includes delegated responsibility Planet FM system (the estates helpdesk and job request system) is being upgraded to allow compliance to be monitored. Head of Estates Compliance in post An audit on the gaps in compliance has been completed. There is a planned programme in place to close the gaps in compliance. The Estates action plan will be further revised as higher risk items are closed.			**Assurance**	External H&S Executive – issue with electrical outlets on Richmond ward has resulted in a notice of contravention of the health and safety act (actions underway). Authorising Engineers appointed in all HTM areas Internal Estates compliance records being assembled. Action plan being monitored and progress updates to the Operational Management Team. This risk is monitored via the Health, Safety & Fire Committee and overseen by the Organisational Risk Committee. Internal audit review findings: whilst some progress has been made with the remaining agreed actions, overall progress has been slower than desired in key areas.
Gaps in controls	All recommendations from the estates action plan are not complete			**Gaps in assurance**	Full compliance reports not yet available.
Actions next period:	To ensure that regular updates are provided to the committees monitoring this risk.				

Principal Risk	03-03 Lack of decant space will result in delays in delivering the capital programme.		
Description	Lack of decant space for capital schemes delays the ability to deliver some large capital schemes.		
Domain	**3.Regulation & Compliance**	**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**

	Original	Residual	Updated Nov 2015	Exec Sponsor	Eric Munro
Likelihood	4	4	4	**Date opened**	May 2014
Consequence	4	4	4	**Date closed**	
Score	16	16	16		

Controls & Mitigating Actions	Risk assessments undertaken for each project. Space surveys are undertaken on an annual basis to provide room usage data to enable the project manager to work out a plan. Monitored through the Capital Programme Board & Project Programme Board Detailed decant plans will sit under the Trust's Development Control Plan Mitigating Action: The Trust received full Planning permission for the new Wandle annex – 4 storeys c 5000m2. Plan in progress to vacate existing chest and breast clinic building as no longer fit for occupation.	**Assurance**	Documented risk assessments received by Project boards and reviewed when business cases approved Capital project delivery is reviewed through Capital Programme Board & Project Programme Boards.
Gaps in controls	Short term planning brings forward new priorities that unbalance existing plans. Impact of turnaround Portakabin to move transactional staff out of clinical areas and release space for redevelopment not in 'shrunk' capital plan	**Gaps in assurance**	Financial position may mean potential inability to finance mitigating actions
Actions next period:	The list of space requests are being collated to assess the requirements. This will form the basis to find and agree the location of a decant space.		

Principal Risk	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.
Description	Delay to the ability to deliver the capital programme and maintenance activity as a result of spaces not being handed over to projects and maintenance as a result of capacity issues.

Domain	3.Regulation & Compliance			Strategic Objective	3.1 Maintain compliance with all statutory & regulatory requirements
	Original	Residual	Updated Nov 2015	Exec Sponsor	Eric Munro
Likelihood	4	4	4	Date opened	May 2014
Consequence	4	4	4	Date closed	
Score	16	16	16		

Controls & Mitigating Actions	Risk assessments undertaken for each project. Monitored through the Capital Programme Board & Project Programme Board. Engage with the department early in the capital scheme and jointly agree how this can be managed. Delivery of Lanesborough 1st Floor project/Hybrid theatres and completion of Bed capacity Project s will provide further mitigations. Capital and capacity planning process	Assurance	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards. CPG – CN and MD in attendance
Gaps in controls	No cumulative view of impacts of several decisions not to proceed or to delay works	Gaps in assurance	Improving governance and prioritisation in advance of forthcoming financial year through new IDDG group (merger of Capital programme group and Business case Advisory Group)
Actions next period:	To improve robust monitoring of project and maintenance activity.		

Principal Risk	03-05 Risk to patient safety as a result of legionella infection.
Description	There is a risk to patient safety from legionella infection. This risk has been increased as a result of legionella being found in isolated areas in the St George's Hospital site.

Domain	3.Regulation & Compliance			Strategic Objective	3.1 Maintain compliance with all statutory & regulatory requirements
	Original	Residual	Updated Nov 2015	Exec Sponsor	Eric Munro
Likelihood	4	3	3	Date opened	14 May 2014
Consequence	4	4	4	Date closed	
Score	16	12	12		

Controls & Mitigating Actions	Water testing regime in place as part of the planned preventative maintenance programme. If high counts of legionella are found it is chemically treated in accordance with trust water management policy. Water testing being carried out in accordance with HTM04, L8 and HSG274 Testing regime and results kept in electronic evidence log book.(Zetasafe) Water risk assessment completed Authorising Engineer (Water Systems) appointed by trust provide independent advice and support. Water responsible persons trained and certificated Head of Estates Compliance in post Detailed action plan in place being led by the Head of Estates.	**Assurance**	Water testing and cross party committee DIPC/IC Committee have recognised improvements across last 18 months Water safety committee report goes to ORC and Health, Safety and Fire Committee
Gaps in controls		**Gaps in assurance**	Specify why it remains as a three whilst dead legs removal is ongoing
Actions next period:	Monitor the testing regime and results.		

Principal Risk	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				
Description	The mortuary functions as a hospital and a public mortuary. And has capacity for 87 adult bodies including 6 bariatric fridge spaces. The expansion of hospital activity together with increasing local (Wandsworth & Merton) population has resulted in increased numbers of deceased requiring mortuary storage. This is compounded by an increase in the average length of stay of deceased patients within the mortuary. This has resulted in the Trust having to use temporary storage fridges due to a lack of capacity. At unannounced inspection in July 2015, the Human Tissue Authority (HTA) found temporary storage inadequate. Failure to correct the issues identified within required timescales may result in the Trust licence for post mortems and storage of the deceased to be revoked and the mortuary closed.				
Domain	**3. Regulation and Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Current**	**Update Mar 16**	**Exec Sponsor**	Chief Nurse/DIPC (Jennie Hall)
Consequence	5	5	5	**Date opened**	27.8.2015 – escalated from Division
Likelihood	5	4	4	**Date closed**	
Score	25	20	20		

Controls & Mitigating Actions	Task and finish group set up to oversee programme of work to address all required actions, led by DDNG for CWDT with representation from: Estates, Pathology, Health & Safety, SWLP, Risk , Infection control, Capital projects Comprehensive action log to ensure readiness for re-inspection Working with local undertakers to ensure any available facility at the undertakers is being used for body storage. Capital projects managing provision of bespoke additional accommodation outside the current footprint but within the lower ground floor of Jenner wing within the security cordon of the current cellular pathology department. Length of stay monitored and reported (via OMT & Datix)	**Assurance**	Internal Reports to DGB/DMB via DDNG Reports to EMT via CN Report to OMT monthly re LOS EMT approved funding for temporary storage 27.8.15 External Weekly reports to the HTA on progress 2 x notifiable incidents to HTA in July regarding Critical HSE report March 2015 HTA and inspector visit confirmed good compliance 24.2.16
Gaps in controls	Inability to exert significant influence on wider system – i.e. Coroner to expedite removal of deceased.	**Gaps in assurance**	First Trust to be subjected to more stringent HTA inspection and as such there is a lack of benchmarking in best practice against recommendations made.
Actions next period:	Review risks re closure to revert to BAU with recommendation to next TB		

Strategy Transformation & development Domain: 4.2 Redesign and reconfigure local hospital services to provide higher quality care

Principal Risk	A533-08: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances				
Description	Likely future reconfiguration of acute services in SWL as current reconfiguration not affordable. Risk of reduced range of services or downsizing of services leading to loss of income and financial margin. Possible adverse effects on the delivery of patient care. Even small shifts of activity are likely to reduce financial margin on outpatient activity. As a result of uncertainty the Trust is unable to define activity, capacity and business plans. Risk that patient flows may either exceed expected numbers, impacting on capacity, performance and the quality of care or elective throughput. Opposite risk that predicted activity does not materialise as anticipated, leaving the trust with under-utilised assets				
Domain	**4. Strategy, Transformation & Development**			**Strategic Objective**	**4.2 redesign and configure our local hospital services to provide higher quality care**
Score	**Original**	**Residual**	**Updated Mar 16**	**Exec Sponsor**	Rob Elek
Likelihood	5	4	4	**Date opened**	30/09/2010
Consequence	5	3	3	**Date closed**	
Score	25	12	12		

Controls & Mitigating Actions	Strategy team analyse the financial impacts of both the shifting of care away from the acute site and also the impact of predicated additional activity following acute reconfiguration as part of the business planning process. This includes sensitivity analyses on both activity and finance. The Trust playing leadership role in reconfiguration, planning and modelling for SW London in collaboration with commissioners and providers Continue close working relationship with CCGs to work together on realistic QIPP and demand management plans through individual and SW London-wide out of hospital and integration programmes, including the Better Care Fund plans. Substantive programme director appointed	**Assurance**	LTFM base case does not assume upside of reconfiguration. Estimated the activity capacity and capital implications of a range of possible reconfiguration options Risk consequence increased to ensure commensurate with risk 01-08 where consequences are largely the same. APC report successfully delivered – end of July 2015, initial CCG feedback positive SWL vanguard not selected but overarching SW London system change programme governance under discussion (including tripartite representation) and workstreams being scoped
Gaps in controls	None identified	**Gaps in assurance**	
Actions next period:	Continue to support CCG and partner providers in developing proposals for sustainable health services in SW London. Continue to implement the trust strategy as per the 14/15 plan		

Strategy Transformation & development Domain: 4.3 Drive research & innovation through our clinical services

Principal Risk	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.				
Description	Although SGH has a Research Strategy, this is not embedded as a driver for research across the Trust. It is a high level document that does not set out how research will be embedded. •Track record in research relatively weak •St. George's brand is not strong in research. •Service demands restrict the ability to develop research at St George's (Historical differences in approach) •Loss of opportunities for research and development. •Inability to sustain research infra-structure and governance.				
Domain	**4. Strategy Transformation & Development**			**Strategic Objective**	**4.5 Drive research and innovation through our clinical services.**
	Original	**Current**	**Updated Nov 15**	**Exec Sponsor**	Simon Mackenzie
Consequence	4	4	4	**Date opened**	28/02/2013

Likelihood	3	2	2	**Date closed**	
Score	12	8	8		
Controls & Mitigating Actions	• AMD for Research working with the Dean of Research and Enterprise. Regular joint meetings between SGUL and SGHT execs. • Research strategy implemented • CLRN Funded PAs for research active consultants within Divisions • Annual Plan for research strategy in place& monitored by research committee • Working with Information team, to integrate research data • Agreement of Divisional Scorecards – and introduction onto DMB or similar agenda • Implementing the Research Board • JREO review approved by Joint Implementation Board • Joint working between SGUL Institutes and SGH NHS			**Assurance**	• Agreed Trust KPIs for research. • Increased levels of recruitment to NHR trials - both on raw and weighted figures. We have had a 40% increase in weighted recruitment • Research KPIs reviewed at TB and EMT • MHRA has signed off compliance with clinical trials • Increase in number of studies approved • Independent report of JREO recommendations accepted
Gaps in controls	• No system or guidance for prioritisation towards studies that contribute to NIHR recruitment (high-impact studies.) • There are capacity gaps for the JREO to in support developing research-interested consultants to initiate getting studies up and running • Lack of integration of research data in Trust information systems • Reduced funding for reserach			**Gaps in assurance**	
Actions next period:	Implementation of JREO changes Apply for funding for NIHR and/or CRF				

Workforce Domain: 5.1 Develop a highly skilled & engaged workforce championing our values

Principal Risk	A516-04: Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas				
Description	Inability to recruit and retain the appropriately skilled workforce to deliver our strategy				
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	**3**	**Date opened**	30/11/2012
Likelihood	4	2	4	**Date closed**	
Score	16	6	12		
Controls & Mitigating Actions	Workforce Utilisation Plan reviewed monthly by the Trust Board. The surgical 24/7 group continues to meet regularly to review progress. ANP and PA posts have been established in most divisions to replace the work previously done by junior doctors. A training and education plan is under development for the PAs and ANPs. Able to appoint to these posts and see them as part of the staffing establishment in the future Review of medical establishment undertaken			**Assurance**	Positive assurance received via regular review within divisions. No real reduction in numbers to date. Known and anticipated reductions in junior doctor numbers will be included in business planning guidance and information for 14/15 business planning round. Medical workforce Planning group has been established
Gaps in controls	None identified			**Gaps in assurance**	Impact of new doctors' contract will be highly controversial and it is possible this will negatively affect the numbers of junior doctors wanting to work at the Trust – the impact is as yet unknown
Actions next period:	Each of the divisions will consider workforce implications as part of the business planning round. Any particular difficulties in recruiting to vacancies will be identified and action plans produced. On-going assessment of how we begin to fill the gaps when junior doctors no longer are available				

Principal Risk	A518-04:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey				
Description	Expectations placed on staff continue to rise in the light of increased clinical activity and tougher standards. Pressure felt by managers and staff often results in inappropriate behaviours. Quality of patient care negatively affected				
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	4	4	**Date opened**	31/05/2010

Likelihood	4	3	4	**Date closed**	
Score	16	12	16		
Controls & Mitigating Actions	Staff are knowledgeable about the Stress Management policy & Dignity at Work: Bullying & Harassment policy. We have a H&B helpline that staff can use supplemented by access to the Staff Support and mediation service. Support is offered to managers on how to develop inter-personal skills through Leadership Development Programmes. Conflict resolution training is offered as part of induction. Regular contact with Staff side reps who raise issues on concern. Annual reports to the Organisational Risk Committee. The Friends and Family test for staff has been launched on a trial basis which will allow us to be aware of areas where there is an increase in pressure. Unconscious bias training for senior managers have taken place Posters on harassment and bullying have been publicised across the organisation. Appointment of Senior HR Managers to take the lead around bullying Extended unconscious bias training to bands 7 (key line managers. Divisions have developed and continue to implement plans in response to staff survey The Listening into Action programme alongside work on the Trust's values will focus on action around harassment and bullying. Senior HR Advisor reviewed all work underway and benchmarked against other Trust – amendments to the policy to be made as a consequence		**Assurance**	Report outlining further work to be undertaken presented to Executive Management Team and Overview and Scrutiny Committee in July 2014. Updated analysis to go to EMT in June 2015 Elevated risk on CQC Intelligent Monitoring Report in May 2015 Staff survey results in relation to bullying and harassment show resulted a positive impact of recent work Feedback received from individuals directly as a result of Trust wide emails provide cause for concern Repeated concern raised externally (CQC) regarding PICU
Gaps in controls	None identified		**Gaps in assurance**	Discussions have developed and are continuing to implement plans in response to bullying	
Actions next period:	Director of HR is developing an Embedding our Values programme for use across the organisation. The Effective People Management course will be revised to include an additional session on managing difficult conversations to assist managers in tackling issues effectively without being seen as harassing/bullying the member of staff. Amendments to policy – will include recommendations of the Carter review that CEO leads on Bullying and Harassment.				

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	New MAST Steering Group set up as task force to address continued risk to non- compliance with target		

period:	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

Principal Risk	5.1-01 Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost				
Description	NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing) and most recently this has been increasing at St. George's. We are also increasing capacity in the Trust, often to areas where we have identified staffing as hard to recruit to, and the combination of these factors has meant that supply has outstripped demand, resulting in a heavier reliance on temporary staff. The impact is particularly significant in relation to band 5 nurses, where there is a very high volume of recruitment and in some specialist areas such as oncology, paediatrics and theatres. We are reporting staffing fill of 90%~+ in Safe Staffing reports but the difficulties in staffing create pressures in terms of being able to deliver their services.				
Domain				**Strategic Objective**	
	Original	**Residual**	**Update 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			**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

	workforce information and developing an annual plan. A medical workforce group is being formed, led by the Medical Director. This group will report to the workforce and education committee. Workforce plans form part of the annual business planning round.		questionnaire data. The nursing and workforce leadership teams met with HESL to review the trust's submission for nursing commissions on 26th June. The trust was assured that the submission was considered to be of high standard. The trust will work with HESL on some suggested approaches such as identifying overseas qualified nurses working as health care assistants already working for the trust and providing a HESL supported nursing conversion course. A planned trajectory for turnover was presented to the trust board in May. Turnover has stabilised but remains at high levels. KPMG are providing support to the workforce planning group to speed the process for reconciling ESR and ledger workforce information. The nursing workforce staff-in-post has grown by 134.3 WTE since September 2014. KPMG have produced a detailed weekly tracker analysing staff in post movements. 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		

Principal Risk	5.1-02 Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.				
Description	There is a risk to both effective engagement and support of the turnaround programme delivery where management capacity is insufficient to support the programme whilst delivering business as usual. Similarly, a risk to service delivery may arise if core business is not prioritised appropriately.				
Domain	**5. Workforce**			**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our values**
	Original	**Residual**	**Update Mar 16**	**Exec Sponsor**	Wendy Brewer
Consequence	3	3	**3**	**Date opened**	30/11/2015
Likelihood	5	5	5	**Date closed**	
Score	15	15	15		
Controls & Mitigating Actions	Programme management approach to the requirements of turnaround. Regular staff and senior team leader briefings Communication messages are designed to be engaging and positive Monthly Chief Nurse open forum launched Nov 2015 Leadership programme launched			**Assurance**	
Gaps in controls	None identified			**Gaps in assurance**	
Actions next period:	Communications to be developed in follow up to Nov Senior team leaders meeting to reassure staff around financial position of trust..				

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 16**	**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	5.1-04 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		
Description	The cap on agency rates introduced in December 2015 may mean the trust is unable to secure sufficient locum workforce to ensure safe and effective service provision.		
Domain	**5. Workforce**	**Strategic Objective**	**5.1 Develop a highly skilled & engaged workforce championing our**

					values
	Original	**Residual**	**Update**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4		**Date opened**	1/12/2015
Likelihood	4	4		**Date closed**	
Score	16	16			
Controls & Mitigating Actions	Response to the national consultation Trust is currently modelling the impact of the cap to understand where we are likely to breach the capped rates in February and April 2016. Staff Bank Manager is liaising with LPP, Procurement and key agencies that we use to establish if they will provide staff at below the capped rate; this will allow us to revise our estimate of where the breaches will occur. We have contacted all managers to encourage them to ask their substantive staff to join the Staff Bank as a means of us reducing reliance on agency staff. Staff Bank recruitment plan for 2016 developed and being implemented.			**Assurance**	The areas of concern have been identified and work is underway to agreed new rates with key agencies. Our plans to recruit our substantive staff to the Staff Bank is having some success which will increase our bank fill rate.
Gaps in controls	Limited capacity to influence national agenda			**Gaps in assurance**	It is not known at this stage if the medical locums agencies will be prepared to reduce their rates sufficiently.
Actions next period:	Staff Bank manager will continue to work with key stakeholders to influence the agencies to reduce their rates Monitor are visiting to carry out a deep dive into trust agency use.				