St George's University Hospitals NHS
NHS Foundation Trust

TRUST BOARD MEETING (Public)

14th January 2016, 9.00 - 12.00 -
H2.5 Boardroom

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

Christopher Smallwood Chair

		Presented by	Time
1.	**Chair's opening remarks**		
2.	**Apologies for absence and introductions**	C Smallwood	
3.	**Declarations of interest** *For Members to declare if they have any interests as individuals or members of other organisations that might relate to Trust business or items on the agenda.*		
4.	**Minutes of the previous meeting** *To receive and approve the minutes of the meeting held 3rd December 2015*	TB (M) Public	
5.	**Schedule of Matters Arising** *To review the outstanding items from previous minutes*	TB (MA) Public	
6.	**Chief Executive's Report** *To receive a report from the Chief Executive, updating on key developments*	M Scott TB Jan 16 - 01	
7	**Quality and Performance**		9.15
7.1	**Quality and Performance Report** *To receive assurance regarding actions being taken to improve the quality of care for patients and to review the Trust's operational performance report for Month 8*	J Hall/P Vasco-Knight TB Jan 16 - 02	
7.2	**Finance Report** • *To receive the finance report month 8* • *To receive an oral report from the Finance & Performance committee held on 16th December 2015*	S Bolam TB Jan 16 - 03	9.45
7.3	**Workforce & Performance Report** *To review month 8 workforce report*	W Brewer TB Jan 16 – 04	
8.	**Strategy**		10.20
8.1	**Emergency Planning (Annual Report)**	P Vasco-Knight/J standing TB Jan 16 - 05	
8.2	**Cancer Action Plan and RTT**	I Hussain TB Jan 16 – 06	
8.3	**Outpatient Recovery Plan**	P Vasco-Knight TB Jan 16 - 07	

8.4	**One version of the truth – Diagnostic report on Emergency Care – Presentation**	P Vasco-Knight/Neil Permain TB Jan 16 – 08	
8.5	**NHS IT Digital Maturity Assessment**	S Bolam TB Jan 16 - 09	
9.	**Governance**		12.30
9.1	**Risk and Compliance Report**	G Hall TB Jan 16 - 10	
10.	**General Items for Information**		
10.1	**Use of the Trust Seal** *To note use of the Trust's seal during the period December 2015:* • The seal was used once on 9th December for Jenner Wing Mortuary Contract	C Smallwood	
10.2	**Questions from the Public** *Members of the public present are invited to ask questions relating to business on the agenda. Priority will be given to written questions received in advance of the meeting.*		
11.	**Meeting evaluation**		
12.	**Date of the next meeting -** *The next meeting of the Trust Board will be held on 4th February 2016*		

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – JANUARY 2015

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

Executive summary

1. Key messages

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

- Quality & Safety
- Strategic developments
- Management arrangements

2. Recommendation

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

Key risks identified:

Risks are detailed in the report under each section.

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

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

If yes, please provide a summary of the key findings

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

1. Strategy

1.01 Business Development

We are delighted to announce that we have been successful in two recent tender submissions. The first is as a provider of Breast Screening Services for South West London. The other is in relation to the National Childhood Influenza Immunisation Service Framework, where we have been selected to be accredited onto the National Framework as a 'Framework Member'.

1.02 Primary Care Engagement and Strategic Development

We are continuing to develop effective working relationships with our primary care colleagues, and are planning how to further improve services for the local population. As well as more general discussions with the GP Federations in Wandsworth and Merton, we are working with Wandsworth CCG and Wandsworth GP Federation on the future model of care for Community Adult Health Services (CAHS), and are involved in plans for the development of a healthcare facility in Mitcham.

To facilitate a better understanding of our services, we are now producing a regular newsletter for our colleagues in primary care and the second edition was issued on 1st December 2015. A version can be downloaded here http://createsend.com/t/i-03EEDE54ED1F21B6.

2. Academic Developments

2.01 Research

On 15th December 2015 the National Institute for Health Research (NIHR) announced a new, open competition for selecting NIHR Biomedical Research Centres (BRCs) and has invited NHS/university partnerships to submit a pre-qualifying questionnaire by 15th February 2016. We have not historically had a NIHR BRC nor a NIHR Biomedical Research Unit (BRU), but we are working jointly with St George's University of London to explore whether or not we should submit a bid.

2.02 Interventional Radiology and Vascular Surgery Trainees

Following HESL's visit to the trust, and the resulting decision to remove trainees from Interventional Radiology and Vascular Surgery, the Medical Director has been working closely with HESL, NHS England and the Divisional Teams to resolve the issue identified. HESL's concerns pertained to radiation safety, clinical incidents, behaviours and team working. The trust has provided HESL with assurance with regards to the immediate safety concerns and thus far, we have confirmed that no patient or member of staff was exposed to dangerous levels of radiation. Both services are currently delivering normally and the next phase of work is to ensure service continuity over coming months. We will also be undertaking further investigatory and developmental work with medical staff both individually and collectively, to enable effective team working. This will create an environment which provides safe patient care and allows training to be re-established. HESL have confirmed that they wish to work with the trust to achieve these objectives. This work will be managed as a formal project reporting to EMT and the Board and the Medical Director will remain in close touch with HESL, NHS England and commissioners.

3. Workforce

3.01 Listening into Action

LIAiSE - update

LIAiSE, the trust's listening and signposting service for staff, based on the PALS model, has gone from strength to strength since its inception in September 2014. Adeptly founded by the first LIAiSE Adviser (Sarah Hemmings), the service saw a change in personnel in September 2015 with the appointment of Karyn Richards-Wright. Building on the work that Sarah had initiated during the first year, Karyn is developing the service still further using her established networks, having worked at the trust for over eight years.

Since September 2014, there have been 219 referrals covering a range of issues including clarification of procedures, ie maternity, sickness, etc, management concerns and bullying concerns. At first, the majority of issues were of an HR nature. Some of this was because of Sarah Hemmings's previous role at the trust as HR administrator. Yet, whilst we continue to receive enquiries of an HR nature the range of issues is diversifying now that the service is better known and becoming well regarded. Examples of these are "conflict resolution", managing difficult situations, staff : manager relations, etc. The new incumbent also has a different skill set to the first post holder.

The LIAiSE service has provided dedicated time to the Fetal Medicine Unit, listening to staff and developing recommendations for local improvements to team working and staff morale. An initial draft of these recommendations has been shared with the Matron with a view to a more formal report being available in January 2016.

A similar approach has been taken with the Bed Site Management team and with Security, with reports back to team leaders expected during January 2016. It is anticipated that members of the Listening into Action sponsor group will work with team leaders and managers to implement actions from agreed recommendations.

Drop-ins are planned at Queen Mary's and St George's and a programme of integration with *Trust Induction* will start in earnest in Spring 2016.

To enhance Karyn's skills in this role, she has attended the trust's accredited mediation training and will attend one of the trust's unconscious bias workshops during January.

It is hoped that during 2016, the service can extend to other sites and teams in the trust, including for example HMP Wandsworth and the Nelson Health Centre in Wimbledon.

3.02 New Board Appointments

<u>Appointment of a new Chair</u>

Christopher Smallwood will complete his term of office as Chairman on 31st January 2016 and the Council of Governors' Nominations and Remunerations Committee is conducting an ongoing search for a substantive successor. From 1st February Sarah Wilton will be acting Chair, whilst we continue with the appointment process. In addition, Mike Rappolt has

agreed to extend his term of office as Non-Executive Director and Vice Chairman for three months, to support Sarah until a new Chairman is appointed.

Other personnel changes to note

I would like to welcome Gillian Hall, who has recently taken up the post of Interim Trust Secretary. Additionally I am sorry to announce that Sofia Colas, the Divisional Director of Operations for the Children and Women's Division will be leaving the trust. Sean Briggs, who is currently the General Manager for Neurosciences, will take up her role as an interim. Finally, Louise Halfpenny, the Head of Communications will also be leaving us. We wish Louise and Sofia the very best for the future.

4. Operational Developments

4.01 One Version of the Truth

From mid-October through November the Trust worked in close collaboration with local CCG's and partner community health, mental health and social care providers to undertake a detailed diagnostic analysis of the emergency pathway. This led to a document that sought to establish a fact-based 'one version of the truth' between all organisations in the local health economy about the root causes of why 4-hour A&E waiting time performance has not recovered above the 95% level. Through discussions at several steering groups, Chief Executive/Chief Officer level discussions and finally at the System Resilience Group we reached agreement on the analysis and a comprehensive action plan of measures to address the underlying problems. The report recognises the significant workload pressures that the Trust experienced in winter 14/15, leading to demand on A&E and particularly on occupancy in non-elective beds, which continued into the summer and autumn of 2015.

There are actions identified for commissioners, for community providers and social care to address some of these. In addition the report also identified a number of opportunities for the Trust to improve the operation of it's internal processes in managing discharge, the operation of the Acute Assessment Unit and in A&E itself for example. The Trust, CCG, Community providers and social care all share responsibility for these important actions that need to be progressed. We have committed to work together as system to take this plan forward and work is now being undertaken on new governance arrangements and resources to support the implementation.

This work will be discussed as part of this month's Board agenda.

5. Communications

5.01 Thank you events

Approximately 400 people attended two events organised by the communications team to say thank you to staff and farewell to Christopher Smallwood. The team managed to secure 250 gifts from local businesses which were given out during the events at St George's and Queen Mary's hospitals. The new induction film was also shown, and values/apprentice awards presented.

5.02 Ask Miles

The first 'Ask Miles' session took place on 10th December. Feedback questionnaires filled out by attendees were overwhelmingly positive and all respondents said they would

recommend the session to a colleague. Based on feedback, the next session will increase from 30 minutes to one hour.

5.03 Turnaround Times newsletter

The first edition of Turnaround Times was published at the beginning of December. Feedback from staff has been positive, especially about the case studies showing what staff have done to save money. Based on staff suggestions, future editions will be printed in black and white rather than colour.

5.04 Media update

- Consultant cardiologist, Stephen Brecker, was interviewed by the BBC for the Today programme on his development of a transcatheter aortic valve implantation, which is a new device for replacing heart valves. The programme discussed the development of innovations in the NHS, and Sir Bruce Keogh spoke on how best to capitalise on these innovations

- A twitter campaign responding to the theft of Christmas presents for nurses on Ruth Myles Ward, resulted in £500 being donated to the trust by members of the public in order to replace the gifts.

- The Daily Mail interviewed Rob Hinchliffe from the Vascular Institute on the pioneering work he has done in treating iliac endofibrosis, a condition which affects cyclists, rowers and triathlon athletes. They also interviewed one of Rob's patients who had surgery for the condition. Rob was pleased with the publicity and hopes that the piece will generate referrals.

- Good Morning Britain filmed from Nicholls Ward for children on Christmas Eve. Dr Hilary Jones, the programme's GP spoke to staff and parents on the day. One of the parents said, "The treatment we get in this hospital is overwhelming." Another said that the staff were 'brilliant'. The piece was broadcast all over the ITV network.

- The Daily Telegraph in Sydney, Australia ran a short piece on 24 Hours in A&E saying it was always 'surprisingly touching'.

REPORT TO THE TRUST BOARD

Paper Title:	Quality and performance Report to Board Month 8 November 2015
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Paula Vasco-Knight – Chief Operating Officer
Authors:	Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Paula Vasco-Knight – Chief Operating Officer
Purpose:	To inform Board/ QRC about Quality Performance for Month 8.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	Finance and Performance Committee Quality and Risk Committee

Executive summary

Performance

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

The trust has seen positive performance improvement in Diagnostics with number of patients waiting greater than 6 weeks reducing significantly and has also seen marked improvement with regards to cancelled operations and the number of patients not re-booked within 28 days.

The trust shows the quality governance score against the Monitor risk assessment framework of 4 as Monitor have imposed additional license conditions in relation to governance.

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

Key Points of Note for the Board to note in relation to November Quality Performance:
The Overall position in November remains consistent with the previous two quarters in terms of the trends for the metrics with some moderate improvement across a number of indicators. Serious Incident numbers remain an area of focus in relation to themes seen and actions being taken. Routine oversight of serious incidents continues to be monitored through the Patient Safety Committee and SIDM.

Effectiveness Domain:

- Mortality performance remains statistically better than expected for the Trust. Despite this position we continue to proactively investigate mortality signals at procedure and diagnosis level. The Report outlines the actions that are being taken by the Mortality Committee following the increase in SHMI which has been previously reported to the board.

- National Audits within the report: The report indicates the results from the PICANet national audit. The Unit is achieving some indicators but not all in relation to the staffing profile, actions are outlined in relation to this element.
- 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 November indicates a similar trend in terms of numbers and level of harm. The Board should note that the trend for Serious Incidents indicates a gradual increase. Of those declared for November the Board will note the issues are across a range of clinical issues, some are mandatory in terms of reporting.
- Safety Thermometer performance slightly improved from the previous month and performance remaining above the national average. There was a slight increase in harms i.e. falls, VTE and CAUTI but this is not significant.
- The pressure ulcer profile for October improved from the previous month with 2 grade 3/4 ulcers. Actions being taken to sustain an improvement in performance are outlined in the report,
- No further MRSA bacteraemia cases were reported for November bringing the total to 3 cases year to date and no cases since Mid-September. There are now a total of 22 C-Difficile cases to the end of November with no cases during the month which is a positive achievement. Therefore we are on target for 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.

Experience Domain:

- The response rate for FFT decreased again. Gaining feedback from patients is an important component in the triangulation of quality data The overall score for the Trust in November is a score of 87.5 %
- The complaints profile in relation to numbers has increased from October in terms of numbers. In relation to turnaround times of complaints a decline still continues to be seen following improvement through to May 2015, although the clinical Division (Community) continues to achieve the target. Further detail about improvement actions will be reported to the board in February

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 95 % 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 November is included this month for both Acute and Community services.

risks identified: Complaints performance (on BAF) Infection Control Performance (on BAF) Safeguarding Children Training compliance Profile (on BAF) Staffing Profile (on BAF)	
Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	
Equality Impact Assessment (EIA): Has an EIA been carried out? **If no, please explain you reasons for not undertaking and EIA.** Not applicable	

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St George's University Hospitals NHS
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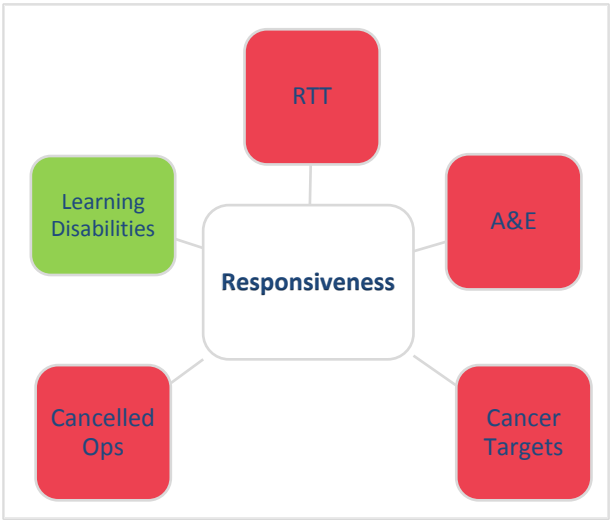
Performance & Quality Report
Trust Board

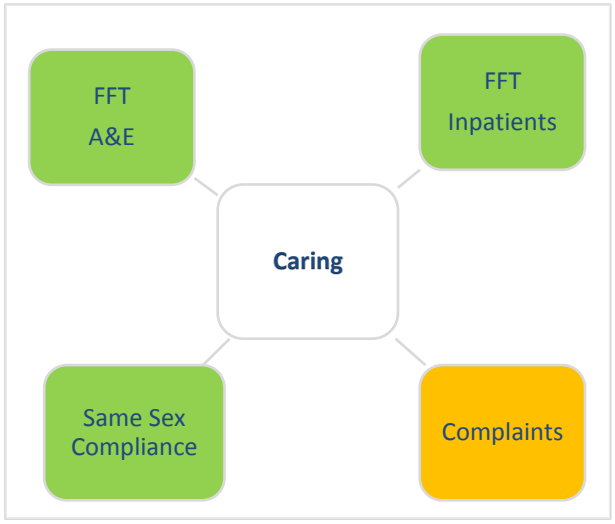
Month 8 - November 2015

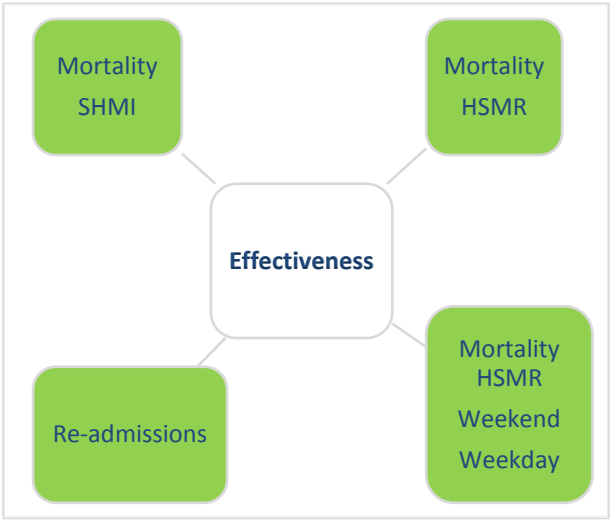
Excellence in specialist and community healthcare

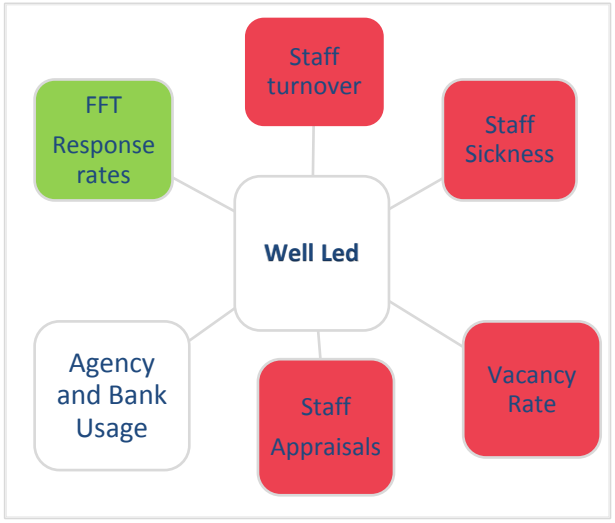
CONTENTS

1. Executive Summary - Key Priority Areas November 2015*









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

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

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

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Performance against Frameworks

Excellence in specialist and community healthcare

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

ACCESS

Metric	Standard	Weighting	Score	YTD	Oct-15	Nov-15	Movement
Referral to Treatment Admitted	90%	N/A	N/A		78.60%	78.98%	0.38%
Referral to Treatment Non Admitted	95%	N/A	N/A		86.50%	90.19%	3.69%
Referral to Treatment Incomplete	92%	1	1		90.20%	91.74%	1.54%
A&E All Types Monthly Performance	95%	1	1	91.94%	91.90%	89.33%	-2.57%
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q2**	**Q3**	**Movement**
62 Day Standard	85%	1	1	81.22%	81.93%	84.35%	2.43%
62 Day Screening Standard	90%			87.97%	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	96.45%	97.50%	100.00%	2.50%
31 Day Standard	96%	1	0	97.38%	97.95%	96.13%	-1.82%
Two Week Wait Standard	93%	1	1	85.27%	77.85%	82.73%	4.87%
Breast Symptom Two Week Wait Standard	93%	1		91.80%	94.48%	89.55%	-4.92%

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Oct-15	Nov-15	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	23	4	0	-4
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 Sept and Oct 2015	50%	1	0		56.3	53.6	-2.7
Referral Information	50%	1	0		88	87.9	-0.1
Treatment Activity	50%	1	0		70.43	69.78	-0.7
Trust Overall Quality Governance Score					4	4	0

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

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

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Areas of underperformance for quality governance are:

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

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

*Cancer Data is reported a month in arrears. Q3 relates October only

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: November 15 Performance (Page 1 of 1)

RESPONSIVENESS

Metric	Standard	YTD	Oct-15	Nov-15	Movement
Referral to Treatment Admitted	90%		78.60%	78.98%	0.38%
Referral to Treatment Non Admitted	95%		86.50%	90.19%	3.69%
Referral to Treatment Incomplete	92%		90.20%	91.74%	1.54%
Referral to Treatment Incomplete 52+ Week Waiters	0	18	4	1	-3
Diagnostic waiting times > 6 Weeks	1%		0.57%	0.38%	-0.19%
A&E All Types Monthly Performance	95%	91.94%	91.90%	89.33%	-2.57%
12 Hour Trolley Waits	0	0	0	0	0.00%
Urgent Ops Cancelled for 2nd time (number)	0	0	0	0	0.00%
Proportion of patients not treated within 28 days of last minute cancellation	0%	15.84%	7.50%	12.50%	5.00%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Sep-15	Oct-15	Movement
62 Day Standard	85%	81.22%	85.71%	84.35%	-1.36%
62 Day Screening Standard	90%	87.97%	95.45%	90.20%	-5.25%
31 Day Subsequent Drug Standard	98%	100%	100%	100.0%	0.00%
31 Day Subsequent Surgery Standard	94%	96%	97%	100.0%	3.33%
31 Day Standard	96%	97.38%	96.13%	96.13%	0.00%
Two Week Wait Standard	93%	85.27%	70.40%	82.73%	12.33%
Breast Symptom Two Week Wait Standard	93%	91.80%	95.04%	89.55%	-5.49%

EFFECTIVENESS

Metric	Standard	YTD	Oct-15	Nov-15	Movement
Hospital Standardised Mortality Ratio (DFI)	100		91.3	91.8	
Hospital Standardised Mortality Ratio - Weekday	100	0		92.9	
Hospital Standardised Mortality Ratio - Weekend	100	0		96.1	
Summary Hospital Mortality Indicator (HSCIC)	100	0	90	92	2
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%	3.10%	2.20%	3.09%	0.9%
Bed Occupancy - Midnight Count	85%		112.0%	108.0%	-4.0%
LOS - Elective			1.9	1.56	-0.3
LOS - Non-Elective			4.4	4.29	-0.11

CARING

Metric	Standard	YTD	Oct-15	Nov-15	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		93.8		-93.8
A&E Scores - Friends & Family Recommendation Rate	46		83.1		-83.1
Complaints			88	101	13.0
Mixed Sex Accomodation Breaches	0	5	0	0	0.0

SAFE

Metric	Standard	YTD	Oct-15	Nov-15	Movement
Clostridium Difficile - Varience from plan	31	23	4	0	-4
MRSA Bacteramia	0	4	0	0	0
Never Events	0	7	1	0	-1
Serious Incidents	0	107	9	12	3
Percentage of Harm Free Care	95%		94.6%	93.5%	-0.011
Medication Errors causing serious harm	0	2	1	1	0
Overdue CAS Alerts	0	4	2	2	0
Maternal Deaths	1	1	0	0	0
VTE Risk Assessment (previous months data)*	95%		97.10%		

WELL LED

Metric	Standard	YTD	Oct-15	Nov-15	Movement
Inpatient Respose Rate Friends & Family	30%		25.1%		-25.1%
A&E Respose Rate Friends & Family	20%		22.4%		-22.4%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		17.5%	17.8%	0.3%
Trust level sickness rate	3.5%		4.1%	3.9%	-0.003
Total Trust Vacancy Rate	11%		15.5%	16.2%	0.7%
% of staff with annual appraisal - Medical	85%		82.5%	84.2%	1.8%
% of staff with annual appraisal - non medical	85%		70.3%	70.9%	0.6%

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

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Performance – areas of escalation

Excellence in specialist and community healthcare

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

Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	Oct-15	Nov-15	Movement	2015/2016 Target	Forecast for Nov-15	Forecast for Dec-15	Date expected to meet standard
FA	91.90%	89.33%	-2.57%	>= 95%	R	R	TBC

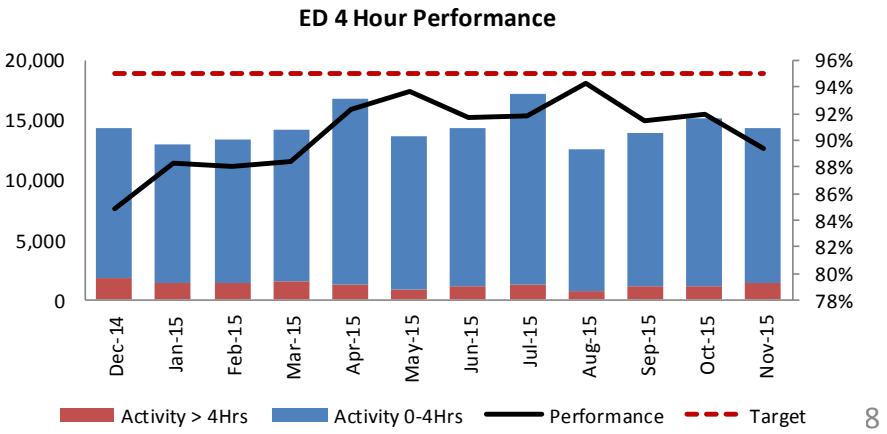
Peer Performance October 2015 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	5	1	3	2
91.90%	90.20%	94.30%	91.70%	94.20%

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 November 89.33% of patients were seen within 4 hours which was a -2.57% lower than previous month.

Factors that continue to affect performance include:

- Continued high number of breaches for patients awaiting a specialist opinion and very high bed occupancy making it challenging to bed patients from ED in a timely manner.
- Capacity pressures within the Emergency Department
- Number of mental health patients breaching, with particularly long delays in placing the patient into the appropriate setting blocking cubicles. There were 62 MH attributable breaches in the month.
- There has been a significant increase in the number of breaches due to diagnostic waits with 101 attributable breaches in November compared to an average of 54 for the year (Oct 22, Sep 93 and November 101)
- Increase in the numbers of delayed transfer of care patients (DTOC) and the level of delay remains a focus area for the organisation as this has a significant impact on flow through the hospital and impact upon ED flow into the organisation. As at 30/12/2015 there were 29 DTOC and 28 Non-DTOC.
- As at 30/11/2015 there were 83 of 630 (13%) patients being tracked within the organisation that were medically fit for discharge. These encompass the DTOC, NDTOC, patients awaiting transfer to another provider and patients going home that day. The trust is working with commissioners and external agencies to expedite this.
- Other factors impacting performance include an increase in conversion rate a trend that has been observed since May and an increase in ED attendances following a referral from a GP

Dec14 - Nov-15	Breach Reason
	Bed Management
	Clinical Exception
	ED Assessment
	ED capacity
	ED Referral
	Treatment Decision
	Mental Health
	Waiting_for_specialist_opinion
	Waiting_for_diagnostic
	Other

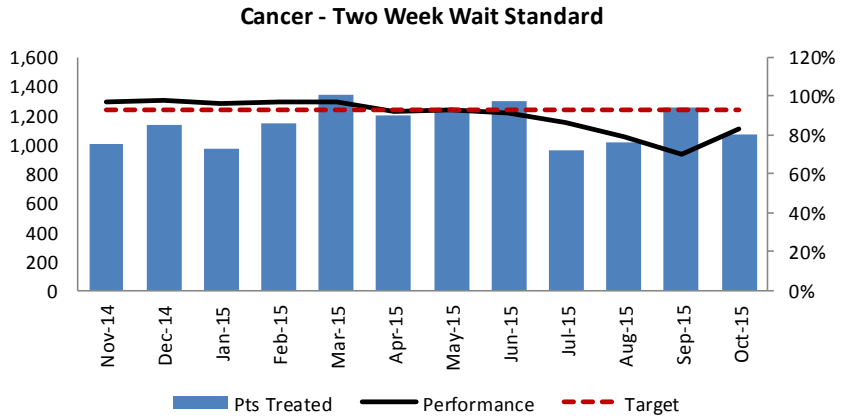


3. Performance Areas of Escalation (Page 2 of 4)
- Cancer Performance – Two Week Wait Standard

Cancer Performance								Peer Performance Latest Published October 2015- 2016				
Lead Director – CC	Sep-15	Oct-15	Movement	2015/2016 Target	Forecast for Sep-15	Forecast for Oct-15	Date expected to meet standard	STG	Croydon	Kingston	King's College	Epsom & St Helier
14 Day GP Referral for all Suspected Cancers	70.40%	82.73%	↑ 12.33%	93%	R	R	Nov-15	82.70%	95.90%	93.20%	95.20%	96.70%

The trust was non compliant against three of the national cancer wait targets for the month of October. In response to the continued under-performance in Q3 the following actions are being undertaken:

- Fortnightly escalation meetings continue to be undertaken as directed by the Chief Operating Officer. These will now be increasing in frequency to weekly.
- A weekly Elective Care Recovery Programme sub-group led by commissioners has been set-up following the tri-partite meeting to track progress against action plans and to drive performance improvement.
- A recovery and long term sustainability action plan has been developed for implementation with support from the SRG. This is to be presented along with recovery trajectories to the tri-partite on 8th January 2016 for approval.
- A demand and capacity review has been undertaken for two week wait referrals. Following this specialties now have a clear understanding of any shortfall in capacity, which is being addressed.
- PTL development is in progress to enhance tracking and escalation mechanisms.
- Reviewing DNA rates and patient choice breaches in accordance with guidance and highlighting mechanisms by which this could be reduced.



Non-achievement of this target relates to 185 breaches which is a significant improvement compared to the 370 reported in

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

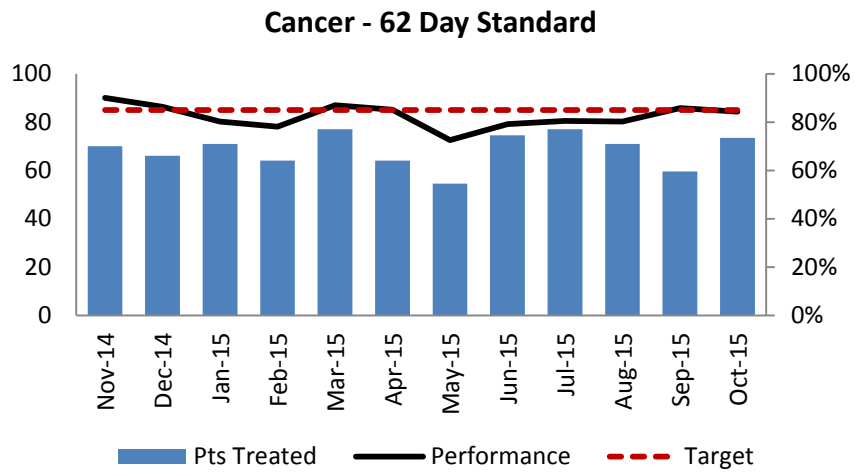
Key issues affecting performance in October:

- Patient choice and high DNA rates
- Capacity in particular in relation to Upper GI and Skin.
- Recruitment of additional outpatient nursing staff to ensure additional clinics requested for 15/16 are consistently staffed.
- Daily update on capacity concerns and breach numbers from the Two Week Wait Referral Office.

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

Cancer Performance							
Lead Director – CC	Sep-15	Oct-15	Movement	2015/2016 Target	Forecast for Oct-15	Forecast for Nov-15	Date expected to meet standard
62 Day Wait Standard	85.71%	84.35%	-1.36%	85%	R	R	Nov-15

Peer Performance Latest Published October 2015- 2016				
STG	Croydon	Kingston	King's College	Epsom & St Helier
84.35%	89.30%	82.30%	91.00%	87.40%



62 day GP Referral to Treatment Wait Standard - Non-achievement of this target in October relates to 11.5 patients breaching of which 7 were on a shared pathway. SGH performance excluding shared patients would have been 89.1% and well within target. Breaches occurred in the modalities of; Gynae, Head & Neck, Lower GI, Lung and Skin.

Key issues affecting performance were:

- Late referrals from other trusts (referrals received after day 42) and referrals with no information (a supporting completed ITT from for tracking). Work with shared providers to improve relationship s and transfer of information is being undertaken . This is also being supported by the recently formed SWL Cancer forum.
- Patients on complex diagnostic pathways.
- Other medical conditions prioritised
- Patient choice / Patient unfit for treatment.
- A recovery and long term sustainability action plan has been developed for implementation with support from the SRG. This is to be presented along with recovery trajectories to the tri-partite on 8th January 2016 for approval.

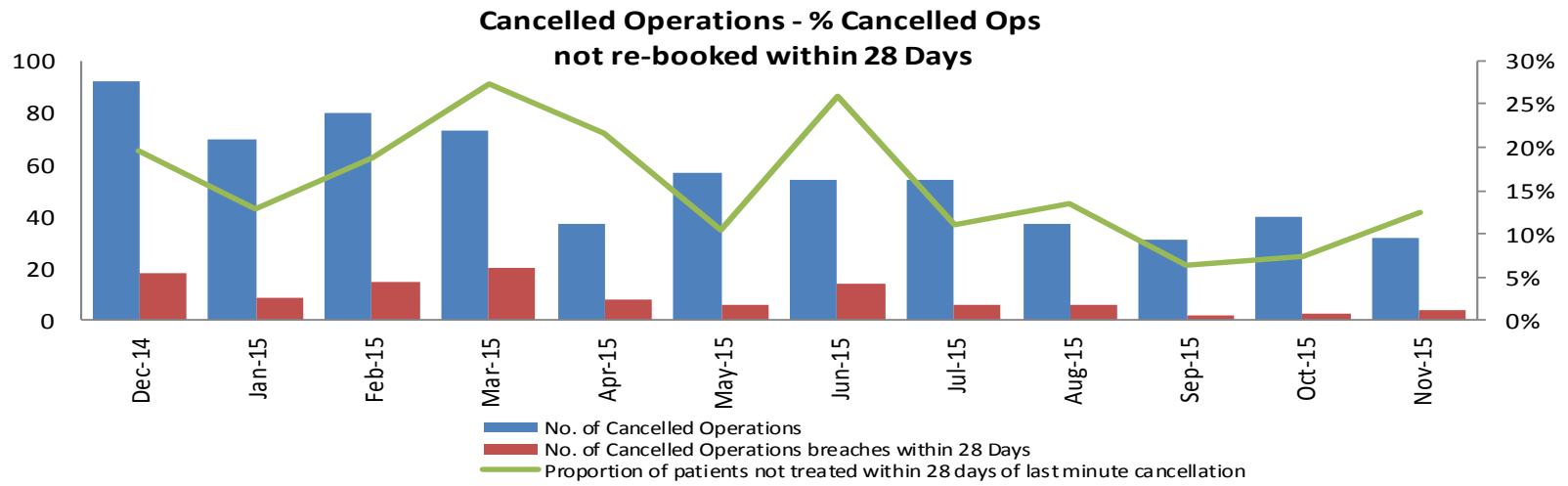
October 2015 performance against national cancer targets by tumour type.

Cancer Indicator	All Types	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Skin	Upper GI	Urological
14 Day GP Referral for all Suspected Cancers	82.70%	90.70%	52.50%	87.50%	91.90%	95.80%	93.10%	66.40%	84.10%	95.80%
14 Day Breast Symptomatic Referral	89.60%	89.60%								
31 Day First Treatment	96.10%	100.00%	100.00%	100.00%	92.30%	100.00%	75.00%	95.00%	100.00%	94.90%
31 Day Subsequent Surgery Treatment	100.00%							100.00%		100.00%
31 Day Subsequent Drug Treatment	100.00%	100.00%					100.00%			100.00%
62 day GP Referral to Treatment	84.40%	100.00%	83.30%	0.00%	81.80%	77.80%	25.00%	80.00%	100.00%	87..7%
62 Day Screening Referral to Treatment	90.20%	100.00%	83.30%			60.00%				
62 Day Consultant Upgrade to Treatment	100.00%						100.00%			

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

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Oct-15	Nov-15	Movement	2015/2016 Target	Forecast for Dec-15	Forecast for Jan-16	Date expected to meet standard
CC	7.50%	12.50%	⇩ 5.00%	0%	G	A	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 32 cancelled operations from 4,570 elective admissions in November. 28 of those cancellations were rebooked within 28 days with 4 patients not rebooked within 28 days, accounting for 12.5 % of all cancellations. There has been a significant decrease in the number of cancelled operations in particular compared to the same period last year. This correlates with a reduction in the number of patients not re-booked within 28 days.

Key contributory factors for the cancellations were related to emergency cases taking precedent and bed capacity issues.

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

Monthly View

			November 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 WEEKS - ADMITTED WAITS (DIVISION LEVEL)	%		86.8	73.5	83.6	79
	18 WEEKS - INCOMPLETE WAITS (DIVISION LEVEL)	%	99.3	91.9	89.8	93.1	91.7
	18 WEEKS – NON-ADMITTED WAITS (DIVISION LEVEL)	%	100	83.4	86.9	87.6	90.2
	52 WEEK WAITERS	No.	0	0	1	0	1
	A&E WAITS (4 HOURS)	%	100	88.2			89.3
	LAS HANDOVER WITHIN 15 MINS	%					32.1
	LAS HANDOVER WITHIN 30 MINS	%					88.6
	LAS HANDOVER WITHIN 60 MINS	No.					0

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

Monthly View

			October 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION)	%	0	0	89.6	0	89.6
	2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION)	%	0	0	82.7	0	82.7
	31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION)	%	0	0	100	0	100
	31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DIVISION)	%			100		100
	31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISION)	%			96.1		96.1
	62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION)	%			84.4		84.4
	62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION)	%			89.2		89.2

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

Monthly View

			November 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	HSMR	Ratio					92
	INCIDENCE OF C.DIFFICILE	No.	0	0	0	0	0
	INCIDENCE OF E-COLI	No.	0	1	0	0	1
	INCIDENCE OF MRSA	No.	0	0	0	0	0
	MATERNAL DEATHS	No.	0	0	0	0	0
	MEDICATION ERRORS CAUSING SERIOUS HARM	No.	0	1	0	0	2
	NEVER EVENTS	No.	0	0	0	0	0
	SERIOUS INCIDENTS (DIVISION LEVEL)	No.	3	5	3	1	12
	SHMI	Ratio					0.9
	TRUST ACQUIRED PRESSURE ULCERS	No.	1	2	1	0	4

Monthly View

			November 2015				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Quality Governance Indicators	PATIENT SATISFACTION (FRIENDS & FAMILY)	%		93.6	87.3	88.5	85.6
	PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION)	%	81.3	87.8	82	84.4	84.2
	PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION)	%	62.9	74.6	74.9	69.7	69.2
	SICKNESS/ABSENCE RATE - (DIVISION)	%	5.7	4.2	3.2	3.4	3.8
	STAFF TURNOVER - (DIVISION)	%	20.8	19.3	13.9	18.4	18
	VOLUNTARY STAFF TURNOVER - (DIVISION)	%	16	16.8	11.9	15.1	14.9

Key Messages:

This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components, as Cancer metric and complaints performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of October 32.5% of patients had handover times within 15 minutes and 89.6% within 30 minutes. both of which are not within target. The 30 minute handover data is currently being validated and is envisaged to significantly increase post validation. The trust had zero 60 minute LAS breaches in September.

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

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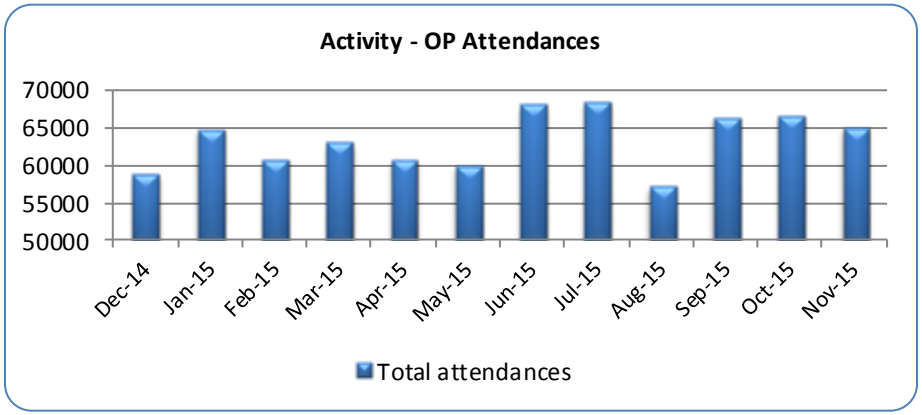
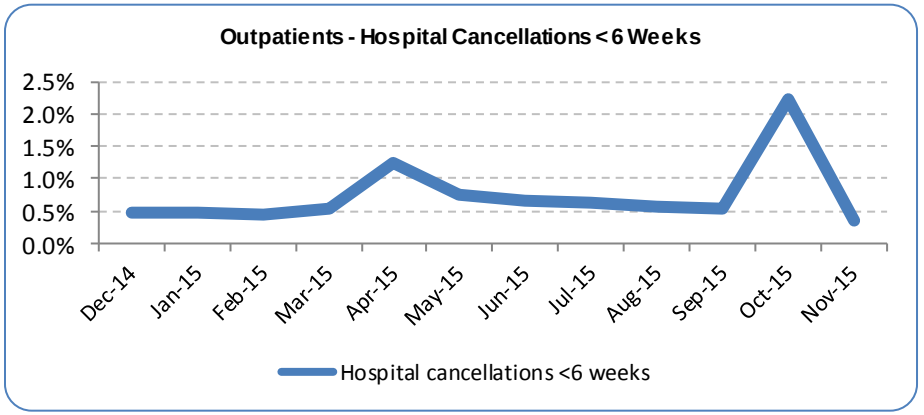
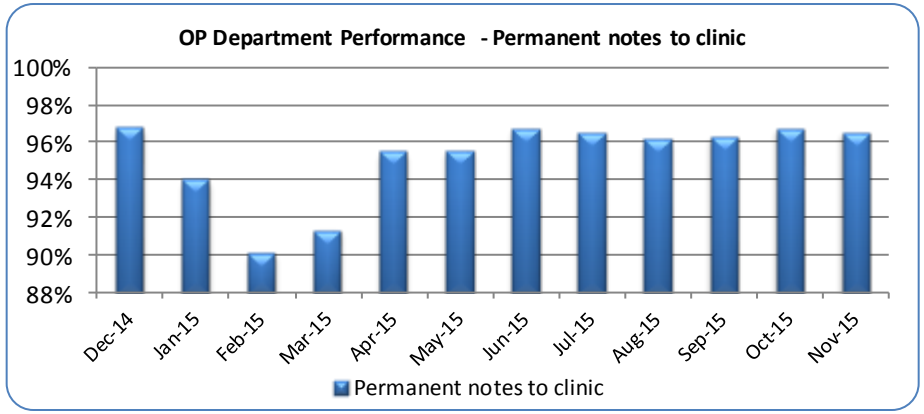
Corporate Outpatient Services Performance

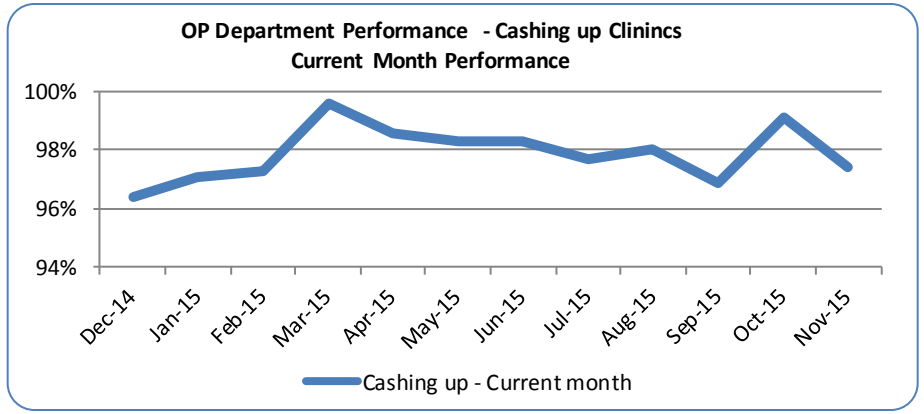
Excellence in specialist and community healthcare

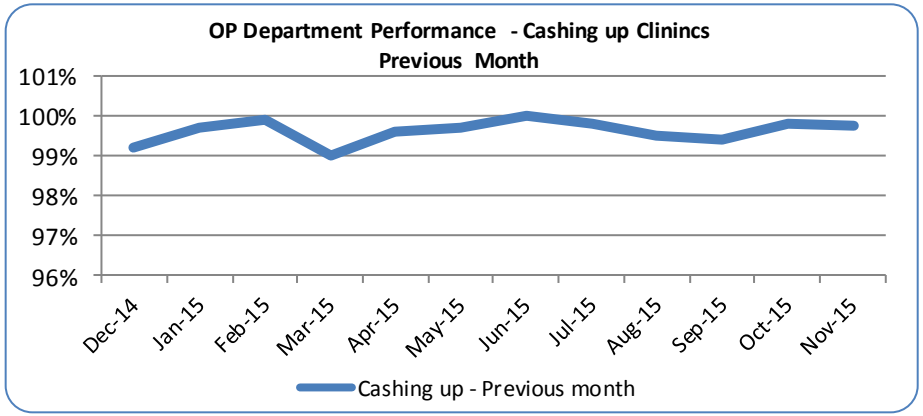
5. Corporate Outpatient Services (1 of 2) - Performance Overview

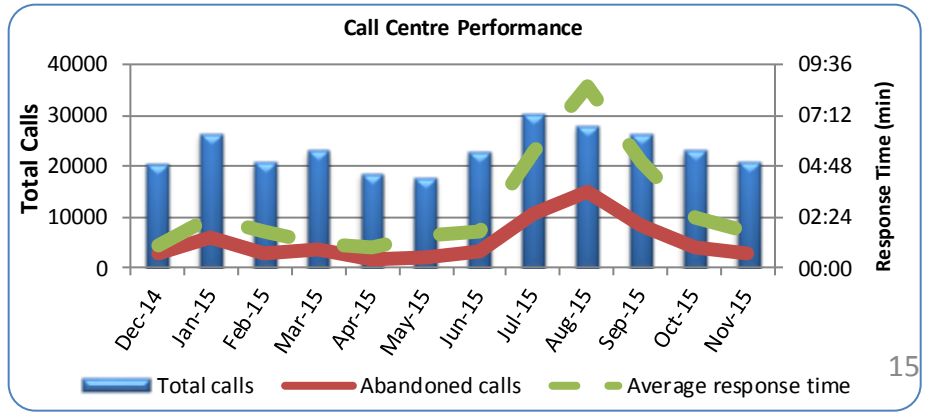












5. Corporate Outpatient Services (2 of 2) - Performance Overview

Corporate Outpatient Services Monthly Scorecard

		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
Activity	Total attendances	N/A	58659	64609	60659	62946	60564	59841	68002	68277	57188	66271	66501	64863
	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%
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%
	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%
	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%
Call Centre Performance	Total calls	N/A	20639	26565	20842	23235	18710	17732	22955	30426	28095	26357	23138	21082
	Abandoned calls	<25%/<15%	2681	5923	2908	3782	1551	2237	3309	10828	15019	8253	3930	2756
	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

Key Messages:

- Slight decrease in activity from October position but still within average for the year.
- Hospital cancellations have improved in November to 0.36% and within target.
- Performance of permanent notes to clinic has continues to be consistent at 96% and remains below target . This remains a priority area for the service.
- The level of activity and the number of abandoned calls have significantly decreased for a third consecutive month and remains within target.
- Positive performance improvement observed for mean call response time in November and is now under 2 minutes. Further work continues to be undertaken to bring this within target.

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Clinical Audit and Effectiveness

Excellence in specialist and community healthcare

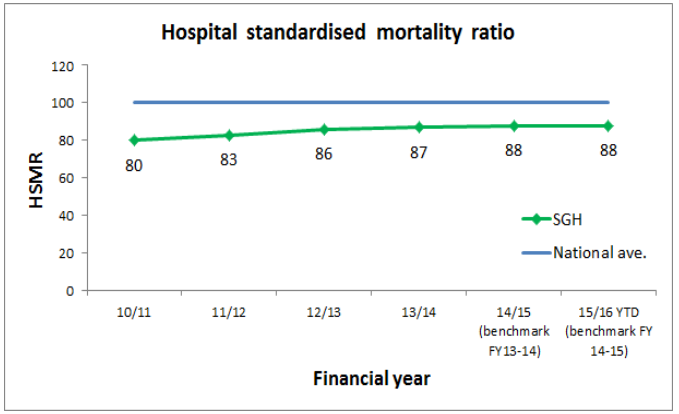
6. Clinical Audit and Effectiveness - Mortality

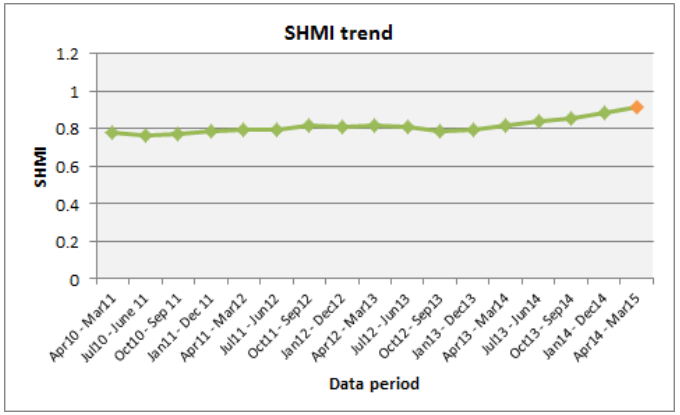
HSMR (Hospital standardised mortality ratio)							
Lead Director	September 15	October 15	November 15	Movement	2015/16 Target	Forecast March 16	Date expect to meet standard
SM	91.3	91.3	91.8	↑	<100	G	Met

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

Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available; currently September 2014 to August 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 28th October 2015 relates to the period April 2014 to March 2015. The next publication is due in January 2016.

Our mortality as measured by the HSMR remains significantly better than expected at 91.8. Looking specifically at emergency admissions shows that for those admitted at a weekend our relative risk is within the expected range (96.1). For weekday emergency admissions our mortality is significantly better than expected (92.9). However, as noted previously our latest SHMI reports our mortality to be as expected. In November the Mortality Monitoring Committee (MMC) fully considered the latest SHMI publication and a comprehensive summary of our data was prepared for the Clinical Quality Review meeting in December. This concluded that the increase is likely to be multifactorial. We have identified and investigated an increase in raw mortality in the Trust over last winter which demonstrated, like many other trusts, an increase in deaths from respiratory illnesses in elderly, frail patients. There has also been an increase in patients with an exceptionally high likelihood of death; these include patients with out of hospital cardiac arrests, patients with un-survivable traumatic brain injury, and patients with multiple trauma. Risk adjustment models do not manage well patients who are expected to die, but such patients have contributed to a small rise in raw mortality. We have not identified an increase in 'avoidable mortality'; however, we continue to strive to understand patterns of mortality by trust level oversight and case review of all mortality outliers. To this end we are currently investigating two broad SHMI diagnosis groups related to T&O and vascular, where mortality appears to be higher than expected.





The main strands of work currently being led by the MMC include: investigating all internally derived alerts from the Dr Foster tools; examining two additional SHMI diagnosis groups; investigating an alert in the deaths in low risk diagnosis groups indicator; ongoing scrutiny of all deaths following elective admission and working to resolve a persistent signal in the 'residual codes unclassified' grouping. The latter is being managed with strong engagement from the coding team; a senior coder has now joined the committee and is allocated to code all deaths. The mortality review protocol that was endorsed by the Executive Management Team in November will be applied to all investigations, with the outcome reported to the MMC in due course.

Over the winter period the group will begin regular monitoring of 'real-time' mortality, using the data presented in Tableau. If a significant increase is observed then an immediate prospective review will be launched. This will allow us to gain a better understanding of the impact of wider trust issues, such as high bed occupancy, staffing, flow, and out of hours care.

Early in January the committee will complete the self-assessment on avoidable mortality that has been requested of all trusts, by Professor Sir Bruce Keogh.

6. Clinical Audit and Effectiveness
- National Audits

PICANet (Paediatric Intensive Care Audit Network) – November 2015 Annual report

PICANet states that in pursuit of excellence in healthcare it is important to ensure:

1. Service providers have the right skills and knowledge

2. The correct systems and processes are in place to enable the right care and treatment to be effectively delivered

3. The culture of the service is right and patient centred

Furthermore they identify that healthcare providers must be able to: measure what they do; compare performance with peers; and identify how performance can be improved. The PICANet programme of work summarised in the report is intended to support these goals.

RESULTS: St George's PICU achievement of key quality indicators:

48 hour readmission: SGH continues to perform well with minimal readmissions.

Length of stay: This is increasing nationally, and the same is true locally with St George's increasing from 2.4 days in 2012 to 3.4 days now. This represents change in expectations, increasing palliative care work (22%) and managing chronic disease

Standardised Mortality Ratio: For the first time in the last 4 years PICU has an SMR greater than 1 (St George's =T in the figure alongside), but remains within the confidence limits and so is not significantly different to the national average.

Staffing: It is noted that nationally only 15% of units meet recommended nursing levels. St George's does not meet the recommended standard; however actions to improve our position which are based on band 5 recruitment, allow us to attain safe staffing levels. This strategy does however place pressure on PICU resources as band 5 recruitment increases the requirement for education, training, mentoring & support.

Other key observations are a higher proportion of ventilated patients (54%) at St George's and that there has been no increase in the oncology cohort.

PICU CONCLUSION & ACTION PLAN: National and local results are to be presented and discussed at the PICU governance meeting for consideration of how the trust can action the national recommendations identified alongside. In respect of staffing, the unit continue to recruit band 5 staff. External recruitment of Band 6 staff has proven challenging, therefore the unit are trying to grow their own staff by training and developing them.

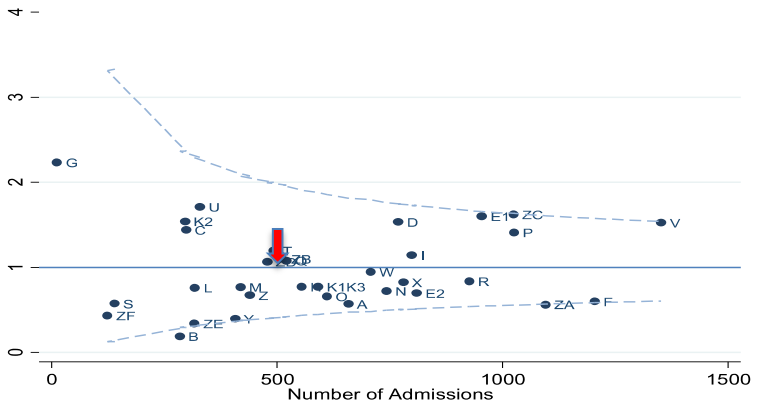


FIGURE 49b PICU STANDARDISED MORTALITY RATIOS BY HEALTH ORGANISATION, WITH 99.9% CONTROL LIMITS, 2014: PIM2r ADJUSTED

PICANet Recommendations

1. Commissioners should work closely with PICUs to ensure adequate staffing levels in accordance with professional standards.

2. Nurse Managers should investigate innovative ways to reduce the dependence of units on Agency and Bank staff and to encourage staff recruitment and retention.

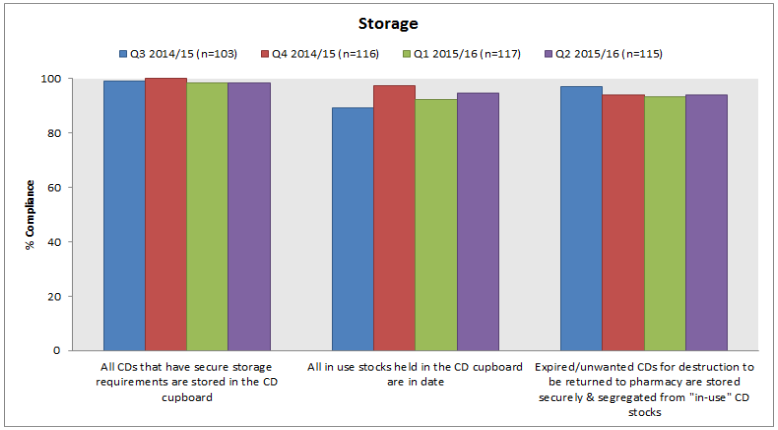
3. Commissions should review the PICANet data for PICUs to inform their planning of critical care services for children.

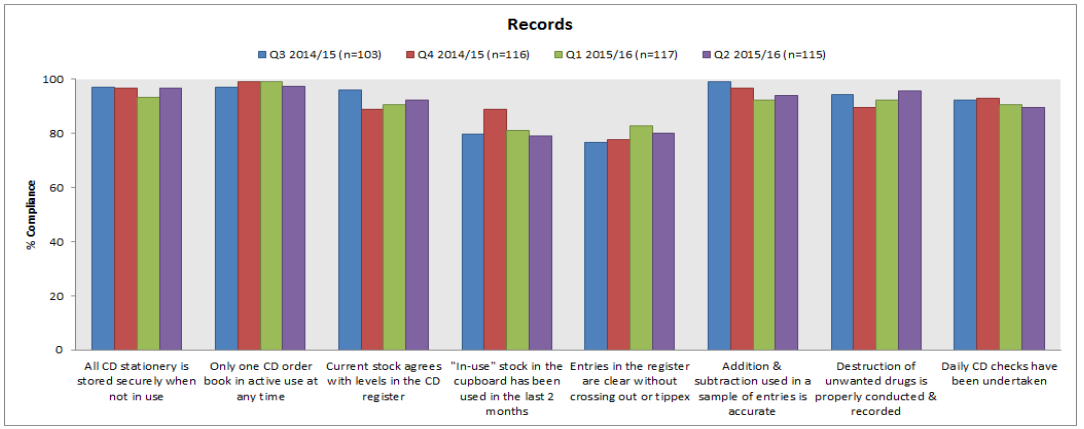
4. All PICUs and specialist PIC transport services should provide information about all referrals and refusals for admission to PIC, to inform future commissioning.

5. PICANet should continue to work with PICUs and the Clinical Advisory Group to develop new morbidity outcome indicators for Paediatric Intensive Care as in-PICU mortality rates remain low (<5%) for all units and show little variation between units over time.

6. Clinical Audit and Effectiveness
- Local Audits

Controlled Drugs Check & Stock Audit Quarter 2 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. Full participation was achieved, with the audit being completed across all 115 clinical areas that stock CDs.

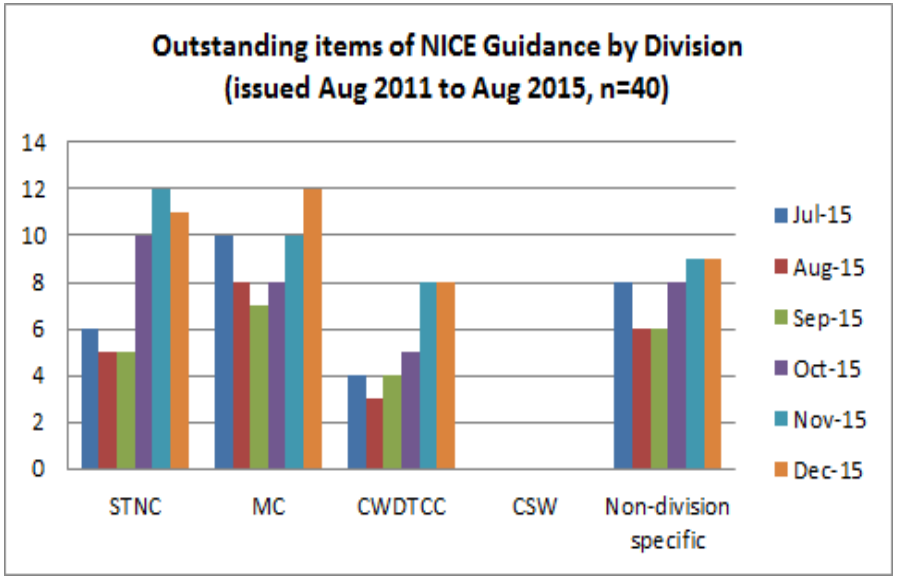
The security of CDs continues to be very good; compliance with 4 out of 5 measures stands at 99% or above. The only issue identified was that in a small number of areas (n=16) the CD keys were not held on a red key holder, separate to other medication cupboard keys. These issues were dealt with at the time of the audit and have been highlighted to ward teams to ensure compliance is achieved and maintained.

Once again results for the storage of CDs were good with performance maintained or improved across all measures. In a few areas the need to proactively ensure prompt removal or disposal of expired/unwanted CDs was identified and corrective action taken.

Practice related to record keeping improved in half of the measures audited. These included secure storage of CD stationery, recording of correct stock levels, accurate addition and subtraction and correctly documenting the destruction of unwanted drugs. It is encouraging that there has been some improvement in the accuracy of physical CD stock levels compared to the register as this was identified as an area for action following the last audit. However there was a decline in the proportion of areas where "in-use" stock in the cupboard has been used in the last 2 months, where only one order CD order book is in use and in entries being clear and uncorrected. A marginal decline in CD checks being undertaken on a daily basis was observed, with compliance dropping below 90 per cent.

The report was presented to the Medications Risk Management Committee meeting in November 2015 and action planning at an organisational level is on-going. Pharmacists carried out local education and training of ward staff as issues were identified during the audit process. Furthermore, divisional reports including targeted action plans will be presented at the DGB meetings. Where non-compliance with any measure has been noted in two consecutive quarters this is stated in the audit report so that support can be targeted appropriately. In some areas ward pharmacists have identified the need for CD training, to include how to order CDs, entering CDs into registers and calculating the amount of medication required. A training package is being piloted on General Medicine wards in Quarter 3 to address these issues

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



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

Division	2010	2011	2012	2013	2014	2015
STNC (n=7)		1	2	1	3	
M+C (n=12)	2	2	4	1	3	
CWDTCC (n=15)	3	1	1	3	6	2
CSW (n=0)						
Non-division specific (n=11)		2		4	1	4

Overview

There has been little overall change in the number of outstanding items of guidance since the last report. It is anticipated that early in the New Year the audit team will be fully staffed allowing a return to previous levels of support and monitoring of NICE guidance. Recently we have not had sufficient resource to follow up outstanding responses as frequently as necessary. Improved resource levels, coupled with a comprehensive review of our methodology, will mean that our monitoring will be more robust. Consequently we expect to see an improvement in the picture of both level of responses and understanding of compliance issues achieved within the first few months of 2016.

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

The Pharmacy department have very recently completed the NICE Technology Appraisals Medicine Report for 2015. This document, which will be available on the public website, summarises medicine TA guidance issued in 2015, our formulary status within 3 months of publication and our level of compliance. This shows that there is no guidance for which the trust is divergent from NICE recommendations.

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Patient Safety

Excellence in specialist and community healthcare

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

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

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

Table 1

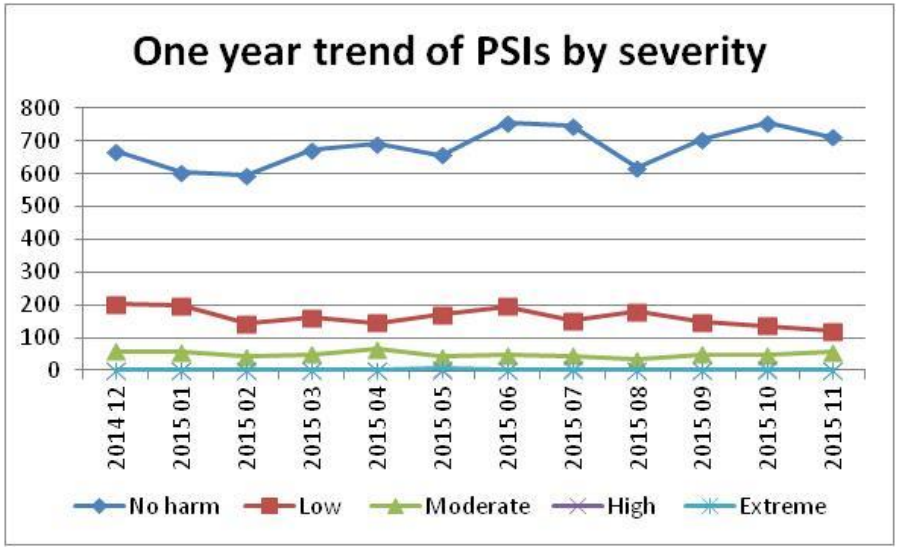
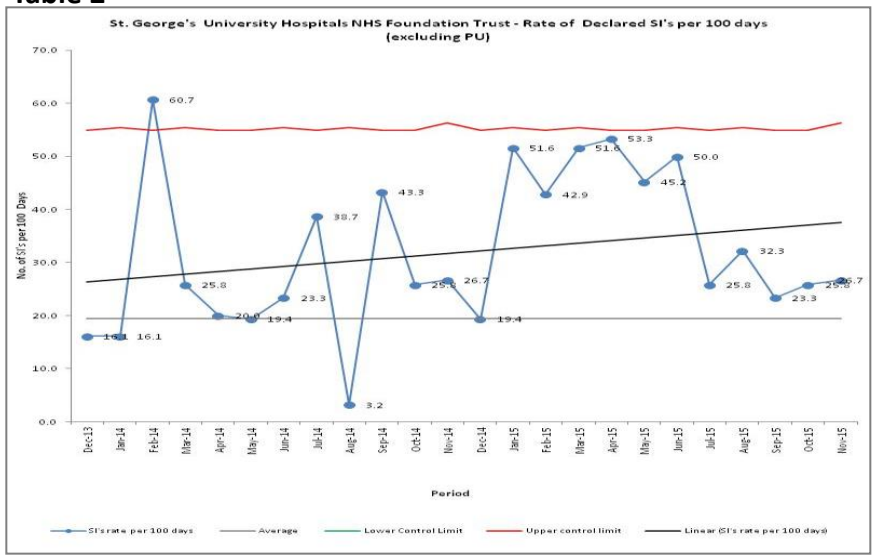


Table 2



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

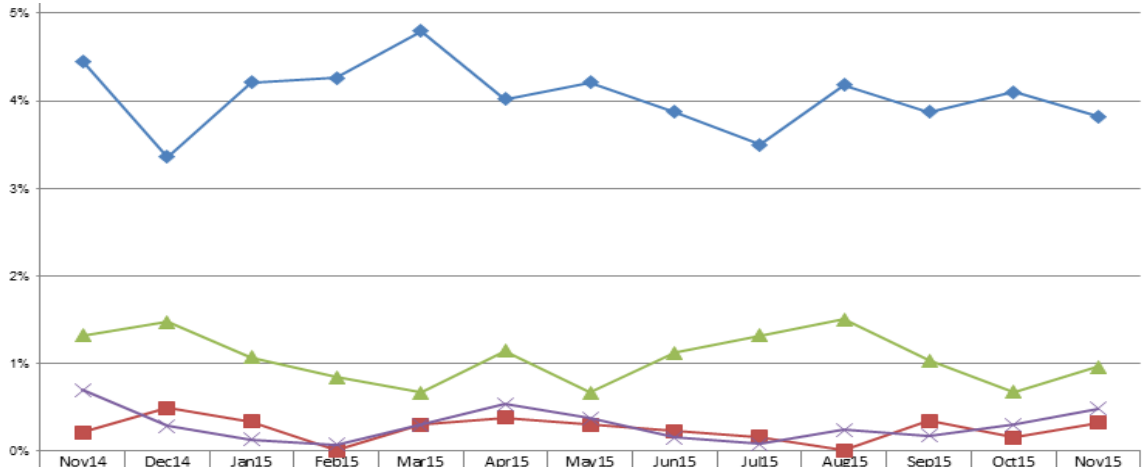
The annual trend for new serious incidents excluding pressure ulcers shown in Table 2 continues to show an increase. There were 8 general SIs reported in November (+4 pressure ulcers) and the subjects are varied.

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

- Death in custody (x2)
- Patient fall (x2)
- Failure to follow up
- Hospital acquired thrombosis
- Inappropriate discharge
- Delay in treatment

7. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	September 2015	October 2015	November 2015	**Movement**	**2015/2016 Target**	**National Average November 2015**	**Date expected to meet standard**
J Hall	94.84%	94.93%	95%	↑	95.00%	94.17%	March 16



	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15
Pressure Ulcers	4.45	3.36	4.21	4.26	4.8	4.02	4.21	3.87	3.5	4.18	3.87	4.1	3.82
Falls	0.21	0.49	0.33	0	0.3	0.38	0.3	0.22	0.16	0	0.34	0.15	0.32
Catheter & UTI	1.32	1.47	1.07	0.84	0.66	1.14	0.66	1.12	1.32	1.5	1.03	0.67	0.96
New VTE	0.69	0.28	0.13	0.07	0.3	0.53	0.37	0.15	0.08	0.24	0.17	0.3	0.48
Patients	1439	1429	1495	1433	1355	1320	1354	1343	1285	1268	1162	1341	1255

Pressure ulcers (48)

- 24 grade 2 (7 new, 17 old)
- 19 grade 3 (5 new, 14 old)
- 5 grade 4 (0 new, 5 old)

CAUTI (12)

- 5 new
- 7 old

Falls (4)

- 3 low harm falls
- 1 moderate harm fall

VTE (6)

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

In November 2015 the proportion of our patients that received harm free care was 95 per cent, which is in line with our target and slightly better than the national average. We reported 70 harms to 69 patients; 68 patients experienced one harm and 1 patient had 2 harms. 27 harms are categorised as new, meaning that they either developed or treatment began whilst under our care.

This month the number of pressure ulcers fell, with a reduction in both old and new harms. A slight increase is observed for the remaining 3 types of harm, with 2 more patients experiencing falls or developing a VTE. Three more patients were observed with a catheter associated UTI this month; however there is attributable to a greater number of old UTIs.

7. Patient Safety
- Safety Thermometer

Children & Young Persons Safety Thermometer (CYPST)

The Children and Young People's Services Safety Thermometer measures commonly occurring harms, as listed below. It is one of the 'next generation' of national patient safety thermometers and is a point of care survey, carried out on one day per month. It aims to support improvements in patient care and patient experience, as it prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines.
The pilot at St George's was launched in June 2015.The clinical lead for the this audit is Rachael Bolland (Nurse Consultant: Acute Paediatrics) and all paediatric wards are included. As with the 'classic' ST, the data collection tool has been set up in RaTE. Issues regarding the audit tool and participation have been addressed and will be monitored to ensure that the process becomes embedded and is of value to staff caring for patients.

The harms measured are:

- Triggered PCAT (paediatric clinical assessment tool)
- Extravasation in last 24 hours
- In pain at time of audit
- Patient with old / new Pressure Ulcer
- Moisture lesion.

Where harms are reported the following actions are to be taken:

- DATIX raised
- MDT form / safety huddle form completed (to identify issues & agree actions)
- DATIX closed once actions completed.

WARD	Cases audited (Jun-Nov 2015)
Jungle	31
Freddie	68
Nicholls	80
Pinckney	99
PICU	50
TOTAL	328

The primary objectives for the first 6 months have been to engage paediatric wards to participate in the audit and work with them to refine the audit criteria in order to accurately capture practice. Processes for real time and monthly reporting of results and action have been set up. Findings will be triangulated with the Paediatric Trigger Tool results and other paediatric audit work to identify priority areas for improvement.

All wards are currently engaging in this audit as required. The pilot demonstrated that some harms were incorrectly reported; several issues were identified and the audit criteria clarified and data set corrected. To date the primary harm that is reported is PCAT not escalated.

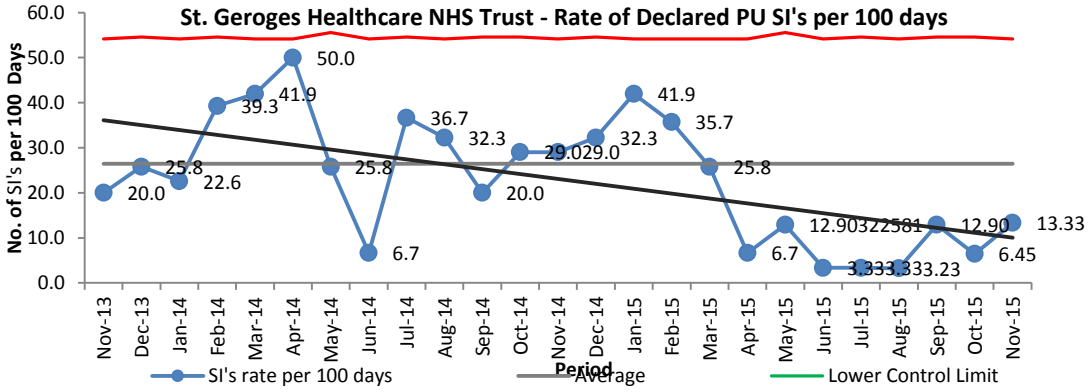
HARMS	No.
Triggered PCAT not escalated	16
Extravasation in the last 24 hours	6
Patient in pain at time of audit	18
Patient with pressure ulcer (new/old)	2
Patient with moisture lesion (new/old)	2

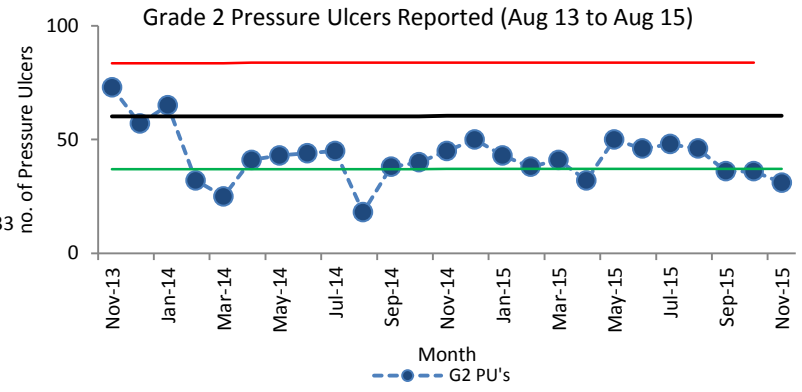
The clinical lead and the audit team have participated in the CYPST national webinar meetings to ensure benefits of shared learning with other Trusts. These meetings indicate variability in reporting against audit criteria; consequently the national team advise data is not suitable for benchmarking.

7. Patient Safety
- Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers										
Type	Jul	Aug	Sep	Oct	Nov	YTD April – May 2016	Movement	2015/2016 Target	Forecast March 2015	Date expected to meet standard
Acute	1	0	2	1	3	**13**			G	-
Community	0	1	2	1	1	**6**			G	-
Total All	1	1	4	2	4	**19**			G	-
Total Avoidable	1	1	4	2	4	**19**		40		-

Grade 2 Pressure Ulcers					
Jul	Aug	Sep	Oct	Nov	Movement
25	23	21	21	11	
23	23	15	15	20	
48	46	36	36	31	





Overview:

November saw an increase in the number of pressure ulcer serious incidents across the trust, however the rise was only seen in the acute sector. There was a reduction in the total number of Grade 2 pressure ulcers across the trust, a reduction from 21 to 11 incidents was seen on the acute side.

Key Themes identified : Further Education and training needed , Increased numbers of new starters needing training , High use of Agency staff unfamiliar with processes. Poor use of patient Information leaflet to increase patient awareness, Patient compliance and refusal , Need Timely risk assessment and referrals

- Poor documentation of repositioning , Reduced support by TVN team, 2 vacancies in Community from Jan 2015 & October 2015 and one on acute site since June 2015

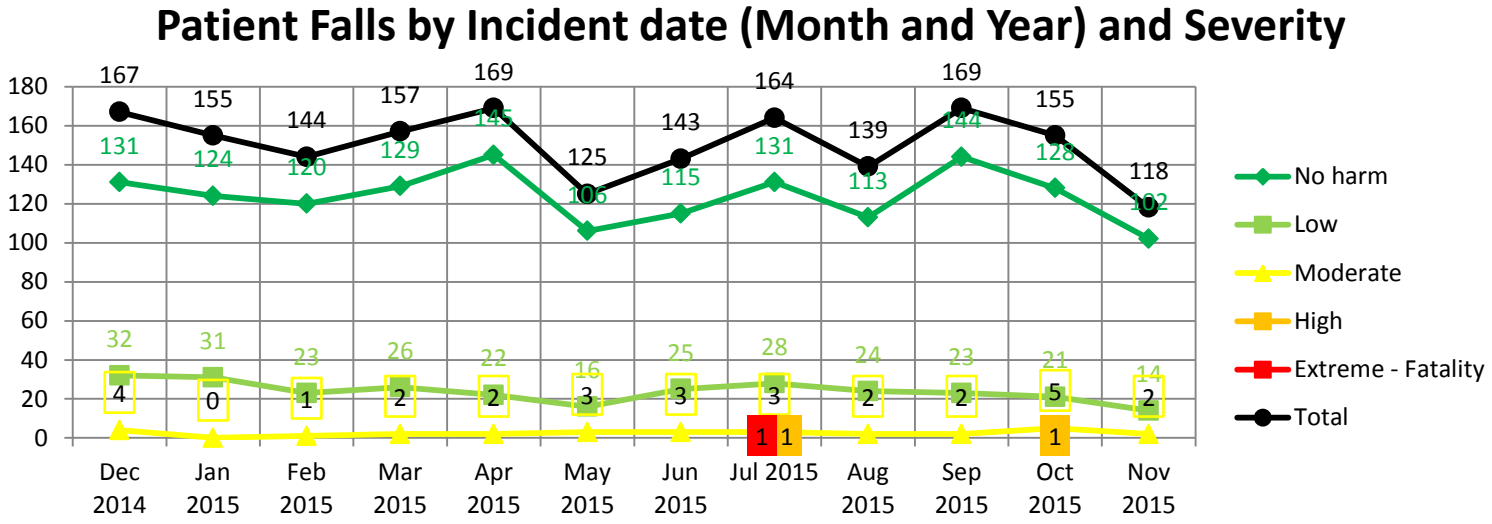
Learning

- Recognition of agency use – implementation of agency leaflet and reinforcement / monitoring of Local induction processes
- Implementation of the IHI programme to drill down and monitor with regular audit of specific issues eg. Repositioning documentation , use of agency information leaflets .
- Learning from the success of surgical Month of awareness – to be replicated in other areas, difficult with limited practice educators in Division of Medicine
- Performance management monitored and strengthened by Pressure Ulcer strategy group for repeated failures in documentation

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

Falls																				
Lead Director	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Movement	2014/2015 Target	Date expected to meet standard
	151	151	125	143	157	154	169	154	144	157	165	126	144	163	140	168	155	118	⟺	100	July 2015

Falls with Harm April 2014- to date				
No Harm	Moderate	Severe	Death	Falls related Fractures
2745	37	5	1	7



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been the lowest number of falls reported this month across all divisions.
Actions: Results from bed rails audit have been shared across all areas with action plan to raise awareness of safe use of bed rails. Post fall protocol audit data collection to commence November 2015. Roll out of NICE compliant multifactorial falls risk assessment and integration of this document into the ED.

7. Patient Safety
- Infection Control

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

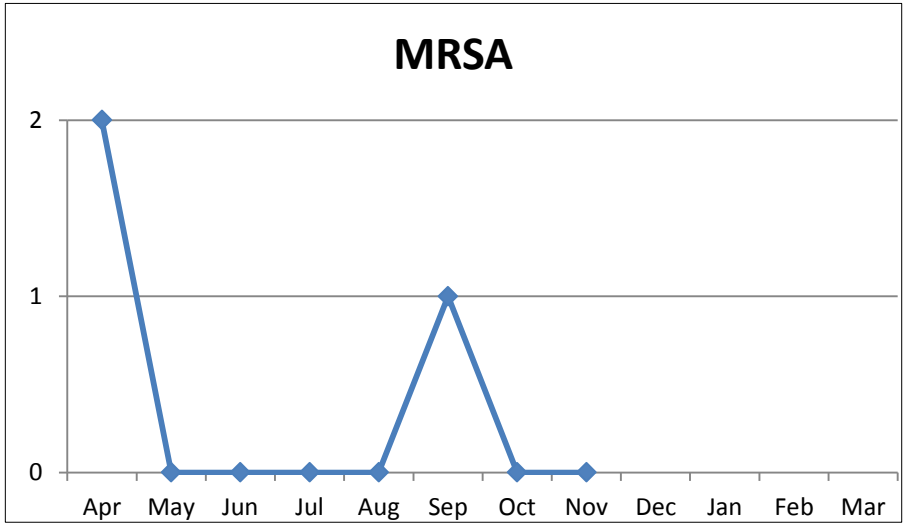
Peer Performance – YTD November 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	2	1	1	3

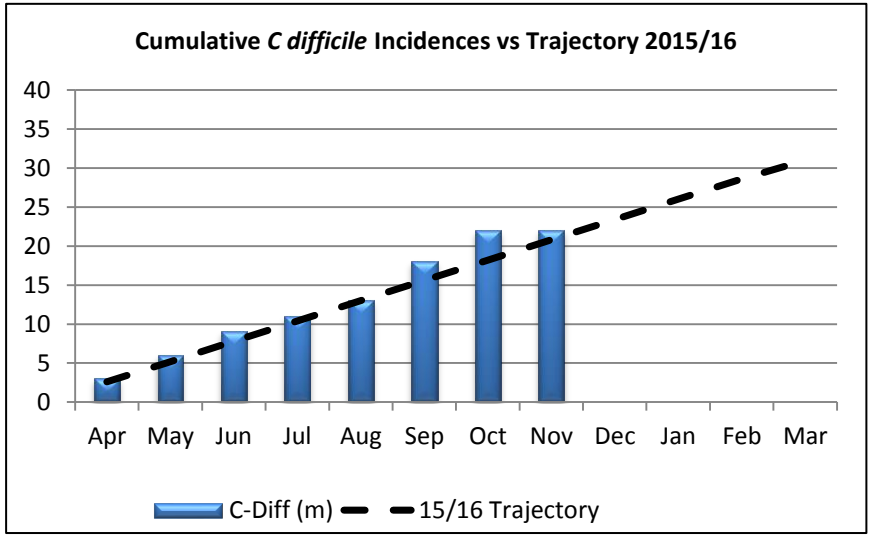
C-Diff						
Lead Director	October	November	Movement	2015/2016 Threshold	Forecast December - 15	Date expected to meet standard
JH	4	0	⇓	31	G	-

Peer Performance – YTD September 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
22 (31)	15(16)	14(9)	59(72)	19(39)

The MRSA bacteraemia threshold is zero. There were no MRSA bacteraemias in October or November. The Trust is non-compliant , with 3 incidents in total. This has reduced from 4 in the previous report. One bacteraemia in September has now been attributed to a third party rather than the Trust, due to the unpreventable nature of this episode. This is reflected in the graph below with the number in September reduced to one.

In 2015/16 the Trust has a threshold of no more than 31 *C. difficile* incidents. in October there were 4 episodes and in November 0 episodes, a total of 22 for the FY to end November. This means that the Trust is currently one above the trajectory for the end of November and thus can still achieve the target at the end of the FY 2015/16.





7. Patient Safety
- VTE

VTE Risk Assessment

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

Data Source	Dec	Jan (2015)	Feb	Mar	April	May	June	July	August	Sept	Oct	Nov
Unify2	93.51%	95.94%	96.03%	96.27%	96.64%	96.45%	96.75%	96.56%	96.78%	97.22%	97.10%	

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	Dec	Jan (2015)	Feb	Mar	April	May	June	July	August	Sept	Oct	Nov
Safety Thermometer (SGH)	75.92%	79.08%	83.89%	85.74%	89.83%	90.19%	95.14%	94.84%	92.38%	91.28%	93.40%	93.24%
National average	83.98%	84.69%	84.82%	84.69%								

Comparison of data streams:

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

Current and Future developments:

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

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

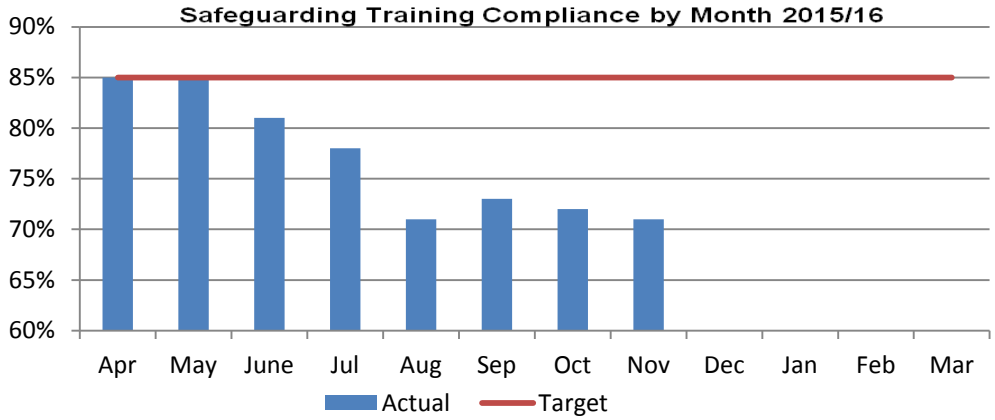
Year		2015
HAT cases identified to date (attributable to admission at SGH)		175
Mortality rate	Total	12.6% (22/175)
	VTE primary cause of death	4.6% (8/175)
Initiation of RCA process		100% (175/175)
RCA pending	<28 days since notification	21
	>28 days since notification (notes requested)	12
RCA complete		81.1% (142/175)

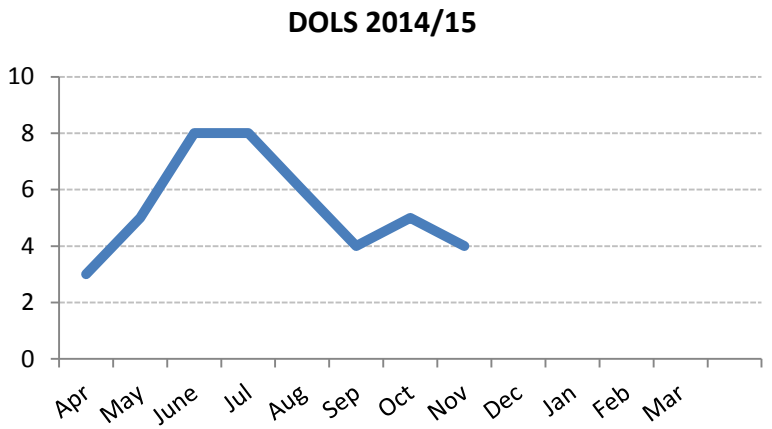
HAT case finding has significantly improved since the start of 2015 resulting in an observed increase in frequency of HAT. This increase brings incidence of HAT at SGH in line with rates observed at other Trusts in London that are of a similar size and status.

7. Patient Safety
- Safeguarding: Adults

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

Safeguarding Adults Training Compliance by Division – Nov 15				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
67%	70%	74%	73%	68%





Overview:

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

Apr 90, May – 70, June 78, July 70, Aug 60, Sep 91, Oct 75. Nov 75

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

Actions:

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

Review procedures following implementation of Care Act - Awaiting revision of Pan London Procedures due Jan 2016

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

Review DOLs activity and impact on resources. Monitor demand on services versus capacity to complete assessments. Produce fresh guidance on DOLS in conjunction with Law Society guidance. Revised briefing paper with legal team was presented to EMT In November indicating current position, impact on resources and future options to manage the governance and workload.. New procedure in place to ensure reporting of those subject to DOLS are reported to the coroner.

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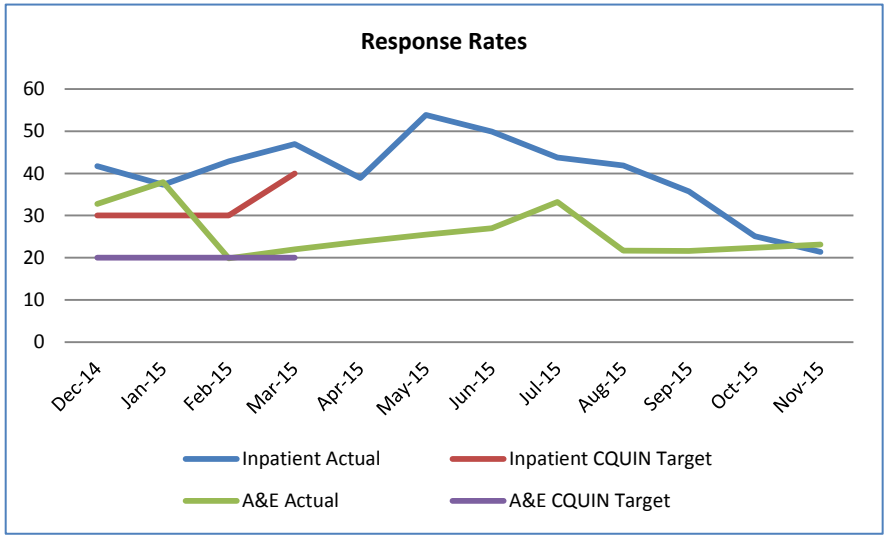
Patient Experience

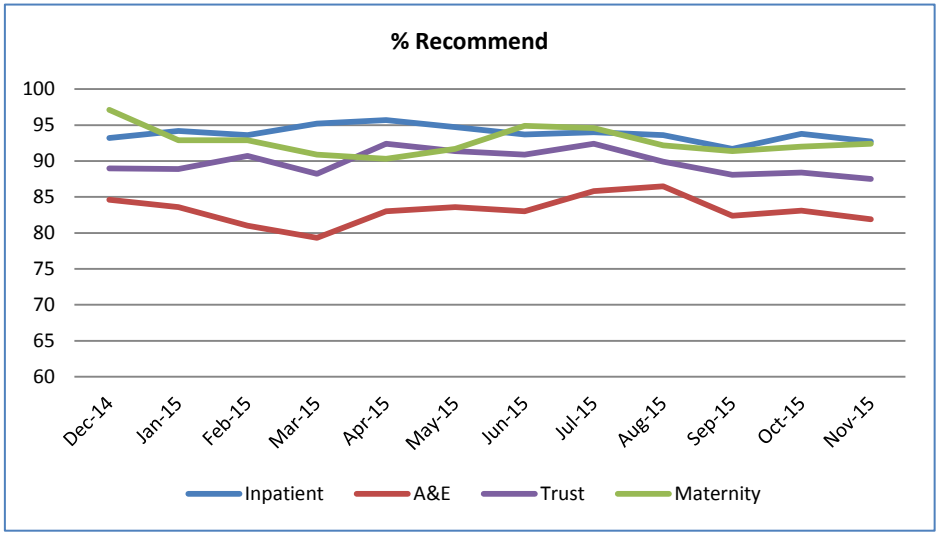
Excellence in specialist and community healthcare

8. Patient Experience
- Friends and Family Test

FFT Response Rate							
Domain	Sep-15	Oct-15	Nov-15	Movement	2015/2016 Target	Forecast	Date expected to meet standard
Trust	26.9	23.6	22.3	▼	-	-	-
Inpatient	35.7	25.1	21.4	▼	-	-	-
A&E	21.6	22.4	23.1	▲	-	-	-
Maternity	N/A	N/A	N/A		-	-	-

	FFT Response Score			
	Sep-15	Oct-15	Nov-15	Movement
	88.1	88.4	87.5	▼
	91.7	93.8	92.7	▼
	82.4	83.1	81.9	▼
	91.4	92	92.4	▲



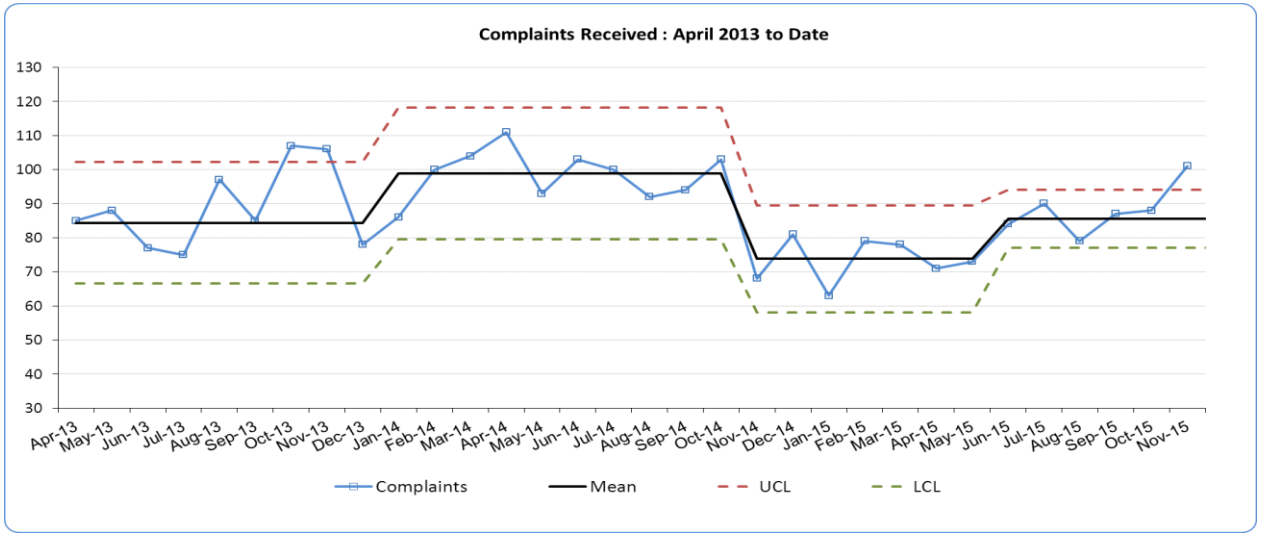


Overview : All CQUINs were met for last year. We are now exploring how to shift our focus from response rates to the content of what our patients are telling us. We are trialling new reports that focus on the 3 areas we score the lowest on. You can preview our latest draft on the next slide.
Inpatient figures now include day cases – this has increased the denominator for the metric by approximately 50%, and the response rate is much lower than historically as a result.

Action :
Continue to monitor response rates, and monitor the 5 poorest performing services in the key areas of noise at night, information about medication side effects and involvement in the discharge process.
Improve the co-ordination of patient experience data with other quality metrics.

8. Patient Experience
- Complaints Received

Complaints Received												
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Move ment
Total Number received	63	79	78	71	72	84	90	79	86	88	101	▲

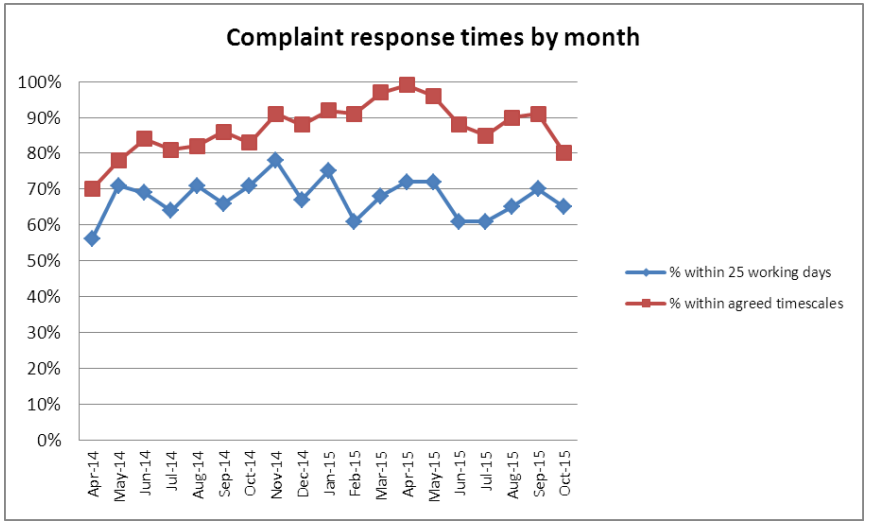


Overview:
This report provides a brief update on complaints received since the last board report (so in November 2015) and information on responding to complaints within the specified timeframes for complaints received in October of 2015/2016. It also includes some posts made on NHS Choices and Patient Opinion. The board will receive more detailed information about complaints received in quarter 3 with divisional breakdowns, analysis of the data to provide trends and themes with actions planned and a severity rating report and once the target date for complaints received in quarter 3 is reached (so March 2016).

Total numbers of complaints received in September 2015
There were 101 complaints received in November of 2015, an increase of 15% when compared to October when 88 complaints were received. The biggest increases were for Women's Services with complaints about Obstetrics rising from 1 to 4 and Gynaecology from 4 to 10 with 5 of these concerning the suspension/closure of the Urogynaecology Service. Complaints about Accident and Emergency Care Group rose from 7 to 12 with recurring themes being clinical treatment – diagnosis and nursing care and attitude. The biggest reductions were for Audiology and ENT (from 9 to 2 and Outpatients and Medical Records (from 9 to 5).

8. Patient Experience
- Complaints Performance against targets

Performance Against Targets October 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	24	15	63%	(4) 79%
Medicine and Cardiovascular	25	15	60%	(5) 80%
Surgery & Neurosciences	28	19	68%	(4) 82%
Community Services	5	3	60%	(1) 80%
Corporate Directorates	6	6	100%	(0) 100%
Totals:	88	57	65%	(13) 80%



Commentary:
Following three months of slow but steady improvement in complaint response times, performance deteriorated for complaints received in the month of October with 65% of complaints being responded to within 25 working days (against an internal target of 85%) and 80% within agreed timescales (against an internal target of 100%) compared to 91% in September.

The only area to achieve the targets was the Corporate Directorates.

As has previously been reported, divisions all have actions in place to improve and maintain performance but in light of the above these will be reviewed and further information reported to the February Board.

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

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

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

Kwhittyj gave Oral and Maxillofacial Surgery at St George's Hospital (London) a rating of 5 stars
Efficient, professional and friendly care
I visited St George's maxillofacial department today to have two wisdom teeth removed and a check on my throat. I found that my appointment was punctual and the team who looked after me were incredibly professional and friendly. They explained the procedures clearly and made me feel very at ease with a warm and friendly approach.

They also went out of the way to explore a medical concern I had which was much appreciated. Thank you very much for your care!

Visited in December 2015. Posted on 11 December 2015

Old Queen Balham gave Accident and emergency services at St George's Hospital (London) a rating of 5 stars
Emergency Admission/Admission to Richmond Ward
I was admitted to Richmond ward for observation and investigations for suspected angina recently. I was treated with dignity and kindness. The staff were excellent and very patient orientated and both A@E and Richmond Ward were clean and felt like a safe space particularly when anxious about being ill.

The only down side for me was (1) the stark bright lighting hurt my eyes and left me with a screaming headache. The other (2) was the drinking water. I dislike tap water, in the London area, purely on taste and the water on the ward tasted foul as though it had been dehydrated then reconstituted and diluted with something from the dark side of the waterworks!

Visited in December 2015. Posted on 14 December 2015

Anonymous gave Diabetic Medicine at St George's Hospital (London) a rating of 3 stars
Need upskilling and training on patient confidentiality!
I have been managed for my complicated pregnancy by the Gestational Diabetes team on the Thomas Addison unit. Although I would certainly say that the attitudes and actual treatment of staff members in general has been very professional in terms of my patient care-my shared care between Maternity and the Diabetics team resulted in 2 x 3 blood samples of mine either 'going missing' and being 'mislabled' with both times causing considerable distress to me as I was forced to wait much longer than I should have for some results of some antibodies tests! Further to this and most shocking was that having told a Diabetic midwife of a personal condition during a routine appointment, just a fortnight later I heard her announce this condition loudly in a busy corridor within the Thomas Addison unit to a colleague!! To say I was disappointed is an understatement and I came away extremely upset at the lack of observance of my rights to confidentiality. Gaping holes in Information Governance and privacy!! I suggest that the importance of patients being able to discuss their health with confidence that the information will be managed correctly and carefully be re-iterated to all to prevent further loss of confidence in what is essentially a good hospital.

Visited in November 2015. Posted on 27 November 2015

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Workforce

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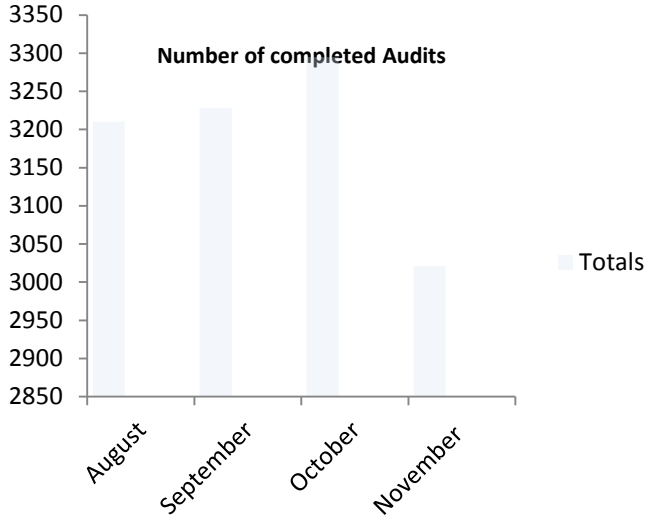
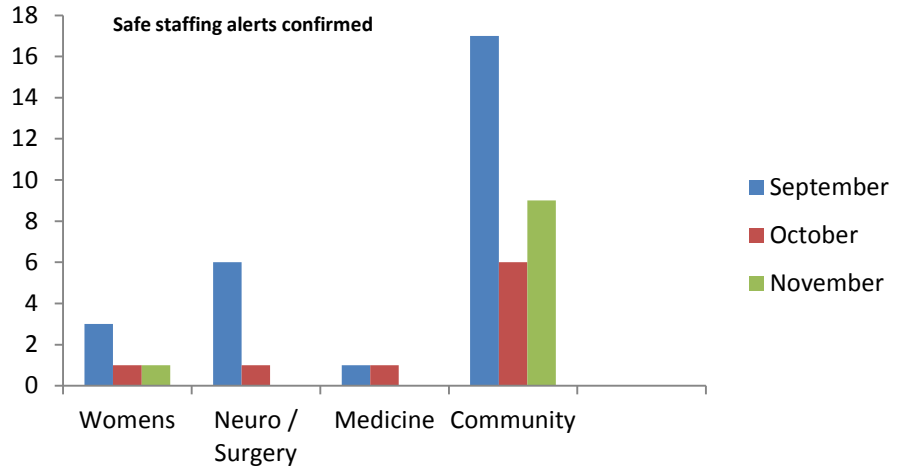
9. Workforce
November 2015 - Safe Staffing alerts





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

The total number of safe staffing audits completed over the past three months were: September 3228, October 3295 and November 3021. There was a slight increase in the number of final alerts reported from 9 in October to 10 in November 2015. Nine of the alerts relate to community services which are unable to provide planned care due to reduced staffing and disruption during their service redesign. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has decreased following on the day investigation (September 14, October 37, November 13). This would indicate that interventions are being made to support safe staffing in the ward areas.

4 nursing related safe staffing concerns were raised on Datix system in November compared to 7 I October. None of the alerts and none of the concerns matched a similar entry on the RATE system.

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

Risk: A safe staffing review is commencing in November.

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

Overview

The information provided on the table below relates to staffing numbers at ward/department level submitted nationally on Unify for November 2015. In line with new national guidance this table shows the number of filled shifts for registered and unregistered staff during day and night shifts. In November the trust achieved an average fill rate of 93.93%, a slight decrease from 94.40% submitted in October.

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

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

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	94.7%	100.0%	98.9%	100.0%
Carmen Suite	129.3%	75.2%	100.0%	85.7%
Champneys Ward	97.9%	91.9%	97.1%	100.0%
Delivery Suite	111.8%	75.7%	110.1%	100.0%
Fred Hewitt Ward	94.7%	104.8%	99.3%	#DIV/0!
General Intensive Care Unit	95.8%	100.0%	98.8%	94.7%
Gwillim Ward	107.5%	57.7%	100.5%	77.8%
Jungle Ward	94.6%	0.0%	#DIV/0!	#DIV/0!
Neo Natal Unit	86.5%	#DIV/0!	92.2%	#DIV/0!
Neuro Intensive Care Unit	93.7%	87.0%	99.2%	99.6%
Nicholls Ward	90.4%	90.5%	99.4%	83.4%
Paediatric Intensive Care Unit	90.6%	97.8%	96.9%	99.0%
Pinckney Ward	97.1%	184.2%	86.4%	#DIV/0!
Dalby Ward	98.6%	100.5%	100.0%	100.0%
Heberden	91.7%	106.4%	100.0%	100.0%
Mary Seacole Ward	95.0%	99.8%	99.0%	99.4%
A & E Department	93.2%	90.1%	101.4%	83.8%
Allingham Ward	94.2%	118.1%	98.5%	100.0%
Amyand Ward	88.6%	103.0%	96.6%	99.0%
Belgrave Ward AMW	94.4%	93.7%	100.0%	100.0%
Benjamin Weir Ward AMW	83.3%	88.5%	99.3%	98.0%
Buckland Ward	91.5%	78.9%	100.0%	100.0%
Caroline Ward	88.5%	86.0%	99.9%	100.0%
Cheselden Ward	93.2%	88.5%	100.0%	99.7%
Coronary Care Unit	104.4%	#DIV/0!	101.7%	100.0%
James Hope Ward	78.5%	96.1%	99.4%	#DIV/0!
Mamham Ward	88.9%	94.4%	98.4%	92.7%
McEntee Ward	97.2%	96.4%	100.0%	100.0%
Richmond Ward	91.3%	91.8%	96.0%	96.9%
Rodney Smith Med Ward	92.7%	93.5%	99.9%	100.0%
Ruth Myles Ward	103.3%	94.9%	97.8%	90.1%
Trevor Howell Ward	98.9%	90.1%	98.9%	98.8%
Winter Ward (Caesar Hawkins)	84.7%	89.4%	97.5%	100.0%
Brodie Ward	91.7%	86.0%	97.3%	100.0%
Cavell Surg Ward	86.7%	85.5%	98.8%	100.0%
Florence Nightingale Ward	90.1%	89.9%	98.3%	#DIV/0!
Gray Ward	90.7%	72.3%	100.1%	99.9%
Gunning Ward	93.4%	91.3%	100.0%	98.3%
Gwynne Holford Ward	84.5%	79.3%	92.5%	98.5%
Holdsworth Ward	88.9%	82.7%	98.9%	100.0%
Keate Ward	96.0%	90.8%	100.0%	75.0%
Kent Ward	91.4%	95.6%	100.0%	100.0%
Mckissock Ward	87.3%	112.5%	96.9%	100.0%
Vernon Ward	85.4%	89.0%	99.2%	96.7%
William Drummond HASU	93.9%	82.0%	98.1%	93.6%
Wolfson Centre	81.5%	103.6%	97.3%	101.1%
Gordon Smith Ward	87.0%	88.1%	97.5%	100.0%
148 - Nightingale Step Down, Off Site Fac	0.0%	0.0%	0.0%	0.0%
Brodie Stroke Ward	0.0%	0.0%	0.0%	0.0%
Trust Total	91.79%	91.26%	97.45%	94.96%

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Heatmap Dashboard
Ward view

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10. Ward Heatmap

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	Jones Unit	0.0	0.0	0.0		0.0	0.0		0.0	1.0	
	Mary Seacole	0.0	0.0	0.0			73.2	1.9	6.0	0.0	4.1
		0.0	0.0	0.0			73.2	1.9	6.0	0.0	4.1
	Primary Care	0.0	0.0	0.0		0.0	0.0		0.0	1.0	
	South Locality (Health Visitin..	0.0	0.0	1.0		0.0	0.0		0.0	1.0	
MEDICINE	ALLINGHAM	0.0	0.0	0.0	85.7	83.3	44.8	-0.7	5.0	0.0	9.5
	AMYAND	0.0	0.0	0.0	90.3	96.3	40.3	4.6	4.0	0.0	2.8
	BELGRAVE	0.0	0.0	1.0	93.5	97.9	48.5	3.6	7.0	1.0	1.9
	BENJAMIN WEIR	0.0	0.0	0.0	97.0	100.0	36.1	10.0	1.0	0.0	4.7
	BUCKLAND	0.0	0.0	0.0	94.7	100.0	37.5	7.3	4.0	0.0	2.0
	CAESAR HAWKINS	0.0	0.0	0.0	82.6	90.3	34.8	9.0	1.0	0.0	11.0
	CARDIAC CARE UNIT	0.0	0.0	0.0	88.9	100.0	118.8	-3.0	2.0	0.0	0.7
	CAROLINE	0.0	0.0	0.0	95.8	89.8	42.2	7.6	2.0	0.0	8.5
	CHESELDEN	0.0	0.0	0.0	90.5	100.0	26.5	4.8	1.0	0.0	6.2
	DALBY	0.0	0.0	0.0	70.4	100.0	38.9	0.2	8.0	0.0	4.7
	EMERGENCY DEPARTMENT	0.0	0.0	0.0		0.0		4.5	7.0	1.0	6.3
	GORDON SMITH	0.0	0.0	0.0	82.4	100.0	69.6		0.0	0.0	1.4
	HEBERDEN	0.0	0.0	0.0	91.7	95.5	56.4	-0.1	6.0	0.0	6.9
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0		15.2	0.0	0.0	1.2
	MARNHAM	0.0	0.0	1.0	85.7	80.0	7.9	6.7	2.0	1.0	13.8
	MCENTEE	0.0	0.0	0.0	100.0	100.0	39.3	1.7	1.0	1.0	2.5
	RICHMOND	0.0	0.0	0.0	100.0	94.7	43.6	6.2	6.0	0.0	6.1
	RODNEY SMITH	0.0	0.0	0.0	85.2	81.3	30.8	4.4	5.0	0.0	1.7
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	91.7	100.0	64.7	0.7	0.0	0.0	1.1
	TREVOR HOWELL	0.0	0.0	0.0	94.4	93.1	38.2	2.5	5.0	0.0	8.0
SURGERY	BRODIE NEURO	0.0	0.0	0.0		0.0	27.7	6.5	2.0	0.0	1.3
	CAVELL	0.0	0.0	0.0	100.0	45.1	41.4	9.5	1.0	0.0	4.6
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	100.0	93.3	78.8	7.2	2.0	1.0	3.7
	GRAY WARD	0.0	0.0	0.0	93.5	94.7	68.5	9.4	0.0	0.0	0.9
	GUNNING	0.0	0.0	0.0	100.0	94.7	73.1	4.8	1.0	0.0	0.9
	GWYN HOLFORD	0.0	0.0	0.0	100.0	100.0	29.4	13.2	6.0	1.0	5.3
	HOLDSWORTH	0.0	0.0	0.0	100.0	100.0	63.2	7.9	3.0	0.0	10.2
	KEATE	0.0	0.0	0.0	100.0	94.0	81.6	4.0	0.0	0.0	1.0
	KENT	0.0	0.0	1.0	93.1	90.0	25.0	4.1	6.0	1.0	0.7
	MCKISSOCK	0.0	0.0	0.0	93.8	100.0	66.7	3.7	1.0	0.0	5.7
	THOMAS YOUNG	0.0	0.0	0.0	96.0	100.0		6.4	4.0	0.0	3.3
	VERNON	0.0	0.0	0.0	86.7	91.1	37.3	9.4	2.0	0.0	5.5
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	97.8	37.4	5.8	2.0	0.0	0.8
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0	88.9	0.0	0.0	3.2	0.0	0.0	4.2
	CARMEN SUITE	0.0	0.0	0.0	100.0	100.0		-7.2	0.0	0.0	0.4
	CHAMPNEYS	0.0	0.0	0.0	100.0	97.7	31.2	2.4	0.0	0.0	6.4
	DELIVERY	0.0	0.0	0.0	100.0	100.0		-7.2	0.0	1.0	6.2
	FREDDIE HEWITT	0.0	0.0	0.0		0.0	0.0	2.4	0.0	0.0	5.5
	GENERAL ICU/HDU	0.0	0.0	0.0		0.0		2.7	0.0	0.0	5.8
	GWILLIM	0.0	0.0	0.0	100.0	90.1		6.9	0.0	0.0	2.3
	JUNGLE	0.0	0.0	0.0		0.0	0.0	6.1	0.0	0.0	0.0
	NEONATAL ICU	0.0	0.0	0.0	100.0	100.0	0.0	8.4	0.0	0.0	3.6
	NEURO ICU	0.0	0.0	0.0	91.7	0.0		3.8	0.0	0.0	4.7
	NICHOLLS	0.0	0.0	0.0		0.0	0.0	6.5	0.0	0.0	5.8
	PICU	0.0	0.0	0.0		0.0		5.8	0.0	0.0	4.7
	PINCKNEY	0.0	0.0	0.0		0.0	0.0	-3.5	0.0	0.0	4.2

10. Ward heatmap
CWDT&CC Division

Cardiothoracic Intensive Care (CTICU)
88.9% scored for harm free care. 18 patients were surveyed, 2 reported to have harm. These harms related to 1 patient with a new DVT and another with a catheter and new UTI (CAUTI).

General Intensive Care (GICU)
Inaccuracies exist in the heatmap and GICU did in fact report a return of 94.1%; 17 patients were surveyed and 2 harms were reported for a single patient, these related to an old grade 3 pressure ulcer and a new grade 2 pressure ulcer.

Neuro Intensive Care (NICU)
91.7% scored for harm free care. 12 patients surveyed, with 2 harms reported for the same patient. This was a patient who had a CAUTI and an old grade 2 pressure.

The adult critical care team will be reviewing the overall number of CAUTIs across the service to look at any emerging themes and interventions that can be implemented to improve care and reduce the overall number.

Sickness
Sickness was above the trust threshold in many areas in November 2015. This was a combination of long term sickness and an increase in short term sickness. It is recognised that some areas need some additional support in order to manage the short term sickness, therefore a monthly HR meeting will be re-established to support this and provide assurance.

Friends and Family
The data errors for the friends and family response continue with no returns noted for some areas that are now reporting (children's wards) and other areas that do not report being assigned a zero return. There is also inconsistency in the reporting of the response rate. As previously the information team have been asked to review this data for the division.

10. Ward heatmap
MedCard

Emergency Department: Falls – These relate to low and no harm falls, of which 2 were related to one patient falling twice. On review of the falls these patients were nursed in an appropriate area with appropriate staffing.

Friends and Family – No data has been recorded against this field in the report and the department has achieved above 20% response rate consistently. This is being addressed with the IT department to ensure accurate reporting.

Sickness – These relate to long term sickness which is being managed with support of the HR department.

Allingham ward: Harm free Care 28 patients were surveyed. 4 patients had harms reported. 2 patients had old grade 2 pressure ulcers. 1 patient had a new grade 3 pressure ulcer and 1 patient had an old grade 3 pressure ulcer.

Falls – The ward has seen a reduction in falls in recent months and these falls relate to the nature of the patient group cared for on this ward. The falls reported are low or no harm.

Sickness – This is attributed to long term sickness which has now been resolved and the staff have returned to work. Short term sickness and one episode of unauthorised absence is being managed with the support of HR.

Marnham: Serious Incident The ward has 1 grade 3 pressure ulcer which is being investigated currently

Sickness This relates to 1 episode of long term sickness and multiple short term sickness which is being managed with the support of HR.

Friends and Family percentage is low due to poor capture by staff and IT connectivity issues. Communication has been given to staff regarding expectations and this task is allocated to staff in the morning based on predicted discharges.

Harm Free Care 28 patients surveyed. 4 patients had harms reported. 2 patients had a catheter and old UTI. 1 patient had a fall with moderate harm and 1 patient had an old grade 4 pressure ulcer.

Rodney Smith: Harm Free Care 27 patients surveyed. 4 patients had harms reported. 2 patients had old grade 2 pressure ulcer's, 1 patient had a new grade 3 pressure ulcer and 1 patient had a catheter and old UTI

Buckland ward: Falls –The ward had 4 falls which is a reduction from previous months and this was due to the same patient falling twice, both were no harm. The other was a staff member who fell due water on the floor within the ward. Falls are shown to reduce again in December currently.

Trevor Howell: Falls -Two falls were of the same patient and 1 visitor also fell but no action was needed. In the other cases, the post falls protocol was undertaken and all patients were reviewed by the SHO on call. 1 patient was deemed to need bedrails which was implemented, 1 patient moved closer to the nursing station for observation. 1 patient also had eyesight issues and due to his diagnosis, could not ring for help. He was therefore moved closer to the nursing station . No patients were deemed to need specialing as a result of the falls and no further harm was reported. The incidents have all been closed on DATIX. Falls are reduced in December to 2 in total currently.

Sickness There were 3 episodes of long term sickness and multiple short term sickness. These have been managed in line with policy and phased returns have been planned for staff who are on long term sick.

10. Ward heatmap
MedCard

Heberden: Harm Free Care – 24 patients surveyed. 2 patients had harms reported. 1 patient had an old grade 2 pressure ulcer and 1 patient had a new grade 2 pressure ulcer

Sickness Due to 1 episode of long term sickness which is currently being managed formally.

Falls The falls resulted in low or no harm, and is an improved position from the previous month.

Dalby: Harm Free Care 27 patients surveyed. 28 harms reported. 2 patients had old grade 4 pressure ulcers, 2 patients had old grade 2 pressure ulcers, 2 patients had low harm falls. 1 patient had a catheter and old UTI. 1 patient had an old grade 2 pressure ulcer

Sickness This sickness is due to an episode of long and short term sickness. This is being managed with the support of HR.

Falls 8 falls in month due to a number of patients with increased confusion. These falls relate to low or no harm falls. Where appropriate an assessment was conducted an special put in place.

McEntee: Serious Incident relating to the accusation of a thrombus whilst in hospital. This is currently being investigated.

Richmond: Falls 6 falls reported in month which are low or no harm. This has been a reduction in falls for the third month and the Ward continues to conduct education regarding falls prevention and pressure ulcers.

Ben Weir: Sickness The ward had 8 separate episodes of sickness during the month. These have been managed in line with policy and staff have been placed on stage 2 sickness monitoring which has shown an improvement.

Belgrave : Pressure Ulcer The ward had 1 Grade 3 pressure ulcer which was avoidable. The investigation showed that staff needed to ensure robust position changing and documentation.

Falls – 7 in the month. There was one patient who fell a number of times. The falls were no or low harm. An action plan to reduce falls has been implemented for the ward.

Cheselden Sickness 6.2 % One member of staff on long term sickness who has been managed and will be leaving the Trust in January. " episodes of short term sickness which has been managed in line with policy and staff have been placed on stage 1 and stage 2.

Friend and Family The ward aims to increase the response rates through identification of discharges at ward round and allocation of FFT capture to the receptionist and housekeeper.

10. Ward heatmap
SNTC

- **Florence Nightingale** – 2 red indicators. The first red indicator was due to 3.7% sickness. This was due to two episodes of short term sickness and 1 long term sickness absence- all have been managed to the sickness policy.
- There was a second red indicator was for a serious incident that was raised in November for a patient who had a fall in July 2015. This is currently being investigated by a panel.
- **Gunning** – No red/amber indicators
- **Holdsworth** – 2 red indicators. The first red indicator was due to 3 falls. All falls were no harm. 2 patients had a mechanical fall and 1 patient fainted when they stood up.
- The second red indicator was due to 10.4% sickness absence in November 2015. This figure is incorrect as for the month of November 2015, 3 staff was sick for 2 days, so the sickness absence percentage should have been approximately 3%
- **Cavell-** 1 red indicator due to 4.6% sickness absence and 1 amber indicator for patient satisfaction at 45.1%. The red sickness indicator was due to 2 short term sickness episodes and 2 long term sickness episodes in November 2015. All sickness was managed in line with the sickness policy.
- The amber indicator for patient satisfaction of 41.5% was due to 43 patients stating that they were neither likely nor unlikely to recommend care or treatment to their family or friends and 2 patients stating that they were unlikely to recommend care or treatment on Cavell ward. The matron and ward sister have addressed this concern by meeting with and managing the individuals responsible for the care of those patients.
- **Keate**- No red/amber indicators
- **Gray**- 1 amber indicator relating to 93.5% Harm Free Care. This was due to 2 patient harms reported in November 2015. 1 patient had an old grade 3 pressure ulcer on admission and 1 patient had a catheter and a new urinary tract infection
- **Vernon-**2 red indicators. The first red indicator related to harm Free care of 86.7%. This was due to 4 patient harms reported in November 2015. Two patients were admitted to an old grade 2 pressure ulcer, 1 patient developed a new grade 2 pressure ulcer and 1 patient had a catheter and new urinary tract infection.
- The second red indicator related to sickness absence of 5.5%. 2 staff members had episodes of long term sickness and were managed in line with the trust policy.
- **Brodie –** 1 red indicator and 1 amber. The red indicator is for 0% Patient Satisfaction (Friends and Family test). This information is inaccurate as the discharge surveys on RATE show 100% satisfaction.
- The amber score is for 27.7% response rate for Friends and Family test. This information is inaccurate. Data is being collected on 2 discharge survey RATE tablets and need to be merged. Tom Magill and his team are undertaking this task.
- Harm Free care on the scorecard indicated that this was not completed for November 2015; it was completed and was 96.2%

10. Ward heatmap
SNTC

- **Kent –** 3 red indicators and 2 amber. The first red indicator was for an acquired grade 3 pressure ulcer and this also accounts for the second red indicator as this has been declared as an SI. Root cause analysis highlights issues with electronic documentation and failure to document that a full assessment of the patient's pressure areas was performed on admission to the ward.
- The third red indicator is for 6 falls. This should not be red as this is below the agreed tolerance level for Kent ward due to the nature of the patients on the ward. The falls related to individual patients and were either due to patients trying to transfer/mobilise without supervision or falls during therapy sessions. All falls were no harm.
- The first amber indicator is for 93.1% harm free care which is due to 1 patient having no documented VTE assessment, 5 patients not having started a VTE prophylaxis and 2 new UTI's. The second amber indicator is for 25 FFT Response rate – this is low on previous months and will be a focus for ward staff next month.
-
- **McKissock –**1 red indicator and 1 amber. The red indicator is for sickness and is due to 2 members of staff being on long term sick leave. Staff are being managed as per the trust policy with regards to their sickness.
-
- The amber indicator is for 93.8 5 harm free care which is not accurate as data entered on RATE shows 100%.
-
- **Gwynne Holford** – 4 red indicators and 1 amber indicator. The first red indicator is for 13.2% unfilled shifts. This is due to the high vacancy factor on the ward. The second red indicator is for 6 falls – all were no harm with 1 patient falling twice. All falls were due to patients trying to transfer themselves.
-
- The third is for an SI where a patient sustained a fractured NOF (patient mobilised to wash basin and did not use his walking aid) and the fourth is for 5.3% sickness rate, all episodes are managed to trust policy. The amber indicator is for 29.4% response rate for FFT, the staff have been reminded to focus on this concern to ensure they have a minimum of 40% completion rate.
-
- **Thomas Young –** 1 red indicator. The red indicator is for falls, 4 have been documented on the scorecard however there are only 2 falls on datix. Both falls were no harm and the patients were independently safe to mobilise. The threshold for falls for Thomas Young is 11 so this shows significant improvement in patient safety and the falls rate on Thomas Young.

11. Community Services Scorecard

Domain	Patiend Safety & Experience Indicator	Frequency	2015/2016 Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Direction
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16		
Patient Safety	SI's REPORTED	Monthly		1	1	2	0	1	4	1	3	
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0	0	0	0	0	
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0	0	1	2	1	1	
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0	0	0	0	0	0	0	
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7	4	12	8	13	10	6	
Patient Safety	Number of moderate falls	Monthly	0	2	1	0	1	0	0	0	0	
Patient Safety	Number of major falls	Monthly	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	
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0	0	0	0	
Patient Safety	CDiff (cumulative)	Monthly	31	1	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	
Patient Safety	Number of Quality Alerts	Monthly		3	5	2	9	11	4	6	7	
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	89.0%	86%	85%	84%	81%	81%	77%	70.0%	
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	90.0%	90.0%	85%	82%	79%	88%	89%	86%	
			Level 2 85%	84.0%	84.0%	82%	82%	74%	66%	67%	63%	
			Level 3 85%	69.0%	69.0%	82%	90.00%	70%	85%	87%	84%	
Patient Outcc	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.86	0.86	0.9	0.9	0.9	
Patient Exper	Active Claims	Monthly		0	0	1	3	1	0		tbc	
Patient Exper	No of Complaints	Monthly		16	18	6	5	2	5	5	5	
Patient Exper	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%	tbc	
Patient Exper	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%	tbc	
Patient Exper	FFT Score (Mary Seacole and MIU)	Monthly							Mary Seacole A - 98%, Mary Seacole B - 93%	94.4	94.4	
Patient Outcc	Catheter related UTI (Trust)			1.14	0.66	1.12	1.32	Not yet available				
	Number of new VTE (Trust)		National 0.005	0.55	0.37	0.30	0.08					
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A	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%	Data available after 17th Dec 2016	
Workforce	Turnover Rate-	Monthly	13%	19.64%	19.94%	20.40%	20.08%	21.00%	21.15%	20.75%		
Workforce	Vacancy Rate-	Monthly	11%	19.41%	19.06%	19.40%	12.60%	13.42%	12.59%	15.67%		
Workforce	Appraisal Rates - Medical	Monthly	85%	66.67%	72.73%	69.57%	69.57%	84.00%	84.00%	79.41%		
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	77.25%	76.80%	75.84%	75.42%	76.02%	68.22%	64.91%		

11. Quality scorecard exception report

- **KPI Exception Report for (for period up to end of Nov 2015)**
- **Serious Incidents:** In Nov 3 Si were reported: 1 PU Grade 3 (CAHS) and 2 Death in Custody (OHC)

- **Complaints:** Community Services numbers of formal complaints remained at 5. Complaints in 100% of September were responded to within 25 working days.

- **Quality alerts:**

	In time	Late	Still open	Total
Community Services	3	0	4	7
Totals:	3	0	4	7

(2 x QMH (dermatology service, Gastro), 5 community nursing)

- **Workforce data** : Vacancy and sickness rates increased on last month. Divisional workforce strategy drafted. Workshop Jan 2016 to review recruitment, retention and foreword planning.

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

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

Access targets and outcomes objectives

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

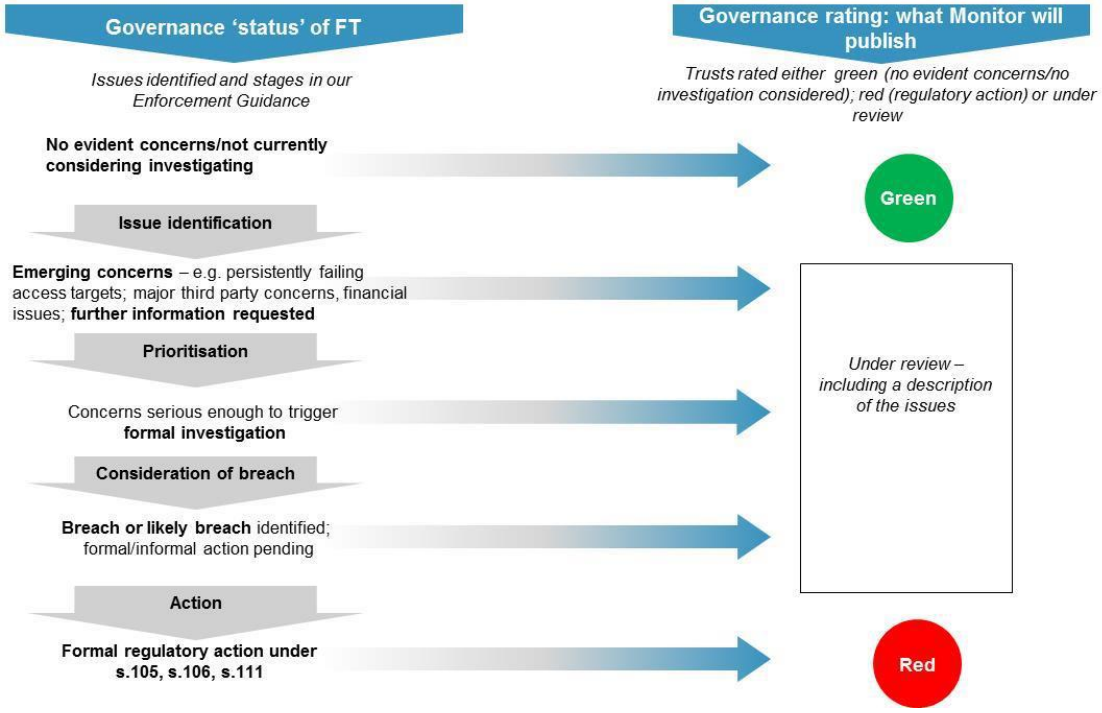
In addition to the above, when assigning governance ratings Monitor also take into account the following which may lead to overrides in the governance rating::

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

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

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

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



Enclosure:

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – January 2016 TB Jan 16 – 03a

Paper Title:	**Finance Report for Month 8 2015/16**
Sponsoring Director:	Steve Bolam, Chief Financial Officer & Deputy Chief Executive
Author:	Anna Anderson, Interim Operational Director of Finance
Purpose:	To inform the Board about the Trust's financial position at the end of November 2015
Action required by the board:	For review and to identify where further action or assurance is required
Document previously considered by:	Finance and Performance Committee

Executive summary

Income and expenditure performance in November has been reported against the reforecast baseline budgets agreed by the Board in November. These result in a year end deficit of £63m but a range of further actions was also agreed with the aim of reducing the deficit to £50m. The change to the reforecast budget means that variances for the first half of the year have been eliminated so year to date variances only relate to months 7 and 8.

The cumulative deficit to the end of November was £39.8m, £2.5m better than the reforecast plan. The main reason for this positive position was the receipt of £1.7m of capital funding from the St George's charity. There have also been pay underspends of £2.3m, a benefit of £1.4m from renegotiation of the facilities management contract and an underspend on clinical consumables. However SLA income continues to be less than plan, particularly in outpatients, and contract penalties have increased.

£21.6m of CIPs have been achieved to date, and the total for the year is now expected to be £37.8m of which 82% are green rated.

The cash balance at the end of November was £9.3m, £6.3m better than planned as a result of strong cash management.

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 third month.

Capital spend is continuing to be slowed down as part of the overall cash management plan and to date spend has been £20.7m, £17.8m less than the revised plan.

The focus now has to be on finalising and implementing the further actions supported by the Board last month to reduce the forecast £63m year end deficit as close as possible to £50m. Alongside this the Trust has to confirm medium term loan funding to support its operational activities.

Enclosure:

Key risks identified: The control of expenditure and the delivery of a higher level of savings in the second half of the year when winter pressures may also be experienced. The need to balance financial measures with maintaining the quality of patient care.	
Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Achieve financial targets in the near term Achieve long term financial sustainability
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	N/A
Equality Impact Assessment (EIA): Has an EIA been carried out? No No specific groups of patients of communities will be affected by the items in this report. Where there may be an impact on patients consultation will be managed as part of that specific programme.	

St George's Healthcare NHS
NHS Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
				15 Oct 2010
1.1 Who is responsible for this service / function / policy?				
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 8 2015/16

Trust Board 14 January 2016

1. Month 8 Headlines & Actions – Income & Expenditure

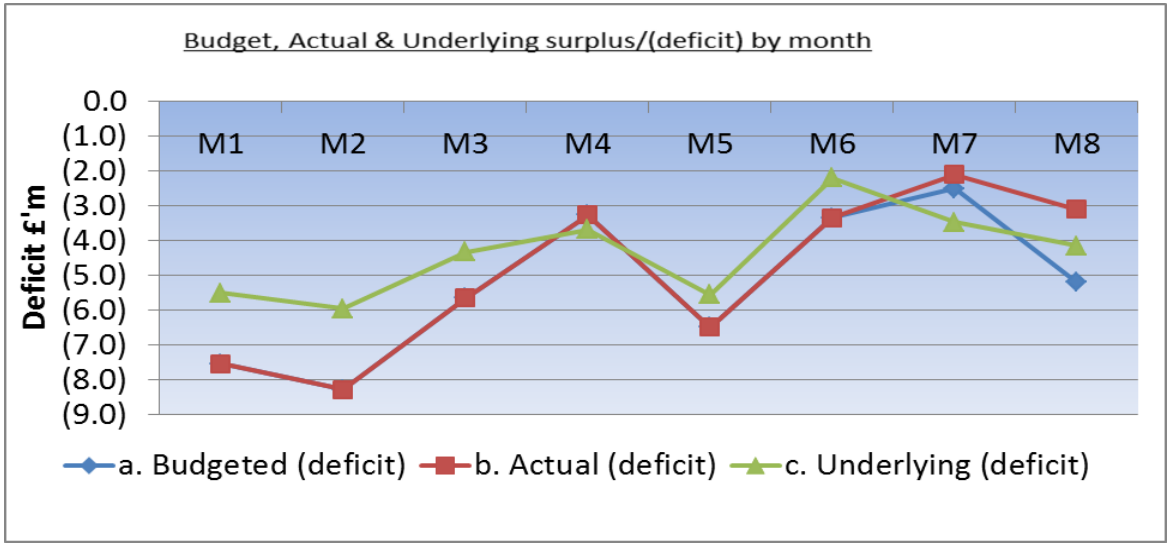
Area of Review	Metric	Key Highlights	Actions	RAG
Overall financial performance in November	Deficit of £3.1m in the month, £2.1m better than reforecast	Budgets have been revised to reflect the outcome of the reforecasting exercise and performance in November, and for the year to date, is measured against this. Detailed expenditure budgets total £63m more than income and plans to achieve further savings have not yet been allocated to divisions. This will be done as further measures are finalised. Year to date variances only relate to months 7 and 8 as revised budgets for earlier months were based on actuals. The main reason that performance is better than expected is that there is a benefit of £1.7m from charitable funding for capital which is treated as revenue income. There are also pay underspends in most areas. The variances on SLA income and non pay in month 7 are due to reprofiling of income and expected spend for winter capacity and flow schemes funded by CCGs.	• Divisions to review month 8 performance and assess likely impact of trends in months 7 and 8 on the forecast year end position. • Ensure remedial action is taken to resolve problems that are highlighted e.g. RTT penalties. • Finalise further measures in 'overlay', take actions to deliver them and revise detailed budgets to reflect their contributions to Trust-wide schemes. • Conclude negotiations with commissioners about penalties, funding for capacity and flow and reinvestment of fines. • Communicate progress clearly across the Trust so that staff know that the better than plan performance does not obviate the need for significant further action to minimise the year end deficit. • Implement monthly forecasting process from month 9.	
Overall financial performance - year to date	Year to date deficit of £39.8m compared to plan of £42.3m i.e. £2.5m better	Month 8 performance is better than month 7 primarily because of charitable fund income. Excluding this other variances are c£0.4m positive in both months. There are pay underspends offset by income shortfalls. The reforecast budget has been rephased to include the benefit from speeding up drug reporting in month 7, this has removed £1.2m of the £1.6m the variance reported orally at the last F&P and at the Turnaround Board	As above	
Activity/Income	Income is £2.7m below plan for the year to date	Activity in all areas was lower in November than October. Unplanned theatre closures have contributed to lower elective activity. Outpatient income is £0.8m below plan despite a £4m reduction in the budget. Penalties increased by £1.3m in November primarily for new to follow up ratios for NHSE outpatient activity and 18 week RTT fines.	• Confirm reasons for negative variances and scope for these to be reduced. • Assess scope to challenge further commissioner challenges especially for outpatient ratios and high cost drugs. • Firm up on possible options to increase activity or discount plans that are unrealistic. • Assess likely impact of theatre maintenance and options to minimise its impact through evening/weekend working	
Expenditure-Pay	Pay budgets are £2.3m below plan for the year to date	Pay spend in months 7 and 8 is very similar to levels in the first half of the year. Of the £2.3m underspend to date £1.2m is in nursing and £0.7 relates to therapists. Both staff groups have been affected by recruitment difficulty, and slower progress than in the reforecast both on recruitment and on the implementation of plans for capacity and other business cases. Temporary staff spend increased from October to November and the reasons for this need to be understood better.	• 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 £0.4m worse than plan	There are three main factors affecting non pay budgets: • Drug spend above plan by £2.6m due to higher use of high cost drugs and greater activity than expected in the pharmacy commercial unit. • Clinical consumables £1m below plan due to lower activity levels in November. • General supplies £1.6m better than plan due to renegotiation of the Mitie contract which is a one off benefit in 15/16	• Finalise pharmacy/finance review of HIV and high cost drug spend • Continue Grip actions to ensure compliance with SFIs in the procurement of goods and services. • Implement bold non pay proposals	
CIP	£21.6m savings delivered to date against plan of £25.4m	Of the £21.6m delivered to date £13.2m is CIPs and £8.4m is non recurrent or run rate savings. Of the £37.8m total schemes expected to be delivered this year £31m, or 82%, are green .	• Items in the bold list and CIP pipeline schemes need to be agreed and implemented to maximise their impact in the remainder of this financial year. • Budgets need to be reduced in month 9 to reflect agreed new CIPs and to reduce the target year end deficit. • Budget holders need to be clear what their further CIP contributions are	

2. Month 8 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights	Actions	RAG
Cash	Cash balance £9.3m	The M08 actual cash balance was £9.3m (£6.3m higher than plan) including cumulative WCF drawdowns of £26.3m. The M08 plan cash balance was £3m including cumulative WCF drawdowns of £34.9m. Therefore the overall cash position was £14.9m better than plan.	The Trust has secured a further drawdown of £10.14m which brings total drawdowns to £36.4m and provides sufficient cash to meet liabilities as they fall due until the end of February. The Trust has submitted its ITFF application for the total £48.7m required this year (inclusive of the £36.4m drawn to date) however DH has since advised that ISF funding may not be confirmed and access to the remaining balance of this sum (£12.3m) may be not be permitted until well into the new year. Meanwhile the Trust is continuing to implement bold actions to reduce the I&E deficit and cash actions to reduce as far as possible the need to borrow further this year in order to minimise risk to the cash position.	
Capital	YTD spend £18.3m, £14.7m less than plan	Capital expenditure was £2.5m in November, an under spend of £3.1m in month against the reduced £48m capital programme agreed in June. Year to date expenditure is £20.7m which is £17.8m less than the revised budget – contributing to the favourable cash position reported above.	In order to support the cash position the Trust is continuing to slow down the rate of capital expenditure where possible until the discussions with Monitor on the interim support funding are concluded.	
Working Capital	YTD movement -- £1.6m, £6.6m better than Plan	Working capital deteriorated by £1.2m in month due to higher debt levels (over performance) and also the reversal of a timing difference on HESL quarterly funding which assisted working capital in M07. Creditors continue to contribute significantly to the working capital position.	The Trust needs to continue to maintain the longer supplier payment terms and secure reductions in overdue debt to build on the improvements made YTD on working capital given the restrictions currently in place over the WCF. In addition stock levels need to reduce further.	
FSRR (formally COSRR)	Rating of 2 compared to plan of 1	The Trust's financial sustainability risk rating for month 8 (November) is 2 which is ahead of plan. The rating reflects a better than planned cash balance and deficit position.	Although works to deliver savings and strong cash management are on-going, the forecast rating for the Trust is 1 later in the year.	

3. Overall Position for the 8 months to 30th November

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	613.5	52.3	47.1	(5.2)	405.2	402.5	(2.7)
Other Income	105.0	8.8	11.8	3.0	67.4	70.6	3.2
Overall Income	**718.5**	**61.1**	**58.9**	**(2.2)**	**472.6**	**473.1**	**0.5**
Pay	(465.3)	(39.2)	(38.8)	0.4	(305.6)	(303.2)	2.3
Non Pay	(281.6)	(24.2)	(20.1)	4.1	(186.6)	(186.9)	(0.4)
Overall Expenditure	**(746.8)**	**(63.4)**	**(58.9)**	**4.5**	**(492.1)**	**(490.2)**	**2.0**
EBITDA	(28.3)	(2.3)	(0.0)	2.2	(19.5)	(17.1)	2.5
Financing Costs	(34.6)	(2.9)	(3.0)	(0.1)	(22.8)	(22.7)	0.1
Surplus / (deficit)	**(63.0)**	**(5.2)**	**(3.1)**	**2.1**	**(42.3)**	**(39.8)**	**2.5**



Commentary

- All budgets are now based on the reforecast/'TRP' exercise. TRP revised budgets are based on months 1-6 actuals, and projections for months 7-12. This means that the year to date variance only reflects variances in October & November.
- The November deficit of £3.1m was £2.1m better than the TRP and the year to date deficit of £39.8m was £2.6m better than plan.
- Income for month 8 was £2.2m worse than plan and £0.5m better than the cumulative plan. Shortfalls in SLA income have been mitigated by other income over performance.
- SLA income is worse than plan in month (£5.2m) and cumulatively (£2.7m). The cumulative position is primarily due to an increase in provision for challenges/fines (£1.5m worse than plan YTD) and loss of NETA income from NHSE (£1.3m).
- In addition the current month variance includes £3m SRG income accrual reduction for capacity and flow which have now been reprofiled to reflect expected actuals. This has resulted in offsetting variances against SLA income and non pay (reserves).
- Pay is better than plan in month and cumulatively. This is due to slippage on business cases and, slower recruitment. Actual pay spend for October & November is in line with the month1-6 average.
- Non pay overspend to date relates to high cost drugs and commercial pharmacy spend above plan.
- Monthly underlying deficits are shown in the graph. Month 8 included net benefit of £1.3m (£1.7m donated asset income from Trust charity, £1.4m refund relating to renegotiation of the Mitie contract, £1.3m NETA income loss and £0.5m new NHSE penalties provision). The underlying deficit in the month was £4.2m.

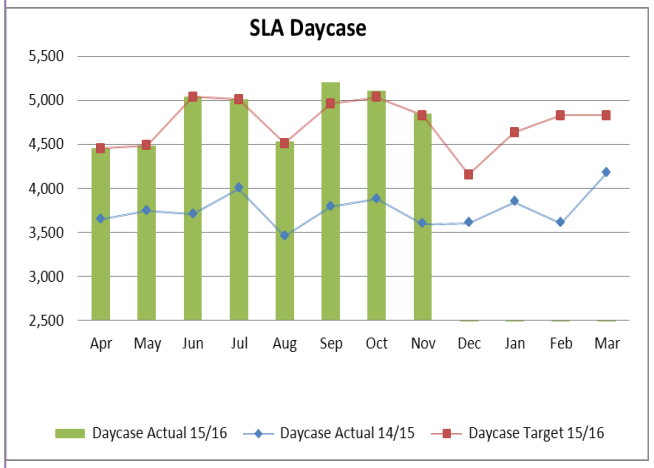
4. SLA Income for the 8 months to 30th November

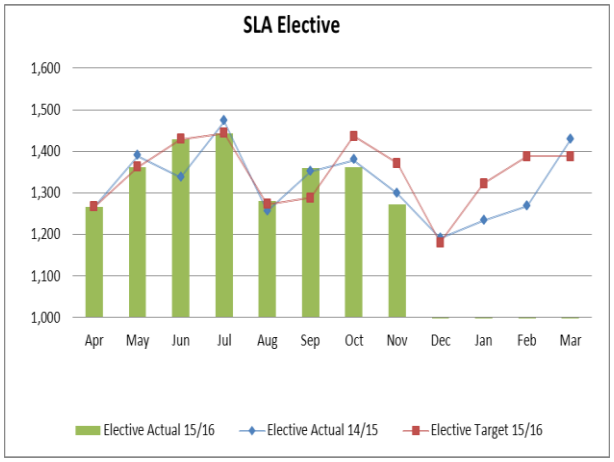
Activity	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
A&E	18.5	1.5	1.5	(0.0)	12.3	12.2	(0.1)
Bed Days	61.9	5.4	5.4	0.1	39.6	39.7	0.1
Daycase	30.6	2.6	2.7	0.1	20.5	20.5	(0.0)
Elective	63.9	5.4	5.5	0.1	43.1	42.8	(0.3)
Non Elective	120.8	9.8	9.5	(0.3)	80.3	79.9	(0.4)
Outpatients	138.8	12.1	11.7	(0.5)	92.4	91.6	(0.8)
Pass-through drugs & devices income (HCD)	74.6	6.2	7.0	0.7	49.6	50.7	1.1
Community Block	49.7	4.2	4.1	(0.0)	33.1	33.0	(0.0)
Fixed Block (HIV)	21.7	1.8	1.8	0.0	14.5	14.5	0.0
Unbundled (Chemotherapy & Diagnostics)	20.7	1.7	2.0	0.2	13.8	14.1	0.3
In Patient Deliveries	10.9	0.9	1.0	0.1	7.3	7.4	0.1
Out Patient Regular Attenders	4.2	0.3	0.4	0.0	2.9	2.9	0.1
Challenges/Penalties	(9.0)	(0.9)	(2.2)	(1.3)	(5.4)	(6.8)	(1.5)
Other (Ex SLA)	6.2	1.2	(3.2)	(4.4)	1.1	(0.2)	(1.3)
Grand Total	**613.5**	**52.3**	**47.1**	**(5.2)**	**405.2**	**402.5**	**(2.7)**

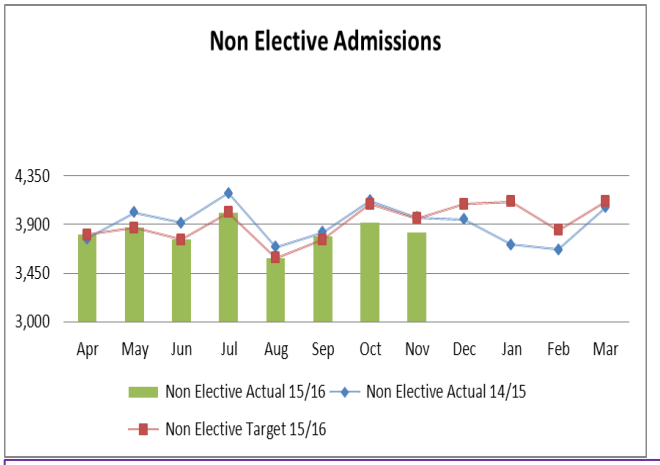
Commentary

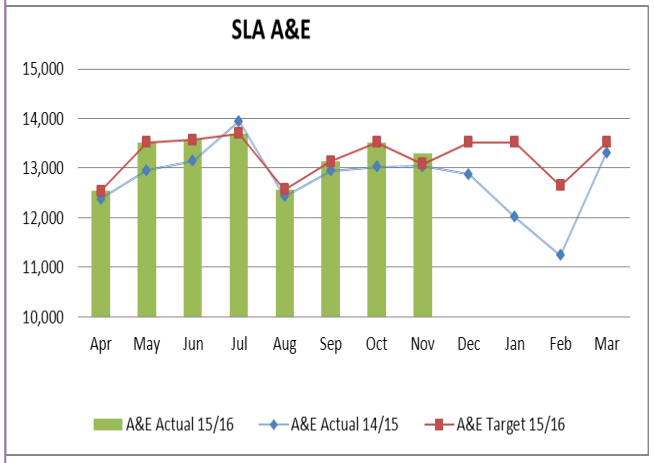
- SLA income was £5.2 below plan in the month and £2.7m below cumulatively for October & November.
- The cumulative variance reflects worse than planned positions against penalties provisions (£1.5m worse) and Ex-SLA income – specifically the expected NETA income loss (£1.3m worse).
- In month £5.2m under-performance against plan is partly due to a £3m re-phasing in 'Other' income' to adjust reporting of SRG/winter income in the winter months.
- There is also a shortfall on outpatient income despite a reduction in the budget. About half of this is in obstetrics and is being investigated. Other areas below plan include Neurology and Trauma & Orthopaedics which impact on Emergency and Outpatient activity [due to delays in planned business cases].
- These shortfalls are offset by higher than expected high cost drug income which is matched by higher drug spend.
- The increase in provision for penalties is concerning and a significant proportion of this relates to a revised assessment of new/follow up outpatient penalties from NHSE. The other main contributory factor is 18 week fines.
- Activity trends are shown on the next page

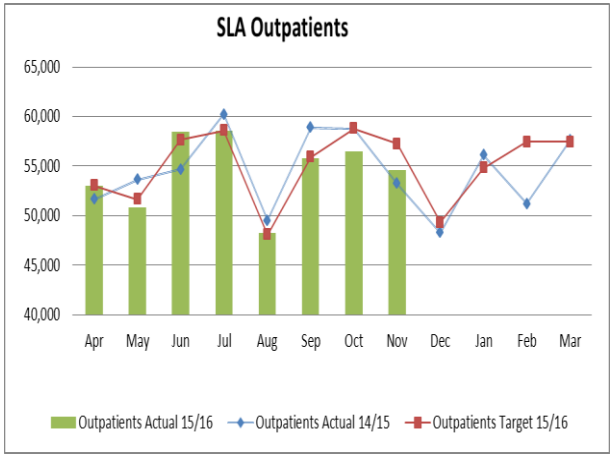
5. Patient activity compared to plan for the 8 months to 30th November











Commentary

The budgeted activity numbers have been updated to reflect those agreed in the recovery plan.

Actual activity across all areas has fallen in November compared to October.

- Daycases are in line with the reforecast plan whilst elective, non elective and outpatients are below the reforecast plan. The shortfall in outpatients is mainly due to obstetrics which is being investigated further. Shortfalls in inpatient work are due to unplanned closures in Theatres.
- Elective activity is 0.25% higher than 2014-15
- A & E activity is 2% higher than last year and outpatients are 1% lower than last year. The COO is working with divisions to assess scope for improvement beyond what is included in the reforecast plan.

6. SLA Income by Commissioner for the 8 months to 30th November

Income	Annual Budget (£m)	Year to Date		
		Budget (£m)	Actual (£)	Better/(Worse) than Budget
NHSE Specialist	212,854	139,474	150,042	10,568
NHSE Public Health	23,713	15,734	15,816	82
NHSE Secondary Dental Care Services	8,708	5,879	5,831	(48)
NHSE Cancer Drugs Fund	2,882	1,849	2,670	821
NHSE SPECIALIST (IFR)	0	0	3	3
Public Health England	422	281	675	394
Subtotal NHSE	**248,578**	**163,217**	**175,038**	**11,821**
NHS Wandsworth CCG	146,926	98,374	99,395	1,021
NHS Merton CCG	58,570	39,217	42,368	3,151
NHS Lambeth CCG	19,964	13,348	13,732	384
NHS Croydon CCG	21,334	14,274	15,495	1,221
NHS Sutton CCG	13,449	8,997	9,001	5
NHS Kingston CCG	12,912	8,643	8,475	(168)
NHS Richmond CCG	11,818	7,944	8,190	247
SURREY CCG	20,023	13,379	13,455	77
Other CCGs	20,877	13,736	12,320	(1,416)
Subtotal CCGs	**325,873**	**217,911**	**222,432**	**4,521**
NCA	8,166	5,438	5,565	128
Other Trusts	1,060	715	852	137
Other Local Authority	7,976	5,391	5,300	(91)
Subtotal CCGs	**17,201**	**11,544**	**11,717**	**174**
Internal Targets: Growth, Business Cases etc	14,104	9,849	-9,435	(19,284)
Ex SLA Income	7,750	2,634	2,729	95
Total NHS Healthcare Income	**613,506**	**405,156**	**402,482**	**(2,674)**
Additional Income				
Private & Overseas Patient	5,459	3,600	3,779	179
RTAs	4,182	2,778	2,765	(13)
Other Healthcare Income	237	181	162	(19)
Education and Training Levy Income	44,201	29,564	29,533	(31)
Other Income	50,917	31,316	35,774	4,458
Total Other Income	**104,996**	**67,440**	**72,012**	**4,573**
Total income	**718,502**	**472,595**	**474,495**	**1,900**

Commentary

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

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

The Trust set an additional internal target of £26.6m, now reduced to £14.1m to reflect patient activity that was expected over and above agreed contract values. This has been reduced since last month in accordance with the TRP. Taking this into account the Trust is below its total planned SLA activity targets by £2.6m year to date.

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

Other income is the income that is generated by South West London Pathology, Pharmacy Income, R & D Project income, Donated Capital income and Parking Services income.

7. Pay costs for the 8 months to 30th November

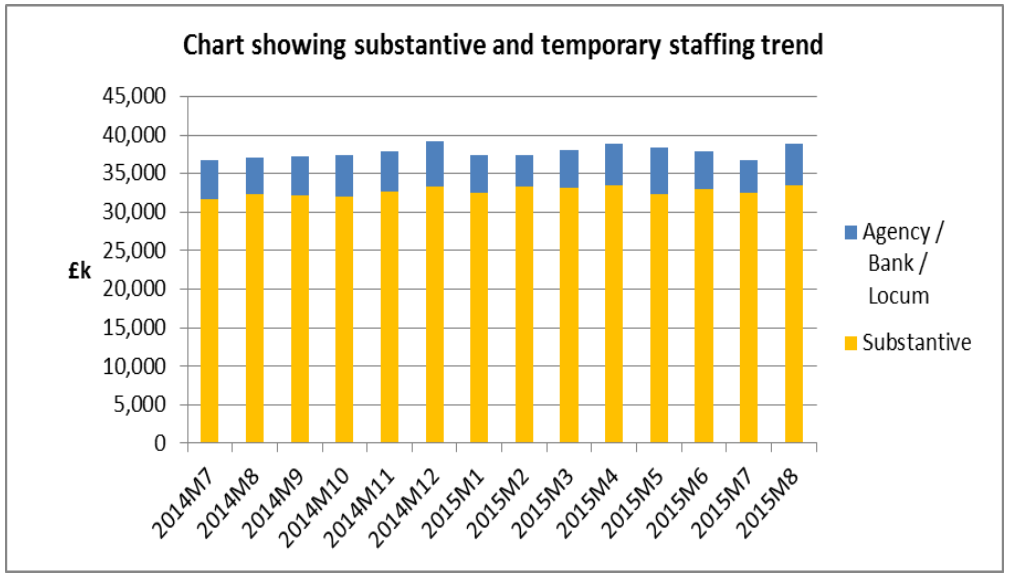
1. Pay spend against budget (In month & YTD)

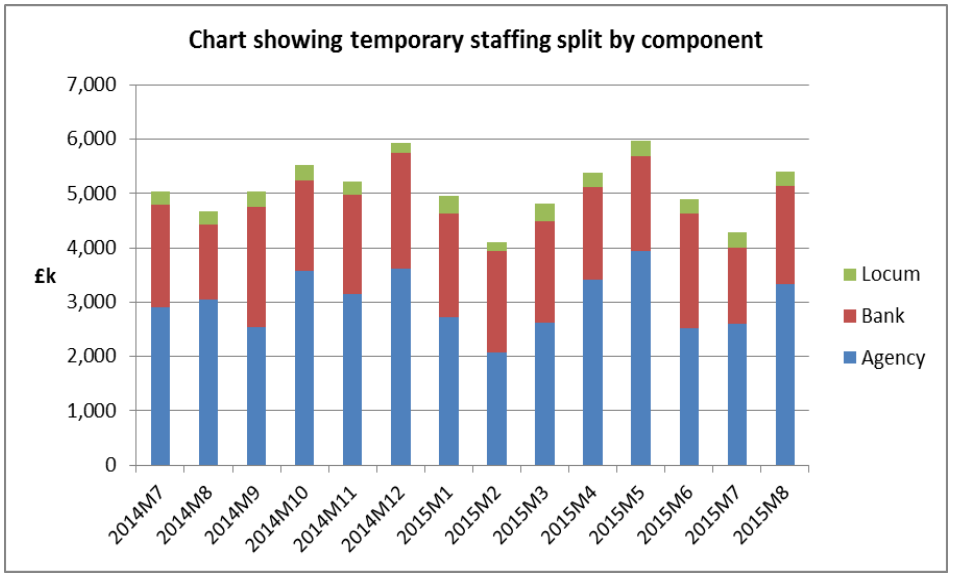
Pay Summary by Staff Type	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Consultants	(72.7)	(6.1)	(6.3)	(0.3)	(48.1)	(48.2)	(0.2)
Junior Doctors	(50.7)	(4.3)	(4.4)	(0.1)	(33.6)	(33.7)	(0.1)
Non Clinical	(78.0)	(6.5)	(6.5)	(0.0)	(51.5)	(51.1)	0.5
Nursing	(180.3)	(15.2)	(14.9)	0.3	(117.7)	(116.5)	1.2
Scientists, Technicians, Therapists	(82.7)	(7.0)	(6.6)	0.3	(54.4)	(53.7)	0.7
Unallocated (Pay Provisions)	(0.8)	(0.1)	0.0	0.1	(0.2)	0.0	0.2
Grand Total	(465.3)	(39.2)	(38.8)	0.4	(305.6)	(303.2)	2.3

Commentary

- Pay expenditure in month is £0.4m better than plan and cumulative pay is £2.3m better than the plan for October & November.
- The underspend is mainly against non clinical, scientific, technical and therapeutic and nursing staff groups. Non clinical and scientific/technical/therapeutic staff underspends are seen in he Children's, Women's, Diagnostics & Therapies (CWDT) and Medicine & Cardiology divisions. Nursing underspend is across all clinical divisions.
- These underspends against the reforecast budgets relate to slippage against projected increases for various business cases and winter capacity schemes that underpinned the reforecast budgets.
- Actual spend in October and November against all staff groups however, is largely flat compared against the months 1 to 6 spend. There is on-going work across the workforce turnaround groups to reduce the expenditure and improve the trend.
- Of note is that pipeline CIPS have yet to be reflected in the TRP budgets.

8. Pay trend for the 8 months to 30th November





Commentary

- Month 8 actual pay is higher than the immediate previous months as it includes £0.4m correction for understated month 7 agency costs (calculation error) as well as £0.2m recruitment & retention paid this month.
- Progress has been made to document processes to record and report temporary pay in order to minimise swings between months due to timing and processing issues and to allow a better understanding of trends. Further work is being done to strengthen processes in the light of experience.
- The proportion of total spend relating to agency remains 8% on average while bank spend is c5%. Work is on-going via the workforce turnaround group to reduce agency spend.
- The department of health directive for formal monitoring of nurse agency spend over the next three years came into effect in month 7 – October. The nurse agency cap for the Trust cap for quarters 3 & 4 is 10% of the total nursing spend.
- Internal trust target for months 7 & 8 was 9% however, the actual nurse agency spend in these months was 11.5% each. This is being monitored and managed via the divisional directors of nursing business meetings.

9. Non pay costs for the 8 months to 30th November

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	(98.3)	(8.3)	(7.5)	0.8	(64.6)	(63.7)	1.0
Drugs	(61.3)	(5.2)	(6.6)	(1.3)	(40.5)	(43.1)	(2.6)
Premises	(44.2)	(4.0)	(3.9)	0.1	(28.5)	(28.6)	(0.1)
Clinical Negligence	(15.1)	(1.3)	(1.3)	(0.0)	(10.1)	(10.4)	(0.3)
Establishment	(11.3)	(1.0)	(1.0)	(0.1)	(7.6)	(7.8)	(0.2)
General Supplies	(16.8)	(1.4)	0.1	1.6	(11.1)	(9.5)	1.6
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)	(4.7)	(4.7)	(0.0)
Consultancy	(5.8)	(0.7)	(0.6)	0.2	(4.8)	(4.5)	0.3
External Facilities	(7.3)	(0.7)	(0.2)	0.4	(4.1)	(3.7)	0.4
Other NHS Facilities	(6.4)	(0.5)	(0.5)	0.0	(4.3)	(4.3)	0.0
Diagnostic Services	(26.1)	(2.1)	(2.2)	(0.1)	(17.5)	(17.6)	(0.1)
Other	(10.4)	(1.1)	(0.8)	0.3	(6.8)	(6.6)	0.2
Reserves	(0.2)	(0.0)	3.0	3.1	(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	1.2	0.1	0.0	(0.1)	0.7	0.8	0.0
Trust Central (Diagnostic Services & Cross charges)	28.7	2.7	2.0	(0.7)	18.9	18.3	(0.6)
Grand Total	**(281.6)**	**(24.2)**	**(20.1)**	**4.1**	**(186.6)**	**(186.9)**	**(0.4)**

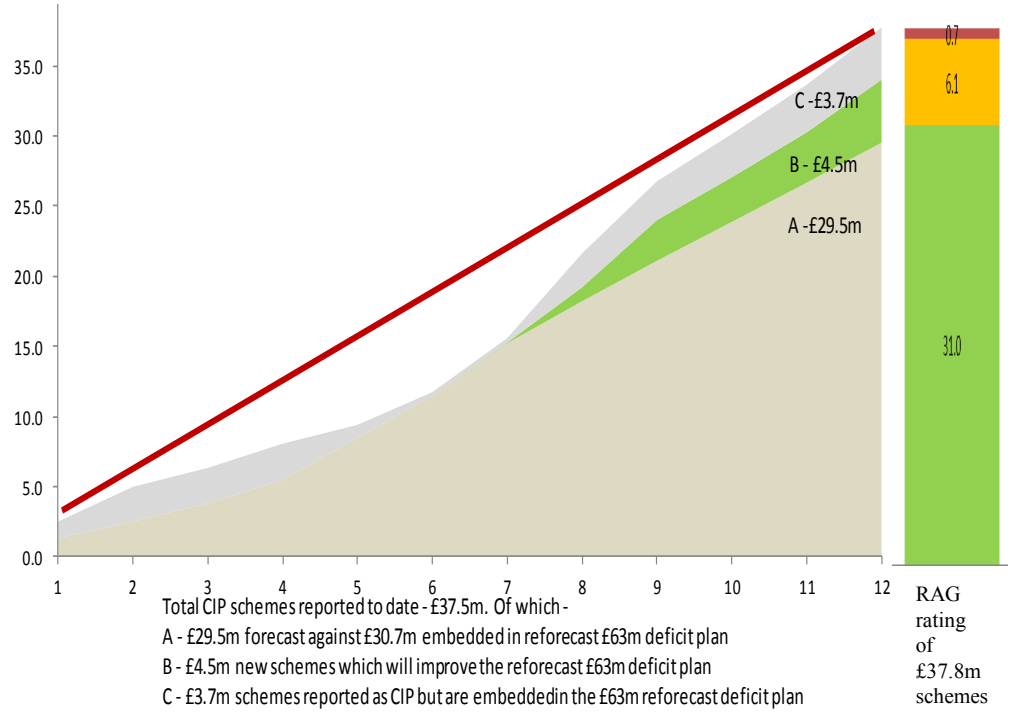
Commentary

- M8 non pay is £4.1m better than budget which is primarily due to:
  1. Adjustment to eliminate the month 7 cumulative accrual (£3m in reserves) for SRG funded capacity and flow schemes which have now been re-profiled to reflect expected timing for the schemes in both income and expenditure budgets. This adjustment has a nil impact on the year to date position as the budget has been re-profiled across the last five months of the year, and devolved in the reforecast process.
  2. £1.4m reduction to Mitie contract spend in the year to date (general supplies) following contract renegotiation and terms which included a reduction to the 15/16 contract

- Cumulative non pay is £0.4m overspent due to high cost drugs and commercial pharmacy activity over performance (both are fully offset by additional income).

- Clinical consumables is £0.8m underspent in month, and £1m cumulatively. This reflects slippage against projected increases for various business cases and winter capacity schemes that underpinned the reforecast budgets.

10. Trust CIP performance



Total CIP schemes reported to date - £37.5m. Of which -
A - £29.5m forecast against £30.7m embedded in reforecast £63m deficit plan
B - £4.5m new schemes which will improve the reforecast £63m deficit plan
C - £3.7m schemes reported as CIP but are embeddedin the £63m reforecast deficit plan

Commentary

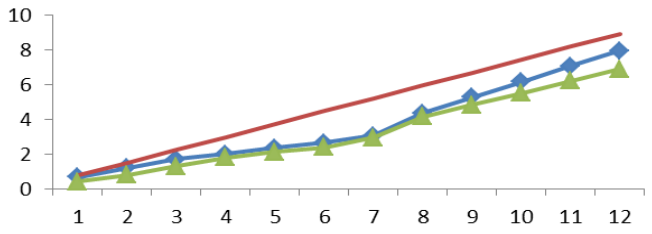
- The CIP target for 2015/16 is £38.1m. The chart alongside shows CIP plans and delivery against the £38.1m target
- In the year to date the Trust has delivered £21.6m of savings compared to a plan of £25.4m. Of the £21.6m delivered so far, £13.2m is CIPs and the balance of £8.4m is non-recurrent and run rate/vacancy control savings
- The baseline forecast £63m deficit plan requires delivery of £30.7m CIP embedded in the TRP. The forecast against this is currently at £29.5m as a number of schemes have not reported actuals. This is under review and is expected to recover.
- £4.5m CIP has been added to the programme and will improve the trust forecast – mainly SWLEOC (£0.7m) and Mitie contract renegotiation (£2.2m non-recurrent). These new schemes have not yet been removed from the budgets which have been set at the baseline reforecast values.
- A further £3.7m is reported as CIP but will not impact the forecast plan. These are already embedded in the trusts reforecast £63m deficit plan.
- Of the total £37.8m CIP reported, £31m is Green
- Looking to 2016/17 the extra full year effect of 2015/16 schemes is £5.7m however this is more than offset by the loss of 2015/16 non recurring schemes of £13.8m. In addition £2.7m of new CIPs have so far been identified for 2016/17.
- Conversion of pipline and Bold non-pay means that against the original £63m deficit plan the trust is forecasting to achieve £59.95m (this exclude other I&E movements)

	TRP	WINTER RISK		CURRENT FC ON £30.7m	CIP PIPELINE	BOLD PAY	BOLD NON-PAY	RTT RECOVERY	CAP TO REV	PENALTIES	FORECAST POSITION
MONTH 6 TRP BRIDGE	63.00	2.00	TARGETS	0.00	2.90	2.00	3.00	2.50	3.50	2.00	50.20
			PIPELINE		0.94				1.80		
	63.00	2.00	ACHIEVED TO DATE	-1.14	2.84		1.65		1.70		59.95
			NEW CIP REPORTED			4.49					

11. Trust CIP performance - divisions

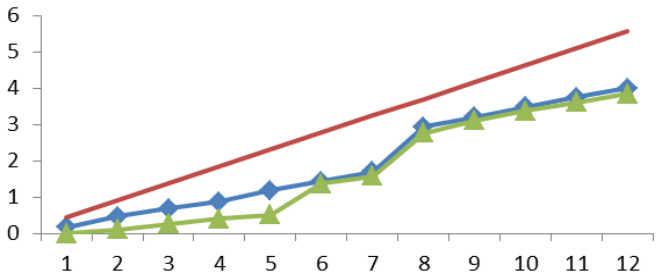
Children and Women

£8.0m schemes have been developed against the £8.9m target so there is a gap of £0.9m. To date £1.6m less than plan has been saved, although this gap is expected to reduce further with run rate schemes. Green schemes are 86.9% of the total identified so far.



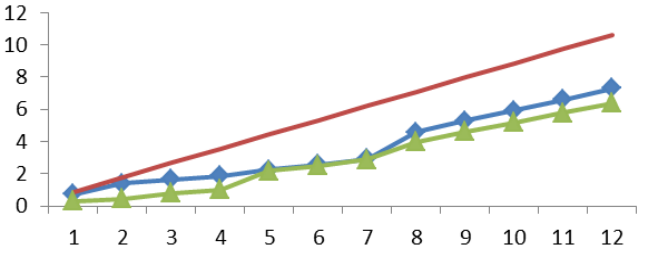
Community Services

£4.0m schemes have been developed against the £5.6m target, the gap is £1.6m and is not expected to be eliminated. Year to date underperformance is £0.8m. Green schemes are 96% of the total.



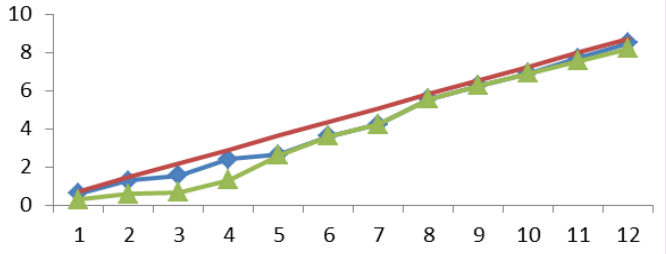
Medicine & Cardiovascular

£7.3m schemes have been developed against the £10.6m target. The gap is £3.3m. Year to date underperformance is £2.5m. Green schemes are 87.5% of the total.



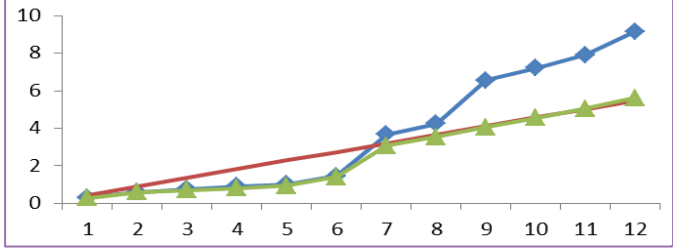
Surgery and Neurosciences

£8.5m schemes have been developed against a £8.7m target. The gap is £0.2m. Year to date savings are £0.3m below plan. Green schemes are 96.5% of the total. The division expects to close the gap with run rate schemes.



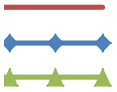
Overheads

£9.2m schemes have been developed against a £5.6m target. In the year to date £0.6m more than plan has been saved. Green schemes are 61.5% 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 £38.1m target phased in 1/12s.The 10% CIP provision is held centrally.
- Overhead departments' performance has improved significantly.
- The biggest forecast shortfall is £3.3m in Medicine.
- Further work is on-going to firm up on red/amber schemes and to complete governance processes so they can become green.



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

12. Divisional Summaries for the 8 months to 30th November KEY HEADLINES

Area of Review	Key Highlights
Medicine & Cardiovascular	The division's performance was £0.3m worse than plan in November and £0.6m ahead of cumulative surplus plan of £33.2m. The favourable position is due to pay underspends against the reforecast budget due to slippage on winter capacity spend and less spend than forecast for agency and specialling care. Of note is that pipeline CIPs have yet to be factored into the budgets.
Surgery, Neurosciences Theatres & Cancer	The division's surplus of £0.6m in month is £1m worse than plan however, cumulatively, the division's £16.3m surplus is on target. An increase in penalties and the impact of theatre closures on elective work done are being mitigated by profit from the Elective Orthopedic Centre and Gibraltar income.
Community Services	The division is £0.2m better than planned surplus of £15.1m. This is attributable to pay underspends against the reforecast budget (vacancies and delay to Nightingale opening). As with other divisions, pipeline CIPs have yet to be included in the new budgets.
Children, Women and Diagnostics	To date, the division overall is £1m better than plan. Pay underspends relate to outpatient administrative and nursing staff, and therapists. Recruitment difficulties I outpatients are likely to impact on capacity to see more patients across all divisions. Over-performance on 'other income' relates to commercial pharmacy activity and has associated drugs overspend.
Overheads	Overhead services performance was £1.9m better than plan for the year to date and £1.6m in month. The favorable position is mainly in Estates & Facilities due to £1.4m rebate following renegotiation of the Mitie contract. There is also income benefit for the renegotiated Moorfield's income (£0.3m cumulatively).

Medicine & Cardiovascular - Divisional I&E for the 8 months to 30th November

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	1.4	1.4	(0.0)	11.6	11.5	(0.0)
Daycase	11.8	1.0	1.0	(0.0)	7.9	7.9	0.0
Elective	23.5	1.9	2.3	0.4	16.1	16.4	0.3
Pass-through drugs/devices/programme	48.2	4.1	4.5	0.4	31.5	32.4	0.9
Non Elective	64.5	5.3	5.3	0.0	43.1	43.1	0.0
Other	17.4	1.4	1.0	(0.4)	11.7	11.4	(0.3)
Outpatients	35.5	3.0	2.9	(0.1)	23.9	23.7	(0.1)
	218.2	18.1	18.5	0.3	145.7	146.5	0.8
Other Income	17.8	1.5	0.8	(0.7)	11.8	11.7	(0.1)
Overall Income	**236.0**	**19.6**	**19.3**	**(0.4)**	**157.5**	**158.2**	**0.7**
Pay							
Consultants	(19.7)	(1.7)	(1.6)	0.1	(13.0)	(12.9)	0.0
Junior Doctors	(18.6)	(1.5)	(1.6)	(0.1)	(12.5)	(12.6)	(0.1)
Non Clinical	(8.7)	(0.7)	(0.7)	0.1	(5.8)	(5.6)	0.1
Nursing	(54.4)	(4.6)	(4.6)	(0.0)	(35.7)	(35.3)	0.4
Scientists, Technicians, Therapists	(5.3)	(0.4)	(0.4)	0.0	(3.4)	(3.3)	0.1
Pay Unallocated	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0
	(106.8)	(9.0)	(8.9)	0.1	(70.4)	(69.8)	0.6
Non-Pay							
Clinical Consumables	(38.6)	(3.2)	(2.9)	0.2	(25.8)	(25.8)	0.0
Drugs	(31.5)	(2.8)	(3.1)	(0.4)	(20.5)	(21.2)	(0.8)
Establishment	(1.6)	(0.1)	(0.1)	0.0	(1.1)	(1.2)	(0.1)
General Supplies	(0.4)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Other	(5.1)	(0.4)	(0.3)	0.1	(3.0)	(3.0)	0.0
Premises	(0.3)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0
	(77.6)	(6.5)	(6.5)	(0.0)	(50.9)	(51.6)	(0.7)
Overall Expenditure	**(184.4)**	**(15.5)**	**(15.4)**	**0.0**	**(121.3)**	**(121.4)**	**(0.1)**
EBITDA	**51.6**	**4.2**	**3.8**	**(0.3)**	**36.2**	**36.8**	**0.6**
Financing Costs	(4.5)	(0.4)	(0.4)	(0.0)	(3.0)	(3.0)	(0.0)
Surplus / (deficit)	**47.0**	**3.8**	**3.5**	**(0.3)**	**33.2**	**33.8**	**0.6**

Commentary

The YTD surplus to month 8 was £0.6m better than plan.

Income was £0.7m above cumulative plan at month 8 due higher than planned income for pass through drugs and devises (£0.9m) and over performance in elective income (£0.3m). This is off set by £0.3m higher than planned fines and £0.1m outpatients underperformance.

Pay is £0.6m favourable YTD due in part to the delay is opening winter capacity (£0.2m). In addition, agency spend within ED has been lower than planned (£0.2m). Ward nursing, and non-clinical agency spend is also lower than planned, in part due to lower specialling.

Non-pay is £0.7m adverse to plan due to higher than planned expenditure on pass through drugs and devices.

Actions

- The division is working extensively to try and minimise Cardiac Surgery activity that is sent to the private sector.
- Working closely with KPMG to convert pipeline schemes into deliverable CIP schemes .
- Recovery plans in place to improve outpatient activity, income and performance to minimise fines.
- Working closely with procurement in an attempt to get traction on CIP schemes.
- Working continues within the flow programme to minimise costs associated with winter.

Forecast – The 15/16 TRP forecast outturn for the division is £47m contribution which the division is working towards. Pipeline CIPs have yet to be built into the TRP budgets.

Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for the 8 months to 30th November

Surgery and Neurosciences

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
Bed Days	7.5	0.7	0.9	0.3	4.8	5.2	0.4
Daycase	14.2	1.2	1.3	0.1	9.4	9.4	(0.0)
Elective	36.3	3.1	2.8	(0.3)	24.3	23.8	(0.5)
Pass-through drugs/devices/progra	11.5	0.9	1.2	0.2	7.9	8.2	0.3
Non Elective	49.5	4.0	3.7	(0.3)	32.6	32.1	(0.5)
Other	1.6	0.1	(0.5)	(0.6)	1.2	0.6	(0.6)
Outpatients	32.4	2.9	2.8	(0.1)	21.4	21.2	(0.3)
	153.0	12.9	12.2	(0.7)	101.6	100.4	(1.2)
Other Income	15.4	1.3	0.7	(0.6)	10.3	10.8	0.6
Overall Income	**168.4**	**14.2**	**12.9**	**(1.3)**	**111.9**	**111.2**	**(0.7)**
Pay							
Consultants	(26.8)	(2.3)	(2.3)	(0.1)	(17.5)	(17.5)	(0.0)
Junior Doctors	(15.4)	(1.3)	(1.4)	(0.1)	(10.3)	(10.5)	(0.2)
Non Clinical	(9.3)	(0.8)	(0.8)	0.0	(6.2)	(6.2)	0.0
Nursing	(44.2)	(3.8)	(3.7)	0.1	(28.4)	(28.1)	0.3
Scientists, Technicians, Therapists	(10.8)	(0.9)	(0.9)	0.0	(7.2)	(7.1)	0.0
	(106.5)	(9.0)	(9.1)	(0.1)	(69.6)	(69.4)	0.2
Non-Pay							
Clinical Consumables	(22.0)	(1.9)	(1.7)	0.2	(14.3)	(13.9)	0.4
Clinical Negligence	(0.0)	(0.0)	0.0	0.0	(0.0)	(0.0)	0.0
Drugs	(9.0)	(0.7)	(0.8)	(0.0)	(6.1)	(6.2)	(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	(0.2)	(0.2)	0.0
Other	(3.9)	(0.4)	(0.2)	0.2	(2.2)	(1.9)	0.3
Premises	(0.8)	(0.1)	(0.1)	(0.0)	(0.4)	(0.4)	0.0
	(36.5)	(3.2)	(2.8)	0.4	(23.4)	(22.9)	0.5
Overall Expenditure	**(143.0)**	**(12.2)**	**(11.9)**	**0.3**	**(93.0)**	**(92.3)**	**0.7**
EBITDA	**25.4**	**2.0**	**1.0**	**(1.0)**	**18.9**	**18.9**	**(0.0)**
Financing Costs	(4.0)	(0.3)	(0.3)	(0.0)	(2.6)	(2.6)	(0.0)
Surplus / (deficit)	**21.4**	**1.6**	**0.6**	**(1.0)**	**16.3**	**16.3**	**(0.0)**

Commentary

The division has delivered a net contribution of £16.3m year to date (YTD) which is in line with the reforecast plan for 15/16.

Income Elective income year to date is significantly lower than plan largely due to theatre closures and a significant increase in the value of challenges and fines in November. Other income has improved due as a profit share from the SW London Orthopaedic Centre is now expected and income from Gibraltar is also now reflected in the position.

Pay -The year to date pay underspend of £0.2m is mainly due to nursing pay, which is partially offset by an overspend on junior doctors.

Non-Pay - £0.5m underspent which relates to clinical consumables and less reliance of the private sector in the month.

Actions to Improve Position

- Work with KPMG to identify new CIPs
- Ensure all high cost activity is correctly recorded in SLAM
- Review the current challenges received
- Validate the PTL to minimise penalties

Forecast – The forecast outturn for SNTC in 15/16 is a contribution of £21.4m and the division expect to achieve this if there are no further unplanned theatre closures.

Community Services - Divisional I&E for the 8 months to 30th November

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)	0.8	0.8	(0.0)
Bed Days	5.6	0.5	0.5	(0.0)	3.6	3.6	(0.1)
Exclusions	8.6	0.7	0.7	0.0	6.0	5.9	(0.1)
Other	59.4	5.0	4.7	(0.2)	39.5	39.4	(0.1)
Outpatients	24.1	2.1	2.2	0.1	16.1	16.3	0.1
	98.8	8.3	8.2	(0.1)	66.0	66.0	(0.1)
Other Income	1.9	0.2	0.1	(0.1)	1.3	1.3	(0.0)
Overall Income	**100.8**	**8.5**	**8.3**	**(0.2)**	**67.3**	**67.3**	**(0.1)**
Pay							
Consultants	(2.4)	(0.2)	(0.2)	(0.0)	(1.6)	(1.6)	(0.0)
Junior Doctors	(2.8)	(0.3)	(0.2)	0.1	(1.7)	(1.6)	0.2
Non Clinical	(7.5)	(0.6)	(0.6)	0.0	(5.0)	(4.9)	0.0
Nursing	(24.7)	(2.1)	(1.9)	0.2	(16.0)	(15.7)	0.2
Scientists, Technicians, Therapists	(10.1)	(0.8)	(0.8)	0.0	(6.7)	(6.6)	0.0
	(47.5)	(4.0)	(3.7)	0.3	(30.9)	(30.4)	0.5
Non-Pay							
Clinical Consumables	(9.5)	(0.8)	(0.8)	(0.0)	(6.2)	(6.2)	(0.0)
Clinical Negligence	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Drugs	(11.8)	(1.0)	(1.2)	(0.3)	(7.9)	(8.3)	(0.4)
Establishment	(1.2)	(0.1)	(0.1)	(0.0)	(0.8)	(0.8)	0.0
General Supplies	(0.1)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Other	(8.7)	(0.8)	(0.7)	0.1	(5.7)	(5.7)	0.1
Premises	(1.0)	(0.1)	(0.0)	0.1	(0.5)	(0.4)	0.1
	(32.3)	(2.8)	(2.9)	(0.1)	(21.2)	(21.4)	(0.2)
Overall Expenditure	**(79.8)**	**(6.8)**	**(6.7)**	**0.1**	**(52.1)**	**(51.8)**	**0.3**
EBITDA	**20.9**	**1.7**	**1.6**	**(0.1)**	**15.2**	**15.4**	**0.2**
Financing Costs	(0.2)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Surplus / (deficit)	**20.7**	**1.7**	**1.6**	**(0.1)**	**15.1**	**15.3**	**0.2**

Commentary

The division has £15.3m surplus to date which is £0.2m better than the reforecast plan.

Income - Outpatient income is £0.1m better than planned with particular improvements in GU Medicine & ENT. This is off-set by increases in penalties (result of coding changes at QMH £0.1m.

Pay – Delays in the opening of the Nightingale unit, continued recruitment challenges in the CAHS services and vacancies in a number of Community services have contributed to the underspend reported.

Non-pay – The non-pay spend in November was over budget mainly due to a GU Medicine drugs issues correction (£0.3m) which is partially off-set by delays in opening the Nightingale (£0.1m) backlog for HIV Homecare drugs. The YTD position reflects prior month HIV invoicing arrears. In November, increased spend in HIV drugs is partially offset by delays in opening of the Nightingale unit.

Actions

- Continue to monitor and deliver recovery plans for Outpatients & Diagnostics, Rehab & Therapies, GU Medicine.
- Improved understanding of the GU Medicine drugs expenditure reporting and forecasting.
- Continue to work towards the opening of the Nightingale unit.

Forecast

The overall forecast of £20.7m surplus includes additional costs in the last 4months of the year relating to the opening of the Nightingale unit and recruitment to a number of vacancies.
The current year to date position is slightly better than forecast.

Children, Women, Diagnostics & Therapies - Divisional I&E for the 8 months to 30th November

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	48.9	4.2	4.0	(0.2)	31.1	30.9	(0.3)
Daycase	4.7	0.4	0.4	0.0	3.2	3.2	(0.0)
Elective	4.2	0.4	0.3	(0.0)	2.8	2.7	(0.1)
Pass-through drugs/devices/programme	2.3	0.2	0.2	0.0	1.6	1.6	(0.0)
Non Elective	8.1	0.6	0.7	0.1	5.7	5.9	0.3
Other	25.4	2.0	2.2	0.2	17.0	17.3	0.3
Outpatients	38.4	3.4	3.1	(0.3)	25.5	25.0	(0.5)
	131.8	11.2	11.0	(0.2)	86.8	86.5	(0.3)
Other Income	21.7	1.8	1.9	0.1	13.9	15.3	1.4
Overall Income	**153.5**	**13.0**	**12.9**	**(0.2)**	**100.8**	**101.8**	**1.1**
Pay							
Consultants	(16.9)	(1.4)	(1.6)	(0.2)	(11.3)	(11.4)	(0.2)
Junior Doctors	(12.9)	(1.1)	(1.1)	(0.0)	(8.5)	(8.5)	(0.0)
Non Clinical	(14.3)	(1.2)	(1.1)	0.1	(9.4)	(9.1)	0.3
Nursing	(52.2)	(4.4)	(4.3)	0.0	(34.5)	(34.3)	0.2
Scientists, Technicians, Therapists	(35.2)	(3.0)	(2.8)	0.2	(22.7)	(22.2)	0.4
	(131.4)	(11.1)	(10.9)	0.2	(86.3)	(85.7)	0.7
Non-Pay							
Clinical Consumables	(13.6)	(1.1)	(1.0)	0.2	(8.7)	(8.3)	0.3
Drugs	(8.8)	(0.7)	(1.4)	(0.7)	(5.9)	(7.3)	(1.3)
Establishment	(0.7)	(0.1)	(0.0)	0.0	(0.5)	(0.4)	0.1
General Supplies	(0.5)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Other	(2.5)	(0.2)	(0.3)	(0.0)	(1.7)	(1.7)	(0.0)
Premises	(1.7)	(0.2)	(0.1)	0.1	(1.0)	(0.8)	0.2
	(27.9)	(2.4)	(2.8)	(0.4)	(18.1)	(18.9)	(0.8)
Overall Expenditure	**(159.3)**	**(13.5)**	**(13.7)**	**(0.2)**	**(104.5)**	**(104.5)**	**(0.1)**
EBITDA	**(5.8)**	**(0.5)**	**(0.9)**	**(0.4)**	**(3.7)**	**(2.7)**	**1.0**
Financing Costs	(6.5)	(0.5)	(0.5)	0.0	(4.3)	(4.3)	0.0
Surplus / (deficit)	**(12.3)**	**(1.0)**	**(1.4)**	**(0.4)**	**(8.0)**	**(7.0)**	**1.0**

Commentary

The division has a cumulative deficit of £7m which is £1m better than the reforecast.

Income – Outpatient underperformance is mainly in Antenatal services and the reasons for this are being investigated. Other Income is £1.4m above plan due to the success of pharmacy commercial operations, there is increased drug spend which offsets much of this.

Pay spend is £0.7m better than the year to date plan. Outpatient budget underspends have contributed to the non clinical and nursing variances reported. The impact of this on capacity to run clinics needs to assessed. The underspend on the scientist line largely reflects the slower than expected pace of recruitment for therapists.

Non pay – The clinical consumable underspend is due to a lower contract price for PET CT scanners and two maintenance contracts costing less than in the reforecast.

The drugs overspend includes £1.1m relating to extra pharmacy commercial income referred to above.

Actions

- Forecast income for antenatal services and the level of under performance for 2015/16 and 2016/17 are being investigated.
- Clinic capacity needs to be reviewed in the light of vacancy levels.

Forecast Position

The favourable position reported currently is expected to reduce due to the antenatal income and other issues detailed in the separate presentation to the committee. However the division expects that it will finish the year ahead of plan but the scale of this has not yet been assessed.

Overheads - Divisional I&E for the 8 months to 30th November

Overheads

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
Corporate Directorates							
Chief Executive & Governance	(20.8)	(1.9)	(2.0)	(0.1)	(14.9)	(15.1)	(0.2)
Executive Director of Nursing	(4.9)	(0.4)	(0.3)	0.1	(3.5)	(3.2)	0.2
Finance, Performance & IT	(26.2)	(2.3)	(2.5)	(0.2)	(17.1)	(17.4)	(0.3)
Human Resources Directorate	(4.8)	(0.4)	(0.5)	(0.1)	(3.1)	(3.0)	0.1
Ops & Service Improvement	(1.6)	(0.2)	(0.1)	0.1	(0.9)	(0.7)	0.1
Pathology - STG	(12.1)	(1.1)	(0.8)	0.4	(8.4)	(8.4)	0.0
Strategy	(1.5)	(0.1)	(0.2)	(0.1)	(1.0)	(1.1)	(0.1)
Total Corporate	(71.9)	(6.5)	(6.3)	0.2	(48.9)	(49.0)	(0.1)
Estates & Facilities							
Energy & Engineering	(11.3)	(1.0)	(1.0)	(0.0)	(7.3)	(7.2)	0.0
Estates	(11.5)	(0.9)	(0.9)	0.0	(7.8)	(7.6)	0.2
Estates Community Premises	(16.7)	(1.5)	(1.5)	(0.0)	(10.8)	(10.8)	0.0
Facilities Services	(4.7)	(0.4)	(0.4)	(0.0)	(3.2)	(3.2)	0.0
Hotel Services	(13.8)	(1.2)	0.4	1.6	(9.2)	(7.6)	1.6
Medical Physics	(2.3)	(0.2)	(0.2)	(0.1)	(1.6)	(1.5)	0.1
Project Management	(0.4)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	0.0
Rates	(2.1)	(0.2)	(0.2)	(0.0)	(1.4)	(1.4)	(0.0)
Total Estates & Facilities	(62.7)	(5.3)	(3.8)	1.5	(41.6)	(39.6)	1.9
Total Overheads	**(134.6)**	**(11.7)**	**(10.1)**	**1.6**	**(90.4)**	**(88.6)**	**1.9**

Overheads Summary

Corporate Services to date is £0.1m worse than plan while Estates & Facilities is £1.9m better than plan.

Corporate

Chief Executive - cumulative overspends of £0.2m due to turnaround costs.

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

Finance, Performance & IT - Pay adverse due to interim costs being incurred to end of December however budget profiled to the end of March.
Non-pay catch up of Cerner costs - increased year to date accrual following meeting with Head of IT.

Strategy: The adverse variance owes to income shortfall relating to overseas visitors & the central share of Gibraltar income.

Estates & Facilities

Month 8 is £1.5m better than plan and £1.9m better than the plan to date. The underspend is mainly due to a reduction the catering & domestics contract provided by Mitie. This provides a £2.15m benefit in 15/16 and £1.4m (8/12ths) of this is included in the month 8 position.
In Estates is also income benefit from revised site recharge to Moorfields (£0.3m for 2014/15 and 2015/16).

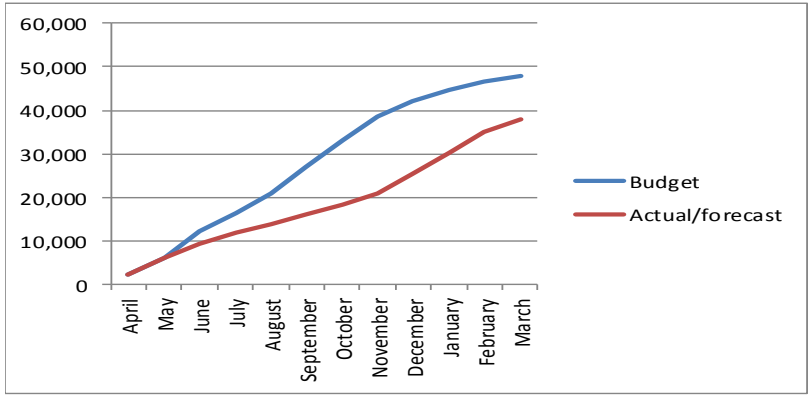
Risks

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

13. Capital

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

Actual/forecast cumulative capital expenditure 2015/16 at M08



- Capital expenditure in November was £2.5m and year to date expenditure is £20.8m, £17.8m 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 £10m (M07 £9m) which indicates an acceleration in spend in the last 4 months of the year.
- The Executive Management Team agreed to delay completion of several major projects to conserve cash last month. The surgical assessments unit, endoscopy unit scheme and coronary care unit 2 scheme have been re-profiled to support the liquidity position between now and the year end.
- The cash benefit of this forecast outturn underspend is estimated at £8.8m (excluding leases).

14. Cash

Cash balance

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

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

	31-Mar £000	30-Apr £000	31-May £000	30-Jun £000	31-Jul £000	31-Aug £000	30-Sep £000	31-Oct £000	30-Nov £000
Plan drawdown	0	0	0	2,138	6,991	14,625	24,483	29,807	34,900
Actual drawdown	**0**	**0**	**0**	**0**	**7,671**	**15,580**	**25,000**	**26,256**	**26,256**
WCF cum drawdowns fav / (adv) variance to plan	0	0	0	2,138	-680	-955	-517	3,551	8,644
Overall Cash fav / (adv) variance to plan	**0**	**-12**	**1,738**	**6,403**	**2,495**	**2,142**	**4,741**	**13,397**	**14,896**

Cash movement: M08 Actuals vs Plan and forecast outturn vs Plan

	Plan M08 YTD £m	Actual M08 YTD £m	Var M08 YTD £m	Plan Outturn £m	M08 F/cast Outturn £m	Var Outturn £m
Opening cash 01.04.15	24.2	24.2		24.2	24.2	
Operating surplus/-deficit	-15.4	-23.3	**-7.9**	-21.6	-39.9	**-18.3**
Sale proceeds re: PPU land	0.0	0.0	**0.0**	2.5	0.0	**-2.5**
WCF/ISF requirement	34.9	26.3	**-8.6**	52.2	48.7	**-3.5**
Cash gap			**-16.5**			**-24.3**
Net change in working capital	-8.2	-1.6	**6.6**	-7.4	-0.6	**6.8**
Capital spend (excl leases)	-34.2	-18.0	**16.2**	-45.5	-31.0	**14.5**
Other	1.7	1.7	**0.0**	-1.4	-1.1	**0.3**
Sub-total			**22.8**			**21.5**
Closing cash M07 / M12 forecast	3.0	9.3	**6.3**	3.0	0.2	**-2.8**

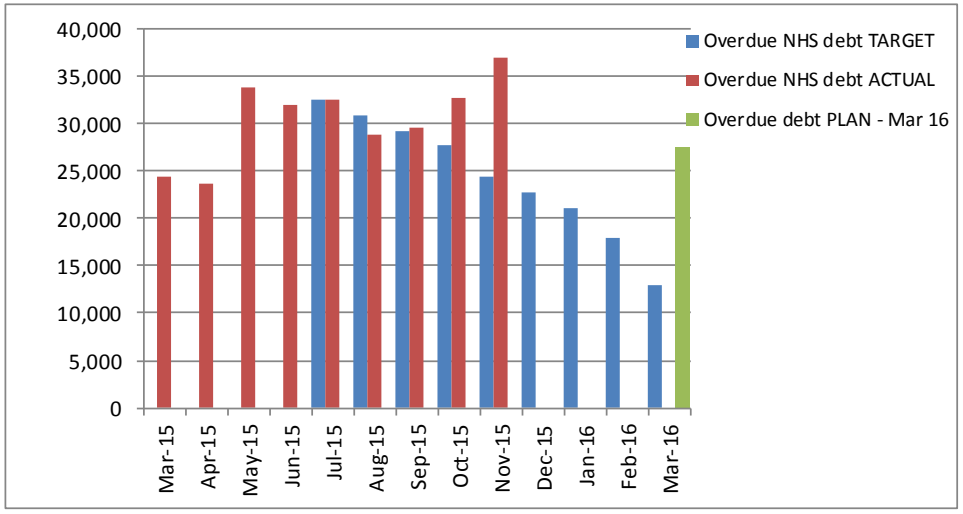
- The **cash balance** table above shows the actual cash balance and WCF drawdowns vs the plan figures.
- The M08 actual cash balance was £9.3m which is £6.3m ahead of plan.
- Cumulative WCF/ISF drawdowns to 30th November are £26.3m which is £8.6m lower than plan.
- LEEF loan impact: The cash balance includes £11.8m unexpended LEEF loan for the energy performance contract and so the cash balance excluding LEEF would be:-£2.6m
- The **cash movement table** compares the actual movement in the cash position YTD versus plan and the TRP forecast versus plan.
- YTD position: The higher operating deficit (£7.9m higher than plan) and £8.6m lower drawdowns from the WCF have been more than offset by the £6.6m better performance on net working capital (longer supplier payments terms etc) and £16.2m cash under spend on capital enabling the Trust to achieve a cash balance at 30th November £6.3m higher than plan.
- Forecast outturn position: The forecast deterioration in the operating deficit and forecast acceleration in capital spend in the last 4 months of the year result in a forecast reduction in the cash balance from £9.3m to just £0.2m by year end. This forecast assumes the Trust can access ISF/WCF drawdowns of £48.7m for the year per the TRP. ***In the event no further drawdowns are permitted the Trust would face a resulting cash gap of approx £10.9m (M07: £22.7m) and would need to implement remaining cash actions– see cash graphs 1 and 2 on next slide.***

15. Debt management

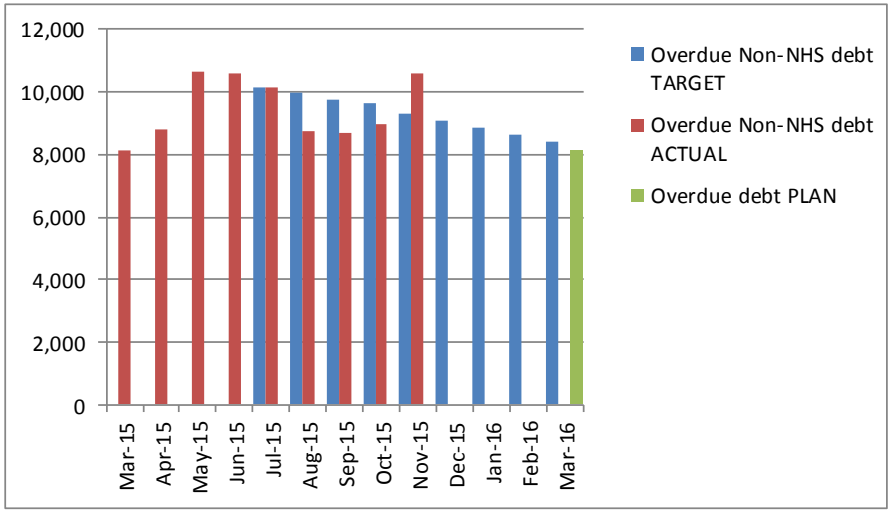
- The Cash Committee approved 'stretch' debt reduction targets for 2015/16 and the baseline is the level of overdue debt (over 30 days old) as at M04.
- Overdue debt reduced by £4.5m in the period M04 – M06 and was ahead of target by £0.9m at M06.
- Since M06 overdue debt has increased by £9.4m and is now behind target. The increase in overdue NHS debt relates primarily to over performance debt, GP Leo hosting services debt and local authority GUM debt
- 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 and has drafted a protocol to agree with NHSE. Unless such an agreement is secured the Trust is likely to miss the overdue debt reduction targets.
- In December the Trust is expecting to make significant inroads into overdue debt – collecting monies from local authorities, NHSE, SGUL and SGHC.

Debtor days	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
NHS income debtor days	18.5	18.8	19.5	19.4	19.4	20.1	21.6	22.1	30.7
Non-NHS income debtor days	204.9	202.0	219.3	229.0	205.1	199.2	198.4	190.9	256.1
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
Overseas patient income	807	789	769	753	761	740	677	793	810

Overdue NHS debt: performance vs stretch reduction targets



Overdue non-NHS debt: performance vs stretch reduction targets



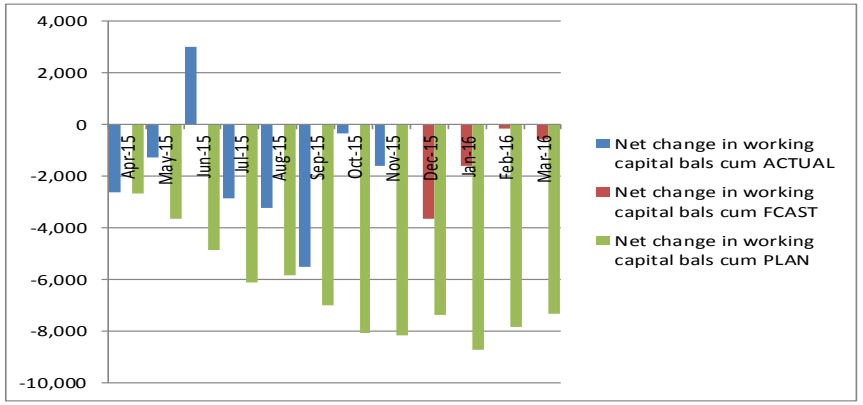
16. Balance sheet as at month 8 2015/16

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

	Nov-15 Plan £000	Nov-15 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	357,564	335,861	*21,703*	Lower capital expenditure than plan - so lower fixed assets
Stock	6,743	7,624	*-881*	Stock action group formed to progress safe reductions in levels.
Debtors	80,733	85,188	*-4,455*	This includes accruals and current debt. Overdue debt higher than target at M08.
Cash	3,000	9,255	*-6,255*	Lower capex, and better working capital performance has enabled Trust to finance higher deficit without requiring higher WCF drawdowns. Cash is £14.9m better than Plan overall.
Creditors	-84,052	-95,991	*11,939*	Longer supplier payment terms implemented in July - slowing rate of payments
Capital creditors	-3,476	-3,514	*38*	
PDC div creditor	-1,180	-1,117	*-63*	
Int payable creditor	-276	-323	*47*	
Provisions< 1 year	-602	-512	*-90*	
Borrowings< 1 year	-42,500	-6,138	*-36,363*	(NB: WCF is classified as non-current liability c/f Plan)
Net current assets/-liabilities	**-41,610**	**-5,528**	*-36,083*	
Provisions> 1 year	-1,181	-1,110	*-71*	
Borrowings> 1 year	-94,506	-116,045	*21,539*	(NB: WCF is classified as non-current liability c/f Plan)
Long-term liabilities	**-95,687**	**-117,155**	*21,468*	
Net assets	**220,267**	**213,178**		
Taxpayer's equity				
Public Dividend Capital	133,761	133,761	*0*	
Retained Earnings	-16,005	-21,963	*5,958*	YTD I&E deficit worse than plan
Revaluation Reserve	101,360	100,229	*1,131*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**220,266**	**213,177**		

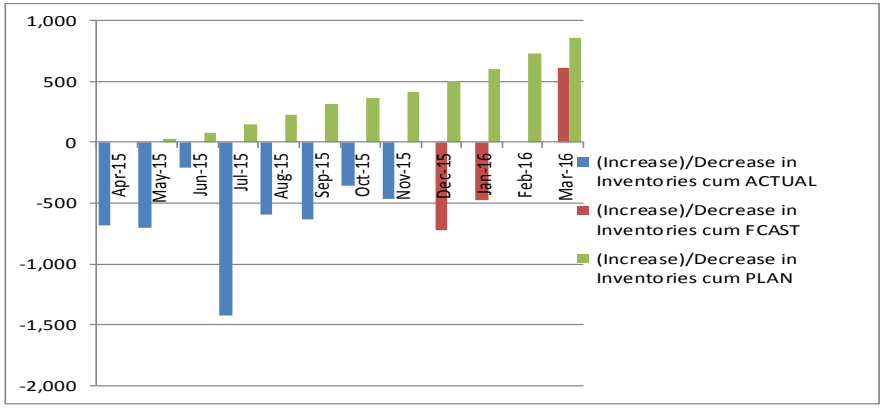
17. Working Capital

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



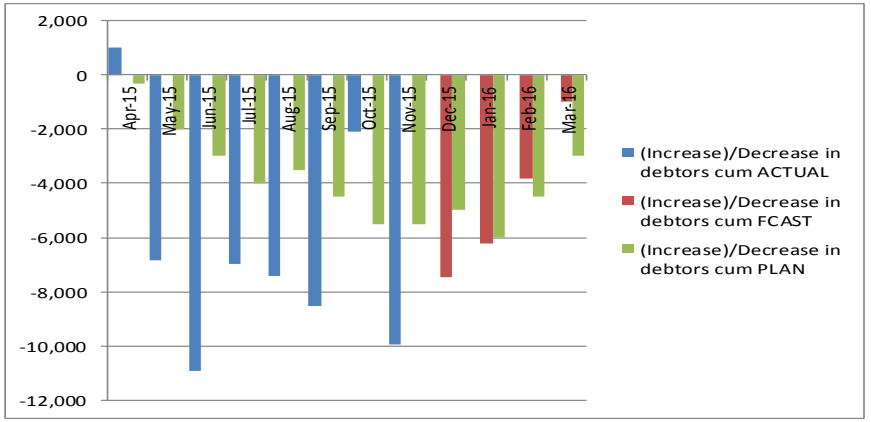
Working capital bals deteriorated by £1.2m in M08 but YTD are better than plan by £6.6m
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories 2015/16 actuals vs plan



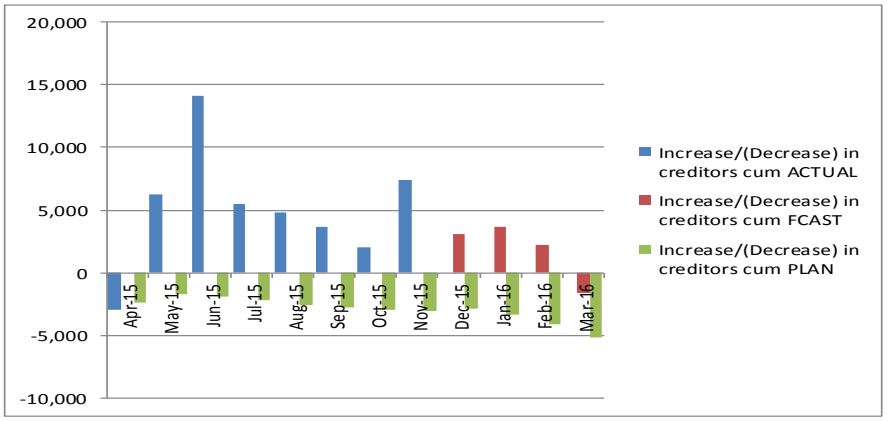
Inventories increased by £0.1m in M08 and are behind plan by £0.9m.
The Trust needs to reduce inventories by £1m to achieve the year end forecast - mainly in pharmacy and the central store.

Change in debtors 2015/16 actuals vs plan



Debtors (invoice and accrued debt) increased by £7.9m in M09 and are £4.5m behind plan.
This relates partly to the reversal of a positive timing difference on HESL Q3 SLA monies which were received in October and accruals for over-performance.
Achieving the overdue debt targets for NHS debt is dependent on timely receipt of over-performance invoices. The Trust is proposing a protocol with NHSE for earlier payment.

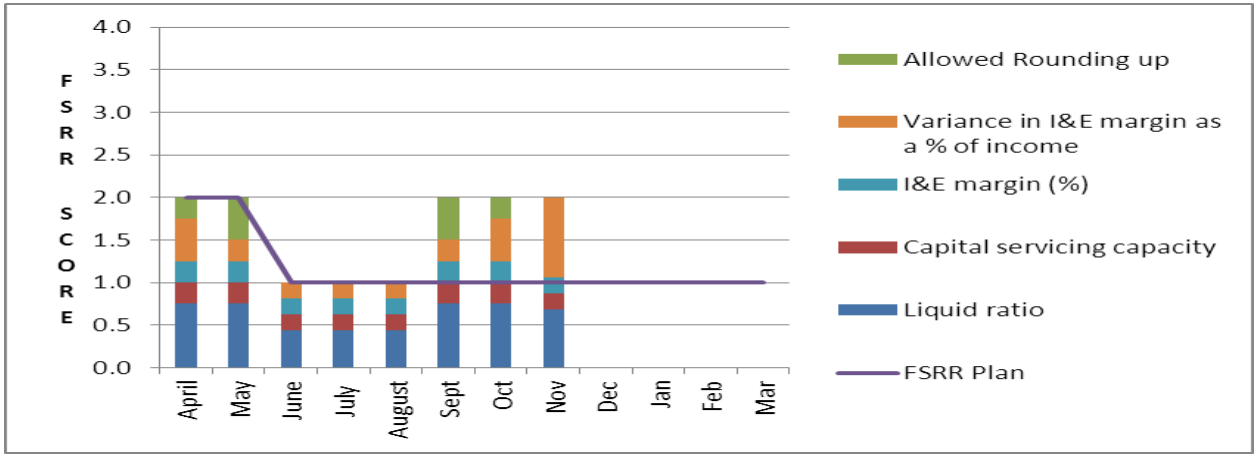
Change in creditors 2015/16 actuals vs plan



Overall level of creditors increased in November by £6.8m and are £11.9m ahead of plan.
Trust continues to pay approved invoices to the new terms.

18. Financial Sustainability Risk Rating (FSRR)

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



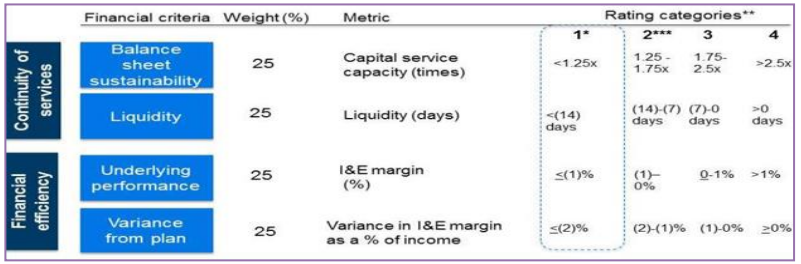
In November the Trust achieved a score of 2 for its risk rating which is ahead of the planned rating of 1. Ratings for capital servicing and I&E margin are in line with planned scores of 1 and variance and liquidity metrics are both better than plan.

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 +0.5% as a percentage of income to date is now within the range for a score of 4 due to improved performance against the I&E plan in November.

Threshold details:



F&P COMMITTEE 16.12.15: ISSUES ARISING

In addition to the Finance Report, which is presented separately, five main matters were discussed by the Committee.

1. The HR initiative to reduce non-agency nursing. The objective was to ensure all agency bookings went through the bank, and although good progress was being made there was still some distance to go. Admin agency usage had reduced by 60% so far. Some booking was still going on outside the process, but the Trust was informing agencies that if they approached the Trust in any way other than the bank office they would not be paid. The Committee asked when we could be confident that there were no bookings outside the process and no payments were being made to agencies outside those centrally approved. WB said she believed this would be achieved by the end of Q4.

2. High cost drugs. The Trust received a high level of challenges from CCGs, but a new funding approval system called Blueteq was successfully introduced last April, as a result of which the main challenges from CCGs now related to patients initiated on medicines before that date, some of which had been taking the medicines concerned for more than 10 years. The Committee encouraged the Trust to challenge the fines, and bring clinicians to the table to discuss each patient where there was a dispute.

3. CIP gaps. Total schemes were expected to deliver £37.8m this year, of which £31m are green. While some schemes continued to be developed, there were structural gaps in Medicine & Cardiovascular and in Community Services which would not be closed. The Finance Director suggested that the problems faced by the CSD were particularly intractable, and that a fundamental review was needed on the contractual position of the Division as the service specifications they were operating to were very specific and there was a real question how deliverable they were given available resources.

4. Outpatient recovery plan. The Committee questioned whether the recovery target was deliverable. The response was that the planned activity was deliverable, but the number of patients who cancel or DNA was very high. If this continued, planned activity might not materialise. The Committee noted that the recovery plan did not include additional sessions at the Nelson, despite the capacity available there. PV-K said the main site had been prioritised as the Nelson was not profitable, although GPs were being asked to refer more patients there.

5. Penalties. The Committee said the Board needed to understand the full range of penalties the Trust was incurring so that it could be assured that every effort was being made to pursue actions to minimise them. Since fines looked set to exceed £10 million, this was an area worthy of Board discussion.

C R Smallwood January 2016

REPORT TO THE TRUST BOARD *January 2016* TB Jan 16 – 04a

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 November 2015

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

Key points to note are:

- An increase in staff in post of 72 WTE.
- Voluntary turnover has remained steady, although gross turnover has increased.
- 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

Introduction

The overall workforce picture remains unchanged, with high levels of turnover impacting on all other workforce metrics. Although the trust benchmarks well with other London trusts, the workforce is under significant pressure.

Vacancy rate

The establishment data is now based on the turnaround reforecast budgets. As set out in the documents considered in the board strategy sessions, the turnaround reforecast budgets drawn up with the divisions anticipate a growth in staff in post of 406 WTE from October 2015 to March 2016.

The main increases in WTE in November are as set out below:

Nightingale Ward has opened (16 WTE)
Outpatients have recruited additional apprentices and also phlebotomists (13 & 7 WTE)
Additional nurses have been recruited in A&E (7 WTE)
Nursing staff and assistant therapists have increased on Thomas Young Ward as part of the Neuro business case (5 & 4 WTE)
Human Resources have increased staffing including the Bank Team, e-Rostering & Recruitment (7 WTE)
Clinical Genetics have increased scientific staff, some in relation to Genomics
Winter Ward staffing has increased (4 WTE)

Each month, changes in staff in post at Trust level are made up of starters and leavers, changes in hours and transfers between departments. There are many other small changes of 1 or 2 WTE in other caregroups, The changes mentioned above are the most significant increases over the period.

Turnover and stability

Although gross turnover has increased, voluntary turnover has remained steady in November. Trust briefings are clearly stating the importance of working according to the trust values and the impact that all of us can have on retaining colleagues. The divisions have detailed turnover reduction plans, which are currently being monitored through the workforce and education committee. A performance management framework for reducing turnover is being drawn up.

Sickness absence

Sickness absence levels have continued to reduce marginally and appear to be returning to the standard pattern of performance, as illustrated by the information presented over a two year period.

Agency and bank staff usage

The information on bank and agency staff usage shows for the first time information regarding the number of shifts that have breached the agency caped rates set by Monitor. This information is reported to Monitor. Although the London Procurement Programme will not be renegotiating framework rates until the summer of 2016, the trust is working with agencies to avoid breaching the caps where possible. It is important that trusts stand together to avoid paying higher rates.

The greatest challenge regarding payment above the capped rates is with medical staff in speciality areas. The long term response is to take a more planned approach to medical staffing and the proposals to introduce a medical rostering system will support this work.

The workforce department are continuing to work with finance colleagues to identify any areas of non-compliance with the temporary staffing policy and good progress is being made.

Mandatory training and appraisal rates

Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)is one of the trust's key workforce risks. In order to ensure that the plans to improve the controls and mitigations are robust, a detailed paper and trajectory will be presented to the workforce and education committee later in January.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 8 - November 2015

Excellence in specialist and community healthcare

Workforce Performance Report Nov ‘14 - Oct ‘15

Contents

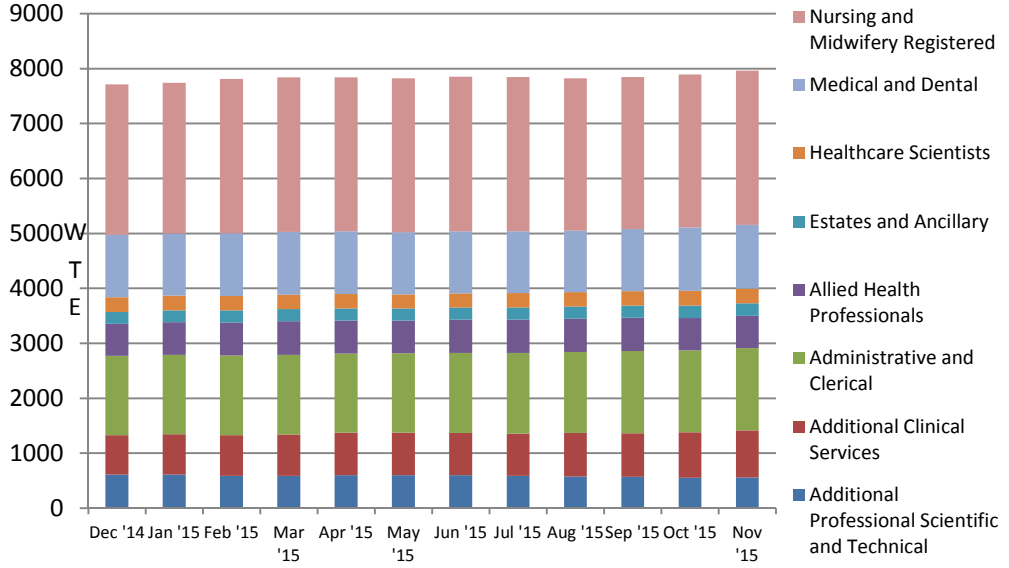
Performance Summary

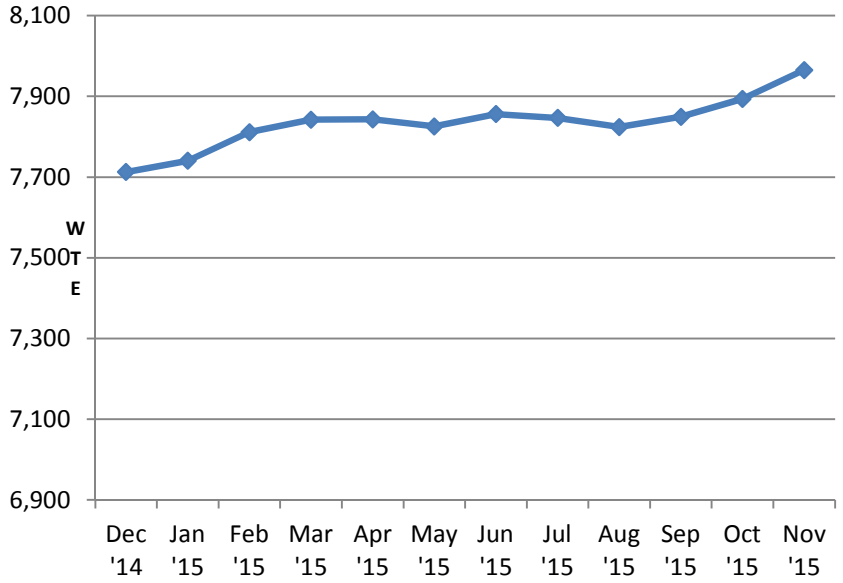
Summary of overall performance is set out below

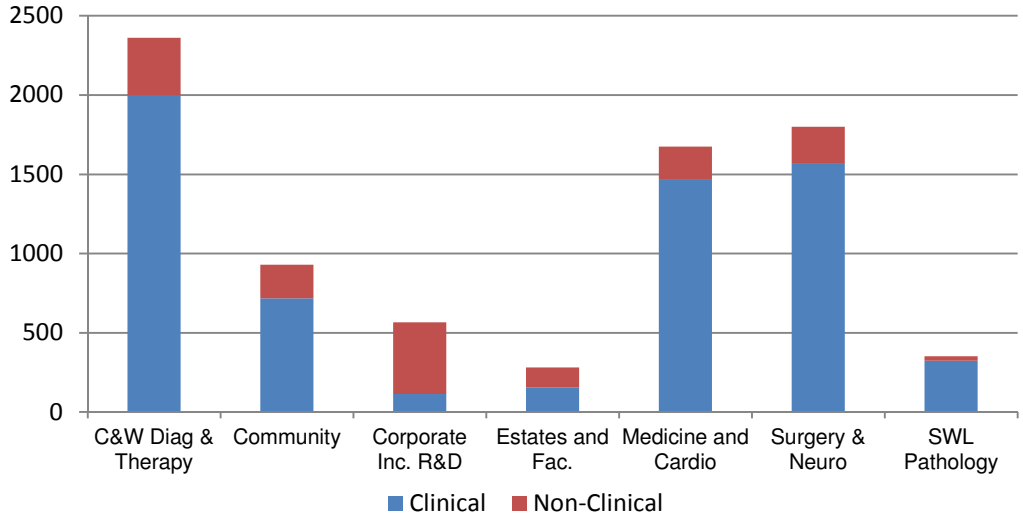
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has increased by 0.3%	13.0%	16.4%	16.7%	↗
6	Turnover	Turnover has increased by 0.3%	17.3%	17.5%	17.8%	↗
7	Voluntary Turnover	Voluntary Turnover has remained the same	14.0%	14.5%	14.5%	↔
8	Stability	Stability has decreased by 1.9%	84.0%	83.1%	81.2%	↘
10	Sickness	Sickness has decreased by 0.1%	3.8%	3.9%	3.8%	↘
15	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 1.4%	14.8%	12.1%	13.5%	↗
17	Mandatory Training	MAST compliance has decreased by 2.1%	75.2%	66.6%	64.5%	↘
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.2%	79.8%	67.9%	67.7%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





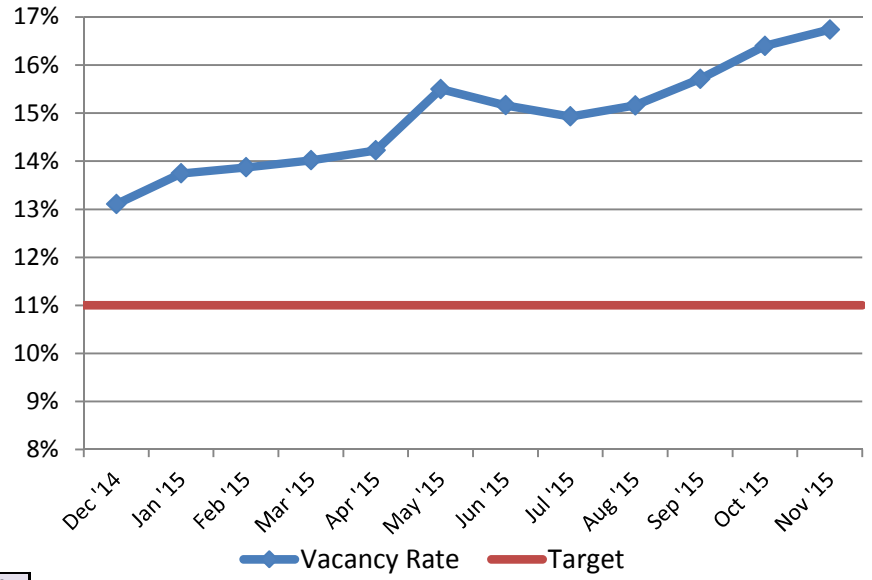


COMMENTARY

The Trust currently employs 8510 people working a whole time equivalent of 7965 which is 72 WTE higher than October. The growth rate in the directly employed workforce since November 2014 is 287 WTE or 3.7%.

The Trust also employs an additional 465 WTE GP Trainees covering the South London area, which makes the total WTE 8430.

Section 1: Vacancies



Vacancies by Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diag & Therapy	10.9%	11.8%	12.4%	13.6%	↗
Community	13.4%	12.6%	15.7%	18.5%	↗
Corporate	16.4%	12.9%	14.5%	15.8%	↗
Estates and Fac.	15.0%	15.5%	16.7%	16.3%	↘
Medical & Cardio	16.7%	16.8%	16.4%	16.6%	↗
Surgery & Neuro	16.7%	19.1%	18.4%	17.9%	↘
SWL Pathology	24.9%	25.5%	25.5%	22.8%	↘
Whole Trust	**15.2%**	**15.7%**	**16.4%**	**16.7%**	↗

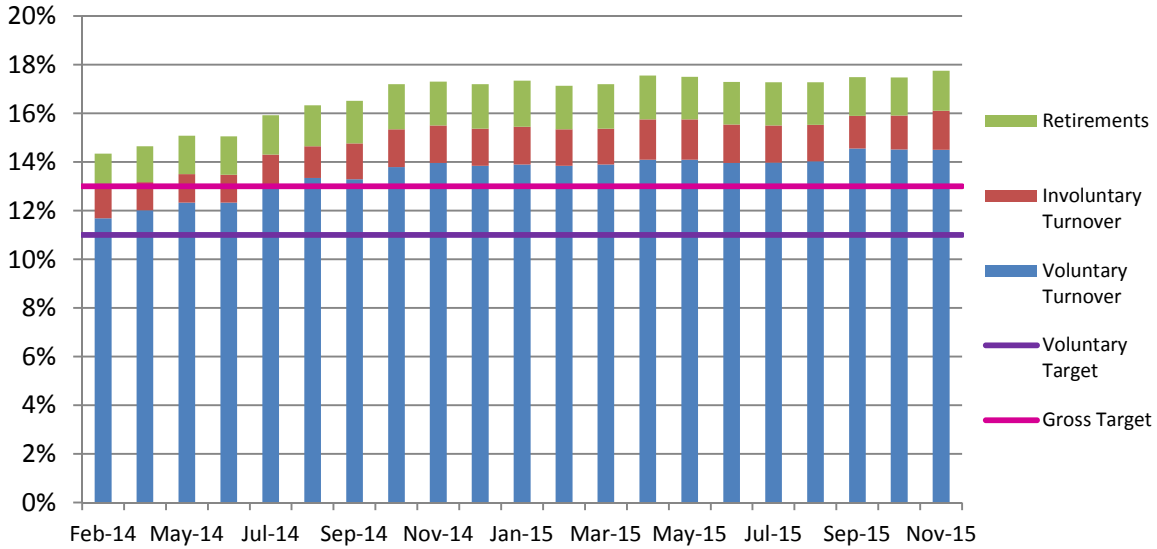
Vacancies Staff Group	Aug '15	Sep '15	Oct '15	Nov '15	Trend
Add Prof Scientific and Technic	21.9%	22.7%	22.7%	23.8%	↗
Additional Clinical Services	17.3%	19.4%	19.3%	18.2%	↘
Administrative and Clerical	15.2%	15.2%	17.0%	18.4%	↗
Allied Health Professionals	9.4%	5.9%	14.0%	14.1%	↗
Estates and Ancillary	20.1%	19.1%	19.3%	17.7%	↘
Healthcare Scientists	18.2%	18.5%	19.4%	20.1%	↗
Medical and Dental	5.9%	5.6%	4.4%	5.3%	↗
Nursing and Midwifery Registered	16.8%	18.3%	18.1%	18.1%	↔
Total	**15.2%**	**15.7%**	**16.4%**	**16.7%**	↗

COMMENTARY

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

Section 2a: Gross Turnover

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



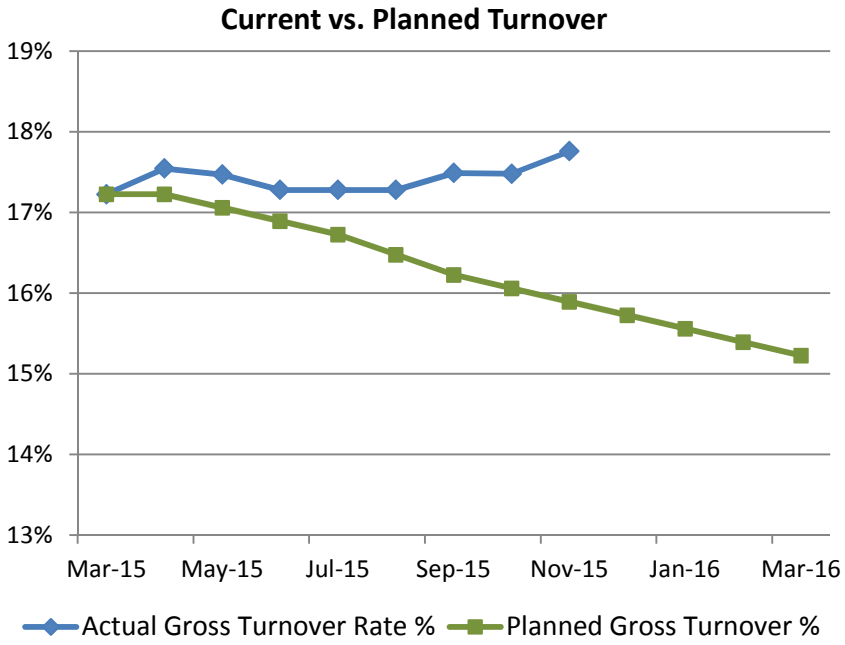
COMMENTARY

The total trust turnover rate has increased this month to 17.8%. This is significantly above the current target of 13%. In the last 12 months there have been 1279 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	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	17.4%	18.1%	18.0%	18.4%	↗
Community Services	21.0%	21.1%	20.8%	20.8%	↔
Corporate	20.6%	18.8%	20.1%	20.6%	↗
Estates and Facilities	16.8%	16.5%	16.0%	16.3%	↗
Medical & Cardiothoracics	17.5%	19.1%	19.1%	19.3%	↗
Surgery, Neurosciences & Anaes	13.7%	13.3%	13.3%	13.9%	↗
SWL Pathology	16.9%	14.4%	14.8%	15.0%	↗
Whole Trust	**17.3%**	**17.5%**	**17.5%**	**17.8%**	↗

	All Turnover				
Staff Group	Aug '15	Sep '15	Oct '15	Nov '15	Trend
Add Prof Scientific and Technic	19.2%	18.6%	20.2%	17.9%	↘
Additional Clinical Services	19.5%	19.6%	19.2%	20.1%	↗
Administrative and Clerical	16.5%	16.4%	16.2%	17.1%	↗
Allied Health Professionals	17.0%	16.3%	17.5%	17.0%	↘
Estates and Ancillary	8.9%	8.5%	8.6%	8.7%	↗
Healthcare Scientists	14.6%	14.5%	14.0%	14.4%	↗
Medical and Dental	11.8%	11.5%	10.6%	12.5%	↗
Nursing and Midwifery Registered	18.7%	19.6%	19.4%	19.7%	↗
Whole Trust	**17.3%**	**17.5%**	**17.5%**	**17.8%**	↗



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover Nov 2015	
Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	14.0%	14.8%	14.9%	15.1%	↗	2.1%	1.2%
Community Services	16.2%	16.8%	16.2%	16.0%	↘	1.2%	3.6%
Corporate	15.0%	14.7%	15.7%	16.2%	↗	2.1%	2.3%
Estates and Facilities	6.6%	8.3%	8.1%	8.4%	↗	5.5%	2.4%
Medical & Cardiothoracics	15.4%	17.2%	17.1%	16.8%	↘	1.3%	1.2%
Surgery, Neurosciences & Anaes	12.3%	12.0%	11.8%	11.9%	↗	0.9%	1.1%
SWL Pathology	15.3%	12.6%	13.2%	12.7%	↘	0.6%	1.7%
Whole Trust	**14.0%**	**14.6%**	**14.5%**	**14.5%**	↔	**1.6%**	**1.6%**

	Voluntary Turnover					Other Turnover Nov 2015	
Staff Group	Aug '15	Sep '15	Oct '15	Nov '15	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	13.2%	14.4%	15.5%	13.4%	↘	4.1%	0.4%
Additional Clinical Services	16.3%	16.9%	16.5%	16.8%	↗	1.0%	2.3%
Administrative and Clerical	12.7%	12.6%	12.4%	13.1%	↗	2.0%	2.0%
Allied Health Professionals	15.9%	15.6%	16.8%	16.1%	↘	0.3%	0.7%
Estates and Ancillary	4.8%	5.4%	5.4%	5.3%	↘	0.5%	2.9%
Healthcare Scientists	11.8%	12.0%	11.5%	11.6%	↗	0.7%	2.0%
Medical and Dental	6.6%	6.7%	5.8%	6.3%	↗	5.0%	1.1%
Nursing and Midwifery Registered	16.3%	17.2%	17.1%	17.1%	↔	0.7%	1.8%
Whole Trust	**14.0%**	**14.6%**	**14.5%**	**14.5%**	↔	**1.6%**	**1.6%**

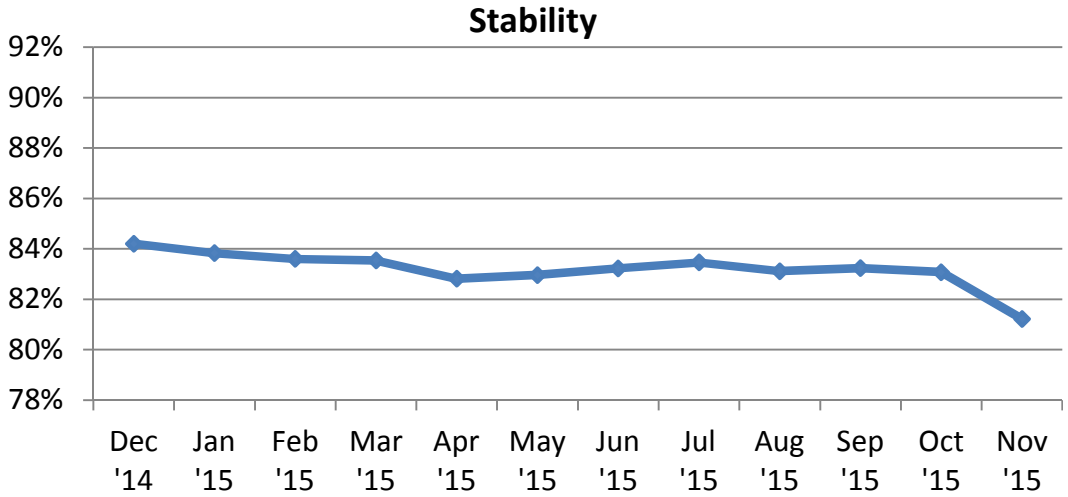
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Cardiac Surgery	91.3	23.8	32.4%
Procurement & Materials Mgmt	38.0	13.0	31.3%
Medical Oncology & Palliative Care	86.3	22.4	29.5%
Trauma & Orthopaedics	130.9	29.3	28.5%
Offender Healthcare HMPW Services	57.0	15.7	27.1%

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	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	83.1%	83.1%	83.0%	80.1%	↘
Community Services	80.1%	79.7%	79.8%	78.0%	↘
Corporate	78.1%	79.1%	78.4%	75.5%	↘
Estates and Facilities	84.9%	85.5%	85.1%	84.0%	↘
Medical & Cardiothoracics	82.1%	81.7%	81.2%	80.0%	↘
Surgery, Neurosciences & Anaes	86.2%	86.2%	86.4%	84.6%	↘
SWL Pathology	89.2%	92.1%	91.0%	89.7%	↘
Whole Trust	**83.1%**	**83.2%**	**83.1%**	**81.2%**	↘

Stability Staff Group	Aug '15	Sep '15	Oct '15	Nov '15	Trend
Add Prof Scientific and Technic	70.4%	70.6%	69.8%	50.4%	↘
Additional Clinical Services	86.3%	83.8%	87.0%	90.1%	↗
Administrative and Clerical	85.5%	85.6%	85.9%	83.2%	↘
Allied Health Professionals	81.9%	83.0%	81.3%	78.7%	↘
Estates and Ancillary	86.7%	88.8%	88.6%	104.0%	↗
Healthcare Scientists	92.3%	92.8%	93.9%	90.3%	↘
Medical and Dental	88.3%	88.3%	90.1%	89.4%	↘
Nursing and Midwifery Registered	82.1%	82.6%	81.3%	84.6%	↗
Total	**83.1%**	**83.2%**	**83.1%**	**81.2%**	↘

COMMENTARY

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

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

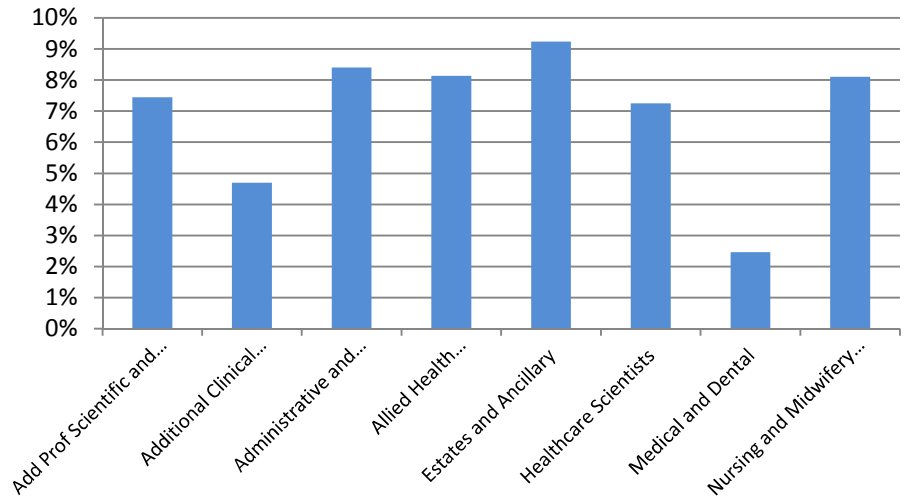
The stability rate has decreased by 1.9% this month.

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

Over the last 12 months the stability rate has declined by 2.7% and is now at 81.2%.

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 November 64 staff were promoted, there were 146 new starters to the Trust and 200 employees were acting up to a higher grade.

Over the last year 7.3% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the SW London Pathology Division followed by the Corporate and Children & Women's Divisions.

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

	No. of Promotions				
Division	Aug '15	Sept '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	13	16	21	28	↗
Community Services	16	18	2	10	↗
Corporate	10	5	3	11	↗
Estates and Facilities	0	1	0	0	↔
Medical & Cardiothoracics	17	8	6	9	↗
Surgery, Neurosciences & Anaes	6	11	9	4	↘
SWL Pathology	11	2	23	2	↘
Whole Trust Promotions	**73**	**61**	**64**	**64**	↔
New Starters (Excludes Junior Doctors)	**121**	**153**	**144**	**146**	↗

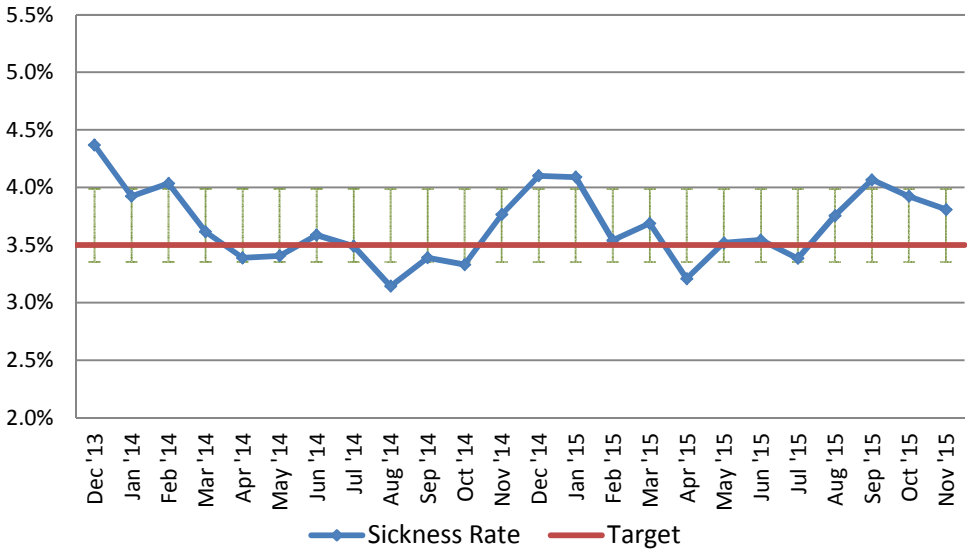
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1894	151	8.0%	93
Community Services	850	43	5.1%	12
Corporate	451	43	9.5%	22
Estates and Facilities	251	18	7.2%	9
Medical & Cardiothoracics	1147	82	7.1%	39
Surgery, Neurosciences & Anaes	1344	79	5.9%	18
SWL Pathology	318	42	13.2%	7
Whole Trust	**6255**	**458**	**7.3%**	**200**
New Starters (Excludes Junior Doctors)		**1500**		

	No. of Promotions				
Staff Group	Aug '15	Sept '15	Oct '15	Nov '15	Trend
Add Prof Scientific and Technic	3	7	2	1	↘
Additional Clinical Services	7	4	19	2	↘
Administrative and Clerical	21	15	12	23	↗
Allied Health Professionals	7	9	6	11	↗
Estates and Ancillary	0	1	0	0	↔
Healthcare Scientists	5	1	1	3	↗
Medical and Dental	0	2	2	0	↘
Nursing and Midwifery Registered	30	22	22	24	↗
Whole Trust	**73**	**61**	**64**	**64**	↔

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	470	35	7.4%	35
Additional Clinical Services	660	31	4.7%	4
Administrative and Clerical	1285	108	8.4%	68
Allied Health Professionals	541	44	8.1%	21
Estates and Ancillary	195	18	9.2%	5
Healthcare Scientists	262	19	7.3%	6
Medical and Dental	486	12	2.5%	3
Nursing and Midwifery Registered	2356	191	8.1%	58
Whole Trust	**6255**	**458**	**7.3%**	**200**

Section 5: Sickness

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



COMMENTARY

Sickness absence is at 3.8% for November, which is a decrease of 0.1% on the previous month.

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

The table below lists the five care groups with the highest sickness absence percentage during November 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	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	3.7%	3.9%	3.9%	3.4%	↘
Community Services	5.7%	5.5%	5.9%	5.7%	↘
Corporate	3.2%	3.6%	3.7%	3.7%	↔
Estates and Facilities	3.9%	4.0%	2.2%	4.7%	↗
Medical & Cardiothoracics	3.9%	4.4%	4.1%	4.2%	↗
Surgery, Neurosciences & Anaes	3.1%	3.4%	3.5%	3.2%	↘
SWL Pathology	2.2%	4.3%	2.1%	2.5%	↗
Whole Trust	**3.8%**	**4.1%**	**3.9%**	**3.8%**	↘

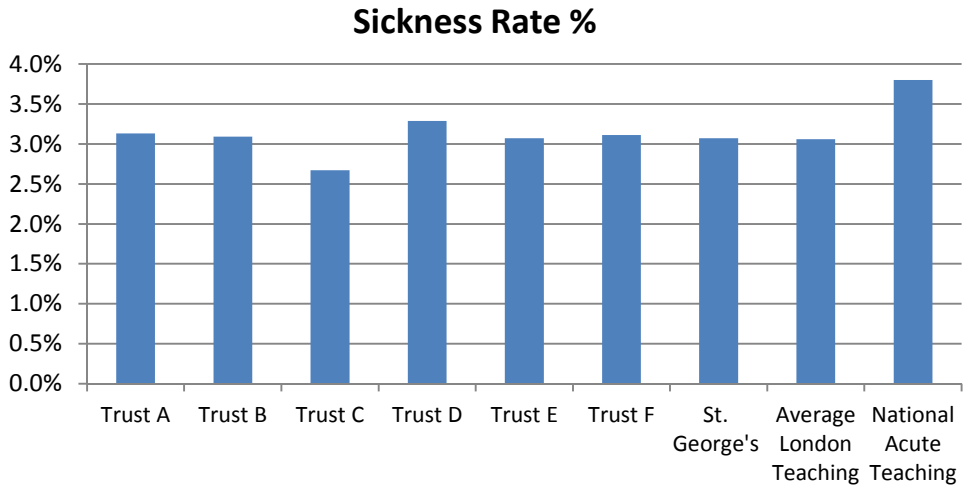
Sickness Staff Group	Aug '15	Sep '15	Oct '15	Nov '15	Trend
Add Prof Scientific and Technic	3.6%	3.2%	4.1%	3.3%	↘
Additional Clinical Services	7.1%	7.5%	6.4%	6.4%	↔
Administrative and Clerical	4.2%	4.2%	3.9%	4.1%	↗
Allied Health Professionals	1.9%	2.9%	2.5%	2.5%	↔
Estates and Ancillary	5.6%	5.7%	3.2%	5.8%	↗
Healthcare Scientists	1.4%	3.0%	2.4%	2.9%	↗
Medical and Dental	0.9%	1.2%	1.7%	1.3%	↘
Nursing and Midwifery Registered	4.2%	4.6%	4.6%	4.2%	↘
Total	**3.8%**	**4.1%**	**3.9%**	**3.8%**	↘

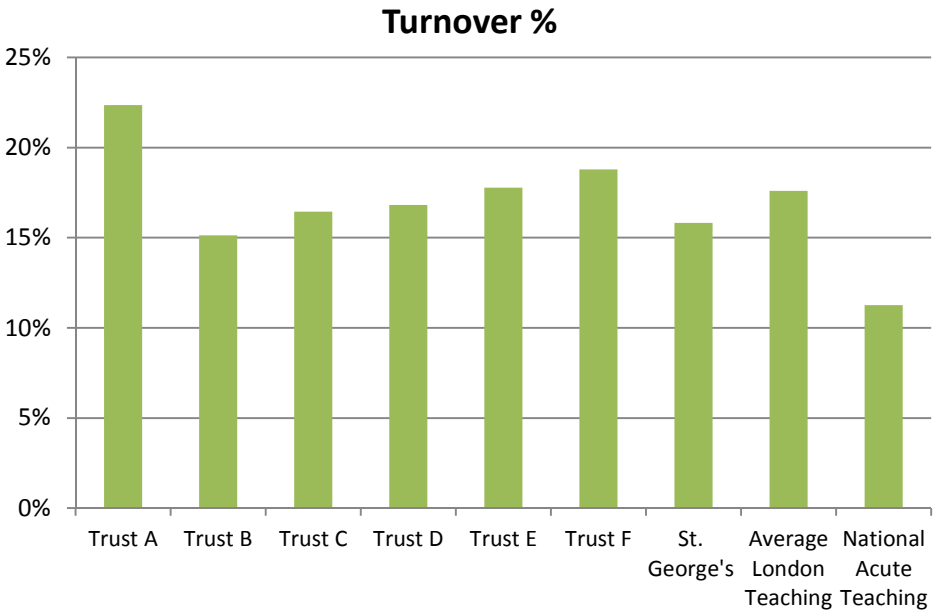
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Energy and Engineering	50.00	237.00	16.0%	£16,782
Breast Screening	52.95	168.75	10.9%	£13,114
Offender Healthcare HMPW Services	57.04	149.00	9.4%	£15,297
Dentistry	50.54	135.73	9.3%	£11,758
Medicine Directorate Overheads	24.84	62.00	8.7%	£9,073

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	33.38%
S25 Gastrointestinal problems	15.38%
S12 Other musculoskeletal problems	8.45%
S10 Anxiety/stress/depression/other psychiatric illnesses	6.73%
S16 Headache / migraine	5.63%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	17.58%
S13 Cold, Cough, Flu - Influenza	15.58%
S12 Other musculoskeletal problems	14.92%
S25 Gastrointestinal problems	8.39%
S11 Back Problems	5.29%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from August '15 which is the mot recent available. Compared to other Acute teaching trusts in London, St. Georges had a slightly higher than average rate at 3.07%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was significantly lower than the national rate for acute teaching hospitals in July.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all leavers (voluntary resignations, retirements, end of fixed term contracts etc.). St. Georges currently has a lower than average turnover compared to the group (12 months to end September). 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 4.6% lower than St. Georges.

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

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	22.36%	77.97%	3.13%
Trust B	15.13%	84.37%	3.09%
Trust C	16.45%	83.13%	2.67%
Trust D	16.82%	82.93%	3.29%
Trust E	17.78%	82.33%	3.07%
Trust F	18.79%	81.00%	3.11%
St. George's	15.83%	83.87%	3.07%
Average London Teaching	17.59%	82.23%	3.06%
National Acute Teaching	11.26%	88.51%	3.80%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	1069.5	1098.6	1094.9	1105.4	↗
Community Services	569.5	583.1	596.4	613.5	↗
Corporate & R&D	68.2	68.2	94.2	95.2	↗
Medical & Cardiothoracics	1248.3	1248.3	1246.1	1253.7	↗
Surgery, Neurosciences & Anaes	1111.7	1152.0	1151.0	1151.0	↔
Total	4067.2	4150.2	4182.6	4218.8	↗

Nursing Staff in Post WTE

Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	973.1	982.8	1007.4	999.5	↘
Community Services	461.2	447.7	441.6	452.9	↗
Corporate & R&D	46.0	46.0	52.5	70.6	↗
Medical & Cardiothoracics	985.9	985.8	986.0	995.4	↗
Surgery, Neurosciences & Anaes	906.8	899.2	906.5	910.9	↗
Total	3373.0	3361.5	3394.0	3429.3	↗

Nursing Vacancy Rate

Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	9.0%	10.5%	8.0%	9.6%	↗
Community Services	19.0%	23.2%	26.0%	26.2%	↗
Corporate & R&D	32.5%	32.5%	44.2%	25.8%	↘
Medical & Cardiothoracics	21.0%	21.0%	20.9%	20.6%	↘
Surgery, Neurosciences & Anaes	18.4%	21.9%	21.2%	20.9%	↘
Total	17.1%	19.0%	18.9%	18.7%	↘

Nursing Sickness Rates

Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	5.3%	5.6%	5.6%	4.7%	↘
Community Services	6.3%	6.4%	6.7%	6.6%	↘
Corporate	3.5%	4.5%	8.4%	5.3%	↘
Medical & Cardiothoracics	4.4%	5.3%	4.6%	4.8%	↗
Surgery, Neurosciences & Anaes	4.2%	4.2%	4.2%	3.9%	↘
Total	4.8%	5.2%	5.1%	4.8%	↘

Nursing Voluntary Turnover

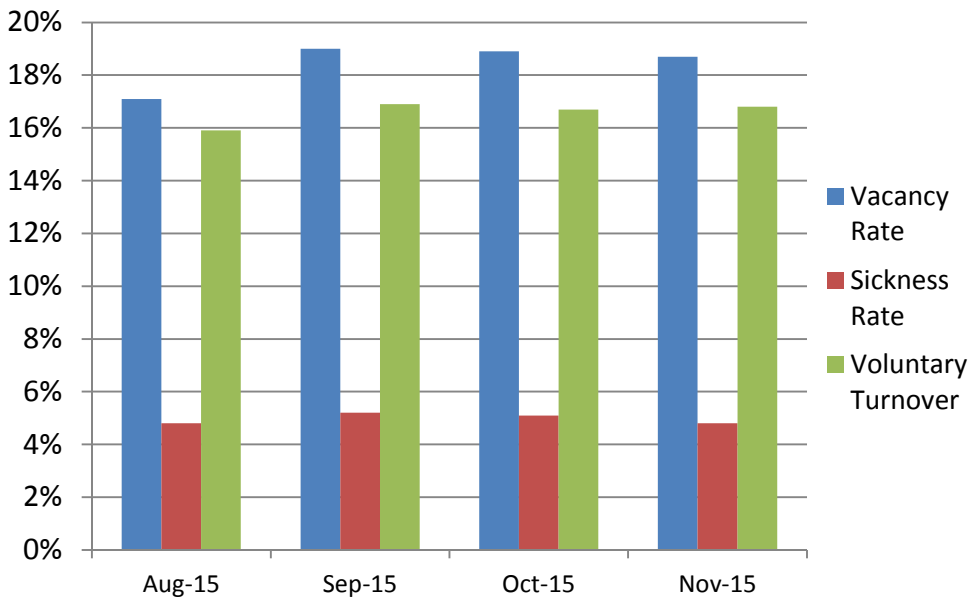
Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	14.81%	15.59%	15.43%	15.03%	↘
Community Services	18.23%	19.38%	18.14%	18.09%	↘
Corporate & R&D	15.37%	14.88%	13.53%	9.47%	↘
Medical & Cardiothoracics	17.97%	19.82%	20.01%	19.15%	↘
Surgery, Neurosciences & Anaes	13.49%	13.72%	13.70%	15.88%	↗
Total	16.0%	16.7%	16.7%	16.8%	↗

COMMENTARY

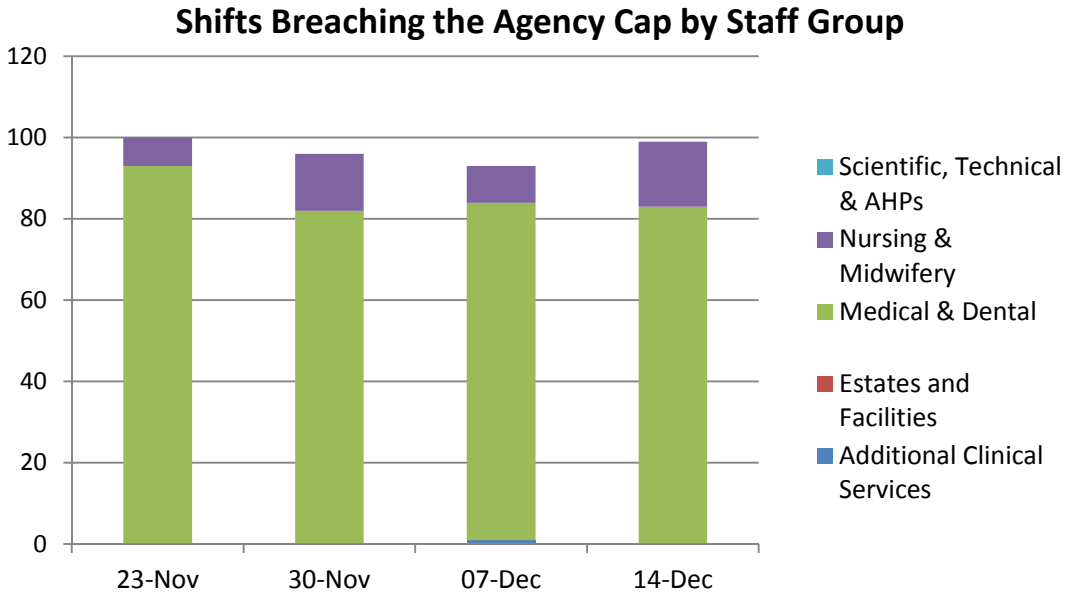
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has increased by 35 WTE in November.

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	23-Nov	30-Nov	07-Dec	14-Dec	Trend
Additional Clinical Services	0	0	1	0	↘
Estates and Facilities	0	0	0	0	↔
Medical & Dental	93	82	83	83	↔
Nursing & Midwifery	7	14	9	16	↗
Scientific, Technical & AHPs	0	0	0	0	↔
Whole Trust	100	96	93	99	↗

Agency Cap Shift Breaches by Division	23-Nov	30-Nov	07-Dec	14-Dec	Trend
C&W Diagnostic & Therapy	9	15	12	19	↗
Community Services	14	11	10	13	↗
Corporate	10	10	15	10	↘
Estates and Facilities	0	0	0	0	↔
Medical & Cardiothoracics	38	36	28	32	↗
Surgery, Neurosciences & Anaes	24	20	23	15	↘
SWL Pathology	5	4	5	10	↗
Whole Trust	100	96	93	99	↗

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.

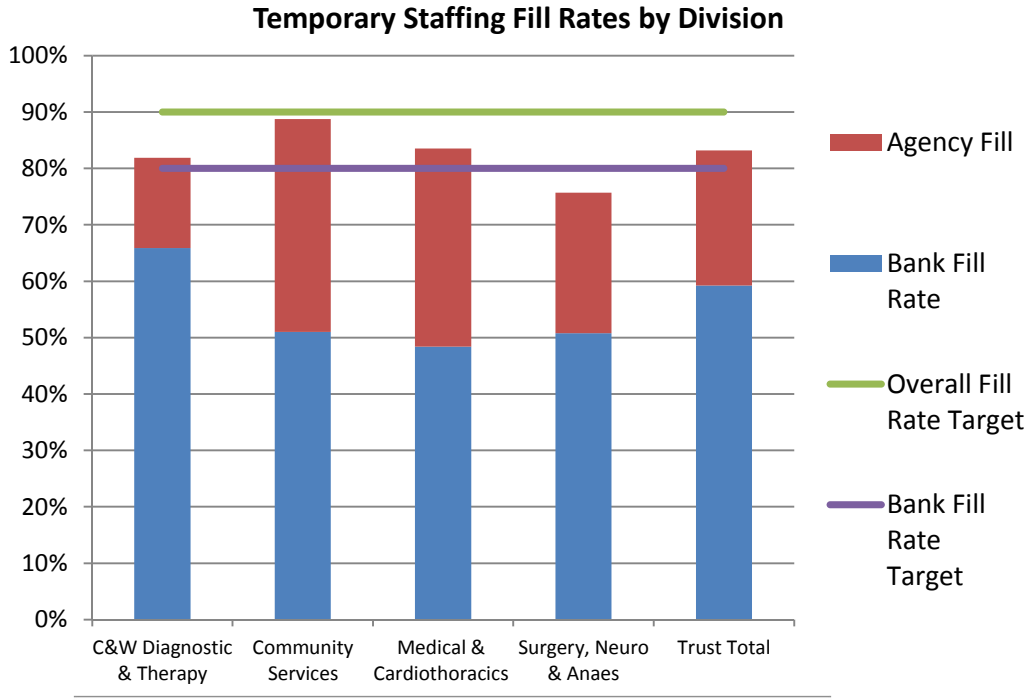
Work is on-going to stop using agencies which breach the caps where possible.

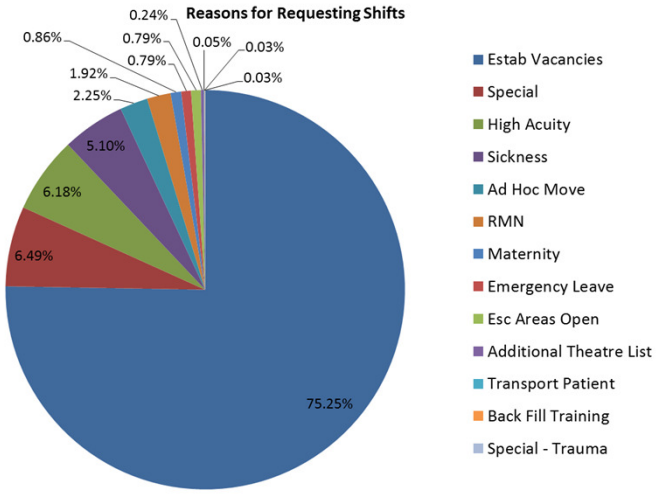
In all cases, services have confirmed there would be an adverse impact upon patient safety should the booking not go ahead.

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.

Capped rates are going to be reduced again in February and April. Using the 14th of December as an indicative week, under the new caps, 240 shifts would breach in February and 511 in April.

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 November the Bank Fill Rate was reported at 59.2% which is 1.1% higher than the previous month. It improved across all Divisions. The Overall Fill Rate was 83.2% which is an increase of 1.6% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

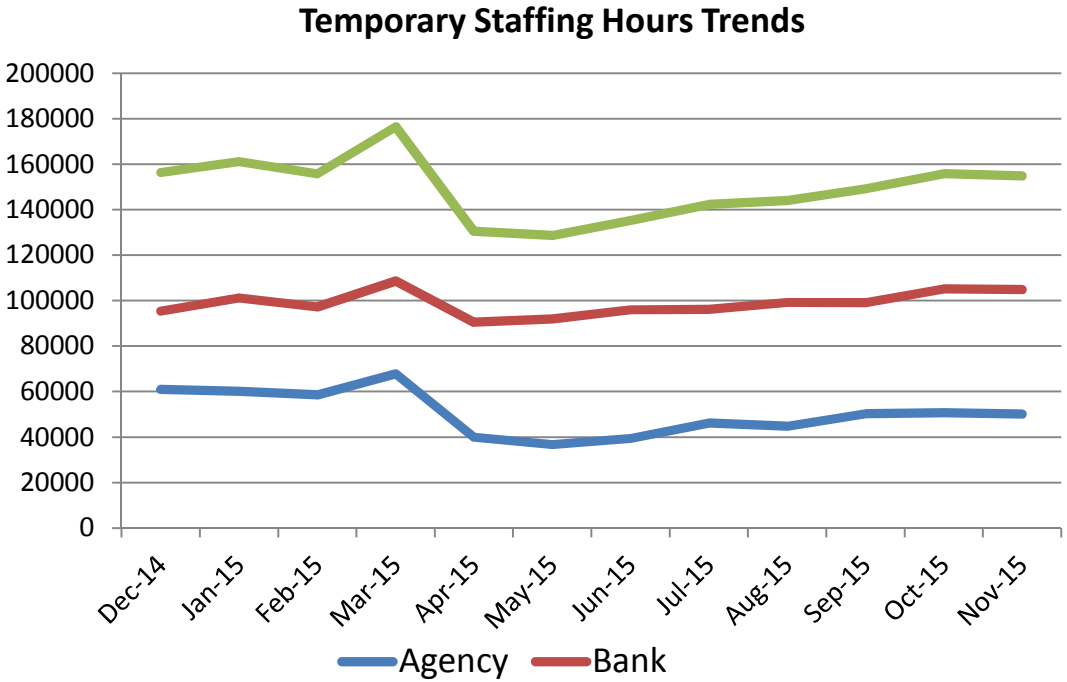
The pie chart shows a breakdown of the reasons given for requesting bank shifts in November. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

Bank Fill Rate % by Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	68.1%	66.3%	65.3%	65.9%	↗
Community Services	50.8%	48.6%	49.7%	51.0%	↗
Medical & Cardiothoracics	47.7%	44.1%	46.2%	48.4%	↗
Surgery, Neurosciences & Anaes	50.9%	53.0%	50.3%	50.8%	↗
Whole Trust	**56.8%**	**55.7%**	**58.1%**	**59.2%**	↗

Overall Fill Rate % by Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	85.8%	83.9%	81.9%	81.9%	↗
Community Services	86.3%	86.5%	88.2%	88.7%	↗
Medical & Cardiothoracics	78.8%	80.0%	79.4%	83.5%	↗
Surgery, Neurosciences & Anaes	74.9%	76.7%	76.8%	75.7%	↘
Whole Trust	**79.5%**	**79.8%**	**81.6%**	**83.2%**	↗

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 worked have both decreased in November.

Agency and Bank hours have increased in Medicine and Cardiothoracis Division (predominately A&E) and in Estates and Facilities (mainly Portering and Medical Physics).

TYPE	Division	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Agency	C&W Diagnostic & Therapy	17489	15550	15363	16791	9525	10750	8656	9638	9210	9921	11112	10724
	Community Services	6146	6208	7800	9890	7938	5769	5245	6077	6422	6421	7086	6605
	Corporate	3772	3454	2763	3488	1246	1331	949	529	32	423	402	384
	Estates and Facilities	0	0	0	0	0	0	0	0	0	0	4	166
	Medical & Cardiothoracics	22515	24387	21773	25876	14492	13202	17823	20429	20285	24408	21792	22626
	Surgery, Neurosciences & Anaes	11041	10454	10809	11833	6582	5462	6386	9195	8560	8620	9994	9362
	SWL Pathology	0	0	0	0	119	204	241	228	237	352	267	150
Agency Total		**60964**	**60053**	**58508**	**67877**	**39901**	**36717**	**39299**	**46097**	**44746**	**50145**	**50657**	**50017**
Bank	C&W Diagnostic & Therapy	26979	28329	27388	31536	27789	28714	29038	25990	26258	28178	32858	31790
	Community Services	11092	10097	9360	10560	8379	7619	7704	8252	9030	8659	9149	9133
	Corporate	7706	7766	7248	7922	7424	7165	8430	7972	7321	11048	11156	9858
	Estates and Facilities	6867	7446	6807	7744	6885	7502	8178	9216	8910	8264	8506	9423
	Medical & Cardiothoracics	24451	25548	25083	27553	23755	24829	24969	26255	29159	26958	26409	28073
	Surgery, Neurosciences & Anaes	15382	18855	18438	20376	13521	13495	14553	14740	15202	15268	16265	15754
	SWL Pathology	2901	3134	2947	2953	2753	2620	3052	3751	3314	638	821	839
Bank Total		**95376**	**101175**	**97272**	**108643**	**90507**	**91944**	**95925**	**96177**	**99193**	**99013**	**105164**	**104870**
Temporary Staff Total		**156340**	**161227**	**155780**	**176520**	**130408**	**128661**	**135224**	**142273**	**143940**	**149157**	**155821**	**154887**

Section 11: Temporary Staffing Weekly Tracking

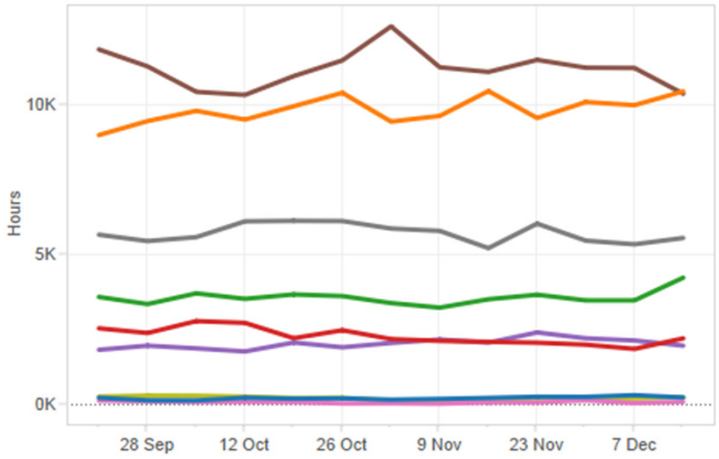
Weekly Hours Used By Division

Division	21 Sep	28 Sep	05 Oct	12 Oct	19 Oct	26 Oct	02 Nov	09 Nov	16 Nov	23 Nov	30 Nov	07 Dec	14 Dec
Capital Division	214	130	126	215	186	198	151	176	209	248	245	301	224
Children and Women's Diagnostic and Th..	8,991	9,456	9,797	9,506	9,949	10,397	9,439	9,628	10,454	9,558	10,089	9,985	10,445
Community Services Division	3,603	3,367	3,724	3,540	3,688	3,633	3,400	3,248	3,527	3,678	3,489	3,490	4,245
Corporate Division	2,560	2,404	2,801	2,741	2,232	2,496	2,202	2,142	2,111	2,082	2,017	1,875	2,225
Estates and Facilities Division	1,846	1,983	1,892	1,791	2,088	1,928	2,074	2,188	2,083	2,423	2,228	2,155	1,984
Medicine and Cardiovascular Division	11,839	11,275	10,430	10,327	10,952	11,474	12,606	11,245	11,091	11,493	11,232	11,224	10,367
Research & Development Division	114	91	69	76	66	24	27	16	59	58	127	35	80
Surgery & Neurosciences Division	5,676	5,463	5,595	6,120	6,138	6,130	5,880	5,803	5,228	6,043	5,477	5,356	5,567
SWL Pathology Division	255	286	283	252	206	210	117	109	109	206	181	196	228
Grand Total	35,097	34,454	34,715	34,567	35,504	36,490	35,895	34,554	34,871	35,788	35,084	34,616	35,364

Type
- Agency
- Bank

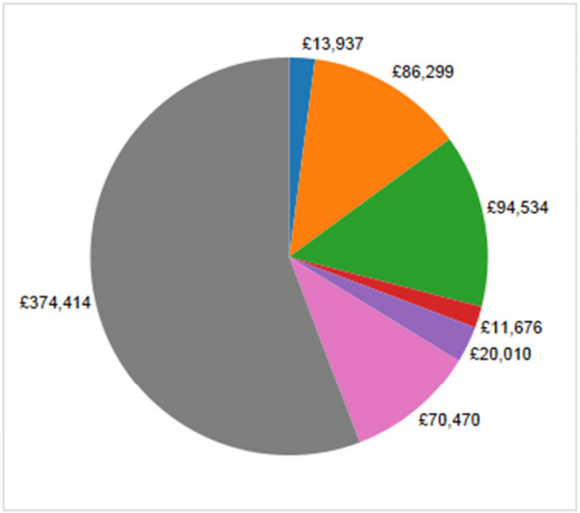
Division
- Capital Division
- Children and Women's D..
- Community Services Divi..
- Corporate Division
- Estates and Facilities Div..
- Medicine and Cardiovasc..
- Research & Developmen..
- Surgery & Neuroscience..
- SWL Pathology Division

Weekly Hours Used Trends



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

Weekly Spend by Staff Group



Total Cost
£671,339

Select Date (W/C)
14/12/2015

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

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

Section 12: Mandatory Training

MAST Topic	Oct '15	Nov '15	Trend
Conflict Resolution	73.3	74.4	↗
Equality, Diversity and Human Rights	75.9	72.7	↘
Fire Safety	70.8	71.3	↗
Health, Safety and Welfare	75.0	71.1	↘
Infection Prevention and Control Clinical	57.0	57.9	↗
Infection Prevention and Control Non Clinical	68.3	63.0	↘
Information Governance	59.9	59.9	↘
Moving and Handling	68.8	62.8	↘
Moving and Handling Patient	48.2	47.4	↘
Resuscitation BLS	40.7	42.7	↗
Resuscitation ILS	50.6	49.8	↘
Resuscitation Non Clinical	59.7	59.4	↘
Safeguarding Adults	72.2	68.2	↘
Safeguarding Children Level 1	72.0	67.3	↘
Safeguarding Children Level 2	70.8	68.3	↘
Safeguarding Children Level 3	69.3	67.0	↘

MAST Compliance % by Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	70.4%	68.4%	67.8%	65.7%	↘
Community Services	70.4%	70.1%	68.8%	65.7%	↘
Corporate	64.1%	65.4%	66.1%	62.9%	↘
Estates and Facilities	64.5%	61.9%	61.9%	62.4%	↗
Medical & Cardiothoracics	60.8%	61.6%	61.4%	61.2%	↘
Surgery, Neurosciences & Anaes	65.9%	66.5%	65.2%	63.9%	↘
Whole Trust	67.8%	67.2%	66.6%	64.5%	↘

COMMENTARY

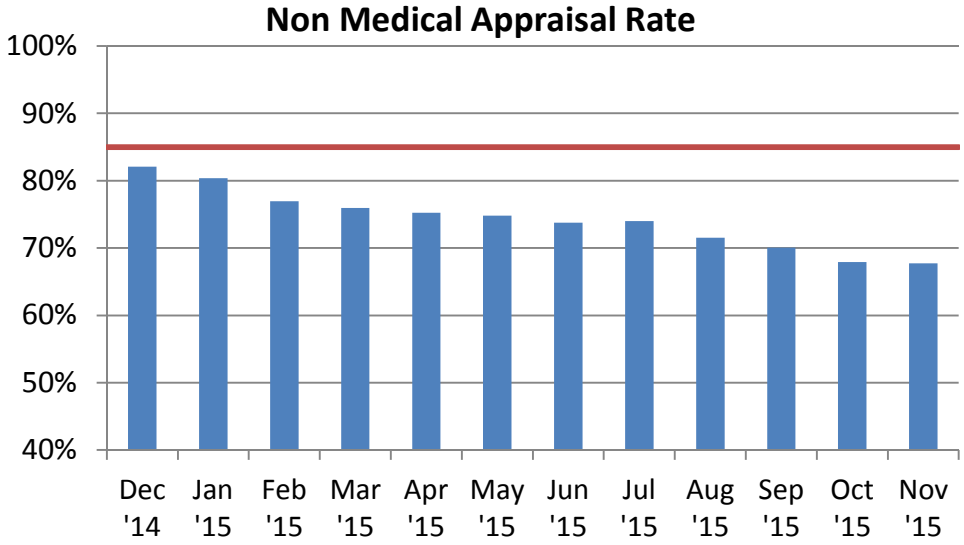
A programme of working is taking place including:

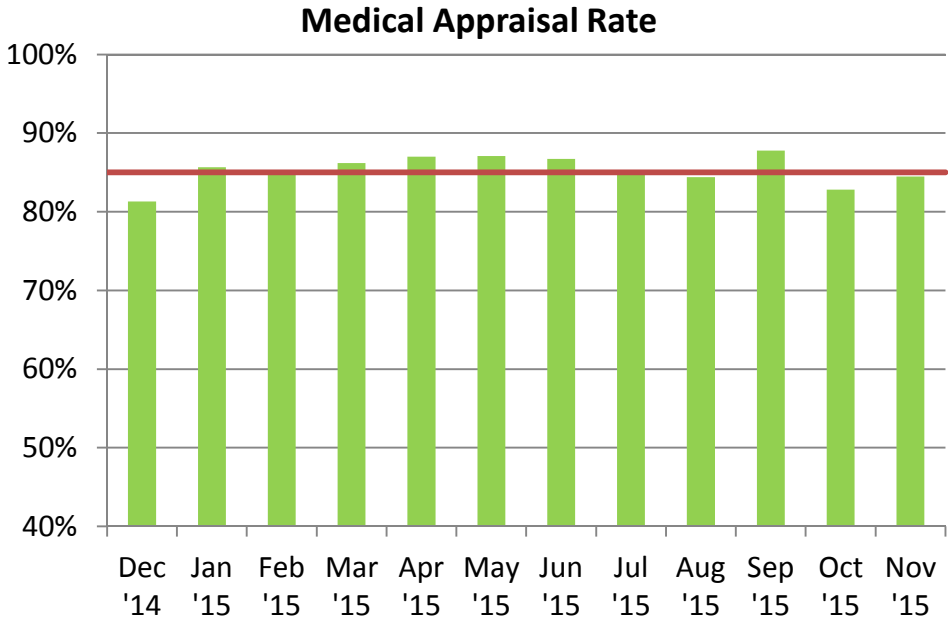
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Providing and accessible on-line system
- Introduced monthly meetings where divisions report on progress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

Current Issues:

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

Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 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 increased this month to 84.5% which is just below target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
Energy and Engineering	0.0%	50.00
SWLP Central Reception	25.0%	53.30
Information Directorate	25.8%	35.80
Finance Directorate	29.9%	112.35
SWLP Biochemistry	30.0%	61.83

Non Medical Appraisals by Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	69.2%	69.0%	68.1%	69.7%	↗
Community Services	72.8%	68.2%	64.9%	62.9%	↘
Medical & Cardiothoracics	74.8%	73.6%	71.6%	74.6%	↗
Surgery, Neurosciences & Anaes	75.2%	74.5%	76.2%	74.9%	↘
Corporate	63.6%	64.3%	53.7%	51.5%	↘
Estates & Facilities	77.7%	64.0%	64.0%	66.9%	↗
Whole Trust	**71.5%**	**70.0%**	**67.9%**	**67.7%**	↘

Medical Appraisals by Division	Aug '15	Sep '15	Oct '15	Nov '15	Trend
C&W Diagnostic & Therapy	84.1%	86.9%	83.5%	84.4%	↗
Community Services	84.0%	84.0%	79.4%	81.3%	↗
Medical & Cardiothoracics	85.2%	87.7%	83.5%	87.8%	↗
Surgery, Neurosciences & Anaes	84.3%	87.7%	81.4%	82.0%	↗
Corporate	100.0%	100.0%	75.0%	75.0%	↔
Whole Trust	**84.4%**	**87.8%**	**82.8%**	**84.5%**	↗

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD - January 2016 TB Jan 16 – 05a

Paper Title:	Emergency Preparedness Resilience and Response (EPRR) Annual Update 2015-16
Sponsoring Director:	Paula Vasco-Knight, Chief Operating Officer and Accountable Emergency Officer
Authors:	Joel Standing, Emergency Planning and Liaison Officer
Purpose:	• To update the Board regarding the status of emergency preparedness, resilience and response, as required by NHS Commissioning Board Emergency Preparedness Framework, 2013 • To fulfil the NHS England (London) requirement to provide assurance to the board that strategies, systems, training, policies and procedures are in place to ensure an appropriate response from the Trust in the event of a major incident or civil contingency event.
Action required by the board:	For information
Document previously considered by:	Organisational Risk Committee

Executive summary

- **Key messages**

The trust has moved the emergency preparedness agenda forward during 2015-16.
Notable achievements include:

- Maintaining the substantial rating during the 2015 annual EPRR Assurance Process but improving on the number of core standards now at a GREEN rating
- Reviewing the Business Continuity Arrangements and introduction of Business Impact Analysis process

- **Recommendation**

To note the report for information and to receive as assurance that focus is given to emergency preparedness.

Key risks identified:
None

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Objective 1 -
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	Outcome 4, Regulation 9, 4b

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes)
If yes, please provide a summary of the key findings

Appendix A:

EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better health 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
				13th Nov 2015

1.1 Who is responsible for this service / function / policy?
Director of Delivery and Improvement

1.2 Describe the purpose of the service / function / policy? *Who is it intended to benefit? What are the intended outcomes?*
To ensure the trust is as prepared as possible, able to respond to and does respond to major incidents (both internal and external) and business continuity incidents proportionately and appropriately

1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*
Ensure compliance with the Civil Contingencies Act 2004

1.4 What factors contribute or detract from achieving intended outcomes?

- Engagement of Lack thereof by stakeholders

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

Neither

1.6 If yes, please describe current or planned activities to address the impact.
n/a

1.7 Is there any scope for new measures which would promote equality?
n/a

1.8 What are your monitoring arrangements for this policy/ service
Sitreps and assurance processes as required by NHS London and SWL Cluster

1.9 Equality Impact Rating [low, medium, high]
Low

2.0. Please give you reasons for this rating
See question1.5

Emergency Preparedness Annual update 2015-2016

Introduction

The Civil Contingencies Act (CCA) 2004 places a legal responsibility on the CEOs from category 1[1] organisations requiring them to put in place a system for planning, implementing and reviewing responses to a range of potentially disruptive incidents. NHS England requires the Accountable Emergency Officer (AEO) to provide assurance to the board that strategies, systems, training, policies and procedures are in place to ensure an appropriate response from the trust in the event of a major incident or civil contingency event. The trust's AEO is the Chief Operating Officer who leads on major incident and business continuity preparedness. This report provides the Board with an annual update for the year 2015-16.

The trust achieved:

- A successful temporary redirect of the Emergency Department's Resus and Majors capability to carry out urgent remedial electrical supply work. This work was a multi-agency event and involved a significant number of key stakeholders including CCG and NHS England (London)
- Continuing review of the Business Continuity arrangements for the trust.
- Closer integration with Local Authority Safety Advisory Groups in Wandsworth, Merton and Lambeth to ensure that the trust is aware of significant public events that may impact on its ability to carry out business as usual
- A Substantial rating as a result of the NHS England (London) 2015 EPRR annual Assurance process. The Trust was assessed against 8 Core Standards of EPRR which incorporated a total of 37 supporting standards. The standards were given a Red, Amber or Green (RAG) status. Of the 37 supporting standards there was only one (1) Amber rating with the rest being assessed as Green. The full assessment findings and actions to improve the Amber ratings are in a separate document.

The trust did not achieve:

- Develop telecommunications resilience further

This work is progressing and a DRAFT operational plan is now at the consultation stage.

Resource

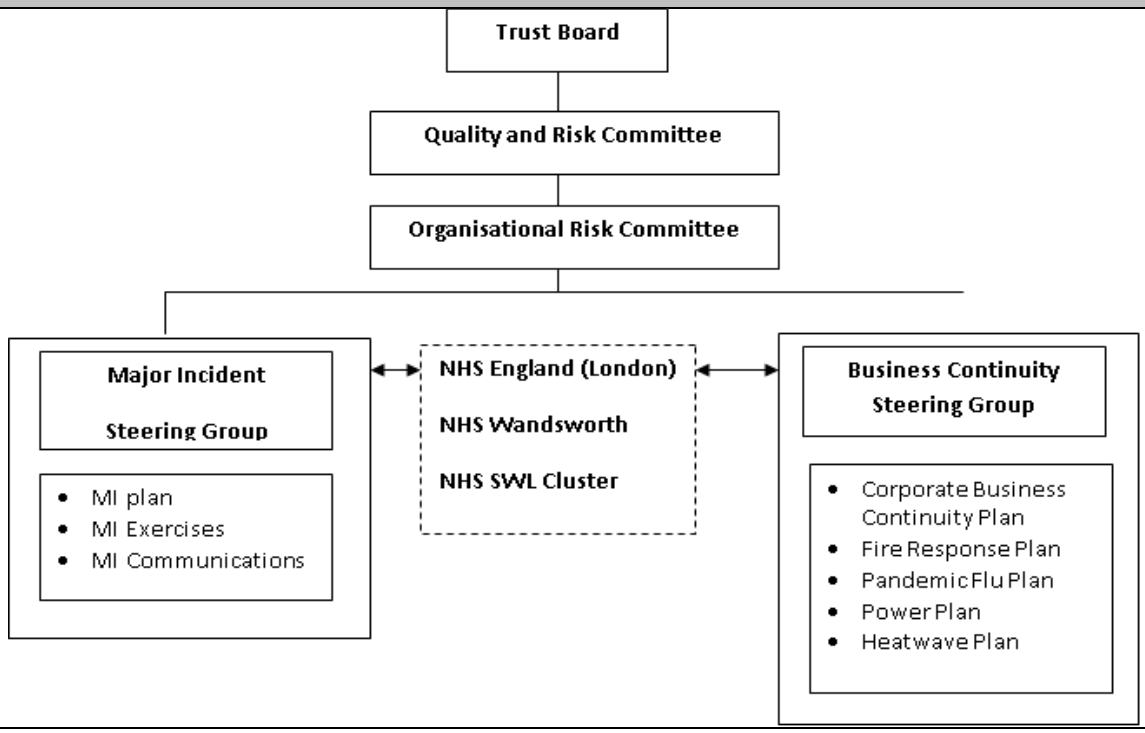
The trust has 1.0 WTE Emergency Planning and Liaison Officer (EPLO). The EPLO sets a work plan for the year broadly under the themes and areas of responsibility denoted by the Civil Contingencies Act 2004 and the NHS CB Emergency Preparedness, Resilience and Response Framework 2013.

Review of Emergency Preparedness during 2015-16

The table below sets out the emergency preparedness work completed during 2015-16; the table is set by themes broadly set out in the Civil Contingencies Act 2004.

Theme (broadly set out in Civil Contingencies Act 2004)	Work completed during 2015-16
Corporate: Maintain governance arrangements for Emergency	The governance structure continues to operate well and the EPLO role reports twice a year to the ORC reflecting the activities of the Major Incident Steering Group and the Business Continuity Steering Group. The governance structure that was in place during 2015-16 is shown below:

[1] Category 1 responders are those organisations at the core of the response to most emergencies (e.g. emergency services, local authorities, NHS bodies). Category 1 responders are subject to the full set of civil protection duties set out in the Civil Contingencies Act 2004.

Theme (broadly set out in Civil Contingencies Act 2004)	Work completed during 2015-16
Planning across the trust.	
To assess risk:	In keeping with the trust's obligation under the CCA 2004 to "*… from time to time assess the risk of an emergency occurring …'* and *'… from time to time assess the risk of an emergency making it necessary or expedient for the person or body to perform any of its functions'*, and the NHS CB Emergency Preparedness Resilience and Response Frame work 2013 to "*Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions*" the Business Continuity Steering Group approved an updated Emergency Planning Risk Register for 2015. In total there are 24 risks listed, 4 of which are extreme, 12 are high, 7 are moderate and 1 is low.
Emergency Planning:	• The Major Incident Steering Group continues to meet three times a year to ensure that continual improvement in major incident planning continues. • There was one activation of the Major Incident plan for the Staines bus crash in March 2015. The incident was declared by South East Coast Ambulance Service and resulted in just one casualty. • The trust has a Major Incident Plan in place. The trust completed a review and revision of the Major Incident Plan and this was updated in October 2015 • The trust has a HazMat (CBRN) plan in place. The trust completed a review and revision of the HazMat (CBRN) plan and this was updated in September 2015
Business Continuity Planning:	• The Business Continuity Steering Group continues to meet three times a year with representation from across the divisions and services of the trust. • Existing Business Continuity arrangements were reviewed. • There have been three business continuity events in 2015 (Temporary Redirect of Resus and Majors, Loss of Mains Water Supply and Burst Heating Pipe in SJW). Two events happened in July and one in December. Both were managed through Operational planning meetings and Business Continuity arrangements at corporate and service level

Theme (broadly set out in Civil Contingencies Act 2004)	Work completed during 2015-16
	• The trust updated its heatwave plan in the summer of 2015. Temperatures breached the Level 3 triggers for one day in July before returning to Level 1 where they remained for the rest of the summer. • The trust remained fully engaged in the RideLondon Cycling Event which is now in its third year and continues to put in place an operational plan for this event.
Communicating with the Public:	• The Communications Department implemented communications campaigns during incidents via its internal and external communication methods to help provide information and assurance where needed to the public in a variety of situations.
Information Sharing	See 'Communicating with the Public' and 'Training and Exercising' sections.
Co-operation between responders:	The trust is fully engaged and takes an active part in local relevant forums including: • London Borough of Wandsworth Borough Resilience Forum • London Borough of Merton Borough Resilience Forum • London Borough Safety Advisory Groups (SAG) for Wandsworth, Merton and Lambeth • SWL Sub-Regional Resilience Forum • SW London and Surrey Trauma Network Meetings • SWL EPLOs meeting

Training and Exercising:	• A training programme for on-call directors and managers continues to run. In 2015-16 this covered:
	  • On Call responsibilities and
	  • Command, Control and Communication
	• A monthly Major Incident and Chemical, Biological, Radiation and Nuclear training day for front-line responders in ED, security and porters including nurses, doctors, receptionists and other support staff has been established. This is run by a small training team including the EPLO, ED staff, Radiation Protection Service and local Metropolitan Police Service (MPS).
	• Dedicated training events for the Clinical Site Management team have been delivered and this will develop into an annual training event.
	• A table top exercise, Exercise Avoco, was run in conjunction with local partners and external agencies at St. George's Hospital in May 2015. The exercise tested the ED temporary Redirect plan.
	• The trust took part in multiple exercises to support the NHS England response to Flu Pandemic.
	• The trust took part in a multi-agency Marauding Terrorist Attack Exercise with the Sub Regional Resilience Forum led by London Fire Brigade
	• The trust took part in a multi-agency Wandsworth Borough SAG exercise for the Battersea Park Fireworks event.

Plans for Emergency Preparedness, Resilience and Response 2015-16

A work plan has been completed for 2015-16. The focus of this work will broadly be:

- Develop a single Incident Management and Response Plan that ensures that Command and Control processes are mirrored for all types of incidents and that links to Major Incident and Business Continuity arrangements.
- Completing the command and control requirements of an Incident Coordination Centre (ICC) to incorporate all command and control room options open to the trust.
- Develop Business Continuity arrangements to seek to certificate one of the trusts core services to the international standard on Business Continuity (ISO22301)
- Strengthen the trust's Surge Capacity Management Plan, incorporating winter planning, to build on the learning of winter 2014-15.

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
Governance										
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	• Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas		G				
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	• Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation. .		G				
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity	Y			G				
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y			G				
Duty to assess risk										
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed		G	24 EPRR risks aligned to the BRF RR. Suggested to link into the LHRP Risk Register			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y			G				

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y			G	All BRF members are invited to the trust EP and BC forums			
Duty to maintain plans – emergency plans and business continuity plans										
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.		G	Looking to have one sole C3 plan which links to both the BCP and MIP, at the moment this is listed in both in similar ways.			
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y			G (with comments)	Excellent plan, well laid out, some great appendices on log keeping. Critical areas plans well laid out / Suggestion to include both levels of criticality as well as RTO's			
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y			G				
		Severe Weather (heatwave, flooding, snow and cold weather)	Y			G				
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y			G				
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y			G				
		Mass Casualties	Y			G				
		Fuel Disruption	Y			G				
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y			G				
		Infectious Disease Outbreak	Y			G				
		Evacuation	Y			A	AMBER from Green - 14/10/15 EPRR Review - Trust now has plan in place, however with recent change in fire officers and the need to undertake further testing in key zones the Trust wishes for this to remain AMBER. ACTION - Plan to be sent to NHSE	To engage with the Fire Safety Advisor to finalise and carry out testing of colour coded "zoning" areas within the Trust	**EPLO and Fire Safety Advisor**	Feb-16
		Lockdown	Y			G				
		Utilities, IT and Telecommunications Failure	Y			G				
		Excess Deaths/ Mass Fatalities	Y			G	Hospital mortuary is also for Sutton and Merton LA's / for past year 3 nutwells given extra 36 spaces, HTA informed new work on extra capacity of 77 spaces in progress			
		N/A	N/A			N/A		N/A	N/A	N/A
		N/A	N/A			N/A		N/A	N/A	N/A
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).		G				

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
#	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.		G				
#	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y			G				
#	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y			G	This is a separate plan			
#	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specify who has been consulted on the relevant documents/ plans etc.		G				
#	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y			G				
Command and Control (C2)										
#	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.		G				
#	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England published competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (i.e. operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.		G	14/10/15 EPRR Review - Policy to next Organisational Risk Committee (OCR) / New staff on-call assessment aligned to core standards in place based on one from the acute learning set - NOW GREEN ACTION - Plan to be sent to NHSE			
#	Documents identify where and how the emergency or business continuity incident will be managed from, i.e. the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and sco	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/coordination centre and manage any events required.		G	New ICC in Larch 2016			
#	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y			G				
#	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y			G				

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
#	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y			G				
#	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y			G				
Duty to communicate with the public										
#	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.		G			

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
#	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.		G				
Information Sharing – mandatory requirements										
#	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and include DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supersedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.		G	Attends both Wandsworth and Lambeth SAG's when incidents relating to the Trust/			
Co-operation										
#	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and membership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area		G				
#	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y			G				
#	Arrangements include how mutual aid a	NB: mutual aid agreements are wider than staff	Y			G	14/10/15 EPRR Review -Sections in the policy, MIP and BCP. Discussion over clarity from region to expectation's of this standard GREEN ACTION - NHS England			
#	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.					N/A		N/A	N/A	N/A
#	Arrangements outline the procedure for responding to incidents which affect two or more regio					N/A		N/A	N/A	N/A
#	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y			G				
#	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared					N/A		N/A	N/A	N/A
#	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months					N/A		N/A	N/A	N/A
#	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y			G				
Training And Exercising										
#	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidents have been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise		G				

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and no evidence of progress Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Review Meeting Score	Review Meeting Comments	Action to be taken	Lead	Time
#	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	annually and live exercise at least every three years		G				
#	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y			G	Trust put forward for funded Emergo next year			
#	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	**Core standard to be considered as part of co**	Y			N/A		N/A	N/A	N/A

St George's University Hospitals NHS
NHS Foundation Trust

Cancer – Recovery Plan for 14 day and 62 day Standards

8 January 2016

NHS Wandsworth Clinical Commissioning Group

NHS Merton Clinical Commissioning Group

NHS Lambeth Clinical Commissioning Group

Agenda

1	**Welcome and introductions** • Purpose of meeting: review and provide Tripartite sign off on cancer recovery plans.
2	**Review actions of lastTripartite cancer escalation meeting (13 November 2015)** • See attachment 1 – letter and actions following last meeting.
3	**Two week rule recovery trajectory (speciality-aggregate/month) demonstrating compliance at 93% with supporting plan** • Clear focus on the recovery of breast, skin and upper GI referrals and capacity. • Overarching actions to demonstrate 48 hour contact with patients to agree appointments and appointments offered at 7-10 days (10 days at the latest).
4	**62-day recovery trajectory (specialty-aggregate/month) demonstrating compliance at 85% with supporting plan** • Focus on urology, lung and head and neck pathways. • Focus on diagnostic capacity with routine use of one stop/straight to test clinics (to manage breaches relating to delays in work up). • Actions relating to the management of all avoidable breaches, including demonstrating proactive navigation of patients through their pathways (MDT coordinators and CNSs) to manage breaches due to administrative delays, MDM delays and delays in work up. • Specific actions relating to the management of patients on an active, live and regularly updated PTL – with the governance arrangements supporting this – including PTL meetings, escalation points. • Specific actions to proactively manage inter Trust transfers 1) into the Trust from SWL providers (specifically Croydon) and 2) out of the Trust (notably to RMH) – backed up with the 42 day compliance trajectory.
5	**42 day ITT compliance trajectory (speciality-aggregate/month) demonstrating compliance at 85%**
Next Steps	

National Cancer Standards

NHS
Interim Management and Support

- There are a number of key cancer standards, forming part of the National Cancer Waiting Times Monitoring Data set:
  - A maximum two week wait from an urgent GP referral for suspected cancer to DATE FIRST SEEN by a specialist for all suspected cancers
  - A maximum one month (31-day) wait from diagnosis (CANCER TREATMENT PERIOD START DATE) to First Definitive Treatment for all cancers
  - A maximum two month (62-day) wait from urgent GP referral for suspected cancer to First Definitive Treatment for all cancers
  - A maximum one month (31-day) wait from urgent GP referral for suspected cancer to First Definitive Treatment for children's cancers, testicular cancers and acute leukaemia
  - A maximum 62-day wait from referral from a cancer Screening Programme to first treatment for all cancers
  - A maximum 62-day wait from a CONSULTANTS decision to upgrade the urgency of a PATIENT they suspect to have cancer to first treatment for all cancers
  - A maximum 31-day wait for all subsequent treatments for new cases of primary and recurrent cancer where an Anti-Cancer Drug Regimen, surgery or Radiotherapy is the chosen CANCER TREATMENT MODALITY;
  - A maximum two week wait from referral for breast symptoms (where cancer is not initially suspected) to DATE FIRST SEEN.

Recent Performance

	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
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	6852.0
	Total Referral	1198.0	1247.0	1296.0	958.0	1016.0	1250.0	1071.0	8036.0
	93%	92.5%	93.0%	91.7%	86.0%	79.3%	70.4%	82.7%	85.3%
14 Day Breast Symptomatic Referral	Seen Within Target	109.0	152.0	184.0	120.0	107.0	115.0	120.0	907.0
	Total Referral	139.0	166.0	187.0	127.0	114.0	121.0	134.0	988.0
	93%	78.4%	91.6%	98.4%	94.5%	93.9%	95.0%	89.6%	91.8%
31 Day First Treatment	Treated Within Target	142.0	122.0	124.0	127.0	154.0	149.0	149.0	967.0
	Total Treated	147.0	126.0	126.0	129.0	155.0	155.0	155.0	993.0
	96%	96.6%	96.8%	98.4%	98.4%	99.4%	96.1%	96.1%	97.4%
31 Day Subsequent Surgery Treatment	Treated Within Target	31.0	22.0	26.0	23.0	26.0	29.0	6.0	163.0
	Total Treated	32.0	25.0	26.0	24.0	26.0	30.0	6.0	169.0
	94%	96.9%	88.0%	100.0%	95.8%	100.0%	96.7%	100.0%	96.4%
31 Day Subsequent Drug Treatment	Treated Within Target	36.0	23.0	22.0	21.0	31.0	47.0	19.0	199.0
	Total Treated	36.0	23.0	22.0	21.0	31.0	47.0	19.0	199.0
	98%	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	386.5
	Total Treated	63.5	54.5	74.5	77.0	71.0	59.5	74.5	474.5
	85%	86.6%	72.5%	79.2%	80.5%	80.3%	85.7%	84.6%	81.5%
62 Day Screening Referral to Treatment	Treated Within Target	13.5	16.0	14.0	19.5	16.5	21.0	18.5	119.0
	Total Treated	15.0	22.0	16.0	21.5	18.0	22.0	20.5	135.0
	90%	90.0%	72.7%	87.5%	90.7%	91.7%	95.5%	90.2%	88.1%
62 Day Consultant Upgrade to Treatment	Treated Within Target	0.5	0.0	0.0	2.0	0.5	5.5	1.0	9.5
	Total Treated	0.5	0.0	0.0	2.5	0.5	7.0	1.0	11.5
	85%	100.0%			80.0%	100.0%	78.6%	100.0%	82.6%

Performance Overview 2015/16 to Date

- **14 day standard** - The Trust had a positive track record of delivering performance against the standard since April 2014. However, since May 2015 the trust has not been meeting the target of 93%. Performance fell significantly for four months to a low of 70% in September 2015.

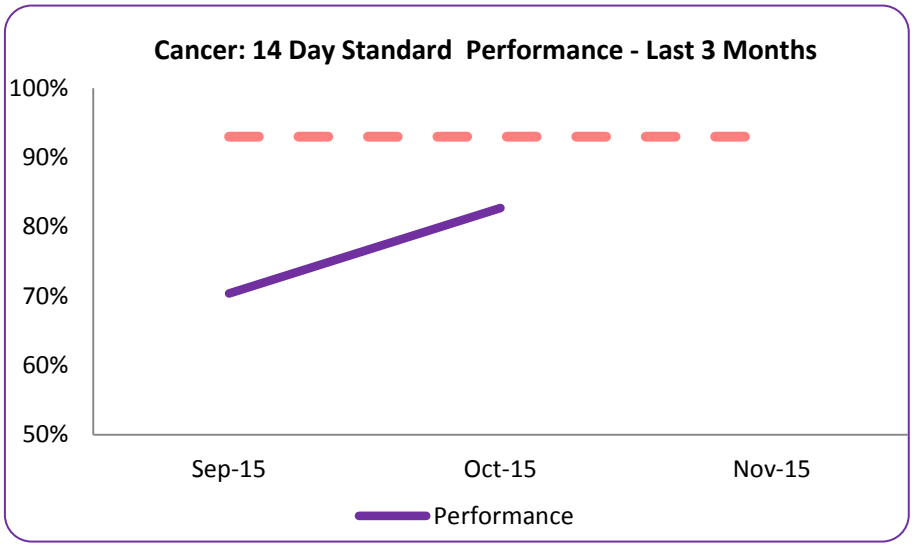
- **62 day GP referral to treatment standard** - The Trust has faced significant challenges on delivering the 62 day standard since April 2015, meeting the standard only twice in months 1-7.

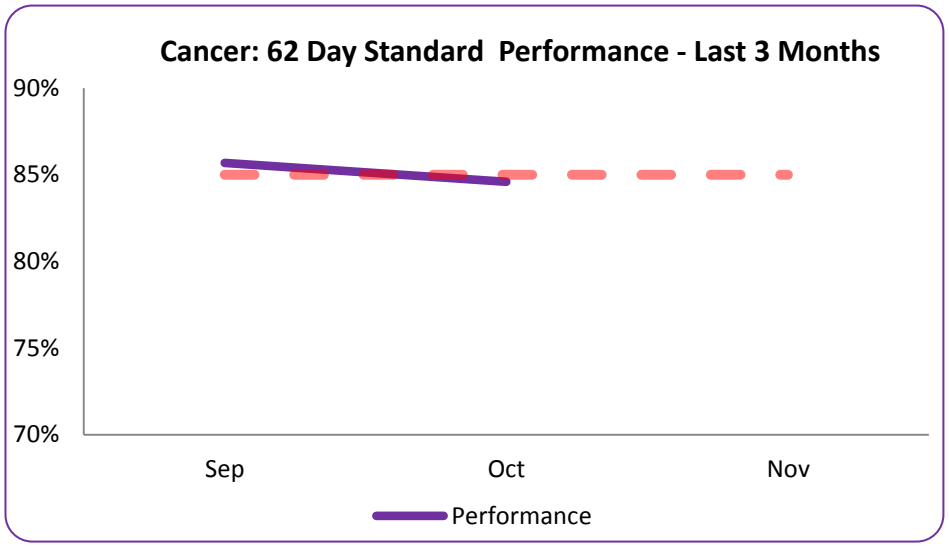
- Key issues affecting performance pre-dominantly relate to internal challenges in relation to tools and resources available for tracking and monitoring targets, capacity and workforce.

- **Immediate focus since October on:**

    - **14 Day Standard:**
        - We have recruited a band 5 TWR office manager to oversee day to day working of the office.
        - Demand and Capacity modelling undertaken by all tumour types to identify shortfalls in substantive capacity. Required substantive capacity at 85% of average weekly referrals has now been identified and action being undertaken to build these slots substantively.
            - Whilst the templates are being substantively, GMs have scheduled ad-hoc clots to cover the shortfall.
        - Capacity shortfall now escalated to GMs on a routine basis for immediate action, instead of service manager as previously done
        - Weekly review of current performance is produced and sent to Cancer GM and COO.
    - **62 Day Standard:**
        - Started work on the development of an automated 62 Day PTL using Infoflex.
        - Weekly PTL meetings in place.
        - Begun training MDT co-ordinators on use of PTL and tracking requirements.
        - Weekly review of all patients waiting 104+ days by Chief Nurse, Medical Director and Chief Executive.
        - Weekly conference calls with referring trusts to discuss shared pathways and IPT compliance.

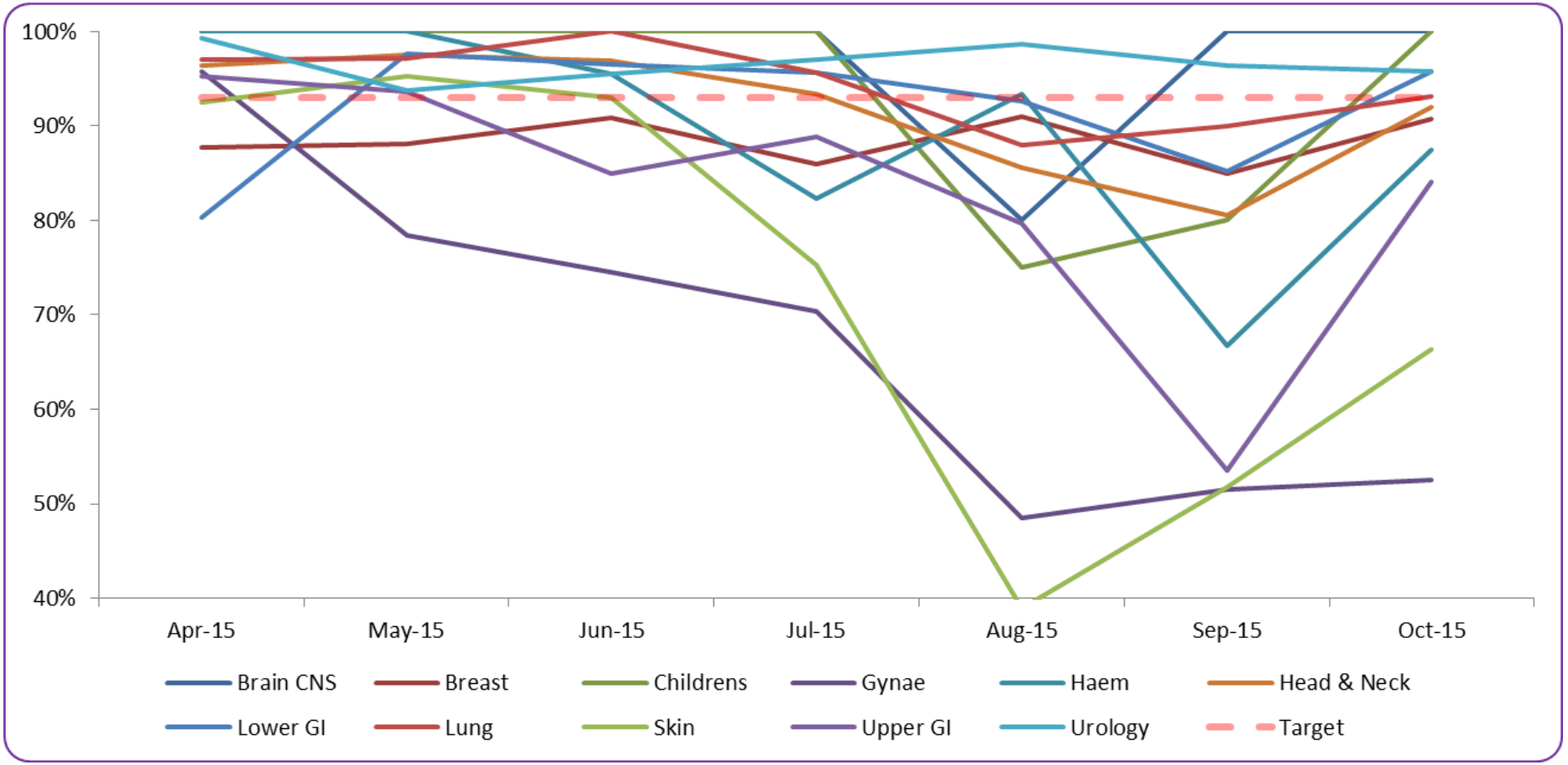
Performance improvement as a result of these actions:





- The trust has observed performance improvement over the last three months against both the 14 and 62 day standards.
- For the 62 day standard, the trust was marginally below target in October . However, excluding late referrals and if re-based on the new breach re-allocation rules the trust would be meeting the target with performance of 89.1%
- The trust recognises that there is still much to do to deliver performance sustainably over the long term. key issues and actions that are required to achieve sustainability have been identified***(as detailed in pages 21-26***).
- A recovery and sustainability action plan addressing the key issues has been developed for implementation across all areas in the organisation. ***(Please find attached as appendix A)***

TWR Performance by Tumour Group:



TWR Demand and Capacity Review:

Tumour Group	Average weekly demand	Average wait to be seen (days)	Weekly defined TWR capacity	Required weekly capacity 85th percentile	Shortfall
Gynaecology	19	11	0	24	24
Lung	8	12	17	10	0
Skin	47	11	40	62	12
Upper GI	21	12	7	28	18
Brain CNS	2	10	5	3	0
Head & Neck	25	12	29	32	3
Lower GI	22	13	24	27	0
Urology	26	11	33	31	0
Haematology	4	10	4	6	2
Breast	80	13	101	93	0
Total	**254**	**115**	**260**	**316**	**59**

TWR Demand and Capacity Review: Actions by tumour type

- Following review of performance and TWR capacity key areas of challenge are:
  - Gynaecology
  - Skin
  - Upper GI
  - Breast
  - Head and Neck
  - Haematology

- From December all specialities have increased slot availability to ensure sufficient capacity is in place to bridge the gap identified by the review.

  - Demand is monitored daily by the TWR office and any changes in required demand due to spikes in referrals above average run rate are escalated to GMs to identify further capacity.

  - No reductions in capacity without prior authorisation from GMs.

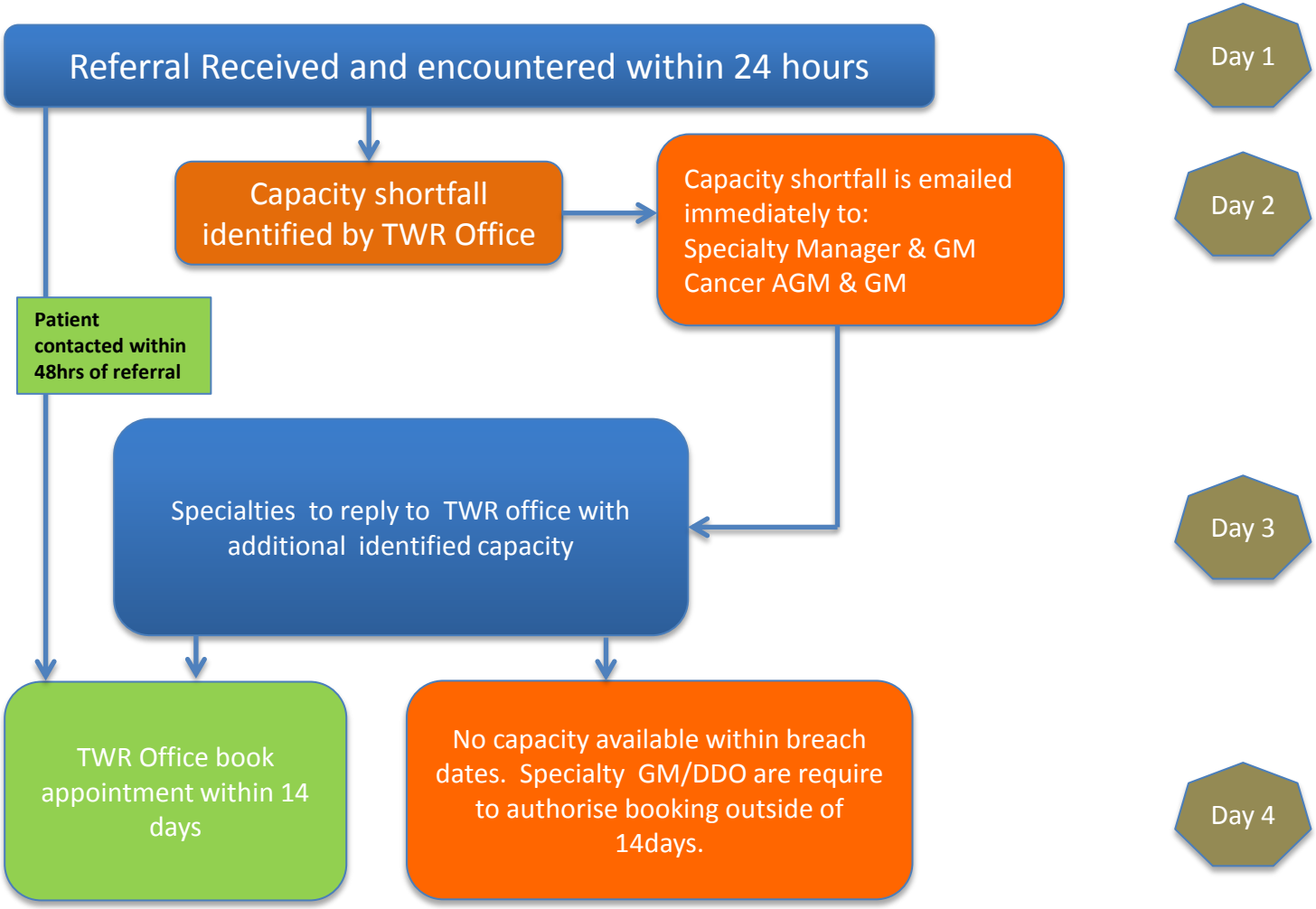
- Shortfalls in capacity due to consultant leave – all specialties are now required to provide ad hoc capacity in other clinics when consultants are on leave.

- Bank holiday periods such as Xmas and Easter for TWRs have an impact on capacity. All tumour types are now required to plan to cover lost slots within the same week as a bank holiday to avoid a dip in capacity. This is done at least 6 weeks in advance and proved successful over the Xmas period.

TWR Actions to Increase Capacity

Specialty	Shortfall	Actions
Gynae	24	-Shortfall bridged with movement from 24 undefined to defined slots plus an additional 12. -Clinical summit do discuss demand management. -Change in referral criteria.
Skin	12	-Shortfall bridged with scheduling of ad-hoc capacity. - Increased clinical capacity with recruitment of a locum who commenced appointment in Nov with an additional locum due to start in Feb-16 -On-going substantive recruitment drive. -QMH and SGH service integration to improve visibility for tracking and flexibility of capacity.
Upper GI	18	-Shortfall bridged with scheduling of ring-fenced ad-hoc capacity. -Specialist registrar appointed and commenced employment in December. -Additional consultant appointment awaiting agreement of start date.
Breast	0	-Additional one-stop clinics scheduled. -QMH and SGH service integration to improve visibility for tracking and flexibility of capacity. -Recruitment of 2 additional consultants.
Head and Neck	3	-Ring-fenced existing TWR slots to bridge capacity gap from December. -Additional TWR evening clinics to commence from 1st February 2016.
Haematology	2	-Ring-fenced existing TWR slots to bridge capacity gap from December

TWR – Real Time Escalation Process

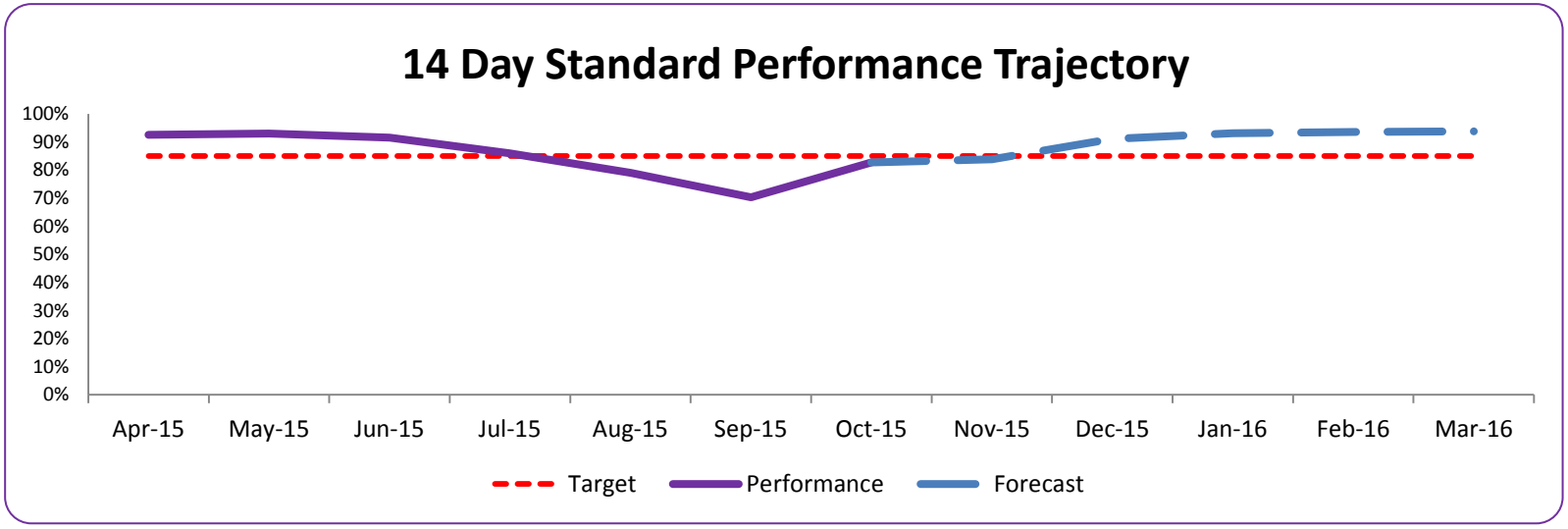


Weekly TWR Performance Report by tumour type sent to all specialties and cancer management for review and to allow for early performance recovery escalation.

TWR - Immediate Next Steps

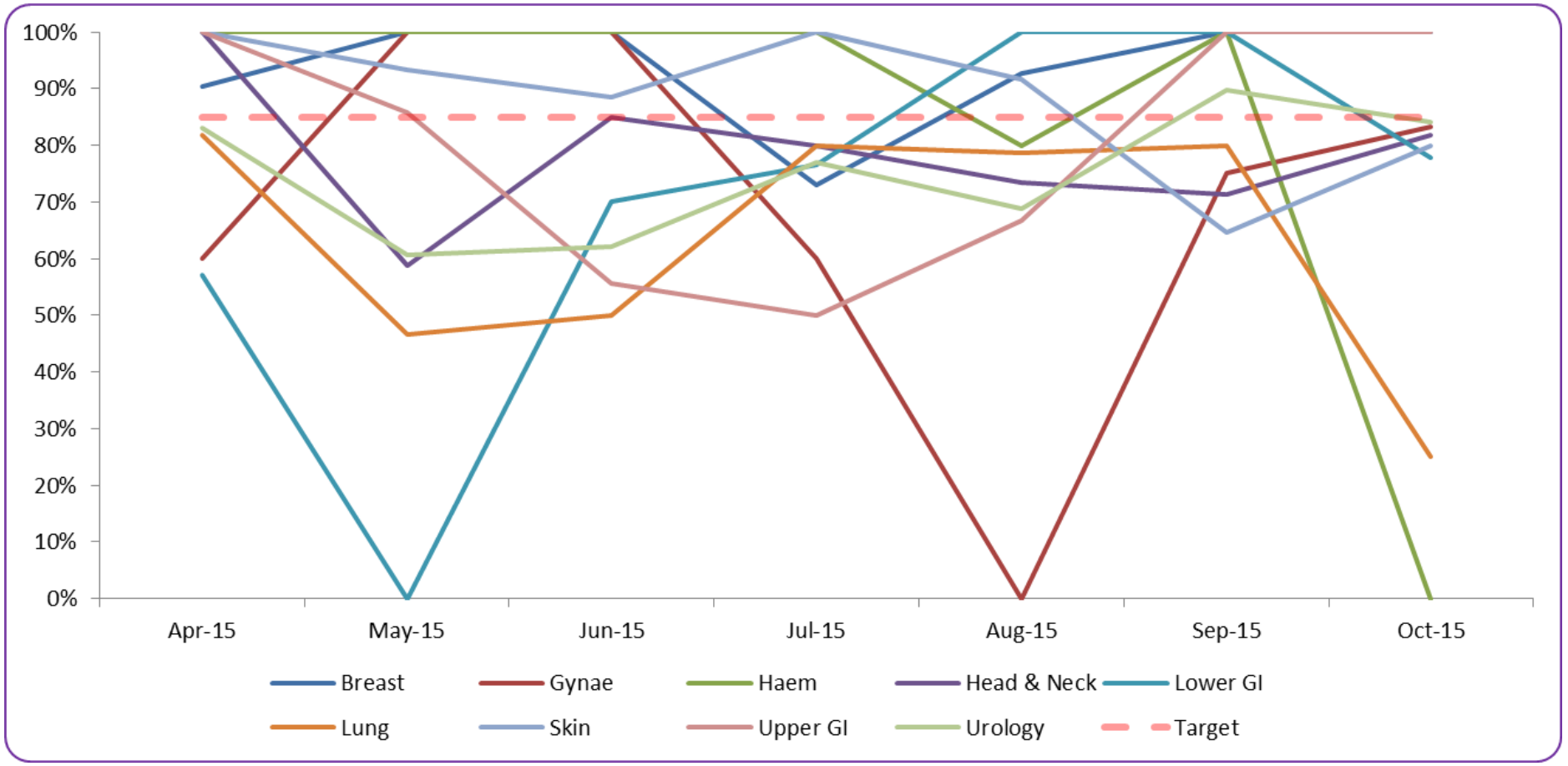
- Key to delivering sustainability is reducing patient booking/contact times to 48hours from receipt of referral and wait time for referral to 1st OP appointment to 7-10 days.
  - Monitoring of average waiting times to identify variability and priority tumour types.
  - This will require a short term increase in TWR booking staff which is contingent on funding.
  - Interim increase in ad-hoc capacity to treat more patients in the short term to bring average waiting times down. Following this capacity can be reduced back to levels identified as part of the original D&C review.
- Gynaecology remains challenged, escalation meeting in place on 11th January with Medical Director, Chief Executive, COO, Clinical Chairs for Cancer and Gynaecology.
- Subject to agreement to re-investment of fines by commissioner, the recruitment of a Cancer Project Manager to lead the implementation and delivery of the plan.
- Further actions to ensure sustainable delivery are being undertaken as per the action plan detailed in appendix a.

- A recovery and sustainability trajectory in view of the actions being taken and to be taken is as follows:



**** Trajectories by tumour type are detailed in appendix b.***

62 Day Standard: Performance by Tumour Group:



62 Day Standard: Key Areas of Challenge

- Following review of performance and breach analysis. key tumour groups of challenge are:
  - Gynaecology
  - Urology
  - Lung
  - Head and Neck

- Flexibility of Diagnostic Capacity

- Active tracking and monitoring of patients to avoid breaches.

- Late referral of patients into and out of the trust.

62 Day Standard: Immediate Actions being undertaken

- Diagnostic demand and capacity review as part of the TCST Pan London Programme.

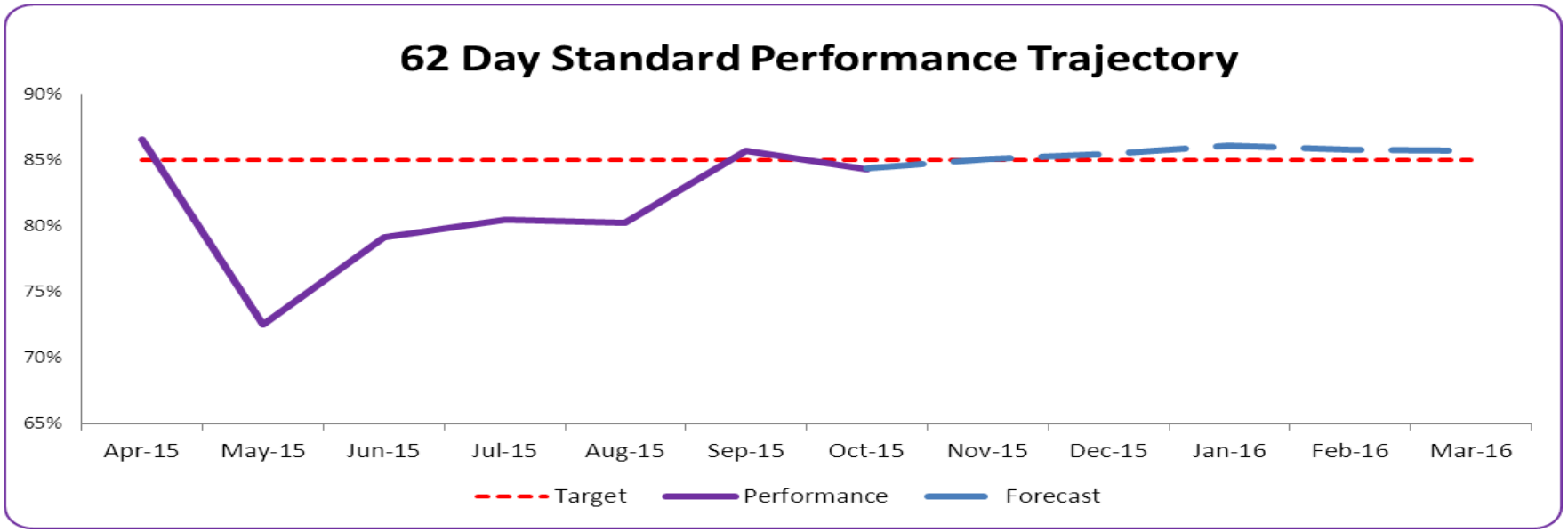
- Active tracking and monitoring to avoid breaches.
    - Started work on the development of an automated 62 Day PTL using Infoflex.
    - Weekly PTL meetings in place.
    - Begun training MDT co-ordinators on use of PTL and tracking requirements.
    - Weekly review of all patients waiting 104+ days by Chief Nurse, Medical Director and Chief Executive.
    - Weekly conference calls with referring trusts to discuss shared pathways and IPT compliance.
    - Active recruitment process underway for 2 additional MDT co-ordinators to allow more time for tracking and real time management and escalation.

- MDT meetings – plans were also made over the Xmas / New Year period by each tumour type to provide an MDT meeting each week to avoid any delays in discussing patients and agreeing treatment plans. The Cancer Clinical Directorate will ask for plans for Easter cover to be planned in the same way.

- Weekly telephone calls with all partner trusts are established to track patients on shared pathways. This gives visibility of the whole pathway to both trusts. We will also be sending weekly lists of all ITTs sent between trusts in SW London. This is to address both patients coming into and out of the trust and to discuss issues pertaining to late referrals and then to subsequently expedite to prevent breaches.

62 Day Standard – Immediate Next Steps

- Continue weekly performance meetings and IPT conference calls.
- Review outputs of Diagnostic demand and capacity review and develop action plan for implementation.
- Establish the new centralised process to track, manage and escalate IPT patients going out of the trust, to ensure they are sent within the 42day best practice threshold.
- Develop a centralised process to track, manage and escalate IPT patients coming into the trust, to ensure they are treated within 20 days of receipt of referral.
- Achieve 85% compliance against IPT 42day transfer standard.



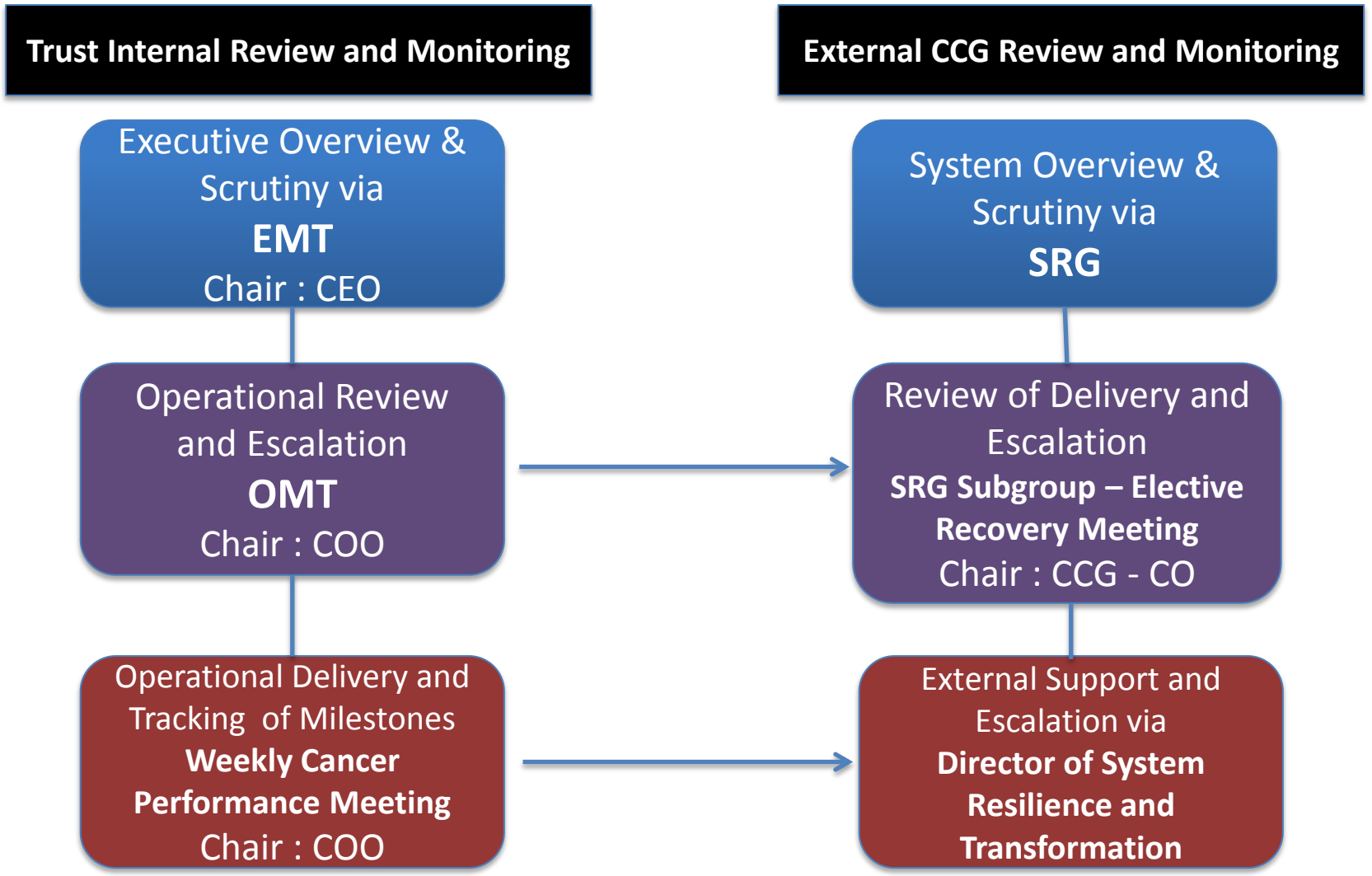
**** Trajectories by tumour type are detailed in appendix b.***

62 Day Standard – Patients Waiting Greater than 104 Days

- Weekly review of all patients waiting 104+ days by Chief Nurse, Medical Director and Chief Executive.
- Chief Operating Officer discusses each patient individually with the relevant specialty at weekly Cancer Performance meeting to ensure plans to treat the patient are in place and expedited.
- Clinical harm review and assurance an integral part of the process.

- Current position is as follows:
  - 18 patients waiting greater than 104 days.
  - All patients have been reviewed at the weekly MDT.
  - 9 of the 18 patients have a long wait due to patient choice.
  - 5 complex patients some with multiple co-morbidities requiring assessment or treatment prior to being able to schedule for surgery.
  - 4 patients referred late into the trust. i.e. after day 42.
  - 1 patient delayed due to administrative reasons.

Governance



- All patients on a PTL that is produced twice weekly with an action for each patient within timed element of pathway.

Performance Tracking and Reporting

- Cancer Performance by Tumour Type is reviewed monthly via Cancer Performance scorecard and reported to Trust Board.

- Currently further developing a suite of monitoring reports in line with SRG – Elective Recovery Sub-group. This includes:
  - TWR:
    - Number of patient on the waiting list and time bands with and without a appointment.
    - Patient DNA and Cancellation rates.
    - TWR referral rates by week.
    - Month to date unvalidated performance.
    - Performance against trajectory.

  - 62 Day Standard:
    - Unify Weekly PTL overview detailing number of patients waiting with and without a decision to treat.
    - Profile of current 62day waits by tumour type and days wait with and without a DTT.
    - Number of IPT patients referred in and out of the trust and compliance against the 42day standard.
    - Review and confirmation of Executive overview and assurance of all patients waiting greater than 104 days.
    - Review of patients waiting greater than 104 days at trust Clinical Quality Review Group meeting. Chaired by CCG Lead GP.
    - Performance against trajectory.

Risks and Mitigation

Risks	Mitigation
Clinical Risk for patients	Robust tracking of every patient by speciality teams and MDT tracker for every tumour type Internal governance structure including weekly cancer performance, weekly MDT's and robust escalation and overview by COO. Weekly report any patient over 104 days to CEO. MD and Chief Nurse
Out Patient Capacity	Out patient improvement programme includes identifying additional; capacity and transforming administration processes- weekend lists and evening lists
Diagnostic capacity	Undertaking demand and capacity review as part of the TCST Pan London review
Recruitment of clinical staff including CNS; s consultants and diagnostic staff	Recruiting plans by individual specialities and use of locum cover were necessary. Macmillan pilot of medical support workers to compliment the work of CNS's to commence in April 2016
Level of change required in action plan	Training, recruitment and accountability responsibility framework . Robust governance for delivery of plan, COO is SRO
Theatre Capacity	Prioritisation of cancer patients over elective and routines in the event of theatre cancellations and use of IS Weekend Lists in place were necessary i.e. Urology, Head and Neck
Financial Turnaround plan	Cancer a priority at board level for investment

Sustainable Delivery of Standards: Key issues

The Trust has collated a revised action plan to focus on the following domains:

Intelligence: Data visibility and tracking

Current Issues:

14 Day Standard

- Lack of daily PTL, to allow for pro-active daily management and demand forecasting. A key issue for this is technical development of Infoflex and synergy between trust PAS systems
- No robust performance forecasting reports in place, to allow for early performance escalation. This is due to system constraints between two different PAS systems (i.e. St Georges and QMH) and Infoflex for central cancer reporting.
- Current workaround to provide capacity alerts is significantly manual.

62 Day Standard

- Lack of robustness of PTL - key fields such as automated DTT and date fields not in place
- PTL heavily reliant on manual validation and completion.
- Patients transferred from other Trusts not visible on PTL, due to late referrals and lack of adherence to IPT policy.
- Late transfer of patients from St Georges to other providers

Actions being taken:

Daily automated TWR PTL

+

Daily TWR performance and escalation report

+

Enhancement of Infoflex standard build to improve functionality and to establish automated links between Trust PAS systems and Infoflex

+

Enhanced 62 day PTL : Included DTT and TCI fields.

Increased automation of PTL.

Increased real time data entry via MDT process.

Enhanced process to ensure patients are referred out in a timely manner

+

Hygiene Factors:

Standardised protocols for BAU validation to ensure accuracy of PTLs

Booking Processes and Escalation

Current Issues:

14 Day Standard

- TWR office issues: Need to increase physical office space and staff establishment to meet demand and decrease turnaround times
- TWR office staff booking outside breach date
- Manual escalation of capacity shortfall by TWR office. This is not pro-actively forecasted and escalated by GMs using automated reporting
- TWR office using 14 day booking window as standard, thus little tolerance patient cancellations
- Lack of visibility of patient pathways and outcomes for QMH

62 Day Standard

- Late referrals from other Trusts and incorrect referral process followed by other trusts.
- Late referrals going from St Georges to other Trusts.
- Lack of flexibility in Diagnostic pathways
- Lack of visibility of patient pathways and outcomes for QMH

Actions being taken:

Relocation of TWR office to Trident House, to allow for increase in team size +

Revised escalation protocol to include: No bookings permitted past breach date without permission from General Manager +

Daily TWR PTL to allow for monitoring of referral patterns and early actioning of potential capacity shortfalls +

Reduce booking window standard to 7 – 10 days. +

Review diagnostic pathways escalation process +

Improve adherence with IPT policy from other trusts through enhanced communication and engagement and also internally for patients going out. +

Undertake diagnostic demand and capacity modelling exercise as part of national programme +

Integration of QMH and St Georges PAS datasets to allow for visibility for all patients across all sites. +

Staff training needs assessment and subsequent training resources to allow for best practice.

Capacity : Non-clinical staffing

Current Issues:

14 & 62 Day Standard

- TWR office vacancies - 1 is existing vacancy and 1 is a new post.
- MDT Vacancies x 2 : need to increase staff to allow for better tracking.
- Lack of I-Clip back office resource to build clinic templates, for both substantive and ad-hoc capacity
- Cancer data team under resourced due to maternity leave and constraints on temporary staff
- Limited central informatics support and development for cancer data and reporting

Actions being taken:

Recruitment to all vacancies + Clear recruitment plans and timelines need to be in place + Temporary staff to cover maternity leave in the cancer data team + Increased technical resource to develop and build PTLs and reporting infrastructure + I-Clip back office development resource plan.

Capacity : Clinical staffing

Current Issues:

14 & 62 Day Standard

- Consultant Vacancies in: Dermatology, Gynae, Upper GI, and Breast
- High Level of CNS vacancies.
- Lack of clinical capacity in Radiology, impacting on reporting turnaround.
- Lack of clinical capacity in Pathology impacting on turnaround of reporting and histology

Actions being taken:

Recruitment to all clinical vacancies + Clear recruitment plans and timelines need to be in place. + Temporary arrangements to cover shortfall. + Diagnostic demand and capacity as part of national programme review to identify any shortfall and particular constraints impacting on turnaround times. + Review SWL pathology recovery plan.

Capacity – OP Slots & Theatre Availability

Current Issues:

14 & 62 Day Standard

- OP capacity shortfall identified following TWR demand and capacity modelling
- Constraints in substantive clinic build development.
- Constraints and lateness of ad-hoc clinic availability.
- OP nursing support for ad-hoc TWR clinics.
- Theatre capacity constraints following theatre closures due to essential repairs and planned maintenance

Actions being taken:

Building of substantive TWR capacity at 85% of average weekly demand. +

Schedule of interim ad-hoc clinics to cover shortfall until substantive development complete. Ensure ad-hoc clinics are scheduled in advance to allow a reasonable window for booking and attendance. +

Executive agreement that TWR capacity scheduling will be prioritised by corporate outpatients. +

Cancer patients are to be prioritised for theatre capacity where available. +

Engagement and utilisation of the IS where clinically appropriate. +

Plan to undertake additional activity to bring down average wait times to sustainable position

Cancer - 14 Day and 62 Day Performance Recovery and Sustainability Action Plan

SGHUFT - Cancer Performane Recovery and Sustainability Action Plan

St George's University Hospitals NHS
NHS Foundation Trust

V 1.2

Domain	Issue	Solution	Action Ref:	Action Required	Additional Resource Required?	Commissioner Penalty Re-investment requested	Exec / Divisional Lead	GM Responsible	Target Date	RAG Rating	Success Criteria	Interim Actions/Comments
Data Visibility and Tracking	Lack of daily PTL, to allow for pro-active daily management and demand forecasting. A key issue for this is technical development of Infoflex and synergy between trust PAS systems	Develop a daily automated TWR PTL	1.1	Identification of fields to be mapped from PAS to Cancer Infoflex system and to develop data extract for integration into Infoflex. Fields which need to be mapped are: Date 1st Seen Confirmed Appointment Date Rescheduled Appointment Date (if DNA, resched etc)			J-J Cambell	J Lawrence	15/01/2016		Data fields for mapping identified and accessible.	TWR Tracking - Weekly PTL in place and circulated to all GMs and TWR office. -Daily escalation email from TWR office to GMs with regards to additional capacity required by specialty. -GM review and prior-authorisation for any patients to be booked outside of breach date with the exception of patient choice.
			1.2	Test and validate PAS dataset to ensure correct fields for mapping are being pulled through. Review data completeness of fields assess level of content being captured. Once confirmed set-up data migration process to Infoflex provider.	Y	Y - to bring in a technical analyst and a Cancer Project manager to work alongside Infoflex and Cancer Data team to work on PTL development end to end. (FT Band 7 - 12m = 55k x 2)	J-J Cambell	J Lawrence	29/01/2016		Successful data extract with identified fields being pulled. High level of data completeness for the extract.	
			1.3	Infoflex provider to undertake technical build intergrating PAS data extract with infoflex			J-J Cambell	S East / L Pilling	19/02/2016		Data extract fields linked to Infoflex system with new fields now accessible as part of trust Infoflex dataset.	
			1.4	New Infoflex data structure/ dataset testing and PTL front end build.	Y	As 1.2	J-J Cambell	S East / L Pilling	04/03/2016		New data fields visible, with data coming through and accessible for reporting.	
	No robust performance forecasting reports in place, to allow for early performance escalation. Current workaround to provide capacity alerts is significantly manual.	Daily Automated TWR Performance and escalation report	2.1	Development of standard daily report from new data extract following action 1.3. Daily automated report to be standardised as part of daily PTL reporting.	Y	As 1.2			11/03/2016		Daily PTL and TWR report will detail: All patients waiting on TWR pathway with and without an appointment and by wait bands. All patients booked outside breach date with comments/reason (Patient choice) Referral Trends - last 7 days vs rolling average. Current unvalidated performance MTD	Month to Date unvalidated performance is now being reviewed weekly to assess forecasted delivery of target and to allow early escalation of additional actions for early performance recovery. This is a manual process and subject to a DQ margin but is providing improved awareness of current performance position. This unvalidated position will also be discussed with commissioners at the weekly SRG - elective recovery meetings.
	System constraints between two different PAS systems (i.e St Georges and QMH) and Infoflex for central cancer reporting.	Enhance tracking of QMH patients on Infoflex.	2.2	TWR administrator at QMH to be trained on Infoflex to update system for TWR PTL (in particular data completeness for Date 1st Seen and DNA).			C Cox	L Pilling	15/01/2016		Increase in data completeness for key fields in Infoflex for QMH patients allowing for enhanced tracking and review.	
			2.3	Sustainable long term action is full Integration of QMH an SGH PAS systems.	Y	Y - to fund additional IT equipment, and software implementation. Approx Cost = £750k	J-J Cambell	S East	30/10/2016			A Full Business Case has been presented to the Trust Board and approved. This is currently awaiting prioritisation as part of the trust capital programme.
		Integration of QMH and SGH Clinical Teams for Breast, Urology and Dermatology.	2.4	Centralise management team for both sites which will improve flexibility in capacity and visibility of patient pathways.			P Vasco-knight	K Lennon / D Treanor	15/01/2016		Reduced requests for ad-hoc capacity. Reduction in number of avoidable breaches	
	Lack of robustness of 62 Day PTL - key fields such as automated DTT and date fields not in place	Enhancement of Infoflex standard build to improve functionality and to establish key fields	3.1	Review and re-build 62 day PTL to include key fileds DTT, and TCI	Y	As 1.2	C Cox	L Pilling	22/01/2016		-Improved tracking and analytical reports -Increased accuracy of Unify returnds. -Reduction in patient pathway length and breaches. -Early escalation of potential breach patients.	
			3.2	MDT Co-ordinators/ clinical staff to update Infoflex in real time post MDT and post clinic.			C Cox	L Pilling	31/03/2016			At present we wait for letter and then update. This ideally should be updated at the end of the clinic. Also, free text field limits degree of analysis that can be undertaken. Additional fields from action 3.1 will support this.
			3.3	Training session for all staff with regards to the new 62 day PTL build and entry requirements for additional fields. This is to be reviewed weekly by monitoring data completenss of key fields in weekly PTLs			C Cox	L Pilling	21/01/2016			
		Executive overview of all long waiters on a 62 day pathway - i.e waits > 104 days	3.4	Weekly review by Chief Nurse/MD of individual patient pathways to ensure that risk of harm has been assessed and is being managed. Weekly sign off of patient listing by CEO.			P Vasco-knight	L Pilling	In Place			
	PTL heavily reliant on manual validation and completion.	Enhancement of Infoflex standard build to improve functionality and to establish automated links between Trust PAS systems and Infoflex	4	This will be resolved by above mentioned actions 1-2			J-J Cambell	-	31/03/2016			
	Patients transferred from other Trusts not visible on PTL, due to late referrals and lack of adherence to IPT policy.	Improve adherence with IPT policy from other trusts through enhanced communication and engagement and also internally for patients going out	5.1	Weekly conference calls with referring Trusts in the sector to raise issues and agree actions.			P Vasco-knight	L Pilling	In Place		Reduction in the number of patients received after day 42 and subsuquent shared breaches.	
		Implement new breach re-allocation policy.	5.2	Implement new breach re-allocation policy. This will serve as a driver to enhance compliance with IPT policy.			P Vasco-knight	L Pilling	01/04/2016		Improved performance reflective of actual trust attributable position.	
		Commissioner system wider action on reducing number of late referrals	5.3	Raise with commissioners on-going issues requiring escalation.			P Vasco-knight	I Hussain/ Lila Pilling	On-going		Improved referral processes from peer providers with a reduction in the number of patients received after day 42 and subsuquent shared breaches.	
	Late transfer of patients from St Georges to other providers	Reduce number of patients referred from St Georges to other providers after day 38.	6	Develop a weekly report detailing all IIT patients sent out from St Georges, with a root cause review of any patients who breach 38 days. Implement any actions arising from RCA.			P Vasco-knight	L Pilling	On-going		Reduction in the number of patients referred out after day 42 and subsuquent shared breaches.	The Trust will action key causes arising out of RCAs for patients referred after 38 days.

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Domain	Issue	Solution	Action Ref:	Action Required	Additional Resource Required?	Commissioner Penalty Re-investment requested	Exec / Divisional Lead	GM Responsible	Target Date	RAG Rating	Success Criteria	Comments
Booking Processes and Escalation	TWR office issues: Need to increase physical office space and staff establishment to meet demand and decrease turnaround times	Relocation of TWR office to Trident House, to allow for increase in team size	7.1	Secure office space at Trident House to accommodate TWR team			P Vasco-knight	L Pilling	07/01/2016		TWR office relocated and operation at Trident House	
			7.2	Refurbishment of offices so they are fit for purpose and agree a move in date.			P Vasco-knight	L Pilling	29/01/2016			Provisional move in date 15/02/2015
	TWR office staff booking outside breach date	Reduce patients booked after breach through improved escalations.	8	Implement revised escalation protocol to include: No bookings permitted past breach date without permission from General Manager			P Vasco-knight	L Pilling	In Place		Reduction in the number avoidable TWR breaches with a correlated increase in performance.	Implemented 11/12/2015
	Manual escalation of capacity shortfall by TWR office. This is not pro-actively forecasted and escalated by GMs using automated reporting	Daily TWR PTL to allow for monitoring of referral patterns and early actioning of potential capacity shortfalls	9	Each tumour type to review capacity prospectively on a daily basis in line with current demand using new PTL and action accordingly.			P Vasco-knight	L Pilling	01/04/2016		Reduction in the number of avoidable breaches. Reduction in average wait times. Reduction in number of ad-hoc clinics scheduled	Currently this is dependant on the TWR office manually escalating each issue to respective GMs via email.
	TWR office using 14 day booking window as standard, thus little tolerance patient cancellations.	Reduce booking window standard to 7 – 10 days	10.1	Re-do demand and capacity modelling with reduced parameters of 10 days to identify: a. immediate additional capacity required to bring waits down. B. long term substantive capacity required to sustain new booking window.			P Vasco-knight	L Pilling	26/02/2016		Reduction in average wait times. Reduction in capacity related breaches. Improved escalation window.	
			10.2	Pilot feasibility of running generic TWR clinics at weekends to provide improved accessibilty for working patients and reduce DNA's, cancellations and waiting times.			C Cox	GM's	31/03/2016		Reduction in: - patient related breaches -DNA rates -patient cancellation rates	
		Implement E-triage for all TWR patients to allow for faster turnaround of referrals that require triage prior to booking 1st OP appointment/test.	10.3	E-triage roll-out to all clinical services and TWR team.			J-J Cambell	I Frost	Complete		Improved escalation of patients. Reduction of inappropriate patients on a TWR pathway.	
			10.4	TWR office to be fully trained on E-triage system			J-J Cambell	I Frost	31/01/2016			
	Lack of flexibility in Diagnostic pathways	Improved flexibilty in diagnostic pathways in times of increased demand.	11.1	Review diagnostic pathways escalation process to avoid long waits in the diagnostic phase of the pathway.			S Briggs	J Fisher	31/01/2016		Reduction in breaches due to diagnostic capacity.	
		Ensuring diagnostic capacity is in line with demand.	11.2	Undertake diagnostic demand and capacity modelling exercise as part of TCST led national programme.			S Briggs	J Fisher	22/01/2016			
	New Cancer access policy currently being developed to include guidance from 'Going Further on Cancer Waits' Version 9	Adherence to cancer access policy across the trust	12.1	Undertake a staff training needs assessment.			C Cox	L Pilling	31/01/2016			
			12.2	Develop training resources for comprehensive understanding and implementation of new policy and associated operational processes.			C Cox	L Pilling	12/02/2016			
			12.3	Agree a training schedule			C Cox	L Pilling	12/02/2016			

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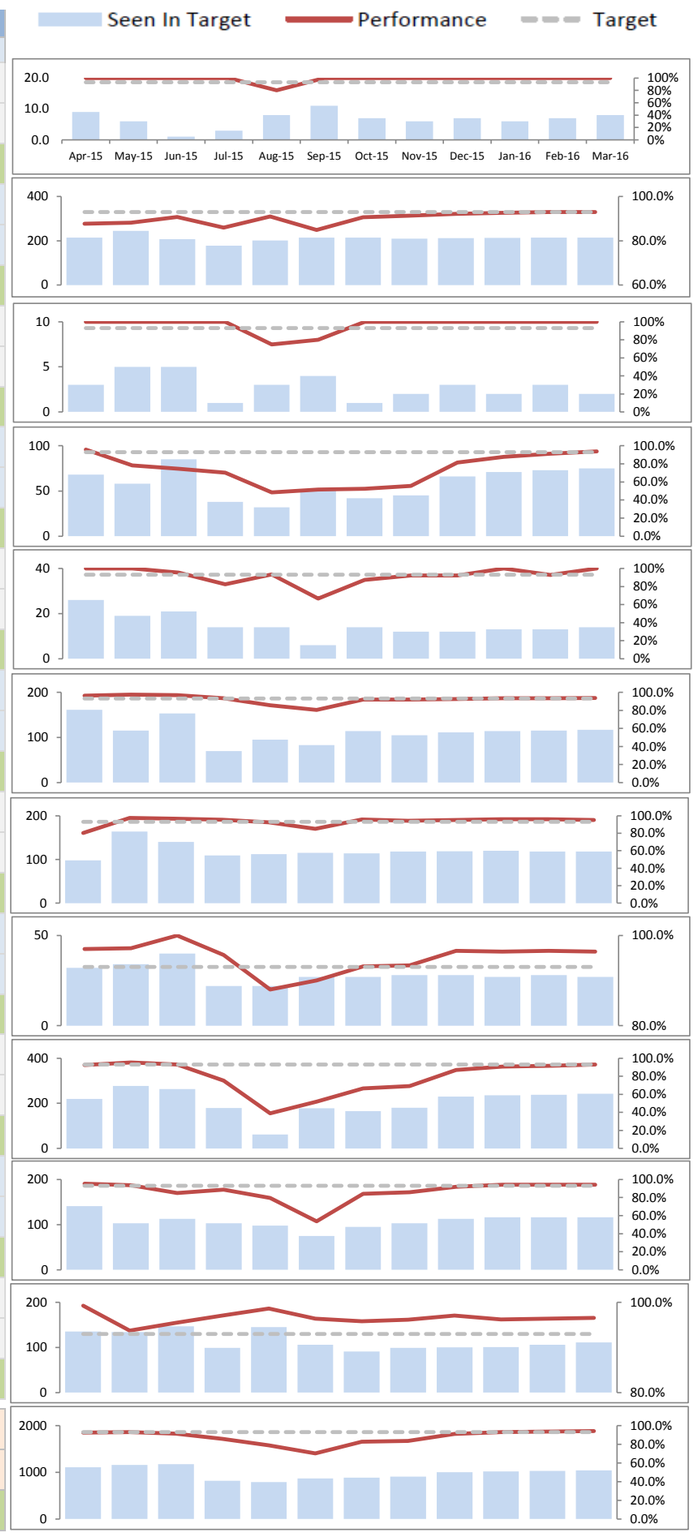
Domain	Issue	Solution	Action Ref:	Action Required	Additional Resource Required?	Commissioner Penalty Re-investment requested	Exec / Divisional Lead	GM Responsible	Target Date	RAG Rating	Success Criteria	Comments
Non Clinical Staffing	TWR office vacancies - 1 is existing vacancy and 1 is a new post.	Recruit to existing vacancy of Cancer Standards Assistant	13.1	Approve vacancy and put out for advert			C Cox	L Pilling	Complete		-Improved tracking and escalation of Cancer patients. - Improved Cancer reporting. -Increased visibility and earlier escalation of performance issues. -Improved performance against national standards	Approved 17/11, out for advert. Interview by 07/01/2015
				Interview and appoint					07/01/2016			
		Recruit to new post - Cancer Standards Assistant	13.2	Approve vacancy and put out for advert								Approved 17/11, out for advert. Interview by 07/01/2015
				Interview and appoint					07/01/2016			Forecast start date March
	MDT Vacancies x 2 : need to increase staff to allow for better tracking.	Clear recruitment plans and timelines need to be in place	14	Approve vacancy and put out for advert					14/01/2016		-Improved tracking and escalation of Cancer patients. - Reduction in avoidable delays in patient pathways. -Improved performance against national standards	1st vacancy approved, interviewed, and offered. Awaiting acceptance and agreed start date. 2nd vacancy approved by DDO in principal. Scheduled to to go to vacancy panel in January for Exec approval prior to advertisement..
				Interview and appoint					01/03/2016			
	Lack of i-Clip back office resource to build clinic templates, for both substantive and ad-hoc capacity	To have sufficient i-Clip back office resource to undertake clinic build development.	15	Recruit additional i-Clip back office staff. 4 x Band 5	Y	Y - i-Clip back office resource 4 x Band 5 = £	J-J Cambell	S East	01/05/2016		-substantive ring- fenced TWR capacity. -Reduction in number of ad-hoc clinics.	
	Cancer data team under resourced due to maternity leave and constraints on temporary staff	Recruit temporary Cancer Data Officer to cover maternity leave in the cancer data team	16	Approve vacancy and put out for advert	Y	Y - Fixed term Cancer Data Officer Band 5 - 6m	C Cox	L Pilling	15/01/2016			HRI vacancy approval form submitted to the trust Vacancy Control Panel for approval for a 6 month fixed term position.
				Interview and appoint					12/02/2016			
	Limited central informatics support and development for cancer data and reporting	Increased technical resource to develop and build PTLs and reporting infrastructure	17.1	Recruit a dedicated Information Analyst for Cancer within the Informatics team. This individual will also be the interface between cancer services and the central information team.	Y	Y- As per action 1.2	J-J Cambell	I Hussain / A Thomas	19/02/2016			This is dependant on securing funding. The individual will also co-ordinate the development and on-going enhancement of cancer reporting and intelligence within the organisation.
			17.2	Develop a suite of automated reports/Dashboards to support operational delivery of cancer targets and on-going performance assessment			J-J Cambell	I Hussain / A Thomas	30/04/2016			
		Pro-active planing for management and implementation for Open Exeter Cancer Reporting System Replacement	17.3	Develop a project plan and identify Informatics/IT resource for implementation of the new system.			J-J Cambell	TBC	TBC			Provisional national go-live date is April 2017

Domain	Issue	Solution	Action Ref:	Action Required	Additional Resource Required?	Commissioner Penalty Re-investment requested	Exec / DDO Lead	GM Responsible	Target Date	RAG Rating	Success Criteria	Comments
Clinical Staffing	Consultant Vacancies in: Dermatology	Recruit to Vacancy	18.1	Approve vacancy and put out for advert			F Ashworth	D Treanor	Complete		Reduction in breaches due to clinical capacity constraints. Improved performance in respective tumour groups.	Interviewed and appointed. Awaitng confirmation of a start date.
				Interview and appoint					Complete			
	Consultant Vacancies in: Gynae	Recruit to Vacancy	18.2	Approve vacancy and put out for advert			S Colas	E Lloyd	Complete			
				Interview and appoint								
	Consultant Vacancies in: Upper GI	Recruit to Vacancy	18.3	Approve vacancy and put out for advert			F Ashworth	D Treanor	Complete			Interviewed and appointed. Awaitng confirmation of a start date.
				Interview and appoint					Complete			
	Consultant Vacancies in: Breast	Recruit to Vacancy - Maternity Cover 12 months	18.4	Approve vacancy and put out for advert			C Cox	K Lennon	Complete			Consultant to cover maternity leave interviewed and appointed. Start date agreed for Mid - February.
				Interview and appoint					Complete			
	High Level of CNS vacancies and increase in establishment required following LCA CNS Review	Recruit a Lead Cancer Nurse to provide leadership and guidance to all Clinical services and to support specialties in their recruitment plans	19.1	Approve vacancy and put out for advert			J Hall	H Tonge			Enhanced nursing leadership for Cancer Services	
			19.2	Interview and appoint								
		To provide extra support to CNS staff to free up time for higher level clinical input to patient pathways	19.3	Implement Macmillan Support Service to directly support CNS work	Y	N - Funding from Macmillan for 18 months agreed	J Hall	H Tonge	01/04/2016		Improved management of patient pathways and reduction in avoidable delays.	
		Recruit additional CNS Staff for Urology, Heamatology and Lower GI	19.4	Approve vacancy and put out for advert					Complete		-Improved tracking of patient pathways. -Increased support for patient decision making. -Reductions in patient pathway lenghts by reducing avoidable delays, patient cancellations, and DNAs	Vacancies approved and are currently out for advert. The success of this action is largely dependant on the nature and number of applicants received. These a challenging vacancies to recruit to.
				Interview and appoint					01/04/2016			
	Lack of clinical capacity in Radiology.	Diagnostics to ensure sufficient clinical capacity in place to meet cancer demand in line with national targets.	20	Undertake diagnostic demand and capacity modelling exercise as part of TCST led national programme to support in identifying any shortfall and particular constraints impacting on turnaround times			S Briggs	J Fisher	05/02/2016			Deadline for submission of D&C review is 22/01/2015. A subsequent workshop to review this by the TCST is scheduled for 26/01/2016.
	Lack of clinical capacity in Pathology impacting on turnaround of reporting and histology	To improve reporting turnaround times to allow patients to be discussed at the earliest possible MDT	21	SWL Pathology to review and monitor turaround times for reports to allow for escalation and to feedback to the Cancer Directorate on key issues.			F Ashworth	J Owen	In Place		-Reduction in turnaround times for histology. -Reduction in number of long waiters reported due to awaiting histology reporting.	Turnaround times are improving.
	SWLP - Shortfall in clinical capacity due to vacancies	Temporary arrangements to cover shortfall	22	Recruit Locum staff to cover shortfall			F Ashworth	J Owen			Reduction in turnaround times for histology reporting.	

Domain	Issue	Solution	Action Ref:	Action Required	Additional Resource Required?	Commissioner Penalty Re-investment requested	Exec / Divisional Lead	GM Responsible	Target Date	RAG Rating	Success Criteria	Comments
Capacity - OP Slots & Theatre	OP capacity shortfall identified following TWR demand and capacity modelling	To have substantive and ring-fenced OP capacity at 85% of average weekly TWR demand.	23.1	Undertake Demand Capacity modelling to identify specialites where OP capacity is less than 85% of average weekly referrals			P Vasco-knight	All GMs	Complete		Capacity shortfalls identified by Tumour Groups	
			23.2	Build substantive templates for ring-fenced TWR capacity as per the D&C modelling.			J-J Cambell	S East	01/03/2016		-substantive ring- fenced TWR capacity. -Reduction in number of ad-hoc clinics.	This has been given increased priority with a build commencement date of 01/03/2016. This will require identification appropriate clinical staff to undertake activity, which may result in additional recrtuiment of staff being needed.
	Constraints in substantive clinic build development.	Schedule Ad-hoc capacity until substantive templates are built	24.1	Gynae - additional 24 slots per week			S Colas	E Lloyd	In Place		Reduciton in capacity related breaches. Reduction in average wait times. Increased performance by Tumour Group to target	
			24.2	Skin - additional 12 slots per week			F Ashworth	D Treanor	In Place			
			24.3	Upper GI - additional 18 slots per week			F Ashworth	D Treanor	In Place			
	Shortfall in Endoscopy capacity to allow patients to go straight to test.	Increase TWR capacity for Lower GI by allowing greater number of patients to go through the straight to test pathway,	25.1	Two additional Endoscopy rooms to be built			F Ashworth	D Treanor	TBC			
			25.2	Undertake additional weekend Endoscopy lists.			F Ashworth	D Treanor	In Place			
	Constraints and lateness of ad-hoc clinic availability.	Schedule of interim ad-hoc clinics to cover shortfall until substantive development complete. Ensure ad-hoc clinics are scheduled in advance to allow a reasonable window for booking and attendance	26.1	To ensure ad-hoc clinics are scheduled with a 5 day window			P Vasco-knight	All GMs	On-going		Reduciton in patient DNA rates Reduction in patient cancellation rates.	
			26.2	Implement revised protocol for substitutional activity to cover cancelled Clinics during bank holidays and consultant leave. As part of the protocol substitutional activity planning is undertaken 6 weeks in advance.			P Vasco-knight	L Pilling	In Place		Stability and maintenance of waiting times following periods of bank holiday and consultant leave.	This was undertaken and was successful over the Christmas period where all specialties had plans in place to undetake substituional capacity for all clinics lost to prevent an increase in waiting times beyond target.
	OP nursing support for ad-hoc TWR clinics.	To increase ad-hoc clinical availabilty.	27	COO to agree with the Chief Nurse to allow OP clinics to go ahead with HCA support where OP nurse unavailable.			P Vasco-knight	L Pilling	In Place		Improved turnaround time in scheduling ad-hoc clinics. Reduction in patient cancellation and DNA rates for ad-hoc clinics	This has now been agreed and is in place.
	Theatre capacity constraints following theatre closures due to essential repairs and planned maintenance	Cancer patients are to be prioritised for theatre capacity where available.	28	Revised Escalation process - Clinical Director to review all potential cancellations of patients on a 62 day pathway and the status of their pathway prior to prioritise and authorise accordingly.			P Vasco-knight		In Place		Reduction in hospital cancellations for cancer patients due to non-clinical reasons.	
	IS Capacity to help improve backlog position	Engagement and utilisation of the IS where clinically appropriate.	29	Specialties to identify appropriate cases for the IS sector and to engage with the IS providers and PMO to identify suitable capacity. This is also to include the displacing of RTT activity from in-house to the IS to allow for more complex Cancer Pathway cases to be undertaken.			P Vasco-knight	All GMs	On-going			Trust is facing difficulty in securing IS capacity as part of the RTT PMO agreements. The Trust is escalating to and working with the PMO to unlock capacity and identify alternative options.

14 Day Pathway Trajectory by Tumour Site

Target 93%		Actual Performance							Forecast					
14 Day Pathway		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Brain CNS	Seen In Target	9.0	6.0	1.0	3.0	8.0	11.0	7.0	6	7	6	7	8
	Referrals	9.0	6.0	1.0	3.0	10.0	11.0	7.0	6	7	6	7	8
	Performance	100%	100%	100%	100%	80.0%	100%	100%	100%	100%	100%	100%	100%
Breast	Seen In Target	215.0	245.0	207.0	178.0	202.0	214.0	214.0	210	212	213	214	214
	Referrals	245.0	278.0	228.0	207.0	222.0	252.0	236.0	230	230	230	230	230
	Performance	87.8%	88.1%	90.8%	86.0%	91.0%	84.9%	90.7%	91.3%	92.2%	92.6%	93.0%	93.0%
Childrens	Seen In Target	3.0	5.0	5.0	1.0	3.0	4.0	1.0	2	3	2	3	2
	Referrals	3.0	5.0	5.0	1.0	4.0	5.0	1.0	2	3	2	3	2
	Performance	100%	100%	100%	100%	75.0%	80.0%	100%	100%	100%	100%	100%	100%
Gynae	Seen In Target	68.0	58.0	85.0	38.0	32.0	51.0	42.0	45	66	71	73	75
	Referrals	71.0	74.0	114.0	54.0	66.0	99.0	80.0	81	81	81	80	80
	Performance	95.8%	78.4%	74.6%	70.4%	48.5%	51.5%	52.5%	55.6%	81.5%	87.7%	91.3%	93.8%
Haem	Seen In Target	26.0	19.0	21.0	14.0	14.0	6.0	14.0	12	12	13	13	14
	Referrals	26.0	19.0	22.0	17.0	15.0	9.0	16.0	13	13	13	14	14
	Performance	100%	100%	95.5%	82.4%	93.3%	66.7%	87.5%	92.3%	92.3%	100%	92.9%	100%
Head & Neck	Seen In Target	161.0	115.0	153.0	70.0	95.0	83.0	114.0	105	111	114	115	117
	Referrals	167.0	118.0	158.0	75.0	111.0	103.0	124.0	114	120	122	123	125
	Performance	96.4%	97.5%	96.8%	93.3%	85.6%	80.6%	91.9%	92.1%	92.5%	93.4%	93.5%	93.6%
Lower GI	Seen In Target	98.0	164.0	140.0	109.0	112.0	115.0	114.0	118	119	120	118	118
	Referrals	122.0	168.0	145.0	114.0	121.0	135.0	119.0	125	125	125	123	124
	Performance	80.3%	97.6%	96.6%	95.6%	92.6%	85.2%	95.8%	94.4%	95.2%	96.0%	95.9%	95.2%
Lung	Seen In Target	32.0	34.0	40.0	22.0	22.0	27.0	27.0	28	28	27	28	27
	Referrals	33.0	35.0	40.0	23.0	25.0	30.0	29.0	30	29	28	29	28
	Performance	97.0%	97.1%	100.0%	95.7%	88.0%	90.0%	93.1%	93.3%	96.6%	96.4%	96.6%	96.4%
Skin	Seen In Target	220.0	277.0	263.0	179.0	62.0	178.0	166.0	180	230	236	238	242
	Referrals	238.0	291.0	283.0	238.0	159.0	344.0	250.0	260	265	260	260	260
	Performance	92.4%	95.2%	92.9%	75.2%	39.0%	51.7%	66.4%	69.2%	86.8%	90.8%	91.5%	93.1%
Upper GI	Seen In Target	141.0	103.0	113.0	103.0	98.0	75.0	95.0	103	113	116	116	116
	Referrals	148.0	110.0	133.0	116.0	123.0	140.0	113.0	120	123	123	123	123
	Performance	95.3%	93.6%	85.0%	88.8%	79.7%	53.6%	84.1%	85.8%	91.9%	94.3%	94.3%	94.3%
Urology	Seen In Target	135.0	134.0	147.0	99.0	145.0	106.0	91.0	99	100	101	106	111
	Referrals	136.0	143.0	154.0	102.0	147.0	110.0	95.0	103	103	105	110	115
	Performance	99.3%	93.7%	95.5%	97.1%	98.6%	96.4%	95.8%	96.1%	97.1%	96.2%	96.4%	96.5%
Total	Seen In Target	1108.0	1160.0	1175.0	816.0	793.0	870.0	885.0	908.0	1001.0	1019.0	1031.0	1044.0
	Referrals	1198.0	1247.0	1283.0	950.0	1003.0	1238.0	1070.0	1084.0	1099.0	1095.0	1102.0	1109.0
	Performance	92.5%	93.0%	91.6%	85.9%	79.1%	70.3%	82.71%	83.76%	91.1%	93.06%	93.56%	94.14%



St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting: **TRUST BOARD** **14th January 2016**
Document Title: **Update on Outpatient additional activity income**
Action for the Finance & Performance Committee: To note the progress made on implementation of the additional activity.
Summary: Good progress has been made on implementation of the additional activity with £1.1m of the £1.6m of activity having identified clinics and consultants. A further £310k of activity should have clinics and consultants identified by the end of January. £164k will not be delivered due to the inability to recruit consultants
Author and Date: Paula Vasco-Knight 7 January 2015
Contact details: Tel: 0208 266 ???? E-mail: paula.vasco-knight@stgeorges.nhs.uk

Activity and income detail

Division	Speciality	OP recovery (patients) as of Nov 2015	Additional Clinics required in 2015/16 for Q4	Value	Notes	New Tarrif	FU Tarrif	Est Average	Current Booked	Notes
Med Card	Chest medicine	198	25	£ 34,413	2 additional Prof Jone	£ 186	£ 102	£ 174	£ 22,860	
	Dermtalogy	298	30	£ 35,184	0.6 WTE consultant from mid-January, not yet on iCLIP, will work across QMH too, still working through specifics. Had forecast additional B7 but no one has applied for post. **Waitlist clinics**	£ 104	£ 68	£ 118	£ 37,152	
	Diabetes/endocrinology	693	87	£ 76,022	full SpR compliment (clinics already on iCLIP) and additional locum consultant from December (2 brand new to be requested from OP tomorrow) - **Clinics permanent most already on the system others in progress**	£ 222	£ 99	£ 110	£ 34,215	Consultant not appointed £42k income shortfall
	Gatroenterology	1351	135	£ 190,249	new locum consultant was forecasted (has since pulled out of job) + 1 specialty doctor (all clinics approved, working across nelson also). **Mix of waitlist and permanent mostly on th esystem - others in progress**	£ 178	£ 101	£ 110	£ 88,160	Consultant not appointed £102k shortfall
	Lymphodema		16	£ 24,260	increase in ad hocs thr	£ 300	£ 300	£ 300	£ 15,600	
	Oncology	200	0	£ 42,000	built in to current clinics	£ 210	£ 91	£ 300	£ 42,000	Additional work to be undertaken in existing clin
Surgery and Neuro	ENT	No response	No response	£ -	Lila will provide tomorrow	£ 103	£ 62	tbc	£ -	All additional work already in run rate
Women and Children's	Gynae Ultrasound	72	8	£ 8,000	**clinics in the system**	--	--	£ 80		
	Gynae	1302	100	£ 377,190	half no. of clinics built, awaiting OP agreement	£ 131	£ 80	£ 110	£ 217,636	100 clinics required 43 booked 57 to book but consultants identiifed
Community	Community	3907	279	£ 450,314	seea ttached template	mixed	mixed		£ 292,479	800k in TRP 350 k assumed to be done in normal time as holidays used early in year. £150k of clinics still to identify consultant
Totals		**8021**	**680**	**£ 1,237,632**					£ 750,102	
									£ 517,364	Womens and CSD assumed deliverable
complete one row for each clinic type and or consultant										
ıch week date identify the number of clinics you will be delivering up to the end of March 2016									**£ 1,267,466**	

Key Points

- Of the £402k additional Medcard activity, £164k will not be delivered due to the inability to appoint consultants in Gastroenterology and Dermatology. The balance of activity has clinics built and consultants identified
- Surgery and Neuro had no additional activity as they had already recovered their shortfall in activity prior to the reforecast. As a result, their additional activity is already within their underlying run rate (ENT)
- Of CWDT's £385k of additional activity £218k of which have clinics built and consultants identified. The balance have clinics identified but need rooms identifying
- Of the £800k of additional Community activity £292k has clinics built and rooms booked, £350k of activity will be completed in the existing clinics as the majority of holidays have been utilised by staff although £150k of activity requires a consultant to be identified.

In summary of the £1,6m of additional activity, £164k will not be delivered due to the inability to recruit consultants, £1.1m of additional activity has either had new clinics built and consultants named or additional work identified into existing clinics. The balance of £160k of CWDT and £150k of Community still require a consultant to be identified.

excellent /
kind /
responsible /
respectful /

St George's University Hospitals NHS
NHS Foundation Trust

NHS
Wandsworth
Clinical Commissioning Group

NHS
Merton
Clinical Commissioning Group

NHS
Lambeth
Clinical Commissioning Group

St. George's University Hospital: "One Version of the Truth" for Emergency Care

Presentation Pack

9th December 2015

We have engaged over 50 stakeholders through individual and group discussions as well as existing forums

Groups and individuals who we have so-far engaged with as part of developing 'one version of the truth'

CCG Commissioners

Merton and Wandsworth CCG

- Lucie Waters
- David Freeman
- Graham Mackenzie
- Adam Doyle
- Diana Lacey (SRG)
- Anita Trayford

Council commissioners and providers

Merton, Wandsworth and Sutton

- Kerry Stevens
- Sydney Hill
- Jenny Rees
- Betty Evans
- Sandra Roche

Acute provider

St. Georges University Hospital

- Miles Scott
- Paula Vasco-Knight
- Eric Munro
- Martin Wilson
- Simon Mackenzie
- Jennie Hall
- Brendan McDermott
- Daniel Camp
- Matt Parkes
- Bryony Elliot
- Bridget Kalber
- Mary White
- Michele Stenning
- Imran Hussain
- Phil Moss
- Fiona Ashworth
- Jason Fitch
- Chloe Cox
- Siobhan Burke
- Orlagh Flynn
- Elzbieta Cifonelli
- Ele Cerri
- Alison Fitzgerald
- Kim Johnson
- Harold Lo
- Helen Jones
- Emily Trembath
- Mary Prior
- Jennifer Randall
- Mick Sanders
- Heather Jarman
- Jane Wilson
- Clare Lucas
- Jane Evans
- Gemma Phillips
- Bridget Kalber
- Nadine Chhangur
- Ben Evans
- Helene Anderson
- Richard Billington[1]
- Susan Heenan
- Tunde Odutoye
- Lisa Pickering

Community healthcare providers

Merton, Wandsworth and Sutton

- Stuart Reeves
- Fleur Norwood
- Paul Courtman
- Debbie Lindon-Taylor

Other

External consultant (if any)

SRG Group

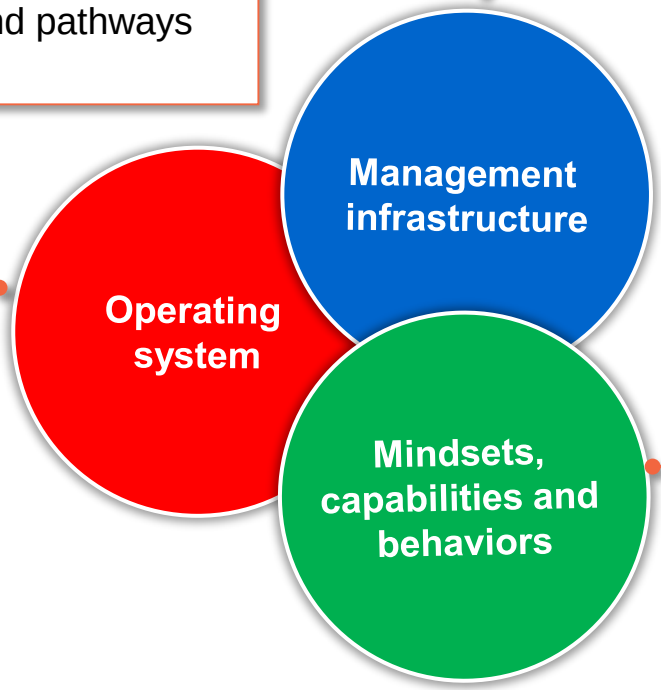
- Karen Haynes
- Beverley Limington
- Amanda Rimington
- Tom Coffey
- Viktoria Jeffries

ILLUSTRATIVE

Reminder: We think about hypotheses and potential actions by looking at three aspects of the emergency care pathway at SGH

"The way assets are configured and operated in order to produce outcomes" e.g.,

- Capacity (Theatre and beds)
- Demand patterns
- Patient flows
- Clinical protocols and pathways
- Staffing levels



"The formal rules and support systems that are put in place to enable the operating system to run effectively " e.g.,

- Organisational structure (e.g., divisions)
- Shift patterns
- Roles and responsibilities
- Performance management
- Weekly capacity meeting
- Incentives

"The way people approach their work and conduct themselves, given the nature of their tasks and constraints in which they operate"

- Ability to make change happen
- "Them and us" culture
- NIH - "Not Invented Here"
- The "art" of medicine
- Skill levels of key players

SOURCE: McKinsey Service Operations

Contents

One version of the truth: Summary Findings (1/5)

Context

St. George's 2014 performance against the 4-hour A&E target was frequently between 92% and 96%, with more than half the weeks from April to October above the 95% standard. Since November 2014, however, the 95% threshold has been missed consistently. Over the winter of 2014/15, performance dropped significantly with periods at 80-85%; ED attendances remained at the long term average but medical bed midnight occupancy rose steeply and held at 93-95%. Although performance has recovered during 2015, it has never returned to 2014 levels. 2015 has seen around 3% rises in ED attendance and reduced adult acute medical and surgical bed occupancy between April and September 2015. The operating challenges have a wide impact on the emergency pathway as a whole, with patients having to sleep in A&E, and outliers between medicine and surgery and causing delays throughout the system.

This diagnostic work's first aim was to establish a common understanding of the root causes of underperformance. This involved quantitative analysis and many visits and interviews across the healthcare system. The most important evidence from this investigation is in the analysis pages 12-70. Further comprehensive back up analysis of all factors is available in pages 72-235.

The diagnostic's second aim was to clearly articulate a single integrated, system-wide action plan for improving how the emergency pathway performs. This plan is evidence-based and addresses the highest impact areas for improvement, with clear priority recommendations. These recommendations are summarised here and included in greater detail with responsible owners in the separate draft implementation plan. This plan should be shared across the whole system to gain widespread commitment. The Systems Resilience Group should lead on overall delivery of the plan and establish governance systems to reinforce clear accountability. The Trust and CCGs have already recognized some of the challenges and put actions in place to try to address them. Many of these initiatives are integrated into the plan. We recommend deprioritising those that are not.

Our assessment of the issues

Using a new approach to validate breach reasons an estimated **52% of all breaches are caused by lack of 'bed flow'.** This includes patients directly delayed by lack of available bed capacity or the knock on effect in ED of reaching capacity constraints in cubicles where patients are unable to move to beds in the hospital. This figure is higher than the previous internal estimate of 44% and is based on reassessing patterns and reasons for breaches using Emergency Department (ED) and admission time data. This same re-assessment also indicates that **20% of the breaches were due to delays within ED processes and 15% due to delays in specialty review in ED**. The **majority of breaches (70%) happen for patients who are subsequently admitted,** with a notable **6% of all breaches occurring for children who are admitted**.

One version of the truth: Summary Findings (2/5)

After assessing the fact base, hearing the perspectives of staff in meetings and making direct observations across the pathway, the root causes of underperformance and most powerful opportunities to improve are:

1. **Inflows and primary care:** there is overall growth in ED inflows, which is varied across groups, areas and months. There are potential opportunities to reduce some numbers by improving knowledge of and access to primary care, and by treating some patients elsewhere.

   Growth in ED demand: Average daily attendances to ED have risen 3% in the year to August 2015. This growth is uneven; particularly high and varied in some winter months and also varying across CCGs (1% Lambeth, 5-6% Wandsworth, Merton and others). Growth has largely been from the local area (<5 miles), and predominantly made up of: walk-ins of working age adults and children's minors; ambulance arrivals of working age adults; and over-65 majors, who add particular pressure to the ED. Complexity of attendances is slightly greater than for a peer group of NHS Trusts although this has not increased recently so does not explain recent performance. Attendance growth and the mix of cases has created some additional pressure on the already constrained ED capacity. There are some possibilities to improve access to and experience of primary care. In particular, there is considerable variation in rates of ED attendance by GP practice, and addressing this could reduce attendances by ~5k in a single year (or ~14 attendances per day).

   Patient groups in ED that could be treated elsewhere in the hospital: ED is currently performing several functions which are unnecessary or inappropriate. By far the most significant group is GP-referred admissions for adult medicine and surgery with an average of 24 patients per day (~5% of all attendances), followed by mental health attendances (4) and Ophthalmology (2) being assessed in ED by ED clinicians instead of directly being assessed and admitted (if necessary) on a receiving ward/assessment unit. These patients add to demand on ED staff time and space and constrain in-ED flow.

2. **Emergency Department capacity and flow:** On average, majors cubicle occupancy is greater than 100% for 14 hours a day; between 11am and 1am. Since this is the median position, majors cubicle demand often exceeds capacity. This pressure results from a combination of long delays for specialty review, delays transferring patients to beds for admission, growth of majors attendances within overall growth and operational inefficiencies in ED (floor coordination; diagnostics; portering etc.). Imbalances of medical and nursing resources and the pattern of arrival of patients cause additional pressure particularly during the morning and should be addressed.

3. **Specialty review and decisions:** Whilst 15% of breaches are attributed to specialty wait, the overall consequences of the current review patterns are much wider, with 22% of all patients who needed specialty referral ending in a breach. Median time to make referrals is 108 minutes from arrival and median time to respond and assess patients by specialty is 50 minutes. This is too long to consistently admit in a timely way. The extended 'tail' of the specialty assessment process waits (24% over 90 minutes and 8% over 150 minutes) means a significant cohort of patients experience breaches and unnecessary time in cubicles, blocking capacity.

One version of the truth: Summary Findings (3/5)

4 **Short stay / assessment units:** AMU and CDU are not operating effectively enough to facilitate timely flow of patients from ED. Patient stays on AMU are too long, with part of AMU operating as a medical base ward (36% >48 hours and 15% >6 days). CDU is operating like a smaller AMU with increasing stays of over 1 day and extending lengths of stay. Sunday-Monday discharges from AMU are low and only 15% of discharges from AMU are before midday whereas the expectation of AMU should be the key part of the system that achieves early and consistent flow. Notably, AMU includes 8 high dependency beds.

5 **Inpatient wards flow and occupancy:** Overall growth in admissions and increased length of stay have added to the challenge of managing occupancy and flow effectively. There are regular weekly and daily fluctuations in occupancy and discharge which put further pressure on the system.

Growth in total admissions, bed utilisation and impact on occupancy: Non-elective adult admissions between April and September 2015 have grown by 1.7% compared to the same period last year. With increased patient length of stay this increased occupied beds by ~60 during winter. In addition to this there has been an increase of ~10 occupied beds from elective ALOS growth (up ~8% over the last year) and from elective day cases (up ~11%). Against this backdrop, SGH's total bed base increased by 37 beds from April 2014. This resulted in rapidly increasing occupancy during winter 14/15 which remained high in Spring 2015. This dynamic means less headroom to cope with daily variation, making it more likely patients stay overnight in ED and have very long ED waits. This slows the early day flow from ED to admission wards. Whilst these trends clearly created difficult conditions to maintain performance and flow from Oct 14 to April 15, subsequent improved occupancy through 2015, specifically April to September, has not resulted in improved 4 hour wait performance. This suggests that a dual focus on capacity balance and widespread improvements in operational grip and flow improvements is the key to improving going forward

Timings and pattern of discharges: During periods of high bed occupancy, rigorous daily and weekly operations and frequent decision making are vital for flow. Current patterns cause admitted breaches. On a weekly basis, Tuesday occupancy is on average 53 beds higher than on Saturday afternoon. This is due to significantly lower weekend and Monday discharges and leads to ~50% more breaches across Mondays and Tuesdays than on other days of the week. The daily pattern of occupancy sees ward admissions mostly happen in the morning while discharges mostly happen in the afternoon (only ~19% happen before 12 noon). This leads to average net daily demand peaking 18-19 beds above the overnight figure, adding to ED breaches while patients wait for discharges.

6 **Delays related to complex discharge processes:** there are limited, and incompatible data sets on performance, but despite this it seems clear that patients are being delayed by a complex discharge process.

Limitations of tracking and recording performance data: There are three different, incompatible ways to count and analyze delay data in the Trust, each with a limited history. Only centrally reported DTOCs have long term trend data. This makes understanding performance data difficult inevitably constrains the ability of the system to communicate and coordinate action to improve.

Beds occupied by patients delayed by complex discharge processes: In October 2015, 61 beds of a bed base of 423 were occupied by patients who were ready for discharge but not able to leave. Nationally reported DTOC data (which is approx. 1/3 of all NDTOC and DTOC levels reported internally) has risen faster than national trends over the last year, with a spike in Sept / Oct 2015. This makes the same trend in overall delays likely. 33 of 61 beds relating to complex discharge delays in October were related to process delays.

One version of the truth: Summary Findings (4/5)

7 **Out of hospital capacity constraints:** 28 of the 61 beds occupied by delayed patients were caused by out-of-hospital capacity constraints. Approximately 8 patients' delays related to community nursing / package of care constraints. A further ~16 relate to placements for bed-based care (comprising rehab, nursing homes, and intermediate care and non-weight-bearing beds).

8 **Repatriations delays:** Repatriation delays can be highly variable, however on recent trends using the most reliable source of data the level ofdelays has risen to ~19 beds occupied in Sept / Oct. The delays are particularly focused on stroke and neurosurgical patients (11 out of 19 beds), primarily from 5 local NHS Trusts. This is unnecessary additional capacity pressure which undermines patient flow.

9 **Performance and programme management:** Improvements are needed in systems and resources for both performance and programme management if improvement is to be achieved and sustained

Programme management: There are several separate plans within the Trust that set out actions to improve performance. The flow programme is managed in a systematic and visible way but not all other plans are governed in the same way. There is no integrated plan at system level of the high impact actions. Resources dedicated to facilitate improvement and govern the emergency care related programme are very limited.

Performance management: Processes exist at various levels in the hospital and information to support is generally good, although it is not necessarily readily accessible at ward / working levels. Day to day operational performance has room for improvement in-hospital and at all levels there needs to be greater accountability for actions against clear standards and escalation triggers.

Solutions needed

A programme of initiatives designed to address the 9 root causes are proposed. The programme builds on and reprioritises existing plans, as well as proposing some new areas of action. The recommended consolidated set of initiatives are described and assigned owners in much greater detail later in the document. In brief here, they are:

1 **Manage inflows through Trust and primary care action:** Create dedicated inflow streams for specific bottlenecks; understand and address access differences among local GP practices

2 **Streamline ED processes and review capacity:** Optimise front end decision-making and floor coordination; facilitate the timely discharge of non-admitted patients; widen clinician admitting rights; adjust rotas to match attendance patterns and develop workforce; and review current cubicle provision in the ED

3 **Improve specialty response and engagement:** Encourage culture of shared ownership of the 4 hour target; establish SOP to get people aligned and hold them accountable; install regular performance management metrics; widen patient admitting rights

4 **Re-evaluate the use of short stay and assessment units:** Deliver early morning discharges consistently; increase weekend discharges; undertake a comprehensive review the role of assessment and short stay wards to ensure they are used as intended

One version of the truth: Summary Findings (5/5)

5. **Improve flow and occupancy of inpatient wards:** Deliver early morning discharges consistently; increase weekend discharges; redesign elective theatre planning; and add bed capacity in a timely way
6. **Improve the complex discharge process:** Improve Trust- and ward-level complex discharge processes; agree system-wide "best practice" processes, operating procedures and decision criteria; install robust governance and performance management; and address mindsets and behaviours
7. **Improve out of hospital capacity:** Address specific capacity shortfalls; consider implementing a discharge to assess policy
8. **Reduce delays due to repatriation:** Develop SOP and escalation policy; improve quality management of the repatriation process
9. **Implement a sustainable performance management structure across the system:** Create performance dashboards; agree a right set of forums and dialogues for in-hospital and interface dashboards; encourage operational leaders to own and drive actions arising; redesign escalation policies and install system to constantly reinforce these
10. **Improvement programme:** Develop implementation governance across the system focusing on ED performance recovery

Mindsets and behaviours

The 4 hour target, although a Trust and system-wide issue, is perceived as an ED problem. This is reflected in the lack of a strong day-to-day working relationship between specialties and ED. There are some Trust-wide cultural issues which also contribute to the 4-hour target performance: Escalation paths are used frequently. As a result, parts of the organisation feel they are in constant escalation and, having become de-sensitised to it, do not fully respond. There is not a tight enough operational grip at the front line and in Trust wide management infrastructure. Short stay wards are perceived as playing the role of traditional wards, rather than as 'treat-and-transfer'.

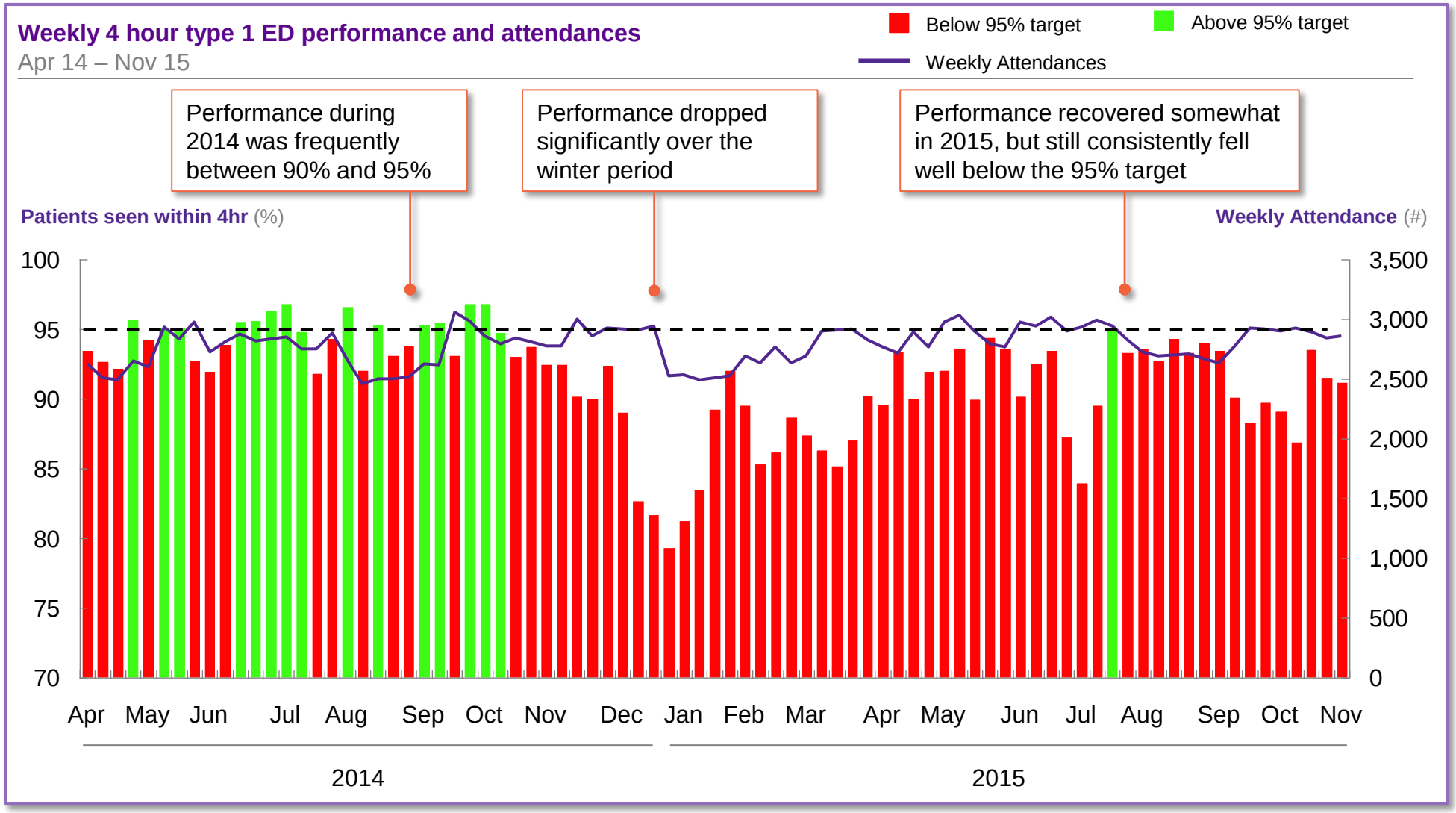
At the back end of the hospital, relationships with out-of-hospital providers are often characterised with a degree of mutual misunderstanding and blame about processes and delays. Furthermore, the speed of response of out of hospital services does not match the pace required to support the hospital in delivering discharge flow, despite specific efforts by the Trust to address this.

Conclusions and recommendations

A range of stakeholders are visibly motivated to improve performance across the whole emergency pathway, but many people have lost the belief that they can recapture a higher level of performance. Several initiatives are already taking place or being planned, and we should maximise the benefits from these. However, current initiatives alone are not enough to improve performance of the emergency care pathway.

It is now critical to provide a high-level integrated implementation strategy with clear accountability. Visible and strong leadership to drive this improvement programme is essential to align everyone on the right high impact schemes, to implement swiftly, and to hold workstream owners individually accountable. Finally, experience shows that the personal, visible role of leaders in driving and sustaining change is critical and this should continue to be a priority for leaders across the system.

St George's site ED 4-hour performance does not appear to link closely to attendance volumes



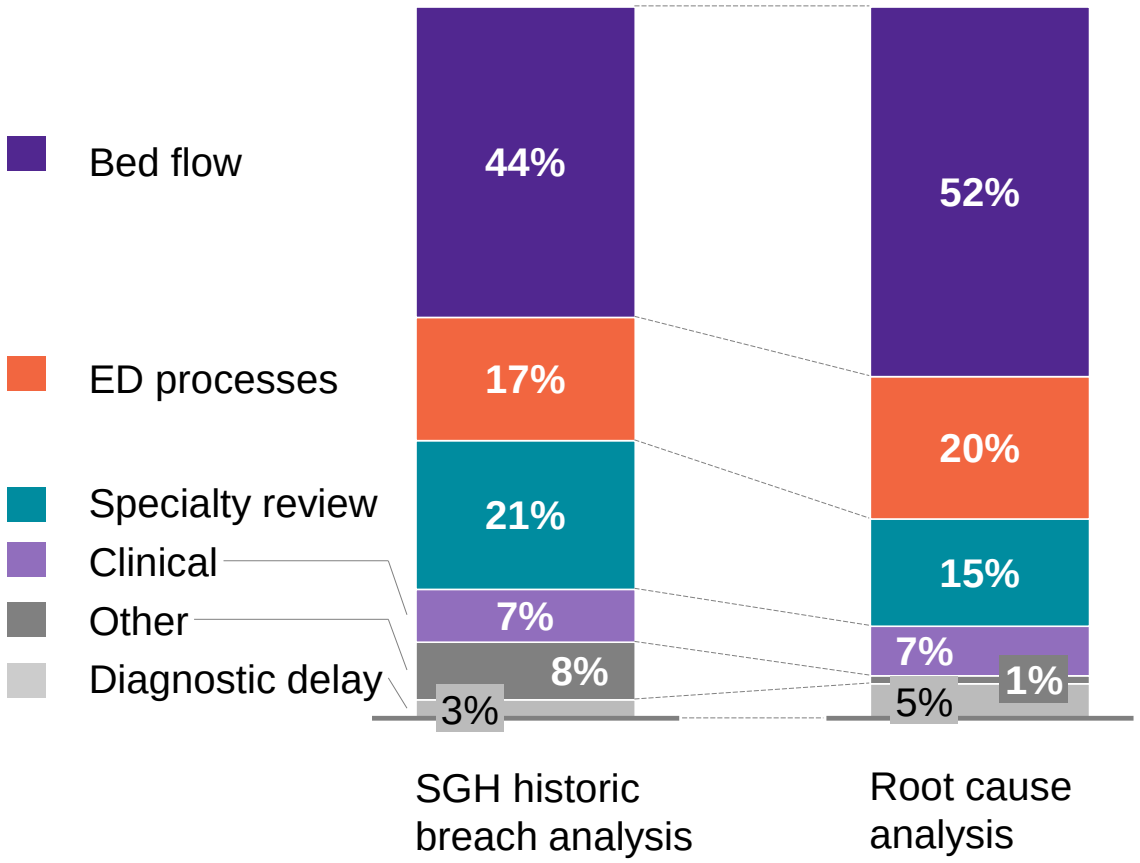
SOURCE: Weekly ED performance report from NHS England, Trust ED Performance Data and McKinsey team analysis

Contents

Root cause analysis suggests that up to 52% of breaches are due to bed flow constraints, which is 8 percentage points higher than SGH records suggest

Breakdown of breaches by reason

% of total breaches, Sep '14 – Aug '15



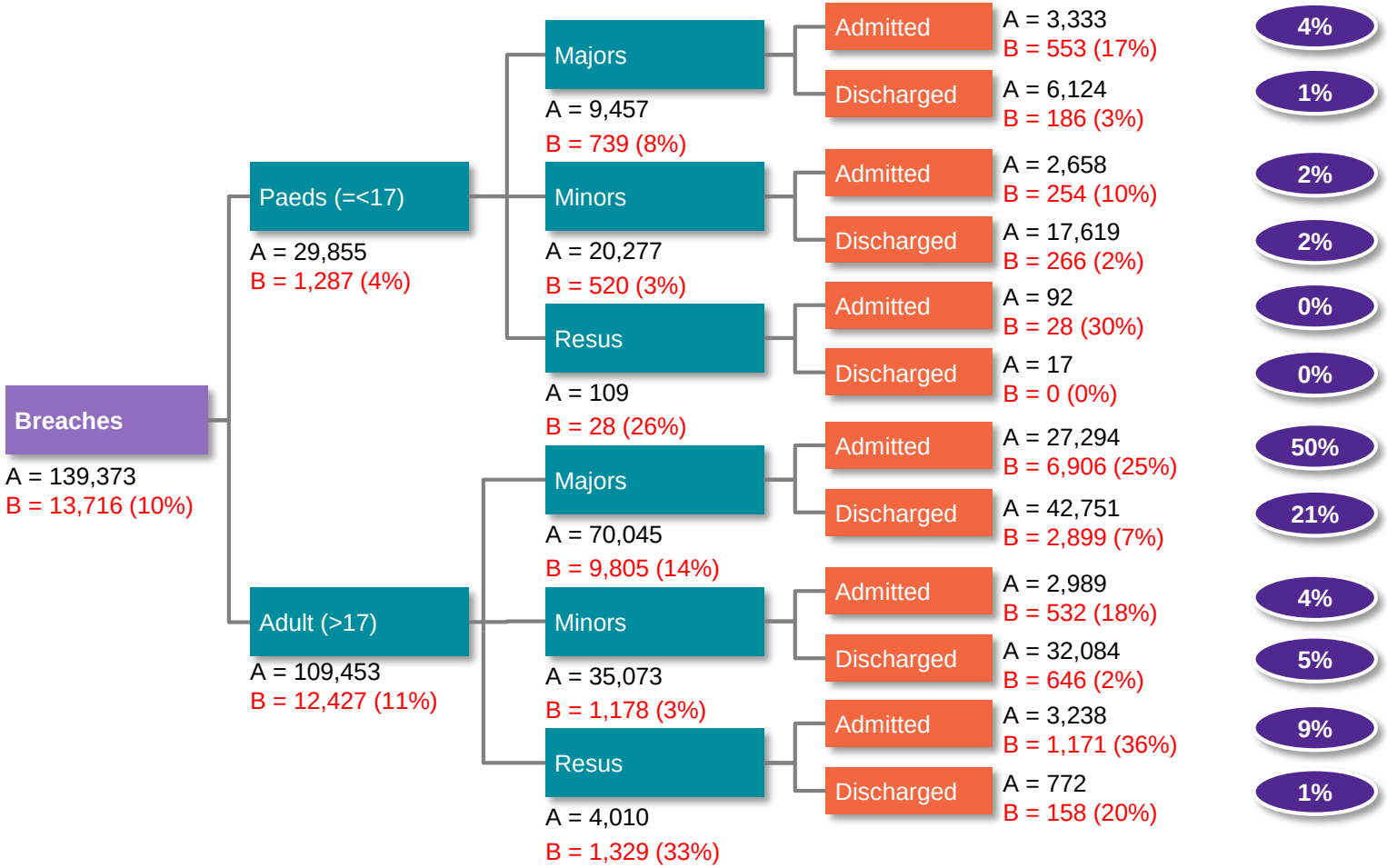
- Root cause analysis suggests **bed flow** issues and **ED processes** cumulatively explain 72% of all breaches in '14-'15
- The root cause analysis differs to the SGH breach analysis as it:
  - Determines how many patients were in the department and whether a lack of flow, and hence space, delayed the time to first assessment
  - Establishes whether seeing the patient any sooner could have prevented a breach – i.e., there was an underlying flow issue that would have caused the breach anyway
- This approach therefore attributes flow constraints to admitting patients as the primary cause of breaches

SOURCE: Trust internal ED data and McKinsey team analysis

Validated breach data shows the greatest opportunity for improvement is in admitted pathways, although non-admitted adult patients could contribute 2.5%

Breakdown of breaches
Sep 2014 – Aug 2015

A = Attendances; B = Breaches; % = Breaches as % of attendances



% of total breaches

4%
1%
2%
2%
0%
0%
50%
21%
4%
5%
9%
1%

- Adults who are eventually admitted contribute 63% of all breaches
- Children account for a 9% share of overall breaches, of which 6% are eventually admitted
- Eliminating breaches for adult non-admitted majors/minors patients could enhance ED performance by up to ~2.5 percentage points

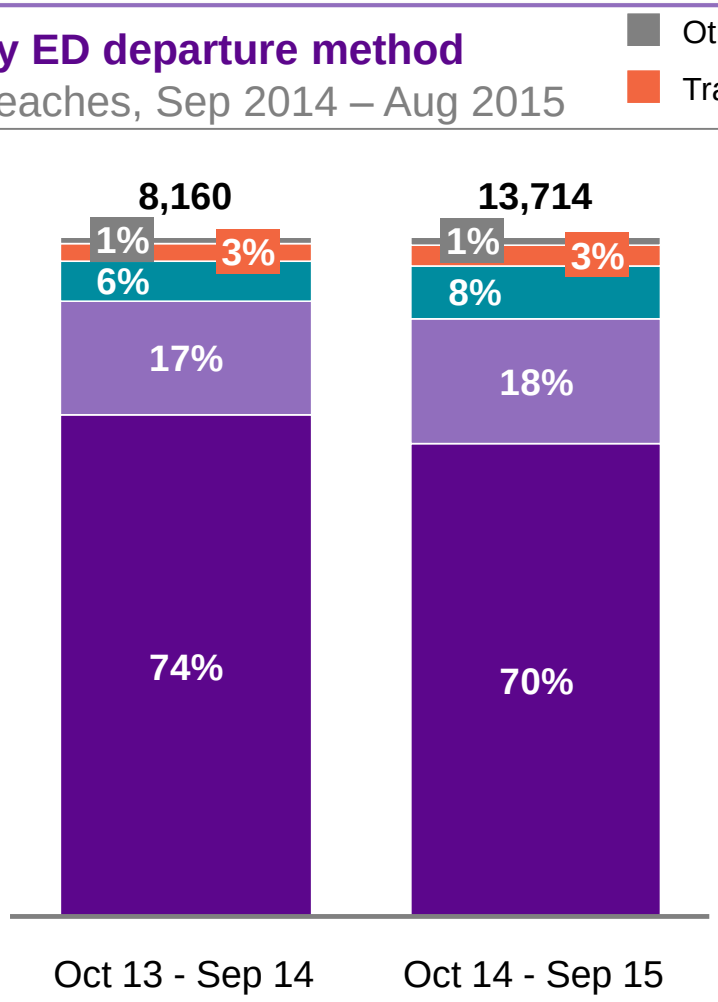
SOURCE: Trust internal ED Data and McKinsey team analysis

Of all patients that breach the 4-hour target 70% require hospital admission

PRELIMINARY

Breaches by ED departure method

% of total breaches, Sep 2014 – Aug 2015



- Total number of breaches have risen by ~5,600 between Oct 13 – Sep 14 and Oct 14 – Sep 15
- In the last 12 months, 70% of all breaches in ED were due to those patients who were eventually admitted to a hospital bed although the % share has decreased compared to the previous year
- 18% of all breaches are for patients who are discharged without any referral or transfer
- 8% of breaches were due to patients who were referred to other services, and this has increased over time

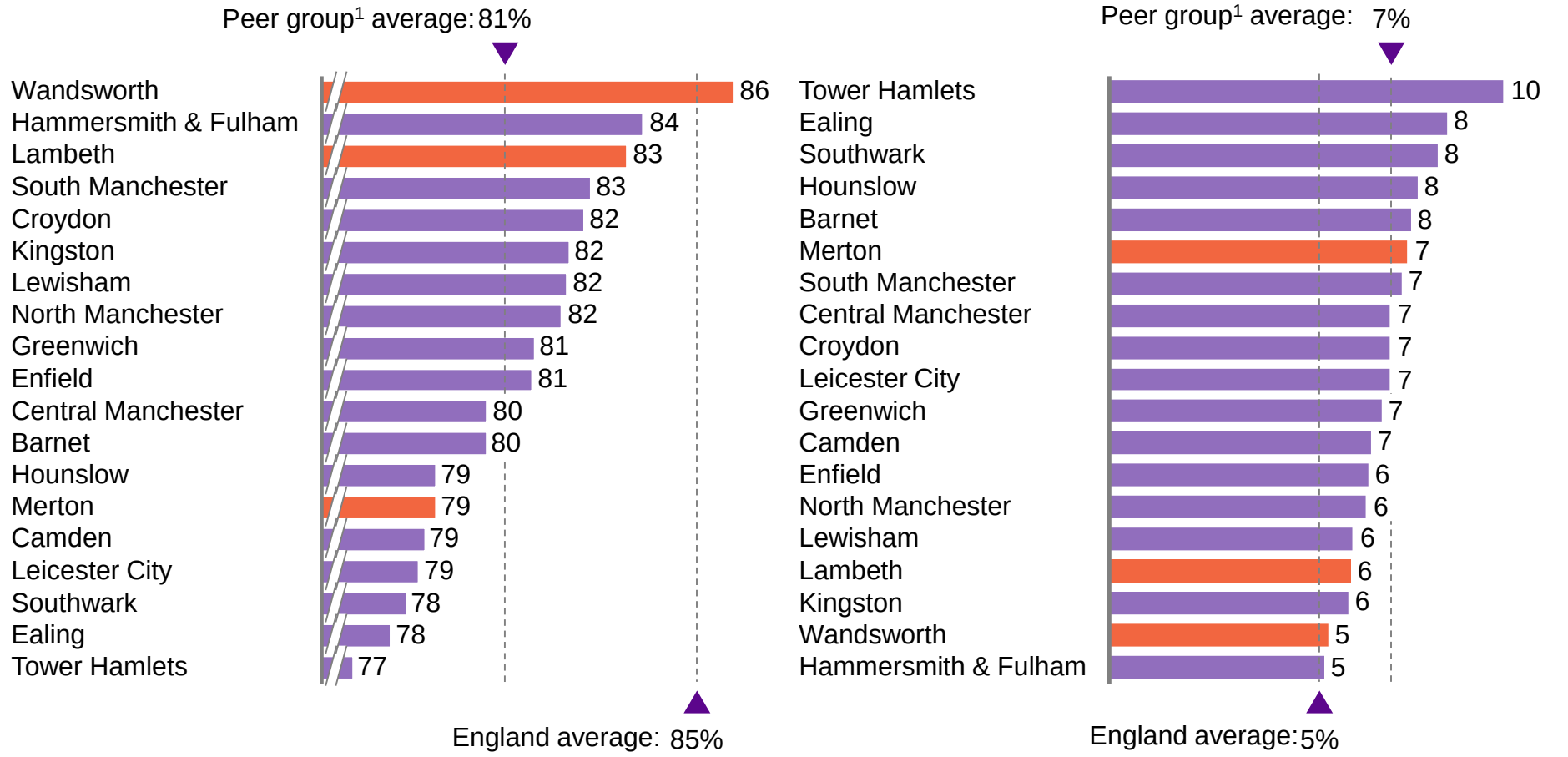
SOURCE: Trust ED data and McKinsey team analysis

PRELIMINARY

Merton has a worse overall GP experience than the peer group and national averages

Main CCGs for SGH

Overall experience of GP surgery, %, July 2015



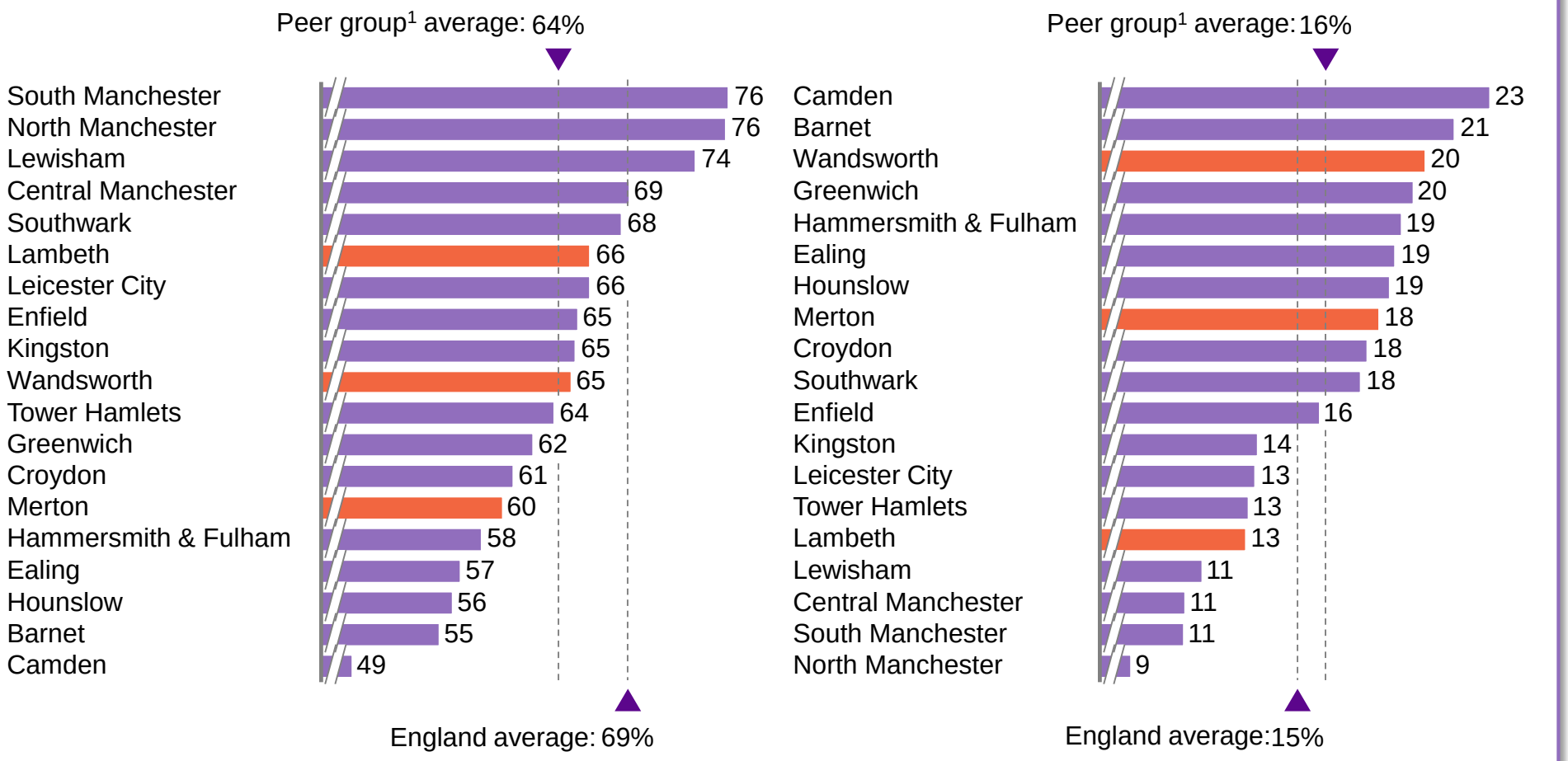
1 CCG peer group are CCGs with similar characteristics to Wandsworth, Merton and Lambeth CCGs based on NHS Networks
SOURCE: NHS Networks, HSCIC and McKinsey team analysis

PRELIMINARY

All 3 CCGs, especially Merton, have worse overall experiences of out-of hours GP services than the national average

Main CCGs for SGH

Overall experience of out-of-hours GP services, %, July 2015

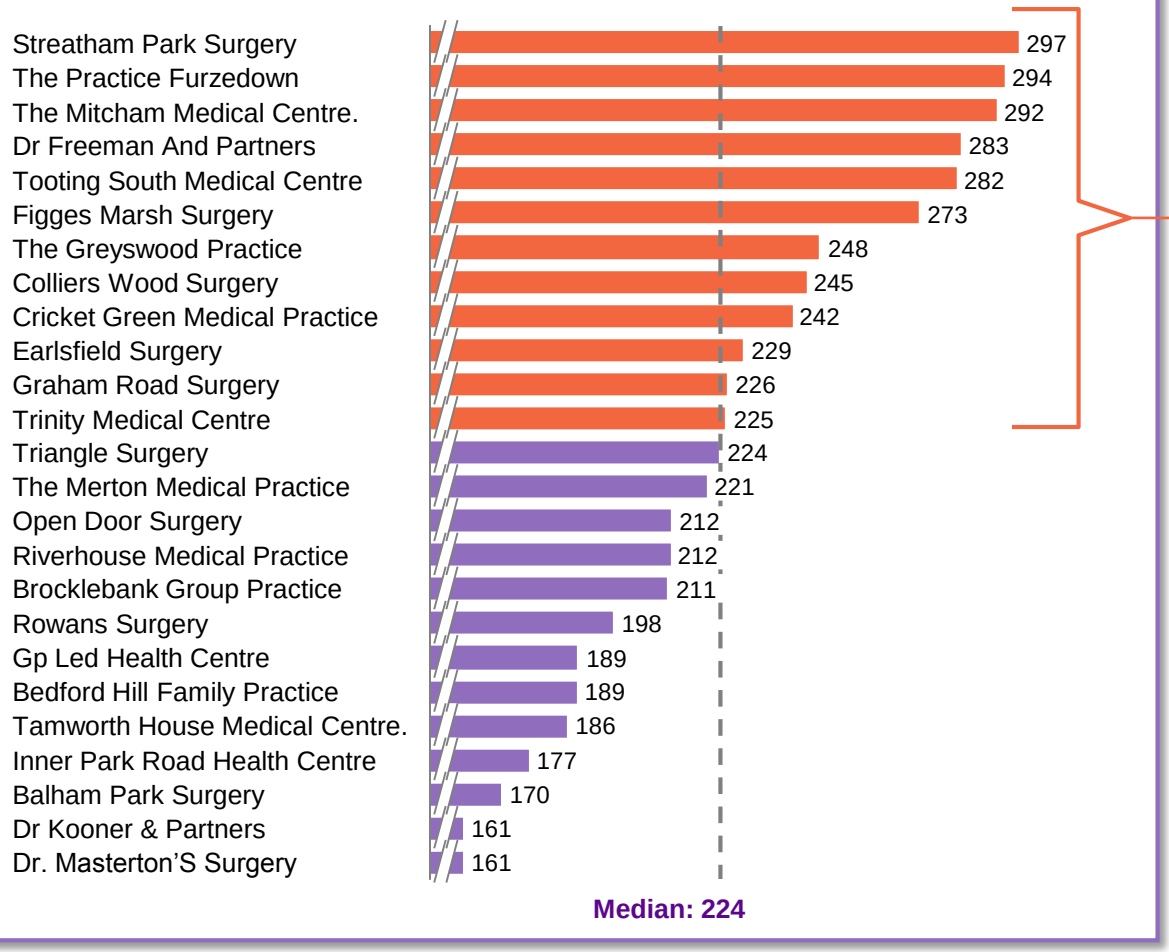


1 CCG peer group are CCGs with similar characteristics to Wandsworth, Merton and Lambeth CCGs based on NHS Networks

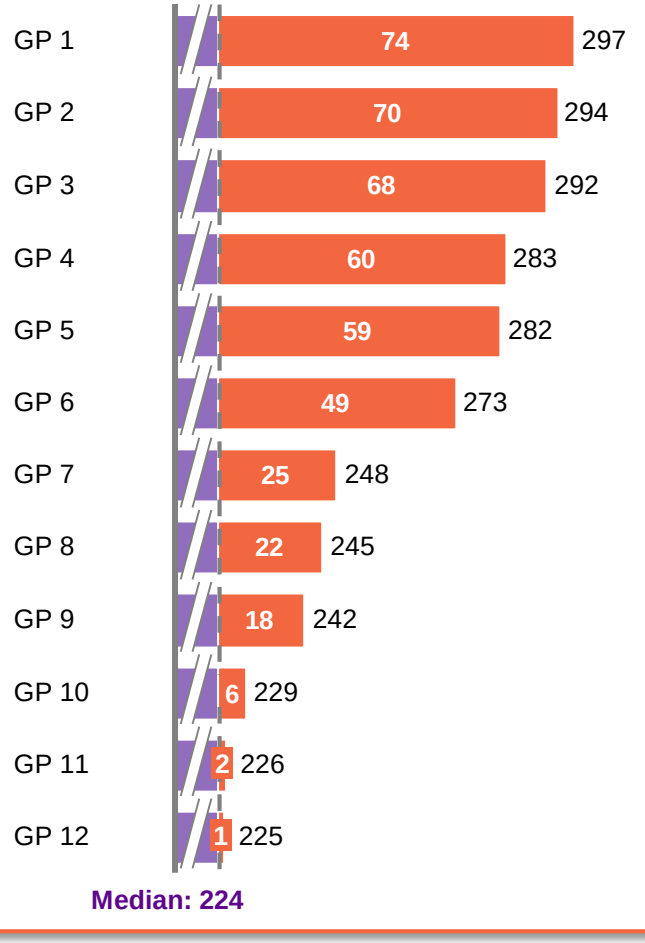
SOURCE: NHS Networks, HSCIC and McKinsey team analysis

Bringing the ED attendance rates of 12 practices in line with the median could result in ~5k fewer attendances

Attendance per 1,000 registrations for GP practices within 3 miles of SGH,
Sep 2014 – Aug 2015, #



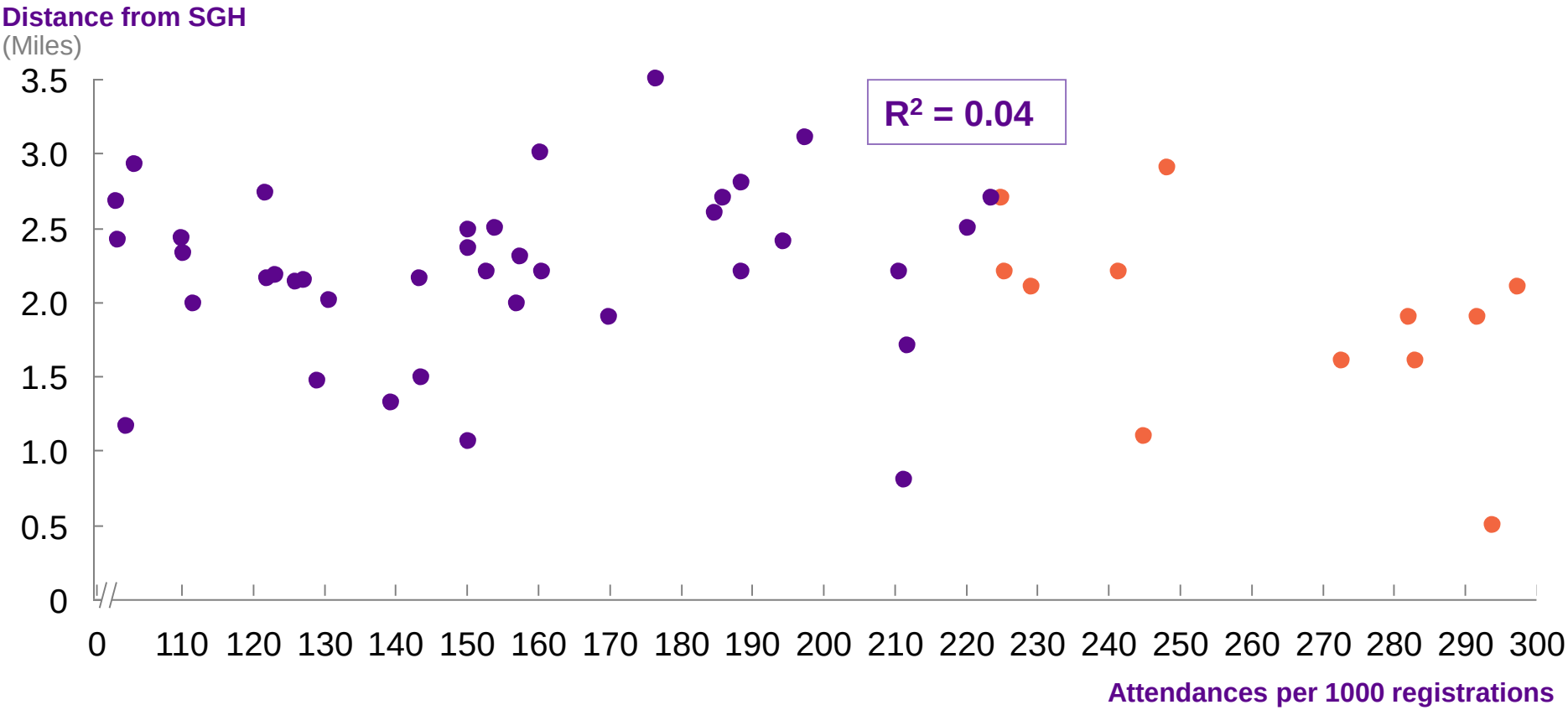
Type 1 attendance at SGH per 1000 registrations,
Sep 2014 – Aug 2015, #



SOURCE: Trust internal ED data, HSCIC and McKinsey team analysis

There appears to be no correlation between distance from SGH and the SGH attendances per registration from GP surgeries

Distance from SGH and attendances per registration[1]



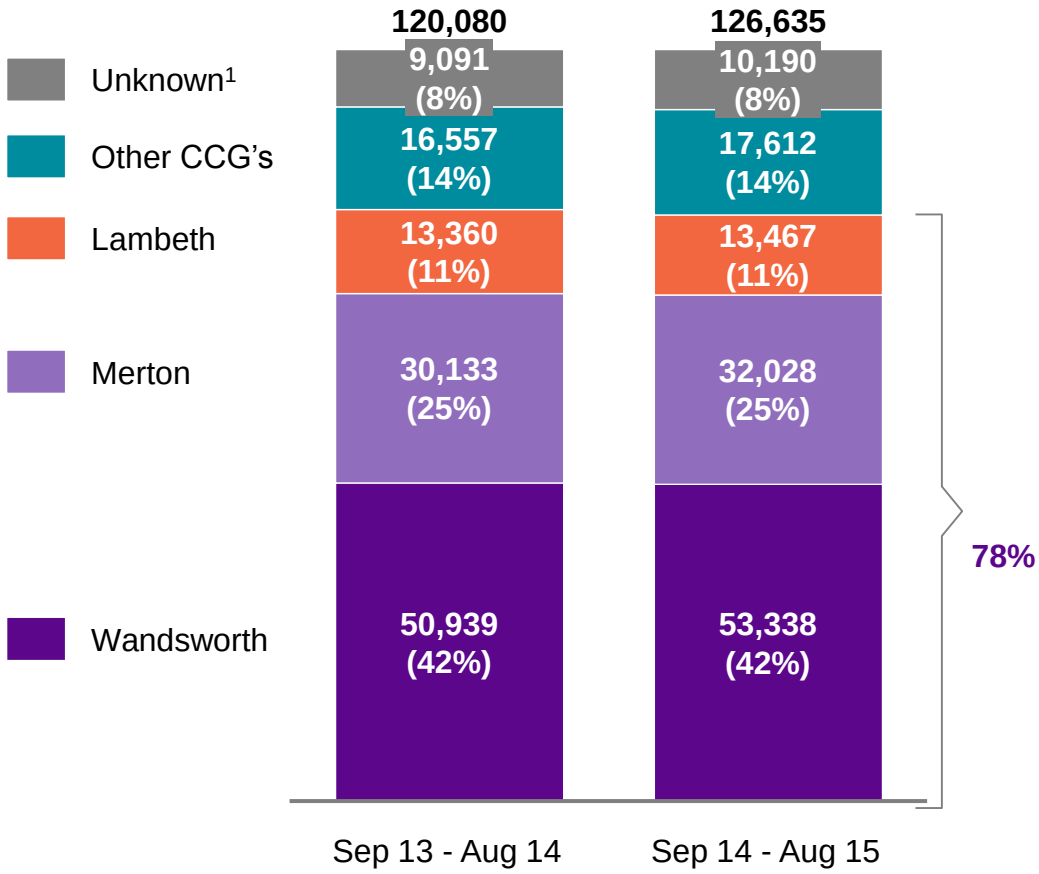
1 For the 51 GP surgeries that have > 100 attendances per registration

SOURCE: Trust internal ED data, HSCIC and McKinsey team analysis

78% of ED attendances are by patients from the three local CCG's, but absolute numbers coming from elsewhere are increasing the most

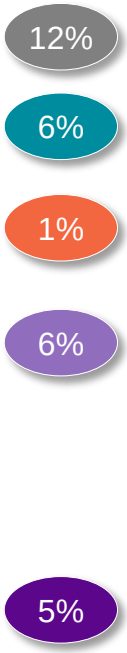
Type 1 ED attendances[2] by source CCGs

%, Sep '13 – Aug '15



Year on year change

%, Sep '13 – Aug '15



- Wandsworth, Merton and Lambeth patients account for 78% of attendances to St. George's ED
- 14% of activity is from other CCG's
- 8% of activity is from unknown GP practices and unregistered patients, and absolute numbers in this group have increased the most

1 Unknown GP's and patients who are not registered with any GP
2 Includes attendances navigated back to primary care

SOURCE: Trust internal ED data and McKinsey team analysis

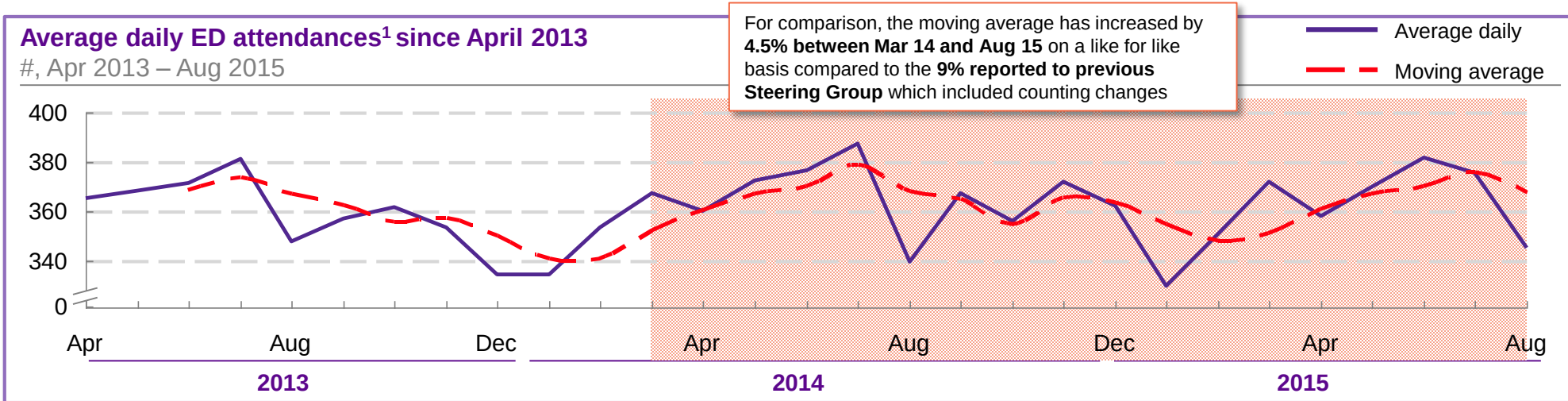
PRELIMINARY

The moving average of 'like for like' daily ED attendances[1] has not changed significantly, however last winter was noticeably busier than the year before

Average daily ED attendances[1] since April 2013

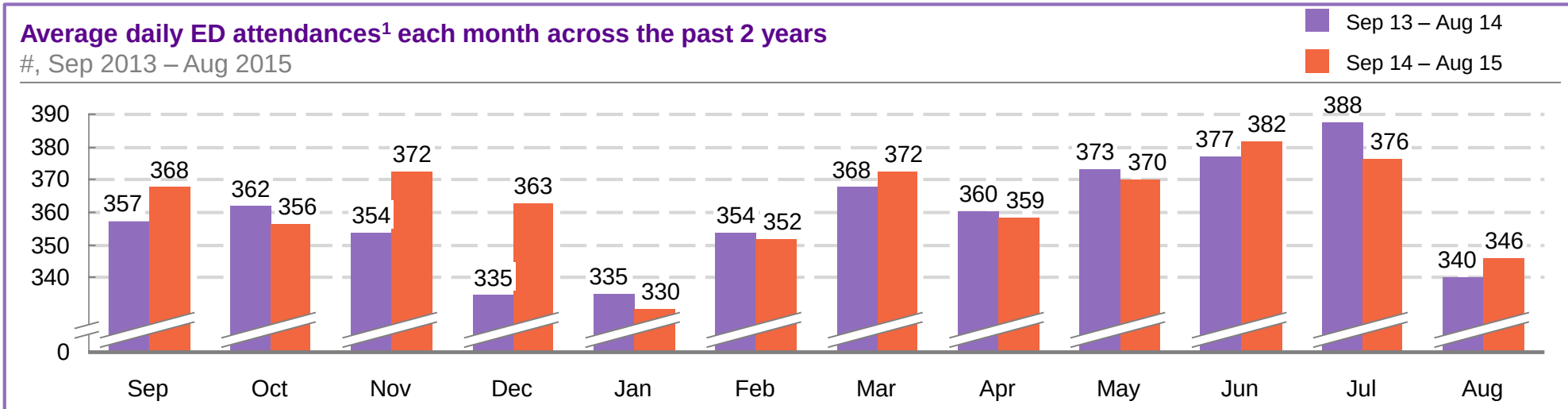
#, Apr 2013 – Aug 2015

For comparison, the moving average has increased by **4.5% between Mar 14 and Aug 15** on a like for like basis compared to the **9% reported to previous Steering Group** which included counting changes



Average daily ED attendances[1] each month across the past 2 years

#, Sep 2013 – Aug 2015



1 All ED attendances at St. Georges site, including UCC but excluding patients navigated to primary care from ED which began to be recorded in June 2014

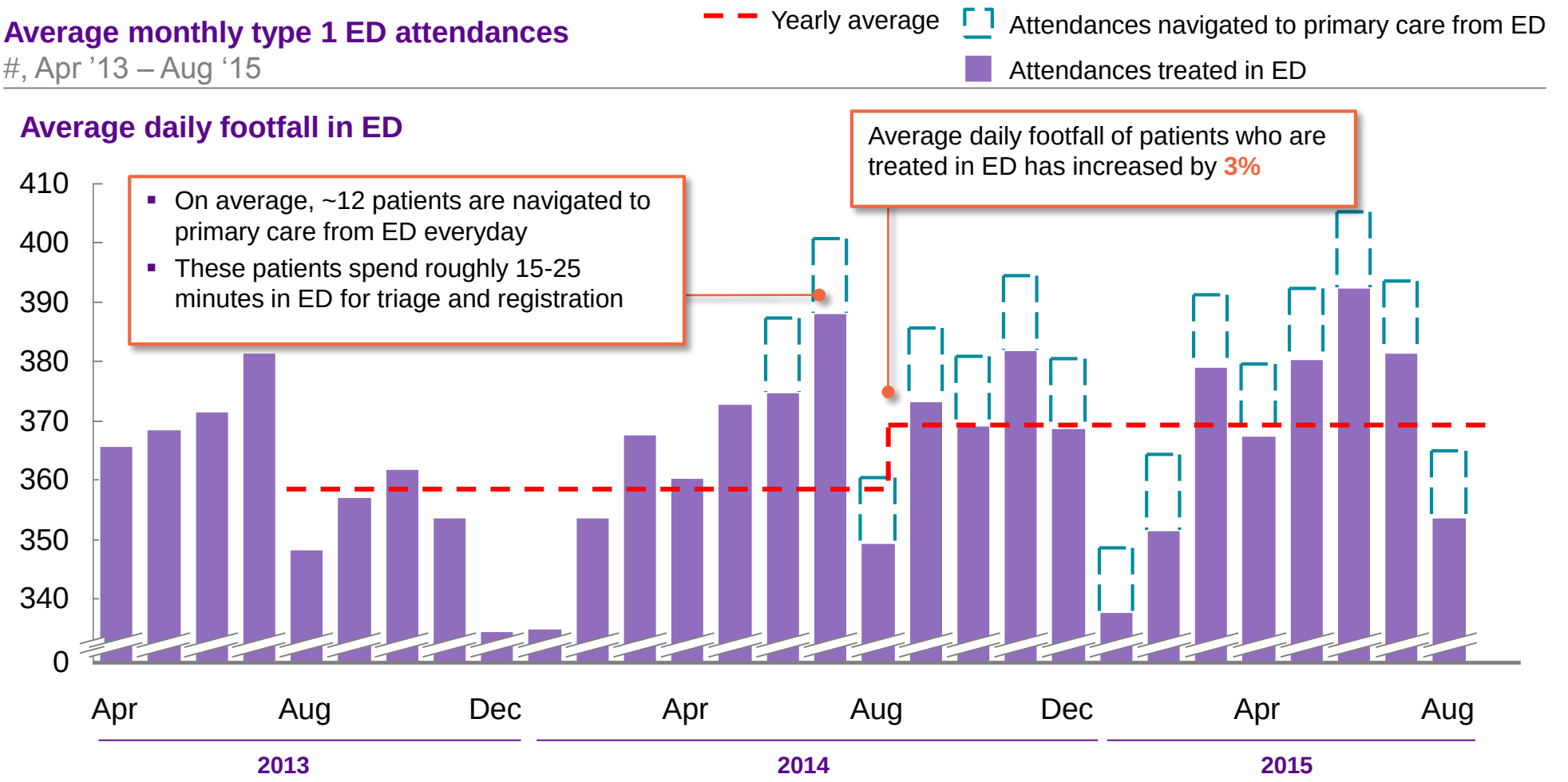
SOURCE: Trust internal ED data and McKinsey team analysis

PRELIMINARY

The number of daily attendances in ED between September 2014 and August 2015 increased by ~3%

Average monthly type 1 ED attendances

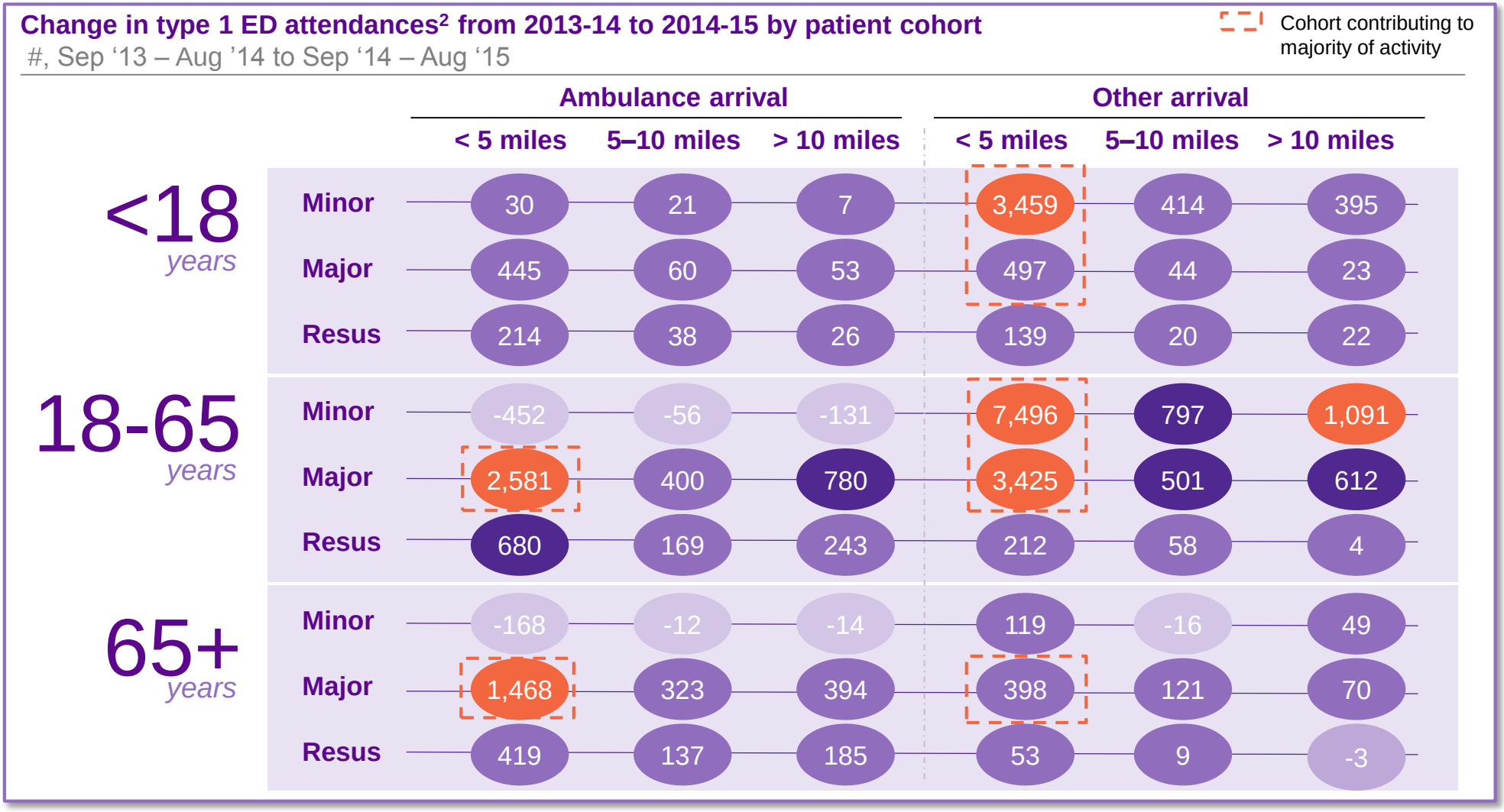
#, Apr '13 – Aug '15



SOURCE: Trust internal ED data and McKinsey team analysis

PRELIMINARY

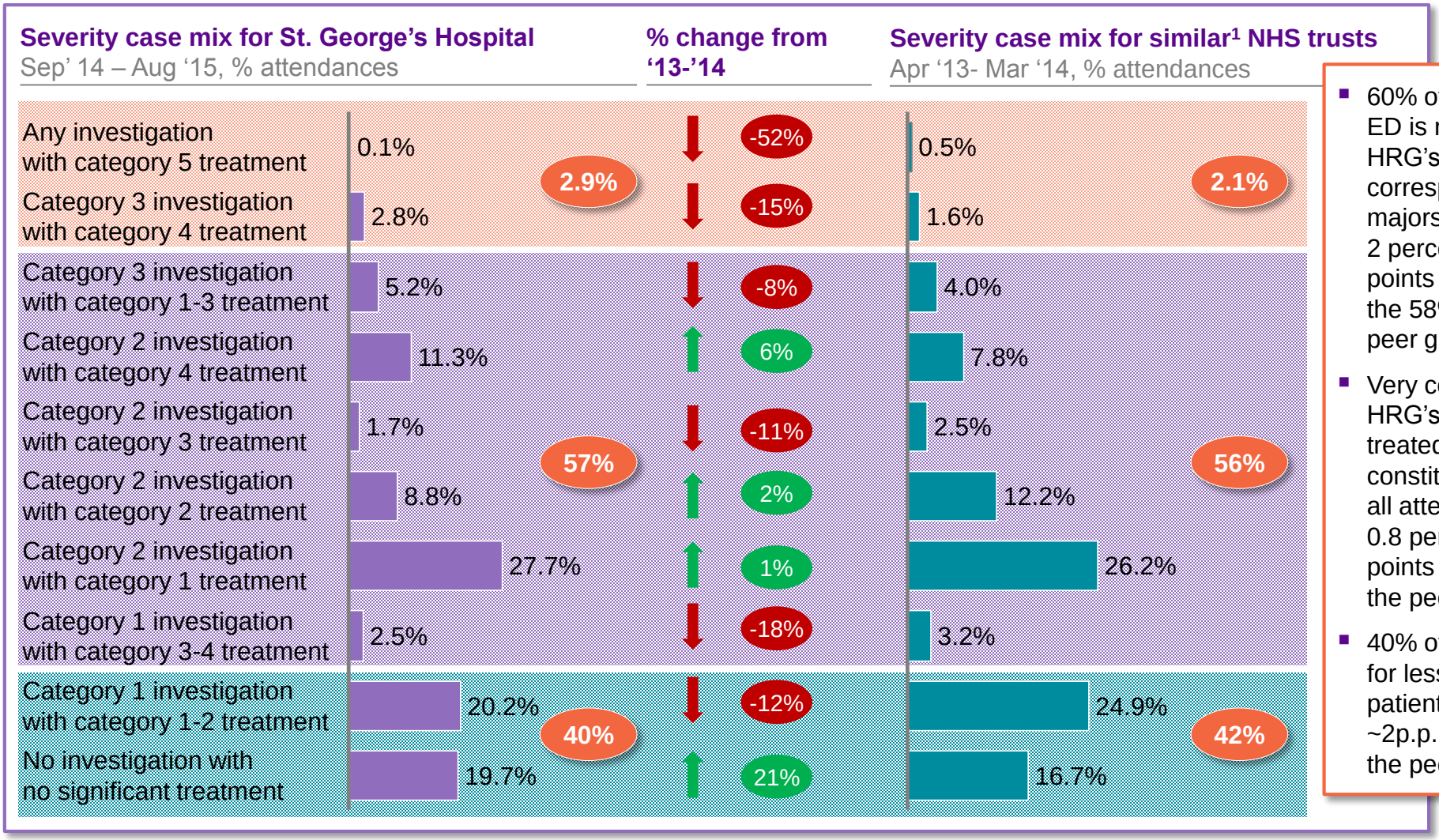
The rise in ED attendances is driven by growth in focused high volume cohorts, mostly from the local area



2 Includes attendances navigated back to primary care
SOURCE: Trust ED data and McKinsey team analysis

PRELIMINARY

Very complex cases represent a slightly larger share of overall ED attendances than in similar NHS trusts

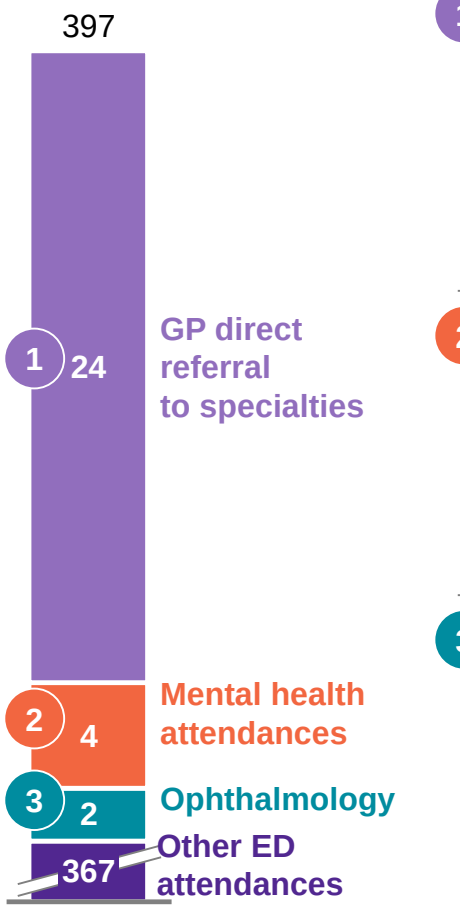


- 60% of activity in ED is related to HRG's corresponding to majors or resus, 2 percentage points more than the 58% for the peer group[1]
- Very complex HRG's likely to be treated in resus constitute ~3% of all attendances, 0.8 percentage points higher than the peer group
- 40% of activity is for less complex patients, which is ~2p.p. less than the peer group

1: Trauma centres with stroke units in England

SOURCE: Trust ED Data, HES 2013-14 and McKinsey team analysis

Deploying dedicated patient pathways for patients who can be treated elsewhere could reduce daily attendances by ~30



	Current status	Improvement hypothesis	Operational impact approach[2]
1	▪ Patients who are GP direct referrals to specialties attend ED and wait there for specialty review	▪ Dedicated pathways for surgical and medical GP-referrals will divert this cohort's attendance away from ED, thereby reducing the flow and number of patients in ED	▪ Diverting 70%-100% of GP-referred patients could produce an attendance reduction of 17-24 patients a day
2	▪ MH require out-of-hospital input, 1:1 nursing and a dedicated majors cubicle; 28% of this cohort breached in Apr-Aug '15	▪ Diverting MH patients along a dedicated pathway could limit flow in ED by freeing up cubicles, and potentially reduce the number of breaches as well	▪ Similar approach as above – estimated daily attendance reduction of 2-4 patients
3	▪ St. Georges is the only Hospital in South London who provide out of hours and weekend ophthalmology services, hence patients who can be treated in other acute centres come to SGH	▪ Diverting this cohort to a dedicated pathway will result primarily in attendance reduction in the ED	▪ Similar approach as above – estimated daily attendance reduction of 1-2 patients

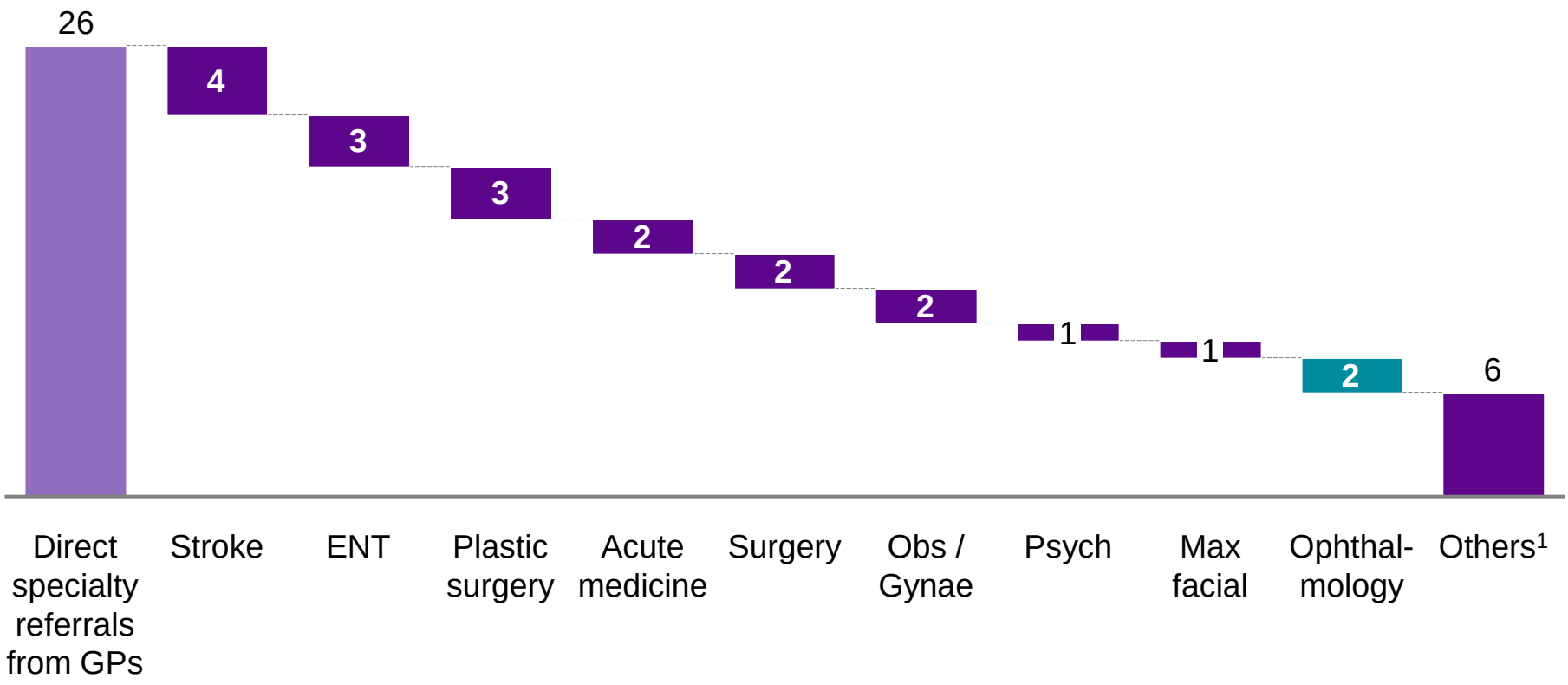
1 Mental health attendances include only case where mental illness is the "present complaint"; 2 Patients who arrived between 6pm and 8am and were then referred to OP clinic
SOURCE: Trust ED Data and McKinsey team analysis

PRELIMINARY

There are an average of 26 patients per day referred for specialist assessment who are routed via ED but could be assessed and/or admitted directly

Average daily number of direct specialty referrals from GP by referred specialty

#, Apr 2015 – Aug 2015



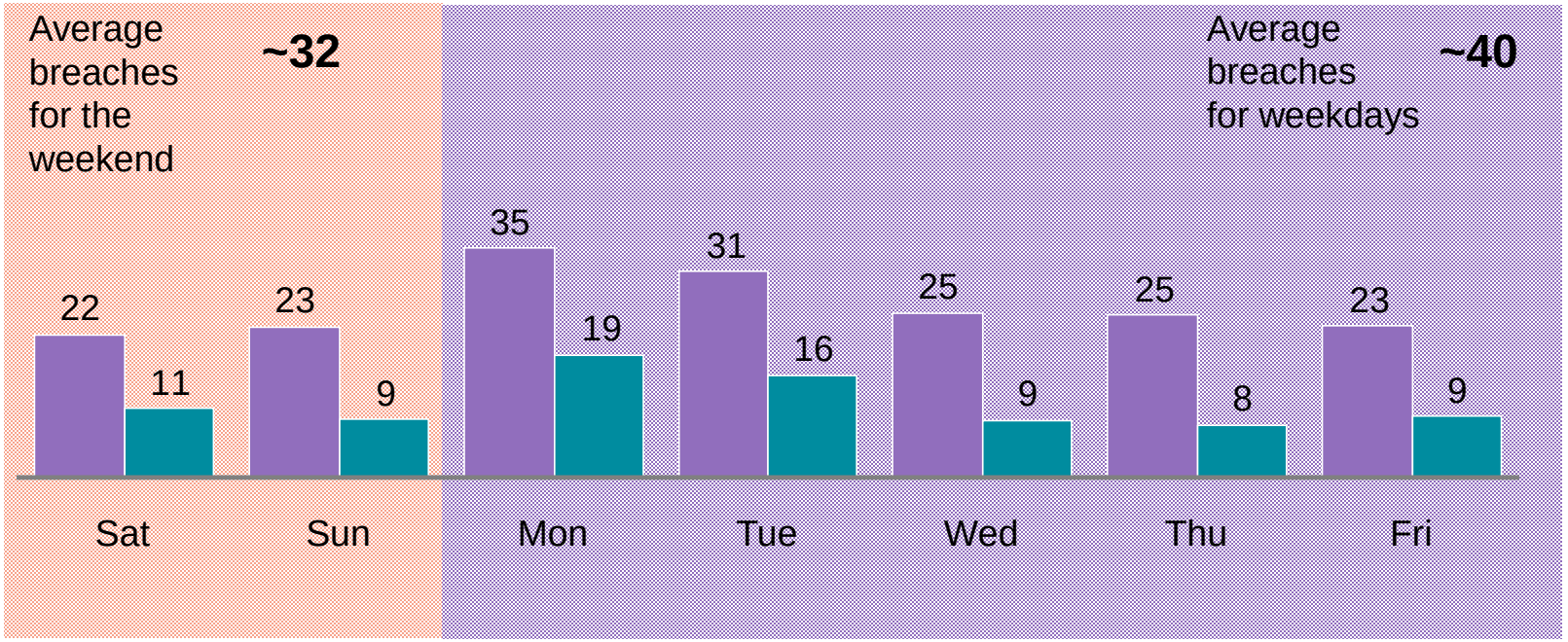
1: Others include urology, vascular surgery, oncology, paediatrics, infectious diseases, neurosurgery, ophthalmology, renal, neurology

SOURCE: Trust ED Data and McKinsey team analysis

Breaches for admitted patients surge on Mondays and Tuesdays, especially during morning peak hours

Average daily number of breaches on St. Georges site by day of week

, Sep 14 – Aug 15



Average daily breaches on Monday increase for both patient pathways, and gradually decline as the week progresses

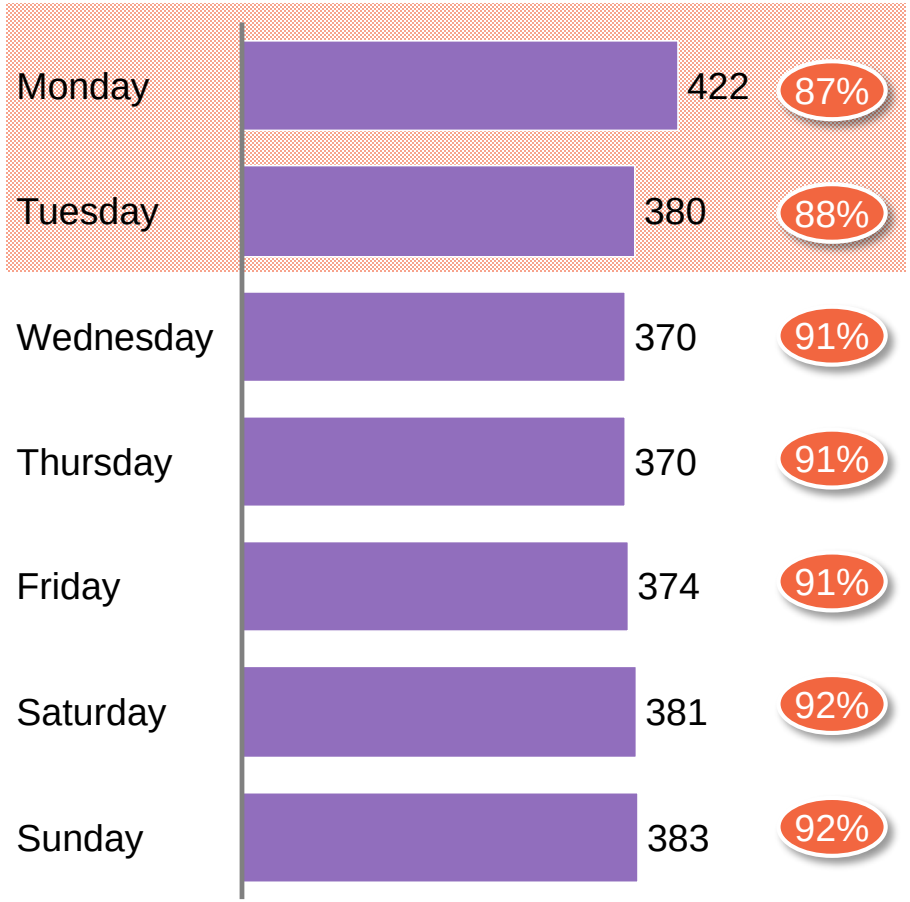
SOURCE: Trust internal ED Data and McKinsey team analysis

PRELIMINARY

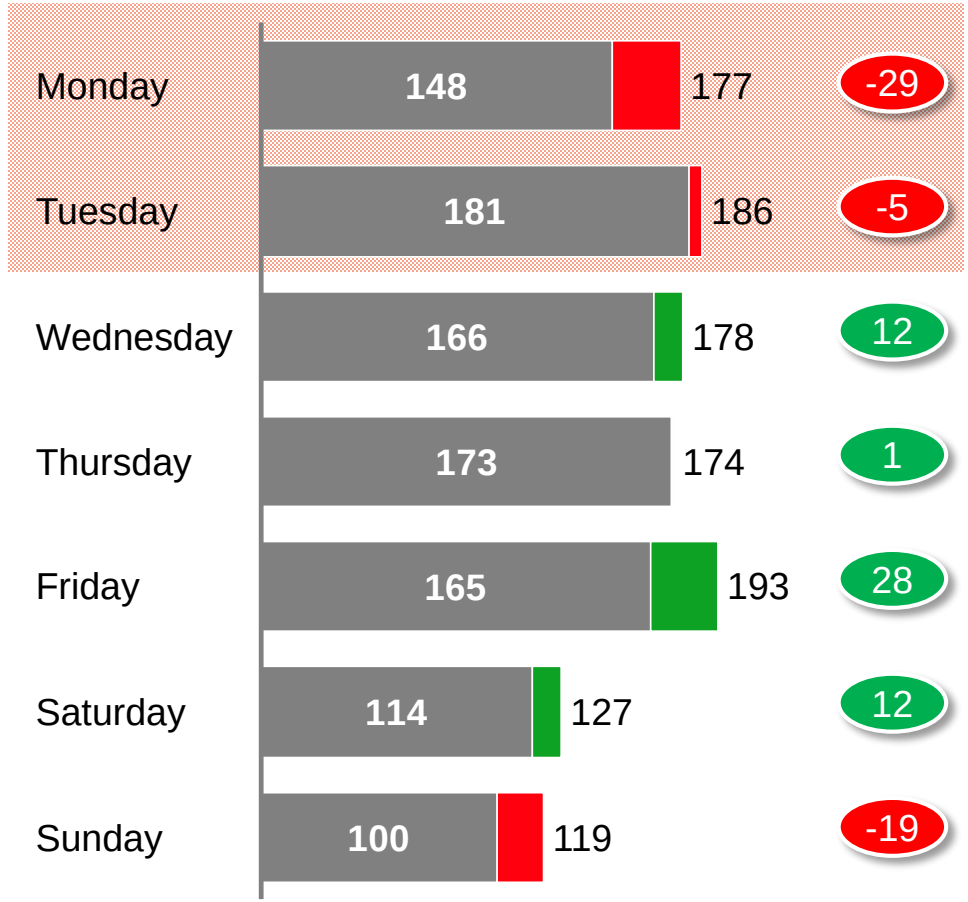
A rise in breaches follows a dip in discharge levels over the weekend, followed by a surge of attendances on Monday

Excess discharges over admissions
Excess admission over discharges

Average daily attendances in type 1 ED, #Average, Sep 14 – Aug 15



Average number of admissions and discharge from wards by day of week, #Average, Oct 14 – Sep 15

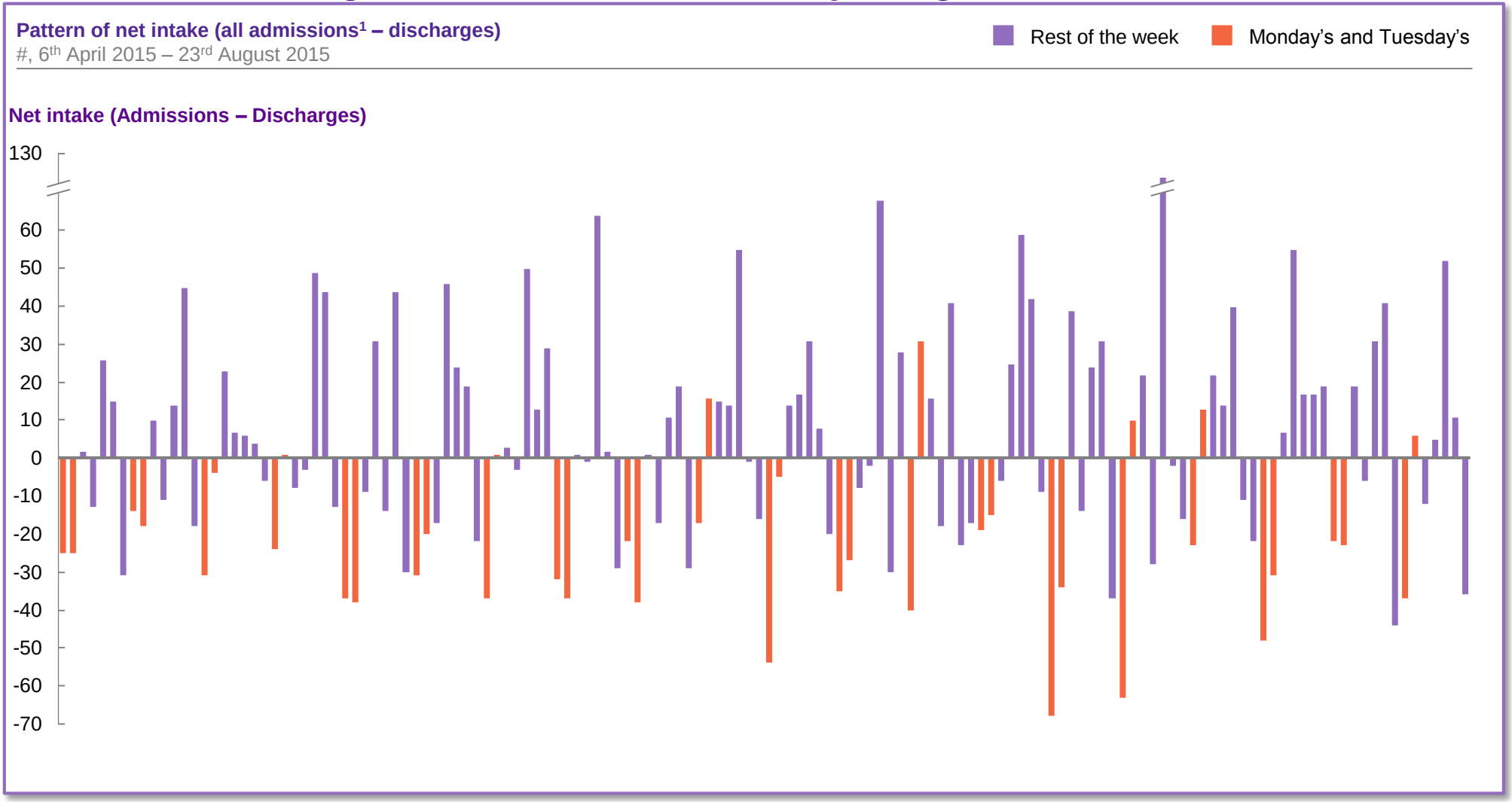


SOURCE: Trust ED and PAS Data and McKinsey team analysis

PRELIMINARY

Analysis for the last 20 weeks confirms that Monday and Tuesday net admission/discharge balance is almost always negative

Pattern of net intake (all admissions[1] – discharges)
#, 6th April 2015 – 23rd August 2015



1: Adult elective and non-elective, excluding paeds (17yrs and under) and maternity patients

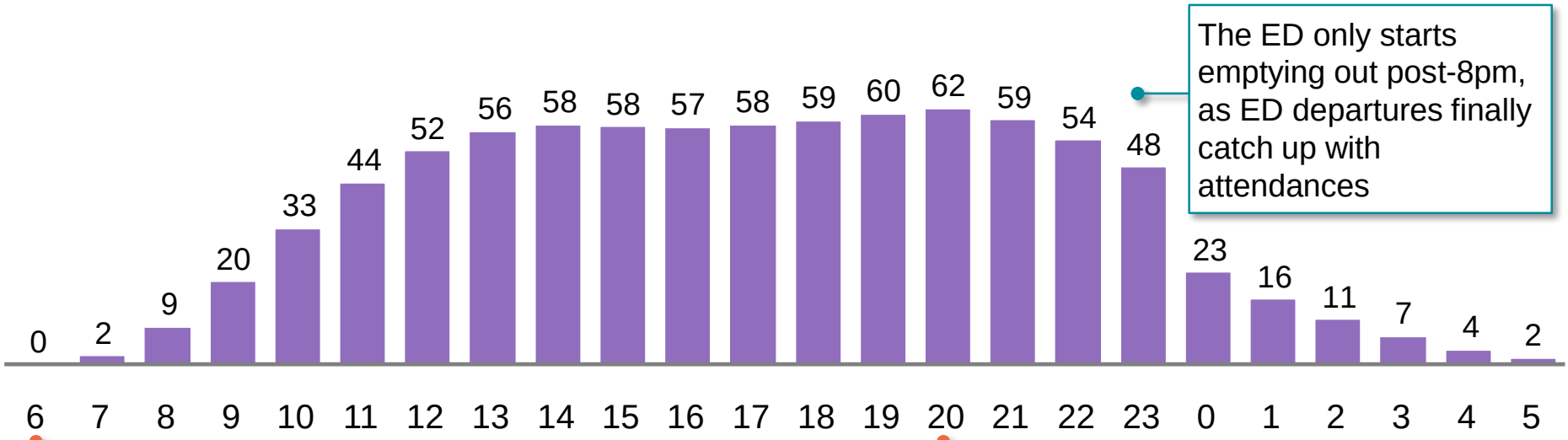
SOURCE: Trust ED Data and McKinsey team analysis

PRELIMINARY

The pattern of attendances and departures results in the ED filling up more each hour until 8pm, with occupancy reducing thereafter until 6am

Net average ED attendances[1] relative to 6am through the day

#, Sep 2014 – Aug 2015



- The ED continues to **fill up for 14 hours** from **6am-8pm** as attendances outstrip ED departures, and only begins to **empty out after 8pm** for the next 10 hours

1 Type 1 ED attendances

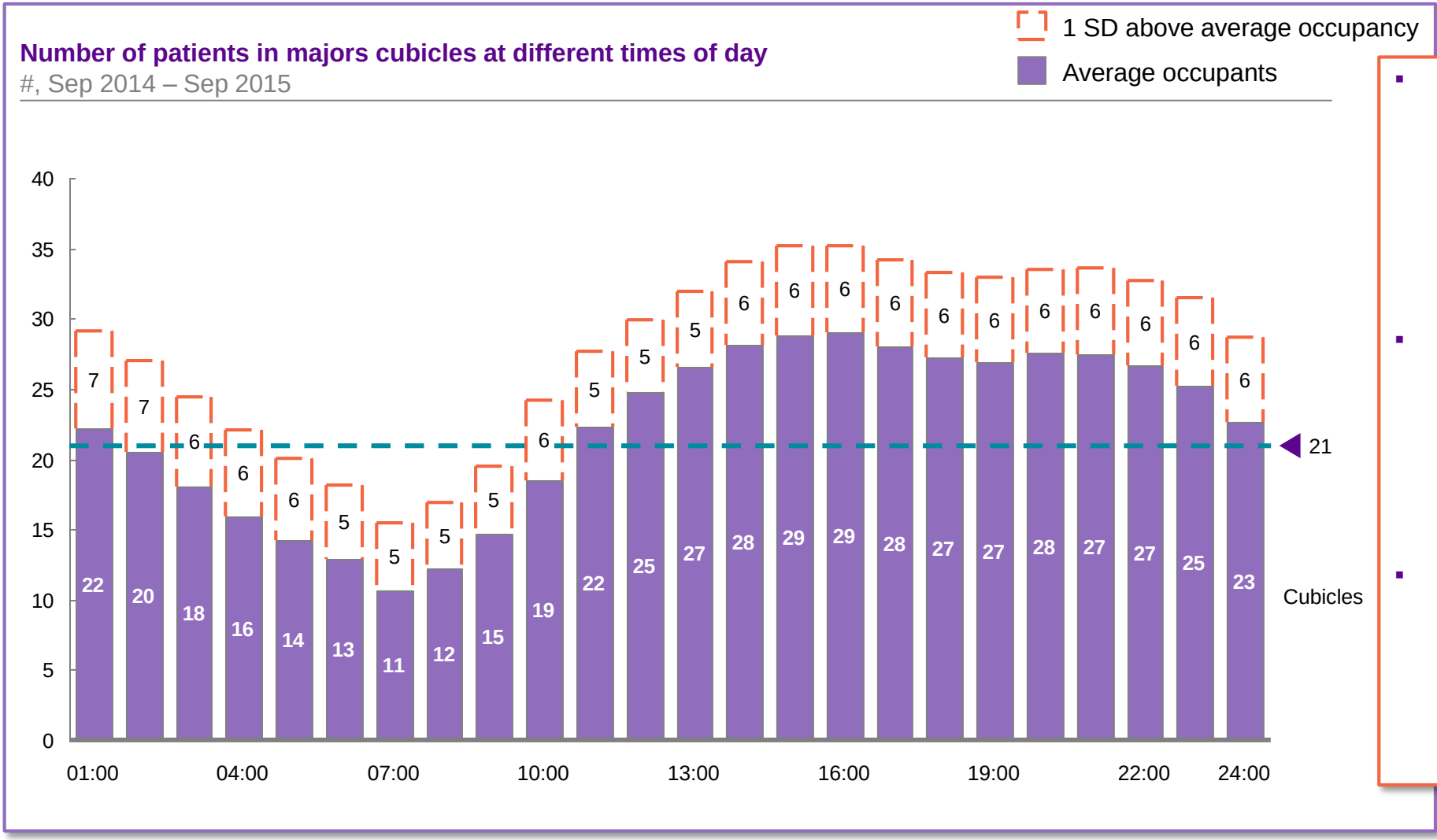
SOURCE: Trust internal ED data and McKinsey team analysis

PRELIMINARY

Majors cubicle occupancy is over 100% for 14 hours on the average day, between 11am and 1am

Number of patients in majors cubicles at different times of day

#, Sep 2014 – Sep 2015



- On an average day, majors cubicle occupancy is **over 100%** for **14 hours** of the day between **11am and 1am**
- Average cubicle occupancy rates at **4pm are 138%**, with **29 patients** in majors
- As shown by the standard deviations, **occupancy is over 100% for over 50% of the day**

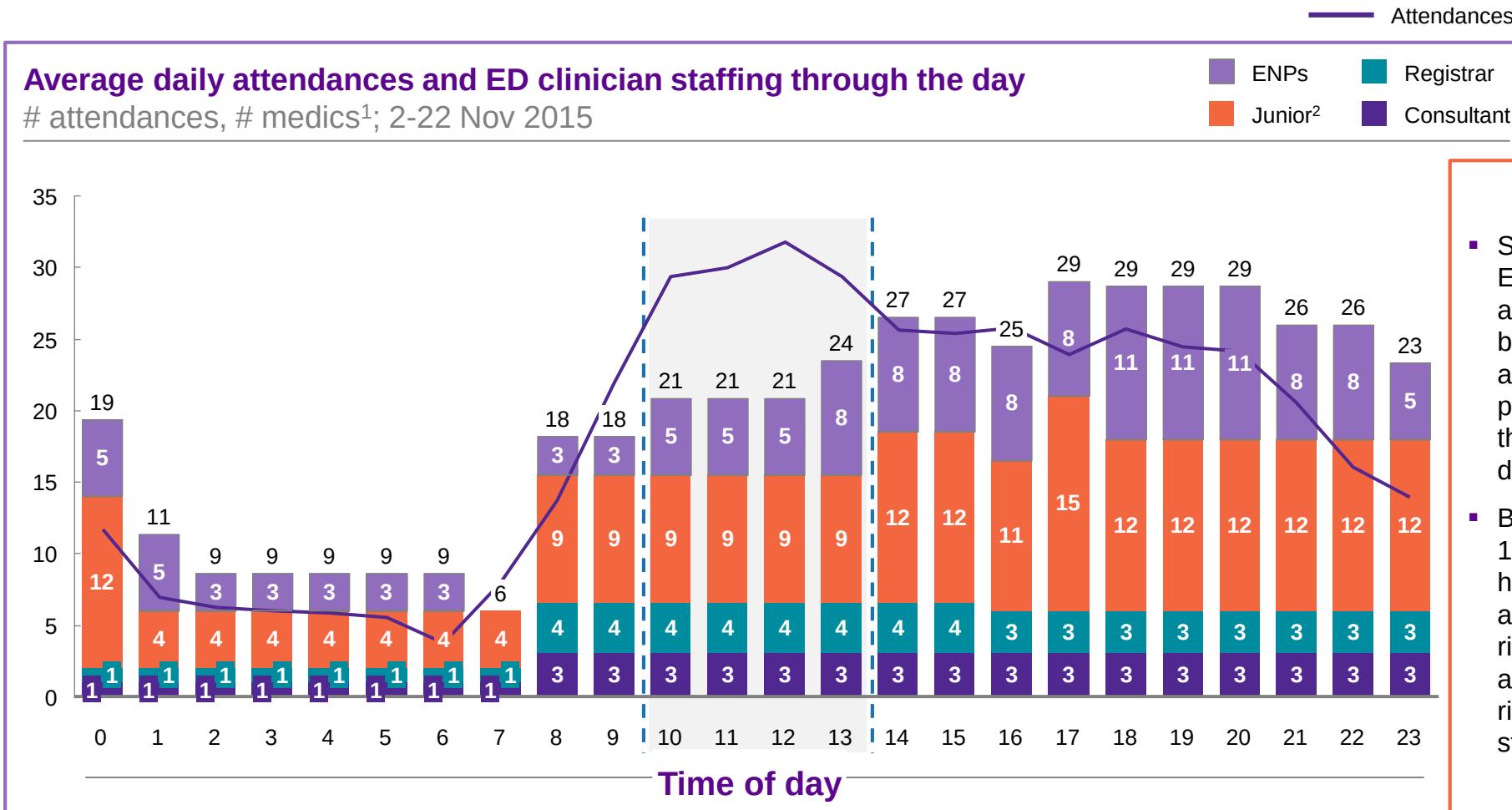
SOURCE: ED Occupancy data and KPMG data analysis

PRELIMINARY

The clinical staffing rota broadly matches the pattern of ED attendances, except for the 10am-2pm window

Average daily attendances and ED clinician staffing through the day

attendances, # medics[1]; 2-22 Nov 2015



- Staffing and ED attendances broadly follow a similar pattern through the day
- Between 10am-2pm, however, attendances rise with no accompanying rise in clinical staffing

1 Number of staff per time of day as per rota averaged during the 7-day week
2 Includes core trainees, tweenies and FY2s

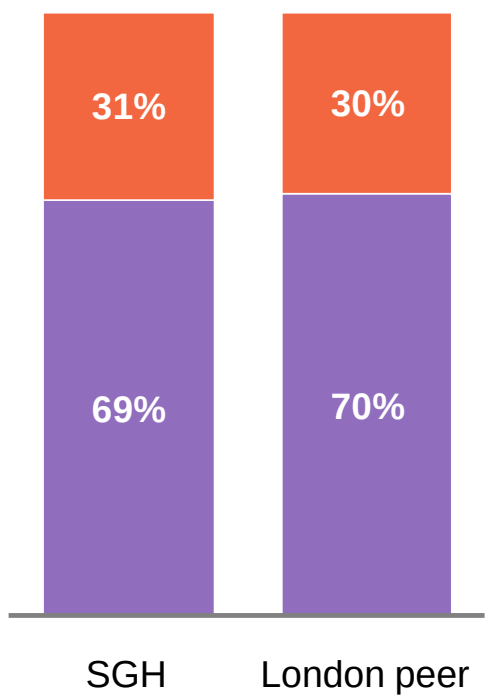
SOURCE: Trust ED medical rota, Trust ED attendance data (2-22 Nov 2015)

PRELIMINARY

Ratio of specialty referrals that result in admission is higher for St. George's compared to a local peer hospital

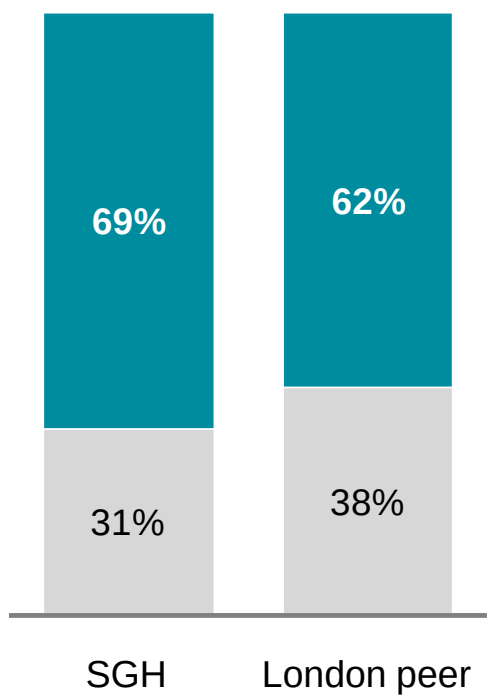
Ratio of specialty referrals compared with another London Trauma centre

%, Apr 2014 – Sep 2015



Ratio of specialty referrals by mode of departure from ED compared with another London Trauma centre

%, Apr 2014 – Sep 2015



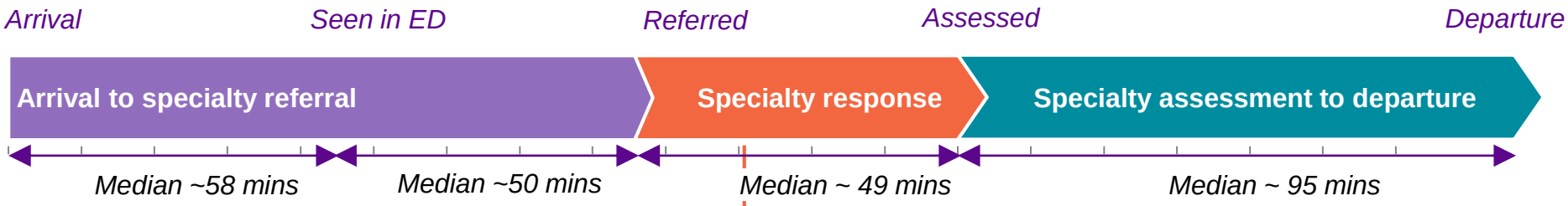
SOURCE: Trust internal ED data, McKinsey case studies and McKinsey team analysis

PRELIMINARY

Specialty referrals are generally made after ~100 mins, and 25% of patients wait more than 90 minutes to be seen by a specialist once referred

Median time spent by a type 1 ED attendance between various stages in department

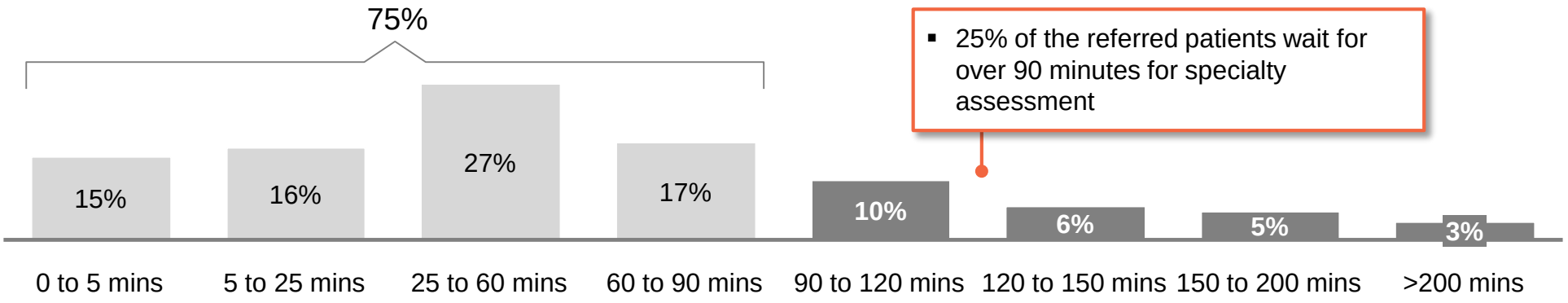
#, Mar 2014 – April 2015



- Median time for ED to refer patients is within target time of 2 hours from arrival
- Median specialty response time is above the target time of 30 mins

Frequency distribution for specialty response

Apr 14 – Sep 15, Days



- 25% of the referred patients wait for over 90 minutes for specialty assessment

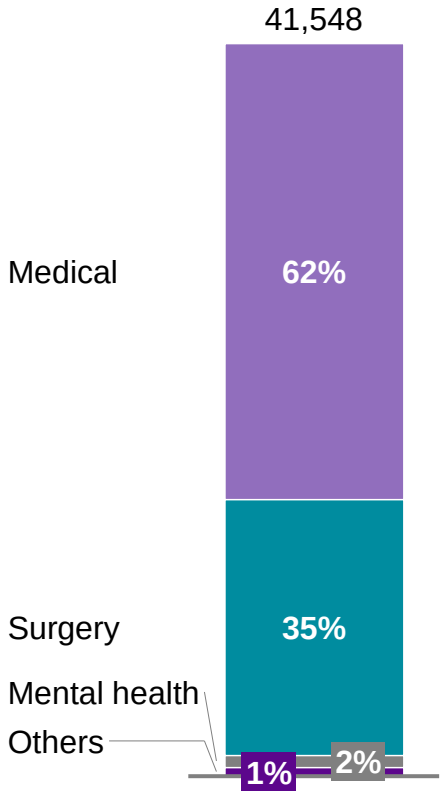
SOURCE: Trust internal ED data and McKinsey team analysis

PRELIMINARY

62% of patients referred to specialties and then admitted are referred to medicine and there is considerable variation between specialties' response

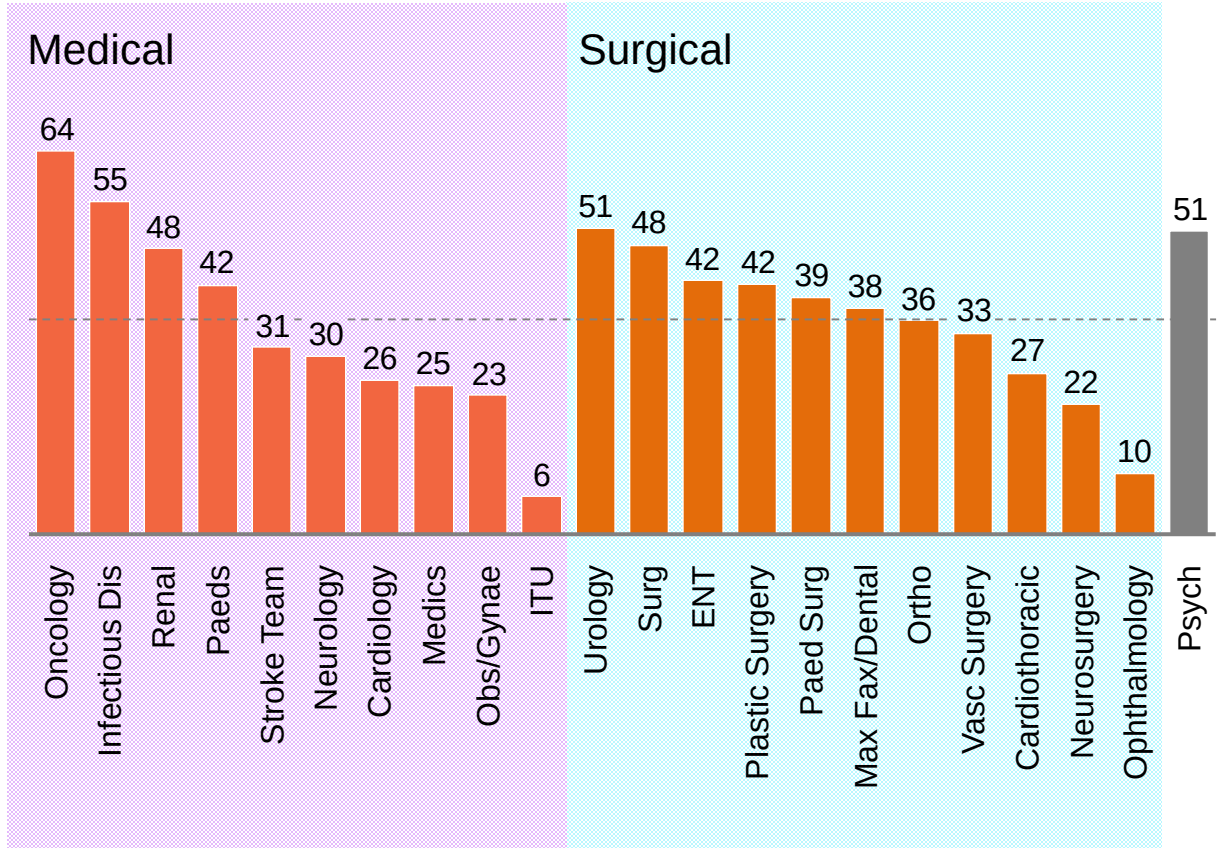
Admitted referrals from type 1 ED by specialty group

%, Apr 2014 – Nov 2015



Median time elapsed between referral to specialty and specialty assessment for admitted patients

#Minutes, Apr 2014 – Nov 2015



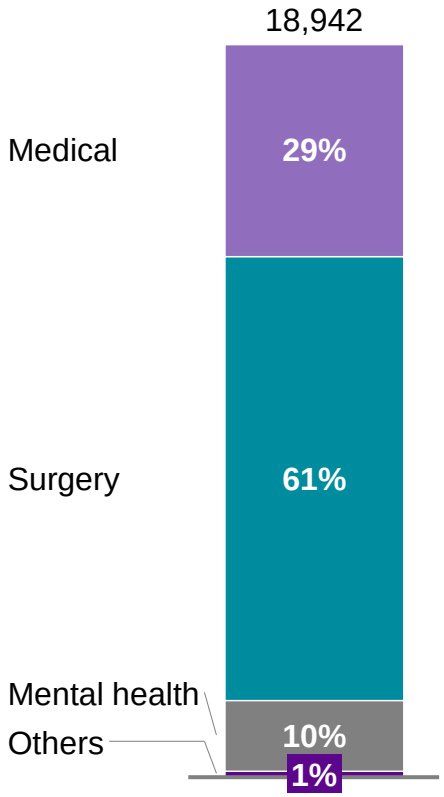
SOURCE: Trust internal ED data and McKinsey team analysis

PRELIMINARY

61% of patients referred to specialties and subsequently not admitted are referred to surgical specialties

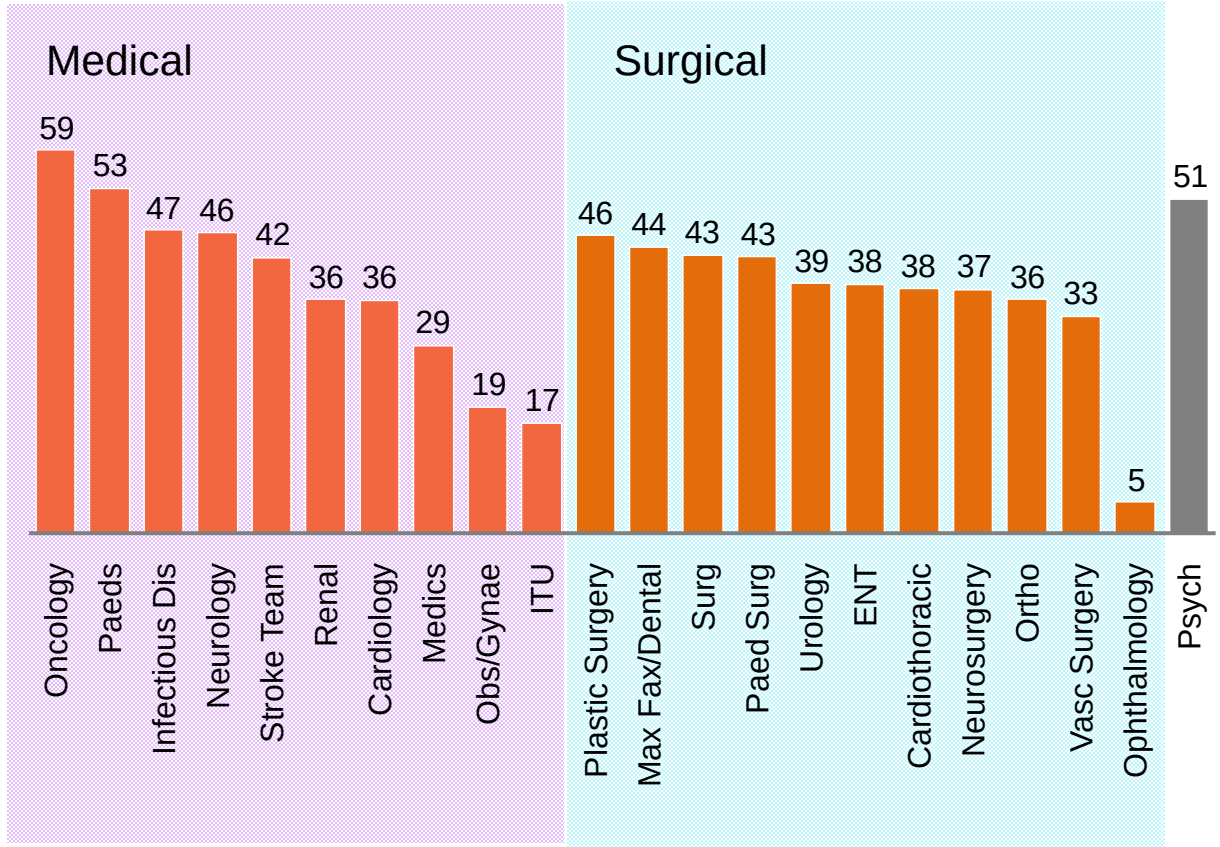
Non-admitted referrals from type 1 ED by specialty group

%, Apr 2014 – Nov 2015



Median time elapsed between referral to specialty and specialty assessment for non-admitted patients

#Minutes, Apr 2014 – Nov 2015



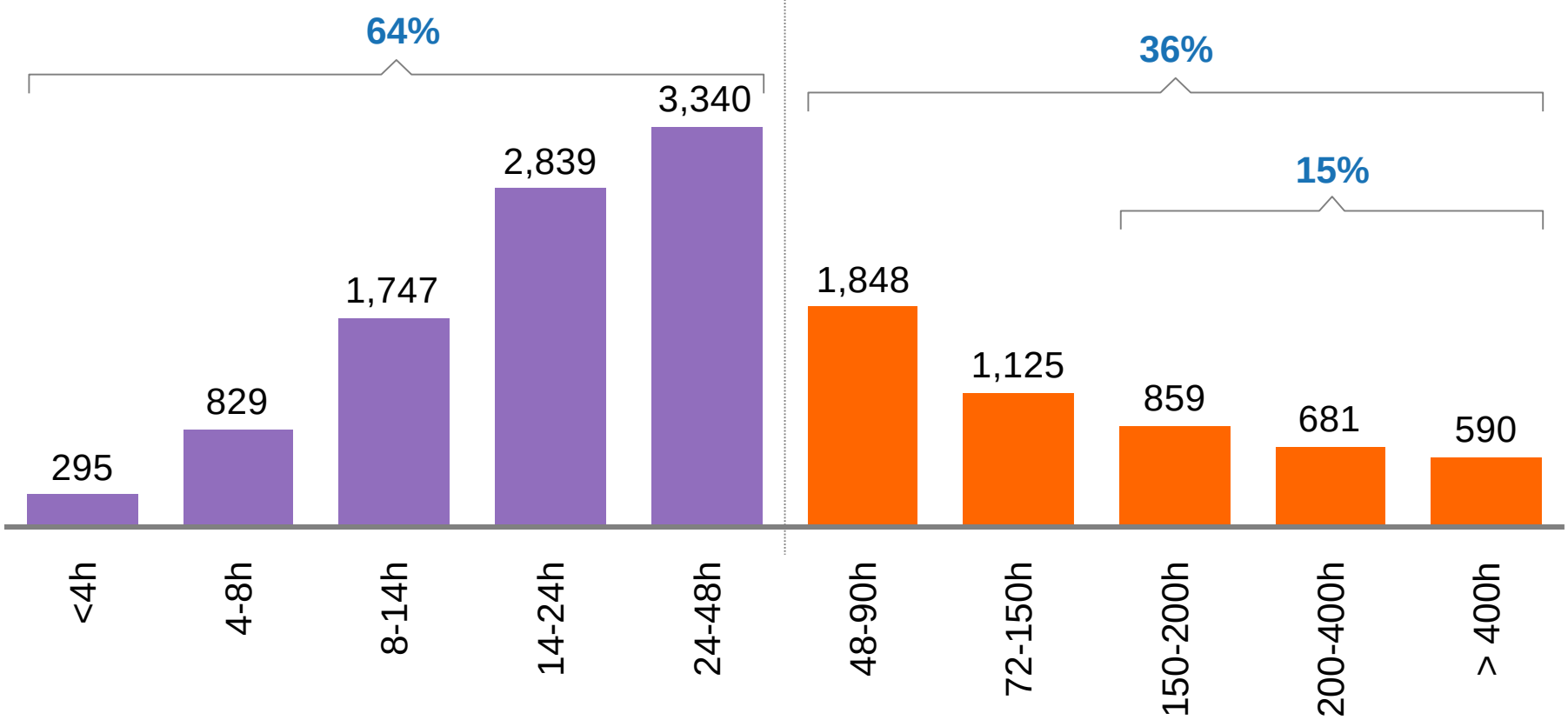
SOURCE: Trust internal ED data and McKinsey team analysis

More than one third of patients admitted to AMU stay longer than 48 hours and 15% stay longer than 6 days representing significant flow restriction

Frequency of duration of patient stays on AMU

Number of patients, Apr 2014 – Sep 2015

X% % of total number of patients in AMU

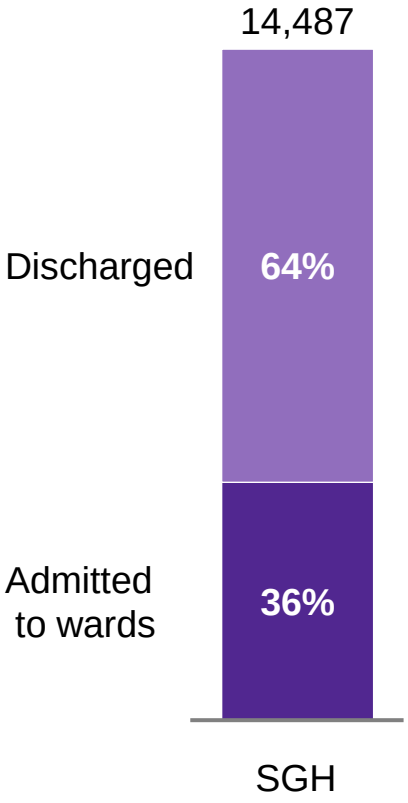


SOURCE: Trust internal wards data and McKinsey team analysis

Only 15% of patients who are discharged home from AMU on any given day leave the hospital before midday, causing significant flow problems

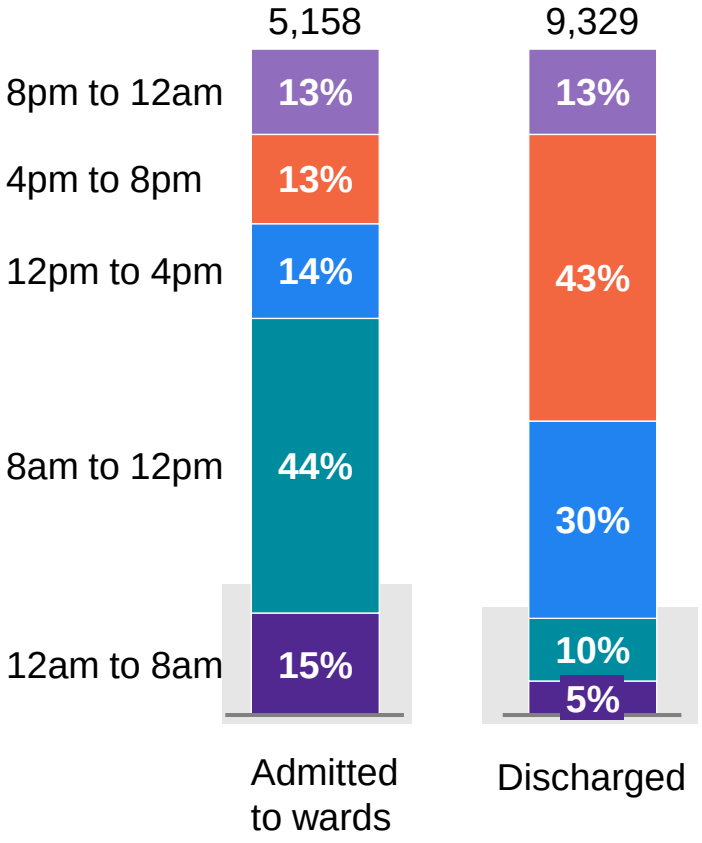
Discharge destination of AMU patients

% of patients, Apr 2014 – Sep 2015



Admission and discharges from AMU by time of day

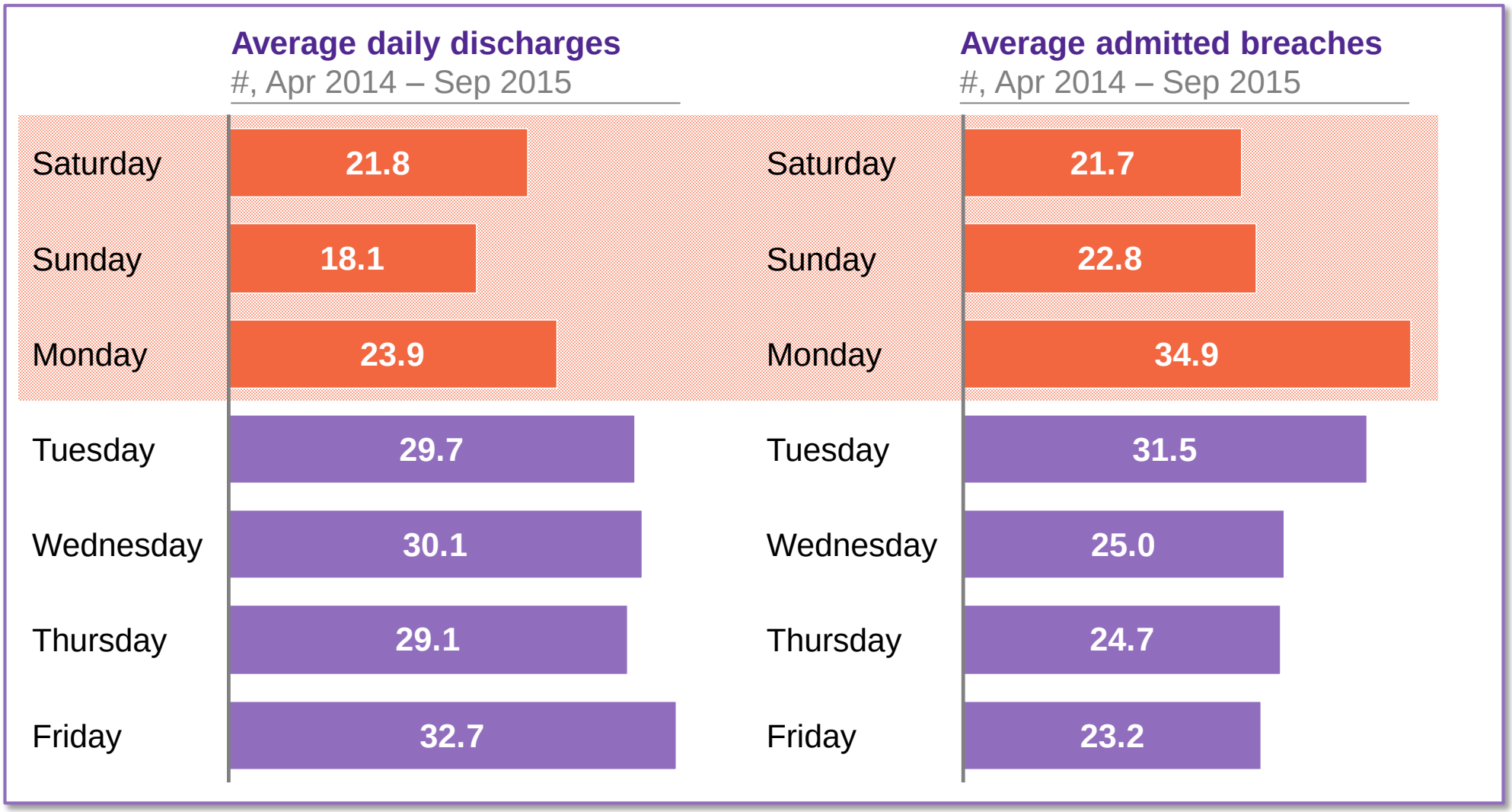
% of patients, Apr 2014 – Sep 2015



- ~60% of transfers from AMU to other wards occur before midday
- only 15% of discharges home from AMU occur before midday and 56% take place after 4.00pm including into late evening
- Since discharges home make up two thirds of AMU departures overall the flow out of AMU is too late in the day to support ED patients needing admission

SOURCE: Trust internal ED data and McKinsey team analysis

Discharges from AMU are lowest Saturday to Monday which, when combined with the Monday attendance peak, leads to high levels of admitted breaches on Mondays



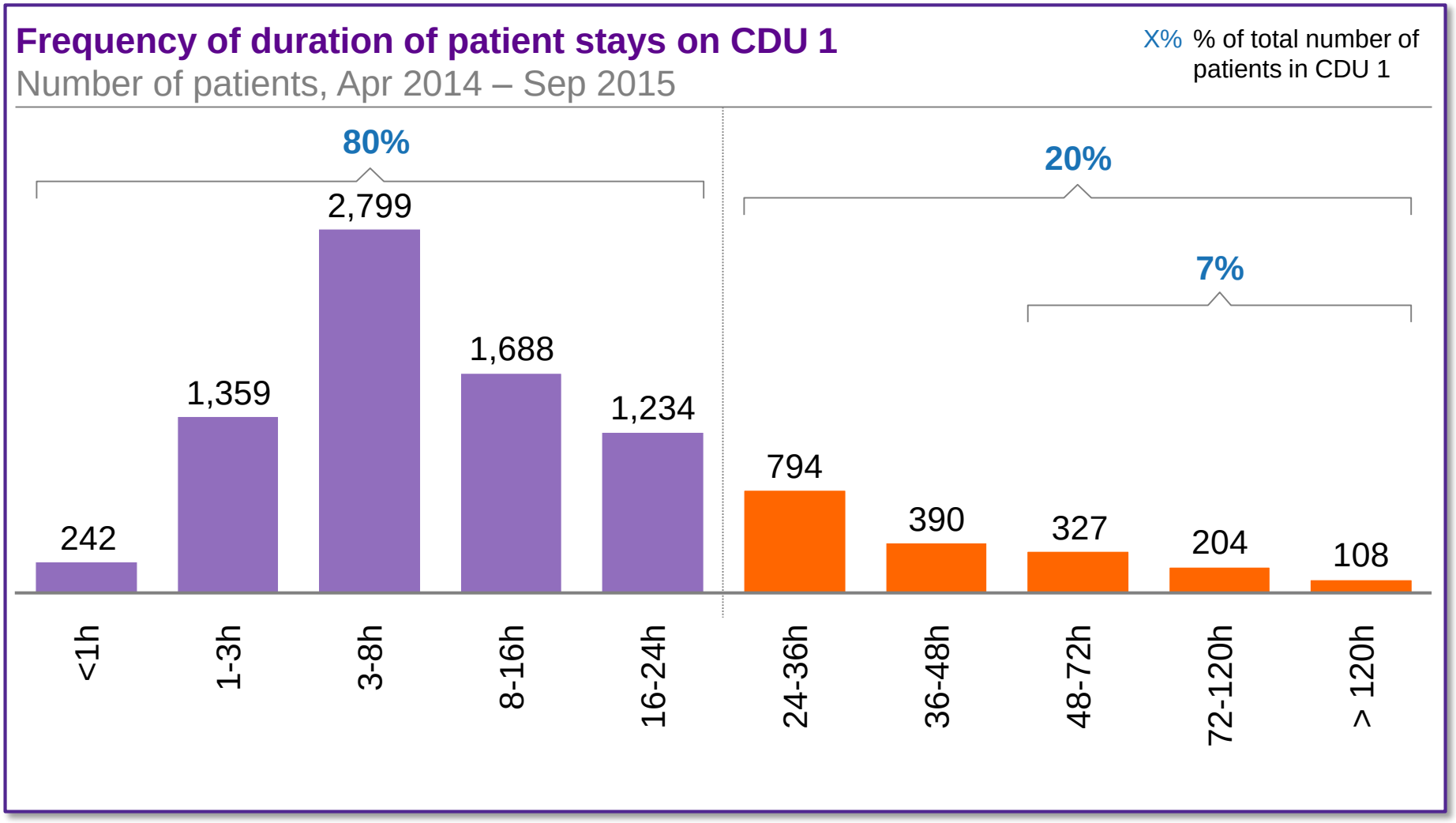
SOURCE: Trust ED and Wards data and McKinsey team analysis

20% of patients stay on CDU 1 for more than 24 hours such that part of CDU capacity functions like a small acute assessment unit

Frequency of duration of patient stays on CDU 1

Number of patients, Apr 2014 – Sep 2015

X% % of total number of patients in CDU 1

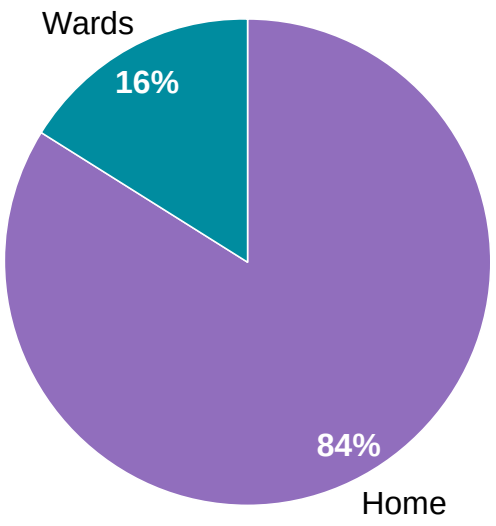


SOURCE: Trust internal wards data and McKinsey team analysis

Flow out of PAU is low between 8am and 4pm, particularly for patients that are transferred to other wards

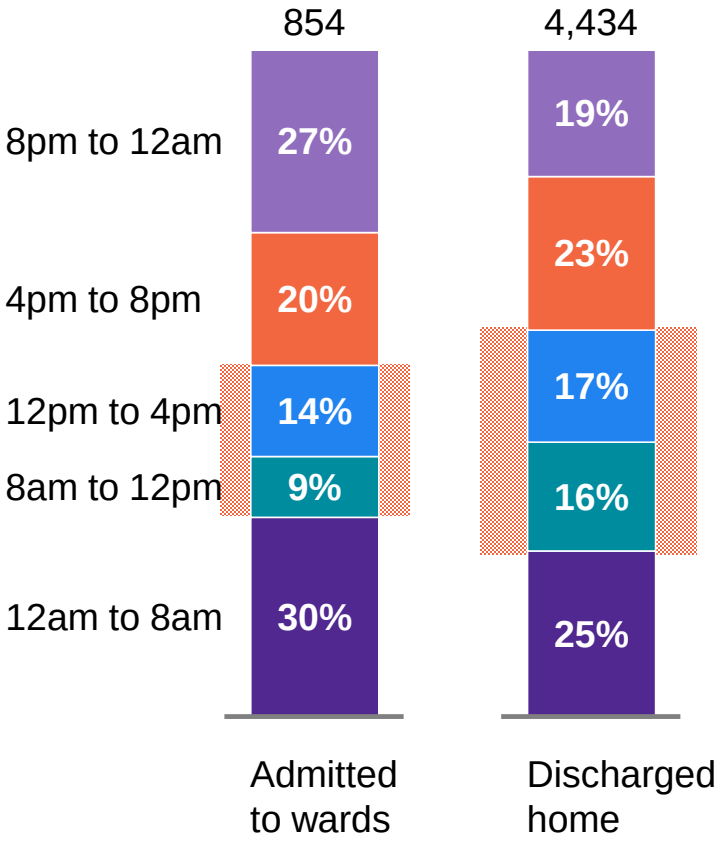
Discharge destination of patients from PAU

% of patients, Apr 2014 – Sep 2015



Admission and discharges from AMU by time of day

% of patients, Apr 2014 – Sep 2015



- 84% of patients are discharged home from PAU
- ~45% of the patients who are discharged home are discharged between 8pm and 8am, and only 33% are discharged between 8am and 4pm
- Similarly, only 23% of transfers to other wards leave PAU between 8am and 4pm, resulting in a long delay for ED patients awaiting a PAU bed

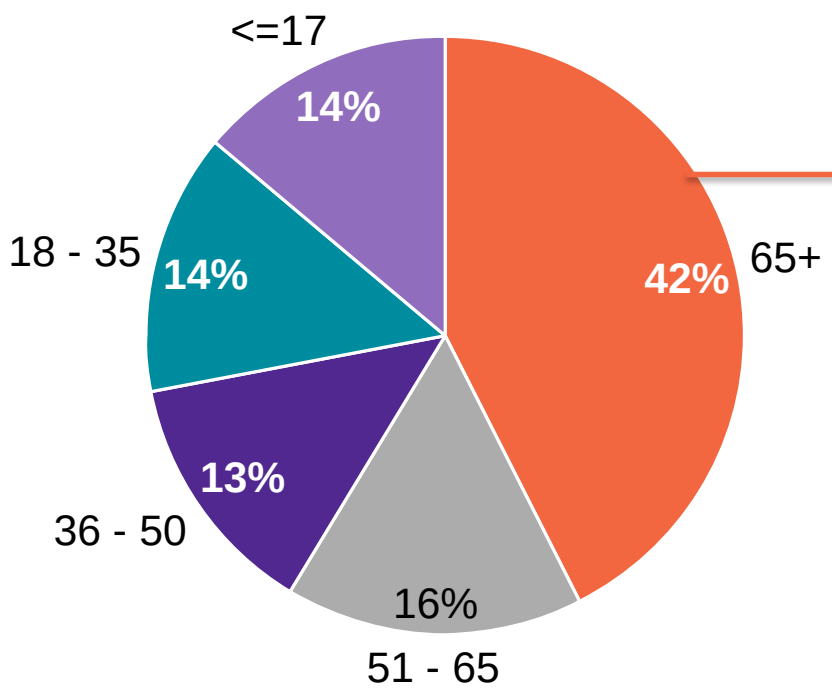
SOURCE: Trust internal ED data and McKinsey team analysis

PRELIMINARY

~ 40% of non-elective inpatients are older than 65, out of which nearly 50% are between the age of 75 and 90

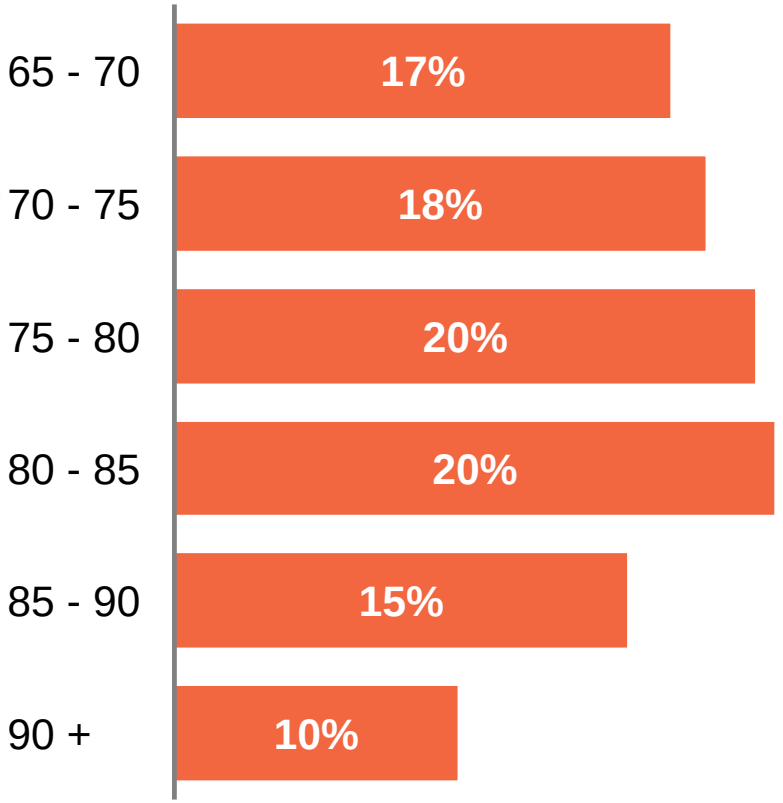
Non-elective spells by patient age

%, Oct 14 – Sep 15



Non-elective spells by patient age for patient aged 65+

%, Oct 14 – Sep 15



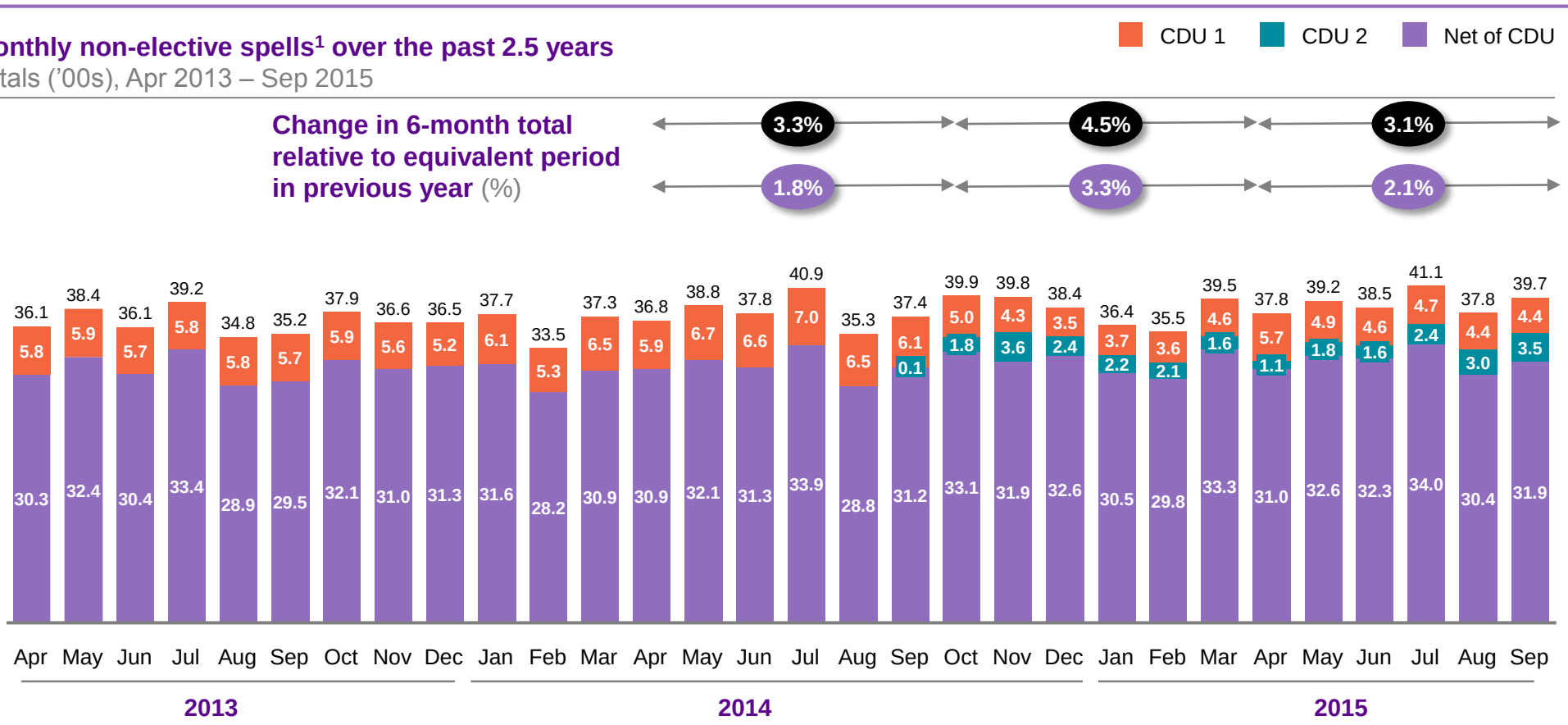
Excluding 0 LOS and maternity patients

SOURCE: Trust internal Wards data and McKinsey team analysis

PRELIMINARY

Non-elective spells net of CDU activity have consistently increased by 2-3% for equivalent 6-month periods since Apr '13

Monthly non-elective spells[1] over the past 2.5 years
Totals ('00s), Apr 2013 – Sep 2015



- Non-elective spells net of CDU activity have consistently risen relative to the same 6-month period in the previous year, albeit at a marginally slower rate than total non-elective spells

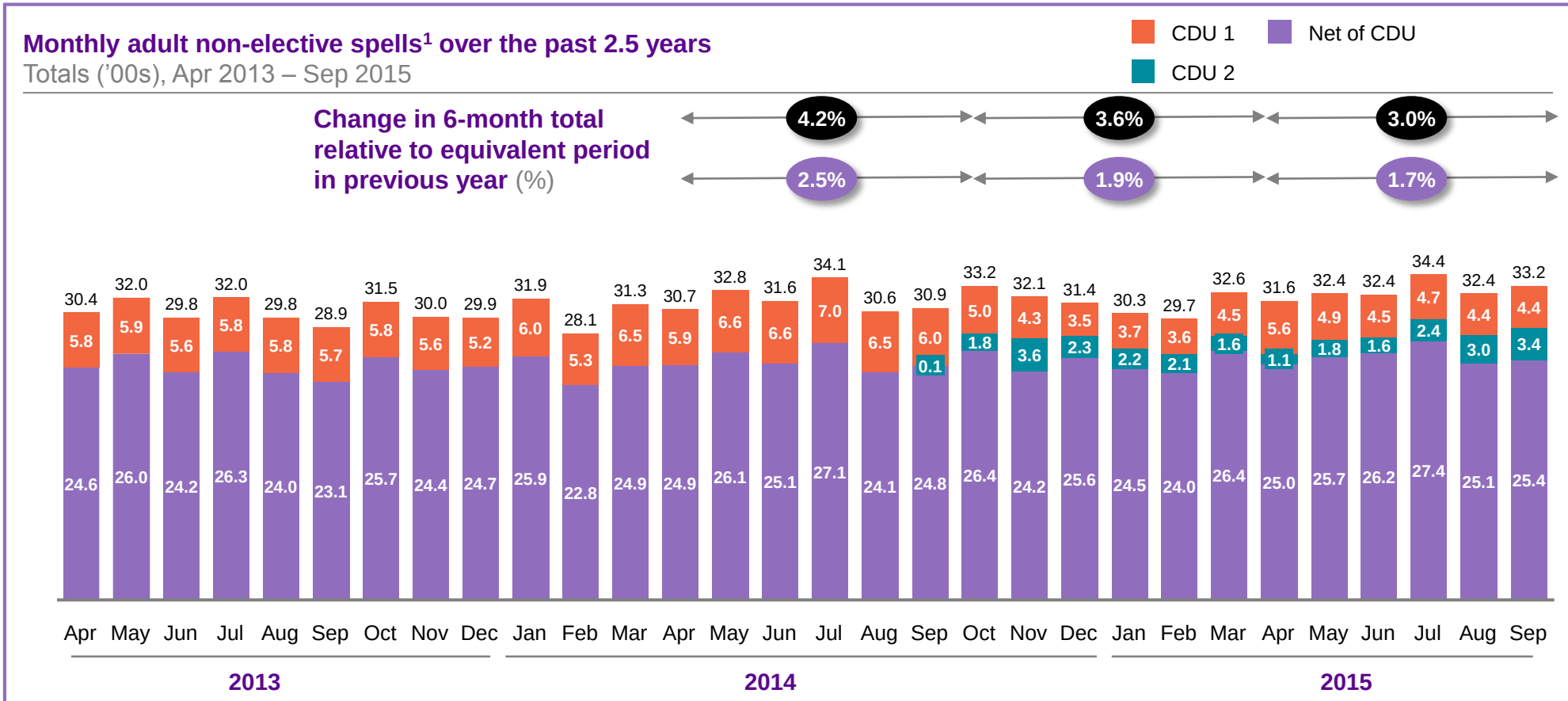
1 Total non-elective admissions, including paeds (17yrs and under) patients; excludes maternity patients

SOURCE: Trust internal inpatient data and McKinsey team analysis

PRELIMINARY

Further, net adult non-elective admissions also increased 1.7% for Apr – Sep ’15 compared to the equivalent 6-months in 2014

Monthly adult non-elective spells[1] over the past 2.5 years
Totals (’00s), Apr 2013 – Sep 2015



- Adult non-elective spells net of CDU activity has consistently grown relative to equivalent 6-month periods in the previous year, and grew 1.7% during Apr – Sep ’15 compared to Apr – Sep ’14

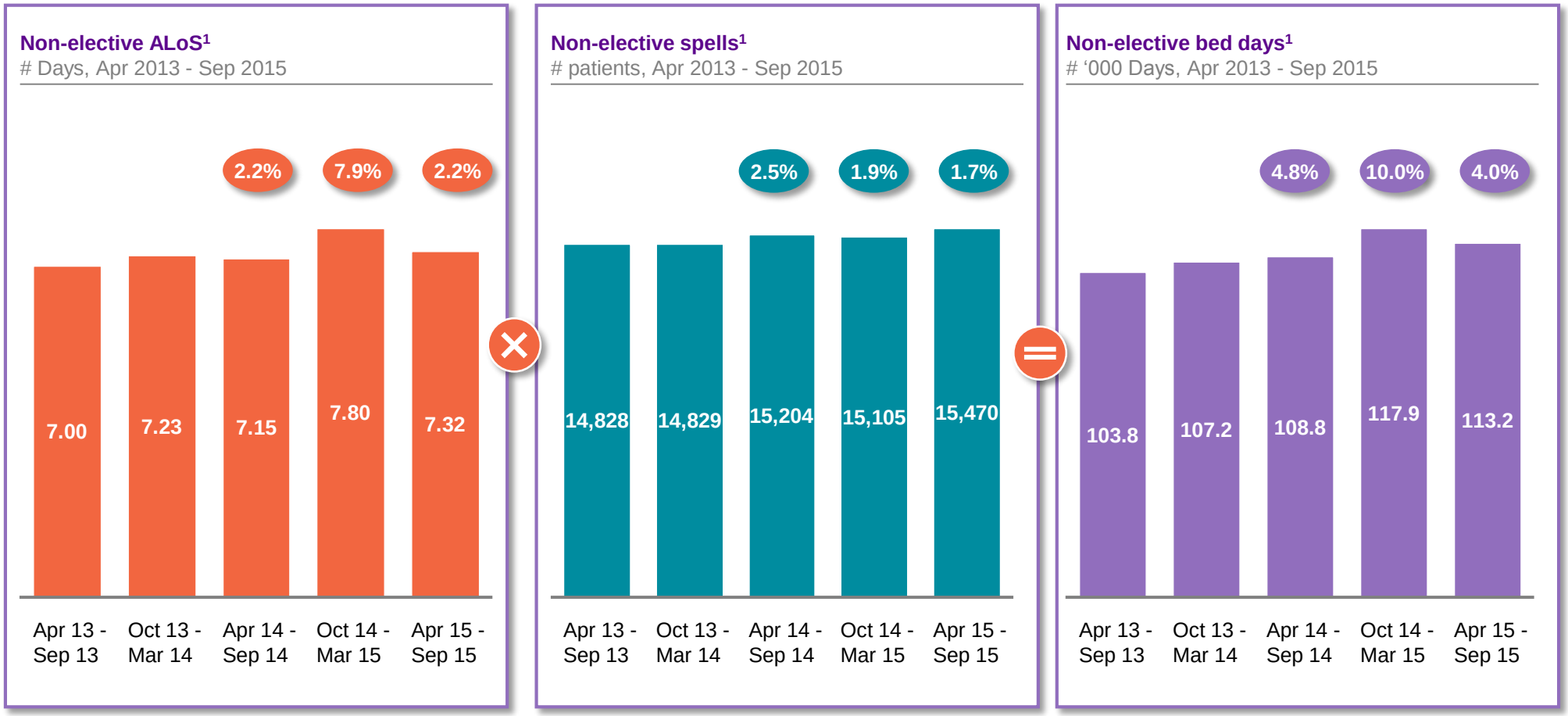
1 Total non-elective admissions, excluding paeds (17yrs and under) and maternity patients

SOURCE: Trust internal inpatient data and McKinsey team analysis

PRELIMINARY

Non-elective bed days and spells grew 4% and 1.7%, respectively, for Apr – Sep ’15 compared to 2014, yielding a 2.2% growth in ALoS

X % change in 6-month total relative to equivalent period in previous year



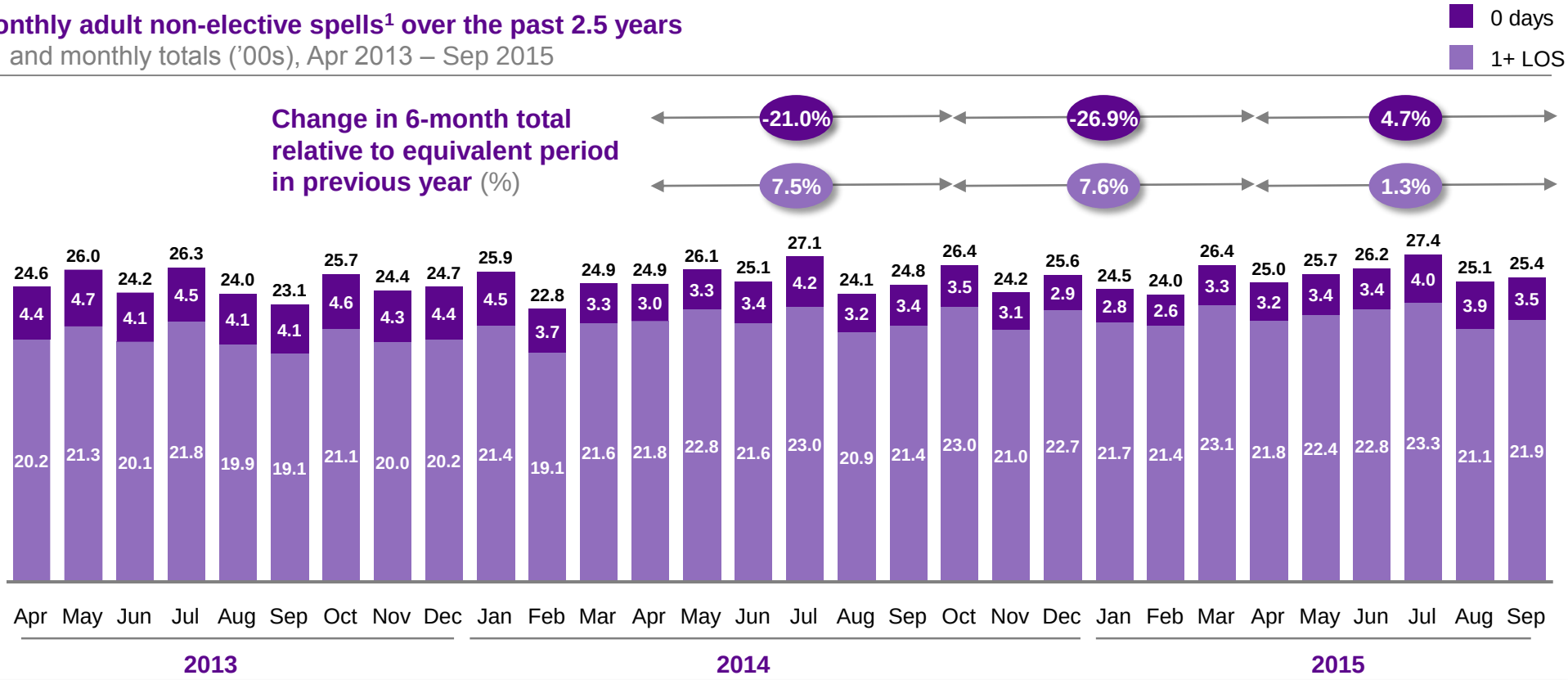
1 Excludes paeds (17yrs and under) and maternity patients, and CDU 1 and CDU 2 admissions

SOURCE: Trust internal inpatient data and McKinsey team analysis

PRELIMINARY

Adult patients with >1 day grew ~7.5% in each half of 14-15, though grew by only 1.3% during Apr – Sep '15 compared to the previous year

Monthly adult non-elective spells[1] over the past 2.5 years
%, and monthly totals ('00s), Apr 2013 – Sep 2015



- Spells of 1+ LOS grew around 7.5% during Apr – Sep '14, and Oct '14 – Mar '15, compared to equivalent 6-month periods the previous year, though grew at a slower 1.3% during Apr – Sep '15
- Non-elective spells of patients with O LOS, however, have grown 4.7% relative to Apr – Sep '14, after having declined in both halves of 14-15

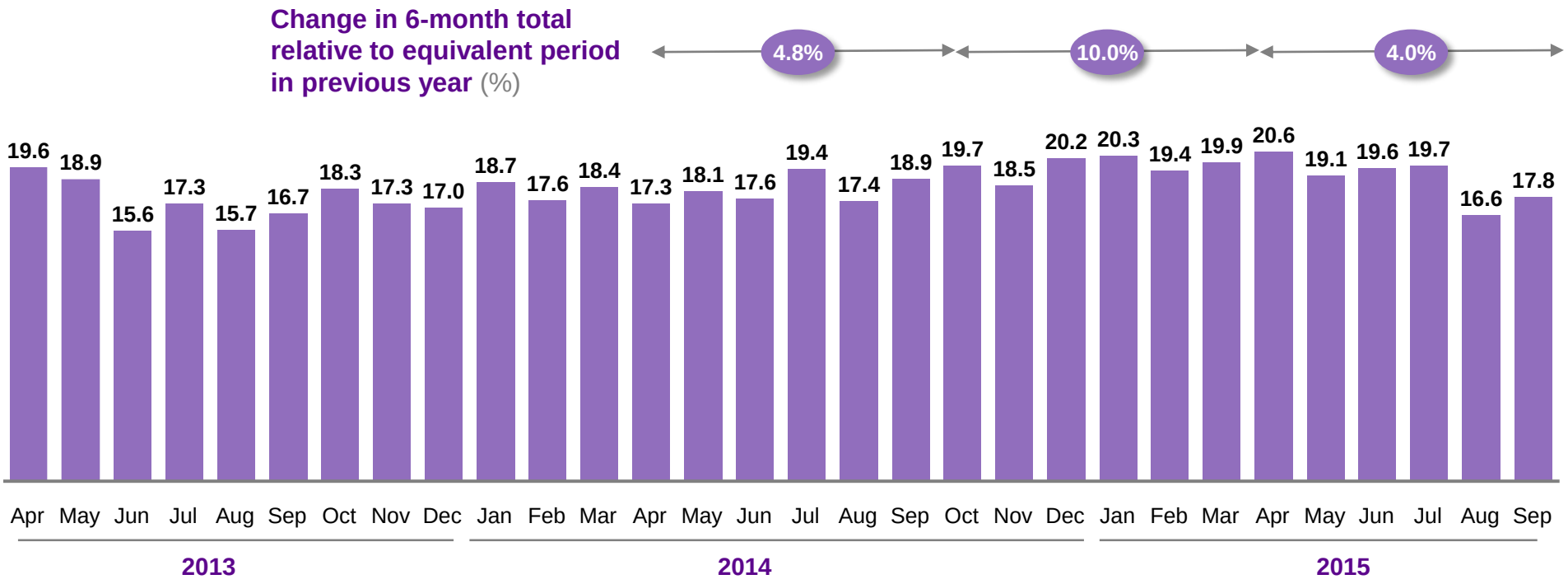
1 Excludes maternity and paeds (17yrs and under) patients, and patients admitted to CDU 1 and CDU 2

SOURCE: Trust internal inpatient data and McKinsey team analysis

PRELIMINARY

Non-elective bed days for adults have consistently increased for equivalent 6-month periods over the past 1.5 years

Monthly non-elective adult bed days[1] over the past 2.5 years
Totals ('000s), Apr 2013 – Sep 2015



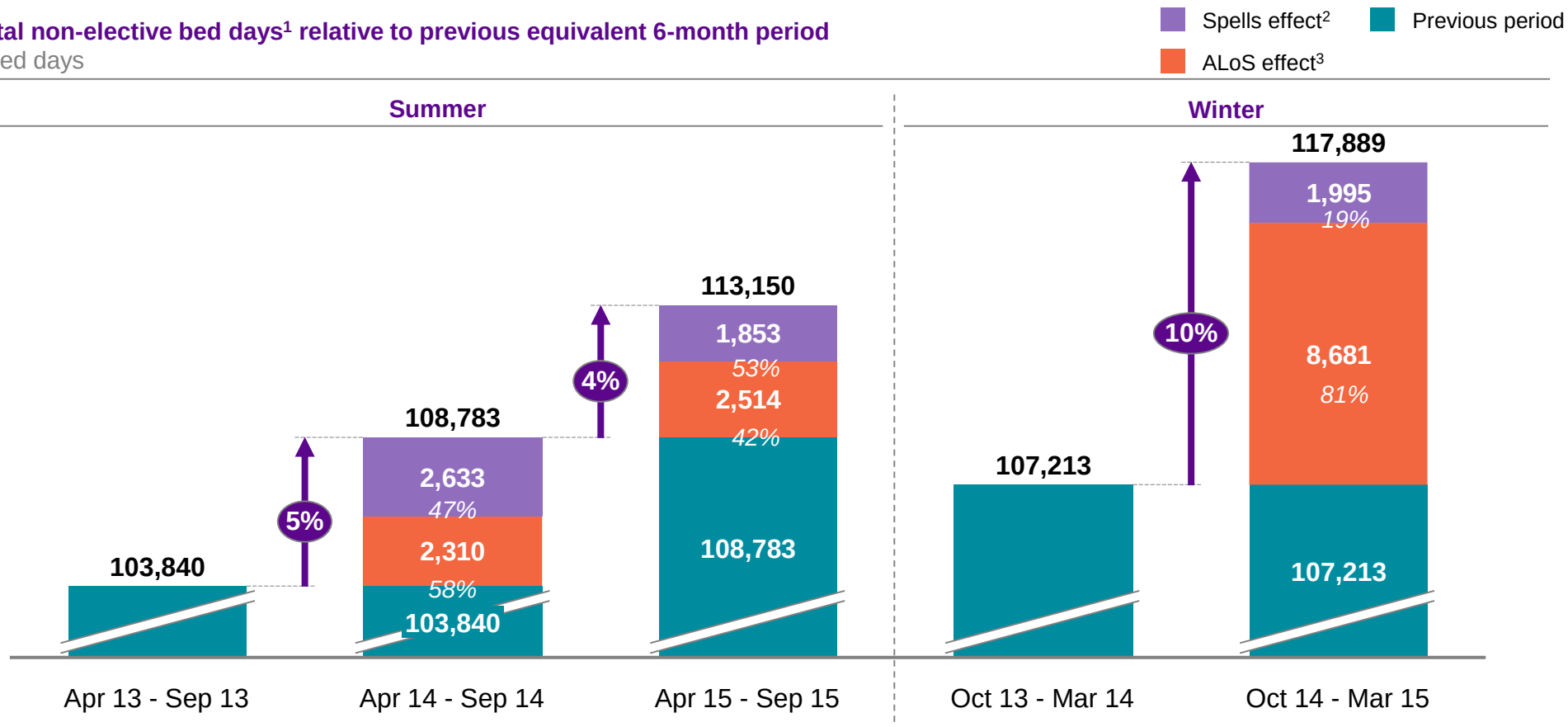
- Non-elective bed days for adult patients grew by over 4% each 6-month period since Apr '14, when compared to the equivalent 6-month period the previous year

1 Excludes paeds (17yrs and under) and maternity patients, and patients admitted to CDU 1 and CDU 2

SOURCE: Trust internal inpatient data and McKinsey team analysis

The spells effect accounts for 47-53% of bed-day increases in the summer, however, in the winter, 81% of the increase is driven by the ALoS effect

Total non-elective bed days[1] relative to previous equivalent 6-month period
bed days



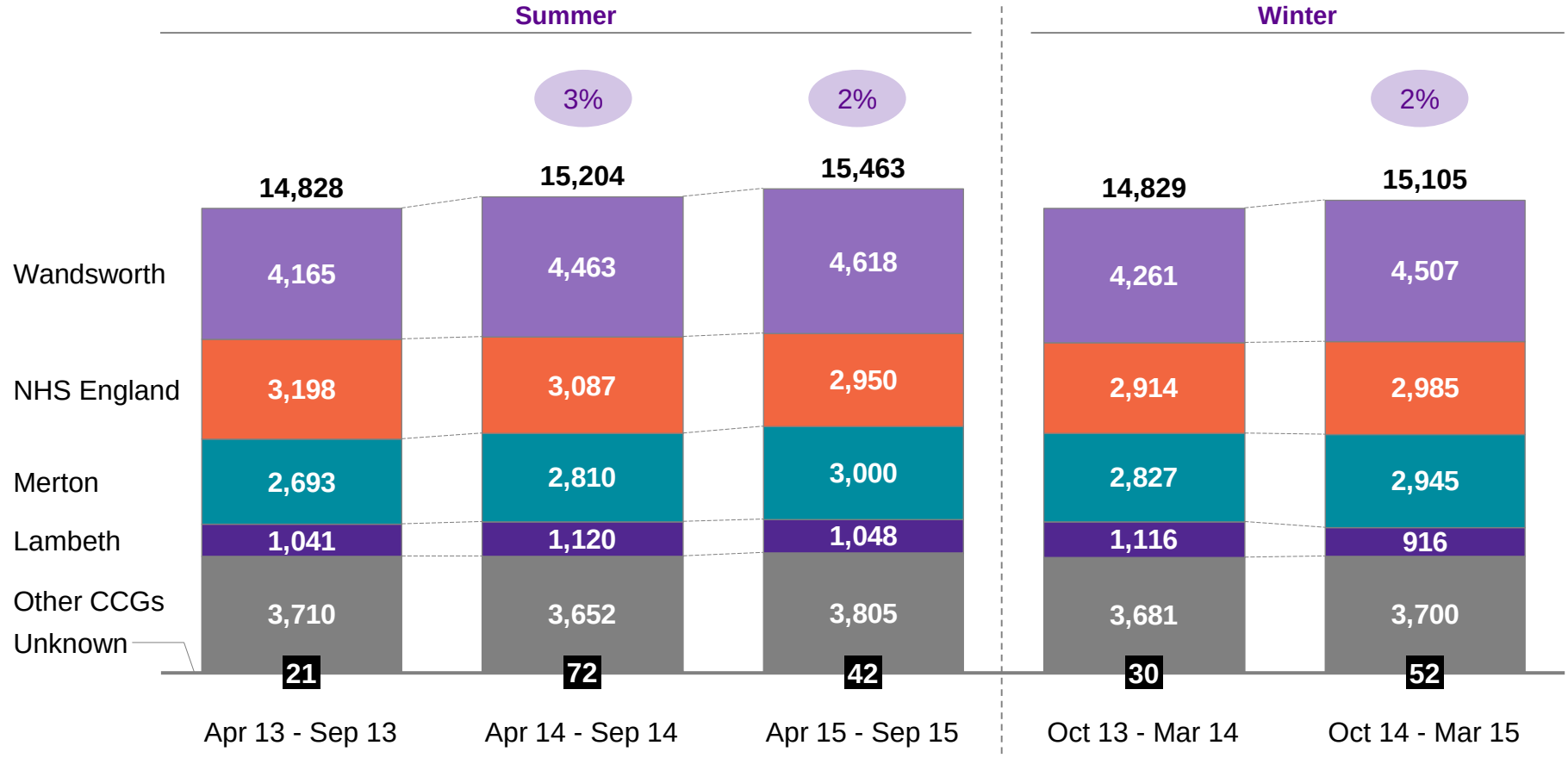
- The spells effect accounts for 47-53% of bed day increases between consecutive summer months
- In contrast, the spells effect accounts for only 19% of the bed day increase from Oct 13 – Mar 14, and Oct 14 – Mar 15

1 Excluding maternity, paeds (17yrs and under), and CDU admissions
2 Bed day increases attributable to rise in volume of spells
3 Bed day increases attributable to rise in ALoS of spells
SOURCE: Trust inpatient data and McKinsey team analysis

Non-elective spells have continuously increased for equivalent 6-month periods for Wandsworth and Merton

Non-elective spells[1] by CCG over the past 2.5 years
spells

x% % overall change since previous equivalent 6-months



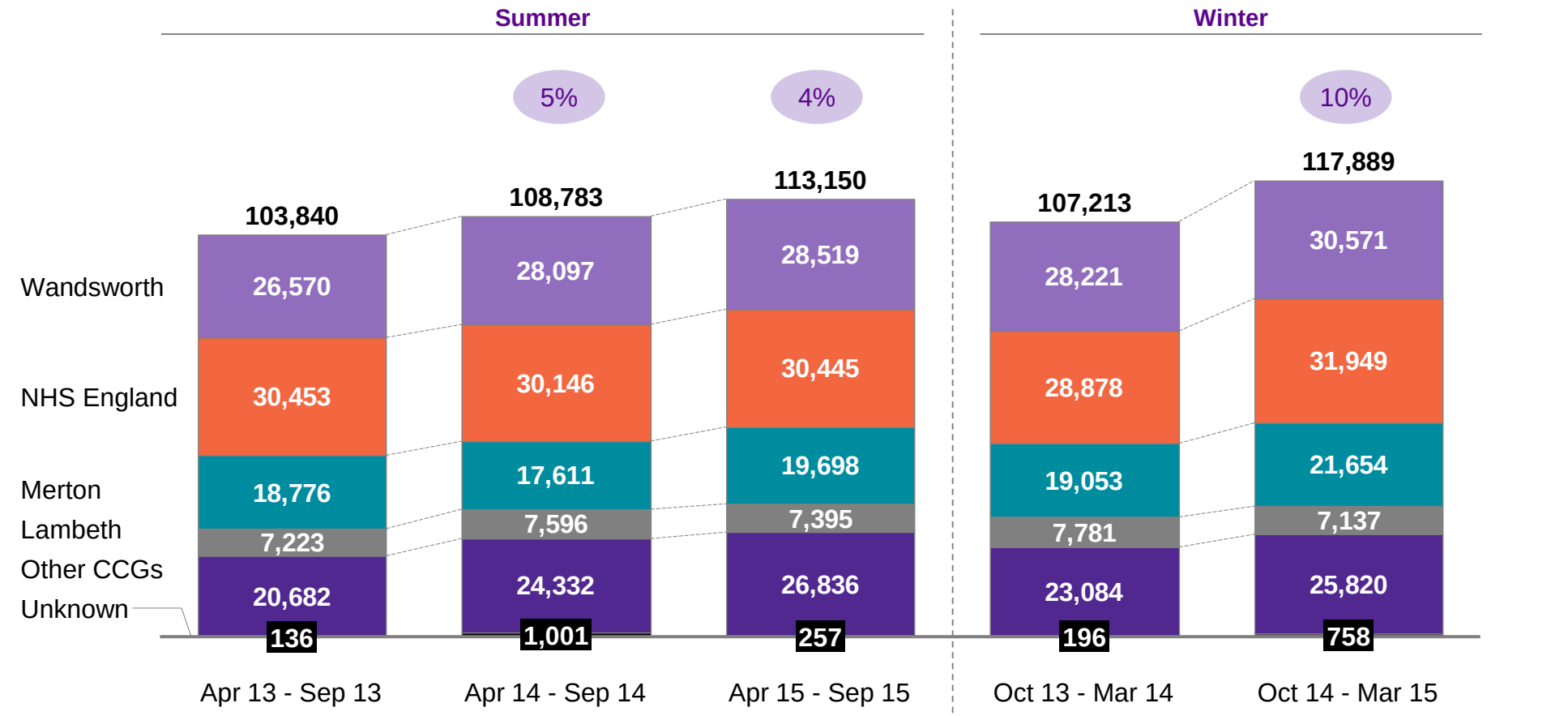
1 Excluding maternity, paeds (17yrs and under), and CDU admissions

SOURCE: Trust inpatient data and McKinsey team analysis

Further, non-elective bed days have consistently increased for Wandsworth, NHS England and other CCGs

Non-elective bed days[1] by CCG over the past 2.5 years
bed days

x% % overall change since previous equivalent 6-months



1 Excluding maternity, paeds (17yrs and under), and CDU admissions

SOURCE: Trust inpatient data and McKinsey team analysis

Changes in bed days are driven by a combination of the ALoS effect and spells effect

Change in non-elective bed days[1] relative to previous equivalent 6-month period
bed days

Spells effect | ALoS effect

CCG	Apr 14 - Sep 14	Apr 15 - Sep 15	Oct 14 - Mar 15
Wandsworth	-374 1,901 **1,527**	-554 976 **422**	1,629 721 **2,350**
NHS England	**-307** -1,057 750	-1,338 1,637 **299**	704 2,367 **3,071**
Merton	**-1,165** -1,981 816	1,191 896 **2,087**	795 1,806 **2,601**
Lambeth	548 -175 **373**	**-201** 287 -488	**-644** -1,394 750
Sutton	**-662** -413 -249	292 350 **642**	236 -31 **205**
Croydon	1,249 48 **1,297**	102 -90 **12**	578 1,801 **2,379**
Kingston	1,064 257 **1,321**	**-523** -211 -312	359 -90 **269**
Richmond	521 -115 **406**	324 576 **900**	463 -400 **63**
Other	-322 1,610 **1,288**	312 1,161 **1,473**	**-180** 858 -1,038

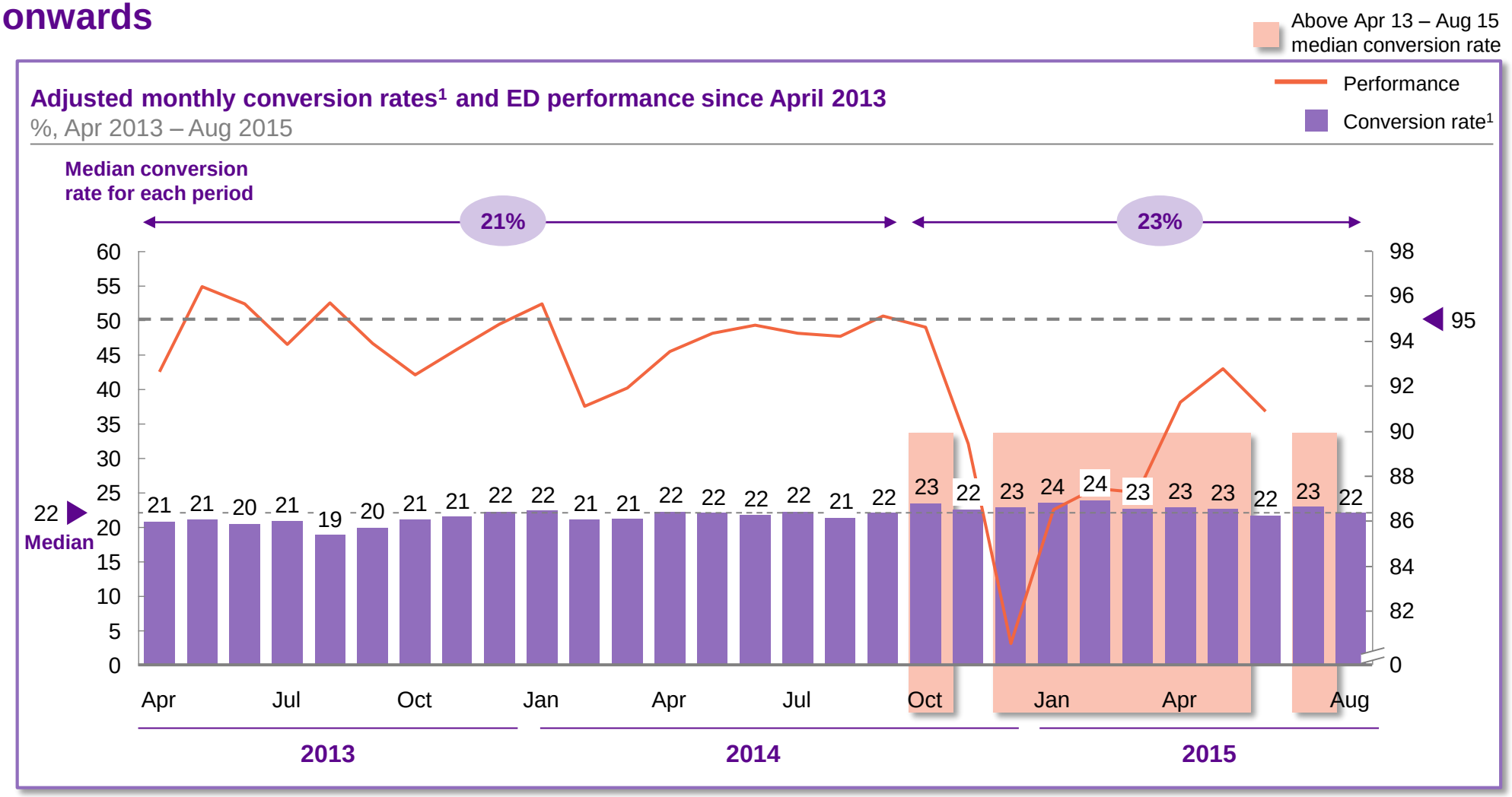
- The spells effect accounts for changes in bed days resulting purely from differences in the volume of spells
- The ALoS effect, in contrast, accounts for changes to bed days from differences in the ALoS of patients across varying periods

1 Excluding maternity, paeds (17 years or younger), and CDU admissions

SOURCE: Trust inpatient data and McKinsey team analysis

PRELIMINARY

Adjusting for recent accounting changes, the median conversion rate for Oct 14 – Aug 15 rose 2 p.p. to 23% compared to the 21% before performance declined in Oct 14 onwards



1 Type 1 A&E attendances divided by admissions via Type 1 A&E, net of CDU admissions – excludes patients navigated back to primary care from attendance figures Jun '14 onwards (not recorded in attendances prior to this); figures include adult and pediatric (17 years and under) activity

SOURCE: Trust internal ED data and McKinsey team analysis

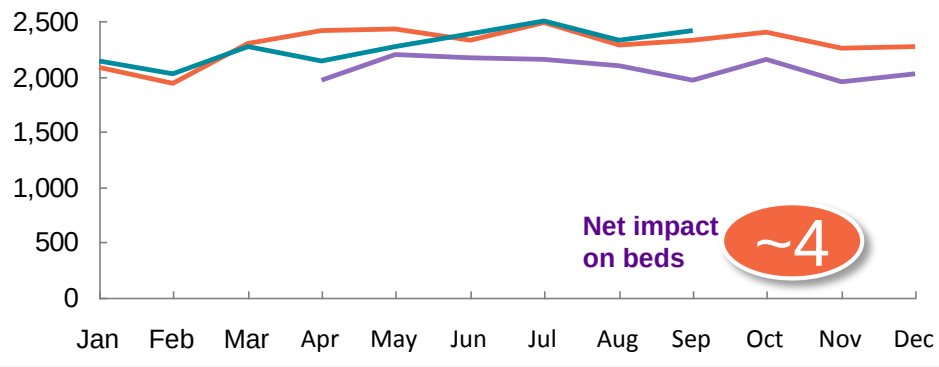
PRELIMINARY

As a result, the hospital has ~86 more non-elective adult beds occupied this year relative to 2013

2013 2014 2015

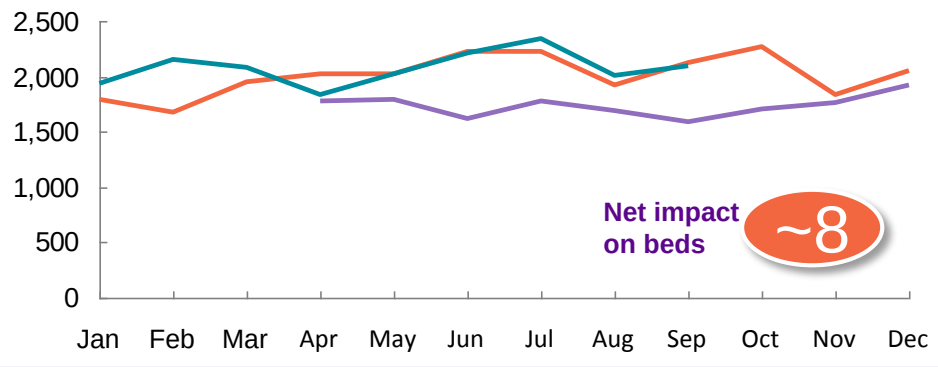
Number of non-elective admissions with 1-3 LOS by arrival month

#, Apr 2013 – Sep 2015



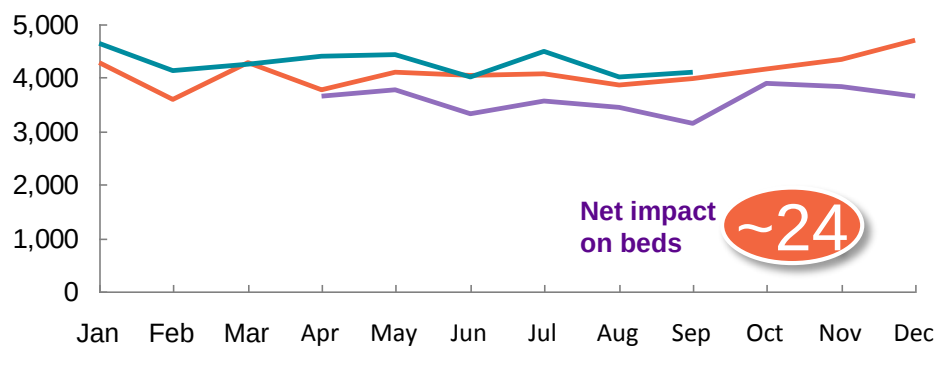
Number of non-elective admissions with 4 – 6 LOS by arrival month

#, Apr 2013 – Sep 2015



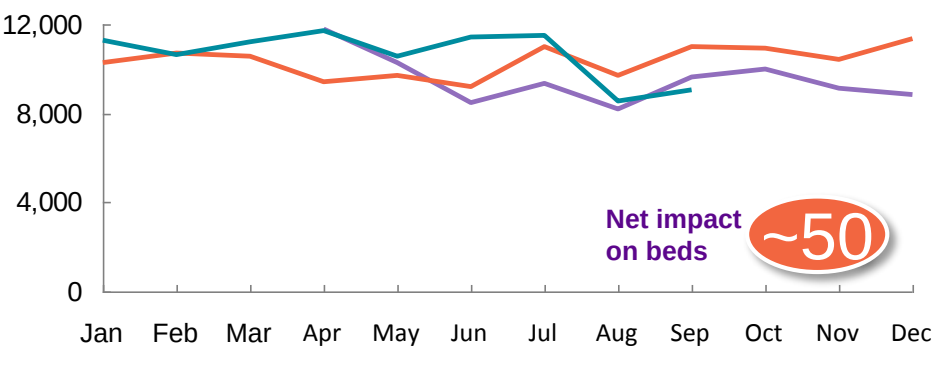
Number of non-elective admissions with 7 – 14 LOS by arrival month

#, Apr 2013 – Sep 2015



Number of non-elective admissions with 14+ LOS by arrival month

#, Apr 2013 – Sep 2015



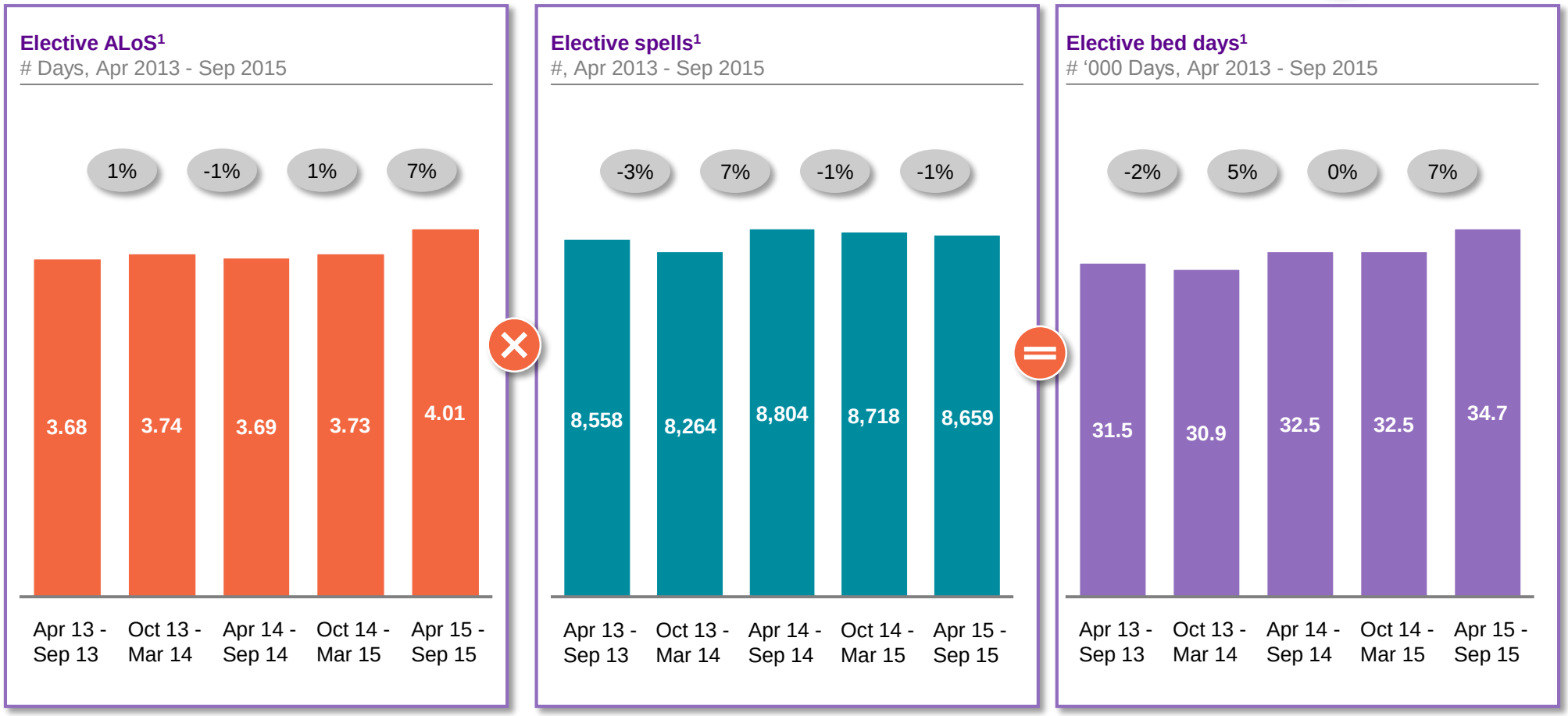
NOTE: Excluding all maternity and paeds (17yrs and under) patients

SOURCE: Trust internal wards data and McKinsey team analysis

PRELIMINARY

Although elective inpatient spells have remained stable for 18 months, elective ALoS has increased, particularly over the last 6 months

X % change



- Both elective bed days and inpatient spells have increased over the last 2 years
- However, since the rise in elective bed days is higher than the rise in number of elective spells, the elective ALoS has also increased in the last 2 years

1 Excluding elective day cases

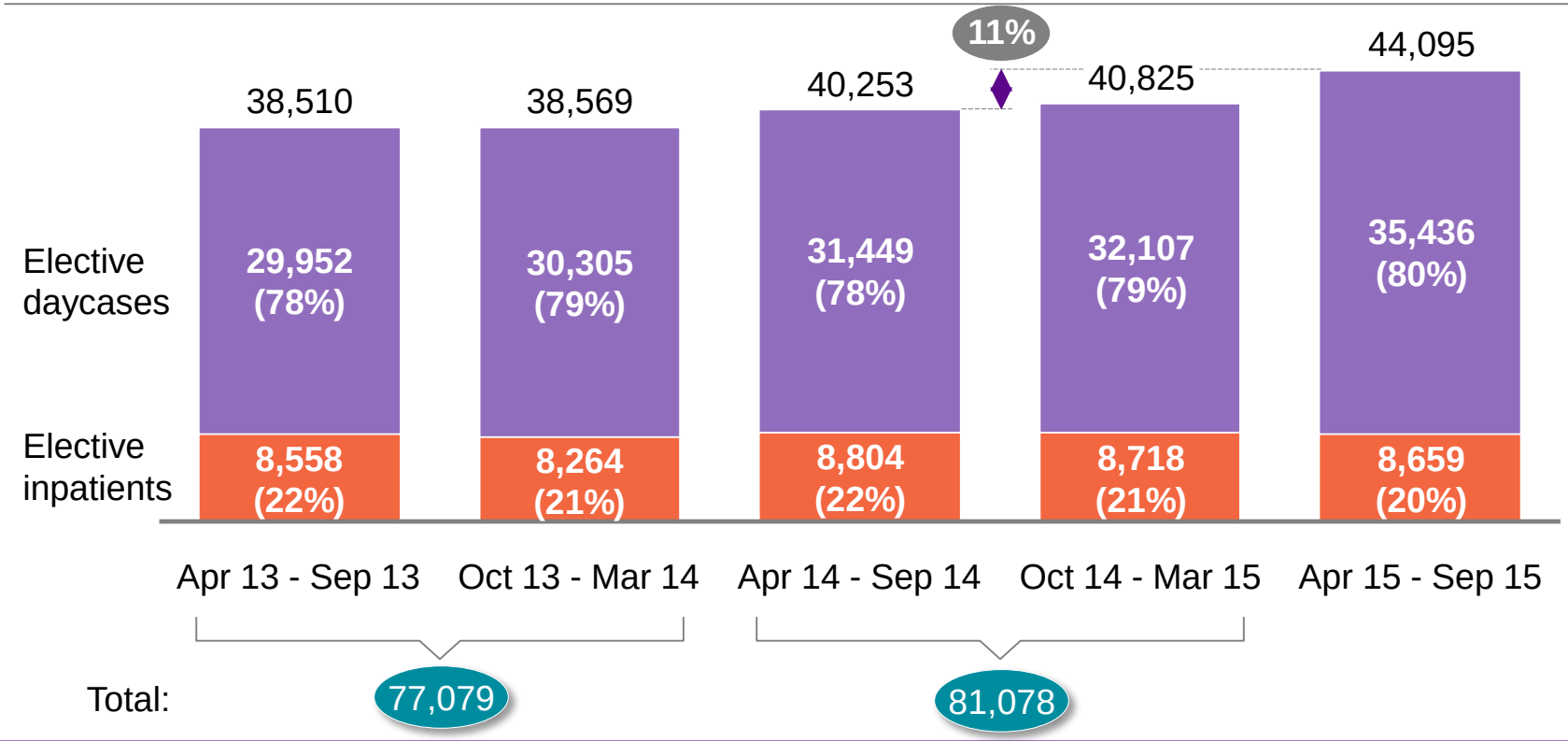
SOURCE: Trust internal inpatient data and McKinsey team analysis

PRELIMINARY

At the same time elective day cases have increased steadily year on year, and by 11% over the last six months

Elective inpatient spells[1] by admission month

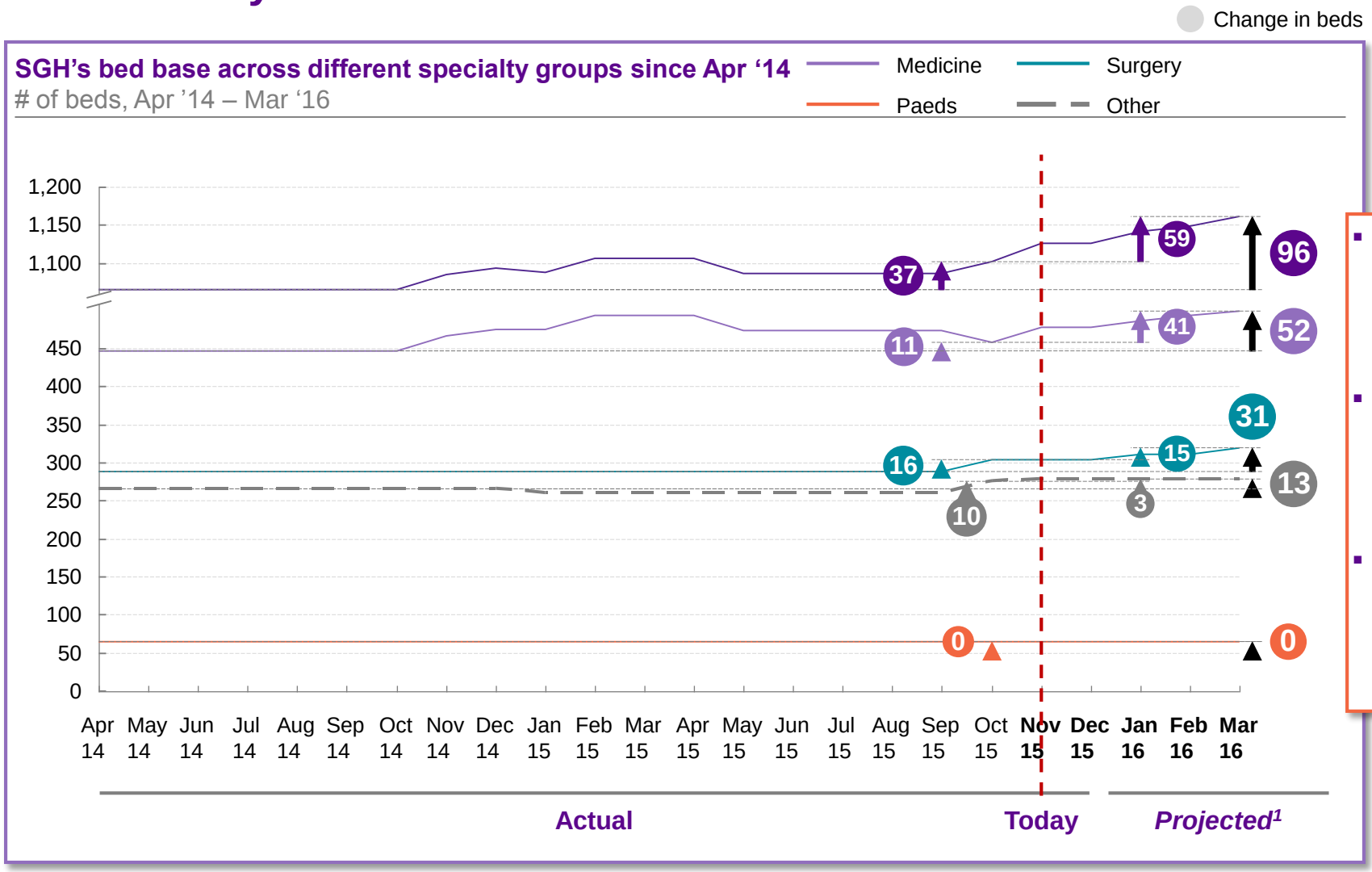
#, Sep 2012 – Aug 2015



1 Excluding maternity patients

SOURCE: Trust internal inpatient data and McKinsey team analysis

SGH's total bed base has increased 3% since April 2014, and is set to grow a further 5% by the end of March 2016



- **37 additional beds** have been added in total since Apr '14, representing a **3% increase**
- SGH has planned for a **5%** further increase, with **59 beds** to be added by **Mar '16**
- The growth in bed-base is driven primarily by **medicine and surgery beds**

1 Projections based on agreed bed numbers for financial year 2015-16

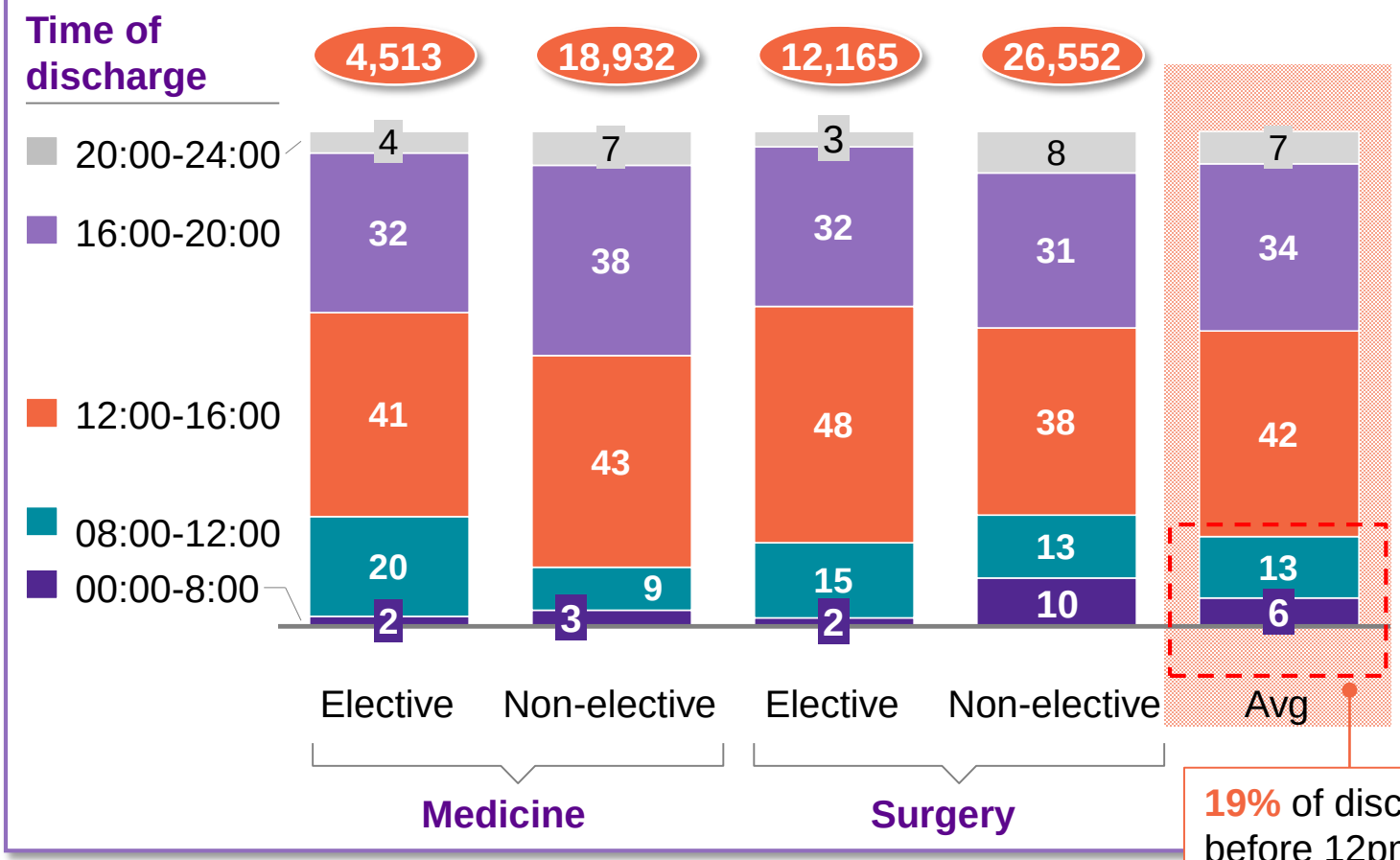
SOURCE: Trust internal ED data and McKinsey team analysis

PRELIMINARY

St. George's discharge only 19% of patients before midday, largely driven by low numbers of early discharges of non-elective medical patients

Proportion of patients[1] discharged by time of day

%, Oct 2014 – Sep 2015



- 19% of overall discharges occur before midday
- Non elective medicine wards show a very low proportion of discharges before midday
- 40-45% of non-elective discharges occur after 4pm

19% of discharges before 12pm

1 Excludes day cases, maternity patients

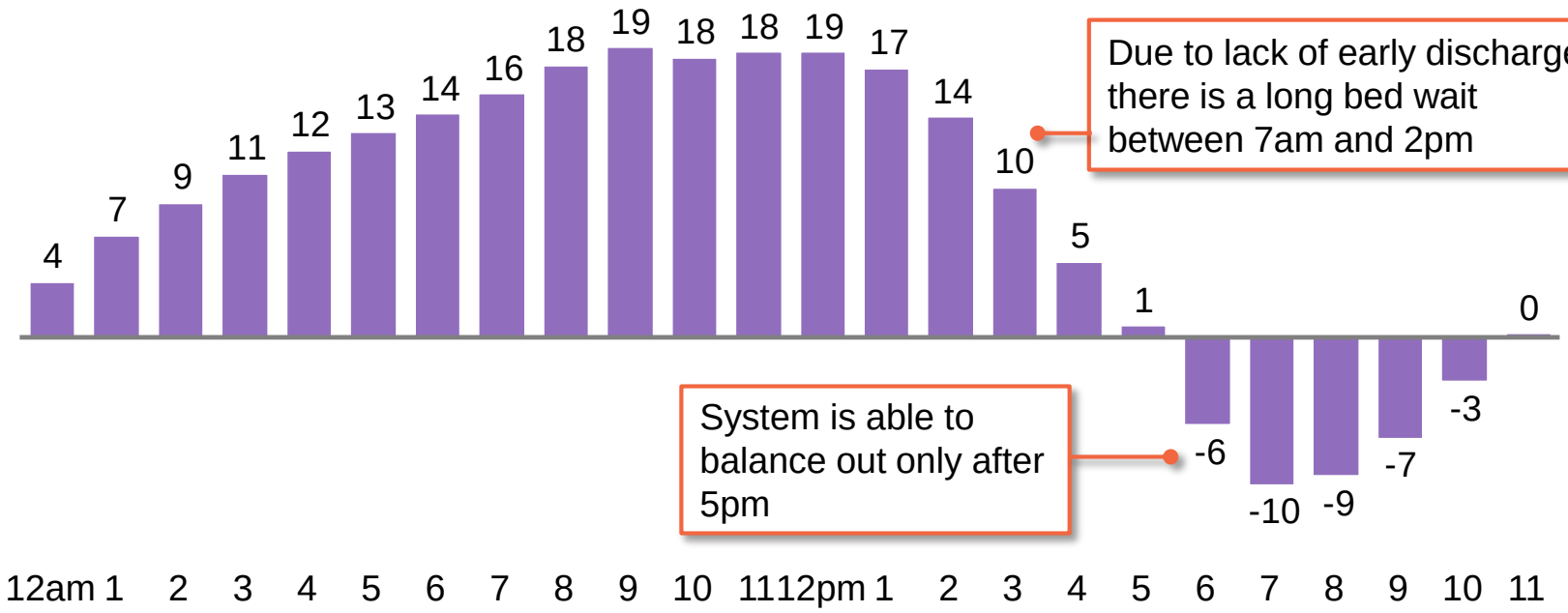
SOURCE: Trust internal inpatient data and McKinsey team analysis

PRELIMINARY

Net balance of non-elective patient admissions and discharges creates a peak additional occupancy of 19 patients and delays early flow from AMU and ED

Average cumulative net flow of non-elective patients[1] throughout the day

#, Oct 2014 – Sep 2015



1. A **lack of discharges** early in the day lead to a daily net inflow until 6pm
2. In times of high occupancy, this net increase result in less beds available to accommodate patients from ED and AMU

1 Excluding maternity and Paeds (17yrs and under), patients

SOURCE: Trust internal inpatient data and McKinsey team analysis

PRELIMINARY

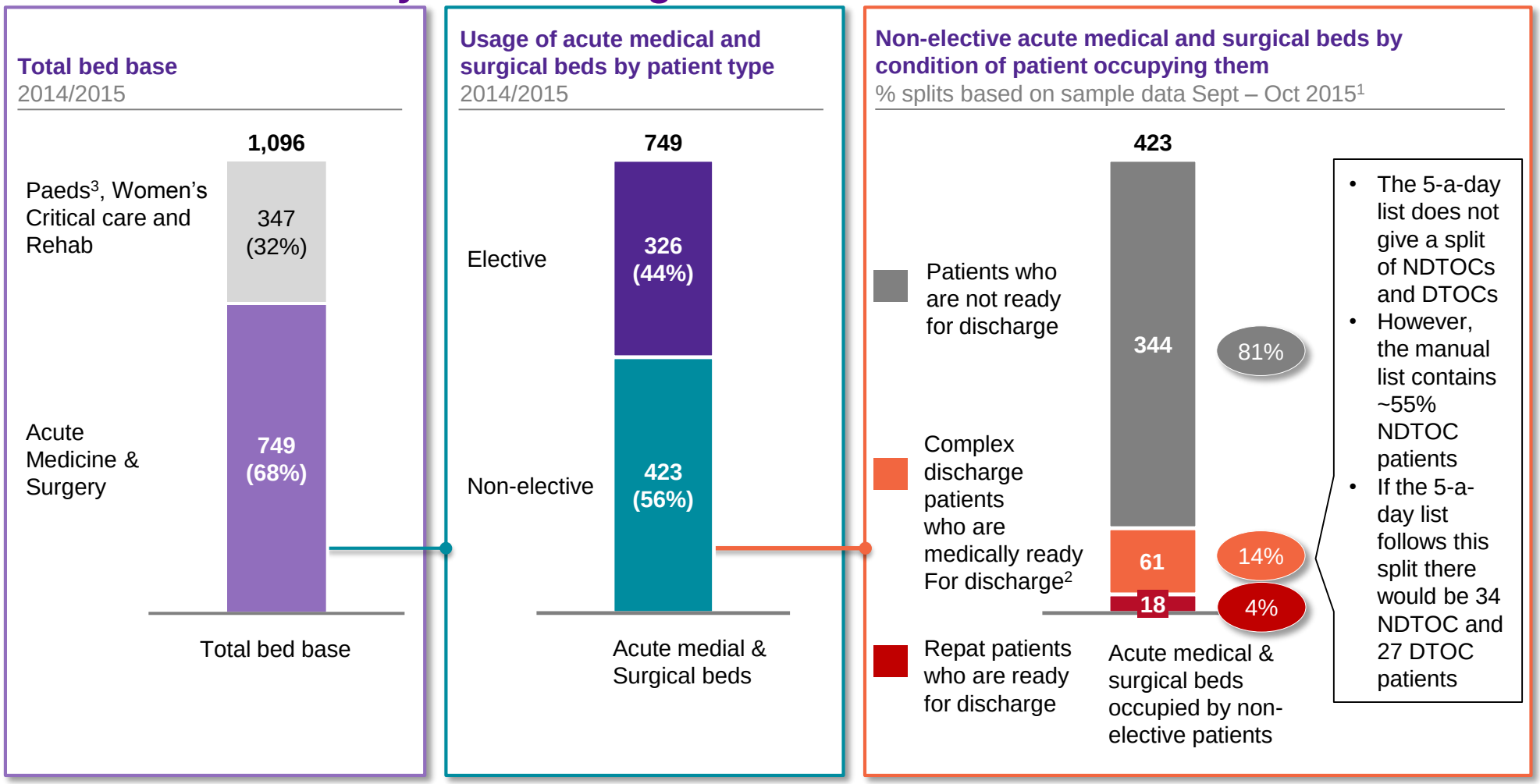
There are four sources of data in the trust to track delayed discharges

Data source	What is it	How we used each data source in our analysis: Sizing the issue	High level trend	Root cause
Manual list of DTOC[1] / NDTOCs[2]	▪ List updated daily by pathway coordinators ▪ Manual data entry (free text) ▪ May miss some patients	☐	☐	☑
5-a-day data	▪ Data validated though iclip ▪ Implemented in May 2015 ▪ Covers 80-85% of inpatients in selected wards	☑	☐	☐
Repatriation data	▪ Electronic web-based dataset ▪ Data collected internally	☐	☑	☑
National DTOC data	▪ Data publically available on the internet ▪ Based on data from the manual list (see above)	☐	☑	☐

1 DTOC (delayed transfer of care): patient in an acute bed, medically and MDT cleared for discharge, safe and awaiting discharge; 2 NDTOC: patient in an acute bed, medically but not MDT cleared for discharge

SOURCE: Expert interviews and McKinsey team analysis

18% of SGH's adult non-elective medical and surgical bed base is occupied by patients who are ready for discharge



1 % splits are based on a sample of 5-a-day data for Sept - Oct 2015 and applied to the non-elective bed base of 423, This method was used because the 5-a-day reporting system is only used for 80-85% of patients across medical and surgical wards.
2 Patients are defined as being 'fit' or 'not fit' in the 5-a-day list. Being 'fit' is taken as meaning medically ready for discharge.
3 17yrs and under

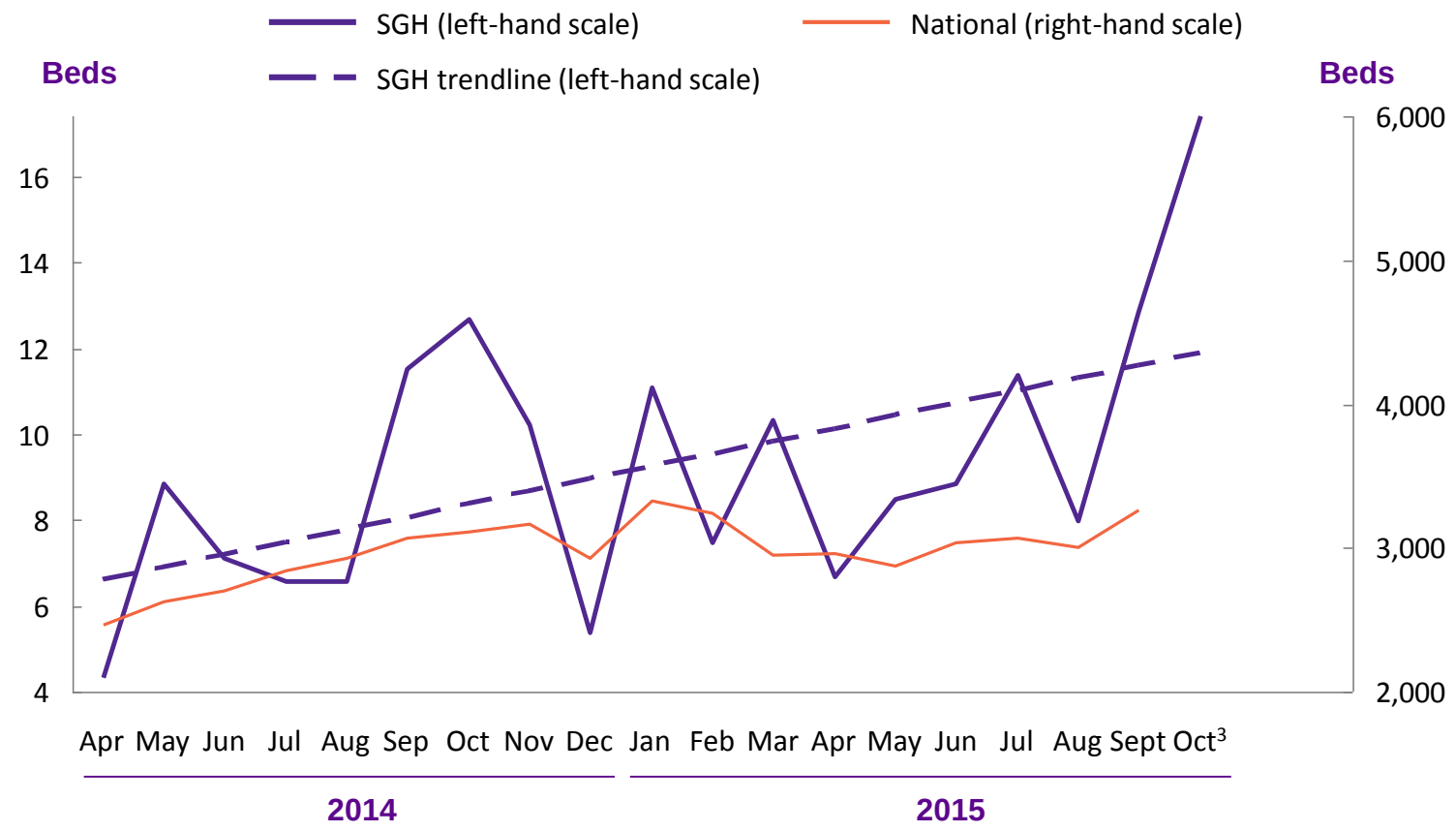
SOURCE: Trust internal data for the 2014/15 financial year, Trust "5-a-day" list Sept-Oct 2015, and Trust repatriation reporting, Apr-Oct 2015

The trend in reported delayed transfers of care has risen above national levels and shows an acute rise in Sept-Oct 2015

PRELIMINARY

Patients with delayed transfers of care (DTOC[1] – NHS England)

Ave # beds occupied by 'DTOC' patients during month[2], Apr 2014 – Sep 2015 (acute and non-acute)



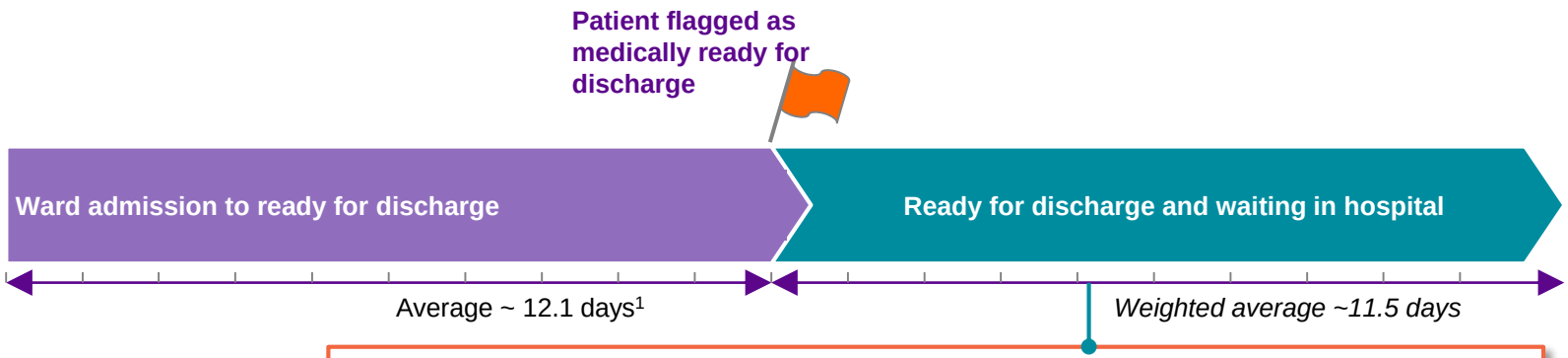
- Reported DTOCs at St Georges show an upward trend over the last two years with a recent rapid deterioration
- There is high variability from month-to-month in the number of reported DTOCs for St George's
- The long term trend is for greater growth than the national trend

1 DTOC = Delayed Transfer of Care
2 Number of DTOC delayed bed days per month divided by days in the month
3 October figures are for acute beds only
SOURCE: NHS national statistics; Trust submission for Unify for October 2015

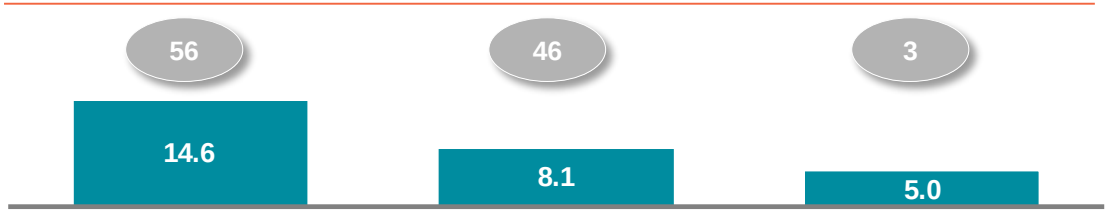
Patients who require complex discharge remain in the hospital for ~12 days after being declared ready for discharge

PRELIMINARY

Process flow for complex discharges
Calendar month from 12th October 2015



Time from ready to discharge by pathway
Calendar month from 12th October 2015



- On average, patients needing a placement[2] waited **~15 days** after being declared ready for discharge, compared to an average of **~8 days** for patients needing domiciliary care[3]
- Trust internal targets include:
  - **24h** for MDT to set discharge plan once patient becomes medically stable
  - **72h** for completion of HNA and checklist, following MDT decision
  - **48h** for completion of DST meeting following HNA and checklist
  - **5 days** for CHC or social services placements

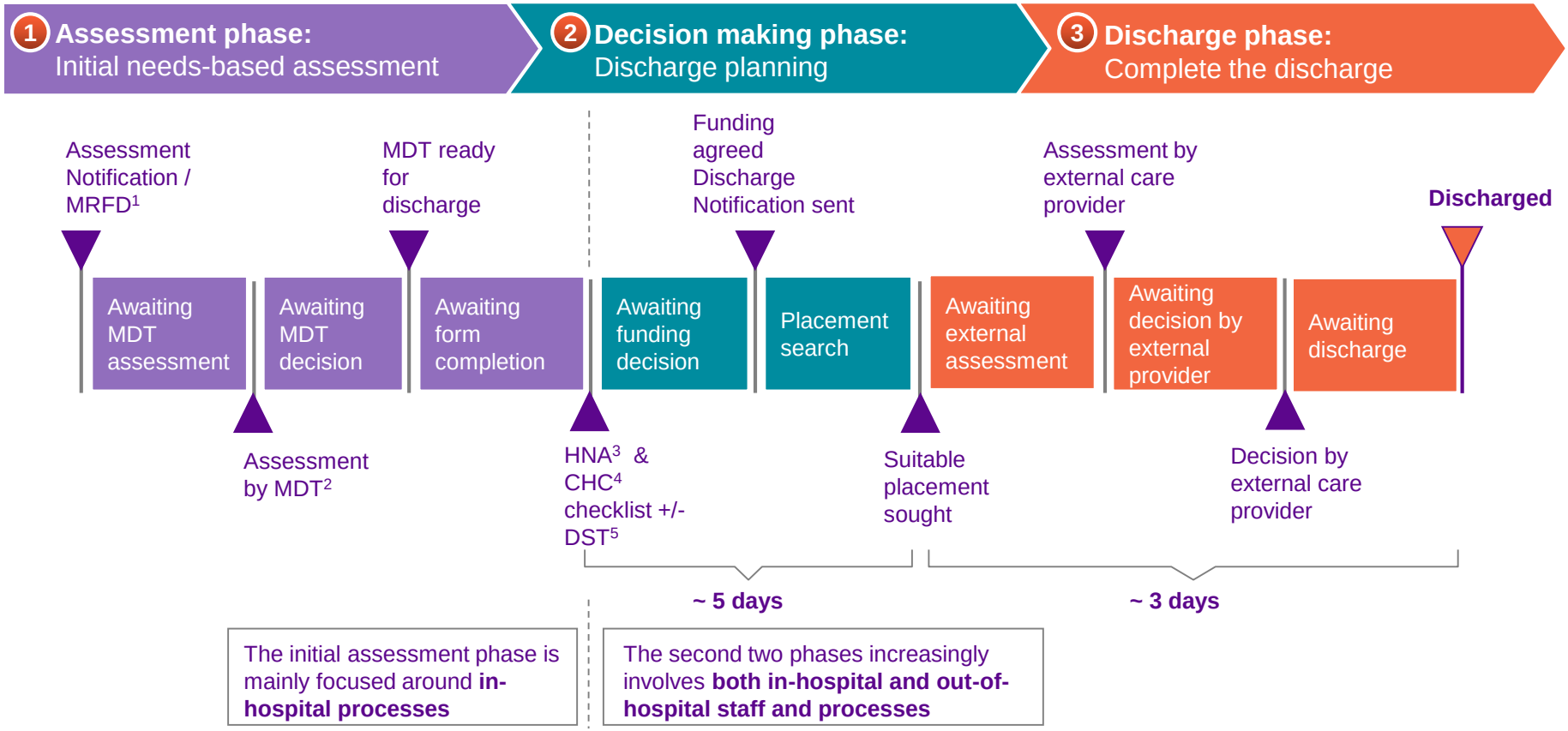
1 Average before "ready for discharge calculated" using 5-a-day data for patients with LoS after "ready for discharge" of >2 days
2 Placement = discharge to a destination other than a patient's home
3 Domiciliary care = care in a patient's home
Source: Trust's NDTOC/DTOC list 06.10.2015 to 13.11.2015 and McKinsey team analysis

Complex discharge patients can follow a number of pathways, but these each follow three generic phases

PRELIMINARY

Process map for continuing healthcare / social services pathways

Total days



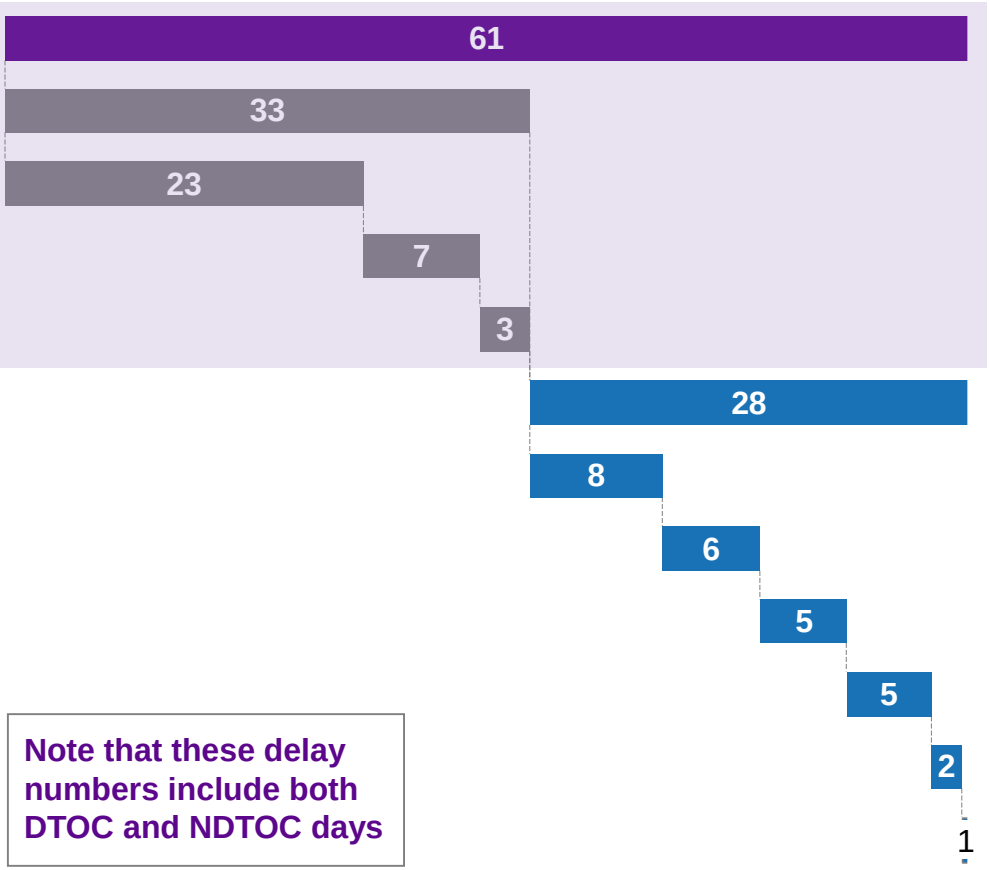
1 Medically ready for discharge
2 Including physiotherapy, occupational therapy and social worker assessments
3 Health Needs Assessment
4 Continuing health care
5 Decision Support Tool
6 Package of care

SOURCE: Trust's NDTOC/DTOC list 06.10.2015 to 13.11.2015 and McKinsey team analysis

A breakdown of the delays in October indicates areas for improving process and capacity

Attribution of beds to reasons for delay, patients from all CCGs
Calendar month from 12th October 2015

Area shown in further detail



Beds

Process[1]

Placement

Domiciliary care

Other

Capacity[2]

Domiciliary - community nursing / POC

Placement - Rehab

Placement - Nursing home

Placement - ICT / NWB[3]

Domiciliary - equipment

Other

1 + 2 Process delays include waiting times in the assessment and decision-making phases

3 Capacity delays include waiting times in the discharge phase

Note that these delay numbers include both DTOC and NDTOC days

Areas for improvement include

- **Processes around placement of a patient** in a care home
- **Community nursing / package of care capacity**
- **Rehab placement capacity**
- **Nursing home capacity**
- **ICT placement capacity**

1 Include delays incurred during Assessment and Decision-making phases

2 Includes delays incurred during Discharge phase

3 Non-weight-bearing bed

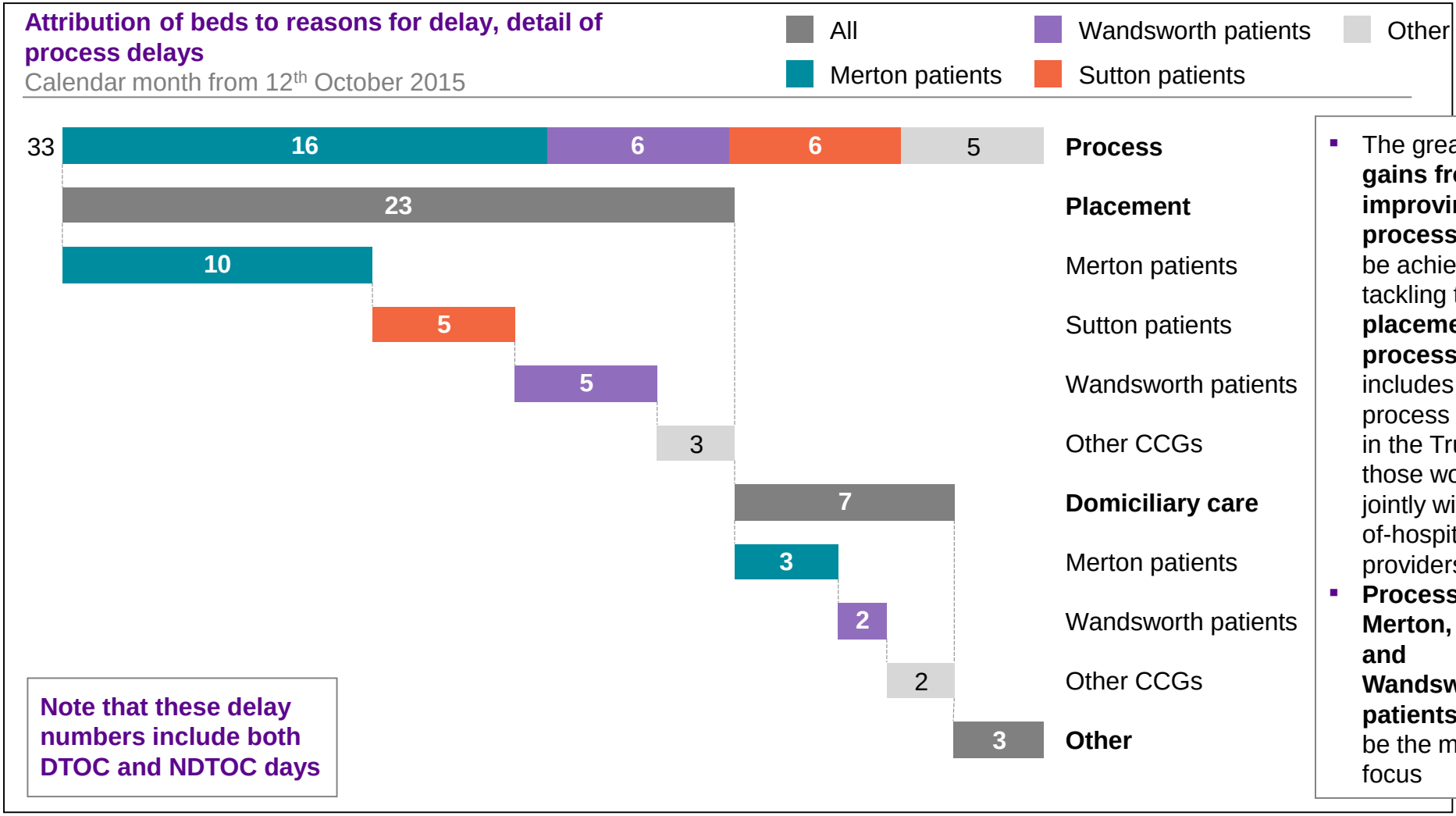
SOURCE: 5-a-day data, NDTOC/DTOC list 06.10.2015 to 13.11.2015 and McKinsey team analysis

PRELIMINARY

1+2 October's delay data suggests that gains can be made by improving processes for placement of patients, particularly for patients from Merton

Attribution of beds to reasons for delay, detail of process delays

Calendar month from 12th October 2015



Note that these delay numbers include both DTOC and NDTOC days

- The greatest **gains from improving process** would be achieved by tackling the **placement process**. This includes both the process stages in the Trust and those working jointly with out-of-hospital providers
- **Processes for Merton, Sutton and Wandsworth patients** should be the main focus

SOURCE: 5-a-day data, NDTOC/DTOC list 06.10.2015 to 13.11.2015 and McKinsey team analysis

1+2 Analysis of process times in October shows longest delays for placement-based care

XX% Percentage of supported discharge patients following pathway

Average process delays for different patient needs (assessment and decision-making phases)

Average # delayed bed days, patients discharged in calendar month from 12th October 2015

- **Placements in a care home took 14 to 18.5 days on average in October**, and account for 18% of complex discharge patients
- **Non-weight-bearing bed placements involved the longest process delays, of 29 days on average.** Although these only accounted for 4% of complex discharge placements, both Trust and out-of-hospital staff report non-weight-bearing beds becoming increasingly problematic
- For **domiciliary care process times were much lower than for placements,** with only home-based ICT having average process times of over 5 days

1 NWB = non-weight-bearing bed

SOURCE: NDTOC/DTOC list 06.10.2015 to 13.11.2015 and McKinsey team analysis

3 A heat map of capacity delays by CCG shows 63% of capacity delays were related to placement-based care

PRELIMINARY

X 0 -3% X 3 – 6% X 7% +

Delay days attributable to end destination for each CCG (discharge phase)

% of delayed bed days during discharge phase, patients discharged in calendar month from 12th October 2015

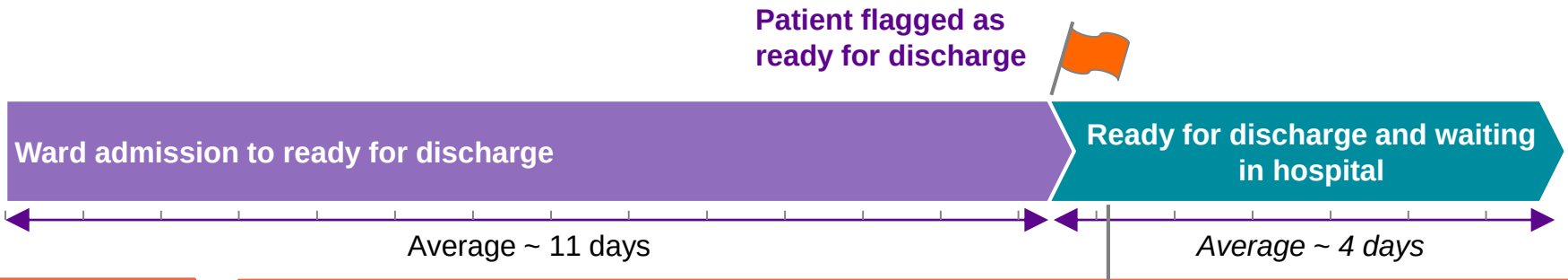
	Destination of patient	Wandsworth	Merton	Lambeth	Sutton	Other	Total	
Placement-based	Rehab (e.g. neuro-rehab)	9%	0%	0%	6%	7%	23%	
	Nursing home	4%	9%	7%	0%	0%	20%	
	Intermediate care / non-weight-bearing bed	2%	16%	1%	0%	1%	20%	63%
	Residential home	0%	0%	0%	0%	0%	0%	
Domiciliary	Community nursing / POC	3%[1]	12%	2%	7%	6%	29%	
	Equipment	2%	3%	2%	0%	0%	7%	37%
	Intermediate care	0%	0%	0%	0%	1%	1%	
Total		**20%**	**40%**	**11%**	**13%**	**15%**	**100%**	

1 For Wandsworth this splits into 3% for social POCs, and 0% for community nursing (i.e. healthcare)

Trust's NDTOC/DTOC list 06.10.2015 to 13.11.2015 and McKinsey team analysis

Over 70% of beds occupied by patients awaiting repatriation are those returning to one of five NHS Trusts

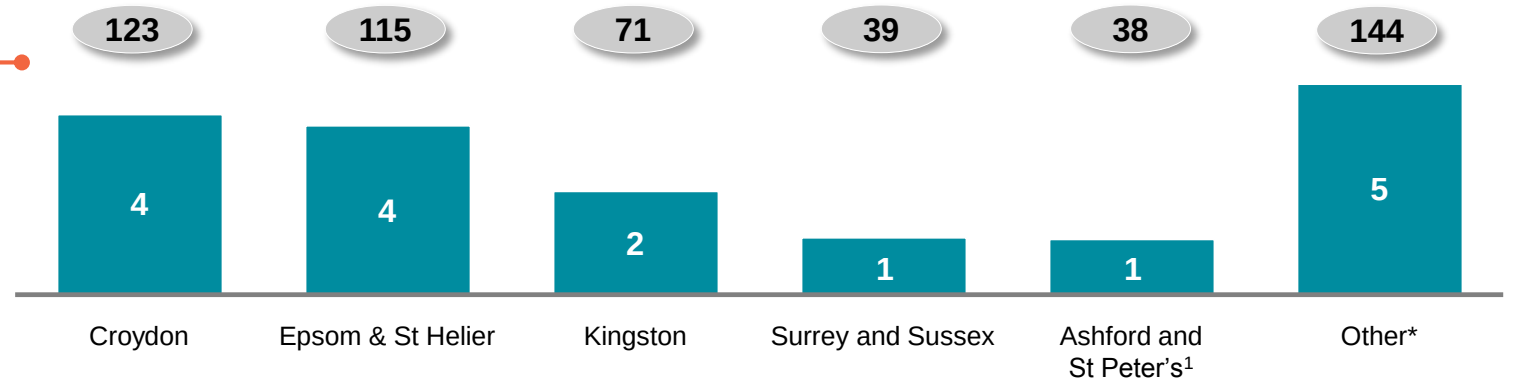
Process flow times for repatriation patients



Five NHS Trusts account for 71% of the beds occupied by patients awaiting repatriation, and 73% of the repatriation delay days

Time from ready for discharge to repatriation by hospital

April - October 2015, # beds occupied per month (average)



SOURCE: Trust repatriation reporting, April – October 2015

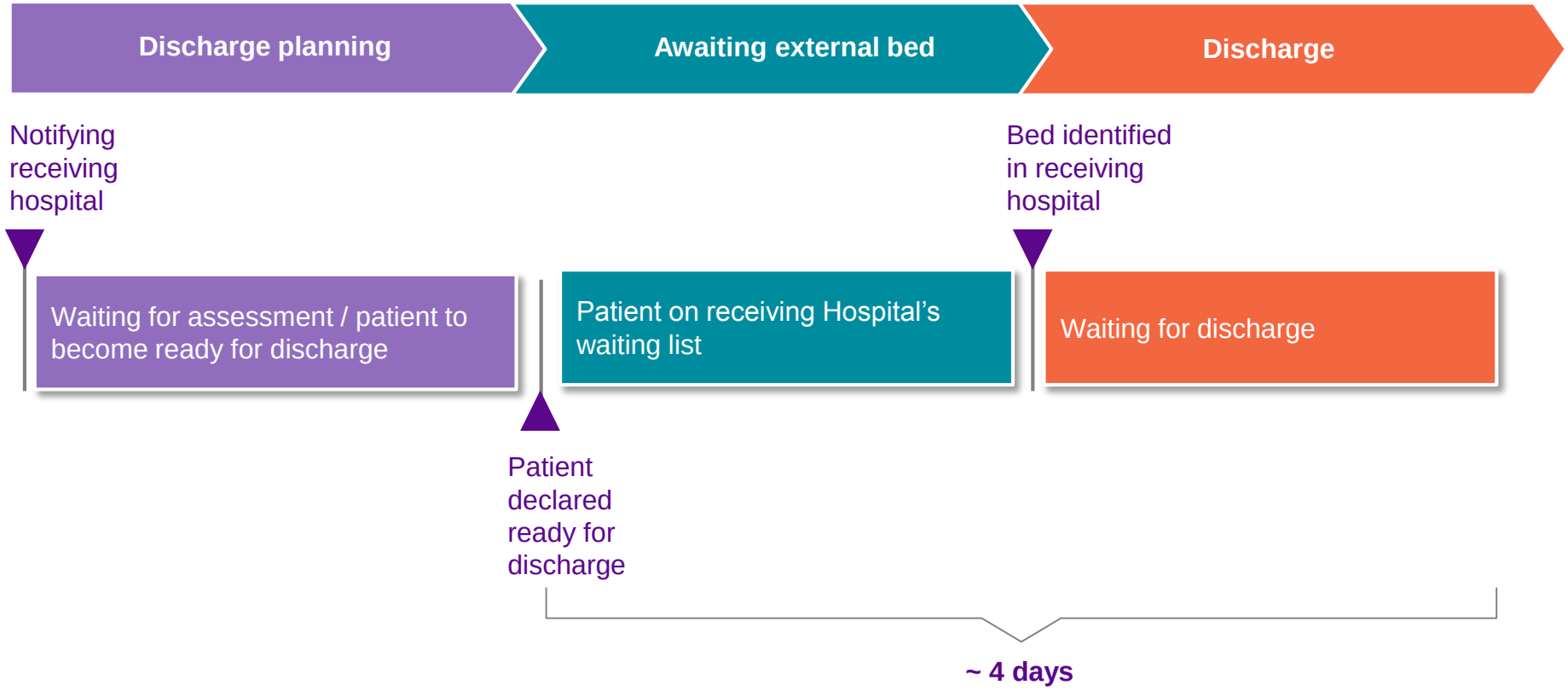
* 35 other NHS Trusts

Repatriation pathway discharge process

PRELIMINARY

Process map for continuing healthcare / social services pathways

Total days

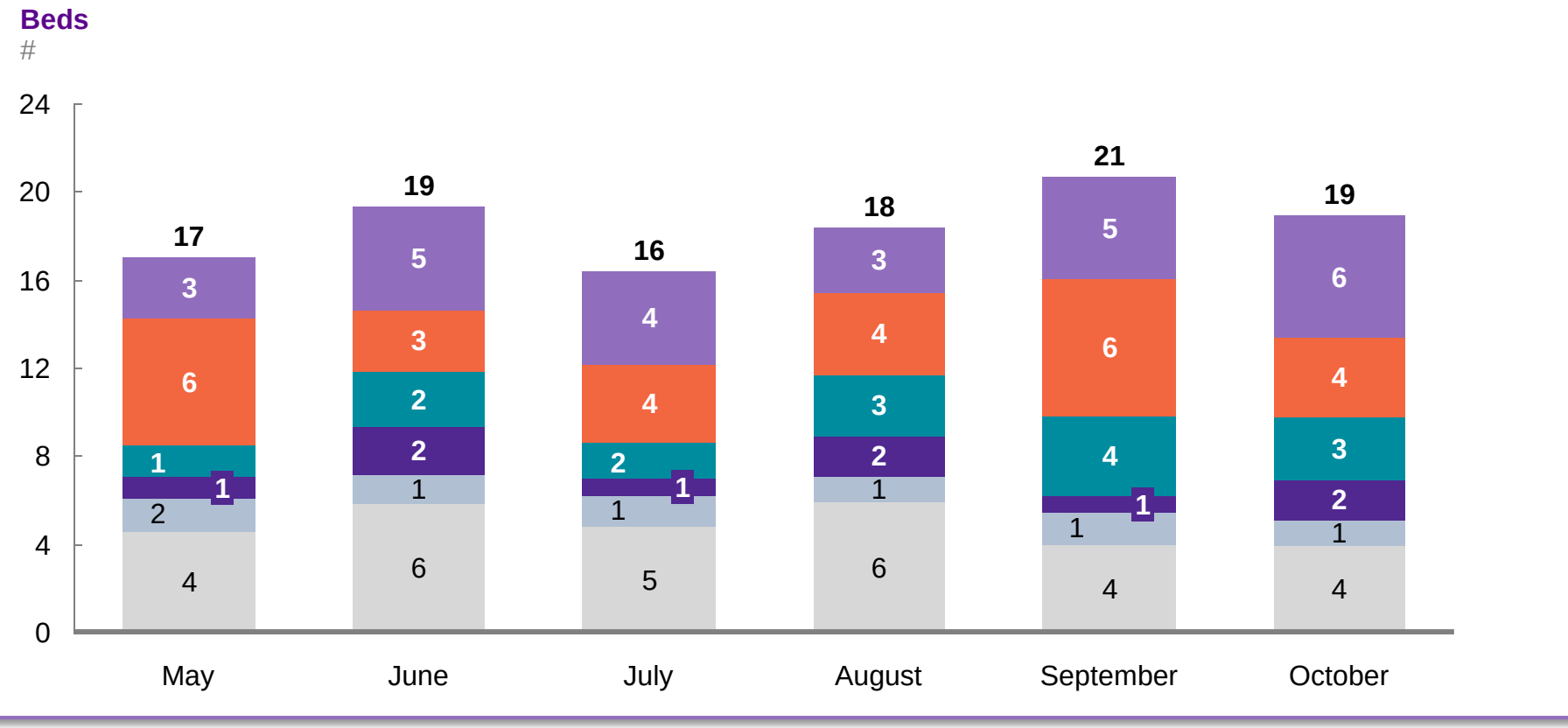


SOURCE: Trust's NDTOC/DTOC list 06.10.2015 to 13.11.2015 and McKinsey team analysis

The total number of beds occupied by ready for repatriation patients has remained relatively stable in the last few months

Delayed repatriation patients by month

Ave # beds occupied by repat patients during month, May 2015 – Oct 2015



1: 35 other NHS Trusts

SOURCE: Trust repatriation reporting

The highest proportion of beds occupied due to repatriation delays are attributable to neurosurgical and stroke patients

Source of discharge delay for patients by specialty and Trust

0-1% | 2-3% | 4% +

% beds occupied when ready for discharge by specialty as a percentage of all patients ready for discharge, monthly average April - October 2015

Speciality	Croydon	Epsom & St Helier	Kingston	Surrey & Sussex	Ashford & St Peter's	Frimley	King's	Other*
Stroke	13%	3%	6%	0%	1%	<1%	1%	3%
Neurosurgery	4%	7%	2%	3%	2%	2%	0%	6%
General Medical	2%	3%	1%	1%	<1%	<1%	<1%	2%
Cardiac Surgery	<1%	2%	1%	<1%	1%	1%	0%	1%
Vascular	1%	1%	1%	2%	1%	<1%	0%	1%
Trauma	1%	2%	<1%	<1%	1%	1%	<1%	2%
Cardiology	1%	1%	1%	1%	<1%	<1%	<1%	1%
General Surgery	<1%	1%	<1%	<1%	1%	<1%	1%	2%
Renal	0%	1%	1%	0%	0%	0%	0%	0%
Other	1%	<1%	1%	1%	<1%	<1%	0%	3%

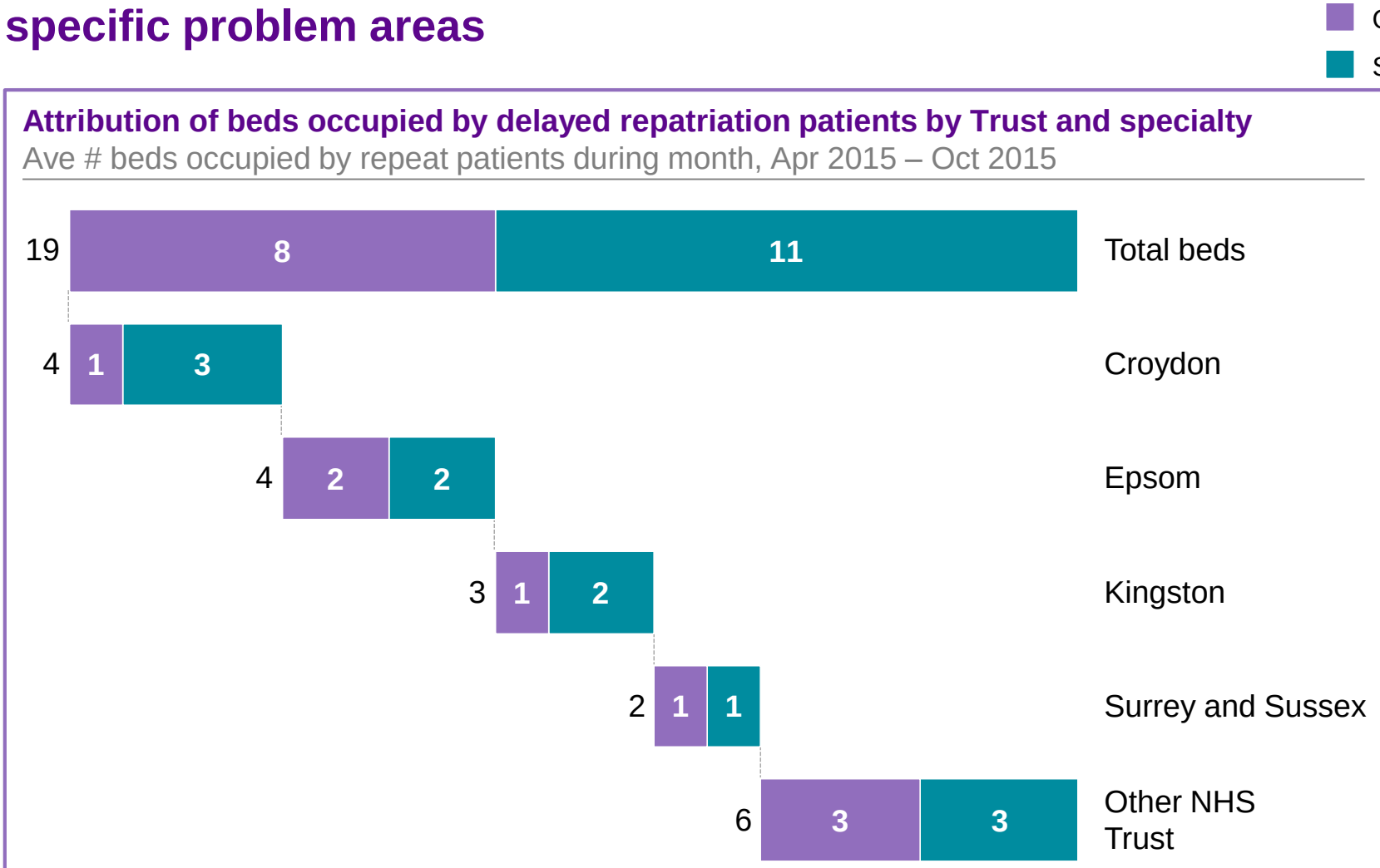
SOURCE: Trust repatriation reporting, April – October 2015

* 33 other NHS Trusts

A breakdown of the repatriation delays from April to October 2015 indicates specific problem areas

Attribution of beds occupied by delayed repatriation patients by Trust and specialty

Ave # beds occupied by repeat patients during month, Apr 2015 – Oct 2015



Areas for improvement include

- **Stroke and Neurosurgery pathways**
- **Repatriations to Croydon, Epsom & St Helier, and Kingston NHS Trusts**

SOURCE: Trust repatriation reporting, April – October 2015 and McKinsey team analysis

St George's University Hospitals NHS
NHS Foundation Trust

Name and date of meeting:

TRUST BOARD
14th January 2016

Document Title:

NHS IT Digital Maturity Assessment

Action for the Trust Board

The Trust Board is asked to note:

- **The contents of the Digital Maturity Assessment that will be submitted on 15th January 2016; and**
- **the national intention to bring this into the regulatory framework from 2018 and make comprehensive electronic clinical patient record a pre-requisite for holding an operating licence from 2020**

Summary:

The NHS is introducing an IT Digital Self-Assessment process for trusts. The Trust is required to make a self-assessment return by 15th January 2016. The draft assessment has been completed and has been reviewed by the Clinical Systems Portfolio Board (CSPB) at its meeting on 17th December 2015.

The assessment will play a role in the CQC's inspection regime from March 2018 onwards. As part of the national drive to a paperless NHS the trust needs to implement a comprehensive electronic clinical patient record by 2018, this is to be a pre-requisite for holding an operating licence by 2020.

The Executive Management Team endorsed the CSPB recommendation that the submission should be presented to the Trust Board prior to submission on the 15th January 2016.

The online form has been converted to a PDF file and is attached for information.

Author and Date:

John-Jo Campbell 5th January 2016

Presented by:

Steve Bolam, Director of Finance, Performance and Information.

NHS IT Digital Maturity Assessment

The NHS Five Year Forward View made a commitment to paperless patient records. This was supported by a Government commitment in 'Personalised Health and Care 2020' that 'all patient and care records will be digital, interoperable and real-time by 2020'. Information flowing more effectively across health and care to support the delivery of direct patient care underpins sustainability and plans to secure service transformation.

Progress towards a fully interoperable digital way of working will be a key component of commissioner assurance and provider continuous improvement, performance and inspection. To encourage progress towards paper-free at the point of care, a three-step process has been set out:

1. Local health and care economies, led by commissioners, were invited to confirm their footprint for the production of local digital roadmaps.
2. The completion of a Digital Maturity Self-assessment by the principal providers delivering care within a local footprint.
3. Producing a local digital roadmap, linked to a local operational delivery plan and sustainability and transformation plan. The trust is currently a leading partner with the CCGs in developing this information.

For 2015/16, the following five objectives for the Digital Maturity Self-assessment process have been identified:

- To identify key strengths and gaps in providers' ability to operate paper free at the point of care
- To support internal planning, prioritisation and investment decisions within providers towards operating paper-free
- To support planning and prioritising of investment decisions within commissioner-led footprints to move local health and care economies towards operating paper-free
- To provide a means of base lining / benchmarking nationally the current ability of providers to operate paper-free
- To identify the capacity and capability gaps in local economies to transform services and operate paper-free

The Trust is required to make a self-assessment return by 15th January 2016. The draft assessment attached has been completed and has been reviewed by the Clinical Systems Portfolio Board at its meeting on 17th December 2015.

Further objectives will be added in subsequent iterations as the assessment model evolves. The assessment will play a role in the CQC's inspection regime from March 2018 onwards. As part of the national drive to a paperless NHS the trust needs to implement a comprehensive electronic clinical patient record by 2018, this is to be a pre-requisite for holding an operating licence by 2020.

The Trust Board is asked to note:

- **the contents of the Digital Maturity Assessment that will be submitted on 15th January 2016; and**
- **the national intention to bring this into the regulatory framework from 2018 and make comprehensive electronic clinical patient record a pre-requisite for holding an operating licence from 2020**

John-Jo Campbell
Chief Information Officer
5th January 2016

Preliminary Digital Maturity Self-Assessment

Organisation Demographics

This section captures additional information about your organisation that will support wider analysis across the provider sector

Services

What type(s) of services does your organisation deliver?

- [x] Acute
- [ ] Mental Health
- [x] Community Health
- [ ] Ambulance
- [ ] Social Care

Patient Statistics

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of the patients who receive care in your organisation come from your local geography, with services commissioned by local CCGs?	○	○	○	◉	○	○	○	○
What proportion of your patients receive specialist commissioned services in your organisation?	○	○	○	◉	○	○	○	○

Budgets

Please indicate your annual IT budgets (in £'000?)

Capital IT budget	£ 6,411

Revenue IT budget	£ 14,000

Which locally delivered or outsourced services are funded from your annual IT capital and revenue budget?

- [x] Networks
- [x] Telecomms
- [x] Hardware and devices
- [x] Applications
- [x] Service desk
- [x] Programme and project manangement
- [x] Information Governance/Security
- [ ] Records Management
- [x] Clinical coding
- [x] Information management, analysis and data quality
- [x] End user training
- [x] Other: Main clinical systems (Millennium & RiO) hosting ar

Maintaining Existing Estate vs New Projects

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of IT budget spend is allocated to new projects?	○	○	◉	○	○	○	○	○

Within the last 12 months has your IT department received any additional funding from an external source? Please list the three largest amounts and sources of funding.

Nursing Technology Fund (Round 2)
Electronic whiteboards £449K

Orders & Results Management

This section focuses on how your organisation uses digital technology to manage clinical orders and results accurately and efficiently

Requesting

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of patient consultations that healthcare professionals request from other clinical colleagues or specialties are ordered digitally?	○	○	◉	○	○	○	○	○
What proportion of laboratory tests are requested through a digital order system?	○	○	○	○	○	◉	○	○
What proportion of radiology tests are requested through a digital order system?	○	○	○	○	○	◉	○	○
What proportion of requests for any other diagnostic tests are made through a digital order system?	○	○	○	○	○	◉	○	○

Digital Orders

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Digital orders are created in a structured format and held as part of the patient's electronic health record.	○	○	○	○	◉	○	○
Digital orders are pre-populated with information already collected at the point of care; healthcare professionals do not have re-enter the same information.	○	○	○	◉	○	○	○
When making diagnostic test requests, healthcare professionals have access to department, specialty or organisation level request/order sets.	○	○	○	○	◉	○	○
Healthcare professionals are alerted of duplicate or conflicting test requests	○	○	○	○	◉	○	○

Request management

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of patients are positively identified through using barcode technology at the point of sample collection and specimen	◉	○	○	○	○	○	○	○

labelling and prior to all diagnostic tests being performed?

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Requests received by diagnostic services are automatically integrated into digital workflows to enable booking, triaging or scheduling.	○	○	○	○	●	○	○
Healthcare professionals can track the status of requests at all times, including receipt, authorisation, scheduling and completion.	○	○	○	○	●	○	○

Results Management

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of laboratory test results are available to healthcare professionals digitally?	○	○	○	○	○	●	○	○
What proportion of radiology test results are available to healthcare professionals digitally?	○	○	○	○	○	●	○	○
What proportion of results from any other diagnostic tests are available to healthcare professionals digitally?	○	○	○	○	○	●	○	○

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Healthcare professionals within your organisation have digital access to all relevant diagnostic test results and images for patients under their care, including those undertaken by other providers.	○	○	○	○	●	○	○
Healthcare professionals have digital access to all relevant diagnostic test results and images for patients under their care, including those undertaken by other **local** providers.	○	○	○	●	○	○	○

Digital results are held in a structured format to enable clinical decision support and data extraction.	○	○	○	○	◉	○	○
Healthcare professionals are automatically alerted of all results that require acknowledgement and an audit trail exists to demonstrate the acknowledgement process and actions taken.	○	○	○	○	◉	○	○
Healthcare professionals can digitally access diagnostic test results and images quickly and easily at the point of care	○	○	○	○	◉	○	○

Leadership

This section focuses on the extent to which your organisation's leadership is driving the digital agenda forward

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Your Board owns the organisation's digital strategy and expects to receive regular updates about progress.	○	○	○	○	◉	○	○
The team leading the organisation's digital transformation includes a board-level sponsor	○	○	○	○	◉	○	○
You have strong clinical leadership through a nominated Chief Clinical Information Officer, Chief Nursing Information Officer or equivalent	○	○	○	○	◉	○	○
Your CCIO or equivalent has adequate protected time as part of his/her job plan to undertake the requirements of the role within your organisation.	○	○	○	◉	○	○	○
Your organisation monitors emerging digital technologies, using regular horizon scanning to keep the digital strategy up to date	○	○	○	◉	○	○	○

Strategic Alignment

This section focuses on the extent to which digital technology supports your organisation's strategic priorities

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Your organisation has a clearly defined digital strategy which is aligned to clinical and corporate objectives.	○	○	○	○	◉	○	○
Implementation of the digital strategy is fully aligned to, and supported by, a service transformation programme(s).	○	○	○	◉	○	○	○
There are effective processes in place to prioritise investment in digital technology and support ideas through to implementation	○	○	○	◉	○	○	○
Digital technology is being used to support improved collaboration and coordination across different parts of your organisation	○	○	○	◉	○	○	○
Your organisation participates in a wider health and care community initiative to achieve digital record sharing	○	○	○	○	◉	○	○

Resourcing

This section focuses on the extent to which your organisation has the resources it needs to deliver your digital priorities

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Your organisation has the buying, contracting, and supplier management capability it needs to manage technology suppliers	○	◉	○	○	○	○	○

Your organisation undertakes quantitative and qualitative benefits identification in conjunction with commercial suppliers	○	○	○	○	◉	○	○
Your organisation ensures adequate resources are available for technology implementation and change management	○	○	◉	○	○	○	○
Your organisation has a clinical safety officer and routinely undertakes assessment of clinical safety and risk for all digital projects	○	○	○	◉	○	○	○
Financial plans are in place for investment in digital technology you require over the next 2-3 years	○	○	○	◉	○	○	○

Governance

This section focuses on the extent to which governance arrangements are in place to deliver your digital priorities successfully

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
There is a Board-led digital programme(s), supported by effective operational IT delivery.	○	○	○	◉	○	○	○
Project and programme boards follow standard project management methodologies, ensuring effective allocation of roles and responsibility.	○	○	○	○	◉	○	○
Digital projects are underpinned by valid business cases and fully-engaged business owners.	○	○	○	○	◉	○	○
Your organisation routinely evaluates the benefits of digital projects using a consistent approach	○	○	○	○	◉	○	○
Your organisation routinely adopts principles outlined in best practice guidelines relating to digital services?	○	○	○	◉	○	○	○

Information Governance

This section focuses on the extent to which information risk is managed effectively in your organisation

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
There is active identification, monitoring and review of cyber security risks.	○	○	○	●	○	○	○
The Board has a full and accurate picture that the organisation's key information is being properly managed and is safe from cyber threats.	○	○	●	○	○	○	○
You are confident the entire workforce understands and follows your organisation's information governance policies & processes.	○	○	●	○	○	○	○
You receive assurance on a regular basis that your suppliers and digital assets are secure, including penetration testing.	○	○	○	●	○	○	○
There are robust due diligence mechanisms in place to ensure all 3rd parties comply with the law and central guidance and provide sufficient guarantees that personal data is handled safely and protected from unauthorised access, accidental loss, damage and destruction.	○	○	●	○	○	○	○
All information governance requirements are articulated in third party contracts and monitored on an ongoing basis.	○	○	○	●	○	○	○

Records, Assessments & Plans

This section focuses on your use of digital care records to ensure healthcare professionals within and outside your organisation have access to the information they need

Information Your Organisation Holds

What proportion of each of the following types of records is available digitally?

in your organisation:

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
Clinical Notes	○	○	○	○	○	●	○	○
Clinical Observations?	○	○	○	○	○	●	○	○
Care Plans	○	○	●	○	○	○	○	○

In what format?
are each of the following types of records held in your organisation:

	Unstructured	Semi-Structured	Fully Structured	Don't Know	N/A
Clinical Notes	○	●	○	○	○
Clinical Observations?	○	○	●	○	○
Care Plans	○	○	●	○	○

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Healthcare professionals can **access** digital records (or relevant components of them) from wherever they need to as part of their regular day-to-day routine.	○	○	○	○	●	○	○
Healthcare professionals can **update** digital records (or relevant components of them) from wherever they need to as part of their regular day-to-day routine.	○	○	○	○	●	○	○
When using digital records, healthcare professionals can find what they need quickly and easily; they rarely have to navigate multiple systems/user interfaces and/or sift large volumes of irrelevant data	○	○	●	○	○	○	○
Healthcare professionals use digital systems to record relevant patient information at the point of collection	○	○	○	●	○	○	○
Information is collected/recorded once; healthcare professionals do	○	○	○	●	○	○	○

not have to copy or re-enter it from one system to another							
Healthcare professionals rely on digital records for the information they need at the point of care; paper records are used by exception.	○	○	○	○	◉	○	○

Information Your Organisation Shares with/receives from External Providers

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Healthcare professionals in your organisation have digital access to the information they need from other local healthcare providers?	○	○	◉	○	○	○	○
Healthcare professionals in your organisation have digital access to the information they need from local social care providers.	◉	○	○	○	○	○	○
Other local healthcare providers have digital access to the information they need from your organisation	○	○	○	◉	○	○	○
Local social care providers have digital access to information from your organisation	◉	○	○	○	○	○	○
Healthcare professionals have access to a consolidated view of their patients' local health and care records?	○	○	○	◉	○	○	○
Healthcare professionals can contribute to a consolidated view of their patients' local health and care records	○	○	◉	○	○	○	○
Patients are able to view and download information from their digital care record	◉	○	○	○	○	○	○

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of information shared with health and care providers outside your organisation is provided in a structured or semi-structured digital format?	○	○	○	◉	○	○	○	○

Transfers of Care

This section focuses on how your organisation uses digital technology to transfer information seamlessly within and between care settings

Transfers of Care Into Your Organisation

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of referrals received for outpatient or non-urgent assessment are automatically integrated into digital workflows to enable viewing, triaging and scheduling of appointments and investigations?	○	○	○	○	○	●	○	○
What proportion of referrals for inpatient care or urgent assessment are automatically integrated into digital clinical workflows to enable viewing, triaging, ordering of investigations or allocation of beds?	○	○	○	●	○	○	○	○

Transfers of Care Within Your Organisation

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of patient information relating to handovers of care within your organisation is shared by Healthcare professionals digitally?	○	○	○	○	●	○	○	○

Transfers of Care from Your Organisation

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
At patient discharge, what proportion of care summaries are shared digitally with GPs?	○	○	○	○	○	●	○	○

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Care summaries are routinely sent digitally to all other local healthcare providers	◉	○	○	○	○	○	○
New care summaries are created in a structured digital format	○	○	○	◉	○	○	○
Care summaries are created in a consistent format across the organisation?	○	○	○	◉	○	○	○
Information held in patients' records is used to pre-populate care summaries to avoid re-keying	○	○	○	◉	○	○	○

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of care summaries are generated in real time and shared digitally with other relevant care providers as soon as completed?	○	○	○	○	◉	○	○	○

Medicines Management & Optimisation

This section focuses on your organisation's use of digital systems to ensure people receive the right combination of medicines every time

Medicines Reconciliation

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Healthcare professionals use digital systems to get a complete view of patients' existing medications/prescriptions	○	○	○	◉	○	○	○

Digital Prescribing

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of inpatient medications are prescribed digitally in your organisation?	○	○	○	●	○	○	○	○
What proportion of discharge medications are prescribed digitally in your organisation?	○	○	○	○	○	●	○	○
What proportion of outpatient medications are prescribed digitally in your organisation?	●	○	○	○	○	○	○	○
What proportion of chemotherapy is prescribed digitally in your organisation?	○	○	○	○	○	●	○	○

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Digital prescribing is routinely performed across all specialties, departments and sites.	○	○	○	○	●	○	○
Complex medicines and infusions are routinely prescribed digitally.?	○	○	○	○	●	○	○
When prescribing, healthcare professionals have access to department, specialty or organisation level medication order sets.	○	○	○	○	●	○	○
Reference sources are seamlessly available during the digital prescribing process.?	○	○	○	○	●	○	○
When prescribing healthcare professionals are alerted of drug: drug interactions, allergy intolerance, duplication of therapeutic class of drug, out of range doses.	○	○	●	○	○	○	○
Calculation of medication doses, based on height, weight or body surface area, is enabled digitally.	○	○	○	○	●	○	○
Completion of a patient risk assessment form offers best practice guidance and prompts prescription of appropriate medications.?	○	○	○	○	●	○	○

Medicines Administration

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Medicines and infusions are automatically scheduled for administration and the outcome is digitally recorded, including reasons for non-administration.	○	○	○	○	◉	○	○
Your organisation digitally monitors prescribed medications administered early, late or not administered at all, and reviews the reasons recorded.	○	○	○	○	◉	○	○

	0%	1% - 20%	21% - 40%	41% - 60%	61% - 80%	81% - 100%	Don't Know	N/A
What proportion of patients and medicines are positively identified prior to administration through automatic identification and data capture using barcode technology?	○	○	◉	○	○	○	○	○

Quality and Safety

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Monitoring of patients on high risk medications is enabled digitally; healthcare professionals are prompted to monitor relevant laboratory tests (such as INR or drug concentration) results are tracked and there is documentation of actions taken.	○	○	○	○	◉	○	○
Your organisation digitally monitors all adverse events resulting from medicines administration and has an audit trail to show actions taken and follow up, including yellow card reporting to MHRA.	○	○	○	○	◉	○	○
Antibiotics are routinely prescribed digitally based on local or national formulary guidelines for the clinical indication documented, with prompts to consider IV to oral switching after a pre-defined course length.	○	○	○	○	◉	○	○

Decision Support

This section focuses on how your organisation uses digital technology to support healthcare professionals in making the right decisions

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Healthcare professionals receive digital alerts to the existence of patient preferences?	○	●	○	○	○	○	○
Healthcare professionals receive digital alerts to specific patient risks?	○	○	○	●	○	○	○
Digital systems are used to alert healthcare professionals of patients whose clinical observations, or early warning scores, are deteriorating and need review?	○	○	○	○	●	○	○
Digital systems alert healthcare professionals outside your organisation to relevant operational information about their patients?	○	○	○	○	○	●	○
Healthcare professionals are directed to relevant and evidence-based reference material as part of digital clinical workflows and care pathways	○	○	○	●	○	○	○
Digital systems provide automatic prompts for the next action required by multi-step care plans, pathways & protocols	○	○	○	●	○	○	○
Healthcare professionals are prompted to complete or remind patients about overdue care actions and/or missing information?	○	○	○	●	○	○	○
Digital systems identify patients who are ready for discharge to a different setting	○	○	○	○	●	○	○

Digital systems support the patient discharge process, including production of section 2 and 5 notifications and multidisciplinary discharge planning	○	○	●	○	○	○	○

Remote & Assistive Care

This section focuses on your organisation's use of remote, mobile and assistive technologies to support the provision of care

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Remote/virtual clinical consultations and clinical advice are available to patients using tools such as online meetings, videoconferencing, skype, email or instant messaging	○	●	○	○	○	○	○
Healthcare professionals are able to contribute remotely to discussions about patient care with colleagues outside your organisation using tools such as online meeting, videoconferencing or skype?	○	○	○	●	○	○	○
You are able to remotely monitor groups of patients who have been discharged home but are at high risk of readmission	○	○	○	○	●	○	○

Asset & Resource Optimisation

This section focuses on your organisation's use of digital technologies that can improve the quality, safety and efficiency of care

Digital Bed Management

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Healthcare professionals use digital systems to manage inpatient beds throughout the organisation?	○	○	○	◉	○	○	○

Digital Patient Flow

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Patient flow is tracked digitally in real time across all departments and sites to identify bottlenecks and delays	○	○	○	◉	○	○	○

Digital Asset Tracking

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
The location of key clinical assets, e.g. medical equipment, devices & prostheses, is digitally tracked throughout your organisation (all sites, buildings, departments, wards etc)	○	○	○	○	○	◉	○

Digital Rostering

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Staff rostering is managed using digital systems throughout the organisation	○	○	○	○	◉	○	○

Monitoring Devices

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Verified data from monitoring devices is uploaded into patient records or charts automatically, avoiding the need for manual recording	○	○	○	◉	○	○	○

Standards

This section focuses on your organisation's use of core national standards that relate specifically to the digital capabilities covered in this assessment

NHS Number

	0% - 50%	51% - 75%	76% - 80%	81% - 85%	86% - 90%	91% - 95%	96% - 100%	Don't know	N/A
For what proportion of patients is a verified NHS number included on all information shared with any other care provider or organisation directly involved in a patient's care and treatment? ?	○	○	○	○	○	○	◉	○	○

Standards

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
SNOMED-CT is the clinical terminology used to support direct management of care.	○	○	○	○	◉	○	○
Dictionary of Medicines and Devices (dm+d) is used to describe all medicines and devices	○	○	○	◉	○	○	○
The Academy of Medical Royal Colleges Standards for clinical structure and content of patients records are used to create digital patient records and transfer of care summaries.	○	○	○	◉	○	○	○
Patients' end-of-life preferences are recorded in accordance with the Palliative Care Co-ordination:	○	○	◉	○	○	○	○

Core Content (SCCI1580) national standard							
GS1 is used to identify all patients, products and places, and for radio-frequency identification (RFID) tagging.	◉	○	○	○	○	○	○

Enabling Infrastructure

This section focuses on the underlying infrastructure that enable the digital capabilities covered in this assessment

Infrastructure

	Disagree Completely	Somewhat Disagree	Neither Agree nor Disagree	Mostly Agree	Agree Completely	Don't Know	N/A
Healthcare professionals have wi-fi access to clinical applications across your estate	○	○	○	◉	○	○	○
Public wi-fi is available in public areas across your estate	○	○	○	○	◉	○	○
Healthcare professionals are equipped with mobile devices to access clinical applications and information at the point of care?	○	○	○	○	◉	○	○
Healthcare professionals have single sign-on access & authentication to clinical applications; they do not have to remember and use multiple usernames & passwords?	○	○	○	◉	○	○	○
Digital systems meet users' expectations regarding the time it takes to log-in to clinical applications and update/retrieve information	○	○	○	◉	○	○	○
Software (including operating systems) used on NHS-owned IT infrastructure is approved and recorded on a software asset & licence register that confirms it is appropriately licensed for such use	○	○	○	◉	○	○	○
Digital services are supported by an IT support Service Desk that prioritises incidents using a consistent approach agreed with nominated service users/owners	○	○	○	○	◉	○	○

The IT support Service Desk follows an ITIL-aligned (or equivalent) Incident Management process that lets users track issues through to resolution?	○	○	○	○	◉	○	○
Business-critical digital services are supported by documented disaster recovery processes, with clear roles & responsibilities assigned ?	○	○	○	○	◉	○	○
Disaster recovery processes have been tested and audited	○	○	○	◉	○	○	○
Business-critical digital services are supported by IT infrastructure with multi-site redundancy; normal operations are maintained in the event of an outage at any particular location?	○	○	○	○	◉	○	○

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD *Jan 2016*

Paper Title:	Risk and Compliance report for Trust Board incorporating: 1. Corporate Risk Register 2. External assurances 3. Update to Board Assurance Framework
Sponsoring Director:	Jennie Hall, Chief Nurse/DIPC / Gill Hall, Interim Trust Secretary
Author:	Sal Maughan, Head of Corporate Governance
Purpose:	To highlight key risks and provide assurance regarding their management.
Action required by the committee:	To receive assurance regarding compliance with external regulatory requirements
Document previously considered by:	**Quality and Risk Committee**

Executive summary

Key messages:

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- Controls are developed for all risks, with a rolling programme of review by QRC during 2015/16

Assurance:

- A full review and redesign of the board assurance framework (BAF) has been undertaken and a proposed format has been agreed by QRC and EMT; an update is included the report. An underpinning procedural document is also being developed with a view to the revised BAF being populated to commence reporting at the start of 2016/17.

Risks
The most significant risks on the Corporate Risk Register are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All CQC Fundamental standards & regulations

Equality Impact Assessment (EIA): Has an EIA been carried out? Yes
If yes, please provide a summary of the key findings

1. Risks – Corporate Risk Register (CRR):

This report identifies the extreme risks on the Corporate Risk Register with the details of the most significant risks (scoring 20 or above) summarised in Table 1. An executive overview of the CRR is included at appendix 1. The rating is prior to controls being applied to the risk. Risks are reduced once there is evidence that controls are effective.

Table one: highest rated risks (detailed controls at appendix 2)

Ref	Description	C	L	Rating ↓↑
01-12	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 NEW**

1.1 New risks included on the CRR

There have been two new risks included during the reporting period, these were escalated through the Workforce and Education Committee:

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**
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	**4**	**4**	**16**

1.2 Summary of risks by score and domain

There are 50 risks on the CRR of which 31 are extreme (a score of 15 or above) this equates to 62% of the total risks, which compares with 60% in Oct 2015. Of these extreme risks, 12 sit within the domain of Quality and seven within Finance and Operations. Of the total risks on the CRR, 44% relate to Quality and 19% to the Finance and Operations domain.

Fig 1&2: CRR Risks by score and domain

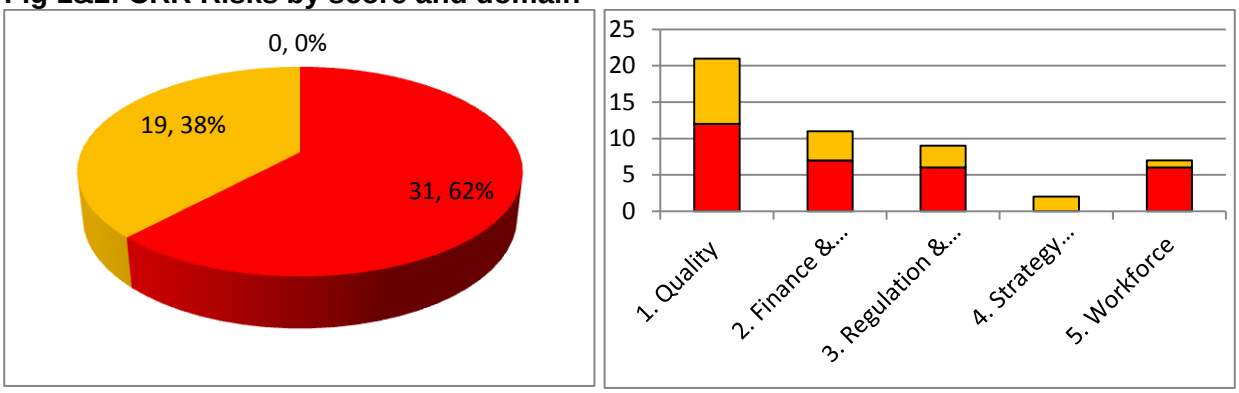


Table three: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Mod)	0-3 (low)	Total
1. Quality	12	9	0	0	21
2. Finance & Operations	7	4	0	0	11
3. Regulation & Compliance	6	3	0	0	9
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	6	1	0	0	7
Total	**31**	**19**	**0**	**0**	**50**

2. Board Assurance Framework

The Board Assurance Framework (BAF) is a document which brings together the total arrangements in place for managing the trust's assurances. It is an extension of the current risk management framework, and should be considered in conjunction with the Corporate Risk Register and all other organisational risk registers at both Divisional and Corporate Directorate level.

As part of the Risk Management Strategy, an agreed action was to separate the Corporate Risk Register (CRR) from the Board Assurance Framework. The CRR is now, separately in place and in use; it is reviewed bi-monthly at QRC and Trust Board with a series of intervening, bi-monthly deep dives at QRC.

The BAF has subsequently been re-developed to encompass and support the trust in meeting three key regulatory requirements of Monitor and the Care Quality Commission (CQC) who require that boards ensure there is an effective and comprehensive process in place to identify, understand and monitor current and future risks.

Monitor's Risk Assessment Framework (RAF) requires Foundation Trusts to submit a series of governance statements as part of the annual planning process. Monitor uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. Monitor will also assess the quality of the underlying planning processes.

Monitor's Well Led Framework, sets out ten key questions against which the trust must self-assess once every three years; it provides a useful framework for the BAF in ensuring that on-going assurance is sought against each of the key requirement as opposed to a less frequent, three yearly assessment.

CQC's Well Led Domain is underpinned by defined characteristics and has developed key lines of enquiry against which all care providers should provide evidence that it is 'Well Led'. Monitor and the CQC have cross referenced their respective guidance.

The Board Assurance Framework and underpinning process has been developed in order to provide the Trust Board with regular and continuous assurance against the Monitor Well Led framework and the CQC Well Led domain. In doing so, it is designed to support the trust in undertaking the annual governance statements, underpinned by robust supporting evidence. A supporting procedural document is under development which sets out the information flows and the responsibilities of Executive Director leads and of the Trust Board sub-committees.

A first draft of the framework was presented to QRC on 28th October 2015 and agreed in principle; it was then presented to EMT on 21st December. The intention is to ensure the document will be populated and in use as a live document at the start of 2016/17 financial year. Once the BAF is a live document, quarterly updates will be provided to QRC and the board. For reference, the full developed guidance of each of the ten Monitor Well Led questions is included at Appendix 3 with an illustration of the format to be used to capture the assurances, risks, gaps and actions inserted for question 1.1.

2.1 Summary of external assurance and third party inspections – Dec 2015

2.1.1 Health Education England/South London (HESL) visit 23d Nov 2015/ NHSE Risk Summit 22nd Dec 2015.

As part of Health Education England, HESL are responsible for educating, training and supporting doctors, dentists, nurses and all health professionals. HESL therefore monitor the quality of training provision in trusts on behalf of the general Medical Council (GMC). On 23rd November, HESL representatives visited the Trust in response to concerns raised regarding trainee supervision and support in Vascular Surgery and Interventional Radiology.

Work undertaken by the Trust following the visit did not identify any harm to patients but did identify opportunities to improve procedures in various areas. The Medical Director summarised initial actions and future plans to a Risk Summit convened by NHS England on 22nd December 2015. HESL confirmed their support for the actions and will work with the trust. Written feedback from the Risk Summit is awaited.

3. Conclusion

The programme of detailed review of risks included on the Corporate Risk Register continues in order to provide stronger assurance to the Trust Board around the management of risks.

The overall long-term risk profile for the trust continues to be driven by the continued financial and operational pressures faced by the trust.

The board assurance framework is currently in development and is designed to strengthen the types and level of assurance to board and to support the board discharge its duties in relation to the annual governance statements and compliance with the CQC Well Led Domain for Trusts.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 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	20	20	20	20	20	20	→	
01-13 Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	20	20	25	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	20	20	16	16	16	16	→	
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	12	12	12	12	12	12	→	
01-01 A risk to patient safety of inappropriate antimicrobial prescribing due to conflicting and out of date guidance being available within the Trust.	JH	12	12	12	9	9	9	→	
01-02: 01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	EM	9	9	9	9	9	9	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	EM	9	9	9	9	9	9	→	
01-04 Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children.	JH	12	12	12	12	12	12	→	
01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the trust.	JH	12	12	12	12	12	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	MW	15	15	20	20	20	20	→	

01-07 Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	MW	20	20	20	20	20	20	→	
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	SM	16	16	16	16	16	16	→	
01-09 Risk to patient safety due to a lack of a trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices	EM	12	12	12	12	12	12	→	
01-10 Risk to patients, staff and public health and safety in the event the trust has failed to prepare adequately for an Ebola incident.	JH	10	10	10	10	10	10	→	
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments	MW	12	16	16	16	16	16	→	
01-18 Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	SM		20	20	20	16	16	→	
01-16 There is a potential risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of run rate schemes.	EM			16	16	16	16	→	
01-17 There is a potential risk to the quality and safety of patient care in the event that required works cannot be undertaken due to capital funding decisions not to fund such projects.	EM			12	12	12	12	→	
01-19 Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment	JH					20	20	→	

Strategic Objective/Principal Risk	**Lead**	**Jun 2015**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**In month change**	**Change/progress**
1.2 Patient Experience								↓↑	
A410-O2: Failure to sustain the trust response rate to complaints	JH	16	16	16	16	16	16	→	
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	JH	16	16	16	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	Lead	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 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			20	20	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			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			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.			20	20	10	10	10	→	
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives			20	20	15	15	15	→	
3.18-05 Cost Pressures - The trust faces higher than expected costs due to:- - unforeseen service pressures - higher than expected inflation - higher marginal costs or costs required to deliver key activity			16	16	16	16	16	→	
3.19-05 Cash-flow Risks – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends			12	12	16	16	16	→	
3.20-05 Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.					20	20	20	→	

Strategic Objective/Principal Risk	Lead	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 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	20	20	20	20	20	20	→	
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	SB	16	16	16	12	12	12	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	16	12	12	12	12	12	→	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 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	5	5	5	5	15	15	→	
A537-O6:Confidential data reaching unintended audiences	SM	12	12	12	12	12	12	→	
A610-O6: The trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training	SM	15	15	15	15	15	15	→	
03-01: Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	EM	16	16	16	16	16	16	→	
03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	EM	16	16	16	12	12	12	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM	16	16	16	16	16	16	→	

03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works.	EM	16	16	16	16	16	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM	12	12	12	12	12	12	→	
03-06 There is a risk of regulatory action should the trust fail to ensure compliance with its HTA licence in relation to the mortuary	JH			20	15	15	15	→	

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 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	12	12	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 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	8	8	8	8	8	8	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Jun 2015	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 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	12	12	16	16	16	16	→	
A516-O4: Possible reductions in the overall number of junior	WB	6	6	9	9	9	9	→	

doctors available with a possible impact on particular specialty areas									
A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	12	12	16	16	16	16	→	
5.1-01 Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost	WB	12	16	16	16	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.						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								**NEW**	
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								**NEW**	

JH	Jennie Hall	Chief Nurse (DIPC)	EM	Eric Munro	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
PVK	Paula Vasco-Knight	Chief Operating Officer	WB	Wendy Brewer	Director of Human Resources
SB	Steve Bolam	Director of Finance Performance & Information	MW	Martin Wilson	Director of Delivery & Performance

Appendix 2: Significant CRR risks (Score >20): detailed controls

Principal Risk	**01-12 Bed capacity** for adult G&A beds may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Root cause: Requirement for high activity volumes in order to meet patient and commissioner needs, and to deliver income margin as part of Trust Cost Improvement Programme. Unlimited demand on A&E which impacts on increase in emergency admissions & capacity for elective admissions affecting 28 day rebook timeframes. Delayed patient repatriation to host hospitals block beds for emergency/elective activity. 14.2% increase in emergency admissions in patients over 70 Challenges in both delivering addition capacity and releasing capacity through flow, to agreed timelines Impact: Potential for commissioner challenges and financial penalties due to breach of ED and RTT targets Potential subsequent impact on patient pathways & patient safety. Adverse reputation				
Domain	1. **Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Update Dec 15**	**Exec Sponsor**	Martin Wilson
Consequence	5	4	4	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	5	5	5	**Date closed**	
Score	25	20	**20**		
Controls & Mitigating Actions	**Controls:** Overall: Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Manager dedicated to capacity. Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Existing capacity: Maximum possible resource is deployed towards the improving patient flow programme so that optimal delivery can be achieved New capacity:			**Assurance**	Negative assurance: - 4 hour operational standard performance - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 Internal capacity assurance: Joint trust & CCG capacity planning for 15/16 undertaken and approved by SRG Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. Follow-up capacity audit is to be completed in Q4 Flow programme dashboard provides real-time analysis of performance against

	Business Planning identified ~72 beds are required in 15/16 to deliver required activity volumes based on 13/14 length of stay. Analysis of 13/14 LOS indicates 8% increase which is driving an additional 70 bed gap Proposals for additional bed capacity agreed with commissioners Risks exist with respect to the timing and delivery of plan. To control these risks, we have increased capital project management capability **Mitigations:** • Build/commission additional 70 beds of capacity • Cap demand for services • Increased command and control of bed management and hospital flow Work with SRG to produce system-wide solutions Development of critical path for all forecast building schemes, and embedding the holding to account of Senior Responsible Owners for delivery of agreed schemes. •		targets External assurance: ALOS benchmarking will provide insight into areas of strong and weak patient flow
Gaps in controls	Ability to deliver agreed additional capacity schemes to agreed timelines remains a challenge	**Gaps in assurance**	
Actions next period:	Realisation of new physical bed capacity New integrated demand & capacity model being developed for 5 year view by KPMG		

Principal Risk	**01-13 Theatre capacity** may not be sufficient for the Trust to meet demands from activity, negatively affecting income, quality, and patient experience				
Description	Requirement for high activity volumes in some specialities in order to meet patient and commissioner needs in particular to deliver 18 week RTT standards, and to deliver income margin as part of Trust Cost Improvement Programme. Potential for commissioner challenges and financial penalties Adverse reputation				
Domain	1. **Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Dec 15**	**Exec Sponsor**	Martin Wilson
Consequence	5	5	5	**Date opened**	01/11/2012 (split into 4 component capacity risks November 2014)
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	**Controls:** Overall: Director of Delivery and Improvement appointed to lead organisation's work on (in year and next year) capacity planning and delivery. Supported by full time Programme Manager dedicated to capacity. Operational Capacity Planner (OCP) developed to plan and track progress on all capacity creation and release schemes. Reviewed weekly at OMT and EMT. Theatre Capacity Plan for 2015 to 2018 developed by Director of Delivery and Improvement with senior leadership from SNCT leadership team. Plan reviewed by extraordinary OMT and regularly reviewed by EMT. Existing capacity: Business Planning for 2015/16 increased alignment between divisional activity and capacity plans. Star chamber held by Director of Finance and Director of Delivery and Improvement with each divisional leadership team to ensure that planned activity numbers are robust. Additional capacity being realised through: • Increased in session utilisation within existing theatre sessions • All day operating sessions within day surgery • Extended day operating in main theatres • Commissioning the planned Hybrid theatre as an additional theatre	**Assurance**	Negative assurance: - RTT backlog of patients- cross ref BAF Risk 01-06 - Cancelled elective surgery during periods of significantly high activity i.e. Feb 2014 - Cancelled elective surgery Aug 15 due to loss of air pressure and ventilation Internal assurance: Internal theatres capacity plan and tactical implementation plan Approved by Executive Management Team. Reported to Finance and Performance committee. Internal audit report has not provided a formal level of assurance but has set out that the current approach to capacity planning and plans that are underway to address identified capacity gaps will provide a reasonable level of assurance once these are fully implemented. 6 of the 13 Day Surgery Unit extended day, (including reallocating sessions of activity from main theatres) Theatres dashboard in use – enables tracking of theatres throughput and utilisation External assurance: Participation in System Resilience Group that has reviewed Trust's capacity plans. Additional funds secured through SRG 1 elective RTT funds.

	• Offsite capacity options (NHS and independent sector) • Business case developed for opening Cardiac 4 as additional theatre • Expert external engineers developing plans for planned preventative maintenance, remedial works and theatre upgrades to minimise loss of capacity Specific theatre capacity analysis and plan developed linked to a longer term theatres strategy currently in development.. A structured approach to appraising the options for creating further physical capacity for 2015-16 and beyond. This work is underway. **Mitigations:** • Seek additional external capacity • Cap demand for services • Divisional management teams & boards to monitor activity against plan ensuring full use of allocated capacity, driving productivity improvements within sessions and outsourcing activity to other providers		Score increased – based upon recently materialised risk regarding theatre ventilation and maintenance
Gaps in controls	Maintenance of theatres behind plan for a number of years, leading to a materliased risk that theatres will break down Urgent plans being developed.	**Gaps in assurance**	Admitted backlog of over 18 week waiters greater than sustainable. Non-admitted backlog numbers not being reduced at planned rate. Theatre performance data dashboards not yet fit for purpose with divisional clinical teams.
Actions next period:	1. Go live with new DSU & paediatric CEPOD timetable 2. Continue installation of new hybrid theatre 3. PPM, remedial works and theatre upgrade plan to be completed & considered by EMT 4. Cardiac 4 business case to be reviewed and approved 5. Secure additional off site theatre and bed capacity through other providers		

Principal Risk	01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists				
Description	Risk to patient safety and patient experience as patients waiting greater than 18 weeks on elective waiting lists. Possible impact that patient's condition deteriorates. Specific issues regarding cardiothoracic surgery waiting lists in particular.				
Domain	**1. Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Residual**	**Updated Dec 15**	**Exec Sponsor**	Martin Wilson (shared with Jennie Hall re Patient Safety)
Consequence	5	5	5	**Date opened**	31.5.2014
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	Management of the RTT 18 week standard is the responsibility of clinical divisions and their general management teams. They are supported in their work by the Information Team and the 18 Week Validation Team which reports into Deirdre Baker – Assistant Director of Finance. Governance arrangements are: Executive leadership for RTT transferred to the Director of Delivery & Improvement Joint trust & CCG contractual investigation to develop and deliver RTT sustainability plan completed June 2015 overseen by DoDI, Surgical Divisional Chair and GP CQR lead (Dr T Coffey). Joint Trust & CCG RTT action plan in place with fortnightly reporting to joint trust & CCG action planning performance group. Compliance Meeting chaired monthly by the Director of Delivery & Improvement, attended by General Managers, Information Team and the 18 weeks team Sub groups for admitted and non- admitted pathways which involve service managers and the 18 weeks team. RTT performance is reported to the FPI Committee on a monthly basis and the issues concerning any particularly challenged specialty are discussed in detail.	**Assurance**	Negative assurances Identified system wide gap of £12-14m of activity required to deliver RTT sustainability Some cancellations in routine elective surgery due to bed pressures Some cancelled patients are not able to be rebooked within 28 days target (7 out of 90 in January) RTT backlog rising in Q4 and now back to end of 2013/14 level of circa 800 patients. Whole system does not yet have a plan for sustainable delivery of RTT standard – specialty summits to address this

	Performance is also monitored by commissioners at the monthly commissioner/SGH meeting and any clinical quality issues discussed at the monthly commissioner/SGH Clinical Quality Review meetings. RTT performance delivery plan to ensure full chronological booking and achievement of RTT aggregate trust levels standards agreed with commissioners. Divisions have reviewed clinical review of waiting lists to ensure any clinical risks due to waiting are reviewed and managed. Approach reviewed by QRC and CQRM committees. Trust data quality group established 1. Specialty based clinical summits to be held with Trust & Commissioner led clinicians and managers to review the RTT position and agree actions to improve performance. To include potential increases in commissioned activity, altered pathways and diversion of referrals to other providers 2. RTT internal improvement plan developed		
Gaps in controls	Delivery on action plan	**Gaps in assurance**	
Actions next period:	1. Develop specialty level sustainability plans for all RTT specialties 2. RTT programme manager to be appointed 3. Move to use of patient tracking lists for booking all outpatient appointments in sequential order 4. Data quality board established		

Principal Risk	01-07 Risk to patient experience and safety as a result of potential Trust failure to meet 95% Emergency Access Standards		
Description	Should the Trust recurrently fail to meet 95% Emergency Access Standards there would be a risk to: - *Patient experience whereby patients would not be treated or transferred within four hours* - *Patient safety – delays in patients receiving ED or specialist senior clinical input* - Risk of regulatory action including from commissioners and regulators - Trust reputational damage of failure to deliver the 95% clinical standard		
Domain	**2. Quality**	**Strategic Objective**	**1.1 Patient Safety**

	Original	Residual	Updated Dec 15	Exec Sponsor	Martin Wilson
Consequence	4	4	4	**Date opened**	1/6/2014
Likelihood	5	5	5	**Date closed**	
Score	20	20	20		

Controls & Mitigating Actions	Trust and CCG Joint Investigation Action Plan developed covering capacity, pathway improvement and performance management in three areas: 1. Emergency department actions – led by DDO and Clinical Director for ED 2. Whole hospital actions – led by Chief Nurse through 'Flow' programme 3. Wider system actions – led by SRG Progress in delivering action plan regularly reviewed: • ED action plan via ED Senior team meeting weekly • Whole hospital actions via OMT fortnightly • Wider system actions via System Resilience Group performance meeting monthly • Overall the plan is reviewed with the CEO and Director of Delivery and Improvement on a fortnightly basis Continued close and pro-active working with ECIST ED dashboard and operational standards agreed, finalised and in place 4. Increases in bed capacity (72 beds) 5. Investments in patient flow schemes (£4m) including ED hot lab	**Assurance**	Q4 and Q1 performance standard has not been met 2015/16 performance forcast under delivery with trajectory of circa 93% Daily reporting to Exec team Escalation meetings between division & DoDI Joint Trust & CCG Investigation completed
Gaps in controls		**Gaps in assurance**	
Actions next period:	Continue implementation of improvement plan (particularly focussed on whole hospital and wider system actions)		

Principal Risk	3.7-06 Failure to meet the minimum requirements of the Monitor Risk Assessment Framework may result in reputational damage or regulatory action.				
Description	There is a risk to the Trust's authorisation should it fail to perform against the Access Metrics set out by Monitor Performance Framework particularly in relation to:- 18 weeks- A&E Waits (4 hours)- Cancer waits (TWR, 31 & 62 day targets).Individual risks, controls and actions to mitigate are set out in Divisional risk registers				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.2 Meet all performance targets**
	Original	**Residual**	**Update Dec 15**	**Exec Sponsor**	Paula Vasco-Knight
Consequence	4	4	4	**Date opened**	30/05/2013
Likelihood	4	5	5	**Date closed**	
Score	16	20	20		
Controls & Mitigating Actions	Management framework in place which measures performance across key domains including operational performance. Divisions are held to account through formal quarterly performance reviews, monthly reporting and monitoring and escalation where required through the DoFPI The Trust has a performance management framework A&E performance meeting is held routinely within the Med/Card division to scrutinise and review ED performance Finance & Performance Committee meets monthly to review in detail the performance report including all areas of the TDA accountability framework Reporting to F&P includes description of key actions and sharing of recovery plans where necessary e.g. cancer recovery plan 12/13 Q4 Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train External scrutiny: Performance is reviewed by the TDA as part of the Accountability Framework and the Trust is held to account at a monthly meeting of senior teams Clinical Quality Review meeting and contract performance meetings are held monthly with commissioners where performance and remedial action			**Assurance**	Positive assurance •HDD, BGAF and QGAF assessments •Internal audit Following a period of joint investigation with commissioners, remedial action plans have been agreed for performance improvement in ED and RTT. Negative assurance Worsening ED performance across Q1 and continued under-delivery in Q2 – cross ref BAF Risk 01-07 RTT performance issues in relation to the incomplete pathway target. Contract query notice served for cancer performance. Tripartite meeting with NHSE & Commissioners held and a recovery plan presented. Weekly performance recovery meetings in place both internally and a separate meeting being chaired by commissioners

	is further scrutinised **Mitigating Actions** •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads •Reporting continues to be improved and developments including desktop access to scorecards for Divisions and the introduction of risk forecasting are in train •Developmental work in place to introduce formal monthly scoring system for Divisions within the performance framework to improve visibility over performance risks and the effectiveness of remedial action •Additional capacity is being introduced to support the Divisions and the performance framework in the shape of a Head of Performance and 2 x Divisional Performance leads		
Gaps in controls	Absence of risk forecasting which is in development	**Gaps in assurance**	
Actions next period:	• Recruit to staff new capacity • Continue to implement joint I investigation actions • Implement cancer recovery plan • Cancer PTL development • Waiting list improvement programme – present proposal to TB and gain agreement		

Principal Risk	**3.14-05 Working capital –** the Trust will require more working capital than planned due to: Adverse in year I&E performance Adverse in year cashflow performance
Description	The Trust's working capital requirement will increase further due to a deterioration in the income and expenditure plans and adverse cashflow movements Details of the contributory risks to working capital from the Income and Expenditure performance are provided under the following financial risks:

	• Income - Tariff • Income - Capacity • Income - Market Share • Cost Pressures • Cost Improvement Programme Details of the additional risks to working capital due to other cashflow changes are set out in the cash flow risk.				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Residual**	**Update Dec 15**	**Exec Sponsor**	Steve Bolam
Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		
Controls & Mitigating Actions	**Mitigating Actions:** **Minimising Support requirement** • Trust has reviewed the commitments against the current capital programme to ensure that the Trust does not need to make an application for capital interim support • Through the cost pressure process, the Trust has ensured that increases in the requirement for new revenue expenditure have been minimised. • The Trust is reviewing its working capital management processes to maximise liquidity; extending creditor payment terms to 60 days; setting targets for debt reduction; and plans to reduce stock. **Interim Financial Support application** • Through the APR and monthly monitoring discussions, the Trust has advised Monitor of the uncertainty of its financial difficulties. • Monitor has agreed to prepare a submission to the ITFF for Interim Financial support on behalf of the Trust once a Turnaround plan has been submitted. • The Trust has engaged KPMG to assist in preparing a			**Assurance**	Monitor have agreed that the Trust should submit a provisional application for Interim financial support to the ITFF in September and intend to submit a further application once the Trust has revised its financial plans in November.

	Turnaround plan for submission to Monitor in November. • The Trust has also applied directly to the ITFF for a temporary loan facility at the end of September to cover the Trust's working capital requirements for the period up to the end of January.		
Gaps in controls	The PWC review identified a number of weaknesses in the Trust's forecasting processes, which the Trust is currently working through to address.	**Gaps in assurance**	Monitor will only approve the Trust Forecasts once the Trust has submitted its re-forecasting exercise and Turnaround Plan
Actions next period:	**Reforecasting Exercise** • Trust will submit the results of the 2015-16 re-forecasting exercise to monitor. • The Trust will develop additional cash mitigation plans to address the impact on cash where the planned deficit is exceeded		

Principal Risk	**3.15-05 Income Tariff Risk** – that national and local tariffs do not deliver the required income				
Description	A key determinant of Trust overall financial position is the tariff that the trust receives for its clinical work and the business rules that govern the application of the tariff. There is the potential for the income position for the trust to worsen due to a range of factors linked to the tariff and application of tariff business rules. Key issues are: ▪ The impact of the Non-Elective Threshold Adjustment (NETA) on the value of increases in non-elective work, where the trust is only paid a proportion of the tariff (currently 30%) ▪ The impact of alternative contract arrangements eg the introduction of the block contract to cover non-elective work, with the associated transfer of risk to St. George's ▪ The reduction in Trust income due to contractual penalties related to poor performance against quality standards and KPIs- payment challenges e.g. RTT performance or 1st to follow up ratios; failure to achieve best practice tariffs and non-payment by CCGs of coding related improvements ▪ That proposed changes in the national tariffs and business rules may adversely impact the trust financial position from 2016-17 eg o the introduction of HRG4+ from 2016/17 o changes in best practice tariffs o reinstatement of CQUIN income o changes in application of marginal rates to non-elective work / specialist work				
Domain	**Finance & Operations**			**Strategic Objective**	
	Original	**Residual**	**Update Dec 15**	**Exec Sponsor**	Steve Bolam
Consequence	5	5	5	**Date opened**	20/07/15
Likelihood	4	4	4	**Date closed**	

Score	20	20	20		
Controls & Mitigating Actions	**Controls** ▪ Engagement with and development of good and positive relationships with all main commissioners. ▪ Proactive identification of changes to patient pathways which impact on the level of emergency admissions ▪ Good clinical engagement to ensure that services maximise income e.g. by not incurring payment or performance penalties ▪ Negotiation of appropriate and realistic thresholds and targets with local CCG's to minimise trust exposure to challenges. ▪ Robust assumptions in business planning and income targets with respect to NETA impacts, Commissioner challenges etc ▪ Mechanisms for the accurate coding and appropriate charging for all activity ▪ Central role played on System Resilience Working Group will allow St. George's to influence the local health economy ▪ Active membership of Project Diamond provides the Trust with a London wide voice to reflect Tertiary Hospital views in the development of the tariff. ▪ Active membership of FT Network to influence tariffs at a national level. ▪ Engagement with Consultation on changes to National Tariff / assessment of impact ▪ Participation with and through South West London Collaborative Commissioning to influence and mitigate the impact of the BCF on St. George's. ▪ Monthly SLAM review group is using SLAM to monitor the benefit/disbenefit of the block contract arrangement. **Mitigating actions:** ▪ Support commissioners to develop realistic and deliverable QIPP plans to manage demand for emergency services ▪ Development of admissions avoidance projects in-year which reduce the total number of patients being admitted to the trust ▪ Year End Settlement discussions to mitigate income losses by agreement with commissioners to a year-end settlement through the SLA negotiation process.		**Assurance**	▪ Role on System Resilience Working Group to positively influence how emergency care is managed in the local health economy and how retained funds are spent ▪ Reported value of emergency threshold tariff loss ▪ SWL system receiving support from PWC as part of 5 year planning process to ensure plans are coherent, consistent and deliverable. ▪ Annual business plans and business planning process though to Finance & Performance Committee and Trust Board

Gaps in controls	▪ Inability to influence QIPP schemes or lack of delivery of those QIPP schemes ▪ The Trust needs to more pro-actively identify specific areas of risk ahead of payment/performance challenges	**Gaps in assurance**	Access to representation on System Resilience Working Groups outside of Wandsworth/ Merton/Lambeth where significant level of STG funding sits
Actions next period:	▪ Robust dialogue and negotiations with commissioners for additional funding through 2016/17 ▪ Discuss NHSE NETA reinvestment at Finance & Recovery Group ▪ Review local tariffs as part of 16/17 contracting round		

Principal Risk	**3.20-05 Income Volume Risk (Capacity)** – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.				
Description	A key determinant of Trust overall financial position is the level of income that the trust receives for the volume of clinical work that it undertakes. The delivery of activity is dependent upon the availability of the necessary capacity in terms of beds, theatres, clinics, critical care and diagnostics. There is the potential for the income position for the trust to worsen due to a range of factors linked to the likely volume of work delivered by the Trust. Key issues are: ▪ The availability of clinical capacity in terms of beds, theatres, clinics, critical care and diagnostic services ▪ The length of stay of patients and flow of activity through the hospital and its impact on bed, theatre and clinic utilisation, especially patient repatriation. ▪ The level of investments made by Commissioners in supporting the Trust's flow and capacity plans ▪ The delivery of the Trust's flow and capacity plans				
Domain	**Finance & Operations**			**Strategic Objective**	
	Original	**Residual**	**Update Dec 15**	**Exec Sponsor**	Steve Bolam
Consequence	5	5	5	**Date opened**	30/09/15
Likelihood	4	4	4	**Date closed**	
Score	20	20	20		
Controls & Mitigating Actions	**Controls** ▪ Business planning process – development of annual capacity plan, agreeing service volumes, capacity utilisation rates and identifying capacity requirements ▪ Benchmarking and monitoring of capacity related performance measures: i.e. capacity availability, productivity and length of stay ▪ Business Case Assurance Group (BCAG) and the business case process for approval of all investments in capacity			**Assurance**	▪ Reporting of performance against planned SLA income and activity targets ▪ Live activity tracking via tableau ▪ Development of integrated demand and capacity model with scenario capabilities

	▪ OMT, EMT, TAB and Trust board oversight of Flow and Capacity plans and delivery **Mitigating actions:** ▪ Sourcing additional capacity in independent sector at tariff to minimise loss of income associated with performance fines ▪ Ring-fencing elective beds to secure elective income ▪ Developing outpatient recovery plans to mitigate under delivery M1-6		
Gaps in controls	▪ Integrated demand and capacity model	**Gaps in assurance**	Integrated demand and capacity model outputs to confirm capacity requirements
Actions next period:	▪ Completion of 2015-16 Reforecasting process and 2016-17 business planning process including development of integrated demand and capacity model		

Principal Risk	5.1-01 Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost				
Description	NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing) and most recently this has been increasing at St. George's. We are also increasing capacity in the Trust, often to areas where we have identified staffing as hard to recruit to, and the combination of these factors has meant that supply has outstripped demand, resulting in a heavier reliance on temporary staff. The impact is particularly significant in relation to band 5 nurses, where there is a very high volume of recruitment and in some specialist areas such as oncology, paediatrics and theatres. We are reporting staffing fill of 90%~+ in Safe Staffing reports but the difficulties in staffing create pressures in terms of being able to deliver their services.				
Domain				**Strategic Objective**	
	Original	**Residual**	**Update Dec 15**	**Exec Sponsor**	Director of Workforce and Organisational Development Chief Nurse for nursing workforce
Consequence	4	4	4	**Date opened**	
Likelihood	3	4	5	**Date closed**	
Score	12	16	20		
Controls & Mitigating Actions	There is a workforce strategy which has an underpinning action plan. This plan is refreshed each year. The overarching objectives and progress is reported to the board. The workforce and education committee meets bi-monthly, supports the development of the plan and monitors its implementation. There is a monthly workforce information report to the board that identifies key trends against the workforce key performance indicators including turnover, vacancy rate and bank and agency			**Assurance**	In response to the increases in turnover, the workforce strategy action plan has been refocused for 2015/16. Divisions have been asked to produce plans to reduce turnover that take into account the information available through exit survey data and the detail of turnover patterns within the division. These plans will be presented to the committee in July. There have been some areas that have reduced vacancy rate and turnover significantly such as paediatrics. This directorate has

	usage. The report includes detail of bank fill rates. The monthly quality report to the board includes detail regarding the nursing workforce including a tracker of SAFE nursing staffing compliance and of staffing alerts that have been reported. The nursing recruitment and retention board is chaired by the Chief Nurse and meets on a 3 weekly basis to steer a programme of work to ensure recruitment and retention of the nursing workforce. A workforce planning meeting takes place weekly, chaired by the Director of Workforce and Education with the purpose of aligning workforce information and developing an annual plan. A medical workforce group is being formed, led by the Medical Director. This group will report to the workforce and education committee. Workforce plans form part of the annual business planning round.		undertaken a focused piece of staff engagement work that has resulted in reduced turnover and vacancies. A business case for overseas recruitment for nursing has been approved by EMT. The nursing board, with the support of HESL, have agreed to recruit all student nurses currently on placement in the trust in the summer of 2015. (Approximately 100 nurses). A simplified process for internal promotion and movement has been introduced in response to feedback from the exit questionnaire data. The nursing and workforce leadership teams met with HESL to review the trust's submission for nursing commissions on 26th June. The trust was assured that the submission was considered to be of high standard. The trust will work with HESL on some suggested approaches such as identifying overseas qualified nurses working as health care assistants already working for the trust and providing a HESL supported nursing conversion course. A planned trajectory for turnover was presented to the trust board in May. Turnover has stabilised but remains at high levels. KPMG are providing support to the workforce planning group to speed the process for reconciling ESR and ledger workforce information. The nursing workforce staff-in-post has grown by 134.3 WTE since September 2014. KPMG have produced a detailed weekly tracker analysing staff in post movements.

Gaps in controls		**Gaps in assurance**	The workforce information on ESR and on the ledger needs to be resolved. KPMG have set a deadline to the finance team for end of July. The nursing recruitment plan needs to be reviewed against current activity and capacity plans. A process will be developed to ensure that the workforce plan is updated as activity and capacity plans change. This process will be managed through the workforce planning group.
Actions next period:	The workforce and education committee will: • Review progress with the workforce plan including progress with reconciling the ledger to ESR. • Review progress on the nursing recruitment plan. • Receive an update on the activity to deliver the workforce strategy action plan. • Receive divisional plans to reduce turnover. • Receive a report from the newly established medical workforce planning group.		

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 Dec 15**	**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	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**	**Exec Sponsor**	Wendy Brewer
Consequence	5	5		**Date opened**	1/12/2015
Likelihood	5	4		**Date closed**	
Score	25	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.
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.. Final plans to be confirmed on Friday, 8th January 2016.				

Appendix 3 – Board Assurance Framework

		1.1 Does the Board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?
1. Strategy and planning	**Board Governance Statements:**	**Statement 5: The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:** (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
	CQC Well led domain: **KLOE W1**: Is there a clear vision and a credible strategy to deliver high quality care to patients and are the risks to achieving this understood?	**Characteristics:** • There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant. • The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others. • The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place. • Strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation. • Staff in all areas know and understand the vision, values and strategic goals.

1. Strategy and planning

1.1 Does the Board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?

CRR Risks		
3.13-05 -Working capital – the trust will not be able to secure the working capital necessary to meet its current plans **(5x2=10)**	**Strategic Objectives**	**To be mapped**
3.14-05 Working capital – the trust will require more working capital than planned **(5x4=20)**	**Sponsoring Director**	Chief Nurse/Medical Director
A534-O7:Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety **(5x3=15)**	**Responsible committee**	Quality and Risk Committee
A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances (4x3=12)		

Assurance statement

Quality is at the heart of the Trust's strategy with the aim; 'to provide outstanding quality of care'.

The Trust's Quality Improvement Strategy is refreshed annually and outlines the trust's vision for quality improvement over a five year period, detailing key priority areas and planned action to promote continuous improvement in the safety and quality of services provided by the trust. This strategy implementation is monitored quarterly by the Quality and Risk Committee, the board committee with over-arching responsibility for quality. Each division has a quality improvement strategy which is aligned to the overarching trust strategy and implementation of these is also monitored by the Quality and Risk Committee bi-annually.

Aligned to its strategic goals, the board has agreed five year strategic objectives and annual objectives to monitor delivery of the trust's strategy. The board receives quarterly performance reports against the annual objectives.

1st line of assurance	2nd line of assurance	3rd line of assurance
• QIS Monitored through QRC • Divisional QIS' monitored through Divisional Governance Boards	• The trust has an annual plan signed off by Trust Board annually • SWL APC on going	• Commissioner ownership and alignment to IBP • Plan submitted to Monitor annually • FT Assessment in February 2015

Gaps	• Monitor investigation / recommendations underway • Requirement to revise strategy • Conditions on FT licence to return trust to sustainable footing financially and operationally (Section 106)
Actions	

		1.2 Is the Board sufficiently aware of potential risks to quality, sustainability and delivery of current and future services?
1. Strategy and planning	**Board Governance Statements:**	**Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes:** (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; **Statement 5: The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:** (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
	CQC Well led domain: KLOE W1: Is there a clear vision and a credible strategy to deliver high quality care to patients and are the risks to achieving this understood?	Characteristics: • There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. • Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care.

		2.1 Does the board have the skills and capability to lead the organisation?
2. Capabilities and culture	**Board Governance Statements:**	**Statement 5: The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:** (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; **Statement 6: The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.**
	CQC Well led domain: KLOE W3: How do the leadership and culture within the organisation reflect its vision and values, encourage openness and transparency and promote delivery of high quality care across teams and pathways?	**Characteristics:** • The board has the experience, capacity and capability to ensure that the strategy can be delivered. • The appropriate experience and skills to lead are maintained through effective selection, development and succession processes. • The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them.

		2.2 Does the board shape an open, transparent and quality focused culture?
2. Capabilities and culture	**Board Governance Statements:**	**Statement 5: The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:** (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.
	CQC Well led domain: KLOE W3: How do the leadership and culture within the organisation reflect its vision and values, encourage openness and transparency and promote delivery of high quality care across teams and pathways?	**Characteristics:** • Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity. • Candour, openness, honesty and transparency and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority. • The leadership actively shapes the culture through effective engagement with staff, people who use the services, their representatives and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported. • Mechanisms are in place to support staff and promote their positive wellbeing. • There is a culture of collective responsibility between teams and services. • The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued

		2.3 Does the board support continuous learning and development across the organisation?
2. Capabilities and culture	**Board Governance Statements:**	**Statement 6: The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.**
	CQC Well led domain: KLOE W5: How does the organisation strive to continuously learn and improve, support safe innovation, and ensure the future sustainability of high quality care?	**Characteristics:** • Information and analysis are used proactively to identify opportunities to drive improvement in care. • There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning. • Staff are encouraged to use information and regularly take time out to review performance and make improvement.

		3.1 Are there clear roles and accountabilities in relation to board governance? (including quality governance?)
3.Process and structures	**Board Governance Statements:**	**Statement 1: The Board is satisfied that the trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.** **Statement 2: The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time** **Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes:** (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (h) To ensure compliance with all applicable legal requirements.
	CQC Well led domain: **KLOE W2:** Do the governance arrangements ensure that responsibilities are clear, quality and performance are regularly considered and problems are detected, understood and addressed?	**Characteristics:** • The board and other levels of governance within the organisation function effectively and interact with each other appropriately. • Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective. • Quality receives sufficient coverage in board meetings and in other relevant meetings below board level.

		3.2 Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?
3.Process and structures	**Board Governance Statements:**	**Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes:** (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
	CQC Well led domain: **KLOE W2:** Do the governance arrangements ensure that responsibilities are clear, quality and performance are regularly considered and problems are detected, understood and addressed?	**Characteristics:** • The organisation has the processes and information to manage current and future performance. • Performance issues are escalated to the relevant committees and the board through clear structures and processes. • Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

		3.3 Does the board actively engage patients, staff and governors and other key stakeholders on quality, operational and financial performance?
3.Process and structures	**Board Governance Statements:**	**Statement 5: The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:** (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources;
	CQC Well led domain: **KLOE W4:** How does the organisation ensure that patients' views and experiences are the key driver for how services are provided, and that staff are involved and engaged?	**Characteristics:** • A full and diverse range of people's views and concerns are encouraged, heard and acted on. Information on people's experience is reported and reviewed alongside other performance data. • The service proactively engages and involves all staff and assures that the voices of all staff are heard and acted on. • Staff actively raise concerns and those who do (including external whistle-blowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted on. • The service is transparent, collaborative and open with all relevant stakeholders about performance.

		4.1 Is appropriate quality information on organisational and operational performance being analysed and challenged?
4. Measurement	**Board Governance Statements:**	**Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes:** (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;
	CQC Well led domain: **KLOE W2:** Do the governance arrangements ensure that responsibilities are clear, quality and performance are regularly considered and problems are detected, understood and addressed?	**Characteristics:** • Integrated reporting supports effective decision-making. • Performance information is used to hold management and staff to account.

		4.2 Is the board assured of the robustness of information?
4. Measurement	**Board Governance Statements:**	**Statement 4: The Board is satisfied that the Trust effectively implements systems and/or processes:** (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; **Statement 5: The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:** (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
	CQC Well led domain: **KLOE W2:** Do the governance arrangements ensure that responsibilities are clear, quality and performance are regularly considered and problems are detected, understood and addressed?	**Characteristics:** • The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.