St George's University Hospitals NHS
NHS Foundation Trust

# MEETING OF THE TRUST BOARD (Public)

## 4th February 2016, 9.00 - 12.00
## Rose Centre (Large Seminar Room)

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.

**Sarah Wilton,Chair**

| | | Presented by | Time |
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| **1.** | **Chair's opening remarks** | | |
| **2.** | **Apologies for absence and introductions** | S Wilton | |
| **3.** | **Declarations of interest**<br>*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**<br>*To receive and approve the minutes of the meeting held 14 January 2016* | TB (M) Public | |
| **5.** | **Schedule of Matters Arising**<br>*To review the outstanding items from previous minutes* | TB (MA) Public | |
| **6.** | **Chief Executive's Report**<br>*To receive a report from the Chief Executive, updating on key developments* | M Scott<br>TB Feb 16 - 01 | |
| **7** | **Quality and Performance** | | 9.15 |
| **7.1** | **Quality and Performance Report**<br>*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 9* | J Hall/P Vasco-Knight<br>TB Feb 16 - 02 | |
| | • *To receive a report from the Quality & Risk Committee 27th January 2016* | S Wilton<br>To follow | |
| **7.2** | **Finance Report**<br>• *To receive the finance report month 9*<br>• *To receive an oral report from the Finance & Performance committee held on 27 January 2016* | S Bolam<br>TB Feb 16 - 03 | |
| **7.3** | **Workforce & Performance Report**<br>*To review month 9 workforce report* | W Brewer<br>TB Feb 16 – 04 | |
| **7.3.1** | **Junior Doctors update** | | |
| **7.4** | • *To receive an update from the Workforce and Education Committee meeting –26 January 2016* | S Pantelides<br>TB Feb 16 – 05 | |
| **7.5** | **Audit Committee Report**<br>*To receive an update from the Audit Committee meeting 20th January 2016.* | M Rappolt<br>TB Feb 16 - 06 | |

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| **7.6** | **Transition Plan FY16/17** | A Burn<br>(To be tabled) |
| **7.7** | **1516 Working Capital Loan Agreement Authorisation** | D Sharp<br>TB Feb 16 - 07 |
| **7.8** | **Monitor update** | A Burn<br>(Verbal) |
| **8.** | **Strategy** | |
| **8.1** | **2015/16 Annual Report process** | R Elek<br>TB Feb 16 – 09 |
| **8.2** | **Annual Operating plan & Corporate Objectives 2016/17** | R Elek<br>TB Feb 16 – 10 |
| **8.2.1** | **Annual (Operational) Plan Q3 monitoring report** | R Elek<br>TB Feb 16 - 11 |
| **9.** | **Governance** | |
| **9.1** | **Procurement Policy (for information)** | S Cook<br>TB Feb 16 – 12 |
| **9.2** | **Charity Independence Report** | TB Feb16 – 13 |
| **9.3** | **Risk and Compliance Report**<br>*To review the Trust's most significant risks and external assurances received* | G Hall<br>TB Feb 16 - 14 |
| **10.** | **General Items for Information** | |
| **10.1** | **Care & Environment Report**<br>• **Arts Strategy** | E Munro<br>TB Feb 16 – 15 |
| **10.2** | **Use of the Trust Seal**<br>*To note use of the Trust's seal during the period January 2016*<br>• The Trust Seal has not been used in January 2016 | |
| **10.3** | **Questions from the Public**<br>*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 3rd March 2016* | |

St George's University Hospitals NHS
NHS Foundation Trust

**Minutes of the meeting of the Trust Board of St George's University Hospital NHS Foundation Trust held on Thursday 14 January 2016 in the Board Room, H2.5, St George's Hospital, Tooting, London, commencing at 9.05 am and concluding at 11.58am.**

**Present**

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| Mr Christopher Smallwood | Chairman |
| Mr Miles Scott | Chief Executive |
| Dr Jenny Higham | Non-Executive Director |
| Ms Judith Hulf | Non- Executive Director |
| Mrs Kate Leach | Non-Executive Director |
| Ms Stella Pantelides | Non-Executive Director |
| Mr Mike Rappolt | Non-Executive Director |
| Ms Sarah Wilton | Non-Executive Director |
| Mr Steve Bolam | Chief Finance Officer |
| Mrs Wendy Brewer | Director of Workforce |
| Mr Rob Elek | Director of Strategy |
| Professor Jennie Hall | Chief Nurse |
| Professor Simon Mackenzie | Medical Director |
| Mr Eric Munro | Director of Estates |
| Ms Paula Vasco-Knight | Interim Chief Operating Officer |
| Mr Martin Wilson | Director of Improvement and Delivery |
| Dr Andrew Rhodes | Divisional Chair CWTDCC |
| Dr Lisa Pickering | Divisional Chair |
| Dr Tunde Odutoye | Divisional Chair STNC |
| Miss Jill Hall | Interim Trust Secretary |

**In attendance**

| Agenda Item | | Action |
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| **1** | **Chair's opening remarks**<br>The Chair welcomed everyone to the meeting and explained that he would be remaining as Chair of the Trust until 31 January 2016. The Board noted that it was Judith Hulf's last Trust Board meeting and thanked her for the contribution she had made over her years as Non-Executive Director, particularly the contribution she had made in the areas of patient safety and quality and work on the Quality and Risk Committee. The Board wished Mrs Hulf well in the future.<br><br>The Board noted that due to a Remuneration and Nomination Committee meeting being called for 12 noon to 13.30, the private Board meeting would start at 13.30. | |
| **2.** | **Apologies for Absence**<br>There were none. | |
| **3.** | **Declarations of Interest**<br>There were none. | |
| **4.** | **Minutes** of the meeting held on 3 December 2015<br>The minutes of the meeting were tabled and members were asked to feed any comments back to the Trust Secretary.<br><br>The Board reiterated the importance of accurate minutes as these for the basis of evidence for the Regulators and other enquiries. | |
| **5.** | **Schedule of Matters Arising** | |

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| | Matters arising were either actioned or listed as items on the agenda. | |
| **6.** | **Chief Executives Report**<br>The Board received and noted the report of the Chief Executive which provided an update on key aspects of the Trusts business, in particular:<br><br>• Noting the changes to the Board composition with effect from 1 February with Sarah Wilton taking on the role of Acting Chair until a substantive was appointed and Mike Rappolt term of office as NED and Vice Chairman, being extended for three months to support Mrs Wilton until a new chair was appointed. These changes were effective from 1 February 2016. Until the new NEDs were appointed it left the Board without appropriate membership on its sub-committees, therefore a proposal to co-opt Governors to sit on the Boards sub-committees was being explored for the interim period. The detail needed to be agreed and governors with the relevant skills would be able to express an interest.<br>• The Board noted the appointment of Luke Edwards as Trust Secretary who would join the Trust in March.<br>• It was noted that Sofi Colas, DDO Children and Women's Division was leaving the Trust to take up an appointment at The Royal Marsden, and Louise Halfpenny, Head of Communication, was leaving, it was noted that Louise had been responsible for 24 hours in A&E, the Board wished them well for the future.<br>• In response to comments on the likely implications of success of two tender submissions, it was noted that both had passed the hurdle rates test and would make a positive contribution, tenders that did not meet that criteria were note pursued. Following discussion, It was agreed a report would be submitted to the Finance and Performance Committee at its meeting on 27 January. | |
| | **Action: report to the Finance and Performance Committee** | RE |
| | **RESOLVED**<br>**That the Trust Board NOTED and DISCUSSED the report and took assurance that the key elements of the trust's strategic development were being progressed by the executive management team.** | |
| **7.** | **Quality and Performance Report**<br>The Board received the report which set out the Trusts performance against the Monitor Risk Assessment Framework and quality indicators for month 8 (November).<br><br>**Performance**<br>Presenting the performance report the Chief Operating Officer reported on the underperformance of RTT incomplete which under-performed the target, achieving 91.74% against the target of 92%, however it was noted that performance was improving in line with the trajectory and action plan. ED continued to underperform against the 4 hour target achieving 89.33 % against the target of 95%. Patients with mental health problems was highlighted as these patients consistently waited over 4 hours due to delays in waiting to be seen by the psychiatric team and availability of appropriate beds, the action plan in place was described.<br><br>The Board noted that performance plans put in place for Christmas had been successful and would be circulated to the Board for information.<br>**Action: COO** | |

The Board also noted the progress being made on reducing the number of cancelled operations on the day which had reduced by 60%, this had been achieved through a number of actions including daily monitoring at the operations meetings, and ensuring that all cancelled operations were re-booked within 28 days. A report to the Boards February meeting was requested on the impact the junior doctors strike had on cancelled operations.

**Action: PV-K**

Cancer performance was also highlighted, particularly where the standard had not been met. Patients' waiting over 104 days were being tracked and escalated to the Chief Executive, Medical Director and Chief Nurse, ensuring monitoring at a corporate level.

Outpatient appointment performance had dipped, it was noted that a lot of work was on-going to improve the high rate of out-patient DNA's, additional capacity had been put on, a report to the Boards February meeting was requested.

**Action: PV-K**

Addressing further comments on outpatient services and DNA rates it was noted that the service used text messaging, a reminder service but needed to improve the admin process for appointments, this was all part of the Outpatient Strategy and change project.

The Board discussed the Trusts performance at length, in response to SP's question relating to October cancer performance and what needed to be done different, it was noted that 14 day referral was a capacity and demand issue and managing all patients on the 85$^{th}$ centile as most were seen on day 11 or after, capacity needed to increase from 24 to 32 ring-fenced clinics to bring back to 7 days, it was noted that KPIs were challenging to achieve without additional capacity. Daily PTL meetings were now being held and improvements were being seen. It was also noted that an IT solution was also required that allowed patients to be followed on the referral pathway. Weekly calls had also been put in place as well as a local standard of seeing patients referred within 42 days allowing a 20 day window to treat.

SW asked for clarification on bed occupancy rates, referring to October and November rates, it was noted the rates reported were a 'snapshot' taken at midnight, a detailed response would be circulated.

**Action: PV-K**

SW also commented on the impact the junior doctors strike had on cancelled outpatient appointments, it was noted that the plans put in place were successful, 402 appointments had been cancelled, 22 cancelled patients turned up for their appointment and were seen. 427 outpatient routine procedures were cancelled. A&E performance for the day was 94% and there was an increase in the number of ambulances.

KL commented on the number of calls that were abandoned by the call centre, and asked if the loss of revenue, caused by the strike, had been planned for, in response it was noted that there was a £189k loss of income which was off set against pay.

It was noted that the performance report was being re-designed and included updating the charts and graphs to show 13 months of data where applicable. The new format of the report would be brought to the Board in April 2016 for debate.

**Quality**

The Chief Nurse presented the quality report, highlighting that the overall position remained consistent with previous quarters, however the number of serious incidents remained an area of focus in relation to themes and actions being taken.

Effectiveness Domain

The Board discussed mortality rates that the Mortality Committee were monitoring and taking action against the increase in SHMI previously reported. MR referred to a press report on the deaths of people with mental capacity issues and if these could be identified as a group in the overall figures. It was agreed that this would be undertaken and reported back.

**Action: JH**

Safety Domain

JH reported that there had been no reported cases of MRSA and C-Diff in November. The board noted that the SI profile was being reviewed. Safeguarding Adults compliance training remained a concern and a key focus, the numbers of staff to be trained was known and actions had been agreed and was being monitored by the Safeguarding Committee.

MR commented on the increase in serious incidents referring to the trend over the last months emphasizing the Board needed to understand if there were any underlying causes and what action was being taken to address, in response JH reported on the 6 month review, which highlighted themes and actions taken. The profile included many themes including: death in custody at Wandsworth prison; diagnostic testing; cancer pathway effectiveness was being picked up in the work by the COO. It was noted that the number of reported moderate incidents was at a higher level and would be looked at going forward. This would be reported through the Quality and Risk Committee. MR asked that the report included an analysis and looked at why there was an increase. SM reported that the trust needed to be aware of risks when the hospital was under pressure and it was important to look at the causes, he also highlighted that the reporting of incidents was good, it was a high number of serious incidents that was the concern.

It was agreed that the 6 month analysis presented to Quality and Risk Committee would be circulated to the wider Board.

JM reported that the response rate to complaints performance was below the standard, discussions were taking place with Divisions over the next 6-8 weeks, it indicated there was pressure in the organisation.

Well-Led

The Chairman highlighted and raised concern at the decline in Friends and Family Test in inpatients, it was noted that in 2014/15 this had been a CQUIN, the fall would be looked into.

SW asked how quickly emerging themes were picked up around complaints and recognised that the improvements made over the last year were now dipping, in response JH suggested the poor performance was a casualty of where we are as an organisation and a way of managing complaints was needed this would be by moving resilience to the divisions where the pressure points were recognised. JHu requested that quarter 3 report should include learning, actions and improvements.

**Action: JH**

In response to a comment on safe staffing trends for the last 6 months it was noted that 95% was a strong position over the previous 3 months.

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| | **RESOLVED**<br>**That the Board NOTED and DISCUSSED the regular Quality and Performance report.** | |
| **7.2** | **Finance**<br>The Chief Financial Officer presented the regular finance report to the Board which set out the financial performance for month 8, in particular it was noted that a 15/16 reforecast had been undertaken resulting in a year end deficit of £50.1m, this had resulted in year to date variances only relating to months 7 and 8. The board noted the cumulative deficit to end of November was £2.5m better than the reforecast at £39.8m, for the reasons set out in the paper. The cash position was ahead, a draw down on the DoH loan had been made with a further smaller drawdown required in February.<br><br>The Board discussed the report in detail, MR commented on the November results suggesting they were influenced by one off events, not performance, he felt that there were underlying performance issues and costs were up and that revenue was down. In response SB reported that there was an underlying £4.2m deficit against a forecast of £5.2m and was influenced by one offs, however, the pay underspend was planned and the result of the work being done by JH and WB with Divisions on recruitment.<br><br>SW welcomed the report and its new style and commented on access to ISF funding, in response it was noted that conversations with the DoH in January were around access to funds and routes to ensure permanent access and board approval so the Trust could access and drawdown permanently, no risks were identified and it was expected that the Trust would need to drawdown between £1-1.5m in February.<br><br>In response to comments on fines and reinvestment of fines it was noted that the Trust was an outlier. SB explained how fines and penalties were applied in terms of the commissioners and NHS England. It was agreed a paper would be submitted to the next Finance and Performance Committee to include why the Trust was an outlier, NHS England, renegotiation of levels, reinvestment and discussions with the CCG.<br>**Action: SB**<br><br>SP referred to agency costs and noted that it appeared stationary at 8%, JH explained that the agency cap was based on actual spend not budgeted spend and aggregated. Actions going forward were noted, particularly around improving the rostering system, the current job market had an effect and vacancies were often covered by agency which needed to be reduced by £150k per month. It was further noted that over November and December escalation wards had been opened and staffed by agency. There was also patients who required extra support and the need for registered mental health nurses.<br><br>MR commented on overachieving SLA's and what the expected income would be, in response it was noted that the trust was underachieving the SLA due to outpatients. MR commented on debtors and the dip in performance in November noting that a number of courses of action were being taken to recover debts.<br><br>The Finance and Performance Committee had discussed a number of reports, particularly reports received on high spend drugs; CIP gaps, noting that Divisions were doing well against CIP plans however there was concern over community services; DNA rates, and penalties and fines which equated to £10m, a quarter of the deficit, the committee had challenged the executive on these points. | |

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| **7.3** | **Workforce and Performance Report**<br>The Board noted and discussed the report of the Director of Workforce which outlined the key workforce performance indicators for November 2015. In particular it was noted that the establishment data was now based on the turnaround reforecast budgets. A forensic review of posts was being undertaken and included freezing posts or not recruiting into all of them. Other actions outlined in the report were noted.<br><br>Statutory and Mandatory training was highlighted as a concern and it was noted that a deep-dive review would be undertaken at the next meeting of the Workforce Committee. A refocus on training had also begun.<br><br>During discussion the emphasis on mandatory and statutory training was highlighted, JH reminded the Board that this was not just about non-compliance there was a risk of staff in practice not being up to date with training. The Board discussed this at length and emphasised the need to find ways to ensure staff completed mandatory training and appraisals. It was noted that the appraisal rate for Doctors was good as this was a requirement for revalidation, from April 2016 nurse revalidation was coming in, appraisal rates for this group would also improve. The corporate departments had the worst rates.<br><br>SW suggested that a trajectory be set to ensure all mandatory training was up to date, it was agreed this would be submitted to the Workforce Board.<br>**Action: WB**<br><br>MR asked for an update and progress on the proposal that the South West London Trusts would set up a shared Bank agency, it was noted that a report would be brought to the Board in the Spring setting out the plans with a Statement of Memorandum.<br>**Action: WB**<br>The Board further discussed turnover rates and SP highlighted that over 50% of turnover was people not wanting to work for the organisation. | |
| | **RESOLVED**<br>**That the Board NOTED and DISCUSSED the report.** | |
| **8.1** | **Emergency Planning Annual Report**<br>The Board received the report of the Interim Chief Operating Officer and noted that following the assessment carried out in November 2015 the Trust's plan achieved assurance and green pass rate. It was noted that a new standard had been brought in post Paris attacks and the Trust's plan had also passed this. | |
| **8.2** | **Cancer Action Plan and RTT**<br>The Board noted that the plans had been signed off by Monitor, NHS England and commissioners on 13 January 2016, the plan would now be fully implemented to ensure sustainable performance improvement. | |
| **8.3** | **Update on Outpatient additional activity income**<br>The Board received an update on outpatient additional activity income which detailed the values of income achieved, it was noted that £164k would not be achieved due to the inability to recruit consultants. To date £1.4m of activity had been identified. MS asked about the sustainability and it was noted that the focus at present was on | |

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| | recovery.<br><br>The Divisional Chairs reported that it was currently based on adhoc booking and required change to job planning via the framework and workforce planning was key aspects.<br><br>The Finance and Performance Committee were asked to review the plan and provide assurance to the Board on its sustainability<br>**Action Finance and Performance Committee (Feb 2016)/COO**<br><br>The Board discussed DNA rates and were informed that the Outpatient Strategy was designed to address this issue. The Outpatient Improvement Programme was being rolled out on 1 April 2016, this was a big change programme that would take time to see the benefits.<br><br>It was further noted that the strategy had a set of trajectories and KPIs and the more granular patient focused KPIs was being developed by the Outpatient Strategy Board. An update on progress would be reported to the March Board.<br>**Action: RE** | |
| **8.4** | **One Version of the Truth**<br>The Board received the report of the Interim Chief Operating Officer and were reminded why the review was carried out. The paper confirmed and outlined the need for change and redesign of the emergency care system.<br><br>The Board discussed the report at length and reiterated that this was a system wide problem that could only be affected by system wide change but the report was also building on existing work already being done at the Trust.<br><br>Following discussion it was agreed a 6 month update would be submitted to the Board in June 2016.<br>**Action: PV-K** | |
| **8.5** | **NHS Digital Maturity Assessment**<br>The Board noted that the NHS were introducing an IT Digital Self-Assessment process for Trusts. All trusts were required to make a self assessment return on 15 January 2016. The draft assessment was reviewed by the Clinical Systems Portfolio Board in December. It was noted that going forward the assessment would play a role in the CQC inspection regime from March 2018.<br><br>The assessment was presented to the Executive Management Team and it was agreed that it be submitted for Board approval prior to being formally submitted on 15 January.<br><br>The Board approved the self assessment. | |
| | **RESOLVED**<br>**That the Board APPROVED the assessment for submission on 15 January 2016.** | |
| **9.1** | **Risk and Compliance Report**<br>The Board received and noted the report which set out the top risks to the organisation and included a draft of the revised Board Assurance Framework (BAF). | |

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| | The Board noted the 2 new risks added since the last report – patient safety risk as a result of the junior doctors strike; and, agency caps.<br><br>Following the recent meeting of the ORC, it had been agreed that the estates risk register needed further work and the Head of Risk would work with the Director of Estates and Facilities.<br><br>The Board noted the redesign of the BAF and that it had been reviewed and approved by both EMT and Quality and Risk Committee. In response to a comment to include flow as a risk it was noted that this was captured under the bed capacity risk. It was suggested and agreed that this risk should be expanded to ensure flow was included as a risk. | |
| **9.2** | **Use of the Trust Seal**<br>The report was noted. | |
| | **Question from the Public**<br>A member of the public highlighted that patients were not always to blame for not attending appointments, sometimes letters and emails were not received. In response the Director of Strategy said that there were a lot of causes to DNA and the process needed to be reviewed. The member of the public was concerned as DNA's went on to patients notes. | |
| | A local Councilor had attended the Board as he thought the Urogynaeocology decision was being brought to the board for decision and he wanted to raise that a number people including Heathwatch felt that the consultation process had been inadequate. The Chief Executive responded and said that the decision would be taken at the Boards meeting in March as long as it was confident and assured of the adequacy of the consultation. | |
| **10** | **Date of next meeting**<br>4 February 2016. | |

St George's University Hospitals NHS
NHS Foundation Trust

**Matters Arising/Outstanding from Trust Board Public Minutes**
**4th February 2016**

| Action No. | Date First raised | Issue/Report | Action | Due Date | Responsible officer | Status at 4 February 2016 |
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| 6. | 03.12.15 | Quality & Performance Report | Prof Hall presented the regular quality report, in particular, it was noted there had been a rise in serious incidents; a paper on trends would be circulated. | TBC | J Hall | |
| 6. | 03.12.15 | Report from Quality & Risk Committee | Mr Rappolt asked about individual consultants disregarding duty of candour. Prof McKenzie stated that any consultants found not to be complying would be taken up by Divisional Chairs at their annual appraisal. | TBC | S Mackenzie | |
| 6.2 | 03.12.15 | Report from the workforce committee | High turnover of staff in community services needs to be addressed with an action timetable. | TBC | W Brewer | Community services will provide a report on management of staff turnover to the workforce and education committee on 26th January. |
| 7. | 14 Jan 15 | Quality & Performance Report | **Mental Health in ED -** Performance plans for Christmas to be shared with the Board | TBC | P Vasco-Knight | |
| 7. | 14 Jan 16 | Quality & Performance Report | **Outpatients appointment performance –** Report on high DNA rates | 04.02.16 | P Vasco-Knight | |
| 7. | 14 Jan 16 | Quality & Performance Report | **Cancelled operations –** impact of Junior Drs strike | 04.02.16 | P Vasco-Knight | |
| 7. | 14 Jan 16 | Quality & Performance Report | **Bed Occupancy rates levels October / November –** check reasons and report back | 04.02.16 | P Vasco-Knight | |

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| 7. | 14 Jan 16 | Quality & Performance Report | **Death of people with mental capacity issues** – identify this group in the mortality figures | 04.02.16 | Jennie Hall | |
| 7.1 | 14 Jan 16 | Quality & Performance Report | **Complaints** – Q3 report to include themes, learning and actions and improvements | 04.02.16 | Jennie Hall | |
| 8.3 | 14 Jan 16 | Outpatient Recovery Plan | Update to Trust Board | 03.03.16 | P Vasco-Knight | |
| 8.4 | 14 Jan 16 | One Version of the Truth | 6 month update | 03.03.16 | P Vasco-Knight | |
| 7.3 | 14 Jan 16 | Workforce & Performance Report | South West London Trusts – Set up shared Bank Agency. Report on the setting out the plans with a statement of memorandum | Spring16 | W Brewer | |
| 8.3 | 14 Jan 16 | Update on Outpatient additional activity income | The strategy had a set of trajectories and KPIs. More granular patient focused KPIs are being developed by the Outpatient Strategy Board. An update on progress . | March 16 | R Elek | |
| 8.4 | 14 Jan 16 | One Version of the Truth | 6 month update | June 16 | P Vasco-Knight | |

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

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| **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.

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| **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

As previously reported, Wandsworth and Richmond Local Authorities put out a joint tender for a Community Contraceptive and Sexual Health Service (C-CASH), and we decided not to bid for this. We are now in dialogue with the Local Authorities about these services, given that they were not able to appoint a contractor.

We are still awaiting details from NHSE in relation to the timelines and arrangements for a national procurement for the provision of Genetics Laboratory services, originally expected in October 2015.

We are pleased that the roll out of our NIPT (Non Invasive Prenatal Testing) service "the SAFE test" is progressing well. The laboratory is the first of its kind and we currently remain the only large scale NIPT in-house provider in the country. We also welcome recent communications from the UK National Screening Committee (15th January) to the Department of Health, recommending NIPT testing on the NHS to high risk pregnant women. This is great news for these women as the new test is non-invasive and the blood sample can be taken locally, thereby avoiding the need for lengthy travel.

### 1.02 Primary Care Engagement and Strategic Development

We continue to work on our relationships with primary care. We recently attended the Wandsworth, Merton and Sutton Local Medical Committee and briefed them on recent developments; including the Recovery at Home Scheme. In January we held three education sessions for different groups of GPs: one at the Nelson; one in Battersea and one at St George's Hospital for GPs from Wandsworth and Merton. We also had our first meeting with the GP Federation in South West Lambeth. On the 9th February we are inviting GPs from across South West London, parts of Surrey and South West Lambeth to an evening meeting with our Neurosurgeons.

### 1.03 Recent Developments – Stroke Services

St. George's continues to focus on improving the care for patients with stroke. In the latest published Sentinel Stroke National Audit Programme (SSNAP) quarterly report, the trust's Hyper Acute Stroke Unit (HASU) was rated an A grade. Increased consultant presence in the Emergency Department has reduced the time to being seen for patients and TIA clinic activity has increased 15% in the last year to help reduce the demand on inpatient beds. Additionally, continued work with radiology means most patients get a CT scan in the Emergency Department within their first hour in hospital.

In 2016, St. George's expects to launch the first 24/7 thrombectomy service in the country. We took part in trials showing this treatment works. We have recently appointed 2 interventional neuroradiologists to make a team of 5 specialists doing the procedure. Thrombectomy removes clots from the arteries of blocked vessels and reduces disability in severe stroke. This service will be offered to patients from southwest London and our neuroscience network of partner hospitals in Surrey.

Finally, we recognise the continuing efforts of the stroke services in our local partner trusts (Kingston, Croydon and St. Helier) in improving patient flow so patients have the best chance of receiving high quality care.

## 2. Academic Developments

### 2.01 Research

We are progressing work on developing a bid to the National Institute for Health Research (NIHR) for a Biomedical Research Centre (BRC). The first stage Pre Qualifying Questionnaire is due for submission on 15th February 2016.

## 3. Operational Developments

### 3.01 Junior Doctors' Strike

The British Medical Association (BMA) wrote to trusts across England informing them of its intention to take industrial action on the following dates:

- 12th January 2016 – 24 hour strike, with emergency care only
- 26th January 2016 – 48 hour strike, with emergency care only
- 10th February 2016 – full withdrawal of labour between 8am and 5pm

The trust prepared carefully for the first strike day, during which junior doctors only provided emergency care for 24 hours. Leadership was provided via a Gold Command, chaired by the Chief Operating Officer who was supported by the Medical Director. There were no serious operational issues and the consultant medical staff provided good support throughout. Approximately 470 appointments were cancelled out of a scheduled 2400. NHS England fed back that London was best prepared region.

The strikes for 26th and 27th January have been cancelled but the strike planned for 10th February remains in place unless negotiations are successful. The February industrial action will be a complete strike – including emergency care – and preparation for it is already underway.

## 4. Council of Governors

### 4.01 Council of Governors Meeting – 26th January 2016

The Council of Governors held a meeting in public on the 26th January 2016.

The Council thanked Christopher Smallwood at his last meeting before retiring, for his time as Chair and for his guidance to the Council. The Council agreed the appointment of Sarah Wilton as Interim Chair for 3 months and Mike Rappolt's 3 month extension as NED and Deputy Chair.

The Council reviewed the monthly quality, workforce and financial performance reports and received a briefing from the trust's Turnaround Director on the development of the trust's financial recovery plans continuing into 2016/17. The Council also received an update on from the Nomination and Remuneration committee on the progress to recruit the new Chair and the two NED vacancies. There will be shortlisting meeting to discuss NED candidates on the 1st February.

## 5. Communications

### 5.01 Maharashtra Ministry of Health visit

Delegates from the Maharashtra Ministry of Health visited St George's on Thursday 14th January to gain a greater understanding of our development, education, training procedures and techniques for clinical staff, in particular nursing staff. The delegation was greeted by Rob Elek, Director of Strategy.

Our staff represented St George's very well. The delegation from both the Maharashtra Ministry of Health and the High Commission were extremely impressed by our processes and commitment to education, as well as our professionalism and enthusiasm.

The delegation expressed a desire to send their education/simulation trainers to St George's Advanced Patient Simulator and Skills Centre (GAPS) to be trained before inviting GAPS to India to provide expertise in the design and management of such facilities.

### 5.02 Media update

ITV's Good Morning Britain filmed Basky Thiliganathan in the trust's NIPT (non-invasive prenatal testing) laboratory, and interviewed him on the significance of the National Screening Committee's announcement that the NIPT test would be available to all pregnant women who are at high risk of carrying a baby with Down's, Edwards' or Patau's Syndrome. St George's was mentioned on ITV and Channel 5 as having been the first NHS unit to offer the test for free and to have its own laboratory on site. Filming in the laboratory demonstrated the process. The story was also picked up by many national newspapers.

Additionally, coverage of the NICE guidelines on infectious diseases on the NICE website, stimulated TV coverage by Channel 4 who filmed in the university's pathology laboratory.

The Guardian focused in depth on the hospital twice – once when it interviewed five of our staff for short interviews on their job and their experience of the NHS (this appeared in the main paper) and once when they interviewed eight of our staff as part of a live blog they wrote while touring the hospital (this appeared on the Guardian website).

### 5.03 Social media coverage from The Guardian's Live Blog (#ThisIsTheNHS)

On Monday 18th January, news reporters and photographers launched The Guardian's #ThisIsTheNHS Live Blog from St George's where they reported from "the front line of the NHS" via The Guardian website and social media (Twitter, Instagram).

The communications team actively engaged with Guardian reporters and photographers throughout the day assisting with article creation and endorsing stories featuring interviews with staff members as they live-blogged. This type of real-time online coverage resulted in the following:

- It generated much higher volumes of positive mentions for the trust (resulting in the second highest spike for the month of January; 129 mentions)
- It reached a larger stakeholder group than we would normally see on our Facebook page (18,760 people)
- We recording much higher engagement levels on Facebook (resulting in the 1st top Facebook post for January; 207 likes, 19 shares and 8 comments).

The newspaper also announced “the Guardian’s first live blog baby”, born during The Guardian’s time at St George’s.

Links:

http://www.theguardian.com/society/live/2016/jan/18/this-is-the-nhs-live-blog

http://www.theguardian.com/society/2016/jan/17/portrait-of-nhs-staff-national-health-service

The communications team has also put together our very own (first) Storify slideshow of tweets and Instagram posts to pay tribute to the care our staff continue to give: https://storify.com/StGeorgesTrust/getting-started

**REPORT TO BOARD** **Paper ref:**

| | |
|---|---|
| **Paper Title:** | Quality Report to Board Month 9.<br>December 2015 |
| **Sponsoring Director:** | Jennie Hall- Chief Nurse/ Director Infection Prevention and Control<br>Simon MacKenzie- Medical Director<br>Pula Vasco Knight – Interim COO |
| **Authors:** | Jennie Hall- Chief Nurse/ DIPC<br>Simon Mackenzie- Medical Director<br>Peter Riley- Infection Control Lead<br>Corporate Nursing Team<br>Divisional Directors Nursing/ Governance<br>Trust Safeguarding Leads<br>Imran Hussain- Head of Performance |
| **Purpose:** | To inform the Board about Quality Performance for Month 9. |
| **Action required by the board:** | To note the report and key areas of risk noted. |
| **Document previously considered by:** | |

**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. However, diagnostic performance deteriorated slightly in December due to the breakdown of a scanner. This is now resolved and the trust is back on track for January.

The Trust has undertaken a One Version of The Truth (OVT) diagnostic exercise which has reviewed emergency care across the system and identified 11 key work streams to action to transform the unplanned care system for the local health and social care economy. Following the OVT review an implementation plan addressing key work streams has been developed and agreed with commissioner and the System Resilience Group (SRG). The SRG have appointed McKinsey to oversee the implementation plan. The trust has observed positive performance improvement in comparison to the same period last year and this is evident of the internal actions that have been implemented.

The trust was non- compliant against the two week wait standard in November. In response to the underperformance, escalation actions include weekly performance and escalation meetings chaired by the COO. Continued areas of focus include:

- Rigorous PTL development, visibility and tracking.
- Actions being undertaken to address capacity constraints in key specialties.
- Renewed focus and improvements to MDT meetings. The meeting will also be expediting actions `arising from MDT meetings.
- Weekly Executive Director and Chief Executive review of all patients waiting greater than 104days on a 62 day pathway.

The trust has developed a recovery and sustainability action plan which has been reviewed and agreed with commissioners and NHSE. This is currently being implemented with positive performance improvement being observed in line with trajectories.

The SRG now also have in place weekly Elective care recovery meetings, chaired by the CCG CCOs, reviewing performance against action plans, current issues and the development of the RTT recovery plan.

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

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

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

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

**Effectiveness Domain:**

- Mortality performance remains statistically better than expected for the Trust. Mortality remains in line with expected for admissions at the weekend and for emergency weekday admissions is better than expected. Despite this position we continue to proactively investigate mortality signals at procedure and diagnosis level. The Report outlines the actions that have been taken by the Mortality Committee in relation to Cardiology mortality alerts. The updated SHMI publication in January indicates that SHMI performance is now returned to “lower than expected”. Further information will be provided to the Board in March.
- National Audits within the report: The report indicates the results from the first National COPD audit indicating no key actions for the Trust. Finally the Vascular registry annual report which shows a positive profile for SGH.
- Local Audits within the report are regular audits within the wider trust audit programme. Discussion has already taken place in relation to moving actions forward particularly in areas where limited progress is seen or there is non-compliance with participation in the audit. It has been made clear this is not an acceptable position and the Divisions have been instructed to manage the actions going forward.
- 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 December indicates a similar trend in terms of numbers and level of harm. The Trend Chart has been re-profiled for the report following discussion last month. However it is important to note that there are changes to reporting requirements annually so it is difficult to make direct comparison between financial years. Of those declared for December QRC will note the issues are across a range of clinical issues, some are mandatory in terms of reporting.

- No further MRSA bacteraemia cases were reported for December bringing the total to 3 cases year to date and no cases since Mid-September. There are now a total of 23 C-Difficile cases to the end of November with one case during the month which is a positive achievement as the Trust is now better than trajectory . 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 70% for adult training. The board will note that the numbers of staff to be trained is known and there are agreed actions both for adult safeguarding which is being monitored by the respective safeguarding Committee. Following validation of the Safeguarding Children data the compliance for the Trust is now 75% at level 3, with Surgery an outlier in relation to Training performance. Given small numbers of personnel for this Division it is required that compliance is achieved before the end of the financial year. The difference between the validated position and ARIS database should be noted.

**Experience Domain:**

- The FFT data has been re-profiled to indicate Patient feedback in relation to likely/ very likely to recommend a service. This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient that would have trouble understanding the standard survey question. Further breakdowns are available for services and location type. The outpatient setting underperforms all other settings in the Trust, while Critical Care and Day case services score highest
- The complaints profile in relation to numbers has decreased from November in terms of numbers. In relation to turnaround times of complaints an improvement can be seen following deterioration in performance. Detail about Divisional improvement actions are included in the report.

**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 December 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:**<br>*Reference to corporate objective that this paper refers to.* | |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | |

**Equality Impact Assessment (EIA): Has an EIA been carried out?**
**If no, please explain you reasons for not undertaking and EIA.** Not applicable

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St George's University Hospitals NHS
NHS Foundation Trust

# Performance and Quality Report

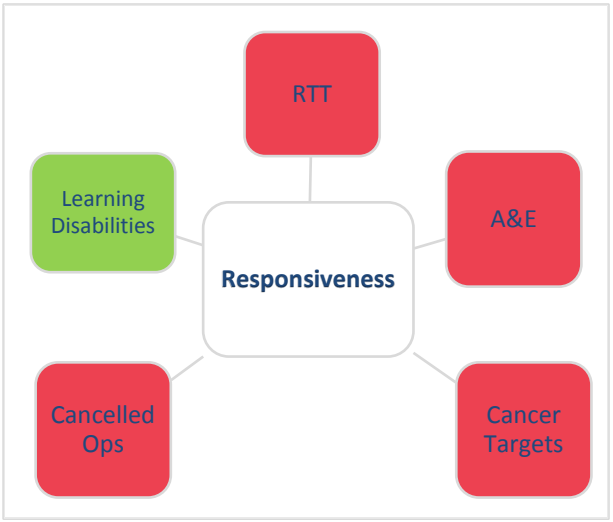
## to the Trust Board

**Month 9 - December 2015**

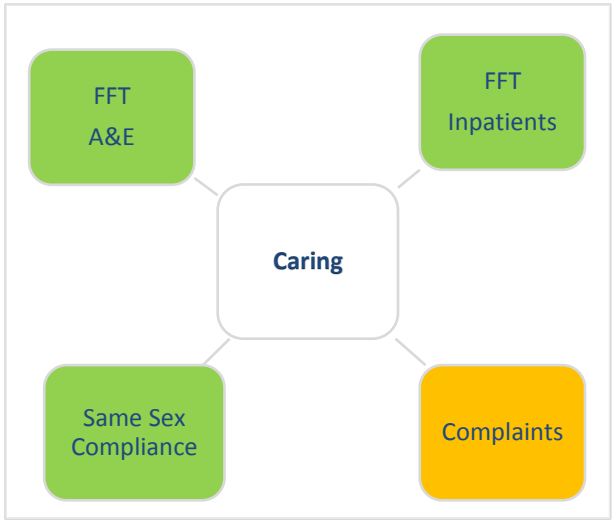

***Excellence in specialist and community healthcare***

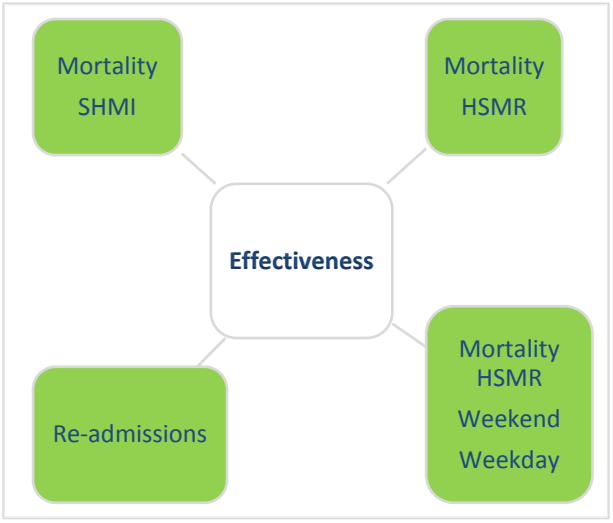
# CONTENTS

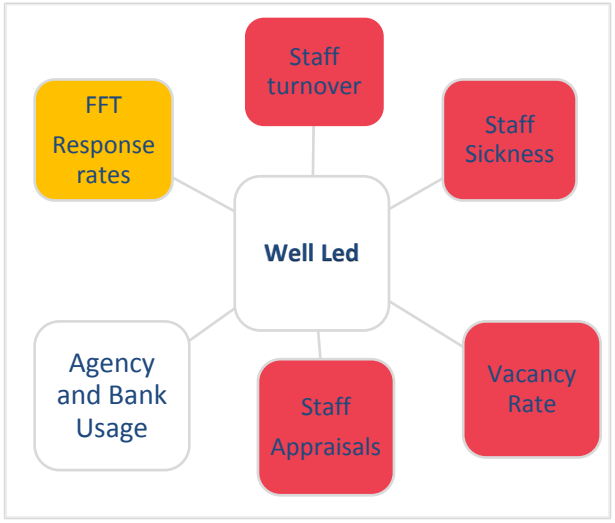
# 1. Executive Summary - Key Priority Areas December 2015*








The above shows an overview December 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 November 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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NHS Foundation Trust

# Performance against Frameworks

*Excellence in specialist and community healthcare*

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

**ACCESS**

| Metric | Standard | Weighting | Score | YTD | Nov-15 | Dec-15 | Movement |
|---|---|---|---|---|---|---|---|
| Referral to Treatment Admitted | 90% | N/A | N/A | | 78.98% | 81.50% | 2.52% |
| Referral to Treatment Non Admitted | 95% | N/A | N/A | | 90.19% | 89.80% | -0.39% |
| Referral to Treatment Incomplete | 92% | 1 | 1 | | 91.74% | 90.20% | -1.54% |
| A&E All Types Monthly Performance | 95% | 1 | 1 | 91.94% | 89.33% | 89.80% | 0.47% |
| **Metric** | **Standard** | **Weighting** | **Score** | **YTD** | **Q2** | **Q3** | **Movement** |
| 62 Day Standard | 85% | 1 | 1 | 81.71% | 81.93% | 84.35% | 2.43% |
| 62 Day Screening Standard | 90% | | | 90.38% | 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 | 96.76% | 97.50% | 100.00% | 2.50% |
| 31 Day Standard | 96% | 1 | 0 | 97.67% | 97.95% | 96.13% | -1.82% |
| Two Week Wait Standard | 93% | 1 | 1 | 85.37% | 77.85% | 82.73% | 4.87% |
| Breast Symptom Two Week Wait Standard | 93% | 1 | | 92.07% | 94.48% | 89.55% | -4.92% |

**OUTCOMES**

| Metric | Standard | Weighting | Score | YTD | Nov-15 | Dec-15 | Movement |
|---|---|---|---|---|---|---|---|
| Clostridium( C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies) | 31 | 1 | 0 | 24 | 0 | 1 | 1 |
| **Certfication of Compliance Learning Disabilities;** | | | | | | | |
| Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| **Data Completeness Community Services:** | | | | | | | |
| Referral to treatment * data is for Oct and Nov 2015 | 50% | 1 | 0 | | 53.6 | 55.7 | 2.1 |
| Referral Information | 50% | 1 | 0 | | 88 | 88 | 0.0 |
| Treatment Activity | 50% | 1 | 0 | | 70.00 | 71.19 | 1.2 |
| **Trust Overall Quality Governance Score** | | | | | 4 | 4 | 0 |

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

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

.

Areas of underperformance for quality governance are:

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

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

*Cancer Data is reported a month in arrears. Q3 relates to Oct-Nov.

| 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: December 15 Performance (Page 1 of 1)

**RESPONSIVENESS**

| Metric | Standard | YTD | Nov-15 | Dec-15 | Movement |
|---|---|---|---|---|---|
| Referral to Treatment Admitted | 90% | | 78.98% | 81.50% | 2.52% |
| Referral to Treatment Non Admitted | 95% | | 90.19% | 89.80% | -0.39% |
| Referral to Treatment Incomplete | 92% | | 91.74% | 90.20% | -1.54% |
| Referral to Treatment Incomplete 52+ Week Waiters | 0 | 22 | 1 | 4 | 3.00 |
| Diagnostic waiting times > 6 Weeks | 1% | | 0.38% | 1.16% | 0.78% |
| A&E All Types Monthly Performance | 95% | 91.94% | 89.33% | 89.80% | 0.47% |
| 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% | 15.49% | 12.50% | 30.00% | 17.50% |
| Certification against compliance with requirements regarding access to health care with a learning disability | Compliant | Yes | Yes | Yes | |

| Metric | Standard | YTD | Oct-15 | Nov-15 | Movement |
|---|---|---|---|---|---|
| 62 Day Standard | 85% | 81.71% | 84.35% | 85.98% | 1.63% |
| 62 Day Screening Standard | 90% | 90.38% | 89.19% | 98.70% | 9.51% |
| 31 Day Subsequent Drug Standard | 98% | 100% | 100% | 100.0% | 0.00% |
| 31 Day Subsequent Surgery Standard | 94% | 97% | 100% | 100.0% | 0.00% |
| 31 Day Standard | 96% | 97.67% | 96.13% | 100.00% | 3.87% |
| Two Week Wait Standard | 93% | 85.37% | 82.73% | 86.20% | 3.47% |
| Breast Symptom Two Week Wait Standard | 93% | 92.07% | 89.55% | 93.71% | 4.16% |

**EFFECTIVENESS**

| Metric | Standard | YTD | Nov-15 | Dec-15 | Movement |
|---|---|---|---|---|---|
| Hospital Standardised Mortality Ratio (DFI) | 100 | | 91.8 | 91.8 | 0 |
| Hospital Standardised Mortality Ratio - Weekday | 100 | 0 | 92.9 | 92.9 | 0 |
| Hospital Standardised Mortality Ratio - Weekend | 100 | 0 | 96.1 | 96.1 | 0 |
| Summary Hospital Mortality Indicator (HSCIC) | 100 | 0 | 92 | 92 | 0 |
| Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust | 5% | 3.10% | 2.20% | 1.77% | -0.4% |
| Bed Occupancy - Midnight Count | 85% | | 100.0% | 100.0% | 0.0% |
| LOS - Elective | | | 1.56 | 2.7 | 1.1 |
| LOS - Non-Elective | | | 4.29 | 4.9 | 0.61 |

**CARING**

| Metric | Standard | YTD | Nov-15 | Dec-15 | Movement |
|---|---|---|---|---|---|
| Inpatient Scores - Friends & Family Recommendation Rate | 60 | | 92.70% | 93.67% | 0.97% |
| A&E Scores - Friends & Family Recommendation Rate | 46 | | 81.90% | 82.37% | 0.47% |
| Complaints (1 month in arreas) | | | 88 | 101 | 13.0 |
| Mixed Sex Accomodation Breaches | 0 | 5 | 0 | 0 | 0.0 |

**SAFE**

| Metric | Standard | YTD | Nov-15 | Dec-15 | Movement |
|---|---|---|---|---|---|
| Clostridium Difficile - Varience from plan | 31 | 24 | 0 | 1 | 1 |
| MRSA Bacteramia | 0 | 3 | 0 | 0 | 0 |
| Never Events | 0 | 8 | 0 | 1 | 1 |
| Serious Incidents | 0 | 116 | 12 | 10 | -2 |
| Percentage of Harm Free Care | 95% | | 93.5% | 93.2% | -0.003 |
| Medication Errors causing serious harm | 0 | 3 | 1 | 1 | 0 |
| Overdue CAS Alerts | 0 | 2 | 2 | 2 | 0 |
| Maternal Deaths | 1 | 1 | 0 | 0 | 0 |
| VTE Risk Assessment (previous months data)* | 95% | | 96.76% | | |

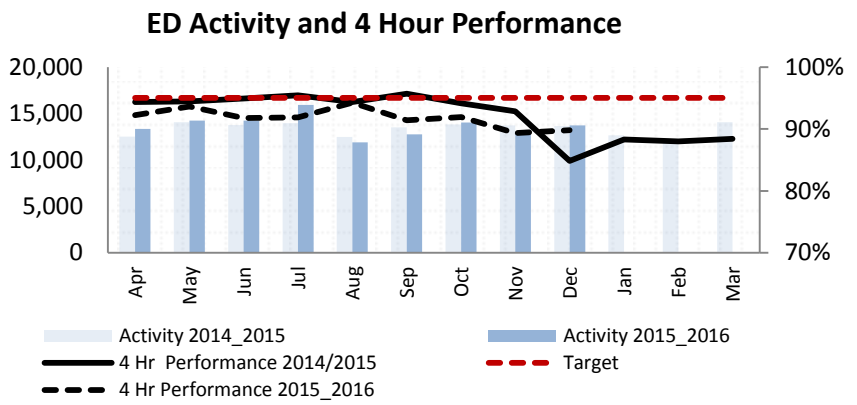
**WELL LED**

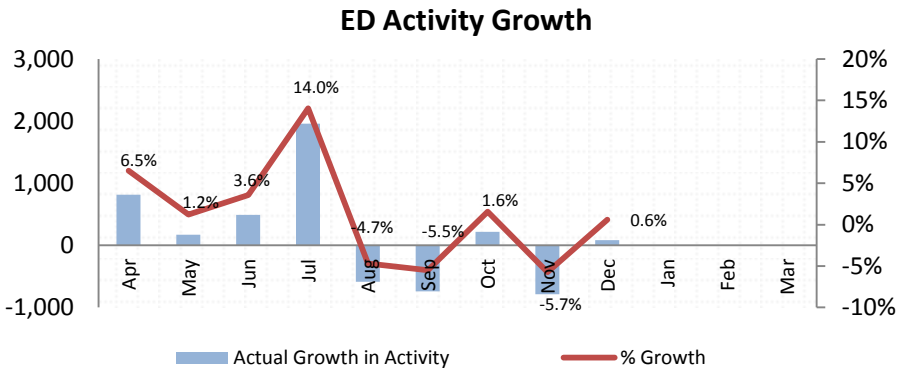
| Metric | Standard | YTD | Nov-15 | Dec-15 | Movement |
|---|---|---|---|---|---|
| Inpatient Respose Rate Friends & Family | 30% | | 21.4% | 20.4% | -1.0% |
| A&E Respose Rate Friends & Family | 20% | | 23.1% | 21.5% | -1.6% |
| NHS Staff recommend the Trust as a place to work | 58% | 62.0% | | | |
| NHS Staff recommend the Trust as a place to receive treatment | 4 | 3.78 | | | |
| Trust Turnover Rate | 13% | | 18.0% | 18.4% | 0.4% |
| Trust level sickness rate | 3.5% | | 3.9% | 3.9% | 0.000 |
| Total Trust Vacancy Rate | 11% | | 16.2% | 17.0% | 0.8% |
| % of staff with annual appraisal - Medical | 85% | | 84.2% | 84.2% | 0.0% |
| % of staff with annual appraisal - non medical | 85% | | 69.2% | 69.4% | 0.2% |

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

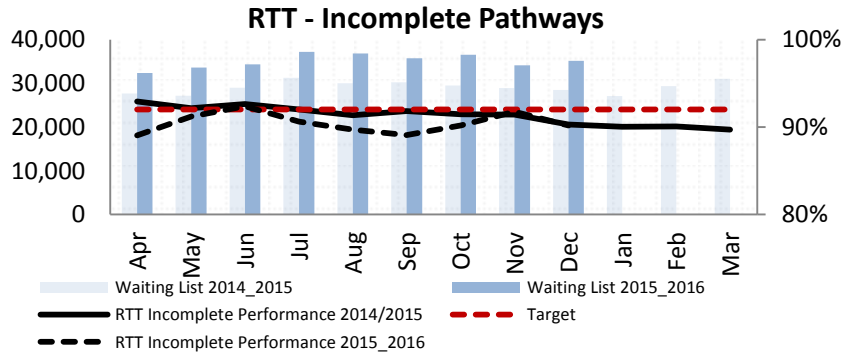
# 3. Trust Key Performance Areas and Activity Comparison to previous year (1 of 2)

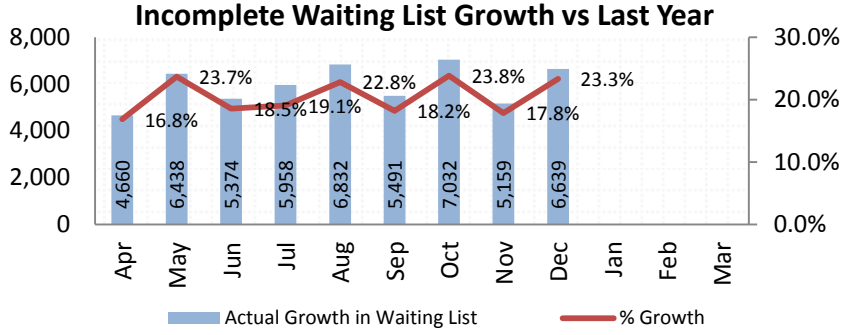
## ED Performance

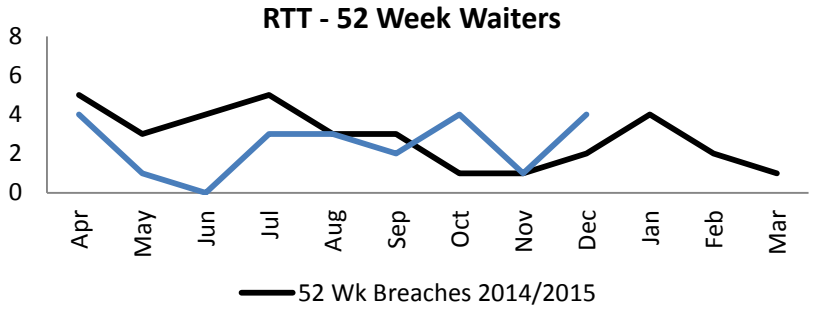


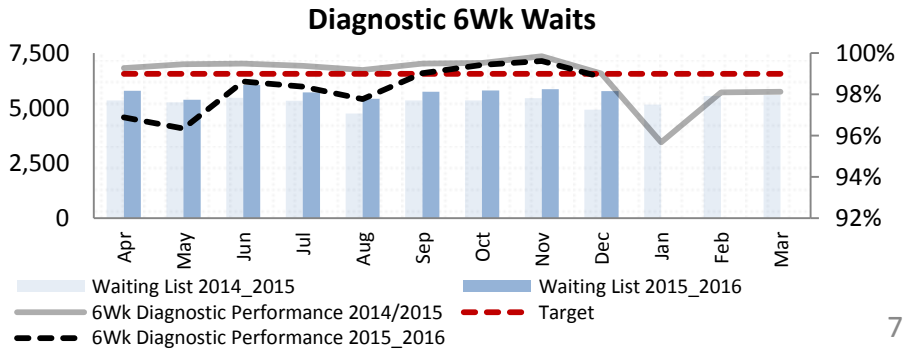




## RTT & Diagnostics



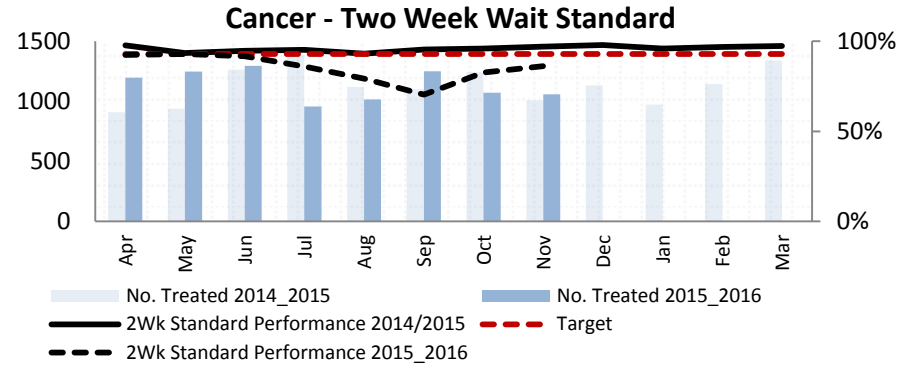



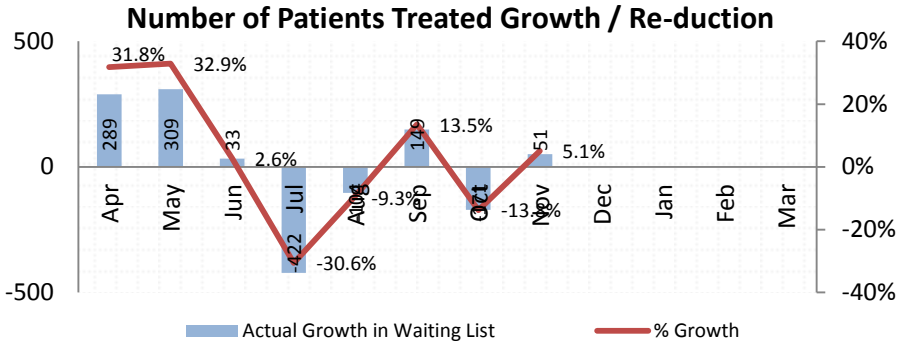



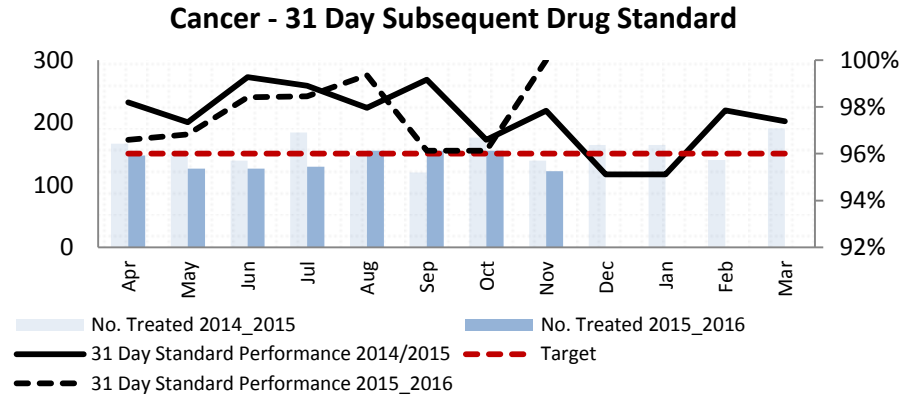
# 3. Trust Key Performance Indicators and Activity Comparison to previous year (2 of 2)

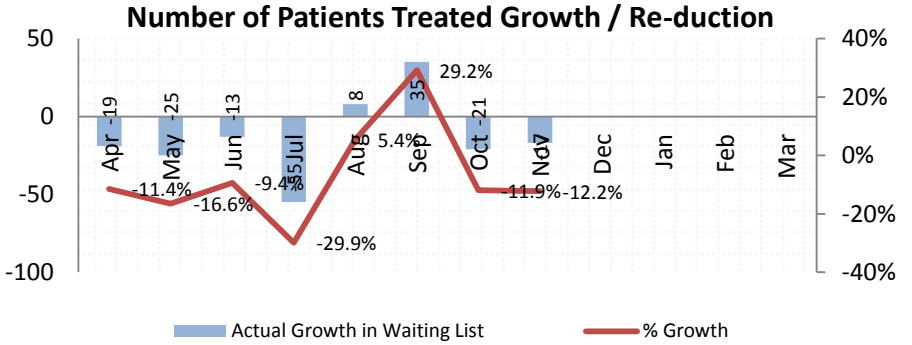
## Cancer - Two Week Wait Standard



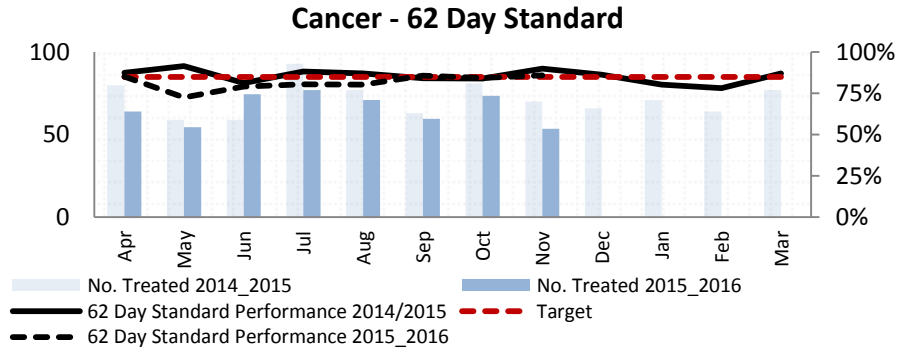



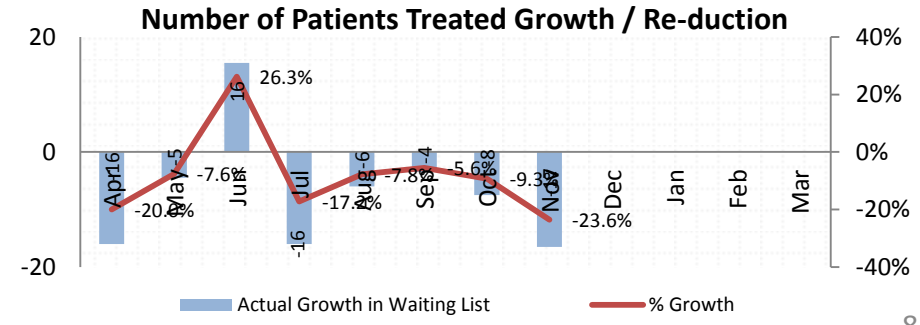

## Cancer - 31 Day Subsequent Drug Standard




## Cancer - 31 Day Subsequent Drug Standard



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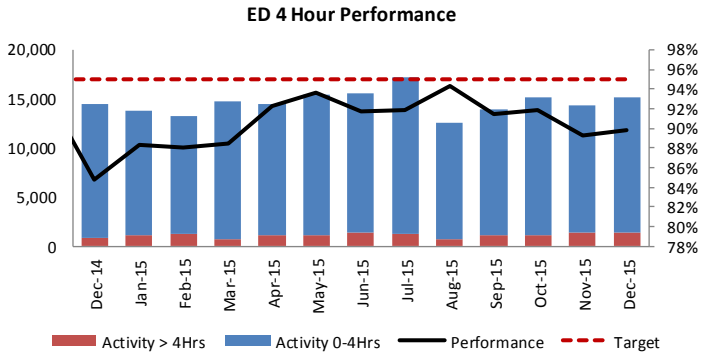
# Performance – areas of escalation

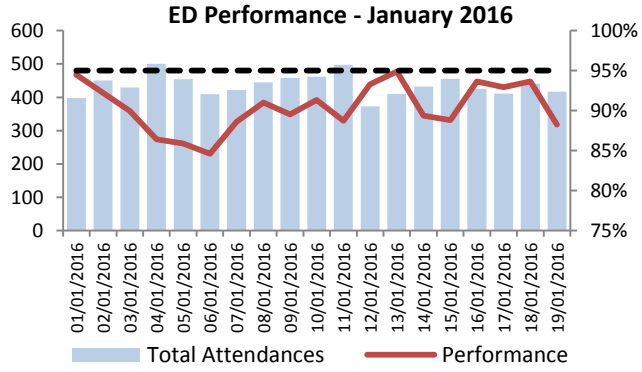
*Excellence in specialist and community healthcare*

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

| Total time in A&E - 95% of patients should be seen within 4hrs | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lead Director | Nov-15 | Dec-15 | Movement | 2015/2016 Target | Forecast for Dec-15 | Forecast for Jan-16 | Date expected to meet standard |
| FA | 89.10% | 89.80% | ⇧ 0.70% | >= 95% | R | R | TBC |

| Peer Performance November 2015 (Rank) | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 4 | 1 | 3 | 5 | 2 |
| 89.10% | 95.20% | 93.60% | 88.80% | 94.40% |

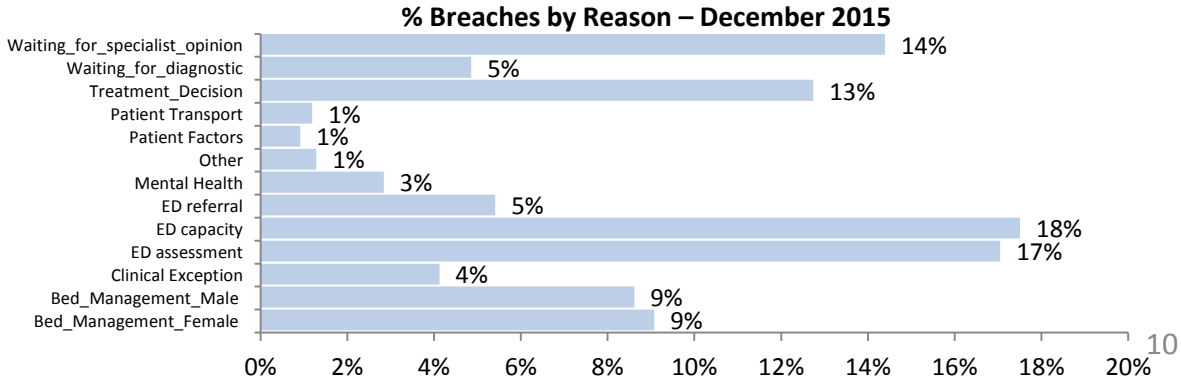



The ED target is that 95% or more of patients should be seen and discharged within 4 hours of attending the Emergency Department. Performance remains challenged being below the target at both the weekly and monthly level. In December 89.80% of patients were seen within 4 hours which was 0.70% higher 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
- 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 06/01/2016 there were 30 DTOC and 41 Non-DTOC.
- As at 06/01/2016 there were 91 of 645 (14%) patients being tracked within the organisation that were medically fit for discharge. These encompass the DTOC, NDTOC, patients awaiting transfer to another provider and patients going home that day. The trust is working with commissioners and external agencies to expedite this.
- The trust has completed the OCT diagnostic exercise which has identified 11 key workstreams required to transform emergency care across the system. An implementation plan has been developed targeting these workstreams.
- ECIP MADE Event undertaken which focused on the re-design of AMU and onward care.

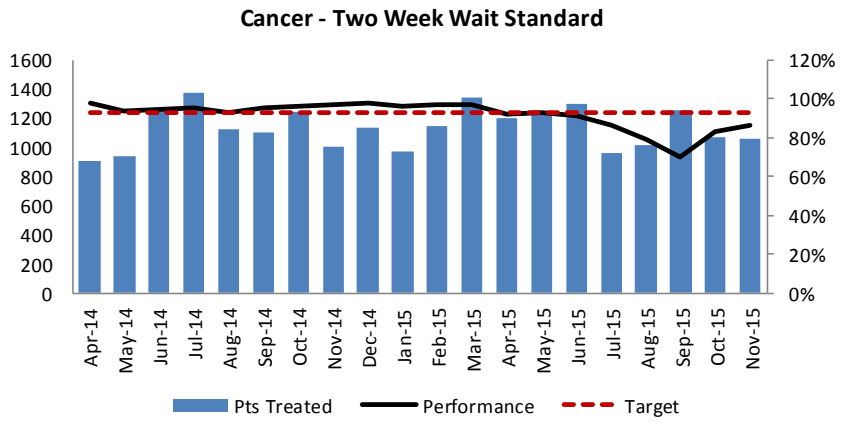


# 4. Performance Areas of Escalation (Page 2 of 5)
# - Cancer Performance – Two Week Wait Standard

| Cancer Performance | | | | | | | | Peer Performance Latest Published October 2015- 2016 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Lead Director – CC | Oct-15 | Nov-15 | Movement | 2015/2016 Target | Forecast for Nov-15 | Forecast for Dec-15 | Date expected to meet standard | STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 14 Day GP Referral for all Suspected Cancers | 82.73% | 86.20% | ⇧ 3.47% | 93% | R | R | Jan-16 | 82.70% | 95.90% | 93.20% | 95.20% | 96.70% |

The trust was non compliant against two of the national cancer wait targets for the month of November , namely the 14 Day standard with performance of 86.20% and the 62 Day Consultant upgrade to treatment standard (failing by a single shared breach within Urology from a total of 3 patients treated in the month). However, the 14 day standard has seen an improvement in performance for a consecutive third month. In response to the continued under-performance in Q3 the following actions are being undertaken:

- Weekly escalation meetings now in place directed and chaired by the Chief Operating Officer reviewing all long waiters and escalation of potential issues impacting on future performance and to review cancer action plan.
- 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 has been presented and approved by NHSE.
- 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 146 breaches which is another sign of improvement compared to the 185 reported in October

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

Key issues affecting performance in November:

- 81 Patients delayed due to capacity (55%)
- 63 Patients delayed due to patient choice (43%)

# 4. Performance Areas of Escalation (Page 3 of 5) - Cancer Performance

## November 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 | 86.20% | 92.30% | 59.80% | 94.70% | 88.80% | 92.80% | 96.80% | 76.50% | 83.30% | 97.00% |
| 14 Day Breast Symptomatic Referral | 93.70% | 93.70% | | | | | | | | |
| 31 Day First Treatment | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| 31 Day Subsequent Surgery Treatment | 100.00% | 100.00% | 100.00% | | 100.00% | 100.00% | 100.00% | 100.00% | | 100.00% |
| 31 Day Subsequent Drug Treatment | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | | | |
| 62 day GP Referral to Treatment | 86.00% | 100.00% | 57.10% | 66.70% | 78.60% | 81.80% | 80.00% | 100.00% | 75.00% | 93.30% |
| 62 Day Screening Referral to Treatment | 98.70% | 98.70% | 100.00% | | | | | | | |
| 62 Day Consultant Upgrade to Treatment | 83.30% | | | | | | 100.00% | | | 66.70% |

## Performance against agreed trajectory

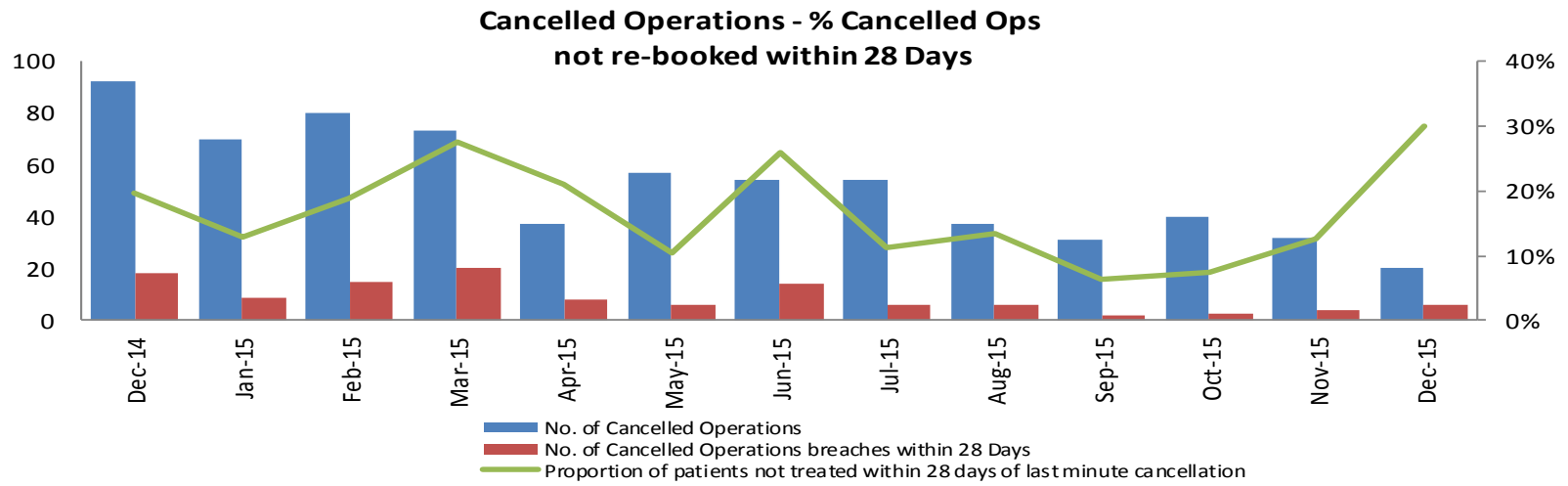
| Cancer Standard | Month | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 Day Standard | Actual | 92.49% | 93.02% | 91.58% | 85.89% | 79.06% | 70.27% | 82.71% | 86.20% | | | | |
| | Trajectory | | | | | | | | 83.76% | 91.08% | 93.06% | 93.56% | 94.14% |
| | Target | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% |

| | Month | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 62 Day Standard | Actual | 86.61% | 72.48% | 79.19% | 80.52% | 80.28% | 85.71% | 84.35% | 85.80% | | | | |
| | Trajectory | | | | | | | | 85.14% | 85.51% | 86.09% | 87.24% | 88.96% |
| | Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

# 4. Performance Areas of Escalation (Page 4 of 5) - Cancelled Operations

| Proportion of Cancelled patients not treated within 28 days of last minute cancellation | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lead Director | Nov-15 | Dec-15 | Movement | 2015/2016 Target | Forecast for Dec-16 | Forecast for Jan-16 | Date expected to meet standard |
| CC | 12.50% | 30.00% | ⇩ 17.50% | 0% | A | G | Jan-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 20 cancelled operations from 4,210 elective admissions in December. 14 of those cancellations were rebooked within 28 days with 6 patients not rebooked within 28 days, accounting for 30% 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. Performance Areas of Escalation (Page 5 of 5) - Diagnostics

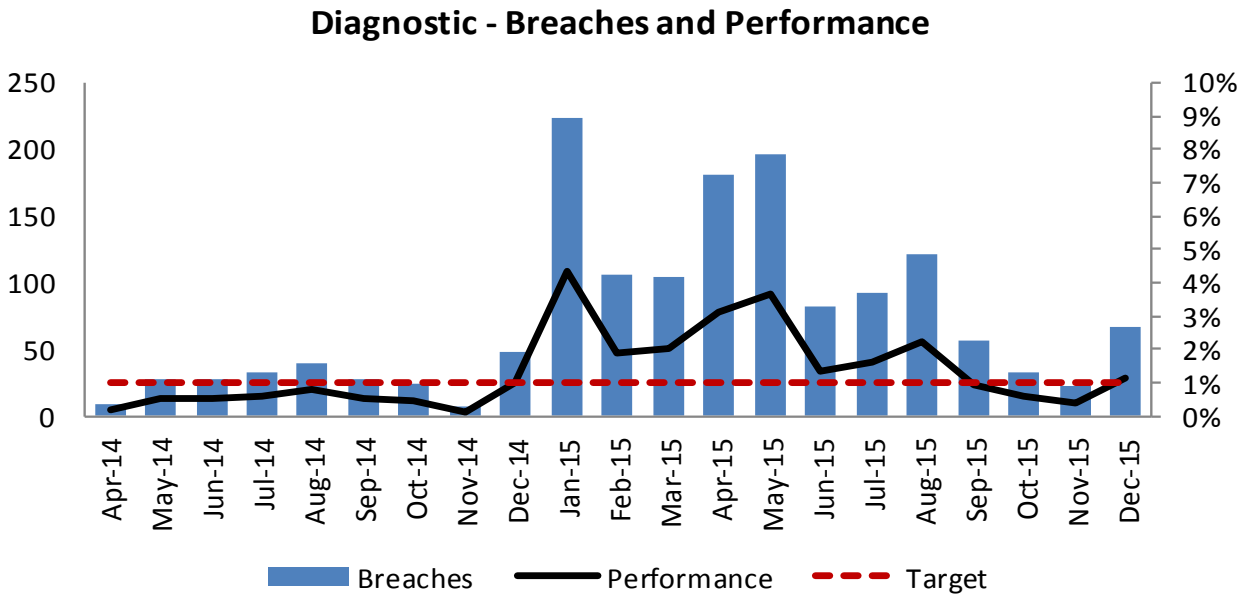
| Diagnostic waiting times > 6 weeks | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lead Director | Nov-15 | Dec-15 | Movement | 2015/2016 Target | Forecast for Dec-15 | Forecast for Jan-16 | Date expected to meet standard |
| SC | 0.38% | 1.16% | ⇩ 0.78% | 1% | G | G | Jan-16 |

| No of Patients waiting >6 weeks – Latest Published Data November 2015 | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 3 | 2 | 1 | 5 | 4 |
| 22 | 16 | 2 | 129 | 31 |

The trust had maintained positive performance improvement with diagnostic waits greater than 6 weeks, meeting performance since September 2015. However, December performance did not achieve the target by 0.16%.

A key issues affecting performance in December, was the unexpected failure of a DEXA scanner, an modality which does not typically have long waits, consultant sickness within neurophysiology which resulted in some last minute cancellations, and capacity shortfall for Neuro MRI as the scanner is being replaced.

The DEXA scanner is now back in operation and additional slots for DEXA have been scheduled to recover performance and as at 17/01 there were no patients waiting greater than 6 weeks within this modality. The Neuro MRI capacity issue remains a challenge whilst the replacement work is undertaken.



# 5. Divisional KPIs Overview 2015/16: December 15 Performance (Page 1 of 2)

## Monthly View

| | | | December 2015 | | | | |
|---|---|---|---|---|---|---|---|
| | | | COMMUNITY SERVICES | MEDICINE | SURGERY | WOMEN & CHILDREN | TRUST LEVEL |
| Access Metrics | A&E WAITS (4 HOURS) | % | 100 | 88.8 | | | 89.8 |
| | CANCELLED OPERATIONS RE-BOOKED WITHIN 28 DAYS (DIVISION) | % | 0 | 23.1 | 25 | 25 | 24.1 |
| | LAS HANDOVER WITHIN 15 MINS | % | | | | | 33.1 |
| | LAS HANDOVER WITHIN 30 MINS | % | | | | | 88.7 |
| | LAS HANDOVER WITHIN 60 MINS | No. | | | | | 1 |

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

| | | | Novemberr 2015 | | | | |
|---|---|---|---|---|---|---|---|
| | | | COMMUNITY SERVICES | MEDICINE | SURGERY | WOMEN & CHILDREN | TRUST LEVEL |
| Access Metrics | 2 WEEK GP REFERRAL TO FIRST OUTPATIENT (BREAST SYMPTOMS) - (DIVISION) | % | | | 93.7 | | 93.7 |
| | 2 WEEK GP REFERRAL TO FIRST OUTPATIENT (CANCER) - (DIVISION) | % | | | 86.2 | | 86.2 |
| | 31 DAY SECOND OR SUBSEQUENT TREATMENT (DRUGS) - (DIVISION) | % | | | 100 | | 100 |
| | 31 DAY SECOND OR SUBSEQUENT TREATMENT (SURGERY) - (DIVISION) | % | | | 100 | | 100 |
| | 31 DAY STANDARD FROM DIAGNOSIS TO FIRST TREATMENT - (DIVISION) | % | | | 100 | | 100 |
| | 62 DAY URGENT GP REFERRAL TO TREATMENT FOR ALL CANCERS - (DIVISION) | % | | | 86 | | 86 |
| | 62 DAY URGENT GP REFERRAL TO TREATMENT FROM SCREENING - (DIVISION) | % | | | 98.7 | | 98.7 |

# 5. Divisional KPIs Overview 2015/16: December 15 Performance (Page 2 of 2)

## Monthly View

| | | | December 2015 | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | COMMUNITY SERVICES | MEDICINE | SURGERY | WOMEN & CHILDREN | TRUST LEVEL | |
| Outcome Metrics | C-SECTIONS (APPLICABLE TO WOMEN & CHILDREN ONLY) | % | | | | 23 | 23 | |
| | HSMR | Ratio | | | | | 91.9 | |
| | INCIDENCE OF C.DIFFICILE | No. | 0 | 1 | 0 | 0 | 1 | |
| | INCIDENCE OF E-COLI | No. | 0 | 2 | 0 | 0 | 2 | |
| | INCIDENCE OF MRSA | No. | 0 | 0 | 0 | 0 | 0 | |
| | MATERNAL DEATHS | No. | 0 | 0 | 0 | 0 | 0 | |
| | MEDICATION ERRORS CAUSING SERIOUS HARM | No. | 0 | 0 | 1 | 0 | 1 | |
| | MSSA | No. | 0 | 0 | 0 | 0 | 0 | |
| | NEVER EVENTS | No. | 0 | 0 | 0 | 1 | 1 | |
| | SERIOUS INCIDENTS (DIVISION LEVEL) | No. | 1 | 3 | 2 | 3 | 10 | * |
| | SHMI | Ratio | | | | | 0.9 | |
| | TRUST ACQUIRED PRESSURE ULCERS | No. | 1 | 0 | 0 | 0 | 1 | |

* Includes Corporate Division incident

| | | | December 2015 | | | | |
|---|---|---|---|---|---|---|---|
| | | | COMMUNITY SERVICES | MEDICINE | SURGERY | WOMEN & CHILDREN | TRUST LEVEL |
| Quality Governance Indicators | PATIENT SATISFACTION (FRIENDS & FAMILY) | % | 100 | 96.3 | 90.1 | 92 | 93.1 |
| | PERCENTAGE OF STAFF APPRAISAL (MEDICAL) - (DIVISION) | % | 87.1 | 87.7 | 79.9 | 86 | 84.2 |
| | PERCENTAGE OF STAFF APPRAISAL (NON-MEDICAL) - (DIVISION) | % | 62.4 | 73.7 | 74 | 71.8 | 69.4 |
| | SICKNESS/ABSENCE RATE - (DIVISION) | % | 6 | 4 | 3.3 | 3.4 | 3.9 |
| | STAFF TURNOVER - (DIVISION) | % | 21.2 | 19.3 | 13.9 | 19.3 | 18.4 |
| | VOLUNTARY STAFF TURNOVER - (DIVISION) | % | 16.2 | 16.9 | 11.7 | 15.9 | 15.2 |

**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 December 33.1% of patients had handover times within 15 minutes and 88.7% within 30 minutes. both of which are not within target. The 30 minute handover data is currently being validated and is envisaged to increase post validation. The trust had one 60 minute LAS breaches in December although this is an unvalidated position

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

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# Corporate Outpatient Services Performance

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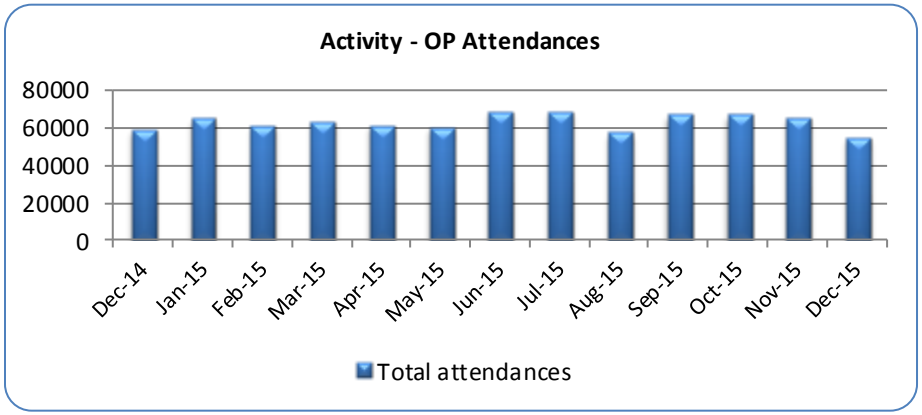
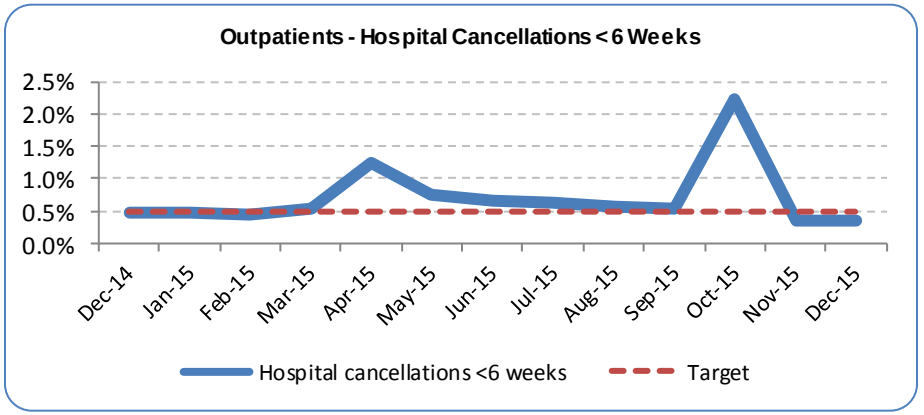
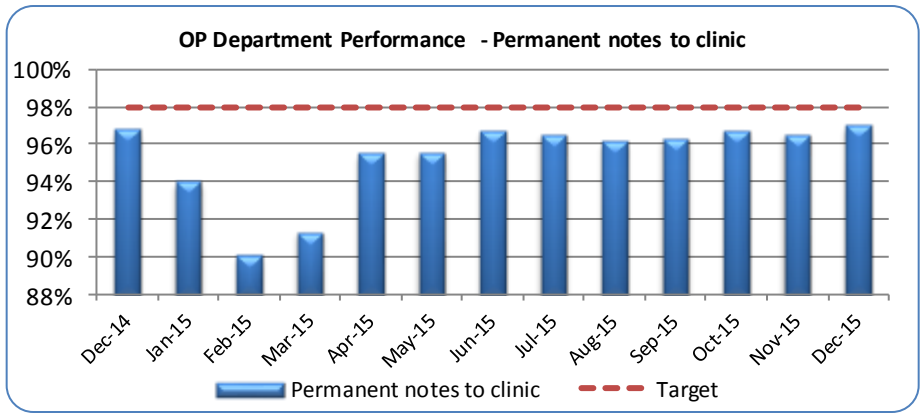
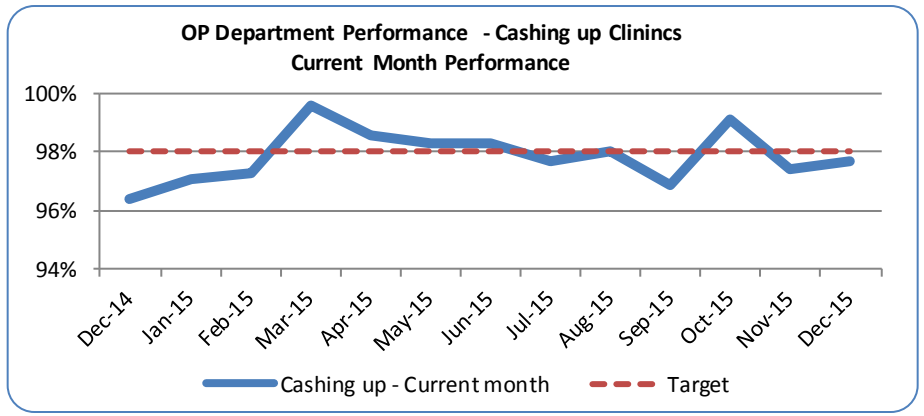
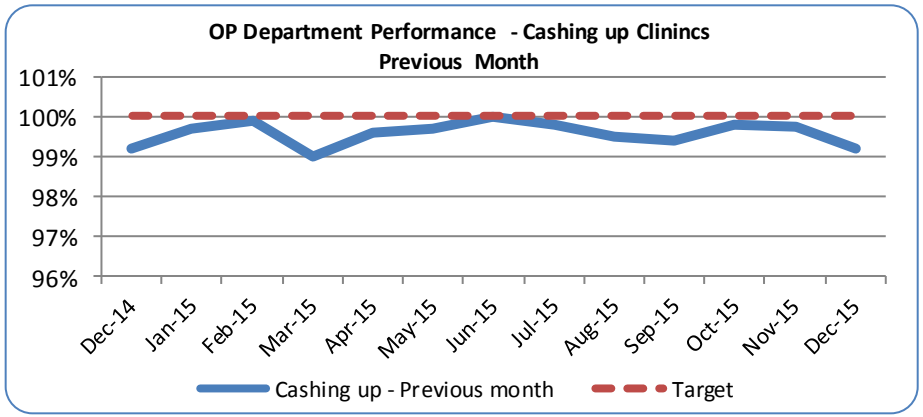
# 6. Corporate Outpatient Services (1 of 2) - Performance Overview

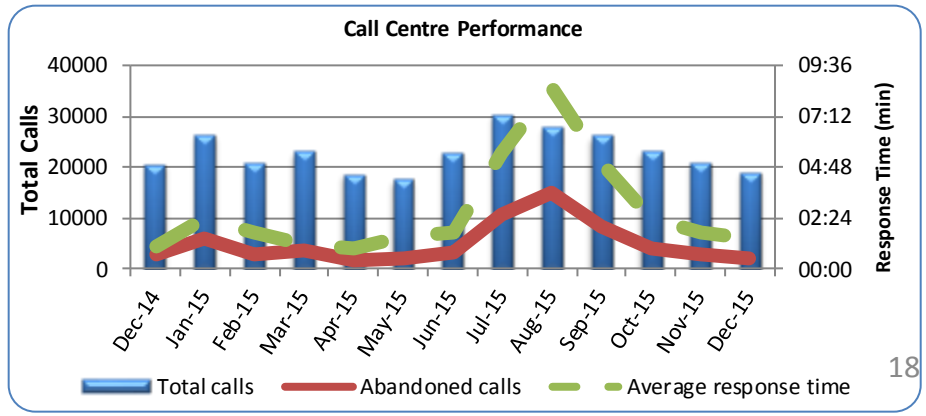


# 6. Corporate Outpatient Services (2 of 2) - Performance Overview

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

**Key Messages:**

- Decrease in activity in December in line with previous years decrease due to seasonal variation in December.
- Hospital cancellations continue to be within target at 0.37%.
- Performance of permanent notes to clinic has slightly increased to 97.02% however 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 December and is now under 1 ½ minutes and within target. Further work continues to be undertaken to sustain this performance

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# Clinical audit & effectiveness

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# 7. Clinical Audit and Effectiveness - Mortality

| HSMR (Hospital standardised mortality ratio) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lead Director | October 15 | November 15 | December | Movement | 2015/16 Target | Forecast March 16 | Date expect to meet standard |
| SM | 91.3 | 91.8 | 92.6 | ↑ | <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 November 2014 to October 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 on 27th January 2016.*

**Overview:**

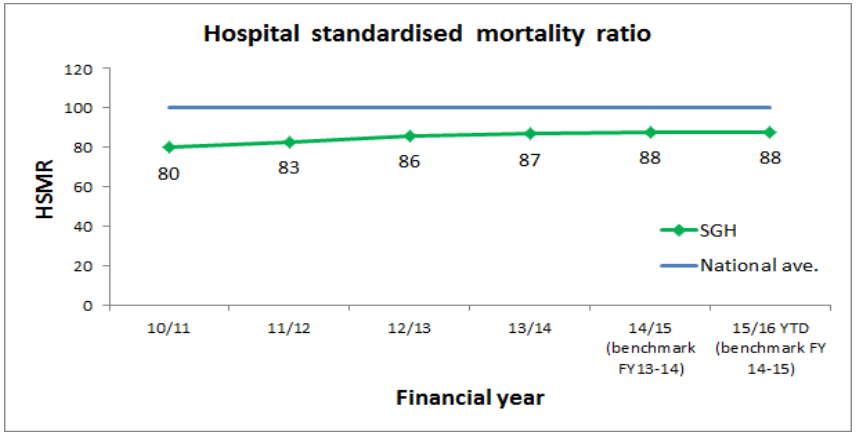
Our most recent HSMR is 92.6, indicating that mortality remains better than expected. Looking at the HSMR for emergency admissions at weekends, our mortality is in line with expected at 92.7 and for emergency weekday admissions it is better than expected at 91.5. The next SHMI publication is due on 27th January 2016; our current banding as published in October shows that our mortality is as expected.

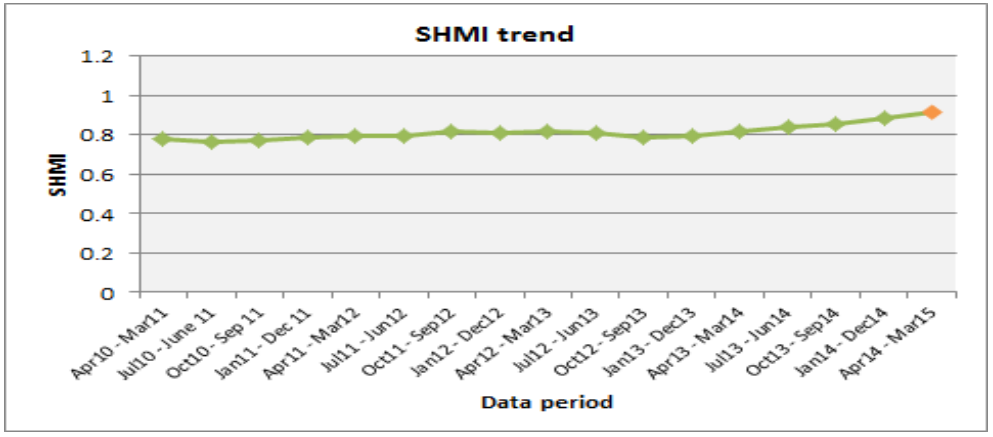
Reviews of the two SHMI diagnosis groups detailed below are moving forward. Progress and outcomes will be discussed at the Mortality Monitoring Committee in February, alongside the data behind the refreshed SHMI indicator. This closer scrutiny and granular analysis of the SHMI is helping us to develop a clearer picture of outcomes.

- Group 123: Joint disorders and dislocations; trauma-related, Spinal cord injury, Skull and face fractures, Other fractures, Sprains and strains
- Group 72: Phlebitis; thrombophlebitis and thromboembolism, Varicose veins of lower extremity, Haemorrhoids, Other disease of veins and lymphatics.

The Head of Audit and Governance for the Cardiology Clinical Academic Group attended the January MMC meeting to provide a detailed update on the actions agreed as a result of the CQC mortality outlier alerts previously investigated. Considerable progress was noted , including prospective review of all deaths, and a timescale for the development of an out of hospital cardiac arrest pathway was agreed.

A review of stillbirths between January and June 2015 was also presented. This found that cases were managed according to current guidelines, but also identified an opportunity for learning which is already being taken forward by the service. The focus of future summaries and a reporting schedule was agreed. It is anticipated that this regular review will strengthen our oversight and learning from these cases.



# 7. Clinical Audit and Effectiveness - National audit

## National COPD Audit Programme: Resources and organisation of Pulmonary Rehabilitation services in England and Wales 2015

**Overview**

Pulmonary Rehabilitation (PR) improves symptoms and overall health and wellbeing in people with COPD. The evidence for the effectiveness of PR is sufficiently strong that its provision for patients reporting significant exercise limitation due to COPD is mandated in all current national and international COPD treatment guidelines. This audit was undertaken by the Royal College of Physicians (RCP) and the British Thoracic Society (BTS) and is the first time that PR services have been audited. The project looked at both service provision and clinical outcomes comparing what is currently happening to the evidence based guidelines set out by the BTS. Detailed below are the national findings concerning PR services and treatment outcomes alongside the comparable results from St George's.

**Audit Results**

The audit looked at 10 Quality Statements. Table 1 indicates St George's compliance to each of these. Data was collected on treatment and outcomes for individual patients. We submitted data for 34 out of 44 patients who gave their consent. Our patient mix and outcomes are largely in line with national results, although there are more with diabetes and cardiovascular disease. Proportionally fewer SGH patients completed the PR course (58% v 71%), but of those that did complete, 84% showed an improvement in their COPD Assessment test, compared to 68% nationally.

| TABLE1: SUMMARY OF QUALITY STANDARDS | ARE WE COMPLIANT? |
|---|---|
| QS1a. People with COPD and self reported exercise limitation (MRC dyspnoea 3-5) are offered PR | YES |
| QS1b. If accepted are enrolled to commence withinin 3 months | 69% of referrals had a completed assessment : this is the same proportion as found nationally |
| QS2. PR programmes accept and enrol patients with functional limitation due to other chronic respiratory diseases | YES |
| QS3a. People admitted to hospital with acute exacerbations of COPD (AECOPD) are referred for PR at discharge | YES |
| QS3b. People referred for PR following admission with AECOPD are enrolled within one month of leaving hospital | PARTIALLY MET |
| QS4. PR programmes are of at least 6 weeks duration and include a minimum of twice weekly supervised sessions | Yes, our programme offers 2 sessions per week for 8 weeks |
| QS5 PR programmes include supervised, individually tailored and prescribed, progressive exercise training including both aerobic and resistance training | Yes, our programme includes cycling, walking and strength training using free weights |
| QS6. PR programmes include a defiend, structured education programme | YES, we provide face to face information and written handouts |
| QS7. People completing PR are provided with an individualised structured written plan for ongoing exercise maintenance | YES |
| QS8. People attending PR have the outcome of treatment assessed using as a minimum, measures of exercise capacity, dyspnoea and health status | YES all these are measured |
| QS9. PR programmes conduct an annual audit of individual outcomes and progress | YES - we maintain a database of patients including attendances, treatment, outcomes and completion |
| QS10. PR programmes produce an agreed standard operating procedure | YES |

**Recommendations**

Overall we provide a robust service that is compliant to all the quality standards set out by the BTS. However, the overall number of referrals both nationally and locally is low compared to the number of patients who are likely to benefit from PR and the figure for the uptake of assessments by patients referred is just 69% (this is both the national figure and that for SGH) although the reason for this is not clear. Given the proven benefits of a PR service the report recommends that the pathway is reviewed and enhanced. The local results suggest that we also look at ways to encourage patients to complete their PR. To commissioners it is recommended that steps are taken to ensure providers have a clear, long-term funding framework that will allow programmes to recruit and retain staff with an appropriate skill and seniority mix, this is already in place for SGH and we are currently recruiting permanent staff members.

# 7. Clinical Audit and Effectiveness - National audit

## National Vascular Registry 2015 Annual Report

### Overview

The 2015 Annual report of the National Vascular registry was published in November 2015 and provides comparative information on the performance of NHS vascular units according to national guidelines including: the "Provision of Services for Patients with Vascular Disease" document and the Quality Improvement Frameworks published by the Vascular Society, and the National Institute for Health and Care Excellence (NICE) guidelines on stroke and peripheral arterial disease.

The report looks at (i) patients undergoing abdominal aortic aneurysm (AAA) repair, (ii) patients undergoing carotid endarterectomy, (iii) patients undergoing a revascularisation procedure (angioplasty/stent or bypass) or major amputation for lower-limb peripheral arterial disease (PAD). In addition, the report presents the findings of an organisational audit conducted in August 2015.

### Audit Results

Overall, the results show an improvement in outcomes for patients. In-hospital mortality for AAA repair is reported as 1.5% compared to almost 8% ten years ago. The delay for patients requiring carotid endarterectomy following a TIA or stroke has reduced with the majority of patients receiving an intervention within fourteen days.

For some indicators including mortality and time from assessment to surgery it is possible to compare performance at St George's with overall results. For all these indicators we are performing better than the national average (see Table 1 below).

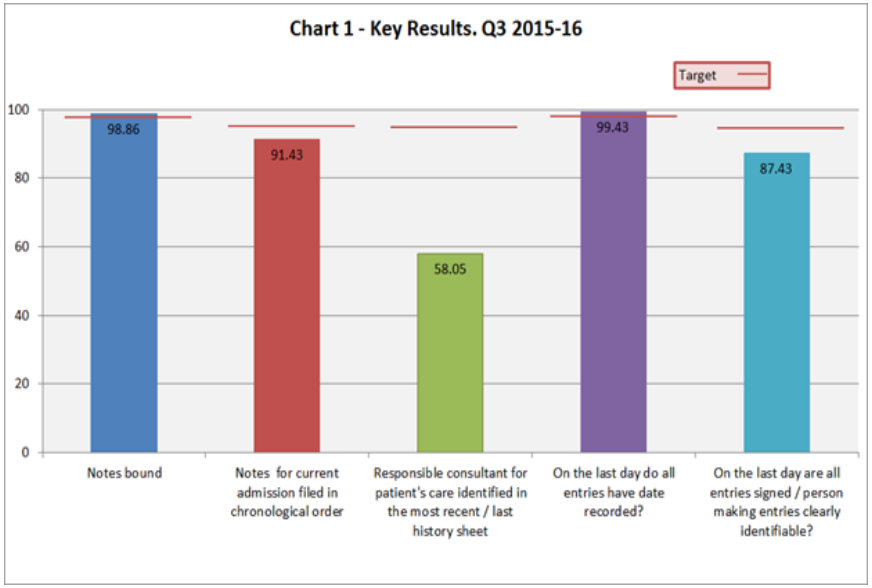
| Indicator | National Results or Guidelines | SGH |
|---|---|---|
| **Infra renal AAA**: Median delay from assessment to surgery(days)* | The majority of trusts reported a median delay between 60-90 days . The National AAA screening target is that patients should not wait longer than 8 weeks | 44 days (IQR 27-71) |
| **Infra renal AAA** In hospital Mortality | 1.50% | 0% |
| Median time from symptoms to **carotid enarctectomy (days)** | NICE guideline is 14 days. | 8 days(IQR 6-13) |
| Risk adjusted rate of death /stroke within 30 days of **carotid enarctectomy** | 2% | 0.90% |
| Median (interquartile range) delay from vascular assessment to surgery for **unilateral major amputation procedures** Jan- Dec 2014 | There is wide variation between all organisations and this will be investigated further in future data collection | SGH is among the organisations with shorter delays, with a median of 7 days |

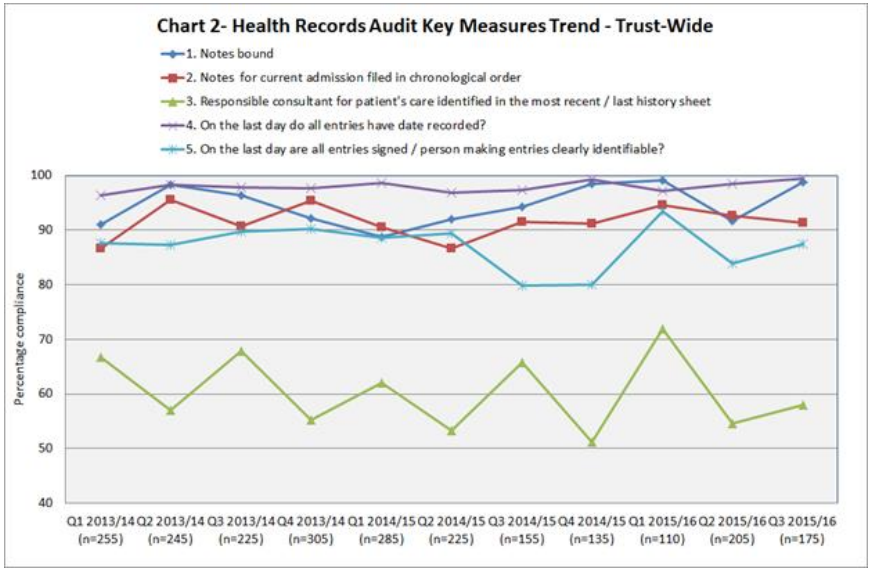
### Recommendations

The report makes a number of recommendations for vascular units. These relate to the use of care pathways for vascular procedures, to the availability of services and to data collection. At St George's we are largely compliant and no specific areas have been highlighted for action by the vascular care group.

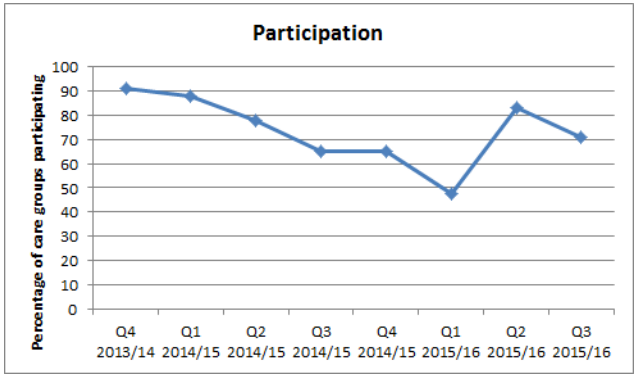
# 7. Clinical Audit and Effectiveness - Local audit

## Healthcare Records Audit Report Q3 2015/16




This quarterly audit is mandatory for all inpatient services; however, participation remains variable. This is despite repeated efforts by the chair of the health records committee, including most recently liaison with educational supervisors to engage junior doctors. This quarter 7 care groups did not participate.




At trust level, compliance was achieved for 2 of the 5 key indicators. For all standards, other than filing in chronological order, the latest results indicate some improvement; however, the variation observed to date suggests that this should be viewed with only cautious optimism. There is significant variation both across divisions and for different standards within divisions.

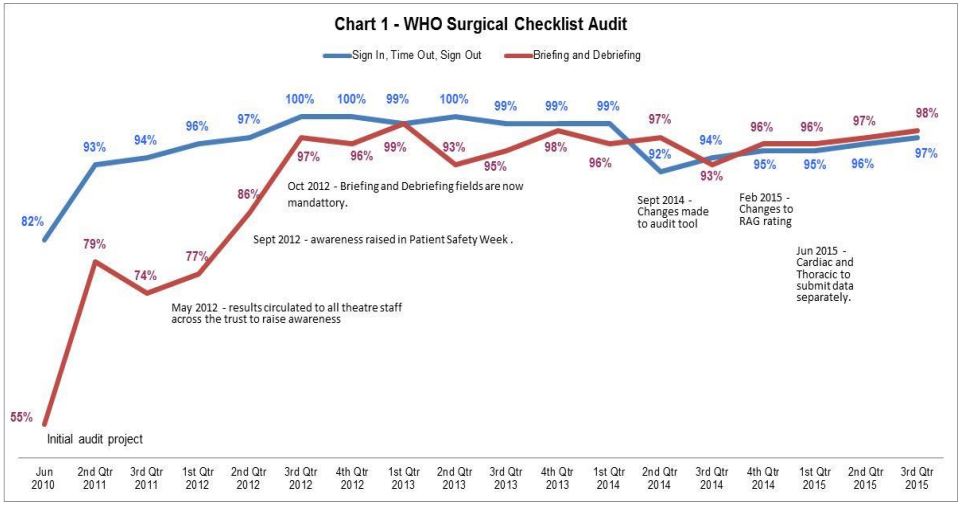
Local action will be required to improve standards and to this end care group results are generated at the time of data collection and divisional analysis is incorporated in the report. A number of measures have been recommended at trust level, particularly around the improved access to patient labels, use of clinician name stamps, patient identification stickers and dividers in ward ring folders.

The clinical audit department hope to create a report in PIEDW (iCLIP) by which to audit the quality of electronic documentation in those areas that use iClip. This is dependent on training, which is scheduled for the end of January.

The standard of documentation as reported by this audit and other data will be considered when formulating the Quality Improvement Strategy for 2016/17. The approach to improvement and measurement of the quality of healthcare records will be informed by the outcome of this process.

# 7. Clinical Audit and Effectiveness
# - Local Audits

## WHO Surgical Checklist Audit 3rdQtr 2015/16




| Table 1 | Specialty | Sign In, Time Out, and Sign Out | | | | | Briefing and Debriefing | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2014/15 | | 2015/16 | | | 2014/15 | | 2015/16 | | |
| | | 3rd Qtr | 4th Qtr | 1st Qtr | 2nd Qtr | 3rd Qtr | 3rd Qtr | 4th Qtr | 1st Qtr | 2nd Qtr | 3rd Qtr |
| Children & Women | Gynaecology | 97% | 98% | 99% | 99% | 99% | 100% | 100% | 100% | 100% | 100% |
| | Obstetric - Elective | 99% | 93% | 99% | 97% | 100% | 100% | 100% | 100% | 98% | 100% |
| | Obstetric - Emergency | 88% | 98% | 85% | 98% | 99% | - | - | - | - | - |
| | Paediatric | 96% | 98% | 97% | 95% | 97% | 100% | 100% | 100% | 97% | 100% |
| Medicine & CardioThoracic | Cardiac | - | - | 73% | 94% | 92% | - | - | 71% | 94% | 100% |
| | Renal | 98% | 98% | 100% | 100% | 95% | 95% | 100% | 100% | 96% | 89% |
| | Thoracic | - | - | 91% | 89% | 98% | - | - | 71% | 57% | 97% |
| | Vascular | 99% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Surgery | AET/T&O | 82% | 82% | 91% | 97% | 88% | 98% | 100% | 98% | 94% | 100% |
| | CEPOD | 97% | 98% | 98% | 98% | 98% | 100% | 100% | 100% | 100% | 100% |
| | DSU | 98% | 98% | 96% | 98% | 98% | 92% | 96% | 96% | 96% | 96% |
| | ENT | 100% | 100% | 99% | 99% | 100% | 100% | 100% | 100% | 100% | 100% |
| | General Surgery | 94% | 93% | 90% | 92% | 92% | 100% | 95% | 100% | 91% | 100% |
| | MaxFax | 86% | 100% | 100% | 100% | 99% | 90% | 100% | 100% | 100% | 100% |
| | Neuro Surgery | 93% | 93% | 99% | 96% | 100% | 95% | 94% | 100% | 96% | 100% |
| | Plastic | 92% | 91% | 92% | 94% | 91% | 98% | 100% | 97% | 100% | 91% |
| | Urology | 100% | 97% | 96% | 99% | 97% | 100% | 95% | 100% | 100% | 100% |

**Overview**
As part of the commitment to improving patient safety, St Georges Healthcare NHS Trust has adopted the WHO Surgical Safety Checklist.

**Overall Performances**
Results show steady improvement towards 100%, with cardiac and thoracic showing major improvement. The team acknowledges that the dissemination of the report has been effective in producing a reaction in major outliers.

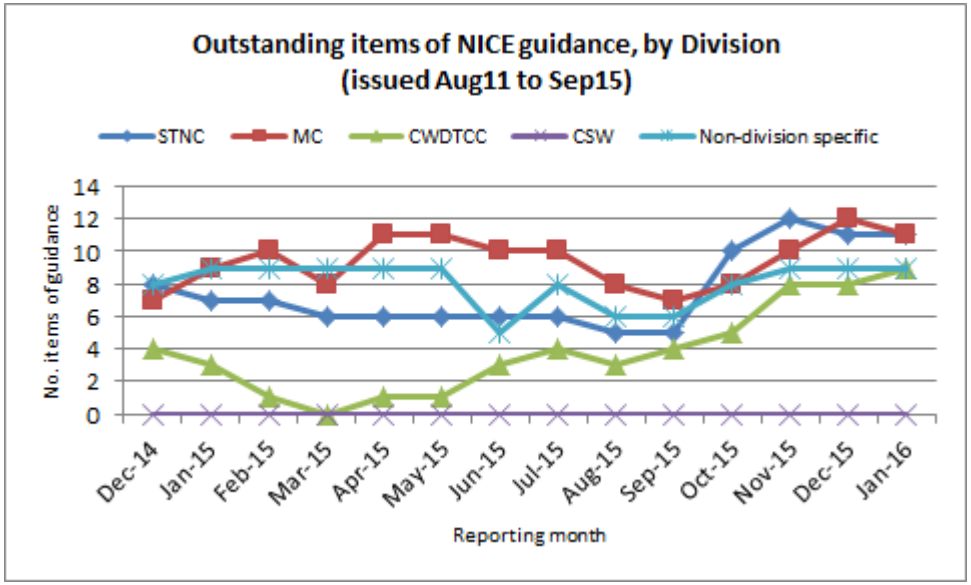
**Sign-in, Time Out and Sign-out**
Chart 1 shows marginal improvement for all fields. The latest results are 97% for Sign-in/Time-out/Sign-out (96% in the last quarter) and 98% for Briefing and Debriefing (97% in the last quarter).

Table 1 shows the breakdown by specialty and Obstetric (Elective), Vascular, ENT and Neurosurgery scored 100% for all fields. Thoracic has shown significant improvement from the last audit round - 98% for Sign-in/Time-out/Sign-out and 97% for Briefing and Debriefing (89% and 57% respectively in the last audit round).

AET/T&O scored 88% for Sign-in/Time-out/Sign-out and Renal scored 89% for Briefing and Debriefing. These are the lowest scores in this audit round.

**Agreed action Plan**:
- ✓ Peer review audit will be undertaken in the next audit round (4th quarter).
- ✓ This information will be included in the new theatre efficiency project led by Martin Wilson
- ✓ To continue circulating the results to Theatres Care Group and Governance leads.

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




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

| Division | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| STNC (n=7) | 0 | 1 | 2 | 1 | 3 | 0 |
| M+C (n=16) | 2 | 2 | 4 | 1 | 3 | 4 |
| CWDTCC (n=16) | 3 | 1 | 1 | 3 | 6 | 2 |
| CSW (n=0) | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-division specific (n=11) | 0 | 2 | 0 | 4 | 1 | 4 |

**Overview**

The overall number of outstanding items of guidance remains unchanged since the last report, with 40 responses not received. The recent increase, which is evident in the chart above, will be addressed by the actions previously detailed. These include a review of methodology and allocation of dedicated resource in clinical effectiveness as soon as the team returns to full staffing levels.

The number of items of guidance where we are not fully compliant has increased slightly this month, and stands at 50 in total. The audit team have just commenced 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.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

# Patient Safety

*Excellence in specialist and community healthcare*

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

| | 2015 SIs Declared by Division (incl. PUs) | | | | |
|---|---|---|---|---|---|
| | M&C | STN&C | CSD | C&W | Corporate |
| **October** | 4 | 3 | 1 | 1 | 1 |
| **November** | 5 | 3 | 3 | 1 | 0 |
| **December** | 3 (1 Shared with C&W) | 2 | 1 | 3 (1shared with M&C) | 1 |

| Closed Serious Incidents (not incl. PUs) | | | | |
|---|---|---|---|---|
| **Type** | October | November | December | **Movement** |
| **Total** | 11 | 8 | 10 | ⮟ |
| **No Harm** | 2 | 2 | 3 | ⮝ |
| **Harm** | 9 | 7 | 7 | ➤ |

**Table 1**

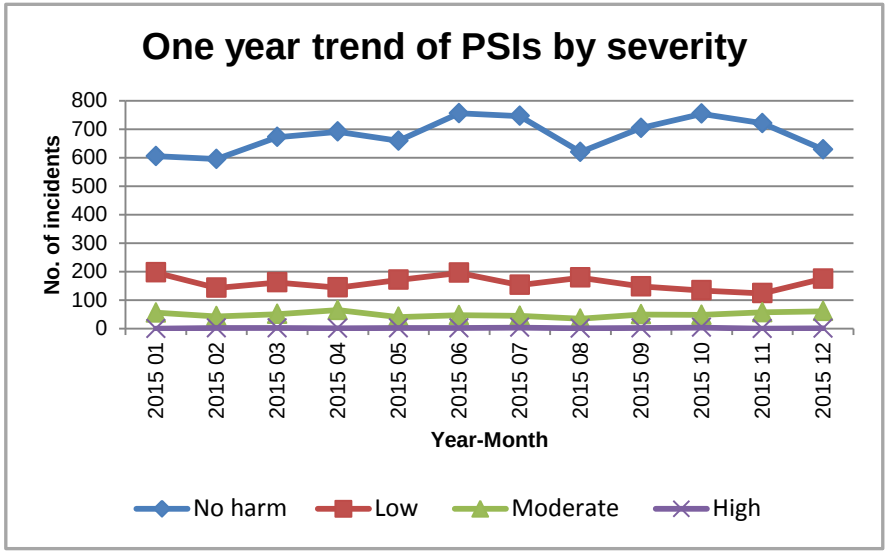
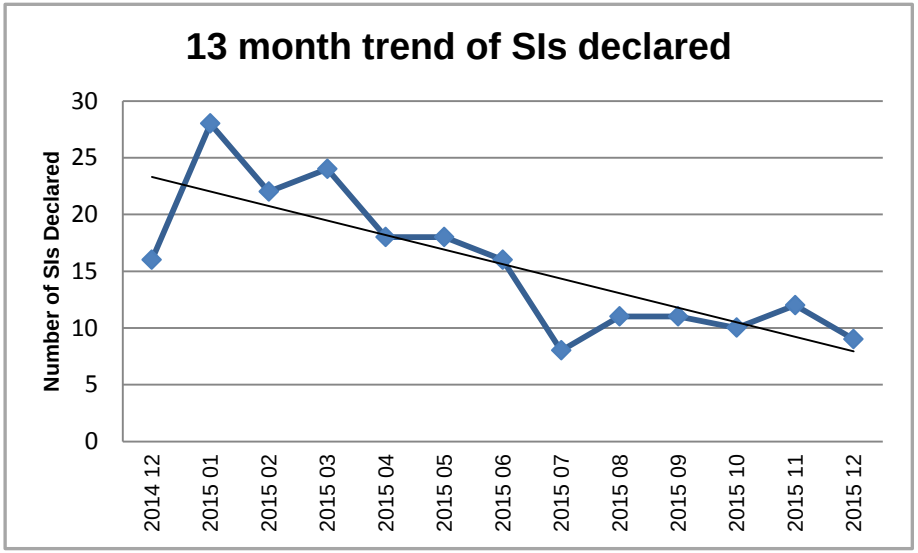



**Table 2**




**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.

There were 8 general SIs reported in December (+1 pressure ulcer) and the subjects are varied.

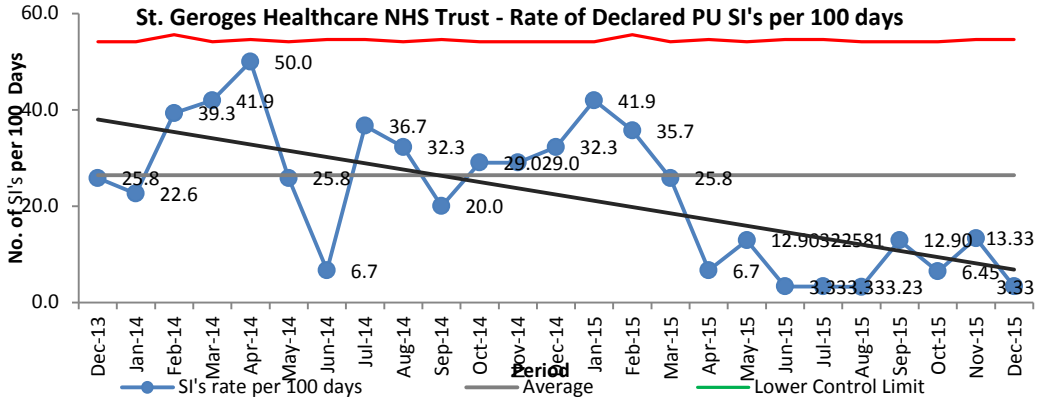
The 8 general SIs declared in December relate to a range of issues. They include the following categories:

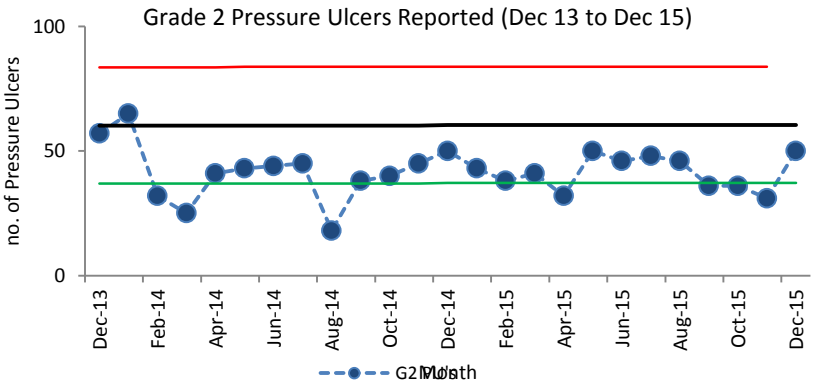
- Unexpected death
- Patient fall
- Failure to monitor
- Retained foreign object (swab)
- Inappropriate/wrong treatment
- Unexpected admission to NNU
- Failure to clinically access/diagnose
- Power failure

# 8. Patient Safety
## - Incident Profile: Pressure Ulcers

| Serious Incident – Grade 3 & 4 Pressure Ulcers | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Type | Aug | Sep | Oct | Nov | Dec | YTD April – May 2016 | Movement | 2015/2016 Target | Forecast March 2016 | Date expected to meet standard |
| Acute | 0 | 2 | 1 | 3 | 0 | **12** | | | G | - |
| Community | 1 | 2 | 1 | 1 | 1 | **7** | | | G | - |
| Total All | 1 | 4 | 2 | 4 | 1 | **19** | | | G | - |
| Total Avoidable | 1 | 4 | 2 | 4 | 1 | **19** | | 40 | | - |
| Previous Year | 3 | 3 | 6 | 8 | 6 | **44** | | | | |

| Grade 2 Pressure Ulcers | | | | | | |
|---|---|---|---|---|---|---|
| Aug | Sep | Oct | Nov | Dec | Movement |
| 23 | 21 | 21 | 11 | 39 | |
| 23 | 15 | 15 | 20 | 11 | |
| 46 | 36 | 36 | 31 | 50 | |
| | | | | | |
| 18 | **38** | **40** | **45** | 50 | |




**Overview:**

December saw a decrease in the total number of pressure ulcer serious incidents, with no declarations in the acute sector. Community services also maintained a consistently low number with only one declaration. There was a rise in the total number of Grade 2 pressure ulcers, despite a decrease noted in community services, with 39 incidents in the acute service. Year on year there was a reduction from 6 avoidable pressure ulcers in December 2014 to 1 in December 2015. The same number of Grade 2 pressure ulcers were seen in both years.

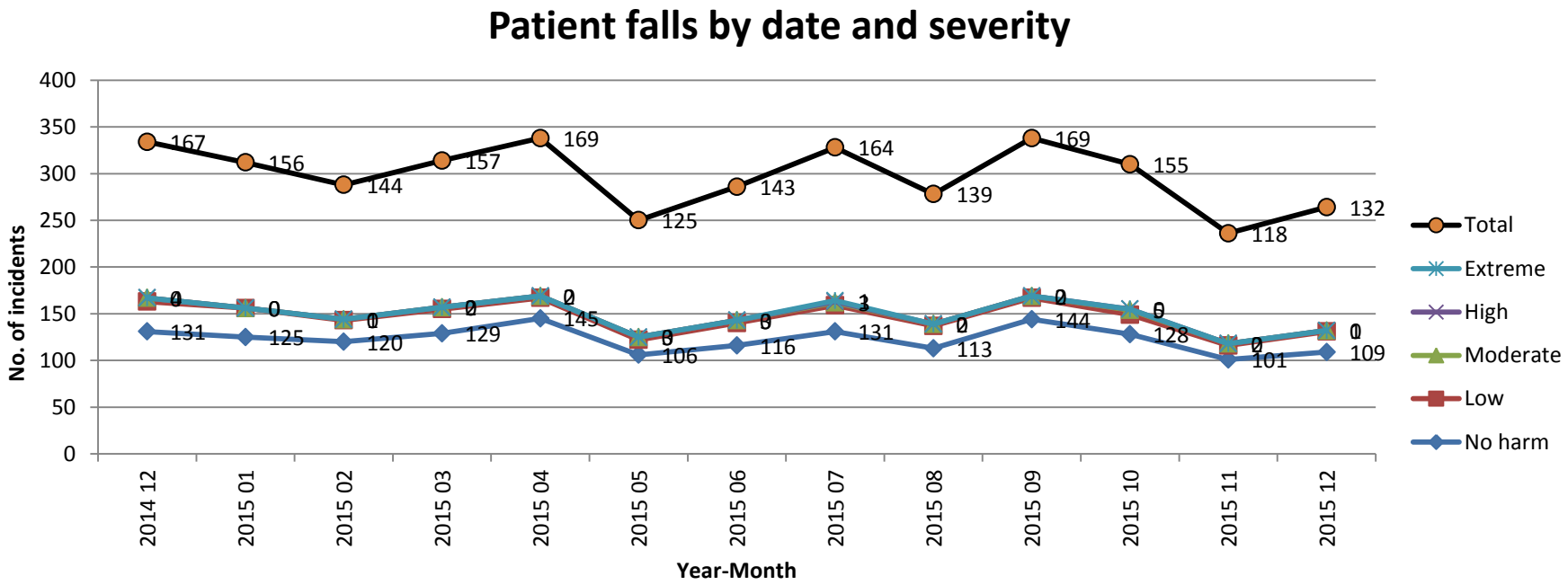
**Actions:**

- Advertising campaign continues for Band 7 TVN for community services, and rotational posts
- Mattress roll out scheduled to begin in March 2016, savings of >£20k per annum calculated. The rollout of new mattress systems will begin in Intensive Care areas and Queen Mary's Hospital, following this mattresses will be replaced systematically throughout the trust beginning with areas with lower patient flow. The new system will ensure that all patients admitted to the trust are nursed on a pressure relieving support surface and there will be no waiting times.
- Quality Improvement programme now underway for all areas who declare a serious incident. Marnham ward are due to begin rolling out the programme in January 2016

# 8. Patient Safety: December 2015
## - Incident Profile: Falls

| Falls | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dec 14 | Jan | Feb | March | April | May | June | July | August | September | October | Nov | Dec | 2014/ 2015 Target | Date expected to meet standard |
| 167 | 156 | 144 | 157 | 169 | 125 | 143 | 164 | 139 | 169 | 155 | 118 | 132 | 100 | July 2015 |

| Falls with Harm Dec 14 to date | | | | |
|---|---|---|---|---|
| No Harm /low harm | Moderate | Severe | Death | Falls related Fractures |
| 1904 | 31 | 2 | 1 | 7 |




**Overview:** The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been a small increase in the number of falls over the last month. This increase is related to the escalation area for medical patients. **Actions:** The Falls Prevention Committee have reviewed the national recommendations from the national inpatient audit to identify key priorities areas. These include development of a Trust Strategy for falls as well as practical steps such as ensuring that there are walking aids for safety on all wards 24 hours per day and increased compliance in assessment of postural hypotension.

# 8. Patient Safety
# - Infection Control

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

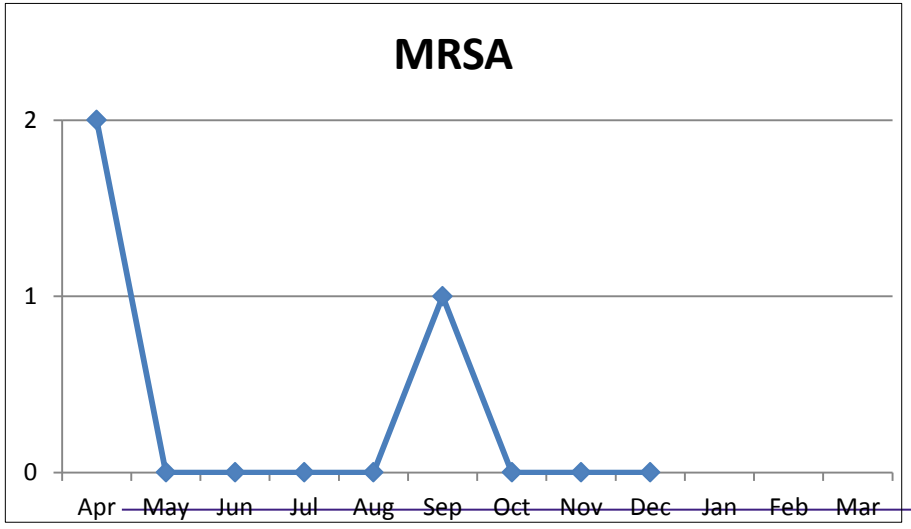
| Peer Performance – YTD December 2015 | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 3 | 2 | 1 | 1 | 3 |

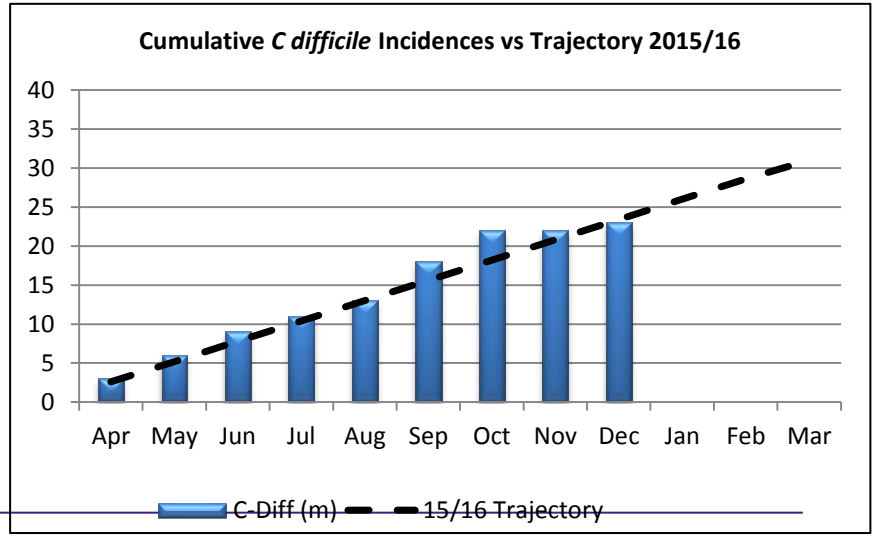
| C-Diff | | | | | | |
|---|---|---|---|---|---|---|
| Lead Director | November | December | Movement | 2015/2016 Threshold | Forecast December - 15 | Date expected to meet standard |
| JH | 0 | 1 | ↑ | 31 | G | - |

| Peer Performance – YTD December 2015 (annual trajectory in brackets) | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 23 (31) | 16(16) | 15(9) | 67(72) | 23(39) |

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

In 2015/16 the Trust has a threshold of no more than 31 *C. difficile* incidents. In November there were 0 episodes and in December one episode. This makes a total of 23 for the FY to end December. This means that the Trust is currently on trajectory for the end of December and thus can still achieve the target at the end of the FY 2015/16.



# 8. Patient Safety - VTE

## VTE Risk Assessment

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

| Data Source | Dec 2014 | Jan 2015 | Feb | Mar | April | May | June | July | August | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Unify2 | 93.51% | 95.94% | 96.03% | 96.27% | 96.64% | 96.45% | 96.75% | 96.56% | 96.78% | 97.22% | 97.10% | 96.8% | |

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 2014 | Jan 2015 | Feb | Mar | April | May | June | July | August | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Safety Thermometer | 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)

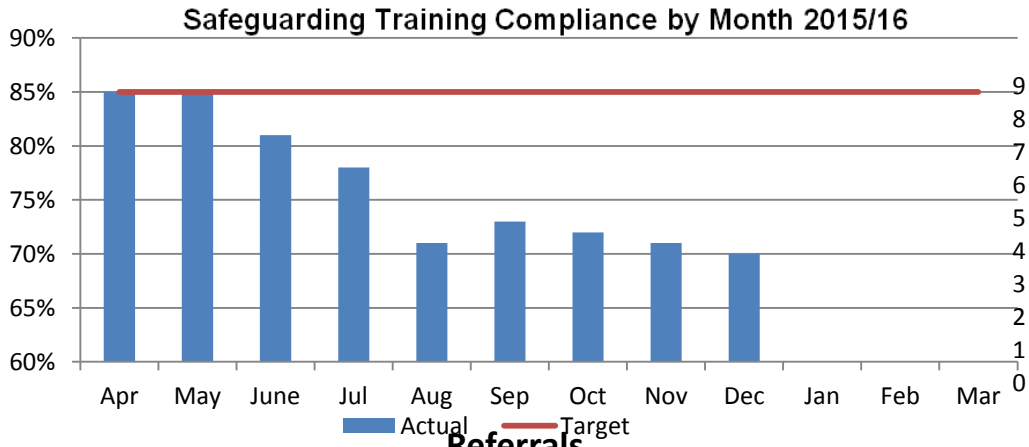
| Year | | 2015 |
|---|---|---|
| HAT cases identified to date (attributable to admission at SGH) | | 190 |
| Mortality rate | Total | 12.1% (23/190) |
| | VTE primary cause of death | 4.2% (8/190) |
| Initiation of RCA process | | 100% (190/190) |
| RCA complete | | 81.6% (155/190) |

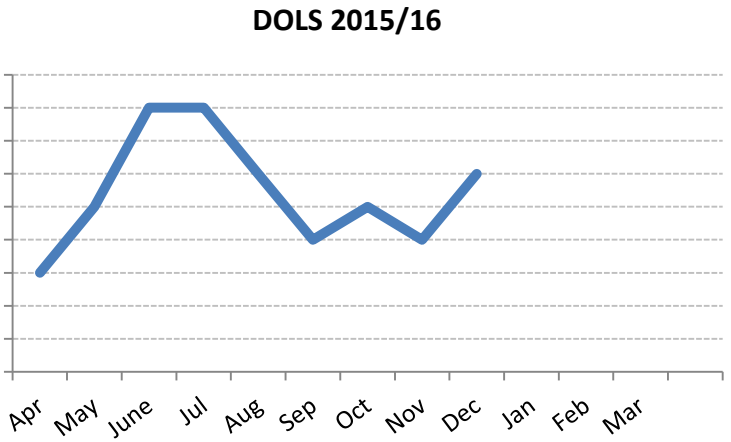
HAT case finding has significantly improved since the start of 2015 resulting in an observed increase in frequency of HAT. This increase brings incidence of HAT at SGH in line with rates observed at other Trusts in London that are of a similar size and status.

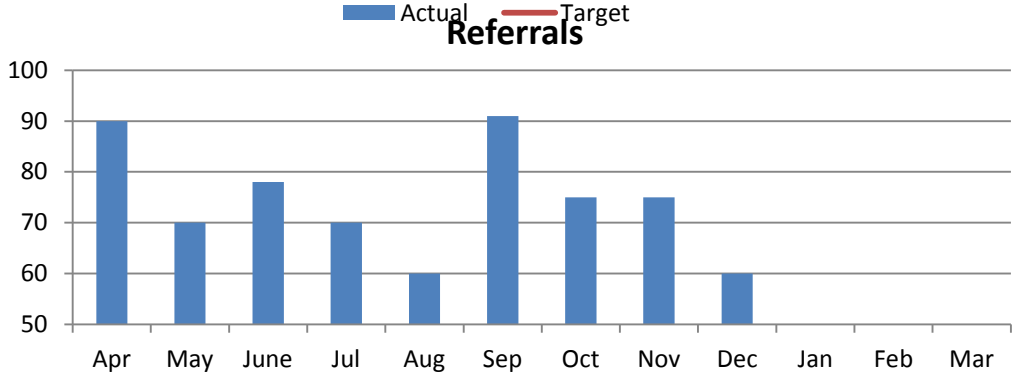
# 8. Patient Safety
## - Safeguarding: Adults

| Safeguarding Training Compliance - Adults | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Lead Director | July | Aug | Sep | Oct | Nov | Dec | 2015/2016 Target | Forecast April 2016 | Date expected to meet standard |
| JH | 78% | 71% | 73% | 72% | 71% | 70% | 85% | A | - |

| Safeguarding Adults Training Compliance by Division – Nov 15 | | | | |
|---|---|---|---|---|
| Med & Card | Surgery & Neuro | Community | Children's and Womens | Corporate |
| 69% | 70% | 70% | 72% | 68% |




DOLS: Since April 2014 and the Supreme Court judgement there has been a significant increase in DOLS activity which is reflected nationwide.. There has been new guidance from the Chief Coroner around the reporting of deaths of those patients subject to DOLS . New Law Society Guidance now indicates that the a significant number of patients are being understandably deprived of their liberty in their best interests. This is not necessarily a reflection of poor care and treatment. July 15 – fresh legal advice obtained around risk to organisation and patients with regard to non application of DoLs. Revised briefing paper presented for QRC July 2015.

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

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

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

# 8. Patient Safety
## - Safeguarding Children

| Data extracted from ARIS 11/01/2016 | | | From Aris DATABASE | Data following manual cleansing as of 19/01/2016 |
|---|---|---|---|---|
| **Division** | **No. requiring training** | **No of staff compliant** | **compliant %** | **Compliant %** |
| Children and Women's Diagnostic and Therapy Services | 638 | 454 | 71% | 75% |
| Community Services | 122 | 104 | 85% | 83% |
| Corporate | 5 | 4 | 80% | 100% |
| Medicine and Cardiovascular | 198 | 91 | 46% | 75% |
| Surgery & Neurosciences | 16 | 0 | 0% | 43% |
| **Total** | **979** | **653** | **67%** | **75%** |

**Training** : The Safeguarding Children team will undertake a quarterly data cleanse for Q4 this month. Training remains on the Trust's Risk Register. Discussions are underway to determine the optimal way forward in delivering both the PREVENT and FGM training requirements.

**Serious Case Reviews and Internal Management Reviews**: Wandsworth Serious Cases Improvement and Learning Sub-committee has considered a family for a SCR or multi-agency learning review. The decision was to have a Multi Agency Learning event. The Acute and Community services are involved in this process.

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

**Other:** LB Wandsworth underwent an OfSTED inspection in December 2015, the outcome is expected in February 2016.

Substantive post of Named Nurse for Acute Services has been recruited to – Belinda Chideme.

The Community Safeguarding team continues to have staffing capacity issues due to long term sickness absence .

Section 11 annual self assessment audit due in February 2016. Discussions are underway with WSCB and Safeguarding team with a view to working together to develop a self assessment staff questionnaire that is suitable for the Trust.

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# Patient Experience

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# 9. Patient Experience
## - Friends and Family Test

| Service | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community Services | 59% n=274 | 86% n=292 ^ | 88% n=518 ^ | 95% n=539 ^ | 96% n=563 ^ | 90% n=284 v | 87% n=352 v | 86% n=401 v | 87% n=430 ^ | 94% n=1223 ^ | 94% n=1337 - | 93% n=526 v | 88% n=6739 |
| Medicine and Cardiovascular | 93% n=610 | 95% n=769 ^ | 96% n=896 ^ | 96% n=808 - | 94% n=837 v | 94% n=872 - | 94% n=752 - | 96% n=580 ^ | 93% n=628 v | 95% n=555 ^ | 95% n=649 - | 96% n=513 ^ | 95% n=8469 |
| Surgery Anaethetics and Neuro | 94% n=834 | 95% n=842 ^ | 96% n=917 ^ | 95% n=1016 v | 96% n=1152 ^ | 95% n=1098 v | 93% n=986 v | 90% n=767 v | 88% n=736 v | 92% n=787 ^ | 90% n=709 v | 91% n=642 ^ | 93% n=10486 |
| Women and Childrens | 86% n=301 | 93% n=303 ^ | 93% n=440 - | 91% n=480 v | 92% n=474 ^ | 95% n=584 ^ | 93% n=566 v | 93% n=497 - | 93% n=429 - | 93% n=474 - | 93% n=395 - | 91% n=332 v | 92% n=5275 |
| **Trust** | **83% n=2019** | **93% n=2206 ^** | **94% n=2771 ^** | **95% n=2843 ^** | **95% n=3026 -** | **94% n=2838 v** | **93% n=2656 v** | **92% n=2245 v** | **90% n=2223 v** | **93% n=3039 ^** | **93% n=3090 -** | **93% n=2013 -** | **92% n=30969** |

We can now report our Friends and Family Test scores (the percentage of people who said they were “Extremely likely” or “Likely” to recommend a service to friends or relatives) by division.

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

Further breakdowns are available for services and location type.

The outpatient setting underperforms all other settings in the Trust, while Critical Care and Day case services score highest.

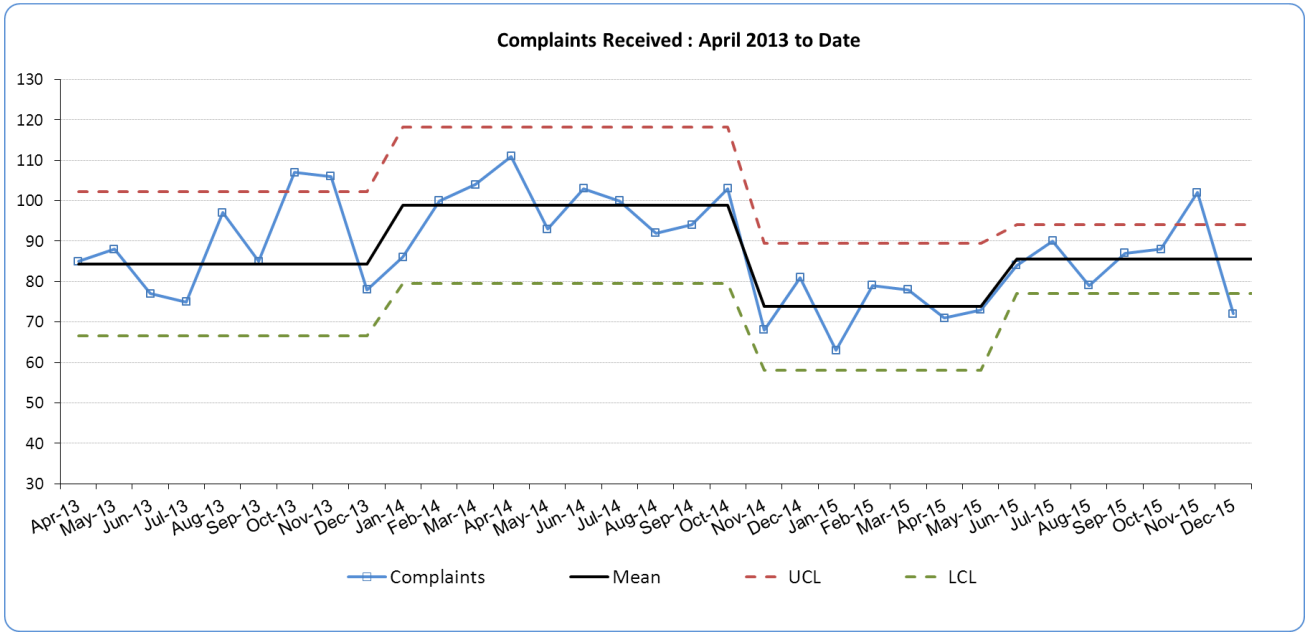
# 9. Patient Experience
## - Friends and Family Test – How we compare

| Service | Sep-15 | Oct-15 | Nov-15 | Dec-15 |
|---|---|---|---|---|
| **TRUST** | **90% (2223)** | **93% (3039)** | **93% (3090)** | **93% (2013)** |
| | | | | |
| **NHS London Average** | No data | 92% (303065) | TBC | TBC |
| **BARTS HEALTH NHS TRUST** | No data | 92% (4522) | TBC | TBC |
| **CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST** | No data | 94% (1977) | TBC | TBC |
| **CROYDON HEALTH SERVICES NHS TRUST** | No data | 92% (7265) | TBC | TBC |
| **EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST** | No data | 88% (870) | TBC | TBC |
| **GUY'S AND ST THOMAS' NHS FOUNDATION TRUST** | No data | 89% (4952) | TBC | TBC |
| **KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST** | No data | 91% (1238) | TBC | TBC |
| **KINGSTON HOSPITAL NHS FOUNDATION TRUST** | No data | 93% (2539) | TBC | TBC |
| **UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST** | No data | 95% (983) | TBC | TBC |

We compare favourably to the newly released FFT scores for other local and similarly size London Trusts

# 9. Patient Experience
# - Complaints Received

| Complaints Received | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Dec | Jan | Feb | March | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Move ment |
| Total Number received | 81 | 63 | 79 | 78 | 71 | 72 | 84 | 90 | 79 | 86 | 88 | 102 | 72 | ↓ |




**Overview:**

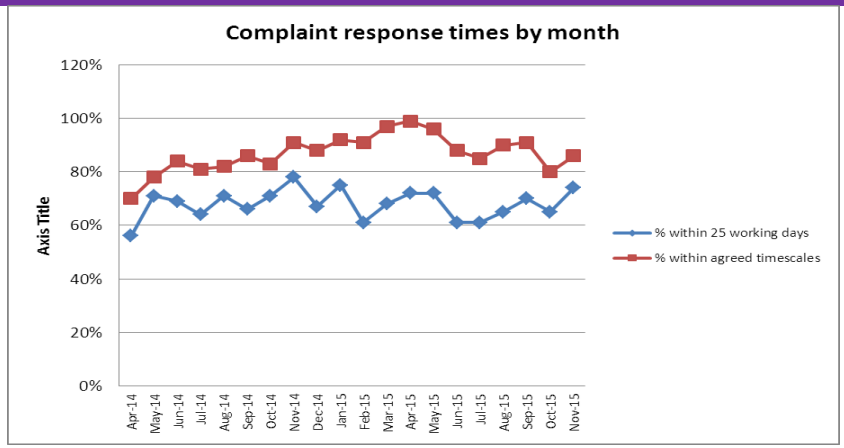
This report provides a brief update on complaints received since the last board report (so in December 2015) and information on responding to complaints within the specified timeframes for complaints received in November of 2015/2016. It also includes some posts made on NHS Choices and Patient Opinion. 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 December 2015**

There were 72 complaints received in December of 2015, an decrease of 29% when compared to November when 102 complaints were received. There is a possibility that the festive season contributed to this reduction which is often seen in December. There were reductions across many care groups with the most significant being in Obstetrics and Gynaecology where complaints reduced from 15 to 5 with 3 for Gynaecology. There were no complaints about the suspension/closure of the Urogynaecology service unlike in previous months.

# 9. Patient Experience
## - Complaints Performance against targets

| Performance Against Targets November 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 | 32 | 19 | 59% | (4) 72% |
| Medicine and Cardiovascular | 36 | 26 | 72% | (7) 92% |
| Surgery & Neurosciences | 24 | 20 | 83% | (2) 92% |
| Community Services | 5 | 5 | 100% | (0) 100% |
| Corporate Directorates | 5 | 5 | 100% | (0) 100% |
| **Totals:** | 102 | 75 | 74% | (13) 86% |




**Commentary:**
There was an improvement in performance in responding to complaints received in the month of November with 74% of complaints being responded to within 25 working days (against an internal target of 85%) compared to 65% in October and 86% within agreed timescales (against an internal target of 100%) compared to 80% in October.
Community Services and Corporate Directorates met both targets. Surgery and Neurosciences Division showed an improvement against both, very nearly reaching the first target with 83%.
**Children's and Women's Division** showed a deterioration in performance against both targets.

**Update from Surgery and Neurosciences Division**
The divisional performance is on an upwards trajectory. The division has refocused efforts in terms of existing process, enlisted additional resource to support with complaints response writing and are using extensions only where essential in complex complaint situations and where agreed from the outset with the DDNG. The impact of this is that complaints performance for the month of November is just below targets. The division aims to maintain this momentum to achieve the trust target by the end of the financial year.

**Children's and Women's Division ; Maternity – actions to improve response times**
- Implemented weekly Friday meeting between management team and Director of Midwifery to agree progress ready for Tuesday meeting with DDNG.
- All complaints/actions timeframes, whose responsible for responding etc written on whiteboard in risk office
- All notes now kept in risk office to enable staff involved to access same
- Director of Midwifery allocated all maternity complaints and staff identified as responders
- Effectively one point of contact & follow up, but visible if Director of Midwifery away
- Working with staff to deescalate at sources, Director of Midwifery will visit patients if required to support staff

**Medcard**
- The division continues to use additional senior nursing resource to support directorates in responding to complaints within the agreed time scales. This has shown a marked improvement in areas previously and will continue given the operational pressures facing the division.
- An exercise of validating has been completed to ensure that there is accurate reporting of agreed extensions and submission of complaints. This will be completed on a monthly basis to ensure accurate reporting.
- The use of local resolution and early contact of complainants to discuss their complaints has seen a sustained improvement in Specialist medicine and Renal Haematology and Oncology and this work will continue.
- The division has completed a review of all reopened complaints to ensure learning which was presented at the DGB and action have now been implemented such as GM responses now being reviewed by complaints and Improvement
- Directorates have reviewed complaint themes which are reported at directorate meetings to address learning from complaints

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

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

If a comment is a cause for concern then the individual is given information via the website about how to obtain a personalised response via the Patient Advice and Liaison service (PALS) or the complaints and improvements department. 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.

**Debora Ansu** *gave Maternity services at St George's Hospital (London) a rating of 5 stars*
**I Can't Thank You enough**
*I can't thank the all the staff at Delivery Suite enough for the wonderful care and attention you gave me over the last week. (05/01/16-10//01/16)*

*This has been a very difficult and traumatic time for me and my family and you all have been there for me to cry on your shoulders. My family and I are truly grateful for the level of care you were able to administer to me. Thank you to all the medical team involved in my care, the consultants, anaesthetic team, obstetrics, and the midwives, you are real credits to St. George's hospital.*

*Thank you, Debora*

Visited in January 2016. Posted on 14 January 2016

**Anonymous** *gave Accident and emergency services at St George's Hospital (London) a rating of 5 stars*
**Excellent care**
*I can not praise the staff of the Ambulance service, A and E and AAA department highly enough. The service and care I received was prompt, compassionate and professional. I felt confident in their thorough care and reassured. I cannot thank them enough.*

Visited in December 2015. Posted on 08 January 2016

**Jim A** gave *Queen Mary Hospital a rating of 1 stars*
**90 minute journey - appointment cancelled!**
*Referred by my GP to this hospital. After a 3 month wait for an appointment today was finally the day to head out on a 3 hour round-trip to Roehampton. Upon arriving the receptionist told me my appointment had been cancelled and there was no consultant available! Apparently "someone should have been trying to contact me" but of course no one had. I was then told the next available appointment would be in 2 months time. At that point I walked out of the hospital in disgust. I am absolutely fuming. Not only have I taken a day out of work to travel 3 hours for my appointment but I now have to wait another 2 months. I understand the NHS is under strain but this is completely unacceptable. Alas... I am sure absolutely nothing will be done to make this up to me and I'll just have to suck it up :(*

Visited in December 2015. Posted on 22 December 2015

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# Workforce

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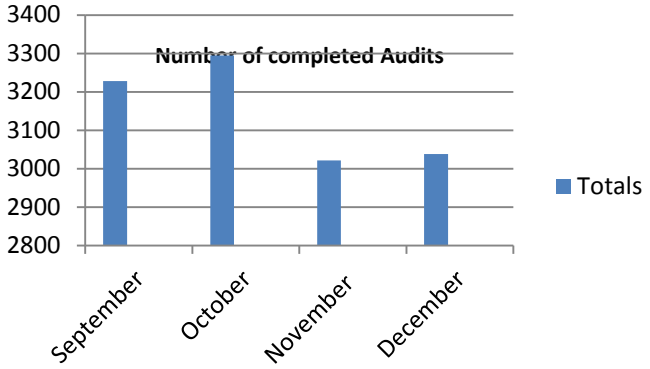
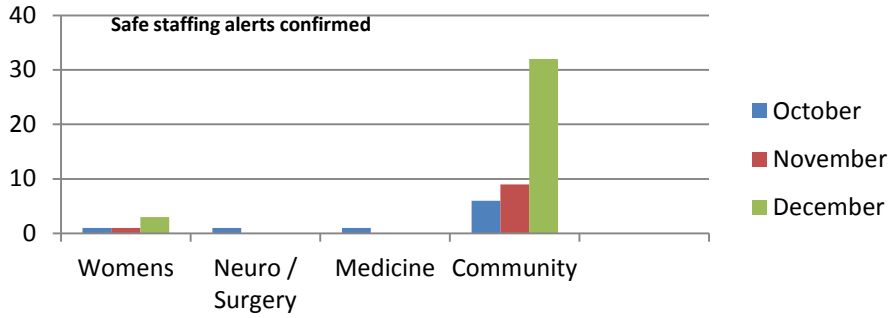
# 10. Workforce
# December 2015 - Safe Staffing alerts




**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: October 3295, November 3021 and December 3038. There was a significant increase in the number of final alerts reported from 10 in November to 35 in December 2015. 32 of the alerts relate to community services. 16 alerts were registered by the tissue viability service. Recruitment to this service has been challenging. The other 16 for community services reflect the high number of vacancies (30%) which has resulted in reprioritising care to ensure patients are safe. Community services have a robust recruitment plan, 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 (October 37, November 13, December 10). 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 5 in December. None of the alerts and none of the concerns matched a similar entry on the RATE system.

| MONTH | DEC 14 | JAN | FEB | MAR | APRIL | MAY | JUNE | JULY | AUG | SEP | OCT | NOV | DEC 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ALERTS | 9 | 11 | 13 | 8 | 10 | 11 | 5 | 2 | 12 | 27 | 9 | 10 | 35 |
| CONCERNS | 31 | 19 | 32 | 25 | 15 | 18 | 16 | 17 | 24 | 14 | 37 | 13 | 10 |

**Acti**

**Risk:** Retention is impacting on safe staffing as is the lack of registered nurses available to fill vacancies.

# 10. Workforce: December 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 December 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 December the trust achieved an average fill rate of 95%, a slight increase from 93.93% submitted in November. The trend over the past six months is outlined below:

| MONTH | JULY 15 | AUG 15 | SEPT 15 | OCT 15 | NOV 15 | DEC 15 |
|---|---|---|---|---|---|---|
| % | 94.3% | 93.99% | 94.6% | 94.4% | 93.93% | 95% |

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

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

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

**Actions**

On going review of temporary staffing

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

| | Day | | Night | |
|---|---|---|---|---|
| Ward name | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) |
| Cardiothoracic Intensive Care Unit | 93.0% | 100.0% | 96.1% | 100.0% |
| Carmen Suite | 128.8% | 76.1% | 99.8% | 93.3% |
| Champneys Ward | 104.1% | 111.7% | 96.6% | 96.6% |
| Delivery Suite | 98.3% | 58.9% | 109.3% | 88.5% |
| Fred Hewitt Ward | 91.1% | 103.7% | 94.9% | 23.1% |
| General Intensive Care Unit | 96.6% | 82.5% | 99.2% | 100.0% |
| Gwillim Ward | 111.4% | 55.5% | 100.7% | 74.2% |
| Jungle Ward | 93.0% | 0.0% | #DIV/0! | #DIV/0! |
| Neo Natal Unit | 90.3% | #DIV/0! | 97.2% | #DIV/0! |
| Neuro Intensive Care Unit | 96.3% | 106.8% | 98.3% | 94.7% |
| Nicholls Ward | 91.1% | 102.3% | 97.3% | 90.9% |
| Paediatric Intensive Care Unit | 103.6% | 74.1% | 100.0% | 96.8% |
| Pinckney Ward | 105.7% | 80.9% | 96.3% | #DIV/0! |
| Dalby Ward | 100.1% | 98.3% | 100.0% | 98.1% |
| Heberden | 90.5% | 106.7% | 97.8% | 100.0% |
| Mary Seacole Ward | 94.1% | 98.1% | 99.9% | 100.0% |
| A & E Department | 93.9% | 84.4% | 101.7% | 87.9% |
| Allingham Ward | 90.6% | 116.4% | 97.6% | 97.1% |
| Amyand Ward | 93.7% | 100.9% | 99.4% | 100.0% |
| Belgrave Ward AMW | 96.2% | 89.9% | 98.2% | 97.3% |
| Benjamin Weir Ward AMW | 83.5% | 70.8% | 96.2% | 97.1% |
| Buckland Ward | 87.9% | 69.3% | 98.9% | 99.7% |
| Caroline Ward | 83.1% | 81.6% | 98.4% | 100.0% |
| Cheselden Ward | 93.3% | 102.1% | 98.9% | 95.3% |
| Coronary Care Unit | 93.0% | #DIV/0! | 100.5% | 150.0% |
| James Hope Ward | 82.6% | 69.2% | 96.6% | #DIV/0! |
| Marnham Ward | 85.6% | 90.2% | 97.8% | 93.8% |
| McEntee Ward | 96.8% | 100.8% | 98.9% | 100.0% |
| Richmond Ward | 93.2% | 84.7% | 95.1% | 95.1% |
| Rodney Smith Med Ward | 90.2% | 89.0% | 100.0% | 94.2% |
| Ruth Myles Ward | 104.2% | 103.9% | 100.0% | 87.0% |
| Trevor Howell Ward | 97.2% | 96.8% | 98.9% | 100.0% |
| Winter Ward (Caesar Hawkins) | 83.7% | 94.6% | 99.2% | 97.8% |
| Brodie Ward | 89.8% | 90.6% | 97.0% | 100.0% |
| Cavell Surg Ward | 96.5% | 87.9% | 89.2% | 96.2% |
| Florence Nightingale Ward | 93.4% | 86.3% | 99.2% | #DIV/0! |
| Gray Ward | 85.4% | 81.0% | 99.3% | 95.2% |
| Gunning Ward | 90.5% | 94.6% | 98.0% | 98.4% |
| Gwynne Holford Ward | 87.9% | 87.7% | 93.4% | 100.0% |
| Holdsworth Ward | 92.2% | 81.2% | 98.0% | 96.8% |
| Keate Ward | 96.0% | 90.2% | 100.0% | 100.0% |
| Kent Ward | 88.6% | 93.8% | 98.4% | 98.4% |
| Mckissock Ward | 91.8% | 111.0% | 99.0% | 100.0% |
| Vernon Ward | 95.5% | 84.4% | 94.0% | 93.6% |
| William Drummond HASU | 102.5% | 108.2% | 88.1% | 90.8% |
| Wolfson Centre | 81.4% | 106.9% | 96.1% | 101.1% |
| Gordon Smith Ward | 84.2% | 90.9% | 100.0% | 90.4% |
| Trust Total | 93.52% | 91.39% | 98.14% | 95.88% |

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

# Heatmap Dashboard
# Ward view

*Excellence in specialist and community healthcare*

Dec 2015

| 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 | St Johns day hospital | 0.0 | 0.0 | 0.0 | | | | | 1.0 | 0.0 | |
| | Mary Seacole | 0.0 | 0.0 | 0.0 | 82.4 | 100.0 | 56.4 | 5.3 | 8.0 | 0.0 | 5.3 |
| | South Locality (CCM) | 0.0 | 0.0 | 1.0 | | | | | 0.0 | 1.0 | |
| MEDICINE | ALLINGHAM | 1.0 | 0.0 | 0.0 | 82.1 | 96.6 | 35.4 | 9.2 | 11.0 | 0.0 | 9.2 |
| | AMYAND | 0.0 | 0.0 | 0.0 | 93.1 | 100.0 | 14.9 | 3.7 | 6.0 | 0.0 | 3.7 |
| | BELGRAVE | 0.0 | 0.0 | 0.0 | 96.8 | 93.0 | 33.1 | 1.4 | 8.0 | 0.0 | 1.4 |
| | BENJAMIN WEIR | 0.0 | 0.0 | 0.0 | 96.6 | 100.0 | 30.6 | 3.1 | 0.0 | 0.0 | 3.1 |
| | BUCKLAND | 0.0 | 0.0 | 0.0 | | 100.0 | 38.4 | 3.8 | 3.0 | 0.0 | 3.8 |
| | CAESAR HAWKINS | 0.0 | 0.0 | 0.0 | 81.8 | 100.0 | 8.8 | 8.9 | 8.0 | 0.0 | 8.9 |
| | CARDIAC CARE UNIT | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 83.3 | 3.3 | 0.0 | 0.0 | 3.3 |
| | CAROLINE | 0.0 | 0.0 | 0.0 | 100.0 | 93.1 | 47.0 | 8.7 | 2.0 | 0.0 | 8.7 |
| | CHESELDEN | 0.0 | 0.0 | 0.0 | 87.0 | 100.0 | 32.4 | 6.2 | 2.0 | 0.0 | 6.2 |
| | DALBY | 0.0 | 0.0 | 0.0 | 77.8 | 92.9 | 29.8 | 7.3 | 4.0 | 0.0 | 7.3 |
| | EMERGENCY DEPARTMENT | 0.0 | 0.0 | 0.0 | | | | 4.6 | 4.0 | 1.0 | 4.6 |
| | GORDON SMITH | 0.0 | 0.0 | 0.0 | 94.4 | 97.3 | 59.7 | 2.4 | 0.0 | 0.0 | 2.4 |
| | HEBERDEN | 0.0 | 0.0 | 0.0 | 87.5 | 100.0 | 16.2 | 5.2 | 2.0 | 0.0 | 5.2 |
| | JAMES HOPE | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 13.0 | 0.7 | 1.0 | 0.0 | 0.7 |
| | MARNHAM | 0.0 | 0.0 | 0.0 | 92.6 | 92.9 | 24.6 | 7.2 | 0.0 | 0.0 | 7.2 |
| | MCENTEE | 0.0 | 0.0 | 0.0 | 100.0 | 95.2 | 44.7 | 1.8 | 1.0 | 0.0 | 1.8 |
| | RICHMOND | 0.0 | 0.0 | 0.0 | 88.2 | 94.8 | 20.8 | 7.7 | 5.0 | 1.0 | 7.7 |
| | RODNEY SMITH | 0.0 | 0.0 | 0.0 | 82.1 | 100.0 | 39.6 | 0.1 | 5.0 | 0.0 | 0.1 |
| | RUTH MYLES DAY UNIT | 0.0 | 0.0 | 0.0 | 91.7 | 85.7 | 58.3 | 1.2 | 2.0 | 0.0 | 1.2 |
| | TREVOR HOWELL | 0.0 | 0.0 | 0.0 | 84.2 | 93.8 | 21.3 | | 1.0 | 0.0 | 6.7 |
| SURGERY | BRODIE NEURO | 0.0 | 0.0 | 0.0 | | | 36.8 | 1.1 | 2.0 | 0.0 | 1.1 |
| | CAVELL | 0.0 | 0.0 | 0.0 | 100.0 | 68.6 | 25.6 | 7.7 | 1.0 | 0.0 | 7.7 |
| | FLORENCE NIGHTINGALE | 0.0 | 0.0 | 0.0 | 100.0 | 95.1 | 32.8 | 5.0 | 2.0 | 0.0 | 5.0 |
| | GRAY WARD | 0.0 | 0.0 | 0.0 | 95.7 | 87.2 | 71.8 | 0.4 | 0.0 | 0.0 | 0.4 |
| | GUNNING | 0.0 | 0.0 | 0.0 | 95.7 | 85.7 | 33.3 | 1.7 | 4.0 | 0.0 | 1.7 |
| | GWYN HOLFORD | 0.0 | 0.0 | 0.0 | 100.0 | 62.5 | 84.2 | 3.6 | 5.0 | 0.0 | 3.6 |
| | HOLDSWORTH | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 14.9 | 9.1 | 3.0 | 1.0 | 9.1 |
| | KEATE | 0.0 | 0.0 | 0.0 | 89.5 | 97.6 | 68.3 | 0.0 | 3.0 | 0.0 | 0.0 |
| | KENT | 0.0 | 0.0 | 0.0 | 96.8 | 100.0 | 7.1 | 0.4 | 8.0 | 0.0 | 0.4 |
| | MCKISSOCK | 0.0 | 0.0 | 0.0 | 100.0 | 90.0 | 49.2 | 6.8 | 4.0 | 0.0 | 6.8 |
| | THOMAS YOUNG | 0.0 | 0.0 | 0.0 | 87.5 | 100.0 | 9.1 | 3.8 | 2.0 | 0.0 | 3.8 |
| | VERNON | 0.0 | 0.0 | 0.0 | 82.1 | 94.7 | 42.6 | 4.2 | 0.0 | 0.0 | 4.2 |
| | WILLIAM DRUMMOND HASU | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 42.1 | 2.1 | 3.0 | 0.0 | 2.1 |
| WOMEN & CHILDREN | CARDIOTHORACIC INTENSIV.. | 0.0 | 0.0 | 0.0 | 93.8 | | 0.0 | 3.6 | 1.0 | 0.0 | 3.6 |
| | CARMEN SUITE | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | | 1.2 | 0.0 | 1.0 | 1.2 |
| | CHAMPNEYS | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 16.1 | 6.9 | 4.0 | 0.0 | 6.9 |
| | DELIVERY | 0.0 | 0.0 | 0.0 | 100.0 | | | 6.9 | 0.0 | 1.0 | 6.9 |
| | FREDDIE HEWITT | 0.0 | 0.0 | 0.0 | | | 275.0 | 0.9 | 2.0 | 0.0 | 0.9 |
| | GENERAL ICU/HDU | 0.0 | 0.0 | 0.0 | 84.2 | | 0.0 | 2.1 | 1.0 | 0.0 | 2.1 |
| | GWILLIM | 0.0 | 0.0 | 0.0 | | 89.1 | | 0.5 | 0.0 | 0.0 | 0.5 |
| | JUNGLE | 0.0 | 0.0 | 0.0 | | | 4.3 | 0.3 | 1.0 | 0.0 | 0.3 |
| | NEONATAL ICU | 0.0 | 0.0 | 0.0 | 100.0 | | | 4.7 | 0.0 | 0.0 | 4.7 |
| | NEURO ICU | 0.0 | 0.0 | 0.0 | 100.0 | | | 2.3 | 0.0 | 0.0 | 2.3 |
| | NICHOLLS | 0.0 | 0.0 | 0.0 | | | 0.0 | 6.0 | 0.0 | 0.0 | 6.0 |
| | PICU | 0.0 | 0.0 | 0.0 | | | | 2.2 | 0.0 | 0.0 | 2.2 |
| | PINCKNEY | 0.0 | 0.0 | 0.0 | 100.0 | | 0.0 | 6.5 | 0.0 | 0.0 | 6.5 |

# Community Heatmap

| Domain | Patient Safety & Experience | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Indicator | Frequency | 2015/2016 Target | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Direction | Comments |
| | | | | 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 | 1 | | |
| Patient Safety | Number of SI's breached | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | |
| Patient Safety | Grade 3 Pressure Ulcers | Monthly | | 1 | 0 | 0 | 0 | 1 | 2 | 1 | 1 | 0 | | |
| Patient Safety | Grade 4 Pressure Ulcers | Monthly | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | |
| Patient Safety | Number of Fall of No Harm and Low Severity | Monthly | | 10 | 7 | 4 | 12 | 8 | 13 | 10 | 11 | 13 | | |
| Patient Safety | Number of moderate falls | Monthly | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 2 | 1 | | |
| Patient Safety | Number of major falls | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Patient Safety | Number of falls resulting in death | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Patient Safety | MRSA (cumulative) | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Patient Safety | CDiff (cumulative) | Monthly | 31 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Patient Safety | CAS ALERTS - Number ongoing- received (Trust) | Monthly | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | | |
| Patient Safety | Number of Quality Alerts | Monthly | | 3 | 5 | 2 | 9 | 11 | 4 | 6 | 5 | 3 | | |
| Safeguarding | % of staff compliant with safeguarding adults training | Monthly | 85% | 89.0% | 86% | 85% | 84% | 81% | 81% | 77% | 74% | 70.0% | | |
| Safeguarding | % of staff compliant with safeguarding childrens training | Monthly | Level 1 85% | 90.0% | 90.0% | 85% | 82% | 79% | 88% | 89% | 86% | 85% | | Changed to green because aim is now as |
| | | | Level 2 85% | 84.0% | 84.0% | 82% | 82% | 74% | 66% | 67% | 63% | 83% | | |
| | | | Level 3 85% | 69.0% | 69.0% | 82% | 90.00% | 70% | 85% | 87% | 84% | 84% | | |
| Patient Outcomes | Mortality SHMI ratio (Trus) | Monthly | <100 | 0.86 | 0.86 | 0.86 | 0.86 | 0.86 | 0.9 | 0.9 | 0.9 | 0.9 | | |
| Patient Experience | Active Claims | Monthly | | 0 | 0 | 1 | 3 | 1 | 0 | 1 | 0 | 0 | | |
| Patient Experience | Number of Complaints received | Monthly | | 16 | 18 | 6 | 5 | 2 | 5 | 5 | 5 | 5 | | |
| Patient Experience | Number of Complaints responded to within 25 days ( reporting 1 month in arrears) | Monthly | 85% | 100% | 88% April 2015 | 78% May 2015 | 100% | 100% | 85% | 100% | 100% | 89% | | |
| Patient Experience | Number of Complaints responded to within 25 days with an agreed extension | Monthly | 95% | 100% | 100% April 2015 | 100% May 2015 | 100% | 100% | 92% | 100% | | 78% | | |
| | PPT Score (Mary Seacole and MIU) | Monthly Mary Seacole A | | 97.0% | 94.7% | 77.7% | 71.0% | 97.3% | 84.2% | 94.4% | 94.4% | 81.8% | | |
| Patient Experience | | Monthly Mary Seacole B | | 81.20% | 90.90% | 75.00% | 95.40% | 90.90% | 75% | 90% | 94% | | | |
| Patient Outcomes | Catheter related UTI (Trust) | | | 1.14 | 0.66 | 1.12 | 1.32 | 1.50 | 1.08 | 0.67 | 0.96 | | | |
| | Number of new VTE (Trust) | | National 0.00% | 0.53 | 0.37 | 0.15 | 0.08 | 0.24 | 0.17 | 0.30 | 0.48 | | | |
| Workforce | Number of DBS Request Made | Quarterly | annually | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | (no baseline data) | | |
| Workforce | Sickness Rate - | Monthly | 3.50% | 5.72% | 6.04% | 6.00% | 4.69% | 5.75% | 5.53% | 5.30% | 5.71% | | | |
| Workforce | Turnover Rate- | Monthly | 13% | 19.64% | 19.84% | 20.40% | 20.08% | 21.00% | 21.15% | 20.75% | 20.76% | | | |
| Workforce | Vacancy Rate- | Monthly | 11% | 19.41% | 19.06% | 18.40% | 12.60% | 13.42% | 12.58% | 15.67% | 20.76% | | | |
| Workforce | Appraisal Rates - Medical | Monthly | 85% | 66.67% | 72.73% | 69.57% | 69.57% | 84.00% | 84.00% | 79.41% | 81.26% | | | |
| Workforce | Appraisal Rates - Non-Medical | Monthly | 85% | 77.25% | 76.80% | 75.84% | 75.42% | 76.02% | 68.22% | 64.91% | 62.92% | | | |

# Community heat map

- **Serious Incidents:** In Dec 1 Si were reported: 1 PU Grade 4 (South Locality CAHS)
- **Complaints:** Community Services numbers of formal complaints remained at 5. 3/5 complaints have been responded to within 25 working data. 2 are yet to be completed within time (due Feb 2016)
- **Quality alerts:** 3 alerts received in December: 2 access to community nursing services (open), 1 related to HV not being located at 166 Roehampton lane (closed)
- **Workforce data**: Vacancy and sickness rates increased on last month. Divisional workforce strategy drafted. Workshop Feb 2016 to review recruitment, retention and foreword planning.
- **Safe staffing alerts** report mechanisms being reviewed to represent new team structures. To note; there has been a marked increase on the overall number of alerts in community nursing (16 Dec), TVN service. Few alerts remain a concern as patients and staff are reallocated (with patients consent), except TVN service. The trust is seeking ways to address recruitment challenges e.g. rotational posts.

**Key areas of concern for workforce:**

- Recruitment and retention: particularly offender healthcare, Mary Seacole ward (QMH), community nursing, school nursing, specialist nursing an therapy posts
- Access to MAST training has been improved by IT solutions.
- Appraisal rate falling

# 11. Ward heatmap
# CWDT&CC Division

Cardiothoracic Intensive Care (CTICU)
93.8% scored for harm free care. 16 patients were surveyed with 1 reported harm, which was a patient with a new grade 2 pressure ulcer.

General ICU/HDU (GICU)
84.2% scored for harm free care. 19 patients were surveyed with 3 patients recorded as having harms; these all related to pressure ulcers with one being a new grade 2 pressure ulcer and the others an old grade 2 and an old grade 3.

The adult critical care team continue to focus on the importance of pressure ulcer prevention amongst this particularly vulnerable group of patients and in particular ensuring any grade 2 pressure ulcers do not deteriorate further.

Sickness
Sickness improved across a number of areas in December 2015, however there is a continued focus on robust sickness management across all areas to maintain this improved performance.

Friends and Family
As stated in previous months there are significant data errors for the division in relation to this metric. The Divisional Director of Nursing and Governance is working with informatics to improve the quality of this data on a consistent basis.

Falls
There was an increase in the number of falls in December 2015 on Champneys ward, this relates to 10 beds being provided to accommodate a cohort of medical patients. None of the falls resulted in harm

Serious Incidents
This related to a retained swab incident, which is reportable as a ‘never event’. The team are working closely with the theatres team to understand the root cause. The events however to not at this stage appear to reflect the issues of previous ‘never events’ relating to retained swabs.

# 11. Ward heatmap
## STNC Division

The report focuses on areas with any red indicator or those with three or more indicators. The key areas where alerts are seen are consistent with previous reports and relate to Falls, FFT and harm free care. The areas where there have been improvements in performance are FFT satisfaction, zero incidence of trust acquired pressure ulcers and zero incidents of MRSA and C/Difficile
There are 14 red alerts for December 2015 compared to 17 for the previous reporting period. There is also a decrease in the overall number of alerts from 24 to 15, however it should be noted that sickness absence and ward staffing filled hours were not included in December's report and therefore it is difficult to monitor the alert trend for this period. It is also important to note that of the 17 red alerts 1 is incorrect; therefore there are 16 red indicators for December 2015.

**Florence Nightingale** – No red/amber indicators
**Gunning** – 1 red indicator due to falls x 4 – all falls were no harm and 2 falls were for the same patient – 2 patients had unwitnessed falls when transferring in the toilet/bathroom.
**Holdsworth** – 3 red indicators – The first red indicator was due to FFT poor compliance of 14.9%. Action plan drafted and visible on RATE. The ward sister has addressed this concern by meeting with all staff to ensure better results.
The second red indicator relates to 3 falls – 3 patients had a mechanical fall (no harm). The Third red indicator is due to declaring an SI of a patient who died and there are concerns regarding imaging and medical review.

## 11. Ward heatmap
## STNC Division

**Cavell -** No red indicators – 1 amber indicator due to FFT compliance of 25.6%. This is being addressed by the new ward leader who is speaking to all ward staff and an action plan had been formulated

**Keate**- 2 red indicators –The first red indicator is due to 3 falls of which 2 relate to the same patient, this patient was non-compliant with using the nurse call bell. All 3 falls were unwitnessed and no harm.

The second red indicator relates to harm free care of 89.5%. This was due to one patient with an old grade 2 pressure ulcer, 1 patient with no completed VTE and risk prophylaxis not started and 1 patient fall no harm. The medical teams have been consulted with by the ward manager to ensure compliance of outlier patients in surgery.

**Gray**- No red/amber indicators

**Vernon**-1 red indicator – this relates to harm free care of 82.1%. Two patients with old grade 2 pressure ulcers and 10 patients who did not have a completed VTE assessment. Both the ward pharmacist and the medical team responsible have been spoken. This has also been raised and discussed at recent care group meeting.

**Brodie** – No red/amber indicators but 2 grey areas related to % harm free care and patient satisfaction for FFT. Harm Free care on the scorecard indicated that this was not completed for December 2015; however it was completed and showed one patient with no documented VTE but all other areas 100%.

# 11. Ward heatmap
## STNC Division

Grey response for Friends and Family test. This continues to be inaccurate as data is still being collected on 2 discharge survey RATE tablets and this needs to be addressed so that only 1 (survey) appears on the tablet. For the first survey patient satisfaction was 100%. For the second survey patient satisfaction was 97% with one entry of neither likely nor unlikely to recommend the hospital. All other entries were either likely or extremely likely. Issues stated were with noise at night, side effects of medication and being involved with the decision regarding treatment.

**Kent –** 2 red indicators. The first red indicator is for 8 falls. The falls related to individual patients and were either due to patients trying to transfer/mobilise without supervision or falls during therapy sessions. All but one fall were no harm. The 1 low harm –this patient sustained bruising to arm and hand; appropriate documentation and falls protocol completed at the time of the fall. The second red indicator is for 7.1% FFT response rate – this continues to remain low as shown in the previous months. This is a priority for the ward sister and ward staff to focus on this next month.

**McKissock –**1 red indicator. The red indicator is for falls. 4 falls occurred in December 2015 although this is below the tolerance indicator for Mckissock. All falls no harm and all due to patients losing balance when trying to independently mobilise.

**Gwynne Holford** – 1 red indicator. The red indicator relates to 5 falls – all were no harm with 1 patient falling twice. All falls were due to patients trying to transfer by themselves.

**Thomas Young –** 2 red indicators. First red indicator is for harm free care 87.5%. This relates to one patient being admitted with an old G4 pressure ulcer, one patient with a new grade 2 pressure ulcer and one patient that had not started appropriate VTE prophylaxis.

The second red indicator relates to FFT response rate of 9.1%. The ward sister is leading on this and an action plan has been completed for staff to adhere to and to ensure compliance.

**William Drummond–**.1 red indicator. The red indicator relates to falls, 3 falls for the month of December 2015 this is an increase of two from the month of November 2015 (monthly tolerance 1). All falls no harm, two patients losing balance and one patient slipping from wheelchair whilst nurse was attending to another patient in the bay. The ward sister will undertake a focused analysis of the increased falls in William Drummond and share the results with the nursing team

Brodie, Florence Nightingale and Gray wards have both made improvements with no flags this month and Thomas Young and Gwynne Holford wards have successfully reduced their level of falls in December 2015.

**Enclosure:**

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO THE TRUST BOARD – February 2016** **Paper Ref:**

| | |
|---|---|
| **Paper Title:** | **Finance Report for Month 9 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 December 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**


The budget for the year was revised in January to reduce the target deficit by £7m from £63m to £56m and performance is reported here against this plan. The Trust's aim is still to improve performance beyond this.

The cumulative deficit to the end of December was £44.3m, £1.8m better than plan. The main reason for this positive position is £4.4m of underspending on pay budgets largely because the pace of recruitment, eg to posts covered by business cases and winter capacity increases, has been slower than planned. These underspends have been partially offset by continuing underperformance on SLA income, particularly for outpatients and non elective admissions, and higher than expected SLA penalties. The worse than plan performance in the month of December is due to the impact of budget adjustments relating to October and November which were actioned this month as part of the move to the improved deficit plan.

£27.1m of CIPs have been achieved to date. Including 'bold' schemes developed recent, the Trust has savings plans totalling £43m for the year and 85% of these are green rated.

The cash balance at the end of November was £15m, £12m more than in the original plan. In addition, use of the working capital facility was £6m lower than expected so overall the cash position is £18m better than plan. This is due to strong cash management and slow down of the capital programme.

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

Capital spend is continuing to be slowed down as part of the overall cash management plan and to date spend has been £23.7m, £18.4m less than the revised plan.

The focus now has to be on maximising the improvement in the Trust's financial position to reduce the year end deficit as much as possible and to further develop budgets and transformation plans for 2016/17. Alongside this, the Trust has to confirm medium term loan funding to support its operational activities.

**Enclosure:**

| | |
|---|---|
| **Key risks identified:**<br><br>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.<br>The need to balance financial measures with maintaining the quality of patient care. | |
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | Achieve financial targets in the near term<br>Achieve long term financial sustainability |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | N/A |
| **Equality Impact Assessment (EIA): Has an EIA been carried out? No**<br>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]**<br><br>**2.0. Please give your reasons for this rating** |

# Summary Finance Report
# Month 9 2015/16

## Trust Board 4 February 2016

# 1. Month 9 Headlines & Actions – Income & Expenditure

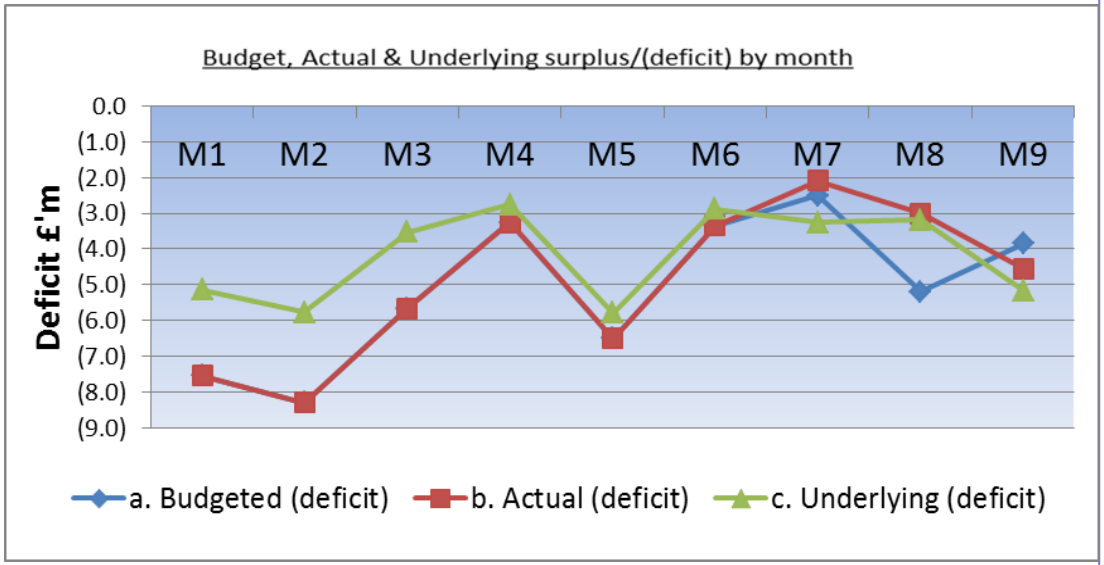
| Area of Review | Metric | Key Highlights | Actions | RAG |
|---|---|---|---|---|
| Overall financial performance in December | Deficit of £4.6m in the month, £0.7m worse than reforecast | The reforecast budgets have been revised to include CIP and other budget adjustments agreed by the Trust Board on 14th January, reducing the budgeted deficit from £63m to £56m. This is now the expected outturn for the Trust.<br>The main reason that performance is worse than plan in the month is because retrospective net budget adjustments of £2.8m CIPs for months 7 & 8 were removed from the M9 budget. | • Divisions to review month 9 performance and assess likely impact of trends to date on the forecast year end position using monthly forecasting model<br>• Ensure remedial action taken to resolve problems e.g. RTT penalties.<br>• Finalise further measures to achieve £56m deficit plan, adjust detailed budgets to reflect contributions to Trust-wide schemes, take actions to deliver agreed measures<br>• Conclude negotiations with commissioners about penalties, and any reinvestment of fines. | |
| Overall financial performance - year to date | Year to date deficit of £44.3m against plan of £46.2m i.e. £1.8m better | Year to date variances relate to months 7 to 9 as reforecast budgets for earlier months were based on actuals.<br>Month 9 cumulative performance is better than budgeted primarily because of pay underspends. Assumptions about recruitment in the reforecast were, with hindsight, too optimistic.<br>The M9 revised reforecast budget has been adjusted for the donated asset income from the Charity and MITIE rebate which underpinned the large favourable variance reported last month. | As above<br>It is now even more important to achieve an outturn no worse than a £56m deficit to access to Sustainability and Transformation Fund in 2016/17. | |
| Activity/Income | Income is £0.6m below plan for the year to date | Actual activity across all areas other than non elective fell in December compared to November. Elective and non elective volumes are in line with the reforecast plan whilst outpatient income is still below the reforecast plan despite a £4m reduction in the budget. Penalties in December are in line with the YTD trend and continue to be high and a risk to the Trust<br>Unplanned theatre closures have contributed to lower elective activity. | • Confirm reasons for negative variances and scope for these to be reduced.<br>• Assess scope to ameliorate further commissioner challenges<br>• Assess likely impact of theatre maintenance and options to minimise its impact through evening/weekend working | |
| Expenditure-Pay | Pay budgets are £4.4m below plan for the year to date (£2.1m better than plan in month) | Pay spend in month 9 shows an improvement specifically, agency spend compared to the earlier parts of the year. This is in part due to a mandated 2 week break for non frontline agency staff.<br>Of the £4.4m underspend to date, £1.9m is in nursing; £1.3m on non clinical staff; and £1.2m on scientists/ therapists. These staff groups have been affected by recruitment difficulty, and slower progress than in the reforecast both on recruitment and on the implementation of plans to increase capacity and other business cases. | • Continue work to remove agency use in non nursing areas and/or switch to bank or permanent appointments<br>• Continue work to improve accuracy of pay spend reporting<br>• Continue challenging all new appointments through the vacancy panel | |
| Expenditure-Non Pay | Non pay for the year to date is £2.1m worse than plan (£1.8m worse than plan in month) | The in month adverse variance is mainly due to £1.4m retrospective CIP budget for MITIE. The cumulative position is mainly due to the following factors:<br>• Drug spend above plan by £2.8m due to higher use of high cost drugs and greater activity than expected in the pharmacy commercial unit.<br>• Clinical consumables spend is £1.2m below plan due to lower SLA activity levels<br>• £0.5m net overspends on other non-pay (clinical negligence and cross charges) | • Continue Grip actions to ensure compliance with SFIs in the procurement of goods and services.<br>• Implement bold non pay proposals | |
| CIP | £27.1m savings delivered to date against plan of £28.6m | Of the £27.1m delivered to date £15.1m is CIPs and £12.0m is non recurrent or run rate savings. Of the £38.5m total schemes expected to be delivered this year £35.4m, or 92%, 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.<br>• Budget holders need to be clear what their further CIP contributions are. | |

# 2. Month 9 Headlines & Actions – Cash and Capital

| Area of Review | Metric | Key Highlights | Actions | RAG |
|---|---|---|---|---|
| Cash | Cash balance £15.2m | The M09 actual cash balance was £15.2m (£12.2m higher than original plan) including cumulative WCF drawdowns of £36.4m. The M09 plan cash balance was £3m including cumulative WCF drawdowns of £42.5m. Therefore the overall cash position was £18.4m better than plan. Higher cash receipts from CCGs in December and a lower level of payments to suppliers in December than expected combined to boost cash to its highest level since April. However it should be noted that these are timing differences and the cash balance will reduce markedly in February and March as a number of cash actions taken before Christmas (eg re-scheduling of CNST premiums and NHS Property Services rental charges) will be reversed. | The Trust has received a draft loan agreement from the ITFF for the total £48.7m interim support funding requested this year (inclusive of the £36.4m drawn to date) and the board will need to approve the loan agreement at its next meeting on 4th February to access further monies.<br>The Trust is continuing to implement bold actions to reduce the I&E deficit and cash actions to minimise further borrowings. | |
| Capital | YTD spend £23.7m, £18.4m less than plan | Capital expenditure was £2.9m in December, an under spend of £0.5m in month against the reduced £48m capital programme agreed in June. Year to date expenditure is £23.7m which is £18.4m less than the revised budget – contributing significantly to the favourable cash position reported above. | The Trust is continuing to slow down the rate of capital expenditure where possible to support the cash position and minimise borrowing. | |
| Working Capital | YTD movement --£1m, £6.4m better than Plan | Working capital improved by £0.6m in month due to reductions in debt levels which more than offset increases in stock and reductions in creditors. | 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. 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 9 (December) is 2 which is ahead of plan.<br>The rating reflects a better than planned cash balance and deficit position. | With continuing efforts to deliver savings and strong cash management the forecast year end rating for the Trust is 2. | |

# 3. Overall Position for the 9 months to 31st December

| 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 | 613.1 | 49.7 | 50.6 | 0.9 | 454.9 | 453.1 | (1.8) |
| Other Income | 107.6 | 10.8 | 8.9 | (1.9) | 78.3 | 79.5 | 1.2 |
| **Overall Income** | **720.7** | **60.5** | **59.5** | **(1.1)** | **533.1** | **532.5** | **(0.6)** |
| Pay | (462.4) | (39.5) | (37.4) | 2.1 | (345.1) | (340.6) | 4.4 |
| Non Pay | (279.6) | (22.0) | (23.7) | (1.8) | (208.5) | (210.7) | (2.1) |
| **Overall Expenditure** | **(742.1)** | **(61.5)** | **(61.1)** | **0.3** | **(553.6)** | **(551.3)** | **2.3** |
| EBITDA | (21.4) | (0.9) | (1.7) | (0.7) | (20.5) | (18.8) | 1.7 |
| Financing Costs | (34.7) | (2.9) | (2.9) | 0.0 | (25.7) | (25.6) | 0.1 |
| **Surplus / (deficit)** | **(56.1)** | **(3.8)** | **(4.6)** | **(0.7)** | **(46.2)** | **(44.3)** | **1.8** |




## Commentary

- All budgets were amended in month 8 to the baseline reforecast budget totalling a £63m deficit. They have now been reduced further to an annual plan for a deficit of £56.1m reflecting the board's decision earlier this month. £3m of this £7m reduction has so far been reflected in detailed budgets, the balance will be adjusted in month 10. There will be no further changes in the overall financial plan for 15/16.
- As reported previously, year to date variances shown only reflect variances from October.
- The December position is an in month deficit of £4.6m which is £0.7m worse than the budget due to retrospective CIP & Income budget adjustments for benefits reported last month.
- The cumulative deficit is £44.3m, which is £1.8m better than plan due to pay underspends.
- Income for month 9 is £1.1m worse than plan and include the impact of £1.2m net retrospective budget increase for CIPs, NETA income loss & donated asset income from the Charity.
- SLA income is £0.9m better than plan in December mainly due to removal of NETA income target. Cumulative SLA income is £1.8m worse than plan as income challenges/penalties are higher than expected, and there is under performance on outpatient and non elective activity.
- Pay is better than plan in month and cumulatively. This is due to slippage on business cases and, slower than expected recruitment. Actual month 9 pay spend, and agency spend in particular, are below the average in the year to date.
- Non pay overspend to date relates to high cost drugs and commercial pharmacy spend above plan.
- Monthly underlying deficits shown in the graph have been revised to include additionally available information. The M9 underlying deficit is £5.2m, which is worse than average for last 3months. Compared against the last 3 months, the December underlying income is £2.6m lower than average while underlying expenditure reduced by only £0.2m.

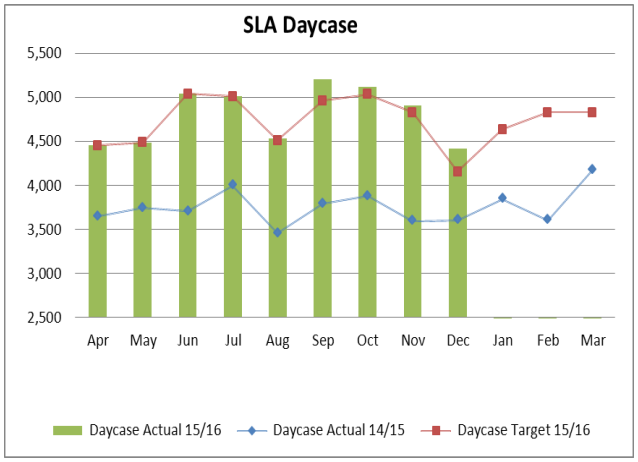
# 4. SLA Income for the 9 months to 31st December

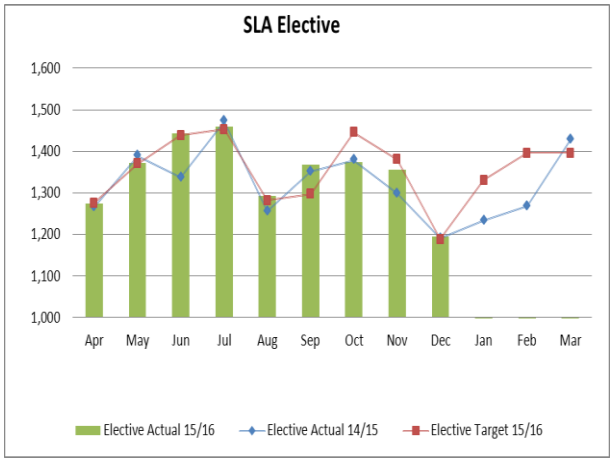
| Activity | Annual Budget £m | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|
| | | Budget £m | Actual £m | Better/(Worse) than Budget £m | Budget £m | Actual £m | Better/(Worse) than Budget £m |
| A&E | 18.5 | 1.6 | 1.5 | (0.0) | 13.8 | 13.7 | (0.1) |
| Bed Days | 59.0 | 3.6 | 3.5 | (0.2) | 43.2 | 43.1 | (0.1) |
| Daycase | 30.6 | 2.3 | 2.4 | 0.1 | 22.8 | 22.9 | 0.1 |
| Elective | 67.1 | 7.0 | 7.0 | (0.0) | 50.1 | 49.8 | (0.3) |
| Non Elective | 121.1 | 10.3 | 10.1 | (0.2) | 90.6 | 90.0 | (0.7) |
| Outpatients | 139.1 | 10.7 | 10.5 | (0.1) | 103.1 | 102.2 | (0.9) |
| Pass-through drugs & devices income (HCD) | 74.6 | 6.2 | 6.4 | 0.1 | 55.9 | 57.1 | 1.2 |
| Community Block | 49.7 | 4.2 | 4.4 | 0.2 | 37.2 | 37.4 | 0.2 |
| Fixed Block (HIV) | 21.7 | 1.8 | 1.8 | 0.0 | 16.3 | 16.3 | 0.0 |
| Unbundled (Chemotherapy & Diagnostics) | 20.8 | 1.8 | 1.5 | (0.3) | 15.6 | 15.6 | 0.0 |
| In Patient Deliveries | 11.1 | 1.0 | 0.9 | (0.1) | 8.3 | 8.3 | 0.0 |
| Out Patient Regular Attenders | 4.2 | 0.3 | 0.3 | 0.0 | 3.2 | 3.3 | 0.1 |
| Challenges/Penalties | (9.0) | (0.9) | (0.7) | 0.2 | (6.3) | (7.5) | (1.3) |
| Other (Ex SLA) | 4.7 | (0.1) | 1.0 | 1.1 | 1.0 | 0.8 | (0.2) |
| **Grand Total** | **613.1** | **49.7** | **50.6** | **0.9** | **454.9** | **453.1** | **(1.8)** |

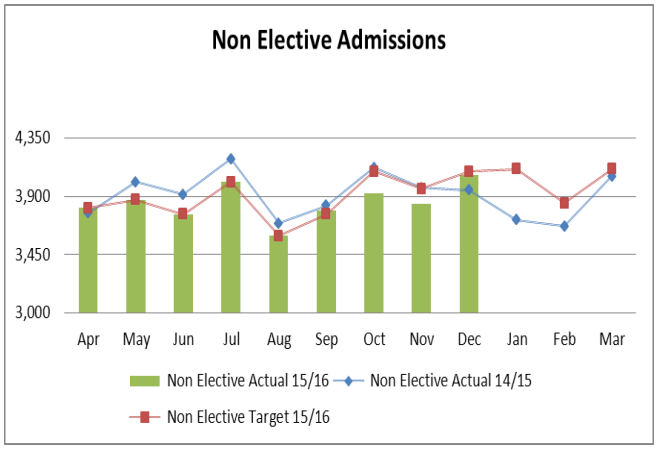
**Commentary**

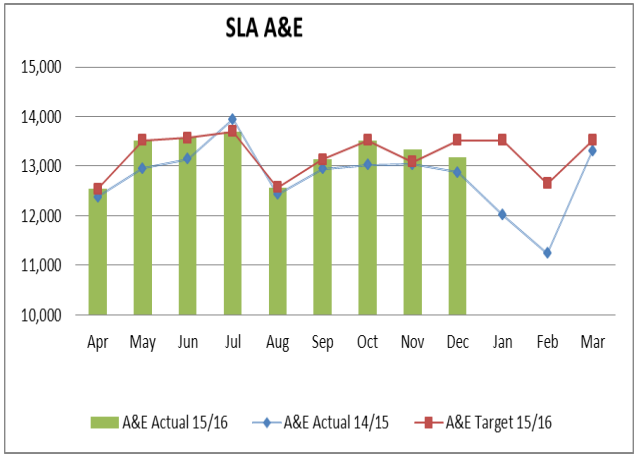
- The December income budget was £2.5m less than November due to the impact of Christmas holidays.
- SLA income was £0.9m over plan in the month and £1.8m below cumulatively for December of which penalties account for £1.3m; further details are provided in slide 7.
- The Ex SLA income is £1.1m over plan in the month as a result of £1.3m retrospective budget adjustment for NETA income loss.
- The other in month movements by type of activity are relatively small
- Activity trends are shown on the next slide

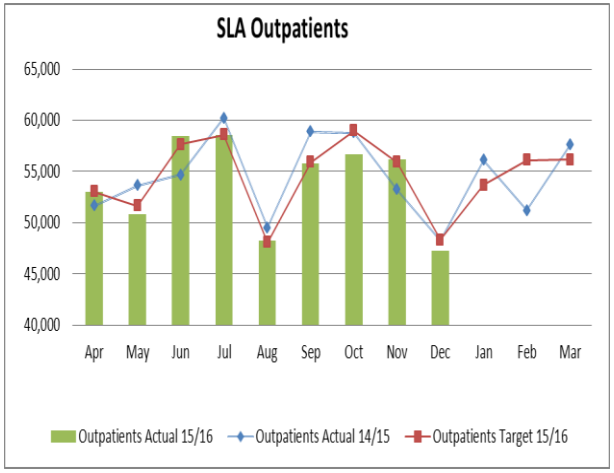
# 5. Patient activity compared to plan for the 9 months to 31st December




## Commentary

- Budgeted activity numbers reflect those the reforecast plan.
- Actual activity across all areas other than Non Elective has fallen in December compared to November.
- Electives and Non Electives are in line with the reforecast plan whilst A&E and outpatients are below.
- The shortfall in outpatients is mainly in obstetrics where the reforecast plan was overstated.
- 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 9 months to 31st December

| Income | Annual Budget (£m) | Year to Date | | |
|---|---|---|---|---|
| | | Budget (£m) | Actual (£) | Better/(Worse) than Budget |
| NHSE Specialist | 212,854 | 157,211 | 170,600 | 13,389 |
| NHSE Public Health | 23,434 | 17,595 | 17,686 | 91 |
| NHSE Secondary Dental Care Services | 8,708 | 6,525 | 6,458 | (67) |
| NHSE Cancer Drugs Fund | 2,882 | 2,089 | 2,996 | 907 |
| NHSE SPECIALIST (IFR) | 0 | 0 | 13 | 13 |
| Public Health England | 422 | 316 | 760 | 444 |
| **Subtotal NHSE** | **248,299** | **183,737** | **198,513** | **14,776** |
| NHS Wandsworth CCG | 146,926 | 110,015 | 111,185 | 1,170 |
| NHS Merton CCG | 58,570 | 43,849 | 47,011 | 3,162 |
| NHS Lambeth CCG | 19,964 | 14,945 | 15,284 | 339 |
| NHS Croydon CCG | 21,334 | 15,957 | 17,188 | 1,231 |
| NHS Sutton CCG | 13,449 | 10,059 | 10,130 | 70 |
| NHS Kingston CCG | 12,912 | 9,665 | 9,333 | (332) |
| NHS Richmond CCG | 11,818 | 8,856 | 9,060 | 204 |
| SURREY CCG | 19,892 | 14,870 | 15,121 | 251 |
| Other CCGs | 20,871 | 15,462 | 13,762 | (1,701) |
| **Subtotal CCGs** | **325,737** | **243,678** | **248,072** | **4,394** |
| NCA | 8,302 | 6,205 | 5,864 | (342) |
| Other Trusts | 1,060 | 792 | 939 | 147 |
| Other Local Authority | 7,976 | 5,993 | 5,890 | (103) |
| **Subtotal CCGs** | **17,337** | **12,990** | **12,692** | **(298)** |
| Internal Targets: Growth, Business Cases etc | 15,461 | 11,914 | (8,651) | (20,565) |
| Ex SLA Income | 6,250 | 2,569 | 2,447 | (121) |
| **Total NHS Healthcare Income** | **613,084** | **454,887** | **453,073** | **(1,813)** |
| | | | | |
| Additional Income | | | | |
| Private & Overseas Patient | 5,459 | 4,069 | 4,438 | 369 |
| Road Traffic Accidents (RTAs) | 4,182 | 3,129 | 3,065 | (64) |
| Other Healthcare Income | 237 | 195 | 182 | (13) |
| Education and Training Levy Income | 44,201 | 33,222 | 32,946 | (275) |
| Other Income* | 53,500 | 37,639 | 38,810 | 1,171 |
| | | | | |
| **Total Other Income** | **107,579** | **78,253** | **79,439** | **1,187** |
| | | | | |
| **Total income** | **720,663** | **533,140** | **532,514** | **(626)** |

**Commentary**

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

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

The Trust set an additional internal target of £26.6m now reduced to £15.4m to reflect patient activity that was expected over and above agreed contract values.

The Trust is below its total planned SLA activity targets by £1.8m year to date.

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

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

# 7. Pay costs for the 9 months to 31st December

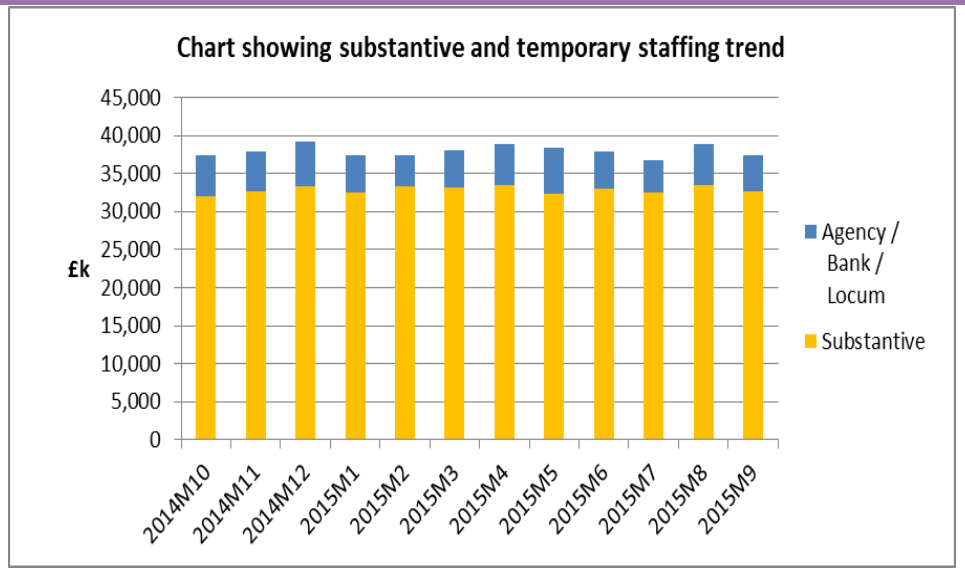
**1. Pay spend against budget (In month & YTD)**

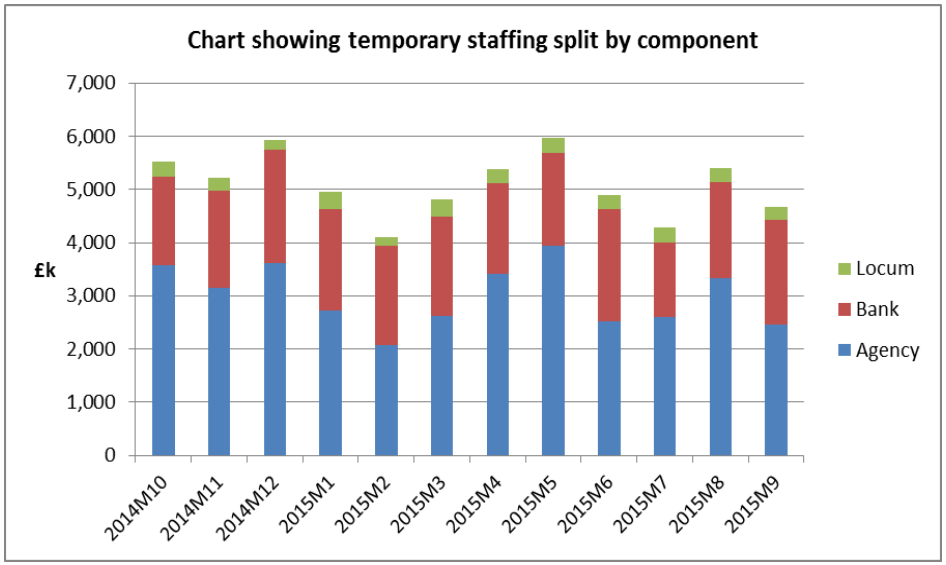
| Pay Summary by Staff Type | Annual Budget £m | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|
| | | Budget £m | Actual £m | Better/(Worse) than Budget £m | Budget £m | Actual £m | Better/(Worse) than Budget £m |
| Consultants | (72.7) | (6.1) | (6.2) | (0.1) | (54.1) | (54.4) | (0.3) |
| Junior Doctors | (50.6) | (4.2) | (4.1) | 0.2 | (37.9) | (37.8) | 0.1 |
| Non Clinical | (78.2) | (6.8) | (6.0) | 0.8 | (58.3) | (57.1) | 1.3 |
| Nursing | (179.8) | (15.2) | (14.5) | 0.7 | (132.8) | (131.0) | 1.9 |
| Scientists, Technicians, Therapists | (82.8) | (7.1) | (6.6) | 0.5 | (61.5) | (60.3) | 1.2 |
| Unallocated (Pay Provisions) | 1.8 | (0.1) | 0.0 | 0.1 | (0.4) | 0.0 | 0.4 |
| **Grand Total** | (462.4) | (39.5) | (37.4) | 2.1 | (345.1) | (340.6) | 4.4 |

**Commentary**

- Pay expenditure in month is £2.1m better than plan and cumulative pay is £4.4m better than the plan.
- The underspend is mainly in non clinical, nursing, and scientific, technical and therapeutic staff groups.
- Non clinical and scientific/technical/therapeutic staff underspends are in the Children's, Women's, Diagnostics & Therapies (CWDT) and reflect lower capacity increases than planned in corporate outpatients, and difficulties in recruitment of scientific & therapeutic staff.
- Nursing spend is less than forecast in the TRP across the 4 clinical divisions due in part to lower than expected winter pressures as well as slippage against various business cases.
- Actual pay spend in December is c£0.5m less than the previous average monthly spend and is due to lower use of agency staff.
- Of note is that pipeline CIPs have yet to be fully reflected in budgets. The M9 budget adjustment for CIPs included only £249k to date on pay. Cumulative pay underspends due to recruitment & business case slippage are expected to be taken out of the budget in M10 as non-recurrent savings.

# 8. Pay trend for the 9 months to 31st December




## Commentary

- December pay spend at £37.4m shows a reduction compared prior months to date YTD (£37.9m/month average).
- The reduction in pay spend in December is mainly against agency spend for non clinical staff and scientific/technical & therapeutic staff. This is due to GRIP initiatives to reduce non front-line agency staff and the requirement for these staff to take a 2 week break over the festive period. There was also an increased use of bank staff rather than agency to cover scientific/technical & therapeutic staff vacancies.
- Pay spend in M9 was 63% of the total income in month which is an improvement on the 65% in the first half of the year. Agency spend was 7% of total spend this month, a 1% reduction compared to the average of 8% in the first half of the year. The bank spend proportion remains at c5%.
- The Department of Health caps on nurse agency spend over the next three years came into effect in October. The nurse agency cap for the Trust cap for Q3 & Q4 is 10% of the total nursing spend. The internal target for months 7, 8 was 9% and 11% for M9. Actual nurse agency spend in these months was 11.5% for M7 & M8, and 10.7% for M9. Q3 nurse agency usage for the Trust was 11.2%. This is being monitored and needs to be reduced.
- Improvements to processes to report temporary pay accurately are now having a positive effect on the quality of information available. The work of the HR team to ensure the bank is used by all departments to book agency staff is continuing and will reduce the amount of estimation required each month.

# 9. Non pay costs for the 9 months to 31st December

| 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) | (8.0) | 0.3 | (72.9) | (71.7) | 1.2 |
| Drugs | (61.3) | (5.3) | (5.4) | (0.2) | (45.8) | (48.6) | (2.8) |
| Premises | (44.4) | (4.0) | (3.7) | 0.2 | (32.5) | (32.3) | 0.2 |
| Clinical Negligence | (15.1) | (1.2) | (1.2) | 0.0 | (11.4) | (11.6) | (0.3) |
| Establishment | (11.2) | (0.9) | (0.7) | 0.2 | (8.4) | (8.5) | (0.0) |
| General Supplies | (14.6) | 0.2 | (1.2) | (1.4) | (10.9) | (10.7) | 0.2 |
| PFI Unitary payment | (7.0) | (0.6) | (0.6) | (0.0) | (5.2) | (5.2) | (0.0) |
| Consultancy | (6.1) | (0.5) | (0.5) | 0.0 | (5.4) | (5.1) | 0.3 |
| External Facilities | (7.9) | (1.1) | (1.2) | (0.1) | (5.2) | (4.9) | 0.3 |
| Other NHS Facilities | (6.4) | (0.5) | (0.2) | 0.3 | (4.9) | (4.5) | 0.3 |
| Diagnostic Services | (26.1) | (2.1) | (2.2) | (0.1) | (19.7) | (19.9) | (0.2) |
| Other | (9.8) | (0.2) | (0.9) | (0.7) | (7.0) | (7.5) | (0.5) |
| Reserves | (0.2) | (0.0) | (0.0) | 0.0 | (0.1) | (0.1) | 0.0 |
| Prior Year Costs | (1.3) | 0.0 | 0.0 | 0.0 | (1.3) | (1.3) | 0.0 |
| Old Year Creditor Adjustments | 1.2 | 0.1 | 0.0 | (0.1) | 0.8 | 0.8 | (0.1) |
| Trust Central (Diagnostic Services & Cross charges) | 28.7 | 2.4 | 2.2 | (0.2) | 21.3 | 20.4 | (0.8) |
| **Grand Total** | **(279.6)** | **(22.0)** | **(23.7)** | **(1.8)** | **(208.5)** | **(210.7)** | **(2.1)** |

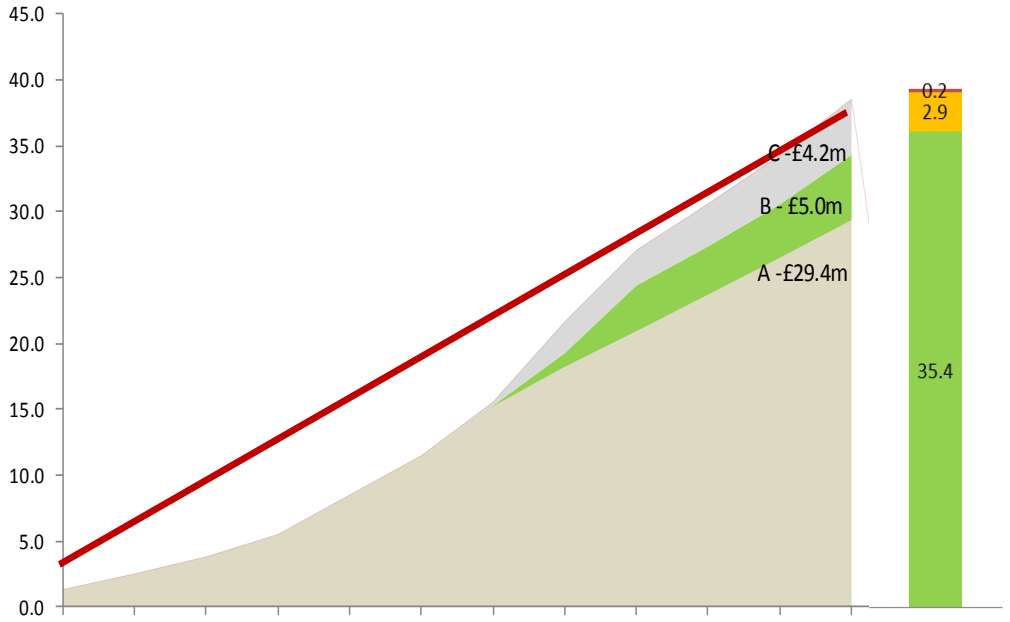
**Commentary**

- M9 non pay is £1.8m worse than budget and non pay is £2.1m worse than budget cumulatively. The adverse variance in December is due to:
  i. Retrospective CIP budget adjustment for MITIE contract extension (£1.6m cost reduction YTD)
  ii. The drug overspend relates to high cost drugs and commercial pharmacy activity over performance (both are fully offset by additional income)
  iii. In month over spend on the 'Other' budget is due to R&D and SWL Pathology spend which will be recovered via income

- Clinical consumables are £0.3m underspent in month, and £1.2m cumulatively. This reflects slippage against projected budgeted increases for various business cases and winter capacity schemes in the reforecast budgets.

- The non-pay actual spend reported in month and for Q3 is comparable to the average in the first half of the year. The underlying M9 and Q3 trend is higher than the first half of the year due to the increase in commercial pharmacy and HCD spend which are offset by extra income.

# 10. Trust CIP performance




Total CIP schemes reported to date - £38.5m. Of which -
A - £29.4m forecast against £30.7m embedded in reforecast £63m deficit plan
B - £5.0m new schemes which will improve the reforecast £63m deficit plan
C - £4.2m schemes reported as CIP but are embeddedin the £63m reforecast deficit plan

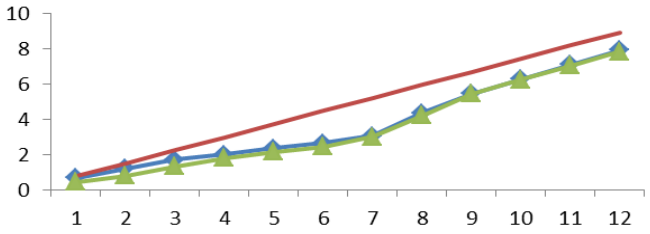
**Commentary**

- 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 £27.1m of savings compared to a plan of £28.6m. Of the £27.1m delivered so far, £15.1m is CIPs and the balance of £12.0m is non-recurrent run rate/vacancy control savings
- The baseline forecast £63m deficit plan required delivery of £30.7m CIP embedded in the TRP. The forecast against this is currently at £29.4m as a number of schemes have been forecast down.
- £5.0m 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 been removed from the budgets.
- A further £4.2m is reported as CIP but will not impact the forecast plan as these schemes are already embedded in the trust's reforecast plan.
- Of the total £38.5m CIP reported, £35.4m is Green
- Looking to 2016/17 the extra full year effect of 2015/16 schemes is £6.6m however this is more than offset by the loss of 2015/16 non recurring schemes of £15.5m. In addition £7.6m of new CIPs have so far been identified for 2016/17.

# 11. Trust CIP performance - divisions

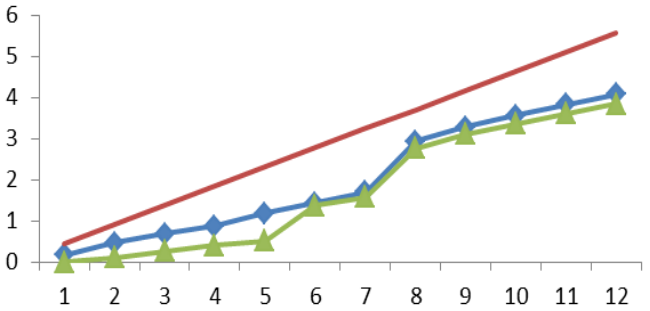
### Children and Women

£7.9m schemes have been developed against the £8.9m target so there is a gap of £1.0m. To date £1.2m less than plan has been saved, although this gap is expected to reduce further with run rate schemes. Green schemes are 99.1% of the total identified so far.



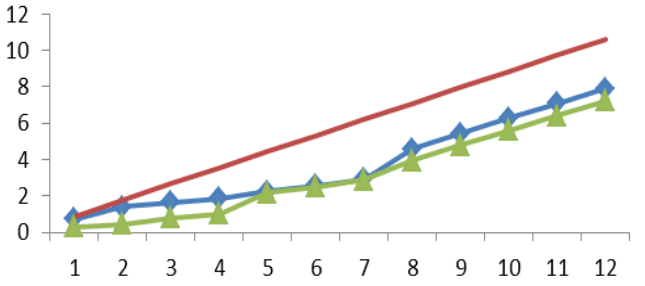

### Community Services

£4.1m schemes have been developed against the £5.6m target, the gap is £1.5m and is not expected to be eliminated. Year to date underperformance is £0.9m. Green schemes are 94.1% of the total.



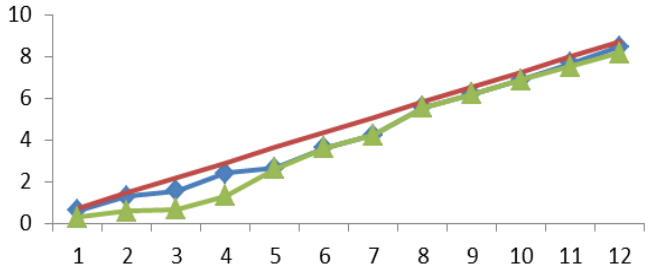

### Medicine & Cardiovascular

£7.9m schemes have been developed against the £10.6m target. The gap is £2.7m. Year to date underperformance is £2.5m. Green schemes are 91.5% of the total.



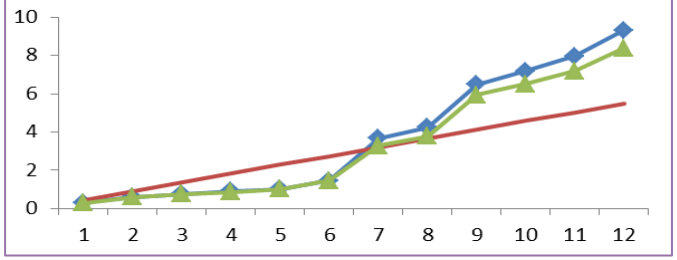

### Surgery and Neurosciences

£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.



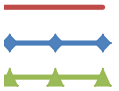

### Overheads

£9.3m schemes have been developed against a £5.5m target. In the year to date £2.4m more than plan has been saved. Green schemes are 90.1% of the total. Corporate functions have closed the gap with the schemes submitted recently. Estates & Facilities have closed the gap through run rate savings and renegotiation of the Mitie contract..




### Commentary

- Divisional targets are based on the original £38.1m target phased in 1/12s.The 10% CIP provision is held centrally.
- Overhead departments' performance has improved significantly.
- The biggest forecast shortfall is £2.7m in Medicine.
- Further work is on-going to firm up on red/amber schemes and to complete governance processes so they can become green.



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

# 12. Divisional Summaries for the 9 months to 31st December KEY HEADLINES



| Area of Review | Key Highlights |
|---|---|
| Medicine & Cardiovascular | The division's performance this month is in line with plan and and £0.6m ahead of cumulative contribution plan of £36.9m. The favourable position is due to pay underspends against the reforecast budget due to slippage on winter capacity increases and less spend than expected on specialling . In addition, ED are underspent as a result of more efficient management of rotas through the winter period.<br><br>Of note is that not all pipeline CIPs have been factored into the divisional budgets. |
| Surgery, Neurosciences Theatres & Cancer | The division's contribution of £1.96m in month and its cumulative contribution of £18.1m are both very close to budget. An increase in penalties and the impact of theatre closures on elective work done are being offset by Gibraltar income, pay and non pay underspends relating to activity underperformance, as well as less than planned transfer of General Surgery activity to external facilities. |
| Community Services | The division is £0.9m above its planned year to date contribution of £17.4m. This is due to pay underspends against the reforecast budget as a result of delays to Nightingale opening and recruitment difficulties in the CAHS service. |
| Children, Women and Diagnostics | To date, the division is £1.6m above plan. This favourable position is due to pay underspends as expected additional outpatient capacity has not been used and recruitment to therapy vacancies has been slower than planned. The lack of uptake of outpatient additional clinics is impacting on the level of outpatient income across clinical divisions. |
| Overheads | Overhead costs were £1.2m worse than plan in month and £0.6m better than plan cumulatively. The adverse in month position is the result of retrospective budget adjustments in estates & facilities for the MITIE rebate (£1.4m favorable non pay position now taken as CIP). The year to date favourable variance relates to the income benefit for the renegotiated Moorfield's contract for use of Trust facilities (£0.3m cumulatively) and slippage on the productive ward in the Directorate of Nursing (£0.2m). |

# Medicine & Cardiovascular - Divisional I&E for the 9 months to 31st December

**Medicine and Cardiovascular**

| Income & Expenditure | Annual Budget £m | Current Month Budget £m | Current Month Actual £m | Current Month Better/(Worse) than Budget £m | Year to Date Budget £m | Year to Date Actual £m | Year to Date Better/(Worse) than Budget £m |
|---|---|---|---|---|---|---|---|
| SLA Income | | | | | | | |
| A&E | 17.4 | 1.5 | 1.5 | (0.0) | 13.0 | 13.0 | (0.1) |
| Daycase | 11.8 | 0.9 | 1.0 | 0.1 | 8.8 | 8.9 | 0.1 |
| Elective | 23.8 | 2.0 | 1.9 | (0.2) | 18.1 | 18.2 | 0.2 |
| Pass-through drugs/devices/programme | 48.2 | 4.1 | 4.3 | 0.2 | 35.6 | 36.6 | 1.1 |
| Non Elective | 64.5 | 5.4 | 5.5 | 0.1 | 48.5 | 48.6 | 0.1 |
| Other | 17.5 | 1.5 | 1.5 | (0.0) | 13.2 | 12.9 | (0.3) |
| Outpatients | 35.6 | 2.7 | 2.8 | 0.1 | 26.5 | 26.5 | (0.1) |
| | 218.7 | 18.0 | 18.3 | 0.2 | 163.7 | 164.7 | 1.0 |
| Other Income | 17.8 | 1.5 | 1.4 | (0.1) | 13.3 | 13.1 | (0.2) |
| **Overall Income** | **236.6** | **19.5** | **19.6** | **0.1** | **177.0** | **177.8** | **0.8** |
| Pay | | | | | | | |
| Consultants | (19.7) | (1.7) | (1.7) | (0.0) | (14.6) | (14.6) | 0.0 |
| Junior Doctors | (18.6) | (1.5) | (1.5) | 0.1 | (14.0) | (14.0) | (0.0) |
| Non Clinical | (8.7) | (0.7) | (0.7) | 0.0 | (6.5) | (6.3) | 0.2 |
| Nursing | (54.2) | (4.4) | (4.4) | 0.0 | (40.2) | (39.8) | 0.4 |
| Scientists, Technicians, Therapists | (5.3) | (0.4) | (0.4) | 0.0 | (3.9) | (3.7) | 0.2 |
| Pay Unallocated | (0.0) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | (106.6) | (8.8) | (8.7) | 0.1 | (79.2) | (78.5) | 0.7 |
| Non-Pay | | | | | | | |
| Clinical Consumables | (38.6) | (3.2) | (3.5) | (0.3) | (29.0) | (29.2) | (0.2) |
| Drugs | (31.5) | (2.8) | (2.8) | (0.1) | (23.2) | (24.1) | (0.8) |
| Establishment | (1.6) | (0.1) | (0.1) | 0.0 | (1.2) | (1.3) | (0.0) |
| General Supplies | (0.4) | (0.0) | (0.0) | (0.0) | (0.3) | (0.3) | 0.0 |
| Other | (5.1) | (0.5) | (0.4) | 0.1 | (3.5) | (3.4) | 0.1 |
| Premises | (0.3) | (0.0) | (0.0) | 0.0 | (0.2) | (0.2) | 0.0 |
| | (77.6) | (6.7) | (6.9) | (0.2) | (57.5) | (58.5) | (1.0) |
| **Overall Expenditure** | **(184.2)** | **(15.5)** | **(15.6)** | **(0.1)** | **(136.8)** | **(137.0)** | **(0.2)** |
| **EBITDA** | **52.4** | **4.1** | **4.1** | **(0.0)** | **40.3** | **40.9** | **0.6** |
| Financing Costs | (4.5) | (0.4) | (0.4) | (0.0) | (3.4) | (3.4) | (0.0) |
| **Surplus / (deficit)** | **47.9** | **3.7** | **3.7** | **(0.0)** | **36.9** | **37.5** | **0.6** |

## Commentary

The YTD contribution at month 9 is £0. 6m better than plan.

**Income** is £0.8m above cumulative plan due to higher than planned income for pass through drugs, which is matched by non-pay (drugs) overspend. Fines are £0.5m higher than YTD plan due to NHSE fines from M8 that were not expected, and all Trust cancer fines are reported within this division.

**Pay** is £0.7m favourable YTD with nursing underspends due in part to Champneys escalation beds not opening yet. Ward nursing is also underspent due to lower than planned specialling. In addition, ED are underspent as a result of more efficient management of rotas through the winter period.

**Non-pay** is £1m overspent and relates to high cost drugs & devices. Both are both pass through costs and offset by additional income. In addition, there is a cost pressure emerging in Oncology for high cost cancer drugs that are not fully covered by the unbundled tariff.

## Actions

- Minimise Cardiac Surgery activity sent to the private sector.
- Working closely with KPMG to convert pipeline schemes into deliverable CIP schemes, recovery plans to improve outpatient activity income and minimise fines.
- Continues flow programme work to minimise extra winter costs.

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

- Cardiac Surgery (ability to continue on site, prospect of using Cromwell)
- Vascular surgery (risk of losing all junior doctors)
- ED (winter pressures), Haematology (marginal rates may apply to income), and Oncology (drugs mentioned above).

# Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for the 9 months to 31st December

**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 | 5.2 | (0.9) | (1.4) | (0.5) | 3.9 | 3.8 | (0.1) |
| Daycase | 14.2 | 1.1 | 1.0 | (0.1) | 10.5 | 10.4 | (0.1) |
| Elective | 39.1 | 4.7 | 4.9 | 0.2 | 28.9 | 28.6 | (0.3) |
| Pass-through drugs/devices/programme | 11.5 | 0.9 | 1.0 | 0.1 | 8.8 | 9.2 | 0.4 |
| Non Elective | 49.5 | 4.2 | 4.1 | (0.1) | 36.8 | 36.2 | (0.6) |
| Other | 1.6 | 0.1 | 0.0 | (0.1) | 1.3 | 0.6 | (0.7) |
| Outpatients | 32.5 | 2.5 | 2.4 | (0.1) | 24.0 | 23.6 | (0.4) |
| | 153.6 | 12.6 | 12.0 | (0.5) | 114.2 | 112.4 | (1.8) |
| Other Income | 16.0 | 1.7 | 1.5 | (0.2) | 12.0 | 12.3 | 0.4 |
| **Overall Income** | **169.6** | **14.3** | **13.5** | **(0.7)** | **126.2** | **124.8** | **(1.4)** |
| Pay | | | | | | | |
| Consultants | (26.8) | (2.3) | (2.2) | 0.0 | (19.8) | (19.8) | 0.0 |
| Junior Doctors | (15.4) | (1.3) | (1.3) | 0.0 | (11.6) | (11.7) | (0.2) |
| Non Clinical | (9.3) | (0.8) | (0.8) | (0.0) | (7.0) | (7.0) | 0.0 |
| Nursing | (43.9) | (3.8) | (3.5) | 0.3 | (32.2) | (31.6) | 0.6 |
| Scientists, Technicians, Therapists | (10.8) | (0.9) | (0.9) | 0.1 | (8.1) | (8.0) | 0.1 |
| | (106.2) | (9.1) | (8.6) | 0.4 | (78.6) | (78.0) | 0.6 |
| Non-Pay | | | | | | | |
| Clinical Consumables | (22.0) | (1.9) | (1.6) | 0.3 | (16.2) | (15.5) | 0.7 |
| 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) | (6.8) | (7.0) | (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) | (0.3) | 0.1 | (2.6) | (2.2) | 0.4 |
| Premises | (0.8) | (0.1) | (0.1) | (0.0) | (0.4) | (0.4) | 0.0 |
| | (36.5) | (3.1) | (2.7) | 0.4 | (26.6) | (25.7) | 0.9 |
| **Overall Expenditure** | **(142.7)** | **(12.2)** | **(11.3)** | **0.8** | **(105.2)** | **(103.7)** | **1.5** |
| **EBITDA** | **26.9** | **2.1** | **2.2** | **0.1** | **21.0** | **21.1** | **0.1** |
| Financing Costs | (4.0) | (0.3) | (0.3) | (0.0) | (3.0) | (3.0) | (0.0) |
| **Surplus / (deficit)** | **23.0** | **1.8** | **1.9** | **0.1** | **18.0** | **18.1** | **0.1** |

## Commentary

The division has delivered a net contribution of £18.1m year to date which is £100k better than 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. Outpatient income is underperforming due to an overstatement of the income target for Neurology in the reforecast. Other income is better than plan as to Gibraltar income is now reflected in the divisional position.

**Pay** - The year to date pay underspend of £0.6m is mainly due to nursing and theatre technician vacancies, bed closures and theatre downtime in December. These are partially offset by an overspend on junior doctors.

**Non-Pay** - £0.9m underspent which relates to lower clinical consumables usage related to activity and less reliance on the private sector in the month.

### Actions to Improve Position

- Work with KPMG on CIPs
- Ensure all high cost activity is correctly recorded in SLAM
- Review contract challenges and validate the PTL to minimise penalties

**Forecast** - The division expects to meet its planned surplus if there are no further unplanned theatre closures.

# Community Services - Divisional I&E for the 9 months to 31st December

**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) | 0.9 | 0.9 | (0.0) |
| Bed Days | 5.6 | 0.5 | 0.4 | (0.1) | 4.1 | 4.0 | (0.1) |
| Exclusions | 8.6 | 0.7 | 0.6 | (0.1) | 6.7 | 6.5 | (0.1) |
| Other | 59.4 | 5.0 | 4.9 | (0.1) | 44.4 | 44.3 | (0.1) |
| Outpatients | 24.1 | 1.8 | 1.9 | 0.1 | 18.0 | 18.2 | 0.2 |
| | 98.8 | 8.1 | 7.9 | (0.1) | 74.1 | 73.9 | (0.2) |
| Other Income | 1.9 | 0.2 | 0.3 | 0.1 | 1.5 | 1.6 | 0.1 |
| **Overall Income** | **100.8** | **8.2** | **8.2** | **(0.0)** | **75.5** | **75.4** | **(0.1)** |
| Pay | | | | | | | |
| Consultants | (2.4) | (0.2) | (0.2) | 0.0 | (1.8) | (1.8) | 0.0 |
| Junior Doctors | (2.7) | (0.3) | (0.2) | 0.0 | (2.0) | (1.8) | 0.2 |
| Non Clinical | (7.6) | (0.7) | (0.6) | 0.1 | (5.6) | (5.5) | 0.1 |
| Nursing | (24.7) | (2.1) | (1.9) | 0.3 | (18.1) | (17.6) | 0.5 |
| Scientists, Technicians, Therapists | (10.1) | (0.9) | (0.8) | 0.1 | (7.5) | (7.4) | 0.1 |
| | (47.5) | (4.1) | (3.6) | 0.5 | (35.0) | (34.0) | 1.0 |
| Non-Pay | | | | | | | |
| Clinical Consumables | (9.5) | (0.8) | (1.0) | (0.2) | (7.0) | (7.2) | (0.2) |
| Clinical Negligence | (0.0) | 0.0 | 0.0 | 0.0 | (0.0) | (0.0) | (0.0) |
| Drugs | (11.8) | (1.0) | (0.9) | 0.1 | (8.9) | (9.2) | (0.3) |
| Establishment | (1.2) | (0.1) | (0.1) | 0.0 | (0.9) | (0.8) | 0.0 |
| General Supplies | (0.1) | (0.0) | (0.0) | (0.0) | (0.1) | (0.1) | 0.0 |
| Other | (8.7) | (0.7) | (0.5) | 0.3 | (6.5) | (6.1) | 0.3 |
| Premises | (1.0) | (0.1) | (0.0) | 0.1 | (0.6) | (0.4) | 0.2 |
| | (32.3) | (2.8) | (2.5) | 0.3 | (24.0) | (23.9) | 0.1 |
| **Overall Expenditure** | **(79.8)** | **(6.9)** | **(6.1)** | **0.8** | **(59.0)** | **(57.9)** | **1.0** |
| **EBITDA** | **20.9** | **1.3** | **2.1** | **0.7** | **16.6** | **17.5** | **0.9** |
| Financing Costs | (0.2) | (0.0) | (0.0) | 0.0 | (0.2) | (0.2) | 0.0 |
| **Surplus / (deficit)** | **20.7** | **1.3** | **2.1** | **0.7** | **16.4** | **17.4** | **0.9** |

## Commentary

The division has £17.4m surplus to date which is £0.9m better than the reforecast plan. The underspend to date due to delays in opening the Nightingale is £0.3m pay and £0.3m non-pay.

**Income** – Overall the December income position is break-even with small underperformance in SLA income off-set in other income.

**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 in month and YTD.

**Non-pay** – Non-pay spend in December was under budget mainly due to a backdated reduction in the MRI contract (£0.1m) and a decrease in GU drugs spend in the month (£0.2m) due to reduced drugs deliveries in December.

## Actions

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

## Forecast

The overall forecast of £20.7m surplus includes additional costs relating to the opening of the Nightingale unit and recruitment to a number of vacancies. The in month position contains a number of one-off benefits. The division should achieve a higher surplus than budget.

# Children, Women, Diagnostics & Therapies - Divisional I&E for the 9 months to 31st December

C&W, Diagnostics, Therapies

| Income & Expenditure | Annual Budget £m | Current Month Budget £m | Current Month Actual £m | Current Month Better/(Worse) than Budget £m | Year to Date Budget £m | Year to Date Actual £m | Year to Date Better/(Worse) than Budget £m |
|---|---|---|---|---|---|---|---|
| SLA Income | | | | | | | |
| Bed Days | 48.2 | 4.1 | 4.5 | 0.4 | 35.2 | 35.3 | 0.1 |
| Daycase | 4.6 | 0.3 | 0.4 | 0.2 | 3.5 | 3.6 | 0.1 |
| Elective | 4.2 | 0.3 | 0.3 | (0.1) | 3.1 | 3.0 | (0.2) |
| Pass-through drugs/devices/programme | 2.3 | 0.2 | 0.1 | (0.1) | 1.8 | 1.7 | (0.1) |
| Non Elective | 8.4 | 0.8 | 0.6 | (0.2) | 6.4 | 6.5 | 0.1 |
| Other | 25.7 | 2.4 | 2.4 | (0.0) | 19.4 | 19.7 | 0.2 |
| Outpatients | 38.4 | 2.9 | 2.9 | (0.0) | 28.4 | 27.8 | (0.5) |
| | 131.8 | 11.0 | 11.2 | 0.2 | 97.8 | 97.7 | (0.1) |
| Other Income | 22.0 | 1.8 | 2.1 | 0.3 | 15.8 | 17.4 | 1.6 |
| **Overall Income** | **153.8** | **12.8** | **13.3** | **0.5** | **113.6** | **115.1** | **1.5** |
| Pay | | | | | | | |
| Consultants | (16.9) | (1.4) | (1.5) | (0.1) | (12.7) | (12.9) | (0.3) |
| Junior Doctors | (12.9) | (1.1) | (1.0) | 0.0 | (9.6) | (9.6) | 0.0 |
| Non Clinical | (14.2) | (1.2) | (1.0) | 0.2 | (10.6) | (10.2) | 0.4 |
| Nursing | (52.2) | (4.4) | (4.4) | 0.0 | (38.9) | (38.7) | 0.2 |
| Scientists, Technicians, Therapists | (35.3) | (3.1) | (2.9) | 0.2 | (25.8) | (25.1) | 0.7 |
| | (131.4) | (11.2) | (10.8) | 0.4 | (97.5) | (96.5) | 1.1 |
| Non-Pay | | | | | | | |
| Clinical Consumables | (13.7) | (1.1) | (1.3) | (0.2) | (9.8) | (9.6) | 0.2 |
| Drugs | (8.8) | (0.8) | (1.0) | (0.2) | (6.7) | (8.2) | (1.5) |
| Establishment | (0.7) | (0.1) | (0.0) | 0.0 | (0.6) | (0.5) | 0.1 |
| General Supplies | (0.5) | (0.0) | (0.0) | 0.0 | (0.4) | (0.3) | 0.0 |
| Other | (2.5) | (0.1) | (0.2) | (0.0) | (1.9) | (1.9) | (0.0) |
| Premises | (1.7) | (0.2) | (0.1) | 0.1 | (1.2) | (0.9) | 0.3 |
| | (28.0) | (2.4) | (2.6) | (0.3) | (20.5) | (21.5) | (1.0) |
| **Overall Expenditure** | **(159.4)** | **(13.5)** | **(13.5)** | **0.1** | **(118.0)** | **(118.0)** | **0.0** |
| **EBITDA** | **(5.6)** | **(0.7)** | **(0.2)** | **0.6** | **(4.5)** | **(2.9)** | **1.6** |
| Financing Costs | (6.5) | (0.5) | (0.5) | (0.0) | (4.9) | (4.9) | 0.0 |
| **Surplus / (deficit)** | **(12.1)** | **(1.3)** | **(0.7)** | **0.6** | **(9.3)** | **(7.8)** | **1.6** |

## Commentary

The division has a cumulative deficit of £7.8m which is £1.6m better than the reforecast.

**Income** – Current month variances have improved but with reduced targets. Outpatient underperformance to date is due to an error relating to antenatal income in the reforecast and Breast Screening is also underperforming.
Other income over performance of £1.6m is the success of pharmacy commercial operations (associated increase in drug spend is £1.5m).

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

**Non pay** – The 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 of £1.5m relates to pharmacy commercial operations referred to above.

## Actions

- Outpatient Clinic capacity needs to be reviewed in the light of vacancy levels.
- Complete updated forecast for 2015/16 year end

## Forecast Position

The division expects to end the year ahead of the plan but will see continued underperformance in Outpatient services and recruitment will reduce the underspends in pay. The delayed development in critical care beds will lead to an underperformance in bed days for the last two months of 2015/16.

# Overheads - Divisional I&E for the 9 months to 31st December

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 | (21.2) | (1.9) | (1.8) | 0.1 | (16.8) | (16.9) | (0.1) |
| Executive Director of Nursing | (4.9) | (0.4) | (0.4) | (0.0) | (3.8) | (3.6) | 0.2 |
| Finance, Performance & IT | (26.2) | (2.3) | (2.2) | 0.1 | (19.4) | (19.6) | (0.2) |
| Human Resources Directorate | (4.8) | (0.4) | (0.5) | (0.0) | (3.5) | (3.5) | 0.0 |
| Ops & Service Improvement | (1.6) | (0.2) | (0.2) | (0.0) | (1.1) | (0.9) | 0.1 |
| Pathology - STG | (12.1) | (0.8) | (0.7) | 0.1 | (9.3) | (9.1) | 0.1 |
| Strategy | (1.5) | (0.1) | (0.1) | (0.0) | (1.1) | (1.2) | (0.1) |
| **Total Corporate** | (72.3) | (6.0) | (5.8) | 0.2 | (54.9) | (54.8) | 0.1 |
| **Estates & Facilities** | | | | | | | |
| Energy & Engineering | (11.3) | (1.0) | (1.0) | 0.0 | (8.3) | (8.2) | 0.0 |
| Estates | (11.5) | (0.9) | (1.0) | (0.1) | (8.7) | (8.6) | 0.1 |
| Estates Community Premises | (16.7) | (1.5) | (1.5) | (0.0) | (12.3) | (12.3) | (0.0) |
| Facilities Services | (4.7) | (0.4) | (0.4) | 0.0 | (3.6) | (3.6) | 0.1 |
| Hotel Services | (11.6) | 0.5 | (0.9) | (1.4) | (8.7) | (8.5) | 0.2 |
| Medical Physics | (2.2) | (0.1) | (0.0) | 0.0 | (1.6) | (1.5) | 0.1 |
| Project Management | (0.4) | (0.0) | (0.0) | 0.0 | (0.3) | (0.3) | 0.0 |
| Rates | (2.1) | (0.2) | (0.2) | 0.0 | (1.6) | (1.6) | 0.0 |
| **Total Estates & Facilities** | (60.5) | (3.5) | (5.0) | (1.4) | (45.1) | (44.6) | 0.5 |
| **Total Overheads** | **(132.8)** | **(9.6)** | **(10.8)** | **(1.2)** | **(100.0)** | **(99.4)** | **0.6** |

**Overheads Summary**

Corporate Services spend to date is £0.1m worse than plan while Estates & Facilities is £0.5m better.

**Corporate**

Chief Executive – under spend in month due to additional budget for Turnaround costs.

Executive Director Nursing - break-even 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 – The overspend relates to higher than expected costs of staff embedded in divisions working on the reforecast.

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

**Estates & Facilities**

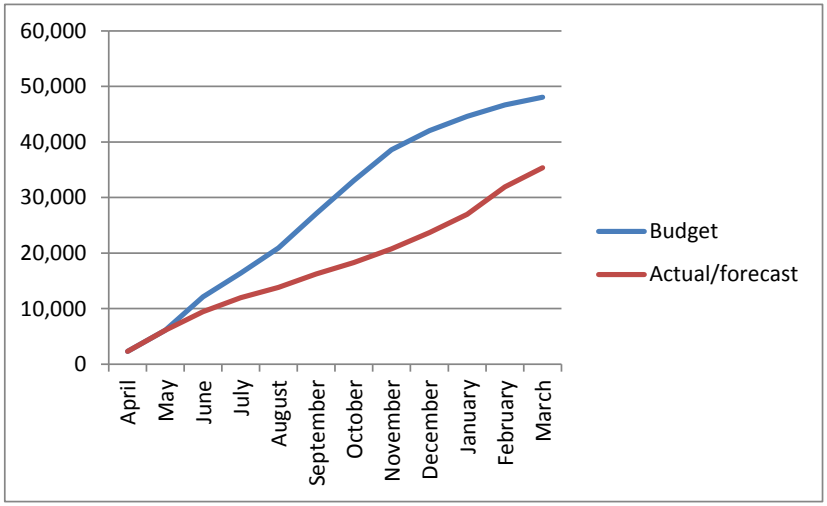
Month 9 is £1.4m deficit to plan but £0.5m better than the plan to date. This is due to the budget being reduced as CIP for the MITIE rebate (£1.6m). This will provide a £2.15m benefit in 15/16 and £1.4m (8/12ths) of this was included in the month 8 position.
In Estates there is also an income benefit from revised site recharge to Moorefield's (£0.3m for 2014/15 and 2015/16).

**Risks**

- Estates backlog maintenance jobs continue to increase

# 13. Capital

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




| Summary cap exp by spend category | New Budget £000 | YTD Budget £000 | YTD Actual £000 | YTD Var £000 | F'cast Outturn £000 | F'cast U/spend £000 |
|---|---|---|---|---|---|---|
| Infrastructure renewal | 9,680 | 6,262 | 3,478 | 2,784 | 6,571 | 3,109 |
| Medical equipment | 12,412 | 11,849 | 6,705 | 5,144 | 9,585 | 2,827 |
| IMT | 6,526 | 6,162 | 3,883 | 2,279 | 4,990 | 1,536 |
| Major Projects | 18,137 | 16,733 | 9,012 | 7,721 | 13,398 | 4,739 |
| Other | 772 | 657 | 524 | 133 | 639 | 133 |
| SWL Path | 500 | 395 | 95 | 300 | 155 | 345 |
| Total | 48,027 | 42,058 | 23,697 | 18,361 | 35,338 | 12,688 |

- Capital expenditure in December was £2.9m and year to date expenditure is £23.7m, £18.4m 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 £12.6m (M08 £10m) and therefore it is expected that thee will be an acceleration in spend in the last 3 months of the year – particularly in medical equipment (replacement of AMW 1.5t MRI scanner and hybrid theatre equipment) and major projects (SAU, hybrid theatre works and AMW bed schemes)
- The cash benefit of this forecast outturn underspend is estimated at £11.3m (excluding leases).

# 14. Cash 1

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 | 31-Dec £000 |
|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 Plan cash (May 2015) | n/a | 14,200 | 6,187 | 3,000 | 3,000 | 3,000 | 3,000 | 3,000 | 3,000 | 3,000 |
| 2015/16 TRP cash | | | | | | | | | 7,037 | 5,264 |
| **Actual cash** | **24,179** | **14,188** | **7,925** | **7,265** | **6,175** | **6,097** | 8,258 | 12,846 | 9,252 | 15,236 |
| Cash bal fav / (adv) variance to plan | 0 | -12 | 1,738 | 4,265 | 3,175 | 3,097 | 5,258 | 9,846 | 6,252 | 12,236 |

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 | 31-Dec £000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan drawdown (May 2015) | 0 | 0 | 0 | 2,138 | 6,991 | 14,625 | 24,483 | 29,807 | 34,900 | 42,544 |
| 2015/16 TRP drawdown | | | | | | | | | 26,256 | 26,256 |
| **Actual drawdown** | **0** | **0** | **0** | **0** | **7,671** | **15,580** | **25,000** | **26,256** | **26,256** | **36,396** |
| WCF cum drawdowns fav / (adv) variance to plan | 0 | 0 | 0 | 2,138 | -680 | -955 | -517 | 3,551 | 8,644 | 6,148 |
| | | | | | | | | | | |
| **Overall Cash fav / (adv) variance to plan** | **0** | **-12** | **1,738** | **6,403** | **2,495** | **2,142** | **4,741** | **13,397** | **14,896** | **18,384** |

**Cash movement: M09 Actuals vs Plan and forecast outturn vs Plan**

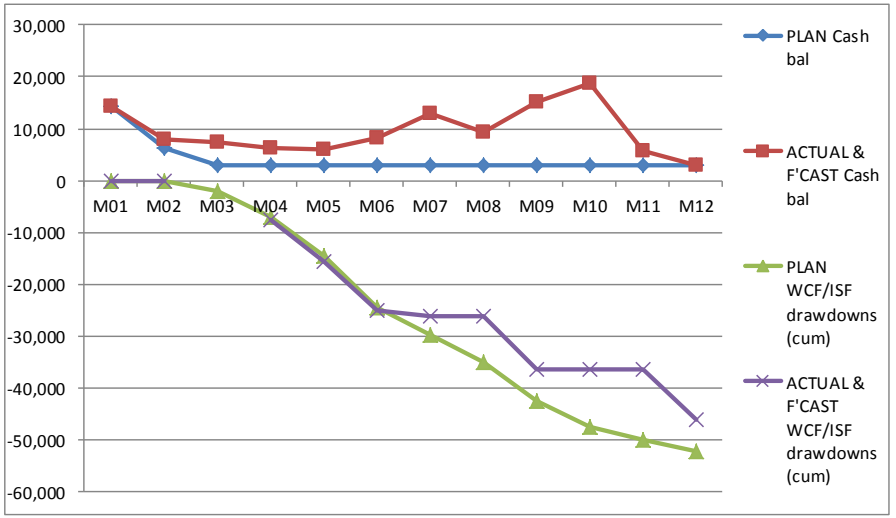
| | Plan M09 YTD £m | Actual M09 YTD £m | Actual M09 VAR £m | Plan Outturn £m | M08 F/cast Outturn £m | Var Outturn £m |
|---|---|---|---|---|---|---|
| Opening cash 01.04.15 | 24.2 | 24.2 | | 24.2 | 24.2 | |
| Operating surplus/-deficit | -18.8 | -25.4 | **-6.6** | -21.6 | -33.1 | **-11.5** |
| Sale proceeds re: PPU land | 0.0 | 0.0 | **0.0** | 2.5 | 0.0 | **-2.5** |
| WCF/ISF requirement | 42.5 | 36.4 | **-6.1** | 52.2 | 46.2 | **-6.0** |
| **Cash gap** | | | **-12.7** | | | **-20.0** |
| Net change in working capital | -7.4 | -1.0 | **6.4** | -7.4 | -0.6 | **6.8** |
| Capital spend (excl leases) | -38.0 | -20.1 | **17.9** | -45.5 | -29.4 | **16.1** |
| Other | 0.5 | 1.1 | **0.6** | -1.4 | -4.3 | **-2.9** |
| Sub-total | | | **24.9** | | | **19.9** |
| Closing cash M09 / M12 forecast | 3.0 | 15.2 | **12.2** | 3.0 | 3.0 | **0.0** |

- The **cash balance** table above shows the actual cash balance and WCF drawdowns vs the plan figures.
- The M09 actual cash balance was £15.2m which is £12.2m ahead of plan.
- Cumulative WCF/ISF drawdowns to 31st December are £36.4m which is £6.1m 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: +£3.4m.
- 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 (£6.6m higher than plan) and £6.1m lower drawdowns from the WCF have been more than offset by the £6.4m better performance on net working capital (longer supplier payments terms etc) and £17.9m cash under spend on capital enabling the Trust to achieve a cash balance at 31st December £12.2m higher than plan.
- Forecast outturn position: The reduction in the forecast operating deficit from £63m to £56.1m and the reduction in the forecast outturn capital spend have enabled the Trust to improve its year end cash balance forecast: the 31/03 forecast cash balance is now £3m (M08: £0.25m) and the forecast total ISF funding is £46.2m (M08: £48.7m).. This forecast assumes the Trust will be able to access ISF/WCF drawdowns of approx £9.7m in March from the new loan agreement (which requires board approval on 4th February).

# 15. Cash 2

- The Trust included total interim cash support funding of £48.7m (Plan £52.2m) for the year in the TRP based on a forecast I&E deficit of £63m. The reduction this month in the forecast I&E deficit to £56.1m and lower forecast capital expenditure indicate the Trust may achieve the £3m minimum required cash balance and lower its total ISF requirement for the year to £46.2m.
- Cumulative WCF drawdowns as at M09 were £36.4m. The cash flow forecast demonstrates the Trust now has sufficient cash through February but will need to draw down approx £9.7m in March.

**CASH GRAPH : Monthly cash balances and WCF/ISF drawdowns: Actual/forecast vs Plan**




1 WCF/ISF requirement for year = £46.2m (M08: £48.7m)
2 **The cash flow forecast assumes Trust can access WCF/ISF again in March to avoid cash deficit as follows:**

| | M07 | M08 | M09 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|
| WCF/ISF drawdowns - forecast £m | | | -10.1 | | 0.0 | 9.8 |
| WCF/ISF drawdowns (cum) forecast £m | -26.3 | -26.3 | -36.4 | -36.4 | -36.4 | -46.2 |

3 Cash benefits of £19.9m realised for year
4 Capital spend £16.1m lower than Plan (M08 : £14.5m lower than Plan)
5 Cash balance reduces from £15.2m (M09) to £3m by year end - furter in-month I&E deficits and unwind of certain cash actions implemented Oct-Dec.

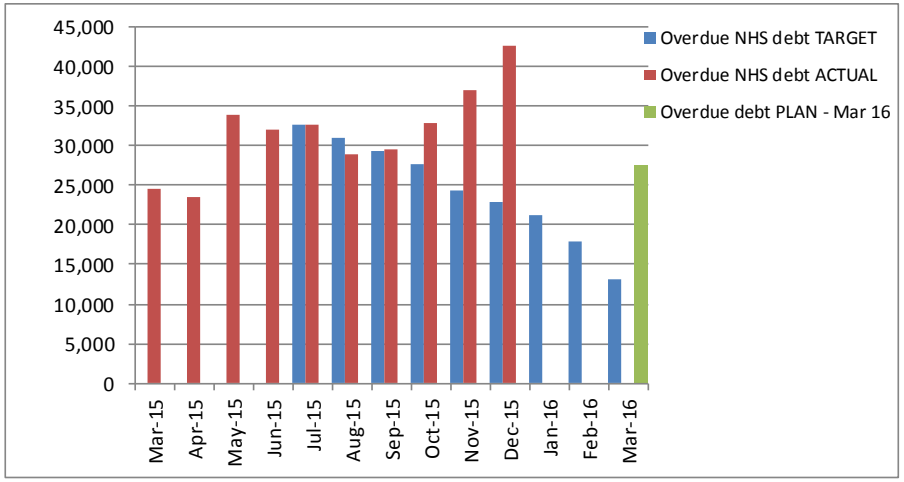
# 16. Debt management

- The Cash Committee approved 'stretch' debt reduction targets for 2015/16 and the baseline is the level of overdue debt (over 30 days old) as at M04.
- Overdue debt reduced by £4.5m in the period M04 – M06 and was ahead of target by £0.9m at M06.
- Although current debt reduced by £10.8m in December – contributing to a strong performance on working capital in M09, overdue debt is behind target. The increase relates primarily to NHSE debt, CCG over performance debt, GP Leo hosting services debt, fetal medicine unit/maternity pathway debt and local authority GUM debt.
- The Trust expects to collect at least £2.5m for 14/15 CQUIN and RTT debt from NHSE in February. Also the Trust continues to press NHS England for an agreement for a payment on account arrangement for in-year over performance similar to the arrangement already in place with SWL CCGs 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.

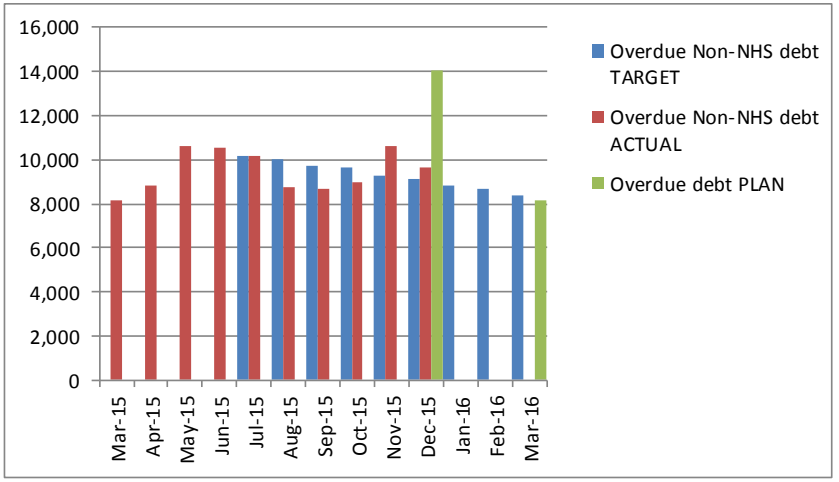
| Debtor days | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 |
|---|---|---|---|---|---|---|---|---|---|---|
| NHS income debtor days | 18.5 | 18.8 | 19.5 | 19.4 | 19.4 | 20.1 | 21.6 | 22.1 | 30.7 | 29.2 |
| Non-NHS income debtor days | 204.9 | 202.0 | 219.3 | 229.0 | 205.1 | 199.2 | 198.4 | 190.9 | 256.1 | 205.5 |
| DWP/CRU debt | 981.1 | 986.8 | 1,000.1 | 1,029.1 | 1,077.7 | 1,019.2 | 1,038.3 | 1,080.3 | 1,083.9 | 1,075.1 |
| Overseas patient income | 807 | 789 | 769 | 753 | 761 | 740 | 677 | 793 | 810 | 780 |

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

**Overdue NHS debt: performance vs stretch reduction targets**




**Overdue non-NHS debt: performance vs stretch reduction targets**



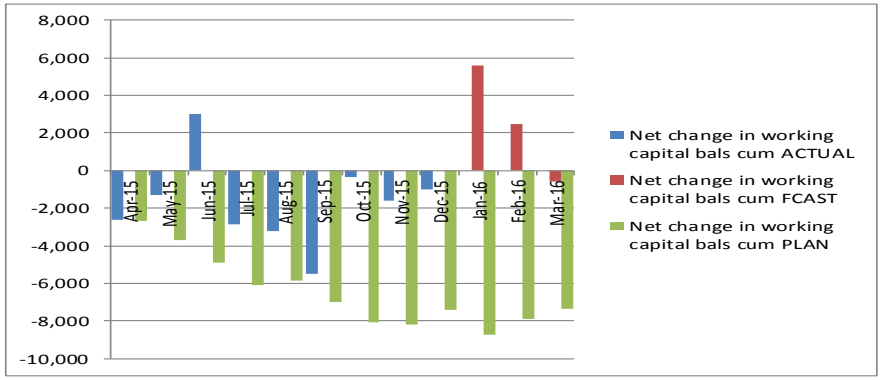
# 17. Balance sheet as at month 9 2015/16

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

| | Dec-15 Plan £000 | Dec-15 Actual £000 | *Variance £000* | **Explanations of balance sheet variances** |
|---|---|---|---|---|
| Fixed assets | 359,583 | 336,857 | *22,726* | Much lower capital expenditure than plan - so lower fixed assets |
| | | | | |
| Stock | 6,648 | 8,345 | *-1,697* | Stock action group formed to progress safe reductions in levels. |
| Debtors | 80,233 | 82,579 | *-2,346* | Current debt reduced in M09 but overdue debt higher than target. |
| Cash | 3,000 | 15,237 | *-12,238* | Lower capex, and better working capital performance has enabled Trust to finance higher |
| | 0 | 0 | | deficit without requiring higher WCF drawdowns. Cash is £18.3m better than Plan overall. |
| Creditors | -84,252 | -94,694 | *10,442* | Longer supplier payment terms since July. Also CNST & NHSPS liabilities deferred till Q4. |
| Capital creditors | -3,476 | -2,683 | *-793* | |
| PDC div creditor | -1,770 | -1,675 | *-95* | |
| Int payable creditor | -223 | -319 | *96* | |
| | 0 | 0 | | |
| Provisions< 1 year | -602 | -512 | *-90* | |
| Borrowings< 1 year | -50,184 | -6,347 | *-43,838* | (NB: WCF is classified as non-current liability c/f Plan) |
| | 0 | 0 | | |
| **Net current assets/-liabilities** | **-50,627** | **-68** | *-50,559* | |
| | 0 | 0 | | |
| Provisions> 1 year | -1,181 | -1,110 | *-71* | |
| Borrowings> 1 year | -93,512 | -127,058 | *33,546* | (NB: WCF is classified as non-current liability c/f Plan) |
| **Long-term liabilities** | **-94,693** | **-128,168** | *33,475* | |
| | | | | |
| **Net assets** | **214,263** | **208,621** | | |
| | | | | |
| **Taxpayer's equity** | | | | |
| Public Dividend Capital | 133,761 | 133,761 | *0* | |
| Retained Earnings | -22,008 | -26,378 | *4,370* | YTD I&E deficit worse than plan |
| Revaluation Reserve | 101,360 | 100,088 | *1,272* | |
| Other reserves | 1,150 | 1,150 | *0* | |
| **Total taxpayer's equity** | **214,263** | **208,621** | | |

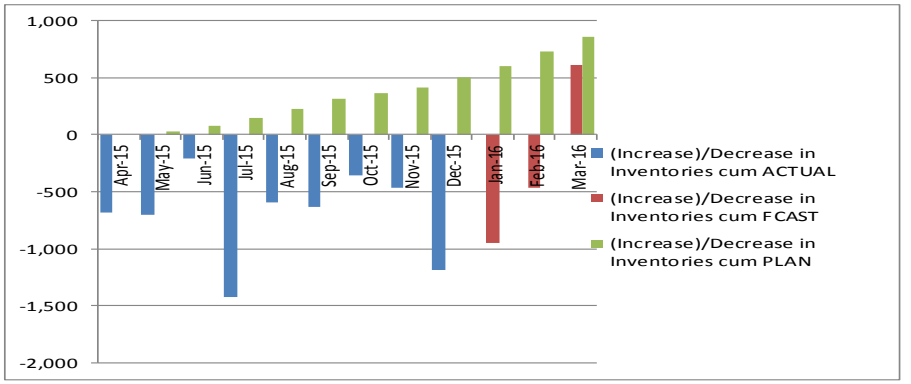
# 18. Working Capital – cumulative position at M09

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



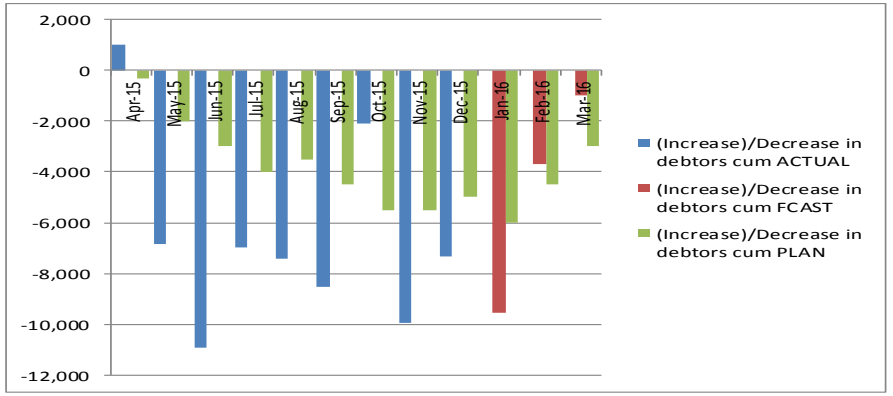

Working capital bals improved by £0.6m in M09 and YTD are better than plan by £6.4m
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

**Change in inventories 2015/16 actuals vs plan**



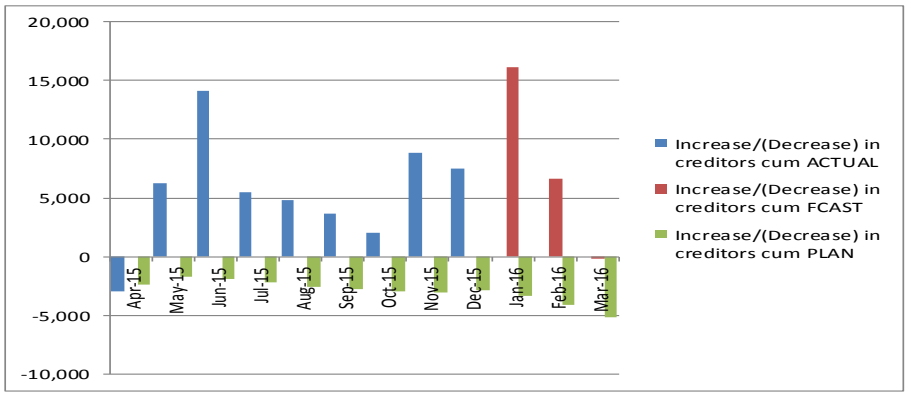

Inventories increased by £0.7m in M09 and are behind plan by £1.7m.
Depts built up stocks before Christmas as a precautionary measure. The Trust needs to reduce inventories by £1.8m mainly in pharmacy, cardiac and central store by year end.

**Change in debtors 2015/16 actuals vs plan**




Total debtors (invoice and accrued debt) reduced by £2.6m in M09 but are £2.3m behind plan.
Overdue debt remains significantly over target and the Trust is intensifying efforts in Q4 to maximise collection with NHSE and CCGs to help minimise borrowings.
Achieving the overdue debt targets for NHS debt is mainly dependent on collection of over-performance invoices by year end..

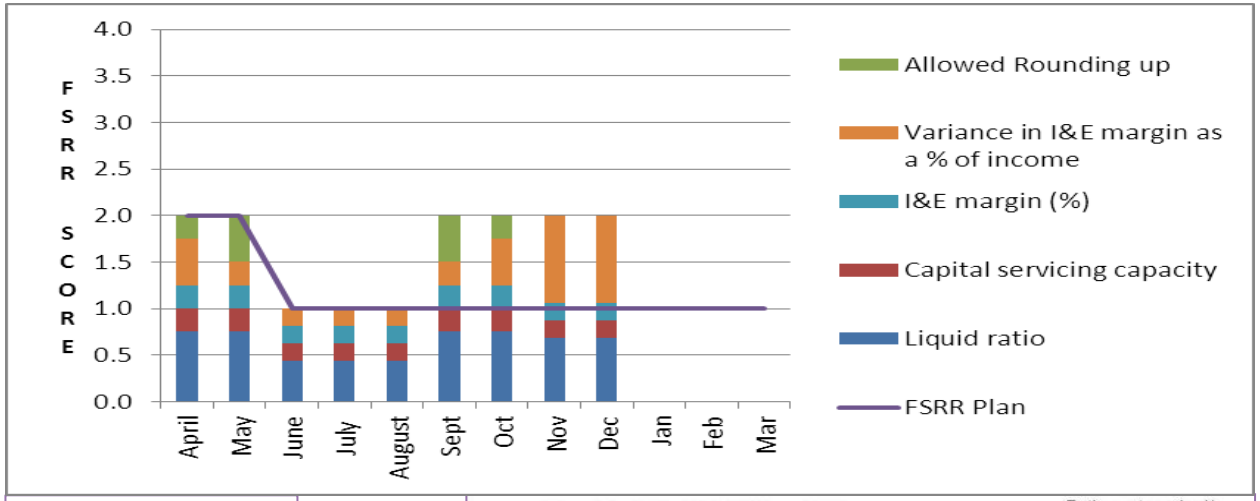
**Change in creditors 2015/16 actuals vs plan**




Overall level of creditors reduced in M09 by £1.3m and are £10.4m ahead of plan.
Trust continues to pay approved invoices to the new terms.
The re-scheduling of CNST payments and NHSPS payments has benefited the cash position however these liabilities will be discharged in Feb and March - resulting in a marked reduction in cash over the last three months of the financial year.

# 19. Financial Sustainability Risk Rating (FSRR)

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




Threshold details:

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

In December 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 +0.3% 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 December.

The forecast out-turn score is currently a 2 overall as well, with the only change from December reflecting an adverse moment in the liquidity metric from 3 to 2.

**REPORT TO THE TRUST BOARD** *February 2016*

| | |
|---|---|
| **Paper Title:** | Workforce report |
| **Sponsoring Director:** | Wendy Brewer, Director of Workforce and Organisational Development |
| **Author:** | Wendy Brewer, Director of Workforce and Organisational Development<br>Rebecca Hurrell, Head of Workforce Information<br>Jacqueline McCullough, Deputy Director of HR<br>Annie Stewart, Head of Occupational Health |
| **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 December 2015
- Report from the Workforce and Education Meeting January 2016
- Report on performance with staff influenza vaccination requirements

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

Key points to note are:

- An overall decrease in staff in post of 54 WTE.
- A sharp further increase in staff turnover, particularly in therapists, scientists and clinical technical roles.
- A reduction in agency usage over the Christmas period.
- 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:**<br>*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:**<br>*Reference to CQC standard that this paper refers to.* | **Are services well led?** |

## Commentary on performance in key workforce indicators

### Introduction

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

### Vacancy rate

The good progress made with recruitment in November reversed in December with a net reduction in 53 WTE in post.

### Sickness absence

Sickness absence levels have increased marginally and the trust has been above its target of 3.5% for four months in a row. Although there would normally be a spike in the winter period it would be normal to see this beginning to reduce.

### Agency and bank staff usage

There was a reduction in temporary staffing usage over the December period as interim managers were directed to take two weeks' leave over the Christmas period and as divisions, such as surgery, reduced staffing in recognition of the planned reduction in activity. Early indicators show that temporary staffing levels have returned to pre-Christmas levels in January.

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

### Mandatory training and appraisal rates

The deterioration in mandatory training compliance and appraisal rates has halted in December, although it is too early to say whether this is the beginning of a turnaround. The workforce and education committee considered the actions being taken to turnaround performance in mandatory training at its meeting in January. Resources have been reallocated to focus on ensuring well-defined training needs analysis, accurate and trusted monitoring of compliance and easy access to training.

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

# Workforce Performance Report
## to the Trust Board

**Month 9 - December 2015**


***Excellence in specialist and community healthcare***

# Workforce Performance Report Jan ‘15 - Dec ‘15

## Contents

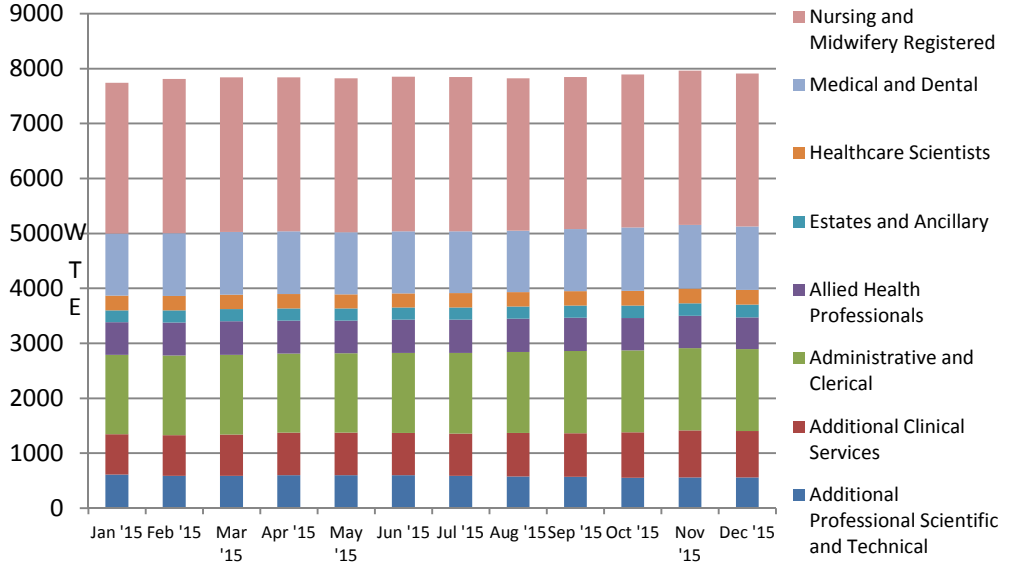
# Performance Summary

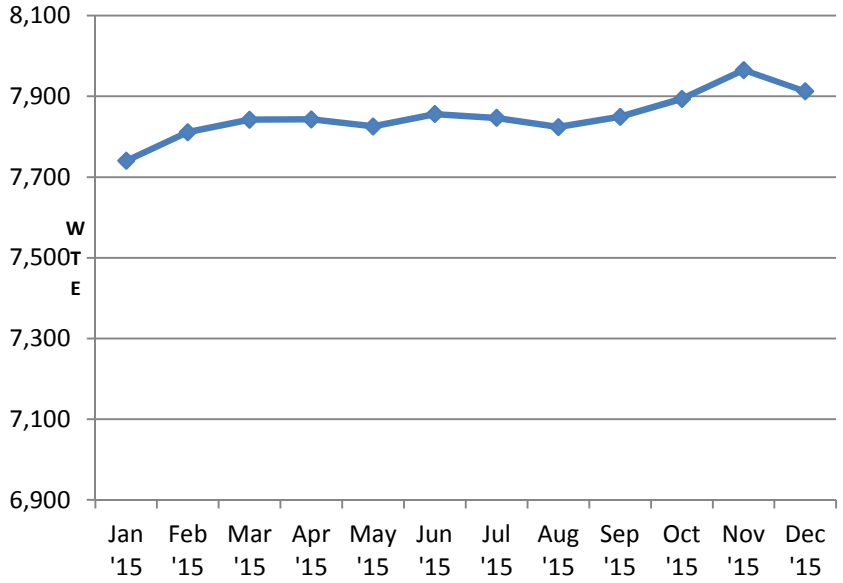
Summary of overall performance is set out below

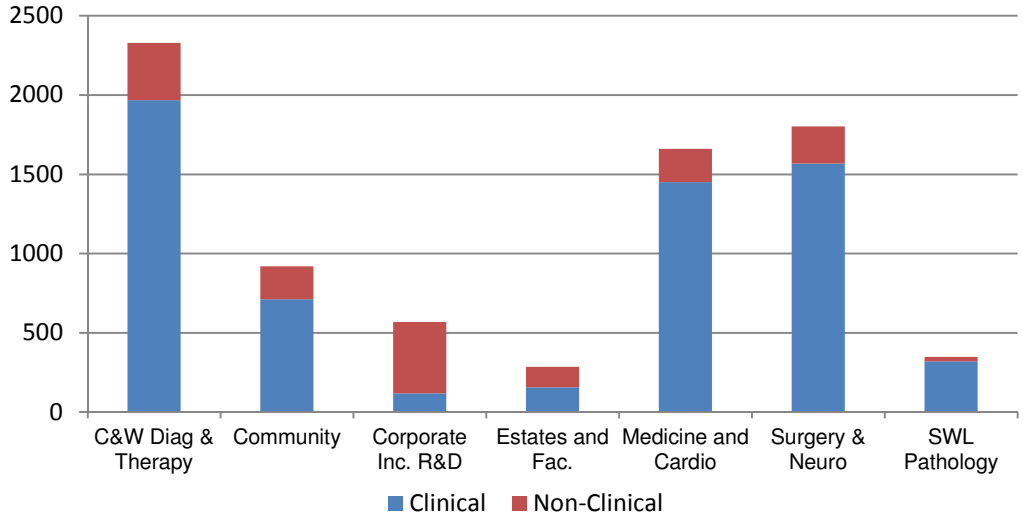
| Page | Areas of Review | Key Highlights | Previous Year | Previous Month | In Month | R-A-G |
|---|---|---|---|---|---|---|
| 5 | Vacancy | Vacancy rate has increased by 0.3% | 13.1% | 16.7% | 17.0% | ↗ |
| 6 | Turnover | Turnover has increased by 0.4% | 17.2% | 17.8% | 18.2% | ↗ |
| 7 | Voluntary Turnover | Voluntary Turnover has increased by 0.4% | 13.8% | 14.5% | 14.9% | ↗ |
| 8 | Stability | Stability has increased by 1.5% | 84.2% | 81.2% | 82.7% | ↗ |
| 10 | Sickness | Sickness has increased by 0.1% | 4.1% | 3.8% | 3.9% | ↗ |
| 15 | Temporary Staffing Usage (FTE) | Temporary Staffing Usage has decreased by 0.8% | 15.8% | 13.5% | 12.8% | ↘ |
| 17 | Mandatory Training | MAST compliance has increased by 1.5% | 74.1% | 64.5% | 66.0% | ↗ |
| 18 | Staff Appraisal | The percentage of staff who have had an appraisal in the past 12 months has increased by 0.2% | 82.1% | 67.7% | 67.9% | ↗ |

# Current Staffing Profile

The data below displays the current staffing profile of the Trust



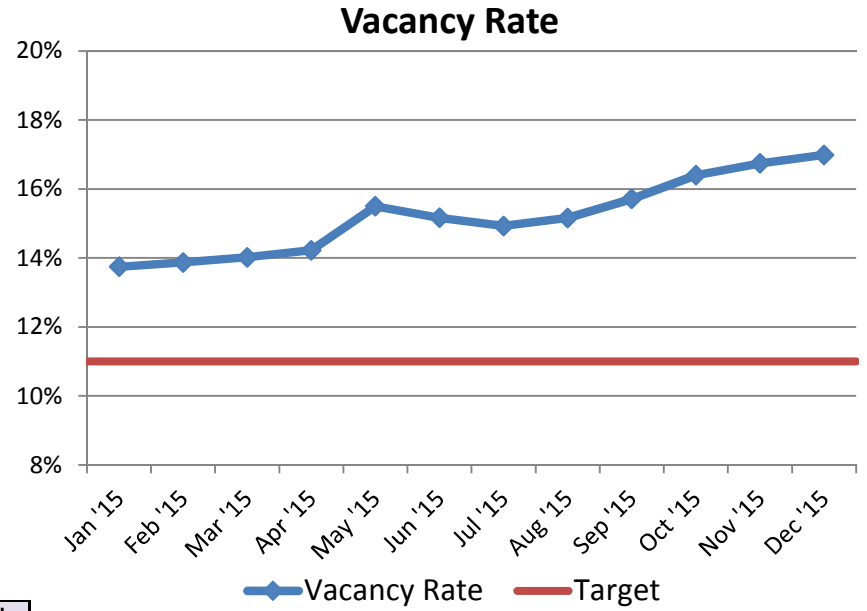




## COMMENTARY

The Trust currently employs 8454 people working a whole time equivalent of 7912 which is 53 WTE fewer than November. The growth rate in the directly employed workforce since December 2015 is 200 WTE or 2.6%.

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 | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diag & Therapy | 11.8% | 12.4% | 13.6% | 15.1% | ↗ |
| Community | 12.6% | 15.7% | 18.5% | 19.4% | ↗ |
| Corporate | 12.9% | 14.5% | 15.8% | 16.3% | ↗ |
| Estates and Fac. | 15.5% | 16.7% | 16.3% | 15.3% | ↘ |
| Medical & Cardio | 16.8% | 16.4% | 16.6% | 17.3% | ↗ |
| Surgery & Neuro | 19.1% | 18.4% | 17.9% | 15.9% | ↘ |
| SWL Pathology | 25.5% | 25.5% | 22.8% | 23.8% | ↗ |
| **Whole Trust** | **15.7%** | **16.4%** | **16.7%** | **17.0%** | ↗ |

| Vacancies Staff Group | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| Add Prof Scientific and Technic | 22.7% | 22.7% | 23.8% | 23.9% | ↗ |
| Additional Clinical Services | 19.4% | 19.3% | 18.2% | 18.5% | ↗ |
| Administrative and Clerical | 15.2% | 17.0% | 18.4% | 18.7% | ↗ |
| Allied Health Professionals | 5.9% | 14.0% | 14.1% | 15.4% | ↗ |
| Estates and Ancillary | 19.1% | 19.3% | 17.7% | 15.8% | ↘ |
| Healthcare Scientists | 18.5% | 19.4% | 20.1% | 20.4% | ↗ |
| Medical and Dental | 5.6% | 4.4% | 5.3% | 5.7% | ↗ |
| Nursing and Midwifery Registered | 18.3% | 18.1% | 18.1% | 18.2% | ↗ |
| **Total** | **15.7%** | **16.4%** | **16.7%** | **17.0%** | ↗ |

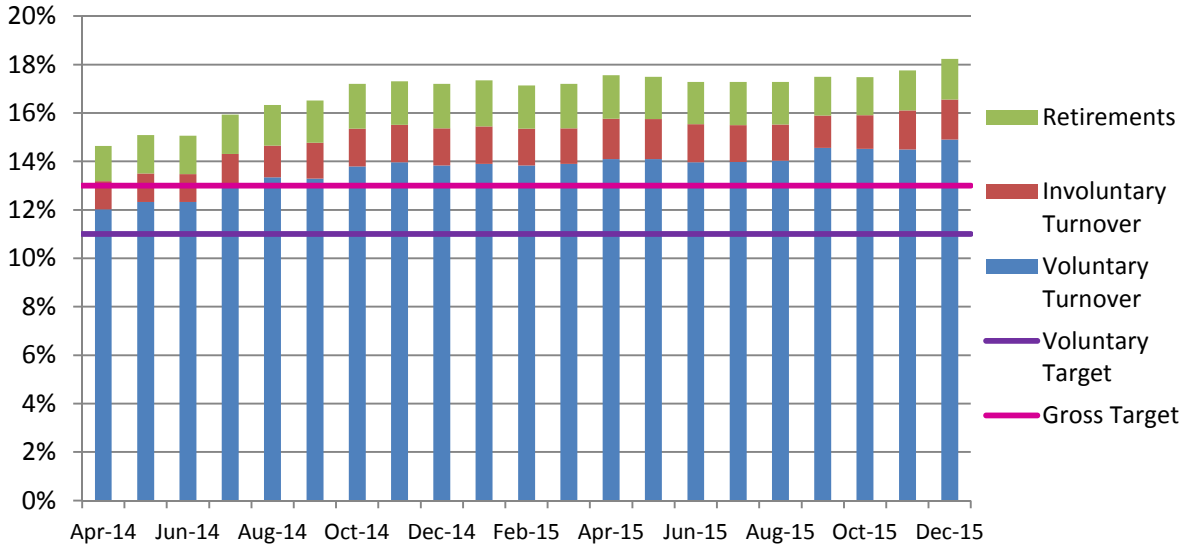
**COMMENTARY**

The vacancy rate has increased in December in line with a reduction in WTE staff in post and is now 17%.

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

# Section 2a: Gross Turnover

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



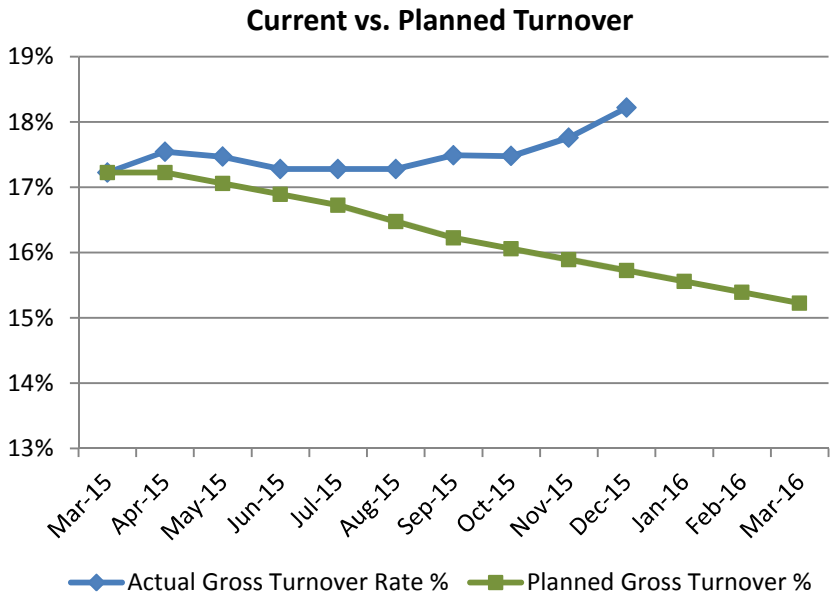

**COMMENTARY**

The total trust turnover rate has increased this month to 18.2%. This is significantly above the current target of 13%. In the last 12 months there have been 1307 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 | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
| C&W Diagnostic & Therapy | 18.1% | 18.0% | 18.4% | 19.3% | ↗ |
| Community Services | 21.1% | 20.8% | 20.8% | 21.2% | ↗ |
| Corporate | 18.8% | 20.1% | 20.6% | 21.1% | ↗ |
| Estates and Facilities | 16.5% | 16.0% | 16.3% | 15.9% | ↘ |
| Medical & Cardiothoracics | 19.1% | 19.1% | 19.3% | 19.3% | ↔ |
| Surgery, Neurosciences & Anaes | 13.3% | 13.3% | 13.9% | 13.9% | ↔ |
| SWL Pathology | 14.4% | 14.8% | 15.0% | 16.6% | ↗ |
| **Whole Trust** | **17.5%** | **17.5%** | **17.8%** | **18.2%** | ↗ |

| | All Turnover | | | | |
|---|---|---|---|---|---|
| Staff Group | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
| Add Prof Scientific and Technic | 18.6% | 20.2% | 17.9% | 21.3% | ↗ |
| Additional Clinical Services | 19.6% | 19.2% | 20.1% | 20.4% | ↗ |
| Administrative and Clerical | 16.4% | 16.2% | 17.1% | 17.7% | ↗ |
| Allied Health Professionals | 16.3% | 17.5% | 17.0% | 19.2% | ↗ |
| Estates and Ancillary | 8.5% | 8.6% | 8.7% | 8.0% | ↘ |
| Healthcare Scientists | 14.5% | 14.0% | 14.4% | 16.3% | ↗ |
| Medical and Dental | 11.5% | 10.6% | 12.5% | 11.8% | ↘ |
| Nursing and Midwifery Registered | 19.6% | 19.4% | 19.7% | 19.3% | ↘ |
| **Whole Trust** | **17.5%** | **17.5%** | **17.8%** | **18.2%** | ↗ |



# Section 2b: Voluntary Turnover

| | Voluntary Turnover | | | | | Other Turnover Dec 2015 | |
|---|---|---|---|---|---|---|---|
| Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend | In-Voluntary | Retirement |
| C&W Diagnostic & Therapy | 14.8% | 14.9% | 15.1% | 15.9% | ↗ | 2.1% | 1.4% |
| Community Services | 16.8% | 16.2% | 16.0% | 16.2% | ↗ | 1.5% | 3.5% |
| Corporate | 14.7% | 15.7% | 16.2% | 17.0% | ↗ | 2.1% | 2.0% |
| Estates and Facilities | 8.3% | 8.1% | 8.4% | 8.0% | ↘ | 5.5% | 2.4% |
| Medical & Cardiothoracics | 17.2% | 17.1% | 16.8% | 16.9% | ↗ | 1.3% | 1.2% |
| Surgery, Neurosciences & Anaes | 12.0% | 11.8% | 11.9% | 11.7% | ↘ | 1.0% | 1.2% |
| SWL Pathology | 12.6% | 13.2% | 12.7% | 14.1% | ↗ | 0.6% | 2.0% |
| **Whole Trust** | **14.6%** | **14.5%** | **14.5%** | **14.9%** | ↗ | **1.7%** | **1.7%** |

| | Voluntary Turnover | | | | | Other Turnover Dec 2015 | |
|---|---|---|---|---|---|---|---|
| Staff Group | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend | In-Voluntary | Retirement |
| Add Prof Scientific and Technic | 14.4% | 15.5% | 13.4% | 15.8% | ↗ | 5.0% | 0.5% |
| Additional Clinical Services | 16.9% | 16.5% | 16.8% | 17.4% | ↗ | 0.8% | 2.2% |
| Administrative and Clerical | 12.6% | 12.4% | 13.1% | 13.4% | ↗ | 2.1% | 2.1% |
| Allied Health Professionals | 15.6% | 16.8% | 16.1% | 17.7% | ↗ | 0.6% | 0.9% |
| Estates and Ancillary | 5.4% | 5.4% | 5.3% | 4.8% | ↘ | 0.4% | 2.7% |
| Healthcare Scientists | 12.0% | 11.5% | 11.6% | 13.2% | ↗ | 0.7% | 2.3% |
| Medical and Dental | 6.7% | 5.8% | 6.3% | 6.0% | ↘ | 4.9% | 1.0% |
| Nursing and Midwifery Registered | 17.2% | 17.1% | 17.1% | 16.8% | ↘ | 0.8% | 1.7% |
| **Whole Trust** | **14.6%** | **14.5%** | **14.5%** | **14.9%** | ↗ | **1.7%** | **1.7%** |

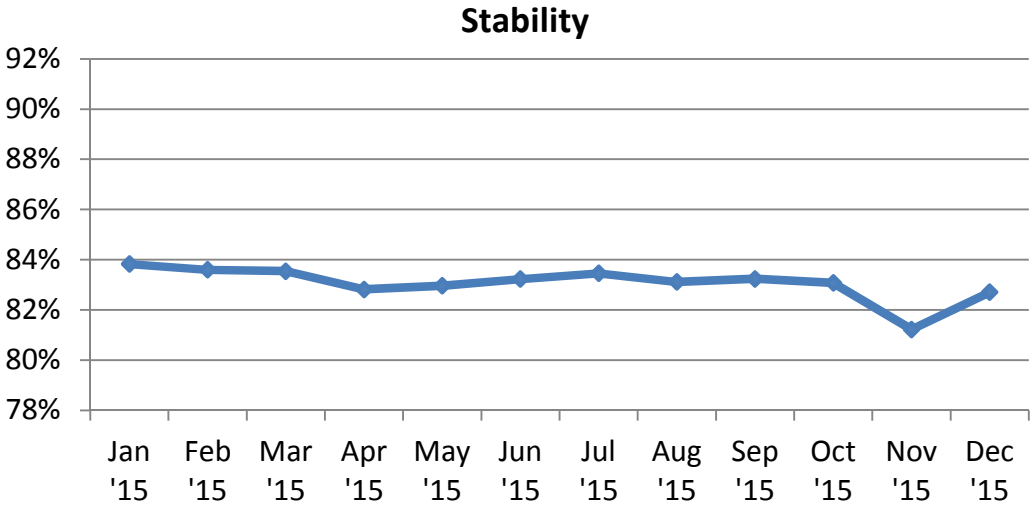
| Caregroup | Staff in Post WTE | Leavers WTE | Voluntary Turnover Rate |
|---|---|---|---|
| Procurement & Materials Mgmt | 39.0 | 13.0 | 31.3% |
| Cardiac Surgery | 88.7 | 22.3 | 30.1% |
| Offender Healthcare HMPW Services | 55.0 | 17.1 | 29.7% |
| Human Resources Directorate | 85.3 | 24.6 | 27.7% |
| Medical Oncology & Palliative Care | 85.1 | 20.8 | 27.7% |

**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 | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 83.1% | 83.0% | 80.1% | 81.3% | ↗ |
| Community Services | 79.7% | 79.8% | 78.0% | 79.3% | ↗ |
| Corporate | 79.1% | 78.4% | 75.5% | 78.0% | ↗ |
| Estates and Facilities | 85.5% | 85.1% | 84.0% | 85.0% | ↗ |
| Medical & Cardiothoracics | 81.7% | 81.2% | 80.0% | 81.4% | ↗ |
| Surgery, Neurosciences & Anaes | 86.2% | 86.4% | 84.6% | 86.8% | ↗ |
| SWL Pathology | 92.1% | 91.0% | 89.7% | 89.5% | ↘ |
| **Whole Trust** | **83.2%** | **83.1%** | **81.2%** | **82.7%** | ↗ |

| Stability Staff Group | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| Add Prof Scientific and Technic | 70.6% | 69.8% | 50.4% | 73.4% | ↗ |
| Additional Clinical Services | 83.8% | 87.0% | 90.1% | 85.9% | ↘ |
| Administrative and Clerical | 85.6% | 85.9% | 83.2% | 84.6% | ↗ |
| Allied Health Professionals | 83.0% | 81.3% | 78.7% | 80.6% | ↗ |
| Estates and Ancillary | 88.8% | 88.6% | 104.0% | 89.3% | ↘ |
| Healthcare Scientists | 92.8% | 93.9% | 90.3% | 89.0% | ↘ |
| Medical and Dental | 88.3% | 90.1% | 89.4% | 90.1% | ↗ |
| Nursing and Midwifery Registered | 82.6% | 81.3% | 84.6% | 80.9% | ↘ |
| **Total** | **83.2%** | **83.1%** | **81.2%** | **82.7%** | ↗ |

## COMMENTARY

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

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

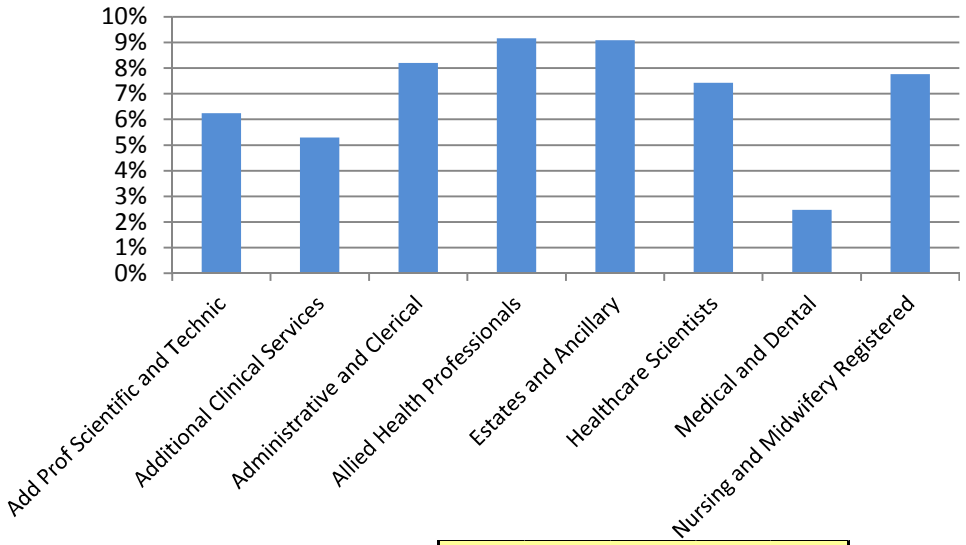
The stability rate has increased by 1.5% this month.

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

Over the last 12 months the stability rate has declined by 1.5% and is now at 82.7%.

# 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 December 45 staff were promoted, there were 47 new starters to the Trust and 195 employees were acting up to a higher grade.

Over the last year 7.2% 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 Allied Health Professionals staff were most likely to be promoted over the last year followed by Estates & Ancillary (NB this is the smallest staff group).

| | No. of Promotions | | | | |
|---|---|---|---|---|---|
| Division | Sept '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
| C&W Diagnostic & Therapy | 16 | 21 | 28 | 12 | ↘ |
| Community Services | 18 | 2 | 10 | 10 | ↔ |
| Corporate | 5 | 3 | 11 | 5 | ↘ |
| Estates and Facilities | 1 | 0 | 0 | 0 | ↔ |
| Medical & Cardiothoracics | 8 | 6 | 9 | 12 | ↗ |
| Surgery, Neurosciences & Anaes | 11 | 9 | 4 | 6 | ↗ |
| SWL Pathology | 2 | 23 | 2 | 0 | ↘ |
| **Whole Trust Promotions** | **61** | **64** | **64** | **45** | ↘ |
| **New Starters (Excludes Junior Doctors)** | **153** | **144** | **146** | **47** | ↘ |

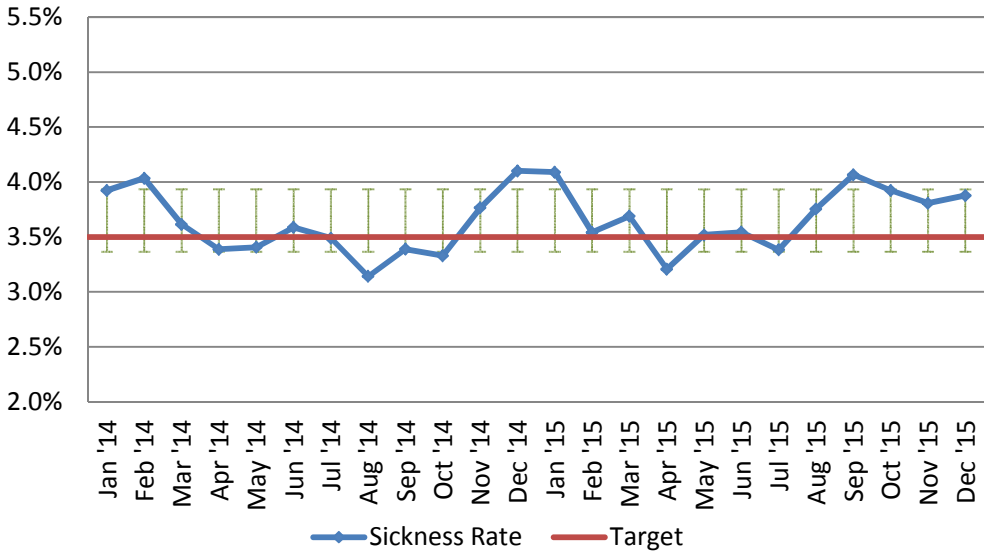
| Division | Staff in Post + 1yrs Service | No. of Staff Promoted | % of Staff Promoted | Currently Acting Up |
|---|---|---|---|---|
| C&W Diagnostic & Therapy | 1914 | 150 | 7.8% | 90 |
| Community Services | 871 | 50 | 5.7% | 9 |
| Corporate | 460 | 38 | 8.3% | 24 |
| Estates and Facilities | 254 | 18 | 7.1% | 10 |
| Medical & Cardiothoracics | 1177 | 82 | 7.0% | 39 |
| Surgery, Neurosciences & Anaes | 1375 | 77 | 5.6% | 18 |
| SWL Pathology | 317 | 45 | 14.2% | 5 |
| **Whole Trust** | **6368** | **460** | **7.2%** | **195** |
| **New Starters (Excludes Junior Doctors)** | | **1436** | | |

| | No. of Promotions | | | | |
|---|---|---|---|---|---|
| Staff Group | Sept '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
| Add Prof Scientific and Technic | 7 | 2 | 1 | 2 | ↗ |
| Additional Clinical Services | 4 | 19 | 2 | 3 | ↗ |
| Administrative and Clerical | 15 | 12 | 23 | 14 | ↘ |
| Allied Health Professionals | 9 | 6 | 11 | 11 | ↔ |
| Estates and Ancillary | 1 | 0 | 0 | 0 | ↔ |
| Healthcare Scientists | 1 | 1 | 3 | 1 | ↘ |
| Medical and Dental | 2 | 2 | 0 | 0 | ↔ |
| Nursing and Midwifery Registered | 22 | 22 | 24 | 14 | ↘ |
| **Whole Trust** | **61** | **64** | **64** | **45** | ↘ |

| Staff Group | Staff in Post + 1yrs Service | No. of Staff Promoted | % of Staff Promoted | Currently Acting Up |
|---|---|---|---|---|
| Add Prof Scientific and Technic | 481 | 30 | 6.2% | 34 |
| Additional Clinical Services | 680 | 36 | 5.3% | 3 |
| Administrative and Clerical | 1316 | 108 | 8.2% | 68 |
| Allied Health Professionals | 557 | 51 | 9.2% | 21 |
| Estates and Ancillary | 198 | 18 | 9.1% | 6 |
| Healthcare Scientists | 256 | 19 | 7.4% | 4 |
| Medical and Dental | 484 | 12 | 2.5% | 3 |
| Nursing and Midwifery Registered | 2396 | 186 | 7.8% | 56 |
| **Whole Trust** | **6368** | **460** | **7.2%** | **195** |

# Section 5: Sickness

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




**COMMENTARY**

Sickness absence is at 3.9% for December, which is a small increase 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 December 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 | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 3.9% | 3.9% | 3.4% | 3.4% | ↔ |
| Community Services | 5.5% | 5.9% | 5.7% | 6.0% | ↗ |
| Corporate | 3.6% | 3.7% | 3.7% | 3.7% | ↔ |
| Estates and Facilities | 4.0% | 2.2% | 4.7% | 5.4% | ↗ |
| Medical & Cardiothoracics | 4.4% | 4.1% | 4.2% | 4.0% | ↘ |
| Surgery, Neurosciences & Anaes | 3.4% | 3.5% | 3.2% | 3.3% | ↗ |
| SWL Pathology | 4.3% | 2.1% | 2.5% | 3.3% | ↗ |
| **Whole Trust** | **4.1%** | **3.9%** | **3.8%** | **3.9%** | ↗ |

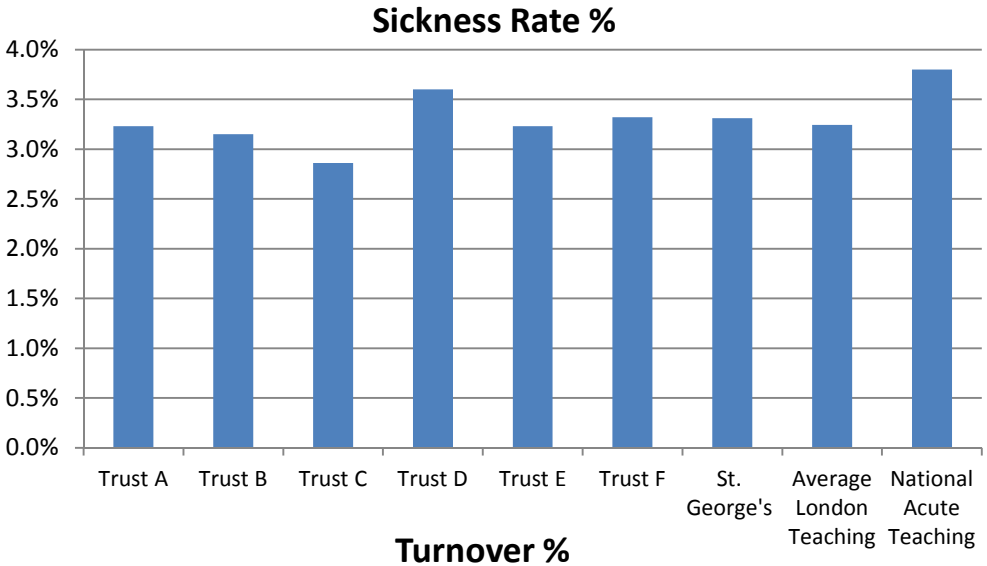
| Sickness Staff Group | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| Add Prof Scientific and Technic | 3.2% | 4.1% | 3.3% | 2.9% | ↘ |
| Additional Clinical Services | 7.5% | 6.4% | 6.4% | 7.4% | ↗ |
| Administrative and Clerical | 4.2% | 3.9% | 4.1% | 4.5% | ↗ |
| Allied Health Professionals | 2.9% | 2.5% | 2.5% | 3.2% | ↗ |
| Estates and Ancillary | 5.7% | 3.2% | 5.8% | 7.4% | ↗ |
| Healthcare Scientists | 3.0% | 2.4% | 2.9% | 2.4% | ↘ |
| Medical and Dental | 1.2% | 1.7% | 1.3% | 0.8% | ↘ |
| Nursing and Midwifery Registered | 4.6% | 4.6% | 4.2% | 4.0% | ↘ |
| **Total** | **4.1%** | **3.9%** | **3.8%** | **3.9%** | ↗ |

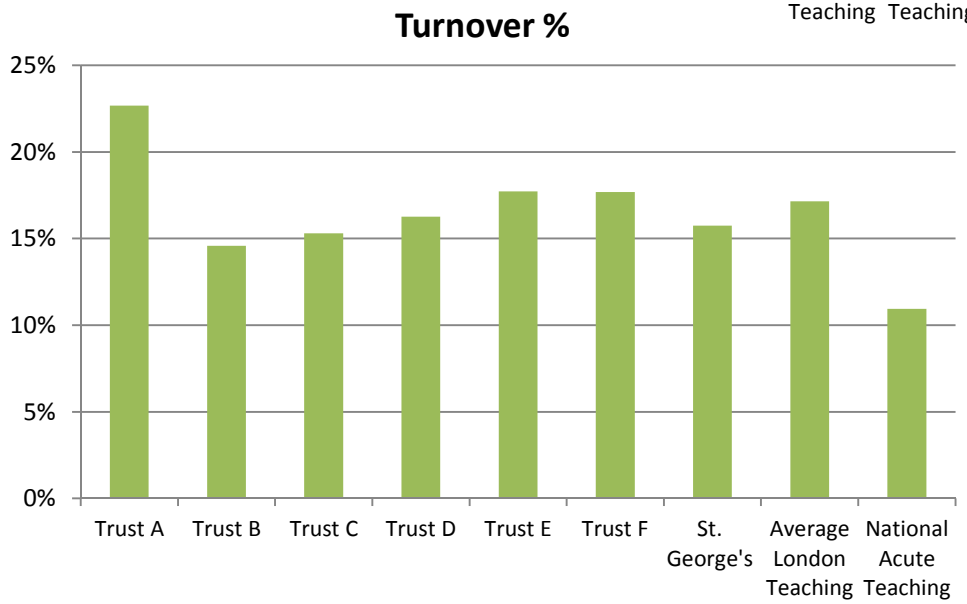
| Caregroup | Staff in Post WTE | Sickness WTE Days Lost | Sickness % | Salary Based Sickness Cost (£) |
|---|---|---|---|---|
| Energy and Engineering | 52.00 | 242.00 | 15.2% | £19,805 |
| Breast Screening | 52.95 | 158.57 | 9.6% | £12,353 |
| Procurement & Materials Mgmt | 39.00 | 102.00 | 8.5% | £7,165 |
| SWLP Central Reception | 54.19 | 121.60 | 7.3% | £5,399 |
| Communications | 13.80 | 31.00 | 7.2% | £1,512 |

| Top 5 Sickness Reasons by Number of Episodes | % of all Episodes |
|---|---|
| S13 Cold, Cough, Flu - Influenza | 35.42% |
| S25 Gastrointestinal problems | 15.37% |
| S12 Other musculoskeletal problems | 7.93% |
| S10 Anxiety/stress/depression/other psychiatric illnesses | 6.82% |
| S15 Chest & respiratory problems | 4.89% |

| Top 5 Sickness Reasons by Number of WTE Days Lost | % of all WTE Days Lost |
|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 18.02% |
| S13 Cold, Cough, Flu - Influenza | 16.65% |
| S12 Other musculoskeletal problems | 12.87% |
| S25 Gastrointestinal problems | 8.29% |
| S28 Injury, fracture | 7.31% |

# Section 6: Workforce Benchmarking




**COMMENTARY**

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

Sickness data shown is from September '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 3.3%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was significantly lower than the national rate for acute teaching hospitals in September.

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 October). 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 4.8% 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 | 22.67% | 77.64% | 3.23% |
| Trust B | 14.58% | 84.98% | 3.15% |
| Trust C | 15.31% | 84.24% | 2.86% |
| Trust D | 16.27% | 83.41% | 3.60% |
| Trust E | 17.73% | 82.38% | 3.23% |
| Trust F | 17.69% | 82.14% | 3.32% |
| St. George's | 15.75% | 83.95% | 3.31% |
| Average London Teaching | 17.14% | 82.68% | 3.24% |
| National Acute Teaching | 10.95% | 88.83% | 3.80% |

# Section 7: Nursing Workforce Profile/KPIs

**Nursing Establishment WTE**

| Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 1098.6 | 1094.9 | 1105.4 | 1110.4 | ↗ |
| Community Services | 583.1 | 596.4 | 613.5 | 614.5 | ↗ |
| Corporate & R&D | 68.2 | 94.2 | 95.2 | 95.2 | ↔ |
| Medical & Cardiothoracics | 1248.3 | 1246.1 | 1253.7 | 1253.7 | ↔ |
| Surgery, Neurosciences & Anaes | 1152.0 | 1151.0 | 1151.0 | 1151.0 | ↔ |
| Total | 4150.2 | 4182.6 | 4218.8 | 4224.8 | ↗ |

**Nursing Staff in Post WTE**

| Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 982.8 | 1007.4 | 999.5 | 980.6 | ↘ |
| Community Services | 447.7 | 441.6 | 452.9 | 452.9 | ↗ |
| Corporate & R&D | 46.0 | 52.5 | 70.6 | 72.5 | ↗ |
| Medical & Cardiothoracics | 985.8 | 986.0 | 995.4 | 982.9 | ↘ |
| Surgery, Neurosciences & Anaes | 899.2 | 906.5 | 910.9 | 909.0 | ↘ |
| Total | 3361.5 | 3394.0 | 3429.3 | 3397.9 | ↘ |

**Nursing Vacancy Rate**

| Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 10.5% | 8.0% | 9.6% | 11.7% | ↗ |
| Community Services | 23.2% | 26.0% | 26.2% | 26.3% | ↗ |
| Corporate & R&D | 32.5% | 44.2% | 25.8% | 23.8% | ↘ |
| Medical & Cardiothoracics | 21.0% | 20.9% | 20.6% | 21.6% | ↗ |
| Surgery, Neurosciences & Anaes | 21.9% | 21.2% | 20.9% | 21.0% | ↗ |
| Total | 19.0% | 18.9% | 18.7% | 19.6% | ↗ |

**Nursing Sickness Rates**

| Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 5.6% | 5.6% | 4.7% | 4.2% | ↘ |
| Community Services | 6.4% | 6.7% | 6.6% | 7.5% | ↗ |
| Corporate | 4.5% | 8.4% | 5.3% | 3.2% | ↘ |
| Medical & Cardiothoracics | 5.3% | 4.6% | 4.8% | 4.8% | ↘ |
| Surgery, Neurosciences & Anaes | 4.2% | 4.2% | 3.9% | 4.2% | ↗ |
| Total | 5.2% | 5.1% | 4.8% | 4.8% | ↗ |

**Nursing Voluntary Turnover**

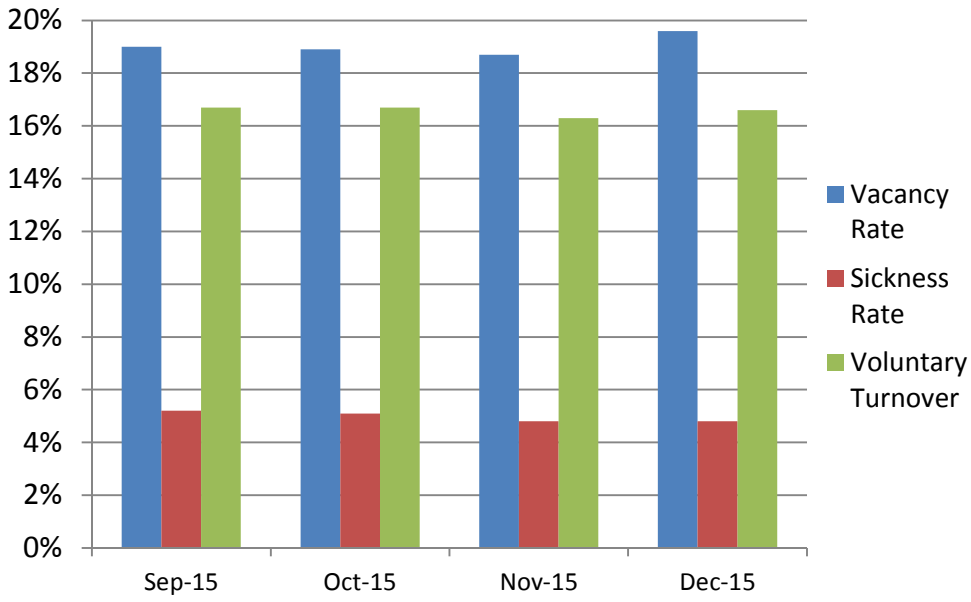
| Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 15.59% | 15.43% | 15.03% | 15.75% | ↗ |
| Community Services | 19.38% | 18.14% | 18.09% | 17.52% | ↘ |
| Corporate & R&D | 14.88% | 13.53% | 9.47% | 10.98% | ↗ |
| Medical & Cardiothoracics | 19.82% | 20.01% | 19.15% | 19.44% | ↗ |
| Surgery, Neurosciences & Anaes | 13.72% | 13.70% | 13.84% | 14.27% | ↗ |
| Total | 16.7% | 16.7% | 16.3% | 16.6% | ↗ |

## COMMENTARY

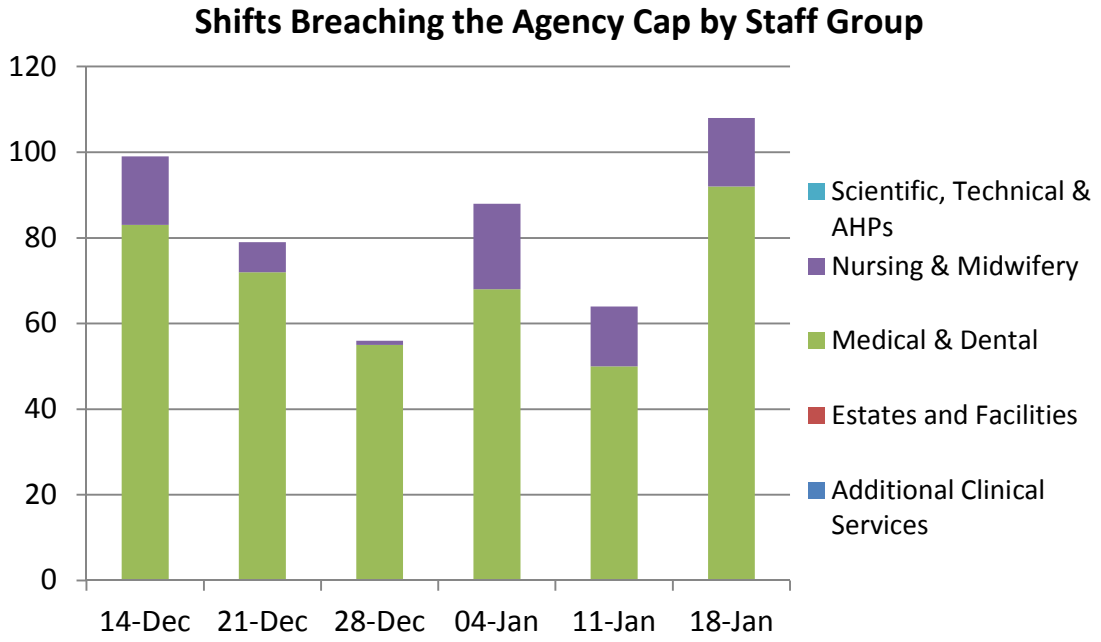
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has decreased by 31 WTE in December.

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 | 14-Dec | 21-Dec | 28-Dec | 04-Jan | 11-Jan | 18-Jan | Trend |
|---|---|---|---|---|---|---|---|
| Additional Clinical Services | 0 | 0 | 0 | 0 | 0 | 0 | ↔ |
| Estates and Facilities | 0 | 0 | 0 | 0 | 0 | 0 | ↔ |
| Medical & Dental | 83 | 72 | 55 | 68 | 50 | 92 | ↗ |
| Nursing & Midwifery | 16 | 7 | 1 | 20 | 14 | 16 | ↗ |
| Scientific, Technical & AHPs | 0 | 0 | 0 | 0 | 0 | 0 | ↔ |
| Whole Trust | 99 | 79 | 56 | 88 | 64 | 108 | ↗ |

| Agency Cap Shift Breaches by Division | 14-Dec | 21-Dec | 28-Dec | 04-Jan | 11-Jan | 18-Jan | Trend |
|---|---|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 19 | 8 | 3 | 18 | 16 | 16 | ↔ |
| Community Services | 13 | 16 | 12 | 14 | 10 | 15 | ↗ |
| Corporate | 10 | 12 | 9 | 10 | 10 | 15 | ↗ |
| Estates and Facilities | 0 | 0 | 0 | 0 | 0 | 0 | ↔ |
| Medical & Cardiothoracics | 32 | 29 | 29 | 37 | 22 | 46 | ↗ |
| Surgery, Neurosciences & Anaes | 15 | 10 | 3 | 9 | 6 | 16 | ↗ |
| SWL Pathology | 10 | 4 | 0 | 0 | 0 | 0 | ↔ |
| Whole Trust | 99 | 79 | 56 | 88 | 64 | 108 | ↗ |

**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.

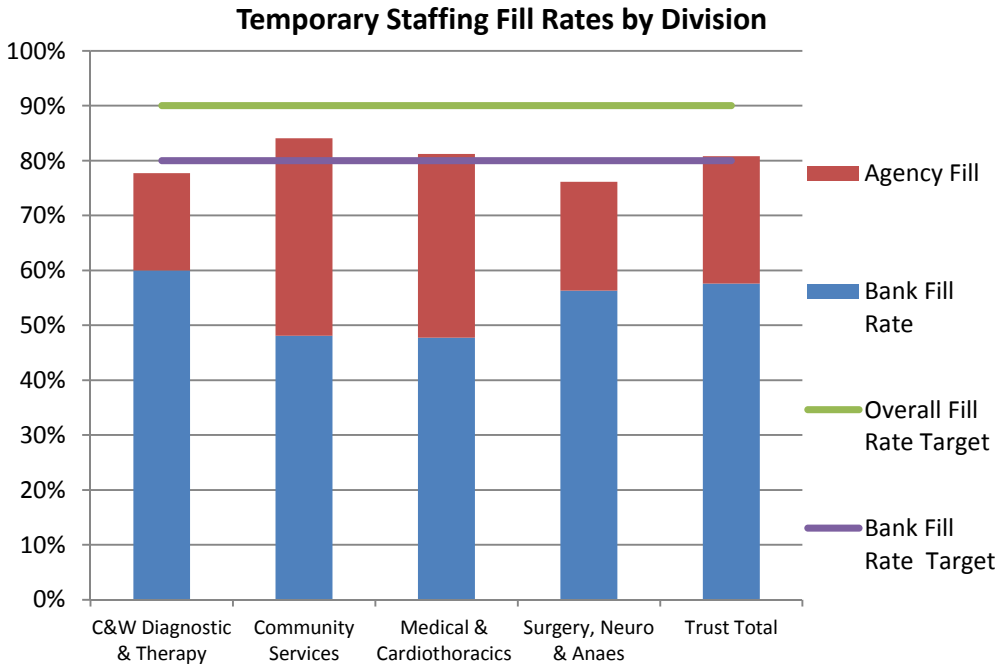
Work is on-going to stop using agencies which breach the caps where possible.

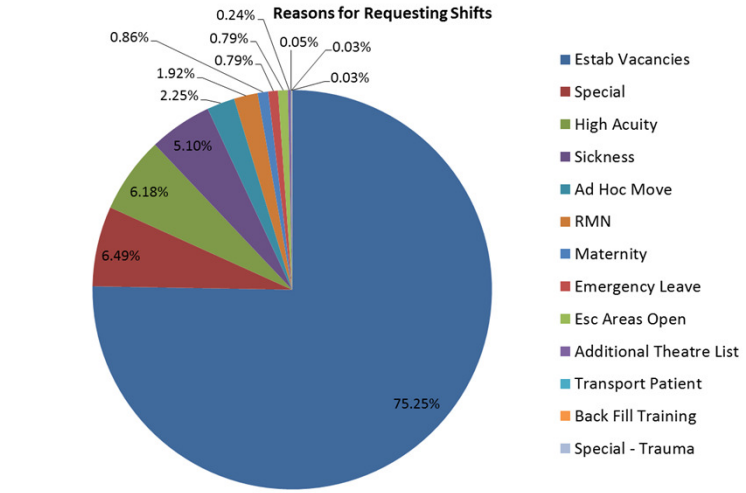
In all cases, services have confirmed there would be an adverse impact upon patient safety should the booking not go ahead.

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 18th of January as an indicative week, under the new caps, 239 shifts would breach in February and 519 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 December the Bank Fill Rate was reported at 57.6% which is 1.6% lower than the previous month. The Overall Fill Rate was 80.8% which is an decrease of 2.4% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

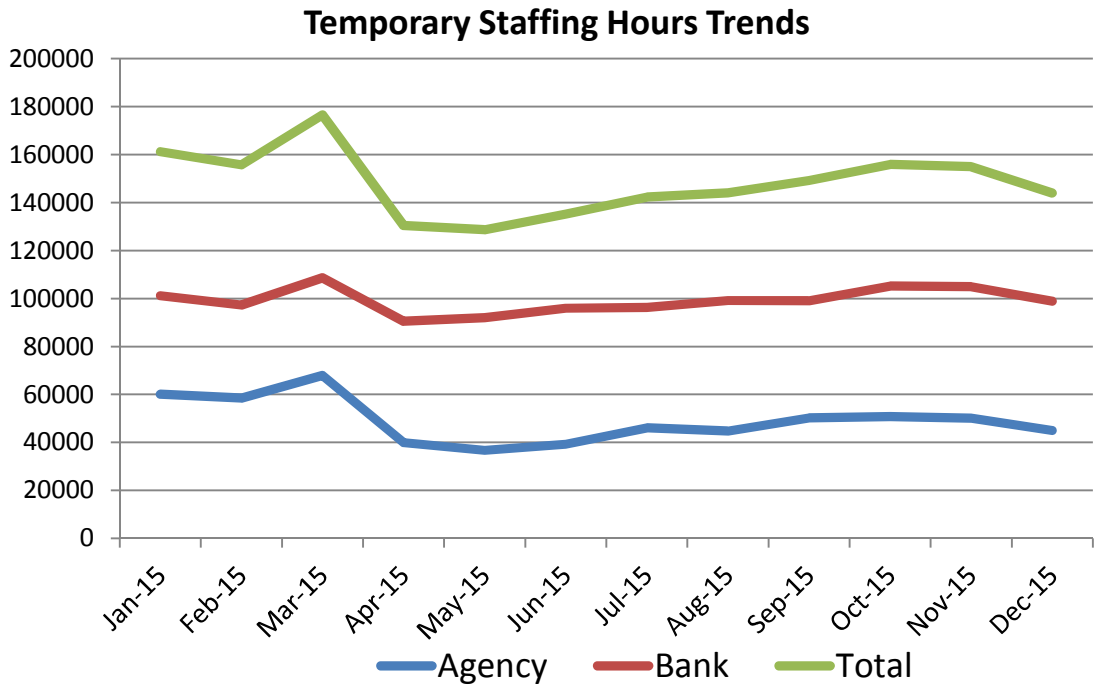
The pie chart shows a breakdown of the reasons given for requesting bank shifts in December. This is very much dominated by covering existing vacancies, specials, sickness, and high acuity patients.

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

| Bank Fill Rate % by Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 66.3% | 65.3% | 65.9% | 60.0% | ↘ |
| Community Services | 48.6% | 49.7% | 51.0% | 48.1% | ↘ |
| Medical & Cardiothoracics | 44.1% | 46.2% | 48.4% | 47.7% | ↘ |
| Surgery, Neurosciences & Anaes | 53.0% | 50.3% | 50.8% | 56.3% | ↗ |
| **Whole Trust** | **55.7%** | **58.1%** | **59.2%** | **57.6%** | ↘ |

| Overall Fill Rate % by Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 83.9% | 81.9% | 81.9% | 77.7% | ↘ |
| Community Services | 86.5% | 88.2% | 88.7% | 84.1% | ↘ |
| Medical & Cardiothoracics | 80.0% | 79.4% | 83.5% | 81.2% | ↘ |
| Surgery, Neurosciences & Anaes | 76.7% | 76.8% | 75.7% | 76.2% | ↗ |
| **Whole Trust** | **79.8%** | **81.6%** | **83.2%** | **80.8%** | ↘ |

# Section 10: Temporary Staffing Duties




**COMMENTARY**

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

The figures show the number of bank and agency hours worked by month by Division. Overall Bank & agency hours have both decreased in December in most areas.

There was an increase in agency hours in the Children & Women's Division, mainly in Paediatric Medicine and Gynaecology.

| TYPE | Division | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency | C&W Diagnostic & Therapy | 15550 | 15363 | 16791 | 9525 | 10750 | 8656 | 9638 | 9210 | 9921 | 11112 | 10724 | 11615 |
| | Community Services | 6208 | 7800 | 9890 | 7938 | 5769 | 5245 | 6077 | 6422 | 6421 | 7086 | 6605 | 6715 |
| | Corporate | 3454 | 2763 | 3488 | 1246 | 1331 | 949 | 529 | 32 | 423 | 402 | 384 | 541 |
| | Estates and Facilities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 166 | 322 |
| | Medical & Cardiothoracics | 24387 | 21773 | 25876 | 14492 | 13202 | 17823 | 20429 | 20285 | 24408 | 21792 | 22626 | 19732 |
| | Surgery, Neurosciences & Anaes | 10454 | 10809 | 11833 | 6582 | 5462 | 6386 | 9195 | 8560 | 8620 | 9994 | 9362 | 5953 |
| | SWL Pathology | 0 | 0 | 0 | 119 | 204 | 241 | 228 | 237 | 352 | 267 | 150 | 143 |
| **Agency Total** | | **60053** | **58508** | **67877** | **39901** | **36717** | **39299** | **46097** | **44746** | **50145** | **50657** | **50017** | **45021** |
| Bank | C&W Diagnostic & Therapy | 28329 | 27388 | 31536 | 27789 | 28714 | 29038 | 25990 | 26258 | 28178 | 32858 | 31790 | 30886 |
| | Community Services | 10097 | 9360 | 10560 | 8379 | 7619 | 7704 | 8252 | 9030 | 8659 | 9149 | 9133 | 9005 |
| | Corporate | 7766 | 7248 | 7922 | 7424 | 7165 | 8430 | 7972 | 7321 | 11048 | 11156 | 9858 | 8426 |
| | Estates and Facilities | 7446 | 6807 | 7744 | 6885 | 7502 | 8178 | 9216 | 8910 | 8264 | 8506 | 9423 | 8467 |
| | Medical & Cardiothoracics | 25548 | 25083 | 27553 | 23755 | 24829 | 24969 | 26255 | 29159 | 26958 | 26409 | 28073 | 25363 |
| | Surgery, Neurosciences & Anaes | 18855 | 18438 | 20376 | 13521 | 13495 | 14553 | 14740 | 15202 | 15268 | 16265 | 15754 | 15791 |
| | SWL Pathology | 3134 | 2947 | 2953 | 2753 | 2620 | 3052 | 3751 | 3314 | 638 | 821 | 839 | 998 |
| **Bank Total** | | **101175** | **97272** | **108643** | **90507** | **91944** | **95925** | **96177** | **99193** | **99013** | **105164** | **104870** | **98936** |
| **Temporary Staff Total** | | **161227** | **155780** | **176520** | **130408** | **128661** | **135224** | **142273** | **143940** | **149157** | **155821** | **154887** | **143957** |

# Section 11: Temporary Staffing Weekly Tracking

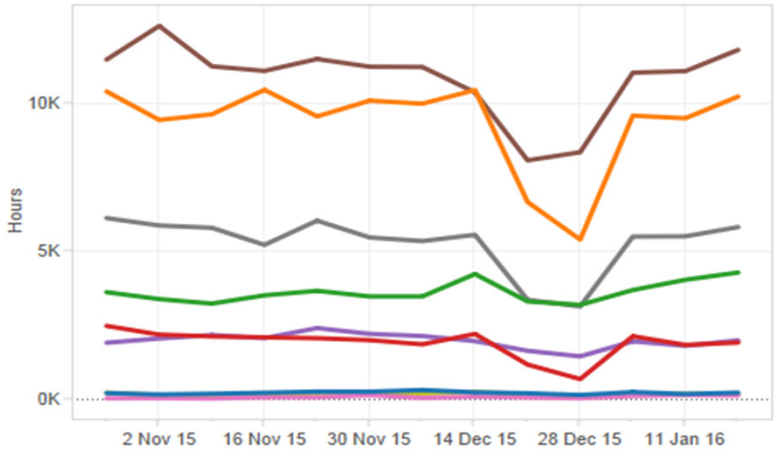
## Weekly Hours Used By Division

| Division | 26 Oct | 02 Nov | 09 Nov | 16 Nov | 23 Nov | 30 Nov | 07 Dec | 14 Dec | 21 Dec | 28 Dec | 04 Jan | 11 Jan | 18 Jan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Capital Division | 198 | 151 | 176 | 209 | 248 | 245 | 301 | 224 | 192 | 133 | 233 | 168 | 214 |
| Children and Women's Diagnostic and Th.. | 10,397 | 9,439 | 9,628 | 10,454 | 9,558 | 10,089 | 9,985 | 10,445 | 6,671 | 5,405 | 9,583 | 9,496 | 10,226 |
| Community Services Division | 3,633 | 3,400 | 3,248 | 3,527 | 3,678 | 3,489 | 3,490 | 4,245 | 3,322 | 3,206 | 3,706 | 4,051 | 4,295 |
| Corporate Division | 2,496 | 2,202 | 2,142 | 2,111 | 2,082 | 2,017 | 1,875 | 2,225 | 1,193 | 704 | 2,148 | 1,855 | 1,935 |
| Estates and Facilities Division | 1,928 | 2,074 | 2,188 | 2,083 | 2,423 | 2,228 | 2,155 | 1,984 | 1,658 | 1,470 | 1,977 | 1,826 | 2,009 |
| Medicine and Cardiovascular Division | 11,474 | 12,606 | 11,245 | 11,091 | 11,493 | 11,232 | 11,224 | 10,367 | 8,077 | 8,351 | 11,031 | 11,084 | 11,799 |
| Research & Development Division | 24 | 27 | 16 | 59 | 58 | 127 | 35 | 80 | 53 | 24 | 101 | 132 | 116 |
| Surgery & Neurosciences Division | 6,130 | 5,880 | 5,803 | 5,228 | 6,043 | 5,477 | 5,356 | 5,567 | 3,375 | 3,154 | 5,507 | 5,515 | 5,827 |
| SWL Pathology Division | 210 | 117 | 109 | 109 | 206 | 181 | 196 | 228 | 161 | 85 | 167 | 165 | 168 |
| Grand Total | 36,490 | 35,895 | 34,554 | 34,871 | 35,788 | 35,084 | 34,616 | 35,364 | 24,701 | 22,532 | 34,451 | 34,293 | 36,589 |

Type
- Agency
- Bank

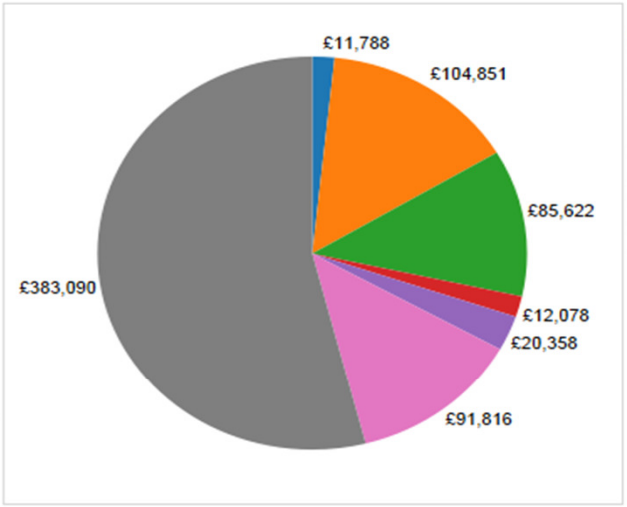
Division
- Capital Division
- Children and Women's D..
- Community Services Divi..
- Corporate Division
- Estates and Facilities Div..
- Medicine and Cardiovasc..
- Research & Developmen..
- Surgery & Neuroscience..
- SWL Pathology Division

## Weekly Hours Used Trends




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

## Weekly Spend by Staff Group




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

Total Cost
£709,602

Select Date (W/C)
18/01/2016

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

# Section 12: Mandatory Training

| MAST Topic | Nov '15 | Dec '15 | Trend |
|---|---|---|---|
| Conflict Resolution | 74.4 | 74.9 | ↗ |
| Equality, Diversity and Human Rights | 72.7 | 74.7 | ↗ |
| Fire Safety | 71.3 | 71.8 | ↗ |
| Health, Safety and Welfare | 71.1 | 72.7 | ↗ |
| Infection Prevention and Control Clinical | 57.9 | 58.9 | ↗ |
| Infection Prevention and Control Non Clinical | 63.0 | 63.7 | ↗ |
| Information Governance | 59.9 | 60.7 | ↗ |
| Moving and Handling | 62.8 | 66.6 | ↗ |
| Moving and Handling Patient | 47.4 | 51.2 | ↗ |
| Resuscitation BLS | 42.7 | 43.7 | ↗ |
| Resuscitation ILS | 49.8 | 50.1 | ↗ |
| Resuscitation Non Clinical | 59.4 | 59.1 | ↘ |
| Safeguarding Adults | 68.2 | 69.9 | ↗ |
| Safeguarding Children Level 1 | 67.3 | 68.3 | ↗ |
| Safeguarding Children Level 2 | 68.3 | 70.0 | ↗ |
| Safeguarding Children Level 3 | 67.0 | 66.7 | ↘ |

| MAST Compliance % by Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 68.4% | 67.8% | 65.7% | 67.3% | ↗ |
| Community Services | 70.1% | 68.8% | 65.7% | 65.6% | ↘ |
| Corporate | 65.4% | 66.1% | 62.9% | 65.5% | ↗ |
| Estates and Facilities | 61.9% | 61.9% | 62.4% | 62.5% | ↗ |
| Medical & Cardiothoracics | 61.6% | 61.4% | 61.2% | 63.5% | ↗ |
| Surgery, Neurosciences & Anaes | 66.5% | 65.2% | 63.9% | 64.9% | ↗ |
| Whole Trust | 67.2% | 66.6% | 64.5% | 66.0% | ↗ |

**COMMENTARY**

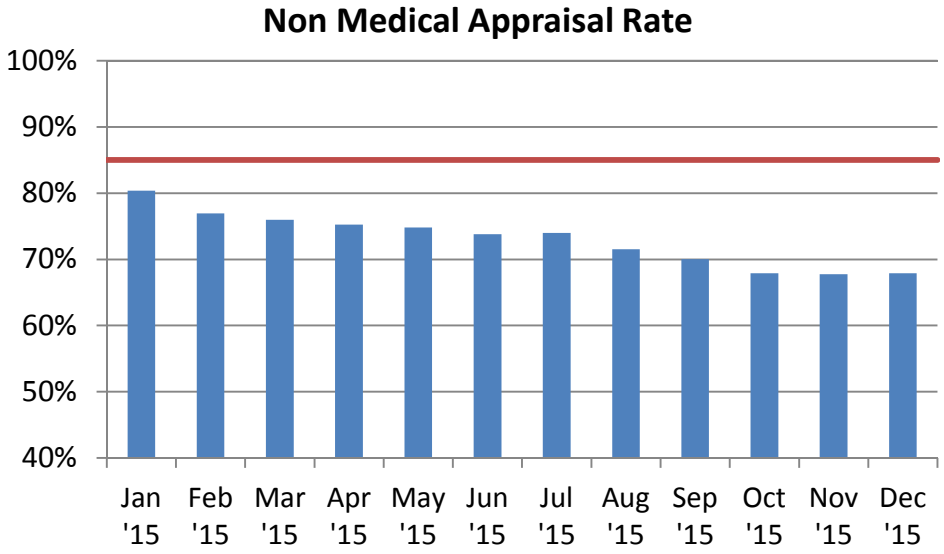
A programme of working is taking place including:

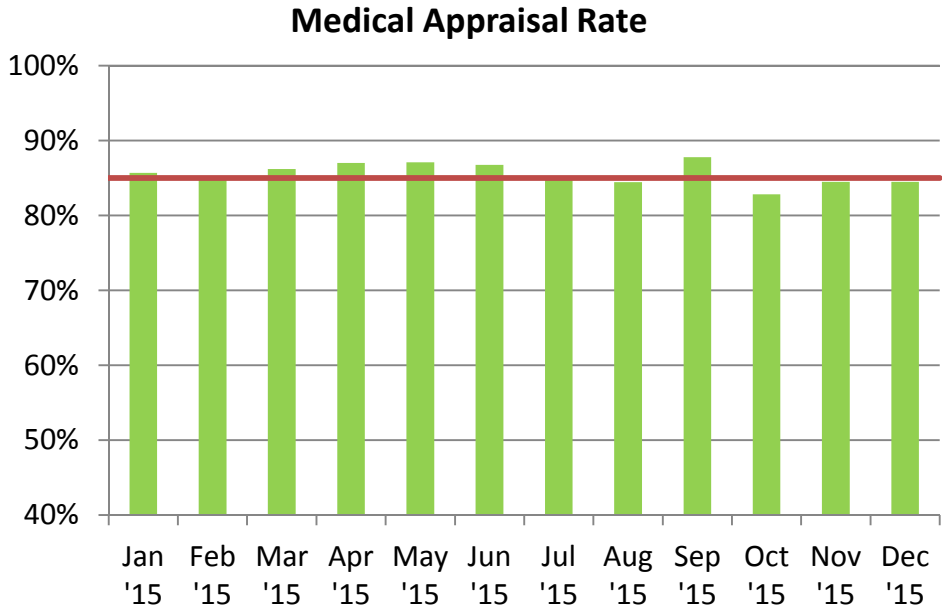
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Providing and accessible on-line system
- Introduced monthly meetings where divisions report on progress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

Current Issues:

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

# Section 13: Appraisal




## Non-Medical Commentary

The non-medical appraisal rate has increased by 0.2% this month to 67.9%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

## Medical Commentary

Medical appraisal rate compliance has remained static this month at 84.5% which is just below target.

| Care Group | Non-Med Appraisal Rate | Staff In Post WTE |
|---|---|---|
| Energy and Engineering | 0.0% | 52.00 |
| Information Directorate | 19.4% | 34.80 |
| SWLP Central Reception | 22.9% | 54.19 |
| SWLP Haematology | 26.7% | 67.33 |
| Finance Directorate | 29.6% | 115.35 |

| Non Medical Appraisals by Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 69.0% | 68.1% | 69.7% | 71.8% | ↗ |
| Community Services | 68.2% | 64.9% | 62.9% | 62.4% | ↘ |
| Medical & Cardiothoracics | 73.6% | 71.6% | 74.6% | 73.7% | ↘ |
| Surgery, Neurosciences & Anaes | 74.5% | 76.2% | 74.9% | 74.0% | ↘ |
| Corporate | 64.3% | 53.7% | 51.5% | 50.2% | ↘ |
| Estates & Facilities | 64.0% | 64.0% | 66.9% | 66.1% | ↘ |
| **Whole Trust** | **70.0%** | **67.9%** | **67.7%** | **67.9%** | ↗ |

| Medical Appraisals by Division | Sep '15 | Oct '15 | Nov '15 | Dec '15 | Trend |
|---|---|---|---|---|---|
| C&W Diagnostic & Therapy | 86.9% | 83.5% | 84.4% | 86.0% | ↗ |
| Community Services | 84.0% | 79.4% | 81.3% | 87.1% | ↗ |
| Medical & Cardiothoracics | 87.7% | 83.5% | 87.8% | 87.7% | ↘ |
| Surgery, Neurosciences & Anaes | 87.7% | 81.4% | 82.0% | 79.9% | ↘ |
| Corporate | 100.0% | 75.0% | 75.0% | 75.0% | ↔ |
| **Whole Trust** | **87.8%** | **82.8%** | **84.5%** | **84.5%** | ↔ |

## Influenza Delivery Strategy 2015/16 and Flu Campaign Overview

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

Vaccinations given to date:

- Approximately 37% of patient facing HCWs vaccinated to date (according to ESR)
- Over 6000 vaccines released from pharmacy to date
- Students - nursing, allied clinical and medical vaccinations -1100 vaccinated

Vaccinations:

- The flu clinic, Monckton theatre foyer opened from 05 10 15 to 08 01 16' Mon -Fri 0800-18.00
- Shivas Pharmacy staff, who were linked to the Trust as part of a CCG funded programme, vaccinated in the trust days and evenings and ran some CSW clinics
- In Occupational Health (OH) all new starters were offered vaccinations on induction day and staff attending for appointments were offered opportunistic vaccination.
- Flu clinic based nurses also undertook ward/area visits- their presence was generally well accepted in most areas but rudeness was experienced from some staff (of all grades) and examples of staff discouraging their colleagues from receiving the vaccination were witnessed, these episodes were reported to senior team members at various trust meetings and by the flu lead to specific managers
- Flu clinics were held at QMH, The Nelson Hospital, St John's Therapy Centre and many of the CSW clusters and outlying clinics. Information and clinic details were sent to each clinic area in advance
- Flu clinics at QMH were successful due to having three clinics run on site. Peer vaccinators based at QMH undertook adhoc vaccinations.
- A clinic was held at HMPW and peer vaccinators were trained for that area.

Vaccinators:

- Generally two Bank staff a day manned the flu clinic/visited all trust areas
- 33 peer vaccinators were trained by OH to vaccinate in their own areas
- Many peer vaccinators were from high risk areas such as ITU and NNU
- One member of staff worked in the flu clinic as a phased return to work programme
- Shivas pharmacy vaccinated in high risk areas from 29 09 15 – 30 10 15

Communications:

- The Flu lead worked with comms to promote the campaign on trust intranet and e-comms bulletins.
- The OH home page had a whole section of flu information
- Each of the OH team had a flu campaign promotion attached to their e-mail signature
- The OH noticeboard in GW corridor was updated regularly
- There were poster displays, myth busters and guidance in the flu clinic and both OH units.
- The flu clinic team wore flu t-shirts and tabards to increase their visibility around the trust
- Flu posters and leaflets were sent out to clinical areas
- The flu vaccination programme was promoted at trust induction and senior team meetings
- Photographs taken of flu clinic nurses, IC nurses and Dr Thayalan whilst delivering peer vaccination training for a piece in Nov SG magazine

Incentives:

- Sweets were offered to staff who had received the vaccination for a short period due to no funding to replenish stock
- Flu stickers were available at all clinics
- Unsuccessful in obtaining rewards from e.g. free / money-off drinks vouchers to be traded at SGH staff canteens
- Unsuccessful in obtaining funding for an incentive for receiving or administering vaccinations such as an iPad or Kindle as was done at other trusts
- Unsuccessful in obtaining support from on-site franchises for e.g. free drinks or vouchers

Senior teams:

- Flu lead/ Senior OH staff attended various senior meetings including Nursing Board, ICC, H&S&F, PSC, comms meetings and Chief Nurse's surgery to update senior teams on progress of campaign

Reporting

- Statistics collated from ESR and Flu consent forms entered onto Cohort - OH software
- ESR report weekly to flu lead and OH team, figures then disseminated in reports
- Uptake rates for patient facing staff, non-patient facing staff and clinical areas reported on
- National reporting monthly via immform (DH)

.

Reporting flu like symptoms and swab taking

A process to guide staff if they suspect they have flu was agreed between OH and Virology and commenced Nov 2015. It involved flu swabs and forms being made available to staff via outlets in Central Pathology Reception, OH units 1 & 2 and the Flu clinic. The aim of this was to stop potentially infected staff from attending their work areas to obtain a swab. Instructions were given on swabbing technique and that staff must inform their managers that they will not be attending work and had been advised to go home and await results.

This process needs some fine tuning in relation to informing OH that swabs have been taken and who is going to inform employees of their of swab results/ advised return to work arrangements. Through this procedure flu positive staff have been identified and advice/ treatment given accordingly.

Way forward for next campaign

- Peer vaccinators to be allocated from each clinical area, aiming for 2 per area including 1 senior and, if possible, from non-ward areas e.g. OPD's etc.
- Training to rollout earlier enabling a high number of vaccinators to commence as soon as the vaccines are available
- Pharmacy to provide peer vaccinators, they need specific training –a plan is in place for 2016/2017 campaign

- To find better ways to advertise external clinics to improve uptake and encourage more peer vaccinators in community clinics

- Better partnership with comms, so that information available to staff is accurate and not significantly changed from the original format

- Work with Virology to update processes for better communication re. identifying staff who have undertaken a swab and have positive, as well as negative, results

- Using staff who are undergoing phased returns to work within the flu clinic, especially when they can then become peer vaccinators in their areas after return to work

- More support from senior nursing and trust staff members, as per GSTT's tip for improving uptake being that recognisable Senior Nursing/IC staff to be involved in vaccinating in the flu clinic or on the wards, however in 2015 some senior staff were approached but were unable to support due to limited time resource.

- Infection control to be actively involved in campaign including becoming peer vaccinators

- Offer incentives to staff. Other trusts have agreements with local coffee shops/canteen to offer reduced or free drinks via a voucher scheme

- For senior teams within the trust to look at how uptake can be increased through adaptation and rewriting of policies and processes and considering mandating flu vaccine

- New equipment for flu clinic for 2016/2017 campaign as some equipment is shoddy or broken

- Flu clinic to be based within a central but more clinical area with basins and privacy

A survey of why staff refused vaccines

A survey was undertaken by OH in relation to refusers of the vaccine.138 staff members completed a form listing possible reasons for refusal

1. I'm fit and healthy so I don't need it = 31

2. I've already had flu this year = 16
3. I've never had flu so I don't need the vaccine = 18
4. I've had a bad reaction at the flu injection site = 2
5. I've had the injection before in the past and it made me ill with flu like symptoms = 19
6. Combination of responses 4&5 = 2
7. Combination of responses 4&6 = 2
8. I had the injection before and it made me ill with other symptoms = 8
9. I don't think it will protect me = 4
10. I am scared of needles/pain = 16
11. I am currently unwell = 7
12. I don't want anything that could make me unwell = 17
13. Other reasons = 24 which included:
    a. I don't think it makes any difference
    b. My GP told me it contains pork products so for religious reasons I am declining
    c. I had pneumonia vaccine yesterday, so I don't need flu jab
    d. No reason- I just don't want it
    e. I'm leaving the trust tomorrow
    f. Had flu jab last two years and still got flu
    g. Personal reasons - would not say why
    h. Could not think of a reason x 3
    i. I choose not to x 5
    j. I want my immune system built up naturally
    k. Everyone who had the flu jab last year got flu
    l. I am too busy to come to the flu clinic to get the vaccine.
    m. Too busy
    n. It gives you cancer
    o. Flu is not real - it is a government conspiracy
    p. It's against my human rights
    q. I had the flu jab last year and got flu
    r. I did a master's degree and worked for a pharmaceutical company who told me the viruses in the vaccines are not always inactivated so sometimes people are vaccinated with live viral strains that cause repeated viral infections once they get into your body. I also had a bad reaction to a HPV vaccine in the past.

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Elaine Mills
Occupational Health Nurse Adviser
Annie Stewart
Senior OHNA / Business Manager
26 January 2016

**REPORT TO THE TRUST BOARD** ***February 2016***

| | |
|---|---|
| **Paper Title:** | Update on junior doctors' contract negotiations |
| **Sponsoring Director:** | Wendy Brewer, Director of Workforce and Organisational Development |
| **Author:** | Wendy Brewer, Director of Workforce and Organisational Development |
| **Purpose:** | *To provide an update on the junior doctors' contract negotiations* |
| **Action required by the board:** | For information |
| **Document previously considered by:** | |

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

## 1. Key messages

Discussions regarding proposed changes to the junior doctors' contract have been taking place since July 2015. The discussions broke down in in August 2015 and the BMA confirmed a strong mandate for industrial action in November 2015. Talks resumed in November 2015 and the planned industrial action in December was averted.

The following action has taken place and is proposed:

- 12 January – emergency care only between 8 am on Tuesday 12 January and Wednesday 13 January (took place)
- 26 January (did not take place)
- 10 February (planned to take place but will not be a full withdrawal of labour. It will be 24 hours as per the action on 12 January.

Discussions are continuing between NHS Employers and the BMA.

The attached briefing note sets out the key points being discussed within the contract.

Contingency planning is being led by the Interim Chief Operating Officer. London was congratulated by NHS England on its response to the action on 12th – 13th January.

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**Key risks identified:**
*Key workforce risks include:*

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. The residual risk is rated at 20.

| | |
|---|---|
| **Related Corporate Objective:**<br>*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:**<br>*Reference to CQC standard that this paper refers to.* | **Are services well led?** |

# *Briefing for **NHS chief executives** on the **junior doctors' contract***

## *Why do we need to change?*

Both the BMA and NHS Employers agree that the junior doctors' contract needs reform. Both wish a new contract to be *safe, fair and effective.* The current contract has significant weaknesses:

### SAFETY – current contract does not support safe working

- Protections on excessive working – the current contract allows employers to roster doctors to work excessive hours. *We propose new restrictions to limit excessive hours worked.*
- Protections on excessive weekend working and consecutive days/nights – the current contract has no limits on the number of weekends for which a doctor can be rostered to work and has high limits on consecutive day/night working. *We propose significant new limits to improve safe hours of work.*
- The NHS is committed to safer, more reliable care, seven days a week to meet clinical standards. The current contract pays significant premia for weekend and evening work regardless of hours worked. *We propose a re-balancing of plain and premium time to even out the costs of weekend work. In time, this will mean that the NHS can afford to increase the deployment of its workforce across seven days consistent with the growth in staff employed.*

### TRAINING – current contract does not adequately support training needs

- The current contract is largely silent on the educational needs of doctors in training. *We propose new terms which support the training needs of junior doctors.*

### PAY – current contract has perverse incentives and does not reward for hours worked or intensity

- The current banding system results in 20, 40, 50, 80 or 100 per cent supplements being paid to junior doctors who work more than 40 hours per week, and it changes in accordance with rotas worked in each placement. *We propose better predictability of pay between different placements by increasing the proportion of pay that is basic pay and reducing, pro rata, the extent of supplementary pay.*
- The current cost of banding is significant and this can encourage employers to avoid higher bands and create inflexible rotas. *We propose paying for the hours actually worked to meet the needs of patients.*
- Current cost of banding is seen by some to act as a protection for excessive hours – but it can also result in payments being made where one hour of additional work can trigger a higher banding supplement for everyone on the rota, resulting in payments disproportionate to hours worked or intensity of work. *We propose a fairer system of paying for work done, while protecting staff from excessive hours worked through the introduction of a trust safety guardian.*
- Current pay progression is automatic and based on time served. We propose replacing this with a tiered system of reward (nodal points) based on level of responsibility.
- There is no mechanism to pay for actual hours worked. *We propose a contract which pays for additional hours or provides protected time off in lieu.*
- Diary exercises to demonstrate excess working are time consuming for juniors and can result in employers experiencing unexpected pay inflation and the risk of unplanned back pay. *We propose a speedier system of resolution which also ensures fairer reward for the trainee and pay stability.*

## What are the benefits of the new contract?

The new contract is based on the principle of cost neutrality. This has been agreed by both NHS Employers and the BMA. Both parties accept that the pay bill will remain the same (plus 1 per cent for 2016/17), while most staff will experience neutral or increased pay, those that would have experienced a reduction will have their pay protected.

- It will go further than the Working Time Regulations and the current contract to protect the safety of doctors from excessive working hours and thereby enhance the safety of patients. No doctor will be rostered to work consecutive weekends, maximum consecutive nights reduce from seven to four, maximum consecutive long days reduce from seven to five, and maximum consecutive days reduce from twelve to eight.
- Currently a doctor could be rostered to work up to 91 hours in a week – this will reduce to a maximum of 72 hours in a single week with the maximum average at 48 hours per week.
- The majority of junior doctors will receive the same pay or better.
- Following the end of pay protection, a minority of posts, where the fewest unsocial hours are worked, will no longer receive the same level of pay premia.
- The proposed contract will reward those working the most onerous rotas and unsocial hours.
- There will be a better link between pay and hours worked, with agreement that doctors will be paid if extra time is necessary and authorised by the employer.
- Pay progression will be linked to responsibility rather than time served.
- The increase in basic pay provides increased career average pension benefits.
- Pay is more stable and predictable for both doctors and employers.
- It allows more flexible rostering without the cliff edges of banding, where small changes result in large financial implications and create perverse incentives.
- It increases the amount of plain time working to facilitate staff deployment to meet the needs of patients on evenings and Saturdays.
- It introduces a guardian role to protect junior doctors within each employing organisation with the authority to impose fines to be invested in educational resources and facilities for junior doctors.
- These financial penalties will be applied if doctors work more than 48 hours on average or 72 hours in a week.
- The guardian will be appointed jointly with the local negotiating committee, and will oversee a process of escalating concerns with rotas and working conditions.
- As part of negotiations, Health Education England (HEE) has agreed to improve the notice of deployment to trainees thereby removing the need for fixed leave and enabling doctors and employers to better plan use of time.

## BMA concerns

- The BMA has suggested that pay will go down by up to 30 per cent. *This is not the case, average pay will remain the same and pay will be more predictable and less variable.*
- Employees wishing to have families will lose out. *We have agreed in principle a pay structure proposed by the BMA which they believe addresses these concerns.*
- Doctors' work will be devalued. *We believe that doctors need to be paid for all the work done and the new offer aims to modernise the way that junior doctors will be rewarded to deliver a fairer deal for doctors and patients. Doctors' pay will more accurately reflect all the work that they do.*
- The contract would be unsafe. *There are improved protections through better rota rules, protected rest, and a new process to escalate concerns overseen by a guardian with authority to levy financial penalties. The guardian would have oversight of junior doctors' work and have direct accountability to the board of every trust, to independently ensure and enforce safe hours of work for junior doctors.*

## *Seven day services*

The NHS has committed to provide safe and reliable care across seven days by progressively delivering the agreed clinical standards whatever the day of the week and where appropriate, whatever the hour of the day. These standards focus on the care which should be provided (timely assessment, effective clinical decision-making and proper handover) for patients requiring emergency and urgent care, and also those who require regular review.

It is recognised that doctors in training already provide a significant level of service across all hours of the day and that the changes that are required to assure reliable delivery of the clinical standards will require changes to the deployment of the total workforce. Indeed, it is most likely that the additional service provided by trainee doctors will be comparatively smaller than that required by consultant staff and other supporting staff. Nevertheless, it is expected that as the workforce grows and as more trainees are employed then the increased numbers will enable supplementary deployment – and probably, most notably at the weekend.

The DDRB published its report in July 2014 which noted that society was changing, such that Saturdays were increasingly being recognised as normal working days in other professions and industries. From the patient's perspective, we must determine what medical and other staffing, with what level of competence and seniority, are required to provide safe and effective care for patients. From the trainee doctor's perspective, we must ensure that service delivery supports opportunistic teaching and experiential learning at the weekends, through senior on-site supervision. We can conclude that to improve the reliability of our services to patients across seven days we must incrementally, as additional staff are employed, deploy a higher proportion of staff across the weekend. It is reasonable therefore that NHS employers recognise these changes and limit the costs that would have to be borne for weekend working – while ensuring that doctors in training do not work more excessive weekends nor that their total pay level is below that which they are currently experiencing if they work weekends.

The proposed contract thereby removes the pay premia for Saturday daytime working and replaces this with a higher level of basic pay for Monday to Saturday daytime working – to put this simply the proposed contract seeks to redistribute Saturday pay premia across the other working days.

## *Areas still to be resolved*

Agreement has been reached with the BMA on a number of issues.

The most significant difference is related to the designation of plain time 7am–7pm on Saturdays and 7pm–10pm on weekdays. It should be noted that NHS Employers has made a conditional improved offer to the BMA.

Junior doctors appear concerned that employers will use the opportunity of plain time pay to allocate doctors to work more frequent weekends.

Employers maintain that they will not dilute the provision of safe and reliable care across Monday – Friday as this is when most elective activity occurs, and will roster workforce to work weekends in a way that is affordable and corresponds to an increase in the overall workforce.

Employers are currently offering an average of 11.3 per cent basic pay increase, with a 50 per cent supplement being paid for night shifts, as these are recognised as being the most onerous and disruptive to rest cycles. 33 per cent is offered for Saturdays 7am–10pm and Sundays 7am–9pm.

The BMA would like a 50 per cent supplement to be paid for all hours outside 7am–7pm Monday to Friday. This is not acceptable to NHS Employers.

**Chief Executive**
**Sir David Dalton**

Telephone: 0161 206 5186
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Salford Royal NHS
NHS Foundation Trust
University Teaching Trust

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DD/JM

1 February 2016

Rt. Hon. Jeremy Hunt MP
Secretary of State for Health
Richmond House
Whitehall
LONDON

Dear Secretary of State

I write to advise you on the progress of negotiations with the BMA JDC as of when we adjourned on 29th January 2016.

I am pleased that substantial progress has been made across a large number of areas, where there is now agreement, most notably in the areas of safety and education & training.

**SAFETY**
We have reached agreement on a majority of hours protections including rest periods, these go further than the Working Time Regulations: a limit of 48 hours worked on average over 26 weeks and an absolute contractual limit of 56 hours where a trainee has opted out of EWR; no doctor would ever be rostered consecutive weekends; maximum consecutive nights reduce from 7 to 4; maximum consecutive long days reduce from 7 to 5; and maximum consecutive days reduce from 12 to 8. These and other changes all provide a substantial guarantee for safe working hours and therefore for patient safety.

The new Guardian role and system are substantially agreed which provide new safeguards in each and every workplace. The Guardian will have the authority to impose fines on an employer if for example, a doctor is found to be working more than 48 hours on average. It is agreed that these fines are to be invested in educational resources and facilities for trainees.

**EDUCATION AND TRAINING**
We have reached agreement on new terms which support the training of medical trainees, which include: ensuring proper notice of deployment to rotational placements; exception reporting applying to missed educational opportunities; and a review of access to flexible training.

**PAY**

We have reached agreement with the BMA on their proposal for a new pay structure based on five pay points with pay progression linked to increased responsibility. We have agreed on the principle of pay for work done, that GP trainees should receive a flexible pay premia to maintain pay parity with hospital-based trainees, that academic trainees should have their pay protected to recognise the longer training path, that there should be pay protection for all medical trainees under a new contract, and that trainees changing to shortage specialties should also have their pay protected.

**OUTSTANDING ISSUES**

The substantive areas where we have not been able to reach agreement are about pay, and the most significant of these is pay linked to unsocial hours.

The key area of difference between the parties remains payment for unsocial hours in the evenings and on Saturday. I confirmed our latest offer (ref. 16th January) which reset the thresholds for the start of premium pay for unsocial hours on the Mon - Fri evenings by one hour (10pm to 9pm) and on Saturday by two hours (7pm to 5pm). Furthermore we provided a new guarantee that any trainee who works one in three Saturdays or more will be paid an enhanced rate for all of the Saturdays they work. I believe that these movements on the employers' side are reasonable and they evidence our willingness to be flexible and responsive. Disappointingly, the BMA restated that they would not negotiate on this issue - and would not concede to any plain time working on Saturdays.

There is a further issue relating to the rate of availability payment for non-resident on call, (these staff are not required to be at their place of work for the period of on call duty unless they are required to attend - when they will be paid for hours worked). An improved final offer of a maximum 10% rate has been made - but has not been accepted by the BMA who are seeking a 20% rate, some two and a half times more than any other employed doctors receive.

There are a small number of subsidiary issues where the BMA is seeking additional payments to trainees: eg, a financial gain to the trainee from the penalty (Guardian) system; additional payment to doctors when a meal break is interrupted (on top of the meal break payment they already receive, which are unpaid for all other staff); and a further payment for doctors who work higher frequency of weekends.

The only outstanding areas which are not pay-related are associated with the definition of night shifts (where the BMA wish to move beyond the definition in the Working Time Regulations); and the question of how the BMA representative on a final stage review panel should be defined.

Interestingly the BMA have indicated their willingness to consider our proposal that the employer would have first refusal on a locum shift, they have not though accepted a proposal for a national rate for internal locum pay.

**NEXT STEPS**

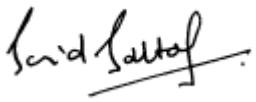
Given that we have made such good progress over the last 3 weeks – and are very nearly there on all but the pay points – it is very disappointing that the BMA continues to refuse to negotiate on the issue of unsocial hours payment. I note that in the ACAS agreement of 30 November, both parties agreed to negotiate on the number of hours designated as plain time and I hope that the BMA will still agree to do that. I am aware that BMA negotiators are meeting their

Executive Committee today and I have confirmed my willingness to continue to talk. I should note though that I do not believe negotiations should restart unless the BMA state beforehand that they will negotiate on the principal outstanding issues.

Should the BMA confirm that they will not negotiate and compromise on weekday and weekend plain time/unsocial hours then I will have to conclude that there is no opportunity for a negotiated settlement, and I would then need to advise you accordingly.
The issues around this and other outstanding contract negotiations have caused great uncertainty in the NHS and it is essential that the service finds out how things will proceed as soon as possible. Specifically, if effective implementation is to be assured for junior doctors then agreement is required by no later than mid-February.

Clearly trainee doctors are expressing a high level of discontent which has been fermenting for some years. Alongside the contract offer, I would also recommend that the government, the Academy of Medical Royal Colleges, Health Education England and NHS Employers commission a review of these longer-standing concerns with recommendations to all parties for action which can improve the welfare and morale of trainees.

Yours sincerely



**Sir David Dalton**
**Chief Executive**
**Salford Royal Hospital NHS Trust**

Copy to:
Clare Panniker
Danny Mortimer
Ben Gummer

**Workforce & Education Committee Meeting of 26 January 2016- Chair's Report**

**Progress against Q3 Actions and Proposed Strategy Focus for 2016/17**

The Committee reviewed progress against the 2015/16 action plan focussing on red RAG'ed areas (turnover reduction, bullying, recruitment process delays) on which the Committee received detailed papers-see below.

The Chair requested that all actions relating to performance appraisal in the 15/16 plan be brought together in a single paper which informs the Committee on how and when the Trust will have in place an appraisal system that:

- Aligns the trust's objectives with individual objectives through a cascading process;
- Assesses values and behaviours as well as achievement and performance;
- Provides a rating system that enables people to know objectively where they stand;
- Enables linkage with pay ( when that is judged appropriate for different levels of seniority and different staff groups);
- Is facilitated by technology.

The Chair understood that good progress had been made in setting the objectives of the Executive but wished to see an implementation plan for the rest of the organisation as this process is fundamental to enhancing performance management and accountability in the trust- an important recommendation in the PWC report and a vital pre-condition to the Trust's turnaround.

In line with steer given to Wendy Brewer in the November '15 meeting, a more focussed and succinct plan was produced for 2016/17 centred on three key areas:

- **Reducing turnover** to a targeted 13% by rolling out the planned leadership development programmes, embedding the trust's values in recruitment and appraisal, tackling bullying more effectively and providing support to divisions as they strive to implement their own divisional t/o reduction plans and improve the organisational climate in the trust.

- **Implementing the workforce efficiency programme** as part of the trust's transformation programme (overseen by TAB –savings of £11-25m), ensuring that the trust is optimally resourced and that appropriate controls are in place to align workforce costs to activity.

- **Developing a clear and agreed education strategy** in conjunction with the University that will enable the trust to maximise the number of undergraduate placements on offer, assure the quality of placements and have clarity over costs and income.

The Committee welcomed the focus of the plan for 2016/17 and asked that measures are now developed so that the implementation of the plan lends itself to monitoring. Details of the implementation plan was promised for the March '16 meeting of the Committee.

**Workforce Efficiency Programme**

Detailed scrutiny of the efficiency programmes under development is being provided by TAB (which the Chair attends). The Committee received an update on the governance arrangements in place and of the key risks to the programme.

The Committee welcomed the programme leadership roles assumed by Chloe Cox ('Reducing Pay Costs') and Fiona Ashworth ('Size and Shape -Spans and Layers').The Committee was also assured

that the leadership role of the DDOs extends beyond responsibility for securing planned savings. Their role includes managing the change so that excessive disruption to staff and quality is avoided.

Divisional participants to the meeting conveyed the need for effective communication of the programmes and involvement of people other than senior managers to their delivery as there is nervousness as to their impact which risks exacerbating the staff turnover situation.

**Turnover Reduction**

The Committee received updated plans from two of the four clinical divisions. It welcomed the greater specificity in the Community Services Division's turnover reduction plan. The Committee asked, however, for evidence of progress against the plan as none was available in the report. Paul Alford set out the difficulties faced by the division, its demographics, its dispersion and the tightly prescribed (by Commissioners) nature of their service design and delivery but promised to provide evidence of progress against the plan even if the impact of those actions may take a while to show through.

The Children's and Women's report, as presented, also provided limited assurance of progress made against their very detailed and well thought out plan. Assurances were provided verbally, however, that a great deal of work is being done, especially in the Children's area.

The Committee requested both divisions to work with the Workforce Function to provide the evidence of progress in a way that the Workforce Committee and the Board can be assured that actions are being followed up by accountable managers.

The Board should note that TAB will also now receive summary information on the progress of the divisional turnover reduction plans as their effectiveness is likely to impact in a profound way the transformation effort (vacancies, agency costs, churn and consequent loss of productivity).

**Securing Educational Placements**

Sarah James presented a paper to the Committee which outlined a series of recommendations on how to maximise the opportunities open to the Trust to secure educational placements across the entire spectrum of trainees and students that the Trust is commissioned to provide educational and training placements for (postgraduate medical and dental trainees, undergraduate medical students, pre-registration nursing and midwifery students, etc).

Sarah's paper took account of various external factors that are impacting the market for placements such as the national cap on medical students, changes in the curriculum, decommissioning of training posts and the removal of the bursary for nursing and midwifery. The plan set out a series of actions proposed for 16/17 which taken together, aim to improve the quality of the experience for trainees, students and newly qualified staff and exploit the Trust's unique selling points to maximize numbers. The plan was also alert to the risks of 'crowding'.

The Committee welcomed the series of recommendation proposed in Sarah's paper. The Chair asked however that:

(a) These are considered as part of a fully developed Education Strategy to ensure that there is no disconnect;
(b) Consider whether 'optimising' might be a preferable strategy to 'maximising' the number of placements, depending on the income generated by each category of students and trainees. In other words, ensure that a commercial lens is applied to the above.

Wendy Brewer assured the Committee that the paper on placements will be considered by EMT in the context of their consideration of the entire Educational Strategy.

**Evaluating the Trust's Approach to dealing with Allegations of Bullying and Harassment (B&H)**

As part of the on-going effort to tackle effectively the incidence of bullying and harassment in the trust, Paulette Lindsey-Greenidge, a senior HR Adviser, was charged with taking a 'fresh look' at the Trust's policies and practices based on her own specialist experience and also by obtaining detailed information on the practices of two other trusts (Royal Free and GSTT) who have a better, and in the case of Royal Free, an improving record in dealing with this complex issue.

Paulette was able to provide a series of differentiators, some of which are listed below:

- Other trusts provide in their policies practical examples of the difference between constructive and destructive criticism and between asserting management authority and bullying. These are all drilled into managers and staff through extensive training so that there is a shared understanding of what constitutes legitimate behaviour and what is bullying.

- Other trusts practise zero tolerance as well as writing it into their policies.

- Other trusts look more closely at the **impact** of poor behaviour on the complainant. This weighs more in their consideration than whether there was an **intent** to bully.

- Other trusts help complainants piece the evidence together and assess the strength of their case before further exposure.

The Committee requested that the recommendations in Paulette's paper be used as a basis for relaunching the trust's policy and recommended that some of these differentiators identified in Paulette's paper find their way into the Trust's training programmes and in the way the policy is implemented.

Divisional representatives also stressed the importance of ensuring that the consultant body is not left out of training or other initiatives that is directed at the Trust's leadership, especially where there are known problems.

Simon Mackenzie agreed to work with Wendy Brewer so that lessons learnt from the Vascular case can form the basis for targeted interventions in clinical areas where there are known issues. Such interventions could include: innovative and safe (to the complainants) ways of gathering the evidence of alleged poor behaviour, provision of feedback to individuals on how their behaviour is impacting others, offering bespoke programmes to entire teams of consultants and improving team working.

The Committee asked that a paper be brought back on the changes that will be implemented as a result of this re-evaluation of the effectiveness of the Trust's policies and practices on B&H.

**Recruitment Process**

A paper was tabled and presented by Jacqueline McCullough providing an update on the effectiveness of the recruitment process. This followed concerns expressed in multiple fora about the length of the recruitment process, the adequacy of staffing of the recruitment team and the

perceived lack of visibility of where candidates are in the recruitment pipeline which makes it difficult for recruiting managers to plan for temporary staff accurately.

The Committee was reminded that the recruitment process had been radically revamped and streamlined only a few months back. As a result of that revamp, it was Jacqueline's belief (backed by external data) that there was no further scope to remove or shorten process steps. However two other factors have contributed to the perceived under- performance of the service:

- The team is new and inexperienced and needed time to become fully effective in operating the new process;
- The team was staffed up to deal with an estimated 1,600 recruits per year. In practice, the Trust is now recruiting at a rate of 2,400 per year (as a result of the higher turnover and other factors).

Jacqueline explained that a new business case is being put forward to expand the team further to deal with the larger volume of recruits. Furthermore, the introduction of a new applicant tracking system (TRAC) which is close to implementation should, in time, resolve the issue of visibility of candidates in the pipeline as users of the system and recruiting managers will be able to track candidates in the pipeline.

The Committee were supportive of the additional investment in manpower and systems and asked to be kept updated of progress. Divisional representatives offered to support the team in this period that they continue to be under-resourced.

**MAST**

Sarah James presented a paper which set out concrete proposals that aim to increase MAST compliance to 75% by June 2016 and subsequently to 85% by December 2016.

The targeted improvement to 75% is underpinned by a series of actions that can be led by the Education & Training Team with support from Subject Matter Experts and other stakeholders. These include measures such as providing classroom based MAST training at induction and for harder to reach groups, capturing and recording accurately previously completed training in other trusts, etc.

The targeted improvement to 85% by December requires cultural change, investing in IT infrastructure and senior management and executive support.

Sarah expressed confidence that a more meticulous analysis of the training needs, a better capture of the data and easier access to the e-learning system could make a very big difference to compliance levels in a very short period of time.

Divisional representatives were prepared to sign up to this stretching improvement provided they were assured that the available information systems produce accurate information that enables them to monitor compliance effectively in their own areas.

Divisions were also prepared to consider a series of sanctions for non-compliant staff and their managers as levers for a change in culture about the importance of completing MAST.

The Committee welcomed the concrete nature of the recovery plans and the provision of a clear trajectory for improvement. This will be monitored regularly by the Committee.

Stella Pantelides 26.1.16

**KEY MESSAGES TO THE BOARD FROM AUDIT COMMITTEE HELD ON 20th January 2016.**

**The key points which the Audit Committee feels it needs to bring to the Board's attention this month based on its last meeting are listed below:**

1. **In our last report on 16th November 2015 we expressed concern that in too many cases actions arising from Internal Audits were not being progressed by the Trust probably due to the tremendous pressure the Trust was under. We stressed the importance of implementing these actions and requested that the Executive address this.**

   **Regrettably in many cases the situation continues seemingly because of a lack of capacity to deliver, ineffective processes surrounding the Audit Committee, changes in systems and changes in personnel.**

   **The evidence for this is that:**

   a. **Out of 33 matters arising from the last Audit Committee meeting 8 had to be carried forward because there was no update and no one knew the status of the action**
   b. **There are 123 actions on the Tracker Report (the Tracker Report tracks the status of agreed actions arising from prior audits); 94 received no updates at all for this meeting, 22 are more than 1 year late in implementation, 39 were regarded as being high priority but had passed their due date, a number (as reported last time) had just been removed from the tracker with no evidence of completion, some of those completed had not supplied any evidence to support the report of their completion and contrary to commitments made at the Board the Tracker had not been to EMT before coming to the Audit Committee**
   c. **A significant number of Internal Audits have been delayed this year leading to bottlenecking at the last Audit Committee meeting of the year when 16 Internal Audits will need to be presented**

   **In our view this now demands a complete change of approach.**
   **We recommend taking the opportunity of the new incoming Internal Auditors, TIAA, to review the entire Tracker List, removing actions no longer relevant and confirm status, dates and priorities of the remaining ones agreeing a single point of Executive responsibility. Entering the status of actions with evidence of their completion into an automated on-line system supplied by the new Internal Auditors should make it easier and more efficient to process them. TIAA will lead on this activity which is targeted to be completed before this financial year end.**

   **We ask the Board to endorse this approach which will require the Executive to co-operate with TIAA, to take responsibility individually and severally as an Executive team for progressing and implementing agreed actions arising from Internal Audits and to report back progress to the**

**Audit Committee in a timely and regular manner. We will report on progress in our Annual Report to the Board and at the April Board meeting.**

2. **The Audit Committee received an Internal Audit on Complaints, completed in December 2015, which received only reasonable assurance. However the control objective relating to action tracking received limited assurance. We are very concerned about this as for many months the Board has received assurances that the poor performance on complaints was being actioned. In one of the two Divisions audited there was no central tracking of complaint actions at Divisional level. In both Divisions there was either no or limited evidence of centralised performance management of implementation of action plans. Although there is evidence that complaints are analysed to identify the main areas of concern, and actions taken/lessons learnt in response to these, where learning themes have been identified from thematic/trend analysis, there is no systematic evidence that improvement plans with clear timescales, responsibilities, and dissemination mechanisms for lessons learnt have been developed. We recommend that the Director of Nursing be required to update the Complaints policy to state clearly:**

    a. **the level of tracking required at the Divisional level of both complaint responses and action implementation plans**
    b. **how widely lessons learned from complaints will be disseminated across the Trust**
    c. **the evidence needed to provide assurance on the above**

    **and report back to the Board when this has been done.**

3. **We received a long and in part forensic draft Internal Audit report on Estates and Facilities procurement practice and compliance with Standing Financial Instructions (SFIs) within Estates. It is a complex report but in summary concludes that SFIs and that in some cases procurement rules have been breached and mistakes have been made. Three procurements worth circa £3 m were examined in detail as well as retrospective purchase orders, tender waivers and the use of preferred contractors. No evidence of fraud was found by the Internal Auditors. However it seems that there has been a combination of very poor support from Procurement and Estates and Facilities taking short cuts sometimes for reasons of urgency/patient safety.**

    **The Chief Executive now needs to consider the 28 recommendations in the report and determine which should be accepted and which rejected giving a reason for the latter and then have a nominated responsible Executive assigned to implement each of the accepted ones with a due date for completion. Together with the Director of Workforce and OD he will need to consider whether any disciplinary action is required.**

    **Once this is done the finalised report will need to be brought back to the Audit Committee.**

4. **Internal Audit undertook a follow up review of Data Quality Governance. Of the six recommendations made in the initial report (June 2014) and due to be completed either in December 2014 or January 2015 none had been completed, 4 had been partially implemented and 2 had not been implemented. Data Quality and integrity is crucial in supporting patient care, clinical governance, performance management, service improvement and ensuring that the Trust receives appropriate payment for the work it undertakes. A set of revised implementation dates have been agreed and the Data Quality Group has been re-launched and is to be chaired by the Medical Director to facilitate greater clinical buy-in.**

5. **We received a report from Counter Fraud. One case, which must remain confidential, contains some very serious allegations. Investigations are proceeding but very slowly. The Audit Committee has requested that every effort be made to speed the investigation up.**

6. **Internal Audit reported on the system of governance, risk and control over Medical Locums. While Reasonable Assurance was given and there have been improvements since the last Internal Audit there are still some weaknesses in the system which concerned the Audit Committee. 74% by value (£1,250,517) of month 3 to 8 bookings did not go through the Bank Office. While this is being addressed the concern is that it may result in lack of control and junior doctors exceeding the European Working Time Directive. A series of recommended actions have been agreed. However in some cases the responsibility for implementation of these actions is diffuse. The Audit Committee has asked that all implementation actions in this, and indeed in all audit reports, be the responsibility of a single senior Executive to enable single point responsibility and performance management.**

7. **An Internal Audit reported that generally sound controls applied within the payroll department and Significant Assurance was given. The one area of concern was that the value of overpayments shows signs of increasing for 2015/16 and recommendations made by Internal Audit to name and shame and to charge consistent divisional offenders had been rejected by the Divisions. We regard this as a failure in performance management and request the Executive support Finance in its introduction. Total net overpayment debt at 1st December 2015 was £584,000. In the current constrained cash position any reduction that can be achieved will only improve the Trust's cash position.**

8. **The Board is asked to note and approve the following changes to the Trust's Audit Plan for 2015/16:**
    a. **Extension of the scope of the Financial Ledger review and reviews of cashiers and commissioners fines and challenges following on from the PWC review**
    b. **Addition of a review of Capital Assets**
    c. **Deferral of the follow-up review of Community Properties pending agreement of the Trust Strategy on these**

**The additional funding required for these changes has already been agreed by the Board.**

9. **The Board will be aware that Internal Audit is undertaking an audit of Discharge Summaries. The completion of this audit has now been delayed by five months because of the failure to find a sufficiently independent clinician willing and able to review the discharge summaries from a clinical perspective. We have asked our new Internal Auditors, TIAA, whether they can help in finding the right person but would ask both the Trust and the University to give high priority to finding an appropriate person so that this Audit which is important both internally and externally to our Commissioners and GPs can be completed.**

10. **We reviewed the External Auditors plans for this year's audit and received assurances that the Trust had plans in place to produce the Financial Accounts, the Quality Accounts and the Annual Report to the revised standards required by Monitor. The Board should note that the auditors are recommending a lowering of overall materiality to 1.25% of gross revenue. We have asked them to justify this figure.**

11. **As already noted in this report the tender process for the Internal Audit has resulted in new Internal Auditors, TIAA, being appointed from 5th April 2016. Despite a protracted and sometimes frustrating contract process TIAA are commencing the handover process from our existing Internal Auditors, London Audit Consortium, whom we would like to thank for their services to the Trust.**

12. **At the end of this month there will be two changes to the membership of the Audit Committee as a result of retirements of Non-Executive Directors. We would like to register our thanks to Judith Hulf and Sarah Wilton for their contribution and support to the Audit Committee over a number of years.**

**MSJR**
**27/01/16**

St George's Healthcare NHS
NHS Trust

**Name and date of meeting:**

**TRUST BOARD**

**4th February 2016**

**Document Title:**

**Cash position update - January 2016**

**Action for the Board:**

1. To note the M09 2015/16 cash position and consider the monthly cash flow forecast to year end.

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**Cash position 2015/16 M09 YTD**

- The Trust's Monitor plan for 2015/16 included a requirement for ISF monies of £52.2m. This requirement was predicated on an income and expenditure deficit of £46.2m for the year and a capital programme (excluding finance leases) of £45.6m.

- The Trust reduced its capital programme (excluding finance leases) in June by £5.9m and at the same time removed the sale proceeds of £2.5m for the PPU land from its capital financing assumptions. These adjustments enabled the Trust to reduce its forecast ISF requirement to £48.7m for the year in July.

- Since July the Trust has needed to access external cash support to finance its deficit in the form of drawdowns from its approved working capital facilities. These drawdowns totalled £36.4m as at 31st December and this sum scores against the ISF request of £48.7m.

- As reported each month to the board a number of cash benefit measures to improve the cash position have been implemented since July including longer supplier payment terms, intensified credit control actions to reduce overdue debt, a managed slowing down in the rate of capital expenditure where appropriate and stock reductions.

- The combined impact of these cash benefit measures has enabled the Trust to finance a higher income and expenditure deficit than original plan and at the same time reduce the drawdowns made under its working capital facilities compared to plan.

- Appendix 1 below demonstrates that as at M09 the Trust had improved its working capital position by £6.4m against plan and had spent £17.9m less on capital than plan: these factors financed the higher deficit and reduced the amount the Trust has needed to draw down from its working capital facilities by £6.1m compared to the plan.

- The Trust's TRP submitted in November to Monitor forecasted an income and expenditure deficit for the year of £63m. The TRP maintained the same forecast level of ISF funding for the year of £48.7m however the forecast year end cash balance was only £0.2m compared to the £3m required.

- Since the completion of the TRP the Trust has developed 'bold actions' to improve the income and expenditure position and enhance cash flow and a cash crisis group was formed in November to manage the serious risk to cash flow posed by the potential suspension of access to working capital facilities resulting from the Trust exceeding the planned I&E deficit of £46.2m.

- Measures including bringing forward the receipt of donated capital grants from March to November enabled the Trust to forecast a YTD deficit for December lower than the £46.2m plan for the year and therefore secure a drawdown of £10.14m in December reducing markedly the risk of a cash shortfall before year end.

- The cash balance at M09 was £15.2m compared to £3m per plan and cumulative WCF drawdowns were £36.4m compared to £42.5m per plan.

**Cash position 2015/16: forecast outturn**

- The Trust's updated income and expenditure forecast at M09 is for a deficit of £56.1m for 2015/16.

- Appendix 2 compares the cash movement for 2015/16 per plan, TRP and M09 forecast outturn.

- The reduction in the forecast deficit from £63m per the TRP combined with lower capital expenditure has enabled the Trust to revise upwards its forecast year end cash balance from £0.2m to £3m and at the same time reduce its forecast ISF requirement for the year from £48.7m to £46.2m.

- The updated monthly cash flow forecast is attached as appendix 3. The forecast is is based on the revised deficit forecast of £56.1m and lower capital expenditure forecast.

- The monthly cash flow indicates the Trust will not require cash support in February but will need to draw down approx £9.7m from the new **interim revenue support facility** (see separate agenda item) in mid-March to achieve the minimum required cash balance of £3m on 31 March

- The March drawdown is required to finance a number of high value payments eg CNST premium payments deferred from earlier in the year, NHSPS rental payments and the second biannual dividend payment in March.

- As noted above the drawdown forecast for March of £9.7m would bring cumulative WCF/ISF drawdowns to £46.2m for the year compared to £52.2m per the original plan and £48.7m per the TRP.

**Author and Date:**

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22nd January 2016

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## Appendix 1

## Cash movement: M09 Actuals vs Plan

| | Plan M09 YTD £m | Actual M09 YTD £m | Actual M09 VAR £m |
|---|---|---|---|
| Opening cash 01.04.15 | 24.2 | 24.2 | |
| Operating surplus/-deficit | -18.8 | -25.4 | **-6.6** |
| Sale proceeds re: PPU land | 0.0 | 0.0 | **0.0** |
| WCF/ISF requirement | 42.5 | 36.4 | **-6.1** |
| **Cash gap** | | | **-12.7** |
| Net change in working capital | -7.4 | -1.0 | **6.4** |
| Capital spend (excl leases) | -38.0 | -20.1 | **17.9** |
| Other | 0.5 | 1.1 | **0.6** |
| Sub-total | | | **24.9** |
| Closing cash M09 / M12 forecast | 3.0 | 15.2 | **12.2** |

1 The table above compares the actual cash movements M01-M09 with the original plan
2 The Trust has more than offset the cash gap of £12.7m relating to the higher deficit, removal of the PPU proceeds and lower WCF drawdown by realising cash benefits of £6.4m on working capital and reducing capital expenditure by £17.9m.
3 The actual cash balance at M09 is £12.2m higher than plan

## Appendix 2

## Cash movement: Forecast outturn vs Plan and vs TRP

| | Plan Outturn £m | TRP Outturn £m | **M09 F/cast Outturn £m** | Var M09 vs Plan £m | Var M09 vs TRP £m |
|---|---|---|---|---|---|
| Opening cash 01.04.15 | 24.2 | 24.2 | **24.2** | | |
| Operating deficit | -21.6 | -40.0 | **-33.1** | **-11.5** | **6.9** |
| Sale proceeds re: PPU land | 2.5 | 0.0 | **0.0** | **-2.5** | **0.0** |
| WCF/ISF requirement | 52.2 | 48.7 | **46.2** | **-6.0** | **-2.5** |
| **Cash gap** | | | | **-20.0** | **4.4** |
| Net change in working capital | -7.4 | -0.1 | **-0.6** | **6.8** | **-0.5** |
| Capital spend (excl leases) | -45.5 | -31.3 | **-29.4** | **16.1** | **1.9** |
| Other | -1.4 | -1.3 | **-4.3** | **-2.9** | **-3.0** |
| Sub-total | | | | **19.9** | **-1.6** |
| Closing cash M09 / M12 forec | 3.0 | 0.2 | **3.0** | **0.0** | **2.8** |

The cash movement table above compares the Plan, TRP and M09 forecast outturn
The M09 forecast outturn indicates the Trust would finance the cash gap of £20m (compared to original Plan) relating to the higher deficit, removal of the PPU sale proceeds and reduction in ISF as follows:

1 realising cash benefits of £6.8m on working capital - supplier payments and better debt collection
2 reducing capital expenditure by £16.1m over the year.

The Other category includes the £3.5m repayment of PDC capital necessitated by the proposed capital to revenue transfer (the I&E benefit of the capital to revenue transfer is included within the Operating deficit - net cash impact is zero)

## Appendix 3

### 2015/16 actual and forecast monthly cash flow

| | Actual Apr-15 £000 | Actual May-15 £000 | Actual Jun-15 £000 | Actual Jul-15 £000 | Actual Aug-15 £000 | Actual Sep-15 £000 | Actual Oct-15 £000 | Actual Nov-15 £000 | Actual Dec-15 £000 | PLAN YTD 2015/16 | Actual YTD 2015/16 | VAR YTD 2015/16 | F'cast Jan-16 £000 | F'cast Feb-16 £000 | F'cast Mar-16 £000 | PLAN Mar-16 £000 | F'cast Total15/16 £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Opening cash balance | **24,179** | **14,188** | **7,925** | **7,265** | ***6,184*** | ***6,096*** | ***8,257*** | ***12,846*** | ***9,252*** | 24,179 | 24,179 | | ***15,237*** | ***18,596*** | ***5,652*** | 24,179 | 24,179 |
| **EBITDA** | **-4,525** | **-5,635** | **-3,081** | **-367** | ***-3,595*** | ***-396*** | ***540*** | ***-50*** | ***-1,677*** | **-11,764** | **-18,786** | **-7,022** | ***673*** | ***-2,333*** | ***-1,316*** | **-9,609** | **-21,763** |
| Non-cash income | -15 | -14 | -14 | -15 | *-14* | *-14* | *-15* | *-14* | *-15* | **-131** | **-130** | **1** | *-15* | *-14* | *-14* | **-174** | **-173** |
| Interest paid | -278 | -311 | -264 | -343 | *-362* | *-308* | *-264* | *-397* | *-388* | **-3,345** | **-2,915** | **430** | *-283* | *-384* | *-492* | **-4,759** | **-4,074** |
| PDC dividend paid | | | | | | *-3,540* | | | | **-3,540** | **-3,540** | **0** | | | *-3,542* | **-7,082** | **-7,082** |
| Operating surplus/-deficit less interest and divs paid | -4,818 | -5,960 | -3,359 | -725 | *-3,971* | *-4,258* | *261* | *-461* | *-2,080* | **-18,779** | **-25,371** | **-6,592** | *375* | *-2,731* | *-5,364* | **-21,623** | -33,092 |
| Change in working capital | | | | | | | | | | | | | | | | | |
| Change in stock | -683 | -23 | 496 | -1,214 | *830* | *-36* | *269* | *-108* | *-719* | **507** | **-1,188** | **-1,695** | *243* | *476* | *1,083* | **857** | **614** |
| Change in debtors | 998 | -7,822 | -4,124 | 3,982 | *-471* | *-1,080* | *6,442* | *-7,880* | *2,609* | **-5,000** | **-7,346** | **-2,346** | *-2,224* | *5,874* | *2,696* | **-3,000** | **-1,000** |
| Change in creditors (excl int pay/cap/pdc) | -2,930 | 9,178 | 7,922 | -8,654 | *-710* | *-1,175* | *-1,561* | *5,335* | *-2,731* | **-2,900** | **4,674** | **7,574** | *7,125* | *-4,452* | *3,146* | **-5,208** | **10,493** |
| Cash recovery actions (CNST) | | | | | | | | *1,434* | *1,434* | **0** | **2,868** | **2,868** | *1,434* | *-1,434* | *-2,868* | | **0** |
| NHS Prop Services | | | | | | | | | *0* | **0** | **0** | **0** | *0* | *-3,567* | *-7,134* | | **-10,701** |
| Net change in working capital | -2,615 | 1,333 | 4,294 | -5,886 | *-351* | *-2,291* | *5,150* | *-1,219* | *593* | **-7,393** | **-992** | **6,401** | *6,578* | *-3,103* | *-3,077* | **-7,351** | *-594* |
| Provisions used | -54 | -35 | -1 | -36 | *0* | *1* | *0* | *-36* | | **0** | **-161** | **-161** | *-30* | *-39* | *-40* | **0** | **-270** |
| Interest received | 3 | 3 | 2 | 3 | *2* | *2* | *3* | *5* | *9* | **56** | **32** | ***-24*** | *3* | *3* | *1* | **75** | **39** |
| Proceeds from sale of fixed assets | | | | | | | | | | **0** | **0** | ***0*** | | | *0* | **2,500** | **0** |
| Capital spend (pymts) - external finance | -713 | -470 | | | | | | | | **-11,845** | **-1,183** | ***10,662*** | *-931* | *-1,108* | *-2,054* | **-14,231** | **-5,276** |
| Capital spend (pymts) - internal capital | -1,495 | -2,064 | -2,421 | -3,072 | *-2,848* | *-1,825* | *-1,800* | *-1,364* | -2,009 | **-26,297** | **-18,898** | ***7,399*** | *-2,264* | *-1,620* | *-1,350* | **-31,338** | **-24,132** |
| Net cash inflow/-outflow from investing activities | -2,205 | -2,531 | -2,419 | -3,069 | *-2,846* | *-1,823* | *-1,797* | *-1,359* | *-2,000* | **-38,086** | **-20,049** | **18,037** | *-3,192* | *-2,725* | *-3,403* | **-42,994** | -29,369 |
| Working capital loan received | | | | | | | | | | | | | | | | | |
| **WCF/ Interim support funding** | | | **0** | **7,671** | ***7,909*** | ***9,420*** | ***1,256*** | ***0*** | **10,140** | **42,544** | **36,396** | ***-6,148*** | ***0*** | ***0*** | ***9,772*** | **52,185** | 46,168 |
| Loans received - LEEF | | | | | | | | | | **0** | | | | | | **0** | 0 |
| Loans received - DH capital | | 1,241 | 1,111 | 1,217 | *0* | *1,825* | *0* | *0* | *234* | **5,628** | **5,628** | ***0*** | | | | **5,628** | **5,628** |
| Loan repayments - LEEF | | | | | | | | | *-739* | **-739** | **-739** | ***0*** | | | | **-739** | **-739** |
| Working capital loan repyments | | | | | *-499.5* | | | | | **-500** | **-500** | ***0*** | | *-499.5* | | **-999** | **-999** |
| Loans repayments - DH capital | | | | | | | | **-296** | | **-186** | **-296** | ***-110*** | | | | **-186** | **-296** |
| Loans repaid - SALIX | | | | | | *-193* | | | | **-193** | **-193** | ***0*** | | | | **-193** | **-193** |
| Finance lease repayments | -227 | -239 | -214 | -181 | *-257* | *-448* | *-209* | **-151** | *-90* | **-2,826** | **-2,015** | ***811*** | *-300* | *-301* | *-467* | **-4,040** | **-3,083** |
| PFI repayments | -72 | -72 | -72 | -72 | *-72* | *-72* | *-72* | **-72** | *-72* | **-650** | **-650** | ***0*** | *-72* | *-72* | *-72* | **-866** | **-866** |
| PDC capital (assume £1.5m extra received) | | | | | | | | | | **0** | **0** | ***0*** | | *-3,474* | *0* | **0** | **-3,474** |
| Net cash inflow/-outflow from financing | -299 | 930 | 825 | 8,635 | *7,080* | *10,532* | *975* | *-519* | *9,473* | **43,079** | *37,632* | *-5,447* | *-372* | *-4,347* | *9,233* | **50,789** | 42,146 |
| Net cash movement in period | -9,991 | -6,263 | -660 | -1,081 | *-88* | *2,161* | *4,589* | *-3,594* | *5,985* | **-21,180** | **-8,942** | **12,238** | *3,359* | *-12,944* | *-2,651* | **1** | -21,179 |
| Closing cash balance | **14,188** | **7,925** | **7,265** | **6,184** | ***6,096*** | ***8,257*** | ***12,846*** | ***9,252*** | ***15,237*** | ***2,999*** | ***15,237*** | ***12,238*** | ***18,596*** | ***5,652*** | ***3,000*** | **3,000** | **3,000** |
| LEEF loan | -13,303 | -13,303 | -13,303 | -13,303 | *-13,303* | *-13,303* | *-13,303* | *-13,303* | *-13,303* | **-13,303** | | | *-13,303* | *-13,303* | *-13,303* | **-13,303** | |
| EPC capital exp (cumulative) | 591 | 698 | 888 | 1,038 | *1,049* | *1,368* | *1,409* | *1,455* | *1,542* | **3,201** | | | *2,473* | *3,377* | *4,225* | **7,772** | |
| Exclude unexpended LEEF loan | -12,712 | -12,605 | -12,415 | -12,265 | *-12,254* | *-11,935* | *-11,894* | *-11,848* | *-11,761* | **-10,102** | | | *-10,830* | *-9,926* | *-9,078* | **-5,531** | |
| **Cash balance excl unexpended LEEF loan** | **1,476** | **-4,680** | **-5,150** | **-6,081** | ***-6,158*** | ***-3,678*** | ***952*** | ***-2,596*** | ***3,476*** | **-7,102** | | | ***7,766*** | ***-4,274*** | ***-6,078*** | **-2,531** | |

St George's Healthcare NHS
NHS Trust

**Name and date of meeting:**

**TRUST BOARD**

**4th February 2016**

**Document Title:**
**(Revised 02.02.16)**

# Interim revenue support facility agreement £48.7m

**Action for the Board:**

1. To review the enclosed documents:

2. Appendix A – compliance matrix re: Schedule 8 terms and conditions
   This document has been prepared at the request of the Finance, Performance and Investment Committee to evaluate the Trust's compliance with the financial and governance requirements of this Schedule of the facility agreement.

   (i) Draft facility agreement
   (ii) Draft board minute
   (iii) Direct debit mandate
   (iv) Utilisation request template

   The documents per (ii) – (v) inclusive above were reviewed by the Finance, Performance and Investment Committee at its meeting on Wednesday 27th January. As stated above document (i) appendix A was prepared following this meeting at the request of the Finance, Performance and Investment Committee.

3. To approve the facility agreement for cash interim support funding (ISF) of £48.7m for 2015/16 from the Independent Trust Financing Facility (ITFF) **as recommended by the Finance, Performance and Investment Committee** and to approve the draft board minute which would record this approval and which would empower the Chief Executive and the Chief Financial Officer to sign the necessary loan documentation on behalf of the board.

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## Facility agreement

- The attached loan agreement is for interim support funding of £48.7m equivalent to the estimated ISF requirement the Trust has advised Monitor since July 2015.

- The Trust's cumulative drawdowns of £36.4m under its working capital facilities score against this estimated ISF requirement.

- Legal advice. No legal advice has been sought for this agreement as it is not deemed necessary for a facility agreement with the Secretary of State for Health. This is consistent with all the other agreements for borrowings already signed by the Trust and the Department of Health specifically: the £14.747m DH capital loans agreement, the £25m working capital facility agreement and the £19.6m working capital facility agreement.

- The key terns of the loan agreement are as follows:

1. A loan of £48.7m for revenue support i.e. to finance the Trust's 2015/16 income and expenditure deficit.

2. The Trust does not have to draw down the full loan in one tranche. In the event the Trust may achieve the minimum £3m cash balance required on 31st March by drawing less than £48.7m then it may do so without losing access to the remaining balance of the loan.

3. Interest rate is fixed at 1.5% per annum

4. Interest is paid at six monthly intervals

5. The minimum cash balance the Trust must maintain is £3m.

6. Disposals of asset (clause 16.4). The Trust would need to secure the written prior consent of the lender (Secretary of State for Health) before disposing of any material assets.

7. Repayment (100%) of the loan is required no later than 18th March 2018.

8. If the Trust was to repay any of the facility ahead of the final repayment date the amount repaid may not be re-borrowed.

**9. Schedule 8 Additional terms and conditions.**

The facility agreement includes a number of additional terms and conditions requiring the Trust to comply with financial and governance requirements - including for example the provision of information on spend, submission of an estates strategy, use of framework-only nursing agencies, controls over consultancy spend, the use of procurement P21 regulations, participation in bench-marking of services etc.

**In response to the request of the Finance, Performance and Investment Committee Appendix A to this paper provides the Trust executives' assessment of whether the Trust is compliant or non-compliant with these requirements and the reasons for this assessment for consideration by the Board.**

**Action following proposed approval of loan agreement by the Board**

- The Trust proposes to draw down £36.396m on 15th February under the interim revenue support facility agreement and with this sum repay in full the amounts drawn to date from the two working capital facilities. The purpose of this circular cash transaction is to take advantage of the lower interest rate of 1.5% available on the ISF facility: the Trust is currently paying 3.5% interest on monies drawn down from the second working capital facility.

- It should be noted that Monitor have corrected their previous advice in relation to the status of the two working capital facilities of £25m and £19.6m once the £48.7m interim revenue support facility has been activated. The £25m working capital facility would be available however the £19.6m working capital facility would not be available.

- On the basis of the M09 year end cash forecast this means that in 2016/17 the Trust would have access to approx £27.5m additional cash to finance a revenue deficit – comprising the £25m working capital facility and the £2.5m undrawn balance of the £48.7m interim revenue support facility.

**2016/17 projected cash flow**

The Trust is in the process of preparing the 2016/17 financial plan and so the cash flow forecast for next year is subject to significant change however a projected cash flow together with the assumptions underpinning the cash flow forecast is shown below.

On the basis of the projected cash flow the Trust would exhaust the £27.5m of approved borrowing available in February 2017 (quarter 3 per the projected cash flow) and require a further £3m (currently unapproved) ISF monies to achieve the minimum year end cash balance on 31t March 2017.

Please note this projected cash flow assumes the Trust incurs an income and expenditure deficit of £17.2m in 2016/17.

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department
2016/17: projected quarterly cash flow

| | 2016/17 Q1 £000 | 2016/17 Q2 £000 | 2016/17 Q3 £000 | 2016/17 Q4 £000 | 2016/17 Total £000 |
|---|---|---|---|---|---|
| **Cash balance b/fwd** | **3,000** | **3,000** | **3,000** | **3,000** | **3,000** |
| EBITDA | 3,778 | 4,992 | 4,233 | 4,990 | 17,993 |
| Non-cash income | -46 | -46 | -46 | -46 | -182 |
| Interest paid | -1,124 | -1,632 | -1,117 | -2,281 | -6,154 |
| PDC dividend paid | 0 | -2,400 | 0 | -2,400 | -4,800 |
| Operating surplus/-deficit less interest and dividends p | 2,608 | 915 | 3,070 | 264 | 6,857 |
| Change in stock | -450 | 225 | 250 | 575 | 600 |
| Change in debtors | -800 | 850 | 500 | 1,250 | 1,800 |
| Change in creditors | -1,500 | -1,000 | -1,500 | -2,000 | -6,000 |
| Net change in working capital | -2,750 | 75 | -750 | -175 | -3,600 |
| Provisions used | -75 | -75 | -75 | -75 | -300 |
| Interest received | 6 | 6 | 6 | 6 | 24 |
| Capital spend (pymts) - internal capital | -9,250 | -9,250 | -3,250 | -3,250 | -25,000 |
| Net cash inflow/-outflow from investing activities | -9,244 | -9,244 | -3,244 | -3,244 | -24,976 |
| Interim support funding requirement (ISF) | 11,722 | 10,191 | 3,441 | 5,172 | 30,525 |
| Loan repayments | -1,040 | -500 | -1,040 | -500 | -3,079 |
| PFI finance lease repayment | -232 | -232 | -232 | -232 | -928 |
| Other finance lease repayment | -990 | -1,130 | -1,170 | -1,210 | -4,500 |
| Net cash inflow/-outflow from financing | 9,460 | 8,330 | 999 | 3,231 | 22,018 |
| **Cash balance c/fwd** | **3,000** | **3,000** | **3,000** | **3,000** | **3,000** |

Notes and assumptions

1 Trust incurs income and expenditure deficit of £56.m in 2015/16 and borrows £46.2m ISF monies.
2 Trust incurs income and expenditure deficit of £17.2m in 2016/17
3 Cash funded capital expenditure is limited to £25m.
4 Energy Performance Contract capital expenditure accounts for approx £9.3m of this £25m capex total.
5 Finance lease funded capital expenditure is £6m.
6 No external capital loans taken out in year.
7 Capital expenditure heavily weighted to first two quarters (74% spent by 30/09) to address infrastructure renewal priorities.
8 Net working capital movement in year -£3.6m - improvement in stock (£0.6m) and debtors (£1.8m) offset by deterioration in creditors (-£6m) due to higher trading deficit and some erosion during the year of the 60 day supplier payment terms implemented in 2015/16.
9 Trust would require WCF/ISF drawdowns totalling approx £30m to finance the deficit, loan repayments and restricted capital programme.
10 Interest rate on first £25m for which approved WCF available = 1.5%
11 Interest rate on ISF required > £25m = weighted average 2.5% (weighted to expect 3.5% followed by 1.5% later in year)
12 Trust would exhaust the approved opening borrowing of £27.5m WCF/ISF monies in February (quarter 3) and would then require access to additional (currently unapproved) borrowing of approx £3m making a total ISF requirement for the year of £30.5m.

## Timeline

- The Trust Board is asked to approve the £47.7m interim revenue support facility agreement and approve the draft board minute would record this approval and which would empower the Chief Executive and the Chief Financial Officer to sign the necessary loan documentation on behalf of the board.

- Following board approval the Chairman, Chief Executive and Chief Financial Officer would sign the board minute, loan agreement and supporting documentation.

- The Trust would then request draw down of £36.396m for 15th February and on the same day repay the two working capital facilities in full as described above.

- The current 2015/16 cash flow forecast indicates the Trust will need to draw down approx. £9.7m from the ISF loan in mid-March to achieve the required minimum year end cash balance of £3m. This would bring cumulative WCF/ISF borrowings for the year to approx. £46.2m

- The Trust would then have £27.5m available for drawdown as approved borrowing in 2016/17.

**Author and Date:**

Dominic Sharp, Assistant Director of Finance – Financial Services

29th January 2016

**Contact details:**

Tel: 020 8725 1345 E-mail: Dominic.Sharp@stgeorges.nhs.uk

## APPENDIX A – COMPLIANCE MATRIX

### SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

| Ref no | Term / Condition | Compliant Yes/No | Reasons for Compliance response |
|---|---|---|---|
| 1. Surplus/Deficit and Capital Limits | | | |
| 1.1. | The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body. These Limits reflect the aggregate of Voted Funds available to the Lender at the date of this Agreement. | Yes. | The revenue deficit of £46m set with the regulator for the year is the Surplus/Deficit Limit. |
| 1.2. | The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement. | Yes. | The Board understands and recognises the Limits and the importance of meeting the Limit. |
| 1.3. | The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender. | Yes | When the Trust submits an utilisation request to Monitor and DH it is accompanied by a monthly income and expenditure forecast which shows whether the Limit is forecast to be exceeded as required by the regulator and the Lender. |
| 1.4. | In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted. | Yes. | As above. The forecast monthly expenditure profile is for the entire financial year and so the risk that the Limit may be exceeded is notified in advance. |
| 1.5. | The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing | Yes. | The Trust's forecast cash flows submitted to Monitor exclude any assumptions regarding unapproved borrowing. The Trust is |

| | | | |
|---|---|---|---|
| | previously agreed to support the relevant Limit(s). | | requesting an increase in the Limit for 2015/16 from £46m to £52.6m.<br>Where the forecast income and expenditure deficit for planning purposes indicates further financial support will be required that has not been previously agreed this is made clear in board papers and in submissions to the regulator and DH. |
| 1.6. | Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body. | Yes. | This is the prerogative of the Lender. The Trust will seek an increase in the 2015/16 Limit from £46m deficit to £52.6m |
| 1.7. | Performance against Limits will be monitored by the relevant Supervisory Body. | Yes. | This requirement is fulfilled by the routine monthly and quarterly returns submitted by the Trust to Monitor. |
| 1.8. | For the avoidance of doubt, as at the date of this Agreement and for the financial year to which this agreement relates, the Surplus/Deficit Limit is (£46,000,000) and the Capital Limit is not applicable. | Yes. | This is the Trust's planned revenue deficit for 2015/16 per the original plan to Monitor submitted in May 2015. Note only: The subsequent TRP forecast of £63m deficit process and revised forecast at M09 of £56.1m represent forecasts and not plans. |
| 2. Nursing agency expenditure: | | | |
| 2.1. | The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to: | | |
| 2.1.1. | Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body. | No. | The Trust's policy is to use only framework agencies however where they are unable to supply the Trust has on an exceptional basis used non-framework agencies when clinically necessary. It is not practicable to request the approval of the Supervisory Body to do so. |
| 2.1.2. | Implement an annual maximum limit for | Yes. | The Trust's workforce efficiency group is |

| | | | |
|---|---|---|---|
| | agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body. | | monitoring compliance with the requirements of the letter. |
| 2.1.3. | Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps. | Yes. | The Trust will implement any additional controls required. |
| 2.2. | The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions | Yes. | The Trust can confirm that it is implementing the 5 high impact actions. In particular the Trust is leading on the implementation of a South West London staff bank. |
| 3. Professional Services Consultancy Spend | | | |
| 3.1. | The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause. | Yes. | This control is in place. |
| 4. VSM Pay Costs | | | |
| 4.1. | Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500. | Yes. | This control is in place. |
| 4.2. | Where the borrower is not authorised as an | Not applicable. | |

| | | | |
|---|---|---|---|
| | NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500. | | |
| 4.3. | The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender. | Yes. | |
| 4.4. | The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment. | Yes. | All redundancy estimates and redundancies have applied the new rules since they came into force. |
| 5. Estate Costs | | | |
| 5.1. | The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. | Yes. | The Trust has recently undertaken two Estates and Facilities benchmarking exercises, one carried out by Green and Kassab and the other by KPMG. |

| | | | |
|---|---|---|---|
| | DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable. | | |
| 6. Surplus Land | | | |
| 6.1. | The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land. | Partially compliant | The Trust is nearing completion of an updated Estates Strategy and Development Control Plan that can be shared with the Lender prior to final Board approval in March. |
| 6.2. | The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020. | Partially compliant | As per 6.1 |
| 6.3. | The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied. | Partially compliant | As per 6.1 |
| 7. Procure21 | | | |
| 7.1. | The Borrower will use the P21+ | Partially compliant | The Trust currently uses P21+ on larger |

| | | | |
|---|---|---|---|
| | Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body. | | capital schemes in excess of £5m |
| 7.2. | Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework. | Yes. | The Trust demonstrates in the commercial section of any business case which procurement route represents best value and why. The Trust also already uses p21+ contracts for some major works. |
| 8. Finance and Accounting and Payroll | | | |
| 8.1. | The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower's finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement. | Yes. | The Trust has provided this data for bench-marking exercises previously including NHS Shared Business Services and SBS soft market testing / benchmarking is part of the Trust's back office modernisation programme. |
| 8.2. | Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender. | Yes. | The Trust has undertaken a bench-marking review of corporate support services in 2015/16. |
| 9. Bank Staffing | | | |

| | | | |
|---|---|---|---|
| 9.1. | The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement. | Yes. | The Trust has an effective Bank office function which has significantly increased supply of bank staff in certain staffing categories eg admin and clerical in the last two years and thereby saved agency premium costs. The Trust reviews the financial viability of the Bank office on a periodic basis. |
| 9.2. | Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender. | Yes. | The Trust is leading on the implementation of a SW London Bank and will consider this option determining the best solution. |
| 10. Procurement | | | |
| 10.1. | The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender, | Yes. | Non-pay expenditure data has already been provided in January 2016 in response to a data request from Monitor. |
| 10.2. | The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, | Yes | The procurement department continually reviews the costs of supplies from NHSSC in comparison to other suppliers. |

| | | | |
|---|---|---|---|
| | on the request of the Lender, | | |
| 10.3. | Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so. | Yes. | This is an integral part of the Trust's business as usual procurement and CIP monitoring activity. |
| 10.4. | The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender. | Yes | This information will be provided as and when requested. |
| 11. Crown Commercial Services ("CCS") | | | |
| 11.1. | The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so. | Yes. | The Trust Procurement function will always assess CCS for suitable solutions. However the Trust retains the right to source from all available routes to market where an alternative approach is both more cost effective, timely, provisions for a more suitable solution and where CCS does not cater for the need. |
| 11.2. | The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions. | Yes | |
| 12. EEA and non-EEA Patient Costs Reporting | | | |
| 12.1. | The Borrower undertakes to: | | |
| 12.1.1. | Become a member of the EEA portal and | Yes. | The Trust is a member of the portal and |

| | | | |
|---|---|---|---|
| | actively report EHIC and S2 patient activity on the portal | | reports this activity on the portal as required. |
| 12.1.2. | Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients) | Yes. | The Trust has participated in workshops organised by DH on overseas patient billing and costs recovery. |
| 12.1.3. | Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients. | Yes. | The Trust has implemented the risk-sharing model with effect from 1st April 2015 with its host commissioner. |
| 13 | On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule. | Yes. | The Trust has submitted data when requested by DH and other collaborative agencies. |

**DATED 2015**

**ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**
**(as Borrower)**

**and**

**THE SECRETARY OF STATE FOR HEALTH**
**(as Lender)**

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**£48,700,000**

# SINGLE CURRENCY INTERIM REVENUE SUPPORT FACILITY AGREEMENT

**REF NO: DHPF/ISWBL/RJ7/2015-12-15/A**

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**THIS AGREEMENT** is dated 2015 and made between:

(1) **ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** of**, Blackshaw Road, Tooting, London, SW17 0QT** (the **"Borrower" which expression shall include any successors in title or permitted transferees or assignees**); and

(2) **THE SECRETARY OF STATE FOR HEALTH** as lender (the **"Lender" which expression shall include any successors in title or permitted transferees or assignees**).

**IT IS AGREED** as follows:

## 1. DEFINITIONS AND INTERPRETATION

### 1.1 Definitions

In this Agreement:

**"Account"** means the Borrower's account held with the Government Banking Service.

**"Act"** means the National Health Service Act 2006 as amended from time to time.

**"Additional Terms and Conditions"** means the terms and conditions set out in Schedule 8.

**"Agreed Purpose"** means working capital expenditure for use only if it has insufficient working capital available as set out under the Terms of this Agreement, to maintain the provision of the Borrower's services in its capacity as an NHS Body. For the purposes of this agreement, working capital expenditure shall include repayment of outstanding loans under any working capital facility provided by the Lender to the Borrower.

**"Authorisation"** means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

**"Available Facility"** means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

**"Availability Period"** means two years from and including the date of this Agreement. The Availability Period may be extended, at the Borrower's option, subject to no outstanding Event of Default. Any extension can be for a period of up to twelve months, subject to the Availability Period expiring no later than the Final Repayment Date.

**"Business Day"** means a day (other than a Saturday or Sunday) on which banks are open for general banking business in London.

**"Capital Limit"** means the overall maximum net inflow/outflow from investing activities incurred by the Borrower as set by the Lender for any relevant financial year

**"Cash Balance"** means the Borrower's available cash balances, whether held within the Government Banking Service or otherwise, on the Utilisation Date to the Monday preceding the 18th day of the following Month.

**"Cashflow Forecast"** means the Borrower's current rolling 13 week cashflow forecast in a form to be agreed with the Lender from time to time (and as prepared on behalf of the Borrower's Board). The forecast must include all utilisations and proposed utilisations under any agreement with the Lender for the relevant period.

**"Compliance Framework"** means the relevant Supervisory Body's frameworks and/or any replacement to such frameworks for monitoring and assessing NHS Bodies and their compliance with any consents, permissions and approvals.

**"Dangerous Substance"** means any natural or artificial substance (whether in a solid or liquid form or in the form of a gas or vapour and whether alone or in combination with any such other substance) capable of causing harm to the Environment or damaging the Environment or public health or welfare including any noxious, hazardous, toxic, dangerous, special or controlled waste or other polluting substance or matter.

**"Default"** means an Event of Default or any event or circumstance specified in Clause 18 (*Events of Default*) which would (with the expiry of a grace period, the giving of notice, the making of any determination under the Finance Documents or any combination of any of the foregoing) be an Event of Default.

**"Default Rate"** means the official bank rate (also called the Bank of England base rate or BOEBR) plus 300 basis points per annum.

**"Deficit Limit"** means the Surplus/Deficit outturn for the Borrower set by the Lender for any relevant financial year before impairments and transfers.

**"Environment"** means the natural and man-made environment and all or any of the following media namely air (including air within buildings and air within other natural or man-made structures above or below ground), water (including water under or within land or in drains or sewers and inland waters), land and any living organisms (including humans) or systems supported by those media.

**"Environmental Claim"** means any claim alleging liability whether civil or criminal and whether actual or potential arising out of or resulting from the presence at on or under property owned or occupied by the Borrower or presence in or escape or release into the environment of any Dangerous Substance from any such property or in circumstances attributable to the operation of the Borrower's activities or any breach of any applicable Environmental Law or any applicable Environmental Licence.

**"Environmental Law"** means all statutes, instruments, regulations, orders and ordinances (including European Union legislation, regulations, directives, decisions and judgements applicable to the United Kingdom) being in force from time to time and directly enforceable in the United Kingdom relating to pollution, prevention thereof or protection of human health or the conditions of the Environment or the use, disposal, generation, storage, transportation, treatment, dumping, release, deposit, burial, emission or disposal of any Dangerous Substance.

**"Environmental Licence"** shall mean any permit, licence, authorisation, consent or other approval required by any Environmental Law or the Planning (Hazardous Substances) Act 1990.

**"Event of Default"** means any event or circumstance specified as such in Clause 18 (*Events of Default*).

**"Facility"** means the Interim Support facility made available under this Agreement as described in Clause 2 (*The Facility*).

**"Facility Amount"** means £48,700,000 at the date of this Agreement and thereafter that amount to the extent not cancelled, reduced or transferred by the Lender or the Borrower (as may be amended by the Lender from time to time).

**"Final Repayment Date"** means 18/03/2018.

**"Finance Documents"** means:

(A) this Agreement; and

(B) any other document designated as such by the Lender and the Borrower.

**"Financial Indebtedness"** means any indebtedness for or in respect of:

(A) moneys borrowed;

(B) any amount raised by acceptance under any acceptance credit facility;

(C) any amount raised pursuant to any note purchase facility or the issue of bonds, notes, debentures, loan stock or any similar instrument;

(D) the amount of any liability in respect of any lease or hire purchase contract which would, in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies, be treated as a finance or capital lease;

(E) receivables sold or discounted (other than any receivables to the extent they are sold on a non-recourse basis);

(F) any amount raised under any other transaction (including any forward sale or purchase agreement) having the commercial effect of a borrowing;

(G) any derivative transaction entered into in connection with protection against or benefit from fluctuation in any rate or price (and, when calculating the value of any derivative transaction, only the marked to market value shall be taken into account);

(H) any counter-indemnity obligation in respect of a guarantee, indemnity, bond, standby or documentary letter of credit or any other instrument issued by a bank or financial institution; and

(I) the amount of any liability in respect of any guarantee or indemnity for any of the items referred to in paragraphs (A) to (H) above.

**“Government Banking Service”** means the body established in April 2008 being the banking shared service provider to government and the wider public sector incorporating the Office of HM Paymaster General (OPG).

**"Interest Payment Date"** means the last day of an Interest Period.

**"Interest Period"** means, in relation to a Loan, the period determined in accordance with Clause 9 (*Interest Periods*) and, in relation to an Unpaid Sum, each period determined in accordance with Clause 8.3 *(Default interest).*

"**Interest Rate**" means 1.5% per annum.

**"Licence"** means the licence issued by Monitor to any person who provides a health care service for the purposes of the NHS.

**"Limits"** means the Deficit Limit and/or the Capital Limit where set out in the Finance Document

**"Loan"** means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

**"Material Adverse Effect"** means a material adverse effect on:

(A) the business or financial condition of the Borrower;

(B) the ability of the Borrower to perform any of its material obligations under any Finance Document;

(C) the validity or enforceability of any Finance Document; or

(D) any right or remedy of the Lender in respect of a Finance Document.

**"Minimum Cash Balance"** means £3,000,000.

"**Monitor**" means the sector regulator for health care services in England or any successor body to that organisation

**"Month"** means a period starting on one day in a calendar month and ending on the numerically corresponding day in the next calendar month, except that:

(A) (subject to paragraph (C) below) if the numerically corresponding day is not a Business Day, that period shall end on the next Business Day in that calendar month in which that period is to end if there is one, or if there is not, on the immediately preceding Business Day;

(B) if there is no numerically corresponding day in the calendar month in which that period is to end, that period shall end on the last Business Day in that calendar month; and

(C) if a period begins on the last Business Day of a calendar month, that period shall end on the last Business Day in the calendar month in which that period is to end,

provided that the above rules will only apply to the last Month of any period.

**"NHS Body"** means either an NHS Trust or an NHS Foundation Trust , or any successor body to that organisation**.**

**"NHS Trust Development Authority"** means the body responsible for monitoring the performance of NHS Trusts and providing assurance of clinical quality, governance and risk in NHS Trusts, or any successor body to that organisation;

**"Original Financial Statements"** means a certified copy of the audited financial statements of the Borrower for the financial year ended 31st March 2015.

**"Participating Member State"** means any member state of the European Communities that adopts or has adopted the euro as its lawful currency in accordance with legislation of the European Community relating to Economic and Monetary Union.

**"Party"** means a party to this Agreement.

**"Permitted Security"** means:

(A) normal title retention arrangements arising in favour of suppliers of goods acquired by the Borrower in the ordinary course of its business or arising under conditional sale or hiring agreements in respect of goods acquired by the Borrower in the ordinary course of its business;

(B) liens arising by way of operation of law in the ordinary course of business so long as the amounts in respect of which such liens arise are not overdue for payment;

(C) any existing Security listed in Schedule 7;

(D) any Security created or outstanding with the prior written consent of the Lender; and

(E) any other Security securing in aggregate not more than £150,000 at any time.

**"Relevant Consents"** means any authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration of whatsoever nature necessary or appropriate to be obtained for the purpose of entering into and performing the Borrower's obligations under the Finance Documents.

**"Relevant Percentage"** means in respect of each Repayment Date, the percentage figure set opposite such Repayment Date in the Repayment Schedule.

**"Repayment Dates"** means the repayment dates set out in the Schedule 6 (Repayment Schedule).

**"Repayment Instalment"** means each instalment for the repayment of the Loan referred to in Clause 6.2.

**"Repayment Schedule"** means the repayment schedule set out in Schedule 6 (*Repayment Schedule*).

**"Repeating Representations"** means each of the representations set out in Clause 14 (*Representations*) other than those under Clauses 14.9, 14.10, 14.12.2 and 14.16.2.

**"Security"** means a mortgage, charge, pledge, lien or other security interest securing any obligation of any person or any other agreement or arrangement having a similar effect.

**"Supervisory Body"** means either the NHS Trust Development Authority and/or Monitor.

**"Tax"** means any tax, levy, impost, duty or other charge or withholding of a similar nature (including any penalty or interest payable in connection with any failure to pay or any delay in paying any of the same).

**"Tax Deduction"** means a deduction or withholding for or on account of Tax from a payment under a Finance Document.

**"Test Date"** means the Utilisation Date and each Interest Payment Date.

**"Unpaid Sum"** means any sum due and payable but unpaid by the Borrower under the Finance Documents.

**"Utilisation"** means a utilisation of the Facility.

**"Utilisation Date"** means the date of a Utilisation, on which a drawing is to be made under the Facility, such date to be the Monday preceding the 18th day of any month.

**"Utilisation Request"** means a notice substantially in the form set out in Schedule 2 (*Utilisation Request*).

**"VAT"** means value added tax as provided for in the Value Added Tax Act 1994 and other tax of a similar nature, whether imposed in the UK or elsewhere.

1.2 **Construction**

1.2.1 Unless a contrary indication appears, any reference in any Finance Document to:

(A) the **"Lender"**, the **"Borrower"** the **"Supervisory Body"** or any **"Party"** shall be construed so as to include its successors in title, permitted assigns and permitted transferees;

(B) **"assets"** includes present and future properties, revenues and rights of every description;

(C) a **"Finance Document"** or any other agreement or instrument is a reference to that Finance Document or other agreement or instrument as amended or novated;

(D) **"indebtedness"** shall be construed so as to include any obligation (whether incurred as principal or as surety) for the payment or repayment of money, whether present or future, actual or contingent;

(E) a **"person"** includes any person, firm, company, corporation, government, state or agency of a state or any association, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing;

(F) a **"regulation"** includes any regulation, rule, official directive, request or guideline (whether or not having the force of law) of any governmental, intergovernmental or supranational body, agency, department or regulatory, self-regulatory or other authority or organisation;

(G) **"repay"** (or any derivative form thereof) shall, subject to any contrary indication, be construed to include **"prepay"** (or, as the case may be, the corresponding derivative form thereof);

(H) a provision of law is a reference to that provision as amended or re-enacted;

(I) a time of day is a reference to London time; and

(J) the word **"including"** is without limitation.

1.2.2 Section, Clause and Schedule headings are for ease of reference only.

1.2.3 Unless a contrary indication appears, a term used in any other Finance Document or in any notice given under or in connection with any Finance Document has the same meaning in that Finance Document or notice as in this Agreement.

1.2.4 A Default (other than an Event of Default) is **"continuing"** if it has not been remedied or waived and an Event of Default is **"continuing"** if it has not been waived or remedied to the satisfaction of the Lender.

1.3 **Third party rights**

1.3.1 Except as provided in a Finance Document, the terms of a Finance Document may be enforced only by a party to it and the operation of the Contracts (Rights of Third Parties) Act 1999 is excluded.

1.3.2 Notwithstanding any provision of any Finance Document, the Parties to a Finance Document do not require the consent of any third party to rescind or vary any Finance Document at any time.

## 2. THE FACILITY

2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower a sterling interim support facility in an aggregate amount equal to the Facility Amount.

2.2 The Facility shall be utilised by the Borrower for the purposes of and/or in connection with its functions as an NHS Body.

## 3. PURPOSE

### 3.1 Purpose

The Borrower shall apply all Loans towards financing or refinancing the Agreed Purpose.

### 3.2 Pending application

Without prejudice to Clause 3.1 *(Purpose)*, pending application of the proceeds of any Loan towards financing or refinancing the Agreed Purpose, the Borrower must deposit such proceeds in the Account.

### 3.3 Monitoring

The Lender is not bound to monitor or verify the application of any amount borrowed pursuant to this Agreement.

## 4. CONDITIONS OF UTILISATION

### 4.1 Initial conditions precedent

The Borrower may not deliver the first Utilisation Request unless the Lender has received all of the documents and other evidence listed in Schedule 1 (*Conditions precedent*) in form and substance satisfactory to the Lender or to the extent it has not received the same, it has waived receipt of the same. The Lender shall notify the Borrower promptly upon being so satisfied.

### 4.2 Further conditions precedent

The Lender will only be obliged to comply with a Utilisation Request if on the date of the Utilisation Request and on the proposed Utilisation Date:

4.2.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware;

4.2.2 the Repeating Representations to be made by the Borrower with reference to the facts and circumstances then subsisting are true in all material respects; and,

4.2.3 the Borrower has provided to the Lender its most recent 13 week cash flow forecast, together with any other information that may from time to time be required.

## 5. UTILISATION

### 5.1 Utilisation

5.1.1 The Borrower may take Loans from time to time hereunder, subject to receipt by the Lender from the Borrower, of a Utilisation Request in accordance with this Agreement and an appropriate Cashflow Forecast.

5.1.2 The Utilisation Request must be for an amount not greater than the amount specified under Clause 5.4.2

5.1.3 Where agreed by the Lender, the proceeds of a Utilisation may be used to repay outstanding loans under any working capital facility between the Lender and the Borrower provided that:

(A) Such agreement is granted by the Lender;

(B) any request is included in the Cashflow Forecast; and

(C) that such repayment is received by the Lender on the same working day as the Utilisation.

5.2 **Delivery of a Utilisation Request**

The Borrower may utilise the Facility by delivery to the Lender of a duly completed Utilisation Request not later than 11.00 a.m. five Business Days before the proposed Utilisation Date unless otherwise agreed.

5.2.1 The Borrower may only issue one Utilisation Request per Month unless otherwise agreed.

5.3 **Completion of a Utilisation Request**

The Utilisation Request is irrevocable and will not be regarded as having been duly completed unless:

(A) the proposed Utilisation Date is a Business Day within the Availability Period; and

(B) the currency and amount of the Utilisation comply with Clause 5.4 (*Currency and amount*).

5.4 **Currency and amount**

5.4.1 The currency specified in the Utilisation Request must be sterling.

5.4.2 The amount of each proposed Loan must be an amount which is not more than the amount required to maintain a Cash Balance equivalent to the Minimum Cash Balance for a period from the Utilisation Date to the Monday preceding the 18th day of the following Month

5.4.3 The amount of each proposed Loan must be an amount which is not more than the Available Facility and which is a minimum of £150,000 or, if less, the Available Facility.

5.5 **Payment to the Account**

The Lender shall pay each Loan:

5.5.1 by way of credit to the Account and so that, unless and until the Lender shall notify the Borrower to the contrary, the Lender hereby consents to the withdrawal by the Borrower from the Account of any amount equal to the relevant Loan provided that any sums so withdrawn are applied by the Borrower for the purposes for which the relevant Loan was made;

5.5.2 if the Lender so agrees or requires, on behalf of the Borrower directly to the person to whom the relevant payment is due as specified in the relevant Utilisation Request; or

5.5.3 in such other manner as shall be agreed between the Lender and the Borrower.

## 6. PAYMENTS AND REPAYMENT

### 6.1 Payments

6.1.1 The Borrower shall make all payments payable under the Finance Documents without any Tax Deductions, unless a Tax Deduction is required by law.

6.1.2 The Borrower shall promptly upon becoming aware that it must make a Tax Deduction (or that there is any change in the rate or the basis of a Tax Deduction) notify the Lender accordingly.

6.1.3 If a Tax Deduction is required by law to be made by the Borrower, the amount of the payment due from the Borrower shall be increased to an amount which (after making any Tax Deduction) leaves an amount equal to the payment which would have been due if no Tax Deduction had been required.

6.1.4 If the Borrower is required to make a Tax Deduction, the Borrower shall make that Tax Deduction and any payment required in connection with that Tax Deduction within the time allowed and in the minimum amount required by law.

6.1.5 Within thirty days of making either a Tax Deduction or any payment required in connection with that Tax Deduction, the Borrower shall deliver to the Lender evidence reasonably satisfactory to the Lender that the Tax Deduction has been made or (as applicable) any appropriate payment paid to the relevant taxing authority.

### 6.2 Repayment

The Borrower shall repay the aggregate value of all outstanding Loans drawn under the Facility in full on or before the last day of the current Availability Period as set out in Schedule 6 *(Repayment Schedule)*.

### 6.3 Reborrowing

The Borrower may not reborrow any part of the Facility which is repaid or prepaid.

## 7. PREPAYMENT AND CANCELLATION

### 7.1 Illegality

If it becomes unlawful in any applicable jurisdiction for the Lender to perform any of its obligations as contemplated by this Agreement or to fund or maintain all or any part of the Loans:

7.1.1 the Lender shall promptly notify the Borrower upon becoming aware of that event;

7.1.2 upon the Lender notifying the Borrower, the Available Facility will be immediately cancelled; and

7.1.3 the Borrower shall repay such Loans on the last day of the Interest Period for Loans occurring after the Lender has notified the Borrower or, if earlier, the date specified by the Lender in the notice delivered to the Borrower (being no earlier than the last day of any applicable grace period permitted by law).

### 7.2 Voluntary cancellation

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, cancel the whole or any part (being a minimum amount of £100,000) of the Facility Amount.

7.3 **Voluntary prepayment of Loans**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than thirty days' prior notice, prepay the whole or any part of any Loan (but, if in part, being an amount that reduces the amount of the Loan by a minimum amount of £250,000).

7.4 **Restrictions**

7.4.1 Any notice of cancellation or prepayment given by any Party under this Clause 7 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall specify the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that cancellation or prepayment.

7.4.2 Any prepayment under this Agreement shall be made together with accrued interest on the amount prepaid without premium or penalty and applied against the outstanding Repayment Instalments in inverse order of maturity.

7.4.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

7.4.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

7.5 **Automatic Cancellation**

At the end of the Availability Period the undrawn part of the Available Facility will be cancelled.

## 8. INTEREST

8.1 **Calculation of interest**

The rate of interest on each Loan for each Interest Period is the Interest Rate.

8.2 **Payment of interest**

The Borrower shall pay accrued interest on each Loan on the last day of each Interest Period.

8.3 **Default interest**

8.3.1 If the Borrower fails to pay any amount payable by it under a Finance Document on its due date, interest shall accrue on Unpaid Sums from the due date up to the date of actual payment (both before and after judgment) at the Default Rate. Any interest accruing under this Clause 8.3 shall be immediately payable by the Borrower on demand by the Lender.

8.3.2 Default interest (if unpaid) arising on an overdue amount will be compounded with the overdue amount at the end of each Interest Period applicable to that overdue amount but will remain immediately due and payable.

## 9. INTEREST PERIODS

9.1 **Interest Payment Dates**

The Interest Period for each Loan shall be six Months, provided that any Interest Period which begins during another Interest Period shall end at the same time as that other Interest Period (and, where two or more such Interest Periods expire on the same day, the Loans to which those Interest Periods relate shall thereafter constitute and be referred to as one Loan).

9.2 **Shortening Interest Periods**

If an Interest Period would otherwise overrun the relevant Repayment Date, it shall be shortened so that it ends on the relevant Repayment Date.

9.2A **Payment Start Date**

Each Interest Period for a Loan shall start on the Utilisation Date or (if already made) on the last day of its preceding Interest Period.

9.3 **Non-Business Days**

If an Interest Period would otherwise end on a day which is not a Business Day, that Interest Period will instead end on the next Business Day in that calendar month (if there is one) or the preceding Business Day (if there is not).

9.4 **Consolidation of Loans**

If two or more Interest Periods end on the same date, those Loans will be consolidated into and be treated as a single Loan on the last day of the Interest Period.

## 10. PREPAYMENT AMOUNT

10.1.1 If all or any part of the Loans are subject to a voluntary prepayment pursuant to Clause 7.3 (*Voluntary prepayment of Loans*), the Borrower shall pay to the Lender on the relevant prepayment date the Prepayment Amount in respect of the same.

10.1.2 For as long as the Secretary of State for Health remains the Lender, the Lender will consider waiving the Prepayment Amount in cases where the Borrower can demonstrate to the Lender's satisfaction that the voluntary prepayment results from the Borrower's proper use of genuine surplus funds resulting from a sale of assets or trading activities.

## 11. INDEMNITIES

11.1 **Currency indemnity**

11.1.1 If any sum due from the Borrower under the Finance Documents (a **"Sum"**), or any order, judgment or award given or made in relation to a Sum, has to be converted from the currency (the **"First Currency"**) in which that Sum is payable into another currency (the **"Second Currency"**) for the purpose of:

(A) making or filing a claim or proof against the Borrower;

(B) obtaining or enforcing an order, judgment or award in relation to any litigation or arbitration proceedings,

the Borrower shall as an independent obligation, within five Business Days of demand, indemnify the Lender against any cost, loss or liability arising out of or as a result of the conversion including any discrepancy between (A) the rate of exchange used to convert that Sum from the First Currency into the Second Currency and (B) the rate or rates of exchange available to that person at the time of its receipt of that Sum.

11.1.2 The Borrower waives any right it may have in any jurisdiction to pay any amount under the Finance Documents in a currency or currency unit other than that in which it is expressed to be payable.

11.2 **Other indemnities**

The Borrower shall, within five Business Days of demand, indemnify the Lender against any cost, loss or liability incurred by the Lender as a result of:

11.2.1 the occurrence of any Event of Default;

11.2.2 a failure by the Borrower to pay any amount due under a Finance Document on its due date;

11.2.3 funding, or making arrangements to fund, all or any part of the Loans requested by the Borrower in a Utilisation Request but not made by reason of the operation of any one or more of the provisions of this Agreement (other than by reason of default or negligence by the Lender alone); or

11.2.4 the Loans (or part of the Loans) not being prepaid in accordance with a notice of prepayment given by the Borrower.

11.3 **Indemnity to the Lender**

The Borrower shall promptly indemnify the Lender against any cost, loss or liability incurred by the Lender (acting reasonably) as a result of:

11.3.1 investigating any event which it reasonably believes is a Default; or

11.3.2 acting or relying on any notice, request or instruction which it reasonably believes to be genuine, correct and appropriately authorised.

11.4 **Environmental indemnity**

The Borrower shall promptly indemnify the Lender within five Business Days of demand in respect of any judgments, liabilities, claims, fees, costs and expenses (including fees and disbursements of any legal, environmental consultants or other professional advisers) suffered or incurred by the Lender as a consequence of the breach of or any liability imposed under any Environmental Law with respect to the Borrower or its property (including the occupation or use of such property).

## 12. MITIGATION BY THE LENDER

12.1 **Mitigation**

12.1.1 The Lender shall, in consultation with the Borrower, take all reasonable steps to mitigate any circumstances which arise and which would result in any amount becoming payable under or pursuant to, or cancelled pursuant to Clause 7.1 (Illegality) including transferring its rights and obligations under the Finance Documents to another entity owned or supported by the Lender.

12.1.2 Clause 12.1.1 does not in any way limit the obligations of the Borrower under the Finance Documents.

12.2 **Limitation of liability**

12.2.1 The Borrower shall indemnify the Lender for all costs and expenses reasonably incurred by the Lender as a result of steps taken by it under Clause 12.1 (Mitigation).

12.2.2 The Lender is not obliged to take any steps under Clause 12.1 (Mitigation) if, in its opinion (acting reasonably), to do so might be prejudicial to it.

## 13. COSTS AND EXPENSES

13.1 **Enforcement costs**

The Borrower shall, within three Business Days of demand, pay to the Lender the amount of all costs and expenses (including legal fees) incurred by the Lender in connection with the enforcement of, or the preservation of any rights under, any Finance Document.

## 14. REPRESENTATIONS

The Borrower makes the representations and warranties set out in this Clause 14 to the Lender on the date of this Agreement.

14.1 **Status**

14.1.1 It is an NHS Body in accordance with the provisions of the Act.

14.1.2 It has the power to own its assets and carry on its business as it is being conducted.

14.2 **Binding obligations**

The obligations expressed to be assumed by it in each Finance Document are legal, valid, binding and enforceable obligations.

14.3 **Non-conflict with other obligations**

The entry into and performance by it of, and the transactions contemplated by, the Finance Documents to which it is party do not and will not conflict with:

14.3.1 any law or regulation applicable to it;

14.3.2 its constitutional documents; or

14.3.3 any agreement or instrument binding upon it or any of its assets.

14.4 **Power and authority**

It has the power to enter into, exercise its rights under, perform and deliver, and has taken all necessary action to authorise its entry into, performance and delivery of, the Finance Documents to which it is a party and the transactions contemplated by those Finance Documents.

14.5 **Validity and admissibility in evidence**

All Authorisations required:

14.5.1 to enable it lawfully to enter into, exercise its rights and comply with its obligations in the Finance Documents to which it is a party; and

14.5.2 to make the Finance Documents to which it is a party admissible in evidence in its jurisdiction of incorporation,

have been obtained or effected and are in full force and effect.

14.6 **Relevant Consents**

14.6.1 All Relevant Consents which it is necessary or appropriate for the Borrower to hold have been obtained and effected and are in full force and effect.

14.6.2 There exists no reason known to it, having made all reasonable enquiries, why any Relevant Consent might be withdrawn, suspended, cancelled, varied, surrendered or revoked.

14.6.3 All Relevant Consents and other consents, permissions and approvals have been or are being complied with.

14.7 **Governing law and enforcement**

14.7.1 The choice of English law as the governing law of the Finance Documents will be recognised and enforced by the courts of England and Wales.

14.7.2 Any judgment obtained in England in relation to a Finance Document will be recognised and enforced by the courts of England and Wales.

14.8 **Deduction of Tax**

It is not required to make any deduction for or on account of Tax from any payment it may make under any Finance Document.

14.9 **No filing or stamp taxes**

It is not necessary that the Finance Documents be filed, recorded or enrolled with any court or other authority in any jurisdiction or that any stamp, registration or similar tax be paid on or in relation to the Finance Documents or the transactions contemplated by the Finance Documents.

14.10 **No default**

14.10.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.10.2 No other event which constitutes a default under any other agreement or instrument which is binding on it or to which its assets are subject which might have a Material Adverse Effect might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.11 **No misleading information**

14.11.1 All factual information provided by or on behalf of the Borrower in connection with the Borrower or any Finance Document was true and accurate in all material respects as at the date it was provided or as at the date (if any) at which it is stated.

14.11.2 Any financial projections provided to the Lender by or on behalf of the Borrower have been prepared on the basis of recent historical information and on the basis of reasonable assumptions.

14.11.3 Nothing has occurred or been omitted and no information has been given or withheld that results in the information referred to in Clause 14.12.1 being untrue or misleading in any material respect.

14.12 **Financial statements**

14.12.1 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) were prepared in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies and/or any other guidance with which NHS Bodies are (or in the case of the Original Financial Statements were) required to comply.

14.12.2 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) fairly represent its financial condition and operations during the relevant financial year.

14.12.3 There has been no material adverse change in the business or financial condition of the Borrower since the date to which its financial statements most recently delivered to the Lender were made up.

14.13 **Ranking**

Its payment obligations under the Finance Documents rank at least pari passu with the claims of all its other unsecured and unsubordinated creditors, except for obligations mandatorily preferred by law.

14.14 **No proceedings pending or threatened**

No litigation, arbitration or administrative proceedings of or before any court, arbitral body or agency which, if adversely determined, might reasonably be expected to have a Material Adverse Effect have (to the best of its knowledge and belief) been started or threatened against it.

14.15 **Environmental Matters**

14.15.1 It is and has been in full compliance with all applicable Environmental Laws and there are, to the best of its knowledge and belief after reasonable enquiry, no circumstances that may prevent or interfere with such full compliance in the future, in each case to the extent necessary to avoid a Material Adverse Effect and the Borrower has not other than in the ordinary course of its activities placed or allowed to be placed on any part of its property any Dangerous Substance and where such Dangerous Substance has been so placed, it is kept, stored, handled, treated and transported safely and prudently so as not to pose a risk of harm to the Environment.

14.15.2 It is and has been, in compliance in all material respects with the terms of all Environmental Licences necessary for the ownership and operation of its activities as presently owned and operated and as presently proposed to be owned and operated.

14.15.3 It is not aware, having made reasonable enquiries, of any Environmental Claim.

14.16 **Repetition**

The Repeating Representations are deemed to be made by the Borrower by reference to the facts and circumstances then existing on the date of each Utilisation Request and on the first day of each Interest Period.

## 15. INFORMATION UNDERTAKINGS

The undertakings in this Clause 15 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

15.1 **Financial statements**

The Borrower shall supply to the Lender its audited financial statements for each financial year and its financial statements for each financial half year (including any monitoring returns sent to the appropriate Supervisory Body), in each case when such statements are provided to the appropriate Supervisory Body.

15.2 **Requirements as to financial statements**

15.2.1 Each set of financial statements delivered by the Borrower pursuant to Clause 15.1 (Financial statements) shall be certified by a director of the Borrower, acting on the instructions of the board of directors of the Borrower, as fairly representing its

financial condition as at the date as at which those financial statements were drawn up.

15.2.2 The Borrower shall procure that each set of financial statements delivered pursuant to Clause 15.1 (Financial statements) is prepared in accordance with any applicable Audit Code for NHS Bodies and any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies or in the case of the Original Financial Statements in accordance with such guidelines with which NHS Bodies are required to comply.

15.3 **Information: miscellaneous**

The Borrower shall supply to the Lender:

15.3.1 copies or details of all material communications between the Borrower and the relevant Supervisory Body, including all relevant official notices received by the Borrower promptly after the same are made or received and, upon the Lender's request, any other relevant documents, information and returns sent by it to the appropriate Supervisory Body;

15.3.2 copies or details of all material communications between the Borrower and its members or its creditors (or in each case any class thereof), including all official notices received by the Borrower promptly after the same are made or received and upon the Lender's request any and all other documents dispatched by it to its members or its creditors (or in each case any class thereof), promptly after they are sent to such members or creditors;

15.3.3 details of any breaches by the Borrower of the Compliance Framework;

15.3.4 details of any breaches by the Borrower of the Licence or the terms of their Licence;

15.3.5 details of any other financial assistance or guarantee requested or received from the Secretary of State for Health other than in the ordinary course of business promptly after the same are requested or received;

15.3.6 upon the Lender's request, information regarding the application of the proceeds of the Facility;

15.3.7 promptly upon becoming aware of them, the details of any litigation, arbitration and/or administrative proceedings which are current, threatened or pending against the Borrower which would reasonably be expected to have a Material Adverse Effect;

15.3.8 promptly, such further information regarding the financial condition, business and operations of the Borrower as the Lender may reasonably request to the extent the same are relevant to the Borrower's obligations under this Agreement or otherwise significant in the assessment of the Borrower's financial performance and further to the extent that the disclosure of information will not cause the Borrower to be in breach of any obligation of confidence owed to any third party or any relevant data protection legislation; and

15.3.9 any change in the status of the Borrower after the date of this Agreement

15.4 **Notification of default**

15.4.1 The Borrower shall notify the Lender of any Default (and the steps being taken to remedy it) promptly upon becoming aware of its occurrence.

15.4.2 Promptly upon a request by the Lender, the Borrower shall supply a certificate signed by two of its directors (acting on the instructions of the board of directors of the

Borrower) on its behalf certifying that no Default is continuing (or if a Default is continuing, specifying the Default and the steps, if any, being taken to remedy it).

15.5 **Other information**

The Borrower shall promptly upon request by the Lender supply, or procure the supply of, such documentation and other evidence as is reasonably requested by the Lender (for itself or on behalf of a prospective transferee) in order for the Lender (or such prospective transferee) to carry out and be satisfied with the results of all necessary money laundering and identification checks in relation to any person that it is required to carry out pursuant to the transactions contemplated by the Finance Documents.

## 16. GENERAL UNDERTAKINGS

The undertakings in this Clause 16 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

16.1 **Authorisations**

The Borrower shall promptly:

16.1.1 obtain, comply with and do all that is necessary to maintain in full force and effect; and

16.1.2 supply certified copies to the Lender of any Authorisation required under any law or regulation of its jurisdiction of incorporation to enable it to perform its obligations under the Finance Documents and to ensure the legality, validity, enforceability or admissibility in evidence in England of any Finance Document.

16.2 **Compliance with laws**

The Borrower shall comply in all respects with all laws to which it may be subject, if failure so to comply would materially impair its ability to perform its obligations under the Finance Documents and shall exercise its powers and perform its functions in accordance with its constitutional documents.

16.3 **Negative pledge**

16.3.1 The Borrower shall not without the prior written consent of the Lender (such consent not to be unreasonably withheld or delayed) create or permit to subsist any Security over any of its assets save for any Permitted Security.

16.3.2 The Borrower shall not:

(A) sell, transfer or otherwise dispose of any of its assets on terms whereby they are or may be leased to or re-acquired by it;

(B) sell, transfer or otherwise dispose of any of its receivables on recourse terms;

(C) enter into any arrangement under which money or the benefit of a bank or other account may be applied, set-off or made subject to a combination of accounts; or

(D) enter into any other preferential arrangement having a similar effect,

in circumstances where the arrangement or transaction is entered into primarily as a method of raising Financial Indebtedness or of financing the acquisition of an asset.

16.4 **Disposals**

16.4.1 The Borrower shall not in a single transaction or a series of transactions (whether related or not) and whether voluntary or involuntary sell, lease, transfer or otherwise dispose of any material asset without the prior written consent of the Lender.

16.4.2 Clause 16.4.1 does not apply to:

(A) any sale, lease, transfer or other disposal where the higher of the market value or consideration receivable does not (in aggregate) in any financial year exceed 10% of the total net assets of the Borrower as at the end of the most recent financial year end for which audited financial statements have been published.

(B) any sale, lease, transfer or other disposal expressly identified in Schedule 8..

16.5 **Merger**

Without prejudice to Clause 16.4 (disposals) the Borrower shall not, without the prior written consent of the Lender, enter into nor apply to the relevant Supervisory Body (including pursuant to Section 56 of the Act) to enter into any amalgamation, demerger, merger or corporate reconstruction.

16.6 **Guarantees**

The Borrower will not, without the prior written consent of the Lender, give or permit to exist any guarantee or indemnity by it of any obligation of any person, nor permit or suffer any person to give any security for or guarantee or indemnity of any of its obligations except for guarantees and indemnities:

16.6.1 made in the ordinary course of the Borrower's business as an NHS Body ; and

16.6.2 which when aggregated with any loans, credit or financial accommodation made pursuant to Clause 16.7 (*Loans*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.7 **Loans**

The Borrower will not make any investment in nor make any loan or provide any other form of credit or financial accommodation to, any person except for investments, loans, credit or financial accommodation:

16.7.1 made in the ordinary course of the Borrower's business as an NHS Body ;

16.7.2 made in accordance with any investment policy or guidance issued by the relevant Supervisory Body; and

16.7.3 which when aggregated with any guarantees or indemnities given or existing under Clause 16.6 (*Guarantees*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.8 **Consents**

The Borrower must ensure that all Relevant Consents and all statutory requirements, as are necessary to enable it to perform its obligations under the Finance Documents to which it is a party, are duly obtained and maintained in full force and effect or, as the case may be, complied with.

16.9 **Activities**

The Borrower will not engage in any activities other than activities which enable it to carry on its principal purpose better, if to do so may, in the Lender's opinion, have a Material Adverse Effect.

16.10 **Environmental**

The Borrower shall:

16.10.1 obtain, maintain and comply in all material respects with all necessary Environmental Licences in relation to its activities and its property and comply with all Environmental Laws to the extent necessary to avoid a Material Adverse Effect;

16.10.2 promptly upon becoming aware notify the Lender of:

(A) any Environmental Claim current or to its knowledge threatened;

(B) any circumstances likely to result in an Environmental Claim; or

(C) any suspension, revocation or notification of any Environmental Licence;

16.10.3 indemnify the Lender against any loss or liability which:

(A) the Lender incurs as a result of any actual or alleged breach of any Environmental Law by any person; and

(B) which would not have arisen if a Finance Document had not been entered into; and

16.10.4 take all reasonable steps to ensure that all occupiers of the Borrower's property carry on their activities on the property in a prudent manner and keep them secure so as not to cause or knowingly permit material harm or damage to the Environment (including nuisance or pollution) or the significant risk thereof.

16.11 **Constitution**

The Borrower will not amend or seek to amend the terms of its authorisation as an NHS Body or the terms of its constitution without the prior written consent of the Lender, in each case if to do so would be reasonably likely to have a Material Adverse Effect.

16.12 **The relevant Supervisory Body**

The Borrower will comply promptly with all directions and notices received from the relevant Supervisory Body to the extent failure to do so might have a Material Adverse Effect and will, upon the Lender's request, provide reasonable evidence that it has so complied.

16.13 **Additional Terms and Conditions**

The Borrower will comply promptly with the Additional Terms and Conditions.

## 17. COMPLIANCE FRAMEWORK

17.1 **Compliance**

The Borrower shall ensure at all times that it complies with its Licence and/or any other terms and conditions set by the Relevant Supervisory Body.

17.2 **Advance Notification**

Without prejudice to the Borrower's obligations under Clause 17.1 (*Compliance*), if the Borrower becomes aware at any time after the date of signing of the Agreement that it is or is

likely to breach any of the terms referred to in Clause 17.1 and/or a material failure under the requirements of the Compliance Framework is likely, it shall immediately notify the Lender of the details of the impending breach.

## 18. EVENTS OF DEFAULT

Each of the events or circumstances set out in this Clause 18 is an Event of Default.

### 18.1 Non-payment

The Borrower does not pay on the due date any amount payable pursuant to a Finance Document at the place at and in the currency in which it is expressed to be payable unless:

18.1.1 its failure to pay is caused by administrative or technical error; and

18.1.2 payment is made within two Business Days of its due date.

### 18.2 Compliance Framework and Negative Pledge

Any requirement of Clause 17 (*COMPLIANCE FRAMEWORK*) or Clause 16.3 (*Negative Pledge*) is not satisfied.

### 18.3 Other obligations

18.3.1 The Borrower does not comply with any term of:

(A) Clause 15.5 (*Notification of default*); or

(B) Clause 16 (*General Undertakings*).

18.3.2 The Borrower does not comply with any term of any Finance Document (other than those referred to in Clause 18.1 (*Non-payment*), Clause 18.2 (*Compliance Framework and Negative Pledge*) and Clause 18.3.1(*Other obligations*) unless the failure to comply is capable of remedy and is remedied within ten Business Days of the earlier of the Lender giving notice or the Borrower becoming aware of the failure to comply.

### 18.4 Misrepresentation

Any representation or statement made or deemed to be made by the Borrower in any Finance Document or any other document delivered by or on behalf of the Borrower under or in connection with any Finance Document is or proves to have been incorrect or misleading in any material respect when made or deemed to be made.

### 18.5 Cross default

18.5.1 Any Financial Indebtedness of the Borrower is not paid when due nor within any originally applicable grace period.

18.5.2 Any Financial Indebtedness of the Borrower is declared to be or otherwise becomes due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.3 Any commitment for any Financial Indebtedness of the Borrower is cancelled or suspended by a creditor of the Borrower as a result of an event of default (however described).

18.5.4 Any creditor of the Borrower becomes entitled to declare any Financial Indebtedness of the Borrower due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.5 No Event of Default will occur under this Clause 18.5 if the aggregate amount of Financial Indebtedness or commitment for Financial Indebtedness falling within Clauses 18.5.1 to 18.5.4 is less than £250,000 (or its equivalent in any other currency or currencies).

except that for as long as the Secretary of State for Health remains the Lender, the provisions of Clause 18.5 relate to Financial Indebtedness owed to any party but do not apply to amounts owed to other NHS bodies in the normal course of business where a claim has arisen which is being disputed in good faith or where the Borrower has a valid and contractual right of setoff.

18.6 **Insolvency**

18.6.1 The Borrower is unable or admits inability to pay its debts as they fall due, suspends making payments on any of its debts or, by reason of actual or anticipated financial difficulties, commences negotiations with one or more of its creditors with a view to rescheduling any of its indebtedness.

18.6.2 A moratorium is declared in respect of any indebtedness of the Borrower.

18.7 **Insolvency proceedings**

Any corporate action, legal proceedings or other procedure or step is taken:

18.7.1 in relation to a composition, assignment or arrangement with any creditor of the Borrower; or

18.7.2 in relation to the appointment of a liquidator, receiver, administrator, administrative receiver, compulsory manager or other similar officer in respect of the Borrower or any of its assets; or

18.7.3 in relation to the enforcement of any Security over any assets of the Borrower,

or any analogous action, proceedings, procedure or step is taken in any jurisdiction.

18.8 **Appointment of a Trust Special Administrator**

An order, made as required under The Act for the appointment of a Trust Special Administrator.

18.9 **Creditors' process**

Any expropriation, attachment, sequestration, distress or execution affects any asset or assets of the Borrower having an aggregate value of £250,000 and is not discharged within ten Business Days.

18.10 **Repudiation**

The Borrower or any other party to a Finance Document repudiates any of the Finance Documents or does or causes to be done any act or thing evidencing an intention to repudiate any Finance Document.

18.11 **Cessation of Business**

Other than with the prior written approval of the Lender, the Borrower ceases, or threatens to cease, to carry on all or a substantial part of its business or operations.

18.12 **Unlawfulness**

It is or becomes unlawful for the Borrower or any other party to a Finance Document to perform any of its obligations under any Finance Document.

18.13 **Material adverse change**

Any event or circumstance or series of events or circumstances occurs which, in the reasonable opinion of the Lender, has or is reasonably likely to have a Material Adverse Effect.

18.14 **Additional Terms and Conditions**

In the reasonable opinion of the Lender, the Borrower fails to make reasonable efforts to comply with the Additional Terms and Conditions.

18.15 **Acceleration**

On and at any time after the occurrence of an Event of Default which is continuing the Lender may by notice to the Borrower:

18.15.1 cancel the Facility whereupon it shall immediately be cancelled; and/or

18.15.2 declare that all or part of the Loans, together with accrued interest, and all other amounts accrued or outstanding under the Finance Documents be immediately due and payable, whereupon they shall become immediately due and payable; and/or

18.15.3 declare that all or part of the Loans be payable on demand, whereupon they shall immediately become payable on demand by the Lender.

## 19. ASSIGNMENTS AND TRANSFERS

19.1 **Assignments and transfers by the Lender**

Subject to this Clause 19, the Lender may:

19.1.1 assign any of its rights; or

19.1.2 transfer by novation any of its rights and obligations,

to another entity owned or supported by the Lender or to a bank or a financial institution or to a trust, fund or other entity which is regularly engaged in or established for the purpose of making, purchasing or investing in loans, securities or other financial assets (the **"New Lender"**).

19.2 **Conditions of assignment or transfer**

19.2.1 The consent of the Borrower is required for an assignment or transfer by the Lender, unless:

(A) the assignment or transfer is to an entity owned or supported by the Lender; or

(B) a Default is continuing.

19.2.2 The consent of the Borrower to an assignment or transfer must not be unreasonably withheld or delayed. The Borrower will be deemed to have given its consent twenty Business Days after the Lender has requested it unless consent is expressly refused (and reasons for such refusal are given) by the Borrower within that time.

provided that nothing in this Clause shall restrict the rights of the Secretary of State for Health to effect a statutory transfer.

19.3 **Disclosure of information**

The Lender may disclose to any person:

19.3.1 to (or through) whom the Lender assigns or transfers (or may potentially assign or transfer) all or any of its rights and obligations under the Finance Documents;

19.3.2 with (or through) whom the Lender enters into (or may potentially enter into) any transaction under which payments are to be made by reference to, any Finance Document or the Borrower;

19.3.3 to whom, and to the extent that, information is required to be disclosed by any applicable law or regulation;

19.3.4 which are investors or potential investors in any of its rights and obligations under the Finance Documents and only to the extent required in relation to such rights and obligations;

19.3.5 which is a governmental, banking, taxation or other regulatory authority and only to the extent information is required to be disclosed to such authority,

any information about the Borrower and/or the Finance Documents as the Lender shall consider appropriate if, in relation to Clauses 19.3.1, 19.3.2 and 19.3.4 the person to whom the information is to be given has agreed to keep such information confidential on terms of this Clause 19.3 provided always that the Lender shall comply with any relevant data protection legislation.

19.4 **Assignment and transfer by the Borrower**

The Borrower may not assign any of its rights or transfer any of its rights or obligations under the Finance Documents.

**20. ROLE OF THE LENDER**

20.1 **Rights and discretions of the Lender**

20.1.1 The Lender may rely on:

(A) any representation, notice or document believed by it to be genuine, correct and appropriately authorised; and

(B) any statement made by a director, authorised signatory or authorised employee of any person regarding any matters which may reasonably be assumed to be within his knowledge or within his power to verify.

20.1.2 The Lender may engage, pay for and rely on the advice or services of any lawyers, accountants, surveyors or other experts.

20.1.3 The Lender may act in relation to the Finance Documents through its personnel and agents.

20.1.4 Notwithstanding any other provision of any Finance Document to the contrary, the Lender is not obliged to do or omit to do anything if it would or might in its reasonable opinion constitute a breach of any law or a breach of a fiduciary duty or duty of confidentiality.

20.2 **Exclusion of liability**

20.2.1 Without limiting Clause 20.2.2, the Lender will not be liable for any omission or any act taken by it under or in connection with any Finance Document, unless directly caused by its gross negligence or wilful misconduct.

20.2.2 The Borrower may not take any proceedings against any officer, employee or agent of the Lender in respect of any claim it might have against the Lender or in respect of any act or omission of any kind by that officer, employee or agent in relation to any Finance Document and any officer, employee or agent of the Lender may rely on this Clause. Any third party referred to in this Clause 20.2.2 may enjoy the benefit of or enforce the terms of this Clause in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

20.2.3 The Lender will not be liable for any delay (or any related consequences) in crediting an account with an amount required under the Finance Documents to be paid by the Lender if the Lender has taken all necessary steps as soon as reasonably practicable to comply with the regulations or operating procedures of any recognised clearing or settlement system used by the Lender for that purpose.

20.2.4 The Lender shall not be liable:

(A) for any failure by the Borrower to give notice to any third party or to register, file or record (or any defect in such registration, filing or recording) any Finance Document; or

(B) for any failure by the Borrower to obtain any licence, consent or other authority required in connection with any of the Finance Documents; or

(C) For any other omission or action taken by it in connection with any Finance Document unless directly caused by its gross negligence or wilful misconduct.

## 21. PAYMENT MECHANICS

21.1 **Payments**

21.1.1 The Borrower shall receive notification 10 working days prior to each payment required under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary at the time for settlement of transactions in the relevant currency in the place of payment.

21.1.2 Payment shall be collected through Direct Debit from a Borrower's account with the Government Banking Service.

21.2 **Distributions to the Borrower**

The Lender may (with the consent of the Borrower or in accordance with Clause 22 (*Set-off*)) apply any amount received by it for the Borrower in or towards payment (on the date and in the currency and funds of receipt) of any amount due from the Borrower under the Finance Documents or in or towards purchase of any amount of any currency to be so applied.

21.3 **Partial payments**

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may at its discretion decide.

21.4 **No set-off**

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

21.5 **Business Days**

21.5.1 Any payment which is due to be made on a day that is not a Business Day shall be made on the next Business Day in the same calendar month (if there is one) or the preceding Business Day (if there is not).

21.5.2 During any extension of the due date for payment of any principal or Unpaid Sum under this Agreement, interest is payable on the principal or Unpaid Sum at the rate payable on the original due date.

21.6 **Currency of account**

21.6.1 Subject to Clauses 21.6.2 to 21.6.5, sterling is the currency of account and payment for any sum due from the Borrower under any Finance Document.

21.6.2 A repayment of the Loan or Unpaid Sum or a part of the Loan or Unpaid Sum shall be made in the currency in which the Loan or Unpaid Sum is denominated on its due date.

21.6.3 Each payment of interest shall be made in the currency in which the sum in respect of which the interest is payable was denominated when that interest accrued.

21.6.4 Each payment in respect of costs, expenses or Taxes shall be made in the currency in which the costs, expenses or Taxes are incurred.

21.6.5 Any amount expressed to be payable in a currency other than sterling shall be paid in that other currency.

21.7 **Change of currency**

21.7.1 Unless otherwise prohibited by law, if more than one currency or currency unit are at the same time recognised by the central bank of any country as the lawful currency of that country, then:

(A) any reference in the Finance Documents to, and any obligations arising under the Finance Documents in, the currency of that country shall be translated into, or paid in, the currency or currency unit of that country designated by the Lender (after consultation with the Borrower); and

(B) any translation from one currency or currency unit to another shall be at the official rate of exchange recognised by the central bank for the conversion of that currency or currency unit into the other, rounded up or down by the Lender (acting reasonably).

21.7.2 If a change in any currency of a country occurs, this Agreement will, to the extent the Lender (acting reasonably and after consultation with the Borrower) specifies to be necessary, be amended to comply with any generally accepted conventions and market practice in the London interbank market and otherwise to reflect the change in currency.

**22. SET-OFF**

The Lender may set off any matured obligation due from the Borrower under the Finance Documents against any matured obligation owed by the Lender to the Borrower, regardless of

the place of payment, booking branch or currency of either obligation. If the obligations are in different currencies, the Lender may convert either obligation at a market rate of exchange in its usual course of business for the purpose of the set-off.

## 23. NOTICES

### 23.1 Communications in writing

Any communication to be made under or in connection with the Finance Documents shall be made in writing and, unless otherwise stated, may be given in person, by post, fax or by electronic communication.

### 23.2 Addresses

The address and fax number (and the department or officer, if any, for whose attention the communication is to be made) of each Party for any communication or document to be made or delivered under or in connection with the Finance Documents is:

23.2.1 in the case of the Borrower, that identified with its name below; and

23.2.2 in the case of the Lender, that identified with its name below,

or any substitute address, email address, fax number or department or officer as the Borrower may notify to the Lender by not less than five Business Days' written notice.

### 23.3 Delivery

23.3.1 Any communication or document made or delivered by one person to another under or in connection with the Finance Documents will only be effective:

(A) if by way of fax, when received in legible form; or

(B) if by way of letter, when it has been left at the relevant address or five Business Days after being deposited in the post postage prepaid in an envelope addressed to it at that address,

and, if a particular department or officer is specified as part of its address details provided under Clause 23.2 (*Addresses*), if addressed to that department or officer.

23.3.2 Any communication or document to be made or delivered to the Lender will be effective only when actually received by the Lender and then only if it is expressly marked for the attention of the department or officer identified with the Lender's signature below (or any substitute department or officer as the Lender shall specify for this purpose).

### 23.4 Electronic communication

23.4.1 Any communication to be made between the Borrower and the Lender under or in connection with this Agreement and any other Finance Document may be made by electronic mail or other electronic means, if the Borrower and the Lender:

(A) agree that, unless and until notified to the contrary, this is to be an accepted form of communication;

(B) notify each other in writing of their electronic mail address and/or any other information required to enable the sending and receipt of information by that means; and

(C) notify each other of any change to their address or any other such information supplied by them.

23.4.2 Any electronic communication made between the Borrower and the Lender will be effective only when actually received in readable form and only if it is addressed in such a manner as the Borrower and the Lender, as the case may be, specify for this purpose.

## 24. CALCULATIONS AND CERTIFICATES

### 24.1 Accounts

In any litigation or arbitration proceedings arising out of or in connection with a Finance Document, the entries made in the accounts maintained by the Lender are *prima facie* evidence of the matters to which they relate.

### 24.2 Certificates and Determinations

Any certification or determination by the Lender of a rate or amount under any Finance Document is, in the absence of manifest error, conclusive evidence of the matters to which it relates.

### 24.3 Day count convention

Any interest, commission or fee accruing under a Finance Document will accrue from day to day and is calculated on the basis of the actual number of days elapsed and a year of 365 days or, in any case where the practice in the London interbank market differs, in accordance with that market practice.

## 25. PARTIAL INVALIDITY

If, at any time, any provision of the Finance Documents is or becomes illegal, invalid or unenforceable in any respect under any law of any jurisdiction, neither the legality, validity or enforceability of the remaining provisions nor the legality, validity or enforceability of such provision under the law of any other jurisdiction will in any way be affected or impaired.

## 26. REMEDIES AND WAIVERS

No failure to exercise, nor any delay in exercising, on the part of the Lender, any right or remedy under the Finance Documents shall operate as a waiver, nor shall any single or partial exercise of any right or remedy prevent any further or other exercise or the exercise of any other right or remedy. The rights and remedies provided in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

## 27. AMENDMENTS AND WAIVERS

Any term of the Finance Documents may only be amended or waived in writing.

## 28. COUNTERPARTS

Each Finance Document may be executed in any number of counterparts, and this has the same effect as if the signatures on the counterparts were on a single copy of the Finance Document.

## 29. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with English law.

## 30. DISPUTE RESOLUTION

The Parties agree that all disputes arising out of or in connection with this Agreement will be settled in accordance with the terms of Schedule 5.

This Agreement has been entered into on the date stated at the beginning of this Agreement.

## SCHEDULE 1: CONDITIONS PRECEDENT

### 1. Authorisations

1.1 A copy of a resolution of the board of directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

### 2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

### 3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

### 4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

## SCHEDULE 2: UTILISATION REQUEST

**From:[ ]**

To: The Secretary of State for Health

Dated:

Dear Sirs

**[ ] – £**
**dated [ ] (the "Agreement")**

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

| | |
|---|---|
| Proposed Utilisation Date: | [ ] (or, if that is not a Business Day, the next Business Day) |
| Amount: | [ ] or, if less, the Available Facility |
| Payment Instructions: | [*Relevant account to be specified here*] |

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards working capital requirements of the Borrower in its requirement as an NHS Trust/NHS Foundation Trust.

5. This Utilisation Request is irrevocable.

Yours faithfully

……
authorised signatory for and on behalf of the Board of Directors
**[ ]**

**SCHEDULE 3: NOT USED**

**SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE**

| £000 | Q1 | Q2 | Q3 | Q4 | TOTAL |
|---|---|---|---|---|---|
| **2015-16** | 0 | 0 | 0 | 48,700 | **48,700** |
| **TOTAL** | | | | | **48,700** |

## SCHEDULE 5: DISPUTE RESOLUTION

### 1. NEGOTIATION

If any claim, dispute or difference of whatsoever nature arising out of or in connection with this Agreement ("**Dispute(s)**") arises, the Parties will attempt in good faith to settle it by negotiation. Each Party will nominate at least one management representative ("**Authorised Representative**") who shall attend and participate in the negotiation with authority to negotiate a solution on behalf of the Party so represented.

### 2. MEDIATION

It shall be a condition precedent to the commencement of reference to arbitration that the Parties have sought to have the dispute resolved amicably by mediation as provided by this paragraph 2.

#### 2.1 Initiation of Mediation Proceeding

(A) If the Parties are unable to settle the Dispute(s) by negotiation in accordance with paragraph 1 within 15 days, either Party may by written notice upon the other initiate mediation under this paragraph 2. The notice initiating mediation shall describe generally the nature of the Dispute.

(B) Each Party's Authorised Representative nominated in accordance with paragraph 1 shall attend and participate in the mediation with authority to negotiate a settlement on behalf of the Party so represented.

#### 2.2 Appointment of Mediator

(A) The Parties shall appoint, by agreement, a neutral third person to act as a mediator (the "Mediator") to assist them in resolving the Dispute. If the Parties are unable to agree on the identity of the Mediator within 10 days after notice initiating mediation either party may request the Centre for Effective Dispute Resolution ("CEDR Solve") to appoint a Mediator.

(B) The Parties will agree the terms of appointment of the Mediator and such appointment shall be subject to the Parties entering into a formal written agreement with the Mediator regulating all the terms and conditions including payment of fees in respect of the appointment. If the Parties are unable to agree the terms of appointment of the Mediator within 10 days after notice initiating mediation either Party may request CEDR Solve to decide the terms of appointment of the Mediator

(C) If the appointed Mediator is or becomes unable or unwilling to act, either Party may within 10 days of the Mediator being or becoming unable or unwilling to act follow the process at paragraph 2.3 to appoint a replacement Mediator and paragraph 2.4 to settle the terms of the appointment of the replacement Mediator.

#### 2.3 Determination of Procedure

The Parties shall, with the assistance of the Mediator, seek to agree the mediation procedure. In default of such agreement, the Mediator shall act in accordance with CEDR Solve's Model Mediation Procedure and Agreement. The Parties shall within 10 days of the appointment of the Mediator, meet (or talk to) the Mediator in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the mediation.

2.4 **Without Prejudice/Confidentiality**

All rights of the Parties in respect of the Dispute(s) are and shall remain fully reserved and the entire mediation including all documents produced or to which reference is made, discussions and oral presentations shall be strictly confidential to the Parties and shall be conducted on the same basis as "without prejudice" negotiations, privileged, inadmissible, not subject to disclosure in any other proceedings whatever and shall not constitute any waiver of privilege whether between the Parties or between either of them and a third party. Nothing in this paragraph 2.4 shall make any document privileged, inadmissible or not subject to disclosure which would have been discloseable in any reference to arbitration commenced pursuant to paragraph 3.

2.5 **Resolution of Dispute**

If any settlement agreement is reached with the assistance of the Mediator which resolves the Dispute, such agreement shall be set out in a written settlement agreement and executed by both parties' Authorised Representatives and shall not be legally binding unless and until both parties have observed and complied with the requirements of this paragraph 2.5. Once the settlement agreement is legally binding, it may be enforced by either party taking action in the High Court.

2.6 **Failure to Resolve Dispute**

In the event that the Dispute(s) has not been resolved to the satisfaction of either Party within 30 days after the appointment of the Mediator either party may refer the Dispute to arbitration in accordance with paragraph 3.

2.7 **Costs**

Unless the Parties otherwise agree, the fees and expenses of the Mediator and all other costs of the mediation shall be borne equally by the Parties and each Party shall bear their own respective costs incurred in the mediation regardless of the outcome of the mediation.

3. **ARBITRATION**

3.1 If the Parties are unable to settle the Dispute(s) by mediation in accordance with paragraph 2 within 30 days, the Dispute(s) shall be referred to and finally determined by arbitration before an Arbitral Tribunal composed of a single Arbitrator.

3.2 Any reference of a Dispute to arbitration shall be determined in accordance with the provisions of the Arbitration Act 1996 and in accordance with such arbitration rules as the Parties may agree within 20 days after notice initiating arbitration or, in default of agreement, in accordance with the Rules of the London Court of International Arbitration which Rules are deemed to be incorporated by reference into this clause.

3.3 London shall be the seat of the arbitration.

3.4 Reference of a Dispute to arbitration shall be commenced by notice in writing from one Party to the other Party served in accordance with the provisions of Clause 23 (Notices).

3.5 The Arbitral Tribunal shall be appointed as follows.

(A) Within 14 days of receipt of any notice referring a Dispute to arbitration the Parties shall agree the identity of the person to act as Arbitrator. In default of agreement or in the event the person so identified is unable or unwilling to act, either party shall be

entitled to request the President for the time being of the Chartered Institute of Arbitrators to appoint an Arbitrator for the Dispute and the parties shall accept the person so appointed.

(B) If the Arbitrator becomes unwilling or unable to act, the procedure for the appointment of a replacement Arbitrator shall be in accordance with the provisions of paragraph 3.5(A).

3.6 The language of the arbitration shall be English.

## SCHEDULE 6: REPAYMENT SCHEDULE

| Repayment Date | Relevant Percentage |
|---|---|
| 18th March 2018 | 100% |

## SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY

**NONE**

## SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Surplus/Deficit and Capital Limits

1.1. The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body. These Limits reflect the aggregate of Voted Funds available to the Lender at the date of this Agreement.

1.2. The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement.

1.3. The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender.

1.4. In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted.

1.5. The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing previously agreed to support the relevant Limit(s).

1.6. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body.

1.7. Performance against Limits will be monitored by the relevant Supervisory Body.

1.8. For the avoidance of doubt, as at the date of this Agreement and for the financial year to which this agreement relates, the Surplus/Deficit Limit is (£46,000,000) and the Capital Limit is not applicable.

2. Nursing agency expenditure:

2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:

2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.

2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.

2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.

2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend

3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs

4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.

4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.

5. Estate Costs

5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land

6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.

6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.

6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21

7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.

7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll

8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower's finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing

9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement

10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender,

10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender,

10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.

10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services ("CCS")

11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.

11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting

12.1. The Borrower undertakes to:

12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal

12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)

12.1.3. Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.

**SIGNATORIES**

**Borrower**

**For and on behalf of ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

By:

Name:

Position:

Address: Blackshaw Road
Tooting
London
SW17 0QT

Email: steve.bolam@stgeorges.nhs.uk

Attention: Steve Bolam

**Lender**

**The Secretary of State for Health**

By:

Name:

Address: Department of Health,
4th Floor,
Skipton House,
80 London Road,
London SE1 6LH

Email: dhloanscentralinbox@dh.gsi.gov.uk

St George's Healthcare NHS
NHS Trust

**Chief Executive's Office**
**Room 28, 1st Floor, Grosvenor Wing**

St George's Hospital
Blackshaw Road
London
SW17 0QT

Direct Line: 020 8725 1640
e-mal: miles.scott@stgeorges/nhs.uk

# BOARD MINUTE

Minute of the approval of the **Single Currency Interim Revenue Support Facility Agreement £48.7m** by the board of St George's University Hospitals NHS Foundation Trust.

IN ATTENDANCE

| NAME | POSITION |
|---|---|
| Sarah Wilton | Acting Chairman. |
| Miles Scott | Chief Executive |

1. The Trust's Chief Financial Officer set out in a cash update paper submitted to the Trust board for its meeting on 4th February 2016 the requirement for the Trust to enter into the **Single Currency Interim Revenue Support Facility Agreement for £48.7m ("the Agreement")** with the Secretary of State for Health.

3. INTERESTS IN PROPOSED TRANSACTIONS AND/OR ARRANGEMENTS WITH THE TRUST NAME NATURE AND EXTENT OF INTEREST

   The Chairman and Chief Executive did not have any interest in the Transaction.

5. CONSIDERATION

   The Board considered the Agreement and supporting documents and the background thereto and were satisfied that:

5.1 the borrowing is consistent with the plans outlined in the Trust's monthly cash flow forecast;

5.2 the Trust's Chief Financial Officer has in place detailed procedural instructions concerning the applications for the funding in relation to the Agreement;

6 RESOLUTIONS

Following consideration, IT WAS RESOLVED by the Trust board that the Agreement would be in the interests of the Trust, and IT WAS FURTHER RESOLVED to:

6.1 approve the Agreement and the terms of the transactions contemplated by the Agreement and authorise any authorised signatory listed below to execute the Agreement on behalf of the Trust subject to such amendment as those executing the same on behalf of the Trust think fit;

6.2 authorise any authorised signatories listed below to do all such acts and things and agree and execute on behalf of the Trust all such other documents to which the Trust is a party and all other documents as may be required in order to implement the Agreement and generally to sign all such certificates and notices as those executing the same on behalf of the Trust think fit;

6.3 confirm that drawdown ("utilisation requests") to secure funding under the Agreement once the Agreement is in place may be signed on behalf of the Trust by the authorised signatories set out in Standing Financial Instructions clause 22.1.17

"*All drawdowns of borrowings "utilisation requests" must be signed/counter-signed by at least two of the following officers - the Director of Finance, the Deputy Director of Finance and an Associate Director of Finance".*

7. AUTHORISED SIGNATORIES FOR SIGNING THE AGREEMENT

The authorised signatories referred to above are:

| Signatory Name | Position | Specimen Signature |
|---|---|---|
| Miles Scott | Chief Executive | …… |
| Steve Bolam | Chief Financial Officer | …… |

9. CLOSE

There was no further business.

..... .....

Sarah Wilton 4th February 2016

Acting Chairman

Department of Health

DIRECT Debit

## Instruction to your bank or building society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send it to:

Department of Health
Provider Finance Team
Floor 2S25
Quarry House
Quarry Hill
Leeds
LS2 7UE

Service User Number

| 6 | 9 | 6 | 8 | 8 | 0 |
|---|---|---|---|---|---|

Name(s) of account holder(s)

St George's University Hospitals NHS Foundation Trust

Reference

| D | H | P | F | / | I | S | W | B | L | / | R | J | 7 | / | 2 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 5 | - | 1 | 2 | - | 1 | 5 | / | A | | | | | |

Please pay Department of Health Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Department of Health and if so, details will be passed electronically to my bank/building society.

Bank/Building society account number

| 1 | 2 | 2 | 7 | 6 | 4 | 1 | 0 |
|---|---|---|---|---|---|---|---|

Branch sort code

| 0 | 8 | 3 | 3 | 0 | 0 |
|---|---|---|---|---|---|

Name and full postal address of your bank or building society

To: The Manager — Bank/Building Society

Citibank

Address

Citigroup Centre

Canada Square

Postcode

London E14 5LB

Signature

Signature

Date:

Banks and building societies may not accept instruction for some types of account

This guarantee should be detached and retained by the payer.

DIRECT Debit

### The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit Department of Health will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Department of Health to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by Department of Health or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society.
- If you receive a refund you are not entitled to, you must pay it back when Department of Health asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

**SCHEDULE 2**

**UTILISATION REQUEST**

**From: ST GEORGE'S UNIVERSITY HOSPITAL NHS FOUNDATION TRUST**

To: The Secretary of State for Health

Dated:

Dear Sirs

**ST GEORGE'S UNIVERSITY HOSPITAL NHS FOUNDATION TRUST**

**– £48,700,000**
**dated [ ] (the "Agreement")**

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

| | |
|---|---|
| Proposed Utilisation Date: | [ ] (or, if that is not a Business Day, the next Business Day) |
| Amount: | [ ] or, if less, the Available Facility |
| Payment Instructions: | [*Relevant account to be specified here*] |

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards working capital requirements of the Borrower in its requirement as an NHS Trust/NHS Foundation Trust.

5. This Utilisation Request is irrevocable.

Yours faithfully

……
authorised signatory for and on behalf of the Board of Directors
**ST GEORGE'S UNIVERSITY HOSPITAL NHS FOUNDATION TRUST**

**Enclosure:**

St George's University Hospitals NHS
NHS Foundation Trust

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

| | |
|---|---|
| **Paper title:** | 2015/16 annual report |
| **Sponsoring Director:** | Rob Elek, Director of Strategy |
| **Author:** | Louise Halfpenny, Head of Communications |

**Purpose:**

- inform the board of plans for the 2015/16 annual report
- seek support for providing accurate content to the right standard and in a timely way
- set out responsibilities

**Action required by the board:**

- approve the plans to produce a low-cost annual report in-house
- commit to the points above
- to decide on frequency and type of future updates

**Document previously considered by:**

- The plans and action points below were agreed at a meeting on 18.01.16 attended by these staff: director of strategy, interim head of governance, senior interim finance support, head of comms, comms manager, comms officer, private secretary to the chief executive

**Executive summary**

**1. Key messages**

The 2014/15 annual report cost £24,385 (plus £3,555 for the summary document). This is a high cost for a document that has limited use as a marketing tool or as a readily accessible source of information about the trust. The high cost for last year's document was the result of:-

- professional design and print
- the necessity to duplicate almost three quarters of the content due to the fact that the report had to cover ten months as a trust and two months as an FT
- excessive editing due to the quality of the content and late content requiring re-editing
- several 'final' versions of the accounts due to the late running of the audit process – this led to whole sections requiring re-setting, new tables to be flowed and the new version also requiring editing
- courier costs, including cancellation of paid couriers due to delays in obtaining signatures.

In addition to the financial cost, the annual report put an unnecessarily high demand on the staff involved which had an impact at the time and also subsequently on BAU when TOIL was taken at the same time as a peak in activity due to filming having just started ('24 Hours in A&E').

**2. Recommendation**

a) The process requires greater respect and compliance. Executive colleagues must ensure that if they are delegating tasks related to content that they are to impress the importance of the task in terms of quality of content and the deadline to whomever they have assigned to the task
b) A simple, low-cost version is produced and that those tasked with supplying content comply with a house style (to be supplied by comms)
c) A professionally designed and printed annual summary is produced (similar to last year's)
d) The audit process concludes earlier in May 2016, allowing for a smoother production process with less requirement for out of hours working and unnecessary expenditure.

**Enclosure:**

| | |
|---|---|
| **Key risks identified:**<br>Lack of buy-in from colleagues who view the task of submitting content as a low priority and therefore deliver poor quality content at a late stage.<br>Demand for content occurs at a time when the trust is operationally very challenged and the same individuals involved in managing operational issues are also required to provide content. | |
| **Related Corporate Objective:** | **2013 – 2018 Comms & Engagement Strategy objectives** |
| **Related CQC Standard:** | |
| **Equality Impact Assessment (EIA): Has an EIA been carried out? (No)**<br>**If yes, please provide a summary of the key findings**<br><br>**If no, please explain you reasons for not undertaking and EIA. Not necessary** | |

**Background and actions**

The annual report is a statutory document which is required to be laid down before Parliament and submitted to Monitor. The quality report is also a statutory document and will be part of the annual report.

The quality report has the added complexity of needed review from health overview and scrutiny committee (HOSC) members and input from Governors, as outlined to them at January's CoG meeting.

This requires an absolute adherence to deadlines. This slipped last year and the HOSC review includes a negative comment about having insufficient time to review the document.

In order to avoid issues of unnecessary cost, effort and reputational embarrassment, a meeting was held on January 18 to discuss a plan of action.

This is the current state of action points for the annual report and quality report:-

| Person | Action | Status |
|---|---|---|
| Interim head of governance | To double check guidance re submission dates to establish the latest date for a final and bound copy | Not yet done – deadline Feb 13 |
| Interim head of governance | To arrange extra audit meetings if required | Will do if needed or pass on to successor for action |
| Interim head of governance | To manage process until successor is in post, including a timetable that allows for external scrutiny of the quality report in time to meet the production timeline | Ongoing |
| Director of strategy | To assist in ensuring that exec colleagues take responsibility for their sections even once they have delegated any writing or fact-finding | Not yet started |
| Head of comms | To provide a house style for the annual report | Not yet done – deadline Feb 13 |
| Interim head of governance | To ensure that governors are aware of the process and their role re quality report | Done (26.01) |
| Comms manager | To work with the chief nurse on producing the quality report | Initial meetings set up |
| Comms officer | Editor in chief – not responsible for WRITING copy per se except the draft of the CEO and Chair's forewords. Responsible for collation, editing and proofreading (proofreading may require outsourcing) | Not yet started |
| Comms officer | To check if photos of board members are required. | Complete. Photos not required. |

| | | |
|---|---|---|
| Private secretary to the chief executive / interim head of governance | To pull together the overall timeline once dates checked by interim head of governance re submission. Overall timeline to include period of scrutiny/feedback and the audit process | Not yet done – deadline Feb 13 |
| Senior interim finance support | To provide detail re the audit process | Done – timetable supplied to comms and interim head of governance (25.01) |
| Senior interim finance support | To provide a more detailed timeline re the 'final' accounts so that only one set is provided and that this is done on time to meet the submission deadline | Started – completion date is end of Feb |
| Head of comms / interim head of governance | To produce initial report for the next trust board meeting | Completed by head of comms 28.01 |

**Next steps**

Further clarity on submission dates (and type – ie do copies need to be wet-signed, bound etc) is required in order to draw up an accurate timetable.

The comms team needs to consider its work plan and how this project may affect the speed with which other plans, such as moving towards an improved intranet, can be completed.

St George's University Hospitals NHS
NHS Foundation Trust

# REPORT TO THE TRUST BOARD – JANUARY 2016

| | |
|---|---|
| **Paper Title:** | Business Planning and Corporate Objectives 2016/17 |
| **Sponsoring Director:** | Rob Elek, Director of Strategy |
| **Author:** | Tom Ellis, Head of Business Planning |
| **Purpose:** | To inform the Trust board of the progress of the current business planning round, some of the key assumptions underpinning the draft plan, and the associated timetable<br><br>The paper also outlines proposals for how the Trusts Corporate Objectives will be formulated and developed |
| **Action required by the board:** | Business planning – to give delegated authority to CEO and CFO to submit draft annual plan and financials on 8th February<br>Corporate objectives – to agree the proposed way forward |
| **Document previously considered by:** | Earlier versions of this paper were presented to EMT on 28th January and F&P on 27th January |

**Executive summary**

## 1. Key messages

- The trust must submit a draft operational and financial plan to Monitor on 8th February 2016
- This builds on the TRP submission to Monitor on 31st December
- The operational plan forms year 1 of a five year Sustainability & Transformation Plan for South West London & Surrey Downs. That plan will be submitted in June 2016
- The operational plan focusses on delivering a number of national mandated 'must do's', most focussing on access target achievement and aggregate financial balance across the STP area
- The operational plan will also outline the trusts quality and workforce plans and position against seven day working and NHS Mandate
- Through the new Sustainability & Transformation Fund, the trust has been offered £17.6m provider support, to deliver a control total deficit of £17.2m. Discussions are on-going internally to agree what the target deficit in our plan will be for next year
- Receiving all this sum will be contingent on delivering financial recovery, access targets and transformation
- The contracting round with commissioners is likely to be challenging, but the trust has built a realistic opening position
- The trust will need to update its corporate objectives for 2016/17, and this paper proposes a new framework, more based on the Transformation Programme than Trust strategy
- The plan being submitted on the 8th February is draft, and will not be able to answer all questions at this stage. The expectation however, is that it will be robust and coherent.
- The paper outlines the process that will be adopted to ensure that we submit the required documentation by mid-day 8th February.

## 2. Recommendation

a) Agree delegated authority to the CEO/CFO to authorise the completed operational plan and financials to Monitor on 8th February
b) Approve the proposed framework for the development of corporate objectives for 2016/17

**Key risks identified:**

*Are there any risks identified in the paper (impact on achieving corporate objectives) – e.g. quality, financial performance, compliance with legislation or regulatory requirements?*

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

| | |
|---|---|
| **Related Corporate Objective:** *Reference to corporate objective that this paper refers to.* | None – the production of the annual plan and corporate objectives will deliver a refreshed set of corporate objectives for 2016/17 |
| **Related CQC Standard:** *Reference to CQC standard that this paper refers to.* | None |

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

**If yes, please provide a summary of the key findings**

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

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

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

St George's University Hospitals NHS
NHS Foundation Trust

# Trust Board – January 2016
# Business Planning & Corporate Objectives 2016/17

## 1. Introduction

The trust needs to produce a robust business plan for 2016/17 for Monitor. The trust normally goes through an annual business planning process between September and April, building up a picture of proposed trust activity, service developments and the income and expenditure required to deliver that activity, finishing with the finalisation of budgets for the coming year.

The 2016/17 Turnaround Reforecast Process, submitted to Monitor on 31st December, addressed at a high level the proposed trust financial position in 2016/17. Much of the information generated through that process is directly usable in the business planning process. However, considerable work remains to take the outputs of that process and produce a robust set of budgets.

For 2016/17 all NHS organisations are required to produce two separate but inter-connected plans:
1. An organisational plan which reflects the emerging "Sustainability and Transformation Plan" (STP).
2. A local health and care system "Sustainability and Transformation Plan" (STP) which covers October 2016 – March 2021. The plan is whole system based and must drive Five Year Forward View delivery.

Linked to the development of the Operational Plan, the trust needs to produce a coherent set of corporate objectives.

This paper focuses on the following:
1. The requirements of the 2016/17 Operational Plan
2. The proposed position the trust is taking in relation to some key points
3. A proposed structure and process to develop the trusts corporate objectives for 2016/17

## 2. 2016/17 Operational Plan

The draft operational plan, which is a short document of circa 20 pages, plus accompanying financials, needs to be submitted on 8th February, and the final plan on 11th April.

The plan needs to address a number of 'must do's', as mandated in the guidance, for 2016/17. These are:
- Development of a high quality and agreed Sustainability & Transformation Plan
- Return the system to aggregate financial balance through cost reduction (e.g. implementing the Agency cap and the productivity opportunities identified in Lord Carter's work)
- Meet the 95% accident and emergency standard
- Meet referral to treatment timescales (92% within 18 weeks for non-emergency pathways)
- Meet the 62 day cancer waiting standard, and the 2 week and 31 day standards, and make progress in improving one-year survival rates
- Develop and implement an affordable plan to make improvements in quality

In addition to this the plan will need to outline the activity assumptions for the year; the capacity to deliver that activity; the trusts approach to quality and quality improvement and seven day services; workforce plans and workforce efficiency, and finally financial plans and the anticipated outturn position for the trust.

The operational plan position on some of these points will be.
- The trust will need to develop trajectories to meet and maintain access targets. Given the trusts issues with access targets, meetings points 3, 4, and 5 above will be challenging. There are plans in place

(Cancer Action Plan) and in development to quantify how this will be achieved. The content of these will form the basis of the response in places.

- The activity and income assumptions are not agreed and will need negotiation with commissioners
- Capacity, both physical and human, to deliver and maintain these targets is the biggest risk
- The trusts developing Transformation Programme will be the main vehicle for delivering much of what the operational plan requires, as well as delivering savings of circa £50m next year
- Expected workforce changes were identified through the TRP position and through the Workforce Plans being developed at Care Group level.
- The guidance is also focuses on the NHS Mandate. The operational plan will seek to outline the trusts position against each of the key deliverables for 16/17 if not covered elsewhere

**3. Seven Day Working**

The importance of 7 day services is restated. The key challenge for acute trusts is reducing excess deaths by increasing the level of consultant cover/diagnostic services available at weekends

St. George's position has been that it will develop 7 day services in line with commissioner support and subject to funding. It is expected that a condition of STF funding will be the continued development of seven day services so the trust will need to review this position for the final submission in April. This might introduce additional cost pressures over and above those identified in the TRP submission.

**4. Sustainability & Transformation Fund**

The government is investing £1.8b of additional provider support next year, through a new STF fund. St. George's received a letter on 15th January indicating that the trust could expect to receive £17.6m through general STF funding, and potentially more through target funding. This offer is made on the basis that St. George's will deliver a deficit of no more than £17.2m in 2016/17. It should also be noted this offer is contingent on the NHS 15/16 provider sector deficit being £1.8b. If it is higher than that, it is likely that this additional overspend will be top sliced from the STF fund, reducing the offer to each trust.

The release of STF funding is however contingent on achieving recovery milestones for deficit reduction, access standards, and progress on transformation. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

The guidance states that providers who are eligible for STF funding in 2016/17 *"will not face a 'double jeopardy' scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed".* It should be noted this applies to national penalties only. Local penalties, e.g. data quality, will continue. The level of anticipated local penalties are currently being estimated.

The trust will accept the offer of £17.6m from the General STF fund, and expects to receive more from the "Targeted" element. In accepting the offer, the trust is committing to meeting the conditions attached to the offer, and any failure to do so will result in a portion of the STF funding being withheld.

**5. SLA Contract Negotiations**

SLA negotiations with all commissioners are likely to be extremely challenging in 2016/17, as both Wandsworth & Merton CCG's have had the minimum permissible uplift in their allocations and NHSE's Specialist Commissioning budgets remain challenged at a national level.

The trust has sent out a 15/16 outturn proposal with the starting point of month 6 freeze activity and income doubled, building through to the trust's view of 15/16 recurrent outturn which is based on the TRP. This also includes unwinding the block agreement for four CCGs and the removal of non-recurrent funding for capacity and some local quality schemes. The next step is to produce a 16/17 proposal building in growth, service developments and any known changes such as the loss of Diabetic Eye Screening or new tenders which has been awarded, e.g. Breast Screening. The 16/17 proposal will be produced firstly at the current tariffs (DTR) and then the proposal will be run through the new 16/17 grouper and tariffs.

The expectation in the guidance is for shared and open book operational planning process for 2016/17 between commissioners and providers, with all contracts signed by end March 2016.

Trust Position

- The trust has also put together a long list of issues to be discussed at a senior level with commissioners throughout the contract negotiation round, including
    - identifying the source of funding for the full year effect of capacity e.g. SAU, Recovery at Home
    - the impact of the loss of non-recurrent funding such as the £1.3m maternity funding and
    - Local penalties and sanctions for 16/17.
- The trust has stated our position on each of these points and has shared the paper with commissioners – this paper is attached as an annex for information.

**6. Corporate Objectives 2016/17**

The operational plan needs to reflect our corporate and organisational priorities for the coming year. 2015/16's plans have articulated these within the seven strategic themes developed in 2012, but have been somewhat scattergun in nature, and were not widely thought to enable a holistic view of organisational performance.

The board has clearly stated its desire to refresh the overarching strategy, both as a pre-requisite to the wider health economy plan, but more importantly to ensure that the route to the future sustainability of the organisation is robustly planned and executed. Through the board strategy sessions, interactions with Monitor, consideration of guidance, internal and external issues, and participation in the SW London and Surrey Downs Health partnerships, the following encapsulates the required direction for the organisation in the coming year:
*"To maintain the quality of care for our patients whilst delivering sustainable operational and financial performance, alongside a strategic repositioning of the organisation to ensure that it is fit for the future"*

To do this we will:

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

The trust will need, as part of this process, to develop a series of coherent Corporate Objectives, and a series of individual Corporate Plans (e.g. Estates & Facilities, IM&T), both of which are linked to the Operational Plan, the emerging STP plan and other mandated or internal requirements.

**7. Sustainability & Transformation Plan (STPs)**

STPs are a new development and requirement of the NHS. The purpose of the STP is for *"every health and social care system to come together, to create its own ambitious local blueprint for accelerating its*

*implementation of the Forward View".* The emphasis is on developing a plan that meets the needs of local populations and is not focused on individual organisations.

The STPs must develop a clear vision and plan for the area which answers the following questions:

- How will you close the health and well-being gap?
- How will you drive transformation to close the care and quality gap?
- How will you close the finance and efficiency gap?

Local health systems will be required to "*develop their own system wide local financial sustainability plan as part of their STP".*

By 29th January the local health and care system is required to agree the scope of their local geographical footprint. Discussions are on-going but it is assumed that St. George's will be in the SW London and Surrey Downs Health Partnership STP. The actual STP plan needs to be submitted to NHSI in June 2016.

**8. Summary and next steps**

The draft operational plan is due for submission on 8th February. Given there has only been five weeks form guidance being released (and the continuing release through January of further guidance) it is not possible to present to the board a full draft of the plan, which is in development, though this paper outlines some of the positions the draft plan will take.

The submission on 8th February will inevitably not answer all the questions required – it is a draft plan produced in short order and when supporting work e.g. SLA negotiations, Transformation DIPs, have not been finalised. Significantly, it will not include at this stage reference to the emerging themes of the STP, as those have not yet been developed. The submission, which requires CEO/Chair approval, but not Board sign-off, will be as accurate a picture that the trust can submit at that moment in time, and will need to acknowledge within the documentation where further work is on-going.

With regard to developing the draft business plan the following process will be followed:

1. That directors and others working on individual sections of the narrative plan will submit to Tom Ellis, who will collate and amalgamate with his work to produce a draft narrative plan
2. The Business Planning Steering Group will meet on Tuesday 2nd. The group comprises five executive directors, will undertake the following reviews, and agree, amend, direct as appropriate to ensure the submission is robust
    a. Review the key financial assumptions that are being used to underpin the financial plan
    b. Review the KPI and Workforce Tab information required by Monitor
    c. Undertake a review of the draft narrative plan as it is at that stage
3. The final operational plan and financials will be completed by mid-day Friday 5th February and presented to CEO/CFO for approval for submission. Any remedial actions required by CEO/CFO will be completed.
4. The submission will be completed by the deadline of mid-day Monday 8th February.

With regard to corporate objectives, this paper outlines a new approach for 2016/17, focussing on the Transformation programme as providing the basic structure the trusts objectives will be developed around. These will be developed through February and March and will be completed in advance of the 11th April deadline for the submission of the final Operational Plan.

**9. Recommendation**

The Trust Board is asked to:

1. Note the work to date to deliver the 8th February submission
2. Agree delegated authority to the CEO/CFO to authorise the completed operational plan and financials to Monitor on 8th February
3. Approve the proposed framework for the development of corporate objectives for 2016/17

**Name and date of meeting:**

**TRUST BOARD 4TH FEBRUARY 2016**

**Document Title:**

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

**Action for the Trust Board:**

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

**Introduction:**

The Annual Plan document was approved by the board in April with associated corporate objectives and submitted to Monitor on 15th May 2015.

The Board considered Q1 progress towards delivery of the Annual Plan in July, and Q2 progress at the November board meeting. Progress towards meeting the individual corporate objectives had marginally improved between Q1 and Q2, with 53% of objectives RAG rated as green, up from 47% in the previous quarter. There has been continued improvement in overall RAG ratings during the third quarter.

**Progress report:**

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

The Q3 detailed report on our granular progress towards delivery of the annual plan is attached to this cover paper as a separate document (Appendix 1).

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

The Board requested that we also develop a critical path approach to monitoring the annual plan, highlighting those key milestones that would give assurance on delivery against these priorities. The critical path appraisal is shown on the page following the objective based dashboard.

**Conclusion:**

The trust set 34 corporate objectives for 2015/16:

- 20 are RAG rated as Green at quarter 3 (+2)
- 11 as Amber (-2)
- 3 Red (No change).

Of the 6 strategic themes, 3 are RAG rated as Green, 3 at Amber (+1) and 0 Red (-1).

Overall performance, when measured quantitatively against these objectives, would therefore be assessed as **Amber** (and improved position from the Amber/Red in Q2).

However, the appraisal of the priorities articulated within the main body of the Annual Plan, how they impact on income and operational performance, and what we consider the resultant overall organisation position to be would lead to a **Amber/Red** assessment (Red in Q2) – this is an upgraded position as the financial forecast is improved and trajectories for improved operational performance are in place.

**Author and Date: Rob Elek, Director of Strategy**
**Tom Ellis, Head of Business Planning**
**27th January 2016**

**Annual Plan dashboard – Q3**
**Performance summary**

| Theme | Commentary | | Q3 Rating |
|---|---|---|---|
| **0. Overall Progress** | 6 themes – 3 green, 3 amber, 1 (Q1 0) red | Net change from Q2: -1 red, +1 amber | ↔ |
| | 34 objectives – 20 green, 12 amber, 2 red | Net change from Q2: +2 green, -1 amber, -1 red | |
| **1. Redesign care pathways to keep more people out of hospital** | 6 objectives – 5 green, 0 amber, 1 red | Net change from Q2: -1 amber, +1 green | ↔ |
| | Community and Adult Health service has made positive progress in quarter and has moved from amber to green. A&E and RTT targets continue to not be met, though plans are in development to improve the position | | |
| **2. Redesign and reconfigure our local hospital services** | 5 objectives – 1 green, 4 amber, 0 red | Net change from 2: +2 amber, -2 red | ↑ |
| | Overall capacity coming on stream (remains at amber). The 5th floor scheme has slipped, overall progress is rated as amber (↑) as positive alternative opportunities that will lead to improved services for children are under discussion/in development. The PPU development is rated as amber (↑) as the Private Patient Strategy, which is not reliant on a new physical unit, was approved in January 2016. Nelson implementation remains slow though income recovery scheme in progress (remains at amber); SWL acute provider work progressing well (green) | | |
| **3. Consolidate and expand our key specialist services** | 5 objectives – 3 green, 1 amber, 1 red | Net change: +1 Red, -1 amber | ↔ |
| | Renal scheme rated as Red (↓) due to problems with proposed model of development and likely requirement to re-think overall scheme. Cardiology beds due to open in Q4. MacMillan partnership work very positive and being implemented. and rehab discussions with Putney Hospital and commissioners on-going but positive (both green) | | |
| **4. Drive research and innovation** | 4 objectives – 2 green, 1 amber, 1 red | Net change: +1 Red, -1 amber | ↔ |
| | R&D objective to grow patient number on research trials moved from amber to red due to challenges associated with Trust Turnaround; Cardiology CAG fully functional. Changes in Neurosciences management slowing discussions around the Neuro CAG (green). Key commercial projects progressing well (green). | | |
| **5. Improve productivity, the environment and systems to enable excellent care** | 9 objectives – 6 green, 3 amber, 0 red | Net change: +1 Green, -1 amber | ↔ |
| | EDM, e-triage and e-referral now green (↑); Outpatient strategy approved by Trust board and moving to implementation; Flow programme continues to progress; compliance on follow-up to diagnostic tests received from Divisional chairs. Sign up to Safety funding bid unsuccessful (objective now amber). | | |
| **6. Develop a highly skilled and engaged workforce championing our values** | 5 objectives – 3 green, 2 amber, 0 red | No change on previous quarter | ↔ |
| | No change on any RAG ratings in quarter. Leadership development programme being implemented (green), though turnover increasing; OD programme accelerating (green); values - staff feedback continues to highlight behaviours as an issue (amber); SWL shared bank programme progressing. | | |

**Annual Plan critical path appraisal – Q3 performance summary and Q4 forecast**

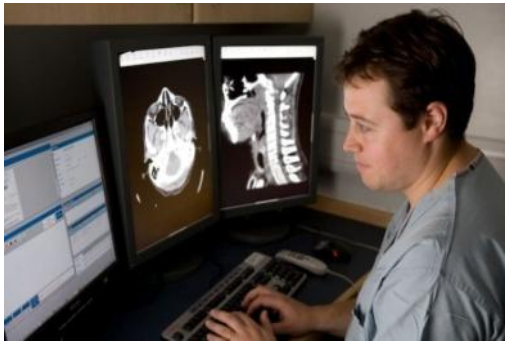
| | Q1 report | Q2 report | Q3 report | Q4 forecast |
|---|---|---|---|---|
| Strategic plan | SLR | SLR | SLR | SLR |
| | PPE post 2013 investments | Wider scope investment review | 2016/17 business planning | 2016/17 annual plan |
| | SWL acute provider scoping | SWL APC report & Vanguard | SWL APC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

| | | | | |
|---|---|---|---|---|
| Overall position | | | | |

St George's University Hospitals NHS
NHS Foundation Trust

# Corporate Objectives 2015/16 Delivery Plan and Monitoring Quarter 3

# Delivery of our 15/16 Annual Plan and Objectives



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

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

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

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

# Governance: Reviewing progress

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

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

# Progress Tracker – Position at Q3

| RAG STATUS | QUARTER | | | | Quarter 3 Commentary |
|---|---|---|---|---|---|
| | Q1 Position | Q 2 Position | Q3 Position | Q4 Position | |
| GREEN | 16 | 18 | 20 | | 59% of objectives (20 / 34) have been classified as Green. Good progress made to delivering the milestones set for the quarter.<br><br>In quarter objectives have moved from amber to green - Complete the redesign of services for frail older people and electronic document management. No objective has moved from green to amber or red. |
| | 47 % | 53% | 59% | | |
| AMBER | 17 | 13 | 11 | | 32% of objectives (11 / 34) have been classified as amber. Two have moved up from Red – Private Patient Unit and Children's & Women's Hospital, and two have moved in the opposite direction – Renal Redevelopment and patient recruitment to research studies |
| | 50 % | 38% | 32% | | |
| RED | 1 | 3 | 3 | | 9% of objectives (3 / 34) have been classified as red. These relate to delivery of access targets, unchanged status from Q2, and the renal redevelopment project and patient recruitment to research studies, both of which were previously amber. |
| | 3 % | 9% | 9% | | |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Implement the new model of care in community adult health services (CAHS)**<br>*Chief Operating Officer* | • Post mobilisation evaluation<br>• Identify quality and performance indicators to measure impact of change and monitor service delivery | • Weekly meeting with Wandsworth CCG and COO from October reviewing implementation and addressing any issues is making good progress and resolving problems as they arise<br>• Good Board to Board resulted in the de-escalation of the CAHS issue by WCCG | ↔ |
| **Complete the redesign of services for frail older people**<br><br>*Chief Operating Officer* | • Develop pathway as required | • Older Person's Advice and Liaison Service (Front Door Frailty) launched in October 2014.<br>• Acute and community services continuing to work with CCGs to develop integrated model. Funding now secured from WCCG for interface geriatrician role. Recruitment in progress for MCCG interface post (HARI) with AAC on 25th Feb 2016<br>• MADE event supported by ECIP took place on 18th & 19th January 2016, with wide stakeholder engagement across health and social care. Commitment to develop discharge to assess model and simplify discharge processes to reduce LOS and DTOCs. | ↑ |
| **Bid to provide Community Services to the residents of Merton**<br><br>*Director of Strategy* | ITT outcome published. If SGH successful begin delivery of mobilisation plan | An ITT was developed in partnership with other providers, however the trust decided not to submit a bid owing to the risk profile of the specification / staffing / activity data / intermediate care provision / potential capital costs / mobilisation costs (in-year) and delivery<br>RAG rating green as Trust has made an informed decision to withdraw from the process | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Support the delivery of the Wandsworth joint health and well being strategy**<br><br>*Director of Strategy* | Will be updated once Health & Well being programme agreed in Q1 | • The new GP premises for Nine Elms / Vauxhall is currently being scoped, we have requested space to deliver outpatient-type services for the local populace.<br>• Following the incomplete community sexual health tender, we are engaging with the local authorities PH department to develop new models of care.<br>• We attended a cross-rail consultation meeting, voicing our concerns around the proposal to move the interchange from Tooting Broadway to Balham, and submitted a written response to the formal consultation process. | ↔ |
| **Develop and implement new models of care and further develop the St. George's network as per 5YFV**<br><br>*Director of Strategy* | Develop programme for review and approval | • The implementation plan for the Marsden Partners vanguard is proceeding, key risks relate to previous LCA processes and how the vanguard will progress them<br>• Engagement with Wandsworth GP federation is gathering pace around the development of a MSCP. The Merton federation is still emerging, though we have provided some R&D funding to support its development. A meeting with SWL Lambeth federation is scheduled for Q4.<br>• The recent board strategy session posed some key strategic questions that we will seek to develop over the coming months, in parallel to the development of the health economy strategic plan (due for submission in June) | ↔ |

# Redesign care pathways to keep more people out of hospital: 3

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Deliver access targets - RTT, A&E and Cancer through**<br>- Robust use of information<br>- Aligning capacity and demand<br>- Working in partnership with providers<br><br>*Chief Operating Officer* | Shared cancer data set across all different providers in cancer pathway, to ensure better information and joined up care | • RTT and A&E targets not being met though A&E has shown improvement in comparison to same time last year as a result of flow and accountability framework that has been put in place<br>• "One Version of the Truth" diagnostic review has been completed and an implementation plan to redesign our unplanned care pathways is to commence in February.<br>• COO commenced waiting list improvement programme /validation exercise<br>• A cancer action plan has been agreed with commissioners and NHSE and is currently being implemented. Performance improvement in line with trajectory is being observed.<br>• The trust is currently working with the RTT IST and commissioners to develop a recovery and sustainability plan. | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Delivering additional capacity in line with clinical need** *Director of Delivery and Improvement / Director of Estates & Facilities* | OPEN:<br>• SAU 8 beds<br>• CDU3 9 beds<br>• Neurosciences (Thomas Young) 16 beds and 7 beds (Neuro gym)<br>• NICU 4 beds and CICU 3 beds<br>• Healthcare at Home 15-30 beds open for winter pressures | • Slippage in AMW bed schemes due to PFI approval delays.<br>• Recovery at Home business case approved with 18th Jan 16 start date.<br>• Hybrid theatre being built, with 13 week delay due to estates issues.<br>• Nightingale was closed over the summer as per plan; Reopening slipped from November to January due to heating problems outwith trust control at Nightingale House.<br>• SAU, CDU3 and CICU schemes all postponed from 15/16 due to funding | ↔ |
| **Children's and Women Hospital** *Director of Strategy* | Develop the strategy further with stakeholders | • Alternative delivery solutions are under consideration for the 5th floor scheme.<br>• Case for support for Centre for Fetal Health under development.<br>• Discussions are in progress with the Marsden for the development of a "Marsden @ SGH" range of paediatric services.<br>• Alternative options for the re-provision of Moorfields services have been shared and are under consideration.<br>• Key meeting hosted by CEO in January re Dalby and other inter-dependencies. | ↑ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Private Patients Unit**<br><br>*Director of Strategy* | Finalise service level agreement with HCA | • PP strategy completed, submitted to January commercial board<br>• Short, medium and long term recommendations include physical capacity needs, service offer and consultant engagement | ↑ |
| **Implement all Merton CCG requirements at the Nelson Health Centre**<br><br>*Chief Operating Officer* | • Implement phase 1 changes<br>• Identify additional redesign areas for year 2 | • Activity at the Nelson continues to be under contracted volume – low levels of direct GP referrals<br>• St. George's and commissioners are working together to develop a plan that will maximise the benefits of the Nelson<br>• The Trust continues to review internally how it can develop services at the Nelson | ↔ |
| **South West London Service Reconfiguration**<br>Continue to work closely with the SW London Collaborative Commissioning Programme and take a leadership role in the Acute Provider and Out of Hospital projects<br>*Director of Strategy* | Develop detailed proposals | • Health partnership now formed. Governance structures still under debate, though key workstreams are now progressing.<br>• Sutton SOC and health economy wide estates requirements need to be surfaced holistically | ↔ |

# Consolidate and expand our key specialist services: 1

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Renal Redevelopment at St. George's**<br><br>*Divisional Chair MC Division* | Enabling works completed | New options being developed by the service due to the delays in finalising the outcome of the PPU proposal. Options include a smaller unit, occupying current space rather than new build. Current renal unit experiencing repeated infrastructure breakdowns which further emphasise the need to bring this work to a conclusion | ↓ |
| **Cardiology expansion**<br><br>*Director of Delivery and Improvement* | No explicit actions | Scheme delayed due to PFI / capital building works issues and reduced CCG funding for heart failure. 7 beds Expected to open Q4 | ↔ |
| **Deliver redesigned cancer services in partnership with MacMillan**<br><br>*Chief Nurse & DIPC / Divisional Chair SNT Division* | Work streams developed<br><br>Partnership communications and evaluation | A great deal of progress has been and continues to be made. The grant application to MacMillan was approved, securing £600,000 funding for the first year of a three year programme.<br><br>Work streams developed and year one will include: Acute Oncology Service redesign project; Macmillan Support Worker Pilot to increase CNS availability; Values Based Standards project to improve the Surgical Pathway Experience; Patient and Public Involvement Pilot.<br><br>Per the Macmillan partnership agreement, joint communications have developed a cobrand and logo and released an announcement of the partnership programme. An evaluation framework has been developed and agreed using a logic model approach. | ↔ |

# Consolidate and expand our key specialist services: 2

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Neurosciences Expansion**<br><br>*Director of Delivery and Improvement* | Professor of Neurology in post | • QMH beds opened.<br>• Thomas Young beds opened.<br>• Professor of Neurology appointed. | ↔ |
| **Develop and implement a rehabilitation strategy**<br><br>Establish a 6 bedded spinal rehabilitation service in partnership with the Royal National Orthopaedic Hospital, Stanmore<br><br>*Director of Delivery and Improvement* | No explicit actions | • Rehab strategy groups established meeting monthly.<br>• Cohorting of patients on new Thomas Young beds.<br>• Discussions underway with CCG re commissioning a spinal rehab unit in partnership with RNOH.<br>• New neuro rehab consultants in post. | ↔ |

# Drive research and innovation through our clinical services: 1

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Continue to increase the number of patients recruited into NIHR studies excluding the impacts of large one off studies**<br><br>*Medical Director* | • Trust website updated<br>• Research Sabbaticals Grant Scheme 2015 | • Website updated and ongoing work continues<br>• Research Sabbaticals Grant Scheme 2016 delayed, pending agreement of 16/17 budget re-forecasting<br>• Research Facilitators agreed in principle by EMT. Funding was identified from commercial research income for one year pilot for one post. Agreement to advertise has been delayed, pending the outcome of the Turnaround/KPMG review in relation to what R&D need to deliver financially in 2016/17 | ↓ |
| **Ensure the Trust is in a position to make a successful bid for NIHR Clinical Research Facility funding**<br><br>*Medical Director* | Implementation of action plan | Plans for a working group developed and to commence meeting weekly in January 2016.<br><br>No date yet announced for the NIHR Clinical Research Facility bidding round, but the NIHR launched the bidding round for Biomedical Research Centres on 15th December 2015. Work to commence immediately to assess whether or not we also want to bid for such a facility. | ↔ |

# Drive research and innovation through our clinical services: 2

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Increase collaborations between SGUL Institutes and Trust clinical directorates through the development of further CAGs: Cardiology Neurosciences**<br><br>*Director of Strategy* | Cardiology CAG fully operational<br>Neurosciences CAG established | The Cardiology CAG is now fully operational. The strategic review has been completed and the CCAG is now working on its business plan across the two organisations.<br><br>Work has continued on developing a proposal for a Neurosciences CAG and this will be reviewed by the Joint Implementation Board at its next meeting in February 2016. | ↔ |
| **Develop additional commercial income streams**<br><br>*Director of Strategy* | Commercial strategy approved | • The Commercial Project Initiation Document (PID) has been completed and is being worked into a Detailed Implementation Plan (DIP).<br>• This project encompasses increasing private patient activity through an increased number of beds, improving performance against the Gibraltar contract, and the development of an offsite Pharmacy Packing Unit (PPU).<br>• Work continues on assessing and applying as appropriate for NHS tender opportunities. We were awarded the contract for breast screening in December 2015.<br>• Good progress continues to be made on NIPT (Non Invasive Prenatal Testing) service. | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Prepare plans to complete the deployment of electronic prescribing, drug administration and clinical documentation for all inpatients, operating theatres and ED on the St. George's campus in 2016/17**<br>*Chief Financial Officer* | Prepare plans to complete the deployment of electronic prescribing, drug administration and clinical documentation for all inpatients, operating theatres and the Emergency Department on the St. George's campus in 2016/17 | • The full business case to complete the deployment on the St. George's campus was agreed by the Business Case Advisory Group on the 16th November 2015. | ↑ |
| **Implement electronic document management and electronic referral system for all new out-patient registrations at St. George's**<br>*Chief Financial Officer* | All newly registered outpatient records scanned for St. George's campus activity | • With the exception of Neurology (which is now scheduled to take place in January 2016) newly registered outpatients records are now completed | ↔ |
| **Develop and implement an Outpatient Strategy**<br><br>*Director of Strategy* | No explicit actions | • Board approved strategy in Q3 – centralising management of outpatients services and adopting a single business model across the organisation<br>• Strategy is key component of transformation change programme for 2016/17<br>• Detailed implementation plan (PID ->DIP) being finalised, delivery of key process and cultural changes have commenced | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Objective to support both effective elective and non-elective flow through the organisation to improve the Patient Experience and support performance standards where applicable**<br><br>*Chief Nurse & DIPC* | Consolidation of the programme | • Winter preparation completed early in Q3- impact being evaluated.<br>• Flow programme presentation to board in Q3 outlining achievements at the end of the first year.<br>• Work completed in Q3 led by the SRG to understand the system profile in relation to patient flow and to agree a set of actions across Health and Social Care settings.<br>• Flow programme to be realigned to deliver further actions following the SRG programme as part of clinical transformation for 16/17. | ↔ |
| **Provide transparency on outcomes by publishing consultant level activity data, clinical quality measures and survival rates from all nationally agreed audits**<br><br>*Medical Director* | Publish first indicators along with plans to address issues arising | • Comply with publication of Consultant-level national audit data. Link for public viewing is on website.<br>• Published activity data available for National Audits.<br>• Action to continually improve learning from national audits and strengthen local data processes.<br>• National Audit data provided in Board report.<br>• Ensure compliance with national mortality monitoring initiatives | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Creating Reliable processes for reducing avoidable harm** - Follow Up of Diagnostic Tests - to implement a framework which will mitigate risk to an acceptable position<br><br>*Medical Director* | Implementation continued | A new Trust Policy on this including mandatory electronic sign off of radiology and histopathology was implemented in September. A report showing results not reviewed has been developed and will be refined. There are some issues with ensuring that all results reach the correct consultant.<br><br>Following the internal audit report Divisional Chairs have assured the Medical Director that recommendations will be implemented in full and compliance is being checked. | ↔ |
| **Commence Sign Up to Safety Programme as element of Quality Improvement Strategy**<br><br>*Chief Nurse & DIPC / Medical Director* | Audit and Evaluation of Programme | The trust was not been successful in its bid to NHSLA for funding for the programme (equivalent to 10% of NHSLA premium charged).<br><br>Discrete work programme in relation to sepsis are in place and continue.<br><br>Position in Q3 as per Q2 | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Ensure delivery of safe clean environments and use of patient feedback as a vehicle for continuous improvement and adoption of best practice**<br>*Chief Nurse & DIPC* | Implementation of actions plans, review and evaluation of data to inform further action | • Outpatient Improvement programme transferred to Outpatient Strategy objective<br>• Feedback for divisional teams on-going on outcomes of patient feedback<br>• Looking to triangulate information by clinical area to develop a truly informed picture of current position which can be shared with clinical teams | ↔ |
| **Evaluation of Clinical Audit results and Acting on findings to ensure audit contributes to improvements for patients**<br><br>*Chief Nurse & DIPC* | As per Q1<br>• Agreed Divisional Programme in place<br>• Quarterly monitoring of Programme against Plan.<br>• Monthly reporting to Board of Key Audits<br>• Ensure Key Actions from Audit findings | • Audit programme is in place and monitoring of progress and outcomes has improved. We are working towards gathering a final position in terms of achievement and outcomes in Q4.<br>• The Q3/4 position will be used to shape the audit programme for 2016/17. Subject to approval by the Patient Safety Committee, and the support of the Clinical Effectiveness and Audit Committee, it is anticipated that the programme for 16/17 will focus on 'getting the basics right' and be used to support and monitor the impact of transformation. Key audits where improvements are not demonstrated will be identified, projects reviewed and reshaped to support implementation and monitoring of improvement in 2016/17 (such as EWS, record keeping, WHO, consent).<br>• To redesign the reporting of audit to the Board and integration into revised Integrated Performance report. | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Develop leadership behaviours to deliver high quality**<br><br>*Director of HR and OD* | • Establish programme of delivery for leadership project<br>• Introduced self assessed electronic process for appraisal | • Leadership development programme designed and agreed by workforce and education committee September 2015.<br>• Assessment process for executive directors commissioned<br>• On track for delivery of electronic appraisal system.<br>• Senior leaders' objectives agreed and circulated.<br>• Nursing establishment review completed for Phase 1 covering approx. 80% of the workforce. Phase 2 now in train and will conclude by end April 2016.<br>• Turnover remains high however , focus on actions to reduce turnover through use of a variety of approaches e.g. exit interviews, training and development. | ↔ |
| **Implement an organisational development programme that supports the Divisional governance review findings**<br><br>*Director of HR and OD* | Where required identify and commission external programmes of support. | • Organisational Development Manager in post with effect from 1st October.<br>• Divisional leadership teams are being allocated organisational development days to meet specific team building and coaching requirements.<br>• Development programmes are being well received by the divisions<br>• Hay Group Executive Management team assessment completed. | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **Embed the Trust values, recognise achievement and ensure staff achieve their maximum potential as well as tackling poor performance**<br><br>*Director of HR and OD* | • Introduce process to ensure recruitment and promotion of staff is based on Trust values<br>• Provide additional resources to support staff support service<br>• Ensure process is in place to implement the recommendations of the "Speak Up" review<br>• Undertake further unconscious bias workshops<br>• Develop personal resilience support | • 2 board development sessions have taken place.<br>• Mid year review now due to take place in November,<br>• Review of bullying policy to be considered by W&E committee in January.<br>• Additional resources allocated to staff support service to undertake targeted interventions.<br>• Mediation scheme established. | ↔ |
| **Ensure the right number of skilled members of staff are available to provide the best possible quality of care**<br><br>*Director of HR and OD / Chief Nurse & DIPC* | • Review and revise nurse induction<br>• Review preceptor programme<br>• Review induction programme<br>• Review current activity and develop a learning and development plan for all staff<br>• Implement SGH components of joint education strategy with SGUL | • Nursing establishment review completed<br>• Proposals for SW London bank in development<br>• Business case for recruitment of overseas nurses has been approved.<br>• Turnover remains high however<br>• Turnover plans to be monitored as part of WEG programme. | ↔ |

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

| Objective and lead | Actions | | RAG |
|---|---|---|---|
| | Q3 planned actions | Update on progress | |
| **To deploy the workforce in the most efficient way possible and improve the efficiency of internal workforce departmental processes**<br><br>*Director of HR and OD* | • No explicit actions | • Benchmarking of workforce department evidences very low cost but efficiency opportunities available.<br>• Programme of work to reduce temporary staffing usage and costs being supported by KPMG. Reduced temporary staffing costs in month 6.<br>• Implementation of recruitment TRAC system has commenced. | ↔ |

**Enclosure:**

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO THE TRUST BOARD** *4 FEBRUARY 2016* **Paper Ref:**

| | |
|---|---|
| **Paper Title:** | **Revised Procurement Policy** |
| **Sponsoring Director:** | **Andrew Burn – Director of Turnaround** |
| **Author:** | **Sara Cook, Procurement Consultant** |
| **Purpose:**<br>*The purpose of bringing the report to the board* | *The Board is asked to note the revised Procurement Policy, which has been approved and ratified by the Trust* |
| **Action required by the board:**<br>*What is required of the board – e.g. to note, to approve…?* | **For information** |
| **Document previously considered by:**<br>*Name of the committee which has previously considered this paper / proposals* | **EMT, PRG and FP Committee in January 2016 (various dates)** |

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

**1. Key messages**

The current financial and operational challenges facing the Trust provide an increased imperative for and an ideal opportunity to improvement procurement governance across the Trust. This revised Procurement Policy, which supports the Trust's Standing Financial Instructions, is key to achieving this. The previous Procurement Policy is out of date (2010), and is not considered to be "fit for purpose." The revised policy – essentially rules to be followed by anyone procuring on behalf of the Trust - uses best practice from elsewhere, improves its robustness and drives accountability thereby improving procurement governance arrangements across the whole of the Trust. The guidance is more explicit thereby removing any avoidance of doubt. It supports mitigating business risk in all procurement activity where possible.

The Procurement Policy supports the Trust's Standing Financial Instructions (SFIs) and has the same authority as the SFIs. The Trust's SFIs form part of the overarching *Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions Policy 2015-16*. The Trust's SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituent operations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes.

It is recognised that the Procurement Policy is quite "dense" and technical. However, this is essential to ensure all the rules and guidelines are covered, which will improve procurement governance across the Trust. Unfortunately, it is difficult to get away from the length. This is reflective of Procurement Policies elsewhere in the public sector, in the NHS, local and central government. A "Procurement Policy in a Nutshell" version will be developed alongside the Communications Team, which will be more digestible at a glance. This will essentially be the Executive Summary.

The revisions to the Procurement Policy:

- Make the policy fit for purpose.
- Make the policy more robust.
- Improve accountability by all budget holders to the procurement process.
- Make the process and "penalties" for non-compliance more explicit.
- Include the sub-title "Rules to be followed when buying on behalf of the Trust."
- Incorporate the requirements of transparency, social value and sustainability.
- Incorporate the Standards of Business Conduct policy, with relevant cross-references made.
- Acknowledge the electronic tendering system that is now used, and delete the references

to the postal tendering process that is note out of date (note this will be a "back pocket" separate policy should the electronic system fail for whatever reason).
- Incorporate feedback from procurement colleagues as to where the current procedure fails.

As part of this, reference is included: Where there is a difference between current legislation for government procurement and this Procurement Policy, the legislation prevails and you must comply with it. This will acknowledge that the legislation does change.

Reference is made to: Where this Procurement Policy appears to conflict with other Trust governance, the Head of Procurement determines which takes precedence.

Reference is made to: Should any difficulties arise regarding the interpretation of the Procurement Policy, then the advice of the Head of Procurement MUST be sought before acting. Failure to comply is a disciplinary matter that may result in dismissal.

It is also made clear that there are no officers within the Trust (or contractors contracted to the Trust) not covered by the Procurement Policy. This will close any avoidance of doubt as to who the policy applies to.

Failure to comply with the Procurement Policy could result in:
- Allegations of fraud and corruption being made against the Trust.
- Re-tendering of goods, services or works, resulting in additional costs and delays.
- Legal challenges / litigation.
- Department of Health investigation.
- Audit intervention.
- Adverse publicity with inevitable damage to the Trust's reputation.
- Disciplinary proceeding against staff who are "non-compliant."

Whilst the latter point (potential disciplinary proceeding) is already stated in the Trust's current SFIs and Procurement Policy, this has been made more explicit and it made clearer that disciplinary action would be considered should someone be in breach of the Procurement Policy and SFIs. It has also been made more explicit that any breaches in policy are reported to the Trust's Audit Committee, where breaches will be challenged and resultant action considered. This might be uncomfortable for some, but is essential to support the challenging financial and operating environment in which the Trust is currently operating.

Implementation of the revised Policy will ensure an auditable trail of all procurement activity across the Trust, with any exceptions (i.e. through Waivers) being formally documented and reported. Non-compliance will be better measured, with action taken by EMT and the Audit Committee where appropriate. Disciplinary action for non-compliance will be taken by the respective DDOs and evidenced on a month-by-month basis in their Turnaround Board (TAB) reports.

The Procurement Policy will be reviewed on an annual basis, with the next review taking place in March 2017. If any amendments are required in the Interim, either legislative or internal requirements, a Procurement Briefing note can be sent out by the Head of Procurement.

**Communications**

Communications to support the revised Policy will be implemented. The Procurement Department is working closely with the Trust's Communications Team to develop a communications plan to support this. Communications initiatives will include regular agenda items at EMT, Senior Leaders Briefing, Chief Nurse's Briefing, emails to Budget holders, and inclusion in the Trust's e-newsletter. Parallel activities will also run with Procurement working with HR to ensure the Procurement Policy and Standing Financial Instructions (SFIs) are incorporated into the Medical and Corporate Induction process, as well as being included in the PDR and PDP process. Mechanisms will also be developed to ensure existing and new staff sign documentation agreeing to adhere to the SFIs and other key Trust policies, including the Procurement Policy. Support will also be provided by the relevant Procurement Managers.

It is essential that all Trust staff are aware of and understand the revised policy, so that penalties

for non-compliance can be considered from 1 April 2016.

**Support for Staff**
Support for staff will be made clear as part of the communications campaign. There are already allocated Procurement Managers, to support the divisional areas within the Trust. The Procurement Managers will play a key role in supporting staff through the procurement process.

An online e-learning module is being developed, which will be included as part of the MAST elearning facility at the Trust. Procurement is working with the MAST team to deliver this. It is hoped that the Procurement module becomes a mandatory module for all Budget Holders to complete, subject to agreement by the MAST Steering Group. It is anticipated that this will be ready for use in Q1 2016/17.

The Corporate and Medical Induction process will be key to capturing new members of staff as they enter the Trust. Again, Procurement is working with HR to develop this. This will include the SFIs and the Procurement Policy.

Support and training can also be offered to members of the Trust's Audit Committee upon request. The Terms of Reference can also be reviewed for this Committee, to ensure their role in the Procurement process is widely documented and recognised.

**2. Recommendation**
It has been recommended by FP Committee that the Board notes the revised Procurement Policy, which has been approved and ratified by the Trust.

**Key risks identified:**
*Are there any risks identified in the paper (impact on achieving corporate objectives) – e.g. quality, financial performance, compliance with legislation or regulatory requirements?*
The revised Procurement Policy incorporates EU and UK procurement legislation. The policy states that failure to comply with its requirements could result in allegations of fraud and corruption being made against the Trust; re-tendering of goods, services or works, resulting in additional costs and delays; legal challenge / litigation; Department of Health investigation; audit intervention; adverse publicity with inevitable damage to the Trust's reputation; disciplinary proceeding against staff who are "non-compliant."

The revised policy is more robust and the guidance has been made more explicit thereby removing any avoidance of doubt. The policy supports mitigating business risk in all procurement activity where possible.

| | |
|---|---|
| **Related Corporate Objectives:**<br>*Reference to corporate objective that this paper refers to.* | **Excellent, Responsible & Respectful** |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | **N/A** |

**Equality Impact Assessment (EIA): Has an EIA been carried out? Yes. The summary can be found in Appendix 4 of the attached Procurement Policy.**

St George's University Hospitals NHS
NHS Foundation Trust

# PROCUREMENT POLICY:

## Rules to be followed when buying on behalf of the Trust

*The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This procedural document has been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individual differences and the results are shown in Appendix 4.*

| **Policy Profile** | | | |
|---|---|---|---|
| **Policy Reference:** | Fin 5.0 | | |
| **Version:** | 1.4 | | |
| **Author:** | Sara Cook, Interim Business Intelligence Consultant | | |
| **Executive sponsor:** | Andrew Burn, Director of Turnaround | | |
| **Executive sponsor sign off:** | *To be added* | | |
| **Target audience:** | ALL Trust staff (including temporary staff) who procure goods, services and works on behalf of the Trust | | |
| **Date issued:** | *ADD Date published - completed by Corporate office* | | |
| **Review date:** | March 2017 | | |
| **Consultation and approval** | | | |
| **Key individuals and committees consulted during drafting** | KPMG | **Dates** | various |
| | EMT | **Dates** | 21/12/2015 |
| | EMT | **Dates** | 11/01/2016 |
| | PRG | **Dates** | 13/01/2016 |
| **Ratification** | | | |
| **Ratification Committee:** | F&P Committee | | |
| **Date:** | 27 January 2016 | | |

| **Document History** | | | |
|---|---|---|---|
| **Version** | **Date** | **Review date** | **Reason for change** |
| 1.1 | 18/08/2010 | | |
| 1.2 | 20/09/2010 | | SFI Waiver form amended |
| 1.3 | 23/09/2010 | August 2013 | Invitation to Quote template added |
| 1.4 | 11/01/2016 | March 2017 (Annual thereafter) | Major overhaul of Procurement Policy to support changes in UK and EU Procurement legislation; follow best practice and improve procurement governance across the Trust |

# Contents

## Executive Summary

The St George's University Hospitals NHS Foundation Trust's Procurement Policy has been developed by the Trust's Procurement Department.

The Procurement Policy defines the procurement "rules" that should be followed by anyone who buys goods, services and works on behalf of the Trust. It applies to all staff (temporary and permanent) working in any of the locations registered by St. George's University Hospitals NHS Trust with the Care Quality Commission (CQC) to provide regulated activities.

The Procurement Policy supports the Trust's Standing Financial Instructions (SFIs) and has the same authority as the SFIs. The Trust's SFI's form part of the overarching ***Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions Policy***. The Trust's SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Community Services Wandsworth integrated with St. George's University Hospitals NHS Foundation Trust with effect from 1 October 2010, South West London Pathology and other Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes.

Only the Procurement Department has the authority within the Trust to place an order with a supplier, or to award a contract to a supplier i.e. to commit monies with external suppliers. However, the Procurement Department cannot do this without the Budget holders' authority to commit those funds from their budget. So, those who hold the budget cannot commit to suppliers, and those who can commit to suppliers do not hold the budget. This is called the division of responsibility, and is an Audit requirement. The Procurement Department can, however, delegate authority to other Departments within the Trust.

There are no officers within the Trust or contractors contracted to the Trust not covered by the Procurement Policy. Compliance with the Trust's Procurement Policy is mandatory.

**Failure to comply is a disciplinary matter that may result in dismissal.**

Failure to comply with its requirements could result in:

- Allegations of fraud and corruption being made against the Trust.
- Re-tendering of goods, services or works, resulting in additional costs and delays.
- Legal challenge / litigation.
- Department of Health investigation.
- Audit intervention.
- Adverse publicity with inevitable damage to the Trust's reputation.
- Disciplinary proceeding against staff that are "non-compliant."

Should any difficulties arise regarding the interpretation or application of the Procurement Policy, then the advice of the Head of Procurement **MUST be sought before acting.**

Where there is a difference between current legislation governing procurement and the Orders, the legislation prevails and you must comply with it. Where the Procurement Policy appears to conflict with other Trust governance, the Head of Procurement determines which takes precedence.

The different tendering limit levels (thresholds) are governed by EU and UK Procurement legislation. These amounts are exclusive of VAT. The thresholds can be seen overleaf:

| Limit Ref. | Applicability | Procurement Requirements | Lower Limit | Upper Limit |
|---|---|---|---|---|
| L1 | Purchase of supplies, goods, services or works | No specific rules, but must demonstrate value for money has been achieved and as part of this must contact Procurement Team for advice on proposed supplier(s)<br>Default position is at least one written quote. It is best practice to seek at least three (3) written quotes | £NIL | £9,999.99 |
| L2 | Purchase of supplies, goods, services or works | Procurement Team must be contacted<br>At least three (3) written quotes from separate suppliers must be obtained | £10,000 | £49,999.99 |
| L3 | Purchase of supplies, goods, services or works | Procurement Team must be contacted and must oversee the tender process<br>At least three tenders from separate suppliers must be sought | £50,000 | £164,176* |
| L4 | Purchase of works (Estates) | Procurement Team must be contacted and must oversee the tender process<br>At least five tenders from separate suppliers must be sought | £50,000 | £4,104,394* |
| L5 | Purchase of supplies, goods or services | Procurement Team must be contacted and must oversee the tender process<br>Must follow the procedure and timetable as directed in the Public Contracts Regulations publication | £164,176* | No upper limit |
| L6 | Purchase of works (Estates) | Procurement Team must be contacted and must oversee the tender process<br>Must follow the procedure and timetable as directed in the Public Contracts Regulations publication | £4,104,394* | No upper limit |

Note: There must be an auditable trail of where suppliers have been contacted for written quotations and formal tendering.

Figures marked * are EU procurement thresholds, as embodied in the UK Public Contracts Regulations 2015. These are revised regularly. The figures included above are valid from 1 January 2016. Note that they may fall as well as rise. The Trust does not operate the Part B threshold for "other residual services" but applies Part A to all supplies and services.

**Please refer to Appendix One for further information regarding this.**

## 1. Introduction

Procurement is the acquisition of goods, services or works from an external source. It is essential that the goods, services or works are appropriate and that they are procured at the best possible cost to meet the needs of the acquirer in terms of quality, quantity, time and location.

Everyone who buys on behalf of the Trust, including staff, contractors and consultants, are responsible for following the Procurement Policy. This Policy incorporates the mandatory requirements of EU and UK Procurement legislation, the Trust's own Standing Orders and Standing Financial Instructions (SFIs), as well as best practice from elsewhere.

Failure to comply with the requirements of the Trust's Procurement Policy could result in:

- Allegations of fraud and corruption being made against the Trust.
- Re-tendering of goods, services or works, resulting in additional costs and delays.
- Legal challenge / litigation.
- Department of Health investigation.
- Audit intervention.
- Adverse publicity with inevitable damage to the Trust's reputation.
- Disciplinary proceeding against staff that are "non-compliant."

The aims and objectives of this Policy are to provide governance to Trust-wide procurement activity, and ensure compliance to EU and UK Procurement legislation, as well as to ensure compliance with the Trust's Standing Orders and Delegation of Powers and Standing Financial Instructions.

The Procurement Department reports to Andrew Burn, Director of Turnaround (from KPMG) who sits on the Trust's Executive Board of Directors. This is a temporary arrangement at the time of writing this revised Procurement Policy, to ensure that procurement governance is improved whilst KPMG is working with the Trust. Later versions of this policy will reflect any changes made into the reporting structure.

## 2. Purpose

### 2.1 Key Principles

The Procurement Policy is based upon the following key principles:

- To secure good **value for money** through appropriate market competition for contracts.
- To be **open and transparent** about how we spend our money.
- To ensure we spend public money **legally and fairly** and to **protect** the Trust from undue criticism or allegation of wrong-doing. This includes ensuring fairness and quality with all suppliers, avoidance of bias, favouritism and that fairness can be demonstrated through an audit trail.
- To support **sustainability** and **social value** objectives, and our public sector **equality** duty, encouraging small businesses to be able to supply to the Trust.

### 2.2 Compliance

The procedure for making all contracts by or on behalf of the Trust shall comply with the Procurement Policy and Standing Financial Instructions. This includes trials of products and equipment; and includes written agreement to enter into new contracts for goods, services and works.

There are no officers within the Trust or contractors contracted to the Trust not covered by the Procurement Policy.

Should any difficulties arise regarding the interpretation or application of the Procurement Policy, then the advice of the Head of Procurement **MUST be sought before acting.**

**Failure to comply is a disciplinary matter that may result in dismissal.**

You must not artificially separate contracts or spending to avoid the Procurement Policy applying at any level.

The Procurement Department must oversee all Capital Bids.

You must not enter into any verbal and written agreements with suppliers. Any terms and conditions for procuring goods, services and works must be authorised by someone in the Procurement Department. Verbal agreements cannot be made.

You must not enter into any agreements for product and / or equipment trials without the involvement of Procurement from the outset.

Where there is a difference between current legislation governing procurement and the Orders, the legislation prevails and you must comply with it.

Where the Procurement Policy appears to conflict with other Trust governance, the Head of Procurement determines which takes precedence.

The Procurement Department reports breaches of the Procurement Policy to the Audit Committee, which has the option of two courses of action:

> **Informal Notice** – where the non-compliance was a result of lack of information or beyond the individual's control, the Trust's Audit Committee makes recommendations to ensure future compliance.
>
> **Formal Warning** – where there is evidence of deliberate non-compliance the Trust's Audit Committee advises the Director of Human Resources & Organisational Development of a formal breach of the individual's terms and conditions for appropriate action to be taken and recommendations made to ensure future compliance.

All members of staff have a duty to disclose any non-compliance with the SFIs. The Procurement Department reports on non-compliance to the Trust's Turnaround Board, to the Executive Management Team and to the Audit Committee.

## 3. Glossary of Definitions

| Term | Definition |
|---|---|
| Aggregate value | The total spend with a supplier over the period of a contract, or the proposed period for new contracts. Individual or annual costs are irrelevant where goods, services or works are of the same type or have similar characteristics. The total cost of the contract (including any extensions available) must be used when deciding which process to use to find a new supplier. For example, a £200k a year contract for 5 years equates to a contract's total value of £1m. For contract extensions, the full value includes the value of the extension and the full contract value i.e. an extension worth £200k, on a contract worth £1m authority is required for an extension against a value of £1.2m, not £200,000. |
| Capital Investment Manual | This guidance. Published in 1994, is intended to reinforce the impact of NHS Reforms to end the bidding by providers for schemes which have not been properly thought through – in effect bringing the damend for capital into balance with supply. The cost of investment to a Trust will be reflected in its prices, and the investment must therefore be affordable and supported by its purchasers. The Capital Investment Manual reflects and reinforces these developments. It represents a comprehensive approach to the planning and delivery of capital investments. It draws heavily on the lessons learned in handling past capital investments, and in particular emphasises the importance of strong leadership, management and control. |
| Contract | An agreement having a lawful objective entered into voluntarily by two or more parties, each of whom intends to create one or more legal obligations between them. The elements of a contract are "offer" and "acceptance" by "competent persons" having legal capacity, who exchange "consideration" to create "mutuality of obligation." |
| Contract management | The monitoring and development of the performance of a contract during its lifetime. |
| EU & UK procurement legislation | Procurement is governed by a set of EU and UK principles that set out to ensure a 'level playing field' for buyers and suppliers in which to conduct business. These principles legally apply to procurement activity above the EU procurement threshold, which is currently £164,176 for NHS Foundation Trusts. |
| Framework agreement | An agreement or other arrangement between one (or more) contracting authorities and one or three or more suppliers which establishes the terms (in particular the terms as to price and, where appropriate quantity) under which the supplier will enter into one or more contracts with a contracting authority in the period during which the framework agreement applies. Generally framework agreements do not have any guaranteed minimum volumes of spend. Contracts awarded via a framework can be via a direct award to a supplier on the framework or by holding a secondary (mini-competition) process that specifies the specifics of the actual contract being procured. |
| OJEU | The Official Journal of the European Union. This is the official gazette of record for the European Union. It is published every working day in all of the official languages of the Member States. Any legal Acts published in the Official Journal are binding. The Supplementary S series contains Invitations to Tender and other document relating to EU Procurement |

| | |
|---|---|
| | Directives. The S Series is the only series that is not issued in every working language of the Union. Each Contracting Authority issues notices in the language of its choice (e.g. St George's in English). |
| Procurement | The acquisition of goods, services or works from an external source. |
| Procurement Policy | The "rules" that should be followed by anyone who buys goods, services and works on behalf of the Trust. It applies to all staff (temporary and permanent) working in any of the locations registered by the Trust. |
| Purchase Order (PO) | A formal order to a supplier for goods, services or works. This is generated through Agresso, the Trust's Purchase to Pay system. |
| Request for Quotation (RFQ) | A formal request to a supplier to provide a price for specified goods, services and works. The RFQ will also indicate how the quote will be evaluated in comparison with others to decide best value. |
| Retrospective spend | Where a Purchase Order is raised once the invoice has arrived from the supplier. This is not allowed as the purchase must be approved properly in advance to ensure the commitment against budget is clearly visible to the budget holder. Failure to raise a Purchase Order in advance is a breach of the Trust's Procurement Policy. |
| Social value | Those aspects of a contract which support a) community well-being, fair and ethical working practices by the supply chain; b) the local economy and local businesses; and c) improvements to the environment. |
| Standing Financial Instructions (SFIs) | Key document setting out the Trusts financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. |
| Supplier management | The process of driving improvements from contracts by developing robust performance plans with the supplier. |
| Supply chain | The chain of suppliers and customers of all the component goods, services or works that go into delivering a given finished good, service or works. |
| Tender | The procurement process of inviting and evaluating bids from people and organisations to provide goods, services or works. |
| Value for money | As a Public Body, the Trust is required to seek and demonstrate Value for Money (VFM) of all its spend. VFM is about obtaining the maximum benefit with the resources available. It is getting the right balance between quality and cost; as well as achieving the right balance between economy, efficiency and effectiveness, known as the 3E's.<br>VFM is best determined through the competition of a robust specification for goods, services or works in an appropriate market place and evaluated using the Most Economically Advantageous Tender (MEAT) methodology. |
| Waiver | Formal tendering processes can be waived in exceptional circumstances, through the completion of a Waiver form. Waivers cannot be given if they would contravene the Public Contract Regulations 2015 or any other applicable legislation. Note: It is the process being waived, and not the expenditure (spend). |

If there are any terms which you do not understand, please contact the Trust's Procurement Department.

## 4. Scope

This Procurement Policy applies to all staff (temporary and permanent) working in any of the locations registered by St. George's Healthcare NHS Trust with the Care Quality Commission (CQC) to provide regulated activities. Locations are not necessarily geographically based or determined. Therefore, the term locations does not just refer to Trust buildings; it is the term used by the CQC to describe the hub of operations for a service or range of services and so includes all activities being performed in the course of performing one's role.

Apart from the exceptions listed below, the Procurement Policy covers all spend with external suppliers' regardless of how they are funded (for example, revenue, capital, grants, ring-fenced government money and / or any third party funding).

The Trust shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and "Estate Code" in respect of capital investment and estate and property transactions, although not binding on Foundation Trusts.

In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS."

The Procurement Policy does not apply to the following items, which are managed by separate policies:

| **Exclusion** | **Relevant Policy / Law** |
|---|---|
| Contracts for permanent or fixed term employment | HR / Recruitment policies |
| Works or Orders placed with utility companies (e.g. re-routing pipework) | This is carried out as part of larger construction contracts |
| Non-trade mandatory payments to third parties, such as insurance claims, pension payments, payments to public bodies | They are not subject to competition due to their nature |
| Medicines | Managed by the Trust's Pharmacy Department through Department of Health and other frameworks. Pharmacy is heavily legislated |

## 5. Roles and Responsibilities

### 5.1 Procurement Activity: ALL

The Head of Procurement is responsible for the process from procurement through to ordering across all services and local systems. Finance is responsible for paying suppliers. The receipt of goods is the responsibility of the Budget Holder. Any developments in the design of the process require the approval of the Head of Procurement and / or Director of Finance or authorised delegate.

The table below shows the responsibilities of the Procurement Team and the responsibilities of anyone in the Trust who buys from external suppliers. If you are in doubt, you should contact someone in the Procurement Team.

| **The Procurement Team is responsible for:** | **Anyone in the Trust who buys from external suppliers is responsible for:** |
|---|---|
| • Ensuring compliance to all internal and external procurement policies and regulations<br>• Providing market knowledge to help you find the best supplier to meet specified needs<br>• Managing and executing all tenders and contract awards over £50,000<br>• Awarding contracts to third parties (suppliers for the procurement of goods, services and works)<br>• Engaging with colleagues from Finance and HR in all contract strategies and awards (where applicable)<br>• Developing strategic action plans for each category of spend<br>• Taking a commercial lead on all strategic and critical contracts and relationships with suppliers<br>• Ensuring that good practice contract and supplier management is written into agreements with our strategic and critical suppliers<br>• Developing the supply chain to deliver performance improvements<br>• Ensuring transparency over spend, contracts and contract opportunities<br>• Embedding social value across the supply chain<br>• Working closely with Accounts Payable to ensure suppliers are paid within agreed payment terms<br>• Obtaining approval for any product and / or equipment trials<br>• Written agreements with suppliers | • Following the Procurement Policy and SFIs, ensuring full compliance<br>• Using suppliers in the Catalogue wherever possible<br>• Goods receipting the goods/services/works in the procurement system (Agresso)<br>• Checking there is adequate budget available prior to procurement activity<br>• Ensuring active participation by Procurement at the start of the process when you need a new supplier or need to review a current contract<br>• Ensuring active participation by Procurement at the start of the process Procurement when using an existing supplier or when require a new supplier/contract<br>• Ensuring technical and clinical specifications meet your requirements<br>• Ensuring specifications take into account equality and diversity as well as social value implications, and carrying out Equality Impact Assessments where appropriate<br>• Putting in place effective monitoring of the performance and management of contracts |

Everyone is responsible for ensuring they are operating with the financial limits set for the Trust's Scheme of Delegation. These limits can be seen in Schedule A of the Scheme of Delegation.

## 6. The Procurement Process: General

### 6.1 General applicability

The Trust shall ensure that competitive tenders are invited for:

- The supply of goods, materials and manufactured articles;
- The tendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- For disposal of assets.

### 6.2 Health care services

Where the Trust elects to invite tenders for the supply of healthcare services the Standing Orders and Standing Financial Instructions shall apply as far as they are applicable for the tendering procedure.

### 6.3 Exceptions and instances where formal tendering need not be applied

Exceptions and instances where formal tendering procedures need not be applied:

- The estimated expenditure or income does not or is not reasonably expected to exceed legal limits or the procedures set out in the annexes;
- Where the supply is proposed under framework arrangements negotiated by the government / Department of Health or appropriate government body;
- Regarding asset disposals and condemnations as set out in SFI No. 26.1.

### 6.4 Waivers (forward looking) and SFI Breaches (backward looking)

#### 6.4.1 Waivers (forward looking)

The Procurement Policy is mandatory and must be adhered to at all times. However, formal tendering procedures may be waived in exceptional circumstances. Waivers are only granted in exceptional circumstances and **cannot be given if they would contravene the Public Contracts Regulations 2015 or any other applicable legislation.** Please note that it is the process that is being waived, and not the expenditure (spend). A copy of the Waiver form can be seen in Appendix 2.

Four weeks should be allowed for Waiver approval, unless the matter is of genuine urgency. In all cases, advice and support should be obtained from the allocated Procurement Manager in the completion of the form. It is not the Procurement Department who completes the form, it is the relevant Budget Holder.

Goods, services or works cannot be purchased until the Waiver process has been completed and fully approved. No Waivers will be granted for retrospective purchases. Retrospective purchases will result in the order / purchase being cancelled and no payment made to the supplier.

The signatory process for the Waiver forms is clearly stated on the form itself. Signatory is required from the Divisional Director (DDO) budget holder, the Procurement Manager, the Head of Procurement and the Director of Finance. Approval by the Head of Procurement must be secured before the Waiver can go to the Director of Finance for approval.

Director of Finance approval is required for ALL extreme urgency requests and other requests with a spend of more than £50,000.

In any remaining exceptional circumstances you must obtain approval in writing (using the Waiver form procedure managed by the Procurement team) prior to progressing with the purchase, as follows:

a. In very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practical or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record and reported to the Audit Committee;
b. Where the requirement is covered by an existing contract;
c. Where Crown Commercial Service and other approved bodies have arrangements in place which have been approved by the Board;
d. Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of consortium members;
e. Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
f. Where specialist expertise, such as ongoing maintenance contracts, is required and is available from only one source;
g. When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be clearly inappropriate;
h. There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
i. For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Head of Procurement will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work; or
j. Where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a party originally appointed through a competitive procedure.

Where it is decided that competitive tendering, or quotations, is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded using the Trust's Waiver Form. The Procurement Department maintains a log of all Waivers. Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

SFI Waivers for the Trust tendering procedure may only be signed by the Trust's Director of Finance and with approval from the Head of Procurement.

Waivers relating to the Trust quotation process may be signed by the Director of Finance, with approval from the Head of Procurement. These Waivers do not have to be reported to Audit Committee, but a full record of such Waivers must be kept for inspection by the Procurement Department.

Competition is deemed to have been carried out if the requirement is covered by a previously tendered contract undertaken by an NHS body such as NHS Supply Chain, London Procurement Partnership or other such approved body; or undertaken by a central government body such as Crown Commercial Service or other such approved body; or there is a consortium arrangement in place. In such circumstances, a Waiver will not be required. However, this does not forego the potential for further competition via a framework as a mini-competition.

**6.4.1 SFI breaches (backward looking)**
A SFI In Breach of form must be completed by Budget Holders as soon as a breach in Procurement Policy has been identified in relation to the procurement of goods, services and works. A breach occurs where Standing Financial Instructions (SFI) rules have not been followed and the conditions for a "Waiver" have not been met.

Completed forms should be signed by various signatories and sent to Procurement for recording purposes. All SFI breaches are reported to the Trust's Audit Committee. A copy of the SFI Breach Incident form can be seen in Appendix 3.

**6.5 Building and engineering construction works**
Competitive tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Head of Procurement and Department of Health approval.

**6.6 Fair and adequate competition**
Where the exceptions in 6.4 (Waivers) apply, the Trust shall ensure that invitations to tenders are sent to a sufficient number of firms / individuals to provide fair and adequate competition as appropriate. Please refer to Appendix One for further guidance as to the number of written quotations and tenders that should be sought.

It shall be confirmed in all tender submissions / quotes that suppliers are not entering into anti-competitive or collusive strategies through a signed declaration of compliance.

**6.7 Items which subsequently breach thresholds after original approval**
Items estimated to be below the limits set in this Procurement Policy (refer to Appendix One) for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Trust's Audit Committee, and be recorded in an appropriate Trust record.

**6.8 Procurement Ethics and standards**
Ethical behaviour in procurement is particularly important for public sector bodies due to the extra scrutiny involved in the expenditure of public funds. The integrity and professionalism of individual members of staff and the Trust as a whole should be maintained at all times.

The guiding principles of ethical behaviour in procurement include:

- The conduct of the Trust's employees should not foster the suspension of any conflict between their official duty and their personal interest.
- The action of the Trust should not give the impression that they have or may have been influenced by a gift or consideration to show favour or disfavour to any person or organisation.
- Dealings with suppliers must at all times be honest and fair.
- Ethical behaviour must be promoted and supported by appropriate systems, such as the procedure set out in this policy and by the governance as set out in the Standing Orders.
- Information provided by suppliers should be regarded and treated as confidential.

- Buyers keep sufficient records to establish an audit trial to demonstrate that appropriate standards have been observed on each purchase.

**It is an offence under the Prevention of Corruption Act 1916 for staff to accept any gifts or consideration as an incentive or reward for doing anything in an official capacity, or showing favour or disfavour to any person in an official capacity.**

All staff in contact with suppliers are vulnerable to accusations of fraud and corruption as they are in contact with the commercial world where it may be normal practice to offer gifts and hospitality.

It is vital that the Trust's staff are, and are **seen to be** above reproach in their actions and must ensure that their personal judgement and integrity cannot reasonably be seen to be compromised by the acceptance of benefits of any kind from a third party.

The following lists a number of irregular situations that must be avoided:

- Sending drawings, specifications, prototypes or samples of one supplier to another.
- Divulging prices of one supplier to another.
- Inventing lower bids to force prices down.
- Refusing to use a supplier's product on the basis of clinical or personal preference, when trials have not been conducted or back up preference and prove use of new supplier represents a clinical risk.
- Refusing to undertake clinical trials to new products / suppliers.
- Exaggerating quantities above known requirements.
- Calling for unnecessarily short delivery times.
- Stating time as 'of essence to the contract' unnecessarily.
- Promising that a contract has a longer term than is warranted or practicable.
- Permitting some suppliers to re-quote while others are denied this facility.
- Giving false information under any circumstances.
- Using a dominant position to take unfair advantage of a small supplier.
- Allowing personal bias or prejudice to influence procurement decisions.
- Taking 'prompt payment' or other discount when they are not 'current' or not earned or relevant.
- Soliciting or accepting from suppliers any 'personal favours'.
- Accepting bribes of any kind.
- Developing personal relationships with sales staff, which could affect decisions.
- Allowing staff to hold undeclared financial interests in suppliers.
- Making alternations to tender documents. If changes are required, correction fluid must not be used and a record of all alterations must be kept with details copied to the supplier.
- Allowing gaps in records.
- Exhibiting bias to a supplier during the tendering process.

### 6.9 Goods inwards / outwards

#### 6.9.1 Goods Inwards

All goods coming into the Trust must be delivered to Receipt & Distribution (R&D). Goods should not be delivered to wards or departments directly unless previously agreed with Procurement. All goods must have a valid Purchase Order number so that the order can be receipted properly. Failure to comply with this policy results in the Trust not paying suppliers on time, and can result in suppliers refusing to supply in future. The Trust's Internal Logistics team will deliver goods to you. You will be required to sign an internal delivery note to say that you have received the goods. You are required to print and sign

your name clearly. Any refusal to sign the paperwork will result in the goods being returned to R&D for collection by the department.

Please note that R&D does not deliver chemicals. These should be delivered directly. Other items such as fridges and beds should also be delivered directly. Anything that breaches the Trust's Manual Handling Policy or Health and Safety guidelines should also be delivered directly.

**6.9.2 Goods outwards / goods being returned to suppliers / goods transferred to other sites or Trusts**

All goods being returned to suppliers or transferred between sites must follow the Goods Outwards Process. A Goods Outwards form must be completed and sent to Stores. This can be obtained from Procurement who will contact the company on your behalf to arrange a return. The goods must be kept in the department until the returns have transferred. Stores will then pick up the item and have it returned or transferred. This needs to be done so the Trust can keep track of its assets. If you transfer goods between the Trust's locations or to a different Trust or back to a supplier and this process is not followed, the Trust will not known where the goods are, and its asset register is therefore incorrect.

**6.10 Loan / trial kit**

Any medical equipment loaned to the Trust by suppliers for clinical trials, or any other purpose, **MUST** be covered by a Loan Equipment Contract or Central Indemnity form. These are available from the Procurement team.

If no contract or indemnity exists (contract position is inclusive of supplier issued Purchase Order) and the equipment is used within the Trust, the Trust is and **NOT INSURED and neither are you**. Clinicians' Professional Indemnity Insurance is at risk if uninsured kit is used by them in any procedure. If in doubt, check with the Procurement Team.

All loan / trial kit must come via Receipt & Distribution (R&D) and be correctly labelled with the name of the person using the equipment and the department name. It will be sent to Medical Physics for the appropriate checks before it is commissioned for use. Again, if Medical Physics have not check the kit before it is used, the Trust's insurance (and your insurance) is invalid.

**6.11 Transparency**

**6.11.1 Publication of Contract Opportunities, Spend and Contracts**

The Procurement Team publishes details of all spend by supplier (minimum value £50,000) each month on the Trust's website, in accordance with current government requirements, as well as a list of current contracts.

The Procurement Team also publishes opportunities for contracts over £50,000 on the national Contracts Finder website. Contracts over the current EU threshold are advertised via the Official Journal of the European Union (OJEU).

**6.11.2 Freedom of Information**

Under the Freedom of Information Act 2000 (FOIA), we have an obligation to publish specific information in the public domain on request. However, the FOIA enables certain confidential information and commercially sensitive materials to be withheld. You must therefore ensure tender information is kept confidential at all stages, especially during tender evaluation and after the contract is awarded. Suppliers must also be given the opportunity to highlight in their tender any information that they would not wish disclosed under FOIA.

### 6.11.3 Conflict of Interest

Market searches, procurement and purchasing must be carried out free from ant conflict of interest to support the Trust's transparency objectives. An 'interest' means any consideration or anything of economic value, indicating future consideration.

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is the responsibility of all staff to ensure that they are not placed in a position that risks or appears to risk conflict between their private interest and NHS duties. The primary responsibility applies to all NHS staff, particularly those who commit NHS resources (for example by the ordering of goods) or those who do so indirectly (for example, by prescribing medicines).

Conflicts of interest can arise when someone who is involved in these processes has a close connection with another party who is also involved, which may mean they could influence, or be influenced by, the outcome of a buying decision.

Conflicts of interest can arise in the procurement process in a number of ways, including:

- Where someone is actually buying goods or services for the Trust, or giving budgetary approval for the purchase, has an interest in the supplier's business.
- Where someone with an involvement in a tender or other sourcing process has an interest in the potential supplier's business.
- Where suppliers bidding for a contract with the Trust have an interest which could enable them to influence unfairly the outcome of a sourcing process.

It is the responsibility of all Trust employees to ensure that they are not placed in a position of conflict between their personal interest and their NHS duties. Agents and contractors acting on behalf of the Trust are similarly required to follow the Trust's ***Standards of Business Conduct Policy***.

All staff who are either responsible for and / or involved in the requisitioning and / or purchasing of goods, services and works should declare any interests they are aware of, either on starting employment or on acquisition of an interest.

The Trust's ***Standards of Business Conduct Policy*** includes specific requirements regarding the Declaration of Interests Register and the Gifts & Hospitality Register.

If you are a Trust employee you must follow the Trust's Standards of Business Conduct. Interests must be declared appropriately, and you must ensure that you do not participate in any buying activity where these conflicts of interest could arise.

Temporary and agency staff, and other consultants or contractors must abide by the terms of their contract with the Trust and follow the Trust's Standards of Business Conduct Policy and on the Trust's Equality & Diversity Policy. Line managers are asked to confirm that all contractors in their areas have been sent the required forms and completed them and returned to the Trust's Company Secretary. The Head of Procurement will cross-check where required and inform the Company Secretary of any changes.

Staff may supply goods, works and services as long as the policy has been followed, and any interests declared at the time a contract is agreed. Staff who become suppliers must not have access to the systems to raise orders or view spend reports. There must be demonstrable transparency and fairness in transactions of this nature.

Suppliers bidding in contracts with the Trust are also required to declare any conflict of interest, and this must be recorded on the Register of Interests.

For ALL procurement activity with a value of more than the OJEU threshold (refer to Appendix One), the Register of Interests must be reviewed to ensure there are no conflicts of interest recorded relating to any of the companies tendering or submitting quotes. This should be undertaken by either Procurement or Estates (for Estates-related procurement) and the check should be formally documented as part of the procurement process.

## 7. The Procurement Process: Buying Via Existing Contracts

### 7.1 Using the Catalogue to find an existing supplier

To buy goods, works or services from external suppliers the Catalogue must be used. It contains a list of products and suppliers and is maintained by the Procurement Department. This is linked to Agresso, the Trust's Purchase-to-Pay system.

Once the right supplier has been found, verbal commitments must not be made but a Purchase Order raised (via Agresso). This must be approved according to the Trust's Standing Financial Instructions before it is sent to a supplier.

The order must not be raised retrospectively (that is, once the invoice has already arrived from the supplier). This is to ensure that the purchase is properly approved in advance and that the commitment against the budget is clearly visible to the budget holder. Failure to raise a Purchase Order in advance is a breach of this Procurement Policy.

## 8. The Procurement Process: Contracting / Tendering Procedure

### 8.1 Invitation to Tender

The Trust operates an electronic tendering system (Due North). All invitations to tender must be requested and received using this system, operated by the Procurement Department. This system provides an electronic governance framework that ensures a record is kept of tender issue and return date, opening procedures and Officers involved in opening, all documents, forms and terms and conditions used in the tender, a record of all written queries and Trust responses, and notification to successful and unsuccessful tenderers.

All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

All invitations to tender shall state that no tender will be accepted unless submitted through the Trust's electronic tendering system.

Where, in accordance with national procurement regulations, electronic tendering is not possible i.e.

- Due to the specialised nature of the procurement, the use of electronic means of communication would require specific tools, devices or file formats that are not generally available or supported by generally available applications;
- The applications supporting file formats that are suitable for the description of the tenders use file formats that cannot be handled by any other open or generally available applications or are under a proprietary licensing scheme and cannot be made available for downloading or remote use by contracting authority;
- The use of electronic means of communications would require specialised office equipment that is not generally available to contracting authorities;

- The procurement documents require the submission of physical or scale models which cannot be transmitted using electronic means then all invitations to tender will state that no tender will be accepted unless:
    - Submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word “Tender” followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager; or
    - That tender envelopes / packages shall not bear any names or marks indicating the sender. The use of courier / postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard forms of Building Contract or Department for Environment, Food & Rural Affairs (GC/Wks) standard forms of contract amended to comply with concode.

When the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and / or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

**8.2 Receipt of Tenders**

All tenders will be through the Trust’s electronic tendering system. As such, the receipt of tenders is automatically recorded. The system will also enable a register to be maintained by the Procurement Department to show for each set of competitive tender invitations despatched:

- The names of firms individuals from which bids/tenders have been received;
- The price shown on each bid/tender; and
- A note where price alterations have been made on the bid/tender.

Incomplete bids/tenders i.e. those from which information necessary for the adjudication of the bid/tender is missing, and amended bids/tenders i.e. those amended by the bidder/tenderer upon his/her own initiative either orally or in writing after the due time for receipt, but prior to the opening of other bids/tenders, should be dealt with in the same way as late bids/tenders.

**8.3 Admissibility**

If for any reason the designated Officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Head of Procurement.

Where only one tender is sought and / or received, the Head of Procurement shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust; or where too few tenders are received the Head of Procurement may decide to cancel the tender process.

### 8.4 Late tenders

The Trust's e-tendering system registers late submissions as submitted after the closing time and date. They will then automatically be excluded unless the Head of Procurement decides that there are exceptional circumstances i.e. a problem with the e-tendering system and delayed through no fault of the tenderer.

Accepted late tenders will be recorded for later scrutiny if required.

### 8.5 Acceptance of formal tenders

Any discussions with a tenderer which are deemed necessary to clarify technical aspects of this tender before the award of a contract will not disqualify the tender.

The tender that most successfully meets the award criteria shall be accepted unless there are compelling reasons to the contrary. Such reasons shall be set out in the tender file or appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

- Experience and qualifications of team members.
- Understanding of client's needs.
- Feasibility and credibility of proposed approach; and
- Ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with the Standing Financial Instructions except with the authorisation of the Head of Procurement.

The use of these procedures must demonstrate that the award of the contract was:

- Not in excess of the going market rate/price current at the time the contract was awarded; and
- The best value for money was achieved.

All tenders should be treated as confidential and should be retained for inspection.

### 8.6 Tender reports to the Trust Board

Reports to the Trust Board will be made as required.

### 8.7 Financial standing and technical competence of tenderers / contractors

The Director of Finance or Head of Procurement may take any enquiries they deem appropriate concerning the financial standing and financial suitability of tenderers and contractors. The financial checks will not constitute a pre-qualification questionnaire (PQQ), but companies can be shortlisted using financial evaluation as part of the process.

The Director with lead responsibility for clinical governance shall similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

Tenders / contractors accreditation will also be checked as part of the tender process.

For major Estates-related contracts, Constructionline is used to ensure suppliers have the required health and safety management and compliance issues in place; along with checks to ensure their financial position and working practices. Estates contractors are selected from approved Constructionline accredited contractors, and must supply their ConstructionLine certification as part of the tender process. If they are not on ConstructionLine, they must not be considered.

## 9. The Procurement Process: Quotations – Competitive and Non-Competitive

### 9.1 General position on quotations

Written quotations are required in all cases where formal tendering procedures are not adopted and in line with the delegated budget limits as shown in **Appendix One**.

The Procurement Department may choose to obtain written quotes or tenders even when not mandatory, if this may lead to better value for money.

If the product you would like to purchase is on the Catalogue on the Trust's procurement system, quotations are not required.

Please refer to Appendix One for latest Tendering Limit information.

***All amounts for supplies, goods, services and works are exclusive (net) of VAT.***

### 9.1.1 Supplies, Goods or Services

| Amount | Requirements | Involvement by Procurement? |
|---|---|---|
| £0 to £9,999<br><br>Total contract value i.e. total over term of contract | Below £10k – **more than one written quotation is normally required**. It is best practice to seek at least 3 written quotes. All purchases must demonstrate value for money.<br><br>Evidence of agreement of the price must be obtained (a computer record will suffice). | Yes. The Procurement department must be contacted prior to purchasing or requisitioning and be involved in the process. |
| £10,000 to £49,999<br><br>Total contract value i.e. total over term of contract | **At least three written quotations are required** where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceed £49.999. | Yes. The Procurement Department must be contacted prior to purchasing or requisitioning and be involved in the process. |
| £50,000 to £164,176 *<br><br>Total contract value i.e. total over term of contract | **At least three separate tenders** from separate suppliers must be sought. | Yes. The Procurement Department must be contacted prior to tender process. Procurement must coordinate the tender process. |
| Greater than £164,176 * | Full competitive OJEU procedure to be undertaken. Must follow the procedure and timetable as directed in the "EU | Yes. The Procurement Department must oversee the tender process. Please |

| | | |
|---|---|---|
| Total contract value i.e. total over term of contract | Procurement Directives" and "Public Contracts Regulations" publications available on www.gov.uk. Potential to use an existing framework which has already been through the OJEU procedure. | allow sufficient time for Procurement's involvement and the tender process itself. |

There must be an auditable trail as to the suppliers that have been contacted i.e. you must be able to evidence that e.g. three suppliers have been approached to provide a written quotation.

Figures marked as * are EU procurement thresholds, as embodied in the UK in the Public Contracts Regulations 2015. These are revised regularly. These thresholds are valid from 1 January 2016. Note: they may fall as well as rise.

### 9.1.2 Works

| Amount | Requirements | Involvement by Procurement? |
|---|---|---|
| £0 to £9,999<br><br>Total contract value i.e. total over term of contract | Below £10k – **more than one written quotation is normally required**. It is best practice to seek at least 3 written quotes. All purchases must demonstrate value for money.<br><br>Evidence of agreement of the price must be obtained (a computer record will suffice). | Yes. The Procurement department must be contacted prior to purchasing or requisitioning and be involved in the process. |
| £10,000 to £49,999<br><br>Total contract value i.e. total over term of contract | **At least three written quotations are required** where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceed £49.999. | Yes. The Procurement Department must be contacted prior to purchasing or requisitioning and be involved in the process. |
| £50,000 to £4,104,394*<br><br>Total contract value i.e. total over term of contract | **At least five separate tenders** from separate suppliers must be sought. | Yes. The Procurement Department must be contacted prior to tender process. Procurement must coordinate the tender process. Please allow sufficient time for Procurement's involvement and the tender process itself. |
| Greater than £4,104,394*<br><br>Total contract value i.e. total over term of contract | Full competitive OJEU procedure to be undertaken. Must follow the procedure and timetable as directed in the "EU Procurement Directives" and "Public Contracts Regulations" publications available on www.gov.uk. Potential to | Yes. The Procurement Department must oversee the tender process. Please allow sufficient time for Procurement's involvement and the |

| | | |
|---|---|---|
| | use an existing framework which has already been through the OJEU procedure. | tender process itself. |

There must be an auditable trail as to the suppliers that have been contacted i.e. you must be able to evidence that e.g. three suppliers have been approached to provide a written quotation.

Figures marked as * are EU procurement thresholds, as embodied in the UK in the Public Contracts Regulations 2015. These are revised regularly. These thresholds are valid from 1 January 2016. Note: they may fall as well as rise.

**9.2 Competitive quotations**
Quotations should be obtained from firms / individuals in line with the ***Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions*** and based on specifications or terms of reference prepared by, or on behalf of, the Trust.

Quotations must be in writing.

All quotations must be treated as confidential and should be retained for inspection.

The relevant Procurement Manager will evaluate the quotation and select the written quote which provides best value for money. If this is not the lowest quotation, if payment is to be made by the Trust, or the highest is payment is to be received by the Trust, then the choice made and reasons why should be recorded in a permanent record.

**9.3 Non-competitive Quotations**
Non-competitive quotations in writing may be obtained in the following circumstances:

- The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible Officer, possible or desirable to obtain competitive quotations.
- The supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts.
- Miscellaneous services, supplies and disposals.
- Where the goods or services are for building and engineering maintenance the responsible works manager must certify that the conditions in the two earlier bullet points apply

**9.4 Quotations to be within financial limits**
No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with the ***Standing Financial Instructions*** except with the authorisation of either the Head of Procurement or relevant Procurement Manager.

**9.5 Authorisation of Tenders and Competitive Quotations**
Providing all the conditions and circumstances set out in the Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided or authorised as set out in Schedule A (Summary Financial Limits for Scheme of Delegation) in the ***Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions***.

The levels of authorisation may be varied or changed and need to be read in conjunction with the ***Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions***.

Formal authorisation must be put in writing. In the case of authorisation by the Trust this shall be recorded in their minutes.

**9.6 Private Finance for Capital Procurement (see overlap with SFI No. 17.13 and SFI No. 24)**

The Trust should normally market test for Private Finance Initiative (PFI) funding when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

- The relevant Procurement Manager shall demonstrate and assure the Head of Procurement that the use of private finance represents value for money and genuinely transfers risk to the private sector.
- Monitor guidance must be adhered to and applied in all respects.
- The proposal must be specifically agreed by the Trust Board; and
- The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Procurement must oversee all Capital Bids from the start of the process.

**9.7 Compliance Requirements for All Contracts**

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State under its terms of authorisation as a Foundation Trust and shall comply with:

- The Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions;
- EU Directives and other statutory provisions;
- Any relevant guidance including reference (not necessarily binding for Foundation Trusts) to the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;
- Such of the NHS Standard Contract Conditions as are applicable;
- Any relevant directions; and
- CQC registration criteria.

Contracts with Foundation Trusts must be in a form compliant with appropriate NHS and Monitor guidance.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited, standard NHS Terms and Conditions should be the default.

In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Head of Procurement shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

**9.8 Personnel and Agency or Temporary Staff Contracts**

The Chief Executive shall nominate Officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. All Officers must comply with the Trust's Temporary Staffing Policy. Temporary staff, whether a contractor, interim or consultant must also complete a Register of Interests form (refer to

Section 6.12.3 Conflict of Interests). The hiring Manager is responsible for ensuring this has been done.

**9.9 Healthcare Services Agreements**
Service agreements with NHS providers and commissioners for the supply of healthcare services shall be drawn up in accordance with the National Health Service Act 2006 and administered by the Trust. Service agreements are contracts in law and are enforceable by the courts.

The Director of Finance will present to the Board the contract plan as part of the business plan and budgets for the forthcoming year. The contract plan will summarise the sources of patient care income and their size, highlighting any significant changes from the previous year.

The Trust is able to enter into the new multi-year contracts to provide services that were not part of a year's business plan subject to i) complying with the rules for committing any associated expenditure and ii) the income reserved / delegated authorities set out in the Standing Financial Instructions (Approval Process for Entering into New Multi-year Contracts to Provide Services that were not part of the Business Plan).

Before entering into a contract to provide services, the Executive and any subsequent approving committee, need to undertake the relevant due diligence to ensure that the contract is in the Trust's best interest and is properly constituted with Procurement support.

The Chief Executive shall nominate Officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

**9.10 Asset Disposals**
*(Please see overlap with SFI 26.1)*

Subject always to guidance and applicable approvals from Monitor, competitive tendering or quotation procedures shall not apply to the disposal of:

- Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Head of Procurement or his/her nominated Officer;
- Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
- Items to be disposed of with an estimated sale value of less than £10,000, this figure to be reviewed on a periodic basis;
- Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- Land or buildings concerning which Monitor guidance has been issued but subject to compliance with such guidance; and
- Coordinated by a Procurement lead.

Care must be taken to ensure that environmental sustainability, as well as security and other associated issues are considered when arranging for the disposals of goods.

You must seek advice from Procurement when making valuations and the book value of the asset will be primarily used to calculate value. In most cases, it is anticipated that the highest bid received will be accepted.

**9.11 In-house Services**
The Head of Procurement shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

In all cases where the Board determined that in-house services should be subject to competitive tendering the following groups shall be set up:

- Specification group, comprising the Chief Executive or nominated Officer(s) and specialist.
- In-house tender group, comprising a nominee of the Chief Executive and technical support; and
- Evaluation team, comprising normally a specialist Officer, a Procurement Manager and a Director of Finance representative. For services having a likely annual expenditure exceeding £250,000, a Non-Executive Director should be a member of the evaluation team.

All groups should work independently of each other and individual Officers may be a member of more than one group but no member of the in-house group may participate in the evaluation of tenders.

The evaluation team shall make recommendations to the Board.

The Chief Executive shall nominate an Officer to oversee and manage the contract on behalf of the Trust.

**9.12 Applicability of Standing Financial Instructions on Tendering and Contracting of Funds Held in Trust** *(See overlap with SFI No. 17.19 and SFI No. 29)*
The Standing Financial Instructions shall not only apply to expenditure from Exchequer funds, but also to works, services and goods purchased from the Trust's funds and private resources.

All commercial contract negotiations / renegotiations must be undertaken and led by Procurement.

## 10. The Procurement Process: Finding & Contracting with New Suppliers

**10.1 Finding and Contracting with New Suppliers**
Wherever it is necessary to contract with a new supplier, the 'aggregate' spend forecast must be taken into account. This is the total amount the Trust would expect to spend with a supplier for the duration of the contract. This value is used to determine the approach to be used to find a supplier and put a suitable contract in place.

This also applies to product and / or equipment trials.

If you are discussing developments with new suppliers you should take care to ensure that you do not inadvertently share key commercial information such as budgets, existing pricing from other suppliers, or suggestions for improvements unless you have a non-disclosure agreement in place. This protects the Trust's interests and intellectual property. Procurement is responsible for putting these agreements in place where appropriate, and can provide commercial advice in dealing with suppliers.

Promises must not be made to suppliers without the formal procurement process being undergone. Rigorous life costings must be included. Consumables, maintenance and other costs must be included, and involvement by Procurement must be sought to calculate the life costings, which will be based on engagement with all suppliers in the market place.

The Procurement Policy must be followed, as well as EU and UK Procurement Regulations. Please ensure involvement by someone in the Procurement Department at the start of the process.

**10.2 Sustainability and Social Value**

The Public Services (Social Value) Act 2012 came into force during 2013 and introduces a statutory requirement for public authorities to have regard to economic, social and environmental well-being. The term 'social value' refers to approaches that seek to maximise the impact of expenditure and the additional benefit to the community from the commissioning or procurement process over and above the delivery of the actual service. The Act therefore places an obligation on the public sector to consider the economic, social and environmental wellbeing of our area when we award services contracts over the EU threshold. This is applied informally through all procurement over the OJEU threshold level (refer to Appendix One) as well.

The Trust's procurement approach, all placed as part of the tender evaluation process, covers these areas:

(i) **Economic Sustainability** – the Trust aims to purchase goods, works and services that enhance the local economy. The Trust recognises the importance of Small & Medium Enterprises to the economy and ensures every effort is made to make our contract opportunities and tender processes accessible to them.

(ii) **Social Sustainability** – the Trust aims to purchase goods, works and services that minimise the Trust's carbon footprint, encourages a positive impact on the local environment, and have the best value costs and benefits taking into account their whole life cycle from origination to disposal.

(iii) **Equalities & Diversity** – the Trust only purchases goods, works and services from suppliers who meet the Trust's standards of quality of employment and service delivery, and the Trust ensures that the tender process is free from discrimination or perceived discrimination in accordance with the Trust's Equality & Diversity Policy.

Procurement must consider Social Value when planning tenders for all contracts over the OJEU threshold limit (refer to Appendix 1). A Social Value Assessment must be carried out and the results recorded as part of the tender evaluation process.

**10.3 Liability & Security**

**10.3.1 Insurance Liability**

To protect the Trust, the following insurance liability criteria should be applied where applicable:

- All procurement where there is a direct advice and / or design service provided by a contractor, including all consultancy arrangements, must have and maintain Professional Indemnity Insurance.

  For contracts up to £499,999, cover of £1 million *or higher* is required.

  For contracts £500,000 and over, cover of £5 million is required.

- All suppliers of works (and designated services) must have and maintain Public Liability Insurance and Employers' Liability Insurance where applicable (may not apply to contractors).

  For contracts up to £499,999, cover of £5 million *or higher* is required.

  For contracts £500,000 and over, cover of £10 million is required, in addition to any other insurance recommended by the Insurance Section. (Sole traders with no employees are not required to have Employers' Liability Insurance).

The Head of Procurement may agree other insurance values for public liability and professional indemnity cover. All variations to agreed levels must be made in discussion with the Head of Procurement. All variations must be recorded in writing and stored on the Trust's Contract Management System.

**10.3.2 Financial Security**
Finance must confirm that suppliers are financially robust prior to contract award.

If either the total aggregate value of the contract exceeds £2 million within twelve months, or there is doubt as to the financial credibility of a supplier but the Trust has decided to accept the level of risk, then additional forms of security to a level determined by the Finance Directorate could be required. For example:

- A Parent Company, Ultimate Company or Holding Company guarantee where their finances prove acceptable.
- A Director's Guarantee or Personal Guarantee where finances prove acceptable.
- A Performance Bond, retained funds or cash deposit.
- Any other security as determined by Finance.

All documents inviting tenders must contain a statement that the supplier needs to provide security of performance and the level of security needed.

Additional documentation, where required, should be stored on the electronic tendering system. This needs to form part of the Trust's tender pack.

Please also refer to Section 8.7 – Financial Standing and Technical Competence of Tenderers / Contractors.

**10.3.3 Document Retention periods**
The retention of tenders and contractual documentation is prescribed in the Limitation Act 1980 and the Public Contracts Regulations 2015. Please refer to the Trust's policy and procedure ***Corporate Records Policy*** for retention periods.

**10.3.4 Anti-Fraud Policy**
The Trust has an Anti-Fraud Policy in place, including the steps that must be taken where fraud or corruption is suspected or discovered. Any person who becomes aware of any fraud, corruption or other illegal act and does not follow this policy could be subject to disciplinary action. The Trust has a nominated Local Counter Fraud Specialist whom staff should contact promptly and in confidence if they have any concerns that a fraud might have taken place.

The Anti-Fraud Policy incorporates the Bribery Act 2010, which includes offences of offering and / or receiving a bribe and it also includes an offence of failing to prevent a bribe.

The Trust is committed to preventing fraud, bribery and corruption against an organisation.

## 11. The Procurement Process: Awarding & Managing Contracts for Best Value

### 11.1 Awarding & Managing Contracts for Best Value

All purchases must be delivered under a form of contract approved by the Procurement Department. The Trust manages the process of awarding contracts via its e-tendering and Contract Management Systems, to ensure that contracts are properly filed and documented.

### 11.2 Mobilisation of new contracts

All contracts, including any variations or amendments, must be registered and maintained by Procurement. The Trust's contract management system is used to store both scanned copies and summary data relating to all contracts.

All contracts over £100k must have a designated Procurement Manager, recorded on the contract management system.

**11.3 Who must sign contracts, amendments and extensions?** The arrangements for contract signature are shown in The Trust's ***Schedule A of the Delegation of Powers – Summary Financial Limits for Scheme of Delegation***. These arrangements include amendments and extensions and the aggregate value of the contract determines the signatory requirement.

All contracts and Terms and Conditions must be approved by Procurement or the Trust's legal representatives via the Procurement Department.

A contract may only be amended (or varied) if the contract permits such a variation and is allowable under the Public Contract Regulations, which state that any variation may only be up to 50% of the original advertised value of the contract. The agreement of the Head of Procurement is required. The amendment (or variation) must be evidenced in writing and signed by the Authorised Officer as detailed in Schedule A of the Trust's Delegation of Powers. The amendment must then be recorded and retained with the original contract.

Requests to extend or amend contracts must be discussed with the relevant Procurement Manager. Such variations must be planned in a timely way, and not used as a way to avoid the proper tender procedures. Variations must also take into account any requirements for supplier diversity in the specification and consider if this needs updating to meet current needs.

The Trust's Waiver process must be used for this (Section 6.4).

The NHS England NHS Standard Contract Technical Guidance (2015/16) states a contract can only be extended once, and for a maximum of 2 years.

Extension options may be used only where:

- A competitive procurement has been undertaken for the contract; and
- It has been made clear from the outset (including OJEU Notice if applicable) the period of any possible extensions to the initial contract term.

You must not extend contract without going through the correct procurement procedure. You must not have rolling contracts.

### 11.4 Remedies Directive

Should a successful challenge be made after a contract has been awarded, the Court could order the contract to be ineffective. This means that the contract will be cancelled and an alternative method of delivering the service will have to be found. This could result in significant costs to the Trust, but if the appropriate standstill periods are correctly applied the Trust will be able to minimise the risk of any challenge. The Procurement Department is responsible for ensuring the correct contract award processes are followed, including observing a standstill period and publishing Award Contract Notices for all contracts over OJEU thresholds.

### 11.5 Legal Status of the Procurement Policy

The Trust is required by The Secretary of State for Health, under the provisions of the National Health Service Act 2006, to maintain the Orders as part of the Standing Financial Instructions.

The Head of Procurement is the custodian of the Procurement Policy and is responsible for keeping them under review. If the EU Directives or any other law is changed in a way that affects the Orders, then the Head of Procurement or representative of will issue a bulletin and the change must be observed until the Orders can be revised.

## 12. Dissemination and implementation

### 12.1 Dissemination:

A robust communications programme will be developed, with support from the Trust's Communications Team. Delivery of the communications programme will increase awareness of the Trust's Procurement Policy, increase awareness and understanding of EU and UK procurement legislation, as well as highlighting the importance of involving Procurement in all procurement activity. It is this communication and education of individuals at all levels in the Trust which will improve procurement governance across the Trust.

This will also support the turnaround that is underway regarding the Trust's financial and operational challenges.

Communications mechanisms to support dissemination and implementation of the Procurement Policy will include:

- Coverage of the Procurement Policy and SFIs as part of the Trust's induction process for new staff (both the Medical and Corporate Inductions).
- Updating of the Trust's Procurement pages on the Intranet to include a Frequently Asked Questions section, the key messages from this policy and why staff must adhere to it as well as signposting regarding who to contact for what in Procurement.
- Utilising key touch points across the Trust. For example, weekly e-newsletter, directly communicating with Budget Holders via email, bi-monthly team briefs, the fortnightly Chief Nurse Brief, as well as attendance at key meeting e.g. Operational Management Team, Executive Management Team, Nursing Board.
- Creating an online elearning module on Procurement to educate and increase awareness of the importance of procurement governance.
- Taking advantage of the restructure of the Procurement Team, which will shortly develop a Category Management approach, and using these category experts to communicate directly with their key stakeholders regarding the revised Policy. This will be key to reinforce the message.

External web pages will also be developed to enable suppliers to have visibility of the Trust's Procurement Policy as well as related policies such as the Supplier Representatives Policy.

It is essential that effective communications takes place to disseminate the revised Procurement Policy, as penalties for non-compliance cannot be pursued without this. Support from senior management and Directors is essential to facilitate this, to ensure the message is driven form top-down.

The effectiveness of the communications can be reviewed and lessons learned shared with other parts of the Trust to drive improvement in communicating corporate policy and improving governance.

### 12.2 Implementation

Delivering the communications programme to support the drive to improve procurement governance across the Trust will help embed the revised Procurement Policy. Buy in from senior management and executives is critical to improve this governance and ensure compliance to the Procurement Policy.

To support the delivery of the revised Procurement Policy, key forms have been updated (for example, the Trust's Waiver form).

Embedding the Procurement Policy will result in:

- A reduction in the number of Waiver forms completed and approved;
- A reduction in the number of requisitions rejected as the procurement process will be better known and understood;
- Minimised risk to the Trust as more effective compliance with EU and UK procurement legislation;
- Better value for money secured through appropriate market competition for contracts;
- Increased transparency about how the Trust spends its money;
- A reduction in the number of suppliers;
- Improved contract management;
- Better business planning to avoid the need for Waivers; and
- Improved procurement governance across the Trust.

## 13. Monitoring compliance

Trust-wide Procurement is overseen by the Finance, Performance & Investment Committee, the Trust's Turnaround Board and the Trust's Audit Committee, and along with the Procurement Department is responsible for setting and monitoring KPIs to establish effectiveness and compliance with the Procurement Policy.

The Trust's Audit Committee received regular reporting regarding Waivers and non-compliance with the Procurement Policy.

The table below outlines the process for monitoring compliance with this document.

| Monitoring compliance and effectiveness table | | | | | |
|---|---|---|---|---|---|
| **Element/ Activity being monitored** | **Lead/role** | **Methodology to be used for monitoring** | **Frequency of monitoring and Reporting arrangements** | **Acting on recommendations and Leads** | **Change in practice and lessons to be shared** |
| **Non compliance:** Number of breaches to Procurement Policy reported to Audit Committee: i) resulting in informal notice ii) resulting in formal warning.<br><br>EMT and Turnaround Board to receive monthly reports (and more often if requested) and appropriate action taken. | Head of Procurement Governance, Policy & Business Intelligence | Procurement will keep an audit trail of non-compliance, and report to Audit Committee, EMT and Turnaround Board | EMT and Turnaround Board to receive reports on non-compliance on a quarterly basis and act appropriately on receipt of this information.<br>Audit Committee to receive report on non-compliance on a quarterly basis and to take appropriate action..<br>The lead and Committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them. | Required actions will be identified and completed in a specified timeframe. | Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders. |
| Number of Waiver forms completed and approved | Head of Procurement Governance, Policy & Business Intelligence | Procurement will keep an audit trail of forms submitted and approved, including reasons for Waiving the process | EMT to receive report on Waivers on at least a monthly basis<br>Turnaround Board to receive monthly reporting on this.<br>Audit Committee to receive report on non-compliance on a quarterly basis | Required actions will be identified and completed in a specified timeframe | Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders. |

| | | | | | |
|---|---|---|---|---|---|
| | | | The lead and Committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them. | | |
| Number of SFI In Breach of Forms completed | Head of Procurement Governance, Policy & Business Intelligence | Procurement will keep an audit trail of forms submitted, including the reasons for the breach in SFIs | EMT to receive report on 'SFI In Breach' on at least a monthly basis<br>Turnaround Board to receive monthly reporting on this.<br>Audit Committee to receive report on non-compliance on a quarterly basis<br>The lead and Committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them. | Required actions will be identified and completed in a specified timeframe | Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders. |
| Number of suppliers | Head of Supply Chain | Procurement will seek to reduce the number of suppliers utilised by the Trust | Monthly reports produced for EMT and Turnaround Board (part of monthly procurement performance reporting)<br>The lead and Committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them. | Required actions will be identified and completed in a specified timeframe | Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders. |
| Number of new starters undertaking | Director of HR | Procurement Policy and SFIs to be incorporated into Corporate and Medical Induction processes from 1 | | | |

| | | | | | |
|---|---|---|---|---|---|
| Induction process | | April 2016. After this date, can report on the number of staff having undergone the induction process | | | |

Other mechanisms will be developed as soon as new communications and awareness channels have been developed and implemented. For example, the number of staff having completed the elearning procurement module. Awareness levels as to the Procurement Policy and SFIs can also be “tested” using, for example, Survey Monkey.

## 14. Associated documentation

Related Trust policies include:

- Standing Orders, Reservation & Delegation of Powers and Standing Financial Instructions.
- Clinical Product Management Policy.
- Company Representatives Policy.
- Supplier Representatives Policy.
- Medicines Management Policy.
- Freedom of Information Policy.
- Standards of Business Conduct.
- Loan Equipment Contract.
- Anti-Fraud Policy.
- Temporary Staff Policy.

This list is not exhaustive.

The Trust's ***Standing Orders, Reservation & Delegation of Powers and Standing Financial Instructions*** sets out the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

The Trust's ***Clinical Product Management Policy*** sets out the Trust's approach to Clinical Product Management (CPM) across the Trust. It applies to all procurement of clinical products to be used within St Georges Healthcare NHS Trust. Utilisation of CPM processes encourages a balance of optimal clinical outcomes and supply governance while striving to deliver objective evidence based clinical analysis through research, multi-disciplinary collaboration and data which includes function, cost, utilisation, impact on infection control and patient outcomes.

The Trust's ***Company Representatives Policy*** in place, which provides a clear, structured and safe pathway for Company Representatives to engage with Trust staff. A Company Representative is any person engaging with the Trust with the intention of supplying the Trust with goods or services, or supporting a product / service already in supply. The Company Representative Policy clearly states that representatives must not visit Clinical areas or Procurement without an appointment; and lays out the process in place for making an appointment with a member of staff. This request is undertaken via the relevant Procurement Manager.

The Trust also has a ***Supplier Representatives Policy***, which sets out the principles on how the Trust will manage and control the whole process of engaging with clinical suppliers. Supplier Representatives means all supplier personnel involved in selling, delivery, management, stock control, development and / or training of clinical products being used or being considered for use by the Trust.

The Trust also has a ***Medicines Management Policy*** in place, which governs pharmaceutical industry representatives. Please contact the Pharmacy Department with regards to this Policy.

The Trust's ***Freedom of Information Policy*** is part of the Government's commitment to greater openness in the public sector giving members of the public the 'right to know'. The Trust's Freedom of Information Policy outlines the processes and procedures established by the Trust in order to satisfy its statutory obligations under The Freedom of Information Act 2000 and to be as transparent as possible.

The Trust's ***Standards of Business Conduct*** sets out how NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is also the responsibility of all staff to ensure that they are not placed in a position which risks or appears to risk conflict between their private interest and NHS duties. The primary responsibility applies to all NHS staff, particularly those who commit NHS resources (e.g. by the ordering of goods) or those who do so indirectly (e.g.by prescribing medicines). This policy should be read alongside the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation, and Bribery Policy which emphasise the importance of ensuring that the Trust maintains the highest standards of business contact and priority at all times.

The Trust's ***Anti-Fraud Policy*** is intended to provide direction and help to staff at all levels who find themselves having to deal with suspected cases of theft, fraud or corruption. All staff in the Trust should be are aware of what constitutes fraud and corruption, and what they should do should they suspect they have witnessed fraud and corruption. Where fraud and corruption are identified, the appropriate sanctions will be applied, whether disciplinary, civil or legal, to ensure that wherever possible the Trust pursues and gains reimbursement and or compensation.

The Trust's ***Temporary Staff Policy*** sets out to ensure control of the Trust's pay bill and good, consistent practice in managing the use of temporary staffing. The policy sets out the procedures and protocols for the use of temporary staffing at the Trust.

Copies of these policies are available on the Trust's Intranet.

## 15. References

The Public Contracts Regulations 2015 (available on www.legislation.gov.uk).

**APPENDIX ONE: TENDERING LIMITS (over the total value over contract term) – threshold levels exclusive (net) of VAT**

| Limit Ref. | Applicability | Procurement Requirements | Lower Limit | Upper Limit |
|---|---|---|---|---|
| L1 | Purchase of supplies, goods, services or works | No specific rules, but must demonstrate value for money has been achieved and as part of this must contact Procurement Team for advice on proposed supplier(s)<br>Default position is at least one written quote. It is best practice to seek at least three (3) written quotes | £NIL | £9,999.99 |
| L2 | Purchase of supplies, goods, services or works | Procurement Team must be contacted<br>At least three (3) written quotes from separate suppliers must be obtained | £10,000 | £49,999.99 |
| L3 | Purchase of supplies, goods, services or works | Procurement Team must be contacted and must oversee the tender process<br>At least three tenders from separate suppliers must be sought | £50,000 | £164,176* |
| L4 | Purchase of works (Estates) | Procurement Team must be contacted and must oversee the tender process<br>At least five tenders from separate suppliers must be sought | £50,000 | £4,104,394* |
| L5 | Purchase of supplies, goods or services | Procurement Team must be contacted and must oversee the tender process<br>Must follow the procedure and timetable as directed in the Public Contracts Regulations publication | £164,176* | No upper limit |
| L6 | Purchase of works (Estates) | Procurement Team must be contacted and must oversee the tender process<br>Must follow the procedure and timetable as directed in the Public Contracts Regulations publication | £4,104,394* | No upper limit |

Figures marked * are EU procurement thresholds, as embodied in the UK Public Contracts Regulations 2015. These are revised regularly. The figures included above are valid from 1 January 2016. Note that they may fall as well as rise. The Trust does not operate the Part B threshold for "other residual services" but applies Part A to all supplies and services.

- The Procurement Team may choose to obtain written quotes or tenders even when not mandatory, if this may lead to better value for money.
- For purchases of items covered by a Crown Commercial Service or London Procurement Partnership or other approved body framework without specified unit prices, it is not

necessary to undertake an EU style tender process even if the value is over the threshold (L5 or L6 above). However, a further competition process may be undertaken in line with the framework's guidance, if the value is over £50,000 and there is more than one supplier on the framework agreement. If the framework allows for direct award and the Trust has good reason to do so, then a direct award may be effected. However, in all cases, any direct award must be strictly in line with the process detailed within the framework. For all direct awards, an audit trail is required to justify the reason for direct award. When using a framework, the Trust must ensure they are eligible to sue that framework, the goods/services/works are covered by the framework, and any award process is carefully followed.

- In the case of contracts covering more than one year, the above limits are applied to the cumulative value of all the years added together. By way of an example, the purchase of a service valued at £40,000 for 5 years is a £200,000 value contract, so L5 applies.
- All limits or authorisation levels of spend are based on the full cost to the Trust, so VAT must be included if the Trust suffers the VAT cost, but must not be included if the Trust recovers the VAT under the contracted out services rules, or recovers the input VAT when making taxable business supplies. If you are in any doubt about the VAT position, consult the Finance Department or Procurement Team.

## APPENDIX TWO: REQUEST FOR PROCURMENT WAIVER FORM

(This can be seen overleaf)

| REQUEST FOR PROCUREMENT WAIVER FORM | | | |
|---|---|---|---|
| **Purpose** | This form should be completed by budget holders ***in advance*** where they believe there are grounds as defined in the Trust's Standing Financial Instructions (SFIs) and Procurement Policy to waive the procurement process. **Allow four weeks** for approval, unless it is a matter of genuine urgency. In ALL cases, please obtain advice and support from your Procurement Manager in your completion of this form.<br>Please note **approval cannot be given if it would contravene the Public Contracts Regulations 2015 or any other applicable legislation**.<br>*Please note that it is the process that is being waived, not the spend.* | | |
| **Raised By & Date** | | | |
| **Position & Cost Centre** | | | |
| **Name of Supplier** | | | |
| **Period of Supply / Service** | | | |
| **Full Description of Goods / Services** | | | |
| **Reason For Waiver Request** | **Reason** | **Tick** | **Additional information for request to Waive SFIs** |
| | Sole supplier (service only available from one supplier) | | |
| | Extension of existing contract | | Please identify why this has not been competitively tendered. Please also identify when you intend to begin the process to ensure compliance. Please append the original contract and provide relevant details separately |
| | Extreme urgency (failure to plan effectively does not meet the grounds of extreme urgency) | | Reason for not competitively tendering? |
| | | | Do you understand the risks to the organisation that this may incur? **Tick** |

## SUPPLIES, GOODS & SERVICES

| | Threshold | Requirement | Tick |
|---|---|---|---|
| **Waiver Required Against (Trust Standing Financial Instructions Requirement)** | £10,000.00 to £49,999.99 | At least THREE written quotations from separate suppliers must be obtained | |
| | £50,000.00 to £99,999.99 | At least THREE tenders from separate suppliers must be obtained | |
| | £100,000.00 to £164,176.00* (EU Procurement threshold) | At least THREE tenders (sealed bids) from separate suppliers must be obtained | |
| | £164,176.00* to no upper limit | Must follow tendering procedure and timetable as directed in EU Procurement Guidance (OJEU Tender)<br>*N.B. Waiver is only possible for monopoly suppliers* | |

*Please note that the above thresholds are for the contract value over the term (duration) of the contract. The thresholds are exclusive of VAT.* OJEU tender threshold levels do change with changes to EU and UK procurement legislation.*

## WORKS (ESTATES)

| | Threshold | Requirement | Tick |
|---|---|---|---|
| **Waiver Required Against (Trust Standing Financial Instructions Requirement)** | £10,000.00 to £49,999.99 | At least THREE written quotations from separate suppliers must be obtained | |
| | £50,000.00 to £4,104,394.00* | At least FIVE tenders from separate suppliers must be obtained | |
| | £4,104,394.00* to no upper limit | Must follow tendering procedure and timetable as directed in EU Procurement Guidance (OJEU Tender)<br>*N.B. Waiver is only possible for monopoly suppliers* | |

*Please note that the above thresholds are for the contract value over the term (duration) of the contract. The thresholds are exclusive of VAT.* OJEU tender threshold levels do change with changes to EU and UK procurement legislation.*

**If you are in any doubt as to whether the 'Supplies, Goods & Services' section or the 'Works (Estates)' section should be completed, please contact your Procurement Manager.**

| | |
|---|---|
| **General Risk Associated With Waiver** | |
| **Financial Risk** | |
| **Learning Collected From Waiver** | |

**Approval MUST be given by ALL listed below.**
*Note: Approval must be secured by Procurement before the Waiver can go to Finance for approval*

| **Divisional Director (DDO) Budget Holder** ***(Enter Below)*** | **Position** ***(Enter Below)*** | **Signature** | **Date** |
|---|---|---|---|
| | | | |
| **Procurement Manager (PM) Approval** ***(Enter below)*** | **Position** ***(Enter Below)*** | **Signature** | **Date** |
| | | | |
| **Head of Procurement Approval** | **Position** | **Signature** | **Date** |
| James Frain | Head of Procurement | | |
| **Finance Approval** **(Required in ALL extreme urgency requests and other requests >£50k)** | **Position** | **Signature** | **Date** |
| Steve Bolam | Director of Finance | | |

**ALL SFI Waivers are reported to the Trust's Audit Committee**

**PROCUREMENT DEPARTMENT USE ONLY:**

Waiver reference (log) number: _____

Requisition number: _____

**If the 'Reason for Waiver request' is 'OTHER', please complete the following:**

Did the requestor contact Procurement to discuss? Yes / No

Discussed with: _____ Date: _____

Procurement comments:

## APPENDIX THREE: SFI BREACH INCIDENT FORM

(This can be seen overleaf)

# PROCUREMENT: SFI BREACH INCIDENT FORM

| | |
|---|---|
| **Purpose** | This form should be completed by budget holders *AS SOON AS* a breach has been identified in relation to the procurement of goods, services and works. A breach occurs where Standing Financial Instruction (SFI) rules have not been followed and the conditions for a "Waiver" have not been met. |

## SECTION A: DETAILS OF SUPPLY

| | | | |
|---|---|---|---|
| **Name of Supplier** | | | |
| **Full Description of Goods / Services / Works** | | | |
| **Total Order Value £ (excluding VAT)** | | **Invoice Value £ (if known)** | |
| **Requisitioner Name** | | **Invoice Date (if known)** | |
| **Requisition Number (if applicable)** | | **Requisition Date** | |
| **Budget Cost Centre** | | **Budget Holder** | |

| | **Reason** | **Tick** |
|---|---|---|
| **Breach Category** | Order / Invoice value exceeds SFI tendering | |
| | Order / Invoice value exceeds SFI quotation | |
| | Supplies requested without official order number | |
| | Lowest quote not selected without approval | |
| | Telephone order exceeded original quantity / value | |
| | Order size split into several orders | |
| | Other (please specify details below) | |

**SECTION B: REASON FOR BREACH (To be completed by Requisitioner, Budget Holder)**

| | | | |
|---|---|---|---|
| **Name of Requisitioner / Budget Holder** | | | |
| **Position of Requisitioner / Budget Holder** | | **Contact Number** | |
| **Please provide an explanation of the circumstances surrounding the SFI breach. Supplementary information to be provided separately. Please summarise in the text box on the right hand side.** | | | |

**SECTION C: PREVENTATIVE ACTION TAKEN (To be completed by General Manager / Corporate Director)**

| | | | |
|---|---|---|---|
| **Name of General Manager / Corporate Director** | | | |
| **Position of General Manager / Corporate Director** | | **Contact Number** | |
| **Please provide details of the preventative action taken to avoid recurrent of SFI breach** | | | |
| **Date** | | | |

**PLEASE EMAIL COMPLETED FORM TO BRIDGET BOYD (PROCUREMENT DEPARTMENT)**

**SECTION D: SIGNATORIES**

**Approval MUST be given by ALL listed below.**

*Note: Approval must be secured by Procurement before the Waiver can go to Finance for approval*

| **Form Completed By:** ***(Enter Below)*** | **Position** ***(Enter Below)*** | **Signature** | **Date** |
|---|---|---|---|
| | | | |
| **Divisional Director (DDO) Budget Holder** ***(Enter Below)*** | **Position** ***(Enter Below)*** | **Signature** | **Date** |
| | | | |
| **Procurement Manager (PM) Approval** ***(Enter below)*** | **Position** ***(Enter Below)*** | **Signature** | **Date** |
| | | | |
| **Head of Procurement Approval** | **Position** | **Signature** | **Date** |
| James Frain | Head of Procurement | | |
| **Finance Approval** **(Required in ALL extreme urgency requests and other requests >£50k)** | **Position** | **Signature** | **Date** |
| Steve Bolam | Director of Finance | | |

## ALL SFI Breaches are reported to the Trust's Audit Committee

**Need assistance with this form? Please contact Procurement on Extension 1813**

**PROCUREMENT DEPARTMENT USE ONLY:**

SFI breach reference (log) number: _____

Procurement comments:

**APPENDIX FOUR:**

## 4a. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

| Service/Function/Policy | Directorate / Department | Assessor(s) | New or Existing Service or Policy? | Date of Assessment |
|---|---|---|---|---|
| Policy | Finance / Procurement | Sara Cook – Interim Procurement Consultant | Revision to existing Policy | 16/12/2015 |

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

This is a Trust-wide Policy, written by the Procurement Department. It is essentially rules to be followed when buying on behalf of the Trust. It is a key supporting document to the Trust's Standing Financial Instructions (SFIs).

**1.2 Describe the purpose of the service / function / policy?** Who is it intended to benefit? What are the intended outcomes?

The aims and objectives of this revised Procurement Policy are to provide improved procurement governance to Trust-wide Procurement activity, and ensure compliance to EU and UK Procurement legislation. It also ensures compliance to the procurement-related aspects of the Trust's Standing Orders and Delegation of Powers and Standing Financial Instructions. The Procurement Policy sets out to:

- To secure good **value for money** through appropriate market competition for contracts.
- To be **open and transparent** about how we spend our money.
- To ensure we spend public money **legally and fairly** and to **protect** the Trust from undue criticism or allegation of wrong-doing. This includes ensuring fairness and quality with all suppliers, avoidance of bias, favouritism and that fairness can be demonstrated through an audit trail.
- To support **sustainability** and **social value** objectives, and our public sector **equality** duty, encouraging small businesses to be able to supply to the Trust.

**1.3 Are there any associated objectives?** E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives

It follows statutory EU and UK procurement legislation.

**1.4 What factors contribute or detract from achieving intended outcomes?**

Compliance with the Procurement Policy is mandatory. Failure to comply with its requirements could result in:

- Allegations of fraud and corruption being made against the Trust.
- Re-tendering of goods, services or works, resulting in additional costs and delays.
- Legal challenge / litigation.
- Department of Health Investigation.
- Audit intervention.

- Adverse publicity with inevitable damage to the Trust's reputation.
- Disciplinary proceedings against staff that are "non-compliant."

**1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights?**
Details: [see Screening Assessment Guidance]

No.

**1.6 If yes, please describe current or planned activities to address the impact.**

Not applicable.

**1.7 Is there any scope for new measures which would promote equality?**

Not applicable.

**1.8 What are your monitoring arrangements for this policy/ service**
Reporting of non-compliance to the Trust's Executive Management Team (EMT), the Turnaround Board and to Audit Committee. Required actions will be identified and completed in a specified timeframe

**1.9 Equality Impact Rating [low, medium, high]- see guidance notes 3.1 above**

Low.

**2.0. Please give you reasons for this rating**

Minimal impact.

*If you have rated the policy, service or function as having a high impact for any of these equality dimensions, it is necessary to carry out a detailed assessment and then complete section 2 of this form*

## 4b. EQUALITY IMPACT ASSESSMENT FORM – DETAILED ASSESSMENT FOR HIGH IMPACT AREAS

| Service/Function/Policy | Directorate / Department | Assessor(s) | New or Existing Policy/Service | Date of Assessment |
|---|---|---|---|---|
| | | | | |

**2.1 In which areas is the service, function or policy judged to be high priority?** *Summarise issues raised at the screening stage. Outlined above*

**N/A**

**2.2 What relevant data is available [e.g. ethnic coding monitoring, complaints, previous consultation etc]? Does the data indicate there is a differential impact on any groups?**

**N/A**

2.3 Is there any national or local guidance on equality issues for this service, policy or function?

**N/A**

2.4 Summarise the consultation. **Who are the main stakeholders? What are their views?**

**N/A**

2.5 What are the recommendations for change arising from the assessment? (To consult with key stakeholders before disseminating trust wide)

N/A

2.6 What are the costs and benefits to the relevant group and to the Trust?

N/A

2.7 Details of the action plan to ensure implementation, including how relevant groups will be advised of the changes.

**N/A**

2.8 Monitoring arrangements

N/A

**APPENDIX FIVE:**

## Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any document submitted to the Policy Ratification Group for ratification.

| Title of document being reviewed | | Yes/No/ Unsure | Comments |
|---|---|---|---|
| **1.** | **Title** | | |
| | Is the title clear and unambiguous? | Yes | Made clearer by adding "Rules to be followed when buying on behalf of the Trust" |
| | Is it clear whether the document is a guideline, policy, protocol or standard? | Yes | Policy – rules to be followed |
| **2.** | **Rationale** | | |
| | Are reasons for development of the document stated? | Yes | Revised the Policy to support the Turnaround agenda, make it fit for purpose and follow best practice from elsewhere |
| **3.** | **Development Process** | | |
| | Is the method described in brief? | N/A | Reference made to making the policy fit for purpose |
| | Are individuals involved in the development identified? | Yes | Author's name stated |
| | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | Yes | Best practice sought from elsewhere informed its development |
| | Is there evidence of consultation with stakeholders and users? | Yes | Consulted with Procurement and EMT in the policy's revision |
| **4.** | **Content** | | |
| | Is the objective of the document clear? | Yes | |
| | Is the target population clear and unambiguous? | Yes | Made clear that it's for ALL Trust staff (including temporary staff) - everyone who procure goods, services and works on behalf of the Trust |
| | Are the intended outcomes described? | Yes | |
| | Are the statements clear and unambiguous? | Yes | |
| **5.** | **Evidence Base** | | |
| | Is the type of evidence to support the document identified explicitly? | N/A | |

| Title of document being reviewed | | Yes/No/ Unsure | Comments |
|---|---|---|---|
| | Are key references cited? | N/A | |
| | Are the references cited in full? | N/A | |
| | Are local/organisational supporting documents referenced? | Yes | |
| **6.** | **Approval** | | |
| | Does the document identify which committee/group will approve it? | Yes | |
| | If appropriate, have human resources/staff side committees (or equivalent) approved the document? | N/A | This is not applicable as this is something that has to be done to support the Trust's current financial position and Turnaround requirements. Procurement governance must be improved across the Trust |
| **7.** | **Dissemination and Implementation** | | |
| | Is there an outline/plan to identify how this will be done? | Yes | |
| | Does the plan include the necessary training/support to ensure compliance? | Yes | MAST eLearning module to be developed; inclusion in induction process; Trust-wide communications; top-down approach |
| **8.** | **Document Control** | | |
| | Does the document identify where it will be held? | Yes | |
| | Have archiving arrangements for superseded documents been addressed? | Yes | Previous policy to be removed from Intranet and replaced with revised policy |
| **9.** | **Process for Monitoring Compliance** | | |
| | Are there measurable standards or KPIs to support monitoring compliance of the document? | Yes | |
| | Is there a plan to review or audit compliance with the document? | Yes | |
| **10.** | **Review Date** | | |
| | Is the review date identified? | Yes | March 2017 |
| | Is the frequency of review identified? If so, is it acceptable? | Yes | Annual |
| **11.** | **Overall Responsibility for the Document** | | |

| Title of document being reviewed | | Yes/No/ Unsure | Comments |
|---|---|---|---|
| | Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation? | Yes | Head of Procurement |

**Enclosure:**

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO THE TRUST BOARD – February 2016** **Paper Ref:**

| | |
|---|---|
| **Paper Title:** | **Independence of St George's Hospital Charity** |
| **Sponsoring Director:** | **Miles Scott, CEO** |
| **Author:** | **Jill Hall, Interim Trust Secretary** |
| **Purpose:**<br>*The purpose of bringing the report to the board* | This paper is being brought to the Trust Board to provide detailed information on the proposals outlined in the report regarding the charity becoming independent. |
| **Action required by the board:**<br>*What is required of the board – e.g. to note, to approve…?* | **For decision** |
| **Document previously considered by:**<br>*Name of the committee which has previously considered this paper / proposals* | **Charity Board** |

**Executive summary**

*Key points in the report and recommendation to the board*

In November 2012 the Department of Health published a report titled 'The Review of the Regulation and Governance of NHS Charities' which concluded that it should revise the governance of their current NHS charities and remove the regulation by ministers, thus enabling them to operate more independently whilst preserving their close relationship with the providers of the NHS services they support.

Following the second reading of the Private Members Bill, the Department of Health has now notified NHS bodies and their related trustees of the introduction of the legislative change and that the implementation of the change is to be deferred so as the NHS Charities will have in the region of two years to complete the move to independence. If the Bill is passed in through the House the Charity will be obliged to either revert to being a Corporate body or convert to independence.

This paper sets out the background and the advantages and disadvantages of converting to become an independent charity and the preferred option of the Trustees to move the charity to independence.

The St George's Charity Trustees have confirmed their belief that the advantages of independence are important and that this, rather than reversion, should be pursued for the reasons set out in the report.

**Recommendation**

**The Trust Board is asked to:**

a) **NOTE and DISCUSS the two options set out in the report,**
b) **AGREE to register its agreement for St George's Hospital Charity to form as a new charity independent from the Department of Health and unaffected by the NHS Act 2006.**

**Enclosure:**

| | |
|---|---|
| **Key risks identified:**<br>*Are there any risks identified in the paper (impact on achieving corporate objectives) – e.g. quality, financial performance, compliance with legislation or regulatory requirements?* | |
| **Financial Implications** | **The only financial implications are positive ones. The charity will continue to provide grants to St George's University Hospitals NHS Foundation Trust and support capital projects through fundraising appeals. Independence will help to reassure donors that their gift will bring charitable benefit to patients.** |
| **Legal/Regulatory Implications** | **Reversion to a Corporate Trustee would require the formation of a new Trustee Committee with accountability to the Charity Commission and dual accounting to the Department of Health.** |
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | **N/A** |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | **N/A** |
| **Equality Impact Assessment (EIA): Has an EIA been carried out? ( Yes / No)**<br>**If yes, please provide a summary of the key findings**<br><br>**If no, please explain your reasons for not undertaking and EIA.** | |

**Enclosure:**

**Appendix A:**

## 1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

| Service/Function/Policy | Directorate / Department | Assessor(s) | New or Existing Service or Policy? | Date of Assessment |
|---|---|---|---|---|
| | | | | 15 Oct 2010 |
| **1.1 Who is responsible for this service / function / policy?** | | | | |
| **1.2 Describe the purpose of the service / function / policy?** *Who is it intended to benefit? What are the intended outcomes?* | | | | |
| **1.3 Are there any associated objectives?** *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives* | | | | |
| **1.4 What factors contribute or detract from achieving intended outcomes?** | | | | |
| **1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability ( physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights** | | | | |
| **1.6 If yes, please describe current or planned activities to address the impact.** | | | | |
| **1.7 Is there any scope for new measures which would promote equality?** | | | | |
| **1.8 What are your monitoring arrangements for this policy/ service** | | | | |
| **1.9 Equality Impact Rating [low, medium, high]**<br><br>**2.0. Please give your reasons for this rating** | | | | |

**Enclosure:**

## Independence for St George's Hospital Charity

### 1. BACKGROUND

St George's Hospital Charity accepts, holds and administers charitable funds on behalf of St George's University Hospitals NHS Foundation Trust.

The Charity was formed on 1st April 2001 when Special Trustees were re-structured into Section 11 Trustees, created pursuant to Section 11 of the NHS & Community Care Act 1990, to enable them to have much wider power to administer funds.

At the same time the funds of St George's Corporate Trustee were also absorbed into the newly formed charity to eradicate the dual accounting of charitable funds for one organisation.

Trustees were, and still are for the time being appointed by the Secretary of State for Health; originally through the Appointments Commission and now by the NTDA, however they are accountable to the Charity Commission.

In November 2012, the Department of Health published a report titled 'The Review of the regulation and Governance of NHS Charities' which concluded that it should 'revise the governance of their current NHS charities that will remove regulation by ministers, and enable them to operate more independently while preserving their close relationship with the providers of NHS services they support'.

The Department of Health is set to repeal statutory powers to appoint separate trustees for NHS Charities, at which stage, unless by then converted to independent status; the NHS Charities will revert to having their associated NHS body as corporate trustee

A Private Members Bill has already had its second reading and the Department has undertaken to notify NHS bodies and their related trustees in advance of the introduction of the legislative change. It also indicated that implementation of the change will be deferred, so as to ensure that the NHS Charity trustees will have in the region of two years from initial notification to complete the NHS Charity's move to independence, if that is what they, with the NHS body's agreement, decide to do. It is expected that the deadline will be 1st April 2018.

### 2. OPTIONS

**Conversion or Reversion?**

In summary what the above means is that if, as expected, the Bill is passed through the House the Charity will be obliged to either revert to being a Corporate body or convert to being fully independent.

The Department's review consulted heavily with the Association of NHS Charities who summarised the possible advantages and disadvantages of converting to independence as follows:

**Possible advantages of conversion**

• The New Charity will be able to demonstrate to donors and the Charity Commission its independence of decision-making (perhaps especially important where the NHS Charity at present has an NHS body as corporate trustee).

• The New Charity will be able to adopt wider charitable purposes (for new money) and to enter into more innovative fund-raising initiatives, collaborations and mergers.

• The New Charity can choose its own trustees and advisers (including auditors) which can include Trust representatives.

• If set up as either a CLG or a CIO, the New Charity's contractual liability will be limited.

• NHS Charities are within the public procurement regime; the New Charity will not be.

• There will be no risk of consolidation of the New Charity's accounts with either the NHS body or the Department of Health (provided no NHS body has 'control' over the New Charity – e.g. power to appoint a majority of the board).

• Where there is the prospect of NHS re-organisation affecting the related NHS body, the New Charity will not be directly affected by the process (although it may subsequently wish to adjust its grant-making to reflect the change), whereas the NHS Charity would be caught up in it.

**Possible disadvantages of conversion**

• The process of effecting the conversion will require some expenditure and application of staff resource for the charity, and will be potentially disruptive during the transition.

• The New Charity will be an independent entity responsible for its own management and operations; this may give rise to additional administration and cost; accordingly, it may not be the right route for a small scale NHS Charity.

• The New Charity will have a new charity number (but may use the old NHS Charity's name).

• The NHS body may fear loss of influence over 'its' NHS Charity (perhaps especially where the NHS body is currently its corporate trustee).

## 3. WAY FORWARD FOR ST GEORGE'S

St George's Hospital Charity has for some years already been largely autonomous, in that its Trustees are distinct from those of the Trust (though Mike Rappolt is a member of both, and it is proposed that when he ceases to be a member of the Trust Board another NED should join the Charity Board). The Charity accepts, of course, the vital importance of working closely with the Trust, and the mechanisms to achieve this have been greatly strengthened, particularly through regular meetings involving the Chairs, CEs and other key individuals from both organisations. But independence has been helpful for governance (avoiding the obvious issues where Trust Directors are also majority Charity Directors) and very important for practical reasons: it has enabled the Charity to recruit staff with relevant professional skills; and, importantly, it supports fundraising, particularly with major donors, by being able demonstrate independence.

Each charity and its Trust need to make their individual decision (though the DoH 'steer' is clearly towards full independence, except for very small NHS charities). It is likely that most major NHS charities will take this route. Some, including St Thomas, GOSH, Barts, Royal Marsden , have already done so or are planning to do so shortly.

The St George's Hospital Charity Trustees have confirmed their belief that the advantages of independence are important and that this, rather than reversion, should be pursued.

In order to convert, the charity requires agreement from its Foundation Trust Board and a joint letter from the chair of the charity and the Foundation Trust is to be sent to the Department of Health of our intention in principle to set up the new charity. The Charity Commission will also be informed.

Following the agreement and acknowledgement by the DoH a Memorandum of Understanding will be drawn up between the charity and FT outlining the objectives of the conversion and detailing agreements on charitable objects, trustee appointments and Foundation Trusts representation, Service Level Agreement, use of hospital name and NHS logo as appropriate..

**RECOMENDATION**

The Board of St George's University Hospitals NHS Foundation Trust is therefore invited to register its agreement for St George's Hospital Charity to form as a new charity independent from the Department of Health and unaffected by the NHS Act 2006.

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO TRUST BOARD** ***Feb 2016***

| | |
|---|---|
| **Paper Title:** | Risk and Compliance report for Trust Board incorporating:<br>1. Corporate Risk Register<br>2. External assurances |
| **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 |

**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:

- Details of external accreditations and inspections undertaken in January 2016 are included in the report.

**Risks**

The most significant risks on the Corporate Risk Register are detailed within the report.

| | |
|---|---|
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | All |
| **Related CQC Standard:**<br>*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**

| 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<br>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 →** |

### 1.1 New risks proposed for inclusion on the CRR

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

- **Radiation protection and governance issues as identified by the recent HESL visit and subsequent risk summit**
  Escalated via Risk and Compliance report/discussion at EMT and QRC (Jan 2016)
  **Controls:**
  A project board has been established, chaired by the Medical Director, to ensure all issues and concerns identified by the recent HESL visit are acted upon.
  The Trust has commenced detailed reporting to the newly established monthly Joint Oversight Group (JOG), hosted by Wandsworth CCG

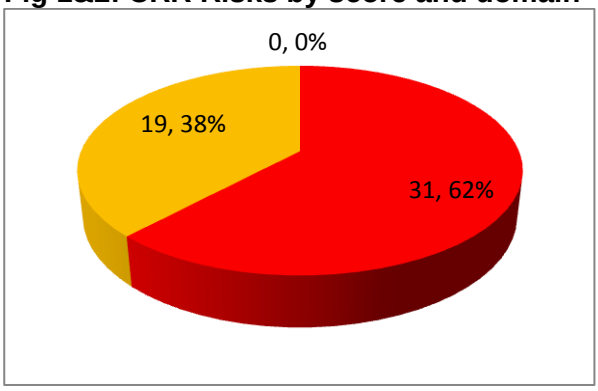
- **Electrical infrastructure in Knightsbridge Wing is in danger of major failure. A recent large power failure caused the wing to be evacuated.**
  Escalated following discussion at the Organisational Risk Committee (Jan 2016)
  **Controls:**

The Electrical supply has been restored but a single point of failure exists regarding the electrical supply to the wing, including the renal wards. Plans to replace the infrastructure are currently being drawn up.

### 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**



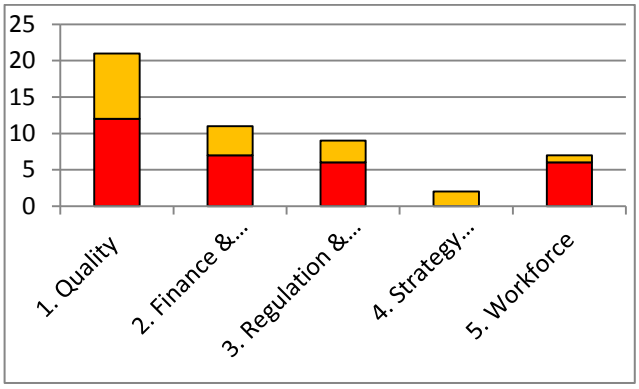




**Table three: CRR Risks by Domain**

| | 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** |

### 1.3 Divisional Extreme Risks

All divisional extreme risks are reviewed at the Organisational Risk Committee on a bi-monthly basis and are considered in tandem with the organisational level risks on the corporate risk register. A summary of the extreme risks is included at appendix 2.

## 2. Assurance map

### 2.1 Summary of external assurance and third party inspections – Jan 2016

#### 2.1.1 Occupational Health SEQOHS (Safe Effective, Quality Occupational Health Service) Accreditation

SEQOHS is a set of standards and a voluntary accreditation scheme for Occupational Health Services in the UK which formally recognise competence in delivering standard OH services. The scheme is managed by Royal College of Physicians of London on behalf of Faculty of Occupational Medicine. The scheme covers business probity, information governance, competency of staff, management of equipment, adequacy of facilities, good customer care and adherence to ethical standards.

The Trust OH services had passed the yearly review of the accreditation on first annual review. The assessors commented that our evidence on audit, complaints process and the recommendations identified in the initial assessment showed continual monitoring, action plans and evidence of continued quality improvements. They said, “We would like to congratulate the staff at St George’s Hospital for their continued commitment to maintaining SEQOHS standards“

### 2.1.2 London Quality Assurance Reference Centre Accreditation - Cervical Screening

Inspection took place on 19th January and the formal feedback is awaited. Informal feedback suggests that a previous and on-going issue and action will be carried forward in the next formal report in relation to the interface between the Colposcopy database and iClip.

### 2.1.3 Joint Accreditation Committee (JACIE) Accreditation Inspection

JACIE's primary aim is to promote high quality patient care and laboratory performance in haematopoietic stem cell collection, processing and transplantation centres through the development of global standards and an internationally recognised system of accreditation.

The Trust underwent an inspection on 20/21st January and awaits formal feedback.

## 3. Conclusion

The programme of detailed review of risks included on the Corporate Risk Register continues in order to provide stronger assurance to the Trust Board around the management of risks.

The overall long-term risk profile for the trust continues to be driven by the continued financial and operational pressures faced by the trust.

## Appendix 1: Executive Overview of Corporate Risk Register

**Domain: 1. Quality**

| Strategic Objective/Principal Risk | Lead | 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:<br>- Adverse in year I&E performance<br>- 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<br>- higher than expected inflation<br>- 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:<br>- Delays in receipt of SLA funding from Commissioners<br>- 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 | | | | | | | 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 | | | | | | | 16 | → | |

| | | | | | |
|---|---|---|---|---|---|
| JH | Jennie Hall | Chief Nurse (DIPC) | EM | Eric Munro | Director of Estates & Facilities |
| SM | Simon Mackenzie | Medical Director | RE | Rob Elek | Director of Strategy |
| PVK | Paula Vasco-Knight | Chief Operating Officer | WB | Wendy Brewer | Director of Human Resources |
| SB | Steve Bolam | Director of Finance Performance & Information | MW | Martin Wilson | Director of Delivery & Performance |

**Appendix 2: Divisional Extreme Risks**

| Risk Ref. | CW&DT<br>Risk | Score | Jan 2016 Change ↑↓ | Rationale for change |
|---|---|---|---|---|
| CW026 | Delay in starting or continuing Induction of Labour on Delivery Suite due to High activity and capacity Issues leading to avoidable adverse outcomes | 15 | → | |
| CW027 | Dirty water leaking through Ceiling on Delivery Suite, Gwillim Ward office and Parent Education room. Leading to loss of usage of space and possible infection control issues | 20 | → | |
| CW049 | Delivery of sub-standard care to sick and premature infants due to insufficient neonatal trained nurses on the neonatal unit | 16 | → | |
| CW057 | The Division is significantly overspent due to a number of adverse movements. | 25 | → | |
| B205 | Loss of data due to clinical database no longer being supported | 16 | → | |
| CW0067 | Financial risk – growth. Risk of CCG not paying for increased income assumptions particularly in children services, radiology and women's | 15 | → | |
| CW0068 | Financial risk – CQUIN From 15/16 Maternity will no longer get CQUIN funding and instead CCG will develop a local tariff for 2015/16. Estimated value of risk in 14/15 = £2.5m | 16 | → | |
| CW0070 | Financial risk – cost.<br>The division fails to achieve its CIP programme | 15 | → | |
| CW0071 | CW0071 - Financial risk – cost.<br>The division does not receive funding for identified cost pressures.<br>Estimated value of risk in 14/15 = c. £1.1m | 16 | → | |
| CW0087 | Call alarms in St James' wing therapy dept not working properly – risk to patient safety in the event of an emergency | 15 | → | |
| CW089 | Insufficient number of CTG monitors for a full triage and full induction bay meaning some women need to wait for monitoring | 20 | → | |
| CW090 | Lack of NICU, GICU & CTICU capacity – presenting both clinical and financial risk | 15 | → | |
| CW093 | Roof leak in room 5.011, 5th Floor Lanesborough Wing | 25 | → | |
| CW0097 | Critical Care Run Rate Risks impacting Patient Care & Staff morale | | | Closed |
| CW098 | Medical Records patient safety & staff safety risk | 16 | → | |
| CW099 | Unable to meet requirements for accreditation by UKAS due to Genetics Vacancies | 15 | → | |

| | | | | |
|---|---|---|---|---|
| CW105 | (C4 x L5 = 20) - STOW (safe transfer of women) maternity system - Missed or delayed postnatal care for mother and baby | **20** | → | |
| CW108 | Deterioration of non-medical staff appraisal rates | **15** | → | |
| CW109 | Failure of Responsible Persons to address and/or rectify Significant Findings contained in Fire Risk Assessments, leading to an increased risk of injury or loss of life in the event of a fire or fire evacuation. | **20** | → | |
| CW110 | Failure of responsible persons to identify sufficient staff to be trained as Fire Wardens, leading to an increased risk of injury or loss of life in the event of a fire or fire evacuation. | **20** | → | |
| CW111 | Risk as a result of reduced radiographic staffing in the Radiology Department - High level of vacancies and delays in recruitment are leading to delayed turnaround times of radiology requests affecting LOS, 18 RRT, 4hr A&E, stressed staff with low morale and an increasing sickness rate. | **15** | **NEW** | |
| CW112 | Failure of air handling unit (AHU) within QC Laboratory<br>The QC Laboratory is accredited by the MHRA which enables testing to be performed for internal and external clients. Suspension of MHRA license likely until AHU unit is repaired. Loss of MHRA license likely to result in loss of senior QA staff (including Qualified Persons) from the organisation as they would not be able to perform their statutory requirements as Qualified Persons. | **20** | **NEW** | |
| | **M&C** | | **Change** | |
| **Risk Ref.** | **Risk** | **Score** | **↑↓** | |
| MC13-D1 | Risk to patient safety from delay in diagnosis or failure to follow up. | **15** | → | |
| MC31-D5 | Risk to patient safety as patients waiting greater than 18 weeks on elective waiting list for Cardiac surgery, Thoracic Surgery and Vascular Surgery. | **15** | → | |
| MC32-D1 | The division is at risk of not delivering a balanced budget if robust CIP schemes are not found. Not all schemes identified in 14/15 have delivered and therefore knock on effect for schemes in 15/16. | **15** | → | |
| MC34-D1 | Risk to patient safety as lack of capacity in hospital is leading to regular occurrences of exit blocking and overcrowding in the ED. | **20** | → | |
| MC37-D1 | Financial and reputational risk arising from failure to meet the 95% ED standard for time attending to leaving the ED | **15** | → | |
| MC46-D2 | Financial Risk – cost pressures within division are not funded | **16** | → | |
| MC55-D2 | Financial – Volume. Lack of theatre and ITU capacity for cardiac surgery impacts on income | **20** | → | |
| MC57-D3 | Fire risk on Knightsbridge wing – following review at April DGB, this risk was increased to reflect the concerns of the LFB regarding no means of stopping smoke from spreading. | **15** | → | |

| | | | | |
|---|---|---|---|---|
| MC59-D1 | Risk to patient safety that vulnerable patients are able to access the helipad form wards in St James Wing | **15** | → | |
| MC68-D1 | Risk to patient safety and patient experience on Caroline ward due to inadequate staffing levels and thoracic pre assessment clinics. | 16 | → | |
| MC67-D1 | Violent and aggressive patient (on Gordon-Smith ward) towards staff. Impact of violent episodes on staff well –being, both psychologically and physical injury. One staff member on sickness absence following a violent episode. | **16** | → | |
| MC69-D1 | Risk to patient safety as no identified haemodialysis machine replacement programme for machines reaching the end of their service. | **20** | → | |
| SM-MC70-D1- | Risk to patient safety, patient experience and financial performance as lack of capacity in outpatient clinics for Gastroenterology, particularly those on a cancer pathway, increases waiting times to beyond nationally ratified targets. | **15** | **NEW** | |
| SM-MC71-D1- | Risk to patient safety, patient experience and financial performance as lack of capacity in outpatient clinics for Dermatology, particularly those on a cancer pathway, increases waiting times to beyond nationally ratified targets. | **15** | **NEW** | |
| ED-MC73-D1 | Lack of traceability of ED cards. | **16** | **NEW** | |
| | **STN&C** | | **Change** | |
| **Risk Ref.** | **Risk** | **Score** | **↑↓** | |
| B253 | SSD risk upgraded in light of recent significant failures and down time of SJW equipment. On-going issues. | **20** | → | |
| B268 | Sterilisation equipment requires replacing and breakdown may cause service failure potentially resulting in cancelled surgery. | **15** | → | |
| C11 | Failure to prescribe essential medication for patients having elective surgery | **16** | → | |
| C05 | Financial Risk – cost. Failure to deliver CIP programme | **20** | → | |
| C06 | Financial Risk – cost. Failure to receive divisional funding for cost pressures | **15** | → | |
| C19 | GPs in some regions (Surrey, Croydon) not prescribing Antiepileptic drugs (AEDs) recommend by consultant neurologists | **15** | → | |
| C20 | Lack of trained fire wardens | **15** | → | |
| C23 | Risks to patient safety associated with roll out of electronic documentation | **20** | → | |
| C24 | Failure to ensure Standard Operating Procedures (SOPs) for reviewing diagnostic tests results are in place in all areas and are effective | **15** | → | |
| tbc | A number of incidents have been seen with regard to availability of necessary equipment for certain surgical procedures | **20** | → | |
| C33 | Neuro MRI scanner. Functionality is unreliable leading to delays in diagnosis and | **20** | → | |

| | | | | |
|---|---|---|---|---|
| | treatment for neuro patients. | | | |
| C28 | Feedback from Major trauma National Peer review – March 2015: Performance against the BOAST 4 guidelines for the management of open fractures is below the national average. | **15** | → | |
| | **CSW** | | **Change** | |
| **Risk No.** | **Risk** | **Score** | **↑↓** | |
| CSW1032-COM-D5 | 2015/16 Cost Improvement Programme and run rate reduction plans not achieving target. | **20** | → | |
| CSW 1035-COM- 04 | staff in community services at risk of not achieving compliance levels with MAST due to inability to access new learning management system (TOTARA) | **12** | ↓ | Downgraded due to impact of actions to address |
| | **E&F** | | **Change** | |
| **Risk No.** | **Risk** | **Score** | **↑↓** | |
| EF108 | Several theatre ventilation plants beyond their economic life and subject to increases in breakdowns/failures. | **16** | ↑ | This risk has been upgraded (from 3x3) due to the number of breakdowns in the Theatre areas and further concerns regarding the age and condition of the Ventilation plants |
| EF132 | Risk of legionella management controls as Flushing of low use outlets and departments not returning data/records. | **20** | → | |
| EF133 | Steam main to Knightsbridge - Old, poor condition and leaking. Risk of failure. Steam main leak has now caused a catastrophic failure of the aged electrical distribution system in Knightsbridge. Numerous parts of the distribution now require urgent replacement. | **20** | ↑ | Failure of electrical distribution at night on 16th December 2015, causing the evacuation of Buckland and Norman Tanner Wards. The failure was due to water ingress into the Electrical supply. Continued steam leaks continue to affect the infrastructure within the wing. |
| EF195 | Electrical upgrades/maintenance to UPS and IPS in AMW | **16** | → | |
| EF198 | Risk of noncompliance with fire regulations as a result of the lack of fire risk assessments for some areas on the St George's Hospital site. | **15** | → | |
| EF200 | Delay to ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for works | **16** | → | |
| EF202 | Absconding patients on the helipad as access is via a fire escape route | | → | |
| EF204 | Failure of hot water system (HWS) calorifiers serving St James Wing. | **25** | → | |
| EF211 | Failure of electrical switchgear causing loss of essential power in STJ for most of the wards and other departments | **25** | → | |

| | | | | |
|---|---|---|---|---|
| EF215 | Master Pact M Circuit Breakers no longer supported by the manufacturer. | **16** | → | |
| EF216 | Automatic changeover contactors are no longer supported by the manufacturer | **25** | → | |
| EF217 | Failure of Genie Evo High Voltage vacuum circuit breakers. The HV Maintenance contract is currently being tendered. | **25** | → | |
| EF222 | The Fire escape from the Helena Robinson gym at QMH leads through to a stairwell which leads to difficulties in evacuating non ambulatory patients | **15** | → | |
| EF224 | Maintenance of Fire Dampers in Ventilation Ductwork | **16** | **NEW** | |
| EF225 | Electrical infrastructure in Knightsbridge Wing is in danger of catastrophic failure**.** | **25** | **NEW** | Escalated via ORC for inclusion on CRR |
| EF226 | CDU Nurse Call Non Compatibility The system does not communicate with other areas such as urgent care, A&E majors, A&E Resus and A&E paeds. | **16** | **NEW** | |
| EF227 | Availability of the lift in the Day surgery/ Maxillo facial building | **15** | **NEW** | |
| | **IM&T** | | **Change** | |
| **Risk No.** | **Risk** | **Score** | **↑↓** | |
| IT016 | Reduction in capacity to deliver new infrastructure, systems and change programs | **20** | → | |
| IT018 | Community staff experiencing access difficulties and slow response to RIO | **16** | → | |
| IT0035 | Fire Risk Assessment compliance. | **20** | → | |
| IT0036 | Low number of fire wardens | **20** | → | |
| | **Corporate Affairs** | | **Change** | |
| **Risk No.** | **Risk** | **Score** | **↑↓** | |
| CORP02 | Risk of regulatory action or penalties upon the Trust in the event of a failure to comply with the legislative requirements of the Freedom of Information Act (2000) Update: position and level of compliance has not improved – risk score remains unchanged | **15** | → | |
| CORP06 | Capacity to deliver plans due to and increased turnover of staff in the Corporate Affairs directorate – Update: further vacancies and limitations on bank and agency mean risk remains. | **16** | → | |
| | **Strategy** | | **Change** | |
| Risk No. | Risk | **Score** | **↑↓** | |
| COM-03 | Potential risks to patient safety by staff accessing out of date policies via the intranet | **16** | → | |
| ST-002 | Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances | **tbc** | **NEW** | |
| ST-003 | Delivery risk of key projects due to staffing constraints | **16** | **NEW** | |

| | **Finance** | | **Change** | |
|---|---|---|---|---|
| Risk No. | Risk | **Score** | **↑↓** | |
| F_Proc_01 | Due to an incomplete contracts database, there is a risk that sub-optimal procurement decisions will be made. | **20** | **NEW** | |
| F_Proc_02 | Due to vacancies within the department, there is a risk that key steps in the Procurement process, will be delayed or omitted. | **25** | **NEW** | |
| F_Proc_03 | Due to a lack of adherence to governance and policy, there is a risk that the Trust will have unnecessary obligations to suppliers. | **20** | **NEW** | |
| F_Res_01 | Financial impact on Trust due to insufficient staff to respond to data challenges generated by the CSU and NHS England. | **16** | **NEW** | |
| F_Pay_02 | There is a risk of salary overpayments being made to staff who have already left the Trust**.** | **16** | **NEW** | |
| F_Pay_05 | There is a risk of non-compliance to regulations, in relation to Pension Auto-enrolment. | **16** | **NEW** | |
| F_Pay_07 | There is a risk that the quality of the payroll process will be compromised. | **16** | **NEW** | |

**Enclosure:**

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO THE TRUST BOARD 4th February 2016** **Paper Ref:**

| | |
|---|---|
| **Paper Title:** | Care & Environment Report |
| **Sponsoring Director:** | Eric Munro, Joint Director Estates & Facilities |
| **Author:** | Rachel Gerdes-Hansen, Capital Projects Manager |
| **Purpose:** | To update the Board on progress with improving care and the environment across the Trust |
| **Action required by the board:** | For information |
| **Document previously considered by:** | None |

**Executive summary**

1. **Key messages:** Improvements to the Hospital Environment & Medical Equipment from November 2015 to January 2016

**Capital Developments:**

**Mortuary Refrigerated store (Phase 1) - Project Value: £340,000**
In August 2016 following a non-routine visit to the Trust by the Human Tissue Authority (HTA), the Trust undertook a series of actions to address recommendations made by the HTA, not least, *'The removal of the temporary Nutwell storage units'*, and item (iii) *'Review its plans to install additional fixed fridges and freezer spaces'.*

A six week programme of works commenced on Monday 19th October 2015, to increase the mortuary footprint, in order to provide; in phase one, an additional seventy fixed refrigerated berths. These works are to form part of a two-phase construction project at the Trust. Phase two will see the development of thirty-five fixed freezer units.

On Monday 30th November works completed both to time and budget on this project The new facilities provide additional fully compliant refrigerated storage. This has allowed for the dismantling of the Nutwell units and has provided the additional capacity required for winter pressures.

**Refrigerated store units in new mortuary store**

**Enclosure:**

**Lanesborough CT Replacement - Project Value: £2,750,000**

The two CT scanners in Lanesborough Wing had reached their 7 year replacement target and a project was established to replace the scanners with high specification equipment. The new scanners were installed in November and December 2015 at a total cost of just over £2m. The new technology will improve reliability and reduce downtime, improve scanning quality and offer lower radiation dose examinations to all patients.

The project also undertook work to refurbish the scanner rooms, install new medical gases and improve the waiting and changing areas. New changing cubicles and a separate waiting area were created to segregate patients in their day clothes from those in beds and hospital gowns. The new layout will offer patients a more pleasant environment in which to wait, in addition to improved privacy and dignity. Artwork has been incorporated into the scanner room ceilings and in the waiting areas to enhance wellbeing for patients' waiting to be treated. In addition to this, patient safety was also addressed by the inclusion of a staff base; for observation of patients pre and post procedure; the installation of a nurse call system.

**Scanner room**

**Waiting area**

**Neonatal Unit) - Project Value: £665,000**

Commencing in September 2015, the aim of the above project was to expand the capacity of the High Dependency Unit (Room 1) by 5 additional spaces, as current demand on these cots, out-weighs the existing provision. On completion of the project the new room has the capacity to support 10 high dependency babies. In addition to this, the project also provided additional infrastructure (data and electrical services) for the IT e-prescription works in (IC1, IC2, IC3, SCBU and HDU 2). The project was undertaken in three phases to allow for the IT project internal decanting and recanting and completed in January 2016.

**Completed High Dependency Unit in NNU**

**Enclosure:**

**Arts St Georges – Arts Strategy (Appendix 1)**

The new Arts Strategy has been developed in collaboration with the Arts Director, The Arts St Georges and the programme is supported by St Georges Hospital Charity. The document sets out the strategic aims for the Arts programme at the Trust from April 2016 to March 2020. These strategic aims have been developed to reflect the past fourteen years' experience of developing art programmes at the Trust and the changing environment of arts in health.

The Arts programme at St George's University Hospitals NHS Foundation Trust uses charitable funds from the St George's Hospital Charity to bring a wide range of innovative and creative forms of the arts to patients.

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Our strategic aims reflect the changing environment of health care as well as the developments in the wider field of the arts in health. It is now common place to see arts programmes within a clinical setting.

Our vision is to make the Arts programmes at the Trust an exemplar within the clinical sector. Our ambition is to bring creative opportunities for every person spending time in the Trust to experience the arts and to participate in facilitated arts activities. Programmes and activities will be developed in collaboration with patients, their families, Trust and Charity colleagues.

The four key areas of the Arts St George's programme for 2016-2020:

- To create, advise, and support the Trust's cultural strategy and work closely with the Capital Projects Department to enhance the clinical environment for patients, staff and the local community
- To conserve, develop and curate the St George's Hospital Charity's art collection for the benefit of patients, staff and the local community
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- To develop robust methodology to provide evidence of the impact of the arts to patients wellbeing.

The Arts programme at St George's is managed by the Trust's Arts Director, and supported by its Curatorial Assistant (2 year fixed term until November 2016), and a freelance Live Arts Co-ordinator (music and performance for adults) and freelance artists/musicians. The Arts St George's Committee and Trust staff provide support and advice on a regular basis to the Arts Director and team.

**Capital medical equipment purchased from November 2015 to January 2016**

| Description of Investment | Total costs incl VAT | Reason for purchase |
|---|---|---|
| **2 - ECG Machines** | £12,9989 | Latest system to speed up patient care |
| **Ultrasound scanner** | £19,990 | To support research activities in foetal medicine |

| | | |
|---|---|---|
| **CTG machine** | £10,059 | To introduce foetal heart rate and maternal vital signs monitoring in unmonitored birthing rooms |
| **Foetal monitors & Mounting Hardware** | £51,750 | To introduce foetal heart rate and maternal vital signs monitoring in unmonitored birthing rooms |
| **Hand rehabilitation equipment** | £9,999 | Replacement of outdated and ineffective equipment (i.e. maintaining a functional hand position). |
| **ACL kit** | £14,929 | Day Surgery Extra Capacity Project |
| **Blood gas software** | £8,491 | To allow all blood gas results to be sent directly to the EPR to be stored electronically within the patient's record. |
| **2 Ultrasound scanners** | £119,502 | replacement of lease equipment |
| **Central station** | £52,766 | Cerner project |
| **Speechmikes software** | £5,610 | Nelson project - to allow reporting of patient scans |
| **Trolley's** | £36,120 | Hybrid project |
| **Conebeam CT** | £113,649 | To allow better planning of maxillofacial surgeries through utilisation of high resolution 3D scans. |
| **Microscope** | £94,649 | Insufficient number of scopes were present |
| **Pre-installation works** | £20,926 | Enabling works to get room ready for new conebeam CT scanner |
| **Cystoscopes** | £97,000 | To reduce patient waiting times for surgery |
| **Urology stack systems** | £44,193 | To reduce patient waiting times for surgery |

**Enclosure:**

| |
|---|
| 2. **Recommendation:** The report is for information purposes only. The Board are asked to note the improvements to the environment and medical equipment since February 2015. |
| **Key risks identified:**<br><br>None |

| | |
|---|---|
| **Related Corporate Objective:** | Strategic Aim no.6 - Continually improve our facilities and environment. Objective 19 - To continually improve efficiency of Estates and Facilities Services |
| **Related CQC Standard:** | Regulation 15 |

| |
|---|
| **Equality Impact Assessment (EIA): Has an EIA been carried out? ( Yes)**<br>**If yes, please provide a summary of the key findings If no, please explain you reasons for not undertaking and EIA.** |

**Enclosure:**

**Appendix A:**

St George's University Hospitals NHS
NHS Foundation Trust

# 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 |
|---|---|---|---|---|
| | | | | |

**1.1 Who is responsible for this service / function / policy?**
Eric Munro

**1.2 Describe the purpose of the service / function / policy?**
To improve the environment of the estate.

**1.3 Are there any associated objectives?**
Patient Led Assessment of the Care Environment (PLACE)

**1.4 What factors contribute or detract from achieving intended outcomes?**
N/A

**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**

No

**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?**
N/A

**1.8 What are your monitoring arrangements for this policy/ service**
N/A

**1.9 Equality Impact Rating**

**2.0. Please give your reasons for this rating**

**Appendix 1**

# St George's University Hospitals NHS Foundation Trust

# Arts Strategy 2016-2020

## Contents

# 1. Executive Summary

This document sets out the strategic aims for the Arts programme at the Trust from April 2016 to March 2020. These strategic aims have been developed to reflect the past fourteen years' experience of developing art programmes at the Trust and the changing environment of arts in health.

The Arts programme at St George's University Hospitals NHS Foundation Trust uses charitable funds from the St George's Hospital Charity to bring a wide range of innovative and creative forms of the arts to patients.

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Our strategic aims reflect the changing environment of health care as well as the developments in the wider field of the arts in health. It is now common place to see arts programmes within a clinical setting.

Our vision is to make the Arts programmes at the Trust an exemplar within the clinical sector. Our ambition is to bring creative opportunities for every person spending time in the Trust to experience the arts and to participate in facilitated arts activities. Programmes and activities will be developed in collaboration with patients, their families, Trust and Charity colleagues.

The four key areas of the Arts St George's programme for 2016-2020:

- To create, advise, and support the Trust's cultural strategy and work closely with the Capital Projects Department to enhance the clinical environment for patients, staff and the local community
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- To develop an innovative participatory programme of visual arts, music and performance for children, young people, adults and staff at the Trust
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The Arts programme at St George's is managed by the Trust's Arts Director, and supported by its Curatorial Assistant (2 year fixed term until November 2016), and a freelance Live Arts Co-ordinator (music and performance for adults) and freelance artists/musicians. The Arts St George's Committee and Trust staff provide support and advice on a regular basis to the Arts Director and team.

## 2. Introduction

The Arts St George's programme at St George's University Hospitals NHS Foundation Trust uses charitable funds from the St George's Hospital Charity to bring a wide range of innovative and creative forms of arts to patients. This includes the purchasing of artwork, commissions and redevelopment of wards and public areas, exhibiting the Charity's significant art collection, delivering participatory Arts programmes and projects to support the wellbeing of patients, their families and carers at the Trust.

Since the early 1990's Arts St George's has made a vital contribution to the wellbeing of patients, their families, visitors and staff at the hospital. This document sets out the strategic aims for the Art programme at the Trust from April 2016 to March 2020. These strategic aims have been developed to reflect the past fourteen years' experience of caring for the expanding art collection and the changing environment of healthcare, in addition to the developments within the wider field of arts in health. This strategy will be reviewed bi-annually to ensure that it meets key aims and objectives.

The positive effect of enhancing the patient environment through arts is not a new concept, Florence Nightingale believed, "*variety of form and brilliancy of colour in objects presented to patients are actual means of recovery* " 1898.[1]

In 2015 the CQC stated that, "*Art can brighten up spaces, reduce anxiety and stress for patients and provide positive distractions, particularly in waiting areas, and so it is something to be encouraged*".[2]

## 3. Context

In the early 1990's a group of clinicians developed small exhibitions and displays to make visible improvements to the hospital environment at St George's Hospital. An Arts Committee was established in 2000. The Arts St George's Committee comprise of hospital staff, patients and external representatives who support the Arts programme and the Trust's Art Director. The group meets quarterly to discuss ways to promote and develop the Arts St George's programme.

In 2001 St George's Hospital employed its first Arts Officer who established the Hospital's first music and performance programme. In 2002 a new Arts Officer took up post to manage the collection, new commissions and performance programmes. In 2014, the Trust employed a new Arts Director to rationalise, curate and manage the Art Collection funded by the St George's Hospital Charity, expand its participatory programmes for all patients across the Trust, and new commissions in collaboration with capital projects. The Art Collection continues to grow as it has for many years by way of acquisition through commission, purchase and occasional donations from patients, family members and artists with particular connections to the hospital.

## 4. Arts St George's Team

The Arts programme at St George's is managed by the Trust's Arts Director, and supported by its Curatorial Assistant (2 year fixed term until November 2016), and a freelance Live Arts Co-ordinator (music and performance for adults) and freelance artists/musicians. The Arts St George's Committee and Trust staff provide support and advice on a regular basis to the Arts Director and team.

[1] Florence Nightingale 1898: Notes on Nursing What It Is, and What It Is Not Florence Nightingale 1898.
[2] Paintings in Hospitals website: 2015 CQC comment on artwork in hospital setting

## 5. Vision

Our vision is to make the art collection, new developments and participatory programmes at the Trust an exemplar for the integration of the arts into healthcare, supporting new learning in the field. Our ambition is to bring creative opportunities for every person spending time in the Trust to experience the arts as an audience and to participate in facilitated arts activities. The arts are a resource for our patients, families and staff. All arts interventions will be developed in collaboration with the patients, their families, Trust and Charity colleagues.

## 6. Arts St George's Aims and Objectives

From 2016 onwards our ambition is to continue to develop clinical and public spaces for patients, staff and the local community. To develop programmes and projects which are evidence based to highlight the impact of the arts on patient wellbeing.

In April 2007 the Department of Health and Arts Council England co-published A Prospectus for Arts in Health, offering guidance and examples of best practice[3]. In 2011, the British Medical Association stated that 'Arts and humanities programmes have been shown to have a positive effect on inpatients. For example, inducing positive physiological and psychological changes in clinical outcomes and reducing drug consumption[4].

Our mission for the Arts programme is *to promote wellbeing through the arts*.
Our strategic aims reflect the changing environment of health care as well as the developments in the wider field of the arts in health. It is now common place to see Arts programmes within a clinical setting.

The strategy is based both on the Trust's organisational values of *excellence, responsible, respectful and kind* and St George's Hospital Charity's constitutional aims. The Charity exists to bring additional benefits to the hospital, providing support 'over and above' what the NHS provides and their support of the trust includes;

- Enhancing the physical environment of the hospital for patients, staff and visitors through refurbishment and building projects.
- Funding clinical research.
- Helping to fund state-of-the-art equipment.
- Supporting St George's staff through training and development.
- Providing new patient therapies.

Patients and staff expectations of the physical environment of care have radically changed, and they expect an Arts programme to be delivered to the same high quality professional standards as any other aspect of care.

[3] A Prospectus for Arts in Health, The Department of Health and Arts Council England, April 2007
[4] Arts and humanities programmes, The British Medical Association, 2011

## 7. Objectives 2016-2020

Since 2001, Arts St George's has explored a diverse range of arts activities, from temporary exhibitions to permanent installations, half-day workshops to artist residencies. This strategy provides us with an opportunity to review the effectiveness of different approaches and to narrow the focus onto projects with the greatest reach and impact.

An Arts programme which responds to the particular needs of our stakeholders, first and foremost our patients and Trust values. An on-going Arts programme will encourage a continued sense of a hospital that is vibrant, welcoming and part of the community it serves. In order to be sustainable, this must demonstrate that it meets the needs of patients and the strategic objectives of the Trust, offer added value and value for money, deliver consistently high quality results and be supported by a robust management structure. Our aim will be to ensure we are developing opportunities with key partners and stakeholders to maximise the use of our limited resources.

The four main areas of the Arts St George's programme 2016-2020:

1. To create, advise, and support the Trust's cultural strategy and work closely with the Capital Projects Department to enhance the clinical environment for patients, staff and the local community
2. To conserve, develop and curate the St George's Hospital Charity's art collection for the benefit of patients, staff and the local community
3. To develop an innovative participatory programme of visual arts, music and performance programme for children, young people, adult and staff at the Trust
4. To develop robust methodology to provide evidence of the impact of the arts to patients health and wellbeing

**To create, advise, and support the Trust's cultural strategy and work closely with the Capital Projects Department to enhance the clinical environment for patients, staff and the local community – Capital Programmes**

As part of the Capital Projects Department the Art Director and Curatorial Assistant will work closely with colleagues on any future Development Control Planning (DCP) works, project spaces and designs to enhance the clinical spaces for staff and patients. The Arts Director has received increasing numbers of requests to advise on visual art within a wider patient amenities bid. Successful projects are managed by the Capital Projects team where appropriate, who collaborate with the Arts team to ensure the art and (re)design are integrated.

The Arts Strategy will enable the Trust to develop its Cultural Action Plan with the support of the Arts St Georges Committee, Arts Director, Assistant Director of Capital Projects, Estates and Facilities and clinical teams. A cultural strategy will be developed to consider the whole site and reviewed and updated in relation to specific projects. The cultural plan will consider the following:

- Ethos and key principles
- Key priorities throughout the phasing of the capital programme
- Summary of future pre-application consultation
- Outline approach – principles that could be adopted over the course of the development at consultation phase, construction phase and final strategy

The plan will need to cover both strategy and implementation of the action plan, considering overarching principles, phasing, budget and capacity to deliver the cultural plan. In order to deliver on its aims and vision, the strategy will recommend four strands:

- Integrated commissions
- Multiple commissions
- Partnership projects
- Heritage integration

The development of a cultural plan will allow us to build our annual timetable around projects, and to provide budgets reflecting the need for consultancy support if necessary. All projects will be underpinned by five core values, making the work:

- Inspirational
- Collaborative
- Realistic
- Affordable
- Sustainable

Over the next 10 years it is anticipated, the hospital redevelopment programme will deliver marked improvements for patients, the staff and local community across a range of health services.
The strategy will place value on the role of culture and creativity to enhance the environment. The Cultural Strategy will identify the following actions: to work with health and community partners in providing reliable and effective health information across the city; and to develop the role of the arts.

The strategy will articulate a vision for a sustainable community which makes effective use of natural resources, enhances the environment, promotes social cohesion and inclusion offering services and infrastructure which are high quality, well-designed and maintained, safe, accessible, adaptable and cost-effective.

Guidance suggests that the Trust aims to secure 1% of the capital costs of major development schemes to be used for publicly sited works of art. Although due to the current NHS financial position the budget for art is undecided.

**To conserve, develop and curate the St George's Hospital Charity's art collection for the benefit of patients, staff and the local community**

One of the ambitions for the collection is to ensure it complies with Spectrum collection management criteria. Our ambition is that by 2020 we work towards becoming an accredited collection by the Arts Council of England; our benchmark within this area is Chelsea and Westminster Charity and Imperial Hospital Charity arts collections.

The St George's Charity's Collection is displayed in public areas, wards, single rooms, day rooms and offices within the two square miles of site. The art works are predominantly on display rather than in storage; and as the hospital expands and develops, there is a constant demand for new work to be hung in small units as well as within redeveloped wards and any new capital programmes planned. As more staff learn about our work, we receive increasing numbers of requests without budgets – whether to improve patient areas or to support new initiatives. We are also regularly approached by outside individuals and organisations proposing to bring their work to the Trust. We must continue to address these ideas, but must use our limited resources as efficiently as possible. We are currently streamlining both the internal and external requests and proposals process, and any projects requiring

significant resources will be brought to the attention of the Director of Estates and Facilities, for assessment.

The volume of Collection on display also makes an up-to-date collection care and location management system essential to safeguard and track work. The regularity of the Collection's movement also means that the conservation care and location management of the Collection takes up a large proportion of administrative time.

An important facet of curatorial work is the conservation and preservation of the Collection. This involves a wide range of tasks: from working with the Trust's Estates Department and Capital Projects during redevelopment or refurbishment, professional conservators to clean sculptures, paintings and frame prints, to moving works in and out of store during hospital refurbishment. The Collection of approximately 900 works is based on the understanding that art has an important part to play in creating a restorative, educational and healing environment. The Collection contains works by leading modern and contemporary British artists. It also has a number of historic works. The Collection is particularly strong in contemporary prints but also includes works on canvas, sculpture and murals. Its current strengths lie in acquiring and commissioning works by established modern and contemporary artists, predominantly British.

In 2014 the St George's Hospital Charity Board of Trustee's agreed the appointment of a Curatorial Assistant, fixed term for two years. The rationale for this decision was that the management of the collection would continue to be a core area of activity and an on-going area to maintain. This post has been invaluable asset to enable the Arts Director to focus on development work, the DCP designs and developments, donations and new commissions and to work with the St George's Hospital Charity to research and apply for funding to extend the Arts programme. To ensure the conservation and management of the collection we will seek to extend this role beyond the interim timeframe. The Arts team have been assigned to manage the Arts Collection at both St George's Hospital and Queen Mary's Hospital in Roehampton.

From 2016-2020 we will need to continue with both collections at St George's and Queen Mary's Hospitals:

- The backlog of research, cataloguing, interpretation and obtaining copyright of the collection
- Provenance checks of the Collection
- Regular care and conservation work including busy public areas with heavy traffic
- Picture hang and de-installation of work
- Regular collection location tracking and the data entry
- Responding to the changes in theTrust capital programme and DCP work
- Developing and updating a new electronic tagging system to manage the regular movement of artworks

**To develop an innovative participatory programme of visual arts, music and performance for children, young people, adults and staff at the Trust**

The aim will be to make the Arts St George's programme an exemplar to other Trust sites. The most successful and sustainable arts interventions have been those in which staff and patients have actively participated in the development or production of programmes and new commissions.

An on-going Arts programme will encourage a continued sense of the Trust being a vibrant, welcoming part of the community. In order to be sustainable, it must demonstrate that it meets the needs of patients and strategic objectives, offer added value and value for money, deliver consistently high quality results and be supported by a robust management structure.

**Children and young people – Arts programme at St George's**
The Trust admits approximately 12,000 children and young people for care as inpatients and outpatients each year. The Trust is the largest healthcare provider in South West London, covering Surrey, Sussex and specialist care in South East England.

The hospital works with young people of all ages, socio-economic backgrounds, cultures and health requirements. Due to ill-health and its impact, many of these young people and their families have not accessed or participated in arts and cultural activities. Young patients often miss school therefore supporting development of critical engagement with the arts is often overlooked. In our 2014/2015 arts pilot programme, 2,000 young people and their families were interviewed.

- 80% had not previously participated in arts activities within a clinical setting
- 75% stated that they had not participated in cultural activity outside of the hospital due to their child's illness and economic situation
- 65% of young people had missed time at school due to their illness

Our consultation highlights the lack of participation of the arts for young people in a clinical environment. The importance of young people being able to make their own creative decisions and engage with artists and ideas cannot be underestimated, particularly within a clinical environment where often choices are restricted. The development of a new Arts programme and the establishment of a youth forum working with socially engaged artists will enable young people to develop their critical thinking, create, curate and participate in arts; and develop their creativity whilst receiving medical treatment. We will develop a strong participatory programme developed with and for young people. We will seek external funding to expand the programme to meet the needs of children based in:

- Jungle Ward
- Dragon Children's Centre
- Children's Wards on the 5th Floor

The projects and programmes will enable us to develop a strong brief for new commissions for any future redevelopment projects.

**Adults and staff – Arts programme at St George's**
Since 2002 we have delivered a Live Arts music and performance programme for patients and their families. Over the next four years we will continue to work with patients across St George's and Queen Mary's. The Live Arts programme is designed for patients in: senior health, inpatients with an emphasis on stays over 28 days, renal, Parkinson's and Neuro-rehabilitation. We offer a weekly programme of activities from music, dance to theatre. Weekly sessions such as Bedside Music are delivered across the adult wards. Recreational arts and activities, brings arts and social activities to the Wolfson at Queen Mary's every weekend of the year. An annual Christmas show tours the adult wards. We have continued to collaborate with community groups, in 2015 we worked with the Pram Chorus, Fresalca Saxophone Quartet and the Great Gustos who performed at St George's raising £300 for the Delivery Suite and Buckland ward. Castelnau Chorale performed at Queen Mary's at Christmas and Doverhouse Singers (also local to Roehampton) plan to play free concerts in spring 2016. St George's has a new patient choir for Cardiology patients set up by Therapies in March 15: Lung Songs performed its first concert this Christmas in the Atkinson Morley Wing foyer and Knightsbridge Wing - Haemodialysis. From 2016 we will continue to collaborate with leading arts organisations such as Rambert Dance Company, Theatre Royal Stratford East to introduce innovative patient-directed events.

We will continue to work with the St George's Hospital Charity to obtain funds to extend the Arts provision at the Trust.

**To develop robust methodology to provide evidence of the impact of the arts to patients wellbeing.**

From March 2016 onwards programmes and projects will be rigorously evaluated. There will be a greater emphasis on seeking robust quantitative and qualitative feedback of patients, staff and visitors as a means of informing the future arts policies and programmes. Evaluation will be disseminated via internal meetings to the Trust and Charity. The Arts Committee will also review evaluation and case studies at quarterly meetings.

- Formal evaluation will now be built into every project including, as appropriate, a pre and post evaluation, photographic and video records, testimonials and focus groups, and addressing the experience of the artists/facilitators as well as the participants
- All projects over £5,000 will result in a case study for publication on the Trust and Charity website, and potentially externally
- Publishable external evaluation of major projects will be built in to all projects over £20K. There are now strong academic teams working in the field onsite and at universities across the UK who would make ideal partners. Such publications would be valuable both to Arts St George's and the wider arts in health community

Clinical trials have the potential to raise our profile significantly, both with clinical and healthcare audiences. Trials are, however, time-consuming and relatively expensive, therefore we will not be developing this area until 2017 onwards. This will ensure that we focus on the general evaluation of programmes.
The vital components of any future work in this area:

- a proactive, committed clinical lead and buy in from senior staff
- the clear separation of research and advocacy at the proposal stage
- a solid research precedent
- the likelihood of relatively large patient numbers
- research design appropriate to the intervention
- research design which addresses the challenges of separating arts from other interventions

## 8. Stakeholders – both internal and external

- St George's Hospital Charity
- Trust Directorate
- Patients (see below)
- Relatives and other visitors
- Trust staff
- Trust members & governors
- Trust Arts Committee – Arts St George's
- Local community
- National arts institutions
- Local arts institutions
- Arts/health organisations & forums
- Other NHS Trusts
- Charitable trusts and foundations, and individual donors
- Wandsworth Borough Council
- Community groups
- Higher education institutions and other academic partners (e.g. SGUL on campus)
- Third sector organisations (e.g. British Heart Foundation, King's Fund, Arts Council England)
- MPs and local government

The Trust works with patients on both a short and long term basis and intervenes at a number of different levels. This strategy will not attempt to prioritise one 'type' of patient over another, but recognises that the programme must consider a variety of elements to match the differing needs of people at different stages of care. The Arts St George's Committee are a vital sounding board for the Arts programme, and will be key to supporting both improved evaluation processes and the implementation of this strategy.

A number of valuable projects and successful funding bids have arisen out of our collaborations with artists and cultural institutions. Over the next four years we will build on and add to these existing relationships, emphasising particularly the development opportunities we are able to offer postgraduate students or young professionals in exchange for their time, and bringing free arts facilitation to the Trust.

We will also use the exhibition spaces at both hospitals to foster new partnerships, offering logistical support to, for example, degree shows, or shows on loan from institutions and artists. We hope to explore additional possibilities with organisations with whom we already have relationships, and whose interest in this field is growing – whether arts organisations such as Tate Modern, Pump House Gallery, Wandsworth or health charities such as the Kings Fund, British Heart and British Lung Foundation.

## 9. Fundraising

We will continue to work closely with the Charity to increase the opportunities to build and extend the breadth of the Arts programme. Arts St George's funding structure is typical of successful hospital-based Arts programmes. Funding for salaries and the costs required to maintain the Arts programme is derived from the Charity, and additional project funding is sourced to extend provision. We have previously received funding from external trusts, foundations and individuals with the support of the St George's Hospital Charity. The Arts team will work with the Charity to further develop this area.

## 10. Marketing

**Internal and external marketing**

With the active support of the Trust Communications Team and Charity, Arts St George's will use the full range of communication channels available internally (including the Trust intranet eG, Gazette and By George! From August 2016 onwards we will develop our presence further through more sophisticated use of social media.

## 11. Advocacy

The Arts St George's team regularly present and disseminate their work in London and nationally. The Arts Director has been a member of the London Arts in Health Forum since 2012 and disseminates the Arts St George's programme and projects to peers working within the arts and clinical health sector.
(www.lahf.org.uk).