St George's University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting (Public)
Thursday 7 April 2016 commencing at 10:00 am
Venue: Richmond & Barnes Room, Queen Mary's Hospital

Item	Time	Item	Owner:	Board Action	Paper No:
Board Business					
1.	**10.00**	**Welcome and Apologies**	D Henshaw		-
2.		**Declarations of Interest**	All	Board Members to declare any pecuniary or non-pecuniary interest in particular agenda items, if appropriate	-
3.		**Minutes of the meeting**	D Henshaw	To consider the Minutes of the previous meeting held on 3rd March 16 and check for amendments and approve	TB (M) Mar 16
4.		**Key Issues**	All	Board members to identify any key issues	-
5.		**Schedule of Matters Arising**	D Henshaw	To discuss any matters arising from previous meetings and provide updates and review where appropriate	TB (MA) Apr 16
6.		**Chief Executives Report**	M Scott	To provide an update on key issues	TB Apr 16 - 01
Business Planning 2016/17					
7.	**10.20**	**Business planning process**	R Elek/I Lynam	The Board is asked to note the process and agree the recommendations on next steps.	TB Apr 16 - 02
8.		**Corporate Objectives**	R Elek	To agree of the upcoming year's Corporate Objectives as part of the business planning cycle	TB Apr 16 - 03
9.		**2016/17 Financial Planning**	I Lynam	To note the latest financial position for 16/17	TB Apr 16 – 04
10.		**Key trajectories 16/17**	P Vasco-Knight	To inform the Board about the process of developing the trajectories for cancer, RTT and ED alongside the assumptions and risks and mitigations	TB Apr 16 - 05
11.		**Communication Plan**	R Elek	To consider the proposed communications strategy and approve the plan.	TB Apr 16 – 06

Patient Safety, Quality and Performance					
12.	**11.20**	**Performance & Quality Report**	J Hall/P Vasco-Knight	To inform the Board about the latest performance and quality report and hear a patient story. RTT Access Policy included for information.	TB Apr 16 - 07
13.		**Workforce & Performance Report**	W Brewer	To inform the Board about the latest position on workforce including an update on the SWL Trust shared Bank Agency and agree next steps on staff engagement	TB Apr 16 - 08
14.		**Workforce & Education Committee**	K Leach	To note the key issues arising from the Committee	Verbal
15.		**Quality & Risk Committee**	S Wilton	To inform the Board about the key issues arising from the Committee	TB Apr 16 - 09
Strategy					
16.	**12.10**	**Update on Renal**	R Hancock	To inform the Board about the progress made on the remedial work	TB Apr 16 – 10
Finance and Performance					
17.	**12.20**	**Finance Report – month 11**	I Lynam	To inform the Board about the latest project outturn	TB Apr 16 – 11
18.		**Finance & Performance Committee**	S Wilton	To inform the Board about the key issues arising from the Committee	TB Apr 16 – 12
Governance and Risk					
19.	**12.40**	**Risk and Compliance Report**	J Hall	To review the Trust's most significant risks and external assurances received	TB Apr 16 – 13
20.		**PWC Recommendations**	M Scott	To review progress against the PWC recommendations	TB Apr 16 – 14
21.		**Annual Audit Report**	M Rappolt	To agree	TB Apr 16 - 15
22.		**Annual Audit Plan**	M Rappolt	To agree	TB Apr 16 - 16
23.		**Audit Committee**	M Rappolt	To note the key issues arising from the Committee	TB Apr 16 - 17

Items for Information					
24.	**1.00**	**Use of the Trust Seal**		To note use of the Trust seal in March 2016. The seal was used 3 times: • Noon Bicknell Lease • Deed of Assignment for Intellectual Property – Mitral Valve Project, Brecker-Saba Atraumatic Cardiac Pacing Lead • Deed of Assignment for Intellectual Property – Mitral Valve Project, Replacement Heart Valve	-
25.		**Questions from the Public**		Members of the public present are invited to ask questions relating to business on the agenda. Priority will be given to written questions received in advance of the meeting	-
26.		**Key reflections**	All	The Board to reflect on key issues	-
Date of next meeting The next scheduled meeting of the Board to be held in public will be 5th May 2016					

Minutes Trust Board

Minutes of the meeting Trust Board of St George's University Hospitals NHS Foundation Trust, held on Thursday 3 March 2016 in Boardroom H2.5, St George's Hospital, commencing at 9am and concluding at 12.50am.

MEMBERS PRESENT

Sarah Wilton	SW	Acting Chair
Mike Rappolt	MR	Deputy Chair, Non-Executive Director
Kate Leach	KL	Non-Executive Director
Stella Pantelides	SP	Non-Executive Director
Prof Jenny Higham	JMH	Non-Executive Director
Miles Scott	MS	Chief Executive
Jennie Hall	JH	Chief Nurse
Simon Mackenzie	SM	Medical Director
Iain Lynam	IL	Interim Chief Finance Officer
Wendy Brewer	WB	Director of Workforce
Martin Wilson	MW	Director of Transformation
Rob Elek	RE	Director of Strategy
Paula Vasco-Knight	PVK	Chief Operating Officer
Anna Anderson	AA	Interim Director of Financial Performance & Planning
Jill Hall	JHA	Interim Trust Secretary
Lisa Pickering	LP	Divisional Chair, Medicine and Cardiology
Paul Alford	PA	Divisional Chair, Community Services
Chloe Cox	CC	Divisional Director of Operations, Surgery
Andy Rhodes	AR	Divisional Chair, Women and Children

Agenda Item	**Action**

1. Chairman's opening remarks

The Chair welcomed everyone to the meeting

2. Apologies for Absence

Apologies were received from Eric Munro and Andrew Burn.

3. Declarations of Interest

There were none.

4. **Minutes** of the meeting held on 4 February 2016 were approved as an accurate record.

5. Matters Arising

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

6. Chief Executives Report

The Board received the regular report of the Chief Executive which gave an update on key developments within the Trust. In particular highlighting the junior Doctors contract dispute and the breakdown in negotiations. The Secretary of State had decided to impose the contract with effect from the 1st August 2016. A letter had been received from NHS Improvement (NHSI) which was sent out to all trusts in England regarding implementation of the new contracts noting that funding of training posts was reliant upon implementation of the contract.

The BMA had announced three more dates for industrial action with a 48 hour strike scheduled for the 9 March from 8am. This had generated a high level of discontent with doctors at all levels across the Trust. It was noted that SM was leading on a piece of work with both senior and junior doctors on improving moral. SM and WB were looking at how the new contract would work in practice. The Board were given assurance that plans were in place to minimise the impact of strike action on patients.

MS suggested that the Trust could informally lobby for talks to restart, however, as the decision had already been made by the Secretary of State no further negotiations were currently planned.

RESOLVED
That the Board NOTED the report.

7. Urogynaecology Report

AR introduced the report and reminded the Board that the Urogynaecology service had been suspended in June 2015 due to concerns regarding the safe running of the service and HR issues. All patients using the service had been advised and their treatment transferred to either Croydon Healthcare, an accredited centre, or other local service providers. The Board were reminded that an internal consultation had taken place with staff and an external consultation with service users, Overview and Scrutiny Committees, local authorities and local Healthwatch. All comments from the consultations had been reviewed and due to the level of response and comments received it had been decided that the recommendation to the Trust Board was that the service would remain suspended whilst the Trust discussed with Wandsworth CCG (the commissioners) on future arrangements should the CCG want to commission one.

SW allowed questions from the public at this point of the meeting. Barbara

Bohanna spoke as patient representative and stated that patients would like the service to restart as soon as possible as it was felt the service provided at Croydon was not satisfactory and was at a loss why the situation could not be resolved more quickly In response AR reported that the Trust did not currently have a lead consultant to lead the service and this would be part of the conversation with the CCG.MR agreed with the recommendation in the report but felt the Trust needed to move quickly to resolve the matter. In response AR highlighted there were a number of issues that needed to be resolved including taking legal advice on HR issues.

MS highlighted that the Trust had been listening to all concerned and would be discussing with Commissioners what a local service would look like should they decide to commission one. It was agreed that the Board would receive an update in 2-3 months' time.

AR May/June 2016

RESOLVED
That the Board DISCUSSED the report and APPROVED the proposal:

a. **To begin a process of liaison with commissioners to understand the appetite and specification for the re-establishment of a urogynaecology service at SGUH;**
b. **That the proposed models arising from the consultation be fed into any discussions, and evaluated, should the CCGs indicate that they wish to commission a service from St George's;**
c. **That any reconfigured service met the requirements of both clinical and financial sustainability in accordance with the trust's business case process;**
d. **That the Trust do any further work to understand the equalities issues (including around access) NOTING that further consultation may be required.**
e. **That the service remains in suspension during this period.**

Patient Safety Quality and Performance

8. Quality & Performance Report

JH presented an update of month 10 (January 2016).

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

Mortality
Figures remained in line with expected for admissions at the weekend, emergency weekday admissions were better than expected. The SHMI position has returned to better than expected. Despite this encouraging position the Trust continued to proactively investigate mortality signals at procedure and diagnosis level.

Safety
There had been no reported cases of MRSA to the end of January, and no

reported cases since Mid-September.
There were now a total of 25 reported cases of C-Difficile to the end of January, the Trust remains on track to meet the annual target of 31 cases for 15/16.

Safeguarding Training
Safeguarding Adults compliance for training remains a key area of focus. The Trust is now demonstrating a compliance of 71% for adult training. The board noted that there was an action in place to achieve adult safeguarding target which was being monitored by the respective safeguarding Committee.

Ward Heat map
The Heat map for January included both Acute and Community services. During the month one clinical ward area had been placed in special measures to support further intervention in relation to the staffing profile and some aspects of clinical practice. There was an action plan in place being led by the Division.

MR asked how long it would take for the ward in special measures to be resolved. In response JH reported this would take about 2 months as it involved recruiting new staff, moving existing staff and running training sessions with medical teams,. It was noted that work had been on going to support the Ward prior to it being placed in special measures.

Performance
Cancer: MS highlighted the huge amount of work undertaken by the cancer team to improve waiting times. It was noted all specialist providers were struggling to meet targets with only the Royal Marsden achieving target. Careful planning on appointments around bank holidays had helped to improve performance against waiting times. It was noted that the breast cancer service at QMH had previously provided by KHFT was now being provided at St George's this had been effective from 1st January 2016.

MR highlighted his frustration with ongoing IT system problems 'not able to talk to each other'.

A&E: One version of the truth was being implemented but had not yet shown results. There had been a 16% increase in admissions during January – nationally the 6th highest increase. During discussion it was agreed there was a need to radically change systems. The escalation committee meet twice weekly to monitor delays in transfer and discharge.

RTT: It was noted the Trust was working with commissioners to clear the backlog.

Outpatient: AR reported that the call centre had suffered a power outage which had shut down the system. It was agreed that external independent IT advice be sought with additional system checking.

RE reported that the Trust would be moving towards online booking for patients and away from telephone booking in the future.

RESOLVED
That the Board NOTED the report.

9. Turnaround Board update

MS reported that 74 of the 75 recommendations would have been implemented from the PwC report by the end of March. The month 11 position was currently £24m ahead of plan and CIP was £43m against a £38m target.

Going forward the Trust will focus on transformation led by MW. It was noted Andrew Burns finished his secondment from KPMG at the end of March. A paper discussing appropriate resources would be discussed later in private session.

RESOLVED
That the Board NOTED the verbal update.

10. Workforce Report

WB reported that staff turnover had remained at the level to which it increased in December. Staff groups with increasing turnover rates included therapists, scientists and clinical technical roles. Nursing turnover was marginally decreasing. Sickness absence has increased again and had now been above target for longer than was usual in the winter. The Trust however continued to benchmark well against similar London Trusts.

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

Appraisal rates continued to deteriorate and further focus would be given to this area. There would be a detailed review of appraisal processes at the workforce and education committee meeting in March.

Career development for staff is a priority with 188 staff currently 'acting up'. The priority was to ensure this was resolved fairly and openly.
The Board noted that there continued to be a high turnover of staff still within the HR department with staff moving on to new roles after gaining experience.

MR raised the issue of effective appraisal systems which were there to help and support staff and thought there was a process in place to ensure that these were completed annually. WB agreed that is was very important for all staff to have an annual appraisal and time needed to be set aside to ensure that they were completed. It was noted that nurse's appraisals would be completed through the mandatory nurse revalidation process being brought in.

The Annual Staff Survey results had been received. It was noted that these were disappointing. The message coming from staff was that they were struggling under intense pressure due to recruitment issues, IT issues and frustration. It was noted that the organisation was looking at how best to support staff through training, management behaviour and recruiting staff to create a stable workforce.

Bullying was an area the Trust has always scored poorly and though an action plan was in place and further work which included looking at how other Trusts managed bullying and harassment.

KL felt that the diagnosis around bullying was not solid enough and staff needed to be engaged with more openly. WB accepted that more can be done in this area.

SP commented on the actions in place for this year with more engagement with staff planned and stressed the importance of considering the wider impacts of turnaround and transformation on the human capital of the organisation. In response MS reminded the Board that financial turnaround had only just started. As a Board the longer term programme was an urgent issue with work to be done around infrastructure and IT which will require investment. NHSi would be providing support to the organisation. It was agreed that messages to staff on the transformation work needed to be positive.

PVK stated that she was inspired by the commitment of staff she meet around the Trust.

RESOLVED
That the Board NOTED the report presented for information.

11. SWLP Implementation Review

Saghar Missaghian-Cully (SMC) (MD SWLP) and Aodhan Breathnach (AB) (Clinical Director, SWLP) updated the Board on the creation of the South West London Pathology. Overall they felt it had been successful and had delivered significant change. Generally outstanding issues can be seen in the context of 'snagging', especially relating to quality, although there is no single major quality issue

MR was pleased to note that the service was now delivering against its objectives. Some concerns were expressed about the quality of the lessons learned report and how these would be used. if these In response Aodhan Breathnach reported new opportunities were being looked at a London tender. The Sexual Health Services testing contract in London is currently being tendered.

RESOLVED
That the Board NOTED and COMMENTED on the report presented for information.

12. Outpatient Recovery Plan update

Outpatients Strategy to be presented at next Board meeting. **RE 07.04.16**

RESOLVED
That the Board AGREED that the Outpatient Strategy be submitted to the Trust Board at its meeting on 7 April

13. Annual Plan 16/17 progress update including budget setting

The Board received a progress update on the annual plan submission for 16/17 noting that the Trust had received feedback from Monitor. It was noted that a timetable had been put in place and included a briefing

session for Governors which would be taking place following the Board meeting and was an opportunity for Governors to feed into the process.

It was noted that a new Associate Director of Communications was joining the organisation in May and would be reviewing the Communications Strategy.

During discussion the following points were raised:

- SP felt that opportunities to raise commercial revenue to assist the Trusts finances was missing from the report.

- JH felt that the vision statement needed work. RE agreed that the executive and Board needed to agree on a statement before submission.

MS stated that that there had been a big turnover in Board membership over the last year and that the Board needed to reconnect vision to where the organisation was now.

RESOLVED
That the Board NOTED the report.

14 Finance Report

The Board received the regular finance report, presented by AA, for Month 10 and reminded the Board that at its meeting on 14 January it had agreed the revised budget of £56.1m.

The Board noted that the cumulative deficit was £0.8m better than plan mainly due to a underspend on pay budgets because recruitment to posts had been slower than planned.

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

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

Discussing NHS England (NHSE) debt it was noted that the total debt owed by NHSE was £15m. MR commented on the debt position with NHSE and that an action plan was needed to secure the money. In response RE reported that the situation was being raised at the highest levels in NHSE. It was noted that other Trusts were facing similar issues. MR felt that it had been going on too long and needed decisive action from the Board and a report to F&P Committee in the first instance.

IL
tbc

RESOLVED
That the Board REVIEWED and DISCUSSED the report.

15. Report from the Finance & Performance Committee

All covered in the previous item.

16. Risk and Compliance Report

JH presented the report and highlighted two issues – high staff vacancies and ongoing estate issues affecting the delivery of patient care.

The Board noted the work in preparation for inspection by the Care Quality Commission in late June 2016.

MR asked why staff moral following staff survey results had not been included in the report. In response it was noted that this was because the results had only just been received and would therefore be reflected in next month's report.

RESOLVED
That the Board NOTED the report.

17. **Use of the Trust Seal**

The Seal was used:

- 02.02.16 – Purley War Memorial Hospital Breast Screening
- 02.02.16 – Bed Capacity Scheme (Option 5 + 8)
- 02.02.16 – Trinity Fire, Lanesborough Wing
- 09.02.16 – Estates Area Lease SGH

RESOLVED
That the Board NOTED the use of the Trust Seal.

18 **Questions from the public**

a. Hazel Ingram stated that recently that had encountered long queues in both the blood clinic and in pharmacy. The blood clinic used to have the waiting time on the wall but not now working. Also when ringing to make an appointment you get prompted to leave a message with your details and the call is not returned. MR responded that he had encountered the same problem.

RE responded that the organisation was moving away from using phones and patients will be able to make appointments more easily on-line – a report would be going to Board next month.

b. Barbara Bohanna said she was horrified to hear that one of the wards was in special measures and asked how the situation had arisen. JH responded that it had not happened suddenly and that they had been aware of pressures with a programme of actions in place. A number of complex factors came to light which meant things needed to be escalated. It was noted that there was no evidence of any harm to patients.

c. Gail Adams (GA) mentioned the unsatisfactory recent annual Staff Survey results and felt that the Trust could make some quick wins before the next CQC inspection and offered to help support the Trust WB thanked GA offer of assistance and agreed with points made. She also asked if all

business that was discussed in private board session really needed to be private.
In response MS reported that there would be a review of Governor involvement and how this could be improved to avoid duplication with Board and Governor committees and that would fully involve Governors. MS highlighted that business transacted in private was often patient/staff sensitive or was commercially sensitive and highlighted that there was not intention to withhold information unnecessarily.

19. **Points of Reflection**
None.

20. **Date of next meeting**
Thursday 7 April 2016

St George's University Hospitals NHS
NHS Foundation Trust

Matters Arising/Outstanding from Trust Board Public Minutes
7 April 2016

Action No.	Date First raised	Issue/Report	Action	Due Date	Responsible officer	Status at 7 April 2016
7.	14 Jan 16	Quality & Performance Report	**Death of people with mental capacity issues** – identify this group in the mortality figures	7 April 16	P Vasco-Knight	Due April 2016
8.4	14 Jan 16	One Version of the Truth	6 month update	July.16	P Vasco-Knight	Due July 2016
7.3	14 Jan 16	Workforce & Performance Report	South West London Trusts – Set up shared Bank Agency. Report on the setting out the plans with a statement of memorandum	April 16	W Brewer	On agenda as part of the Workforce Report
8.3	14 Jan 16	Update on Outpatient additional activity income	The strategy had a set of trajectories and KPIs. More granular patient focused KPIs are being developed by the Outpatient Strategy Board. An update on progress .	April 16	P Vasco - Knight / R Elek	Should sit within the outpatient strategy update for April 16 Due to pressure on the agenda, has been deferred to May
4.	4 Feb 16	Minutes of previous meeting 14 Jan 16 (amendment)	Call centre performance to be looked at to aim to reduce the number of abandoned calls	TBC	P Vasco-Knight	
6	4 Feb 16	Chief Executives Report	In response to a question on primary care and GP involvement and views on strategic development it was noted that a report would be brought to the Boards meeting on 7 April 2016	7 April 16	R Elek	Due to pressure on the agenda, has been deferred to May
7.	4 Feb 16	Quality Report	Flow programme to be circulated to the Board. (Also be part of the Transformation Programme)	Feb 16	J Hall	This is OVOT which the Board have been briefed about, PID will be presented at the challenge session.
7.	4 Feb 16	Quality Report	RTT plan to be submitted to the Board to ensure the Board have a good understanding.	7 April 16	P Vasco-Knight	On the agenda
7.	3 Mar 16	Urogynaecology Report	It was agreed that the Board would receive an update in 2-3 months' time.	May / June 16	A Rhodes	
12.	3 Mar 16	Outpatients Recovery Plan Update	Outpatients Strategy due at April meeting.	7 April 16	R Elek	Due to pressure on the agenda, has been deferred to May

14.	3 Mar 16	Finance Report	Debt position NHSE and action plan	TBC	I Lynam	

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

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

Executive summary

1. Key messages

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

- Quality & Safety
- Strategic developments
- Management arrangements

2. Recommendation

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

Key risks identified:

Risks are detailed in the report under each section.

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

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

If yes, please provide a summary of the key findings

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

1. Academic Developments

3.01 Research

St George's University – Times Higher Education World University Rankings 2016-17

I am delighted to share that the University has been ranked top for 'research influence', by the Times Higher World University Rankings 2015-16. Research influence was examined by capturing the number of times a university's published work is cited by scholars, versus the number of citations a publication of similar type and subject is expected to have. To reach the findings, 51 million citations in 11.3 million journal articles published over five years were examined, and the data was drawn from 23,000 academic journals. Regarding the university's overall ranking (which considers teaching, international outlook, research etc.) St George's was ranked joint 196th in the world.

The full article can be read on the SGUL website via the following link: http://www.sgul.ac.uk/research/research-news/st-george-s-ranked-best-in-world-for-research-influence

1.02 Education and Training

Excellence in Education

On Wednesday 16th March, St George's was proud to present the second annual Excellence in Education Event, showcasing all that is good about education and training at the trust. An impressive array of educational and QI posters were judged by the Associate DMEs, and prizes went to Daniel George, Bliss Anderson, Dr Christine Fessey, Dr Richard Chavasse and Dr Anuradha Shankar (Asthma Education) for '*Best Educational Poster*' and Elaine Sheehan, Basky Thilagnathan, Sandra Linton and Asma Khalil (Evaluation of home monitoring of hypertension in pregnancy) for '*Most Innovative Quality Improvement Project'*

Professor Jenny Higham, Principal of SGUL, talked about her vision for the integration of training between the University and the trust. Professor Janet Grant then gave a challenging Keynote, showing attendees how professional experience and wisdom needed to take centre stage in the design and assessment of training.

Prizes were given to those recognised by their peers as outstanding in educational roles. These included David Palethorpe for Best Peer Group Teacher / Mentor, Jane Forman for Most inspiring Lecturer, Silvia Campo for 'Staff member who has made the biggest educational impact on my career', Deborah Bowman for Most Inspiring Non Clinical Teacher, Paul Johns for Most Inspiring Lecturer and Debasish Banerjee for Overall Contribution to Education. Divisional Contribution to Education prizes were awarded to:

- Medicine and Cardiovascular: Zoe Astrolakis, Cardiology;
- Surgery: Dominic Spray, ITU / Anaesthetics;
- Women's: Vanessa Elliott, ICU.

Lastly, a special award was made by Dr Given-Wilson to Dr Cleave Gass for his towering contribution to education and training in the trust.

Vascular Surgery and Interventional Radiology Trainees

Further to the initial update provided in the January Chief Executive's Report, work has been done to secure the Vascular and Interventional Radiology services from a staffing perspective. The headlines regarding progress are that the services are now secure from a manpower point of view, with multiple fellows and locums manning them. Physician associates and a prescribing pharmacist are now also working in Vascular. We have also identified how the services should work operate, both at a practical level and with regards to training. We hope to re-establish training, but there is work still to be done.

MDECs contracts.

All stage 1 contracts (now extended to their maximum) are due to expire in October 2016. For St George's this relates to Core Medicine, Core Surgery and Dental. We have been asked to bid for a SLA style contract to continue for a further year. It is expected that in October 2017 all bundles will then be aligned and a new process will be launched. The nature of this new process is yet to be clarified.

2. Operational Developments

2.01 Escalated Industrial Action

On 23 March 2016, trusts received an email from Daniel Mortimer, CEO of NHS Employers, informing them that the BMA had just announced that it will escalate the industrial action planned for 26 and 27 April, to remove emergency cover. As it stands therefore, details of the updated industrial action days are:

- **6 to 8 April 2016**

  Emergency care only between 8am on Wednesday 6 April and 8am on Friday 8 April (48 hours)

- **26 to 28 April 2016**

  Full withdrawal of labour between the hours of 8am and 5pm on Tuesday 26 and Wednesday 27 April (20 hours in total)

The trust will be preparing contingency plans so as to minimise the effects of the strikes on patient care.

3. Board Appointments

3.01 New members of the executive team

Community Services Divisional Chair

I would like to congratulate Alison Benincasa on her appointment as Community Services Divisional Chair. Alison has been a registered nurse since 1988 and also qualified as a health visitor in 1990. Alison joined the former Richmond Twickenham and Roehampton

Trust in 1991 as a health visitor (later became Wandsworth PCT) and worked in management roles in community services since 1992. As an employee of WPCT, Alison joined St George's when they integrated with the trust in October 2010.

As Divisional Chair, Alison is accountable for providing the strategic direction and leadership to the division to ensure delivery of all quality, safety, financial and performance metrics. By working with the Divisional Management Team, Alison will support the Directorates and Care Groups in the delivery of quality patient care; ensuring that there is effective cross-divisional and directorate working to improve patient care pathways.

Head of Governance/Chief of Staff

I am pleased to announce Luke Edwards has joined us as the new Head of Governance/Chief of Staff on 7th March. Luke joins us from the Civil Service having undertaken a variety of corporate and policy roles in the Ministry of Justice, HM Treasury, HM Revenue and Customs and most recently the Home Office. He will be focusing on supporting the Board, Council of Governors and leading our corporate governance and assurance work. Gill Hall, who been acting Trust Secretary will be supporting Luke until the end of the month to ensure a managed transition.

Director of Transformation

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

As we move into a new phase of the turnaround, Martin will be leading on the transition from a transformation programme heavily resourced by KPMG, to one supported by capacity built into the trust's own workforce. As part of this process, Andrew Burn will be handing over his responsibilities as Turnaround Director to Martin, and will finish in post at the end of March. Members of KPMG will stay beyond then, to ensure a smooth transition. I would like to thank Andrew for the enormous momentum he has generated in the turnaround programme which is bringing down our deficit each month and has successfully addressed the recommendations for improved management systems identified in the PwC report.

Director of Estates and Facilities

Eric Munro has accepted the offer of a post at Edinburgh Napier University. I would like to thank him for all of his hard work since he joined the board and wish him well in the future.

I am pleased to announce that Richard Hancock has been appointed to take over from Eric, in an interim capacity until a permanent Director of Estates and Facilities comes on board. Richard has a lot of experience in leading and running critical infrastructure portfolios and Capital Projects in central government departments, the BBC (as a member of the Estates Board) and the NHS, where he took over the Move Programme at North Bristol NHS.

Richard will be accountable for maintaining and improving our infrastructure and is keen to engage with team and representatives from all areas of the trust, to understand the challenges and to seek your views and support to take things forward together.

4. Communications

Communications update

- Scoping work is underway for an improved intranet which will be launched in the summer. Twelve focus groups were held in March with different sets of staff to understand more about what functionality and structure would be most helpful for them. Some initial technical preparations have also started, with a staging site set up.

Media update

- The Evening Standard interviewed two junior doctors at St George's about the strike. On the first day of the strike we had Reuters, Sky and the BBC reporting from outside the St George's site.
- The first ever Transcatheter Aortic Valve Implantation (TAVI) procedure has taken place in the Cayman Islands. The event was widely covered by different media in the area. The local surgical team was guided by Stephen Brecker in this game-changing operation.
- The SAFE blood test for Down's and other similar syndromes, trialled at St George's, is being recommended for use in hospitals.
- The BioMonitor 2 to help heart patients monitor their condition will be available now in the UK. Riyaz Kaba from St George's welcomed the availability of the device as it transmits patient data direct to the physician. The item appeared in a number of international journals.
  Health News featured the new hybrid theatre which recently opened at St George's on the first floor of the St James' wing. They also mentioned the development of a test for STIs trialled at St George's.
- Initial results from a new chicken pox vaccine trialled at St George's shows that the vaccine can protect 98% of children and 75% in adolescents and adults, but is only offered in the UK to children and adults who are particularly vulnerable to complications of the illness, such as those with a weakened immune system. The story was covered in the Mirror, the Independent and several other publications in the UK and abroad.
- The Clinical Services Journal reported on improved patient monitoring equipment which is being rolled out in the trust.

Social media

- There was a lot of positive feedback from the healthcare tech community and our staff about St George's Chief Clinical Information Officer, Dr Martin Gray presenting lessons learnt for clinical change at @HIMSS Leadership forum.
- 14th - 20th March was Nutrition & Hydration Week 2016. We were involved on social media by sharing facts, images from our events and sharing content posted by others. On Facebook our posts on Nutrition & Hydration Week pulled in a total reach of 1,628, 20 likes and nine comments. On Twitter, our tweets received more than 60 favourites and 40 retweets.
- We also published a post on Facebook in mid-March about Trevor from Project Search. This post has been well received by our Facebook community with a reach of over 116k, 1,500 likes, 119 shares and 89 comments. It's the best performing post we've published since January 2015.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – 7th April 2016

Paper Title:	St. George's Business Planning and Budget setting 2016/17
Sponsoring Director:	Rob Elek, Director of Strategy
Author:	Tom Ellis, Head of Business Planning
Purpose:	To update the Trust Board on development of the 2016/17 annual plan
Action required by the board:	For discussion and approval
Document previously considered by:	The content of this paper synthesises conversations at EMT and F&P and the trust board on 24th March relating to business planning and budget setting for 2016/17

Executive summary

The trust is required to submit to NHS Improvement (NHSI) an annual plan and a set of APR templates (Annual Planning Review) that detail financial plan and other key operational parameters for the organisation for the upcoming year. This submission is currently required on the 11th April.

For a number of reasons the trust is not as well advanced on the development of its plans, particularly the financial elements, as it would like to be by this stage. This paper seeks to outline the current position on business planning and budget setting and the next steps to enable the submission of a robust plan to NHSI.

It should be noted that this paper has been completed in advance of on-going work relating to business planning, to enable circulation in line with the normal board timetable. The process is very fluid at the moment, and there is a risk therefore, that some of the content of this paper may have been superseded.

The annual plan, and more recently the financial plans, have been reviewed at EMT, the trust board and F&P on 30th March. Significant challenges remain to be overcome to ensure that budgets are signed off in a timely manner. The Trust Board is asked to note:

1. That additional papers may be circulated in advance of the 7th April trust board, that provide further detail on the finances for 2016/17 as well as on the narrative annual plan
2. To discuss, challenge and agree where appropriate the content of circulated documents
3. To agree the governance relating to delegated authority for submitting the 2016/17 plan if required

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 paper outlines risks to the submission of the annual plan to the current agreed timetable of 11th April.

Related Corporate Objective: *Reference to corporate objective that this paper*	None

refers to.	
Related CQC Standard: *Reference to CQC standards that this paper refers to.*	The annual plan arguably helps the trust meet all of the 16 core standards
Equality Impact Assessment (EIA): Has an EIA been carried out? No **If no, please explain your reasons for not undertaking an EIA.** No. There should be no risks identified within this annual plan that are not already on a trust risk register of some description.	

St George's University Hospitals NHS
NHS Foundation Trust

March Trust Board
7th April 2016

Business Planning and Budget setting 2016/17

1. Introduction

The trust is required to submit to NHS Improvement (NHSI) an annual plan and a set of APR templates (Annual Planning Review) that detail financial plan and other key operational parameters for the organisation for the upcoming year. This submission is currently required on the 11th April.

For a number of reasons the trust is not as well advanced on the development of its plans, particularly the financial elements, as it would like to be by this stage. This paper seeks to outline the current position on business planning and budget setting and the next steps to enable the submission of a robust plan to NHSI.

It should be noted that this paper has been completed in advance of on-going work relating to business planning, to enable circulation in line with the normal board timetable. The process is very fluid at the moment, and there is a risk therefore, that some of the content of this paper may have been superseded.

2. Finance & Performance Committee feedback

Finance & Performance Committee F&P discussed the current business planning position and the difficulty in arriving at a truly robust set of figures for submission, linked to the issues identified in the board presentation on 24th March entitled 'Financial Position for 16/17'. F&P agreed the following key points:

- It was difficult to envisage the ability of the trust to move from its current position to a robust set of financial plans between now and the 7th, for the Board, or the 11th, when submission is due.
- This would be discussed with Monitor/NHSI by Board members week beginning 4th April, to ensure there is agreement with Monitor/NHSI about what is expected and when
- Those working on both the submissions would continue to progress them to the original timetable, as significant elements are not finance dependent, it being best practice to ensure that the submissions are complete as early as possible, and the trust may be required to make a submission on 11th April.

3. Monitor Feedback on 8th February submission

The trust submitted a draft plan and APR on the 8th February to Monitor. The submission on the 11th April builds on that draft plan, though the expectation is that the changes between the two submissions should be relatively limited.

Guidance indicated that Monitor would provide feedback on the draft submissions by the 18th March. In the event, the feedback from Monitor arrived on the 24th March. The key points of the feedback from Monitor were as follows:

- A challenge to the trust on the 16/17 forecast financial position and the figure we are aiming for. They note the trusts run rate has improved during 2015/16, and question whether meeting the control total deficit of £17.2m is ambitious enough. They also reference the difference between the control total and the figure the trust presented to Monitor on 28th January of a £5m deficit.
- Greater detail on the trusts Transformation Programme, and assurance on its deliverability
- Agreement on activity levels and trajectories relating to meeting access targets
- Workforce numbers, and phasing of changes, as well as meeting the agency cap
- Readiness for CQC, and potential preparatory costs

Much within the letter the trust can and will respond to in the updated annual plan, for example, agreement has been reached with commissioner regarding the trajectories for achieving access targets. However, the main challenge remains the forecast financial position for next year.

4. An update on some of the key requirements and issues in business planning

The draft 2016/17 Annual Plan

The annual plan remains under development, and a draft will be circulated as soon as it is possible to do so. The annual plan should be an update on the 8th February submission, not a complete re-write. Key points to note are:

- Monitor are very prescriptive about the format and content and the trust works within that
- It will outline key challenges the trust needs to address, alongside the financial imperative:
    - Addressing the trusts estate challenge, including addressing renal and the Children and Women's Hospital development and IT
    - Delivering access targets
    - Addressing the trusts wider demand and capacity challenge
    - Meeting the workforce challenge of staff recruitment and retention
- Delivering access targets – 18 week RTT, A&E 4 hour, and Cancer waits, as these are three of the nine 'must-do's'. Delivery against this links to receiving agreed STF funding of £17.6m
- The plan provides detail on the Transformation programme content
- The document is clear on the risks to delivering the proposed plan.

The Sustainability and Transformation Plan

Sustainability and Transformation Plans (STPs) are the vehicle that the NHS will be using to drive sector wide change over the coming 5 years. St. George's is in the South West London STP. The development of the STP is being co-ordinated by the SW London Collaborative Commissioning Project, utilising the system architecture in place already within the sector e.g. SWL APC, SWL & Surrey Downs Health Partnership etc. St. George's will be in a sub-regional planning group (SPRG) along with Wandsworth and Merton CCG's. This SPRG will report in to the wider STP.

The STP is required to be delivered by June 2016, an STP that runs through to 2021. The trusts 2016/17 Annual Plan is year one of this five year plan.

5. Next steps

Work is on-going to finalise the budgetary position for 2016/17, though significant issues remain unresolved e.g. the trust has no signed SLA's at this moment in time, and series of cost pressures that need to be reviewed and challenged.

It is anticipated that the key elements of the financial plan for 2016/17 will be circulated to the Board in advance of the meeting on the 7th April. If NHSI do require a submission on 11th April, the board will need to agree the governance underpinning that submission.

6. Summary and recommendations

The trust submitted a draft plan on 8th February. The trust is meant to submit a final version of the Annual Plan on the 11th April, but this deadline is looking increasingly difficult to achieve given the challenges in delivering a budget that the board can approve.

The annual plan, and more recently the financial plans, have been reviewed at EMT, the trust board and F&P on 30th March. Significant challenges remain to be overcome to ensure that budgets are signed off in a timely manner. The Trust Board is asked to note:

1. That additional papers may be circulated in advance of the 7th April trust board, that provide further detail on the finances for 2016/17 as well as on the narrative annual plan
2. To discuss, challenge and agree where appropriate the content of circulated documents
3. To agree the governance relating to delegated authority for submitting the 2016/17 plan if required

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – 7th April 2016

Paper Title:	St. George's Corporate Objectives 2016/17
Sponsoring Director:	Rob Elek, Director of Strategy
Author:	Tom Ellis, Head of Business Planning
Purpose:	The Trust Board is asked to review, comment, amend and agree the 2016/17 Corporate Objectives
Action required by the board:	For approval
Document previously considered by:	• Trust Board 24th March 2016 • EMT 21st March 2016

Executive summary

The board has clearly stated its desire to refresh the overarching strategy to ensure that the route to the future sustainability of the organisation is planned and delivered against a strategy that reflects current circumstances. The refreshed strategy is also needed to inform the wider health economy's Sustainability & Transformation Plan, due for submission in June 2016.

The agreement of the upcoming year's Corporate Objectives is a key part of the business planning cycle. The Board has agreed that there should be a limited number of focussed objectives under each of the Corporate Objective headings. Once signed off, quarterly milestones will be added.

The draft Corporate Objectives were shared in early March with the Council of Governors, along with the draft annual plan, in line with the trust's constitutional obligation to involve governors in our planning process. The Corporate Objectives presented are reflective of the Governors comments, feedback at EMT on 21st March and the Board "stocktake" undertaken on 24th March, from which a revised focus has been developed.

The trusts Corporate Objectives for 2016/17 will be grouped under the following headings:

1. Ensure the trust has an unwavering focus on all measures of quality, safety and patient experience
2. Ensure our workforce is supported and motivated, and that they understand, and are engaged with, the challenges facing the organisation
3. Deliver our Transformation Programme enabling the trust to meet its operational and financial targets
4. Refresh the trust's strategy, to develop a sustainable service model with a clear and consistent message
5. To develop and deliver programmes of education and research that attract students and grow the St. George's brand
6. Ensure we make the most of our buildings and estate, and maximise efficiency through improving back office and corporate functions

This paper outlines what the individual actions are that will be undertaken under each of these headings against the following overarching statement of intent:

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?

Many objectives directly address current trust risks and as such are potentially controls or mitigations for current risks. It is not felt that any corporate objectives directly increase or add new risks to the trust. When approved, the Corporate Objectives will be reviewed against the new Corporate Risk Register to ensure appropriate cross-referencing.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	None
Related CQC Standard: *Reference to CQC standards that this paper refers to.*	The corporate objectives arguably help the trust meet all of the 16 core standards, but the following would be explicitly addressed through their production. Outcome 1: Respecting and involving people who use the services Outcome 4: Care and welfare of people who use the services Outcome 6: Cooperating with other providers Outcome 8: Cleanliness and infection control Outcome 10: Safety and suitability of premises Outcome 11: Safety, availability and suitability of equipment Outcome 12: Requirements relating to workers Outcome 13: Staffing Outcome 14: Supporting workers Outcome 16: Assessing and monitoring the quality of service provision

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

If no, please explain your reasons for not undertaking an EIA.
No, not at this stage. Once the Corporate Objectives have been approved, and following the cross-referencing with the Corporate Risk Register, a decision will be taken about whether they are required for each objective and associated action and if so, who and how that will be progressed.

St George's University Hospitals NHS
NHS Foundation Trust

Trust Board
Thursday 7th April 2016
St. George's Corporate Objectives 2016/17

a) Introduction

2015/16's Corporate Objectives were articulated within the seven strategic themes developed in the 2012 Trust Strategy. However, the 2015/16 objectives are perceived as 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 to ensure that the route to the future sustainability of the organisation is planned and delivered against a strategy that reflects current circumstances. The refreshed strategy is also needed to inform the wider health economy's Sustainability & Transformation Plan, due for submission in June 2016.

The agreement of the upcoming year's Corporate Objectives is a key part of the business planning cycle. The Board has agreed that there should be a limited number of focussed objectives under each of the Corporate Objective headings. Once signed off, quarterly milestones will be added.

The draft Corporate Objectives were shared in early March with the Council of Governors, along with the draft annual plan, in line with the trust's constitutional obligation to involve governors in our planning process. The Corporate Objectives presented are reflective of the Governors comments, feedback at EMT on 21st March and the Board "stocktake" undertaken on 24th March, from which a revised focus has been developed.

The board is asked to review and agree the 2016/17 overarching statement of intent and the Corporate Objectives outlined below.

b) Revised focus

The board consensus was that whilst the past year has been very difficult, the coming year presents an opportunity to reset the narrative and engage with staff, patients and stakeholders in a much more proactive manner.

The key actions relate to:

1. Developing a clear and compelling message that simply articulates what happened last year, without shrinking from both the internal and external factors which caused the financial and operational pressures.
2. Refreshing our strategy to create clarity of purpose and a 'golden thread' that runs throughout our plans and communications.
3. Acknowledging the historic underinvestment in infrastructure, and developing affordable and deliverable plans to improve the estate environment and IT at pace.
4. Delivering operational and financial sustainability through the transformation programme, but acknowledging that progress will be highly dependent on getting the basics right first.
5. Rigorous prioritisation of objectives and actions, and transparent progress monitoring, at every level of the organisation

c) 2016/17 Statement of Intent

The following over-arching Statement of Intent has been developed to encapsulate the organisations focus for 2016/17:

"To support our committed staff to focus on getting the basics right, particularly by investing in our estate and IT infrastructure - ensuring the continued excellence of clinical services for our patients; and to address operational and financial performance challenges, through the implementation of our transformation programme"

d) Draft 2016/17 Corporate Objectives

Objective Title	**Ensure the trust has an unwavering focus on all measures of quality, safety and patient experience**
Lead Director/s	Jennie Hall, Chief Nurse & Director of Infection Control – Quality & patient experience Paula Vasco-Knight, Interim Chief Operating Officer – Target delivery
Actions	1. To develop and implement a Quality Plan for 2016/17 that measurably improves the outcomes of care, including delivery of the NHS Constitution and Mandate standards 2. To ensure the trust is ready for the rigours of a CQC inspection, to welcome the outcomes of the inspection and transparently address any areas of weakness identified. 3. To identify indicators for patient experience where the trust currently scores poorly, and identify and implement remedial actions to deliver a quantifiable improvement in patient experience for those areas 4. To continue to develop the Patient and Public Involvement programme, ensuring the trust is open and accountable to patients, general public, members and governors. 5. To implement the recommendations of the National Maternity review 6. To meet the national requirements around 7 day working in the four clinical priority areas: Time to first consultant review; Access to Diagnostics; access to Consultant-directed Interventions; and consultant review of acutely ill patients 7. To deliver all access targets – A&E 4 hour, 18 week referral to treatment for elective work, Cancer 62 day and other targets – in line with national guidelines and the agreed trust trajectories

Objective Title	**Ensure our workforce is supported and motivated, and that they understand, and are engaged with, the challenges facing the organisation**
Lead Director	Wendy Brewer, Director of Workforce & Organisational Development
Actions	1. To understand and address the issues identified in the 2015 staff survey, as well as other surveys or indicators of staff engagement, experience and satisfaction 2. To focus on understanding the drivers for staff turnover, which will in turn inform measures that will help retain our most valuable asset 3. To drive performance on mandatory and statutory training, appraisal and other key workforce requirements and indicators 4. To develop meaningful two-way communication with all staff groups, through a refreshed communications strategy

Objective Title	**Deliver our Transformation Programme enabling the trust to meet its operational and financial targets**
Lead Director	Martin Wilson, Director of Transformation – Transformation Iain Lynam, Interim Chief Financial Officer – Financial Targets
Actions	1. To deliver the Clinical Transformation Programme, leading to radical and measurable changes in the way St. George's delivers healthcare and improved patient experience. Key to these are: a. Outpatients – improving systems and processes to enhance: patient experience; GP satisfaction; clinic utilisation and overall trust efficiency b. Flow – treating patients faster, and improving their discharge out of hospital thereby freeing up beds c. Diagnostic – utilising diagnostic capacity more fully, minimising downtime and matching diagnostic capacity to demand d. Theatres – delivering more activity through the same number of theatres by starting earlier, better scheduling and extending to a three session day and more weekend working 2. To deliver the workforce efficiency programme, reducing pay costs through a range of actions including the active management of agency staff 3. To ensure the trust meets its financial targets for 2016/17, delivering the agreed Monitor control total of £17.6m deficit 4. To have an IT programme that addresses the basics as well as develops the use of ICT to support clinical care 5. To identify and maximise the opportunities for Out of Hospital Healthcare to both prevent admissions and speed discharges

Objective Title	**Refresh the trust's strategy, to develop a sustainable service model with a clear and consistent message**
Lead Director	Rob Elek, Director of Strategy
Actions	1. To refresh the trust strategy, engaging with staff in its development, with an end product that is easily understood and communicated both internally and externally 2. To develop our 5 year strategic plan, submit to NHSI and begin implementation 3. To review the profitability of all clinical services, acting where service costs exceed income, including working with commissioners to ensures appropriate funding 4. To shape the Sustainability & Transformation Plan (STP) for south west London and - post June submission - to ensure St. George's positively drives implementation internally and across south west London 5. To identify and develop opportunities outside of the south west London STP, ensuring our strategic plans take appropriate account of St. George's role as a specialist provider 6. To continue to develop and implement the Cancer Vanguard programme 7. To scope and grow the commercial income for the trust by identifying clinical or other skills within the trust, e.g. pharmacy, and utilising these to support the overall delivery of NHS services

Objective Title	**To develop and deliver programmes of education and research that attract students and grow the St. George's brand**
Lead Director	Simon Mackenzie – Medical Director – Research Wendy Brewer – Director of Workforce & Organisational Development - Education
Actions	1. To work with SGUL to grow and expand the research portfolio at the trust, and associated funding, by a measurable amount 2. To continue to explore new models of service delivery, including the potential creation of additional Clinical Academic Groups 3. To work with St George's University and other higher education institutes to ensure high quality undergraduate placements 4. To work with St George's University to develop a quality assurance and branding process for education and training programmes offered by the two institutions 5. To take steps to ensure that the trust is in a good position to provide high quality education to nursing and AHP students following the changes in the commissioning and funding processes 6. To ensure that the education offered, both to students and staff, is of the first order, and that education income grows at the Trust

Objective Title	**Ensure we make the most of our buildings and estate, and maximise efficiency through improving back office and corporate functions**
Lead Director	Richard Hancock – Director of Estates & Facilities - Estates Martin Wilson – Director of Transformation – Back office
Actions	1. To undertake a Six Facet Survey of the Tooting site, and to develop a work plan in response to the outcomes of that survey, including the potential re-prioritisation of the Trust capital programme and bids for additional capital monies from the Department of Health to ensure the trust estate is fit for purpose 2. To review the total trust estate, ensuring that the trust is using its estate as efficiently and effectively as possible, including vacating buildings where clinically appropriate 3. To develop solutions for services occupying the most inadequate parts of our estate, particularly renal and children's 4. To identify realistic savings from the benchmarking undertaken by Lord Carter, delivering on those opportunities and on further savings via an investment in / restructuring of the Procurement Function at St. George's. 5. By working differently, and in conjunction with other health organisations, to reduce our spend on back office functions whilst not affecting quality

REPORT TO THE TRUST BOARD – 7 April 2016

Paper Title:	**Financial Plan 2016/17**
Sponsoring Director:	Iain Lynam, Interim Chief Financial Officer
Author:	Anna Anderson, Interim Director of Financial Performance
Purpose:	To inform the Board about the progress on completing the financial plan for 2016/17, to obtain approval for expenditure, and to comply with the SFIs
Action required by the board:	For comment, to approve expenditure in April and May, and to agree the further action required to finalise the plan
Document previously considered by:	Finance and Performance Committee

Executive summary

The short paper provides an update on financial planning for 2016/17.

As is the case in most parts of the country, the Trust has not yet agreed SLAs with commissioners. Work on savings plans is progressing but plans are not yet complete and further decisions are needed to finalise baseline budgets particularly to reduce pay budgets to reflect the Trust's likely ability to recruit staff. Discussions have started with NHS Improvement to secure additional funding to support work to address key estates and IT issues which are impacting adversely on the quality of care for patients and the Trust's ability to operate efficiently.

The aim is to bring the final Operating Plan, including the financial plan, to the board for approval in May.

In the meantime the board is asked to approve spending in line with 2/12 of the revenue and capital budget in the first two months of the year. This is to ensure the Trust is not acting ultra vires and in breach of its SFIs.

Key risks identified:

The need to balance financial measures with maintaining the quality of patient care and achieving key service targets.

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

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

No specific groups of patients of communities will be affected by the items in this report. Where there may be an impact on patients, consultation will be managed as part of that specific programme.

Trust Board meeting 7 April 2016

Progress update on draft financial plan for 2016/17

This short paper summarises the current assessment of draft budgets for 2016/17 and the key assumptions underpinning the draft. It also asks the board to approve an overall level of spending for April and May to cover the period until a final budget can be agreed in May.

Basis of draft financial plan

Income and expenditure budgets

The overall assumptions are as follows:

- The Trust plans to achieve a deficit of £17.2m in line with the control total issued by Monitor and in line with the draft Operational Plan submitted to Monitor in February. This level allows the Trust to access £17.6m of Sustainability and Transformation Funding
- SLAs with CCGs and NHSE are not agreed yet so income levels are based on an estimate of the most likely outcome.
- A target level of additional SLA income above sums agreed with CCGs of £18.4m.
- £50m of savings will be delivered, this is a gross figure and the costs of achieving the savings plan are budgeted separately.
- The £50m savings target includes the profit from expected asset sales.
- Established posts and draft pay budgets will be reduced to reflect the Trust's expected ability to recruit staff in line with experience in 2015/16.
- Ward nursing budgets are based on the recent nursing establishment review with an allowance for use of temporary staff where needed and reflecting likely ability to recruit.
- Only business cases supported by CCGs are included.
- Only capacity/flow investments supported by specific CCG funding are included.
- There is a 1% contingency.
- £9.6m income and expected costs, are included to meet RTT trajectories.

The Trust is in discussion with NHS Improvement about securing additional funding to address backlog estates and IT issues. The costs and impact of undertaking this work have not yet been firmed up or agreed and these are not included in the draft budget.

Over the next 4 weeks these plans need to be finalised. The key actions required are:

- Finalise SLAs with commisssioners and Trust income target above SLA values.
- Agree establishment/vacancy reductions to base budgets to reflect a realistic level of recruitment.
- Finalise savings so that detailed delivery plans are completed and savings are delivered. Adjust detailed budgets for finalised operational delivery plans.
- Ensure changes from the 2016/17 reforecast exercise (TRP2) are understood and tested.

- Review recently agreed business cases to test whether they make sufficient contribution.
- Ensure budgets agreed support the delivery of key service targets and high quality care for patients.

Capital

The capital programme will need to be amended to cover essential backlog estates/IT investment when the scale of this, and funding, is clearer.

Cash

Further work will be needed once the income and expenditure position is clearer to ensure appropriate cash management arrangements can be put in place.

Approval of expenditure

SFI 13.1 requires the board to agree a budget before the start of each financial year. As a final budget is not yet available, the board is asked to authorise revenue spending in April and May of up to £61.8m/month, this is based on 1/12 of the draft plan. The board is also asked to approve spend of £5m capital in the first 2 months of the year.

AMA 5 April 2016

2016/17 Financial Plan - work in progress as at 5 April 2016

All values shown are current estimates/judgements or work in progress

	Forecast outturn 15/16 £m	Reforecast 16/17 £m	Draft budget 16/17 £m
Income			
CCG/NHSE SLA agreement likely values	608.7	650.9	638.2
Adjust to 85% achievement of CQUIN			-2.2
Challenges and penalties	-10.3	-10.1	-9.0
Capacity and flow funding	6.6		1.7
ex SLA income for projects/posts	5.9	7.6	3.6
Local income target			18.4
	610.9	648.4	650.7
Non NHS clinical income (private patients, Gibraltar)	10.6	10.0	10.2
Sustainability and Transformation Funding			17.6
Other income	99.2	91.2	95.7
Total income	720.7	749.6	774.2
Expenditure			
Pay	-456.2	-475.0	-470.6
Non pay	-284.4	-292.7	-301.0
Cost pressures			-7.1
Transformation costs			-7.7
Savings target		46.3	50.0
Pay awards		-12.3	-12.3
Contingency 1%		-7.5	-7.5
Total expenditure	-740.6	-741.2	-756.2
EBITDA	-19.9	8.4	18.0
Non operating costs (depreciation, interest, dividend etc)	-34.1	-35.2	-35.2
Net deficit	-54.0	-26.8	-17.2

St George's Healthcare NHS
NHS Trust

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

Paper Title:	**2016/17 Access Target Trajectories** Part 1 - Overview and flow plan Part 2 - RTT recovery and sustainability
Sponsoring Director:	Paula Vasco-Knight – Interim Chief Operating Officer
Authors:	Head of Performance McKinsey and Company Divisional Directors of Operations
Purpose:	To inform Board about access target trajectories submitted for 2016/17.
Action required by the board:	To note the report and key assumptions and caveats to delivery noted.
Document previously considered by:	Finance and Performance Committee

Executive summary

The trust was required to submit trajectories for performance delivery against the four key national access targets. Following a period of review and approval from commissioners, the trust submitted trajectories on 18/03/2016. These trajectories are now under-review with NHSE-London and NHSI for scrutiny and approval. Key headlines in relation to envisaged recovery and compliance are:

- ED 4 hour standard – 95% compliance to be achieved from February 2017 onwards.
- RTT Incomplete pathways standard – 92% compliance to be achieved at an overall trust level from March 2017.
- Cancer 62 day standard – 85% compliance to be achieved and maintained from April 2016.
- Diagnostics 6 Weeks standard – less than 1% of patients waiting greater than 6 weeks for a diagnostic appointments compliance to be maintained throughout 2016/17.

risks identified:

Caveats to delivery and dependencies detailed within the reports.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	

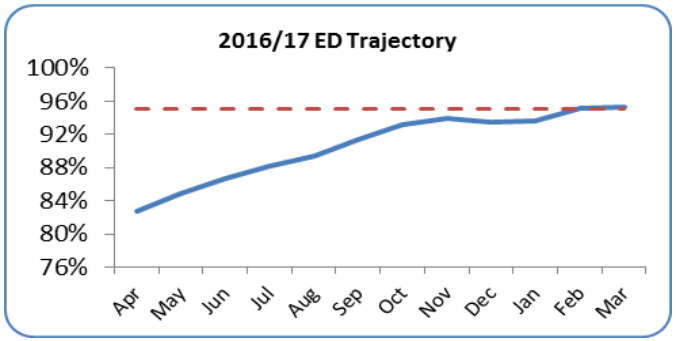
Equality Impact Assessment (EIA): Has an EIA been carried out?
If no, please explain you reasons for not undertaking and EIA. Not applicable

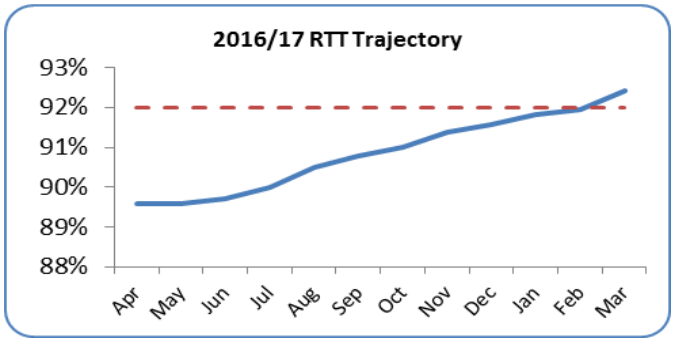
Trajectories- St Georges Hospital NHS Foundation Trust

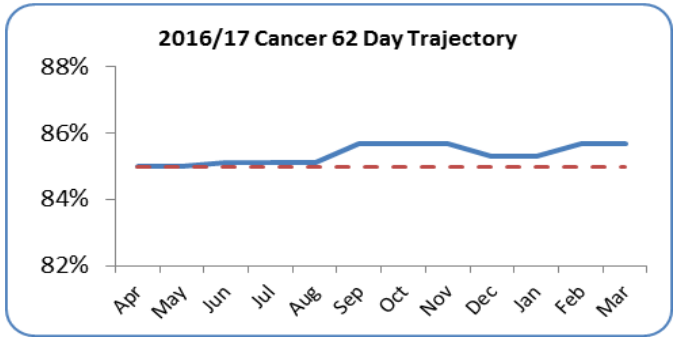
- Diagnostics
- Cancer
- 18 weeks Referral to Treatment
- Emergency Care (ED)

SGH 2016/17 TRAJECTORIES SUBMISSION – 18/03/2016

Standard	Target	2016-17 (%)											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E	95%	82.70%	84.80%	86.60%	88.10%	89.40%	91.30%	93.10%	93.90%	93.40%	93.60%	95.10%	95.20%
RTT	92%	89.60%	89.60%	89.70%	90.00%	90.50%	90.80%	91.00%	91.40%	91.57%	91.82%	91.96%	92.43%
Cancer - 62 Day	85%	85.00%	85.00%	85.10%	85.10%	85.10%	85.70%	85.70%	85.70%	85.30%	85.30%	85.70%	85.70%
Diagnostics	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%







2016/17 Access Target Trajectories

The trust was required to submit trajectories for performance delivery against the four key national access targets. The trajectories as detailed earlier have been reviewed and agreed with commissioners, and are currently under review with NHSE-London and NHSI. The trust has submitted the trajectories with compliance to be achieved as follows:

- ED 4 hour standard
  - ED trajectory is based on action plan following OVOT programme with McKinsey and Company.
  - 95% compliance to be achieved from February 2017 onwards.

- RTT Incomplete pathways standard
  - RTT trajectory is based on demand and capacity work undertaken with the IST and supported by commissioners. An operational recovery plan to support the trajectory is currently in development.
  - 92% compliance to be achieved at an overall trust level from March 2017.

- Cancer 62 day standard
  - Cancer trajectory is based on delivery of agreed performance and sustainability action plan and continued delivery of compliance in Q1 2016/17 from agreed Q4 trajectory as part of the plan.
  - 85% compliance to be achieved and maintained from April 2016.

- Diagnostics 6 Weeks standard
  - Diagnostics trajectory is based on continued performance delivery from existing position and in line with agreed activity forecasts.
  - less than 1% of patients waiting greater than 6 weeks for a diagnostic appointments compliance to be maintained throughout 2016/17.

Key assumptions and caveats to delivery

ED

-no further growth in attendances beyond forecast.

-no further growth in admissions beyond forecast.

-Flow scheme funding is required to be maintained.

- Dependency of delivery of external system workstream initiatives which will contribute to a reducing demand/attendances, improving flow by facilitating discharge and releasing occupancy.

- Implementation of OVOT action plan to prescribed timescales, and timely benefit realisation of workstream initiatives as set out in the plan

.

-Unexpected/out of variation winter pressures.

RTT

- referral growth remain stable throughout the year in line with forecasted demand.

- Theatre maintenance programme being delivered within planned timescales (i.e. no slippage).

- Agreement and mobilisation of operational recovery plan by end of April 2016.

- PTL process improvement work with IST on-going. Trajectory will need review by the end of Q1 to reflect the findings of this work and the operational plan for backlog reduction.

-Trust being able to recruit additional or existing vacancy consultant posts as set out in the roadmap timescsales.

-Where required additional external capacity is able to be identified and procured.

- activity levels for specialised commissioning not yet agreed. These will need adding back as an overlay to the Q1 trajectory review.

-ability to mobilise additional capacity and commissioner affordability.

-IST RTT technical review commenced in February 2016. The Trust is awaiting the outputs of the review. Therefore, there may be a level of impact not yet known if adjustments to exclusion criteria are required.

Executive summary of trajectory forecast for St. Georges FT A&E performance

This forecast trajectory has been constructed to model the impact of improvement initiatives being delivered as part of the 'Flow Programme' across the St.Georges/Wandsworth/Merton health system. The accompanying Excel spreadsheet contains the numerical outputs of the modelling and this slide pack illustrates the key assumptions used to construct the trajectory.

The approach involves assigning impact on breach reduction to linked 'bundles' of initiatives which are then phased according the current expectations of timetable for implementation. A further assumption is made of the rate of achievement of the full impact by estimating the time in the lifetime of each initiative that 25%, 50%, 75% and then the full impact is achieved. These assumptions are illustrated on slide 2 and the impact on breach numbers shown on slide 3.

This pack also shows the assumptions that have been made on ED Type 1 attendances and emergency admissions via A&E for the St. Georges site on slides 4 and 5.

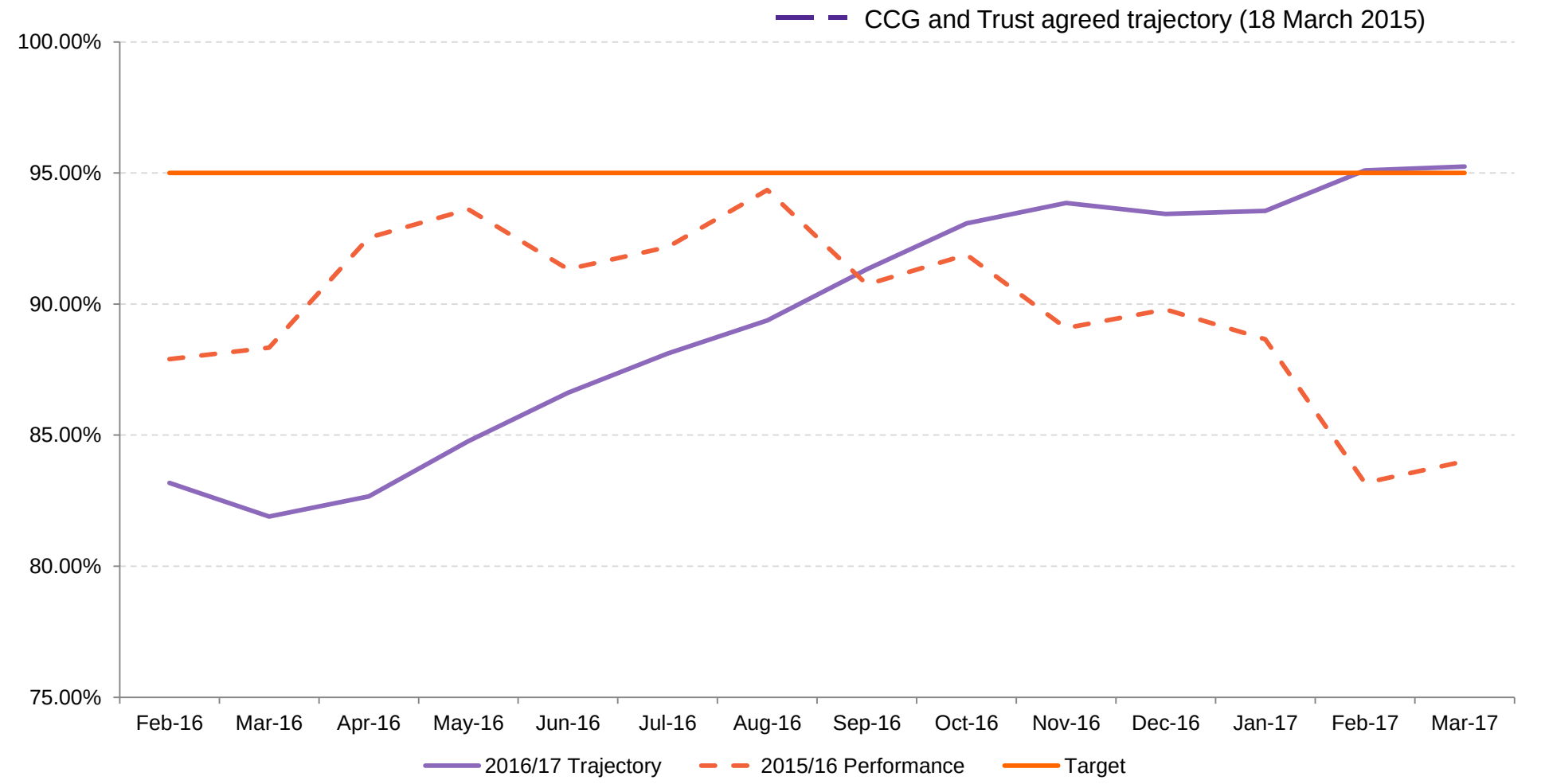
Whilst this approach already yields a detailed and relatively sophisticated approach, there are two known areas of clarity that could further aid an understanding of trends and risk:

1. No detailed forecasts of bed occupancy have been used to underpin the model. The assumption is that occupancy will repeat the pattern of 2015/16, whereas if there is a specific capacity and occupancy model to be applied this could be included in the set of assumptions
2. The model is silent on whether a specific group of capacity schemes will be implemented or maintained in 2016/17 as the CCG and Trust have not reached a final decision on these at the time of submission (noted in the text box on slide 2)

Performance against trajectory to March 2016

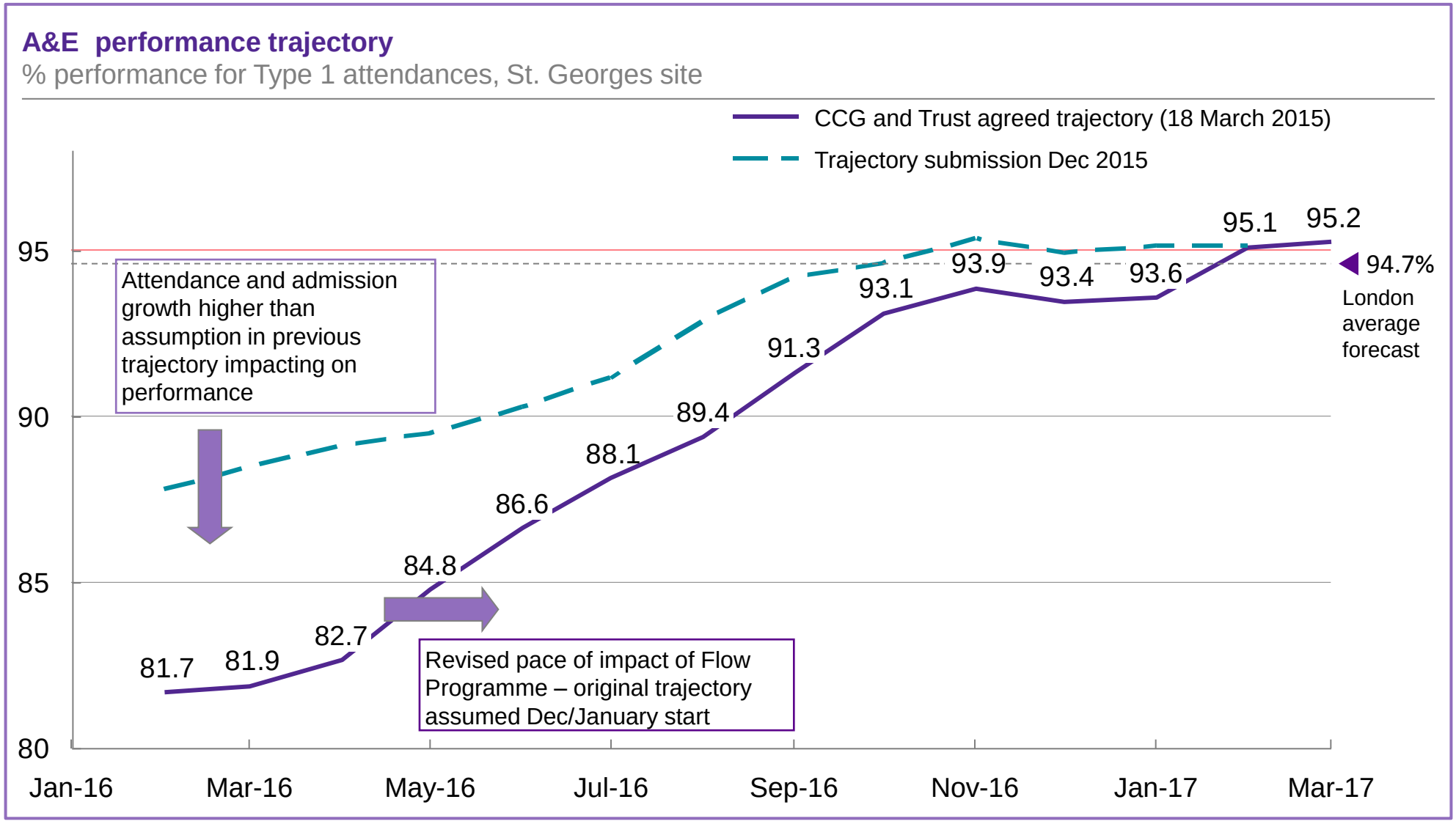
A&E performance trajectory and actual performance

% performance for Type 1 attendances, St. Georges site



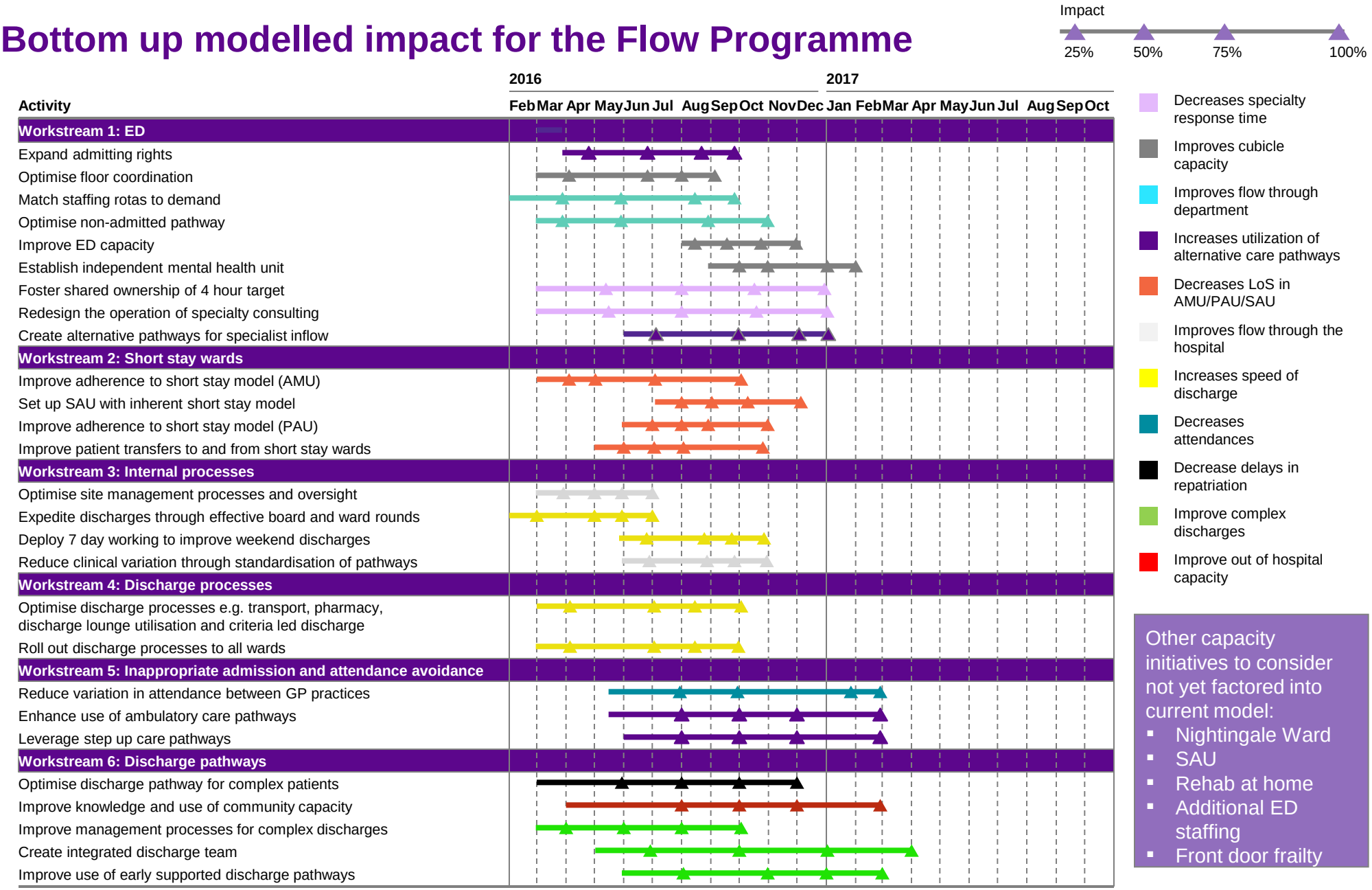
SOURCE: Trust performance trajectory model

A&E trajectory agreed by CCGs and St. Georges FT



SOURCE: Trust performance trajectory model

Bottom up modelled impact for the Flow Programme



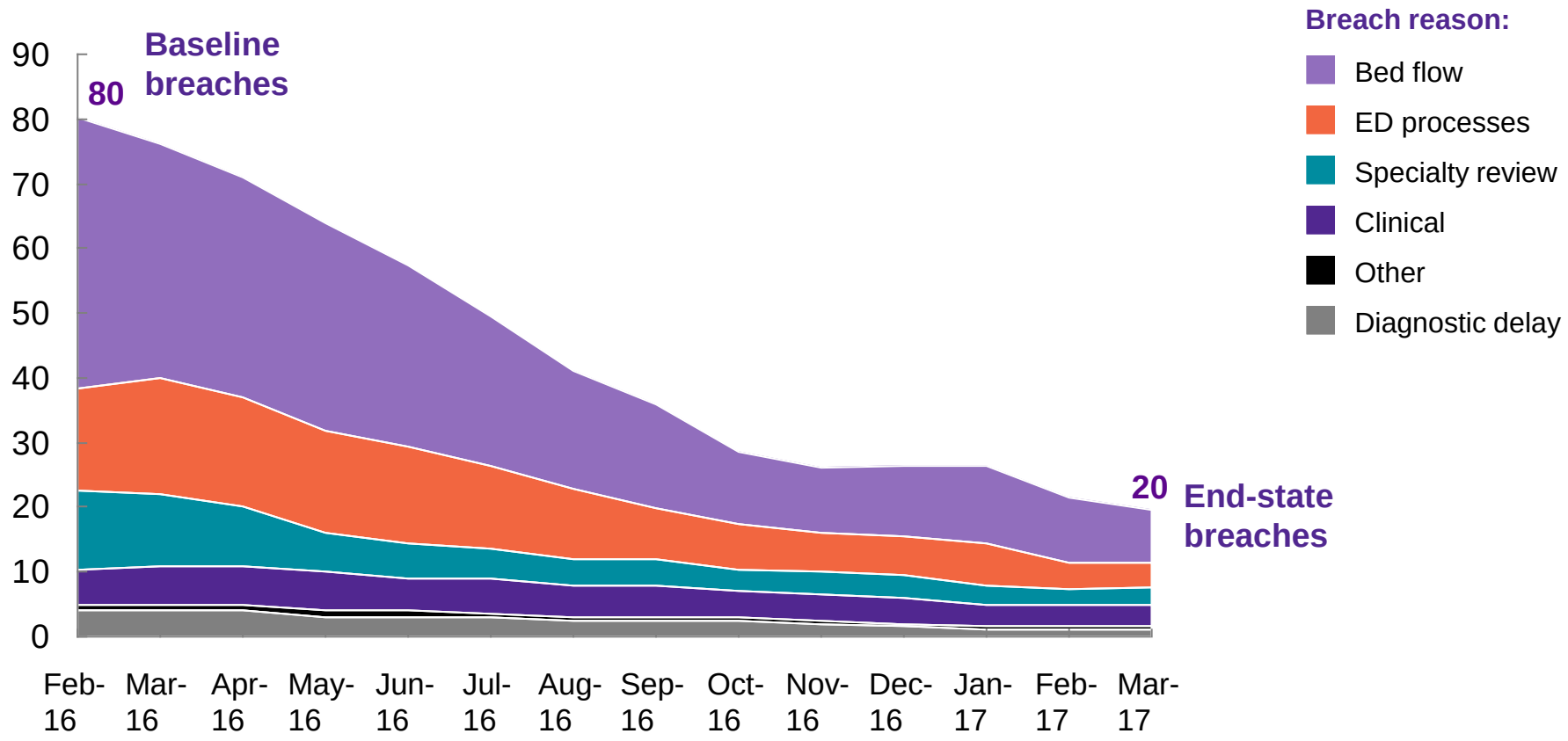
Other capacity initiatives to consider not yet factored into current model:

- Nightingale Ward
- SAU
- Rehab at home
- Additional ED staffing
- Front door frailty

Number of Type 1 breaches based on timing of initiative impact assumptions

Breach numbers change as implementation of initiatives drives impact

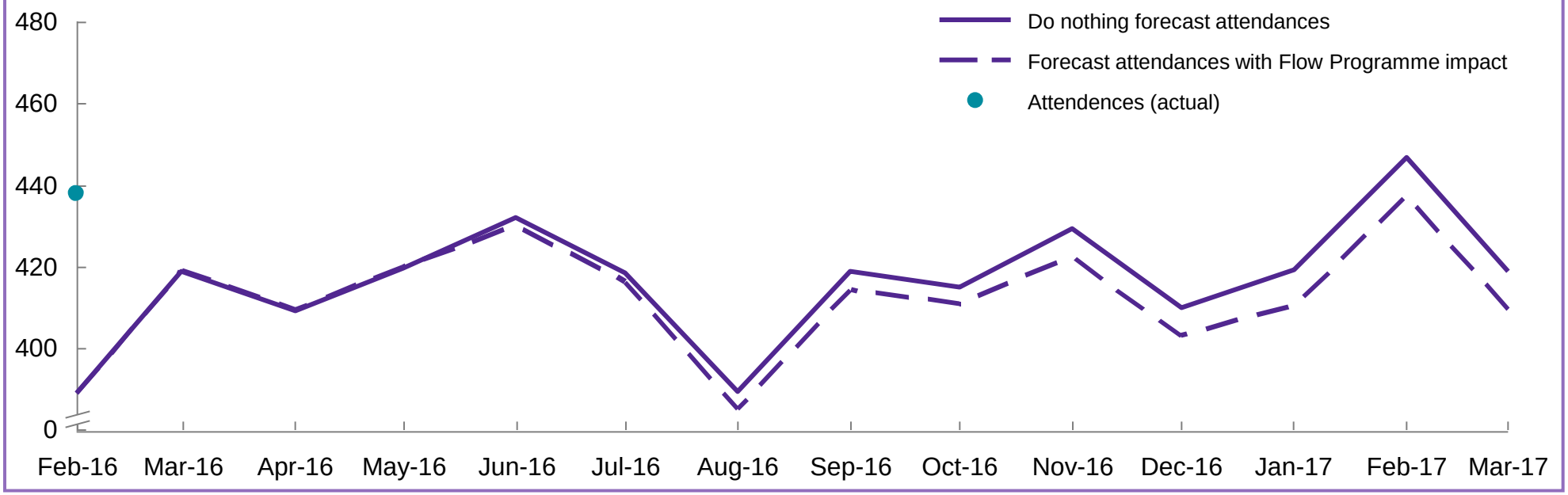
Mean # breaches/day



SOURCE: Trust performance trajectory model

Trajectory assumption on trends in A&E Type 1 attendances

Mean number of daily attendances for Feb 2016 – Mar 2017[1], #



Avg. daily attendances	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2016	Feb 2017	Mar 2017
Do nothing forecast attendances[2]	390	419	409	420	432	419	390	419	415	429	410	420	447	419
Forecast attendances after impact[3]	390	419	409	420	430	417	386	415	411	423	404	411	438	410
Actual mean daily attendances	438	-	-	-	-	-	-	-	-	-	-	-	-	-

1 Average daily Type 1 attendances by month 2 Assumes 2015 admissions grow by 3.7% in 2016 3 Do nothing forecast with Flow Programme impact applied

SOURCE: Trust Information Services, St Georges University Hospital

excellent /
kind /
responsible /
respectful /

St George's University Hospitals NHS
NHS Foundation Trust

NHS
Wandsworth
Clinical Commissioning Group

NHS
Merton
Clinical Commissioning Group

NHS
Lambeth
Clinical Commissioning Group

Update to SRG subgroup

FLOW PROGRAMME

22nd March 2016

Contents

Drivers of performance in the last two weeks and lessons learned

Extract from ED performance dashboard for w/c 14/03/2016

Performance	
Last week	86.14%
Month to date	83.93%
Quarter to date	85.22%
Year to date	90.24%

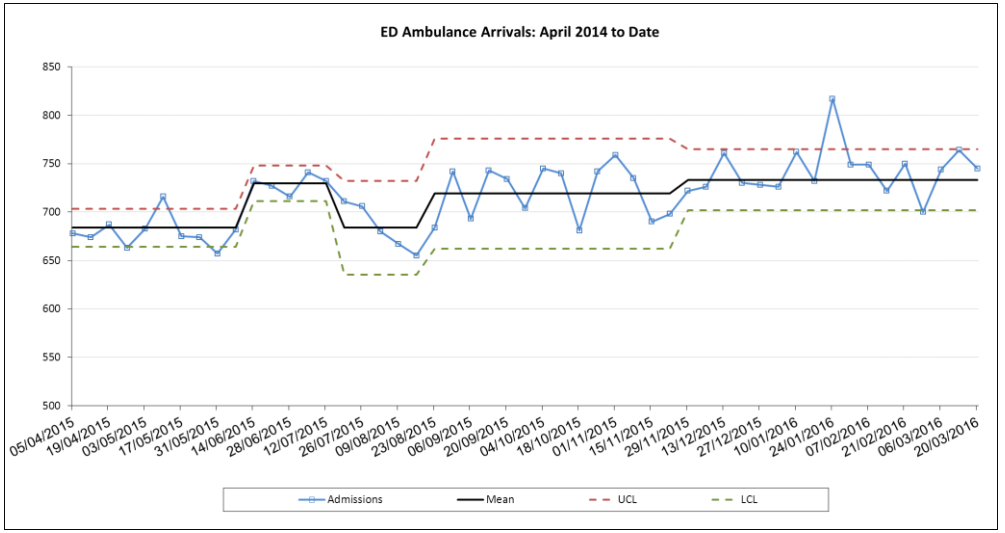
Presentation & Flow	Last week	YTD
Total Type 1 attends	3101	
Total ambulances	745	
Total over 70	389	
Admissions (all)	853	
Conversion rate	27.51%	
Admissions (excl CDU, AAA)	617	
Conversion rate (excl CDU, AAA)	19.90%	
DToC (bed days)	119	
0-1 day AMU LoS	45	

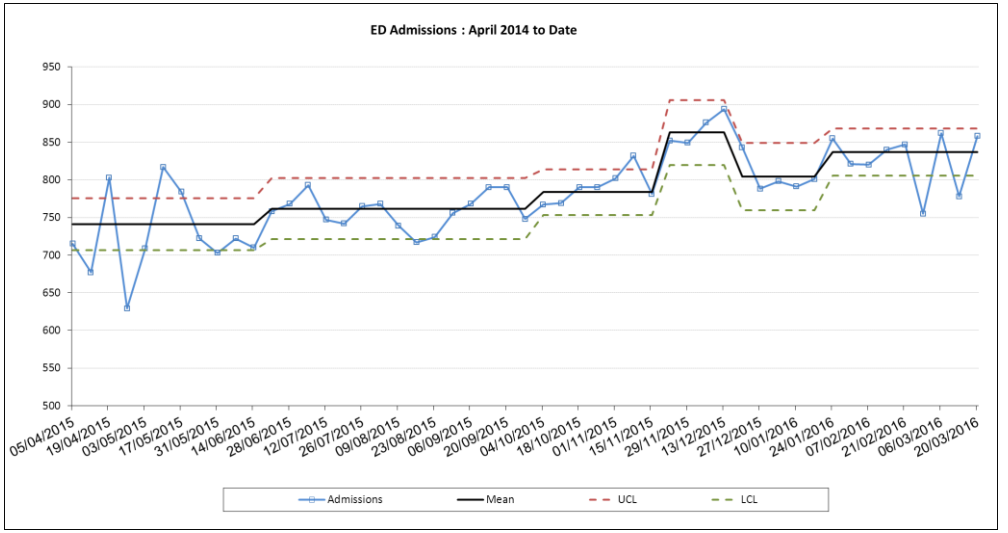
Breach reasons	Number		%				
	Last week	YTD	Last week	YTD	Mean YTD	Tolerance	vs YTD
A&E assessment	28		5.93%		9.31%	13	
A&E referral	19		4.03%		4.21%	6	
Bed_Management_Female	79		16.74%		11.01%	15	
Bed_Management_Male	83		17.58%		11.00%	15	
Clinical Exception	11		2.33%		5.21%	7	
ED capacity	101		21.40%		18.78%	26	
Mental Health	13		2.75%		4.25%	6	
Other	8		1.69%		1.80%	3	
Patient Factors	2		0.42%		0.95%	1	
Patient Transport	3		0.64%		0.91%	1	
Treatment Decision	51		10.81%		12.25%	17	
Delay Social Services	0		0.00%		0.14%	0	
Waiting_for_diagnostic	12		2.54%		4.70%	7	
Waiting_for_specialist_opinion	62		13.14%		15.48%	22	
Grand Total	472		100.00%		100.00%	140	

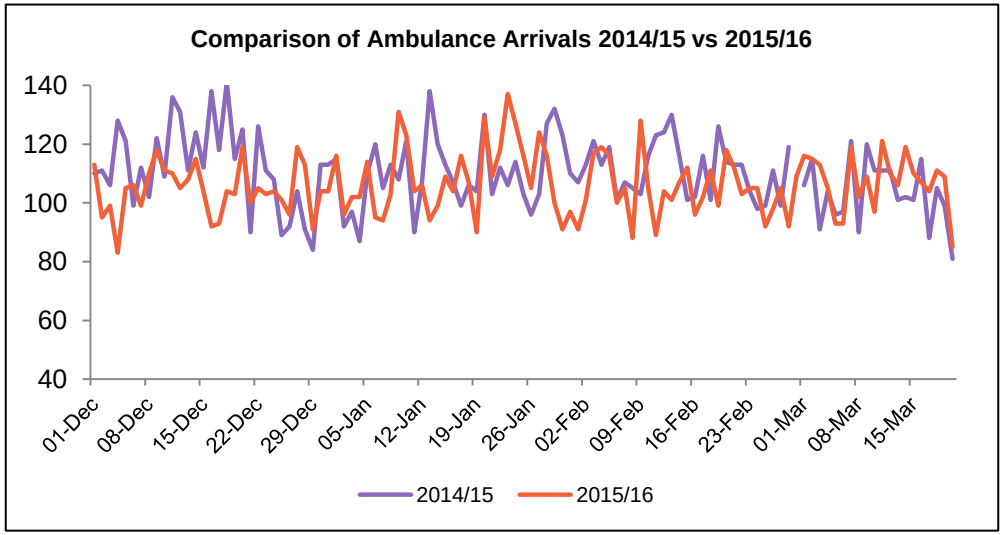
- Continued high attendances (7 of last 8 weeks have had >3000 type 1 attends)
- Conversion rates stable, therefore higher number of admissions
- Breaches predominantly driven by bed management and ED capacity, followed by specialist opinion and treatment complexity

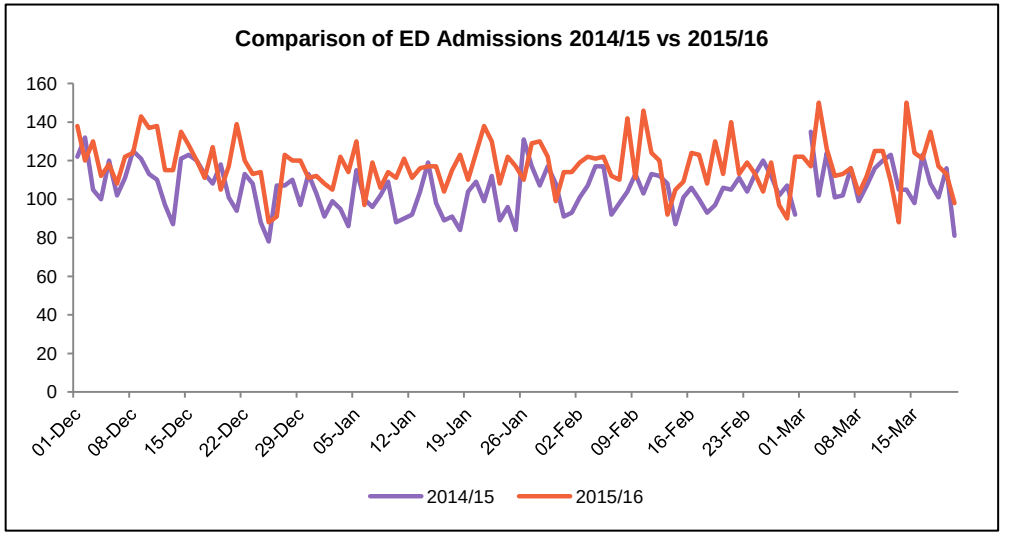
SOURCE: Source

Trends: Ambulance Arrivals and Admissions via ED



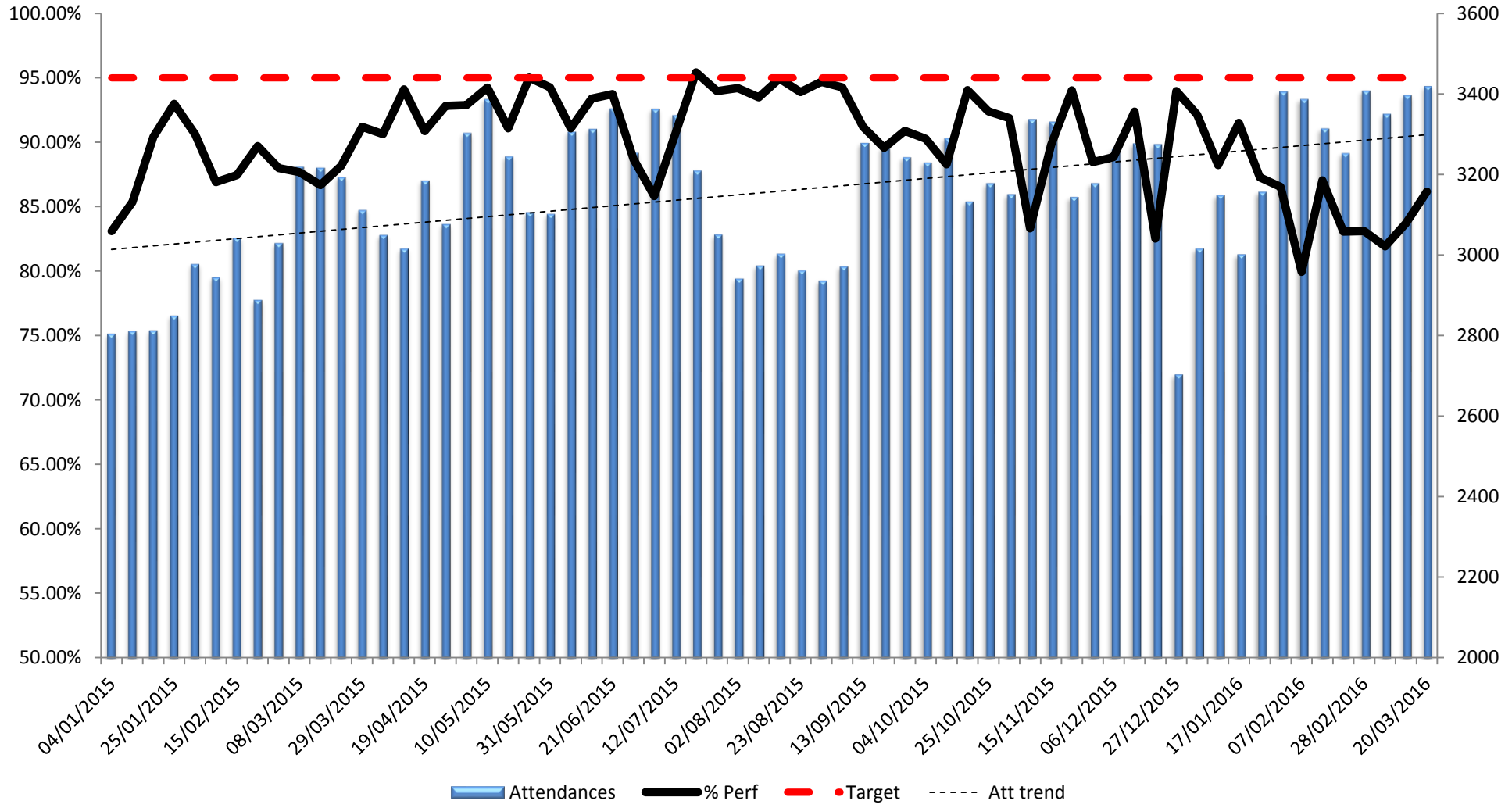






Both attendances and breaches are higher than the same time period last year

Performance and Attendances by Week January 2015 to date



Key metrics & the national picture

Average daily attendance:
- 1st Jan-14th Mar 2016: 427
- 1st Jan-14th Mar 2015: 381

National ED performance in January 16 was 88.7% compared to 91.0% in December 15 and 91.2% in January 15;

SGHFT A&E performance in January 16 was 88.3% compared to 89.8% in December 15 and 89.1% in January 15;

Average daily breaches:
- 1st Jan-14th Mar 2016: 68
- 1st Jan-14th Mar 2015: 50

National 175,000 more A&E attendances were seen in the month compared to January 15, an increase of over 10%;

SGHFT A&E 1,349 more A&E attendances were seen in the month compared to January 15, an increase of over 10%;

Average daily ambulance arrivals:
- 1st Jan-13th Mar 2016: 107
- 1st Jan-13th Mar 2015: 98

National There were 484,568 emergency admissions in January 16 an increase of 4.6% from January 15;

SGHFT A&E There were 3159 emergency admissions in January 16 an increase of 5.6% from January 15;

Average daily admissions:
- 1st Jan-13th Mar 2016: 116
- 1st Jan-13th Mar 2015: 101

National In January 16 1,690,633 patients were seen within the 4-hour target, 112,000 more than in January 15;

SGHFT A&E In January 16 12,408 patients were seen within the 4-hour target, 1,144 more than in January 15;

National There were 158 over 12-hour trolley waits compared to 650 in January 15.

SGHFT A&E There were 0 over 12-hour trolley waits compared to 0 in January 15.

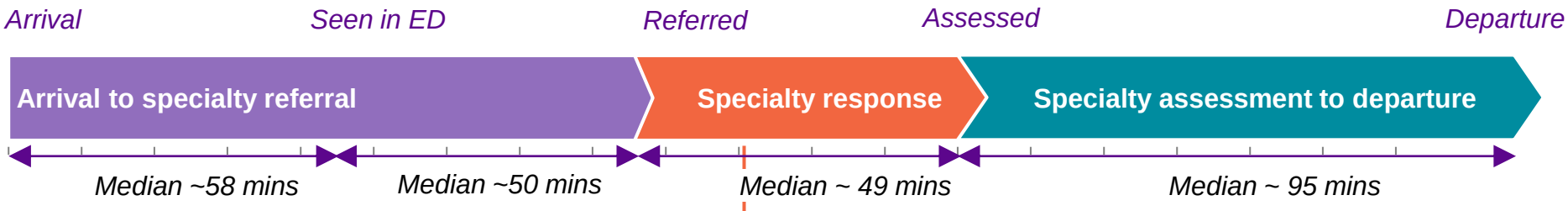
Contents

- Performance tracking
- **Selected Flow initiative updates**
  - **Specialty review**
  - Daily site operations (Flow and Safety huddles)
- Previous meeting actions
- Update on implementation of full capacity protocol

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

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

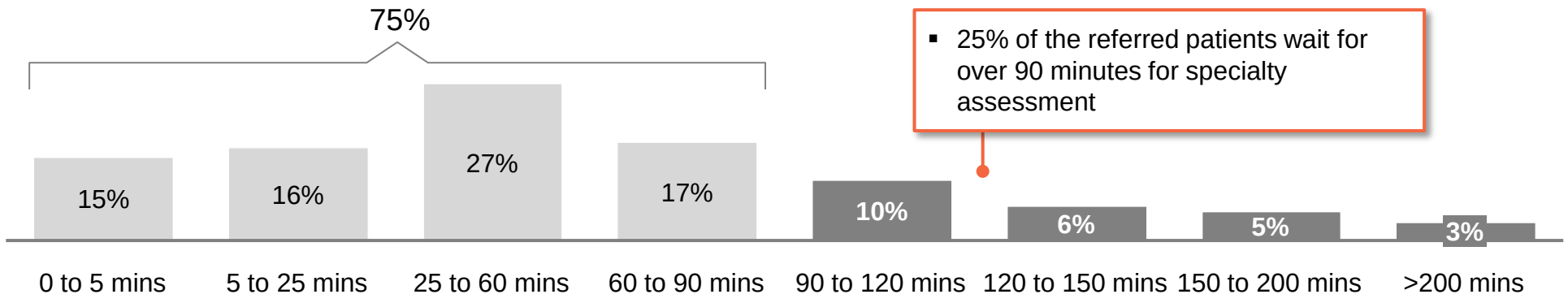
#, Mar 2014 – April 2015



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

Frequency distribution for specialty response

Apr 14 – Sep 15, Days



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

SOURCE: Trust internal ED data and McKinsey team analysis

Key messages arising from our discussions with medical and surgical SpRs

Key themes for specialty referral delays

- Generally, SpRs feel the quality and volume of referrals are manageable
- The main reason for delayed specialty response times to the ED is having to deal with sick patients on the ward
- Patients in resus consume a lot of the SpRs time, which prevents cases in majors and UCC being seen promptly
- Out-of-hours staffing levels vary between specialties – some have SHOs that cross-cover multiple specialties, others have no SHO at all – and this likely contributes to delays
- It was felt by some that ED do little to work patients up prior to specialty arrival, that they are "washing their hands of responsibility" as soon as the referral has been made

Consequences of delays

- Delayed specialty response contributes to poor ED performance, as patients often wait in cubicles whilst awaiting specialist opinion
- This prevents other patients from being brought into cubicles to be assessed
- The effects of a lack of cubicle capacity on patient care can be significant. There are recent examples of patients with severe illness being treated in suboptimal settings

SOURCE: Interviews with SpRs from orthopaedics, paediatrics, neurology, and oncology

From discussions with ED and the wider hospital an internal professional standards (IPS) document has been developed and agreed

Internal professional standards in the Emergency Department

1. All ED referrals to admitting specialty teams will be made to a registrar (ST3 grade) or higher. This doctor will triage referrals for urgency and clinical need

2. A decision-making doctor should see new patients in the ED so that a management plan is documented within 60 minutes of referral by the ED team. Specialty assessment breaches will be escalated to the appropriate consultant and clinical director by the ED clinical leadership team

3. No admitting team can refuse a request to assess a patient in the ED. Seeing the referred patient is not dependent on diagnostic results being available. Referral refusal will trigger direct specialty consultant contact

4. If another specialty would provide more appropriate care, it is the responsibility of the first specialty, not the ED, to make the second referral and arrange transfer of care

5. Patient care and admission will not be delayed by inter-specialty dispute over clinical ownership. ED consultants will contact the most appropriate specialty consultant to ensure clinical ownership and admission

6. Patients will not be transferred from the outpatient areas to the ED unless they are discussed with the ED consultant in charge and require immediate emergency medical care

7. Accepting referrals from primary care means that specialties take responsibility for evaluating the patient in ED. Specialty teams should inform ED staff about incoming expected patients at all times

8. A telephone call from primary care to specialty will not be a prerequisite for ED to stream patients directly to an admitting specialty team

9. The Trust does not admit patients who are likely to be able to go home from the ED to avoid a breach of the emergency care quality indicators

10. The bed management team will automatically accept bed requests from nursing staff for patients referred to specialties. Bed requests for patients referred to a specialty should not be predicted or refused by the bed management team

SOURCE: Internal Trust document

This has been ratified by the Medical Board

Objectives

- To briefly present the findings of the OVOT related to specialty response
- To describe recent events in the ED which are related to specialty response
- To formally introduce the Internal Professional Standards
- To seek initial thoughts on, and questions arising from, the medical and surgical leads on the IPS
- To plan the next steps, in particular a follow-on meeting with the wider specialty consultant and SpR body

Outcomes

- A context and background to the Internal Professional Standards, including rationale was presented by the Medical Director
- This was followed by a point-by-point discussion of the Internal Professional Standards, drafted by Dr Jason Fitch
- An engaging discussion ensued, followed by universal agreement on the Internal Professional Standards

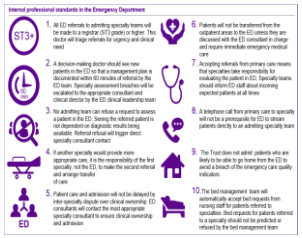
Next steps

- Attendees at the Board Meeting to discuss the Internal Professional Standards within their own teams
- Arrange a wider meeting with the consultant and registrar body for all medical and surgical specialties to raise further awareness of the topic
- Work with specialties to address structural problems preventing adherence to IPS
- Develop performance management architecture for specialty response times

SOURCE: Medical Board Meeting, Monday 7th March 2016

Impact has been realised and the main priorities for implementation going forward include the following

Impact of IPS



- Facilitated the presentation of the IPS to the Medical Board, which was crucial for its sign off and acceptance by the wider Trust
- Created a visually appealing version of the standards for dissemination across the Trust

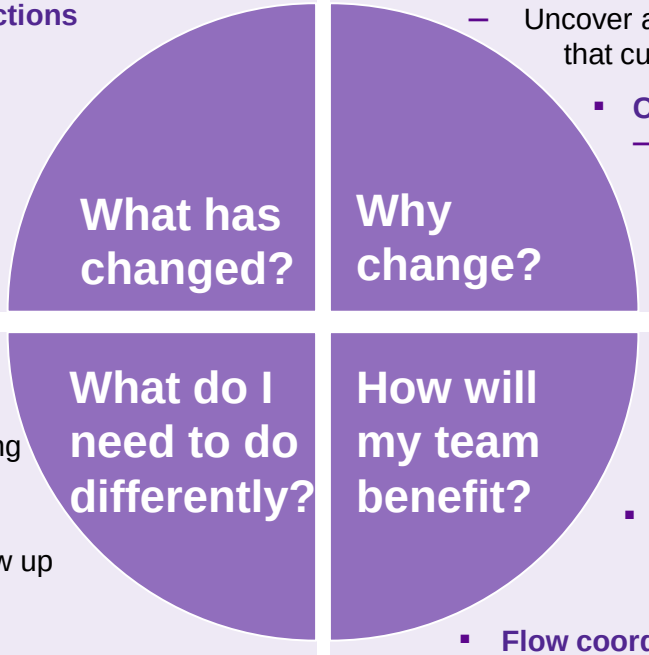
Next steps

- Ensure smooth rollout of IPS as planned beginning Monday, March 14
- Monitor effect of IPS using metrics on specialty response
- Ensure escalation policy clear to all stakeholders

Contents

- Performance tracking
- **Selected Flow initiative updates**
  - Specialty review
  - **Daily site operations (Flow and Safety huddles)**
- Update on implementation of full capacity protocol

From the 16th of March St George's Hospital flow and safety huddles replaced current bed meetings to improve patient safety and flow



- **First meeting at 08:30**
- **ED nurse, AMU nurse,** and **nurses from each ward** to attend to open two-way communication channel and rapidly solve ward issues
- **Focus on early discharges and actions**
- **Focus on raising issues** and solving them immediately

- **Improve patient safety and flow:**
  - Discharge patients earlier in the day
  - Give wards a voice to raise and resolve issues
  - Uncover and resolve large systemic problems that currently fall through the cracks
- **Connect the whole hospital:**
  - Ensure everyone is aware of the overall hospital situation every day
  - Share front door pressures with the team as a whole

- **Matrons**
  Refocus from tracking bed position to escalating and immediately solving issues faced by ED, AMU, wards
- **Medics:** Support nursing staff to unblock obstacles for flow and follow up with junior doctors
- **Bed managers:** relay necessary data between wards and the site management office
- **Support services:** representatives from OT/PT, discharge lounge, pharmacy, estates, to attend meetings

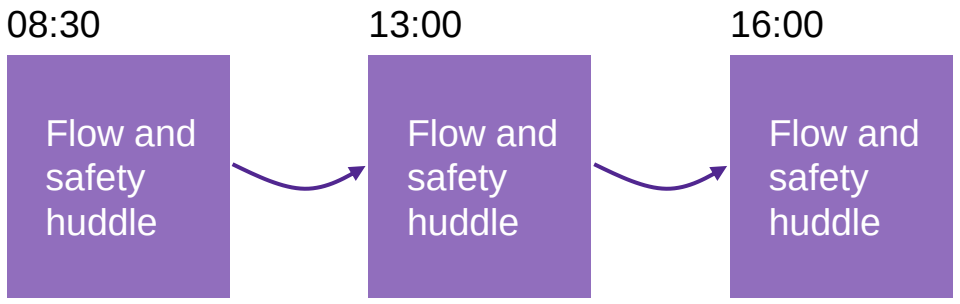
- **Site managers:** have more of a balanced overview of whole site; closer operational links with clinical needs
- **Matrons:** be heard and immediately find solutions for the issues you face on your wards
- **Flow coordinators:** Save time on fewer meetings, coordinate discharges across the hospital more easily, gain a forum to escalate issues
- **Support services:** have more visibility into teams and coordinate better with the rest of the hospital

Flow and safety huddles will be an upgrade to current ops meetings to make a step change in emergency access

Objective

- Flow and safety huddles will be set-up to improve patient flow for emergency and planned care to achieve an action-orientated and process driven approach
- It is crucial that tasks derived from these huddles are supported equally amongst nursing, medical and managerial staff

Future timing of the flow and safety huddles at SGUH



Key Initiatives

1. **Realign the focus and culture of the flow meeting** to develop an action orientated plan with a clear focus on accountability and early escalation to place patients quickly and safely
2. **Increase divisional representation** to have people in the room who are close to respective areas (e.g., wards, ED)
3. **Increase senior leadership involvement** Senior leadership to attend meetings on a rotational basis (i.e., director of the day)

SOURCE: Observation Analysis of the SGUH Bed Meeting (February 2016)

Flow and safety huddles - terms of reference 8.30am

8.30am

Purpose & Mechanics

Purpose

- Create good visibility of the hospital's operational status early in the day and work on the basis of a prediction for the day towards optimal patient flow

Frequency and timing: Daily at 8.30am

Attendees

- Director of the Day (see rota)
- Senior Medical
  - On call consultant/Med.Director
- Head of Operations (CHAIR)
- Estates (transport, portering)
- Matrons to cover ED, Med., Surg., Crit. care, Paeds, Neuro, AMU, Cardiac, Community)
- Infection Control
- Pharmacy
- Therapies
- Discharge lounge

Draft agenda

Duration: 30 minutes

Chaired by Head of Operations

Update – 5min

- Overnight issues (HAN)
- Hospital performance review (i.e., 4h, ED, AMU update)

Department and ward level reporting - 20 min

- ED, AMU update
- Confirmation of bed status incl. bed ready reckoner – bed status prediction for the day
- Confirmed/query discharges
- Staffing issues, safety concerns

Wrap-up and close – 5 min

- Develop action plans for high priority issues (e.g., early discharges, staffing shortages, safety concerns)

Preparation

- Attendees will provide agreed information for their areas
  - Ideally this information is shared in advance to focus on actions and solutions during the actual meeting
- HAN – handover information
- Diagnostic waits
- Pathology capacity

Objectives

- Review hospital performance (e.g., 4/12 hour breaches)
- Bed status update by clinical division
- Discuss solutions to high priority issues which could potentially compromise clinical care
- Information sharing

Outcomes

- Plan the day based on an predicted bed status with the overall objective to achieve appropriate flow during the entire day and night
- Propose a clear set of actions with responsible owners and timelines
- A clear plan to escalate high priority issues impeding patient flow

Roles and responsibilities

	Objective	Responsibilities
Director of the day	▪ Provide 24/7 director level support for operational delivery ▪ Drive actions/decisions	▪ Final arbiter in resolving issues of patient flow ▪ Unblock complex flow related issues across departments/divisions
Support Services (e.g., transport, pharmacy, estates)	▪ Provide support to wards and departments	▪ Unblock flow related issues
Senior Medical representative	▪ Provide support to wards and departments	▪ Unblock flow related issues
Matrons	▪ Provide an status overview of respective departments and wards	▪ Present required metrics and agree actions

Contents

- Performance tracking
- Selected Flow initiative updates
- **Previous meeting actions- LAS plan**
- Update on implementation of full capacity protocol

LAS Turnaround Plan

Performance (unvalidated):

	Current (unvalidated)	Same week last year	Pan-London	Projected
15 mins	37%	20%	37%	62%
30 mins	89%	87% (validated)	84%	98%

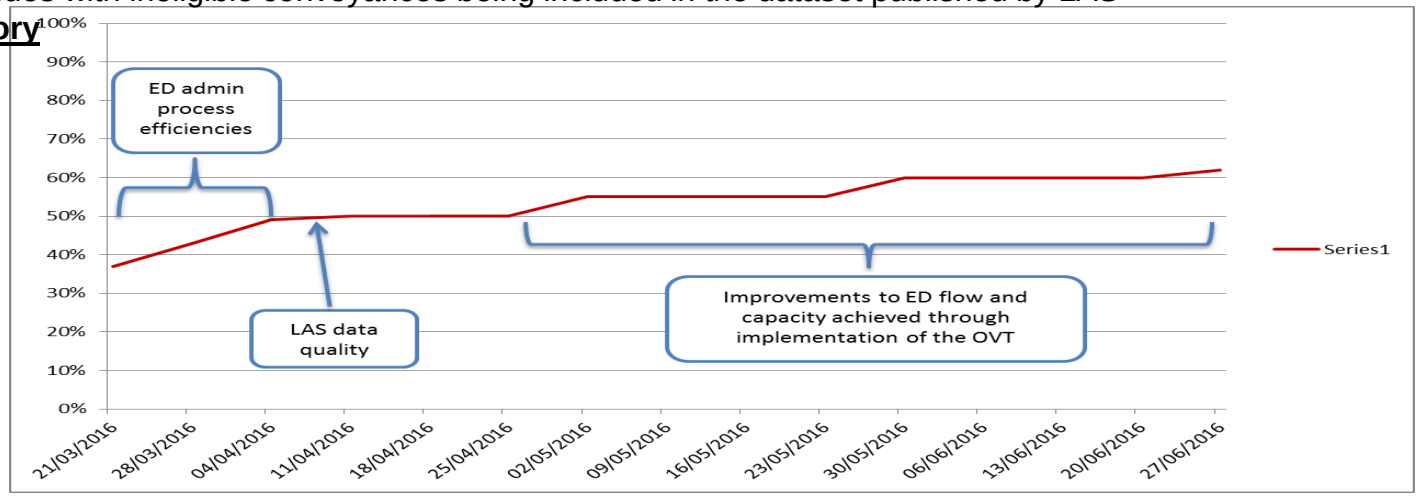
Completed actions:

- Validation of LAS data
  - Review of Jan & Feb shows 23% of reported 15 min breaches were not breaches. This would uplift performance by just over 10 p.p., to approx 50% handovers within 15 mins
  - 3% of LAS 15 minute breaches were non-arrivals, a continuing trend from the 30 mins data
- Review of admin handover process – this has reduced the handover process by 3 minutes and has contributed to an uplift in performance
- Publishing of Internal Professional Standard – see previous slides

Outstanding actions

- Remaining OVT recommendations re: flow & discharges – this is essential work as the ED remains exit blocked most days, and bed management/ED capacity breaches are at peak for the year, indicating a significant constraint on space in which to offload LAS
- Ongoing issues with ineligible conveyances being included in the dataset published by LAS

Revised trajectory



SOURCE: Source

Contents

- Performance tracking
- Selected Flow initiative updates
- Previous meeting actions
- **Update on implementation of full capacity protocol**

St George's University Hospitals NHS
NHS Foundation Trust

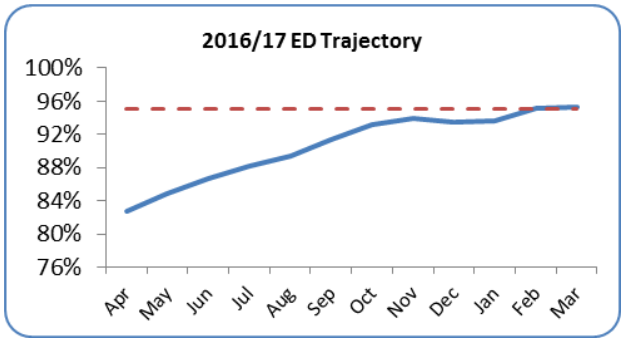
Referral to Treatment (RTT) Standard –
Recovery Plan Trajectory

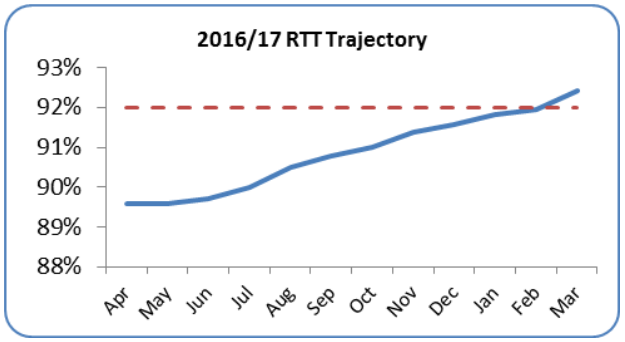
18 March 2016

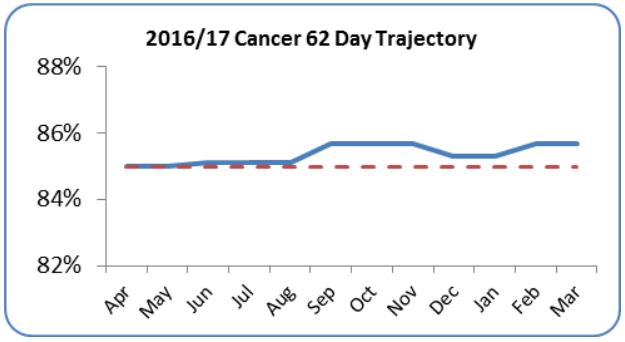
V1.3

SGH 2016/17 TRAJECTORIES SUBMISSION – 18/03/2016

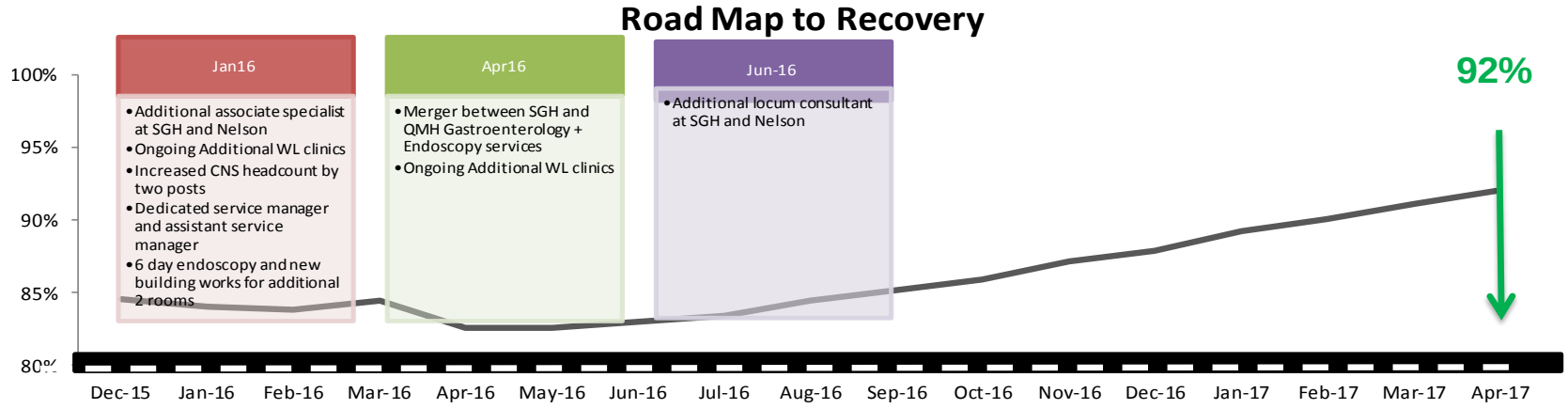
Standard	Target	2016-17 (%)											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E	95%	82.70%	84.80%	86.60%	88.10%	89.40%	91.30%	93.10%	93.90%	93.40%	93.60%	95.10%	95.20%
RTT	92%	89.60%	89.60%	89.70%	90.00%	90.50%	90.80%	91.00%	91.40%	91.57%	91.82%	91.96%	92.43%
Cancer - 62 Day	85%	85.00%	85.00%	85.10%	85.10%	85.10%	85.70%	85.70%	85.70%	85.30%	85.30%	85.70%	85.70%
Diagnostics	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%



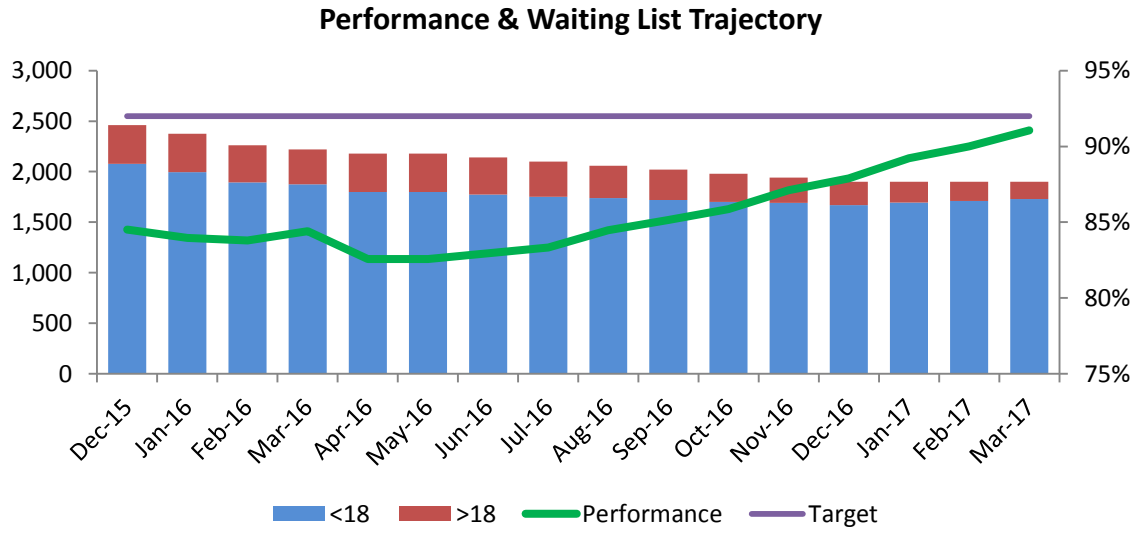




GASTRO



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total	2,460	2,375	2,260	2,220	2,180	2,180	2,140	2,100	2,060	2,020	1,980	1,940	1,900	1,900	1,900	1,900	1,900
>18	381	381	366	346	380	380	365	350	320	300	280	250	230	205	190	170	152
<18	2,079	1,994	1,894	1,874	1,800	1,800	1,775	1,750	1,740	1,720	1,700	1,690	1,670	1,695	1,710	1,730	1,748
Performance	84.5%	84.0%	83.8%	84.4%	82.6%	82.6%	82.9%	83.3%	84.5%	85.1%	85.9%	87.1%	87.9%	89.2%	90.0%	91.1%	92.00%



Dependencies & Risks

Trajectory dependant on:

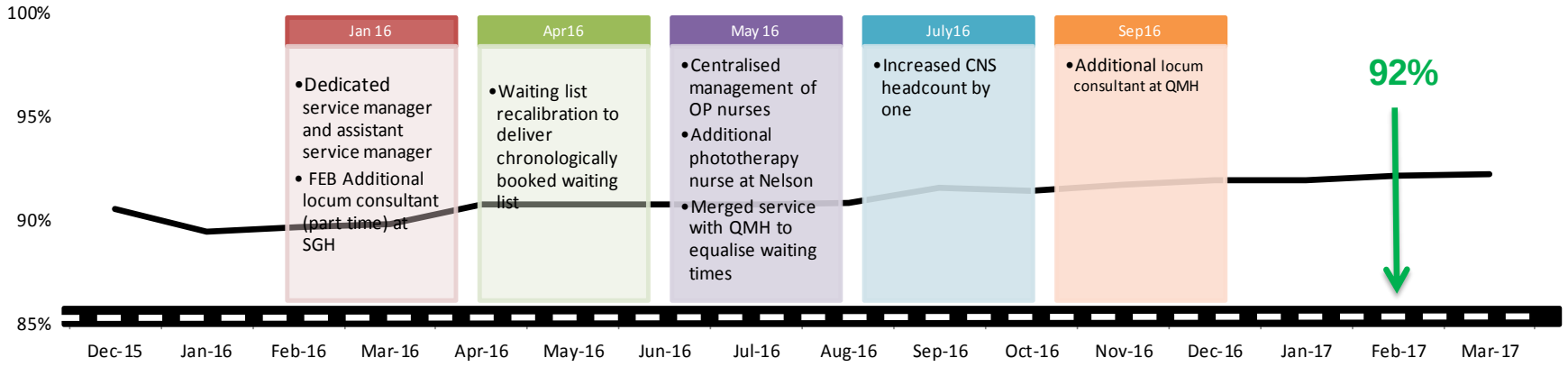
- The successful recruitment of Consultant in June
- Endoscopy building works to increase capacity to be completed by June

Risks:

- The merger efficiency outputs due to senior staff leaving QMH + Nelson site

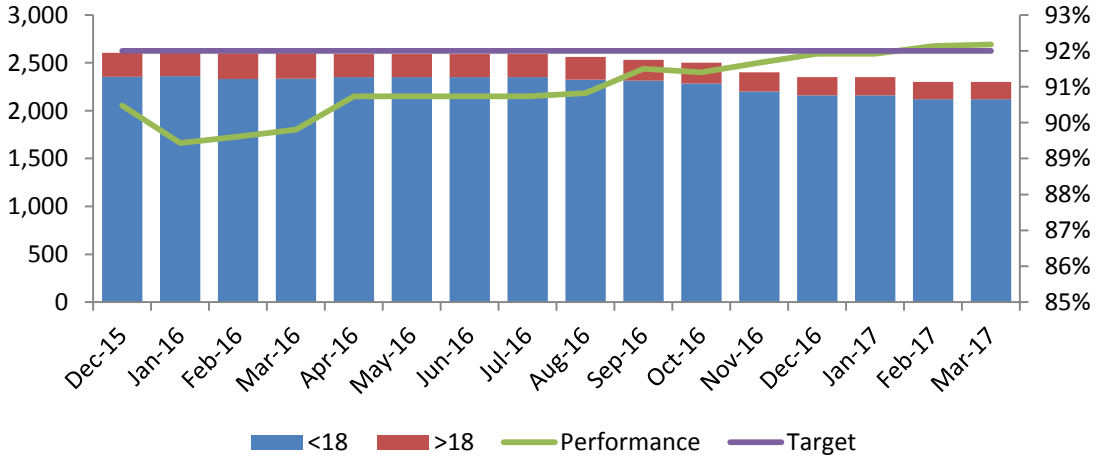
DERM

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total	2,603	2,639	2,599	2,599	2,590	2,590	2,590	2,590	2,560	2,530	2,500	2,400	2,350	2,350	2,300	2,300
>18	248	279	270	265	240	240	240	240	235	215	215	200	190	190	181	180
<18	2,355	2,360	2,329	2,334	2,350	2,350	2,350	2,350	2,325	2,315	2,285	2,200	2,160	2,160	2,119	2,120
Performance	90.5%	89.4%	89.6%	89.8%	90.7%	90.7%	90.7%	90.7%	90.8%	91.5%	91.40%	91.67%	91.91%	91.91%	92.13%	92.17%

Performance & Waiting List Trajectory



Dependencies & Risks

Trajectory dependant on:

- The successful recruitment of Consultant
- The booking process within Central booking service (CBS) working sufficiently
- The installation of the Phototherapy machine at nelson in May
- Being able to see non Merton patients at the Nelson
- Stable workforce and retention of staff

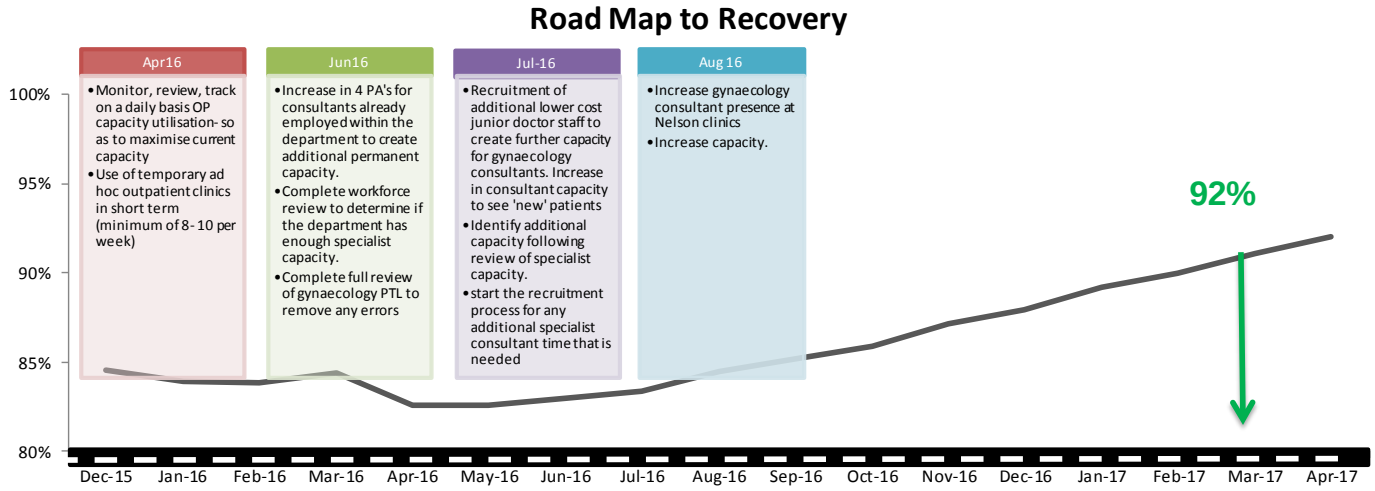
Risks:

- Summer spike in TWR Referrals which may delay 18 week recovery

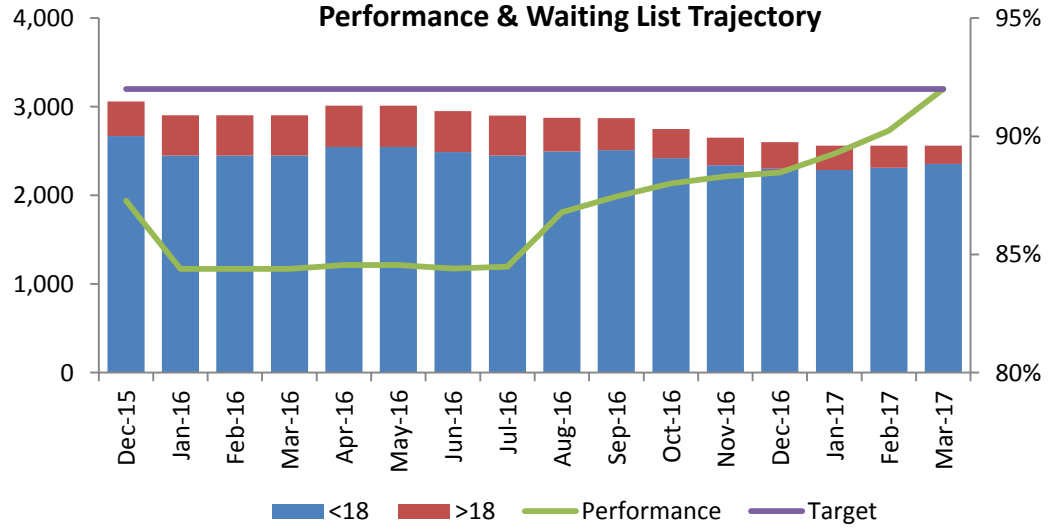
- D&C model based on specialty and not sub specialty
- Growth not considered within plan

GYNAE

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total	3,058	2,902	2,902	2,902	3,010	3,010	2,950	2,900	2,875	2,870	2,750	2,650	2,600	2,560	2,560	2,560
>18	389	453	453	453	465	465	460	450	380	360	330	310	300	275	250	205
<18	2,669	2,449	2,449	2,449	2,545	2,545	2,490	2,450	2,495	2,510	2,420	2,340	2,300	2,285	2,310	2,355
Performance	87.3%	84.4%	84.4%	84.4%	84.6%	84.6%	84.4%	84.5%	86.8%	87.5%	88.0%	88.3%	88.5%	89.3%	90.2%	92.0%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

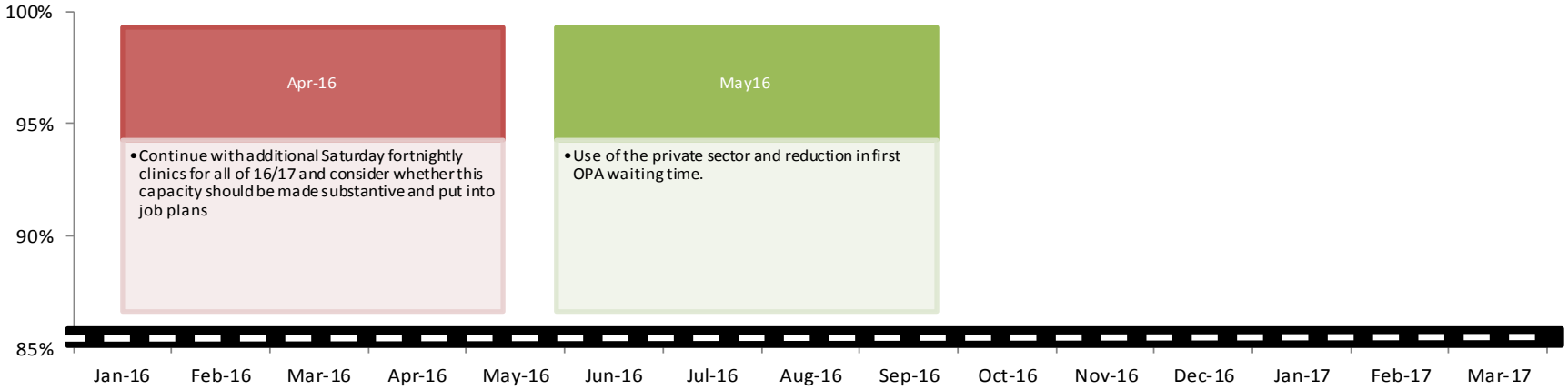


Dependencies & Risks

- Risk to trajectory if full theatre allocations allocated are not available.
- Trajectory requires continued support and capacity in the Independent sector.
- Trajectory relies on potential recruitment for additional specialist capacity .
- There will need to be a reduced cancellation rates.

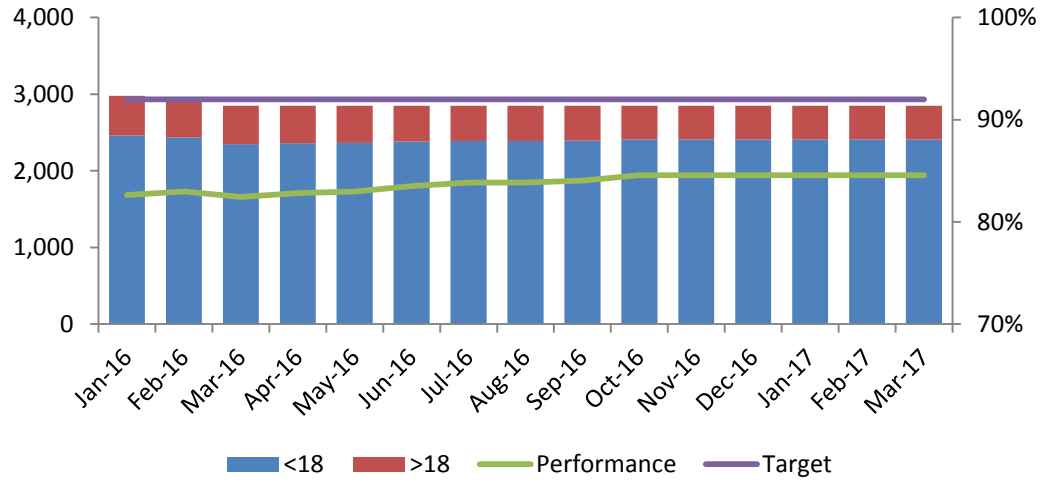
ENT

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total	3,024	2,980	2,936	2,850	2,850	2,850	2,850	2,850	2,850	2,850	2,850	2,850	2,850	2,850	2,850	2,850
>18	536	518	500	500	490	490	485	470	460	460	455	440	440	440	440	440
<18	2,488	2,462	2,436	2,350	2,360	2,360	2,365	2,380	2,390	2,390	2,395	2,410	2,410	2,410	2,410	2,410
Performance	82.3%	82.6%	83.0%	82.5%	82.8%	82.8%	83.0%	83.5%	83.9%	83.9%	84.0%	84.6%	84.6%	84.56%	84.56%	84.56%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Performance & Waiting List Trajectory

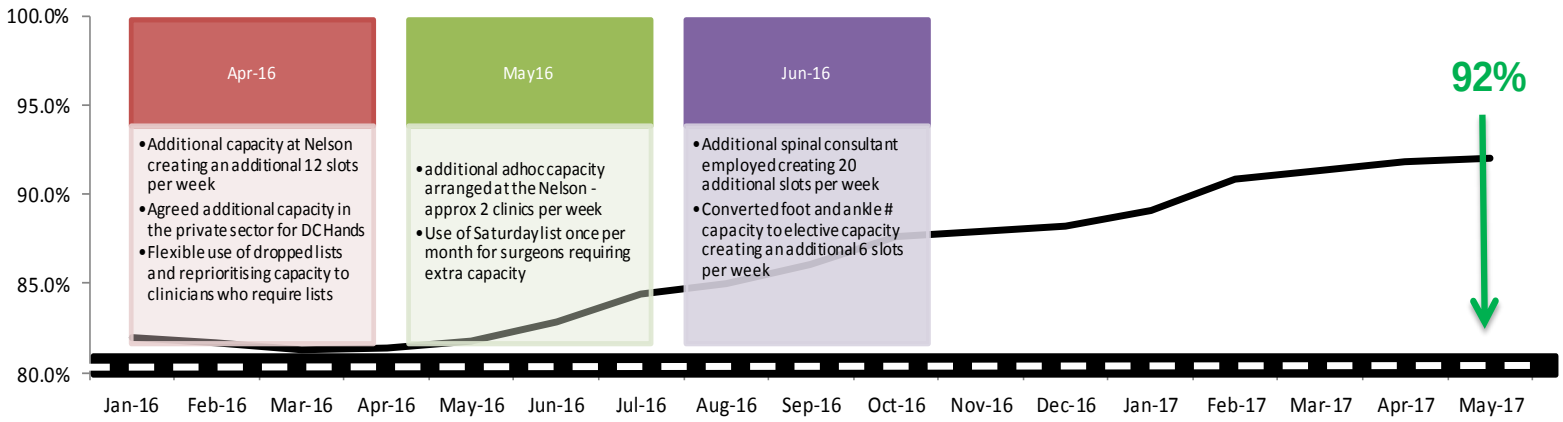


Dependencies & Risks

- Trajectory requires continued support and capacity in the Independent sector
- To achieve a waiting list reduction of 400 patients, 135 half day sessions need to be created which cannot be supported internally

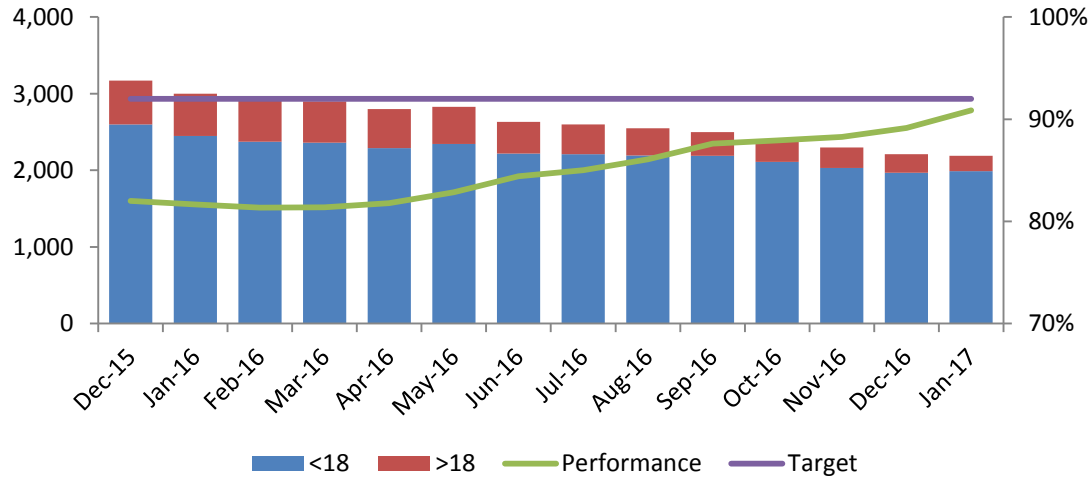
T&O

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Total	3,384	3,171	3,000	2,920	2,900	2,800	2,830	2,630	2,600	2,550	2,500	2,400	2,300	2,210	2,190	2,190	2,190	2,190
>18	580	571	550	545	540	510	485	410	390	355	310	290	270	240	200	190	180	175
<18	2,804	2,600	2,450	2,375	2,360	2,290	2,345	2,220	2,210	2,195	2,190	2,110	2,030	1,970	1,990	2,000	2,010	2,015
Performance	82.9%	82.0%	81.7%	81.3%	81.4%	81.8%	82.9%	84.4%	85.0%	86.1%	87.6%	87.9%	88.3%	89.14%	90.87%	91.32%	91.78%	92.01%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Performance & Waiting List Trajectory



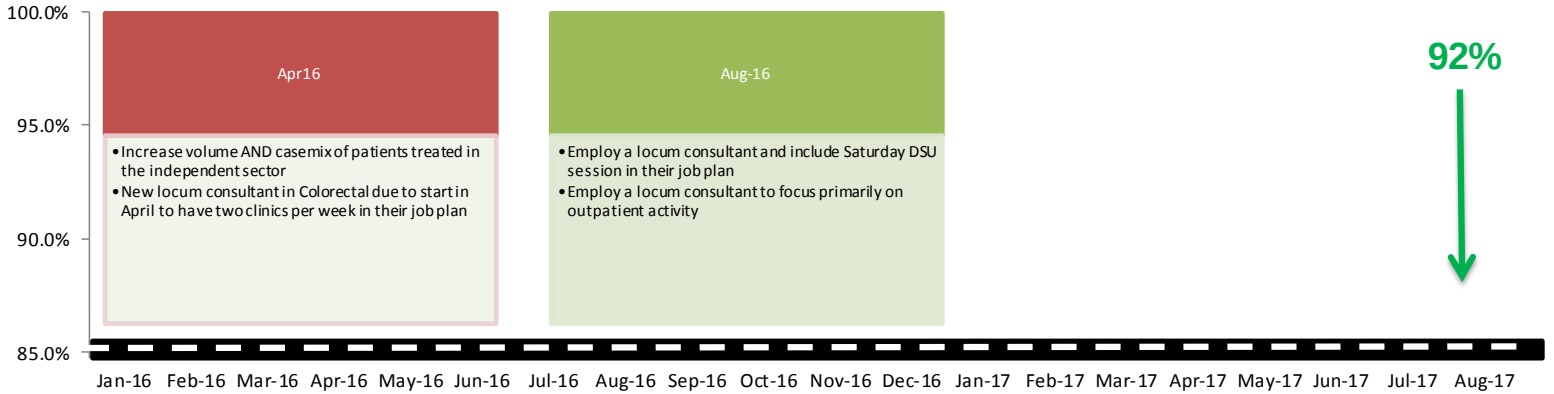
Dependencies & Risks

- Trajectory dependant on the successful recruitment of Spinal Consultant
- Requires removal of 11 week booking horizon to allow us to book chronologically
- Requires 'Outpatient Speciality Fix' Program to progress as planned
- Demand and Capacity model has only been calculated at a high level – no subspecialty data

GENERAL SURGERY

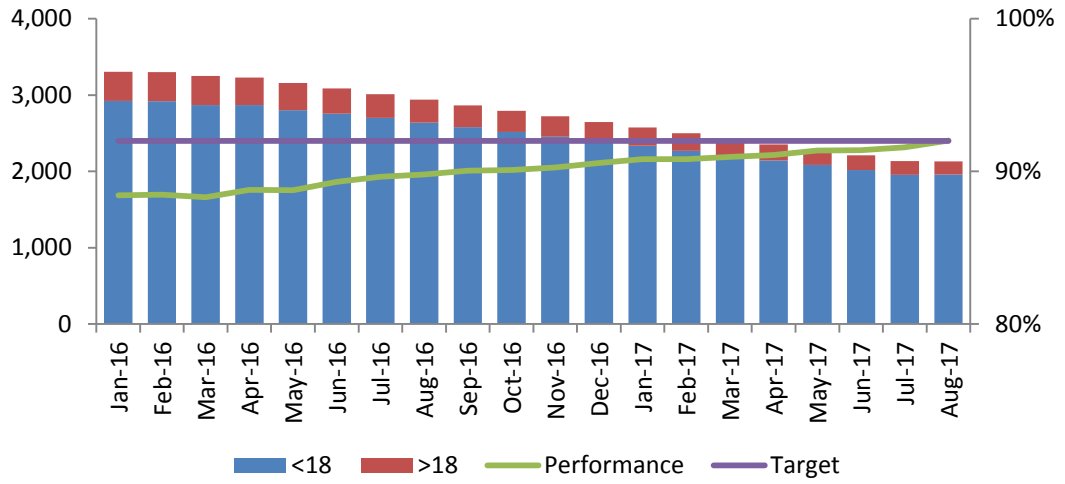
Includes; General Surgery, Colorectal, Upper GI & Breast & Endocrine

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Total	3,384	3,305	3,300	3,250	3,232	3,159	3,086	3,013	2,940	2,867	2,794	2,721	2,648	2,575	2,502	2,429	2,356	2,283	2,210	2,137	2,131
>18	383	382	380	380	362	355	330	312	300	285	277	265	250	237	230	220	210	197	190	180	170
<18	3,001	2,923	2,920	2,870	2,870	2,804	2,756	2,701	2,640	2,582	2,517	2,456	2,398	2,338	2,272	2,209	2,146	2,086	2,020	1,957	1,961
Performance	88.7%	88.4%	88.5%	88.3%	88.8%	88.8%	89.3%	89.6%	89.8%	90.1%	90.1%	90.3%	90.6%	90.80%	90.81%	90.94%	91.09%	91.37%	91.40%	91.58%	92.02%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Performance & Waiting List Trajectory

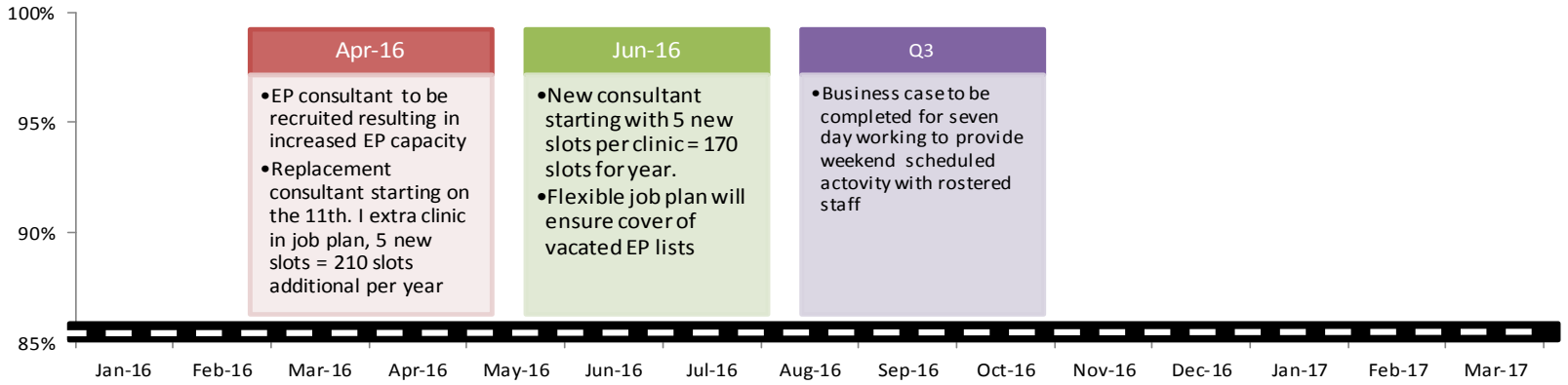


Dependencies & Risks

- High volume of general surgery going to the independent sector – this needs to be funded and can be up to 200% of tariff
- Requires further Saturday operating at St George's – not possible if theatre refurbishment extends beyond current plan
- Recruitment – being given permission to recruit additional consultants for this work
- Day surgery is speciality based and not subspecialty based; this may present a risk if there is not flexibility between subspecialties.

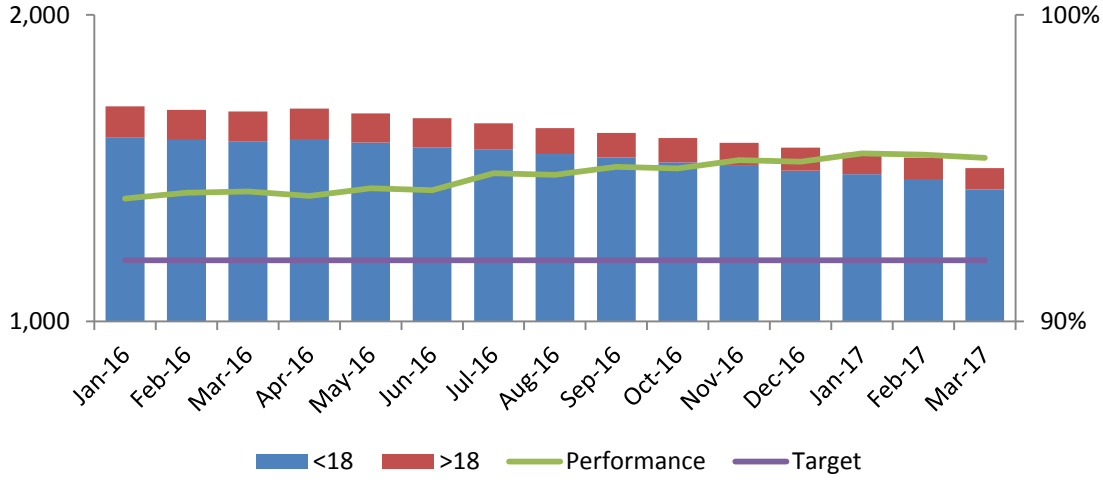
CARDIOLOGY

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total	1,728	1,702	1,690	1,685	1,695	1,695	1,679	1,663	1,647	1,631	1,615	1,599	1,583	1,567	1,551	1,535
>18	74	102	98	97	100	100	95	95	85	85	80	80	75	75	70	70
<18	1,654	1,600	1,592	1,588	1,595	1,595	1,584	1,568	1,562	1,546	1,535	1,519	1,508	1,492	1,481	1,465
Performance	95.7%	94.0%	94.2%	94.2%	94.1%	94.1%	94.3%	94.3%	94.8%	94.8%	95.0%	95.0%	95.3%	95.2%	95.49%	95.44%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Performance & Waiting List Trajectory

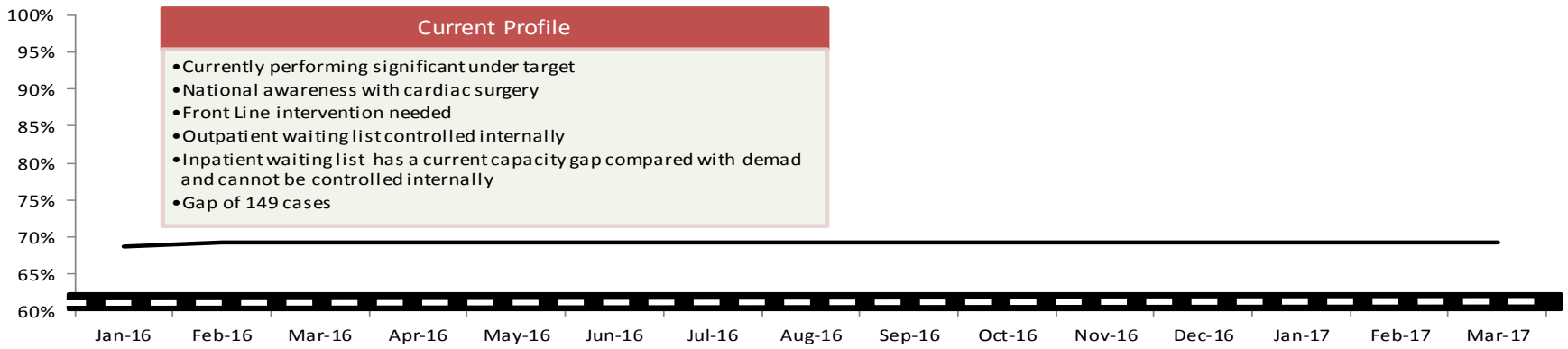


Dependencies & Risks

- Availability of skilled EP physiologists and ability to recruit

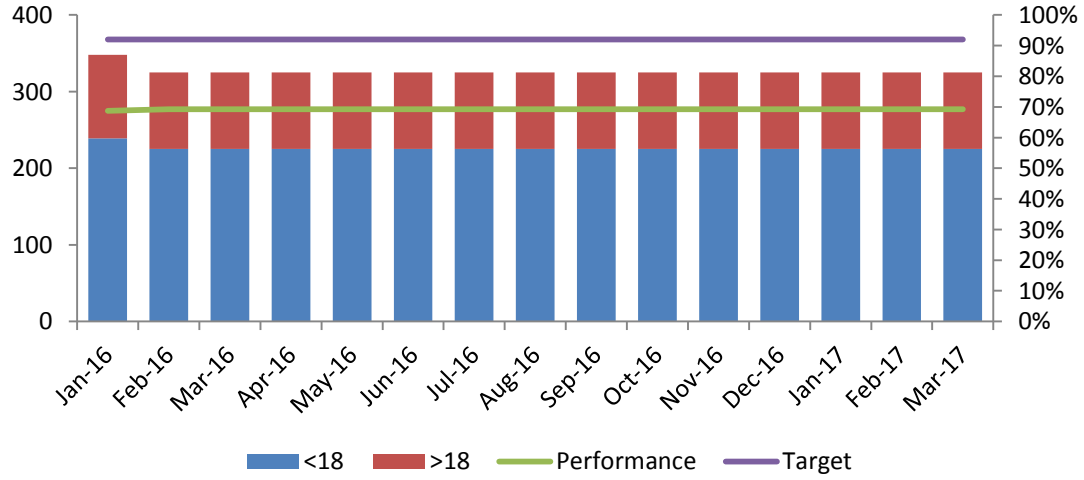
CARDIAC SURGERY

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total	302	348	325	325	325	325	325	325	325	325	325	325	325	325	325	325
>18	93	109	100	100	100	100	100	100	100	100	100	100	100	100	100	100
<18	209	239	225	225	225	225	225	225	225	225	225	225	225	225	225	225
Performance	69.2%	68.7%	69.2%	69.2%	69.2%	69.2%	69.2%	69.2%	69.2%	69.2%	69.2%	69.2%	69.2%	69.23%	69.23%	69.23%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Performance & Waiting List Trajectory

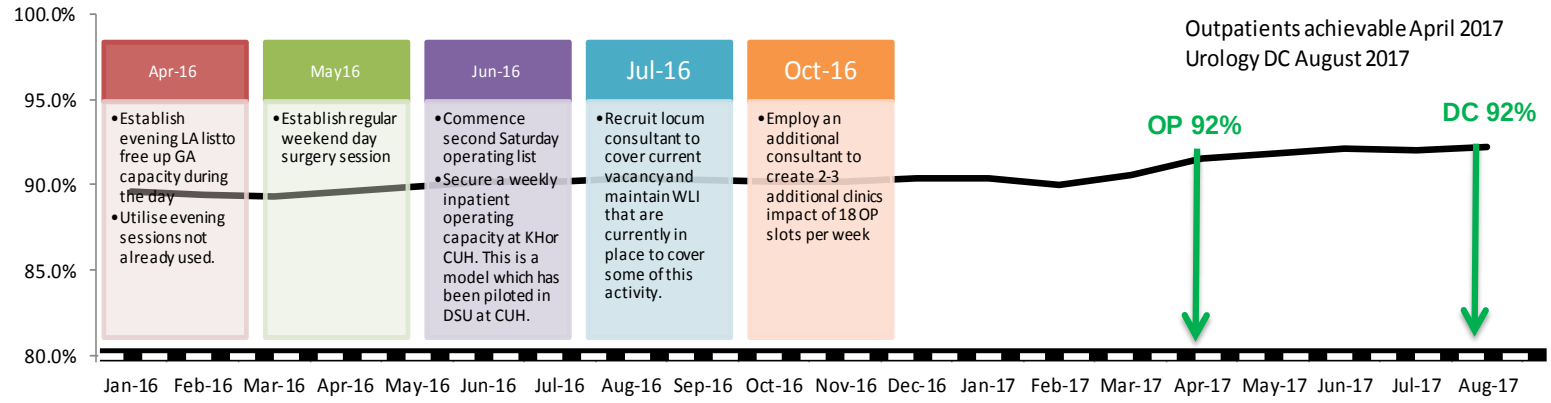


Dependencies & Risks

- The Cardiac Surgery department has not delivered its SLA in 15/16. Whilst additional capacity has been put in place for 16/17 this enables the department only to achieve its 16/17 SLA proposal.
- The service believe they are able to do a further 40 cases in the private sector to drive down the backlog. This would be contingent on commissioners agreeing additional funding for activity at above tariff rates.

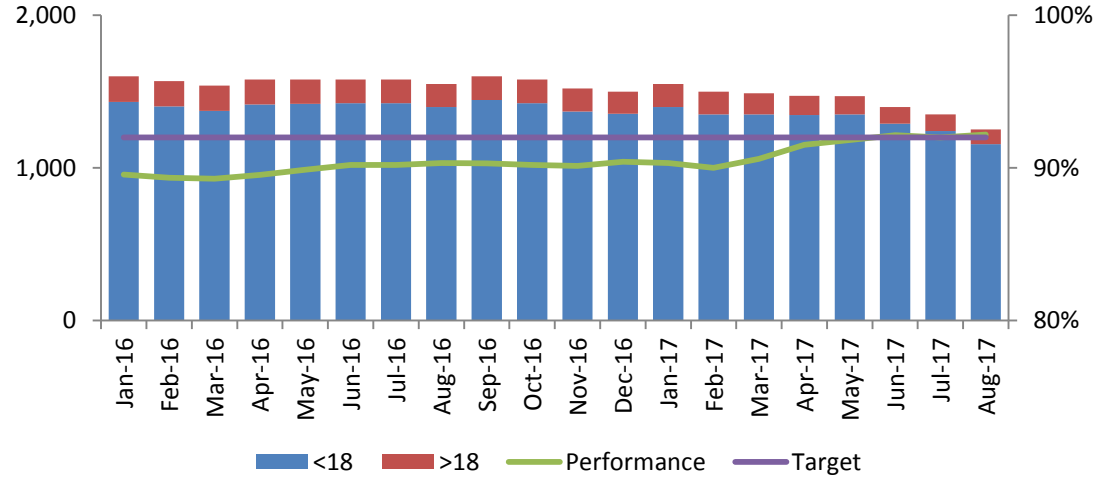
UROLOGY

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Total	1,608	1,600	1,570	1,540	1,580	1,580	1,580	1,580	1,550	1,600	1,580	1,520	1,500	1,550	1,500	1,490	1,472	1,470	1,400	1,350	1,253
>18	176	167	167	165	165	160	155	155	150	155	155	150	144	150	150	140	125	120	110	108	98
<18	1,432	1,433	1,403	1,375	1,415	1,420	1,425	1,425	1,400	1,445	1,425	1,370	1,356	1,400	1,350	1,350	1,347	1,350	1,290	1,242	1,155
Performance	89.1%	89.6%	89.4%	89.3%	89.6%	89.9%	90.2%	90.2%	90.3%	90.3%	90.2%	90.1%	90.4%	90.32%	90.00%	90.60%	91.51%	91.84%	92.14%	92.0%	92.18%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Performance & Waiting List Trajectory

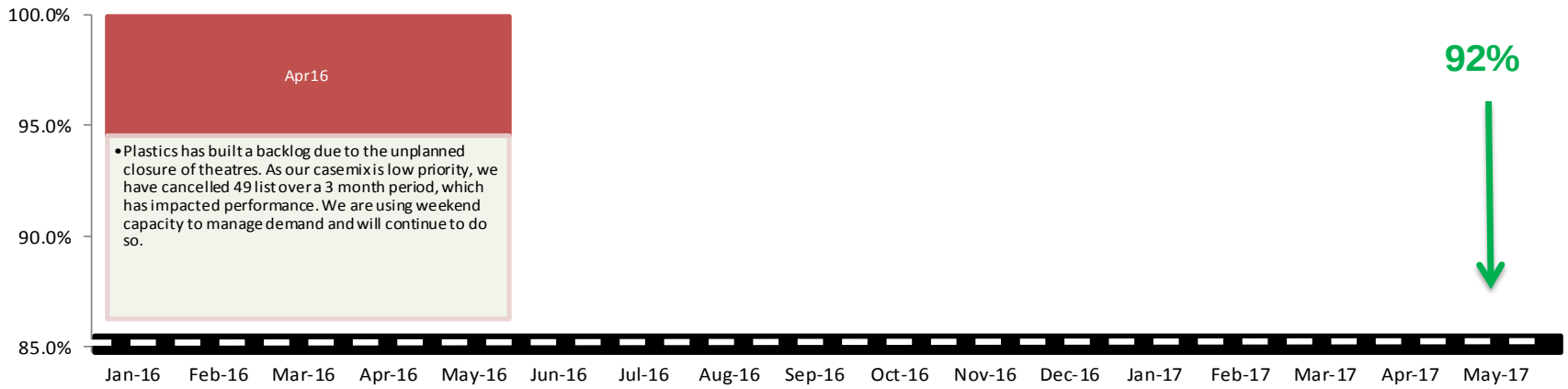


Dependencies & Risks

- Recruitment – being given permission to recruit additional consultants for this work.
- Requires further Saturday operating at St George's – not possible if theatre refurbishment extends beyond current plan
- Trajectory based on Outpatients and Day Case achieving waiting list reduction. Inpatient performance will remain non-compliant.

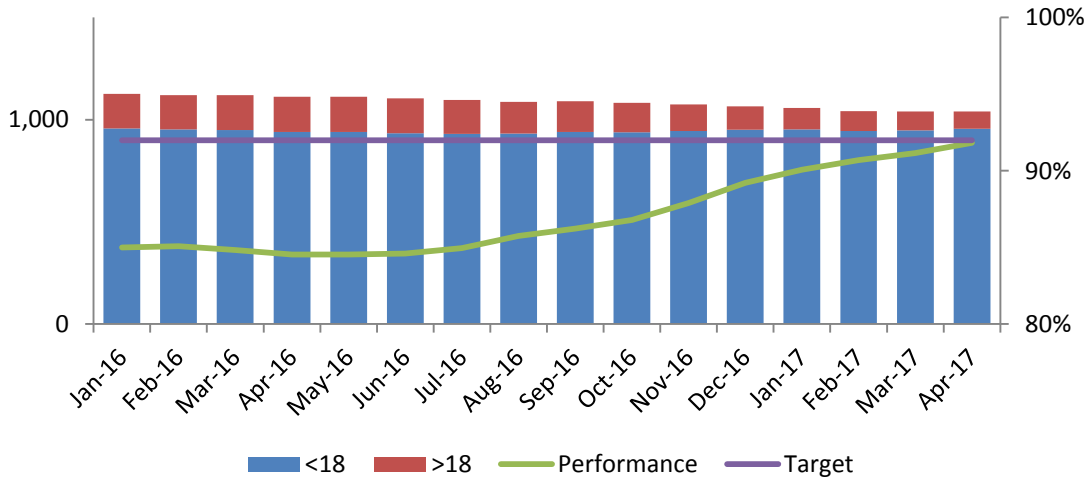
PLASTICS

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Total	1,143	1,126	1,120	1,120	1,112	1,112	1,104	1,096	1,088	1,090	1,082	1,074	1,066	1,058	1,042	1,040	1,040	1,040
>18	183	169	167	170	172	172	170	165	155	150	143	130	115	105	97	92	85	83
<18	960	957	953	950	940	940	934	931	933	940	939	944	951	953	945	948	955	957
Performance	84.0%	85.0%	85.1%	84.8%	84.5%	84.5%	84.6%	84.9%	85.8%	86.2%	86.8%	87.9%	89.2%	90.08%	90.69%	91.15%	91.83%	92.02%

Performance & Waiting List Trajectory

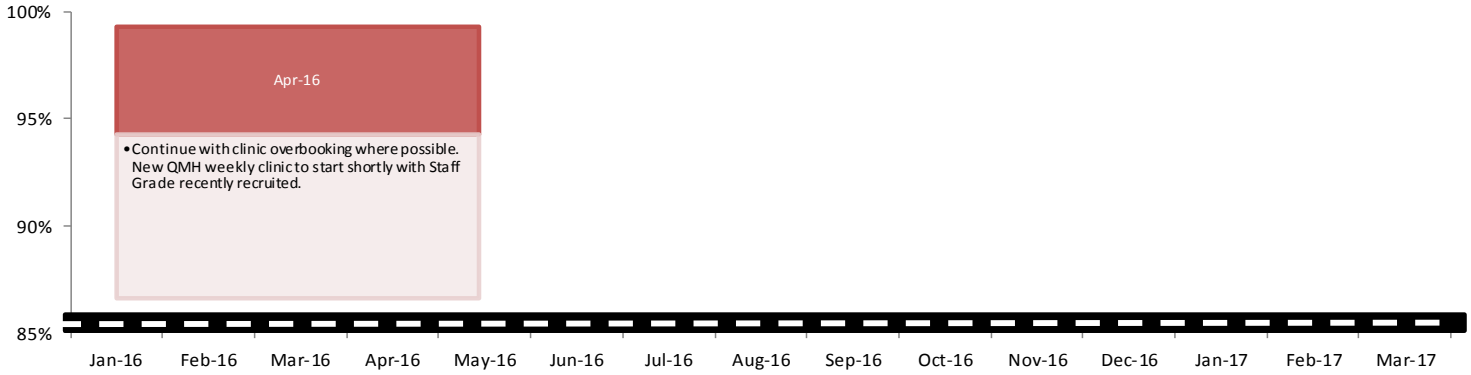


Dependencies & Risks

- Theatre maintenance program completes as per schedule
- No further breakdowns of theatre capacity
- Continued use of weekend capacity

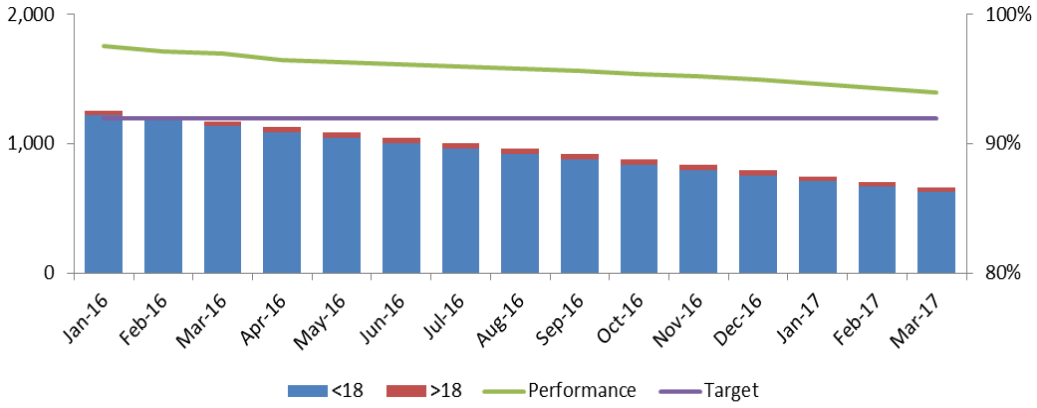
MAX FAX

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total	1,254	1,254	1,212	1,170	1,128	1,086	1,044	1,002	960	918	876	834	792	750	708	666	624
>18	26	30	35	35	40	40	40	40	40	40	40	40	40	40	40	40	40
<18	1,228	1,224	1,177	1,135	1,088	1,046	1,004	962	920	878	836	794	752	710	668	626	584
Performance	97.9%	97.6%	97.1%	97.0%	96.5%	96.3%	96.2%	96.0%	95.8%	95.6%	95.4%	95.2%	94.9%	94.67%	94.35%	93.99%	93.59%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	192%

Performance & Waiting List Trajectory

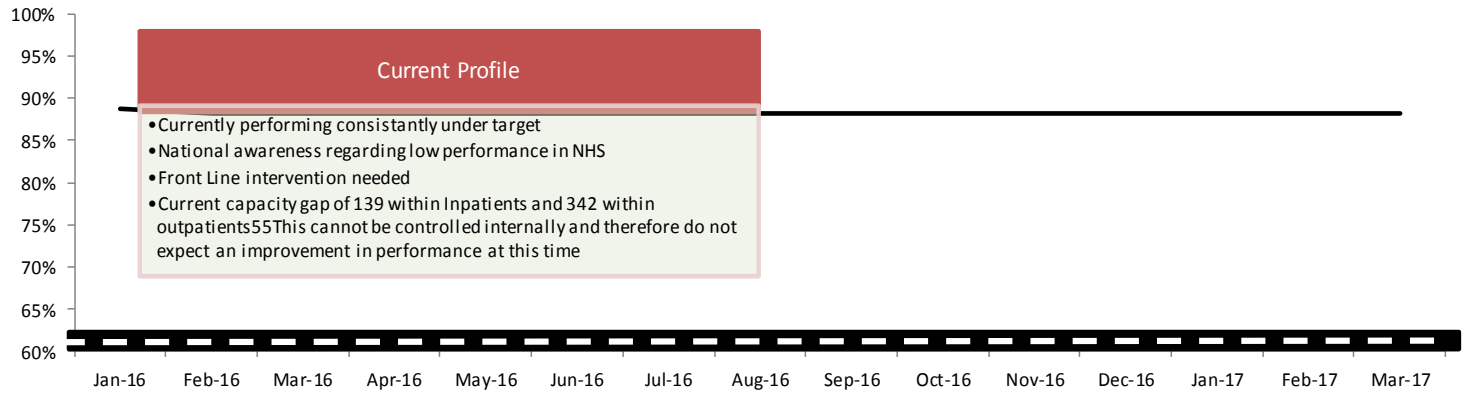


Dependencies & Risks

- Unexpected/out of variation winter pressures impacting on elective beds, and availability of ITU support.
- Theatre maintenance program completes as per schedule

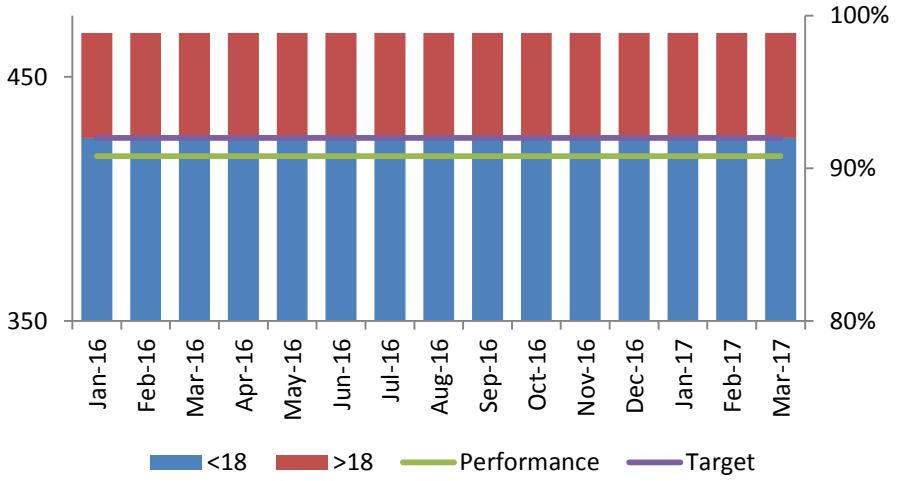
VASCULAR

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total	430	468	468	468	468	468	468	468	468	468	468	468	468	468	468	468
>18	53	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43
<18	377	425	425	425	425	425	425	425	425	425	425	425	425	425	425	425
Performance	87.7%	90.8%	90.8%	90.8%	90.8%	90.8%	90.8%	90.8%	90.8%	90.8%	90.8%	90.8%	90.8%	90.81%	90.8%	90.8%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Performance & Waiting List Trajectory

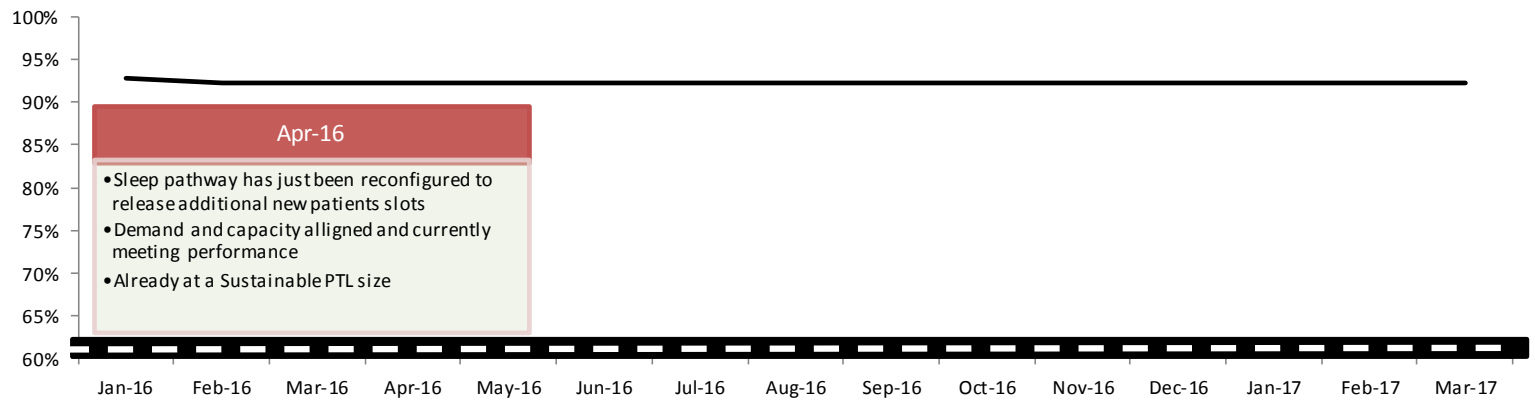


Dependencies & Risks

- The Vascular department is unable to deliver any activity above the SLA for the foreseeable future.

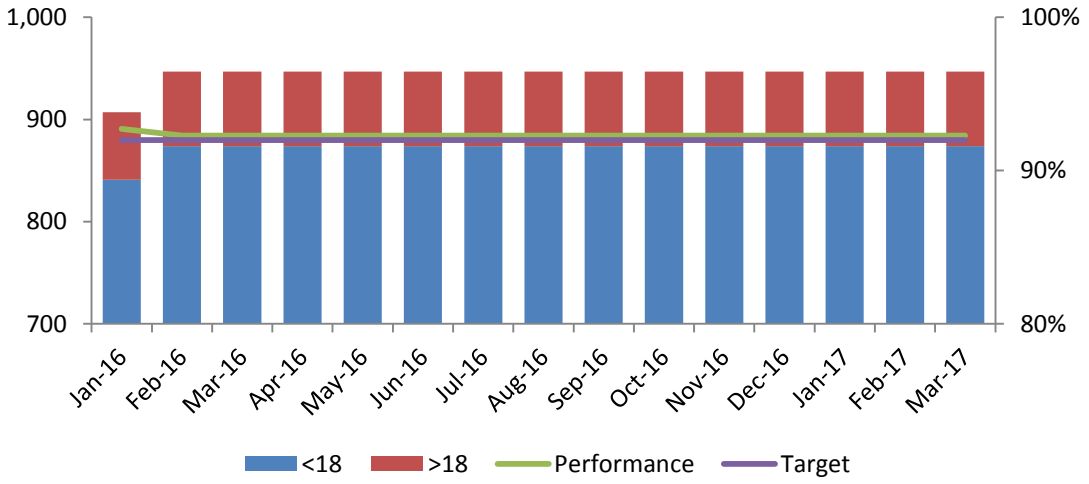
RESPIRATORY

Road Map to Recovery



Version 1	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total	986	907	947	947	947	947	947	947	947	947	947	947	947	947	947	947
>18	79	66	73	73	73	73	73	73	73	73	73	73	73	73	73	73
<18	907	841	874	874	874	874	874	874	874	874	874	874	874	874	874	874
Performance	92.0%	92.7%	92.3%	92.3%	92.3%	92.3%	92.3%	92.3%	92.3%	92.3%	92.3%	92.3%	92.3%	92.29%	92.29%	92.29%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Performance & Waiting List Trajectory



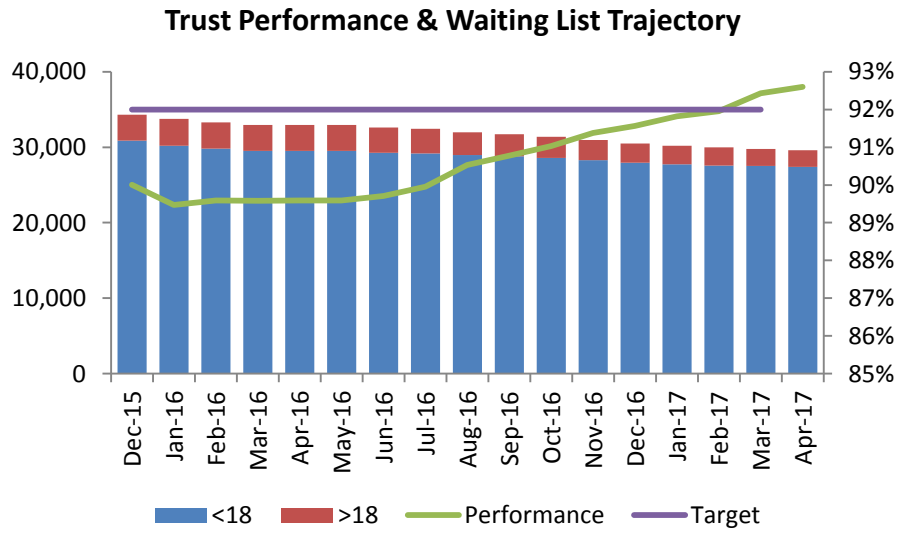
Dependencies & Risks

Road Map to Recovery

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

- Chronological Booking
- Use of outcome forms
- Improved PTLs to enable better monitoring
- Additional Theatre & Endoscopy space
- Project Cerner – use system appropriately to enable staff to track rather than validate
- Improved Escalation Process
- Emergency Winter Planning

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



Dependencies & Risks

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

GAP ANALYSIS OUTPATIENTS

Specialty	Waiting list Reduction reqd for Sustainability	WL Reduction F/Up	2016-17 Total Gap (New + Fup)	Trust Achievable Position	Final GAP (Reqd - Achievable)
Urology	123	224	347	347	0
General Surgery - Colorectal	400	512	912	912	0
General Surgery - Upper GI	58	59	117	117	0
General Surgery - Breast and Endocrine	0	0	0	0	0
General Surgery	0	0	0	0	0
Plastics	0	0	0	0	0
T&O	981	1,509	2,490	0	-2,490
Neurology	0	0	0	0	0
Neurosurgery	0	0	0	0	0
ENT	550	664	1,214	0	-1,214
Maxfax	0	0	0	0	0
Gastro	400	640	1,040	1040	0
Dermatology	300	632	932	932	0
Rheumatology	0	0	0	0	0
Respiratory	0	0	0	0	0
Diabetes	0	0	0	0	0
Infection	0	0	0	0	0
Haematology	50	189	239	239	0
Nephrology	0	0	0	0	0
Oncology	21	179	200	200	0
Cardiology	20	9	29	29	0
Cardiac surgery	35	25	60	60	0
Thoracic Surgery	3	11	14	14	0
Vascular	150	192	342	0	-342
Gynaecology	222	102	324	324	0

GAP ANALYSIS INPATIENTS / DAY CASE

Specialty	Waiting list Reduction reqd for Sustainability	Backlog Conversions	2016-17 Gap Total (WL reduction + Conversions)	Trust Achievable Position	Final GAP (Reqd - Achievable)
Urology	354	85	439	439	0
General Surgery - Colorectal	6	35	41	41	0
General Surgery - Upper GI	83	15	98	98	0
General Surgery - Breast and Endocrine	6	0	6	6	0
General Surgery	119	0	119	119	0
Plastic Surgery	69	0	69	69	0
T&O	25	243	268	0	-268
Neurosurgery	0	0	0	0	0
ENT	400	166	566	0	-566
Maxfax	0	0	0	0	0
Cardiology	150	23	173	173	0
Cardiac surgery	106	43	149	0	-149
Thoracic Surgery	3	4	7	7	0
Vascular	53	86	139	0	-139
Gynaecology	120	22	142	142	0

RISKS

Risk to achieving Trajectory

- The recruitment and appointment of Consultants and specialists posts
- Endoscopy works to be completed by June
- Booking Process Change for chronological booking to be successful
- Unpredicted growth in demand
- Private sector capacity
- Theatre building works to be completed within timescale
- Retention of staff

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD: April 2016

Paper Title:	**Develop an understanding of our current priorities & Build a shared vision for success**
Sponsoring Director:	**Rob Elek**
Author:	**Paul Sheringham**
Purpose: ***The purpose of bringing the report to the board***	***To agree the 30/60/90-day communications strategy for the trust's current priorities and to agree a launch campaign and budget to communicate the trusts objectives and transformation programme.***
Action required by the board: ***What is required of the board – e.g. to note, to approve…?***	**For decision**
Document previously considered by: ***Name of the committee which has previously considered this paper / proposals***	**None**

Executive summary:

The following over-arching Statement of Intent and corporate objectives have been developed to encapsulate the organisations focus for 2016/17:

- *"To support our committed staff to focus on getting the basics right, particularly by investing in our estate and IT infrastructure - ensuring the continued excellence of clinical services for our patients; and to address operational and financial performance challenges, through the implementation of our transformation programme"*

Organisations focus for 2016/17 – Corporate objectives

- Ensure the trust has an unwavering focus on all measures of quality, safety and patient experience
- Deliver our Transformation Programme enabling the trust to meet its operational and financial targets
- Ensure our workforce is supported and motivated, and that they understand, and are engaged with, the challenges facing the organisation
- Develop and deliver programmes of education and research that attract students and grow the St. George's brand
- Ensure we make the most of our buildings and estate, and maximise efficiency through improving back office and corporate functions.
- Refresh the trust's strategy, to develop a sustainable service model with a clear and consistent message

The purpose of the paper, which was commissioned by TAB, is to seek approval from the board for a phased 30/60/90-day approach to communicating the trust's current priorities and corporate objectives i.e. to communicate the assessment gap between how the trust is currently seen (getting the basics right) and how it wants to be seen (corporate objectives).

The communications strategy will need to integrate both internal and external streams and audiences; this paper focusses only on internal communications.

A significant proportion of the investment in the strategy circa £70 - 80k will dedicated to a two-month campaign that encompasses the corporate objectives and a segmented campaign to support the transformation programme – which will enable us to develop targeted communications media and processes that meet the needs of the distinct audiences and stimulate receptivity to the

corporate objectives, including the transformation programme.

It is vital that we use the campaign to develop new channels, appropriate for distinct audiences, timings, or styles of learning, that extend beyond the use of existing corporate communication channels which have limited reach.

This paper also outlines the current corporate communications function at the trust to help the reader put the strategy in to context. Some of this work has been supported and had input from Roz Harvey, a KPMG consultant.

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?

2015 McKinsey Global Survey confirms a long-standing trend that few executives say their organisations' transformations succeed:

Today, just 26 percent of respondents surveyed say the transformations have been experienced have been very or completely successful at both improving performance and equipping the organisation to sustain improvements over time.

Communication, specifically, contributes the most to a transformation's success. At companies where senior managers communicate openly and across the organisation about the transformation's progress, respondents were 8 times as likely to report a successful transformation as those who say this communication doesn't happen.

Good communication has an even greater effect at enterprise-wide transformations, where company-wide change efforts were 12.4 times more likely to be successful when senior managers communicate continually. It also helps when leaders develop a clear change story that they share across the organisation. This type of communication is not common practice, though. When asked what they would do differently if the transformation happened again, nearly half of respondents (and the largest share) wish their organisations had spent more time communicating a change story.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	**Trust strategy**
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	**Well-led**

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes / No)
If yes, please provide a summary of the key findings

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

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

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] **2.0. Please give your reasons for this rating**				

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Develop an understanding of our current priorities &
Build a shared vision for success

Excellence in specialist and community healthcare

Business and communications objectives

Business Objective

- Trust wide dissemination of where we are and what we plan to do next year
    - **What do we want this to deliver?** Focused on the immediate priorities for the trust and measured in clinical and quality outcomes, performance, recruitment and retention and financial performance

Communications objective

- Reach as wide a range/number of staff as possible over 30 / 60 / 90 day horizon
    - **What do we want staff to think, feel, believe?**
        - A very clear narrative is required that is focused on the attitudes and beliefs of the staff, what does the messages promise to the trust staff, what's the experience?
    - **What do we want them to do?**
        - Focused on the desired behaviour change

excellent
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St George's University Hospitals NHS
NHS Foundation Trust

The current corporate communications landscape

Excellence in specialist and community healthcare

What are we currently doing and why

- We've been working on making sure that everything we do ladders up to our agreed trust objectives such as the transformation programme
- We have been working to develop our channels including redesigning the intranet, newsletters and internal publication and working towards a new 'agency type' approach to enable the communications team can adequately support the trust and to extend our reach in to the organisation
- Short term, we're focusing on internal communications and embedding the transformation programme as we need our key properties (messages/ channels) defined and managed in a consistent way
- We know we have very varying degrees of success across communications and engagement on the areas below

Communications framework

There are 5 key categories for communications within a programme structure of local and national activity. The five categories provides the organisation with a terms of reference when considering other activities and a basis from which to plan individual programmes of work and resource accordingly. We have designed enablers to develop throughout 2016/17.

	Transformation	Reputation & Brand	Regulatory/Obligatory	Crisis	Internal & Engagement
Objective	To create an organisation which is stronger and better able to provide outstanding healthcare to the community for the future	To be the hospital of choice with an excellent reputation specialist services	To proactively manage consultations and regulatory communications requirements	To manage the press and other 'non planned for 'communications in order to minimise reactionary communications	To provide accurate, timely information which builds engagement and trust amongst internal and external stakeholders
Enabler/ Comms task	Develop an overarching Change Programme rather than a series of piecemeal communications activities in order to achieve a successful outcome	Develop the brand essence and identity (personality), communicate it and ensure understanding and advocacy. Enhance and maintain the reputation (including recruitment & retention) and the outcomes from the staff survey through a series of programmes	Proactively identify & manage. Develop a series of 'off the shelf' blueprints, templates and toolkits.	Proactively identify & manage. Develop a series of 'off the shelf' press responses/ releases for general issues and have a process in place for dealing with crisis that cannot be foreseen.	Develop a series of programmes which provide channels for information provision to include: dissemination of information, creating dialogue, gathering feedback, canvassing opinion and evaluating progress.

Communications Plan / Develop an understanding of current priorities & Build a shared vision of success

Internal stakeholders

We recently undertook an exercise to group internal stakeholders by job role in order to identify their needs, characteristics, influence and impact on success and from this enable planning for the communications work going forward.

	Nursing and midwifery	Consultants and medical	Junior Doctors	Clinical Management Band 7+	Senior leaders	Non Clinical	AHP's	Band 2-6
Size	3500	500	700		150			
Needs	Demonstration on how to make the change	Evidence based rational for change	Becoming more significant	Ensure they can be an advocate, ambassador and support role for their staff. Challenges betweens needs of trust and patients	Ensure they are working in partnership to solve trust challenges and put in place practices to raise performance, effect morale and make savings	Disparate group with a variety of roles, responsibilities and management.- susceptible to process change	Ensure that they are not marginalised.	Ensure that they are not marginalised. Empower to make the change. Provide support.
Influence	Can be influencers of change. Strong team base. Large group	Strong – long tenure. Hold power and influence powerbase	Medium but could be influencers of change	Managers will have make change happen and stick	Significant influence	Frontline staff with an influence on brand & reputation.	Varies	Will be affected by the changes and need to understand their role in the success
Current position	Low engagement	Not engaged	Low engagement	Low engagement	Medium - High engagement	Engagement varies across disciplines	Engagement varies across disciplines	Low engagement
Tone/ Message	Emotionally driven	Scientific & evidence based	Scientific & evidence based	Responsible for driving & supporting the change	Accountability and required to cascade information	Emotionally driven– recognise the role and importance they play	Part of the whole team that will make change happen	They are central the success and engagement is key

Corporate communications relative position

STRENGTHS

- Trusted brand by the patients and the public
- Strong social media presence and recognised as one of the leading London trusts for social media activity
- Good relationship with broadcast media orgs and seen as one of the go to trusts for media requests
- A wealth of coverage across online, television, radio and social such as 24hrs in A&E
- Good relationship with trust staff for supporting their immediate requests
- Recognised the need to adapt to new platforms such as the intranet and digital and mobile technologies
- Viral is very strong – all staff messages seem to extend from the desktop to most parts of the organisation
- High quantity of innovative practice and excellent staff at the trust resulting in a constant base of 'good news stories'
- Able to react to sensitive issues to protect the trusts brand

WEAKNESSES

- Limited investment in our corporate communications channels resulting in low richness of media opportunities such as not being able to use video internally
- Relying on reactive communications which have been passive rather than aimed at generating receptivity and engagement
- Not having a 'choreography' of events that are focused on the staff rather than the pipeline of corporate messages
- Limited investment in our corporate communications channels resulting in services seeking alternative methods to share host information - external websites, cloud based hosting, externally hosted intranet type platforms
- Significant barriers preventing key information from corporate channels (team brief) cascading its way down the organisation
- Measurement , metrics and analysis and correlating our communications to quality, performance or operational change
- Lack of resource to take the learning and insights from one project in to the next
- Lack of profile and identify for the corporate communications team resulting in staff not knowing when to contact us or sharing positive stories with us
- Unable to reach and engage with key groups such as ward staff, bands 2 -6, 'research', consultants

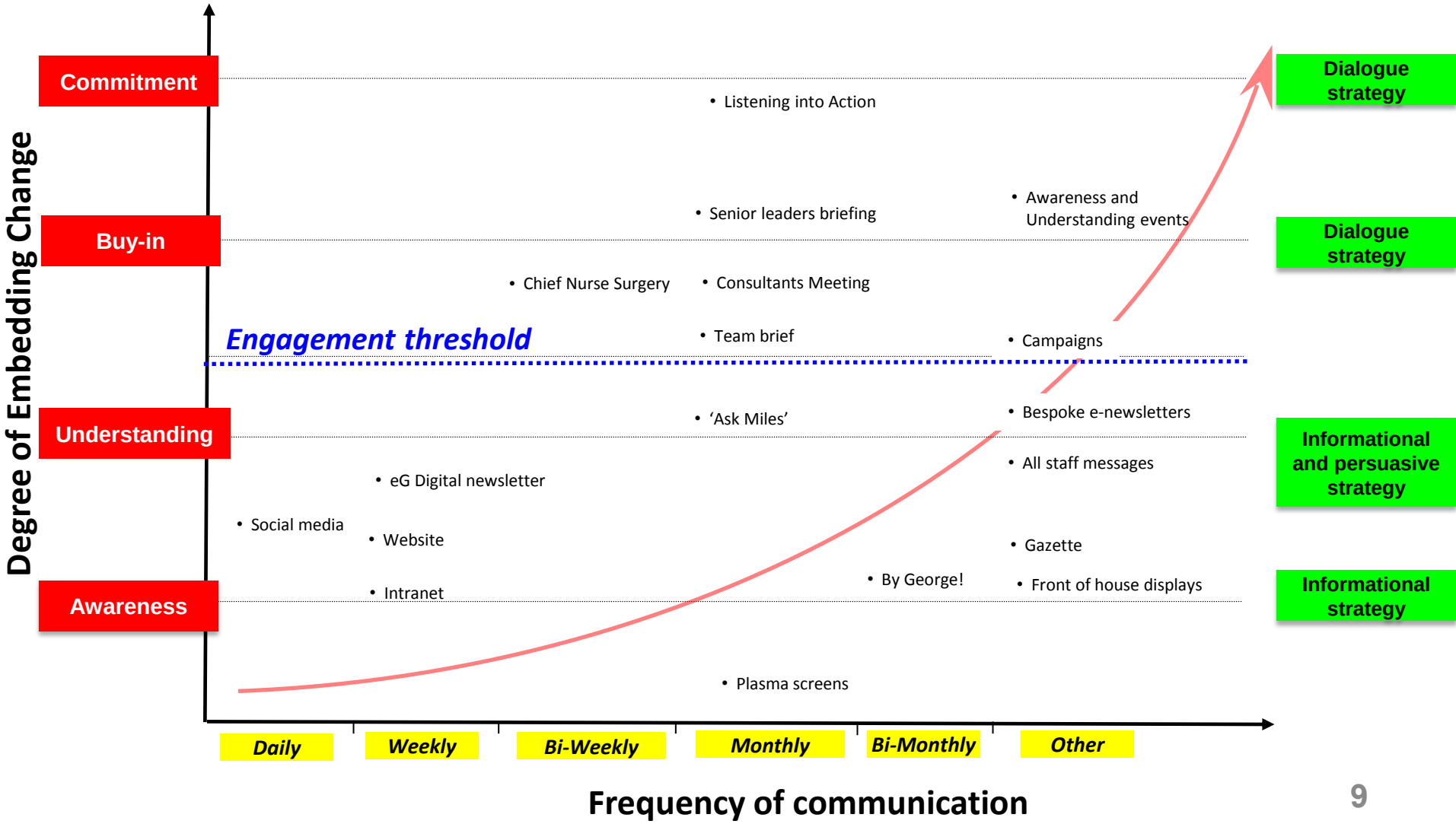
OPORTUNITIES

- Growing appetite for news and information across mobile technologies
- Social platforms and growth in online communities and conversation
- Digital age of innovation and forward thinking
- Staff motivated by good news stories
- Short form content and bite size information sources
- Better content management that is trusted, authoritative and of the highest quality
- Develop channels for information provision to include: dissemination of information, creating dialogue, gathering feedback, canvassing opinion and evaluating progress.
- Accurate, timely information which builds engagement and trust amongst internal and external stakeholders
- Performance measures for internal communications
- Embed communications and engagement disciplines at all levels of the trust whilst ensuring it is not seen as an 'add-on' bureaucratic process.
- Appetite from across the trust to communicate well and change which provides opportunities to be more radical

THREATS

- Lack of time for staff prevents them from attending corporate F2F events or cascading information
- key stakeholders express dissatisfaction with the intelligence they receive and our external website presence
- Loss of reputation (Brand and Reputation)
- Financial issues and lack of investment
- Loosing specialists (Maintain reputation)
- Staff morale leading to a lack of engagement with communications and engagement programmes
- General sense of staff feeling 'worn out' from the previous 12 months and may not be receptive more change.
- Lack of retention leading to tacit knowledge leaking from the organisation
- Communications activities are very corporate and have not changed significantly over the past 5 years leading to disengagement.

Current internal corporate communications and engagement channels



excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Develop an understanding of current priorities &
Build a shared vision of success

Communications Plan

Excellence in specialist and community healthcare

2016/17 Statement of Intent

The following over-arching Statement of Intent has been developed to encapsulate ***the organisations focus for 2016/17*:**

- *"To support our committed staff to focus on **getting the basics right**, particularly by investing in our estate and IT infrastructure - ensuring the continued excellence of clinical services for our patients; and to address operational and financial performance challenges, through the implementation of our transformation programme"*

- The communications strategy involves an initial 30/60/90 day approach to achieve the aforementioned position and to address the accepted assessment gap between how the trust is currently seen **(*getting the basics right)*** and how it wants to be seen **(*corporate objectives*)**

  Organisations focus for 2016/17 – Corporate objectives

- **Ensure the trust has an unwavering focus on all measures of quality, safety and patient experience**
- **Deliver our Transformation Programme enabling the trust to meet its operational and financial targets**
- **Ensure our workforce is supported and motivated, and that they understand, and are engaged with, the challenges facing the organisation**
- **Develop and deliver programmes of education and research that attract students and grow the St. George's brand**
- **Ensure we make the most of our buildings and estate, and maximise efficiency through improving back office and corporate functions.**
- **Refresh the trust's strategy, to develop a sustainable service model with a clear and consistent message**

Develop an understanding of current priorities & Build a shared vision of success

Strategic Objective

- Plan must stretch from the board to the individual contributor and all levels in between. Each level will have it's "what's in it for me?", "how does it affect me?" as well as thoughts on "how painful will this be for me?"

- Communications framework must ensure changes are embedded and sustained in the long term throughout the trust (e.g. clinical communities and other key stakeholders) with key ingredients for high trust relationships

- Messaging and narrative must be sensitive the current environment and clearly articulate overall organisational goal from the perspective of the stakeholders

- Help the business to deliver its objectives focus on delivering internal communications that have a hard and fast link to business delivery and to ensure that we can demonstrate that through evaluation of everything we do. To do this we have to provide internal communicators with the skills and support to be excellent in their job.

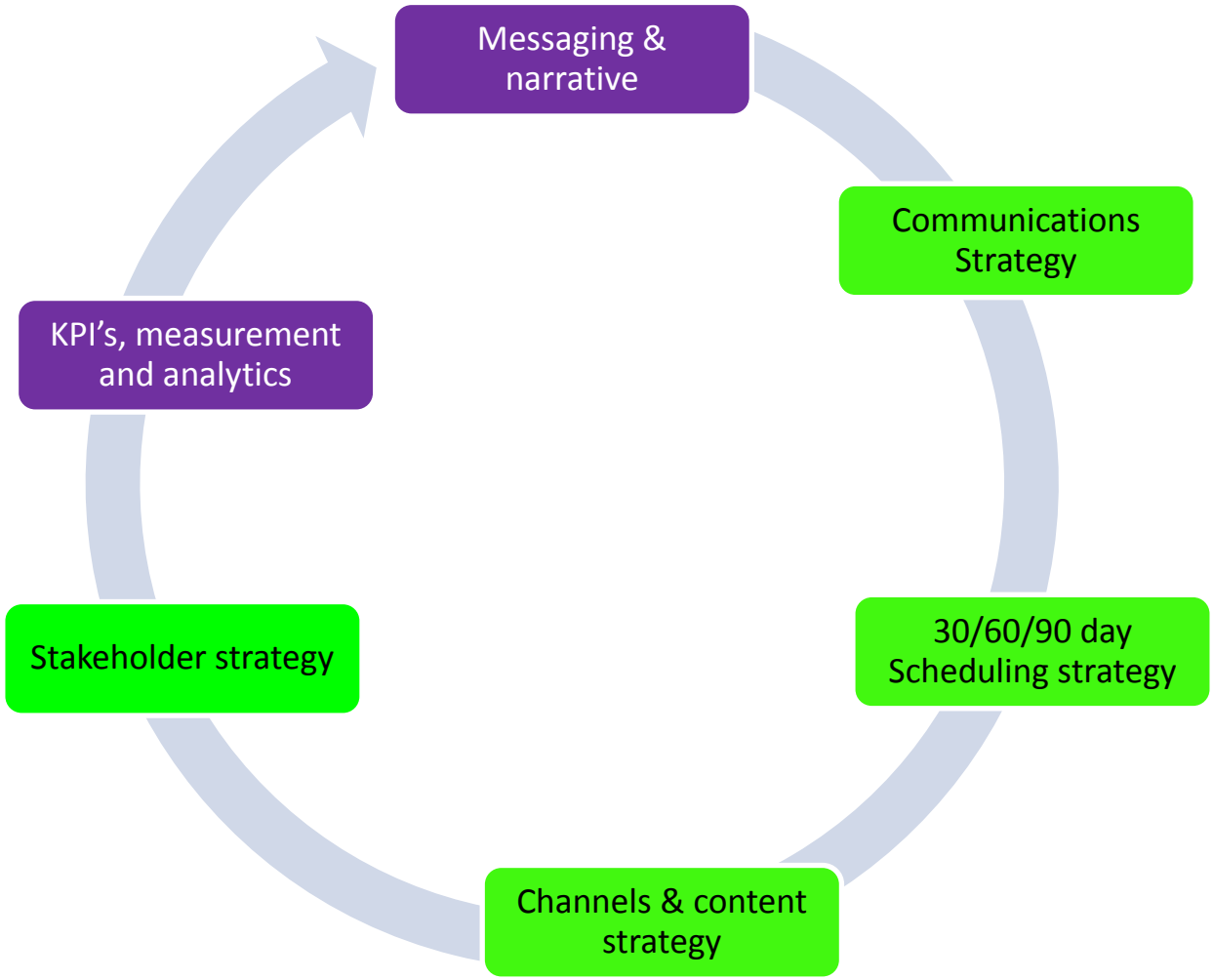
- Help staff see the connection between their job and the organisation's vision so that can staff understand and believe in the trust's vision and values, which can lead to increased staff loyalty and advocacy. It's not about forcing a corporate message on staff, but helping to get staff to emotionally connect with the vision and be able to easily translate this to the personal offer they make in their day-to-day jobs.

Develop an understanding of current priorities & Build a shared vision of success

Objectives

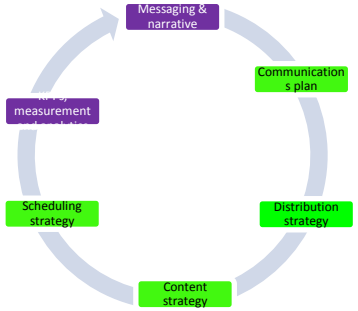
1. Help staff to fully understand the trust's 2016/17 objectives and vision, values and culture.
2. Show staff what change will look like and provide clarity for the case for change and get staff excited about the change and want to be involved
3. Help staff fully understand how we are addressing current priorities so that we have the fundamentals in place to build our reputation upon
4. Explain to staff how they and we, with their support, will get from A to B and what B will look like to motivate staff
5. Establish a shared commitment between board and ward about priorities and goals for improvement so that staff feel part of the change ?
6. Provide easy access to important information so everyone can perform their jobs well
7. Reignite passion for STG and new ways of thinking

How are we going to do it? To successfully deliver the plan we need to impact more than one strategic driver



Messaging and narrative

Messaging & narrative

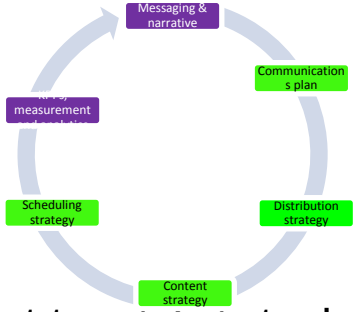


- The story /narrative will be developed through the board with support from the communications team *(what do we want staff to think, feel, believe)* ***the organisations focus for 2016/17***
- Narrative and messaging to be trialled by a group of staff prior to dissemination to ensue that are achieving the messaging is achieving its strategic intent ***the organisations focus for 2016/17***
- Communications team take the lead on macro communications and embedding messaging (i.e. product development, synchronising with existing communications channels and general communications) and conversion of learning and insights into digital or stand-alone product material.
- Board and execs to work with the communications team to develop messaging in to a *Strategy Map* with operational metrics that can be communicated to staff
- Board and execs to broker activities and communicate *joined up* consistent messages and actions that continuously reinforce the commitment to priorities and vision.
- Run alignment meeting at the start of each 30 day phase to sign-off messaging and project approach /communication needs to ensure that activities meet both requirements and utilise wider internal communication opportunities

Communications strategy

30/60/90 day Scheduling strategy

Communications strategy



The focus of the communications strategy is to provide a set of logical processes to support the statement of intent and corporate objectives

1. From mid–April (and throughout the 90 day cycle) the first phase of communications will focus on how we are **addressing the current priorities** and will utilise existing internal corporate communication channels and new channels where we have limited reach and low engagement
2. **A critical phase during April is to develop the narrative for the *corporate objectives***
3. The communications team presented a model to embed the transformation programme (by stakeholder) which included a launch campaign which includes a commitment to staff with the following objectives
    - Provide clarity around the case for change and a commitment to change
    - Involve staff in creating the change and give them ownership
    - Centre this around leadership vision and behaviours
    - Show what the future and success will look like
    - Create the stories

- Our suggestion is that this campaign is used to communicate the overarching ***corporate objectives*** in a way that is relevant to staff (including transformation) This necessitate tweaking its positioning but will enable us to reach areas where we have limited reach and engagement (see next slide for the transformation campaign approach)

How are we going to do it? (transformation) Campaign Strategy

Communications strategy

Stakeholder strategy

The proposed approach to communicating the transformation programme can be modified to include trust objectives as the overarching proposition with stakeholder segmentation and dedicated transformation messages

Organisation Wide Campaign – 'Spirit of St George's' or 'better for staff, better for patients, better efficiencies' or 'the shape of things to come'- *The case for change, the challenges and opportunities ahead for the organisation*

Trust Objectives

10 Commitments (tbc)
1. Commitment to quality
2. Transformation Programme
3. Workforce is supported and motivated
4. Education and research
5. Maximise efficiency
6. Empower to make change
7. Provision of tools
8. Work life balance
9. Your Health & wellbeing
10. Open & Honest

Segment level Campaigns – 'A future to believe in' – What do the challenges and opportunities look like for you

Nurses | Consultants | Junior Doctors | AHP's | Admin band 2 - 6 | Managers band 7+ | Non - Clinical

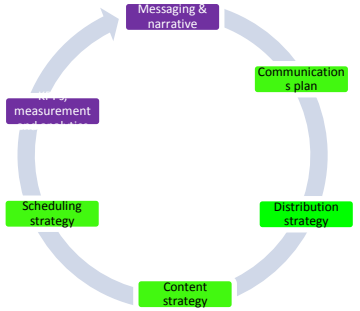
CAMPAINGS AND DEDICATED SUPPORT (DIPS)

Workforce efficiency | **Clinical transformation** | **Portfolio optimisation** | **Divisional functional improvements** | **Corporate efficiency** | **Infrastructure**

Communications strategy

30/60/90 day Scheduling strategy

Communications strategy



5. A new set of tools will be designed to support the communication process. This includes the design of a Strategy Map with metrics that can be posted in high traffic hallways or on wards or gathering areas to provide a visual metaphor for the strategy
6. By end of April the communications team will have redesigned eG in to separate newsletters and redesigned the trusts internal publication providing an excellent opportunity in each to shine a spotlight on 'strategy' .This will also provide new opportunity to have regular messages from the chair and CEO, Recognise and reward change ,Publicly recognise key people for their contributing to change though a new wards structure (see next slide) celebrate when key milestones are achieved to boost morale
7. During April & May it is critical that all execs take the opportunity to increase their visibility at front of house events and F2Fopportunities. During April communications team to design metrics and KPIs for measure impact alongside staff FFT etc
8. From May the message will move to the ***organisations focus for 2016/17*** which will provide the opportunity for the messaging on current priorities to circulate ' allowing longer term messaging to seem more feasible. Campaign launch beginning of May
9. The messaging for ***organisations focus for 2016/17*** will be disseminated through existing communications channels and though new bespoke channels and products
10. During April& May ,Lead Directors and communications team to work on bringing each of the 6 corporate objectives to life. Work on the transformation programme communications is well underway and there is an immediate need to understand and address the issues identified in the 2015 staff survey, and to develop meaningful two-way communication with all staff groups, through a refreshed communications strategy .For example redevelopment of the trust intranet provides an ideal opportunity to digitise the 'quality observatory'.

New awards scheme dedicated to change transformation and innovation (working titles)

A new award scheme dedicated to change and transformation that works alongside the values awards and chief nurse surgery awards – and recognises and rewards staff for their contribution to change. These will also generate a range of good news stories and content for trust corporate communications channels

- **Innovation Award**

  A medical/clinical innovation or an individual has designed and embedded a new innovative approach to care in to the trust
- **Collaboration award**

  An individual who has proactively collaborated outside of their service or organisational boundaries to successfully effect and embed transformation and change
- **Investigation Award**

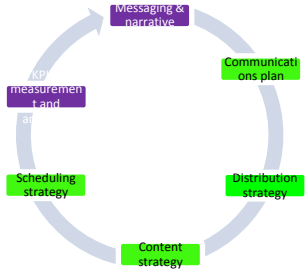
  An individual who has proactively brought learning and practice from outside SGH and embedded that learning in to the trust
- **Inspiration award**.

  An individual who has successfully embedded transformation and change in to their environment and motivated others to follow.

Communications strategy

30/60/90 day Scheduling strategy

Communications strategy



- **Create the change narrative**– explains what the future of the organisation will look like
- Explain how the vision will be executed
- Build in flexibility to adapt
- Communicate the current priorities
- Develop the vision and strategy

- Talk often about the change vision
- Utilise all communications channels
- Openly and honestly address the concerns and anxieties
- Lead by example
- Apply this to all areas of the organisation
- Empower employees for action
- Identify change leaders who will be the conduit for the vision

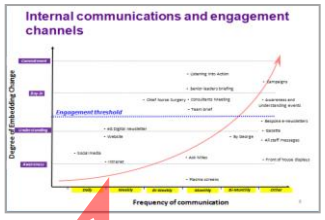
- Recognise and reward change
- Generate short term wins and communicate
- Look for sure fire projects that can be implemented easily
- Celebrate when they are achieved to boost morale
- Set goals to build momentum
- Include change ideals and values in recruitment process and training policies
- Publicly recognise key people for their contribution

April | **May 0 -30 days** | **June 30-60 days** | **July 60-90 days**

Creative | **Collaborative** | **Courageous** | **Radical**

April - delivery plan

Channels & content strategy



Note there are a range of other events and communications activities that this programme can feed in to

Awareness

- **All staff message** from the Chairman - First reflections & key priorities
- **eG** - Chairman - First reflections & key priorities
- **eG** - Director of Estates - First reflections & key priorities
- **Intranet** - Home page banner with link to message from chairman

Understanding

- **Core brief -** Topics to include to how we are addressing the current priorities, CQC inspection and £17m performance based gov funding & Transformation
- **Ask Miles** - Advertised as an opportunity to present/discuss current priorities and to openly address the concerns and anxieties

Buy-in

- **Senior Leaders Briefing & Chief Nurse Surgery** - Director of Estates, CIO & CCIO to present current priorities
- **Consultants meeting -** Medical Director, Director of Estates & CIO , CCIO to present current priorities at Consultants meeting

Commitment

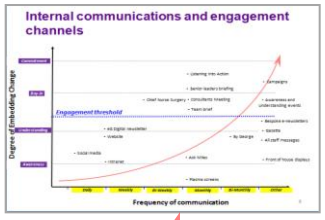
- **NEW Back to the floor -** Board and execs to join at least one 'taking the chief nurse surgery back to the floor' visits (weekly visits to wards leading up to CQC inspection)
- **NEW Team meetings - Board and execs to join team meetings around the trust – communications team to identify meetings to join**

- **Story /narrative developed through the board with support from the communications team** ***(what do we want staff to think, feel, believe) the organisations focus for 2016/17 with measurable objectives*** Communications team and Board to translate narrative in to visual metaphor (may require outsourcing to agency) and create the change vision
- **Campaign** - Board and TAB to sign off Corporate Objectives and Transformation trust wide Campaign launches utilising on and off line media to ensure that the campaign reaches all staff within the organisation – we envisage this will include a dedicated microsite, video, posters, banners, leaflets, email and social media
- **Chief Nurse Surgery -** model changes to require every ward and clinical area to send at least one representative to attend
- Communications team to work with Chief Nurse and Director of Estates to bring each of the 6 corporate objectives to life – linked to CQC and organisational development

Enablers

May delivery plan: 0-30 days

Channels & content strategy



Awareness

- **All staff message** CEO – 2016/17priortites with story /narrative developed through the board
- **eG** - 2016/17priortites /narrative developed through the board – feature on one of the six corporate objectives
- **Intranet** - Strategy section created on exiting intranet
- **Social media** – Utilise to engage on corporate priorities

Understanding

- **Core brief** - May team brief to include the organisational focus for 2016/17 and progress towards priorities
- **Ask Miles** - Advertised as an opportunity to discuss organisational focus for 2016/17
- **NEW Campaign launches** utilising on and off line media to ensure that the campaign reaches all staff within the organisation – we envisage this will include a dedicated microsite, video, posters, banners, leaflets, email and social media.
- **NEW internal newsletters launch** with an opportunity to have regular features on staff wellbeing, quality and strategy to communicate change vision
- **Visual metaphor for strategy map** completed and disseminated around the trust

Buy-in

- **Senior Leaders Briefing /Consultants meeting Chief Nurse Surgery** - CEO & Director of strategy to present organisational focus for 2016/17 and explain how the vision will be executed. Transformation director to update
- **Senior Leaders Briefing /Consultants meeting Chief Nurse Surgery** - Director of HR to present progress towards issues identified in the 2015 staff survey (communications strategy completed)

Commitment

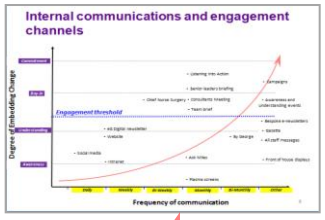
- **NEW Back to the floor** - Board and execs to join at least one 'taking the chief nurse surgery back to the floor' visits (weekly visits to wards leading up to CQC inspection)
- **NEW Team meetings** - Board and execs to join team meetings around the trust – communications team to identify meetings to join
- **Back to the floor** Well-being walk about by Chair and council of governors to engage with staff on current priorities

Enablers

- Identify change leaders who will be the conduit for the vision
- Communications team to purchase video equipment and digital editing software in preparation for new intranet launch to Commission bite size , sharable information that appeals to busy staff.

June delivery plan: 30-60 days

Channels & content strategy



Awareness

- **All staff message** CEO – Recognise and reward change. Communicate short term wins. Celebrate project achievements to achieved to boost morale
- **NEW internal newsletters** Utilise voice of the professions and change leaders who will be the conduit for the vision
- **NEW internal newsletters dedicated strategy sections** Communicate short term wins. Celebrate project achievements to achieved to boost morale
- **Social media** – Utilise to engage on corporate priorities

Understanding

- **Core brief** - core brief to update on the organisational focus for 2016/17 and progress towards priorities and opportunity for thoughts on corporate objectives
- **Ask Miles** - Advertised as an opportunity to discuss organisational focus for 2016/17
- **Campaign continues** Board and execs to attend front of house stands
- **NEW Visual metaphor for strategy map** completed and disseminated around the trust
- **Transformation communications to individual stakeholders continues**
- **NEW** 6 corporate objectives are bough to life and communicated via all internal channels

Buy-in

- **Senior Leaders Briefing /Consultants meeting Chief Nurse Surgery** - CEO & Director of strategy to present – Are we on track? Communicate short term wins. Celebrate project achievements to achieved to boost morale
- **Senior Leaders Briefing /Consultants meeting Chief Nurse Surgery** - CEO & Director of strategy to present – Are we on track? Communicate short term wins. Celebrate project achievements to achieved to boost morale
- **NEW transformation and awards launch**

Commitment

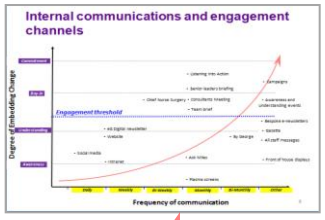
- **NEW Show and Tell day – Hyde Park Room – All board to attend. Visuals and posters banners etc to describe the trust objectives. Creative methods to engage staff vision. Ideally before CQC visit**
- **NEW Back to the floor** - Board and execs to join at least one 'taking the chief nurse surgery back to the floor' visits (weekly visits to wards leading up to CQC inspection)
- **NEW Team meetings** - Board and execs to join team meetings around the trust – communications team to identify meetings to join
- **Back to the floor** Well-being walk about by Chair and council of **governors post CQC inspection**

- **Communications team to have worked with Directors to explore corporate objectives and communicate in a compelling way for staff**

Enablers

July delivery plan: 60-90 days

Channels & content strategy



- **All staff message & EG** Chair to reflect upon first 3 months at the trust
- **All staff message & eG Director** of Estates 3 months in posts how we have addressed the current priorities
- **New internal newsletters** Utilise voice of the professions and change leaders who will be the conduit for the vision
- **New internal newsletters dedicated strategy sections** Communicate short term wins. Celebrate project achievements to achieved to boost morale
- **Social media** – Utilise to engage on corporate priorities

- **Core brief -** June brief to include to the organisational focus for 2016/17 - transformation - progress towards priorities and opportunity for thoughts on corporate objectives
- **Campaign continues** Microsite and digital resources updated to reflect current position
- **Transformation communications to individual stakeholders continues**
- **NEW intranet launches**
- **AMM**
- 6 corporate objectives are bough to life and communicated via all internal channels

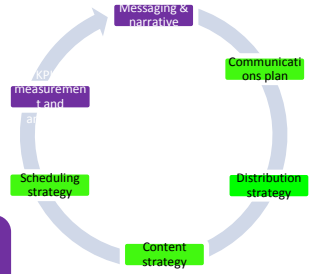
- **Senior Leaders Briefing /Consultants meeting Chief Nurse Surgery** - CEO & Director of strategy to present – Are we on track? Communicate short term wins. Celebrate project achievements to achieved to boost morale
- **Senior Leaders Briefing /Consultants meeting Chief Nurse Surgery** - CEO & Director of strategy to present – Are we on track? Communicate short term wins. Celebrate project achievements to achieved to boost morale

- **Future of St George's – Big Conversation in mid July – are we on the right track and sense checking**
- **Team meetings -** Board and execs to join team meetings around the trust – communications team to identify meetings to join

Awareness | **Understanding** | **Buy-in** | **Commitment**

Enablers

KPIs, measurement and analytics



KPI's, measurement and analytics

- Staff FFT
- Sense checking by board members at events
- Clinical and quality outcomes
- Performance, recruitment and retention
- Financial performance

- The communications team will devise a framework for measuring communications success to include numbers for

  - Intranet pages activity and readership (measurable with new system)
  - Good news stories articles in staff magazine
  - Good news stories articles in staff newsletter
  - Managers attending briefings
  - Staff attending events, what did they think of the event
  - Staff who recognised the messages, measured through walkabouts
  - Submissions to awards
  - Where the staff have co-authored new ideas and change

St George's Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD

Paper Title:	Quality and performance Report to Board Month 11 February 2016
Sponsoring Director:	Jennie Hall- Chief Nurse/ Director Infection Prevention and Control Simon MacKenzie- Medical Director Paula Vasco-knight – Chief Operating Officer
Authors:	Hazel Tonge, Deputy Chief Nurse Jennie Hall- Chief Nurse/ DIPC Simon Mackenzie- Medical Director Peter Riley- Infection Control Lead Corporate Nursing Team Divisional Directors Nursing/ Governance Trust Safeguarding Leads Head of Performance
Purpose:	To inform Board/ QRC about Quality Performance for Month 11.
Action required by the board:	To note the report and key areas of risk noted.
Document previously considered by:	Finance and Performance Committee Quality and Risk Committee

Executive summary

Performance

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

The trust continued to see a positive performance in Diagnostics in February with the number of patients waiting greater than 6 weeks reducing. There was however a slight increase with regards to cancelled operations and the number of patients not re-booked within 28 days compared to the previous month, due to bed availability, emergency cases, hospital cancellations and list's over running.

The trust was non-compliant against 4 cancer targets in January, the 62 Day standard and screening, the 31 Day and Two week standard. Following the underperformance the trust has had a meeting with NHSE and commissioners and some revisions to the Trust recovery plan have been agreed with a key focus on enhancing the patient tracking process allowing for earlier escalation and expedition in the patient pathway. The Trusts recovery plan continues to be reviewed weekly via the trust cancer performance meetings and externally by commissioners and NHSE-London via the Elective System Resilience Group.

The trust continues to implement its unplanned care recovery programme which encompasses the flow programme and the outputs of the OVOT. A supporting trajectory for recovery of the ED 4 hour standard has produced in conjunction with the OVOT programme and is being monitored via the Trust Flow Programme Board and externally via commissioners and NHSE through the Unplanned Care System Resilience sub-group.

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.

Key Points of Note for the Board to note in relation to February 2016 Quality Performance

The Overall position in February 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. The Mortality Monitoring Committee review SHMI in detail. Investigating phlebitis, thrombophlebitis and thromboembolism: varicose veins of lower extremity, haemorrhoids, other diseases of the veins and lymphatic's found no avoidable mortality.
- National Audits within the report: The first report indicates the results from the Rheumatoid and Early Inflammation Arthritis national audit. The report highlights the need for improvement in waiting times and treatment for initial stages of rheumatoid and early arthritis. In addition, the report indicates adult community acquired pneumonia (CAP) national audit, which showed continued improvement in provision of antibiotics and sustained improvement in in patient mortality, although low concordance with antimicrobial recommendations, mortality in line with national average but a higher number of patients readmitted in 30 days of discharge. Finally, the neonatal national audit programme (NNAP) found that the trusts standards are largely similar to the national results. On a positive note follow up data was followed up for 100% babies from SGH. The report makes several recommendations for commissioners, clinical teams and trust boards, highlighting increased need for support with data capture.
- The report indicates the position with compliance with NICE guidance for the period August 2011 to November 2015. The number of outstanding areas of non-compliance has increased, however actions have been put in place to recover this position. Lack of resource of the Clinical Effectiveness Team has delayed follow up of outstanding guidance and will be a priority in April now new resource has joined the team.

Safety Domain:

- The number of general reported incidents in February indicates a similar trend in terms of numbers and level of harm. Of those declared for February the Board will note the issues are across a range of clinical issues.
- Safety Thermometer performance deteriorated slightly from the previous month 92.64% which is below the national average. There was an increase in both old and new harms, with an increase in pressure ulcers on Safety thermometer which is a point prevalence data point.
- The trend line appears to indicate falls incidence has slightly increased over the last year, although this month showed a downward trend, with 1 severe case of harm reported which is being investigated as an SI.
- The pressure ulcer profile for February saw a reduction in total number of pressure ulcers SIS with no declarations across the trust plus reduction in number of grade 2. Year on year there has been an improvement.
- There were no MRSA Hospital-acquired bacteraemias in December or January. The last hospital-acquired MRSA bacteraemia was on 23rd September 2015. The Trust is non-compliant , with 3 incidents in total against a target of zero. In December there was one *C. difficile* episode and two in January. This makes a total of 25 against a trajectory of 31 cases. .
- Safeguarding Adults compliance for training remains a key area of focus. The Trust is now demonstrating a compliance of 73% 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.
- Safeguarding children compliance for children's training remains a focus with level 3

compliance at 81%, and is included on the risk register.

Experience Domain:

- February MSA breaches show a disappointing spike with 6 breaches, one patient breaching and 5 others being affected. The trust has had 11 breaches year to date the other reported breaches in October when there was one breach with 4 patients affected. The breach occurred at a time when the ED department was experiencing significant capacity and bed pressures
- In February 94% of people were extremely likely / likely to recommend the service to friends or relatives this is tabulated in the attached report. Response rate in OP are underperforming which day cases and critical care are scoring the highest.
- The complaints profile in relation to numbers has increased slightly in terms of numbers. In relation to turnaround times of complaints there has been an improvement compared to December when 67% complaints were responded to in the time scale. A complaints workshop has been rescheduled for April 2016.

Well Led Domain:

- The safe staffing return is included for all inpatient areas. The average fill rate for the Trust is 94.1% % 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 February is included this month for both Acute and Community services. Medcard will be added for the Trust Board report.

risks identified:
Complaints performance (on BAF)
Infection Control Performance (on BAF)
Safeguarding Children Training compliance Profile (on BAF)
Staffing Profile (on BAF)

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	

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

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St George's University Hospitals NHS
NHS Foundation Trust

Performance and Quality Report

For Trust Board

Month 11 – February 2016

Excellence in specialist and community healthcare

CONTENTS

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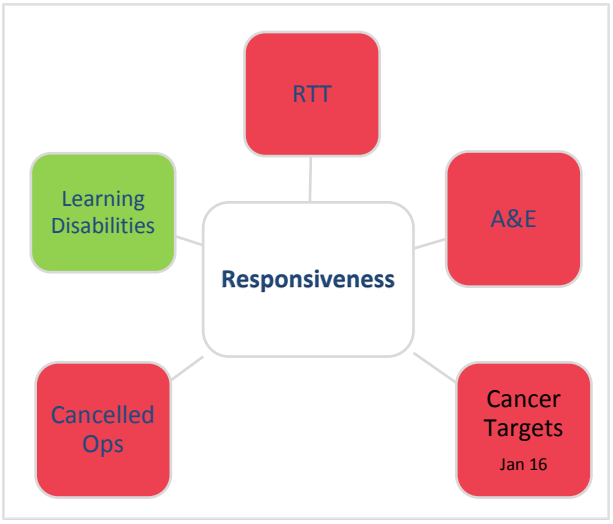
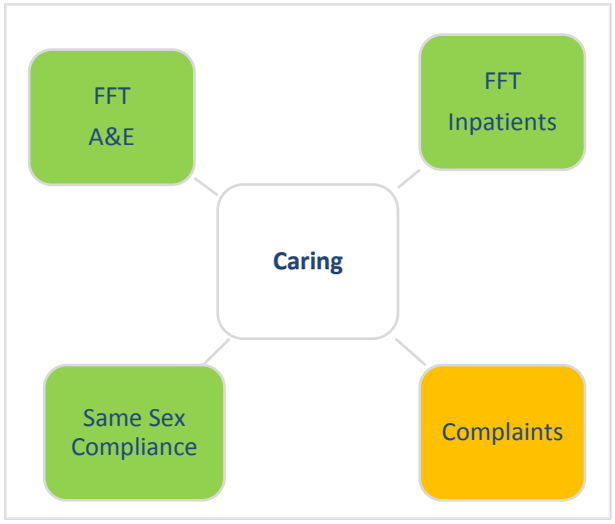
St George's University Hospitals NHS
NHS Foundation Trust

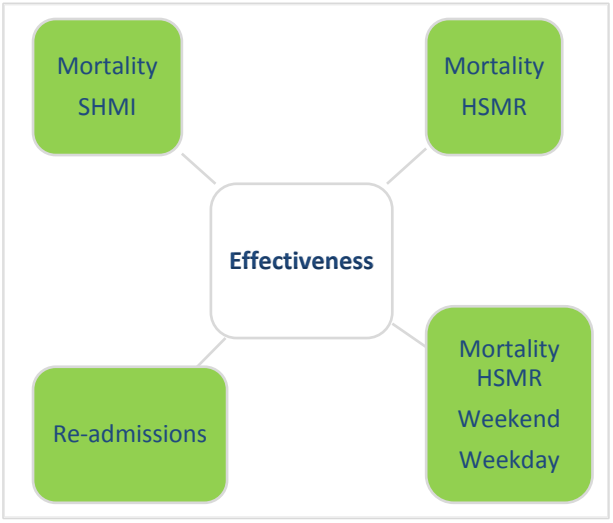
Performance against Frameworks

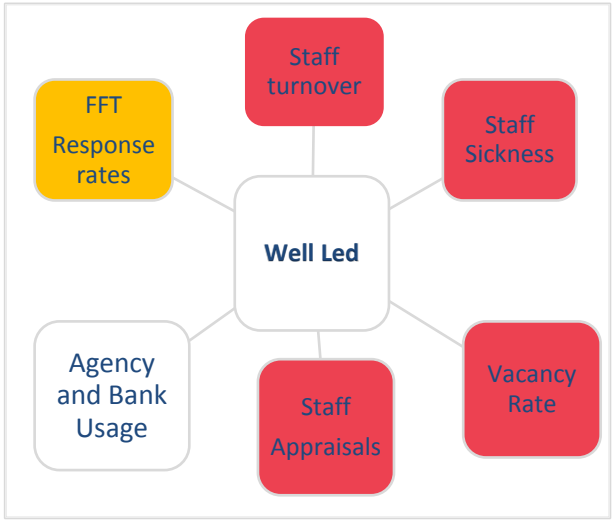
Excellence in specialist and community healthcare

1. Executive Summary - Key Priority Areas February 2016*









The above shows an overview February 2016 performance for key areas within each domain and also as detailed in the Monitor Risk Assessment Framework. These domains correlate to those of the CQC intelligent monitoring framework.

The overview references where the trust may not be meeting 1 or more related targets. (*Note Cancer RAG rating is for January 2016 as reported one month in arrears)

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

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

ACCESS

Metric	Standard	Weighting	Score	YTD	Jan-16	Feb-16	Movement
Referral to Treatment Admitted	90%	N/A	N/A		78.20%	76.90%	-1.30%
Referral to Treatment Non Admitted	95%	N/A	N/A		91.00%	89.70%	-1.30%
Referral to Treatment Incomplete	92%	1	1		89.70%	90.30%	0.60%
A&E All Types Monthly Performance	95%	1	1	91.71%	88.70%	83.18%	-5.52%
Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q3**	**Q1**	**Movement**
62 Day Standard	85%	1	1	82.52%	85.50%	83.58%	-1.91%
62 Day Screening Standard	90%			90.04%	94.25%	86.44%	-7.81%
31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%		0	96.72%	97.87%	97.06%	-0.81%
31 Day Standard	96%	1	0	96.90%	97.83%	90.21%	-7.62%
Two Week Wait Standard	93%	1	1	86.90%	88.24%	91.13%	2.89%
Breast Symptom Two Week Wait Standard	93%	1		93.20%	93.78%	96.65%	2.87%

OUTCOMES

Metric	Standard	Weighting	Score	YTD	Jan-16	Feb-16	Movement
Clostridium(C.) Difficile - meeting the C.difficile objective (de minimis of 12 applies)	31	1	0	28	2	3	1
Certfication of Compliance Learning Disabilities;							
Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are resonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	1	0	Yes	Yes	Yes	
Does the Trust have protocols in place to regulary audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant	1	0	Yes	Yes	Yes	
Data Completeness Community Services:							
Referral to treatment * data is for Oct and Nov 2015	50%	1	0		55.6		-55.6
Referral Information	50%	1	0		87.9	87.7	-0.2
Treatment Activity	50%	1	0		69.92	70.37	0.5
Trust Overall Quality Governance Score					4	4	0

February 2016 Performance against the risk assessment framework is as follows:

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

.

Areas of underperformance for quality governance are:

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

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

*Cancer Data is reported a month in arrears. Q4 relates to Jan 16 only.

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

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

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

RESPONSIVENESS

Metric	Standard	YTD	Jan-16	Feb-16	Movement
Referral to Treatment Admitted	90%		78.20%	76.90%	-1.30%
Referral to Treatment Non Admitted	95%		91.00%	89.70%	-1.30%
Referral to Treatment Incomplete	92%		89.70%	90.30%	0.60%
Referral to Treatment Incomplete 52+ Week Waiters	0	23	0	1	1.00
Diagnostic waiting times > 6 Weeks	1%		0.75%	0.45%	-0.30%
A&E All Types Monthly Performance	95%	91.71%	88.70%	83.18%	-5.52%
12 Hour Trolley Waits	0	0	0	0	0.00%
Urgent Ops Cancelled for 2nd time (number)	0	0	0	0	0.00%
Proportion of patients not treated within 28 days of last minute cancellation	0%	17.31%	12.68%	16.20%	3.52%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Dec-15	Jan-16	Movement
62 Day Standard	85%	82.52%	86.13%	83.30%	-2.83%
62 Day Screening Standard	90%	90.04%	91.07%	86.40%	-4.67%
31 Day Subsequent Drug Standard	98%	100%	100%	100.0%	0.00%
31 Day Subsequent Surgery Standard	94%	97%	96%	97.1%	1.10%
31 Day Standard	96%	96.90%	97.81%	90.20%	-7.61%
Two Week Wait Standard	93%	86.90%	94.84%	91.10%	-3.74%
Breast Symptom Two Week Wait Standard	93%	93.20%	97.11%	96.60%	-0.51%

EFFECTIVENESS

Metric	Standard	YTD	Jan-16	Feb-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		90.9	91.0	0.1
Hospital Standardised Mortality Ratio - Weekday	100	0	89.7	87.0	0.3
Hospital Standardised Mortality Ratio - Weekend	100	0	92.5	91.0	-1.5
Summary Hospital Mortality Indicator (HSCIC)	100	0	90	90	0.0
Emergency Re-admissions within 30 days following Elective or emergency spell within the Trust	5%	3.10%	1.50%	1.40%	-0.1%
Bed Occupancy - Midnight Count Generl Beds Only	85%		99.7%	97.4%	-2.3%
LOS - Elective			3.7	3.98	0.3
LOS - Non-Elective			4.6	5.1	0.50

CARING

Metric	Standard	YTD	Jan-16	Feb-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		93.23%	93.11%	-0.12%
A&E Scores - Friends & Family Recommendation Rate	46		83.21%	80.69%	-2.52%
Complaints (1 month in arreas)			78	74	-4.0
Mixed Sex Accomodation Breaches	0	11	0	6	6.0

SAFE

Metric	Standard	YTD	Jan-16	Feb-16	Movement
Clostridium Difficile - Varience from plan	31	28	2	3	1
MRSA Bacteramia	0	3	0	0	0
Never Events	0	8	0	0	0
Serious Incidents	0	120	7	8	1
Percentage of Harm Free Care	95%		94.1%	93.0%	-0.011
Medication Errors causing serious harm	0	3	0	1	1
Overdue CAS Alerts	0	2	2	2	0
Maternal Deaths	1	1	1	0	-1
VTE Risk Assessment (previous months data)*	95%		96.60%	96.70%	0.001

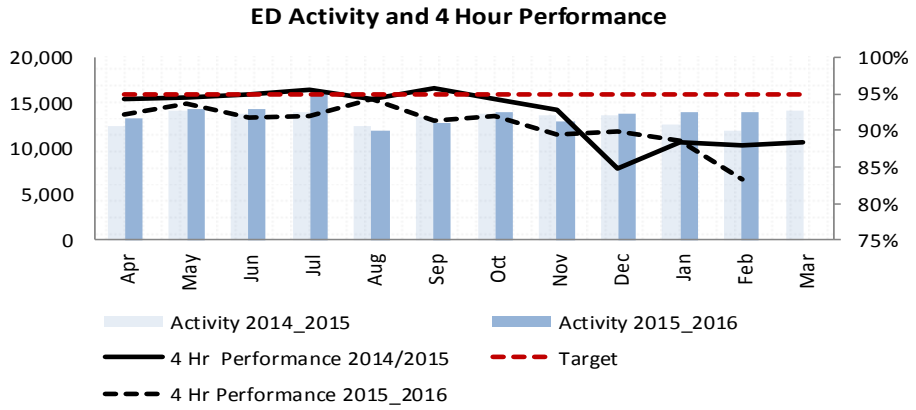
WELL LED

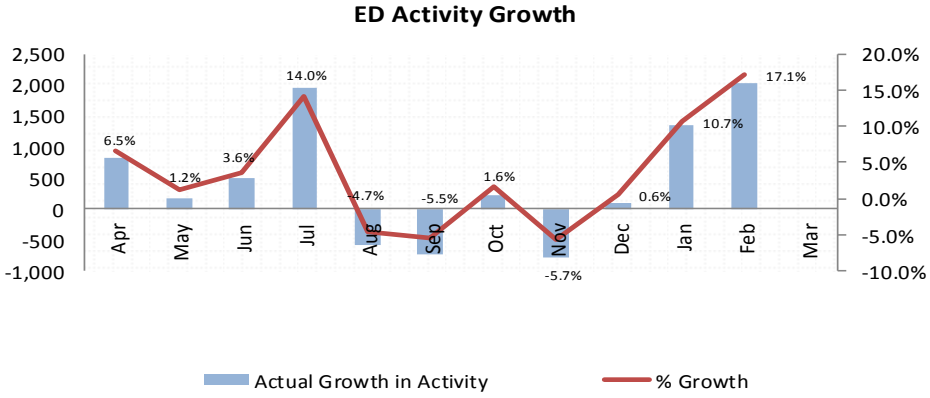
Metric	Standard	YTD	Jan-16	Feb-16	Movement
Inpatient Respose Rate Friends & Family	30%		20.1%	19.5%	-0.6%
A&E Respose Rate Friends & Family	20%		23.7%	26.0%	2.3%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		18.5%	18.7%	0.2%
Trust level sickness rate	3.5%		4.3%	4.3%	0.0
Total Trust Vacancy Rate	11%		16.7%	15.9%	-0.8%
% of staff with annual appraisal - Medical	85%		85.2%	86.4%	1.24%
% of staff with annual appraisal - non medical	85%		69.4%	68.9%	-0.47%

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.

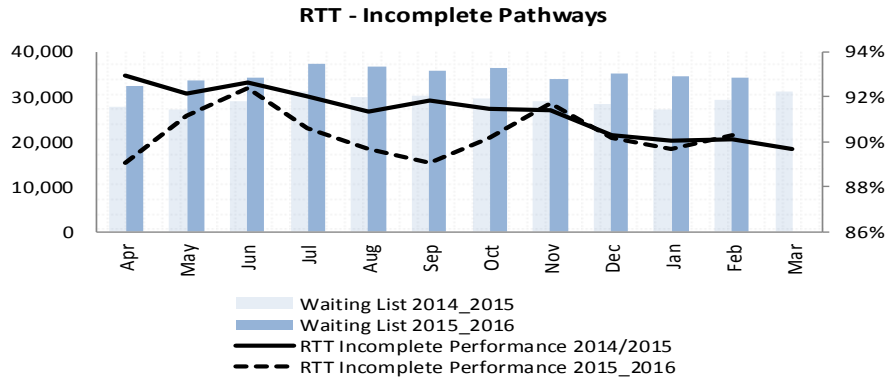
3. Trust Key Performance Areas and Activity Comparison to previous year (1 of 2)

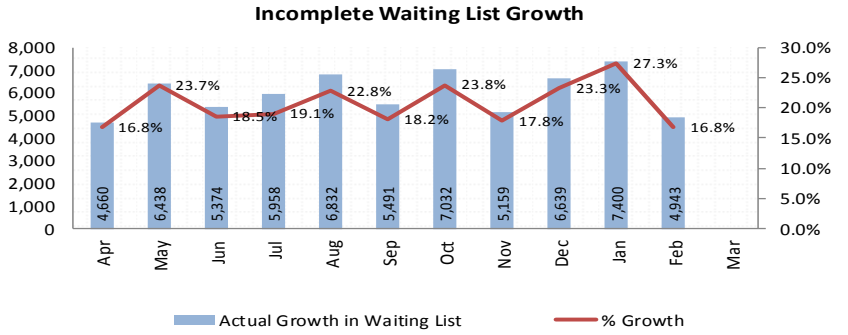
ED Performance

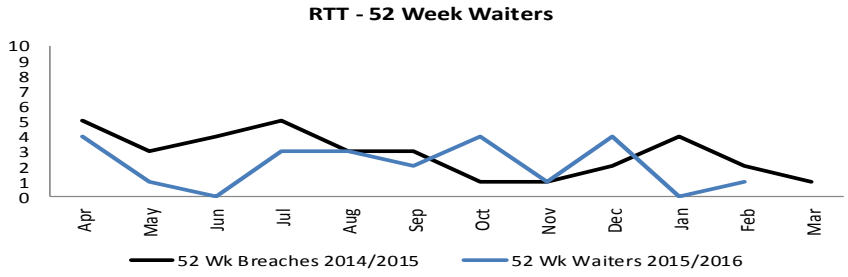


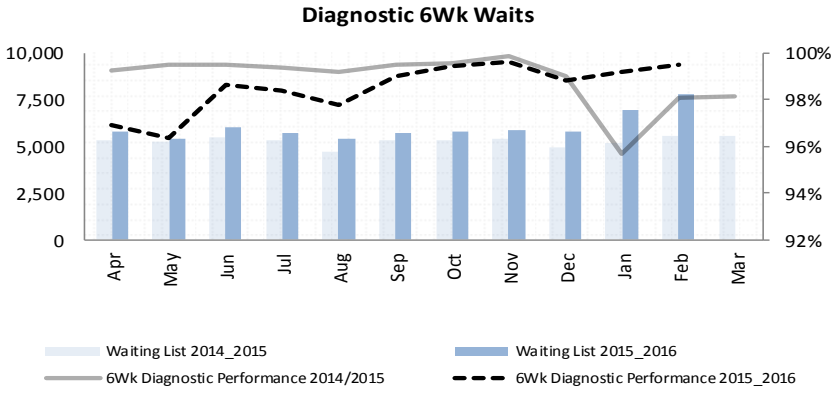


RTT & Diagnostics

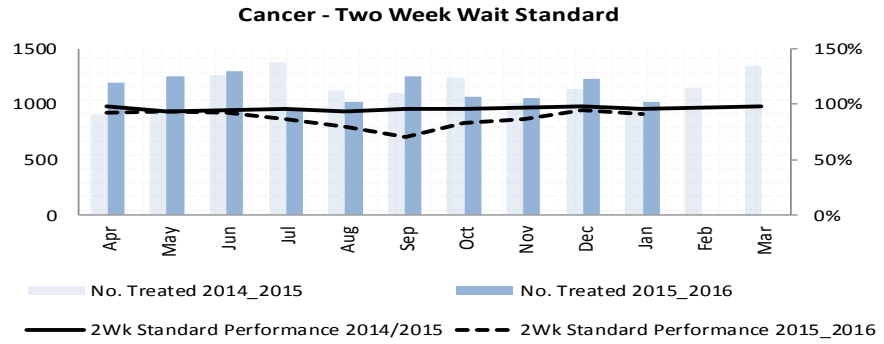


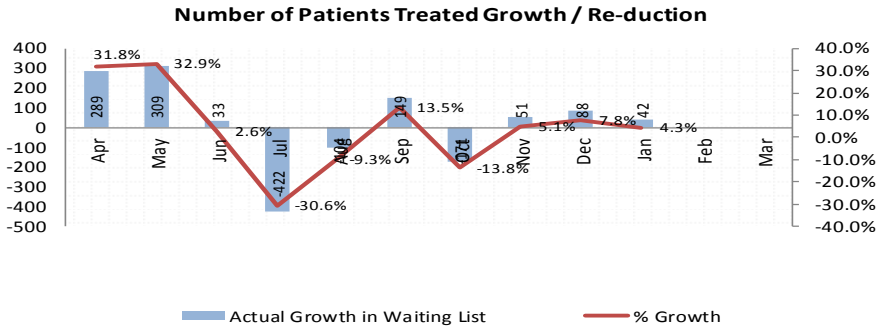


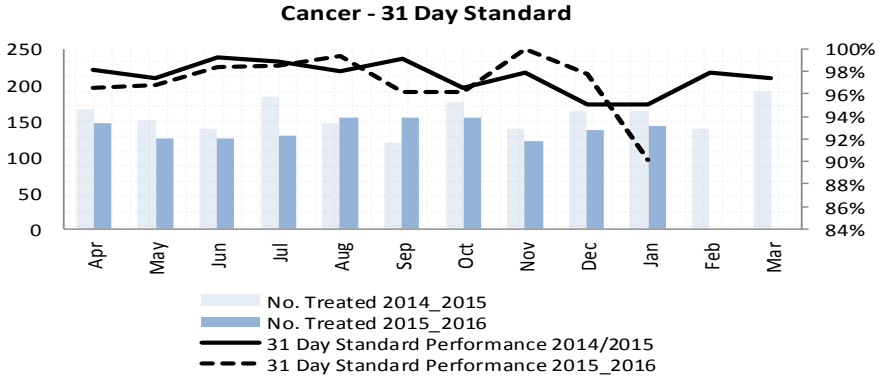


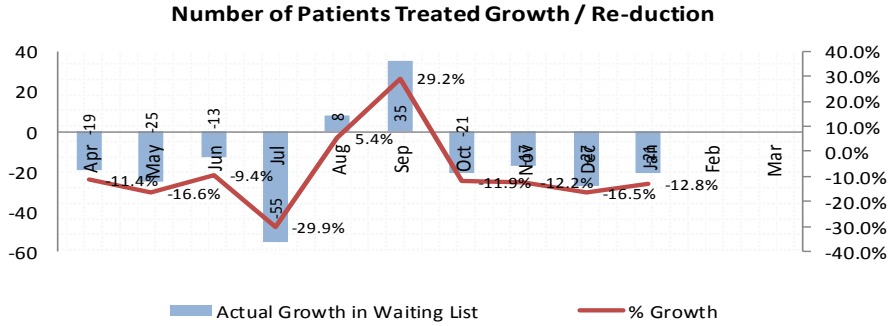


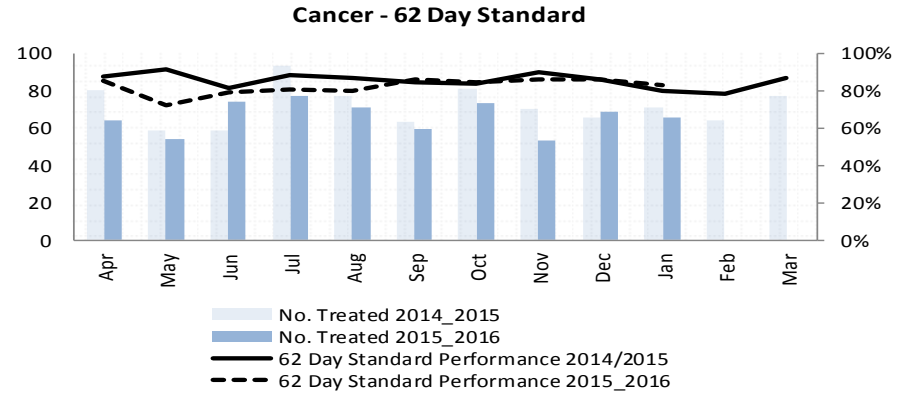
3. Trust Key Performance Indicators and Activity Comparison to previous year (2 of 2)

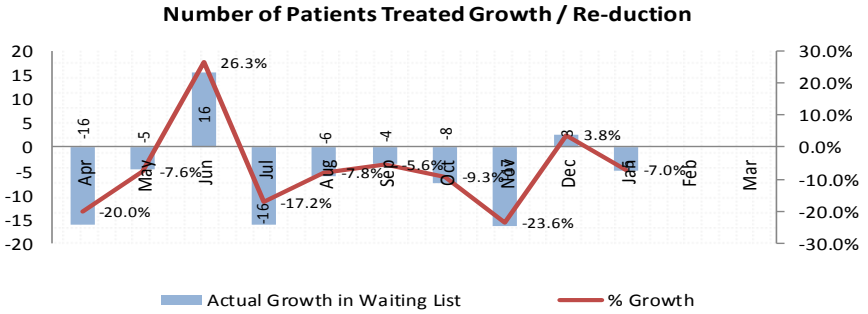












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Performance – areas of escalation

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	Jan-16	Feb-16	Movement	2015/2016 Target	Forecast for Feb-16	Forecast for Mar-16	Date expected to meet standard
FA	88.70%	83.18%	-5.52%	>= 95%	R	R	TBC

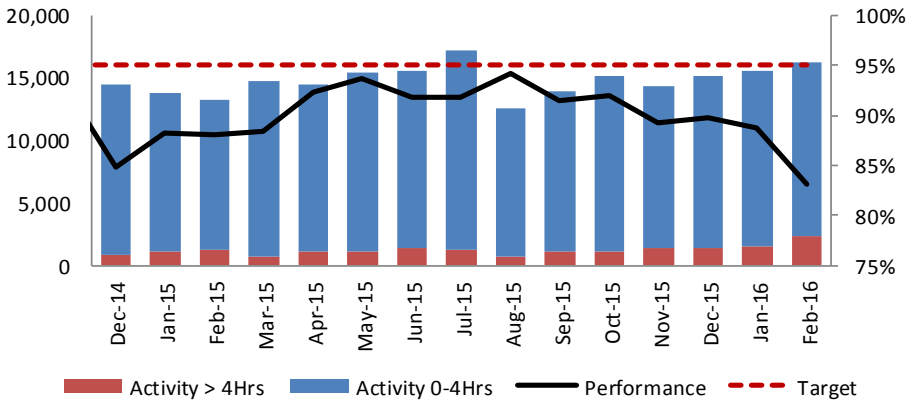
Peer Performance January 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	3	5	1
88.70%	91.80%	91.70%	86.20%	92.10%

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 February 83.2% of patients were seen within 4 hours which was 5.52% lower than January 2016.

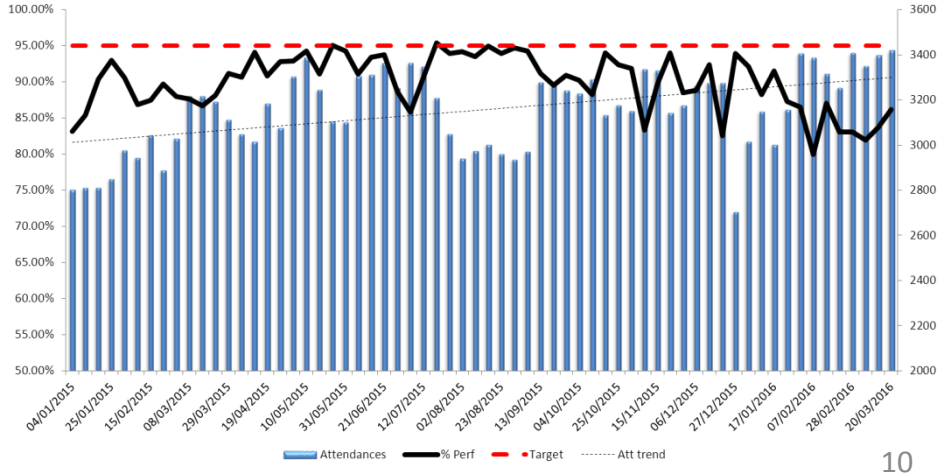
Factors that continue to affect performance include:

- Capacity pressures within the Emergency Department
- An increase in the numbers of delayed transfer of care patients (DTOC) in comparison to last month and the level of delay. This remains a focus area for the organisation as this has a significant impact on flow through the hospital and impact upon ED flow into the organisation. As at 01/03/2016 there were 20 DTOC and 23 Non-DTOC.
- As at 01/03/2016 there were 54 of 601 (9%) 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.
- Continued high number of attendances (7 of last 8 weeks have had >3000 type 1 attends)
  Conversion rates remain stable, therefore higher number of emergency admissions from ED.
  Breaches predominantly driven by bed management and ED capacity, followed by specialist opinion and treatment complexity
- The trust continues to implement its unplanned care recovery programme which encompasses the flow programme and the outputs of the OVOT. (A separate update paper in relation to the flow programme is part of the agenda)

ED 4 Hour Performance



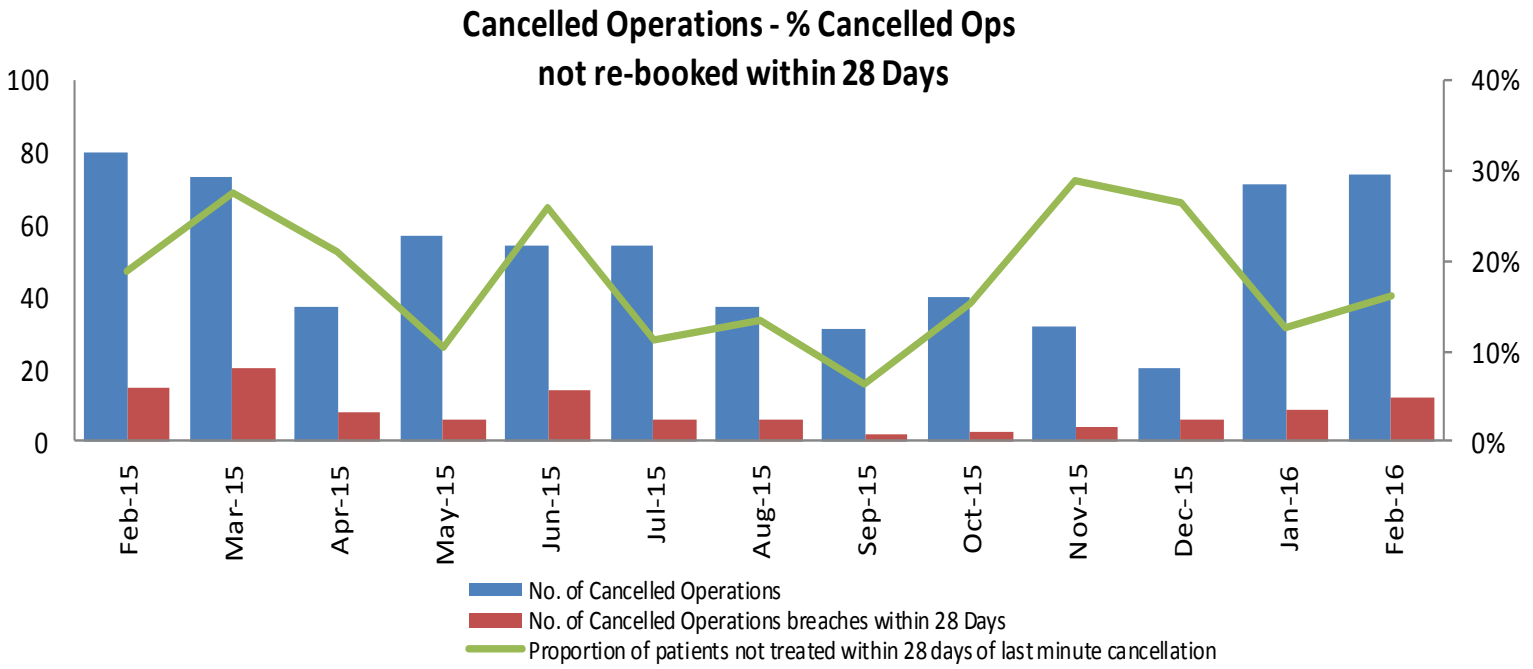
Performance and Attendances by Week January 2015 to date



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

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Jan-16	Feb-16	Movement	2015/2016 Target	Forecast for Feb-16	Forecast for Mar-16	Date expected to meet standard
CC	12.68%	16.20%	⇩ 3.52%	0%	G	G	Feb-16

Peer Performance Comparison – Latest Available Q3 2015/16				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	5	3	1
23.5%	2.3%	0.0%	12.0%	1.2%



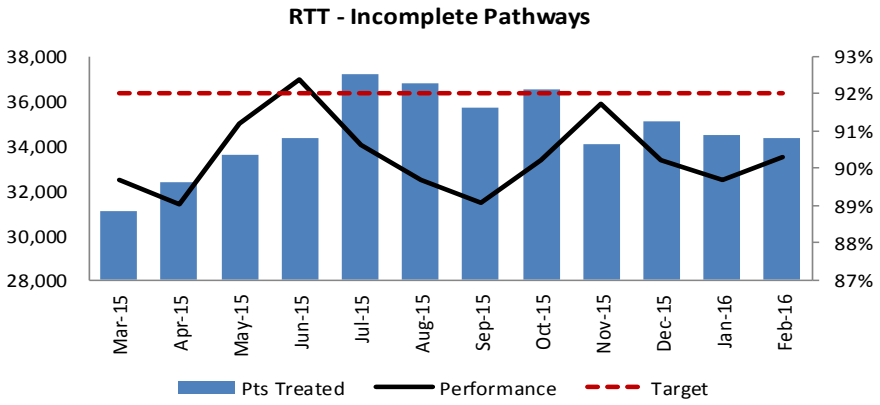
The national standard is that all patients whose operation has been cancelled for non clinical reasons should be treated within 28 days.

The trust had 74 cancelled operations from 4593 elective admissions in February. 62 of those cancellations were rebooked within 28 days with 12 patients not rebooked within 28 days, accounting for 16.2% of all cancellations. There was a slight increase in the number of cancelled operations compared to the previous month. The majority of cases were cancelled due to bed availability, emergency cases, hospital cancellations and list's over running.

4. Performance Areas of Escalation (Page 3 of 5) - RTT Incomplete Pathways

Referral to Treatment Incomplete Pathways							
Lead Director	Jan-16	Feb-16	Movement	2015/2016 Target	Forecast for Feb-16	Forecast for Mar-16	Date expected to meet standard
PVK	89.70%	90.30%	↑ 0.60%	92%	R	R	TBC

Peer Performance January 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	2	1		3
89.70%	94.00%	96.90%	-	92.10%



The Trust has been non-compliant against RTT incomplete pathways for a number of months however in February there was a slight increase in performance from 89.7% in January to 90.3% in February.

As part of the trust RTT recovery and sustainability programme, through validation at month end the waiting list size reduced by 0.4%, with the biggest decrease in General Surgery (-249 pts) and Dermatology (-103 pts). There are a number of specialties shown in the table below who remain challenged with performance below target of 92%. However Cardiothoracic and Thoracic Surgery have seen a dip in the last month.

RTT remains a challenge and the trust acknowledges the importance of not just reducing long waiters but achieving a position of sustainability. The trust following work with the IST has developed a trajectory for performance recovery for 2016/17. A supporting recovery and sustainability action plan to deliver the trajectory is in development to address the operational and process changes required to deliver sustainability and improve the management of patient pathways.

	Waiting List Size					Backlog Size (18+)					Performance			
Specialty	Dec-15	Jan-16	Feb-16	Var	Var%	Dec-15	Jan-16	Feb-16	Var	Var%	Dec-15	Jan-16	Feb-16	Var%
Gen Surg	3,392	3,311	3062	-249	-7.5%	383	383	343	-40	-10%	88.7%	88.4%	88.80%	0.4%
Urology	1,608	1,600	1593	-7	-0.4%	176	167	177	10	6%	89.1%	89.6%	88.89%	-0.7%
T&O	3,394	3,178	3130	-48	-1.5%	580	572	560	-12	-2%	82.9%	82.0%	82.11%	0.1%
ENT	3,026	2,981	2960	-21	-0.7%	536	518	522	4	1%	82.3%	82.6%	82.36%	-0.2%
Ophthalmology	262	269	264	-5	-1.9%	1	2	7	5	250%	99.6%	99.3%	97.35%	-2.0%
Oral Surgery	2,048	1,927	2076	149	7.7%	39	39	49	10	26%	98.1%	98.0%	97.64%	-0.4%
Neurosurgery	944	915	976	61	6.7%	58	51	37	-14	-27%	93.9%	94.4%	96.21%	1.8%
Plastic Surgery	1,143	1,126	1141	15	1.3%	183	169	137	-32	-19%	84.0%	85.0%	87.99%	3.0%
Cardiothoracic	302	348	349	1	0.3%	93	109	119	10	9%	69.2%	68.7%	65.90%	-2.8%
General Medicine	622	617	661	44	7.1%	27	32	23	-9	-28%	95.7%	94.8%	96.52%	1.7%
Gastroenterology	2,461	2,375	2402	27	1.1%	381	381	296	-85	-22%	84.5%	84.0%	87.68%	3.7%
Cardiology	1,728	1,702	1656	-46	-2.7%	74	102	85	-17	-17%	95.7%	94.0%	94.87%	0.9%
Dermatology	2,610	2,645	2542	-103	-3.9%	249	279	279	0	0%	90.5%	89.5%	89.02%	-0.5%
Thoracic Surgery	986	933	1064	131	14.0%	79	77	119	42	55%	92.0%	91.7%	88.82%	-2.9%
Neurology	1,175	1,225	1171	-54	-4.4%	25	30	33	3	10%	97.9%	97.6%	97.18%	-0.4%
Geriatric Medicine	33	37	33	-4	-10.8%	0	0	0	0	#DIV/0!	100.0%	100.0%	100.00%	0.0%
Rheumatology	989	1,031	983	-48	-4.7%	25	39	38	-1	-3%	97.5%	96.2%	96.13%	-0.1%
Gynaecology	3,059	2,903	3023	120	4.1%	389	453	328	-125	-28%	87.3%	84.4%	89.15%	4.7%
Other	5,345	5,344	5254	-90	-1.7%	143	164	163	-1	-1%	97.3%	96.9%	96.90%	0.0%
Total	35,127	34,467	34340	-127	-0.4%	3,441	3,567	3315	-252	-7%	90.2%	89.7%	90.35%	0.6%

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

Cancer Standard	Target	Q1 15/16 Apr-Jun	Q2 15/16 Jul-Sep	Q3 15/16 Oct-Dec	Q4 15/16 Jan	YTD
62 Day Standard	85%	79.7%	81.9%	85.5%	83.6%	82.5%
62 Day Screening Standard	90%	82.1%	92.7%	94.3%	86.4%	90.0%
31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	100.0%	100.0%
31 Day Subsequent Surgery Standard	94%	95.2%	97.5%	97.9%	97.1%	96.7%
31 Day Standard	96%	97.2%	97.9%	97.8%	90.2%	96.9%
Two Week Wait Standard	93%	92.4%	77.9%	88.2%	91.1%	86.9%
Breast Symptom Two Week Wait Standard	93%	90.4%	94.5%	93.8%	96.6%	93.2%

Cancer Standard	Target	Oct-16	Nov-16	Dec-16	Jan-16
62 Day Standard	85%	84.4%	86.0%	86.1%	83.3%
62 Day Screening Standard	90%	89.2%	98.7%	91.1%	86.4%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	100%
31 Day Subsequent Surgery Standard	94%	100%	100%	96.0%	97.1%
31 Day Standard	96%	96.1%	100%	97.8%	90.2%
Two Week Wait Standard	93%	82.7%	86.2%	94.8%	91.1%
Breast Symptom Two Week Wait Standard	93%	89.6%	93.7%	97.1%	96.6%

The trust was non compliant against 4 cancer targets in January, the 62 Day standard and Screening , and the 31 Day and Two week standard

Two Week Standard

This Standard was not achieved in Gynaecology ,Skin Upper and Upper GI and Urology pathways

Contributory factors included patient choice in Gynae over the xmas period and capacity issues in skin. Capacity issues are currently being addressed as recruitment plans are in place for additional clinical fellows, with commencement dates of April/ May 16.

31 Day Standard

The 31-day standard was not achieved in head and neck, skin and urology pathways. Capacity issues again being a contributing factor, in both skin and urology

62 Day Standard

The standard was not achieved in Head and Neck, Lung and Upper GI. The numbers of patients treated in January were 11% below the planned numbers in the agreed trajectory. (67 treatments vs 75.5 planned)

62 Day Screening

The standard was failed on the Lower GI pathway. Low number of patients treated means that there is a small tolerance for breaches each month within this standard . As the host of the breast screening service, the Trust will incur half-breaches for any patient not treated in time by another Trust, despite the patient never having been seen or treated at St Georges.

Following the underperformance, the Trust have had a meeting with NHSE and commissioners and some revisions to the Trusts recovery plan have been agreed, with a key focus on enhancing PTL development, validation and improving tracking processes which is required. This will provide greater visibility of patient pathways, allowing for earlier escalation and expedition of next steps in patient pathways and will also provide greater assurance on projected performance forecasts. The Trust continues to implement its recovery and sustainability action plan, which continues to be reviewed weekly via the Trust cancer performance meeting and externally by commissioners and NHSE-London via the Elective System Resilience Group.

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

January 2016 performance against national cancer targets by tumour type

Cancer Standard	Target	All Types	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Skin	Upper GI	Urological
62 Day Standard	85%	83.3%	90.5%	84.6%	100.0%	50.0%	100.0%	75.0%	85.7%	0.0%	90.0%
62 Day Screening Standard	90%	86.4%	94.4%				0.0%				
31 Day Subsequent Drug Standard	98%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 Day Subsequent Surgery Standard	94%	97.1%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%		100.0%
31 Day Standard	96%	90.2%	100.0%	100.0%	100.0%	40.0%	100.0%	100.0%	72.7%	100.0%	93.9%
Two Week Wait Standard	93%	91.1%	97.6%	62.4%	100.0%	98.0%	99.1%	97.6%	87.6%	92.7%	91.4%
Breast Symptom Two Week Wait Standard	93%	96.6%	96.6%								

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%	94.1%	91.10%		
	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%	86.1%	83.30%		
	Trajectory								85.14%	85.51%	86.09%	87.24%	88.96%
	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

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

Monthly View

February 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	18 weeks - admitted waits (division level)	%		84.3	71.1	84	76.9
	18 weeks - incomplete waits (division level)	%	99.1	89.6	88.3	92.7	90.3
	18 weeks – non-admitted waits (division level)	%	100	82.8	85.4	88.4	89.7
	52 week waiters	No.	0	1	0	0	1
	A&E waits (4 hours)	%	99.7	81.6			83.2
	LAS handover within 15 mins	%					33.8
	LAS handover within 30 mins	%					88.7
	LAS handover within 60 mins	No.					2

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

January 2016

			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 week gp referral to first outpatient (breast symptoms) - (division)	%			96.6		96.6
	2 week gp referral to first outpatient (cancer) - (division)	%			91.1		91.1
	31 day second or subsequent treatment (drugs) - (division)	%			100		100
	31 day second or subsequent treatment (surgery) - (division)	%			97.1		97.1
	31 day standard from diagnosis to first treatment - (division)	%			90.2		90.2
	62 day urgent gp referral to treatment for all cancers - (division)	%			83.3		83.3
	62 day urgent gp referral to treatment from screening - (division)	%			86.4		86.4

5. Divisional KPIs Overview 2015/16: February 16 Performance (Page 2 of 2)

Monthly View

			February 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	C-sections (applicable to women & children only)	%				23.9	23.9
	CAS alerts	No.					2
	HSMR	Ratio					91
	Incidence of c.difficile	No.	0	2	0	1	3
	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
	MSSA	No.	0	0	0	0	0
	Never events	No.	0	0	0	0	0
	Serious incidents (division level)	No.	0	1	3	4	8
	SHMI	Ratio					0.9
	Trust acquired pressure ulcers	No.	0	0	0	0	0
	Falls (ward level)	No.	8	100	46	3	157
	Medication errors causing serious harm (division)	No.	0	0	0	1	1

			February 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Quality Governance Indicators	Patient satisfaction (friends & family)	%	95.7	96	87.2	92.9	92.3
	Percentage of staff appraisal (medical) - (division)	%	83.9	90.5	84.1	85.9	86.4
	Percentage of staff appraisal (non-medical) - (division)	%	63.5	72	75	68.3	68.9
	Sickness/absence rate - (division)	%	6.2	3.5	3.8	4.6	4.3
	Staff turnover - (division)	%	21.5	18.8	15.1	19.3	18.7
	Vacancy rate - (division)	%	18.7	16.1	14.8	15.3	15.9
	Voluntary staff turnover - (division)	%	16	16.4	12.7	16.1	15.5
	Ward staffing: unfilled duty hours	%	4.5	5.9	9.7	3.5	5.9

Key Messages:

This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components,. Cancer performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of February 33.8% of patients had handover times within 15 minutes and 88.7% within 30 minutes. both of which are not within target.. The trust had two 60 minute LAS breaches in February

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

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Self-Assessments and Submissions

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6. Self-Assessments and Submissions

The trust have been required to make the following submissions in relation to 2016/17 outlook, and ask the board to note the submissions made:

1. Cancer Self Assessment against 8 Priorities
   The trust has responded as meeting the 8 priorities being assessed. The submission was made on 22/03/2016 and is currently under review by NHSE-London.

2. 2016/17 Access Target Trajectories
   The trust was required to submit trajectories for performance delivery against the four key national access targets. The trust has submitted trajectories as detailed on page 20, with compliance to be achieved as follows:

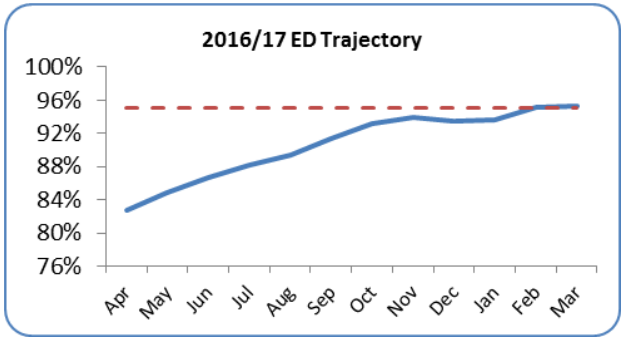
   - ED 4 hour standard – 95% compliance to be achieved from February 2017 onwards.
   - RTT Incomplete pathways standard – 92% compliance to be achieved at an overall trust level from March 2017.
   - Cancer 62 day standard – 85% compliance to be achieved and maintained from April 2016.
   - Diagnostics 6 Weeks standard – less than 1% of patients waiting greater than 6 weeks for a diagnostic appointments compliance to be maintained throughout 2016/17.

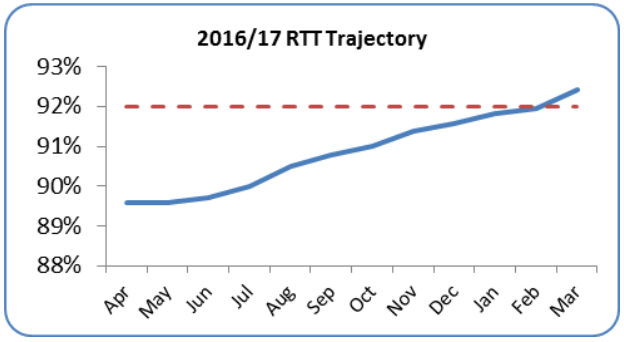
6. Cancer Self Assessment against 8 Priorities – Submitted 22/03/2016

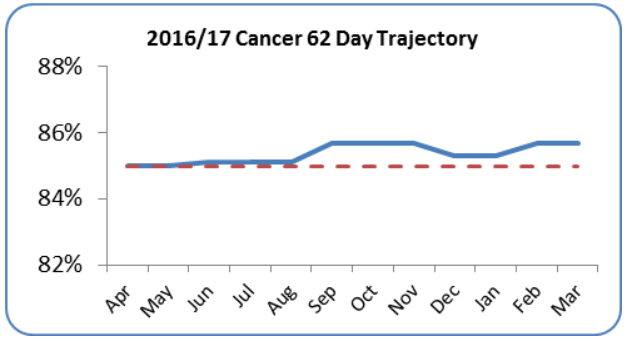
	Cancer Self-Assessment on 8 priorities	Trust Response - Yes/No	Please provide appropriate supporting narrative for each question. Where you have given a "No" response could you please include in your narrative when you expect to be compliant.
1	Does the Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards?	Yes	Paula Vasco-Knight, Chief Operating Officer, paula.vasco-knight@stgeorges.nhs.uk. 0208 725 1421
2	Does the Board receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average?	Yes	Board Performance papers include a monthly cancer scorecard that gives performance against each of the 8 cancer performance standards by tumour type. 2WW and 62 performance is also reviewed weekly at the Cancer Performance Meetings chaired by the COO.
3	Does the Trust have a cancer operational policy in place and approved by the Trust Board? This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.	Yes	Trust Cancer Access Policy has recently been redrafted to include GFOCW version 9 Guidance and the Escalation Processes to ensure standards are met. This policy is currently in the consultation stage and is due to be ratified by Trust Board in Q1 16/17.
4	Does the Trust maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast? These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.	No	**Cancer Treatment pathways are in place for all tumour groups but not all have detailed timings and are not actively used to manage pathways in some tumour groups. An audit programme has been developed to map current pathways at St Georges against timed exemplars, with actions plans developed to address and gaps in service delivery. Action plans will be monitored to ensure delivery through the weekly Cancer Performance Meetings. Shared pathways with other providers will need full mapping to ensure patients are transferred to the treating provider with full diagnostic work-up and a DTT in place wherever possible. Where this is not possible, an agreement on how the pathway is shared will need to be put in place.**
5	Does the Trust maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance? The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.	Yes	There is a daily PTL to track TWRs, 62 day pathway and 31 day pathways. The PTL tracking meetings take place weekly and The Trust are introducing a weekly PTL assurance meeting chaired by the GM for Cancer Services to ensure that risks to performance delivery and patient care is appropriately managed. The PTL summary, movements and risks will be discussed at the trust-wide weekly Cancer Performance Meeting chaired by the COO.
6	Is root cause breach analysis carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching)? These should be reviewed in the weekly PTL meetings.	Yes	RCAs are completed monthly for all breaches of the CWT standards. In addition, The Trust has implemented a process to complete root cause analysis (RCA) for all patients on a PTL over 95 days (with and without a confirmed cancer diagnosis). This process is weekly, and incorporates clinical review to assess every patient for clinical or psychological harm, and any considered as potential serious incidents will be managed in line with our existing SI governance processes. . All RCAs are reviewed and signed off by our Chief Operating Officer, CEO, Director of Nursing and Medical Director before submission to our Commissioners
7	Is capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) carried out? There should also be an assessment of sustainable list size at this point.	Yes	TWR Demand and Capacity modelling has been completed for all tumour types using the IST model. The diagnostic demand and capacity modelling has also been completed using the IST models.
8	Is an Improvement Plan prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.	Yes	There is an action plan in place which covers all aspects of cancer work which has been signed off by the trust Finance and Performance Committee and also with commissioners. Oversight of the delivery of the action plan is via the weekly Cancer Performance meeting chaired by the COO.

6. 2016/17 ACCESS TARGET TRAJECTORIES SUBMISSION – 18/03/2016

Standard	Target	2016-17 (%)											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E	95%	82.70%	84.80%	86.60%	88.10%	89.40%	91.30%	93.10%	93.90%	93.40%	93.60%	95.10%	95.20%
RTT	92%	89.60%	89.60%	89.70%	90.00%	90.50%	90.80%	91.00%	91.40%	91.57%	91.82%	91.96%	92.43%
Cancer - 62 Day	85%	85.00%	85.00%	85.10%	85.10%	85.10%	85.70%	85.70%	85.70%	85.30%	85.30%	85.70%	85.70%
Diagnostics	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%







The above trajectories have been reviewed and agreed with commissioners, and are currently under review with NHSE-London and NHSI.

- Diagnostics trajectory is based on continued performance delivery from existing position and in line with agreed activity forecasts.
- Cancer trajectory is based on delivery of agreed performance and sustainability action plan and continued delivery of compliance in Q1 2016/17 from agreed Q4 trajectory as part of the plan.
- ED trajectory is based on action plan following OVOT programme with McKinsey and Company. (A separate paper will be presented in relation to this in the meeting)
- RTT trajectory is based on demand and capacity work undertaken with the IST and supported by commissioners. An operational recovery plan to support the trajectory is currently in development.

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Corporate Outpatient Services Performance

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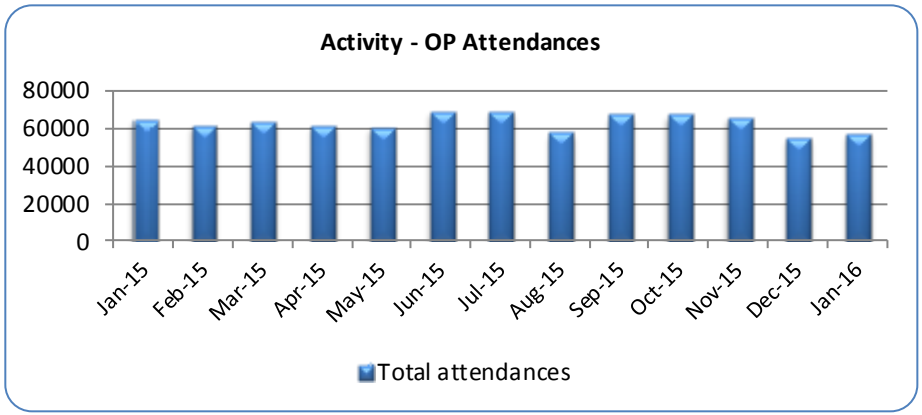
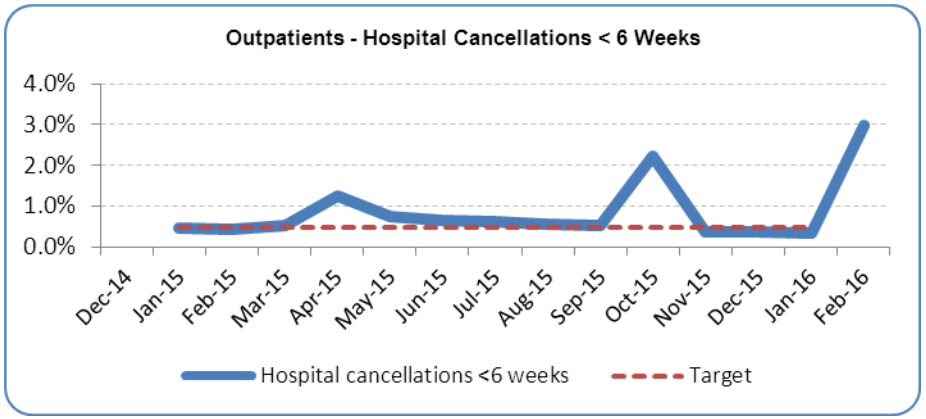
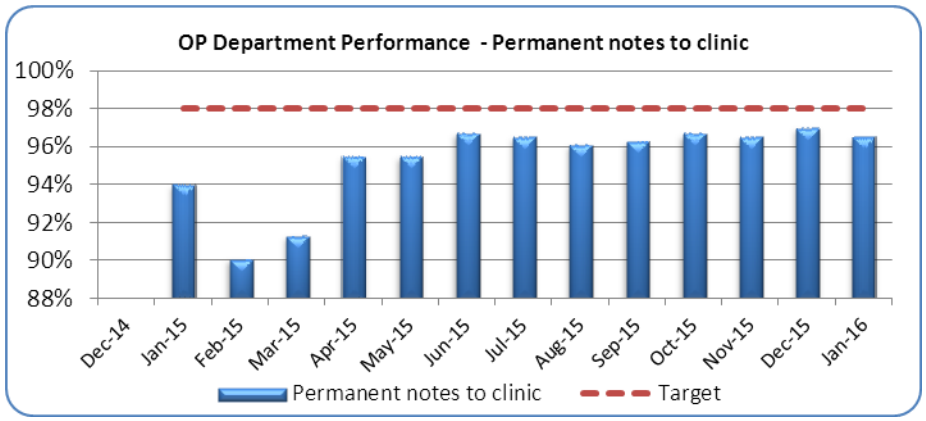
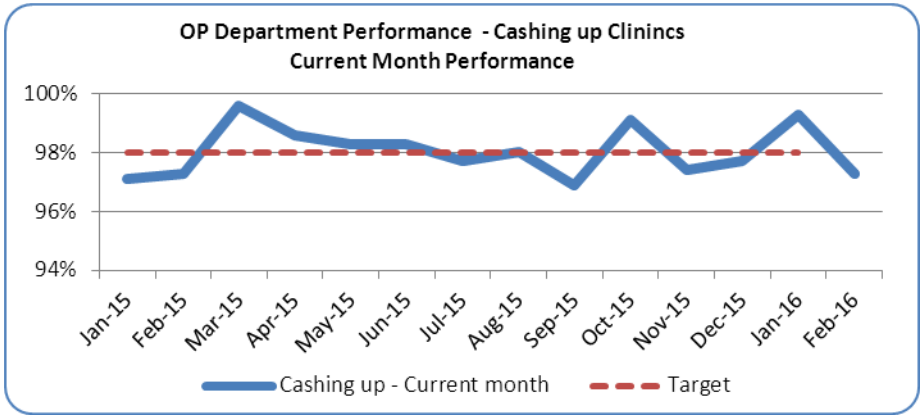
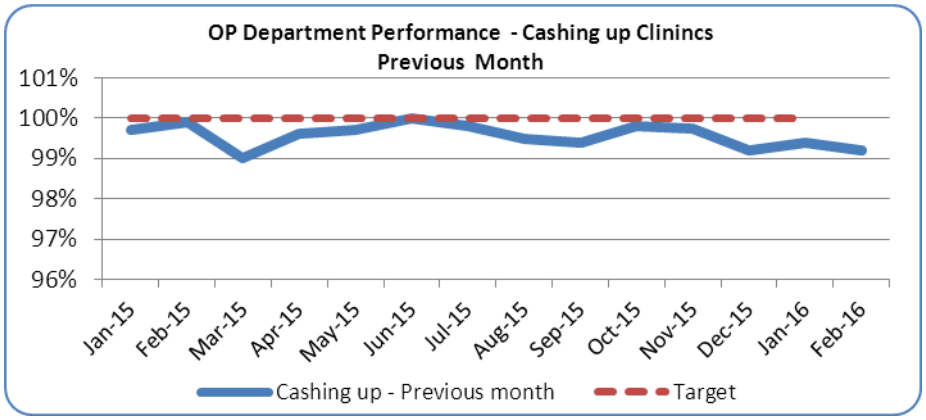
7. Corporate Outpatient Services (1 of 2) - Performance Overview

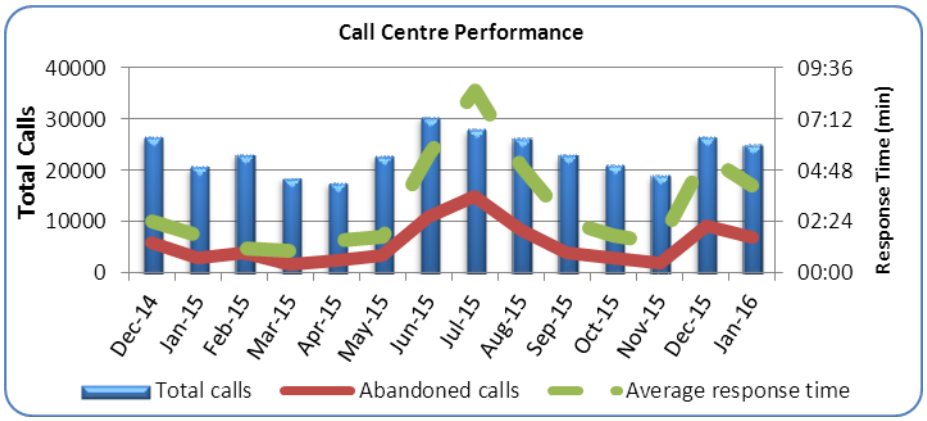












7. Corporate Outpatient Services (2 of 2)
- Performance Overview

		Target	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Activity	Total attendances	N/A	64609	60659	62946	60564	59841	68002	68277	57188	66271	66501	64863	54618	56239	41552
	Hospital cancellations <6 weeks	<0.5%	0.47%	0.45%	0.54%	1.26%	0.74%	0.66%	0.64%	0.56%	0.54%	2.24%	0.36%	0.37%	0.35%	2.97%
OPD performance	Permanent notes to clinic	>98%	94.05%	90.12%	91.32%	95.52%	95.54%	96.74%	96.54%	96.14%	96.31%	96.72%	96.52%	97.02%	96.50%	95.42%
	Cashing up - Current month	>98%	97.10%	97.30%	99.60%	98.60%	98.30%	98.30%	97.70%	98.00%	96.90%	99.10%	97.40%	97.70%	99.30%	97.30%
	Cashing up - Previous month	100%	99.70%	99.90%	99.00%	99.60%	99.70%	100.00%	99.80%	99.50%	99.40%	99.80%	99.75%	99.20%	99.40%	99.20%
Call Centre Performance	Total calls	N/A	26565	20842	23235	18710	17732	22955	30426	28095	26357	23138	21082	19093	26557	25273
	Abandoned calls	<25%/<15%	5923	2908	3782	1551	2237	3309	10828	15019	8253	3930	2756	1953	9084	6949
	Mean call response times	<1 m/<1m30s	02:24	01:43	01:08	01:00	01:29	01:42	05:31	08:34	04:59	02:24	01:43	01:24	05:30	04:06

Key Messages:

- Decrease in activity in February in line with previous years decrease.
- Hospital cancellations were above target in February. A key contributing factor to the high cancellation rate was the junior doctors strike.
- Performance of permanent notes to clinic has slightly dipped to 95.42% and remains below target . This continues to be a priority area for the service.
- The level of activity and the number of abandoned calls have seen a slight improvement since January.
- High call response time due to telephone and system issues and concentration on RTT work.

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Quality Report

February 2016

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Clinical Audit & Effectiveness

Excellence in specialist and community healthcare

8. Clinical Audit and Effectiveness - Mortality

HSMR (Hospital standardised mortality ratio)							
Lead Director	January 16	February 16	March 16	Movement	2015/16 Target	Forecast March 16	Date expect to meet standard
SM	92.6	90.9	87.5	↓	<100	G	Met

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

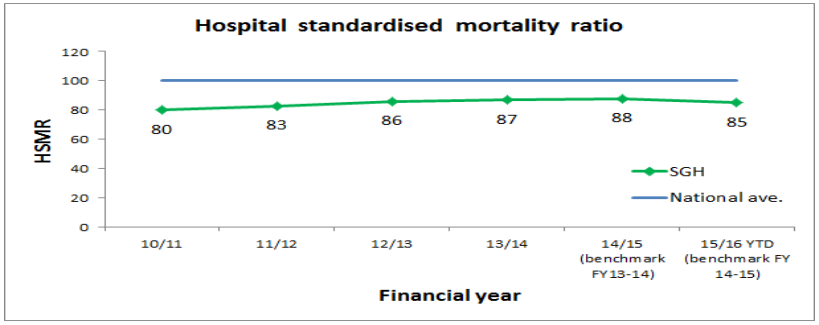
Note: Source for HSMR is Dr Foster Intelligence. Data is most recent 12 months available (updated 17/03/16) January 2015 to December 2015, and benchmark period is the financial year 2014/15. SHMI data is published by the Health and Social Care Information Centre. The last 12 month period as published on 23rd March 2016 relates to the period October 2014 to September 2015. The next publication is due in June 2016.

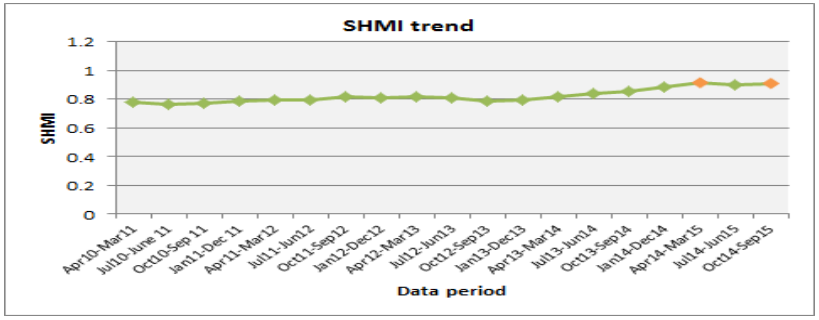
Overview:

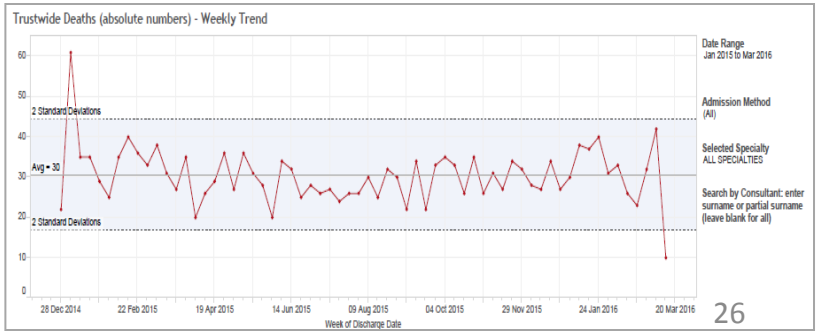
Our mortality as measured by the HSMR is significantly lower than expected. The trust's most recent HSMR is 87.5, which is statistically significantly better than expected. Looking at the HSMR for emergency admissions at weekends, our mortality is in line with expected at 91.0 and for emergency weekday admissions it is better than expected at 87.0.

The Health and Social Care Information Centre published the latest SHMI for the period October 2014 to September 2015 on the 23rd March. Our SHMI value for the period is 0.91, and with 95% control limits of 0.91 to 1.10 we have moved just into the 'as expected' banding once again. We anticipate that we will continue to move between bandings until the impact of last winters increased mortality is excluded. For this period 103 of 136 non-specialist acute trusts are categorised as 'as expected', 18 as 'higher than expected' and 15 as 'lower than expected'.

The quarterly data release includes observed and expected deaths by trust for each of the 140 diagnosis groups that make up the SHMI. For St George's there are 44 groups where observed deaths are lower than expected, ranging from a difference of 0.13 to 68.5. For 59 groups the difference cannot be calculated as the number of events is too small. There are 37 diagnosis groups where observed deaths exceed expected, with a difference ranging from 18.9 to 0.1. The Mortality Monitoring Committee continue to consider the SHMI in detail. Investigation into the grouping Phlebitis; thrombophlebitis and thromboembolism; varicose veins of lower extremity; haemorrhoids; other disease of veins and lymphatics, which was led by the MMC chair has concluded and found no avoidable mortality. We are working with the service to take forward review of the T&O grouping previously identified. Raw mortality is also considered by the MMC each month, and as shown by the chart alongside, our mortality continues to be within normal limits.







8. Clinical Audit and Effectiveness
- National Audits

National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (British Society for Rheumatology BSR)

Overview This audit looked at care given to patients newly diagnosed with inflammatory arthritis to compare practise with NICE Quality Standards for rheumatoid arthritis and patient reported measures of experience and outcome The project included an organisational survey clinical data and patient reported questionnaires completed, at various points on the patient pathway.

Standards:

1 People with suspected persistent synovitis affecting the small joints of the hands or feet, or more than one joint, are referred to a rheumatology service within 3 working days of presentation.

2. People with suspected persistent synovitis are assessed in a rheumatology service within 3 weeks of referral.

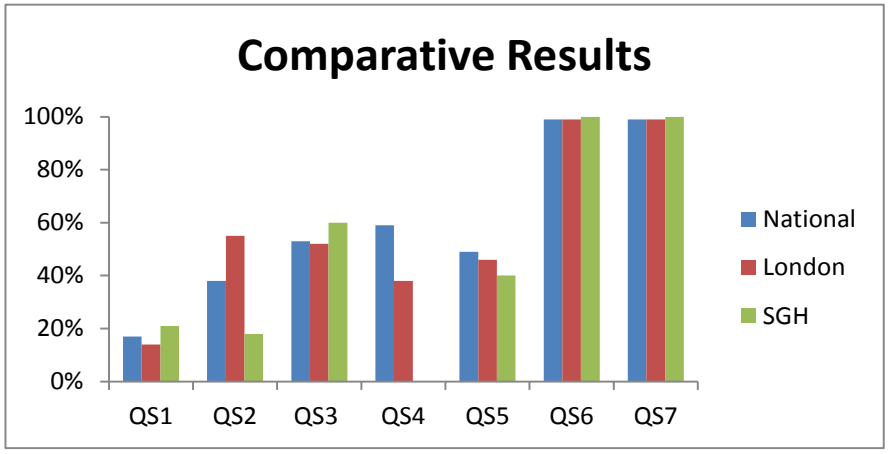
3. People with newly diagnosed rheumatoid arthritis are offered short-term glucocorticoids and a combination of disease-modifying anti-rheumatic drugs (DMARD) by a rheumatology service within 6 weeks of referral.

4 People with rheumatoid arthritis are offered educational and self-management activities within 1 month of diagnosis

5 People who have active rheumatoid arthritis are offered monthly treatment escalation until the disease is controlled to an agreed low disease activity target.

6:People with rheumatoid arthritis and disease flares or possible drug related side effects should receive advice within 1 working day of contacting the rheumatology service.

7 People with rheumatoid arthritis have a comprehensive annual review that is coordinated by the rheumatology service.



Report recommendations The report highlights the need for an improvement in waiting times and treatment of the initial stages of Rheumatoid and Early Inflammatory arthritis, and suggests that best practise is shared within trusts. The authors also anticipate that the audit will provide the beginnings of a National registry of patients that can be used to monitor outcomes and for further research.

Comments and Actions

Details of the report have been discussed within the care group. A major concern was the amount of resources required to complete the audit which was complex and used a data collection system that was very unreliable. SGH submitted data for 28 patients. More were recruited, but the need for follow up and patient submitted data meant that there was a considerable drop off in numbers.

The low result for Standard 2, is mainly due to an error in data entry and the poor reliability of the BSR IT system for data collection delayed formal response to a compliance notice which would have allowed us to amend errors in the data. In fact, only 38% of trusts achieved Standard 2- although not addressed in the report this may be due to the fact that more than half of GP referrals do not mention persistent synovitis. Locally we have already started education to GP's to address this.

For standard 4 we scored 0% as although we do offer a DMARD education session for patients run by our specialist nurse we did not have the resources at the time of the audit to offer this within 1 month of diagnosis. We are planning earlier DMARD training for patients, although this is dependent on resources as the unit is currently understaffed.

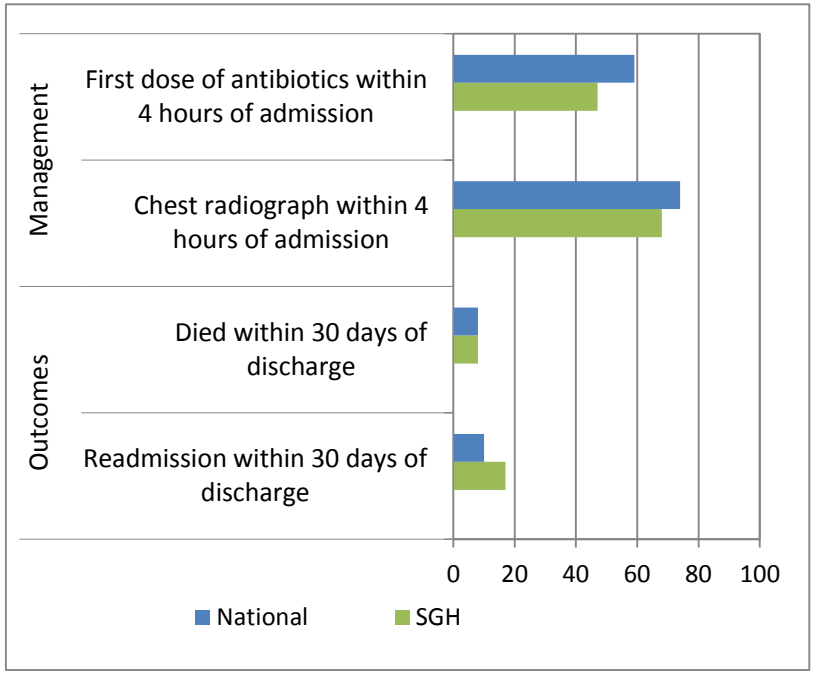
Issues concerning the audit have been fed back to the BSR and a local audit of practise is underway, as it is felt that the published results of the national project do not present an accurate picture of the service we provide.

8. Clinical Audit and Effectiveness - National audit

Adult Community Acquired Pneumonia (CAP) December 2014 – January 2015

The report of the fifth British Thoracic Society CAP audit was published in November 2015. The audit comprised three sections, Part 1 collected data on adult CAP admissions, Part 2 was a supplementary audit and collected information on coding and diagnoses and Part 3 related to audit processes. Due to lack of resources to complete the audit, St Georges did not participate in part 2.

Nationally the audit found continued improvement in provision of antibiotics and a sustained reduction in in-patient mortality, although there was low concordance with antimicrobial recommendations. For some of the key questions SGH results are compared to the national average in the chart below. SGH mortality is in line with the national result, however a higher proportion of patients are readmitted within 30 days of discharge. SGH results for "Senior review within 6 hours appear to be worse than the national average and for "antibiotics prescribed in line with local guidelines" they seem better; however, these are not illustrated as for both of these measures there was a considerable amount of missing information. In particular the timing and sometimes date of consultant review was poorly documented. Improving documentation is something that will be targeted locally.



Recommendations

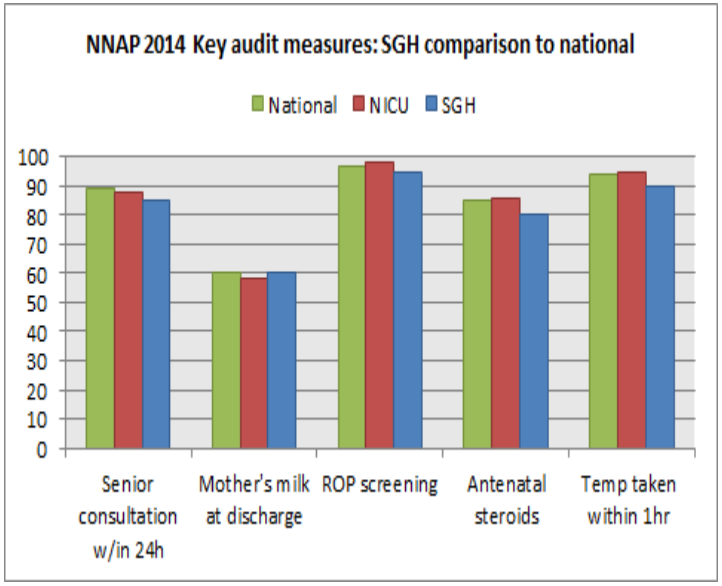
The main recommendations of the audit (with 3 year targets) are

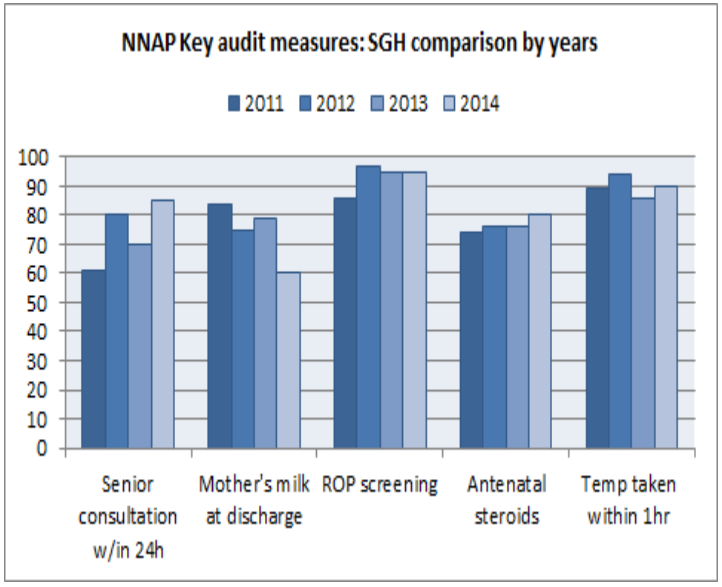
- to increase the proportion of patients who have a chest radiograph within 4 hours of admission to 90%
- to increase the proportion of patients who receive their first dose of antibiotic therapy within 4 hours to 85%
- to improve the proportion of adults with moderate and high severity CAP administered combination β-lactam and macrolide therapy to 85%
- to improve the proportion of coded CAP cases of pneumonia who have a CXR confirmed pneumonia to 85% (i.e. to improve accuracy of diagnosis)

These improvements will be facilitated by better use of the CAP care bundle and this has already been adopted within SGH. There will be no national audit in 15/16 or 16/17 but it is anticipated that progress will be monitored in a local audit.

8. Clinical Audit and Effectiveness - National Audits

Neonatal National Audit Programme (NNAP): 2015 Annual Report on 2014 data





This is the eighth annual report, detailing the care received by 86,287 babies admitted in 2014. The audit aims to assess whether babies requiring specialist neonatal care receive consistent high quality treatment and to identify areas for improvement. St George's, a neonatal intensive care unit, submitted data for 2,243 babies to the audit.

For the key standards the trust's performance is largely similar to the national results and neonatal intensive care units. Our results have been maintained or improved from 2013 for all measures, other than babies being fed with mother's milk at discharge, although we remain one of the leading units nationwide. It is very positive to note that follow-up data was recorded for 100% of eligible babies discharged from St George's. Obtaining this data as a standardised assessment of developmental outcome is highlighted as being of key importance.

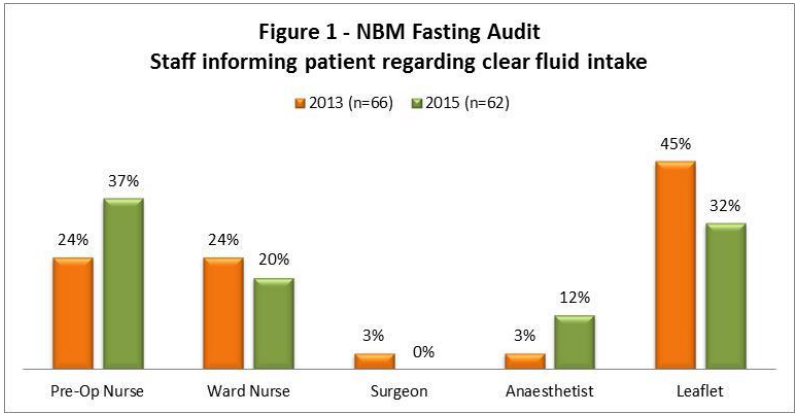
The report authors note that nationally completeness of data has improved over recent years, and the same appears to be true here with very few data items missing. This improvement is supported by the clinical lead who reviews the regular national data quality reports. Consideration is also being given to whether further resource is necessary to improve data recording, quality and completeness. Many tertiary units have a data manager to manage this audit and that option will be explored.

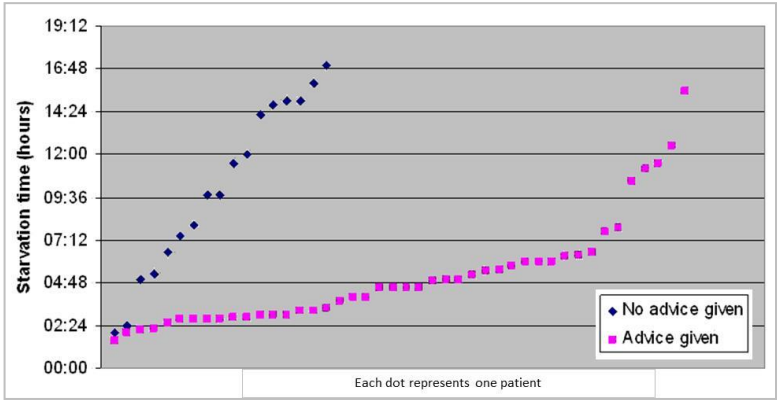
The report makes a number of recommendations for different audiences, including commissioners, NNU clinical teams, Trust Boards and networks. The unit have considered these in full. Responses to those most relevant in the light of our results are summarised below, and reflects the difficulties with the organisation of the audit and the need for increased support with data capture.

Recommendation	Response
Units with antenatal steroid administration less than 85% should consider care pathways with obstetric colleagues and review care to see if opportunities to follow best practice were missed.	SGH data is affected by the number of transfers into the trust whom we do not care for antenatally.
All units should aim for 100% for ROP screening and should review clinical and organisational pathways in discussion with ophthalmology colleagues	The unit is confident babies are not missed and our screening is under-recorded. Improved processes are being defined.
Units should critically review processes for communication with parents and recording of this, learning from other units as appropriate.	Babies born after 34 weeks tend not to be admitted to the unit if they are well, which means that data regarding time of consultation is often absent.

8. Clinical Audit and Effectiveness - Local audit

Pre-Operative Fasting Audit – 2016





Introduction

The Trust's Fasting Guidance and Policy highlights that both healthy adults and children should have an intake of water up to two hours before the induction of anaesthesia for elective surgery which improves patient well-being. Other clear fluids including clear tea and black coffee with or without sugar can be taken up to two hours before induction of anaesthesia in healthy adults. A minimum preoperative fasting time of six hours is recommended for food (solids and milk) for both healthy adults and children.

Aims and Objectives

To re-audit starvation times of elective and emergency preoperative patients after revision of NBM (Nil by Mouth) pathway. The pathway was revised in 2012 after concerns raised by the Care Quality Commission with regards to pre-operative starvation times within the Trust.

Standards

Trust's guidelines - Policy and Guidance for Perioperative Fasting Clin.3.18 and Adult Nutrition and Hydration Policy Clin.5.32. AAGBI (The Association of Anaesthetists of Great Britain & Ireland) guidelines on fasting.

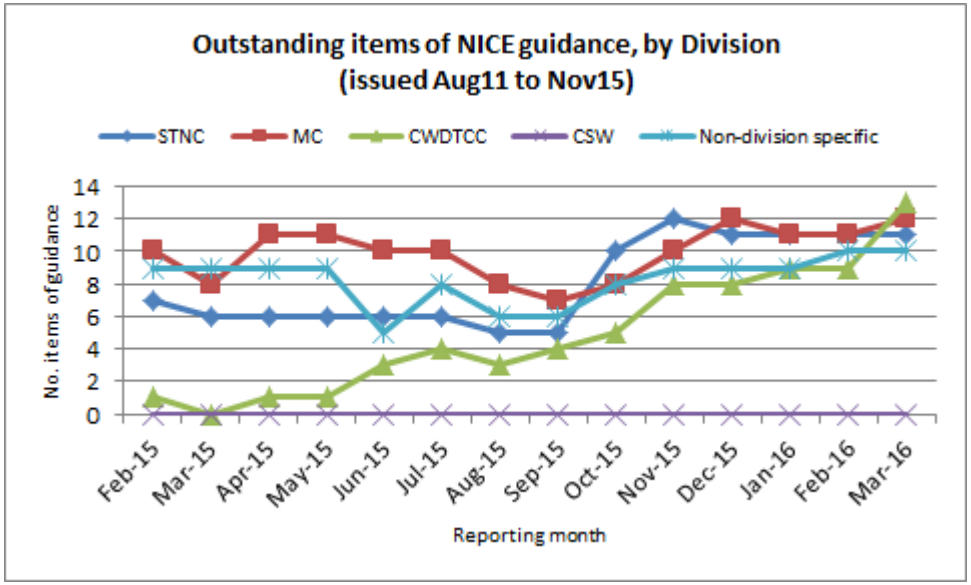
Results - NBM Fasting Audit (n=62)

- The majority of patients (72%) are receiving advice (Fig 2 - pink dots). This is good news, with some room for improvement as those who do not receive advice (Fig 2 - blue dots) are starving for much longer.
- The number of patients given starvation information by anaesthetists has grown since 2013; this is excellent news as it means we are better at giving tailored advice on the day of surgery.
- There are a significant number of patients who still starve themselves excessively despite being given information, these push the average up markedly.

Action Plans:

1. Information to Patient Pathway Co-ordinators (PPCs) and Surgical Admission Lounge (SAL) staff around fasting so they can share this with patients more easily
2. Change patient information leaflets to emphasize negative impact of prolonged fasting
3. More prominent information displayed in SAL about availability of water etc.
4. Longer term project to improve emergency theatre communication with wards to reduce fasting times.
5. Re-audit upon completion of action points 1-3 (expected completion in 3 months).

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



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

Division	2010	2011	2012	2013	2014	2015
STNC (n=7)	0	1	1	1	4	0
M+C (n=17)	2	2	4	1	2	6
CWDTCC (n=17)	3	1	1	3	6	3
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 has increased since the last report. There are 46 items of guidance for which we have not received responses as to implementation. All new guidance is being disseminated in a timely way; however, there has been limited follow up of outstanding guidance due to a lack of resource in the clinical effectiveness team. This will be made an immediate priority when our new team member joins us in April and we plan complete the review of guidance with compliance issues within the month. The number of items of guidance where we are not fully compliant has also remained fairly stable, and stands at 52 in total.

It is positive to note that of the 39 items of guidance issued in the first two months of 2016 we have already received responses from clinicians for 17 (44%). This figure excludes technology appraisals; there were 11 items of guidance issued in the same period.

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St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

Excellence in specialist and community healthcare

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

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

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

Table 1

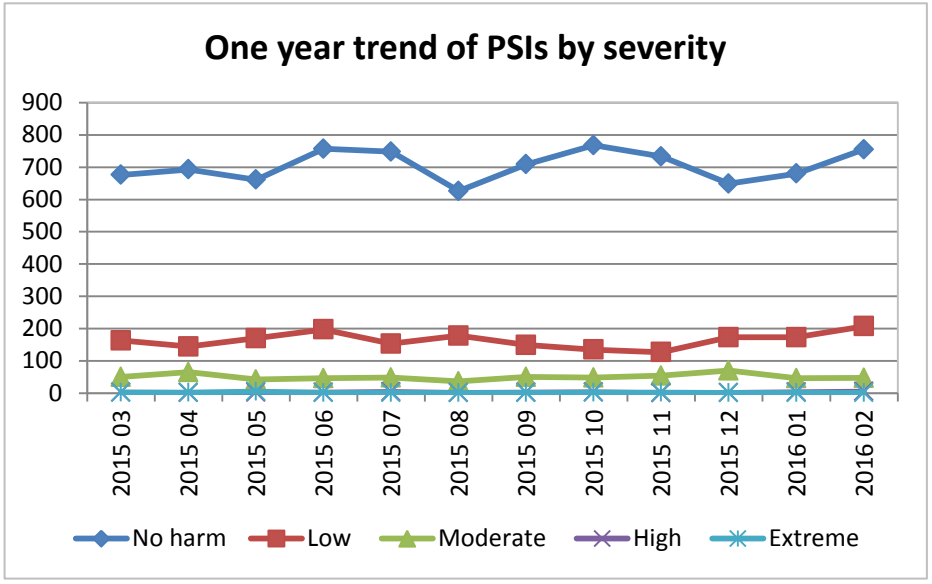
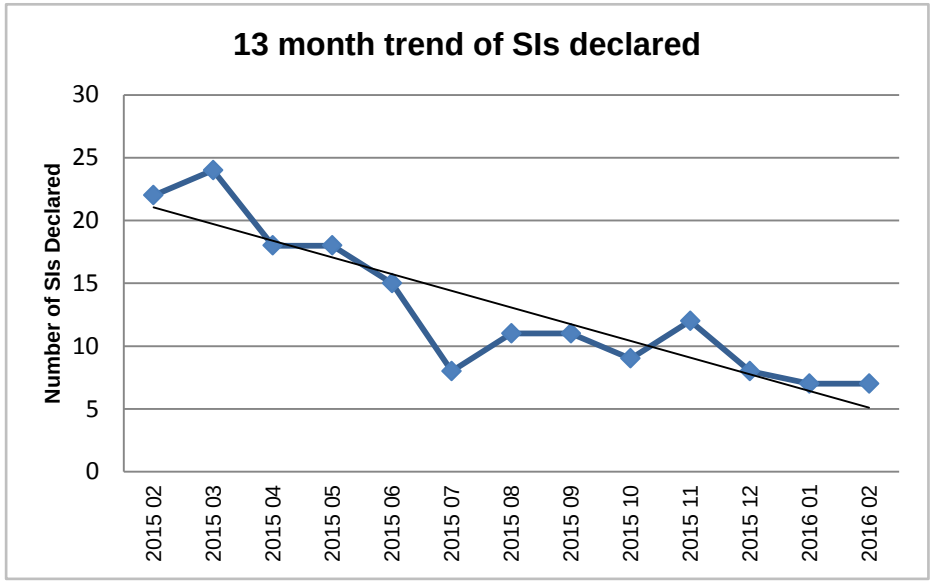


Table 2



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.

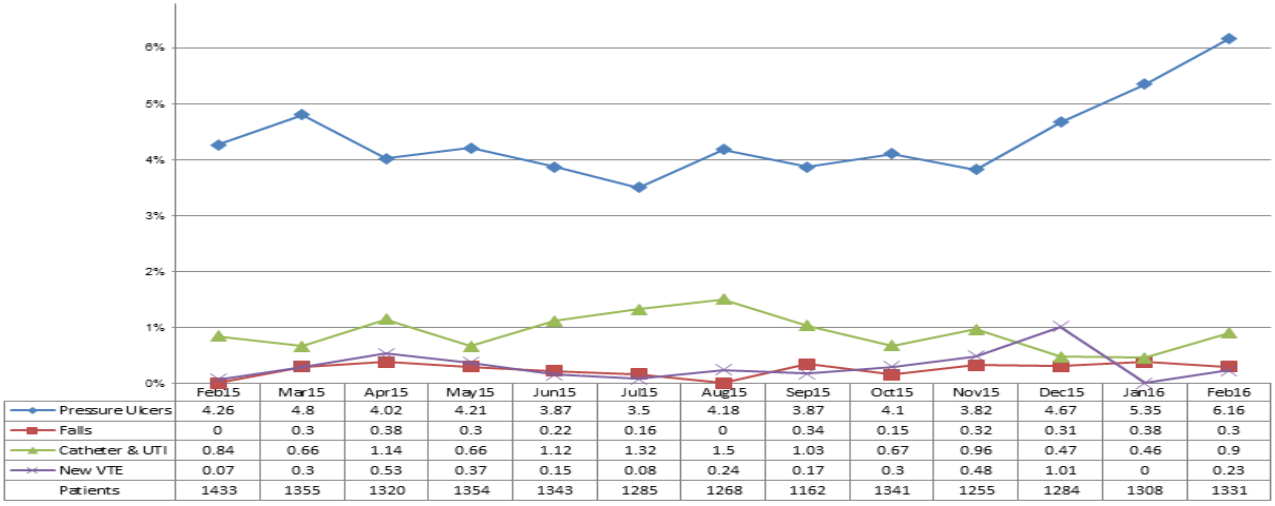
There were 7 general SIs reported in February (0 pressure ulcers) and the subjects are varied.

The 7 general SIs declared in February relate to a range of issues. They include the following categories:

- Unforeseen complications during treatment/procedure
- Failure to follow up
- Delay to act on adverse test results
- Delay in treatment
- Medication error (wrong dose)
- Unexpected admission to NNU
- Stillbirth

9. Patient Safety
- Safety Thermometer

% Harm Free Care							
Lead Director	December 2015	January 2016	February 2016	**Movement**	**2015/2016 Target**	**National Average February 2016**	**Date expected to meet standard**
J Hall	93.69%	93.96%	92.64%	↓	95.00%	94.05%	March 16



	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16
Pressure Ulcers	4.26	4.8	4.02	4.21	3.87	3.5	4.18	3.87	4.1	3.82	4.67	5.35	6.16
Falls	0	0.3	0.38	0.3	0.22	0.16	0	0.34	0.15	0.32	0.31	0.38	0.3
Catheter & UTI	0.84	0.66	1.14	0.66	1.12	1.32	1.5	1.03	0.67	0.96	0.47	0.46	0.9
New VTE	0.07	0.3	0.53	0.37	0.15	0.08	0.24	0.17	0.3	0.48	1.01	0	0.23
Patients	1433	1355	1320	1354	1343	1285	1268	1162	1341	1255	1284	1308	1331

Pressure ulcers (82)

- 58 grade 2 (22 new, 36 old)
- 14 grade 3 (3 new, 11 old)
- 10 grade 4 (4 new, 6 old)

CAUTI (12)

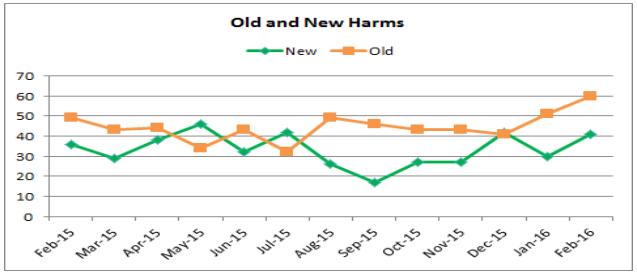
- 7 old
- 5 new

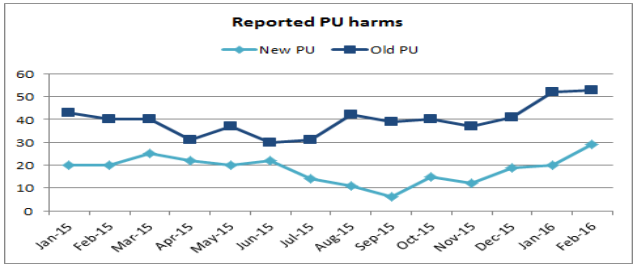
Falls (4)

- 4 low harm falls

VTE (3)

- 1 new PE
- 2 new other



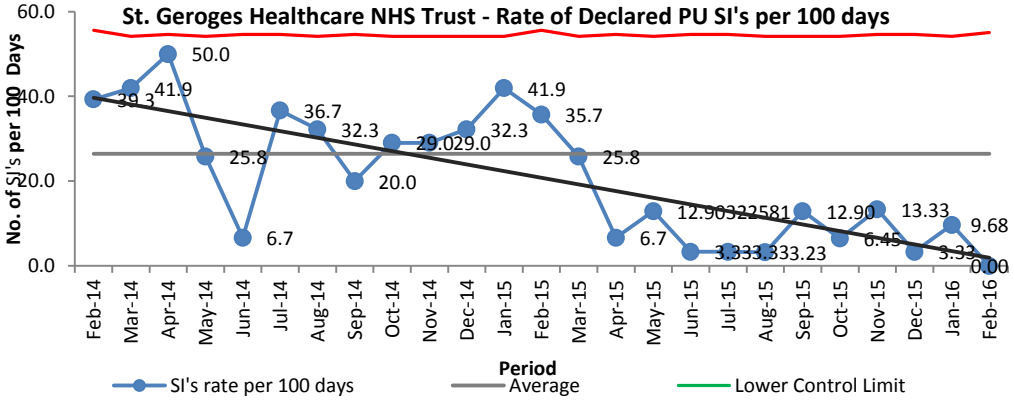


The safety thermometer data represents a snapshot of harms as collected by ward staff on one nationally agreed day per month. This point prevalence audit shows that in February 2016 the proportion of our patients that received harm free care was 92.64 per cent, which is below our target and the national average for the month of 94.05%.

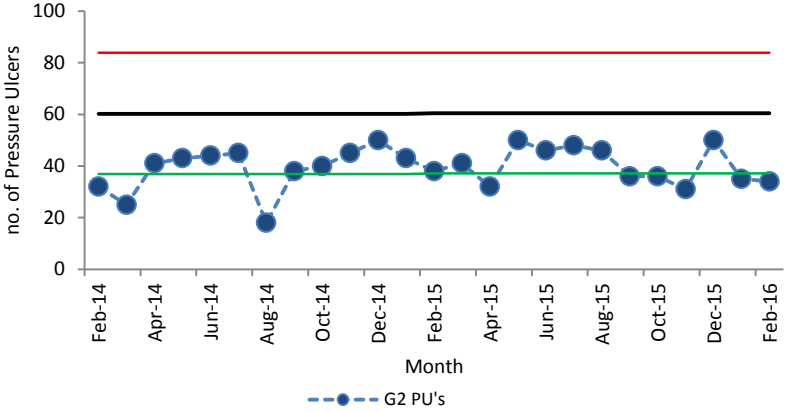
In January we reported 101 harms to 98 patients; 95 patients experienced one harm and 3 patient had 2 harms. There was an increase in both new and old harms reported at 41 and 60 respectively. The number of pressure ulcers reported by clinical teams increased once again this month. This is currently being reviewed as it is thought that a number of pressure ulcers were incorrectly graded. Any amendments will be made retrospectively and reflected in the March data. It should be noted that this data is unlikely to correspond with the PU incident data due to the way the Safety Thermometer measures harm, i.e. a snapshot of one day, with PU harms that developed at any point whilst under the care of St George's recorded as new. Although final numbers are not confirmed as yet, it appears that there were significantly fewer PUs recorded in March.

9. Patient Safety
- Incident Profile: Pressure Ulcers

Serious Incident – Grade 3 & 4 Pressure Ulcers											Grade 2 Pressure Ulcers					
Type	Oct	Nov	Dec	Jan	Feb	YTD April – March 2016	Movement	2015/2016 Target	Forecast March 2016	Date expected to meet standard	Oct	Nov	Dec	Jan	Feb	Movement
Acute	1	3	0	2	0	**14**			G	-	21	11	39	20	20	
Community	1	1	1	1	0	**8**			G	-	15	20	11	15	14	
Total All	2	4	1	3	0	**22**			G	-	36	31	50	35	34	
Total Avoidable	2	4	1	3	0	**22**		40		-						
Previous Year	6	8	6	8	3	**52**					40	45	50	43	38	



Grade 2 Pressure Ulcers Reported (Feb 14 to Feb 16)



Overview:

February saw a reduction in the total number of pressure ulcers serious incidents with no declarations across the trust. There was also a reduction in the total number of grade two pressure ulcers seen across the trust. Year on year there was a reduction in both areas which reflects the hard work of staff across the trust and the increases awareness of this issue.

Actions:

- Appointment of two Tissue Viability Support Nurses across the service, references pending.
- Band 7 Community TVN job currently out for advert.
- TVN working closely with the clinical audit team with the rollout of the IHI improvement work, action plan formulated with two new wards introduced each month.

9. Patient Safety - Infection Control

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

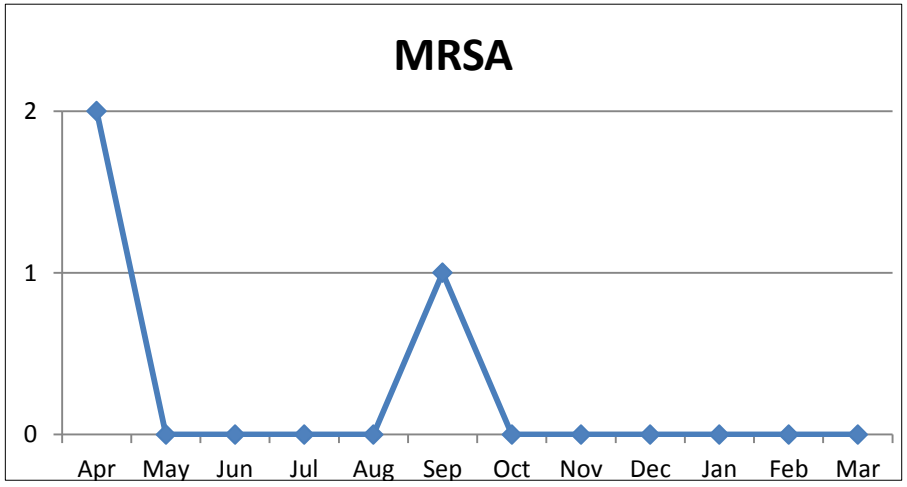
C-Diff						
Lead Director	January	February	Movement	2015/2016 Threshold	Forecast March - 16	Date expected to meet standard
JH	2	3	⇑	31	G	-

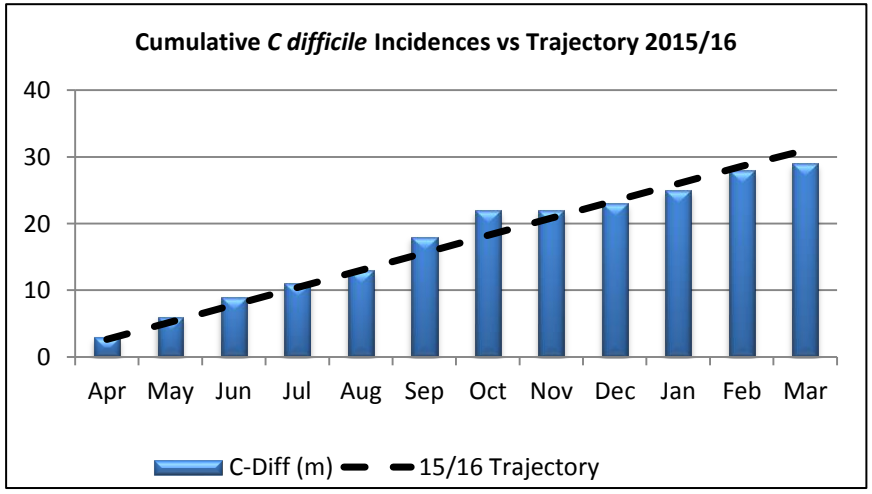
Peer Performance – YTD December 2015				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	2	1	2	4

Peer Performance – YTD December 2015 (annual trajectory in brackets)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
29 (31)	17(16)	14(9)	77(72)	25(39)

The MRSA bacteraemia threshold is zero. There were no MRSA Hospital-acquired bacteraemias from December 2015 to February 2016. The last hospital-acquired MRSA bacteraemia was on 23rd September 2015. This makes a total of 3 for the FY to end March 2016 , however this figure may changed as samples from the end of March may not have yet been processed. The Trust is non-compliant , with 3 incidents in total against a target of zero.

In 2015/16 the Trust has a threshold of no more than 31 *C. difficile* incidents. In December there was one episode , two in January, three in February and one in March. This makes a total of 29 for the FY to end March 2016 , however this figure may changed as samples from the end of March may not have yet been processed. This means that the Trust is currently on trajectory and can still achieve the target at the end of the FY 2015/16.



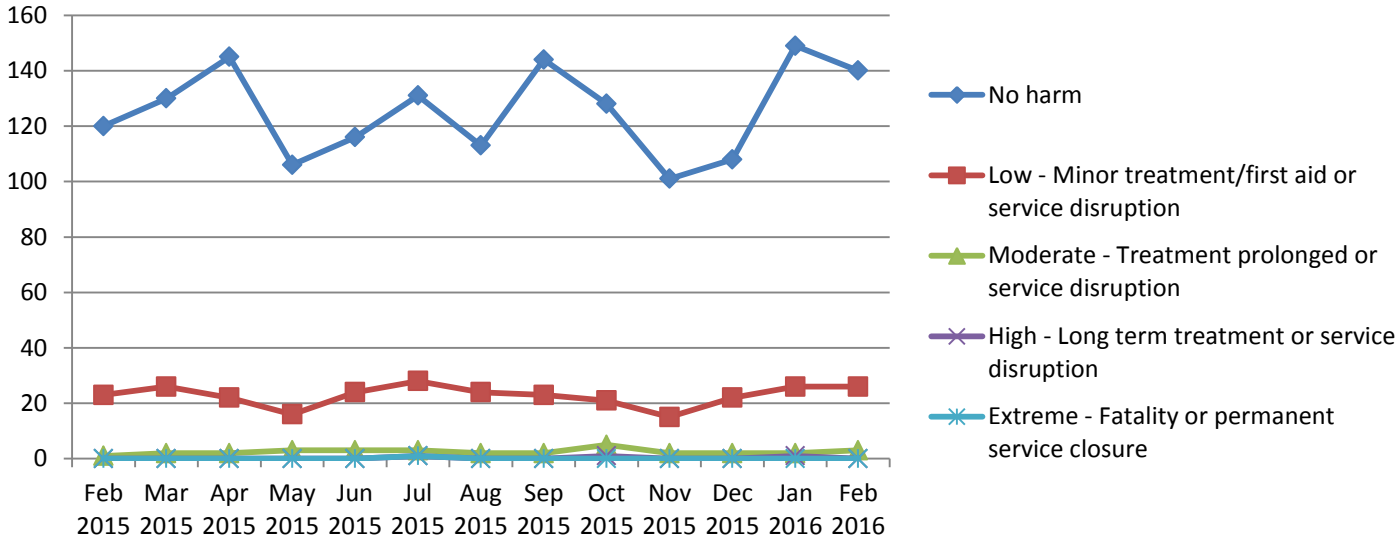


9. Patient Safety: February 2016
Incident Profile: Falls

Falls														
Lead Director	Feb 15	March	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 16	Feb 16	Movement
	144	157	165	126	144	163	140	168	155	118	132	179	170	↑

Falls with Harm Feb 2015 to 2016		
No Harm	Moderate	Severe
1938	22	1

Incidents by Incident date (Month and Year) and Severity



Overview: The graph shows the profile of falls across both acute and community services including bed-based care and patients' own homes. It is important to note that this data is sourced from incident reporting and is not individually verified. There has been a slight downward trend this month compared to last month but the general trend is an increase over time. It is recommended that the raw figures are individually verified and then converted to incidence per 1000 days in order to monitor falls and activity. Funding for the NICE compliant falls risk tool (paper version) has now been agreed as an interim step in areas where electronic documentation is not yet live.

9. 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	Feb 2015	Mar	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 2016	Feb
Unify2	96.03%	96.27%	96.64%	96.45%	96.75%	96.56%	96.78%	97.22%	97.10%	96.8%	96.5%	96.6%	

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	Feb 2015	Mar	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan 2016	Feb
Safety Thermometer	83.89%	85.74%	89.83%	90.19%	95.14%	94.84%	92.38%	91.28%	93.40%	93.24%	88.56%	94.10%	90.2%
National average	84.82%	84.69%											

Comparison of data streams:

There are differences in the methodology of collecting the different data streams. Data submitted to the Safety Thermometer is regularly validated by the thrombosis nursing team. The team consistently find variation in the interpretation of the audit tool across the Trust, resulting in inconsistent and sometimes inaccurate results. This problem is encountered nationally and limits the reliability and value of the data presented. The RAG ratings represented on this data sheet (**from April 2015 onward**) are as follows: **Green** >95%, **Amber** >90-<95%, **Red** <90% (this may differ to RAG ratings used in other reporting tools).

Current and Future developments:

- The Hospital Thrombosis Group is expanding its VTE champion network and working to further establish the network to drive improvement in VTE prevention across the Trust. The group hold monthly meetings with the Champions to discuss issues highlighted at HTG and listen to feedback from the Champions about clinical practice relating to VTE prevention from across the Trust. The network is multi-disciplinary with representation including doctors, pharmacists, physician's associates and midwives. The group are interested in recruiting nursing staff in addition to increasing the numbers of other staff groups already present. The aim of the network is to grow a culture of engagement with the VTE prevention programme, and embed good practice relating to VTE prevention as part of routine clinical practice. Representatives from the HTG are taking part in a working group led by Cerner UK to help co-design an improved VTE pathway for the electronic system which will support safe and effective implementation of VTE prevention guidelines.
- The Hospital Thrombosis Group has reviewed their process for disseminating learning following the occurrence of preventable hospital acquired thrombosis. A face to face meeting between HTG representatives and representatives from both the clinical and ward based teams involved will be scheduled to review the care of the patient in question within a month of the incident. This is to encourage increased engagement in learning from incidents and ensure that the learning is shared amongst the wider team.

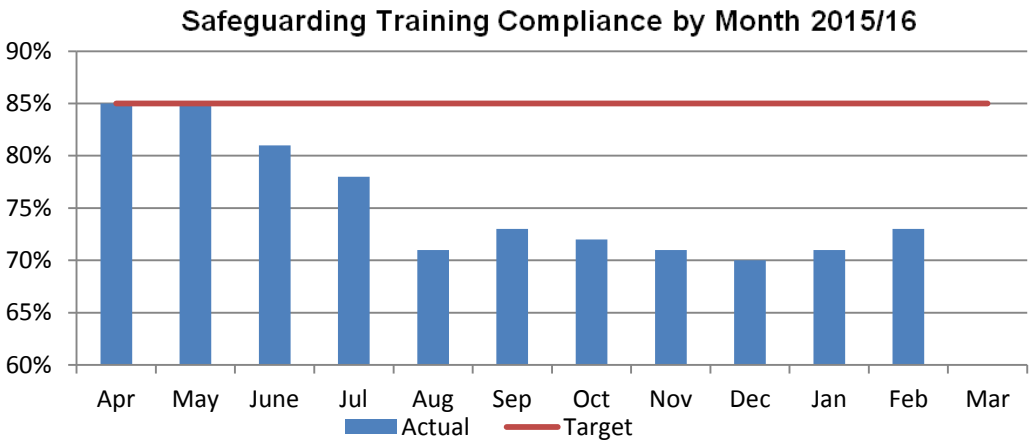
Root Cause Analysis (RCA) of Hospital Acquired Thrombosis (HAT)

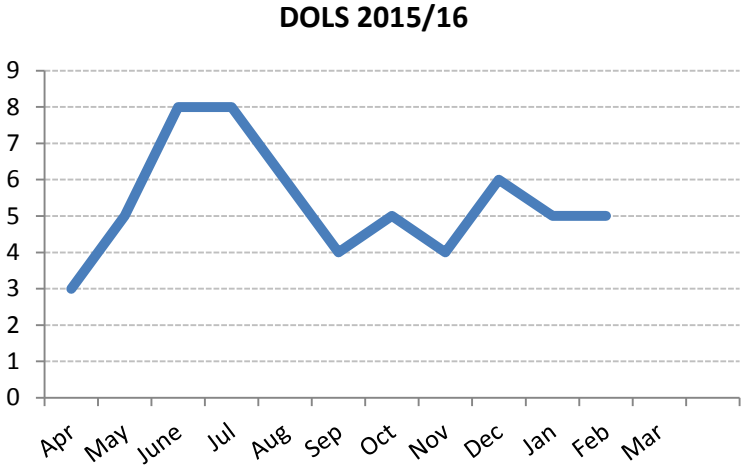
Year		2016
HAT cases identified to date (attributable to admission at SGH)		40
Mortality rate	Total	3 (7.5%)
	VTE primary cause of death	1 (2.5%)
Initiation of RCA process		100%
RCA complete		55% (22/40)
Cases where adequate prophylaxis was provided		21
Cases where inadequate prophylaxis was provided		1
Incidents jointly reviewed by HTG and clinical team		pending
Incidents investigated as SI		-

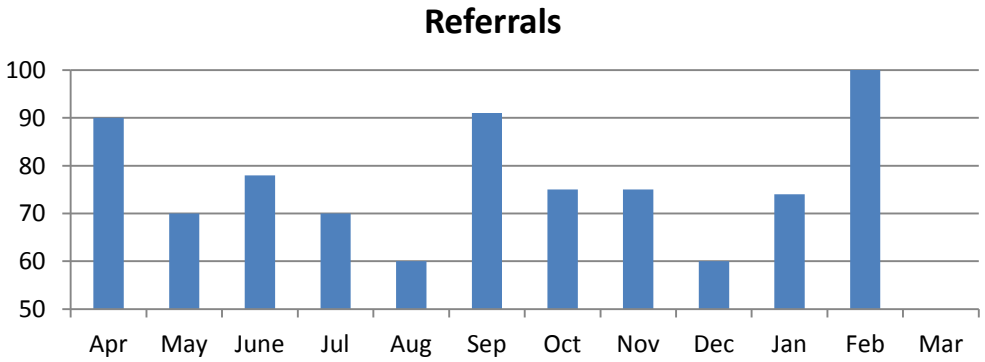
9. Patient Safety
- Safeguarding: Adults

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

Safeguarding Adults Training Compliance by Division – Feb16				
Med & Card	Surgery & Neuro	Community	Children's and Womens	Corporate
71%	72%	71%	76%	70%







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

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

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

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

9 Patient Safety - Safeguarding Children

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

Training : Remains on the risk register. Manual review continues to demonstrate a higher compliance rate

Serious Case Reviews and Internal Management Reviews: None in February

SI – The process of escalation of safeguarding issues is currently being trialled..

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

Section 11 annual self assessment audit completed, report and action plan underway.

Multi Agency audit 'Step up / Step down underway.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Patient Experience

Excellence in specialist and community healthcare

10. Patient Experience
- Friends and Family Test

Service	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Average
Community Services	74% n=486	95% n=539 ^	96% n=565 ^	90% n=284 v	87% n=353 v	86% n=401 v	87% n=430 ^	94% n=1213 ^	94% n=1337 -	93% n=536 v	94% n=392 ^	96% n=384 ^	91% n=6920
Medicine and Cardiovascular	94% n=896	96% n=808 ^	94% n=837 v	94% n=872 -	94% n=752 -	96% n=580 ^	93% n=628 v	95% n=555 ^	95% n=649 -	96% n=513 ^	96% n=591 -	97% n=579 ^	95% n=8260
Surgery Anaethetics and Neuro	94% n=917	95% n=1016 ^	96% n=1152 ^	95% n=1098 v	93% n=986 v	90% n=767 v	88% n=736 v	92% n=787 ^	90% n=709 v	91% n=642 ^	92% n=677 ^	90% n=598 v	92% n=10085
Women and Childrens	89% n=440	91% n=480 ^	92% n=474 ^	95% n=584 ^	93% n=567 v	93% n=498 -	93% n=429 -	93% n=480 -	93% n=397 -	91% n=336 v	92% n=271 ^	93% n=248 ^	92% n=5204
Trust	**86% n=2739**	**95% n=2843 ^**	**95% n=3028 -**	**94% n=2838 v**	**93% n=2658 v**	**92% n=2246 v**	**90% n=2223 v**	**93% n=3035 ^**	**93% n=3092 -**	**93% n=2027 -**	**93% n=1931 -**	**94% n=1809 ^**	**93% n=30469**

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

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

Further breakdowns are available for services and location type.

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

10. Patient Experience
-Mixed Sex Accommodation breaches

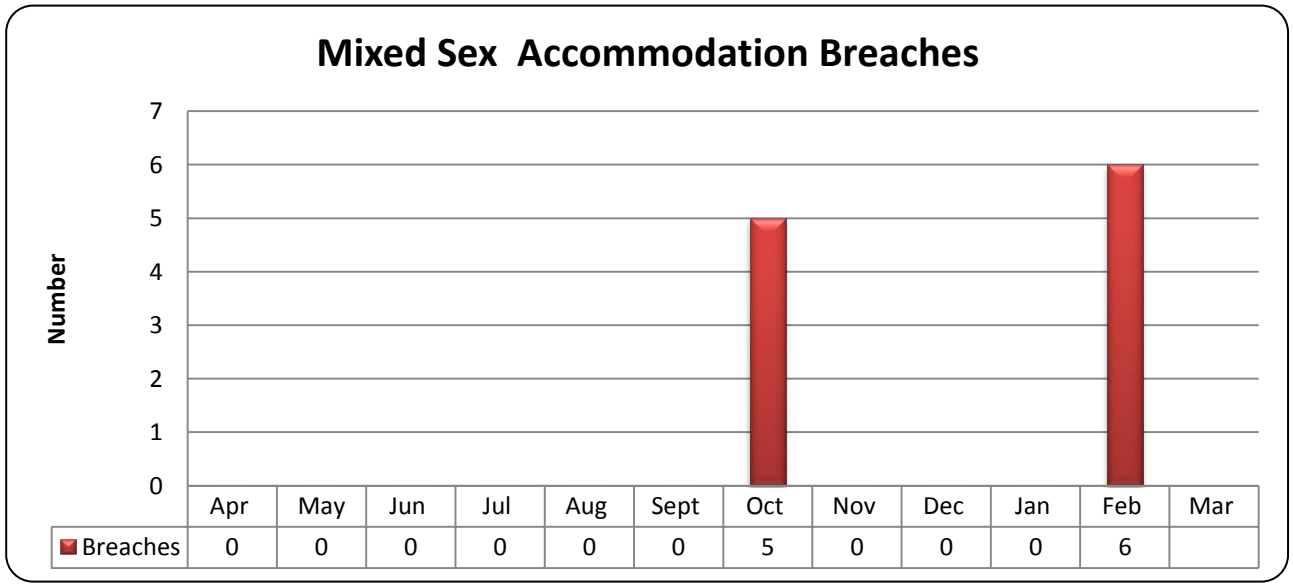
Mixed Sex Accommodation						
Lead Director	January	February	Movement	2015/2016 Threshold	Forecast March- 16	Date expected to meet standard
JH	0	6	↓	0	G	-

Peer Performance – February 2016				
STG	Croydon	Kingston	King's College	Epsom & St Helier
6	0	0	0	0

All NHS organisations are expected to 'eliminate mixed sex accommodation breaches except where it is in the overall best interest of the patient , or reflects their personal choice. The Mixed Sex Accommodation threshold is zero

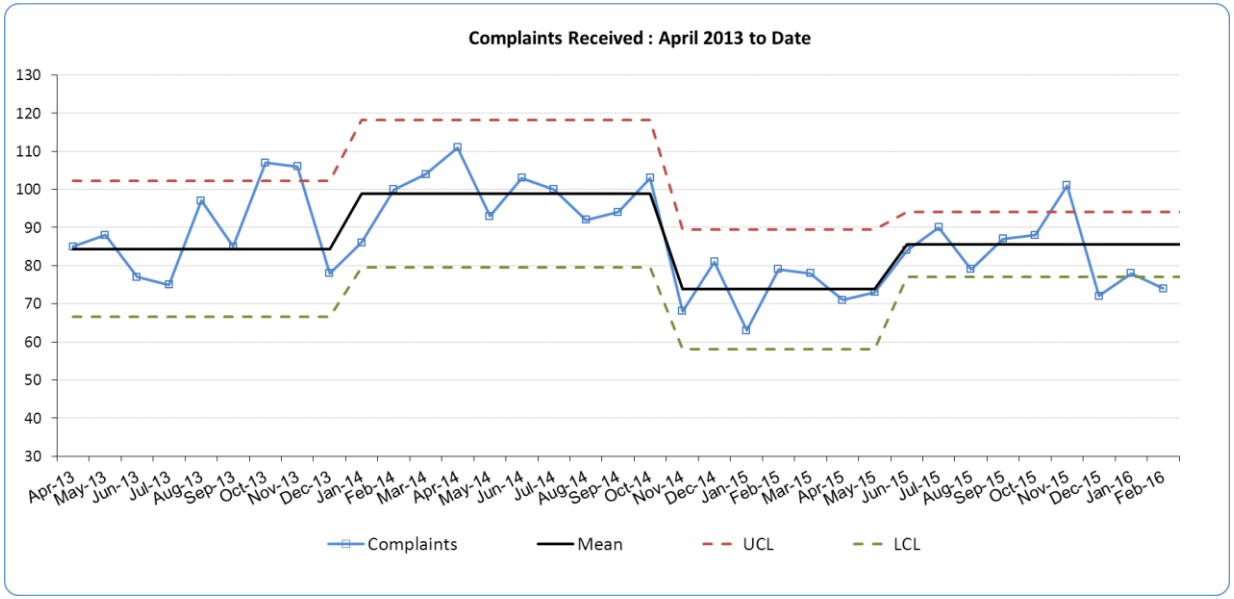
February MSA breaches show a disappointing spike with 6 breaches , one patient breaching and 5 others being affected. The trust has had 11 breaches year to date the other reported breaches in October when there was one breach with 4 patients affected. The breach occurred at a time when the ED department was experiencing significant capacity and bed pressures.

A root cause analysis report is prepared for all breaches highlighting cause and actions.



10. Patient Experience
- Complaints Received

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

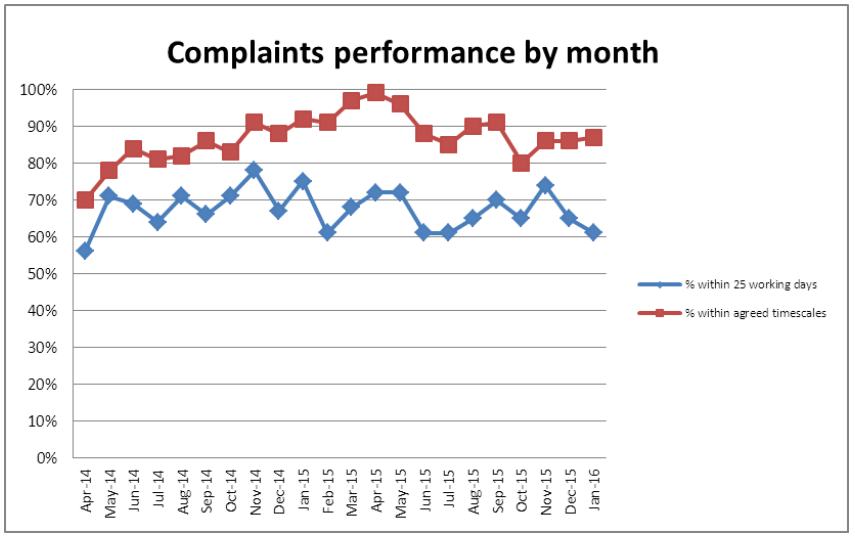


Overview:
This report provides a brief update on complaints received since the last board report (so in March 2016) and information on responding to complaints within the specified timeframes for complaints received in January of 2015/2016. It also includes some posts made on NHS Choices and Patient Opinion. The board will receive more detailed information about complaints received in quarter 4 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 4 is reached (so June 2016).

Total numbers of complaints received in February 2016
There were 74 complaints received in February of 2016, not a significant change when compared to December 2015 and January 2016. The number of complaints received about the Accident and Emergency Care Group remained steady but high (11) with the top subjects being clinical treatment – diagnosis and communication. There were no complaints received for the Cardiology Care Group compared to 4 in January 2016. Complaints about the Obstetrics and Gynaecology Care Group increased from 2-7 with the majority (5) being about the Gynaecology Speciality across a number of subjects including verbal communication and cancellation of operation.

10. Patient Experience
- Complaints Performance against targets

Performance Against Targets January 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	15	7	47%	(7) 93%
Medicine and Cardiovascular	32	21	67%	(8) 91%
Surgery & Neurosciences	20	12	60%	(4) 80%
Community Services	4	2	50%	(1) 75%
Corporate Directorates	7	6	86%	(0) 86%
Totals:	78	48	62%	(20) 87%



Commentary:

There was a decline in performance against the first target in January 2016 when compared to quarter 3 of 2015/2016. 62% of complaints were responded to within 25 working days (against the internal trust target of 85%) compared to 69% in quarter 2. Performance against the second target remained the same as in quarter 3 with 87% of complaints responded to within agreed timescales (against internal trust target of 100%).

Estates and Facilities Directorate was the only area which reached the target of 85%. The target of 100% was missed due to an Estates complaint breaching. All Facilities complaint responses went out on time, Community Services received only 4 complaints and so missing the targets on one for each meant a very low percentage was achieved. Children's and Women's and Medicine and Cardiovascular Divisions both improved on the second target with over 90% of complaint responses being sent out within agreed timescales.

Action plans are in place in consistently poorly performing divisions to improve and to deliver performance against internal standards but these are not achieving the desired results .

The complaints workshop which was originally scheduled to take place on 7 March 2016 had to be rescheduled due to the absence of key staff and is being rescheduled for April 2016. The aim of the workshop is to review how the complaints process is working from beginning to end and the governance/reporting/performance management. Participating will be the Deputy Chief Nurse, Divisional Directors of Nursing and Governance, Heads of Nursing, General Managers, Divisional Governance Managers and the corporate complaints and PALS teams.

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

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

If a comment is a cause for concern then the individual is given information via the website about how to obtain a personalised response via the Patient Advice and Liaison service (PALS) or the complaints and improvements department. Below are some examples of comments/stories posted on NHS Choices and Patient Opinion since the last board report. Of note only one negative comment was received out of nine posts made since the February board report.

Anonymous *gave Neurology at St George's Hospital (London) a rating of 5 stars*
Outstanding service
My husband and I attended t h e Atkinson Morley department on / Friday 4th March the service he received was outstanding and a definite 5 star service the member of staff who met us lovely and knowledgeable and was very reassuring, this person is an asset to the NHS, the consultant was very kind and took my husband's fears away well done especially to the member of staff we met I. Wish i could name them well done / and thank you.

Visited in March 2016. Posted on 05 March 2016

Patricia Buck *gave Orthopaedics at St George's Hospital (London) a rating of 5 stars*
A brilliant hospital., many thanks.
My sister has just been sent home from the orthopaedic ward after receiving over two weeks of outstanding care from the nursing staff, doctors and therapists. The support staff were brilliant too, patiently finding time to chat to her, meet her needs and help my sister throughout her stay. She received plenty of input from the physios and occupational therapists. Her progress was regularly monitored and everything possible was done to speed her recovery. We are so grateful to everyone concerned. Thank you so much St George's for providing such a highly professional, friendly and clean environment, You are a credit to the NHS.

Visited in March 2016. Posted on 16 March 2016

Anonymous *gave Ear, Nose & Throat at St George's Hospital (London) a rating of 1 stars*
ENT Department Worst Service Ever
My girlfriend injured her nose while exercising on Monday 22/02/16. Suspecting a broken nose and as she had trouble breathing and nose bleeding, we went to the A&E service the same night. After waiting for 4 hours, she was examined by a doctor who told us that an ENT doctor would see her once the swelling has gone down after 5 days.

The next day the ENT department called us and we were told that the earliest we can get an appointment is Thursday 03/03/16. We explained to the person on the phone that it's a bit late as if a realignment procedure is needed (which it was as her nose was slightly deviated), it needs to be done within 2 weeks. They told us that if realignment is necessary, it might be done the same day.

On Thursday 03/03/16, she was seen by a doctor, who didn't even greet her, introduce them self or ask her if she was ok. They had trouble making sentences in English and understanding us. They then told my girlfriend that her nose looked fine, but changed their judgment after carefully examining her and admitted that it might be broken. We were told that realignment is required. Usually this procedure needs to be done within 2 weeks as past this it will too late, as the nose will be healed. They said they would write that it is urgent and needs to be done within 1 week, so we will be contacted by the clinic shortly and that's all they can do. They were really rude and at no point caring or helpful.

After few days, we didn't receive any call and we started to panic as it might be too late, so my girlfriend called back on Wednesday 09/03/16 and battled to get an answer. She managed to speak to someone who was obviously concerned as they made a mistake. She was told that she will be contacted by the manager the same day. The manager contacted her only on Thursday 10/03/16 and only after my girlfriend insisted. Now she has been told that its too late for realignment and that she needs to see a consultant who will advise what to do. The earliest appointment they can give her is the 1st week of April 2016. How ridiculous? The consultant will probably tell her that having a deviated nose and difficulty breathing is not a priority for the NHS.

The whole experience was really distressful. The people working there don't seem to really care or to be qualified. We have never experienced such a poor service and it's a shame for such a hospital. We hope that our message will be heard as of today she is very upset.

Visited in March 2016. Posted on 10 March 2016

10. Patient Experience
- Patient stories

The reason my surgery became urgent was due to being lost in the Ortho department administration. Referred for surgery in April by July still had no notification of surgery date despite multiple requests for same. In the end the same procedure I believe was carried out as emergency but all the drama could have been saved if the admin side was working correctly. This seems to be the only downside to a very positive hospital experience.

I recently recieved treatment at Atkinson-Morley Hospital under Mr A Martin. I have been treated by many other specialists within the oncology teams under the umbrella of The Royal Surrey Hospital who reffered me.

I would like to commend the kindness, care and concern afforded me at all times during my treatment. Your staff made a fairly traumatic experience, bearable. Always good humoured, bright and chatty, nobody failed to meet the standard.

The N.H.S.is a truly fantastic benefit and long may it continue. The media highlight the relatively few shortcomings, mostly in outsourced areas, but fail to applaud the totality.

Please relay my thanks to your wonderful staff, my "head man", Mr Martin and Dr Fay his registrar.

I got the appointment in the day surgery unit in St George's Hospital at 12:00 (fasting from the last night). I was waiting for more than 4 hours to go to the theatre. I had general anaesthetic and the surgery was bigger than the doctors expected because they had to remove the ovary and *** to be completely. However, I was discharged 2 hours after they finished the operation because the unit was near to close. I was the last patient and I had to go home. In my opinion I needed more time to recover, staying in the hospital, because I felt drugged, in pain and I was unable to get at home in the 3rd floor without lift (I said this several times)

I wanted to write in having visited the hospital yesterday after being referred by my GP. A day earlier, I had to visit a private GP as I couldn't get hold of my local GP to even book an appointment, much to my disappointment.

Having visited the hospital I was surprised by both the speed and quality of service provided. I counted having direct contact with at least 6 individuals and each individual carried out their duties professionally. I know the NHS comes in for a lot of criticism and the junior doctors have been going through a challenging time, but I truly felt that I walked into a world class service and wanted to write in to show my appreciation.

I didn't write down the names of everyone I dealt with but would hope you can pass on my thanks to each of your staff that I had contact with. Keep up the fantastic work.

excellent
kind
responsible
respectful

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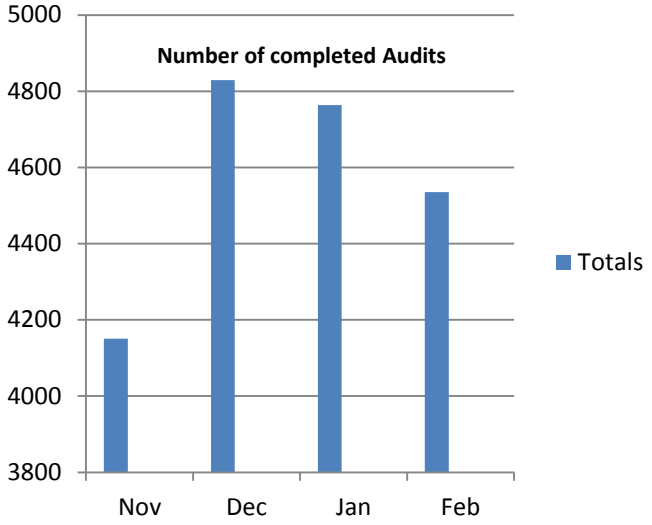
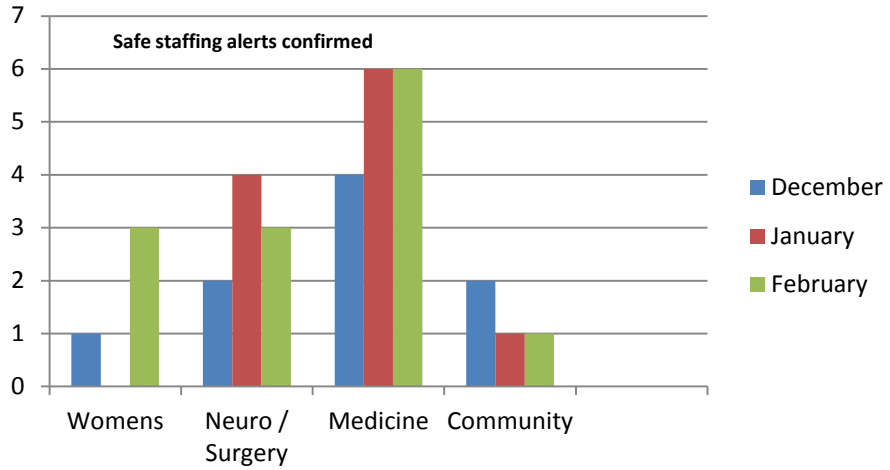
WORKFORCE

Excellence in specialist and community healthcare

11 . Workforce
February 2016 - Safe Staffing alerts





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

The total number of safe staffing audits completed over the past three months were: December 4829, January 4764 and February 4535. There was a slight increase in the number of final alerts reported from 11 in January to 13 In February. The number of alerts reduced to a concern (ward is safely staffed but some care needs will not be completed) has increased during the previous three months following on the day investigation (December 31, January 19, February 32).

10 nursing related safe staffing concerns were raised on Datix system compared to 19 in January. None of the Datix reports matched a similar entry on the RaTE system. The information contained in some of the Datix reports suggests that some of these could have been recorded as an alert (3), concern (3) or safe(4).

HMS prison Wandsworth did not complete safe staffing. This has been escalated to the Head of Nursing for the area.

Actions: Raise the link between Datix and the rate system with the nursing body with the aim to achieve greater consistency. Safe staffing posters have been displayed through out the trust identifying the process to follow for staff, patients and visitors in case they wish to raise a safe staffing alert.

11. Workforce: February 2016
- Safe Staffing profile for inpatient areas

Overview

The information provided on the table above relate to staffing numbers at ward/department level submitted nationally on Unify for February 2016. In line with new national guidance this table shows the number of filled shifts for registered and unregistered staff during day and night shifts. In February the trust achieved an average fill rate of 94.1%, an improvement from 91.3% submitted in January. Data cleansing continues to ensure that the report is being run consistently and only relevant front line nursing roles are included. It is thought that this and a better fill rate overall has improved the February position.

An additional column has now be added to highlight and RAG rate wards with fill rates lower than 85% as red and under 90% as amber.

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.
- Higher than 100% fill rates relate to areas which require more staff than they are profiled for. This could be because the patients the team are looking after are exceptionally unwell or require one to one nursing or supervision called specialing.
- Lastly 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

- The Division of Medicine and Cardiac has carried out a review of its vacancies, triangulated with quality indicators and is taking forward a range of actions to improve staffing on the ward. Going forward Divisions have been asked to carry out a similar review of their staffing situation.
- The Trust wide Nursing/ Midwifery Workforce programme, chaired by the Chief Nurse continues including work-streams for recruitment, retention, temporary staffing, marketing and forward planning. Colleagues from HR, Finance and Divisional representation support the delivery of the programmes of work. the progress of this programme of work is reported to the Workforce and Education committee.
- The focused work on recruitment resulted in the trust employing 63 more Band 5 nurses in February than left.

11. Workforce: February 2016
- Safe Staffing profile for inpatient areas

Overview
The information provided on the table below relates to staffing numbers at ward/department level submitted nationally on UNIFY for February 2016. In line with new national guidance this table shows the number of filled shifts for registered and unregistered staff during day and night shifts. In February 2016 the trust achieved an average fill rate of 93.92%%, a slight decrease from 94.33% submitted in January 2015. The trend over the past six months is outlined below:

MONTH	SEPT 15	OCT 15	NOV 15	DEC 15	JAN 16	FEB 16
%	94.6%	94.4%	93.93%	95%	94.33%	93.92%

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

11. Workforce: February 2015
- Safe Staffing profile for inpatient areas

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

11. Ward Safe Staffing: Community

Safe staffing Community Nursing Report

Service	Nov-15 Concerns	Nov-15 Alerts	Dec-15 Concerns	Dec-15 Alerts	Jan-16 Concerns	Jan-16 Alerts	Feb-16 Concerns	Feb-16 Alerts	Mar-16 Concerns	Mar-16 Alerts	Total Concerns	Total Alerts
Community District Nursing - North	1	0	0	1	0	0	0	0	0	0	1	1
Community Nursing Doddington	1	0	0	0	1	0	0	0	0	0	2	0
Community Nursing East 1 - Brocklebank	15	3	18	2	17	2	17	4	4	6	71	17
Community Nursing East 2 - Southfields and Tudor Lodge	7	1	11	2	13	0	9	0	4	2	44	5
Community Nursing North 1 - Stormont	5	0	0	0	0	2	0	0	7	2	12	4
Community Nursing North 2 - Bridge Lane and Doddington	0	0	0	0	0	0	0	0	0	2	0	2
Community Nursing North 3 - Chatfield	1	0	0	0	1	0	0	0	1	2	3	2
Community Nursing South 1 - Tooting	1	0	2	0	8	4	5	3	6	0	22	7
Community Nursing South 2 - Greyswood	11	1	5	5	4	3	2	0	3	1	25	10
Community Nursing South 3 - Balham	5	2	1	0	4	1	2	0	2	3	14	6
Community Nursing Tudor Lodge	12	3	9	2	7	7	11	5	1	0	40	17
Community Nursing West 1 - Westmoor	2	1	2	6	12	0	6	2	4	6	26	15
Community Nursing West 2 - Eileen Lecky	3	0	4	2	5	0	9	3	6	2	27	7
Diabetes Specialist Nurses	4	0	4	0	3	0	11	2	1	0	23	2
Total	68	11	56	20	75	19	72	19				95

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

HEATMAP DASHBOARD
WARD VIEW

Excellence in specialist and community healthcare

12. Ward Heatmap

Division	Ward	Incidence of c.difficile	Incidence of MRSA	Trust acquired pressure ulcers	Percentage of harm free care	Patient satisfaction (friends & family)	Friends & family response rate	Ward staffing: unfilled duty hours	Falls (ward level)	Serious incidents (ward level)	Sickness/ absence rate - (ward)
SURGERY	CAVELL	0.0	0.0	0.0	91.7	46.6	24.8	10.5	2.0	0.0	16.5
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	95.5	94.9	59.5		2.0	0.0	5.3
	GRAY WARD	0.0	0.0	0.0	86.2	91.4	61.9	15.4	1.0	1.0	0.7
	GUNNING	0.0	0.0	0.0	86.2	100.0	34.6	3.6	4.0	0.0	1.0
	GWYN HOLFORD	0.0	0.0	0.0	100.0	77.8	60.0	10.8	6.0	0.0	5.7
	HOLDSWORTH	0.0	0.0	0.0	100.0	95.0	45.7	7.2	1.0	1.0	5.7
	KEATE	0.0	0.0	0.0	100.0	92.1	70.0	6.3	1.0	0.0	8.9
	KENT	0.0	0.0	0.0	96.9	100.0	15.7	7.5	7.0	0.0	1.5
	MCKISSOCK	0.0	0.0	0.0	94.4	88.5	59.6	14.1	4.0	0.0	11.6
	THOMAS YOUNG	0.0	0.0	0.0	91.7	92.3		11.4	4.0	0.0	4.3
	VERNON	0.0	0.0	0.0	90.0	95.7	35.6	9.0	2.0	0.0	4.6
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	95.5	27.2	11.8	3.0	0.0	2.5
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0	88.9			3.1	0.0	0.0	7.7
	CARMEN SUITE	0.0	0.0	0.0				-4.6	0.0	0.0	0.4
	CHAMPNEYS	0.0	0.0	0.0	100.0	100.0	6.7	-3.2	2.0	0.0	2.7
	DELIVERY	0.0	0.0	0.0		100.0		-4.4	0.0	2.0	6.1
	FREDDIE HEWITT	0.0	0.0	0.0			0.0	9.0	0.0	0.0	7.2
	GENERAL ICU/HDU	1.0	0.0	0.0	72.2			4.4	0.0	0.0	4.2
	GWILLIM	0.0	0.0	0.0	100.0	89.9		5.9	0.0	0.0	4.4
	JUNGLE	0.0	0.0	0.0			4.8	2.9	1.0	0.0	2.0
	NEONATAL ICU	0.0	0.0	0.0	100.0		0.0	3.6	0.0	1.0	4.5
	NEURO ICU	0.0	0.0	0.0	63.6			7.0	0.0	0.0	3.6
	NICHOLLS	0.0	0.0	0.0			0.0	9.0	0.0	0.0	12.8
	PICU	0.0	0.0	0.0		100.0		8.5	0.0	0.0	2.6
	PINCKNEY	0.0	0.0	0.0			0.0	-6.4	0.0	0.0	5.7

12. Ward Heatmap

Division	Ward	Incidence of c.difficile	Incidence of MRSA	Trust acquired pressure ulcers	Percentage of harm free care	Patient satisfaction (friends & family)	Friends & family response rate	Ward staffing: unfilled duty hours	Falls (ward level)	Serious incidents (ward level)	Sickness/ absence rate - (ward)
COMMUNITY SERVICES	Mary Seacole	0.0	0.0	0.0		95.0	54.1	3.4	6.0	0.0	7.6
	Nightingale	0.0	0.0	0.0		100.0	10.3	6.7	2.0	0.0	3.7
	South Locality (CCM)	0.0	0.0	0.0					0.0	0.0	
MEDICINE	ALLINGHAM	0.0	0.0	0.0	100.0	95.0	27.0	1.2	7.0	0.0	10.5
	AMYAND	0.0	0.0	0.0	87.1	100.0	19.0	6.0	9.0	0.0	8.8
	BELGRAVE	0.0	0.0	0.0	100.0	95.7	45.5	4.3	5.0	0.0	1.3
	BENJAMIN WEIR	0.0	0.0	0.0	96.6	96.8	56.4	9.6	5.0	0.0	3.9
	BUCKLAND	1.0	0.0	0.0	90.5	97.6	46.2	15.0	1.0	0.0	2.4
	CAESAR HAWKINS	0.0	0.0	0.0	95.7	95.7	45.6	5.6	8.0	0.0	10.0
	CARDIAC CARE UNIT	0.0	0.0	0.0	71.4	100.0		2.7	0.0	0.0	1.5
	CAROLINE	1.0	0.0	0.0	100.0	100.0	58.0	11.9	3.0	0.0	10.0
	CHESELDEN	0.0	0.0	0.0	95.2	100.0	55.3	3.4	4.0	0.0	0.8
	DALBY	0.0	0.0	1.0	90.9	75.0	33.3	2.0	13.0	1.0	8.0
	EMERGENCY DEPARTMENT	0.0	0.0	0.0				6.2	8.0	0.0	3.6
	GORDON SMITH	0.0	0.0	0.0	100.0	95.8	47.1	9.9	4.0	0.0	0.4
	HEBERDEN	0.0	0.0	0.0	79.2	100.0	54.1	1.6	6.0	0.0	4.5
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	0.0	10.0	0.0	0.0	0.5
	MARNHAM	0.0	0.0	0.0	85.7	100.0	7.7	5.8	5.0	0.0	2.6
	MCENTEE	0.0	0.0	0.0	100.0	100.0	11.7	4.7	0.0	0.0	1.3
	RICHMOND	0.0	0.0	0.0	90.2	94.0	16.8	7.8	9.0	0.0	6.0
	RODNEY SMITH	0.0	0.0	0.0		96.0	39.6	5.0	7.0	0.0	2.1
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	84.6	100.0	112.5	-0.3	2.0	0.0	2.0
	TREVOR HOWELL	0.0	0.0	0.0	100.0	93.8	46.8	3.8	3.0	0.0	7.6

12. Ward Heatmaps: STNC

Cardiothoracic Intensive Care (CTICU)

88.9% scored for harm free care. 18 patients were surveyed with 2 reported harms. 1 patient had an old grade 4 pressure ulcer and 1 patient had an old grade 2 pressure ulcer.

General Intensive Care (GICU)

72.2% scored for harm free care. 18 patients were surveyed with a total of 5 harms reported. 3 patients had new grade 2 pressure ulcers, 1 had an old grade 2 pressure ulcer and 1 patient had a new grade 4 pressure ulcer.

Neuro Intensive Care (NICU)

The heatmap reports a score of 63.6% however this is not consistent with the raw data provided from the safety thermometer team who report a score of 100%. Clarification with the service confirms that the score for February 2016 was 100%

Sickness

The staff sickness profile continues to improve across the division. Further work is required in specific areas to drive this down further such as Nicholls ward and Delivery suite. Divisional meetings commenced in mid-March 2016 to ensure there is good rota management and that all sickness is being managed appropriately, these meetings will be held on a bi – monthly basis going forward, with ward / department sisters and matrons attending.

Friends and Family

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

Falls

There were 2 falls on Champneys in February 2016, this is the same as the previous month and relates to a cohort of medical patients that are now located on the ward. This is a sustained position following a peak in falls in December 2015.

Serious Incidents

There were a total of 3 serious incidents in this month, 1 relating to a drug incident in NNU, this is currently being investigated by the serious incident panel; recommendations and learning from this will be shared across the trust once concluded. The 2 remaining incidents pertain to the delivery suite, 1 relates to an unexpected admission to NNU and the other a stillbirth; all of which are being investigated.

12. Ward Heatmaps: WCDOP Division

Incidence of CDT

2 cases of CDT were reported in February 2015, 1 in CTICU and 1 in NICU. Both cases are being reviewed and root cause analysis completed. The CTICU case is being incorporated into a bigger piece of work to improve infection control within CTICU.

Trust Acquired Pressure Ulcers

1 grade 3 pressure ulcer reported in GICU in month. The root cause analysis is currently being completed for this, but initial findings suggest that this may have been previously inaccurately assessed as a grade 2 pressure ulcer.

% of harm free care

CTICU – 87.5%

1 patient harm was noted, this was 1 old grade 2 pressure ulcer.

Champneys – 93.3%

2 patient harms were recorded on the day of audit. These were 1 old grade 2 pressure ulcer and 1 new grade 2 pressure ulcer.

Friends and Family Response Rate

Champneys ward have reported a slight improvement in the response rate in month, however they are still not reaching the desired 30 % target. Technical problems contributed to this in the early part of February, with paper documentation being used to support this, however further work is planned in order to achieve compliance. This work will be facilitated the Matron and Ward sister.

Serious Incidents

5 reported in month, these all relate to delivery and the admission of babies to NNU. The incidence of such cases has been discussed at DGB and further analysis is being completed in addition to the respective root cause analysis.

Sickness

Three areas are reporting higher than average sickness rates. Bi -monthly rota management meetings continue within the division with the ward sisters and matrons which also includes a review of sickness absence rates and the overall management of sickness. This ensures that there is adequate support for staff in managing sickness and early escalation of any difficult cases.

12. Ward Heatmaps:
Mary Seacole

Falls: 6.0 The figure is lower this month however we continue to monitor and manage this. We work alongside our therapy colleagues to reduce risk of falling in patients, all patients have Falls risk assessment completed and reviewed, patients at high risk are assessed for need for 1:1 supervision and this is monitored by ward sisters daily. In handovers and team meetings the level of falls will be discussed and we will continue to review all falls and action ones where we consider there was a failure in correct action being taken to prevent.

Sickness 7.6, there remain challenges around sickness with some long term sickness. I am confident that all staff are managed appropriately through the sickness policy and referred for OH when required. I work with the ward sisters to ensure this happens and will review all staff with the sisters as part of their supervision to ensure this is happening. A number of staff are managed through the short term sickness absence policy and this is supported by our HR advisor.

13. Community Services – CSD Scorecard

Domain	Patiend Safety & Experience Indicator	Frequency	2015/2016 Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
				Quarter 1 2015/16			Quarter 2 2015/16			Quarter 3 2015/16			Quarter 4 2015/16		
Patient Safety	SI's REPORTED	Monthly		1	1	2	0	1	4	1	3	1	1	0	
Patient Safety	Number of SI's breached	Monthly	0	0	0	0	0	0	0	0	1	0	0	0	
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly		1	0	0	0	1	2	1	1	0	1	0	
Patient Safety	Grade 4 Pressure Ulcers	Monthly		0	0	0	0	0	0	0	0	1	1	0	
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly		10	7	4	12	8	13	10	11	13	10	13	
Patient Safety	Number of moderate falls	Monthly	0	2	1	0	1	0	0	0	2	1	0	0	
Patient Safety	Number of major falls	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	
Patient Safety	CDiff (cumulative)	Monthly	31	1	0	0	0	0	0	0	0	0	0	0	
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2	2	2	2	2	2	2	2	2	2	
Patient Safety	Number of Quality Alerts	Monthly		3	5	2	9	11	4	6	7	4	7	5	
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	89.0%	86%	85%	84%	81%	81%	77%	74%	70.0%	70.0%	68.0%	
Safeguarding	% of staff compliant with safeguarding children's training	Monthly	Level 1 85%	90.0%	90.0%	85%	82%	79%	88%	89%	86%	85%	89%	79%	
			Level 2 85%	84.0%	84.0%	82%	82%	74%	66%	67%	63%	83%	80%	85%	
			Level 3 85%	69.0%	69.0%	82%	90.00%	70%	85%	87%	84%	84%	84%	80%	
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.86	0.86	0.86	0.86	0.86	0.9	0.9	0.9	0.9	0.9	tbc	
Patient Experience	Active Claims	Monthly		0	0	1	3	1	0	1	0	0	0	tbc	
Patient Experience	Number of Complaints received	Monthly		16	18	6	5	2	5	5	5	5	4	4	
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	100%	88%	78%	100%	100%	85%	100%	100%	89%	100.0%	50%	
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	100%	100%	100%	100%	100%	92%	100%		78%	100%	tbc	
Patient Experience	FFT Score (Mary Seacole)	Monthly M S A		97.0%	94.7%	77.7%	71.0%	97.3%	84.2%	94.4%	94.4%	100%	90%	95%	
		Monthly M Se B		81.20%	90.90%	75.00%	95.40%	90.90%	75%	90%	94%		85%		
Patient Outcomes	Catheter related UTI (Trust)			1.14	0.66	1.12	1.32	1.50	1.03	0.67	0.96	0.47	0.46	0.90	
	Number of new VTE (Trust)		National 0.005	0.53	0.37	0.15	0.08	0.24	0.17	0.30	0.48	1.01	0.00	0.23	
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Workforce	Sickness Rate -	Monthly	3.50%	5.72%	6.04	6.00	4.69	5.75	5.53	5.90	5.71	6.00%	6.5	6.19	
Workforce	Turnover Rate-	Monthly	13%	19.64	19.94	20.40	20.08	21.00	21.15	20.75	20.76	21.20	20.80	21.59	
Workforce	Vacancy Rate-	Monthly	11%	19.41	19.06	19.40	12.60	13.42	12.59	15.67	18.50	19.40	18.90	18.7	
Workforce	Appraisal Rates – Medical	Monthly	85%	66.67	72.73	69.57	69.57	84.00	84.00	79.41	81.26	87.10	87.10	86.87	
Workforce	Appraisal Rates - Non-Medical	Monthly	85%	77.25	76.80	75.84	75.42	76.02	68.22	64.91	62.92	62.40	63.20	63.53	
safe staffing	concerns													66	
safe staffing	alerts													46	

13. Community heat map
- CSD Exception Report

Community

- No serious incidents for February 2016.
- Falls incidents increased to 13 as includes 3 no/low harm for patients at St G @ Nightingale.
- Quality alerts: 3 (QMH: appointments) 2 Community nursing (phlebotomy, INR testing). 6 Quality alerts remain open, 3 overdue (QMH, Community nursing, maximising independence). Clarity being sought on details of alert as referrer unknown.
- Technical access to MAST training, including safeguarding (adult and child) is improving due to migration of community staff to St Georges IT server.
- 2 complaints breached completion target - extension now agreed.
- No improvement on workforce data. Focus on turnover, appraisal and MAST training (inc. IG training).
- Safe staffing: Daily 'sit rep' for community nursing pilot (led by Hon CN) continues. Patient allocation and staff resources are reviewed to manage safe staffing and capacity concerns.
- FFT report to follow to CQRG March 2016

St George's University Hospitals NHS
NHS Foundation Trust

Referral to Treatment Access Policy

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This Referral to Treatment Access Policy has therefore 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 1.

Policy Profile			
Policy Reference:	*Provided by the Corporate office*		
Version:	Version 1.2		
Author:	Traci Dean - Head of Elective Access		
Executive sponsor:	Chief Operating Officer		
Target audience:	All staff involved in the management of referrals, appointments, waiting lists and admissions		
Date issued:	*Date published - completed by Corporate office*		
Review date:	*One year from date of issue or earlier if changes in guidance or practice are published*		
Consultation			
Key individuals and committees consulted during drafting		**Dates**	
	Divisional Management Teams, Operational Managers, Administrative Staff	**Dates**	
		Dates	
Approval			
Approval Committee:			
Date:			
Ratification			
Ratification Committee:	Policy Approval Group		
Date:			

Document History			
Version	**Date**	**Review date**	**Reason for change**
V1	**December 2011**	**December 2012**	
V1.1	**December 2015**		Updated to reflect current RTT guidance

Contents

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Executive Summary

St George's University Hospitals NHS Foundation Trust has a reputation for providing excellent clinical care to local South West London residents as well as the wider national population. This policy describes how the Trust will ensure that access to its clinical services is equitable and fair to all patients in accordance with clinical need.

This policy provides a set of standards for the management of referrals, waiting lists and appointments and admissions to ensure that the Trust maintains clinical priorities and meets statutory responsibilities with regard to the 18 Week Referral to Treatment maximum waiting time for elective patient pathways.

The principles outlined in this policy support the Trust in achieving the national objectives to reduce waiting times for Outpatient, Diagnostic and Inpatient treatments and improve patient choice.

Access Principles

- Patients should only be added to the waiting list if there is a real expectation that they will be treated, i.e. they should be willing, able and fit to undergo the planned procedure
- Patients will be treated in order of their clinical need and priority will be given to clinically urgent patients
- Where patients have the same or comparable need they will be treated in chronological order, thereby minimising the time spent on the waiting list and improving the quality of patient experience
- All referral, appointment and waiting time activity must be recorded accurately on the relevant Trust databases (Cerner, Solitan, EPR, E-Triage, etc)
- All patients will be able to choose/negotiate their appointment or admission date
- The Trust will work to ensure fair and equal access to services for all patients.

All staff involved in the management of referrals, appointments, and waiting lists across all patient-accessible clinical services should demonstrate a sound knowledge of the principles of this policy and full compliance with the accompanying protocols.

This policy was written in consultation with the St George's University Hospitals NHS Foundation Trust RTT Compliance Group, Operational Managers and the Wandsworth Clinical Commissioning Group.

1 Introduction

The length of time a patient needs to wait for hospital treatment is an important quality measure and a visible indicator of the efficiency of clinical services provided by the Trust. This policy describes how St George's University Hospitals NHS Foundation Trust will manage access to its elective services ensuring compliance with the 18 Week waiting time standard and fair, clinically appropriate treatment for all patients.

The arrangements provide clear guidance to all staff involved in the management of patient pathways and specifically the application of 18 Week Referral to Treatment principles. It is vital that these principles are applied for the Trust to achieve the national objectives to reduce waiting times and improve patient choice.

2 Purpose

The purpose of this document is to ensure that patients requiring access to outpatient appointments, diagnostic tests and elective inpatient or day case treatment are managed consistently, according to national frameworks and definitions while maintaining the overriding importance of customer care. It is the responsibility of all staff to ensure that internal processes work to support patients in receiving a fair and efficient service.

Every process in the management of patients who are waiting for treatment must be clear and transparent to patients and to partner organisations and must be open to inspection, monitoring and audit. Having in place up to date policies and procedures, robust data collection systems and appropriate continuous staff training is essential to the accuracy of referral and waiting list management and for monitoring key access targets, both internally and externally to commissioners.

The policy will provide a systematic approach to the management of referrals, appointments/admissions and waiting lists within the organisation, from receipt of referral to discharge of care. Assurance will be provided that appointments and admission processes are being managed effectively and equitably through monitoring compliance and regular review, as outlined within the policy.

The policy is intended to:

- ensure that patients receive treatment according to their clinical priority, with urgent cases seen first and routine patients treated in chronological order subject to clinically appropriate exclusions
- support the continued reduction in waiting times and cancelled operations and the achievement of key access targets by establishing a number of good practice guidelines to assist staff with the effective management of patients requiring outpatient, diagnostic, inpatient and day case treatment.
- ensure that the rules governing the management of 18 Week Referral to Treatment pathways are followed
- provide a practical and easy to follow guide for administrative staff responsible for managing waiting lists. The policy cannot specify all eventualities but aims to give a framework to work within. A common sense approach that maintains the best interest of the patient should be applied to cases that fall outside the policy and advice should be sought from the relevant manager where further clarification is required.

3. Scope

This document defines the policy to be followed by all staff at St George's University Hospitals NHS Foundation Trust involved in the management of elective pathways. It

defines roles and responsibilities and sets out the parameters for booking and scheduling and establishes a number of good practice guidelines. The policy determines the framework for managing referral to treatment pathways within 18 weeks and defines the application of 18 week principles of clock starts, stops, pauses and active monitoring.

The policy applies to all elective inpatient, day case and outpatient pathways, including diagnostic and therapy appointments and will be implemented consistently and fairly across the Trust. The Trust will work towards shorter waiting times and improved care pathways for all patients, including those referrals/pathways not subject to performance monitoring.

4. Roles and Responsibilities

Whilst responsibility for achieving targets lies with the Clinical Management Board and the Trust Board, it is the responsibility of all members of staff to understand the 18 Week principles and definitions. These must be applied to all aspects of referral and waiting list management and individual pathways.

4.1 The Chief Executive

The Trust Board, through the Chief Executive has a corporate responsibility to ensure equitable access to the Trust's clinical services and the management of patients in accordance with the principles described in this policy. The Chief Executive delegates the operational management of the Trust to the Chief Operating Officer.

4.2 The Chief Operating Officer

The Chief Operating Officer is responsible for the development, ratification, implementation and monitoring of this policy through the divisional management structure. The Chief Operating Officer will ensure that this policy is updated in response to changes in national guidance and local arrangements with commissioners.

4.3 Divisional Directors Of Operations, Divisional Chairs and Clinical Directors

The Divisional Directors of Operations and Clinical Directors have delegated responsibility for the operational management of clinical services and access to these services.

- The Divisional Directors of Operations and Clinical Directors for each Directorate/Specialty have the responsibility for implementing and ensuring adherence to this policy within their areas.

4.4 Hospital Clinicians

- decide which patients require addition to a waiting list and their clinical priority
- ensure that patients added to a waiting list are willing, able and fit to undergo their treatment
- are responsible for the care of all patients on their lists, ensuring that priority is given to clinically urgent patients and thereafter routine cases are seen in strict chronological order within the timescales set out in this policy
- review their waiting list on at least a monthly basis
- ensure that all clinical decisions impacting the patient's pathway are recorded properly and timely communications to other parties involved in the patient's care
- ensure that referrals are reviewed and returned to the Central Booking Service for action within two working days for non-cancer referrals and 24 hours for suspected cancers

4.5 General/Service Managers

Managers within the Trust are responsible for ensuring that the policy and supporting standards and guidelines are built into local processes and that there is on-going compliance. In support of this they will:

- proactively plan and manage demand, capacity and activity and any backlog to ensure that all patients receive treatment according to clinical priority and within nationally and locally agreed targets
- monitor that all staff in their departments adhere to the Referral to Treatment Access Policy and associated procedures and provide on-going training and compliance assessment with additional training and support for staff who fail to work to the necessary standard
- provide clinicians with details of patients on their waiting list to enable them to clinically manage their patients
- support clinicians understanding and use of RTT coding and clinic outcome forms, advising of any revisions to guidance and implementing change where appropriate

4.6 Administrative Teams

Administrative staff are responsible for ensuring that correct administrative processes are followed in accordance with this policy to:

- enable patients to have the maximum opportunity to attend their consultations and admissions in the required time
- ensure that data recorded on the Trust's systems is accurate and timely and that any corrections are made promptly
- escalate to their managers any issues affecting compliance with this policy.

4.7 General Practitioners (GPs)

GPs are responsible for ensuring that only those patients who are eligible for NHS treatment and who are available to be seen within the timescales stipulated in the policy are referred to the Trust.

4.8 Head of Elective Access

The Head of Elective Access has responsibility for monitoring access arrangements and ensuring compliance with the Trust's Referral to Treatment Access Policy by:

- ensuring a co-ordinated approach to referral, appointment and waiting list management across the Trust
- supporting the Divisional Directors of Operations and Chief Operating Officer in identifying best practice and defining and implementing Trust policy
- working closely with staff across the organisation to ensure that the Referral to Treatment Access Policy guidance and standards are understood and adhered to

4.9 Patients

- have a responsibility to make themselves available for treatment within the timescales set out in this document, unless exceptional circumstances or complex clinical issues preclude this.
- must understand the implications of cancelling or failing to attend their agreed consultation or treatment.

4.10 Escalation Procedures

If patients are identified as being at risk of moving outside the boundaries of their pathway and no suitable capacity can be found, the problem will be escalated for action.

Level A: Service Manager

The Divisional Service Managers are responsible for creating additional capacity as required, to ensure that patients are given suitable appointments within the 18 week standard.

If Service Managers are unable to find solutions to capacity problems then on Day 8, this will be escalated to Level B status.

Level B: General Manager

The General Manager has 48 hours to resolve the issue. If the issue remains unresolved at this time then the problem is escalated to Level C.

Level C: Divisional Management Team

Responsibility for ensuring sufficient clinical capacity is in place for delivery of a successful 18 weeks pathway lies with the Divisional Director of Operations and the Clinical Director. The Divisional Management Team will make the ultimate decision relating to capacity shortfalls which include any that impact upon the Trust's ability to uphold the NHS Constitution.

5 18 Week Referral to Treatment Standard

5.1 18 Week Referral to Treatment Performance Target

The 18 Week Referral to Treatment (RTT) performance target is concerned with improving patients' experience of the NHS by providing high quality elective care without unnecessary delay. Nationally from December 2008 no patient will wait longer than 18 weeks from GP referral to hospital treatment (NHS Improvement Plan 2004). A small tolerance level is set for those patients who wish to wait longer than 18 weeks or who have complex co-morbidities which preclude them from being treated within the standard. The 18 week pathway does not allow for delays in patient care due to administrative processes or capacity constraints.

It does not replace existing shorter waiting time guarantees such as referral for suspected cancer. The management and reporting of cancer and suspected cancer pathways is separate but runs concurrently with 18 week RTT performance monitoring If a suspected cancer patient subsequently proves to be benign, the cancer pathway ends but the 18 week pathway continues until treatment or discharge.

5.2 National Waiting Times Standards

The following national access targets (or operational standards) apply to all patients on an RTT pathway referred to consultant-led services:

- **Incomplete**: **92%** of all patients waiting to start treatment should have been waiting less than 18 weeks (126 days) from referral. These are also known as `waiting list' waiting times.
- **Diagnostic**: No patient will wait longer than **six weeks** for a diagnostic test or image

- **Audiology Direct Access: 95%** of patients referred to a direct access audiology service (not led by a medical or surgical consultant) should be treated within 18 weeks. Audiology Direct Access waiting times are subject to RTT rules but monitored under separate provision

NB. Patients waiting or treated on the 126th day of their 18 week pathway are within the national standard.

5.3 18 Week Performance Standards for 2015/16

As set out in the **NHS Standard Contract 2015/16**, providers are expected to achieve all of the Operational Standards and National Quality Requirements. The consequences for failure to achieve these standards are set nationally.

National Quality Requirements mandate zero tolerance of RTT waits over 52 weeks for Incomplete pathways and a financial penalty per patient is applied by the relevant Clinical Commissioning Group for each patient waiting over 52 weeks at the end of each month.

5.4 Trust Access Targets

Patients are entitled to receive their first definitive treatment within 18 weeks of referral if it is clinically appropriate to do so. To facilitate delivery of this target and in line with good practice, the Trust's standard policy is to offer routine patients a first outpatient attendance within an upper limit of 11 weeks of receipt of the referral by the hospital. Admission for inpatient or day case treatment should be offered within 10 weeks of addition to the waiting list.

Individual specialties may operate a degree of flexibility when setting internal targets for first attendance and admission, subject to availability of capacity and pathway requirements, however the combined waiting time, including any diagnostic tests, should not exceed the 18 week maximum target unless it is necessary on clinical grounds.

Separate arrangements apply for urgent referrals and these will be offered a first attendance within four weeks of the referral being received. Urgent referrals for suspected cancer will be seen within 14 days of referral.

5.5 18 Week Referral to Treatment Terminology and Definitions

Terminology

Term	Brief Description
RTT	Referral to Treatment
RTT Status	The stage at which the patient is at along the 18 week pathway
Clock Start	Waiting time starts
Clock Pause *(No longer applicable)*	Waiting time is paused, i.e. temporarily frozen for IP/DC waiting list only. NB. effective from 1st October 2015 clock pauses are no longer permissible
Clock Stop	Waiting time stops
Incomplete Pathway	Ongoing RTT waiting list, patients not yet treated
Active monitoring / watchful waiting	Clinical decision is made to monitor the patient's condition without clinical intervention or diagnostic procedures
First Definitive Treatment	First intervention intended to manage a patient's disease, condition or injury and avoid further intervention
Non-Admitted Pathway	Care provided in an outpatient setting
Admitted Pathway	Care provided as a day case or inpatient

18 Week Status Definitions

Clock Starts	An 18-week clock starts when any care professional or service makes a referral to:	A consultant led service, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner
	Choose and Book	A patient converts their unique booking reference number (UBRN)
	Self-Referrals	An 18-week clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional
Clock Starts	Upon completion of an 18-week referral to treatment period, a new 18-week clock only starts:	When a patient becomes fit and ready for the second of a consultant-led bilateral procedure
		Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan
		Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral
		When a decision to treat is made following a period of active monitoring.
		When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock

Clock Pauses	A period of time where the admitted pathway clock is frozen:	From 1st October 2015 clock pauses are no longer permissible and no adjustments may be applied to admitted pathways however for audit purposes these should still be recorded.

Clock Stops	Clock stops when first definitive treatment is given via:	Consultant led service
		Interface service
		Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions
		A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

Clock Stops	Clock stops for 'non-treatment' when:	It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care
		A clinical decision is made to start a period of active monitoring
		A clinical decision is made not to treat

		A patient DNA's their first appointment following the initial referral that started their 18 week clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient.
		A patient DNA's any other appointment and is subsequently discharged back to the care of their GP, provided that:
		i) the provider can demonstrate that the appointment was clearly communicated to the patient;
		ii) discharging the patient is not contrary to their best clinical interests;
		iii) discharging the patient is carried out according to local, publicly available, policies on DNA's.
		iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders

Patients may continue to have on-going treatment for the same chronic condition for many years. The 18 week pathway only applies to the time immediately following referral from a GP to the first definitive treatment, or from any new clock being started later in a patient's pathway for a significantly different treatment.

6 Key Principles

- Patients should not be referred for secondary care services unless they are ready, able and willing to commence treatment within a maximum of 18 weeks.
- All patients must be booked in order of clinical need, with urgent and suspected cancer cases taking priority, followed by routine patients scheduled by chronological waiting time.
- Offers of appointments and admission should be agreed with the patient and be reasonable. All dates offered must be within a timeframe to enable the patient to be treated within 18 weeks of referral.
- The scheduling of routine patients must be managed via 18 Week Referral to Treatment PTLs (Priority Treatment Listings) to agreed maximum internal waiting times for each stage of the pathway.
- Written and verbal communications with patients should be clear and concise, outlining the possible consequences of failing to attend without prior notification, periods of patient unavailability or patient-initiated cancellations.
- Patient letters should be generated from the Trust's Cerner Patient Administration System for each event affecting a patient's waiting time to provide consistency and an audit trail of all communications sent. Copies of all patient letters should be sent to the GP or referring clinician
- All patients should receive written guidance to consult their GP if their condition worsens whilst on the waiting list. The instructions must be embedded in Cerner generated letters or other equivalent correspondence. Contact details for the relevant service must also be included. Routine long waiting patients may have their appointment or admission date expedited if there is concern that their clinical condition has changed.
- Any change in the patient's treatment status should be recorded on the Trust's information systems within 24 hours
- Patients may not be discharged and returned to the referrer due to non-attendance, cancellations or non-availability without prior agreement by the lead clinician.

Urgent cases must be escalated immediately to the relevant operational manager to ensure the clinician takes the appropriate action to contact the patient to discuss the need for treatment.

- The accuracy of referral and waiting list information held on the Trust's information systems is the responsibility of all staff involved in the management and recording of pathways.

7 Outpatients

The guidance within the Outpatient section of this policy document is specific to the management of 18 week Referral to Treatment pathways. Detailed instructions relating to the process rules for recording referrals, administering the outpatient waiting list and booking appointments can be found in the Corporate Outpatient Service's standard operating procedures.

7.1 Management of Referrals

Referrals made to the Trust must be legible, follow agreed referral protocols and provide appropriate detail to register and appoint the patient. All referrals must contain sufficient clinical information (including clinically relevant imaging/diagnostic results) for the healthcare professional to make an initial decision about the patient's condition or treatment.

The Trust will make repeated attempts to request any missing information whilst progressing the booking of an appointment. Where the above criteria are not met, the Trust will escalate their concerns to the referring commissioner.

7.1.1 GP Referrals

Referrals should only be made to the Trust if the patient is willing and able to be treated within the maximum access target, if this is not the case the referral should not be sent until such time as the patient is available.

The Trust supports the full utilisation of referrals via the Choose and Book system, ensuring its Directory of Services is up to date and the appropriate level of capacity is published to make sure that patients have choice of access to services at a convenient date and time.

The Trust is working with local Primary Care Trusts to promote the use of Choose and Book for all referrals originating from a GP; however access times and administrative standards are applicable to both paper and electronic referral routes. Operational managers must ensure that Choose and Book polling ranges are set to make sufficient capacity available within a waiting time appropriate to the service and consistent with an 18 week pathway.

Letters will be opened and stamped with the date of receipt. All referrals received will be registered on Cerner within 24 hours. Where referrals start a new 18 week pathway, as is the case for GP and Dental referrals, the date of receipt will constitute the clock start. The 18 week pathway for patients referred via the e-Referral service will commence from the date the Unique Booking Reference Number (UBRN) is converted into an appointment by the patient.

7.1.2 Tertiary Referrals

- **On-going pathway, referral for treatment at St George's**

Pathways that include more than one provider will not usually start on the date that the Trust receives the referral. The clock start date for the existing pathway must be provided by the referring organisation. Tertiary referrals into St George's University Hospitals NHS Foundation Trust from another secondary care provider must include an agreed minimum data set for the purposes of establishing the patient's RTT status and the point along the 18 week pathway. The prescribed format is the Inter Provider Transfer Minimum Data Set proforma (IPTMDS) and these must be forwarded to the 18 Week Team for verification and entry onto the Cerner system within one working day of receipt.

Details of the referring organisation and clinician for tertiary referrals must be entered into the "Pathway ID Issuer" and "Referring Clinician" fields on the Cerner LC1 Outpatient Referral Conversation screen to enable the correct RTT status and waiting time to be determined. Should the Pathway ID Issuer or Referring Clinician not be available from the drop down menus, the information must be recorded in the free text comments field. Capturing this detail is extremely important, particularly where an IPTMDS proforma is not supplied.

- **New pathway, referral for treatment at St George's**

Occasionally tertiary referrals to St George's are made from other providers for a new condition or a significantly different intervention, for example surgery after outpatient treatment has not been successful. In these cases a new 18 week monitoring period starts from the date the referral is received in the Trust.

- **Referral for diagnostics or second opinion (not treatment)**

As St George's is a specialist tertiary centre many providers refer their patients for advanced diagnostics or second opinion only, with the intention that the patient will be returned to the referring organisation for treatment. Responsibility for the pathway does not transfer to the Trust and remains with the referring clinician and provider. The resulting interim phase at St George's is added to the overall waiting time by the referring provider. These patients are not included within the Trust's 18 week performance returns but are subject to the six week maximum diagnostic waiting time.

7.1.3 Internal Referrals (St George's consultant to St George's consultant)

Consultant to consultant referrals for patients with the same underlying condition will be included within the same 18 week pathway, with the waiting time continuing from the original referral.

Consultant to consultant referrals for a separate (different) condition will start a new Referral to Treatment pathway with a new 18 week clock. If the patient has not been treated for the original referral/condition the waiting time for the first pathway will run concurrently until the patient is treated or discharged by the original consultant.

Details of the referring clinician and originating specialty for all consultant to consultant referrals must be entered in the appropriate Cerner fields in the LC1 Outpatient Referral Conversation. This enables the 18 Week Team to link the activity pathway and validate the patient's RTT status and waiting time.

7.1.4 Private Patients

Private patients are excluded from 18 week referral to treatment monitoring. If a patient is found to require private treatment then the Private Patients team must be informed.

Patients may transfer from private patient status to NHS care on the receipt of a clinical referral. The 18 week clock will start on the date the referral was received and the patient may join the pathway at the appropriate point, however no advantage can be gained over patients whose complete pathways have been under NHS management.

7.1.5 Overseas Visitors

A patient must be registered with a GP and have been resident in this country for a minimum of 12 months to be eligible for NHS care. If a patient cannot confirm whether they have lived legally in the UK for 12 months then the Overseas Visitors team must be informed. Patients will be considered to be on an 18 week pathway until such time as eligibility is determined.

7.1.6 Military Veterans

From 1st January 2008, all veterans should receive priority access to NHS secondary care for any conditions which are likely to be related to their service, subject to the clinical needs of all patients (HSG(97)31). Veterans are ex-service personnel who have served at least one day in the UK armed forces and sustained injuries during that service. Priority should not be given for unrelated conditions.

GPs are required to complete the relevant documentation and state clearly in referrals that the patient is a military veteran and requires priority treatment for a condition that in their clinical opinion may be related to their military service. On receipt of such requests Trust administrative staff must highlight the status of the patient to the relevant clinician and to the service manager for appropriate recording, prioritisation and action.

7.1.7 Prioritisation of Referrals

Referrals will be scanned onto the electronic patient record, electronic document management and/or E-triage systems by the Central Booking Service or other referral staff within one working day of registration. It is the responsibility of individual specialties to ensure routine referrals are rejected or accepted and prioritised by consultants or their representatives within two working days, with clear directions regarding booking and scheduling. Separate arrangements apply for urgent referrals and these must be triaged and returned to the Central Booking Service within 24 hours.

7.2 Booking Appointments

All appointments must be booked according to the principles specified within this policy, irrespective of location or service.

7.2.1 Appointment Offers

The Central Booking Service and other staff responsible for arranging appointments will agree a first attendance date with the patient within the specified target, ensuring that patients are seen in the correct clinic by the correct clinician. Routine patients should be offered appointments in chronological RTT wait order to ensure equity of access.

Two attempts will be made to contact routine referrals by telephone at different times on different days to agree a first appointment. If routine patients cannot be contacted by telephone, a PB1 fourteen day response letter will be sent inviting them to call the Trust to arrange a date.

Appointments should be negotiated with patients at all times however it may sometimes be necessary to send fixed appointments to very urgent patients not contactable by telephone within three working days of receipt of the referral.

7.2.2 Patient Availability

The overriding principle is that patients are able to choose to delay their treatment for any length of time. However, it would be prudent for clinicians to decide on a time frame over which the clinical team is contacted to review if the delay represents a clinical risk. If there is a risk to the patient a discussion about the delay should occur. It may be clinically in the best interest of patients to be discharged back to the care of their GP following this discussion.

7.2.3 Reasonable Offers

Reasonable offers of appointments will give a minimum of two weeks' notice and two choices of dates. Patients may be offered earlier dates with less than two weeks' notice if these are the first available, however if accepted they are considered to be reasonable and are subject to the same management criteria. If the patient declines a short notice offer it will not have any adverse effect on the management of their pathway. Routine patients who are unavailable to be seen despite having been given adequate notice and choice of dates should be discharged back to the care of the GP (or referring clinician with notification to the GP) where it is clinically safe to do so.

7.2.4 Recording Appointments

All offers of appointments should be recorded on the Cerner system using the agreed processes and workflows. Appointments must be linked to the appropriate referral that has already been registered on the Cerner system. Staff must not create duplicate referrals as this causes reporting errors and miscalculation of waiting times.

Corporate outpatient staff will ensure that clinic utilisation is maximised and will escalate potential capacity issues as soon as they are identified to the relevant service manager.

Patients will be sent a confirmation letter regarding their booked appointment. The letter will be clear and informative and should include a point of contact and telephone number to call with any queries and also specify arrangements for cancelling or rearranging appointments. The letter must explain clearly the consequences should the patient cancel or fail to attend the appointment at the agreed time. It must also provide guidance to contact their GP for advice or potential escalation should their condition deteriorate prior to attendance.

7.2.5 Patients Not Contactable by Telephone

Routine patients who cannot be contacted by telephone to agree a reasonable first appointment will be sent a PB1 fourteen day response letter inviting them to call the Trust to arrange a date. Patients who fail to call back within this period will be sent a PB2 discharge letter, removed from the waiting list and discharged back to the care of their GP or referring clinician. The patient's GP and where relevant the referring clinician will be notified by letter of the discharge.

Flexibility exists to reinstate patients who do not contact the Trust within the specified timeframe and a common sense, patient focused approach should be applied. Patients calling within fourteen days of the PB2 discharge letter being sent should be added back to the list starting from the date of the original referral. Patients contacting the Trust more

than 14 days after the discharge letter was sent should not be reinstated and must arrange to be re-referred by the GP or other clinician. Patients who require re-referral should contact their GP practice (or other referring clinician) by telephone to request this.

7.3. Cancelled Appointments

The 18 week referral to treatment pathway is unaffected by cancellations of appointments by either the patient or the hospital or via e-Referrals and the waiting time is not automatically reset or adjusted. Therefore it is imperative that appointment cancellations for whatever reason are managed strictly and in a timely manner.

Pathways will continue unless an appropriate RTT clock stop code denoting a decision not to treat is recorded against the cancelled appointment. Should the unavailability or actions of a patient result in discharge back to the GP or referring clinician, the 18 week pathway will end. A new RTT pathway will start if the patient is re-referred.

7.3.1. Appointments Cancelled by the Patient including those via e Referral

Patients giving prior notification that they will not be attending an agreed appointment are classified as patient cancellations and cannot be recorded as a `Did Not Attend', irrespective of whether the cancellation was made on the day of the appointment and the notice minimal.

Where a patient gives prior notice of non-attendance of an agreed appointment they should be rebooked straight away or informed that they must make contact within two weeks to reschedule. The Trust will attempt to make contact with the patient by letter asking them to call and reschedule their appointment. If the patient does not book another appointment within this timeframe, a clinical review of the case by the accepting clinician will take place and they may be returned to the care of their GP or referrer, with both the patient and GP notified by letter of this action. Any clinical information not yet passed to the patient or recommendations for on-going management should be included in the correspondence.

New appointments cancelled by the patient must be rescheduled and a further appointment offered within a period of one week. Should the patient be unable to accept a second choice of appointment within this timeframe they may be discharged back the care of the GP until such time as they are available. If the hospital is not able to identify an appointment within eight weeks then the next available appointment will be offered and this must be escalated to the relevant Specialty Manager as per the escalation process.

Appointments made via e-Referral that are not required must be cancelled within Cerner as well as the e-Referral system along with the associated open e-Referral request.

7.3.3 Appointments Cancelled by the Hospital

Hospital cancellations should be avoided wherever possible and cover arrangements put in place to minimise disruption and inconvenience to patients. Where this is unavoidable and appointments are cancelled by the hospital, patients should be rebooked at the point of cancellation as close to the original date as possible and within two weeks of the date of the cancelled appointment. It is the Trust's responsibility to make contact with the patient to rearrange the appointment.

Trust policy stipulates that a minimum of six weeks prior notice of clinic cancellations must be given by clinicians and a cancellation proforma must be completed. Clinicians are encouraged to provide as much notice as possible when requesting a clinic cancellation, as the greater the notice given the fewer patients will be inconvenienced by having a re-

scheduled appointment. Authorisation must be obtained from the General Manager/Divisional Director of Operations for the relevant specialty for clinic cancellations under six weeks.

7.4 Patients Who Fail to Attend (Did Not Attends – DNA's)

The Trust operates a `One DNA discharge' policy for routine adult new and follow-up patients. Patients failing to attend without giving prior notification will, subject to clinical review/approval, be discharged back to the care of the GP or referring clinician. Exceptions to the one DNA discharge rule must be agreed with the relevant service and include: clinically urgent cases as advised by the clinician; suspected cancers; vulnerable patients (including dementia); paediatrics; and all conditions where discharge would be clinically inappropriate.

A DNA-discharge letter will be sent to the patient and GP advising them of this decision. Any clinical information not yet passed to the patient or recommendations for on-going management should be included in the correspondence.

7.4.1 New Appointment DNA's

Failure to attend a first outpatient appointment will result in both the referral and the DNA being `nullified' for 18 week monitoring purposes. In practical terms, both the referral and the DNA are excluded from reporting. However should the patient be allowed to reschedule, a new RTT pathway will start afresh from the date the patient agrees a new appointment (the booking date).

7.4.2 Follow-up Appointment DNA's

Patients who DNA a subsequent appointment after attending for the first time will not affect their pathway waiting time and the 18 week clock continues to run until the patient receives their first definitive treatment or a decision is made to discharge the episode.

7.4.3. Safeguarding Children – Non-Attendance

A child should only be discharged from clinic after non-attendance if it is considered by the lead clinician that they no longer require the service or if a more acceptable service can be provided elsewhere. If it is likely that a child's medical care may be compromised by non-attendance or it may be a pointer to wider concerns about the child's welfare, the clinician should be proactive in arranging another appointment and help to facilitate attendance. If it is not possible to engage a family and by non-attendance a family is not meeting the needs of the child, the child's safeguarding procedures should be instigated.

7.5 Appointment Outcomes

Clinicians are responsible for completing an `Attendance Outcome Form' for all patients by the end of each clinic. This records the status along the 18 week pathway and details of procedures performed for coding and charging purposes, and if another appointment is required. A decision whether or not to offer a follow-up appointment for patients who have failed to attend should be made by the consultant. If no instructions are given and the patient does not meet the exception criteria (section 7.4), the DNA policy will be applied. The patient will be discharged and confirmation sent by letter to the patient and their GP.

It is imperative for the monitoring of patient pathways that all attendances are cashed up with the correct Referral to Treatment status code. This will signify patient's stage of treatment and identifies whether the 18 week clock continues, stops or a new pathway begins.

Attendance and 18 week status codes must be recorded accurately on Cerner by clinic staff at the end of each clinic or within one working day as decisions regarding the patient's on-going care will be actioned from this information. Patients referred back to their GP should have their registration closed at this stage using the correct Cerner process.

Where clinics are held off-site in a community setting, services should utilise generic nhs.net email accounts to facilitate the transfer of outcome forms to corporate outpatient service staff. This will enable cashing up within the specified one working day timeframe.

7.5.1 Active Monitoring

If the patient has not yet received treatment but instead requires a period of watchful waiting followed by further review at a follow-up appointment, this should be recorded as `active monitoring' and the 18 week pathway will stop. If the patient subsequently needs to be sent for investigations or admitted, a new 18 week pathway period will commence.

Patients not requiring further monitoring or follow-up should be discharged back to the care of the GP or referring clinician.

7.5.2 Thinking Time

On occasion a patient may be given a choice of treatment options and request time to consider the preferred alternative. Where a patient is given thinking time this is usually limited to a maximum of two weeks but may be extended at the discretion of the consultant responsible for the patient's care. This must be documented in clinical correspondence.

Where the patient requires longer to consider the options and see how their condition progresses, this should be agreed between clinician and patient and documented in the patient record: a clock stop will then be applied for a period of `patient initiated active monitoring'. When the patient and clinician agree that treatment is the best option, for example via a telephone call or attendance at a follow-up clinic, a new 18 week pathway will start.

7.5.3 Patients Referred for Outpatient Diagnostics

Diagnostics is the term used to describe a test or procedure to identify a person's disease or condition and which allows a medical diagnosis to be made. Diagnostics are an integral part of the 18 week Referral to Treatment pathway and cover imaging, endoscopy, pathology and elements of physiological measurement. Pathways can include both a diagnostic test and therapeutic treatment, however pathways may stop at the diagnostic phase if it is decided that further investigation or treatment is not required. Direct Access requests from a GP will not start an 18 week pathway; neither will referrals via national screening programmes. Separate arrangements exist under the 18 weeks rules for monitoring direct access referrals to Audiology and treatment for 95% of these patients within the maximum 18 week target is required.

All diagnostics, including Direct Access referrals, must be carried out within a DH target of six weeks from request. The 18 week Referral to Treatment standard includes time required for the diagnostic phase, therefore tests and follow-up appointments to review results must be scheduled to avoid unnecessary delays.

7.5.4 Patients to be Added to the Inpatient or Day Case Waiting List

It is extremely important that if the decision is made to add a patient to the inpatient or day case waiting list for a diagnostic or treatment procedure, the admission card is completed

and forwarded to the relevant Patient Pathway Co-ordinator within 24 hours of the decision to admit. Any unnecessary delays in receipt and recording of the waiting list entry will impact on the ability of the Trust to treat the patient within 18 weeks.

7.5.5 Procedures Requiring CCG Authorisation

Where the decision is made that a specific procedure or device is required that is excluded from the Contract Schedule, prior authorisation to treat must be obtained from the patient's Clinical Commissioning Group (CCG). The General Manager or Service Manager for the specialty will request permission to proceed via an Individual Funding Request to the relevant CCG. For a small number of procedures the Trust may treat without having to request prior approval providing that patients meet certain criteria. Equally, for a small number of treatments (mainly cosmetic) it is the GP that seeks approval from the CCG and patients present to the Trust with an approval letter. These procedures are listed in the South West London CCGs' Effective Commissioning Initiative Procedures Protocol.

In the event of urgent clinical need or risk to patient safety, CCGs should grant retrospective approval.

The clock start date remains the date the referral was received in the Trust or the UBRN was converted and the 18 week pathway continues to run. In order to manage these patients within the 18 week target, decisions on these cases must be communicated by the CCG to the Trust within two weeks. If no decision has been received in this time the issue will be referred to the Trust's Assistant Director of Finance – Resources, for escalation and resolution.

7.5.6 Outgoing Inter Provider Transfers

Where the outcome of an attendance is the clinical decision to refer a patient onwards from St George's for treatment at an alternative provider, the local RTT outcome code of `06: Transfer to Another Trust' should be applied and the pathway will continue with the receiving provider.

Patients referred onwards from St George's for elective treatment or care at another provider must have an Inter Provider Treatment Minimum Data Set proforma (IPTMDS) forwarded to the receiving trust at the point of the referral. This identifies the patient's 18 week pathway status and waiting time. Until such time as an electronic system for the transfer of this information can be implemented, the Trust's 18 Week Team should be contacted for advice by the secretary of the referring clinician.

7.5.7 Removal from the Outpatient Waiting List

Patients whose outpatient episode is to be closed must be discharged from the Cerner system using the correct workflow.

A new GP referral must be received for a patient with an existing condition if a request for further consultation is made after the original referral has been discharged (the exception being late responses to outpatient PB1 letters within 14 days of the expired deadline).

8 Inpatient and Day Case Waiting Lists

The administration of inpatient and day case waiting lists must be consistent, easily understood, patient focused and responsive to clinical decision making. The date on the waiting list will be the date the decision to treat was agreed with the patient, usually at an outpatient attendance. Children up to the age of 16 should be managed on a separate waiting list to adults. Patients who no longer need treatment should be removed from waiting lists.

The 18 week clock stops on the date of admission for treatment, when a clinical decision is made that treatment is not required or a patient declines treatment. An inpatient or day case admission for diagnostics will not stop the 18 week pathway unless treatment is carried out as part of the admission or it is agreed at the time that no further investigations or treatment are required.

8.1 Adding Patients to the Elective Waiting List

The decision to add a patient to the waiting list will be made by the consultant after discussion and agreement with the patient. Patients should not be added to the waiting list unless they are fit, ready and available for procedure/surgery and there is a serious expectation of treatment. A request for admission should not be made to reserve a place in the queue `in case' the patient needs surgery or if the intended procedure is not currently available within the Trust or funded by commissioners.

At the time of the decision to admit patients will be given a letter explaining that they will be added to the Trust's waiting list and that within one week they will receive written confirmation this has happened. The letter will contain details of whom to contact should this not arrive. Every patient will receive written confirmation of their addition to the waiting list and the agreed admission date and time. This notification will include guidance to contact their GP should the patient's condition deteriorate while on the waiting list. Routine long waiting patients may have their TCI date expedited if there is concern that their clinical condition has changed.

8.1.1 Additions to the Waiting List Following Clinic Attendance

Patients who require elective admission will be identified by the relevant outcome on the Clinic Outcome sheet and completion of the administrative To Come In (TCI) card. Additions to the waiting list must be linked to the appropriate referral that has already been registered on the Cerner system.

The electronic order will be placed on Cerner using the agreed functionality and workflows within one working day of the date of the decision to admit. Suitable arrangements for adding patients to the waiting list within this timeframe must be made for patients attending satellite clinics.

8.1.2 Tertiary Additions to the Waiting List

Tertiary additions to the elective waiting list received from another secondary care provider must be accompanied by an agreed minimum data set for the purposes of establishing the patient's RTT status and point along the 18 week pathway. The prescribed format is the Inter Provider Transfer Minimum Data Set proforma (IPTMDS) and these must be forwarded to the 18 Week Team for verification and entry onto the Cerner system.

Details of the referring organisation and clinician for tertiary waiting list additions must be entered into the "Pathway ID Issuer" and "Referring Clinician" fields on the Cerner LC1

Inpatient Waiting List Conversation screen to enable the correct RTT status and waiting time to be determined. Should the Pathway ID Issuer or Referring Clinician not be available from the drop down menus, the information must be recorded in the free text comments field. This is extremely important, particularly where an IPTMDS proforma is not received. The provision of IPTMDS proformas will be subject to performance monitoring by the Trust, however the absence of a proforma will not delay the patient's treatment.

8.2 Pre-operative Assessment

Following a decision to treat, patients are generally referred for pre-operative assessment. Wherever possible, pre-assessment appointments should be agreed with the patient and confirmed by letter explaining the importance of attending and that failure to do so without prior notification may result in postponement of the procedure or removal from the waiting list.

8.2.1 Pre-Operative Assessment DNAs

Patients, including children, vulnerable adults and those suspected or diagnosed with cancers that DNA their Pre-Operative assessment should be contacted to establish the reason for the failed attendance and a further appointment if appropriate will be booked. Discharge of the patient back to the care of the GP may be appropriate after clinical review if the patient declines treatment. Should the patient fail to attend a second time this must be escalated to the lead clinician for liaison and follow-up with the patient's GP.

8.2.2 Pre-Operative Assessment Outcomes

Where patients are passed fit for surgery, a local RTT outcome code 13 should be used to denote readiness to proceed and that the pathway continues. Patients who are assessed as unfit at nurse-led pre-assessment should be recorded against an RTT outcome code of 14 and referred back to the consultant for a decision to be made regarding the appropriate clinical management.

It is the responsibility of the consultant to advise the patient and GP of the outcome of assessment and decide on the further management of the patient's condition. If it is apparent that the patient will not become medically fit for the proposed treatment without active intervention, stabilisation and monitoring within primary care, the patient should be discharged back to the GP.

When the patient becomes fit for surgery the GP practice may contact the Patient Pathway Co-ordinator or the Consultant's secretary to arrange for the patient to start a new pathway at the most clinically appropriate stage. In these circumstances the 18 week pathway will commence from the date the GP contacted the Trust. Should the GP contact the Trust more than six months after the patient was discharged, a new referral may be required.

8.3 Admission Offer (**TCI Date**)

Selecting patients for admission entails balancing the needs and priorities of the patient and Commissioners against available resources of theatre time and staffed beds. To ensure equity of access, patients will be selected from the waiting list for admission according to clinical priority and thereafter by order of 18 week waiting time.

8.3.1 Patient Availability

Patients should be available for admission booked with reasonable notice within 18 weeks of referral. Every effort will be made to agree an admission date by week 15 of the pathway. If the hospital is not able to offer admission for treatment within the maximum 18 weeks waiting time, the next available date will be offered. However this will result in a

breach of the waiting times guarantee and these patients will form part of the RTT 8% tolerance.

Under the NHS Constitution patients have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible and the patient requests it. Should a patient invoke their Constitutional right to treatment by an alternative provider it is the responsibility of the relevant General Manager or Specialty Manager to co-ordinate the Trust's internal process, identify the availability of treatment options and respond to the patient.

8.3.2 Reasonable Offers of Admission

All offers of admission will be agreed with the patient. Reasonable offers of admission will give a minimum of three weeks' notice and a choice of two dates, both within a timeframe to enable treatment within 18 weeks of referral. Patients may be offered earlier dates with less than three weeks' notice, if accepted these are deemed to be reasonable offers. If the patient declines a short notice offer, this will not have an adverse effect on the management of their pathway.

Patients will be sent a confirmation letter regarding their booked pre-operative assessment and admission date. The letter will be clear and informative and should include a point of contact and telephone number to call with any queries, specifying the process for cancelling or rearranging admission dates. The letter must explain clearly the consequences should the patient cancel or fail to attend at the agreed time.

8.3.3 Patients Not Contactable by Telephone

Routine patients who cannot be contacted by telephone to agree a reasonable admission date will be sent a fourteen day response letter. Details of patients who fail to call back within this period will be referred to the consultant in charge of their treatment for a clinical review of their suitability for discharge. Only where is it is clinically safe to discharge patients without treatment should the waiting list entry be cancelled and the patient discharged back to the care of the GP or referring clinician. The patient and GP, if relevant the referring clinician, will be notified by letter of the discharge.

In cases where the patient fails to make contact with the Trust to agree an admission date and it is not clinically appropriate to discharge the patient, the consultant should make arrangements to review the circumstances with the patient or their GP.

Flexibility exists to reinstate patients who do not contact the Trust within the specified limit and common sense; patient-centred approach should be applied where extenuating circumstances are known. Patients contacting the Trust up to fourteen days after the original deadline for response should be added back to the list using the original pathway start date. Patients who contact the Trust more than 14 days after the deadline for response should not be reinstated and must arrange to be re-referred by the GP or other referring clinician.

8.4 Patients Not Clinically Fit for Admission Whilst on the Waiting List

Patients who are not clinically fit to undergo treatment should not be added to the waiting list. Patients already on the waiting list who become unfit for treatment due to anything other than a short-term minor condition should be removed from the active waiting list for suitable management until they are ready for surgery. RTT pathway waiting times cannot be adjusted for periods of social or medical unavailability and the 18 week clock continues to run.

The clinician will decide whether it is optimal to actively monitor the patient under watchful waiting within outpatients or to return the patient to primary care. The RTT local clock stop code 8 will be recorded against the waiting list cancellation and a new monitoring period will start when the patient is assessed and agreed as fit to proceed.

If the patient is returned to primary care at such time as the patient becomes fit for surgery the GP practice may contact the Patient Pathway Co-ordinator or the Consultant's secretary to arrange for the patient to start a new pathway at the most clinically appropriate stage. In these circumstances the 18 week pathway will commence from the date the GP contacted the Trust. Should the GP contact the Trust more than six months after the patient was discharged, a new referral will be required.

8.4.1 New Information Received Regarding the Health of a Long Waiting Patient on an Inpatient or Day Case Waiting List

Patients who are on an elective inpatient or day case waiting list that have been identified as clinically non-urgent should be dated in chronological order. All patients added to the waiting list should receive a letter confirming the decision to admit and this should include guidance to consult their GP if their condition deteriorates whilst waiting for treatment. Routine long waiting patients may have their TCI date expedited if there is concern that their condition has changed.

The process for this is as follows:

- If a patient or GP contacts the PPC/secretary to raise concerns about deterioration in the patient's health while awaiting their surgical procedure, this should be highlighted to the relevant consultant within 48 hours with any available information, e.g. letter from the GP, notes from the phone call and the patient's medical notes. If the consultant is away for a period of time, another consultant or appropriately senior registrar may review the information
- The consultant should inform the PPC/secretary if this changes the patient's clinical priority and an earlier admission date is necessary. Should the consultant identify that the need for treatment is now urgent, the PPC/secretary should offer the patient an urgent TCI date and update the patient's status to urgent on Cerner.
- If the consultant does not feel this information alters the clinical priority of the patient, the PPC/secretary should note the consultant's decision and continue to date patients according to the agreed booking plan. They should also advise the patient or GP of the consultant or senior registrar's decision.

8.5 Patients Choosing to Delay Admission

From 1st October 2015 RTT pathways may no longer be paused for patients on an inpatient or day case waiting list who choose to delay treatment due to unavailability and are subsequently unable to accept reasonable offers of admission. The Cerner suspension functionality may continue to be used to capture periods of unavailability but this will be for administrative purposes only and will not affect the patient's monitored waiting time.

Patients who are unavailable for admission for more than eight weeks despite having been given adequate notice and a choice of dates will be subject to a clinical notes review and following this may be discharged back to the care of their GP or referring clinician if it is agreed as being in the best interest of the patient. When the patient is available the GP practice or patient may contact the Patient Pathway Co-ordinator or the consultant's secretary to arrange for the patient to start a new pathway at the most clinically appropriate stage.

A new 18 week pathway will commence from the date the GP or patient contacts the Trust. Should this be six months or more after the patient was discharged, a new referral will be required.

8.6 Admission Dates Cancelled by the Hospital

Patients whose procedure is cancelled by the hospital for non-clinical reasons prior to admission should be offered an alternative date at the time of the cancellation and this must be within the 18 week target. The alternative date should be booked at the patient's earliest convenience and as close to the original date as possible. Patients whose treatment has been cancelled once by the hospital must not be cancelled a second time.

8.6.1 28 Day Readmission Guarantee

The Trust takes every reasonable precaution to avoid cancelling a patient's treatment on the day of admission or surgery and it is the expectation this should not happen. The Trust escalation process must be followed if this is identified as likely.

On occasions where a cancellation on the day for non-clinical reasons does occur, national guidance stipulates patients must be rebooked a new date for their procedure within 28 days of the cancellation or within the maximum 18 week RTT wait, whichever is sooner. A new TCI date should be agreed with the patient within seven days of the cancellation. Patients may choose not to be readmitted within 28 days, in such cases a period of unavailability will be recorded on Cerner, with the reasons entered in the comments field for audit purposes. This will not affect the patients 18 week clock.

If the Trust is unable to offer a date for readmission within 28 days the patient must be offered alternative available dates, however the patient should also be given the option of treatment at a provider of their choice.

8.7 Admission Dates Cancelled by the Patient

Patients who cancel an agreed pre-operative assessment or admission date booked with reasonable notice are given the opportunity to change their pre-operative assessment or admission date once within the maximum waiting time allowed.

Cancellations by the patient do not affect the 18 week waiting time and the clock continues to run unless treatment is given or the patient is otherwise removed from the waiting list and discharged back to the care of the GP.

8.8 Patients Who Do Not Attend (DNA)

The Trust operates a one DNA discharge policy for routine adult patients. Patients who fail to attend for pre-operative assessment or elective admission without giving prior notification will, with the consultant's agreement, be removed from the waiting list and discharged to the care of the GP or referring clinician. Exceptions to the one DNA discharge rule include: clinically urgent cases (as advised by the patient's consultant); suspected cancers and patients on a cancer pathway; vulnerable patients; paediatrics; and conditions where discharge would be clinically inappropriate.

A DNA-discharge letter will be sent to the patient and GP advising them of this decision. Any clinical information not yet passed to the patient or recommendations for on-going management should be included in the correspondence.

Failure to attend for pre-assessment or admission will in itself not stop an 18 week pathway. The 18 week clock continues to run with the accrued waiting time until the date the patient is removed from the waiting list and is discharged back to the care of their GP, or alternatively, the patient is rescheduled and the clock stops on treatment.

8.9 Elective Admission

The 18 week RTT period stops on admission for treatment and the pathway is deemed to have ended. The exceptions to this rule are if the admission is for a purely diagnostic procedure and the patient requires a subsequent admission for the treatment phase or alternatively if the procedure does not take place for any reason but is still required.

8.10 Planned Waiting List

Patients on a planned sequence of treatment pathway must not be included on the planned waiting list unless there are specific clinical reasons why the procedure cannot be undertaken until a specified period of time has elapsed. Patients waiting for planned admissions such as check cystoscopies, removal of metalwork and periodic reviews (surveillance) are outside of the scope of RTT monitoring and are not included within the 18 weeks maximum waiting times standard. These patients are not waiting for an initial RTT treatment, but for a planned continuation of treatment already received. Age or growth related procedures are also considered to be planned as is a series of pain relieving injections.

Although planned procedures are not counted as being part of the waiting list for 18 week purposes, the same waiting list management rules should apply if a patient cancels or DNA's an admission date.

It is the responsibility of Patient Pathway Co-ordinators to ensure that the entry onto Cerner specifies the date the patient's planned treatment is required. Patients on a planned pathway take first choice of capacity to ensure they are allocated an admission date for the scheduled month or timescale. Oversight of the planned list is the responsibility of the Divisional Management team via an agreed weekly PTL meeting

9 Training

An appropriate continuous training programme should support all levels of staff on an on-going basis, with special regard given to newly recruited staff.

Training in the definitions and principles of the 18 Week Referral to Treatment measurement will be available to all staff involved in the implementation of this policy. This will ensure accurate and timely data collection and enable pro-active management of patient pathways.

A formal training programme will be developed for validation staff with competency tests to assess knowledge. Written guidance will be available, including local scenarios for conditions or pathways found to be most problematic

Staff will be trained to a standard level via a generic training package; however this will be tailored to individual requirements where appropriate. Refresher training will be provided as required. New changes in processes will be managed by ad hoc training.

All staff involved with patient contact, e.g. reception staff, patient pathway co-ordinators, will receive training in customer care.

All staff involved in the management of electronic systems used to support the outpatient and elective admission function will be given adequate training that is fit for purpose and enables them to utilise those systems to an acceptable standard. This includes Cerner, EPR, E-Triage, Tiara, and Choose and Book.

The above training will be undertaken as part of induction in the first instance and reviewed on an annual basis. A continuous staff training programme will be implemented and adherence to the policy will be included within the administrative staff appraisal process.

10 Monitoring Compliance

10.1 Process for Monitoring Compliance

The Trust will undertake regular planned audits and spot checks on the systems defined and outlined in this policy. This may be in the form of locally performed audits specific to individual departments or specialties or audits undertaken by the Internal Audit team. GP involvement will be requested where this will provide helpful external scrutiny of services and compliance. The Trust also expects to be audited by the replacement body for the Audit Commission and other Department of Health bodies in line with national programmes.

Training logs will be kept at departmental level of attendance at RTT and Cerner system sessions, to be reviewed by lead managers.

10.2 Compliance Reporting

In addition, compliance with and effectiveness of the Referral to Treatment Access Policy and related operational procedures will be monitored and regular reports made to:

- The Trust Board
- Divisional Management Boards
- Directorate Monthly Performance Reviews
- General Managers' RTT Compliance Meeting
- Monthly RTT Performance Returns made to the DH and Commissioners

Compliance with the policy will be monitored on a weekly basis via the Trust's outpatient first appointment and Continuing OP PTLs, the inpatient and day case waiting list PTL, and the RTT Admitted PTL Dashboard.

Under no circumstances should any member of Trust staff feel pressurised to misrepresent, misreport or otherwise falsify waiting times for an individual patient or performance at a corporate level. Should such circumstances arise, the individual must escalate the issue to their line manager or lead clinician. Should this not be possible, staff can raise concerns in confidence with the Trust secretary or a non-executive director. Alternatively, concerns may be raised by clicking the whistle blowing link on the intranet home page.

This policy shall be reviewed at least annually, or earlier as changes in guidance or practice are implemented.

10.3 Standards/Key Performance Indicators

In addition to local standards outlined in the policy and operational procedures, the Trust will also adhere to the national access targets for 18 Weeks, Cancer and other relevant indicators.

Additional audit reports developed by the Information Team will monitor and review compliance with the policy in relation to multiple cancellations and DNAs, unactioned RTT outcomes, triage delays and elapsed time from Decision to Admit to addition to the WL.

11 Associated Documents

This document provides a broad outline of the Trust's policy for managing 18 week pathways. More detailed guidance and definitions can be found within the following Department of Health publications:

"Referral to treatment consultant-led waiting times - Rules Suite": Department of Health, October 2015

"Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care" – NHS England October 2015

"Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: Frequently asked questions" – NHS England October 2015

"National Direct Access Audiology Clock Rules" – Department of Health, April 2011

"Frequently Asked Questions: Direct Access Audiology Referral to Treatment Data Collection" – Department of Health, April 2011

"The NHS Constitution for England": Department of Health July 2015

"NHS Constitution Waiting Times FAQ - The NHS e-Referral Service and Waiting Times" NHS e-Referral Service Programme Team February 2015

"Implementation of the right to access services in the maximum waiting times: guidance to strategic health authorities, primary care trusts and providers": Department of Health, March 2010

"Diagnostics waiting times and activity - Guidance on completing the diagnostic waiting times & activity" monthly data collection" - Department of Health, Updated: 11 March 2015

Diagnostics FAQs: Frequently Asked Questions on completing the "Diagnostic Waiting Times & Activity" monthly data collection

NHS Choices: Information for Patients: Your Rights in the NHS
http://www.nhs.uk/choiceinthenhs/rightsandpledges/waitingtimes/pages/guide%20to%20waiting%20times.aspx

The policy should be read in conjunction with the following operational guides and documents accessed via the Trust's intranet:

Intranet 18 Weeks Homepage

Information Governance Policy

Private Patients Policy

Overseas Visitors Policy

Health Records Policy

Confidentiality Code of Conduct

Safeguarding Children

Whistle Blowing Policy

12 References

The NHS Improvement Plan: Putting people at the heart of public services. Department of Health, June 2004
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084476

The Revision to the Operating Framework for the NHS in England 2010/11 (June 2010)
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_116856

2014/15 South West London Effective Commissioning Initiative
http://www.wandsworthccg.nhs.uk/newsAndPublications/Publications/Documents/Effective_Commissioning_Initiative%202014-2015.pdf

APPENDIX A:

St George's Healthcare NHS
NHS Trust

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Referral to Treatment Access Policy	Surgery Finance	Wilfred Carneiro Traci Dean To be agreed	Update from 2005 Update from 2011	04/11/2010 To be agreed

1.1 Who is responsible for this service / function / policy?
Chief Operating Officer

1.2 Describe the purpose of the service / function / policy? Who is it intended to benefit? What are the intended outcomes?
The purpose of this document is to ensure that patients requiring access to outpatient appointments, diagnostic tests and elective inpatient or day case treatment are managed consistently, according to national frameworks and definitions.

1.3 Are there any associated objectives? E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives
Compliance with standards specified within the NHS Operating Framework, and NHS Constitution. To be the provider of choice.

1.4 What factors contribute or detract from achieving intended outcomes?
Dissemination and implementation of policy consistently across the organisation; staff training programme; compliance with referral criteria; review of patient appointment and admission letters to ensure that patients clearly understand processes and their responsibilities.

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]
Positive impact in terms of Human Rights to access healthcare in line with current legislation.

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?
Ensuring that patients understand how to access support such as PALS and interpreting services should they require them

1.8 What are your monitoring arrangements for this policy/service? Monthly performance reviews at Trust Board, Divisional Management Board and Directorate meetings. Monthly RTT performance and returns made to the DH and commissioners. Monitoring and validation of weekly PTLs by operational managers and administrative staff. Training logs to be kept at departmental level of attendance at RTT and Cerner system sessions, to be reviewed by lead managers.

Checklist for the Approval of the Referral to Treatment Access Policy			
	Title of document being reviewed:	**Yes/No/ Unsure**	**Comments**
1	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the main document is a policy rather than guidelines or procedures?	Yes	
2	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3	**Development Process**		
	Are people involved in the development identified?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4	**Content**		
	Are the objectives and aims defined?	Yes	
	Is target population as mentioned in Scope clear?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5	**Evidence Base**		
	Is the type of evidence required to support the document identified explicitly?	Yes	
	Are the references cited in full?	Yes	
	Are all supporting documents referenced?	Yes	
6	**Consultation**		
	Where appropriate, e.g. HR Policies, has the Partnership Forum been consulted on the document?	N/A	
	Where appropriate, have Community Services been consulted on the document?	Yes	Primary Care via Commissioners
	If relevant, does the policy meet all the prescribed NHSLA standards applicable?	N/A	
7	**Prescribed format**		
	Has the table of control information been completed on the front cover of the Policy?	Yes	
	Has an Equality Impact Assessment been completed? Is the EIA is an appendix to this policy?	Yes	
	Has the Policy Checklist been completed and attached to the back of the policy?	Yes	
8	**Dissemination and Implementation**		
	Does the plan include the necessary training and support to ensure compliance?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
9	**Review Date**		
	Is the frequency of review identified?	Yes	
10	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-coordinating the dissemination, implementation and review of the document?	Yes	

Approval by the Policy Approval Group: Date: (TBC)

REPORT TO THE TRUST BOARD ***April 2016***

Paper Title:	Workforce report
Sponsoring Director:	Wendy Brewer, Director of Workforce and Organisational Development
Author:	Wendy Brewer, Director of Workforce and Organisational Development Rebecca Hurrell, Head of Workforce Information Jacqueline McCullough, Deputy Director of HR
Purpose:	*To provide a report to the board on performance against key performance indicators*
Action required by the board:	For information
Document previously considered by:	Executive Management Team Meeting

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

1. Key messages

The workforce report includes:

- The workforce performance report February 2016
- Draft workforce and staff experience action plan 2016/17
- Monitor agency expenditure ceilings for all staff briefing paper
- South West London bank briefing paper

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

Key points to note are:

- There has been a marginal decrease in the vacancy rate to 17% as there has been an increase of 58 WTE in month.
- However, staff turnover has increased again to 18.5%. After two months of reduction, nursing turnover has returned to November 2015 levels.
- Sickness absence has increased again and has now been above target for longer than is usual in the winter and is at a higher level than it has been for two years.
- The trust continues to benchmark reasonably well against similar London trusts for sickness absence and turnover.

Key risks identified:
Key workforce risks include:

- Failure to recruit and retain sufficient staff in relation to annual turnover rates and to safely support future increases in capacity'
- Failure to reduce the unacceptable levels of bullying and harassment reported by staff in the annual staff survey.
- Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas.
- Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	**To develop a highly skilled and engaged workforce championing our values that is able to deliver the trust's vision.**
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	**Are services well led?**

Commentary on performance in key workforce indicators

Vacancy information

The attrition that the trust has seen over previous months has slowed, with a net increase of 58 WTE in month including a very small net increase in nursing.

Turnover

Turnover levels have increased again, including a returned increased level of turnover in nursing.

Sickness absence

While it is normal to see a blip of increased sickness absence in the winter months, this year the increased levels are protracted and have increased again. The main reasons for absence remain coughs and colds. However, it is clear that the workforce is increasingly tired.

Agency and bank staff usage

Temporary staffing levels continued to rise in February, particularly in nursing, as escalation areas have been open in response to winter pressures.

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.

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

Mandatory training and appraisal rates

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

Appraisal rates continue to deteriorate and further focus will be given to this area. There will be a detailed review of appraisal processes at the workforce and education committee meeting due to take place in March.

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St George's University Hospitals NHS
NHS Foundation Trust

Workforce Performance Report
to the Trust Board

Month 11 - February 2016

Excellence in specialist and community healthcare

Workforce Performance Report Mar ‘15 - Feb ‘16

Contents

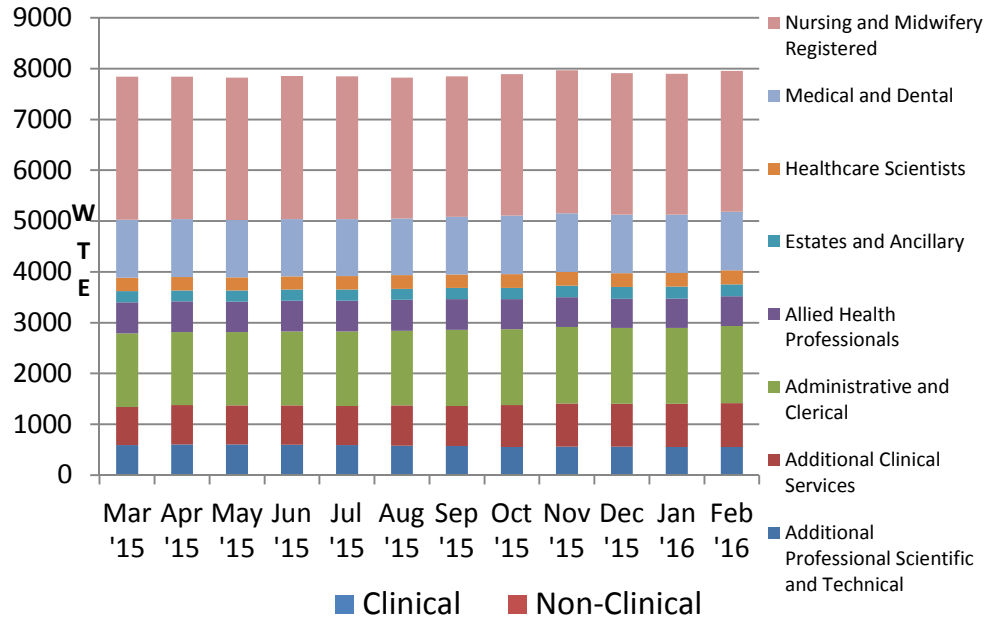
Performance Summary

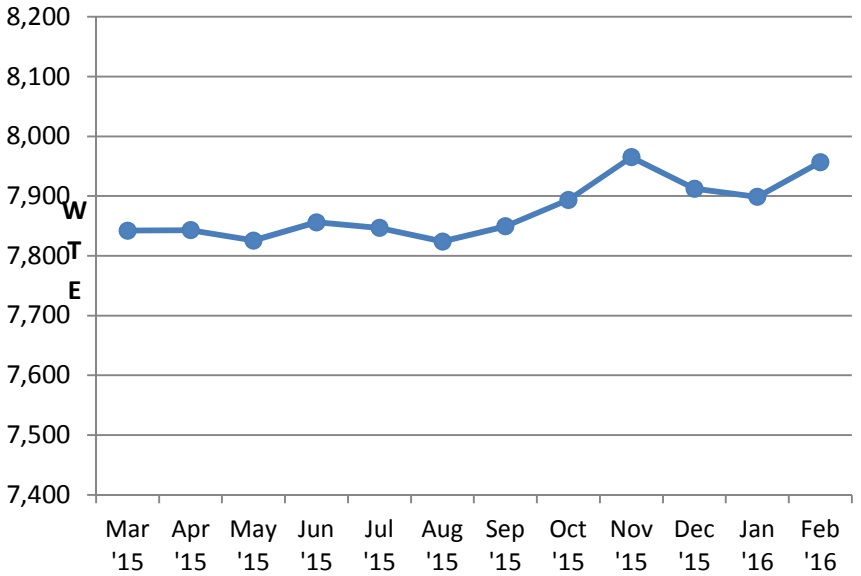
Summary of overall performance is set out below

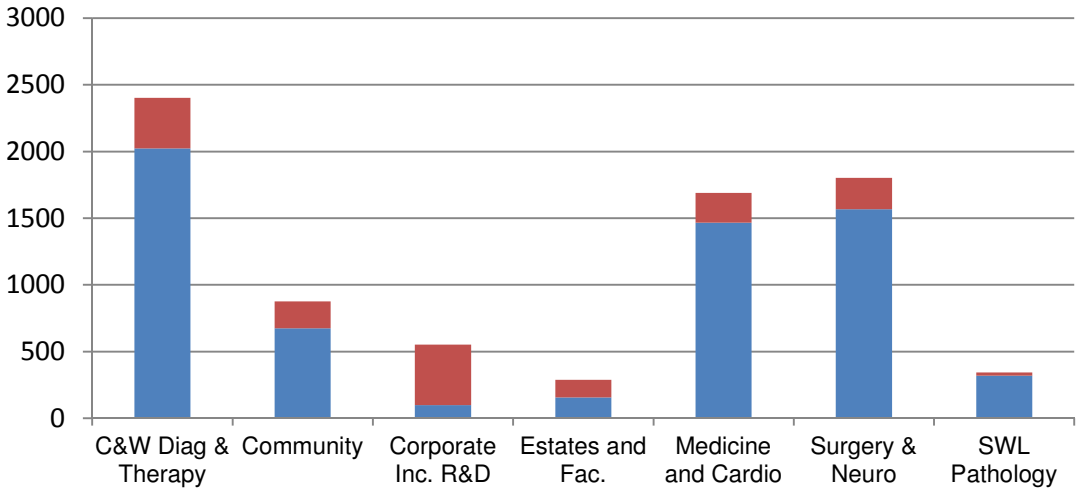
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	R-A-G
5	Vacancy	Vacancy rate has decreased by 0.2%	13.9%	17.2%	17.0%	↘
6	Turnover	Turnover has increased by 0.3%	17.1%	18.2%	18.5%	↗
7	Voluntary Turnover	Voluntary has increased by 0.3%	13.8%	14.9%	15.2%	↗
8	Stability	Stability has decreased by 0.4%	83.6%	82.5%	82.1%	↘
10	Sickness	Sickness has increased by 0.1%	3.5%	4.2%	4.3%	↗
15	Temporary Staffing Usage (FTE)	Temporary Staffing Usage has increased by 2.1%	15.5%	14.9%	15.7%	↗
17	Mandatory Training	MAST compliance has increased by 3.1%	74.7%	67.1%	70.2%	↗
18	Staff Appraisal	The percentage of staff who have had an appraisal in the past 12 months has decreased by 0.8%	77.0%	67.7%	66.9%	↘

Current Staffing Profile

The data below displays the current staffing profile of the Trust





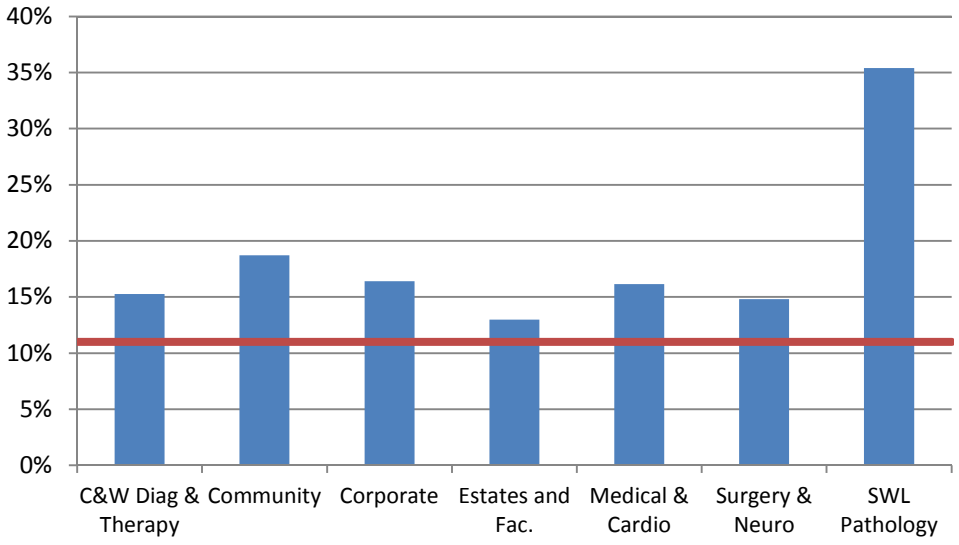


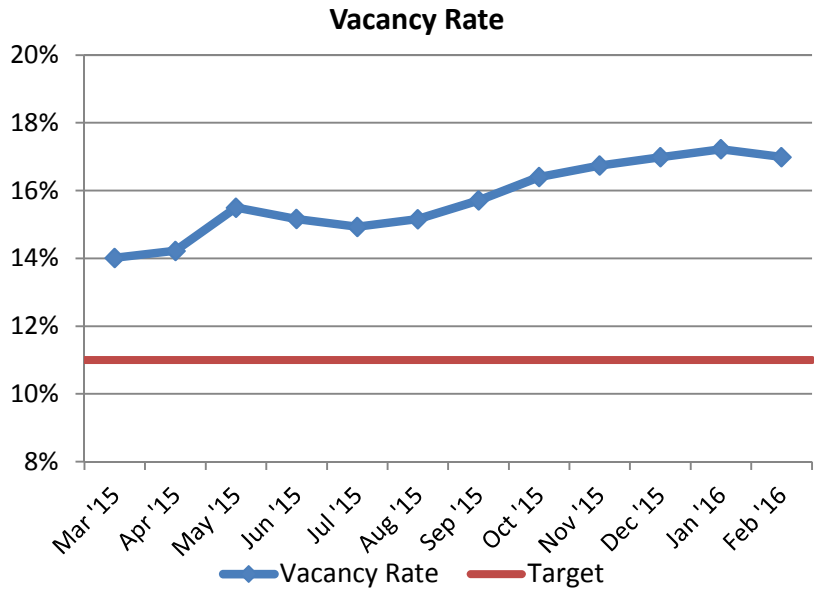
COMMENTARY

The Trust currently employs 8502 people working a whole time equivalent of 7957 which is 58 WTE higher than January. The growth rate in the directly employed workforce since February 2015 is 146 WTE or 1.9%.

The Trust also employs an additional 459 WTE GP Trainees covering the South London area, which makes the total WTE 8416.

Section 1: Vacancies





Vacancies by Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diag & Therapy	13.6%	15.1%	16.0%	15.3%	↘
Community	18.5%	19.4%	18.9%	18.7%	↘
Corporate	15.8%	16.3%	16.9%	16.4%	↘
Estates and Fac.	16.3%	15.3%	14.3%	13.0%	↘
Medical & Cardio	16.6%	17.3%	16.7%	16.1%	↘
Surgery & Neuro	17.9%	15.9%	16.7%	14.8%	↘
SWL Pathology	22.8%	23.8%	25.4%	35.4%	↗
Whole Trust	**16.7%**	**17.0%**	**17.2%**	**17.0%**	↘

Vacancies Staff Group	Nov '15	Dec '15	Jan '16	Feb '16	Trend
Add Prof Scientific and Technic	23.8%	23.9%	23.8%	20.4%	↘
Additional Clinical Services	18.2%	18.5%	19.4%	19.2%	↘
Administrative and Clerical	18.4%	18.7%	18.5%	16.4%	↘
Allied Health Professionals	14.1%	15.4%	15.3%	14.5%	↘
Estates and Ancillary	17.7%	15.8%	15.4%	13.8%	↘
Healthcare Scientists	20.1%	20.4%	20.5%	36.2%	↗
Medical and Dental	5.3%	5.7%	6.4%	5.7%	↘
Nursing and Midwifery Registered	18.1%	18.2%	18.5%	18.3%	↘
Total	**16.7%**	**17.0%**	**17.2%**	**17.0%**	↘

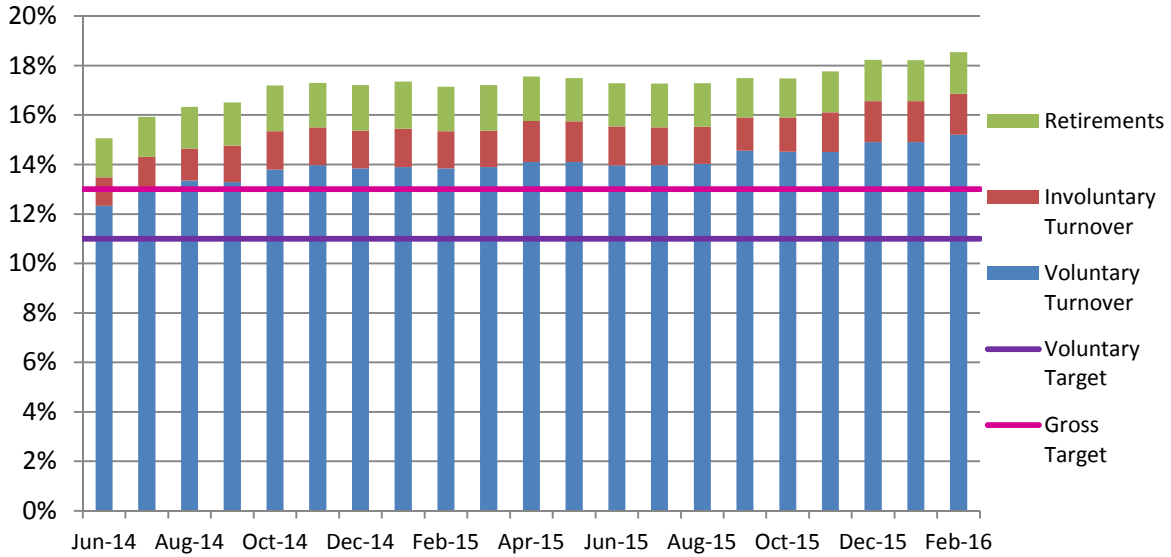
COMMENTARY

The vacancy rate has increased in February in line with an increase in WTE staff in post and is now 17.0%.

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:



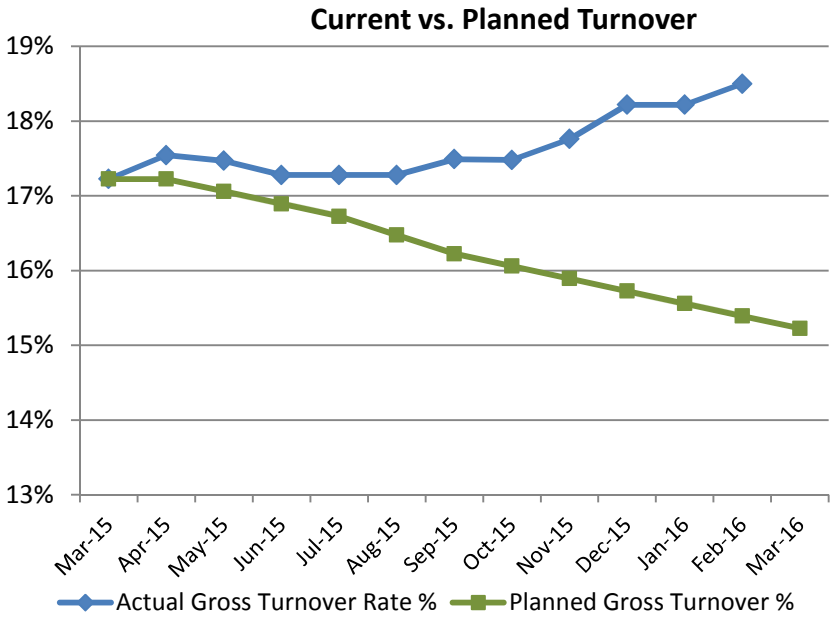
COMMENTARY

The total trust turnover rate has increased this month to 18.5%. This is significantly above the current target of 13%. In the last 12 months there have been 1345 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	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	18.4%	19.3%	19.2%	19.3%	↗
Community Services	20.8%	21.2%	20.8%	21.6%	↗
Corporate	20.6%	21.1%	22.2%	22.3%	↗
Estates and Facilities	16.3%	15.9%	14.2%	14.5%	↗
Medical & Cardiothoracics	19.3%	19.3%	18.9%	18.9%	↔
Surgery, Neurosciences & Anaes	13.9%	13.9%	14.6%	15.1%	↗
SWL Pathology	15.0%	16.6%	17.2%	18.9%	↗
Whole Trust	**17.8%**	**18.2%**	**18.2%**	**18.5%**	↗

	All Turnover				
Staff Group	Nov '15	Dec '15	Jan '16	Feb '16	Trend
Add Prof Scientific and Technic	17.9%	21.3%	21.9%	21.5%	↘
Additional Clinical Services	20.1%	20.4%	20.6%	21.0%	↗
Administrative and Clerical	17.1%	17.7%	18.2%	18.2%	↔
Allied Health Professionals	17.0%	19.2%	19.7%	19.8%	↗
Estates and Ancillary	8.7%	8.0%	5.8%	6.1%	↗
Healthcare Scientists	14.4%	16.3%	16.5%	17.6%	↗
Medical and Dental	12.5%	11.8%	11.4%	11.1%	↘
Nursing and Midwifery Registered	19.7%	19.3%	18.9%	19.6%	↗
Whole Trust	**17.8%**	**18.2%**	**18.2%**	**18.5%**	↗



Section 2b: Voluntary Turnover

	Voluntary Turnover					Other Turnover FEB 2016	
Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend	In-Voluntary	Retirement
C&W Diagnostic & Therapy	15.1%	15.9%	16.0%	16.1%	↗	1.9%	1.2%
Community Services	16.0%	16.2%	15.3%	16.1%	↗	1.6%	3.9%
Corporate	16.2%	17.0%	18.2%	18.3%	↗	2.0%	2.0%
Estates and Facilities	8.4%	8.0%	7.4%	7.8%	↗	5.4%	1.3%
Medical & Cardiothoracics	16.8%	16.9%	16.5%	16.4%	↘	1.3%	1.2%
Surgery, Neurosciences & Anaes	11.9%	11.7%	12.2%	12.7%	↗	1.0%	1.4%
SWL Pathology	12.7%	14.1%	14.3%	15.6%	↗	0.9%	2.4%
Whole Trust	**14.5%**	**14.9%**	**14.9%**	**15.2%**	↗	**1.7%**	**1.7%**

	Voluntary Turnover					Other Turnover FEB 2016	
Staff Group	Nov '15	Dec '15	Jan '16	Feb '16	Trend	In-Voluntary	Retirement
Add Prof Scientific and Technic	13.4%	15.8%	16.1%	15.7%	↘	5.1%	0.7%
Additional Clinical Services	16.8%	17.4%	17.5%	17.5%	↔	1.2%	2.3%
Administrative and Clerical	13.1%	13.4%	13.8%	13.8%	↔	2.1%	2.3%
Allied Health Professionals	16.1%	17.7%	18.3%	18.4%	↗	0.6%	0.8%
Estates and Ancillary	5.3%	4.8%	4.0%	4.3%	↗	0.4%	1.3%
Healthcare Scientists	11.6%	13.2%	13.5%	14.6%	↗	0.7%	2.3%
Medical and Dental	6.3%	6.0%	5.4%	5.3%	↘	4.4%	1.5%
Nursing and Midwifery Registered	17.1%	16.8%	16.6%	17.3%	↗	0.7%	1.6%
Whole Trust	**14.5%**	**14.9%**	**14.9%**	**15.2%**	↗	**1.7%**	**1.7%**

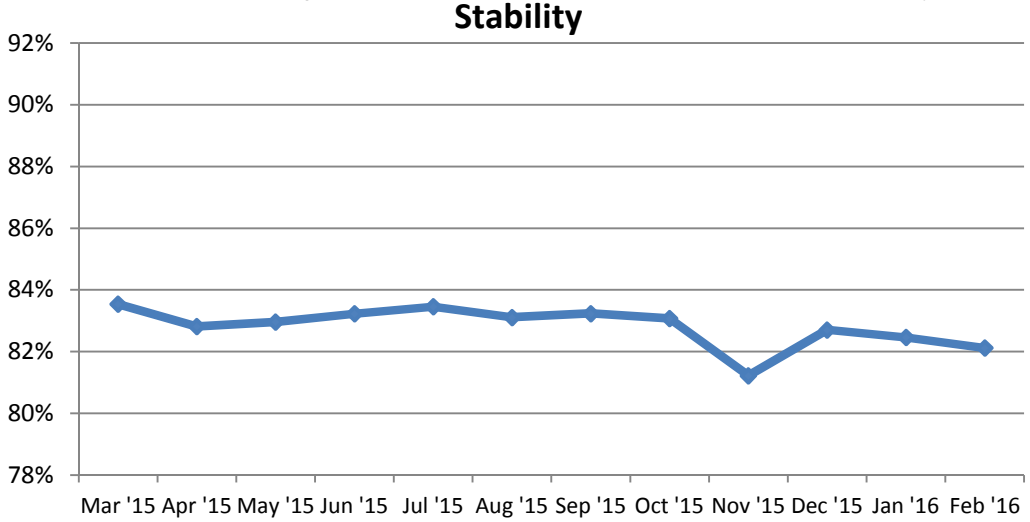
Caregroup	Staff in Post WTE	Leavers WTE	Voluntary Turnover Rate
Procurement & Materials Mgmt	37.0	11.0	28.2%
Cardiac Surgery	94.4	22.3	27.6%
SWLP Microbiology	63.1	18.3	25.7%
Human Resources Directorate	92.7	24.1	25.5%
Medical Oncology & Palliative Care	89.2	20.7	25.4%

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	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	80.1%	81.3%	81.8%	81.7%	↘
Community Services	78.0%	79.3%	79.1%	79.1%	↔
Corporate	75.5%	78.0%	76.0%	75.9%	↘
Estates and Facilities	84.0%	85.0%	85.9%	86.5%	↗
Medical & Cardiothoracics	80.0%	81.4%	81.9%	81.0%	↘
Surgery, Neurosciences & Anaes	84.6%	86.8%	86.0%	85.7%	↘
SWL Pathology	89.7%	89.5%	88.5%	87.0%	↘
Whole Trust	**81.2%**	**82.7%**	**82.5%**	**82.1%**	↘

Stability Staff Group	Nov '15	Dec '15	Jan '16	Feb '16	Trend
Add Prof Scientific and Technic	50.4%	73.4%	76.7%	73.8%	↘
Additional Clinical Services	90.1%	85.9%	84.7%	84.9%	↗
Administrative and Clerical	83.2%	84.6%	83.5%	83.7%	↗
Allied Health Professionals	78.7%	80.6%	80.3%	79.1%	↘
Estates and Ancillary	104.0%	89.3%	92.4%	93.2%	↗
Healthcare Scientists	90.3%	89.0%	88.3%	89.7%	↗
Medical and Dental	89.4%	90.1%	90.4%	90.2%	↘
Nursing and Midwifery Registered	84.6%	80.9%	80.2%	79.9%	↘
Total	**81.2%**	**82.7%**	**82.5%**	**82.1%**	↘

COMMENTARY

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

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

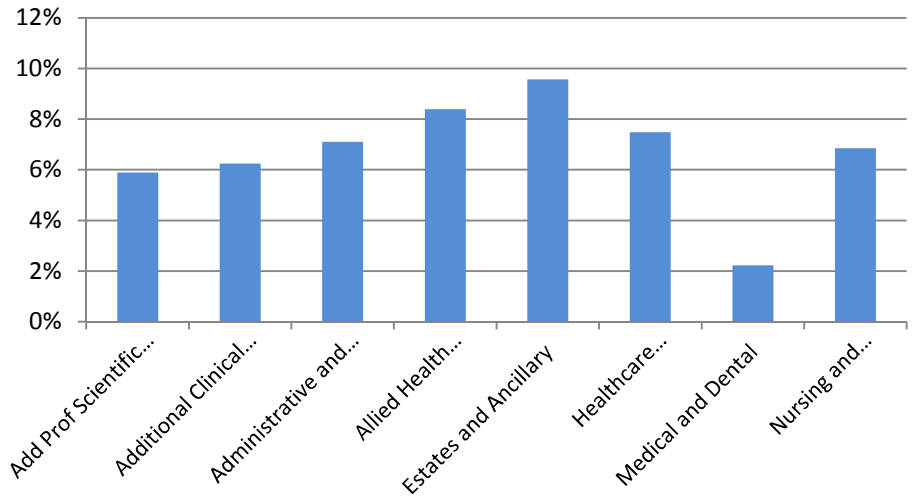
The stability rate has decreased by 0.4% this month.

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 82.1%.

Section 4: Staff Career Development

The chart below shows the percentage of current staff promoted in each staff group over the last 12 months.



COMMENTARY

Staff exit survey data tells us that one of the key drivers for retaining staff is to support their development within the trust. In February 31 staff were promoted, there were 137 new starters to the Trust and 169 employees were acting up to a higher grade.

Over the last year 6.7% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the SW London Pathology Division followed by Corporate.

Estates and Facilities staff are seen as having the highest promotion rate on the graph (NB a small team were upgraded to bring them in line with similar staff at other Trusts) followed by the Allied Health Professionals staff group.

	No. of Promotions				
Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	28	12	25	9	↘
Community Services	10	10	10	4	↘
Corporate	11	5	9	2	↘
Estates and Facilities	0	0	0	0	↔
Medical & Cardiothoracics	9	12	14	1	↘
Surgery, Neurosciences & Anaes	4	6	12	9	↘
SWL Pathology	2	0	1	6	↗
Whole Trust Promotions	**64**	**45**	**71**	**31**	↘
New Starters (Excludes Junior Doctors)	146	47	125	137	↗

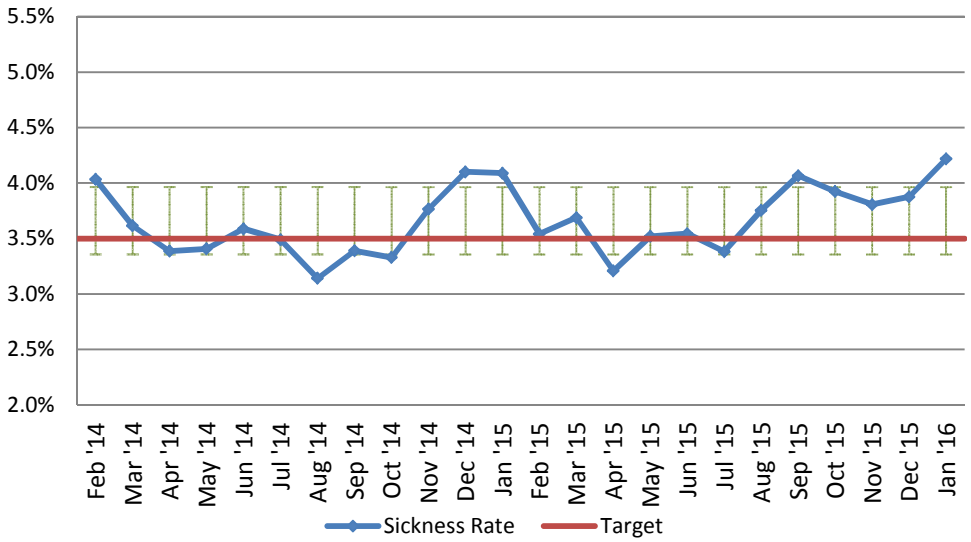
Division	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
C&W Diagnostic & Therapy	1987	133	6.7%	78
Community Services	817	37	4.5%	4
Corporate	437	40	9.2%	27
Estates and Facilities	259	20	7.7%	8
Medical & Cardiothoracics	1230	71	5.8%	29
Surgery, Neurosciences & Anaes	1371	80	5.8%	16
SWL Pathology	311	46	14.8%	7
Whole Trust	**6412**	**427**	**6.7%**	**169**
New Starters (Excludes Junior Doctors)		1431		

	No. of Promotions				
Staff Group	Nov '15	Dec '15	Jan '16	Feb '16	Trend
Add Prof Scientific and Technic	1	2	4	0	↘
Additional Clinical Services	2	3	5	4	↘
Administrative and Clerical	23	14	30	8	↘
Allied Health Professionals	11	11	8	3	↘
Estates and Ancillary	0	0	0	0	↔
Healthcare Scientists	3	1	2	3	↗
Medical and Dental	0	0	0	2	↗
Nursing and Midwifery Registered	24	14	22	11	↘
Whole Trust	**64**	**45**	**71**	**31**	↘

Staff Group	Staff in Post + 1yrs Service	No. of Staff Promoted	% of Staff Promoted	Currently Acting Up
Add Prof Scientific and Technic	475	28	5.9%	34
Additional Clinical Services	689	43	6.2%	1
Administrative and Clerical	1309	93	7.1%	68
Allied Health Professionals	560	47	8.4%	16
Estates and Ancillary	209	20	9.6%	4
Healthcare Scientists	254	19	7.5%	6
Medical and Dental	495	11	2.2%	1
Nursing and Midwifery Registered	2421	166	6.9%	39
Whole Trust	**6412**	**427**	**6.7%**	**169**

Section 5: Sickness

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



COMMENTARY

Sickness absence is at 4.4% for February, which is an increase of 0.1% on the previous month. Analysis of reasons for absence this month shows seasonal colds and flu to be the main reason for being off work.

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

The table below lists the five care groups with the highest sickness absence percentage during February 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	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	3.4%	3.4%	4.3%	4.6%	↗
Community Services	5.7%	6.0%	6.5%	6.2%	↘
Corporate	3.7%	3.7%	3.4%	4.2%	↗
Estates and Facilities	4.7%	5.4%	4.7%	5.2%	↗
Medical & Cardiothoracics	4.2%	4.0%	3.8%	3.5%	↘
Surgery, Neurosciences & Anaes	3.2%	3.3%	3.8%	3.8%	↔
SWL Pathology	2.5%	3.3%	2.8%	3.6%	↗
Whole Trust	**3.8%**	**3.9%**	**4.2%**	**4.3%**	↗

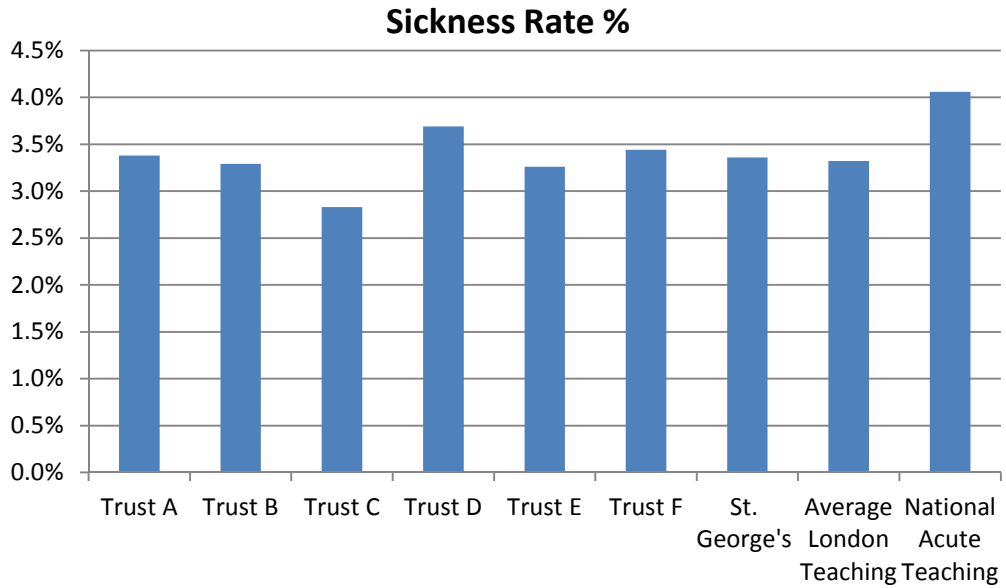
Sickness Staff Group	Nov '15	Dec '15	Jan '16	Feb '16	Trend
Add Prof Scientific and Technic	3.3%	2.9%	3.4%	3.0%	↘
Additional Clinical Services	6.4%	7.4%	8.1%	6.7%	↘
Administrative and Clerical	4.1%	4.5%	4.5%	4.6%	↗
Allied Health Professionals	2.5%	3.2%	3.6%	3.8%	↗
Estates and Ancillary	5.8%	7.4%	6.2%	6.3%	↗
Healthcare Scientists	2.9%	2.4%	2.4%	2.7%	↗
Medical and Dental	1.3%	0.8%	1.3%	1.6%	↗
Nursing and Midwifery Registered	4.2%	4.0%	4.5%	5.0%	↗
Total	**3.8%**	**3.9%**	**4.2%**	**4.3%**	↗

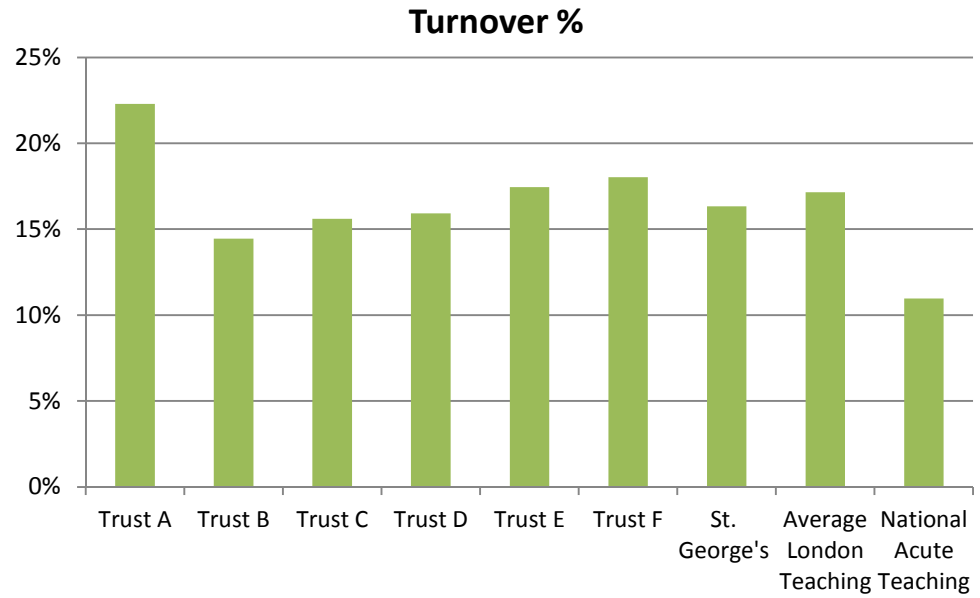
Caregroup	Staff in Post WTE	Sickness WTE Days Lost	Sickness %	Salary Based Sickness Cost (£)
Energy and Engineering	53.13	197.00	12.7%	£16,253
Offender Healthcare HMPW Services	57.72	200.98	12.2%	£15,408
Paediatric Surgery	59.67	185.65	10.3%	£18,227
Procurement & Materials Mgmt	37.00	106.00	9.4%	£7,802
Surgery Directorate Overheads	85.52	207.00	8.4%	£13,240

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	36.68%
S25 Gastrointestinal problems	15.64%
S16 Headache / migraine	6.17%
S12 Other musculoskeletal problems	6.04%
S10 Anxiety/stress/depression/other psychiatric illnesses	5.79%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S13 Cold, Cough, Flu - Influenza	22.73%
S10 Anxiety/stress/depression/other psychiatric illnesses	13.69%
S12 Other musculoskeletal problems	10.69%
S25 Gastrointestinal problems	9.10%
S28 Injury, fracture	6.35%

Section 6: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from November '15 which is the most recent available. Compared to other Acute teaching trusts in London, St. Georges had a rate very slightly higher than average at 3.36%. In the top graph, Trusts A-F are the anonymised figures for this group. The Trust's sickness rate was lower than the national rate for acute teaching hospitals in November.

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 December). Stability is also higher than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is 5% lower than St. Georges.

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

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	22.29%	77.90%	3.38%
Trust B	14.44%	85.13%	3.29%
Trust C	15.60%	83.96%	2.83%
Trust D	15.92%	83.69%	3.69%
Trust E	17.44%	82.57%	3.26%
Trust F	18.03%	81.96%	3.44%
St. George's	16.33%	83.44%	3.36%
Average London Teaching	17.15%	82.66%	3.32%
National Acute Teaching	10.97%	88.81%	4.06%

Section 7: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	1105.4	1110.4	1150.9	1152.9	↗
Community Services	613.5	614.5	598.4	598.4	↔
Corporate & R&D	95.2	95.2	67.8	61.1	↘
Medical & Cardiothoracics	1253.7	1253.7	1279.2	1279.2	↔
Surgery, Neurosciences & Anaes	1151.0	1151.0	1113.7	1094.0	↘
Total	4218.8	4224.8	4210.0	4185.6	↘

Nursing Staff in Post WTE

Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	999.5	980.6	996.4	997.7	↗
Community Services	452.9	452.9	448.0	441.6	↘
Corporate & R&D	70.6	72.5	56.1	55.1	↘
Medical & Cardiothoracics	995.4	982.9	993.5	999.6	↗
Surgery, Neurosciences & Anaes	910.9	909.0	903.1	904.2	↗
Total	3429.3	3397.9	3397.0	3398.1	↗

Nursing Vacancy Rate

Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	9.6%	11.7%	13.4%	13.5%	↗
Community Services	26.2%	26.3%	25.1%	26.2%	↗
Corporate & R&D	25.8%	23.8%	17.3%	9.9%	↘
Medical & Cardiothoracics	20.6%	21.6%	22.3%	21.9%	↘
Surgery, Neurosciences & Anaes	20.9%	21.0%	18.9%	17.4%	↘
Total	18.7%	19.6%	19.3%	18.8%	↘

Nursing Sickness Rates

Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	4.7%	4.2%	5.0%	6.1%	↗
Community Services	6.6%	7.5%	8.7%	7.8%	↘
Corporate	5.3%	3.2%	2.5%	3.5%	↗
Medical & Cardiothoracics	4.8%	4.8%	4.7%	4.1%	↘
Surgery, Neurosciences & Anaes	3.9%	4.2%	4.8%	4.8%	↗
Total	4.8%	4.8%	5.4%	5.4%	↗

Nursing Voluntary Turnover

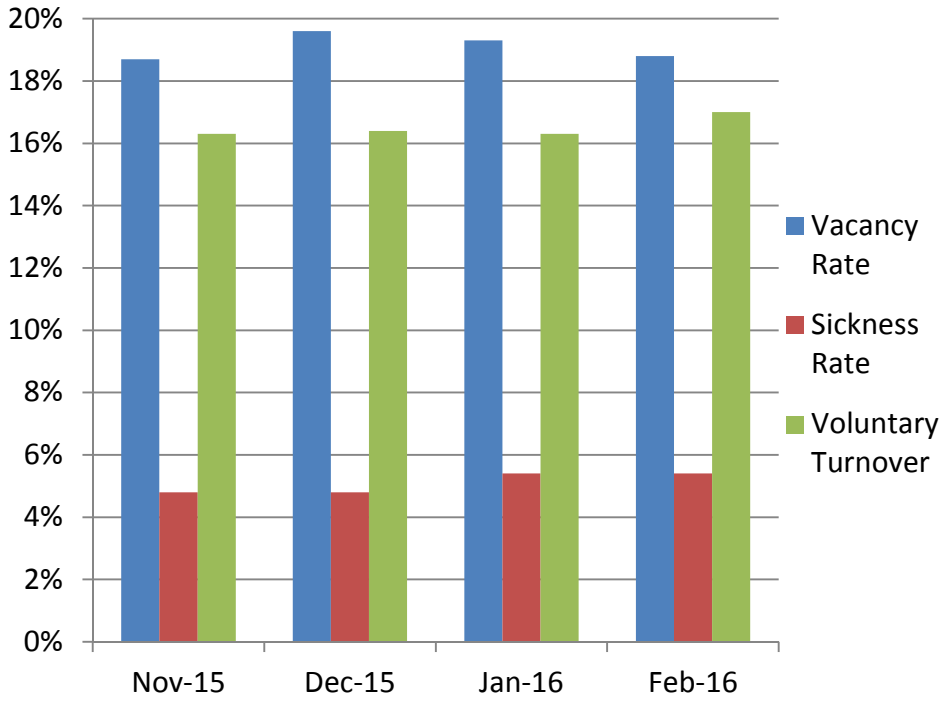
Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	15.03%	15.75%	15.11%	15.68%	↗
Community Services	18.09%	17.52%	16.16%	17.72%	↗
Corporate & R&D	9.47%	10.98%	12.37%	14.16%	↗
Medical & Cardiothoracics	19.15%	19.44%	19.35%	19.34%	↘
Surgery, Neurosciences & Anaes	13.84%	14.27%	14.90%	15.65%	↗
Total	16.3%	16.4%	16.3%	17.0%	↗

COMMENTARY

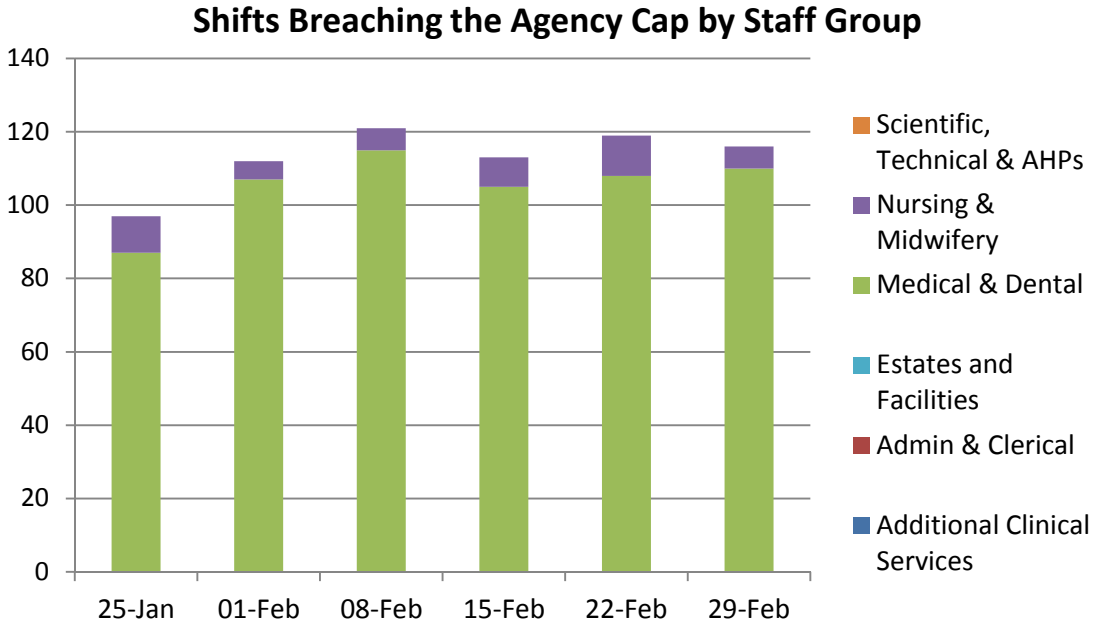
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has increased by 1.1 WTE in February.

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	25-Jan	01-Feb	08-Feb	15-Feb	22-Feb	29-Feb	Trend
Additional Clinical Services	0	0	0	0	0	0	↔
Admin & Clerical	0	0	0	0	0	0	↔
Estates and Facilities	0	0	0	0	0	0	↔
Medical & Dental	87	107	115	105	108	110	↗
Nursing & Midwifery	10	5	6	8	11	6	↘
Scientific, Technical & AHPs	0	0	0	0	0	0	↔
Whole Trust	97	112	121	113	119	116	↘

Agency Cap Shift Breaches by Division	25-Jan	01-Feb	08-Feb	15-Feb	22-Feb	29-Feb	Trend
C&W Diagnostic & Therapy	6	4	6	5	9	13	↗
Community Services	15	16	12	12	12	15	↗
Corporate	15	15	15	16	15	16	↗
Estates and Facilities	0	0	0	0	0	0	↔
Medical & Cardiothoracics	45	61	75	69	69	66	↘
Surgery, Neurosciences & Anaes	16	16	13	11	14	6	↘
SWL Pathology	0	0	0	0	0	0	↔
Whole Trust	97	112	121	113	119	116	↘

COMMENTARY

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

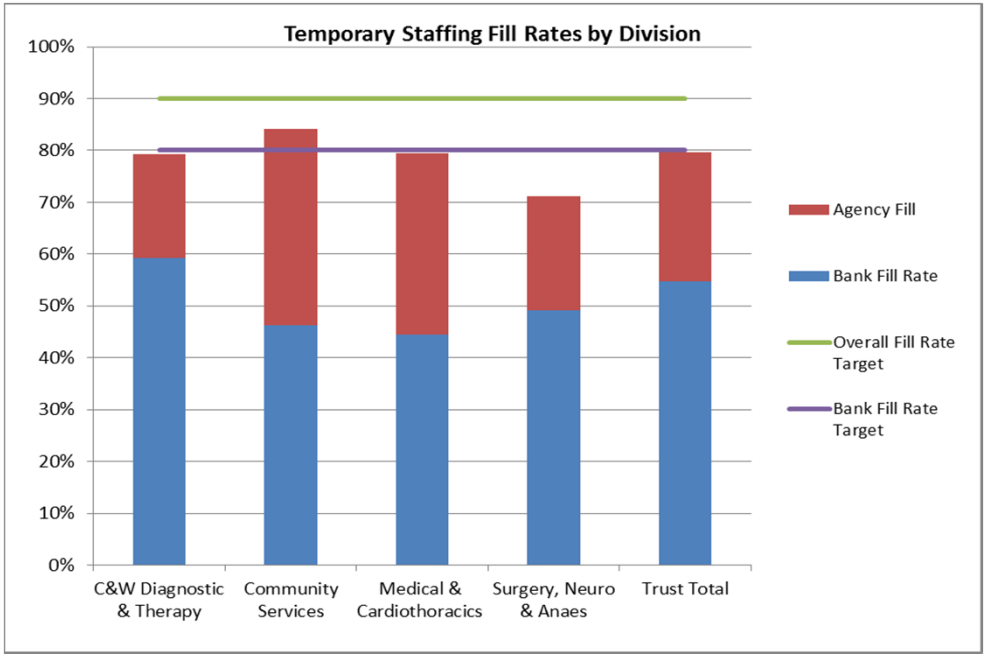
Work is on-going to stop using agencies which breach the caps where possible.

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

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

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

Section 9: Temporary Staff Fill Rates



COMMENTARY

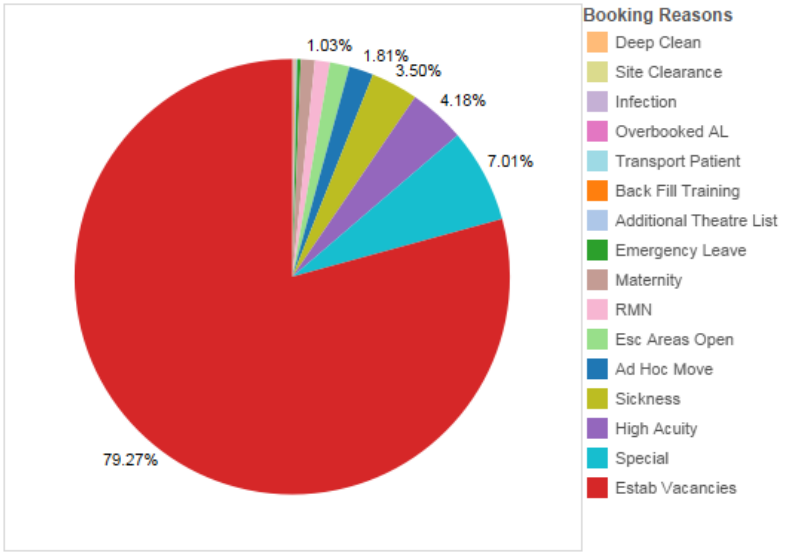
This data comes from the Trust's e-rostering system.

The "Overall Fill Rate" is the percentage number of requests made to the Staff Bank to cover shifts which were filled by either trust bank staff, or by an agency. The remainder of requests which could not be covered by either group are recorded as being unfilled. The "Bank Fill Rate" describes requests that were filled by bank staff only, not agency.

In February the Bank Fill Rate was reported at 54.7% which is 2.2% lower than the previous month. The Overall Fill Rate was 79.6% which is a decrease of 1.1% on the previous month. The Community Services Division is currently meeting the demand for temporary staff most effectively.

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

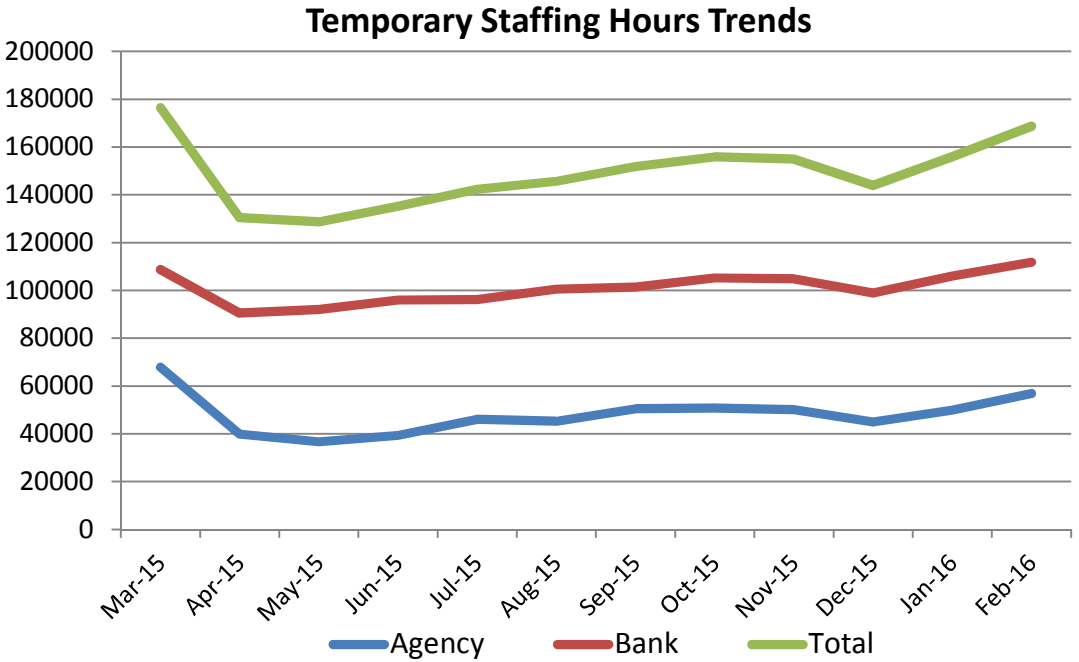
This data only shows activity requested through the Trust's bank office.



Bank Fill Rate % by Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	65.9%	60.0%	63.3%	59.2%	↘
Community Services	51.0%	48.1%	48.4%	46.2%	↘
Medical & Cardiothoracics	48.4%	47.7%	46.2%	44.5%	↘
Surgery, Neurosciences & Anaes	50.8%	56.3%	51.5%	49.1%	↘
Whole Trust	**59.2%**	**57.6%**	**56.9%**	**54.7%**	↘

Overall Fill Rate % by Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	81.9%	77.7%	80.3%	79.3%	↘
Community Services	88.7%	84.1%	86.9%	84.1%	↘
Medical & Cardiothoracics	83.5%	81.2%	81.2%	79.5%	↘
Surgery, Neurosciences & Anaes	75.7%	76.2%	70.9%	71.2%	↗
Whole Trust	**83.2%**	**80.8%**	**80.7%**	**79.6%**	↘

Section 10: Temporary Staffing Duties



COMMENTARY

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

The figures show the number of bank and agency hours worked by month by Division. Overall Bank & agency hours have both increased in all areas apart from the Corporate Division.

The largest increase in agency hours is seen in the Children & Women's Division almost half of which is accounted for by the Intensive Care Units.

Bank hours increased in Estates & Facilities (mainly in Portering and Medical Physics) as well as in Surgery and Neuro Division (mostly ward staffing).

TYPE	Division	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Agency	C&W Diagnostic & Therapy	16791	9525	10750	8656	9638	9408	10033	11112	10724	11615	11158	14779
	Community Services	9890	7938	5769	5245	6077	6422	6421	7086	6605	6715	7298	8717
	Corporate	3488	1246	1331	949	529	46	423	402	384	541	1021	793
	Estates and Facilities	0	0	0	0	0	0	0	4	166	322	140	176
	Medical & Cardiothoracics	25876	14492	13202	17823	20429	20348	24428	21792	22626	19732	23154	23159
	Surgery, Neurosciences & Anaes	11833	6582	5462	6386	9195	8730	8860	9994	9362	5953	7161	9211
	SWL Pathology	0	119	204	241	228	245	352	267	150	143	0	0
Agency Total		**67877**	**39901**	**36717**	**39299**	**46097**	**45199**	**50517**	**50657**	**50017**	**45021**	**49932**	**56835**
Bank	C&W Diagnostic & Therapy	31536	27789	28714	29038	25990	26657	30745	32858	31790	30886	33343	34999
	Community Services	10560	8379	7619	7704	8252	9033	8695	9149	9133	9005	9225	9796
	Corporate	7922	7424	7165	8430	7972	7206	8828	11156	9858	8426	8674	8773
	Estates and Facilities	7744	6885	7502	8178	9216	8910	8264	8506	9423	8467	8428	10122
	Medical & Cardiothoracics	27553	23755	24829	24969	26255	29728	27842	26409	28073	25363	26990	26921
	Surgery, Neurosciences & Anaes	20376	13521	13495	14553	14740	15545	16118	16265	15754	15791	18358	20155
	SWL Pathology	2953	2753	2620	3052	3751	3389	803	821	839	998	1016	1050
Bank Total		**108643**	**90507**	**91944**	**95925**	**96177**	**100468**	**101295**	**105164**	**104870**	**98936**	**106034**	**111816**
Temporary Staff Total		**176520**	**130408**	**128661**	**135224**	**142273**	**145667**	**151811**	**155821**	**154887**	**143957**	**155966**	**168651**

Section 11: Temporary Staffing Weekly Tracking

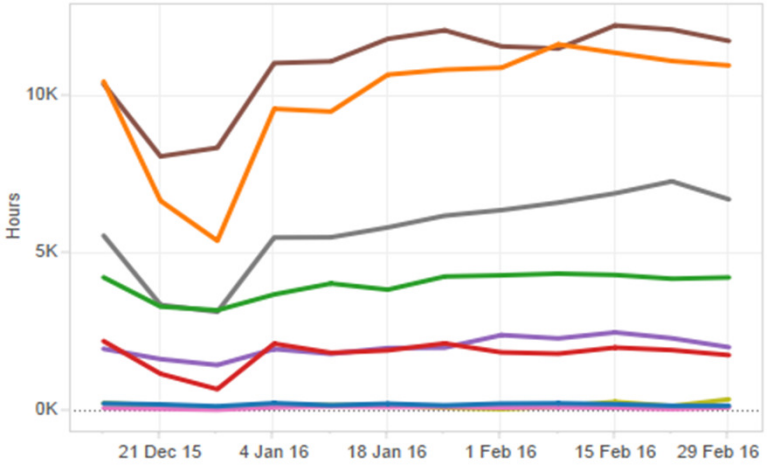
Weekly Hours Used By Division

Division	14 Dec	21 Dec	28 Dec	04 Jan	11 Jan	18 Jan	25 Jan	01 Feb	08 Feb	15 Feb	22 Feb	29 Feb
Capital Division	224	192	133	233	168	214	162	218	227	200	149	151
Children and Women's Diagnostic and Th..	10,445	6,671	5,405	9,583	9,496	10,665	10,822	10,884	11,624	11,357	11,097	10,957
Community Services Division	4,245	3,322	3,206	3,706	4,051	3,856	4,273	4,311	4,364	4,323	4,202	4,243
Corporate Division	2,225	1,193	704	2,148	1,855	1,935	2,155	1,870	1,829	2,023	1,943	1,785
Estates and Facilities Division	1,984	1,658	1,470	1,977	1,826	2,009	2,020	2,419	2,313	2,503	2,318	2,035
Medicine and Cardiovascular Division	10,367	8,077	8,351	11,031	11,084	11,799	12,070	11,559	11,492	12,223	12,093	11,734
Research & Development Division	80	53	24	101	132	116	124	93	109	88	46	99
Surgery & Neurosciences Division	5,567	3,375	3,154	5,507	5,515	5,827	6,199	6,376	6,614	6,907	7,287	6,717
SWL Pathology Division	228	161	85	167	165	168	91	44	128	272	136	352
Grand Total	35,364	24,701	22,532	34,451	34,293	36,589	37,916	37,774	38,700	39,896	39,271	38,071

Type
- Agency
- Bank

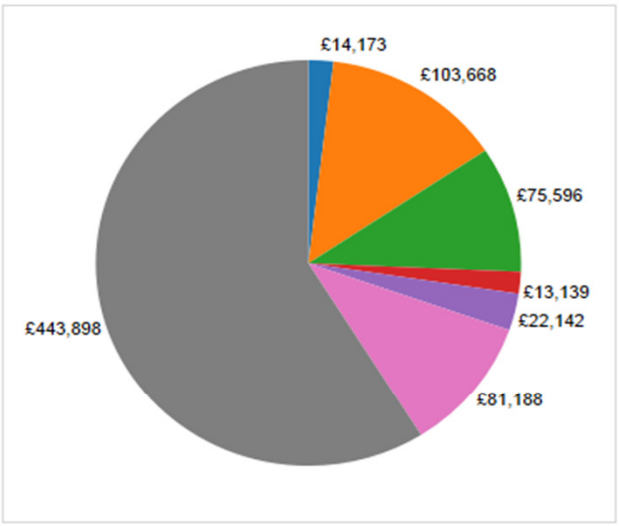
Division
- Capital Division
- Children and Women's D..
- Community Services Divi..
- Corporate Division
- Estates and Facilities Div..
- Medicine and Cardiovasc..
- Research & Developmen..
- Surgery & Neuroscience..
- SWL Pathology Division

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
£753,804

Select Date (W/C)
29/02/2016

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

Section 12: Mandatory Training

MAST Topic	Jan '16	Feb '16	Trend
Conflict Resolution	76.2	79.4	↗
Equality, Diversity and Human Rights	75.8	78.2	↗
Fire Safety	71.9	74.2	↗
Health, Safety and Welfare	73.5	75.7	↗
Infection Prevention and Control Clinical	59.6	61.7	↗
Infection Prevention and Control Non Clinical	64.6	69.2	↗
Information Governance	60.8	65.5	↗
Moving and Handling	68.6	71.5	↗
Moving and Handling Patient	61.3	63.5	↗
Resuscitation BLS	44.0	49.1	↗
Resuscitation ILS	50.6	54.7	↗
Resuscitation Non Clinical	59.7	61.8	↗
Safeguarding Adults	70.8	72.7	↗
Safeguarding Children Level 1	68.5	72.1	↗
Safeguarding Children Level 2	71.7	73.0	↗
Safeguarding Children Level 3	67.6	68.7	↗

COMMENTARY

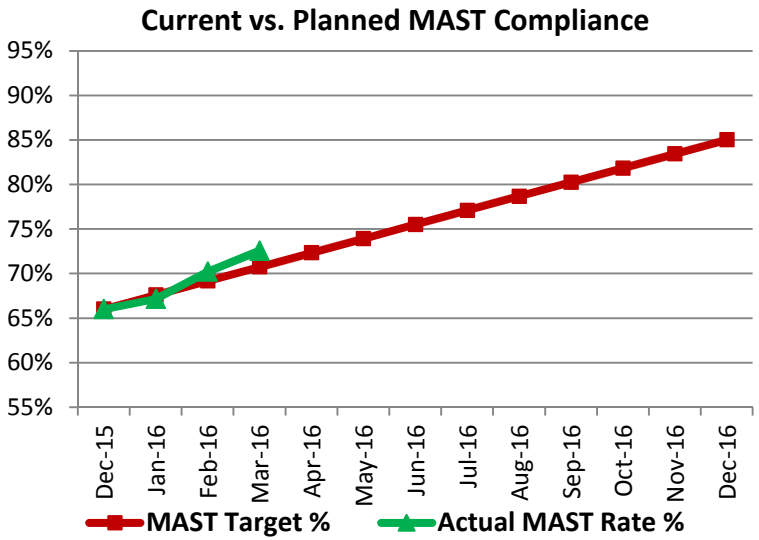
A programme of working is taking place including:

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

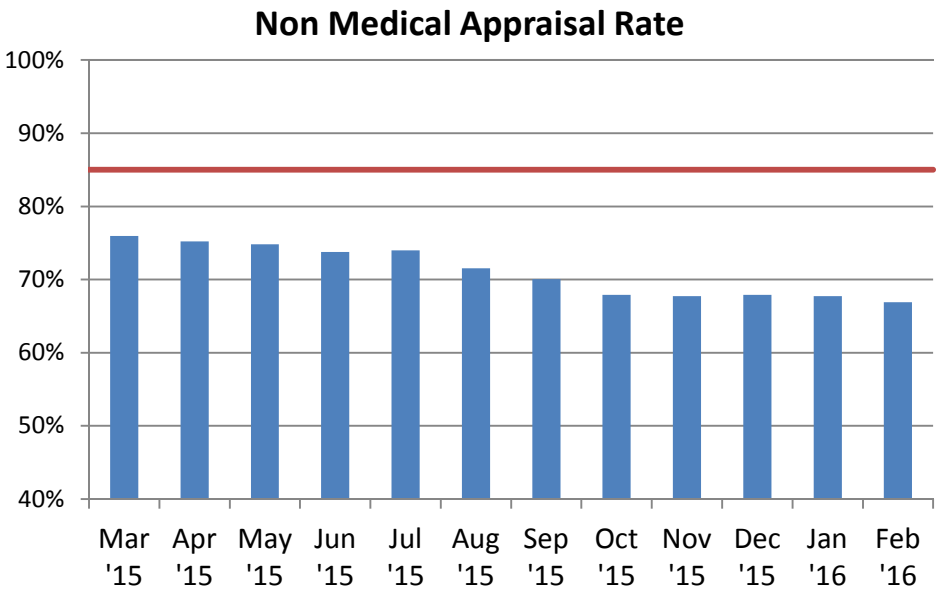
Current Issues:

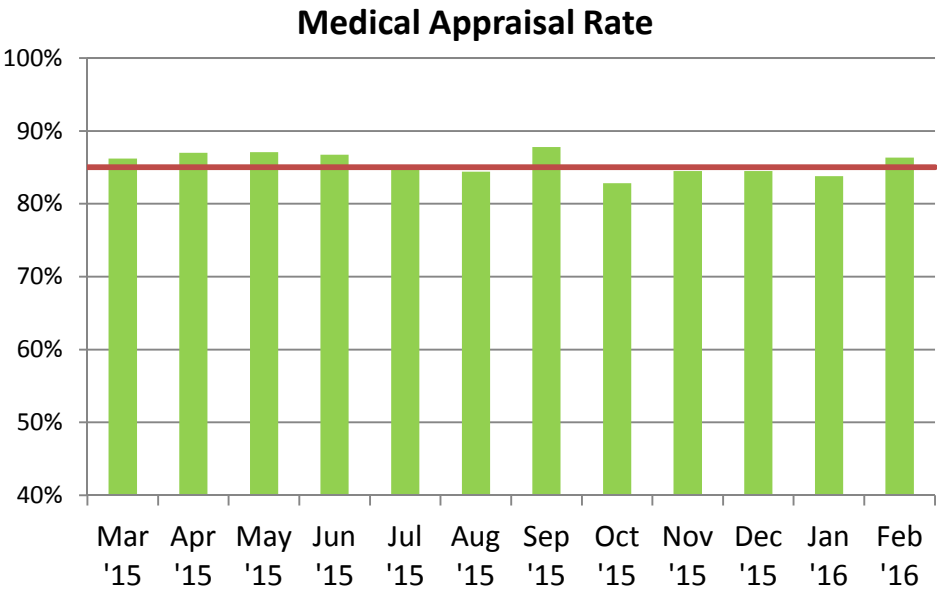
- Fall in compliance rates – largely due to staffing pressures
- Community access to Totara is on the risk register, in the interim we are visiting community sites with tablets and developing a permanent solution in parallel
- Staff unable to access training externally- Software and licencing and IG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

MAST Compliance % by Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	65.7%	67.3%	69.0%	71.9%	↗
Community Services	65.7%	65.6%	65.9%	68.4%	↗
Corporate	62.9%	65.5%	66.1%	69.5%	↗
Estates and Facilities	62.4%	62.5%	62.1%	68.6%	↗
Medical & Cardiothoracics	61.2%	63.5%	65.0%	66.9%	↗
Surgery, Neurosciences & Anaes	63.9%	64.9%	66.1%	68.4%	↗
Whole Trust	64.5%	66.0%	67.1%	70.2%	↗



Section 13: Appraisal





Non-Medical Commentary

The non-medical appraisal rate has decreased by 0.8% this month to 66.9%. Appraisals are still being managed closely by the appraisal project team who are monitoring progress every two weeks and scrutinising divisional plans. The Corporate Division currently has the lowest non-medical compliance rate. Appraisal completion is now linked to incremental progression for bands AFC band 7 - 9 staff. The table below lists the five care groups with the lowest non medical appraisal rate this month

Medical Commentary

Medical appraisal rate compliance has decreased this month to 86.4% which is above target.

Care Group	Non-Med Appraisal Rate	Staff In Post WTE
SWLP Central Reception	12.5%	60.27
SWLP Haematology	13.5%	61.28
SWLP Biochemistry	18.9%	55.39
Energy and Engineering	22.5%	53.13
Procurement & Materials Mgmt	28.1%	37.00

Non Medical Appraisals by Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	69.7%	71.8%	70.7%	68.3%	↘
Community Services	62.9%	62.4%	63.2%	63.5%	↗
Medical & Cardiothoracics	74.6%	73.7%	72.3%	72.0%	↘
Surgery, Neurosciences & Anaes	74.9%	74.0%	75.1%	75.0%	↘
Corporate	51.5%	50.2%	52.2%	56.8%	↗
Estates & Facilities	66.9%	66.1%	64.9%	63.0%	↘
Whole Trust	**67.7%**	**67.9%**	**67.7%**	**66.9%**	↘

Medical Appraisals by Division	Nov '15	Dec '15	Jan '16	Feb '16	Trend
C&W Diagnostic & Therapy	84.4%	86.0%	82.2%	85.9%	↗
Community Services	81.3%	87.1%	87.1%	83.9%	↘
Medical & Cardiothoracics	87.8%	87.7%	85.7%	90.5%	↗
Surgery, Neurosciences & Anaes	82.0%	79.9%	86.0%	84.1%	↘
Corporate	75.0%	75.0%	100.0%	100.0%	↔
Whole Trust	**84.5%**	**84.5%**	**83.8%**	**86.4%**	↗

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

DRAFT

Workforce and staff experience action plan 2016/17

Wendy Brewer , Director of Workforce and Organisational Development

Excellence in specialist and community healthcare

Introduction

The focus for the workforce strategy plan for 16/17 has been:

- Activity that reduces staff turnover
- Delivery of the workforce efficiency programme
- Ensuring high quality undergraduate education provision.

The results from the staff survey indicate the importance of setting out the work taking place to support staff experience and seeking feedback to develop more effective and substantial plans.

The first feedback meeting was held on 30th April and the high level responses are on the next slide. Feedback indicates the need for a fundamental shift:

- A return to greater earned autonomy for the front line
- Clearer channels of communication
- Enhanced management skills in engaging with staff in a constructive way
- Freeing up time for important engagement and a focus on quality

This work must be supported by reducing vacancy rates and responding to infrastructure challenges.

Finally, it is proposed that there is a recognition of how hard staff have worked over the past year by the introduction of a 3-month sickness policy amnesty, an additional day's leave for staff who have attended for the whole year.

Feedback from staff survey session on 30th March

- Communication – new intranet/front page/social media/whatsapp groups
- Quarterly all staff meetings – identify staff champions and empower with key issues to achieve.
- Protected time for team brief meetings
- Back to the floor for execs and non-execs
- Execs to be linked with specific clinical areas/directorates
- No meetings on Fridays – talk to teams instead
- Introduce a scheme of immediate rewards (such as a voucher for a cup of coffee)
- 'You are a star' board instant feedback
- Empowerment at a local level – first time resolution of estates and IT issues
- Decisions to be made at the right level
- Faster resolution from IT help desk
- Take stock of current hardware and software and compatibility, get everyone to a minimum level
- Shorten HR1 process
- Amnesty on distribution lists
- Stop emails out of hours
- Training for managers in facilitating staff engagement & engaging with staff
- Proper resourcing for Listening into Action
- Email address for patients to feedback to
- Unconscious bias training for all
- Examples of good appraisal processes, make it something staff want

The following series of slides set out the programme of work that is currently being delivered alongside detail of planned further work.

The programme is set out in accordance with the DH Staff pledges, which are tested through the staff survey. The pledges are as follows:

Staff pledge 1: To provide all staff with clear roles, responsibilities and rewarding jobs**.**
Staff pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential**.**
Staff pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
Staff pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

There are additional questions about:
Equality and diversity
Errors and incidents
Patient experience

Pledge 1- To provide all staff with clear roles, responsibilities and rewarding jobs

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Values Awards	Speed up the process for awarding awards. *Introduce a 'You are a star 'scheme of instant recognition.* *Review awards for long service.* *Introduce a simple method for managers to award staff.*	*Agree an arrangement with one of the catering providers.*
	Introduce a system of 'earned autonomy' where directorates meeting targets etc are more able to make local decisions.	*This will need to be worked through at EMT level.*
In principle agreement to introduce a pay structure for management levels 8C and above.		Commission support from Hay Group to draw up proposals.
Spans and layers work initiated.	Spans and layers work implementation. Clarification of divisional roles.	Commission support from Hay Group to define divisional roles.
Review all acting up arrangements	Confirm in post people who have been acting up for more than 6 months.	

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

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Interim appraisals for the 'top 100 leaders' to re-set objectives	All of this group to access 360 feedback within 12 months	Purchase of licences @£50 p.p. Time to complete assessments, and to receive feedback
Pro-forma appraisal to include revalidation for N&M and Drs	Develop Totara to hold this electronically Briefing sessions for experienced appraisers All new managers/supervisors to be trained *Think of ways of making appraisal more meaningful and attractive to staff so that they want their appraisal*	£25k system development
	Introduce succession planning for key roles such as Care Group Lead and Ward Manager	Establish a project board and working group. Time for Head of Corporate Training to take this forward. Process for calibration – senior leaders time. Software to support the process/development of Totara, estimated £20k
Successful introduction of the Care Certificate. HCAs taking QCF in Care or Health and Social Care Pilot of HCAs undertaking Mental Health observation training	Include the mental health course as part of induction process for all new HCAs and over the next 2 years train all HCAs in mental health HCAs to undertake 'apprenticeship' instead of just the QCF	Costs are being obtained for either a 2 day or 3 day course, this will be included in the business plan to HESL for CPPD funding. Opportunity cost of release. No direct cost for the 'apprenticeship'
A better process for the approval of study funding and leave	CPPD funding comes from HESL, but is diminishing so we plan to introduce a regular panel to consider applications for masters etc.	Development of on-line application Panel member time

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

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Won funding for Acclimatisation training for overseas trained staff from HESL	Make this part of the induction process for relevant staff	Release time
Re-vamped Corporate Induction Revamped Medical Induction Made a welcome to George's Induction video	Make the MAST component more relevant and interesting through video based e-learning All new managers to attend an additional half day	£25-£30k for production costs Payback hours to staff who complete it pre-employment HR Advisor time and managers time
Developed a preceptorship training programme	Make this a mandatory part of new band 5 starters 1st year. To be scheduled onto e-rostering as they start	4 days release p.p.
Run several cohorts of apprentices	Increase capacity . Set up accredited centre Make ILM programmes into Apprenticeships Make QCF programmes into Apprenticeships Work with Corporate Nursing on the Band 4 role and increase the Foundation Degree provision to support that (it is already an apprenticeship) Partner with South Thames College to recruit a % of their students into HCA apprenticeships	£200k for in-house team. £1m saving in salaries per 100 apprentices Re-coup apprenticeship levy costs from 2017
Trained a pool of accredited mediators	Ensure that they are publicised and used to nip workplace conflicts in the bud	Mediators to be released Mediators supervised by Staff Support
	We will be piloting a 2 year rotation for prison nursing, moving a cohort of 9 nurses through the Prison x 2 placements, Community Services, and the Emergency Department, supported by a full training programme including post graduate module and mentorship.	

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

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Team building on request	Role out OD consultancy to the tripartites at Divisional and Care Group levels using a whole systems approach	£50k for an external consultant
Help teams in trouble on request	Continue to be responsive	Associate Director and Head of Training time
	Support the Transformation projects Provide training in: • Managing Change • Leading with Impact & Authority • Holding Difficult conversations • Systems thinking Provide individualised support	£10-£15k Associate Director and Head of Training time
Matched individuals to coaches on an ad-hoc basis	Create an in-house accredited cohort Incorporate 'coaching for performance' into all leadership development	£20k We can use the London Leadership Academies resource to hold the profiles of the coaches for free
Staff accessing external leadership development on an ad hoc basis when funding made available via Monitor or other bursaried places	Ensure that there is a transparent process in place for when these opportunities arise	Associate Director time
A coherent leadership development plan Top leaders attended a whole systems event 1st cohort of New Leaders run and evaluated	Provide leadership support to the divisions Put in place programme for aspiring leaders Put in place role specific programme for Care Group Leads/CDs Make Band 6 and Band 7 programmes multi-disciplinary	Mostly in-house design, facilitation, and delivery time.

Pledge 3 To provide support and opportunities for staff to maintain their health, well-being and safety

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
A programme of activities based on four themes: • Active lifestyle • Changing behaviours • Emotional wellbeing • Healthy eating Significant activity achieved but resources are limited and the steering group is led through good will.	To resource, expand and communicate the programme more effectively. There is a CQIN requirement for healthy workforce. *Suspend sickness absence first stage warnings for the first ¼ of 2016/17.* *Allow all staff who have had no absence in 15/16 an additional day's leave.*	Funding for two days a week at band 8A level, full time band 4 post. Funding of circa £30k for a pensions advisory service. Funding of circa £10k for a non-pay budget to fund exercise classes etc. Funding to be identified to meet the CQIN requirements of £75k flu immunisation rates.

Pledge 3 To provide support and opportunities for staff to maintain their health, well-being and safety

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Active Lifestyle		
Successful 2015 global corporate challenge 15 teams taking part	Run global corporate challenge 2016 with executive participation and increased uptake from staff	A successful business case has secured £5,670 from the charity to fund 100 places. Further places can be offered by local budget holders at a cost of £48 per staff member
1 season of weekly Pilates with a qualified physio	Continue into a second season	£30 per session to pay instructor
Secured funding via a business case to introduce a Physio to OH services	Recruit a suitable post holder	Cost of B7 met through business case
Take the stairs campaign		Cost met through the Estates department
Staff discounts available at local sports centres including Virgin Active	Expand offering	Dependent on B4 wellbeing coordinator appointment to research and communicate
Cycle to work scheme available via salary sacrifice		Administration already met by Payroll team
	Further possible programmes: Walking club Calorie counter – Staff can calculate their calories lost by walking between sites Trust sports day Staff dancaathon Group cricket and rounders Introduction of a cinema club	These events require full scoping, e.g. a lead and different walking routes. Dependent on the appointment of a B4 wellbeing coordinator

Pledge 3 To provide support and opportunities for staff to maintain their health, well-being and safety

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Changing lifestyle behaviours		
'New Year New You' Health and Wellbeing fair	Run a similar awareness event at QMH	This event ran on contributions from volunteers
The introduction of revitalised online health and wellbeing portal	Continue to provide	3 year contract paid to 2016 £3,995
Flu vaccinations available throughout flu season	Continue and put in plans to achieve 75% compliance.	Additional resource will be needed to meet the 75% target. To be scoped.
Regular complimentary smoking cessation clinics		Cost met by Wandsworth stop smoking service
	Refresh the intranet pages on wellbeing – Timing will be in line with the wider Trust intranet review	Funding has been identified by the communications team
	Brand 'visible' health behaviours as key to a healthcare professionals role	A business case has secured the required funding from HIN and Southbank University are supporting the project
	Reduce your alcohol intake challenge	This initiative requires full scoping, i.e. from idea to implementation. It is dependent on the appointment of a B4 wellbeing coordinator
	Annual plan linking to 'national health days' to form a communication strategy to staff	Dependent on appointment of B4 wellbeing coordinator to research and coordinate

Pledge 3 To provide support and opportunities for staff to maintain their health, well-being and safety

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Emotional wellbeing		
Resilience training available to all staff	Continue to provide this	Education budget
Mediation services available to all staff		Costs already met and mediators trained
Established a partnership with Improving Access to Psychological Therapies Programme (IAPT)	Facilitate classroom based training on coping strategies	Cost met by IAPT (South West London and St George's Mental Health Trust)
Dedicated childcare adviser and access to childcare vouchers to support balancing home and work		Established post holder – costs in place.
Take a break day held in September 2015	Hold a similar event at QMH	Costs of massage and treatments met by SE Thames college
Complimentary staff support services including coaching and counselling	Extend the team and the services	Fund additional band 7 staff Counsellor
Regular Schwarz rounds	Extend for a further two years.	Costs have been met from CPPD budget.
Regular mindfulness courses		Cost met by chaplaincy
	The introduction of a not for profit credit union for staff	Payroll admin cost to be identified
	Introduction of a Pensions Advisory service for all staff	Circa £30,000 plus VAT annually.

Pledge 3 To provide support and opportunities for staff to maintain their health, well-being and safety

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Healthy eating		
Staff restaurants signed up to pledge in public health responsibility deal	Extend traffic light/ nutritional symbols to all catering areas on site	Absorbed by Mitie
Slimming world promotion for staff held in January 2016		N/A
	Introduce the sharing of healthy recipes	This will be dependent on the refreshed intranet page and the appointment of a B4 wellbeing coordinator
	Fruit boxes in clinical work areas/ staff rooms	£8.25 per box x 48 wards = £408 per month/ agreed frquency
	'Weight-loss challenge' event for staff	Dependent on appointment of B4 wellbeing coordinator to plan and implement

Pledge 3 To provide support and opportunities for staff to maintain their health, well-being and safety

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Reducing bullying		
Reviewed policy and practice and compared with GSTT and Royal Free	Restated firm commitment of EMT to not tolerate bullying and in support of engagement.	
Taken action in all cases identified by CQC in 2014.	Revised policy to be introduced including more methods of informal resolution.	
Resourced staff support service to provided coaching to managers managing poorly performing staff members.	Launch policy through series of team briefing sessions led by CE and Director of Workforce.	
Taken action against identified bullies.	Train a team of consultants as mediators.	
Made an EMT level commitment not to tolerate bullying.	Ensure that all line managers are trained in how to engage with staff.	To be included in leadership development programme.
	New violence and aggression policy including greater support to staff reporting an issue. Launch and briefings.	
Trained a team of accredited staff mediators.		

Pledge 4 - To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Listening into Action programme has been in place for 3 years and has worked with more than 30 teams across the trust.	Embed LiA into the trust more effectively. *Training for managers in facilitating staff engagement*	Review whether more resources are needed.
Liaise service has been in place for 18 months. 219 individual referrals and a series of team building support sessions. Well regarded.		Review whether more resources are needed.
100 day interviews taking place with new staff	Collate and act on the information.	
Communication channels have been reviewed. 'Ask Miles', Chief Nurse sessions.	There needs to be a further review of resources & methodology for internal communications.	To be taken forward by Director of Strategy.
	Back to the floor visits. *All staff meetings and staff champions.*	

Workforce : Diversity & Inclusion

Our Initiatives & Achievements

Unconscious Bias Training

- Rolling programme of sessions run by external trainer
- Expanded to target at all staff with line management responsibilities
- Case study for IPA/ Blue tulip training to assess benefit
- *Unconscious bias training for all*

WRES Task Group

- Reviewing WRES data
- Work with Staff Network Advisory Group to develop initiatives and improve equity of staff experience
- Review of all Acting Up arrangements to ensure a more transparent process
- Review of ER casework to identify any patterns in data

Staff Network Advisory Group

- LiA events held to connect with interested individuals
- Advisory Group is in early stages and is using a facilitated model
- Advisory Group is meeting monthly
- Working to develop a Network for Staff
- Develop an action plan

LGBT

- Joint LGBT Group formed with St George's University
- Increased visibility of LGBT staff and the LGBT group through articles in Trust's newsletter Eg. Pride, festive social event, LGBT History Month.

Mediation

- Pool of in house mediators have been trained
- Access is being made available via staff support
- Aim is to diffuse workplace conflicts on a voluntary basis before formal stages

Project Search

- Supported work placements
- Agreement in place for simplified recruitment process
- Successful recruitment into substantive posts

Demographics

- Diverse population of staff (42% BME) is higher than local population
- Further work is required to improve representation in posts Band 7 and above

Errors and incidents & patient safety

What have we already achieved?	What do we plan to do?	What are the resource implications/ costs?
Nursing forums (matrons', ward sisters', Chief Nurse surgery, student nursing). Concerns reported to EMT.		
Whistleblowing policy investigations regularly take place.		
	Speak up Guardian to be appointed by September 2016.	

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Agency expenditure ceilings and price caps

Update for the Trust Board April 2016

Excellence in specialist and community healthcare

Introduction

- Monitor introduced hourly price caps for agency staff in late 2015 along with a ceiling for nursing agency expenditure
- The aim is to support Trusts when they procure workers from agencies, and to encourage staff to return to permanent and bank working in the NHS
- We have processes in place to report any breaches of these capped rates to Monitor (NHS Improvement) on a weekly basis
- The final caps came into force on 1st April 2016
- All Trusts have been given an agency expenditure ceiling for 2016/17 for all staff groups
- We were advised of our ceiling for 2016/17 on 17th March 2016
- This presentation provides an update for the Trust board on progress to date and our proposed action plan to meet the NHS Improvement requirements.

Nursing Agency Expenditure Cap

- A target of 10% agency expenditure for nursing and midwifery staff was set in October 2015
- % spend for February was 13.6%, and cumulatively since October this is 11.6%
- The Trust will not meet the 10% target for 2015/16
- The measures in place to reduce nursing agency expenditure will continue, led by the Corporate Nursing team

Agency expenditure ceiling - all staff groups

- A ceiling for agency expenditure has been extended to include all staff groups from 1st April 2016
- NHS Improvement has set an agency expenditure ceiling for St.George's of **£23,037,000** in 2016/17
- Our anticipated agency spend for 2015/16 is at least £35,426,000
- The 2016/17 ceiling represents a 35% reduction against current spend levels

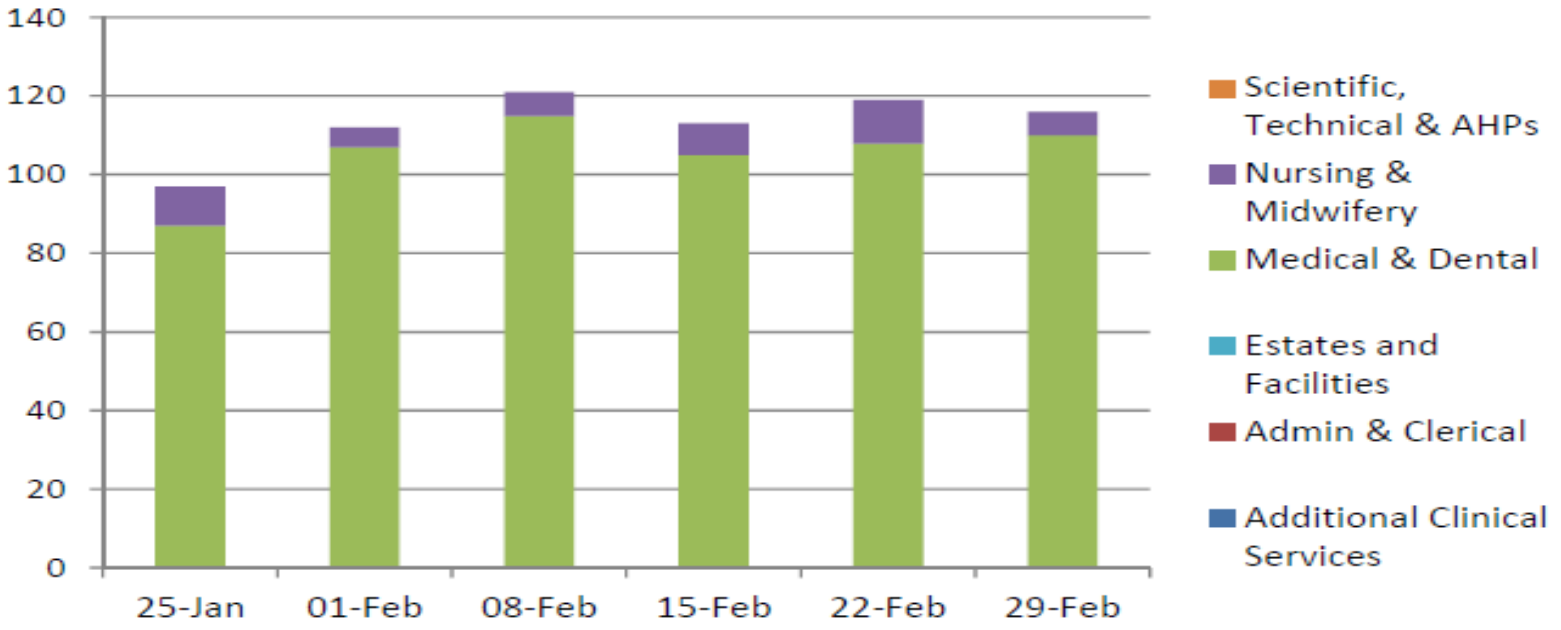
Agency expenditure ceiling – all staff groups (continued)

- The expenditure ceilings will be apportioned to the Divisions and Corporate Directorates
- Existing work to reduce agency spend through turnaround plans is being quantified to measure contribution towards meeting the reduction in spend, and any gap identified
- Regular, weekly meetings will be held with Divisional representatives to track and monitor spend against the ceiling
- The current Workforce Efficiency Group workstream targeted at temporary staffing will be used to support this process
- The implementation plan will be submitted to the Turnaround Board by 30th April

Agency hourly rate caps

- The capped rates for all staff groups have been phased in on 23rd November 2015 with further reductions on 1st February and 1st April 2016.
- All breaches of the capped rates are reported to Monitor (NHS Improvement) on a weekly basis.
- Until 1st April 2016, only framework agency breaches for nursing and midwifery staff were required but this now applies to all staff groups

Shifts Breaching the Agency Cap by Staff Group



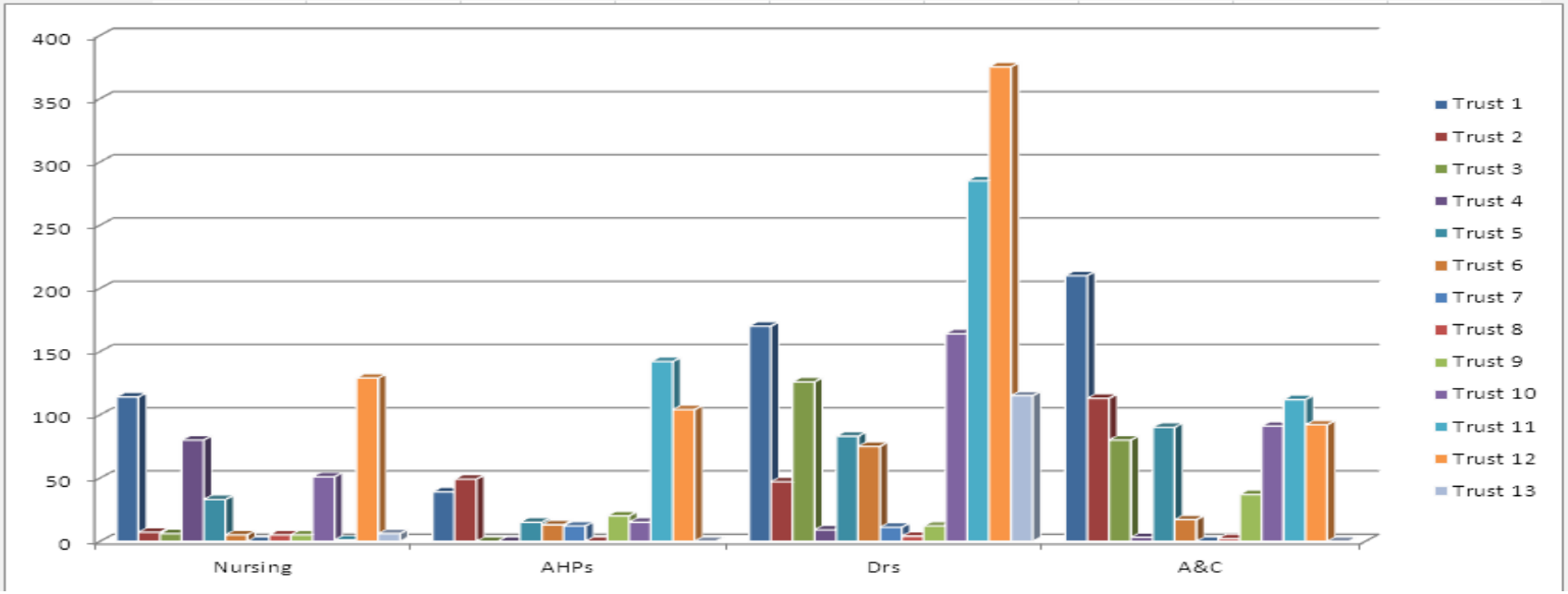
Agency Cap Shift Breaches by Staff Group	25-Jan	01-Feb	08-Feb	15-Feb	22-Feb	29-Feb	Trend
Additional Clinical Services	0	0	0	0	0	0	↔
Admin & Clerical	0	0	0	0	0	0	↔
Estates and Facilities	0	0	0	0	0	0	↔
Medical & Dental	87	107	115	105	108	110	↗
Nursing & Midwifery	10	5	6	8	11	6	↘
Scientific, Technical & AHPs	0	0	0	0	0	0	↔
Whole Trust	**97**	**112**	**121**	**113**	**119**	**116**	↘

Agency Cap Shift Breaches by Division	25-Jan	01-Feb	08-Feb	15-Feb	22-Feb	29-Feb	Trend
C&W Diagnostic & Therapy	6	4	6	5	9	13	↗
Community Services	15	16	12	12	12	15	↗
Corporate	15	15	15	16	15	16	↗
Estates and Facilities	0	0	0	0	0	0	↔
Medical & Cardiothoracics	45	61	75	69	69	66	↘
Surgery, Neurosciences & Anaes	16	16	13	11	14	6	↘
SWL Pathology	0	0	0	0	0	0	↔
Whole Trust	**97**	**112**	**121**	**113**	**119**	**116**	↘

Price cap breaches – comparison with other Trusts (week 8th- 14th February 2016)

	Nursing	AHPs	Drs	A&C	Total
Trust 1	114	39	170	210	533
Trust 2	7	49	47	113	216
Trust 3	6	0	126	80	212
Trust 4	80	0	9	3	92
Trust 5	33	15	83	90	221
Trust 6	5	13	75	17	110
Trust 7	0	12	11	0	23
Trust 8	5	0	4	2	11
Trust 9	5	20	12	37	74
Trust 10	51	15	164	91	321
Trust 11	1	142	285	112	540
Trust 12	129	104	375	92	700
Trust 13	6	0	115	0	121

St.George's is Trust 13



Investigating Breaches

- We have a weekly report of each individual breach
- We are refining our approach to reporting interims e.g. distinguishing between those covering substantive posts and special projects
- At present, the highest number of breaches is in medical locums (normally 100-110 breaches per week)
- These are mainly due to vacant posts being covered by locums until the posts can be filled
- All areas have been asked to identify a timeline for removing locums, and this will be monitored as part of the tracking process
- The latest reductions in the capped rates will result in a marked increase in the number of breaches for all staff groups, but particularly nursing and midwifery staff with an estimated 350-450 shifts per week being over the capped rates

Investigating Breaches (continued)

- Work is on-going with agencies to negotiate reduced rates to bring them below cap
- It is unlikely that rates for some specialities (critical care, midwifery and most medical locums) will be successfully negotiated below the capped rates but we will work with LPP and other Trusts on this.

Use of non-framework agencies

- The requirement to report the use of non-framework agencies will be extended to all staff groups from 1st April 2016
- This will present a problem for us for medical locums (15% of bookings are from non-framework agencies)
- We cannot source some medical locums except from non-framework agencies (e.g. HMP Wandsworth and Histopathology)
- We need to quantify the number of non-framework interims

Building up the staff bank

- We have on-going recruitment campaigns for the Staff Bank
- All new nursing and midwifery staff are automatically signed to the bank at the point of recruitment unless they opt out and this is being extended to other staff groups
- Supply for some staff groups is scarce and recruiting “pure” bank staff is challenging, in line with the general workforce supply problems that we face with substantive recruitment
- The Trust is part of the SW London Staff Bank project that we estimate will operate from October 2016 (subject to approval and agreement from all Trusts) and will increase supply rates
- We are advertising the changes in agency rates across the organisation to attract agency staff to join the Staff Bank.

Increase in Staff Bank numbers by Staff Group (internal bank) January 2015 – January 2016

As At 31-Jan-2015

Bank Posts Held	Division	Add Prof Scientific and	Additional Clinical S	Administrative and C	Allied Health Profes	Estates and An	Healthcare Scie	Medical and D	Nursing and Midwifery Re	Grand Total
Bank and Substantive	Capital Division	0	0	0	0	0	0	0	0	0
	Children and Women's Diagnostic and Therapy Services Div	13	74	41	77	5	0	2	372	584
	Community Services Division	0	52	16	15	0	0	0	97	180
	Corporate Division	2	0	35	0	0	0	1	12	50
	Estates and Facilities Division	0	0	4	0	54	0	0	0	58
	Medicine and Cardiovascular Division	1	115	22	0	2	3	4	365	512
	Refund Posts Division	0	0	0	0	0	0	0	0	0
	Research & Development Division	0	0	0	0	0	0	0	0	0
	Surgery & Neurosciences Division	65	108	8	8	19	0	1	312	521
	SWL Pathology Division	4	2	1	0	0	6	0	0	13
	Trust Locum & Bank Division	15	0	20	2	6	0	2	33	78
Bank and Substantive Total		100	351	147	102	86	9	10	1191	1996

As At 31-Jan-2016

	Percentage Increase in 12 months		28%	17%	16%	0%	44%	6-%	25%	23%
Bank Posts Held	Division	Add Prof Scientific and	Additional Clinical S	Administrative and C	Allied Health Profes	Estates and An	Healthcare Scie	Medical and D	Nursing and Midwifery Re	Grand Total
Bank and Substantive	Capital Division	0	0	0	0	0	0	0	0	0
	Children and Women's Diagnostic and Therapy Services Div	27	88	56	88	5	1	6	445	716
	Community Services Division	1	74	20	19	0	0	0	123	237
	Corporate Division	3	0	43	0	0	0	3	14	63
	Estates and Facilities Division	0	0	5	0	61	0	0	0	66
	Medicine and Cardiovascular Division	2	139	31	0	2	5	16	470	665
	Refund Posts Division									
	Research & Development Division	0	0	0	0	0	0	0	2	2
	Surgery & Neurosciences Division	51	142	12	12	20	1	0	435	673
	SWL Pathology Division	2	9	2	0	0	6	0	0	19
	Trust Locum & Bank Division	0	0	3	0	0	0	1	0	4
Bank and Substantive Total		86	452	172	119	88			1489	2445

There has been an overall increase of 23% in the internal staff bank numbers (Jan 15 – Jan 16)

Divider title Arial Bold 30pt

South West London Collaborative Staff Bank Project

Supported by

as Project Delivery Partner

Planning & Approval Phase – Executive Summary of Recommendations and Request for Approvals

Owners:	Project Board
Authors:	Daniel Elkins, Project Director
Version:	V0.4
Status:	Final Draft
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Document Control

Approval Level

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Authors:		Daniel Elkins, Project Director	
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31-Jan-16	0.1	Daniel Elkins	First Draft
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24-Mar-16	0.4	Daniel Elkins	Final Draft following meeting of DoNs & DoWs

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Related products/information		
Title/Date Published		

Executive Summary

Background

It is generally accepted that whilst the use of agency workers is sometimes necessary (particularly for last minute absenteeism), excessive use of agency workers presents a risk to patient safety and can compromise the quality of care provided as well as being more expensive. Agency workers often do not have access to Trust IT systems, are not necessarily familiar with equipment, policies and procedures used leading to a greater burden on the substantive staff and resentment if those agency staff receive high rates of pay.

The use of agency workers has been rising and so has the average rates of pay. During the last 11 months, the 5 Trusts operating in South West London, used agency workers to fill 1,012,070 hours of nursing and midwifery shifts, costing £31.7 million and equating to an average agency pay rate of £31.37 per hour. This compares to 909,215 hours for the whole of FY14/15, costing £27.5 million and an hourly rate of £30.22 per hour. This equates to a 12.2% increase in demand for agency and a 3.8% increase in pay rates.

There are many factors that have contributed to these rises and given the finite supply of some workers, it is also important to consider the supply side dynamics of the market, e.g. the needs and preferences of nurses and the aggressive selling tactics employed by agencies to promote and encourage more agency working.

SWL Staff Bank Project

The SWL Staff Bank Project has sought to identify both the demand and supply side factors, to formulate a plan of action that will slow and ultimately reverse these upward trends. Clearly altering market forces is unlikely by an individual Trust, the collaborative of the dominant NHS employers within the SW London area provides a real opportunity to have a significant impact. The aim has been to find ways to increase the number of workers wanting/willing to work via Trust banks than via agencies.

A specific task of the project was to plan the roll out of a technology solution to effectively connect the existing Trust staff banks virtually to form what is essentially a regional staff bank. The project was not tasked to establish a single shared bank for SWL or find an outsourced alternative, however, it is believed that the recommendations provide firm operational foundations for such an arrangement, if that were to follow in due course.

Over several months, the project has completed extensive postcode analysis, bank rate benchmarking, reviews of rostering policies and practices, reviewed best practices of staff bank functions and gathered available workforce information. This analysis combined with inputs from procurement experts and legal advisors have led to the Six Core Recommendations. The project has been led by the 5 Directors of Workforce, with input from the Directors of Nursing.

Agreement to the 6 Core Recommendations is now sought from the Chief Executives and where relevant, the Trust Boards, so that the project can move forwards into an implementation phase.

Benefits Realisation

The project has calculated that if 50% of agency shifts can be delivered instead via staff banks with cost reductions of approx. 30% for each these shifts then **the cost reduction for nursing and midwifery would be £4.5 million p.a. shared amongst the 5 SWL London Trusts.** The benefit for each Trust will

vary considerable depending largely on each Trust's operational starting point and their local needs (more detail has been provided in a later section to highlight the benefits to each Trust.)

The recommendations also lay the foundations for the same or similar approaches to be rolled out for AHPs, Admin and Clerical and Medical workers, potentially generating far greater cost reductions. Other London Trusts are also keen to follow SW London's lead, which would compound the benefits to cover larger catchment areas, resulting in a more significant positive effect on the market.

From a unit cost perspective, the hourly cost of an agency worker is approx. 42% higher than a bank worker. Whilst some of this reflects the agency administration that will otherwise be incurred in the form of bank staff administration, it is estimated that hourly rates could be reduced by some 30%, perhaps more if the fixed rates can be set towards the lower end of the current spectrum. Clearly the agency caps imposed by NHS Improvement will have some impact on these premiums and Trusts should do everything possible to comply and hold to their caps, in any case, the agency margin remains on average 22% so plenty of room for savings to be made. Whilst the immediate cost reduction is clearly of high importance and urgency, it is considered most important that benefits are sustainable and can be progressively implemented and increased over time.

When the recommendations are approved and the project moves into an implementation phase, then it is estimated that during the first 6 months some benefits will be realised as the approach is communicated and implemented to workers living in SW London, with the bulk of the benefits being generated within a 12 month period, after which the full monthly benefits are expected to be realised. The Six Recommendations should not be considered to be absolute and instead will provide a platform for additional improvements to be made either by individual Trusts or as a collaborative.

The benefits realisation for each individual recommendation is difficult to quantify as on their own as their individual impact may be marginal but when implemented as a package the confidence that benefits will be realised rises significantly. Similarly, given the substantial overlap of workers home addresses, if one Trust were to implement them alone, the benefits would not likely be fully realised, however, as the dominant NHS employers within the SW London postcodes the impact of collective action will be significant. A benefits calculator has been developed that each Trust can use to calculate their anticipated individual financial benefit.

6 Core Recommendations

1. **Transparency of hours worked** – Currently workers are typically able to work substantively at one Trust and work additional hours via agencies or bank at other Trusts. It is proposed that such practice should become much more transparent, such that the substantive employer is able to see each and every shift worked at any Trust whether a substantive, bank or agency shift. This is essential to ensure workers do not work unsafe shift patterns, will be used when revalidating and provides the information that managers need to understand whether workers are over-working and risking their health and well-being and the safety of patients. It is also expected to lead to better discussions between managers and their staff regarding any financial pressures that individual staff members are under. This recommendation will be achieved through amendments to employment contracts, including clauses in procurement frameworks (already done) and then systematically gathering data for it to be routinely uploaded into the e-Rostering systems. This recommendation will be beneficial to all London Trusts and perhaps nationally if NHS Improvement choose to roll it out more widely. Dir. of Nursing and Dir. of Workforce all agree that this needs to be rolled out very much as a patient safety and quality of care initiative and not a cost saving initiative, ideally at a London or national level.

2. **Controlling Demand** – Currently each Trust, and in some cases each ward, publishes their rosters at different times. This provides a regular, almost daily, flow of unfilled shifts to both bank workers and agencies. This results in competition between Trusts and all the negotiating power in the hands of the workers and the agencies, because they can refuse an individual shift in the knowledge that more will be released, perhaps later that day or the next day. The proposal is that all Trusts operate strictly to

publish their rosters 6 weeks prior to roster start and that these are made available in agreed timings to substantive staff first, then bank workers and as late as possible (subject to some exceptions) to agencies. It is also recommended that all 5 Trusts synchronise their releases such that the flow of unfilled shifts is controlled. The effect will be to highlight the preferential treatment that substantive staff and bank staff get, particularly encouraging those that want early confirmation of their shift patterns. It will also position agencies very much as a last minute option to help cover absenteeism. The Dir. of Nursing and Dir. of Workforce have agreed that the 6 week rostering should be a clear commitment to staff and have emphasised the importance of carefully timing the release of shifts, especially for specialist areas with clear shortages so that these are not negatively impacted. This recommendation will send a clear message to the market that the 5 SWL Trusts are working together and that substantive and bank workers are preferred.

3. **Capping and Fixing Bank Pay Rates** – Currently Trusts' propositions to bank staff vary considerable in terms of pay and non-pay benefits and how they are promoted. This variation results in workers in the SW London postcodes claiming that other Trusts pay higher rates (in reality this is sometimes the case and sometimes not) and this leads to a general price inflation. Whilst SWL Trusts clearly impact on each other, it is important to understand the impact of surrounding Trusts, e.g. Kings, GSTT etc. which fall outside SW London, so the wider any capping or fixing of pay rates goes the greater impact it will have. The recommendation is that rates are immediately capped such that net pay rates are no greater than the rates that staff would receive for agency work and quickly and progressively individual pay rates are fixed, subject to sign off by each and every Trust. A separate and more detailed paper have been produced to highlight the complexities of fixing pay rates and the process that it proposed.

4. **Procure Technology to create a Virtual Regional Bank** – Currently if an individual Trust is not able to fill shifts then these shifts utilising their internal or outsourced staff bank then the shifts are released to agencies. Giving the proximity and overlap of workers travel catchment areas (see postcode analysis) the early release to agencies has a negative impact on neighbouring trusts, because agencies will seek to recruit substantive and bank workers from neighbouring trusts to fill these shifts. Whilst the capacity and capability of Trust's individual staff banks will remain the responsibility of individual Trusts, supporting each other as a region will have a benefit to all SW London Trusts. The recommendation is, therefore, to procure technology that effectively creates a virtual, regional staff bank whereby unfilled shifts are published to each other's staff banks prior to releasing to agencies. Due to Croydon's successful relationship with NHS Professionals, it is not anticipated that NHS Professionals will not be willing to participate in this arrangement, however, NHS Professionals will be invited to present what they can offer through the procurement process. The technology is already available on the market with proven case studies, most notably in the West Midlands where 3 Trusts have operated a virtual bank for locums and have recently extended it to cover nurses. They quote savings of £6m for locums and anticipate a further reductions from the roll out to nursing. It is also worth noting that the competition to provide such technology is high and the costs for the technology are volume related. This means that (other than a small set up fee) costs are only incurred if the product is used and a benefit is generated. The approx. cost is 1% fee compared to an agency margin of 22%, therefore, the saving would be 21% of any shifts delivered via the platform. LPP have agreed to lead the procurement process on behalf of the 5 Trusts and any procurement will enable the platform to be expanded to cover other staff groups and Trusts without further procurement. Whilst not absolutely essential for all speciality rates, the fixing of general nursing bank pay rates is highly desirable to clearly communicate to bank workers that they receive the same pay regardless of which SW London Trust they work in. The Dir. of Workforce have discussed and agree the contractual arrangements for this virtual, regional staff bank to ensure that bank staff are able to work equally at any one of the 5 SW London Trusts without having to repeat training and employment checks. This will enhance the proposition to SW London bank workers that they can access all the shifts of the 5 SW London Trusts, albeit slightly later than if they were substantive workers but earlier than if they were agency workers.

5. **Co-ordinate activities to recruit more bank workers** – Currently each Trust embarks on its own activities to recruit more bank workers and these will be directly in competition with each other and

with agencies who equally are looking for SW London workers to register with them. Whilst it will remain the responsibility of each Trust to increase the size of their Trust staff banks, it will be beneficial to all if such recruitment is co-ordinated and maximised. This will help to strengthen the proposition for workers to prefer either substantive or bank working over working via agencies. The more consistent and clearly this proposition is presented, the higher the volumes that should be recruited to at least one of the Trust banks and the less negotiating power the agencies and agency workers will have. It is notable that the postcode analysis highlighted that whilst approx. 30% of bank only workers are substantive workers at one of the other 4 Trusts, the catchment area for each Trust's bank only workers extends the catchment area for the SW London Trusts. This suggests that staff are willing to travel from further afield for bank shifts than they are for substantive work and co-ordinated bank recruitment could help to pull workers in from outside the 4 core SW London postcodes. Ultimately, it is essential that the proposition presented to workers in SW London is equally if not more compelling than the proposition offered by agencies. Compelling, consistent and persistent campaigns via all media, especially social media, is essential to win the hearts and minds of workers in SW London to work directly for their local Trusts rather than via agencies.

6. **Mini-Competition for Agencies** – Currently approx. 81% of all SW London agency spend is with just 10 agencies and agencies are actively 'poaching' substantive staff from each other's Trusts to then supply at higher prices. LPP are currently in the process of re-procuring their nursing and midwifery framework, due to be completed in July 2016, and within that clauses have been inserted to support recommendation 1 above. In addition, there is an facility to run a 'mini-competition' whereby the long list of agencies on the LPP framework can be reduced dramatically and in exchange for chosen agencies being provided with exclusivity over the volumes from the 5 SW London Trusts, they agree can be required not to poach substantive staff from the 5 SW London Trusts and instead are focused on adding value, i.e. filling shifts that are a) required at short notice due to absenteeism and b) due to real staff shortages in given specialities whereby say 2 or 3 agencies could be selected to compete against each other to provide sufficient, high quality nurses at agreed prices – all within the NHS Improvement caps. This will enable the SW London Trusts to form stronger partnerships with a select group of quality agencies to help deliver where agencies provide added value.

Each of these recommendations will provide some benefit to each Trust but when implemented in parallel it is anticipated that this will have a marked impact on the way in which the bank and agency market in SW London operates. These benefits will be progressive and sustainable over the long term if all Trusts agree to proceed and then work closely together to get the detailed implementation right.

Financial benefits are reasonably predictable and can be sustained over the medium and long term and these provide the core foundations, in terms of consistent approach to rostering and employment checks, which will enable staff to work more flexibly across SW London, supporting other objectives of the APC.

Individual Trust Situations and Benefits

All Trusts will benefit from each of the Recommendations to some extent or other, with all London Trusts benefiting greatly from Recommendation 1 and below is a summary of how each Trust is most likely to benefit:

Croydon – Croydon already operates a tight rostering process with a fully operational and successful outsourced staff bank with NHS Professionals. Croydon has clearly stated that they do not wish to or believe that NHS Professionals will be willing to participate in Recommendation 5 regarding the virtual, regional staff bank. Croydon will particularly benefit from Recommendation 3 (Capping and Fixing of Pay Rates) as their staff are being attracted by higher bank pay rates of neighbouring Trusts to the north (Inner London waiting) to the south west (Epsom paying higher rates) and to the east (Kings paying higher rates). Croydon will also benefit from Recommendation 6 and to a lesser extent Recommendation 2 and 5.

Epsom & St Helier – St Helier hospital is located most centrally so has the greatest overlap with the neighbouring hospitals. Epsom hospital has a lesser but still significant catchment overlap. Epsom

operates a successful in-house staff bank achieving high fill rates, although this appears in part due to higher pay rates being offered. Epsom and St Helier has a great deal to benefit from all 6 Recommendations and for pay rates to be reduced this will need to be carefully done to ensure that fill rates do not significantly reduce. It may prove to be in the interests of the lower paying Trusts to slightly raise bank pay rates to increase bank fill rates and reduce agency spend. This will be a delicate balance.

Kingston – Kingston has a small in-house staff bank with limited bank only staff registered and limited opening hours. Bank pay rates are relatively low, however, shifts are often unfilled and released to agencies earlier than other Trusts. It is recommended that in addition to the Six Recommendations, Kingston consider how to build additional in-house capability, team up with one of the neighbouring Trusts to establish a Shared Service or outsources their staff bank function to NHS Professionals or another. Increasing this capability will not only benefit Kingston in terms of higher bank fill rates and lower reliance on agency workers but it will also benefit regionally because shifts will be realised later into the agency market. The virtual regional bank will also greatly support this build-up of Trust's own staff bank capability.

St Georges – As the largest of the SW London Trusts, with the closest proximity to the London transport network and the only acute Trust that pays the 5% higher pay Inner London waiting, St Georges has a considerable pull for workers in SW London. Against St Georges is its scale and the challenges with implementing operational best practices across 480 rosters. The team are committed to and working hard to consistently achieve the 6 week rosters and maximise bank fill rates, however, it is likely to take some time to fully implement. St Georges has the most to gain from all 6 Recommendations and also has most to offer to the other 4 Trusts in terms of positively impacting the SW London market. Of particular concern for St Georges is the need for specialist staff and specialist rates, particularly for critical care being one of London's 4 Trauma Centres. The fixing of pay rates will, therefore, initially focus on general nursing and then progressively look at specialist areas, where caps or exceptions may prove more applicable.

South West London and ST Georges Mental Health – As the only mental health Trust in this collaborative the overlap of qualified staff is lesser and therefore the benefits are likely to be limited in terms of qualified nurses. There is, however, a high use of Specials with dementia or other MH knowledge amongst the acute Trusts and SWLSTG has a low need for staff during night shifts. SWLSTG does operate at sites all across SW London and therefore the regional overlap is very high, meaning that they will benefit from the communications and word of mouth that the SW London Trusts are working together fixing pay rates etc. will bring. More strategically, SWLSTG will benefit more when the virtual, regional staff bank is rolled out to HCAs and admin and clerical workers and also if/when it is extended to other MH Trusts. There is also the more strategic potential for staff with MH skills to work alongside acute colleagues and for registered nurses working in acute settings to gain more mental health skills.

As summarised above, each Trust is starting from slightly different positions, has different priorities and can benefit in different ways from this project. What is clear though, is that acting as a collaborative to clearly communicate to healthcare workers living in SW London and implementing all six recommendations in parallel, will have a significant impact in terms of how the market operates. Many of the recommendations also provide essential and long term foundations not just for the 5 SW London Trusts to operate successfully in the short term but also provide the core operational foundations for a more mobile and flexible workforce, thereby supporting all the work of the SW London Acute Provider Collaborative.

Approvals Sought

Approval is sought from each and every Trust to the following:

1. To agree in principle to proceed to implement the Six Recommendations (with Croydon opting out of Recommendation 4) and to authorise engagement with operational staff and staff side representatives to carefully start their implementation.

2. To confirm your Trust's support for Recommendation 1, which will involve lobbying LPP, NHS Improvement and relevant systems providers as a collaborative to help implement the operational practicalities. As detailed above, this recommendation will need careful communication.
3. To commence the detailed work to first cap and then progressively fix individual bank pay rates, with each individual pay rate requiring sign off of an Impact Assessment by Directors of Workforce, Directors of Nursing and Directors of Finance of each Trust prior to fixing.
4. To instruct your respective Trust procurement leads to be involved in the technology procurement (Recommendation 4) and the mini-competition (Recommendation 6). Discussions have already taken place with procurement leads and PwC who are leading the procurement project to make sure this work is prioritised and does not overlap with the objectives of that project. LPP will lead the technology procurement and a Trust is yet to be confirmed to lead the mini-competition.
5. To authorise the SW London Acute Provider Collaborative to determine and allocate any project management costs required to support the implementation of these Six Recommendations. Any specific spend relating to procurement of technology or similar will be presented at the appropriate time, in accordance with existing delegated authorities.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *April 2016*

Paper Title:	**Quality and Risk Committee – Key Messages**
Sponsoring Director:	**Sarah Wilton, Non-Executive Director**
Author:	**Sarah Wilton, Non-Executive Director**
Purpose:	*To update the board on key messages from the Quality and Risk Committee held on 30th March 2016*
Action required by the board:	**For information**

Key messages

This was a full QRC meeting. The meeting was quorate although only one NED member of the committee was in attendance. One governor also attended. The committee secretary was asked to review the annual planning for QRC meetings to ensure that if possible the week after Easter is avoided in future. The Committee hoped that Sir Norman Williams would soon be able to join QRC as its third NED member.

Key matters addressed at this QRC meeting were:

* Quality Report: was reviewed in detail. The Committee noted concern at the recent backlog in compliance with NICE guidance owing to staffing gaps: a new appointment in April will help address this urgently and QRC asked for an update next month. Safeguarding training compliance, while improving in some areas, continues to be too low: QRC was assured that there are agreed actions in place for both adult and children's MAST safeguarding training and asked for a further update next month. The Complaints workshop planned for April will address the urgent need to improve both response times and quality and the evidencing of action taken, and learning disseminated, in response to complaints

* Synopsis of Significant SIs: this report was reviewed in detail. QRC was assured that all actions arising from SI investigations continue to be robustly tracked by the Patient Safety Committee. A detailed audit of completed SI reports and action plans has been undertaken in order to provide assurance to commissioners – although the findings were largely reassuring in terms of actions completed, a number of recommendations have been made in order to ensure actions are smart and that effectiveness can be robustly tested in practice. Reviewing new SI 2016/6566, the Committee noted with great concern that compliance of diagnostic follow-up, following a number of SIs arising from such shortfalls, continues to be very challenging in some areas, both from an IT and from an individual consultant compliance perspective. As QRC is not yet assured that the controls are secure in all areas, although recognises that considerable progress is being made, a further full update from the medical director to the next QRC meeting is required.

* End of Life Care: Hazel Tonge provided a detailed update on the EOLC programme which is progressing substantially as planned.

* Clinical Audit Annual Plan - update: Kate Hutt attended to provide an interim update on completion of clinical audits against the agreed 2015/6 plan and to brief QRC on progress towards finalising the 2016/7 plan and to ask for feedback. Good progress has been made across a wide range of areas - although QRC asked for more information about 'discontinued' audits and the

cross-referencing of the clinical audit to SI themes and findings.. The 2016/7 plan will be finalised in liaison with the internal auditors and be brought to QRC after review by the Patient Safety Committee in April.

* Risk and Compliance: QRC reviewed Sal Maughan's report on the Trust's updated risk reporting: it agreed that the BAF and risk register overall, and its update, including the continued currency and effectiveness of divisional risk registers will be reviewed in detail at the April seminar meeting. QRC noted that while it completes deep-dive reviews of significant risks on a cyclical basis, it was important to link this to the regular reviews of significant financial risks by the F&P Committee

* Health, Safety and Fire Report - 6 monthly update: Eric Munro attended but was only able to provide an oral report which gave limited assurance only that all matters of concern identified both in the 2014/5 Annual Report, and during the year as a result of SIs, notifications and other incidents, have been addressed. He did note that there had been a concerning fall-off in compliance with MAST H&S compliance but that urgent action was being taken by Zac Briggs to address this. Eric Munro was urged to provide a very full handover on these matters to the interim E&F director.

The Committee noted that reports from all feeder committees will be presented at the next (April) QRC meeting as this March meeting was originally planned as a seminar meeting.

Sarah Wilton
2nd April 2016

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD 7th April 2016

Paper Title:	Renal Estate up-date Report
Sponsoring Director:	Richard Hancock, Director Estates & Facilities
Author:	Sharon Welby, Assistant Director Capital Projects Peter Alesbury, Head of Estates
Purpose:	To update the Board on progress with improving the renal services accommodation in Knightsbridge Wing
Action required by the board:	For information
Document previously considered by:	None

Renal Estate Up-date April 2016

Introduction

At the January 2016 Board meeting a paper was presented outlining the escalating issues with the Knightsbridge wing accommodation and concerns relating to the changes to the Renal Development business case.

This paper provides an update on the immediate actions being taken regarding the estate in Knightsbridge Wing and an up-date on the medium / long term plans.

Immediate actions being taken in Knightsbridge Wing

Issue	Status	Owner	Open /Closed
Knightsbridge Wing Condition and compliance report by Stewart Associates	Draft Report received 1/4/2016 Report requires review and a verbal report may be provided at the Board meeting	Richard Hancock P Alesbury S Welby	Open
Heating Lack off / no heating in Knightsbridge Wing	Heating restored to Buckland Ward and Norman Tanner Unit, subject to survey review (above). Further works being undertaken to renal offices heating system.	Richard Hancock Peter Alesbury	
Electrical upgrade programme. This will reduce the risk of power and heating outages.	Parts are due to arrive 4/4/16 – Asbestos removal also required before electrical repairs can be carried out. Expected panel install date from 11/4/16 (approx. 4 weeks installation)	Richard Hancock Peter Alesbury	Open
Replacement showers installed. Increase in patient privacy, dignity and experience.	Completed	Richard Hancock Peter Alesbury	Closed
'Make good' work on Buckland ward. This involves minor works to ceilings, windows, sinks, flooring in the ward bays. Dependent on decant possibility – see below.	Three months- Subject to condition survey	Richard Hancock Peter Alesbury	Open
Decant bay creation. The service will move patients to satellite dialysis units in order to free up a four bed bay to allow for decanting patients while works carried out.	Estates to meet with the users to prioritise improvement works and agree a programme in order for the users to make plans for the closure of the 4 bed bay.	Francesca Trundle (GM)/Daniel Jones (CGL)	Open

Medium to long term renal redevelopment plans
At the recent Renal Project Board meeting (February 2016) a number of options for renal re-provision were discussed, these include:

- Grosvenor Wing – Ground and first floor
- Refurbishment of existing accommodation
- Modular development behind the Hotung Centre
- Courtyard Clinic existing accommodation plus a new 1sr floor development on top.

Grosvenor Wing has been identified as the preferred option subject to the relocation of the 1st floor Trust Management offices and part of the Medical Records back office team on the ground floor of Grosvenor Wing. The clinical team are currently reviewing the future service requirements and this will inform the new development project brief. Once the project scope has been defined costs can be worked up for funding consideration.
An architect has been appointed but not yet instructed, pending results of service review (May 2016).

Recommendation: The report is for information purposes only.

Key risks identified:

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)
If yes, please provide a summary of the key findings If no, please explain you reasons for not undertaking and EIA.

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?
Richard Hancock

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

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD – 7 April 2016

Paper Title:	**Finance Report for Month 11 2015/16**
Sponsoring Director:	Iain Lynam, Interim Chief Financial Officer
Author:	Anna Anderson, Interim Director of Financial Performance
Purpose:	To inform the Board about the Trust's financial position at the end of February 2016
Action required by the board:	For review and to identify where further action or assurance is required
Document previously considered by:	Finance and Performance Committee

Executive summary

In February the Trust had a deficit of only £0.6m compared to a plan of £2.1m. The plan was lower than plans for recent months as a capital to revenue transfer of £3.6m was expected this month. A transfer of £4.6m was actually received and this was the main factor contributing to the actual deficit being better than plan.

Cumulatively the Trust had a deficit of £49.4m which was £2.9 better than expected. As reported in previous months, the main reason for this positive position is £4.6m of underspending on pay budgets largely because the pace of recruitment, eg to posts covered by business cases and winter capacity increases, has been slower than planned. These underspends have been partially offset by continuing underperformance on SLA income, particularly for outpatients, a lower level of elective activity than planned, and higher than expected SLA penalties.

£36.9m of CIPs have been achieved to date. The Trust expects this to rise to £42.1m by the year end.

The cash balance at the end of February was £13.4m, £10.4m more than in the original plan. In addition, use of the working capital facility was £13.5m lower than expected so overall the cash position was £23.9m better than plan. Since the end of the month, positive progress has been made in securing payment from NHSE for overperformance on its contract.

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.

Capital spend is continuing to be slowed down as part of the overall cash management plan and to date spend has been £27.1m, £19.6m less than the revised plan.

Based on bottom up forecasts by Divisions, the year end outturn is still expected to improve to a £54m deficit, £2m better than the revised plan.

The focus now has to be on finalising SLAs, budgets and transformation plans for 2016/17

Key risks identified:

The need to balance financial measures with maintaining the quality of patient care.
The need to improve staff morale in the light of the last staff survey and the impact of financial challenges.
The impact of one off measures this year on 2016/17.
The tension between reducing capital spend and addressing urgent needs for capital investment in the estate and IT.

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

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

St George's Healthcare NHS
NHS Trust

Appendix A:

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

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

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

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

1.2 Describe the purpose of the service / function / policy? *Who is it intended to benefit? What are the intended outcomes?*

1.3 Are there any associated objectives? *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives*

1.4 What factors contribute or detract from achieving intended outcomes?

1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights

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

Summary Finance Report
Month 11 2015/16

Finance and Performance Committee 30th March 2016

1. Month 11 Headlines & Actions – Income & Expenditure

Area of Review	Metric	Key Highlights	Actions	RAG
Overall financial performance in February	Deficit of £0.6m in the month, £2.1m better than reforecast	Performance is £2.1m better than plan due to £1m more capital to revenue income than in the reforecast, and continuing underspends due to business case slippage. No further CIP budget adjustments were made this month or are expected to be made in M12.	• Finalise impact of year end accounting (partially completed spells, bad debt provisions etc.) on the forecast year end position. • Ensure 15/16 spend/income is captured and recorded correctly so it is accounted for in the right year. • Conclude negotiations with commissioners about relief from contract penalties.	
Overall financial performance - year to date	Year to date deficit of £49.4m against plan of £52.3m i.e. £2.9m better	Month 11 cumulative performance is better than budget due to: • Pay underspends, as assumptions about recruitment in the reforecast were too optimistic. • £1m more capital to revenue income than in the reforecast Income continues to be below plan despite a lower reforecast plan.	As above	
Activity/Income	Income is £3.1m below plan for the year to date	Actual activity across all areas other than A&E was below plan for February. Elective income under performance is partly due to unplanned theatre closures, changes to theatre schedules and adjustment to marginal rate calculations for neuro rehab. Outpatient activity continues to underperform against plan and penalties continue to be high. YTD position includes the extra £1m capital to revenue income .	• Identify ways to minimise the negative impact of theatre changes and closures for unplanned maintenance • Ameliorate further commissioner challenges by improving performance against targets. • Complete work to address RTT pressures	
Expenditure-Pay	Pay budgets are £4.6m below year to date plan and £0.3m better than plan in month	Pay spend in month 11 shows an increase in agency costs. This is due to a combination of higher usage and recording of agency invoices previously not captured on the ledger. The large underspend to date is mainly in nursing, non clinical and scientists/ therapists. This is due to recruitment difficulty and, slippage on plans to increase capacity and other business cases.	• Continue work to remove agency use in non nursing areas and/or switch to bank or permanent appointments • Continue work to improve accuracy of pay spend reporting • Continue challenging all new appointments through the vacancy panel	
Expenditure-Non Pay	Non pay for the year to date is £2.1m worse than plan (£0.1m worse than plan in month)	The cumulative M11 position is mainly due to: • Drugs overspend due to use of more high cost drugs and greater commercial pharmacy activity (covered by income over performance). • Clinical consumables under plan due to lower SLA activity levels	• Continue actions to ensure compliance with SFIs in the procurement of goods and services. • Continue implementing bold non pay proposals	
CIP	£36.9m savings delivered to date against £34.9m plan	Of the £36.9m delivered to date £19.6m is CIPs and £17.4m is non recurrent or run rate savings. Of the £42.1m total schemes expected to be delivered this year £37.1m, or 88%, are green .	• Continue to work on remaining schemes as well as developing transformation/divisional CIPs for 2016/17	
Forecast outturn	£54m deficit	Based on year end forecasts from divisions and an assessment of risks, e.g. additional NHSE contract penalties, and a possible upside on pay spend, the year end outturn is estimated to be a deficit of £54m which is £2m better than the revised budget. An improvement in community of £1m is offset by expected balance sheet changes.	As above in top box.	

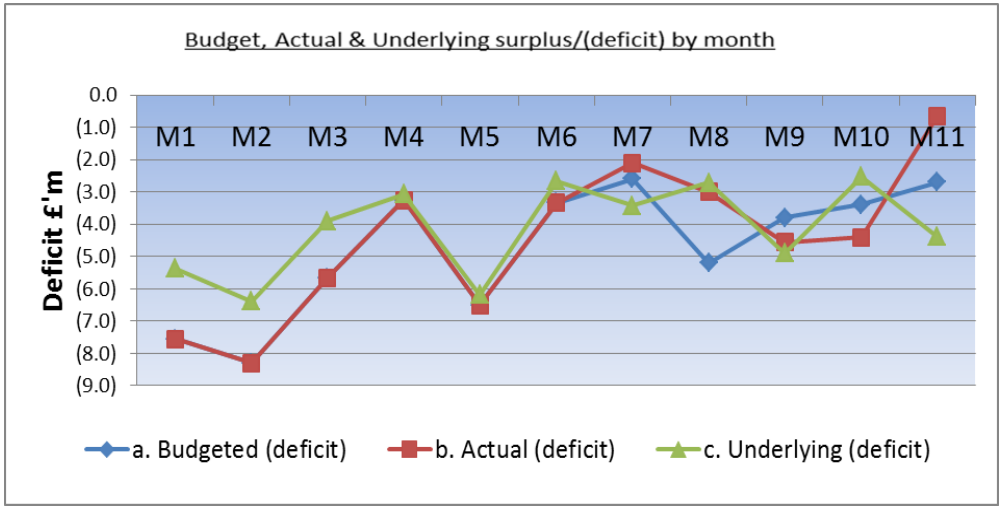
2. Month 11 Headlines & Actions – Cash and Capital

Area of Review	Metric	Key Highlights	Actions	RAG
Cash	Cash balance £13.4m	The M11 actual cash balance was £13.4m (£10.4m higher than original plan) including cumulative WCF drawdowns of £36.4m. The M11 plan cash balance was £3m including cumulative WCF drawdowns of £49.9m. Therefore the overall cash position was £23.9m better than plan. The cash balance reduced by £8.5m in month due to the unwinding of cash measures taken before Christmas – eg deferral of CNST premiums and rental payments to NHS Property Services. The Trust received some 14/15 aged debt receipts from NHS England however no payments have been received from them for any 15/16 SLA over-performance. The Trust escalated this matter again in early March (see below).	The Trust drew down £36.4m on 15th February to repay the amounts drawn to date under its two working capital facilities to reduce interest costs. A drawdown of £4m for 14th March was approved by Monitor and the ITFF at the end of February which will bring cumulative ISF borrowings to £40.4m compared to £52.2m per the original plan. The Trust is continuing to implement bold actions to reduce the I&E deficit and minimise borrowings. The year end forecast cash balance is £9.8m.	
Capital	YTD spend £27.1m, £19.6m less than plan	Capital expenditure was £1.4m in February. Year to date expenditure is £27.1m which is £19.6m 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. Additional investment is proposed for infrastructure renewal in 2016/17 to address high priority estates areas.	
Working Capital	YTD movement -+£6.2m, £14m better than Plan	Working capital deteriorated by £4.1m (YTD+£6.2m) in month due primarily to the reversal of the benefit of the HEE quarterly payment received in January and also the payment of CNST premium and NHSPS rental charges in February that had been deferred from earlier in the year. However working capital performance YTD remains significantly better than plan. Overdue NHS debt is still high mainly due to non payment of in-year over performance by NHS England but there has been some improvement in February and further reductions are expected in March. Stock reduced by £0.2m in M11.	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. NHS England over performance debt remains the highest risk to the year end working capital position however the Trust received £7.2m from NHSE on 22nd March. Stock needs to reduce by approx £1.3m in March to achieve the year end forecast.	
FSRR (formally COSRR)	Rating of 2 compared to plan of 1	The Trust's financial sustainability risk rating for month 11 (February) is 2 which is ahead of plan. The rating reflects a better than planned cash balance and deficit position.	With continuing efforts to deliver savings and strong cash management the forecast year end rating for the Trust is 2.	

3. Overall Position for the 11 months to 29th February

Note: YTD variances reflect variances from Oct (M7)

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	615.2	55.4	56.1	0.7	562.7	559.6	(3.1)
Other Income	106.2	8.7	9.9	1.2	96.2	99.3	3.1
Overall Income	**721.4**	**64.1**	**66.0**	**1.9**	**658.9**	**658.9**	**0.1**
Pay	(462.9)	(39.4)	(39.1)	0.3	(422.9)	(418.4)	4.6
Non Pay	(280.2)	(24.5)	(24.6)	(0.1)	(256.7)	(258.8)	(2.1)
Overall Expenditure	**(743.1)**	**(63.9)**	**(63.7)**	**0.2**	**(679.7)**	**(677.1)**	**2.5**
EBITDA	(21.7)	0.2	2.3	2.1	(20.8)	(18.2)	2.6
Financing Costs	(34.4)	(2.9)	(2.9)	(0.0)	(31.5)	(31.2)	0.3
Surplus / (deficit)	**(56.1)**	**(2.7)**	**(0.6)**	**2.1**	**(52.3)**	**(49.4)**	**2.9**



Commentary

- Performance is reported against the revised plan to achieve a £56.1m deficit at the end of the financial year as agreed by the board in January .
- The February deficit of £0.6m was £3.8m lower than the deficit in M10 and £2.1m better than plan. The M11 position includes £4.6m capital to revenue income (£1m more than plan) which has contributed to the lower deficit along with a smaller patient activity income shortfall and slippage in business cases.
- The cumulative deficit of £49.4m is £2.9m better than plan primarily due to pay underspends associated with delayed business cases, escalation areas not opened and recruitment challenges, and some additional non SLA income including the extra capital to revenue transfer referred to above.
- **SLA income** in February is £0.7m better than plan mainly as a result of the extra £1m capital to revenue transfer than planned. Cumulative SLA income is £3.1m under plan due to under performance on outpatient, elective and non elective activity and higher income challenges/penalties than expected.
- **Pay** spend this month increased by £0.4m compared to M10 but is still slightly better than plan. Cumulatively pay budgets are £4.6m underspent.
- **Non pay** overspend to date relates to high cost drugs and commercial pharmacy spend above plan and offset by extra income.
- Monthly underlying deficits shown in the graph are updated each month to reflect new information. The M11 underlying deficit of £4.4m, is worse than the £3.6m average since turnaround (i.e. from M4). This reflects the increase in underlying expenditure this month which is not matched by underlying income growth.

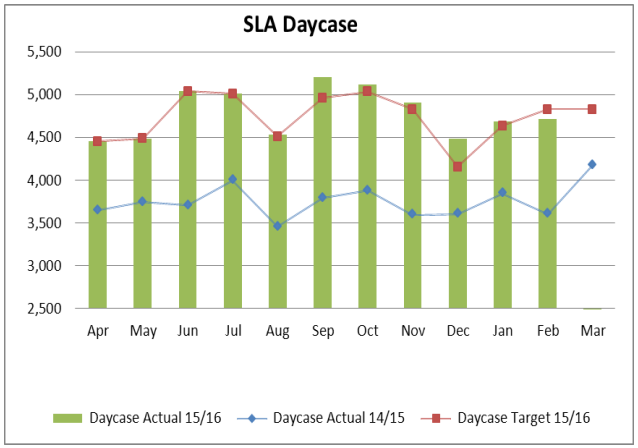
4. SLA Income for the 11 months to 29th February

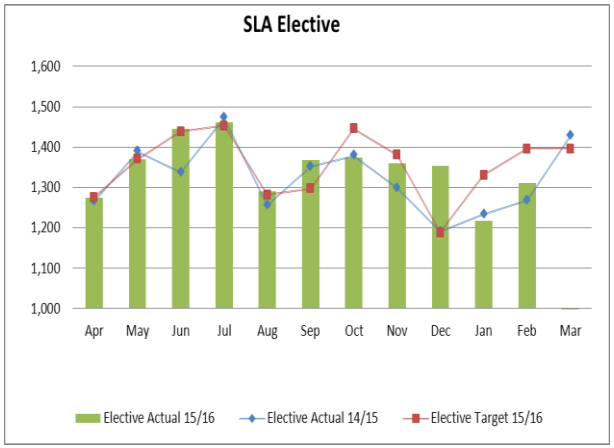
Activity	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
A&E	18.5	1.5	1.4	(0.0)	16.9	16.7	(0.2)
Bed Days	59.0	5.2	5.0	(0.2)	53.6	52.8	(0.7)
Daycase	30.6	2.6	2.8	0.2	27.9	28.4	0.5
Elective	67.1	5.7	5.3	(0.5)	61.3	59.9	(1.5)
Non Elective	121.2	9.7	9.8	0.1	110.8	109.9	(0.9)
Outpatients	139.1	12.2	12.0	(0.2)	126.9	125.2	(1.8)
Pass-through drugs & devices income (HCD)	74.6	6.3	6.4	0.2	68.4	70.3	1.9
Community Block	49.7	4.2	4.1	(0.1)	45.5	45.7	0.2
Fixed Block (HIV)	21.7	1.8	1.8	0.0	19.9	20.0	0.0
Unbundled (Chemotherapy & Diagnostics)	20.8	1.7	1.8	0.1	19.0	19.1	0.0
In Patient Deliveries	11.1	0.9	0.8	(0.0)	10.1	10.0	(0.1)
Out Patient Regular Attenders	4.2	0.3	0.3	0.0	3.9	3.9	0.1
Challenges/Penalties	(10.3)	(1.4)	(1.6)	(0.2)	(8.6)	(10.4)	(1.8)
Other (Ex SLA)	4.4	1.1	1.4	0.3	3.4	3.6	0.2
Other Income (Capital to Revenue income)	3.6	3.6	4.6	1.0	3.6	4.6	1.0
Grand Total	**615.2**	**55.4**	**56.1**	**0.7**	**562.7**	**559.6**	**(3.1)**

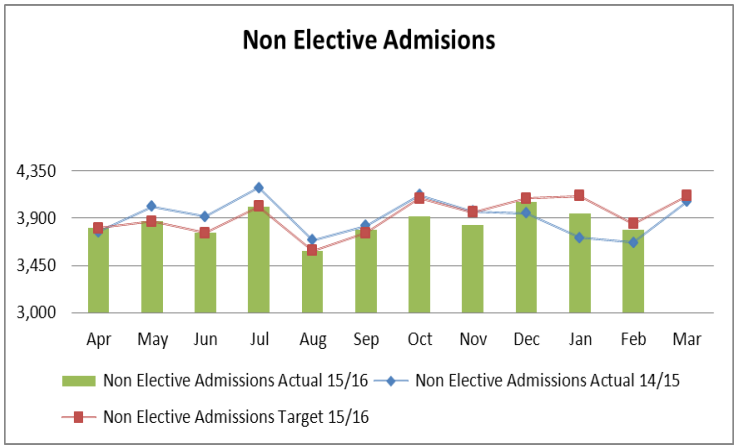
Commentary

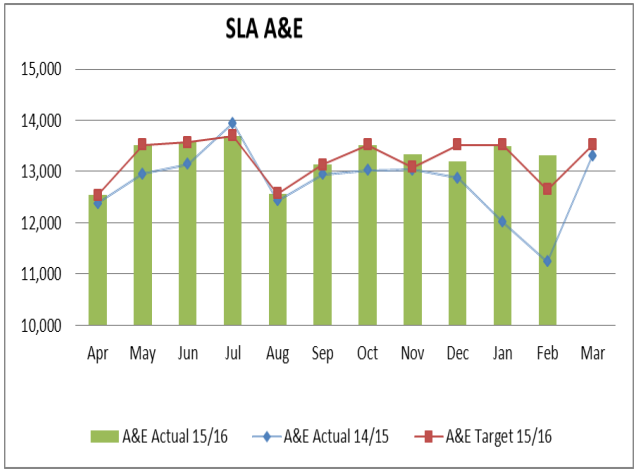
- The February income budget is £0.6m lower than January reflecting the lower number of working days in the month.
- SLA income is £0.7m under plan in the month and £3.1m below plan for the year to date, this includes the £1m additional capital to revenue income from NHSE. Excluding the capital to revenue transfer, income for patient activity is £0.3m lower than plan in month and £4.1m lower than the year to date plan. Penalties account for £1.8m of the shortfall to date, elective activity £1.5m and outpatient activity £1.8m. In contrast, pass through income for drugs and devices is £1.9m higher than expected.
- Admitted elective income has underperformed in the month especially within neurosciences due to slippage on the gym business case. Cardiac surgery was below plan in February due to the transition to the new Hybrid Theatre when 2 operating days were lost.
- Activity trends are shown on the next slide

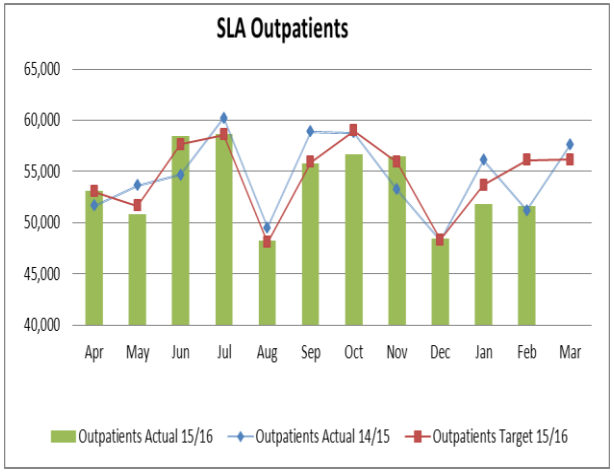
5. Patient activity compared to plan for the 11 months to 29th February











Commentary

- Actual activity across all areas other than A&E was below plan in February.
- Actual activity is consistent with activity reported in the previous month but there has been an increase in elective work as the Trust works toward the RTT trajectory target.
- The shortfall in outpatients is mainly in T&O due to lower activity at the Nelson and within Neurosciences due to the delayed business case on the acute site.
- A & E activity is 4% higher than last year and outpatients are 1% lower than last year.

6. SLA Income by Commissioner for the 11 months to 29th February

Income	Annual Budget (£m)	Year to Date		
		Budget (£m)	Actual (£)	Better/(Worse) than Budget
NHSE Specialist	212,854	193,521	207,000	13,479
NHSE Public Health	23,434	21,466	21,415	(51)
NHSE Secondary Dental Care Services	8,708	7,967	7,856	(111)
NHSE Cancer Drugs Fund	2,882	2,569	3,652	1,082
NHSE SPECIALIST (IFR)	0	0	13	13
NHSE - HEPC	0	0	914	914
Public Health England	422	387	938	552
Subtotal NHSE	**248,299**	**225,910**	**241,788**	**15,878**
NHS Wandsworth CCG	146,926	134,422	135,569	1,146
NHS Merton CCG	58,570	53,559	57,188	3,629
NHS Lambeth CCG	19,964	18,255	18,771	517
NHS Croydon CCG	21,334	19,499	20,644	1,144
NHS Sutton CCG	13,449	12,293	12,320	28
NHS Kingston CCG	12,912	11,808	11,341	(467)
NHS Richmond CCG	11,818	10,814	11,071	257
SURREY CCG	19,892	18,181	18,271	90
Other CCGs	20,871	19,039	17,124	(1,915)
Subtotal CCGs	**325,737**	**297,871**	**302,300**	**4,429**
NCA	8,440	7,716	7,026	(691)
Other Trusts	1,060	969	1,153	184
Other Local Authority	7,261	6,653	7,005	352
Subtotal CCGs	**16,760**	**15,339**	**15,184**	**(155)**
Internal Targets: Growth, Business Cases etc	14,889	15,051	(9,725)	(24,776)
Ex SLA Income	5,930	4,900	5,462	562
Total NHS Healthcare Income	**611,615**	**559,071**	**555,009**	**(4,062)**
Additional Income				
Private & Overseas Patient	5,459	5,002	6,106	1,104
Road Traffic Accidents (RTAs)	4,182	3,831	3,416	(415)
Other Healthcare Income	237	223	218	(5)
Education and Training Levy Income	44,258	40,591	41,142	551
Other Income	55,667	50,140	52,979	2,839
Total Other Income	**109,803**	**99,787**	**103,860**	**4,074**
Total income	**721,418**	**658,858**	**658,870**	**12**

Commentary

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

The Trust is over performing by £16m on the NHSE contract and nearly £6m on contracts with local CCGs (Wandsworth, Merton and Croydon). The NHSE specialist over performance mainly relates to High Cost Drugs.

The Trust set an additional internal target of £26.6m now reduced to £15m to reflect patient activity that was expected over and above agreed contract values.

The Trust is below its total internal SLA activity targets by £4m year to date but £20m over commissioners' plans.

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 11 months to 29th February

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

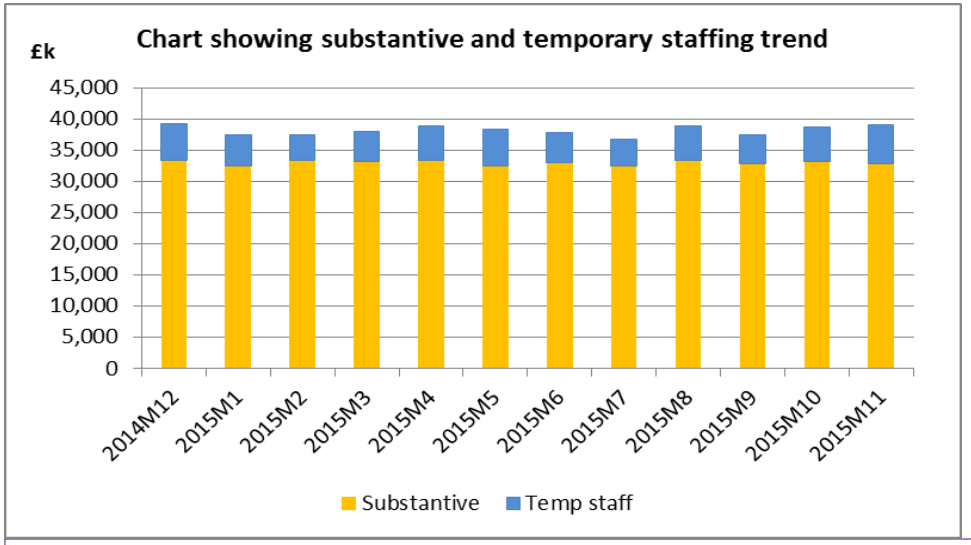
Pay Summary by Staff Type	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Consultants	(72.7)	(6.2)	(6.0)	0.2	(66.5)	(66.7)	(0.2)
Junior Doctors	(50.6)	(4.3)	(4.2)	0.0	(46.3)	(46.3)	0.1
Non Clinical	(78.1)	(6.6)	(6.4)	0.2	(71.4)	(69.7)	1.7
Nursing	(178.8)	(15.7)	(15.4)	0.2	(163.2)	(161.2)	1.9
Scientists, Technicians, Therapists	(82.6)	(7.1)	(7.0)	0.1	(75.4)	(74.5)	1.0
Unallocated (Pay Provisions)	(0.2)	0.4	0.0	(0.4)	(0.1)	0.0	0.1
Grand Total	(462.9)	(39.4)	(39.1)	0.3	(422.9)	(418.4)	4.6

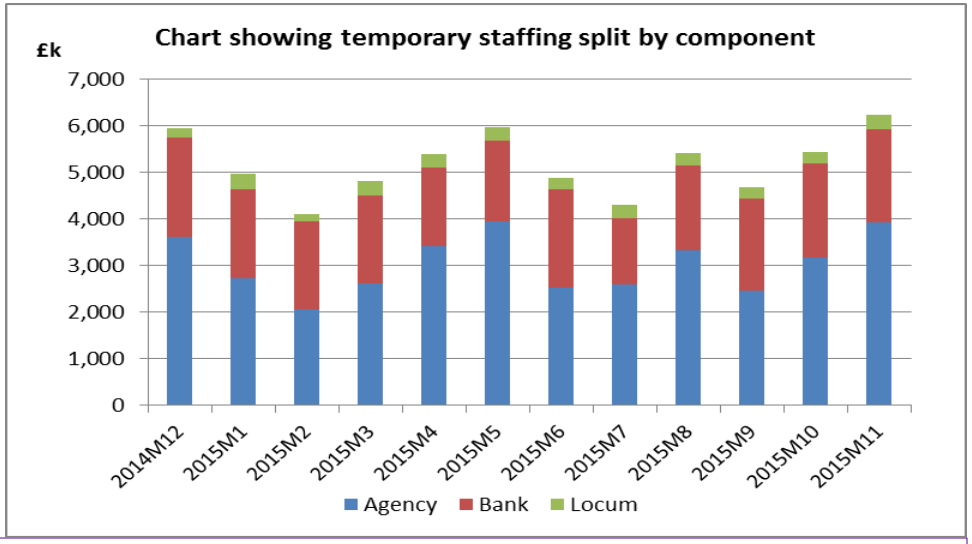
2. Monthly Pay trend by Staff-type	M1 £m	M2 £m	M3 £m	M4 £m	M5 £m	M6 £m	M7 £m	M8 £m	M9 £m	M10 £m	M11 £m	Total £m
Consultants	(5.8)	(5.8)	(5.9)	(6.4)	(5.9)	(6.2)	(5.9)	(6.3)	(6.2)	(6.2)	(6.0)	(66.7)
Junior Doctors	(4.3)	(4.2)	(4.2)	(4.2)	(4.3)	(4.0)	(4.2)	(4.4)	(4.1)	(4.2)	(4.2)	(46.3)
Non Clinical	(6.1)	(6.0)	(6.1)	(7.5)	(6.6)	(6.3)	(6.0)	(6.5)	(6.0)	(6.2)	(6.4)	(69.7)
Nursing	(14.6)	(14.7)	(15.0)	(14.1)	(14.5)	(14.6)	(14.0)	(14.9)	(14.5)	(14.8)	(15.4)	(161.2)
Scientists, Technicians, Therapists	(6.6)	(6.7)	(6.8)	(6.6)	(7.1)	(6.7)	(6.6)	(6.6)	(6.6)	(7.1)	(7.0)	(74.5)
Grand Total	**(37.4)**	**(37.4)**	**(38.0)**	**(38.8)**	**(38.4)**	**(37.8)**	**(36.7)**	**(38.8)**	**(37.4)**	**(38.7)**	**(39.1)**	**(418.4)**
Average per qtr :			**(37.6)**			**(38.3)**			**(37.6)**			

Commentary

- Pay this month is £0.3m lower than plan and cumulatively £4.6m less than the plan to date with the biggest variances on nursing, therapy and non clinical staff groups, as in previous months. These reflect delays in business cases, recruitment challenges and escalation areas not used.
- Pay spend in February was £0.4m higher than January and £1.2m (3%) more than monthly average spend for the previous 3 quarters due to:
  - £0.4m increase in nurse agency bookings
  - £0.3m previously unregistered nurse agency invoices not matched by shifts on Health Roster and £0.1m underestimate in M10 agency accruals
  - £0.2m increase in Research and Development pay spend which is fully recovered via income.
  - £0.1m DoH seconded staff (Jan – August) for the South West London Provider Collaborative project
- Over half of the increase in spend relates to periods before February and shows that work needs to continue to improve systems for capturing accurate information on pay spend.
- The adverse variance against 'Unallocated pay provisions' follows a coding tidy-up to clear the annual budget on that line (reduced from £0.8m shown last month)

8. Pay trend for the 11 months to 29th February





Commentary

- The proportion of total pay spend relating to use of bank staff was 5% in February, comparable to the average for the first 3 quarters.

- However the proportion of pay spend this month relating to agency staff has increased to 10% which is significantly higher than the 7.5% average for quarters 1- 3. This reflects higher use of agency staff in February and invoices previously not reflected in the ledger and relating to prior months as explained on the previous page. The transaction processing team will now register invoices with signed timesheet, but without booking details, on a central cost centre while the correct allocation is determined so that invoices can be included in agency spend reported.

- Department of Health caps on nurse agency spend came into effect in October and the cap for the Trust for Q3 & Q4 is 10% of total nursing spend.
- M11 actual nurse agency spend was 13.6%, excluding the impact of prior months' invoices (invoices recorded this month for prior months is reflected in the cumulative nurse agency spend of £7.6m against total nursing pay of £65.3m i.e. 11.6%.
- Spend for all months since the monitoring started in October has been worse than the Department of Health 10% target and the transformation workforce work stream is working on reducing agency spend.

- Work is also in progress to avoid breaching other temporary spend controls e.g. on maximum rates of pay and use of frameworks.

- The HR team is continuing to work to ensure all departments book agency staff via the bank office focusing on areas of low compliance. This will improve control & reduce the estimation required each month and also allow better information on headcount.

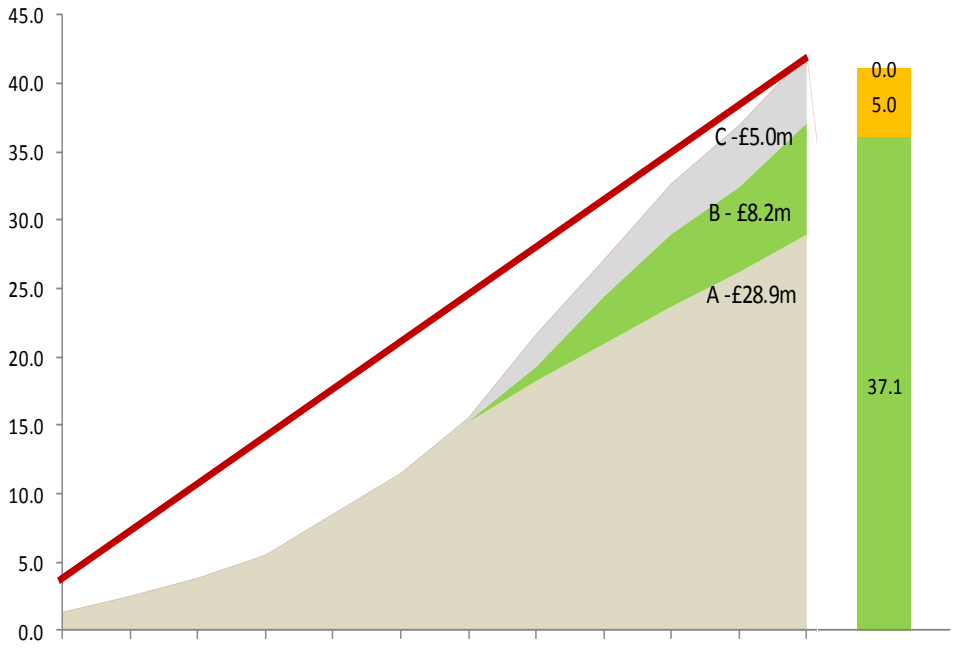
9. Non pay costs for the 11 months to 29th February

Non Pay Category	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
Clinical Consumables	(97.6)	(8.2)	(8.4)	(0.2)	(89.3)	(87.5)	1.8
Drugs	(61.3)	(5.3)	(5.8)	(0.5)	(56.3)	(59.6)	(3.3)
Premises	(43.7)	(3.8)	(3.6)	0.1	(39.7)	(39.7)	0.0
Clinical Negligence	(15.1)	(1.2)	(1.3)	(0.0)	(13.8)	(14.1)	(0.3)
Establishment	(11.2)	(0.9)	(0.9)	0.0	(10.2)	(10.2)	0.0
General Supplies	(14.6)	(1.4)	(1.4)	0.0	(13.7)	(13.3)	0.4
Non Pay Unallocated	(0.0)	(0.0)	0.0	0.0	(0.0)	(0.0)	(0.0)
PFI Unitary payment	(7.0)	(0.6)	(0.6)	0.0	(6.4)	(6.4)	(0.0)
Reserves	(0.2)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Prior Year Costs	(1.3)	0.0	0.0	0.0	(1.3)	(1.3)	0.0
Old Year Creditor Adjustments	1.4	0.2	0.2	0.0	1.3	1.0	(0.3)
Consultancy	(7.3)	(0.6)	(0.7)	(0.1)	(6.6)	(6.5)	0.1
External Facilities	(8.2)	(1.1)	(1.1)	(0.0)	(7.2)	(7.0)	0.2
Other NHS Facilities	(6.4)	(0.5)	(0.4)	0.1	(5.9)	(5.4)	0.5
Other	(7.9)	(1.1)	(0.7)	0.4	(7.4)	(8.6)	(1.2)
Grand Total	**(280.2)**	**(24.5)**	**(24.6)**	**(0.1)**	**(256.7)**	**(258.8)**	**(2.1)**

Commentary

- In M11 non pay spend was £0.1m higher than planned and cumulatively it is £2.1m higher than plan. AS previously reported, the overspend in month and to date is driven by drugs overspending which is recoverable via income from commercial pharmacy activity and, commissioner reimbursed high cost drugs.
- Clinical consumables spend to date remains under budget as a result of slippage against various business cases.
- The adverse variance against 'Other' is due to cross charges for which there is offsetting favourable income (relates to cross charges for SWLP).
- M11 non-pay spend increased by £1.1m above M10. The increase mainly comprises of £0.5m on drugs (offset by £0.8m increase in commercial pharmacy & excluded drugs income) and £0.4m on clinical consumables (new robot in clinical genetics and increases in imaging consumables and Trust pathology costs driven by activity).

10. Trust CIP performance



Total CIP schemes reported to date - £42.1m. Of which -
A - £28.9m forecast against £30.7m embedded in reforecast £63m deficit plan
B - £8.2m new schemes which will improve the reforecast £63m deficit plan
C - £5.0m schemes reported as CIP but are embeddedin the £63m reforecast deficit plan

RAG rating of £42.1m schemes

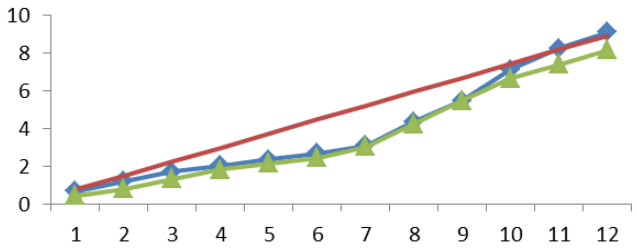
Commentary

- The original CIP target for 2015/16 was £38.1m. The chart alongside shows CIP plans and delivery against this original £38.1m target
- In the year to date the Trust has delivered £36.9m of savings compared to a plan of £34.9m. Of the £36.9m delivered so far, £19.6m is CIPs and the balance of £17.4m is non-recurrent run rate/vacancy control savings
- The baseline forecast £63m deficit plan required delivery of £30.7m CIP embedded in the revised plan. The forecast against this is currently at £28.9m as forecasts for a number of schemes have been reduced.
- £8.2m CIP has been added to the forecast and will improve the trust position – this includes SWLEOC (£0.6m) and Mitie contract renegotiation (£2.2m non-recurrent), delays in opening winter capacity and funding from the St George's charity, as well as run rate savings. These new schemes have been removed from the budgets. *Can we say how much more is expected before year end instead*
- A further £5.0m 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 £42.1m CIP reported, £37.1m is Green
- Looking to 2016/17 the extra full year effect of 2015/16 schemes is £5.1m however this is more than offset by the loss of 2015/16 non recurring schemes of £20.0m.

11. Trust CIP performance - divisions

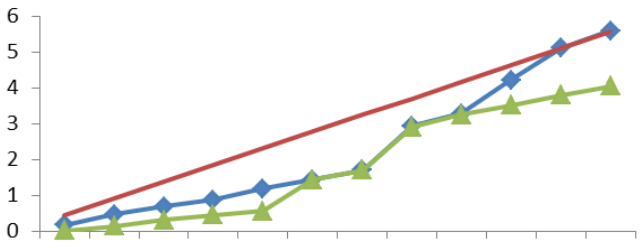
Children and Women

£9.1m schemes have been developed against the £8.9m target so the gap has been closed. To date £80k more than plan has been saved. Green schemes are 89.7% of the total identified so far.



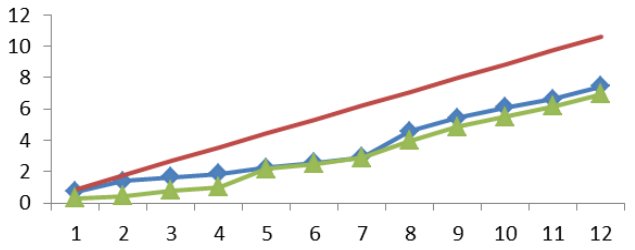
Community Services

£5.6m schemes have been developed against the £5.6m target. Year to date is slightly up on on target, at £15k over. Green schemes are 72.3% of the total.



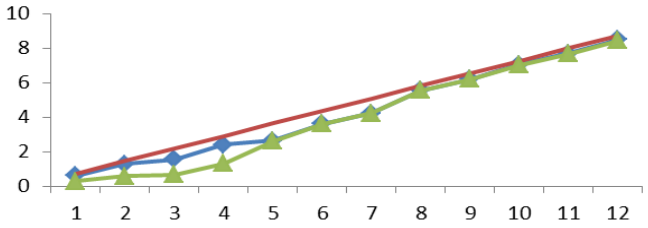
Medicine & Cardiovascular

£7.4m schemes have been developed against the £10.6m target. The gap is £3.2m. Year to date underperformance is £3.1m. Green schemes are 93.4% of the total.



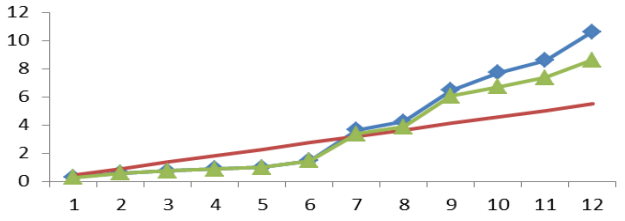
Surgery and Neurosciences

£8.5m schemes have been developed against a £8.7m target. The gap is £0.2m, expected to be closed in M12. Year to date savings are £0.3m below plan. Green schemes are 99.5% of the total.



Overheads

£10.6m schemes have been developed against a £5.5m target. In the year to date £3.5m more than plan has been saved. Green schemes are 81.2% 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.
- Overhead departments' performance has improved significantly.
- The biggest forecast shortfall is £3.2m in Medicine.
- Further work is on-going to firm up on red/amber schemes and to complete governance processes so they can become green.
- Focus is now on the 16/17 programme

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

12. Divisional Summaries for the 11 months to 29th February
KEY HEADLINES

St George's University Hospitals NHS
NHS Foundation Trust

Area of Review	Key Highlights
Medicine & Cardiovascular	The division's performance in month and cumulatively is in line with plan. SLA and 'other' income (mainly RTA income) under performance is offset by pay underspends. Some of the pay underspend is attributable to lower than expected use of specialling, and also more vacancies in A&E through the winter period . The division forecasts to be in line with the reforecast plan at the year end.
Surgery, Neurosciences Theatres & Cancer	The division's contribution of £1.6m in month is in line with plan and the cumulative contribution is £0.2m below plan. Cumulative adverse position comprises of income underperformance due to increase in penalties, impact of theatre closures on elective work and delays to the Neuro gym business case. Most of the income under performance is mitigated by expenditure underspends related to delays to the business case, reduced use of the private sector and more 'other' income than planned (private patient/overseas income, Gibraltar income and SWLEOC profit share). The division expects to end the year with a £21.1m contribution, £0.4m below the reforecast. This is due to unplanned theatre closures and continued delays to the Neuro gym business case.
Community Services	The division's performance was £1m better than plan in January and £1.7m better than plan for the year to date. The better than expected M11 position is due to £0.5m higher income, due to improvement in penalties and outpatient activity, continuing pay underspends, especially in CAHS, and GU drugs underspend. The cumulative position reflects recruitment difficulties (CAHS service) and better income than planned. The forecast outturn for community services division is £2.1m better than the planned £21.7m surplus in the reforecast plan.
Children, Women & Diagnostics	The cumulative deficit for CWDT is £1.6m better than plan and the February deficit is £0.3m better than plan. In month position is due to a catch- up on recharges to Medicine for outliers in Champneys Ward and a greater contribution from Pharmacy wholesale dealer commercial activity. The favourable variance to date is due to higher than planned commercial pharmacy activity contribution and pay underspends reflecting low use of planned additional outpatient clinics and slower recruitment of scientific/therapeutic staff vacancies. The lack of uptake of outpatient additional clinics is reflected in outpatient income under performance across the acute clinical divisions. The division is forecast to be £1.6m better than the £11.6m planned deficit in the reforecast.
Overheads	Overhead costs are broadly in line with plan this month and £0.2m better than plan for the year to date. While the corporate directorate is over spent against plan due to higher than budgeted turnaround costs, Estates & Facilities directorate is under spent (higher recharge to Moorfields for use of premises and underspends on energy, domestics & catering as a result of lower patient volumes and a milder than

Medicine & Cardiovascular - Divisional I&E for the 11 months to 29th February

Medicine and Cardiovascular

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
A&E	17.4	1.4	1.4	(0.0)	15.9	15.8	(0.1)
Daycase	11.8	1.0	1.1	0.1	10.8	11.0	0.3
Elective	23.8	1.9	1.8	(0.1)	21.9	21.7	(0.1)
Pass-through drugs/devices/programme	48.2	4.1	3.9	(0.2)	43.8	45.0	1.2
Non Elective	64.6	5.1	5.2	0.1	59.1	59.5	0.4
Other	17.6	1.5	1.2	(0.3)	16.2	15.4	(0.8)
Outpatients	35.6	3.1	3.0	(0.0)	32.5	32.1	(0.5)
	218.9	18.1	17.6	(0.4)	200.1	200.5	0.4
Other Income	17.8	1.5	1.5	(0.0)	16.3	15.8	(0.5)
Overall Income	**236.7**	**19.6**	**19.1**	**(0.4)**	**216.4**	**216.3**	**(0.1)**
Pay							
Consultants	(19.7)	(1.7)	(1.6)	0.1	(18.0)	(18.1)	(0.1)
Junior Doctors	(18.6)	(1.5)	(1.5)	(0.0)	(17.1)	(17.1)	(0.0)
Non Clinical	(8.7)	(0.7)	(0.7)	0.0	(8.0)	(7.7)	0.3
Nursing	(53.9)	(4.7)	(4.6)	0.0	(49.3)	(48.9)	0.4
Scientists, Technicians, Therapists	(5.3)	(0.5)	(0.5)	0.0	(4.8)	(4.6)	0.2
Pay Unallocated	(0.0)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
	(106.3)	(9.1)	(8.9)	0.2	(97.2)	(96.4)	0.8
Non-Pay							
Clinical Consumables	(38.6)	(3.2)	(3.2)	0.0	(35.4)	(35.7)	(0.3)
Drugs	(31.5)	(2.8)	(2.7)	0.1	(28.8)	(29.6)	(0.8)
Establishment	(1.6)	(0.1)	(0.1)	(0.0)	(1.5)	(1.5)	(0.1)
General Supplies	(0.4)	(0.0)	(0.0)	0.0	(0.4)	(0.4)	(0.0)
Other	(5.1)	(0.5)	(0.5)	0.1	(4.6)	(4.1)	0.5
Premises	(0.3)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
	(77.6)	(6.7)	(6.6)	0.1	(70.9)	(71.6)	(0.7)
Overall Expenditure	**(183.9)**	**(15.8)**	**(15.5)**	**0.3**	**(168.1)**	**(168.0)**	**0.1**
EBITDA	**52.8**	**3.8**	**3.6**	**(0.1)**	**48.3**	**48.3**	**0.0**
Financing Costs	(4.5)	(0.4)	(0.4)	(0.0)	(4.1)	(4.1)	(0.0)
Surplus / (deficit)	**48.3**	**3.4**	**3.2**	**(0.1)**	**44.1**	**44.2**	**0.0**

Commentary

The division had a year to date surplus of £44.2m against a target of £44.1m.

Income

Cumulative SLA income of £200.5m is £0.4m better than plan due to:

- £1.2m over performance on pass through drugs/devices which is matched by spend above budget
- £0.8m adverse variance on 'Other' relates to income challenges/fines and include NHSE fines for new to follow up ratios that were not anticipated in the reforecast, as well as penalties for underperformance on the ED 4hr wait target.
- £0.5m under performance on outpatient income which is due to lower than expected activity, an increase in DNA rates, and the move of retinal screening service to the private sector

'Other' income is £0.5m lower than plan due to low RTA income.

Pay is £0.8m less than planned year to date. Les specialling than expected has been used in ward areas, ED are also underspent as a result of lower than expected availability of temporary staff during the winter period. The M11 pay position includes recharges from CWDT for Medical outliers on Champneys ward over the last 3 months.

Non-pay is £0.7m higher than planned due to high cost drugs & devices spend offset by additional income.

Forecast The division's forecast is to deliver the £48.3m surplus target as planned.

Surgery, Neurosciences, Theatres & Cancer - Divisional I&E for the 11 months to 29th February

Surgery and Neurosciences

Income & Expenditure	Annual Budget	Current Month			Year to Date		
		Budget	Actual	Better/(Worse) than Budget	Budget	Actual	Better/(Worse) than Budget
	£m	£m	£m	£m	£m	£m	£m
SLA Income							
Bed Days	5.2	0.4	0.3	(0.1)	4.8	4.5	(0.3)
Daycase	14.2	1.2	1.3	0.0	12.9	12.9	(0.1)
Elective	39.1	3.4	3.0	(0.4)	35.6	34.3	(1.3)
Pass-through drugs/devices/programme	11.5	0.9	1.3	0.3	10.7	11.5	0.7
Non Elective	49.5	4.1	4.0	(0.0)	45.2	44.1	(1.0)
Other	1.8	0.1	(0.1)	(0.2)	1.7	0.5	(1.1)
Outpatients	32.5	2.9	2.6	(0.2)	29.6	28.9	(0.8)
	153.8	13.1	12.5	(0.6)	140.5	136.7	(3.9)
Other Income	16.0	1.3	1.5	0.2	14.6	15.6	0.9
Overall Income	**169.8**	**14.4**	**14.0**	**(0.5)**	**155.2**	**152.3**	**(2.9)**
Pay							
Consultants	(26.8)	(2.3)	(2.3)	0.0	(24.4)	(24.3)	0.2
Junior Doctors	(15.4)	(1.3)	(1.3)	(0.0)	(14.2)	(14.4)	(0.2)
Non Clinical	(9.3)	(0.8)	(0.7)	0.0	(8.5)	(8.5)	0.1
Nursing	(43.7)	(3.9)	(3.7)	0.3	(39.8)	(38.8)	1.0
Scientists, Technicians, Therapists	(11.0)	(0.9)	(0.9)	(0.0)	(10.1)	(9.9)	0.2
	(106.2)	(9.2)	(8.9)	0.3	(97.0)	(95.8)	1.2
Non-Pay							
Clinical Consumables	(22.0)	(1.9)	(1.8)	0.1	(20.1)	(18.9)	1.1
Drugs	(9.0)	(0.7)	(0.9)	(0.1)	(8.3)	(8.6)	(0.3)
Establishment	(0.4)	(0.0)	(0.0)	0.0	(0.4)	(0.4)	(0.0)
General Supplies	(0.3)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Other	(3.9)	(0.4)	(0.3)	0.1	(3.4)	(2.8)	0.6
Premises	(0.8)	(0.0)	(0.1)	(0.0)	(0.6)	(0.6)	0.0
	(36.5)	(3.2)	(3.1)	0.1	(33.0)	(31.5)	1.5
Overall Expenditure	**(142.7)**	**(12.5)**	**(12.0)**	**0.4**	**(130.1)**	**(127.3)**	**2.7**
EBITDA	**27.1**	**2.0**	**2.0**	**(0.0)**	**25.1**	**24.9**	**(0.2)**
Financing Costs	(4.0)	(0.3)	(0.3)	0.0	(3.6)	(3.6)	0.0
Surplus / (deficit)	**23.2**	**1.7**	**1.6**	**(0.0)**	**21.5**	**21.3**	**(0.2)**

Commentary

The division has delivered a net contribution of £21.3m year to date which is £0.2m below the plan for 15/16.

Income - Elective income and income for patients transferred from other hospitals is significantly lower than plan year to date largely due to theatre closures and delays to implementation of the Neuro Gym business case which have reduced available capacity. Outpatient income is underperforming within T&O due to a delay in the approval of the consultant business case and an overstated Neurology income target in the reforecast. Other SLA income is £1.1m worse than plan due to an increase in the value of challenges and fines. 'Other' (non SLA) income is over performing on private and overseas patients and Gibraltar work.

Pay - £1.2m cumulative pay underspend reflects nursing and theatre technician vacancies and underspends partly related to theatre downtime and lower than expected winter escalation costs.

Non-Pay - £1.5m better than budgeted and relates to lower clinical consumables mainly in Neurosurgery, due to lower activity than planned and within T&O due to non pay controls and greater clinical engagement. There has been less reliance on use of the private sector for General Surgery.

Forecast - The forecast contribution is £22.8m is £0.4m worse than plan. This is due to delay in implementing the Neuro Gym business case and unplanned theatre downtime both of which have impacted on activity/income.

Community Services - Divisional I&E for the 11 months to 29th February

Community Services

Income & Expenditure	Annual Budget £m	Current Month Budget £m	Current Month Actual £m	Current Month Better/(Worse) than Budget £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Better/(Worse) than Budget £m
SLA Income							
A&E	1.2	0.1	0.1	(0.0)	1.1	1.0	(0.0)
Bed Days	5.6	0.5	0.5	(0.0)	5.1	4.9	(0.2)
Exclusions	8.6	0.7	0.8	0.1	8.1	8.1	0.0
Other	59.3	5.0	5.4	0.4	54.3	54.6	0.3
Outpatients	24.2	2.1	2.1	0.0	22.1	22.3	0.2
	98.8	8.3	8.8	0.5	90.6	90.9	0.3
Other Income	1.9	0.2	0.2	0.0	1.8	1.9	0.2
Overall Income	**100.7**	**8.5**	**9.0**	**0.5**	**92.4**	**92.9**	**0.5**
Pay							
Consultants	(2.4)	(0.2)	(0.2)	0.0	(2.2)	(2.2)	(0.0)
Junior Doctors	(2.7)	(0.3)	(0.2)	0.0	(2.5)	(2.2)	0.3
Non Clinical	(7.6)	(0.7)	(0.6)	0.1	(6.9)	(6.7)	0.3
Nursing	(24.1)	(2.2)	(2.1)	0.1	(21.9)	(21.6)	0.3
Scientists, Technicians, Therapists	(10.1)	(0.9)	(0.9)	(0.0)	(9.2)	(9.0)	0.2
	(46.8)	(4.2)	(4.0)	0.2	(42.7)	(41.7)	1.0
Non-Pay							
Clinical Consumables	(9.4)	(0.8)	(0.7)	0.1	(8.6)	(8.8)	(0.2)
Drugs	(11.8)	(1.0)	(0.9)	0.1	(10.9)	(10.7)	0.2
Establishment	(1.2)	(0.1)	(0.1)	0.0	(1.1)	(1.0)	0.1
General Supplies	(0.1)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
Other	(8.6)	(0.7)	(0.8)	(0.1)	(7.9)	(7.8)	0.1
Premises	(0.7)	(0.1)	(0.1)	0.0	(0.6)	(0.6)	0.0
	(31.9)	(2.7)	(2.5)	0.2	(29.2)	(29.0)	0.2
Overall Expenditure	**(78.7)**	**(6.9)**	**(6.5)**	**0.4**	**(71.8)**	**(70.6)**	**1.2**
EBITDA	**21.9**	**1.6**	**2.5**	**1.0**	**20.5**	**22.2**	**1.7**
Financing Costs	(0.2)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	(0.0)
Surplus / (deficit)	**21.7**	**1.5**	**2.5**	**1.0**	**20.3**	**22.0**	**1.7**

Commentary

The in month divisional position is a surplus of £2.5m which is £1m better than budget due to improvements in both income and expenditure. The cumulative position is £1.7m better than budget.

Income – The in month income position against the budget is £0.5m favourable. There is £0.4m within "other", which includes improvements in penalties of £0.2m and the release of the GUM tariff provision of £0.2m. The GUM tariff reduction within Outpatients of £0.2m, is off-set by increases in QMH income. In addition, increases in Prosthetics hardware of £0.1m are included with "Exclusions". The year to date income position is favourable by £0.5m due to increases in QMH activity against the budget and Escort and Bed watch funding of £0.25m.

Pay – The in month variance in Nursing and Non-Clinical pay of £0.2m continues the trend shown in the year to date position. There remains recruitment challenges mainly within the CAHS services, Health visiting and School Nursing.

Non-pay – The in month underspend of £0.2m relates to HIV drugs of £0.1m, the QMH Radiology contract and less than budgeted ad hoc Consultant charges of £0.1m. The year to date variance of £0.2m comprises of an underspend in GU drugs of £0.3m, off-set by overspends in the Escort and Bed watch budget of £0.2m.

Actions

- Improve the Divisional forecasting.
- Understand the impact on the budgets for 2016/17.
- Understand and manage the impact on 2015/16

Forecast - The overall forecast has been revised reflecting the in month benefit of £1m to a surplus of £23.8m although there continue to be Commissioning risks which could impact on the position.

Children, Women, Diagnostics & Therapies - Divisional I&E for the 11 months to 29th February

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	4.3	4.2	(0.1)	43.7	43.4	(0.3)
Daycase	4.6	0.4	0.4	0.1	4.2	4.5	0.3
Elective	4.2	0.4	0.4	0.1	3.8	3.8	(0.0)
Pass-through drugs/devices/programme	2.3	0.2	0.1	(0.0)	2.1	2.1	(0.1)
Non Elective	8.4	0.6	0.7	0.0	7.7	7.9	0.2
Other	25.7	2.0	2.2	0.1	23.6	24.0	0.5
Outpatients	38.4	3.4	3.4	(0.0)	35.0	34.5	(0.5)
	131.8	11.3	11.5	0.2	120.2	120.2	(0.0)
Other Income	21.6	1.9	2.7	0.8	19.6	22.3	2.7
Overall Income	**153.3**	**13.3**	**14.2**	**1.0**	**139.8**	**142.5**	**2.7**
Pay							
Consultants	(16.9)	(1.4)	(1.5)	(0.1)	(15.5)	(15.8)	(0.4)
Junior Doctors	(12.9)	(1.1)	(1.1)	0.0	(11.8)	(11.7)	0.0
Non Clinical	(14.2)	(1.2)	(1.1)	0.1	(13.0)	(12.4)	0.6
Nursing	(52.2)	(4.4)	(4.5)	(0.1)	(47.8)	(47.6)	0.2
Scientists, Technicians, Therapists	(34.9)	(3.2)	(3.0)	0.2	(31.7)	(31.0)	0.7
	(131.1)	(11.3)	(11.1)	0.2	(119.8)	(118.5)	1.2
Non-Pay							
Clinical Consumables	(13.0)	(1.0)	(1.4)	(0.4)	(11.9)	(11.9)	(0.0)
Drugs	(8.8)	(0.8)	(1.3)	(0.5)	(8.3)	(10.6)	(2.4)
Establishment	(0.7)	(0.0)	(0.1)	(0.0)	(0.7)	(0.6)	0.1
General Supplies	(0.5)	(0.0)	(0.0)	(0.0)	(0.5)	(0.4)	0.1
Other	(2.7)	(0.3)	(0.3)	0.0	(2.4)	(2.7)	(0.3)
Premises	(1.5)	(0.2)	(0.1)	0.0	(1.3)	(1.2)	0.2
	(27.3)	(2.4)	(3.2)	(0.8)	(25.0)	(27.3)	(2.3)
Overall Expenditure	**(158.4)**	**(13.7)**	**(14.3)**	**(0.7)**	**(144.8)**	**(145.9)**	**(1.1)**
EBITDA	**(5.0)**	**(0.4)**	**(0.1)**	**0.3**	**(4.9)**	**(3.4)**	**1.6**
Financing Costs	(6.5)	(0.6)	(0.6)	(0.0)	(6.0)	(6.0)	0.0
Surplus / (deficit)	**(11.6)**	**(1.0)**	**(0.7)**	**0.3**	**(10.9)**	**(9.3)**	**1.6**

Commentary

The division has a cumulative deficit of £9.3m which is £1.57m better than the reforecast.

Income – In the current month income for Children's day case activity and Imaging Unbundled activity has improved. Critical Care bed day activity increase is lower than the reforecast due to business case delays. Outpatient activity has improved in Antenatal services reducing the underperformance to date. Breast Screening underperformance to date has reduced with higher activity this month.
Other income over performance of £2.7m reflects the success of pharmacy commercial operations (associated increase in drug spend is £2.4m).

Pay spend is £1.2m 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. The underspend on the scientist line largely reflects the slower than expected pace of recruitment for therapists.

Non pay – The drugs overspend of £2.4m relates to pharmacy commercial operations referred to above.

Actions / Risks

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

Forecast Position

The division remains on track to be £1.6m better than budget at year end.

Overheads - Divisional I&E for the 11 months to 29th February

Overheads

Income & Expenditure	Annual Budget £m	Current Month			Year to Date		
		Budget £m	Actual £m	Better/(Worse) than Budget £m	Budget £m	Actual £m	Better/(Worse) than Budget £m
Corporate Directorates							
Chief Executive & Governance	(22.4)	(1.9)	(2.1)	(0.3)	(20.5)	(21.1)	(0.6)
Executive Director of Nursing	(4.9)	(0.4)	(0.3)	0.1	(4.5)	(4.2)	0.3
Finance, Performance & IT	(26.2)	(2.3)	(2.2)	0.0	(23.9)	(24.1)	(0.2)
Human Resources Directorate	(4.8)	(0.4)	(0.5)	(0.1)	(4.3)	(4.5)	(0.1)
Service Improvement	(1.9)	(0.4)	(0.2)	0.2	(1.7)	(1.3)	0.3
Pathology - STG	(12.1)	(0.9)	(1.0)	(0.1)	(11.1)	(11.1)	(0.0)
Strategy	(1.5)	(0.1)	(0.1)	0.0	(1.3)	(1.3)	(0.0)
Total Corporate	(73.6)	(6.4)	(6.5)	(0.1)	(67.4)	(67.7)	(0.3)
Estates & Facilities							
Energy & Engineering	(11.0)	(1.0)	(0.7)	0.3	(10.0)	(9.8)	0.3
Estates	(11.7)	(0.9)	(1.0)	(0.1)	(10.8)	(10.7)	0.1
Estates Community Premises	(16.4)	(1.4)	(1.7)	(0.2)	(15.0)	(15.2)	(0.3)
Facilities Services	(4.7)	(0.4)	(0.3)	0.0	(4.4)	(4.3)	0.1
Hotel Services	(11.6)	(1.2)	(1.1)	0.1	(11.0)	(10.6)	0.4
Medical Physics	(2.2)	(0.2)	(0.2)	(0.0)	(2.0)	(2.0)	(0.0)
Project Management	(0.4)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Rates	(2.0)	(0.2)	(0.2)	0.0	(1.9)	(1.9)	0.0
Total Estates & Facilities	(60.2)	(5.2)	(5.2)	0.0	(55.4)	(54.9)	0.6
Total Overheads	**(133.8)**	**(11.7)**	**(11.7)**	**(0.1)**	**(122.8)**	**(122.5)**	**0.2**

Overheads Summary
Corporate Services spend to date is £0.3m worse than plan while Estates & Facilities is £0.6m better.

Corporate
Chief Executive – over spend due to higher costs for turnaround, recruitment fees and one-off cost of £0.1m in M11 for NHSE secondment post working on the SWL Provider collaborative.

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

Finance, Performance & IT – The cumulative overspend relates to increased costs in Procurement and Computing.

Service Improvement – Budget allocated for the Recovery at home project from central budgets (£0.25m) . Costs had been included last month Under in month due to budget increase to fund the Recovery at Home Project.

Estates & Facilities
The budget broke even in month 11. YTD surplus includes loss on sale of boiler £0.1m and expected £0.1m reimbursement of energy cost to SGUL following a review of meter readings
The underspend relates to lower spend on energy and hotel services than planned. And, increased space charge to Moorfields.

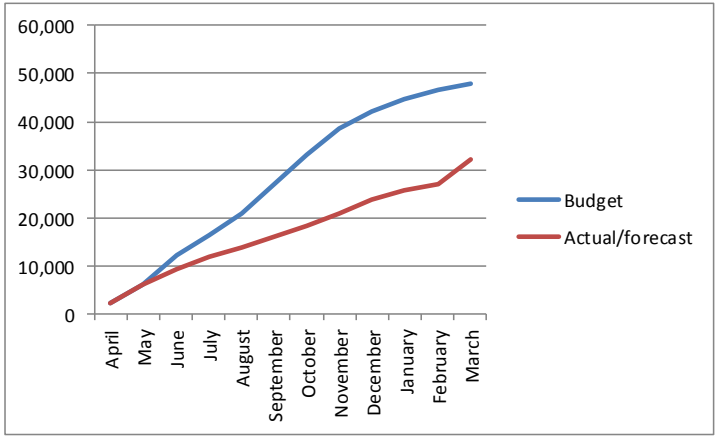
Risks:
High number of outstanding maintenance jobs (c2,0000) which if Completed would increase costs.

Forecast – Overheads is expected to be £0.5m better than TRP plan.

13. Capital

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

Actual/forecast cumulative capital expenditure 2015/16 at M11



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	8,751	3,672	5,079	3,869	5,811
Medical equipment	12,412	12,224	6,993	5,231	9,579	2,833
IMT	6,526	6,526	4,714	1,812	5,342	1,184
Major Projects	18,137	18,002	11,132	6,870	12,606	5,531
Other	772	672	565	107	665	107
SWL Path	500	479	55	424	75	425
Total	48,027	46,654	27,131	19,523	32,136	15,891

- Capital expenditure in February was £1.4m and year to date expenditure is £27.1m, £19.6m less than budget.
- The Trust has deliberately slowed down capital expenditure where appropriate to support the cash position. The forecast outturn under spend is approximately £15.9m (M10 £14.6m) and therefore it is expected that there will be an increase in spend in the last month of the year – particularly in medical equipment (replacement of AMW 1.5t MRI scanner and hybrid theatre equipment) and major projects (SAU, hybrid theatre works and AMW bed schemes).
- The under spend on the capital programme enabled the Trust to agree with Monitor and DH a capital to revenue transfer which was processed in February – improving the in-month reported I&E deficit by £4.6m.
- The cash benefit of this forecast outturn underspend is estimated at £14.2m (excluding leases).

14. Cash balance and WCF drawdowns vs plan

Cash balance

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast
	31-Mar	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	29-Feb	*31-Mar*
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	*£000*
2015/16 Plan cash (May 2015)	n/a	14,200	6,187	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
Actual/forecast cash	24,179	14,188	7,925	7,265	6,175	6,097	8,258	12,846	9,252	15,236	22,036	13,374	*9,842*
Cash bal fav / (adv) variance to plan	0	-12	1,738	4,265	3,175	3,097	5,258	9,846	6,252	12,236	19,036	10,374	*6,842*

Working Capital Facility - drawdowns within cash balance above

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast
	31-Mar	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	29-Feb	*31-Mar*
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	*£000*
Plan drawdown (May 2015)	0	0	0	2,138	6,991	14,625	24,483	29,807	34,900	42,544	47,618	49,892	*52,185*
Actual drawdown - in-month						7,909	9,420	1,256	0	10,140	0	0	*4,000*
Actual drawdown - cumulative	0	0	0	0	7,671	15,580	25,000	26,256	26,256	36,396	36,396	36,396	*40,396*
WCF cum drawdowns fav / (adv) variance to plan	0	0	0	2,138	-680	-955	-517	3,551	8,644	6,148	11,222	13,496	*11,789*

Overall Cash fav / (adv) variance to plan	0	-12	1,738	6,403	2,495	2,142	4,741	13,397	14,896	18,384	30,258	23,870	*18,631*

- The **cash balance** table above compares the actual cash balance and WCF drawdowns with the May plan.
- The M11 actual cash balance was £13.4m which is £10.4m ahead of plan. Cumulative WCF/ISF drawdowns to 29th February are £36.4m which is £13.5m lower than plan.
- LEEF loan impact: The cash balance includes £11.6m unexpended LEEF loan for the energy performance contract and so the cash balance excluding LEEF would be: +£1.8m.
- The forecast cash balance for March is £9.8m . The reversal in March of cash management actions taken before Christmas will reduce the cash balance by approx £3.6m in month – most significantly the payment of deferred £2.8m CNST instalments, £7m rental charges to NHS Property Services and the £3.4m dividend payment.
- Receipts from debtors have been high in March : most importantly NHSE paid £7.2m as a payment on account for 15/16 over performance on 22nd March.
- The Trust must maintain a minimum cash balance of £3m at month-end under the terms of its ISF borrowing facility.
- The forecast year end cash balance includes the drawdown of £4m in March agreed with Monitor and the ITFF from the recently approved interim revenue support facility. This drawdown will bring cumulative WCF/ISF borrowings to £40.4m for the year - £11.8m lower than the May Plan.

15. Analysis of cash movement YTD and year end forecast

Cash movement M11 2015/16

	Year to date vs Plan			Forecast outturn vs Plan		
	Plan YTD £m	Actual YTD £m	Actual YTD VAR £m	*Plan Outturn £m*	*Forecast Outturn £m*	*Forecast M12 YTD VAR £m*
Opening cash 01.04.15	24.2	24.2		*24.2*	*24.2*	
Operating surplus/-deficit	-19.3	-25.5	**-6.2**	*-21.6*	*-31.9*	***-10.3***
Sale proceeds - asset disposals	0.0	0.0	**0.0**	*2.5*	*0.2*	***-2.4***
WCF/ISF borrowing	49.9	36.4	**-13.5**	*52.2*	*40.4*	***-11.8***
			-19.7			***-24.5***
Net change in working capital	-7.9	6.2	**14.1**	*-7.4*	*8.8*	***16.2***
Capital spend (excl leases)	-43.1	-23.8	**19.3**	*-45.6*	*-26.9*	***18.6***
Other	-0.9	-4.2	**-3.3**	*-1.3*	*-4.9*	***-3.5***
Sub-total			**30.1**			***31.3***
Closing cash 29 Feb / 31 Mar	3.0	13.3	**10.4**	*3.0*	*9.9*	***6.8***

- The cash movement table above compares the M11 YTD and forecast outturn cash movement with the original plan
- At M11 the Trust has more than offset the adverse cash impact of £19.7m relating to the higher operating deficit and lower WCF/ISF borrowing with the positive movement in working capital and the capital under spend.
- The year end forecast includes the reversal of cash actions re: deferral of payments of CNST premiums and NHSP rental charges taken earlier in the year however this is forecast to be offset by higher than expected receipts from NHS debtors – in particular NHS England who paid £7.2m as a payment on account for 2015/16 over performance on 22nd March following repeated escalation earlier in the month..
- The outturn working capital movement is better than last month as a result of these higher levels of aged debt receipts and is now forecast to be £16.2m better than the May plan.
- The Trust drew down £4m borrowing on 14th March bringing total WCF/ISF borrowing for the year to £40.4m which is £11.8m lower than plan.

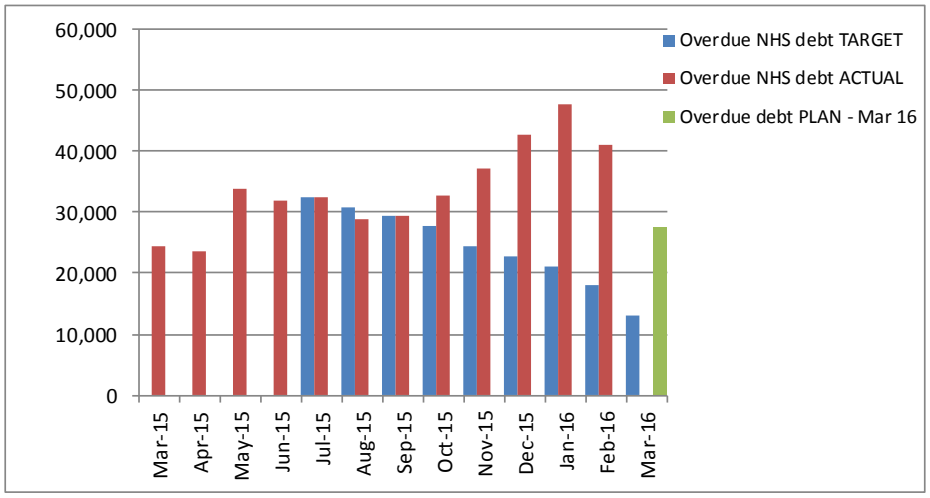
16. Debt management

- The Cash Committee approved 'stretch' debt reduction targets for 2015/16 and the baseline is the level of overdue debt (over 30 days old) as at M04.
- NHS overdue debt reduced in February by £6.8m and this contributed to a stronger performance on working capital than forecast last month. However overdue debt remains significantly behind the 'stretch' targets. The Trust has been pursuing a 'hit list' of key overdue debts with CCGs and NHS Trusts and is expecting to receive approx £7.2m from NHSE in late March in respect of in-year SLA over-performance. It should be noted the overdue debt targets below are 'stretch' targets and on the grounds of prudence the year end cash forecast does not assume they are met.
- Also the Trust continues to press NHS England for an agreement for a payment on account arrangement for 2016/17 over performance similar to the arrangement already in place with SWL CCGs.(£7.2m received on 22nd March).
- Non-NHS debt is in line with the overdue debt reduction targets.

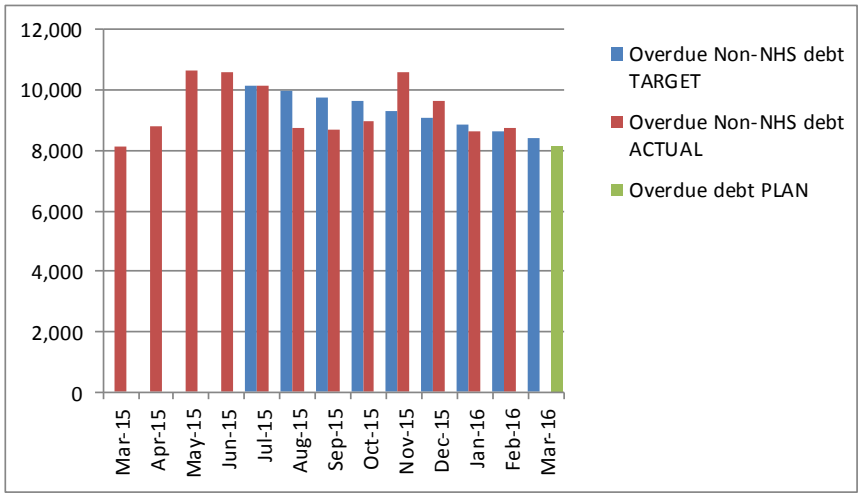
Debtor days	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
NHS income debtor days	18	19	19	19	19	20	22	22	31	29	27	27
Non-NHS income debtor days	205	202	219	229	205	199	198	191	256	205	205	227
DWP/CRU debt	981	987	1000	1029	1078	1019	1038	1080	1084	1072	1212	1266
Overseas patient income	807	789	769	753	761	740	677	793	810	778	690	682

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 11 2015/16

Balance sheet February 2016

	Feb-16 Plan £000	Feb-16 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	361,426	336,495	*24,931*	Much lower capital expenditure than plan - so lower fixed assets
Stock	6,423	7,814	*-1,391*	Stock action group formed to progress safe reductions in levels. Reduction of £0.25m in Feb.
Debtors	79,733	76,572	*3,161*	NHS overdue reduced by £6.8m in Feb but remains higher than stretch target.
Cash	3,000	13,373	*-10,373*	Lower capex, and better working capital performance has enabled Trust to finance higher deficit and borow less than planned. Cash is £10.4m better than Plan.
Creditors	-83,052	-95,381	*12,329*	Longer supplier payment terms since July. Also CNST & NHSPS liabilities deferred till Q4.
Capital creditors	-3,476	-2,261	*-1,215*	
PDC div creditor	-2,950	-2,792	*-158*	
Int payable creditor	-250	-458	*208*	
Provisions< 1 year	-602	-512	*-90*	
Borrowings< 1 year	-57,702	-6,186	*-51,516*	(NB: WCF is classified as non-current liability c/f Plan)
Net current assets/-liabilities	**-58,876**	**-9,831**	*-49,045*	
Provisions> 1 year	-1,181	-1,110	*-71*	
Borrowings> 1 year	-93,039	-126,231	*33,192*	(NB: WCF is classified as non-current liability c/f Plan)
Long-term liabilities	**-94,220**	**-127,341**	*33,121*	
Net assets	**208,330**	**199,323**		
Taxpayer's equity				
Public Dividend Capital	133,761	129,501	*4,260*	
Retained Earnings	-27,941	-31,275	*3,334*	YTD I&E deficit worse than plan
Revaluation Reserve	101,360	99,947	*1,413*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**208,330**	**199,323**		

18. Borrowings analysis at M11

ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Finance Department

Borrowings summary - February 2016

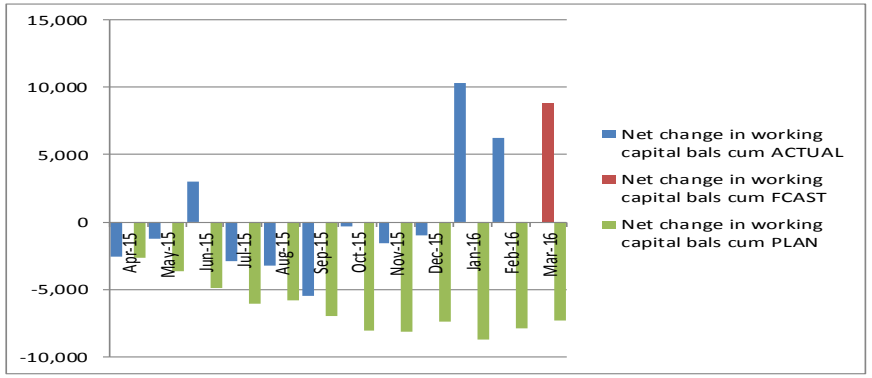
	Lender	Description	Interest rate fixed/variable	Interest rate pa	Term	Repayment terms	Maximum Facility value £000	Borrowings repay<1 yr at 29/02/16 £000	Borrowings repay>1 yr at 29/02/16 £000	Borrowings at 29/02/16 £000
	Loans									
1	Dept of Health	Capital loan	Fixed	2.20%	25 yrs	Repayable in bi-annual instalments	-14,747	-601	-13,850	-14,451
2	Dept of Health	Working capital loan	Fixed	1.38%	15 yrs	Repayable in bi-annual instalments	-15,000	-999	-13,002	-14,001
3	Dept of Health	Working cap facility	Variable: base rate+1%	1.50%	5 yrs	100% repayable on 18/04/20	-25,000	0	0	0
4	Dept of Health	Working cap facility	Variable: base rate+3%	3.50%	5 yrs	100% repayable on 21/09/20	-19,600	0	0	0
5	Dept of Health	Interim revenue support facility	Variable: base rate+1%	1.50%	2 years	100% repayable March 2018	-48,700	0	-36,396	-36,396
6	London Energy Effic. Fund	Capital loan	Fixed	1.50%	10 yrs	Repayable in bi-annual instalments	-13,303	-1,478	-11,086	-12,564
	Loans - total							-3,078	-74,334	-77,412
	Leases									
7	Blackshaw Health. Servs PL	PFI scheme	Implicit rate	7.50%	35 yrs	Repaid monthly in unitary charge	N/A	-922	-44,736	-45,658
8	Various lessors	Finance leases	Implicit rates	3%-7.5%	Various	Repaid quarterly or annually	N/A	-2,186	-7,161	-9,347
	Leases - total							-3,108	-51,897	-55,005
	Total Borrowings							-6,186	-126,231	-132,417

Notes

1 DH capital loan £14.747m approved in 2014 for bed capacity projects, hybrid theatre, surgical assessments unit etc.
2 Working capital loan £15m: approved in January 2015 on licensing of Foundation Trust status to boost Trust's working capital resilience. Drawn down in full in March 2015
3 Working capital facility £25m approved in January 2015 on assumption of Foundation Trust status. Drawn down in tranches July - Sept 2015 inclusive.
This facility will be repaid in full on 15th February 2016 when the drawdown is made from the recently approved interim revenue support facility (see no. 5)
4 Working capital facility £19.6m approved in September 2015 to provide cash support for period October 2015-January 2016 inclusive pending agreement of interim revenue support funding for 2015/16.
This facility will also be repaid in full on 15th February 2016 when the drawdown is made from the recently approved interim revenue support facility (see no. 5)
5 Interim revenue support facility £48.7m approved in February 2016.
The Trust drew down £36.396m from this facility on 15th February 2016 and repaid the amounts drawn under the working capital facilities per 3. and 4. above as set out in the paper approved by the board on 4th February.
6 London Energy efficiency Fund loan for the energy performance contract.
7 AMW PFI building is accounted as on-balance sheet. The 'borrowing' figure for the lease represents the capital value of the building, fixtures and fittings encompassed in the PFI contract.
8 Finance leases for medical equipment - eg major diagnostic equipment. The capital value of new finance leases represents capital investment and is reported as such in the capital programme.

19. Working Capital – cumulative position at M11

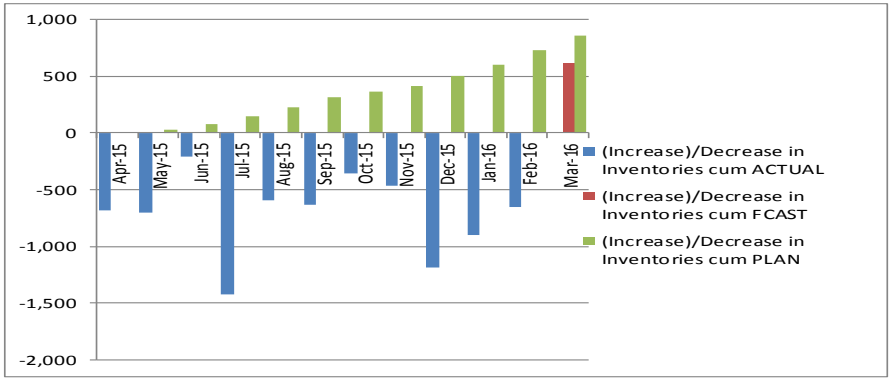
Change in all working capital balances 2015/16 actuals vs plan



£14.1m BETTER than Plan. Working capital bals deteriorated by £4.1m in M11 but YTD are better than plan by £14.1m

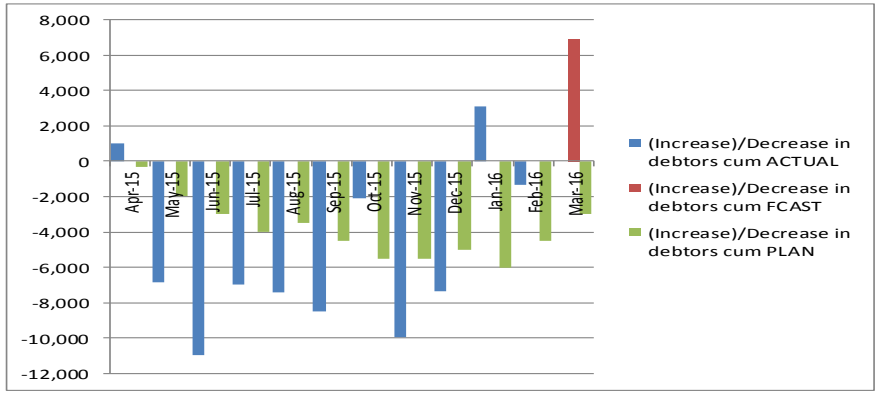
Other 3 graphs on this slide break down this movement by inventories, debtors and creditors.

Change in inventories (stock) 2015/16 actuals vs plan



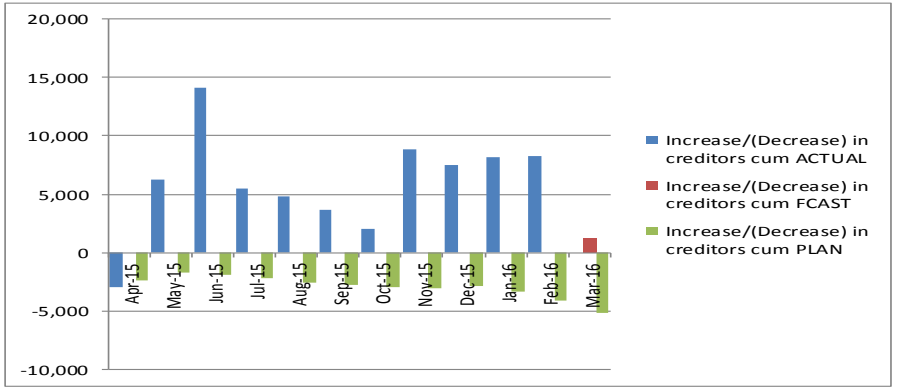
£1.4m WORSE than Plan. Stocks reduced by £0.25m in M11 but are behind plan by £1.4m. Depts built up stocks before Christmas as a precautionary measure. The Trust set targets to reduce inventories mainly in pharmacy, cardiac and central store by year end.

Change in debtors 2015/16 actuals vs plan



£3.2m BETTER than Plan. Debtors (invoice and accrued debt) increased by £4.1m in M11 however this is due mainly to reversal of benefit last month re: Q4 monies received from HEE.
NHS overdue debt reduced by £6.8m in Feb but remains over target and the Trust is pursuing a hit list of overdue debts to help minimise borrowings.
A significant reduction in overdue debt for NHS debt is forecast for M12 given payments from NHSE and other debtors received to date in March.

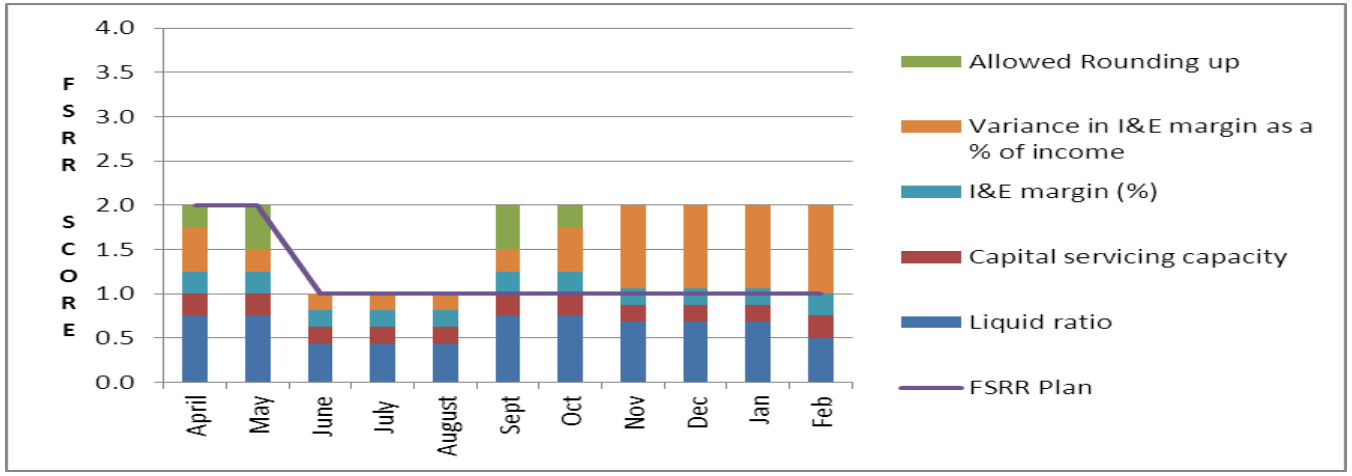
Change in creditors 2015/16 actuals vs plan



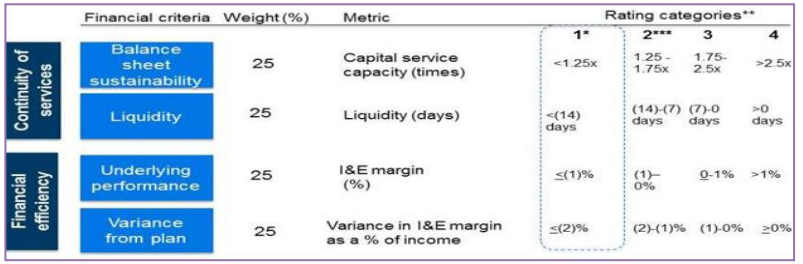
£12.3m BETTER than Plan. Overall level of creditors was broadly unchanged in M11.
The Trust continues to pay approved invoices to the new terms.
The re-scheduling of CNST payments and NHSPS payments has benefited the cash position however these liabilities will be discharged in Feb and March - resulting in a reduction in cash over the last two months of the financial year.

20. Financial Sustainability Risk Rating (FSRR)

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



Threshold details:



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

In February 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 .

The deterioration in net current assets has moved the Liquid ratio metric to a 2.

The I&E variance of +0.4% as a percentage of income to date is within the range for a score of 4 due to improved performance against the I&E plan to February.

The forecast out-turn score is currently a 2 overall, in line with the YTD score for all individual metrics.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD *April 2016*

Paper Title:	Report to the Board from Finance & Performance Committee: 30 March 2016
Sponsoring Director:	Sarah Wilton, Acting Chair
Author:	Sarah Wilton, Acting Chair
Purpose:	To provide the Board with a summary of the proceedings from the last Finance and Performance Committee
Action required by the board:	To note the update
Document previously considered by:	N/A

Report to the Board from Finance & Performance Committee: 30 March 2016

The Committee noted with concern that several F&P papers for this meeting had been circulated very late and urged the executive to ensure that the agreed deadlines for F&P papers must be met from April onwards in order to ensure that this board Committee is able effectively to meet its terms of reference.

2015/2016 outturn

While current forecasts indicate that the I&E outcome is expected to be a c£54m deficit against the c£56m agreed with Monitor in January, F&P noted that there are a number of matters which need to be determined very promptly by the executive as the year end is closed, including:

* impairment of carried forward development costs
* decision relating to possible restatement of 14/15 accounts
* final agreement of quantum and treatment of penalties and fines from commissioners
* high cost drugs: F&P was briefed on how the pharmacy lead is responding to significant commissioner challenges estimated to total £700k+ to M11: these need to be robustly managed for 2015/6 close
* ensuring full and accurate year-end cut-off accounting, particularly in relation to agency and interim staffing costs

F&P commended the whole executive team across the Trust for the achievement of, and indeed exceeding, the very challenging 2015/6 CIP target of £42m. £37m has been delivered YTD of which £17.4m, ie nearly 50%, is non-recurrent. The recurring portion will contribute to achieving the demanding 2016/7 forecast, but the Board should note the significant proportion of non-recurrent savings.

2016/2017 budget

Based on extensive and detailed Trust-wide 'TRP' budgeting work in Q3 and Q4, with support provided by KPMG and the outcome challenged by F&P and Board, to establish a sound 2016/17 forecast, the Board approved in January our STF proposal for £17.6m STP funding over the year.

We submitted to Monitor ('the APR submission') a 2016/17 forecast deficit of £17m, after £17.6m of STF funding and before taking into account the proceeds of any asset sales. This return reflected, in summary, a £72.6m baseline I&E position for the year, less £50m (gross of expenses) of validated but not yet fully resourced improvement plans, with some additional small adjustments,

and was supported by detailed validation and recommendation from the turnaround director and his KPMG supporting team.

F&P reviewed Monitor's written response to this return in which we are being urged to improve the proposed position further by reflecting the current positive staff cost variances and in other ways.

F&P Committee wishes the Board to be aware of the following significant factors relating to the 2016/17 forecast, all of which were discussed in detail at F&P and need to be discussed and challenged in and by the Board at this meeting:

* SGH is presently due to submit to Monitor our final 2016/17 budget, finalising our forecasts and responding to Monitor's comments, by 11 April. F&P urged the executive to develop and share a clear timetable for this submission, allowing sufficient time for detailed and robust engagement, review and challenge by divisions and by F&P and the Board. It was suggested at F&P that it may be necessary to agree a delayed return with Monitor: F&P urges the executive to conclude this, in agreement with the Board, one way or another urgently and to agree with the Board today a realistic submission process and timetable

* F&P emphasised the urgent need for all Trust budget holders for 2016/17 to be determined and to have clear and agreed budgets in place for the year, from the start of the year, which they 'own' and for which they can be and are held accountable

* contracts with our commissioners are not yet agreed despite our best efforts, with Deirdre Baker being supported by Duncan Calverley from KPMG now that Andrew Burn has moved on. The most significant potential gap, of c£20m, is with NHSE. Considerable and urgent work is still required across the Trust to ensure that where activity is not being funded for 2016/17, the necessary decisions are made and implemented soon to reduce capacity and staffing accordingly. Work is also needed to ensure that any 'fix, close, transfer' implications are agreed with commissioners and reflected in the 2016/17 forecast, but the current timescale for these appears not to be fast enough to allow inclusion in the 2016/17 plans

* significant remedial and improvement work is required on the Trust's IT and estates infrastructure: no costings are yet available, nor is there yet any indication of whether or not the necessary additional capital funding might be able to be secured

* the Trust's cash flow forecasts and the loan and facility arrangements currently in place reflect the 2016/17 forecasts already submitted to Monitor. F&P sought and received assurance that all the conditions of these arrangements continue to be fully met. However, should the forecasts change then clearly the loans and facilities now in place will need to be renegotiated

* the accepted STF funding of £17.6m, due to be received quarterly on demonstrating compliance with the detailed STP conditions and challenging performance targets, is linked to the current 2016/17 forecast, and the offer may be withdrawn or payments delayed if we are unable to meet the agreed conditions each quarter. F&P stressed the need for complete clarity of reporting, at least monthly, against these agreed requirements

* the 2016/17 submitted budget reflects £50m, gross of the £7m delivery costs, of improvement programme savings, for which DIPs had been validated with KPMG support, although with £9.8m marked as ‘unidentified as yet’. The latest optimistic analysis now shows a net DIP total for 2016/17, before asset sales, of £33m reflecting delays in the programmes and resourcing difficulties and improved accuracy of estimated savings. Martin Wilson as Director of Improvement is overseeing the validation and improvement of the overall programme and the development of stretch targets to fill this significant emerging gap. F&P noted that the procurement DIP continues, disappointingly, to fail to be in a position to deliver the significant savings expected of it with the interim team still engaged in early-stage recruitment and department restructuring

* while not reflected in the APR submission, the Trust has developed preliminary asset sale plans and is effectively holding these as contingency. F&P noted that considerable work is required to firm up project plans and timetables, reflecting planning and other approval timings, if these asset sales are realistically to be held as any form of contingency. Links to strategic objectives

have yet to be clarified

Performance

F&P reviewed in detail the Trust's performance to date and also the developing trajectories and plans to achieve the significant and sustainable recovery in ED, RTT, Cancer and other key performance targets for 2016/17 which are required to meet the STP requirements. Board presentation and discussion will cover these key points in depth so they are not outlined separately in this note.

Sarah Wilton
3 April 2016

Key risks identified:
Risks are detailed within the report.

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

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

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.

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO TRUST BOARD *April 2016*

Paper Title:	Risk and Compliance report for Trust Board incorporating: 1. Corporate Risk Register 2. External assurances 3. CQC Statement of Purpose
Sponsoring Director:	Jennie Hall, Chief Nurse/DIPC
Author:	Sal Maughan, Head of Risk/ Corporate Governance
Purpose:	To highlight key risks and provide assurance regarding their management.
Action required by the committee:	The board are asked to: - *Discuss and make recommendations* around the current risk profile as set out in the report to ensure this reflects the range of current risks to the organisation, including its external environment - *Review and approve* the attached CQC Statement of purpose (Appendix 3) prior to formal submission to the CQC

Executive summary
Key messages:

Corporate Risk Register (CRR):

- The most significant risks on the CRR are detailed.
- There are currently five new risks under risk assessment
- Controls are developed for all risks, with a rolling programme of review by QRC

Assurance:

- Details of external assurances are included within the report
- The Trust is currently preparing for re-inspection by the Care Quality Commission in Q1 2016/17.
- The CQC Statement of Purpose has undergone a full annual update to ensure all regulated activities undertaken by Trust location are accurately reflected in this formal document. No material changes have been made.

Risks
The most significant risks on the Corporate Risk Register are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	All CQC Fundamental standards & regulations

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

1. Risks – Corporate Risk Register (CRR):

This report identifies the extreme risks on the Corporate Risk Register with the details of the most significant risks (scoring 20 or above) summarised in Table 1. An executive overview of the CRR is included at appendix 1. The rating is prior to controls being applied to the risk. Risks are reduced once there is evidence that controls are effective.

Table one: highest rated risks

Ref	Description	C	L	Rating ↓↑
01-12	Bed capacity for adult G&A beds may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	**5**	**4**	**20 →**
01-13	Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	**5**	**4**	**20 →**
01-07	Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access Standard	**4**	**5**	**20 →**
01-06	Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	**5**	**4**	**20 →**
01-18	Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	**5**	**4**	**20 →**
3.7-06	Failure to meet the minimum requirements of the Monitor Risk Assessment Framework	**4**	**5**	**20 →**
3.14-05	Working capital – the trust will require more working capital than planned due to: Adverse in year I&E performance Adverse in year cash-flow performance	**5**	**4**	**20 →**
3.15-05	Risks to income – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust.	**5**	**4**	**20 →**
3.20-05	Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.	**5**	**4**	**20 →**
01-19	Risk to patient safety arising from delays and/or failures to ensure the correct medical equipment is available	**5**	**4**	**20 →**
5.1-01	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost	**5**	**4**	**20 →**
5.1-03	Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes	**5**	**4**	**20 →**
A520-04	Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	**4**	**5**	**20 →**
5.1-06	Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce	**4**	**5**	**20 NEW**

1.1 New risks proposed for inclusion on the CRR

During March the following new risks have been identified for inclusion on the CRR:

- Ransom-ware: escalated via the Information Governance Committee
- Resource and capacity to support Safeguarding Adults (DOLS) agenda: escalated via Patient Safety Committee (from Corporate Nursing risk register)

There are two risks previously identified which are currently undergoing risk assessment:

- Transformation programme associated risks
  - Communications and engagement with staff (Director of Strategy)
  - Translation into contracts (Chief Financial Officer)

Seven new risks have been included and detailed controls are included at Appendix 2:

- 01-21: Risk to patient safety arising from inconsistent and/or multiple issues of discharge summaries to GP surgeries.
- 01-22: Potential risk to patient and staff safety resulting from a failure to ensure Trust processes and procedures are followed due to significant numbers of Trust policies being out of date
- 01-23 Patient Safety risk due to electrical infrastructure in Knightsbridge Wing in danger of major failure. A recent large failure of an electrical panel caused the wing to be evacuated
- 03-07: Risk of regulatory action or penalties upon the Trust in the event of a failure to comply with the legislative requirements of the Freedom of Information Act (2000)
- 5.1-06 Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce
- 5.1-05 Lack of success of the transformation programme without sufficient organisational support
- Transformation resources are of insufficient capacity and/or capability to deliver the expected benefits in 16/17

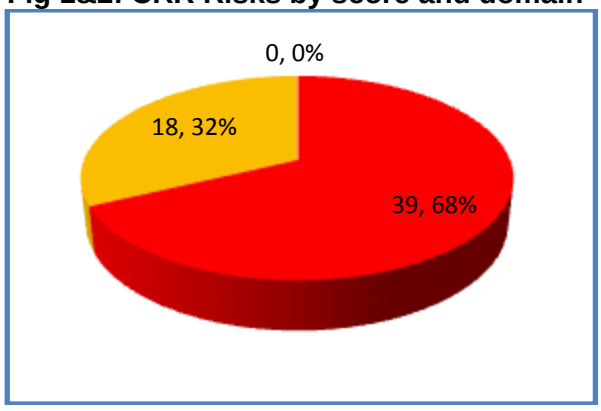
1.2 Risks proposed for closure

There are no risks proposed for closure during the interim reporting period.

1.3 Summary of risks by score and domain

There are 57 risks on the CRR of which 39 are extreme (a score of 15 or above). Of these extreme risks, 15 sit within the domain of Quality and seven within Finance and Operations. Of the total risks on the CRR, 41% relate to Quality.

Fig 1&2: CRR Risks by score and domain



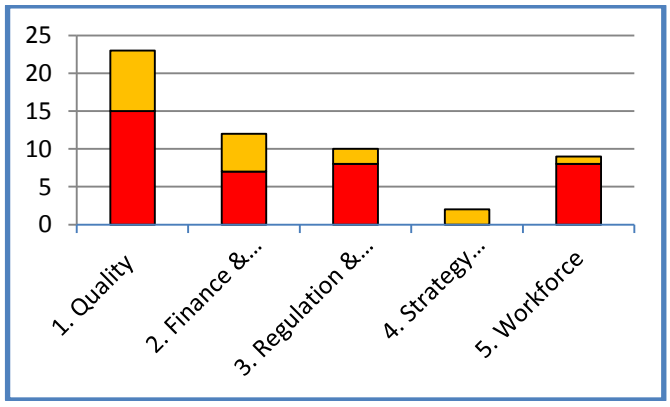


Table three: CRR Risks by Domain

	15 or above (Extreme)	8-12 (High)	4-6 (Mod)	0-3 (low)	Total
1. Quality	15	8	0	0	23
2. Finance & Operations	8	5	0	0	13
3. Regulation & Compliance	8	2	0	0	10
4. Strategy Transformation & Development	0	2	0	0	2
5. Workforce	8	1	0	0	9
Total	**39**	**18**	**0**	**0**	**57**

1.4 Risk Management Strategy update

The Risk Management strategy was developed in response to Monitor's recommendations to ensure strengthen the existing risk framework to ensure all risks are appropriately identified, managed and escalated.

The aim of the strategy is therefore to strengthen the existing risk management framework, embedding risk management at a local level and ensuring appropriate escalation of risks through the organisation to the Board, supported by training and tools. It aims to embed greater local level ownership of risk, enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements to support the current framework. Additionally the BAF and Corporate Risk Register have been separated as part of the implementation of the strategy.

Full implementation has not yet been achieved due to a lack of resource to support this during 2015/16, however appropriate resource is now in place to support implementation and a revised implementation timeline ensures full completion of the strategy by end of 2016/17 financial year.

A revised timeline has been presented to the Organisational Risk Committee (ORC) and the Quality and Risk Committee (QRC) for approval in March. The QRC receive quarterly progress reports upon strategy implementation.

2. Board Assurance Framework

The Board Assurance Framework (BAF) is a document which brings together the total arrangements in place for managing the trust's assurances. It is an extension of the risk management framework in place, and should be considered in conjunction with the Corporate Risk Register and all other organisational risk registers at both Divisional and Corporate Directorate level.

As part of the Risk Management Strategy, an important action was to separate the Corporate Risk Register (CRR) from the Board Assurance Framework.

The BAF has subsequently been re-developed to encompass and support the trust in meeting three key regulatory requirements of Monitor and the Care Quality Commission (CQC) who require that boards ensure there is an effective and comprehensive process in place to identify, understand and monitor current and future risks:

- **CQC's Well Led Domain**
- **Monitor's Well Led Framework**
- **Monitor's Risk Assessment Framework (RAF)**

A working document is to be in place by the end of April 2016 for presentation to May board. This timeline allows for population of the document by each of the executive leads and builds in the opportunity for appropriate challenge of the content before final agreement and sign off at QRC and board. Once the BAF is a live document, quarterly updates will be provided to QRC and the board.

3. Assurance map

3.1 Care Quality Commission (CQC) – preparation for inspection

The Trust will undergo a full announced inspection by the CQC on 21st – 23rd June 2016. A core delivery team is in place with work stream and core service leads reporting to a weekly steering group meeting. A project manager is in place to support the readiness project and a project team is in the process of being recruited to.

The first formal information request was provided to the CQC on 8th March and a second, more detailed information request is due to be returned to the CQC by 19th April 2016. This will encompass a self-assessment from the Trust against the CQC key lines of enquiry. Work is underway within divisions to undertake a detailed self-assessment which will support this submission.

A detailed communications plan is also in place with staff briefings via e-Gazette having already commenced.

There is regular reporting upon progress and actions to address key risks to the Executive Management Committee.

3.2 Care Quality Commission – Annual update to Statement of Purpose

The CQC statement of purpose is a legally required document that includes a standard set of information about the Trust (provider)'s service. In accordance with CQC guidance the statement must describe:

- The provider's aims and objectives in providing the service.
- Details of the services provided including the service types (for example, hospice services)
- The health or care needs the service sets out to meet.
- The provider's and/ or any registered managers' full name and contact details
- Details about the legal status of the provider
- All of the regulated activities and locations from which these are provided.

The information in the statement of purpose must always be accurate and up to date. The Trust's statement of purpose is updated whenever service provision changes (for example when a new regulated activity or location is added/removed) or in the event of no change in service, it is updated annually. This is an annual update and no changes to activities or locations have been made.

3.3 Summary of external assurance and third party inspections: Jan -Mar 2016

3.3.1 Local Supervising Authority (LSA) Annual Audit of Statutory Supervision

The LSA Audit occurred on 24th February 2016. The team of auditors included LSA Support Officer, two supervisors of midwives (SOM) from two London trusts and a lay auditor.

The evidence tabled by SGH met requirements outlined in the London LSA Tool for the Statutory Supervision of Midwives 2016', and was submitted two weeks prior to the audit. The evidence related to the statutory framework as outlined in the NMC Midwives' Rules 2012.

- The past: Unit Profile and Action plan from 2015 Audit
- The present: SOM team innovations for 2015 including the Birth Reflections Clinic (see below)
- The future: Impact analysis of removal of Statutory Supervision for women and midwives.

The initial feedback provided was very positive. The LSA audit team identified several areas with strong evidence. A full report will be available within six weeks.

3.3.2 Cervical Screening QA Visit

The cervical screening service for the acute trust (Cytology, Colposcopy and Histology) underwent a QA Visit as part of a three yearly cycle. The visit occurred on 19th Jan 2016 and the Tryst awaits the final report, action plan and recommendations.

3.4 Summary of future external assurance and third party inspections

3.4.1 Patient Led Assessment of the Care Environment (PLACE)

Expected in May 2016 and preparations are underway.

4. 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. There are an increasing number of risks to patient safety and experience identified arising from issues related to estates management and IT infrastructure.

The overall long-term risk profile for the trust continues to be driven by the continued financial and operational pressures faced by the trust.

There have been no significant issues highlighted as a result of external inspections or reviews, however an extensive preparation project ahead of CQC inspection in June 2016 is underway and encompasses an intensive internal inspection programme which will be triangulated with external inspection findings on an on-going basis.

Appendix 1: Executive Overview of Corporate Risk Register

Domain: 1. Quality

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 2016	In month change	Change/progress
1.1 Patient Safety									↓↑	
01-12 Bed capacity for adult G&A beds may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	11/2012	20	20	20	20	20	20	→	
01-13 Theatre capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	11/2014	20	25	20	20	20	20	→	
01-15 Adult critical care capacity may not be sufficient for the trust to meet demands from activity, negatively affecting income, quality, and patient experience	MW	11/2014	20	16	16	16	16	16	→	
A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff	JH	05/2010	12	12	12	12	12	12	→	
01-02 Lack of established process for use, provision, decontamination and maintenance of pressure relieving mattresses	EM	07/2013	9	9	9	9	9	9	→	
01-03 Lack of embedded process for use, provision and maintenance of bed rails	EM	01/2014	9	9	9	9	9	9	→	
01-04 Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children.	JH	05/2014	12	12	12	12	12	12	→	
01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the trust.	JH	05/2014	12	12	12	12	12	12	→	
01-06 Risk to patient safety as patients waiting greater than 18 weeks on elective waiting lists	PVK	05/2014	15	20	20	20	20	20	→	
01-07 Risk to patient safety and experience as a result of potential trust failure to meet 95% Emergency Access	PVK	06/2014	20	20	20	20	20	20	→	

Standard										
01-08 Risk to patient safety due to inconsistent processes and procedures for the follow up of diagnostic test results	SM	07/2014	16	16	16	16	16	16	→	
01-09 Risk to patient safety due to a lack of a trust wide visible training needs analysis, and lack of a system for ensuring these have been met in relation to Medical Devices	EM	10/2014	12	12	12	12	12	12	→	
01-11 Risk to patient safety and experience where full permanent sets of medical records are not available for scheduled outpatient appointments	PVK	06/2015	16	16	16	16	16	16	→	
01-18 Risk to patient safety in the event of failures in the blood track system causing delays in provision of blood products	SM	07/2015	20	20	20	16	16	16	→	
01-16 There is a potential risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of run rate schemes.	EM	07/2015		16	16	16	16	16	→	
01-17 There is a potential risk to the quality and safety of patient care in the event that required works cannot be undertaken due to capital funding decisions not to fund such projects.	EM	07/2015		12	12	12	12	12	→	
01-19 Clinical impact of delays in procurement and/or authorisation of medical supplies and equipment	JH	11/2015				20	20	20	→	
01-20 Potential risk to staff and patient safety in the event of a failure of the Trust to meet its requirement of IR(ME)R or other IRR requirements.	SM	01/2016						12	→	
01-21 Patient care is compromised and incorrect prescribing occurs because General Practitioners receive draft copies of discharge summaries	SM	03/2016						15	**NEW**	
01-22 Potential risk to patient safety due to a failure to ensure all Trust policies are up to date and available to all staff	LE	03/2016						16	**NEW**	

01-23 Patient Safety risk due to electrical infrastructure in Knightsbridge Wing in danger of major failure. A recent large failure of an electrical panel caused the wing to be evacuated								16	**NEW**	

Strategic Objective/Principal Risk	**Lead**	**Start date**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**In month change**	**Change/progress**
1.2 Patient Experience									↓↑	
A410-O2: Failure to sustain the trust response rate to complaints	JH	04/2009	16	16	16	16	16	16	→	
02-01 Risk of diminished quality of patient care as a result of Cost Improvement Programmes (CIPs)	JH	07/2013	16	16	16	16	16	16	→	

Domain: 2. Finance & Performance

Strategic Objective/Principal Risk	**Lead**	**Start date**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**mar 2016**	**In month change**	**Change/progress**
2.1 Meet all financial targets									↓↑	
3.13-05 -Working capital – the trust will not be able to secure the working capital necessary to meet its current plans	IL	07/2015	20	20	10	10	10	10	→	
3.14-05 Working capital – the trust will require more working capital than planned due to: - Adverse in year I&E performance - Adverse in year cash-flow performance	IL	07/2015	20	20	20	20	20	20	→	
3.15-05 Risks to income – that national and local tariffs do not deliver the required income to ensure an at minimum, break even position for the trust	IL	07/2015	20	20	20	20	20	20	→	
3.16-05 Market Share risks – that the trust loses market share, negatively impacting on the trusts activity and	IL	07/2015	20	20	10	10	10	10	→	

income.										
3.17-05 Cost Improvement Programme slippage - The Trust does not deliver its cost improvement programme objectives	IL	07/2015	20	20	15	15	15	15	→	
3.18-05 Cost Pressures - The trust faces higher than expected costs due to:- - unforeseen service pressures - higher than expected inflation - higher marginal costs or costs required to deliver key activity	IL	07/2015	16	16	16	16	16	16	→	
3.19-05 Cash-flow Risks – Cash balances will be depleted due to: - Delays in receipt of SLA funding from Commissioners - Capital overspends	IL	07/2015	12	12	16	16	16	16	→	
3.20-05 Income Volume Risk (Capacity) – that the trust has insufficient clinical capacity, negatively impacting on the trusts activity and income.	IL	07/2015			20	20	20	20	→	

Strategic Objective/Principal Risk	**Lead**	**Start Date**	**Jul 2015**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Jan 2016**	**Mar 2016**	**In month change**	**Change/progress**
2.2 Meet all operational & performance requirements									↓↑	
3.7- 06 Failure to meet the minimum requirements of Monitor Risk Assessment Framework:	PVK	05/213	20	20	20	20	20	20	→	
3.8 – 06 Low compliance with new working practices introduced as part of new ICT enabled change programme	SB	06/2013	16	16	12	12	12	12	→	
3.9 – 06 Risk of inappropriate deployment of e-prescribing and electronic clinical documentation	SB	07/2014	12	12	12	12	12	12	→	
3.21 Transformation resources are of insufficient capacity and/or capability to deliver the expected benefits in 16/17	MW	1/4/2016						15	**NEW**	

Domain: 3. Regulation & compliance

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 2016	In month change	Change/progress
3.1 Maintain compliance with all statutory & regulatory requirements									↓↑	
A534-O7:Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety	JH	10/2010	5	5	5	15	15	15	→	
A537-O6:Confidential data reaching unintended audiences	SM	10/2010	12	12	12	12	12	12	→	
A610-O6: The trust will not attain the nationally mandated target of 95% of all staff receiving annual information governance training	SM	10/2011	15	15	15	15	15	15	→	
03-01: Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	EM	03/2013	16	16	16	16	16	16	→	
03-02 Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with Estates and Facilities legislation	EM	10/2012	16	16	12	12	12	12	→	
03-03 Lack of decant space will result in delays in delivering the capital programme.	EM	05/2014	16	16	16	16	16	16	→	
03-04 Delay to the ability to deliver the capital programme and maintenance activity due to clinical and capacity demands preventing access for estates and projects works.	EM	05/2014	16	16	16	16	16	16	→	
03-05 Trust wide risk to patient, public and staff safety of Legionella	EM	05/2014	12	12	12	12	12	16	→	
03-06 There is a risk of regulatory action should the trust fail to ensure compliance with its HTA licence in relation to the mortuary	JH	08/2015		20	15	15	15	15	→	
03-07 Risk of regulatory action or penalties upon the Trust in the event of a failure to comply with the legislative								15	**NEW**	

requirements of the Freedom of Information Act (2000)										

Domain: 4. Strategy, transformation & development

Strategic Objective/Principal Risk	Lead	Start Date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 2016	In month change	Change/progress
4.2 Redesign & configure our local hospital services to provide higher quality care									↓↑	
A533-O8: Reconfiguration of healthcare services in SWL result in unfavourable changes to SGHT services and finances	RE	09/2010	12	12	12	12	12	12	→	

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 2016	In month change	Change/progress
4.5 Drive research & innovation through our clinical services									↓↑	
05-05 Research does not form a key part of St. George's future activity which may result in the loss of funding and an inability to recruit and retain staff.	SM	03/2013	8	8	8	8	8	8	→	

Domain: 5. Workforce

Strategic Objective/Principal Risk	Lead	Start date	Jul 2015	Sept 2015	Oct 2015	Nov 2015	Jan 2016	Mar 2016	In month change	Change/progress
5.1 Develop a highly skilled & engaged workforce championing our values									↓↑	
A518-O4:Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey	WB	05/2010	12	16	16	16	16	16	→	
A516-O4: Possible reductions in the overall number of junior doctors available with a possible impact on particular specialty areas	WB	11/2012	6	9	9	9	9	12	→	

A520-O4: Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)	WB	05/2010	12	16	16	16	16	20	→	
5.1-01 Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost	WB	11/2015	16	16	16	20	20	20	→	
5.1-02 Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual.	WB	12/2015				15	15	15	→	
5.1-03 Business continuity risk and risk to patient safety as a consequence of failure to adequately plan for junior doctors' strikes	WB	12/2015					20	20	→	
5.1-04 Risk of inability to retain adequately staffing levels arising from a shortage of agency staffing resulting from the national introduction of a cap on agency rates for nurses and locum doctors	WB						16	16	→	
5.1-05 Lack of success of the transformation programme without sufficient organisational support								16	**NEW**	
5.1-06 Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce								20	**NEW**	

JH	Jennie Hall	Chief Nurse (DIPC)	EM	Richard Hancock	Director of Estates & Facilities
SM	Simon Mackenzie	Medical Director	RE	Rob Elek	Director of Strategy
PVK	Paula Vasco-Knight	Chief Operating Officer	WB	Wendy Brewer	Director of Human Resources
IL	Iain Lynham	Director of Finance Performance & Information	MW	Martin Wilson	Director of Transformation

Appendix 2 – New Risks

Principal Risk	01-21 Patient care is compromised and incorrect prescribing occurs because General Practitioners receive draft copies of discharge summaries				
Description	When draft discharge summaries are saved in Merlin, a copy is sent electronically to the GP. The GP may therefore believe that the patient has left hospital when they are still an in patient. This can generate unnecessary work. More seriously, the GP may take action including changing prescriptions based on this information rather than the final version				
Domain				**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Simon Mackenzie
Consequence	3	3		**Date opened**	March 2016
Likelihood	5	5		**Date closed**	
Score	15	15			
Controls & Mitigating Actions	There are no current controls - see action next period. Some possible mitigating actions explored have been determined to carry additional risks. (1. Not producing draft summaries in advance would result in the summary being produced in hast and probably less accurately. It would also adversely impact on patient discharge and therefore delay other admissions. 2. Writing draft at top as free text is unlikely to be reliably implemented and equally might not be removed so increasing uncertainty)			**Assurance**	Negative assurance: Feedback via Clinical Quality Review Group for GP colleagues is that this happens frequently but not yet quantified.
Gaps in controls	See above			**Gaps in assurance**	No clear quantification of how often this problem occurs due to the reliance upon GP colleagues feeding back.
Actions next period:	Explore immediate IT fix to prevent draft summaries being sent out - this refers to Martin's email. Check whether Merlin can be modified to not send summary when draft is saved. Accelerate move to Cerner discharge summaries which do not have this problem. Priority areas Medicine, Medicine of the Elderly				

Principal Risk	01-22 Potential risk to patient and staff safety resulting from a failure to ensure Trust processes and procedures are followed due to significant numbers of Trust policies being out of date					
Description	Policies and Procedures are available on the staff intranet to deal with issues related to patients, staff, major incidents, health and safety and community services, amongst other concerns. Most policies should be reviewed at regular intervals but many are out of date. As a result, external bodies such as CQC or Monitor could potentially find that some policies or procedures that are currently available to staff are in fact out of date or do not cover current legislation or good practice.					
Domain	**Quality**			**Strategic Objective**		**Patient Safety**
	Original	**Current**	**Update**	**Exec Sponsor**		Luke Edwards
Consequence	4	4		**Date opened**		1-3-2016 (escalated from Corporate Affairs Risk Register)
Likelihood	4	4		**Date closed**		
Score	16	16				
Controls & Mitigating Actions	Monthly Policy Ratification Group meeting to review and approve all new policies and policy updates - chaired by Head of Governance/Chief of Staff Plan and recovery trajectory agreed at PRG meeting on 22nd March 2016.			**Assurance**		Oversight by Quality & Risk Committee - report to Jan QRC reported significant number of policies require review Executive Management team appraised of significant number of our of date policies – and plan to recover position – linked to CQC preparation. Intranet site now unable to support updates to ;olicies and needs rebuild.
Gaps in controls	Corporate Administrator post with responsibility for oversight and management of policy catalogue shortly to become vacant (8 April 16) No named job title/ lead for policies. No formalised process of alerting and ensuring timely review Outstanding community policy catalogue requires full integration into Trust catalogue			**Gaps in assurance**		
Actions next period:	Seek additional resource to project manage backlog and process of review and ratification – for four month period. Map current position against critical policies ahead of CQC inspection Request Executive leadership around review of policies Complete build of intranet					

Principal Risk	01-23 Patient safety risk due to electrical infrastructure in Knightsbridge Wing in danger of major failure. A recent large failure of an electrical panel caused the wing to be evacuated.				
Description	The aged electrical panel had a catastrophic failure and the wing was evacuated. Temporary repairs have been undertaken while a permanent replacement panel is being manufactured and installed. The electrical infrastructure has reached the end of its useful life.				
Domain	**3.Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory & regulatory requirements**
	Original	**Residual**	**Updated**	**Exec Sponsor**	Richard Hancock
Likelihood	5	4		**Date opened**	1.3.2016
Consequence	4	4		**Date closed**	
Score	20	16			
Controls & Mitigating Actions	Temporary repairs undertaken. Replacement panel manufacture is underway.			**Assurance**	To provide adequate assurances the electrical services in Knightsbridge wing to be tested and refurbished to BS 7671 and where appropriate additional circuits and accessories fitted to HTM 06.
Gaps in controls	Temporary repair will only keep the panel operational for the short term. Does not address deficiencies in infrastructure.			**Gaps in assurance**	Building was due to be decanted and demolished , therefore little expenditure on electrical infrastructure in recent years.
Actions next period:	The replacement panel, as advised by the manufacturer, should be supplied and installed by mid April 2016. Six facet survey to be undertaken to indicate condition of infrastructure and remedial actions required now building has life expectancy of circa 5 years.				

Principal Risk	03-07 Risk of regulatory action or penalties upon the Trust in the event of a failure to comply with the legislative requirements of the Freedom of Information Act (2000)				
Description	The provisions of the Freedom of Information Act stipulate that any questions asked of the Trust under the Act must receive a response within 20 days. A lack of timely response from Trust-wide staff in relation to each request results in a late submission. Respected instances could lead to penalties or regulatory action being taken against the Trust				
Domain				**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Luke Edwards
Consequence	5	5		**Date opened**	1-3-2016 (escalated from Corporate Affairs Risk Register)
Likelihood	3	3		**Date closed**	
Score	15	15			
Controls & Mitigating Actions	One dedicated person coordinating requests received and temporary resource secured from 29th March until additional substantive post in place. Policy in place.			**Assurance**	Current backlog of overdue requests over 250 as at 24.3.2016. Two requests for internal review by applicants whose request has been overdue No reporting or escalation mechanism by which to performance monitor divisional responses. Divisional response rates poor and a lack of understanding of importance of timely response to either re-direct or provide requested info.
Gaps in controls	Senior corporate Administrator responsible for FOI currently covering vacant team in role means less focussed time upon FOI process Manual system with no automated capacity to manage requests			**Gaps in assurance**	No formal oversight by a Trust Committee hence level of risk and route of escalation is not clearly defined
Actions next period:	Explore electronic workflow solutions which would automate reminders and produce performance and status reports Explore possible ways to increase awareness amongst divisional staff in order to create a higher profile Develop formal monthly report for each division of outstanding requests Recruit to substantive post				

Principal Risk	5.1-05 Lack of success of the transformation programme without sufficient organisational support				
Description	If Exec Directors and Divisional leadership teams are not engaged and supportive of the transformation programme it will not succeed.				
Domain	**HR & OD**			**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4		**Date opened**	1/3/2016
Likelihood	5	4		**Date closed**	
Score	20	16			

Controls & Mitigating Actions	There is a detailed organisational development programme to support the transformation programme Plan of work in place to develop the required support/resource : 1. Ensure Exec team are positively leading engagement and communications around change 2. Embedding leadership development 3. Support for individual teams	**Assurance**	Board Development programme in place. Reports to Turnaround board and Workforce and education Committee.
Gaps in controls	Resource in the OD team to support the work plan may not be sufficient as it is difficult to anticipate the full extent of what of required for whole programme at this stage.	**Gaps in assurance**	Gap in terms of resource will be identified as the programme develops.
Actions next period:	Detailed session with workforce efficiency programme lead, OD lead and KPMG to identify all resource needed Continue to review the plan		

Principal Risk	5.1-06 Impact upon capacity to deliver quality core services and transformation programme due to disengaged workforce				
Description	Staff survey and medical engagement scores and results indicate a significantly reduced level of engagement amongst staff				
Domain				**Strategic Objective**	
	Original	**Current**	**Update**	**Exec Sponsor**	Wendy Brewer
Consequence	4	4		**Date opened**	1/4/2016
Likelihood	5	5		**Date closed**	
Score	20	20			
Controls & Mitigating Actions	Delivery of workforce action plan for 16/17 themes focus upon: - Staff feeling able to report concerns - Pressure felt by staff - Engagement & communication with leaders - Appraisal - Fairness - Bullying Support from staff side representatives and governors in engaging staff			**Assurance**	Negative Staff survey results and medical engagement score Progress against workforce action plan reports to Workforce and Education Committee
Gaps in controls	Limited ability to influence or mitigate external factors including; London wide issues of staff turnover, turnaround and financial position Levels of disengagement amongst managers make it difficult to effectively deliver the programme			**Gaps in assurance**	Difficult to ascertain level of management engagement
Actions next period:	Staff survey open session Review bullying and harassment policy Recruit from Philippines to alleviate staffing pressures				

Principal Risk	3.21 Transformation resources are of insufficient capacity and/or capability to deliver the expected benefits in 16/17				
Description	The transformation programme is expected to deliver improvements in quality and £50m of in year cost improvements through 6 key work areas and 22 projects. Delivery of this complex trust wide programme requires				
Domain	**Transformation**			**Strategic Objective**	**Deliver our Transformation Programme enabling the trust to meet its operational and financial targets**
	Original	**Current**	**Update**	**Exec Sponsor**	Martin Wilson, Director of Transformation
Consequence	4	4		**Date opened**	1/3/2016
Likelihood	5	4		**Date closed**	
Score	20	15			

Controls & Mitigating Actions	Detailed implementation plans have been developed for each element of the transformation programme, including the resource requirements of each project. An overarching transformation resource plan has been developed, which sets out the quantity, skills and timescales for required resources together with proposed sourcing strategy (secondments, interims, recruitment etc). Dedicated HR and KPMG resources have been secured to source the required individuals. The resourcing risks are being mitigated by pursuing parallel sourcing routs (including secondments, KPMG consultants and interims) for some key roles. Appropriate handover periods are arranged where there is a transition between individuals. A twice weekly executive level Resource Gap Group has been established to oversee the sourcing of individuals within the resource plan and to take any mitigating actions required.	**Assurance**	Programme area and/ or project level assurance meetings were held with Board, divisional and Monitor representatives to test assumptions and implementation readiness of all detailed implementation plans. KPMG has provided independent quality assurance throughout their development. The DIPs and overall resource plan together with the financial impact has been approved by Turnaround Board, Finance and Performance Committee and the Board. The resource plan has been submitted to NHS Improvement as part of the business case approvals process.
Gaps in controls		**Gaps in assurance**	Capability of individuals and project teams to deliver transformation programme is not expressly assured currently.
Actions next period	Continue implementation of resource plan. Exception reporting via steering groups to Turnaround Board and where necessary Finance and Performance Committee.		

Appendix 3

Care Quality Commission - Statement of Purpose April 2016

Introduction
St George's University Hospitals NHS Foundation Trust is one of UK's largest teaching hospitals. It is the largest provider of hospital services in the South West sector of London and the largest single site hospital in London.

St George's hospital is situated within the South West London borough of Wandsworth, the catchment area of our community services division. Our divisions serve a catchment area covering 33 electoral wards from the boroughs of Wandsworth (15), Merton (14) and Lambeth (4) a population of approximately 400,000. The trust community is characterised by:

- A young age profile
- A highly mobile population that moves into and out of the area frequently
- Relative affluence compared to London as a whole and nationally, although there are pockets of deprivation especially amongst children
- Younger people in the population have healthy lifestyles, while the health status of older population is worse than the national average
- A high incidence of cancer and stroke in the Wandsworth population compared to England
- Low life expectancy compared to England.

The aim of this statement of purpose is to outline the services that are provided by St George's (STG) University Hospitals NHS Foundation Trust

STG Trust Nominated Individual is Ms Jennie Hall (Chief Nurse & Director Infection Prevention and Control), jennie.hall@stgeorges.nhs.uk

Vision, mission and values

Vision
In 2015, St George's Healthcare NHS Trust became a Foundation Trust at the heart of its strategy is to provide an integrated health care system that delivers improved patient care in the community, hospital and specialist settings, supported by a unique and nationally recognised programme of research, education and employee engagement.

Mission
Our mission is to improve the health of our patients and our local community by achieving excellence in clinical care, research, education and employment

Values
Our current services and our future work are based upon a set of **values** that help us guide our work to provide excellent patient care. We have worked with staff from across the organisation and distilled our values into the following four:

- Excellent
- Kind
- Responsible
- Respectful

These values are underpinned by behaviours that we wish to encourage, behaviours we will not accept and behaviours that describe how will do business. We are ensuring that these values and behaviours are explicitly part of the appraisal process for all staff in the Trust.

Our vision, values and behaviours are congruent with the values within the NHS Constitution which are:

- respect and dignity
- commitment to quality of care
- compassion
- improving lives
- working together for patients
- everyone counts

Services provided at present:

St George's University Hospitals NHS Foundation Trust is an integrated trust providing community services alongside specialist teaching hospital services for secondary and tertiary care.

St George's hospital is a recognised tertiary centre, providing care for the most complex injuries and illnesses. Many specialist services are provided as part of clinical networks, in which we are the specialist hub. We are one of the four trauma centres in London and in 2009 became a designated hyper-acute stroke unit. We were the first Trust in London to provide primary angioplasty services 24 hours a day and we are the only hospital in South West London to provide inpatient paediatrics services

Table 1: An overview of our clinical services at present

Specialist level	Catchment population		Services provided
	Area	Population	
Community	Wandsworth borough	231k	Children & Families services Adult, specialist and diagnostic services Older people and neurological rehabilitation services
Secondary	33 wards across Wandsworth, Merton and Lambeth	400k	Accident and emergency Acute medical services General surgery Maternity Paediatrics Diagnostics Therapies
Tertiary	South West London & Surrey	>2m	Cancer services Neonatal intensive care Plastic and reconstructive surgery ENT SW London and Surrey Trauma Network

Specialist level	Catchment population		Services provided
	Area	Population	
Supra-regional	SW London, & South East England	2m – 6m	Cardiothoracic medicine and surgery Neurosciences Renal transplant Complex pelvic trauma
National specialist centre	England		Family HIV care Bone marrow transplant Urology/penile cancer Endoscopy

Our services are split into four divisions and a consortium at present (see table 2):

- Medical and Cardiovascular services
- Surgery, Neuroscience and Cancer services
- Children, Women and Maternity services
- Community Services
- South West London Pathology Services consortium

Location sites of STG

As part of the registration process for the Care Quality Commission (CQC), St George's University Hospitals NHS Foundation Trust has six registered locations form which it provides regulated activity (see table 3 – 4):

- St George's Hospital site in Tooting
- St John's Therapy Centre, Battersea.
- Queen Mary's Hospital
- HMP Wandsworth
- Nightingale House
- Nelson Health Centre

As of 01 April 2014, St. George's University Hospitals NHS Foundation Trust became host Trust for South West London Pathology Services (SWLP), a consortium consisting of St. George's, Kingston and Croydon Trusts. Under this new arrangement St George's additionally provides pathology services at Kingston and Croydon Hospitals.

Divisional management structure

The Trust is structured into clinical divisions (in addition to SWLP consortium), supported by corporate directorate.

Figure 1: shows the Divisional management structure

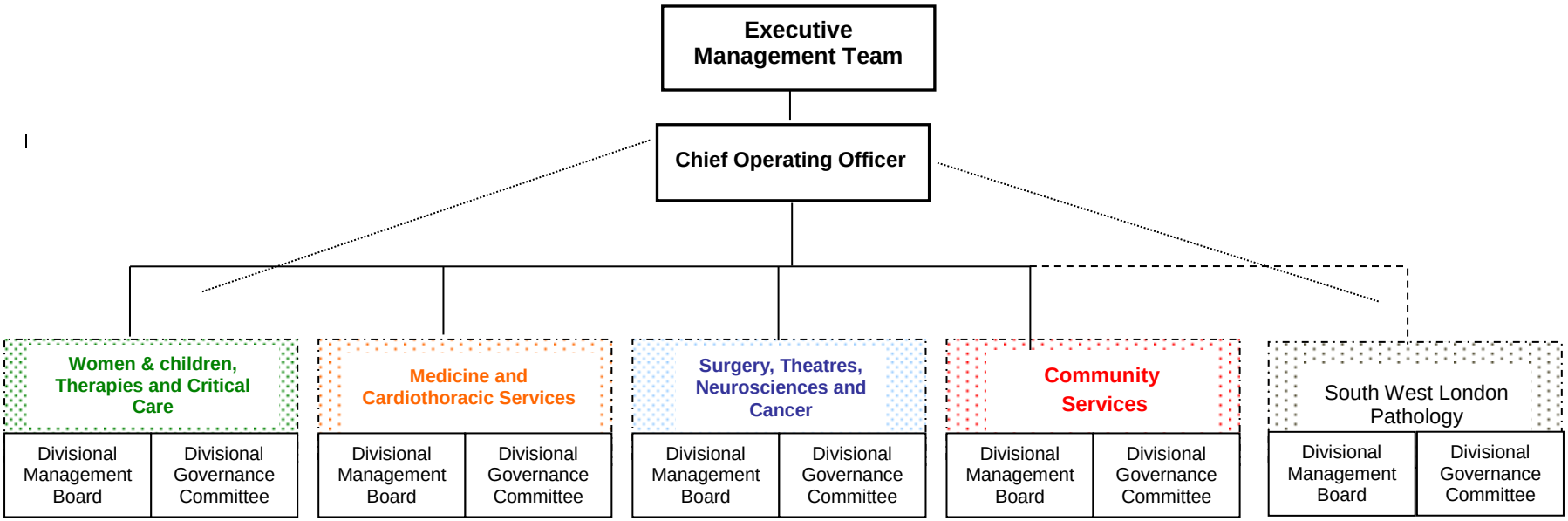


Table 2: Breakdown of services by Clinical Divisions and SWLP consortium April 2016

Surgery, Neurosciences, Theatres & Anaesthetic, and Cancer Division	Medicine & Cardiovascular Division	Children & Women's, Diagnostic and Therapeutic Service Division	Community Services Division	South West London Pathology
Surgery Clinical Directorate **Care Groups:** • Urology • General Surgery • Trauma & Orthopaedics • Plastics • Maxillofacial & Oral Surgery • Dentistry • Audiology and ENT	**Acute Medicine Clinical Directorate** **Care Groups:** • Accident & Emergency • Acute Medicine • Geriatric medicine	**Diagnostics Clinical Directorate** **Care Groups:** • Breast screening • Radiology • Clinical Genetics • Mortuary	**Ambulatory Care Directorate** **Care Groups:** • Integrated sexual health services (HIV/GUM & Reproductive sexual health) • Offender Health Care – HMP Wandsworth • Outpatients and Diagnostics	**South West London Pathology** **Care Groups:** • Clinical Blood Sciences • Microbiology • Cellular Pathology

Neurosciences Clinical Directorate **Care Groups:** • Neurosurgery • Neuroradiology • Neurology & Neurophysiology • Neurorehabilitation/ Stroke	**Cardiothoracic & Vascular Services Clinical Directorate** **Care Groups:** • Cardiology • Cardiothoracic surgery • Vascular Sciences	**Children Clinical Directorate** **Care Groups:** • Neonatal • Paediatric Medicine • Paediatric Surgery • PICU	**Community Adult and Children's health Care Services Directorate** **Care Groups:** • Children and families Services • Rehabilitation and Adult Therapy • Community Adult Health Services	
Anaesthetics & Theatres Clinical Directorate **Care Groups:** • Anaesthetics, Acute pain & Resuscitation • Theatres, Day Surgery & Decontamination	**Specialised Medicine Clinical Directorate** **Care Groups:** • Clinical Infection Unit • GUM • Gastroenterology& Endoscopy • Rheumatology • Dermatology & Lymphoedema • Diabetes & Endocrinology • Chest Medicine • BPU	**Women Clinical Directorate** **Care Groups:** • Obstetrics • Gynaecology • Fetal Medicine		
Cancer Clinical Directorate	**Renal, Haematology & Oncology Clinical Directorate** **Care Groups:** • Renal • Medical Oncology & Palliative Care • Clinical Haematology	**Outpatients Clinical Directorate** **Care Group:** • Outpatients St. George's • Outpatient QMH • Outpatient Nelson		

		• Outpatient's St. John's		
Major Trauma Directorate		**Critical Care Clinical Directorate** **Care Groups:** • General ICU • Cardiac ICU • Neuro ICU		
		Therapeutics Clinical Directorate **Care Group:** • Therapies		
		Pharmacy clinical Directorate **Care Group:** • Medicine Management / Pharmacy		

Table 3: List of Location for CQC registration and provided services:

Location for CQC registration	Regulated Activities	Services Included
St. George's Hospital	Treatment of disease, disorder or injury	Emergency Department [Majors area, Urgent Care Centre (UCC), Clinical Decision Unit (CDU), Children ED, Paediatric Assessment Unit (PAU), Minor injuries in QMH] Acute and Senior Health medicine Heart Failure Unit Gerontology Rheumatology

		Dermatology & lymphoedema Diabetes and endocrinology Infection Unit Chest medicine Gastroenterology Endoscopy Interventional radiology Medical oncology Clinical haematology Renal Cardiology Urology Orthopaedics Head & Neck Dentistry Neurosciences Paediatrics Cardiothoracic ICU Paediatric ICU Neuro ICU General ICU HDU Neonatal Unit/SCBU Paediatric oncology Palliative care Podiatry Anti-coagulation Physiotherapy Hand therapy Occupational Therapy Speech and Language Therapy Dietetics Rehabilitation Sexual Health (GUM – HIV – reproductive sexual health) Long-term conditions services Radiotherapy

	Surgical operations	Paediatric surgery Neuro surgery Cardiac surgery Vascular surgery Thoracic surgery Urology surgery Plastic surgery Maxillofacial & Oral surgery Audiology & ENT surgery Dentistry surgery Gynaecology surgery Obstetric – caesarean sections Neonatal surgery Orthopaedic surgery Renal surgery Colorectal surgery Breast surgery Upper GI Interventional Radiology
	Diagnostic and screening procedures	
	Pathology	Blood Science Medical Microbiology Cellular pathology Genetics
	Radiology	CT scan MRI Ultrasound Antenatal ultrasound x-ray Angiography Fluoroscopy Breast screening Ultrasonography Magnetic resonance Nuclear Medicine SPECT-CT

		PET-CT (mobile van) DEXA scan
		Endoscopy Cardiac Vascular
	Management of the supply of blood and blood derived products	
	Maternity and midwifery services	Maternity (antenatal, delivery and post natal) Fetal medicine
	Termination of pregnancy	In patient
	Family planning services	Maternity clinics Community clinics
Queen Mary Hospital	Treatment of disease, disorder or injury	Elderly in-patient rehabilitation Community services for adults Cardiology Dermatology Endoscopy Neuro-rehabilitation Complex neuro-rehabilitation / amputee service Orthotics & Prosthetics Minor Injuries Rehabilitation Physiotherapy Paediatric therapies Children's community nurses Urology Health visiting team Children, young people and families Sexual integrated health services
	Surgical operations	Minor operations Dermatology

	Diagnostic and screening procedures	Rapid diagnostic and treatment facilities Radiology (CT / MRI / x-ray) Endoscopy Phlebotomy
Nightingale House	Treatment of disease, disorder or injury	Elderly in-patients
St. John Therapy Centre	Treatment of disease, disorder or injury	Audiology Cardiology Chest Medicine Dermatology Gastroenterology Geriatric Medicine (Elderly Day Hospital) Head and Neck (Macmillan) Hearing Aid Support Musculoskeletal Interface Neuro-rehabilitation Neurology Paediatrics Paediatric Gastro Renal Medicine Rheumatology Urology (suspended after 14/4) Vascular Plastic Colorectal Community Neuro-rehab Elderly Day Hospital Community services for adults Therapies Children, young people and families
	Maternity and midwifery services	Community midwives
Nelson Health Centre	Treatment of disease, disorder or injury	Cardiology Dermatology General medicine

		Gynaecology Respiratory medicine Rheumatology Trauma & orthopaedics Urology Colorectal Upper GI Vascular Diabetes Anti-coagulation
	Surgical operations	Plastic surgery (minor procedures) Dermatology (minor procedures)
	Diagnostic and screening procedures	X-ray Ultrasound Phlebotomy Endoscopy Cardiac testing
HMP Wandsworth	Treatment of disease, disorder or injury	24 hour nurses cover /inpatient facilities Prison drug rehab programmes Primary care (GP/nurses) GUM & HIV outreach
Croydon Health Services NHS Trust, 530 London Road, Croydon CR7 7YE. (South West London Pathology Services).	Diagnostic and screening procedures	Clinical Blood Sciences
Kingston Hospital NHS Trust, Galsworthy Rd, Kingston upon Thames KT2 7QB. (South West London Pathology Services).	Diagnostic and screening procedures	Clinical Blood Sciences

Table 4: List of health centres from which community services are provided (clinics or outreach) which as regulated activity is encompassed within the main site as a location:

Location	Regulated Activities	Services included
Balham Centre	Treatment of disease, disorder or injury	Health Visiting School Nursing Homeless and asylum health team Reproductive sexual health
	Diagnostic and screening procedures	Haemoglobinopathy team
Doddington Clinic	Treatment of disease, disorder or injury	Health Visiting School Nursing Reproductive sexual health
Eileen Lecky Clinic	Treatment of disease, disorder or injury	Health Visiting Child health Reproductive sexual health
Greenmead	Treatment of disease, disorder or injury	Community physiotherapy team Community rehabilitation team (OT/SALT)
Linden Lodge	Treatment of disease, disorder or injury	Community physiotherapy team Community rehabilitation team (OT/SALT)
Oak Lodge	Treatment of disease, disorder or injury	Community physiotherapy team Community rehabilitation team (OT/SALT)
Paddock School	Treatment of disease, disorder or injury	Community physiotherapy team Community rehabilitation team (OT/SALT)
Tooting Health Care	Treatment of disease, disorder or injury	Health Visiting School Nursing Complex Care Management South Locality Reproductive sexual health
Trident Business Centre	Treatment of disease, disorder or injury	CAHS nursing management team Community Heart Failure nurses

		Community respiratory nurses Facilitated and supported discharge function Complex care management – night service
Stormont Health Centre	Treatment of disease, disorder or injury	Health Visiting Complex care management – north locality Access and coordination team POINT Young Person clinic
Tudor Lodge Medical Centre	Treatment of disease, disorder or injury	Health Visiting Complex Care Management East Locality
Aspire Centre / Southfield community College	Treatment of disease, disorder or injury	School nursing
Brocklebank Health Centre	Treatment of disease, disorder or injury	Health Visiting Reproductive sexual health
Bicknell Centre	Treatment of disease, disorder or injury	Community learning disability
Bridge Lane Health centre	Treatment of disease, disorder or injury	Health Visiting
Garrat Park School	Treatment of disease, disorder or injury	SALT therapy
Ronald Gibson House	Treatment of disease, disorder or injury	Therapy in reach
Southfields Group Practice	Treatment of disease, disorder or injury	Rapid response function of care
Trinity Medical centre	Treatment of disease, disorder or injury	Health Visiting
Westmoor Community clinic	Treatment of disease, disorder or injury	Complex Care management West locality

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD ***April 2016***

Paper Title:	**PwC Recommendations**
Sponsoring Director:	**Andrew Burn**
Author:	**Michael Lewis**
Purpose: *The purpose of bringing the report to the board*	*To provide an update on the PwC recommendations and how the outstanding recommendations will be resolved.*
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	**Approve the recommendations of this paper**
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	**n/a**

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

1. Overview

- PwC provided the Trust with a list of 76 actions ("PwC Actions") on 31 July 2015.
- The PwC Actions were assigned to SROs, who have been implementing the appropriate recommendations.
- On 7 March 2016, a status report was circulated to all SROs regarding the outstanding PwC Actions.
- A complete list of the PwC Actions is appended to this report.

2. Review

- As of 7 March 2016, 62 PwC Actions had been completed, 13 remained open and one was not accepted by the Trust.

- The one PwC Action not accepted was:

  "The Divisional Management Board agendas should be revised to include the reporting of divisional risk registers, with clear recording and tracking of any new risks, and the monitoring and challenge of CIP and SIP delivery."

- Subsequently, a full review of all 76 PwC Actions has been undertaken focusing on:
  - actions required to complete the open recommendations and identifying the responsible person to complete the actions; and
  - ensuring that completed actions have been implemented and can be evidenced.

- The review was completed on 21 March 2016 and the outcomes have been summarised below.

3. Outcome

- Following the review, 65 recommendations have been completed and 11 remain open.

- This includes one recommendation moving from "complete" to "progressing" due to insufficient evidence being available to confirm that the recommendation had been actioned.

- This recommendation is:

  "The Trust should review the meetings cycle for the Trust and map out the flow of information

between committees and the Board. The Trust should also consider the various sub-groups and working groups that report into the committee structure and identify whether there is any duplication in theses in terms of attendees and reports being discussed. This review should consider exception reporting where appropriate through to the Board."

- The information flow map has not yet been completed and as such a full assessment of duplication has not been conducted.

- One recommendation was initially signed off as "not accepted" (as detailed above). On review, governance work will be undertaken to implement a protocol for the reporting of divisional risk registers. As such, the recommendation has been reopened.

- The outstanding recommendations fall into four areas:
  - Governance – six recommendations
  - Finance – three recommendations
  - Procurement – one recommendation
  - HR – one recommendation

4. Outstanding recommendations and actions

- *Governance*

PwC ref	PwC action	Review Comments - 17 March 2016	Complete by 31/3/16?	Status As at 7 March 2016	Status As at 21 March 2016	Responsible owner post 31 March 2016	Anticipated Completion Date
45	There should be an overall review of Board and sub-Committee papers to provide greater insight and intelligence. These should drive action focused conversations, setting out the reasons for performance variances, the actions being taken, how these actions will be monitored, when they are expected to be delivered and who is responsible for it. In the longer term, the Trust should consider more integrated reporting to incorporate, performance, quality and finance. This would enable the Board to identify Trust-wide performance against key metrics, with clear actions to address adverse performance. The Trust needs to ensure reports are succinct and contain the headline points.	Integrated performance report is in place but needs refinement - lacks detail on actions required to address issues. Requires details of controls and assurances for risks on the risk register. QIA of intergrated report summary to be completed by responsible ED pre circulation. New cover sheet template being produced for all papers, which will provide an audit trail regarding which committees papers have been to prior to Board as well as a high level outcomes and actions section. This will require approval by the new chair and rolling out. Anticipated that this will be in place by May 2016.	No - new front sheet to be agreed and refinements to performance report to be implemented.	PROGRESSING	PROGRESSING	Luke Edwards	31-May-16
64	Challenge at the Board and sub-committees should focus more on seeking assurance over actions taken to address adverse performance and in relation to risk. The provision of more concise and focused financial reports that highlight clearly the key issues, risks and proposed actions should enable more effective challenge.	Improved financial reporting is in place. Additional actions still required to ensure sufficient challenge and assurance at Board meetings. Work is being undertaken as to how to measure that this has been achieved. It wil be approached through coaching and training - Board Development Programme is ongoing. Need to ensure that training covers the correct level and appropriateness of challenge that should be applied. Conclusions of the work flow review will help to get the correct core documents and better agendas so as to shape the conversation. New interim chair now in place to help shape the board and provide leadership. This action will be complete by the end of June 2016.	No - Specific governance workstream being developed to address all the governance actions. This acton will be complete by the end of June 2016.	PROGRESSING	PROGRESSING	Luke Edwards	30-Jun-16
65	The Board should ensure that it considers all the relevant matters pertaining to a single issue. For example, when considering overall activity, we would expect to see the triangulation of capacity, workforce and commissioner/ other funding to ensure that appropriate decisions are made. When facing recruitment issues, we would expect the Quality and Risk Committee ("QRC") to look at risk to patient safety, the Workforce Committee to look at recruitment processes and the F&PC to look at financial impact of temporary staff.	F&P and QRC happen on the same day so not possible for outcomes of one to be shared with the other unless common attendees. This is interdependent with recommendation 66 and the map of information flow. Testing on the minutes of the three committees to ensure that the outcomes of each are impacting on it. New front sheet for board reports will allow more transpamecy to ensure that triangulation has occured.	No - Specific governance workstream being developed to address all the governance actions. This acton will be complete by the end of June 2016.	PROGRESSING	PROGRESSING	Luke Edwards	30-Jun-16
66	The Trust should review the meetings cycle for the Trust and map out the flow of information between committees and the Board. The Trust should also consider the various sub-groups and working groups that report into the committee structure and identify whether there is any duplication in theses in terms of attendees and reports being discussed. This review should consider exception reporting where appropriate through to the Board.	Lack of evidence to confirm that this work has been undertaken. Map of information flow not completed - this is still ongoing. Requirement to check the Terms of Reference for meetings to review how minutes flow. Need to complete map to review whether there is duplication.	No - Anticipate first draft of information map and terms of reference to be prepared by May 2016. This will then need to be rolled out and will be complete and fully implemented. Specific governance workstream being developed to address all the governance actions. This acton will be complete by the end of June 2016.	COMPLETE	PROGRESSING	Luke Edwards	30-Jun-16
73	The Divisional Management Board agendas should be revised to include the reporting of divisional risk registers, with clear recording and tracking of any new risks, and the monitoring and challenge of CIP and SIP delivery.	Unclear as to why the recommendation was not accepted. Processes to be brought in place to address this. Need to ensure that divisional governance boards are reporting to the DMB and that there is not a governance gap.	No - process to be defined to ensure that divisional governance boards are reporting to DMB. Specific governance workstream being developed to address all the governance actions. This acton will be complete by the end of June 2016.	NOT ACCEPTED	PROGRESSING	Luke Edwards	30-Jun-16

74	An accountability framework should be established which clearly sets out the responsibilities of the care groups, directorates, divisions and the Board. This framework should define the performance management processes and the consequences for failure to deliver. The current performance management process should be reviewed and refreshed to ensure that (a) there is clear accountability and responsibility and (b) responsibility sits with those with relevant experience. For example, the PMO function should not have responsibility for finance functions and vice versa.	The Trust has taken several steps to address this: 1. Introduction of the COO, with DDOs being accountable to her 2. Performance management has been moved from the Finance to the COO 3. Developed and implemented a new performance framework in August 2015. 4. The PMO has been moved to the Director of Transformation, who does not have financial responsibilities 5. A consistent set of objectives have been introduced for the 100 top leaders via their PDP 6 Accountability for transformation programmes has been set in to the Executive SROs objectives and appraisals. This action needs to remain open as the framework needs to be refreshed, to include consequences of failure to deliver changes to the .	No - it is anticipated that the refreshed framework will be in place by May 2016. The COO has taken over responsibility for this action.	PROGRESSING	PROGRESSING	Paula Vasco-Knight	30-Apr-16

- *Summary next steps*
  - Luke Edwards is preparing a governance programme to address five of the outstanding governance PwC Actions. This programme will complete the five actions by the end of June 2016.
  - The sixth governance PwC Action, the production of an accountability framework, has been substantially completed. The action has not been closed as the performance framework developed in response to this action in August 2015 is now out of date. The framework requires updating to reflect changes in the Board e.g. the introduction of the COO, and to include consequences for failure to deliver. Paula Vasco-Knight has taken over responsibility for this and this will be completed by May 2016.
- *Recommendations*:
  - The outstanding governance actions are incorporated into a specific governance workstream, led by Luke Edwards, for completion by the end of June 2016.
  - The accountability framework is refreshed by May 2016 and then updated annually by the COO as part of business as usual.

- *Finance:*

PwC ref	PwC action	Review Comments - 17 March 2016	Complete by 31/3/16?	Status As at 7 March 2016	Status As at 21 March 2016	Responsible owner post 31 March 2016.	Anticipated Completion Date
2.2	Responsibility for budget setting should be clearly defined in job descriptions and monitored through the appraisal process.	Appropriate wording regarding budget setting has been prepated but as yet has not been included in job descriptions. This delay is due to revisions being made to the list of budget holders and HR are awaiting a revised list. Revised list has been produced by Kevin Harbottle and is awaiting EMT approval. Action can be implemented relatively quickly once the list has been agreed. Anna Anderson to provide the revised list to Wendy Brewer once confirmed to allow the action to be completed.	No - Awaiting EMT approva for revised list. Assuming is approved at EMT on 4 April 2016, aim for completion by end May 2016 to allow HR time to update.	PROGRESSING	PROGRESSING	Anna Anderson/ Wendy Brewer	31-May-16
52	Strategic Finance Managers ("SFMs") should have a role in up skilling and raising financial awareness amongst management in their division and within directorates. The Trust should consider developing a programme of finance training for budget holders covering how to set, manage and monitor financial performance.	A training programme has been developed. This has been delayed due to the revised list of budget holders being agreed by EMT. Once this has been done the mandatory training process will be rolled out. Coaching elements have been added to job descriptions.	No - this will remain open until June 2016 when the reduction in budget holders has been transacted and the training programme has commenced..	PROGRESSING	PROGRESSING	Anna Anderson	30-Jun-16
67	The content included in the Financial Risk Assessment should continue to be prepared and presented for the whole financial year (we note that from M5 (August) the paper was amended to a Forecast Outturn paper. This will ensure that the delivery of mitigations is more effectively tracked. A single, consistently prepared paper should be designed, which incorporates the key content from both the Financial Risk Assessment and the Forecast Outturn paper.	The FRA is not currently being produced. A new process for producing a single consistently prepared paper is being designed for implication in 16/17. Anna Anderson is preparing this new process and it is anticipated to be in place for the start of the new financial year.	Yes	PROGRESSING	PROGRESSING	Anna Anderson	31-Mar-16

- *Summary next steps*
  - Actions 2.2 (responsibility for budget setting in job descriptions) and 52 (training for budget holders) remains open. Finance have produced a revised list of budget holders, which is awaiting approval by EMT. Once approved, the two actions can be implemented.

- Action 2.2 will require the revised list of budget holders to be shared with HR. Anna Anderson will be responsible from Finance from sharing this information and Wendy Brewer for ensuring the job descriptions are updated. This will be completed by 31 May 2016.

- Anna Anderson will be responsible for rolling out the prepared training plan to the budget holders. This will be completed by 30 June 2016, once the training programme has been commenced.

- Action 67, the production of a single consistently prepared pack including the Financial Risk Assessment and Forecast Outturn, will be completed by Anna Anderson by April 2016.

- *Recommendations*:

  - Clear plans are in place for each of the three PwC Actions and should be completed accordingly.

  - Going forward, changes in budget holders, training, appraisals etc. should be incorporated into business as usual and be the responsibility of Iain Lynam with support, where appropriate, from Wendy Brewer.

- *Procurement:*

PwC ref	PwC action	Review Comments - 17 March 2016	Complete by 31/3/16?	Status As at 7 March 2016	Status As at 21 March 2016	Responsible owner post 31 March 2016.	Anticipated Completion Date
9	A scaled review, based on value, of contracts should be undertaken to ensure that the ongoing costs are reflected accurately within budgets. This should include a complete mapping of the timescales associated with the contracts and when contracts or elements thereof will cease and renewals are required.	Basic contract database is now in place. The database is not fully populated and is maintained on an ad hoc basis. A Contracts Manager is currently being recruited- aim to be in post by 30 June 2016.	No - requires appointment of new contract manager. Once in post this will become BAU. Complete by July 2016	PROGRESSING	PROGRESSING	Iain Lynam	31-Jul-16

  - *Summary next steps*

    - The outstanding recommendation has been part transacted but the appointment of a new contracts manager is required for this action to be completed in full. The new contract manager's role will include maintaining a contracts. This Action should be completed by July 2016 and has transferred to Iain Lynam as the Executive responsible for Procurement.

  - *Recommendations*:

    - Appoint new contracts manager and on-board by July 2016.

    - Responsibility for maintaining and updating the register becomes business as usual as part of the manager's role.

- *HR:*

PwC ref	PwC action	Review Comments - 17 March 2016	Complete by 31/3/16?	Status As at 7 March 2016	Status As at 21 March 2016	Responsible owner post 31 March 2016.	Anticipated Completion Date
42	An effective workforce tracking mechanism should be put in place to ensure a complete overview is available, in 'real time', of current and known future headcount, vacancies and the associated costs to ensure greater oversight at a Trust-wide level.	KPMG have supported the development of a tracker for current and past workforce tracking. Trac in place and operational. Issue with the weekly reporting onto Tableau. This is being addressed. Future workforce tracking is reliant on business planning process that is currently being undertaken.	No - tableau issues to be addressed by IT and business planning needs completing. Anticipate that this will be dealt with and recommendation can be signed off by 30/04/2016.	PROGRESSING	PROGRESSING	Wendy Brewer	30-Apr-16

  - *Summary next steps*

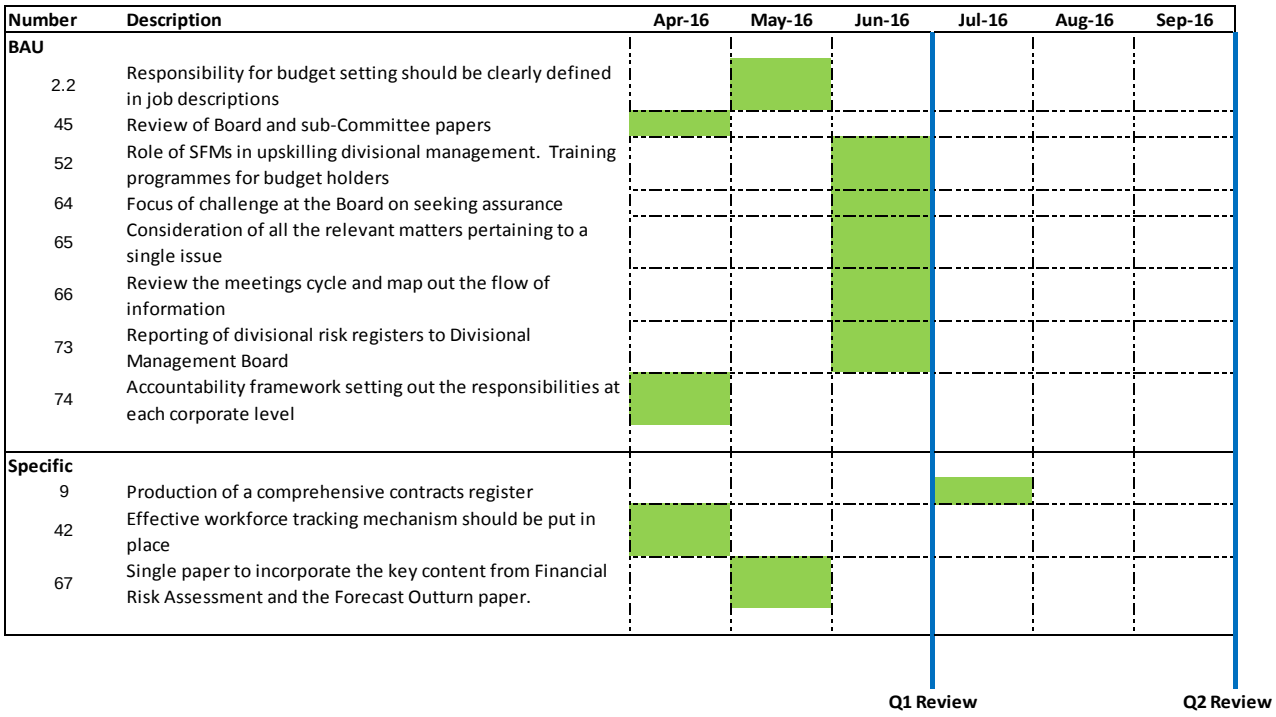
    - The remaining actions required to complete this action will be undertaken by the end of April 2016 by Wendy Brewer.

- *Recommendations*:

  - Action completed by April 2016 and subsequent changes to be incorporated into business as usual. Wendy Brewer will be responsible for this.

5. Overall Summary

- PwC Actions to be completed in line with the above recommendations.
- Review to ensure PwC Actions completed at the end of Q1 with subsequent review at the end of Q2 if required.
- Chair to be responsible for ensuring the Q1 and Q2 reviews are completed.



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?

Closing the PwC recommendations and moving to business as usual creates the risk that the actions are not completed due to lack of accountability.
This is mitigated by having clearly identified owners for each action and a review process to ensure implementation.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	*n/a*
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	*n/a*

Equality Impact Assessment (EIA): Has an EIA been carried out? No
If yes, please provide a summary of the key findings

If no, please explain you reasons for not undertaking and EIA. n/a

PwC Summary

	As at 7 March 2016				As at 21 March 2016			
Board Sponsor	**Complete**	**Not accepted**	**Progressing**	**Grand Total**	**Complete**	**Not accepted**	**Progressing**	**Grand Total**
Andrew Burn	6	-	2	**8**	7	-	-	**7**
Martin Wilson	1	-	1	**2**	1	-	-	**1**
Mike Rappolt	3	-	-	**3**	3	-	-	**3**
Miles Scott	3	-	1	**4**	4	-	-	**4**
Rob Elek	1	-	-	**1**	1	-	-	**1**
Anna Anderson	44	-	-	**44**	44	-	-	**44**
Wendy Brewer	2	-	1	**3**	3	-	1	**4**
Gill Hall	2	1	2	**5**	1	-	-	**1**
Iain Lynam	-	-	3	**3**	-	-	1	**1**
Anna Anderson	-	-	-	**-**	-	-	3	**3**
Sarah Wilton (acting chair)	-	-	3	**3**	1	-	-	**1**
Luke Edwards	-	-	-	**-**	-	-	5	**5**
Paula Vasco-Knight	-	-	-	**-**	-	-	1	**1**
Grand Total	**62**	**1**	**13**	**76**	**65**	**-**	**11**	**76**

PwC Actions

PwC ref	PwC action	DEADLINES AS AT END NOV 15	Owner for planned actions	Board Sponsor	End milestone	Review Comments - 17 March 2016	Complete by 31/3/16?	Status As at 7 March 2016	Status As at 21 March 2016
1	The timeline for business planning and budgeting should be reviewed and should clearly set out milestones to ensure that there is sufficient time to sign off budgets without caveats by the time commissioner contracts are agreed. This process should commence earlier in the year, in line with other trusts. For example, the planning process should commence in M7 (October) with semi-formed budgets agreed by M9 (December), a final draft budget in M10 (January) and a fully signed off budget (including fully identified and worked up CIPs) in M11 (February). Subsequently, budgets should only be changed in line with SFIs.	31/03/2016	Stuart Diggles (Interim)	Steve Bolam	October F&P sign off of 1617 business planning process, timetable and draft budget	Process have been implemented e.g. TRP but timescales have subsequently slipped against the TRP schedule and budget planning is currently ongoing. As process etc are in place this is complete. Timely management and enforcement of timescales is BAU.	Yes	COMPLETE	COMPLETE
2.1	The budgeting process should be simplified, and additional support provided to clinicians and General Managers to ensure that they understand the process and are able to engage fully in it.	31/10/2015	Stuart Diggles (Interim)	Steve Bolam	A shorter unqualified budget sign off with fewer budget holders and increased 'buy in'	Budget setting process have been revised as part of TRP. Budget setting for 16/17 has been shorter. Is unclear how the DIPs will fit in given that they will not go to cost centre level. Needs careful management to ensure staff engagement is retained going forward. This forms part of BAU.	Yes	COMPLETE	COMPLETE
2.2	Responsibility for budget setting should be clearly defined in job descriptions and monitored through the appraisal process.	31/03/2016	Wendy Brewer	Iain Lynam	improved accountability for budgets	Appropriate wording regarding budget setting has been prepated but as yet has not been included in job descriptions. This delay is due to revisions being made to the list of budget holders and HR are awaiting a revised list. Revised list has been produced by Kevin Harbottle and is awaiting EMT approval. Action can be implemented relatively quickly once the list has been agreed. Anna Anderson to provide the revised list to Wendy Brewer once confirmed to allow the action to be completed.	No - Awaiting EMT approva for revised list. Assuming is approved at EMT on 4 April 2016, aim for completion by end May 2016 to allow HR time to update.	PROGRESSING	PROGRESSING
3	Where the intention is to allocate reserves to divisions or directorates, these should be established as part of the signed off budget in place from M1 (April), to ensure that effective monitoring of actual to budget is achieved from M1 (April) close.	31/10/2015	Stuart Diggles (Interim)	Steve Bolam	Signed off budget with minimal/ no central reserves (objective - only minimal contingencies)	TRP process has seen reserves allocated to divisions. The principle is set and will apply for all future budget setting. Majority of reserves are held centrally rather than at divisional level.	Yes	COMPLETE	COMPLETE
4	The connectivity between activity, capacity, workforce and capital programmes must be considered from service level upwards when developing budgets to create achievable plans.	31/12/2015	Stuart Diggles (Interim) supported by Wendy Brewer/ Martin Wilson	Steve Bolam	1) Integrated demand and capacity model signed off for turnaround reforecast and will underpin 16/17	Demand and capacity model has been created and is in use for testing the activity in TRP compared to the trusts bed and theatre capacity. Recommendation completely implemented as revised plan now submitted to Monitor.	Yes	COMPLETE	COMPLETE
5	The budgeting approach for significant costs should be reviewed; these should reflect prior year activity (with a focus on the most recent trends), known events and trends, both internally and in the wider health sector (particularly in South West London) and non-recurrent matters. For example: - budgeting for pay costs must reflect a realistic level of temporary staff usage, based on prior year trends, the recruitment strategy, current recruitment activity and the market conditions; - income and costs impacted by expected events such as winter pressures should be appropriately profiled to reflect this; and - where budgets are rolled forward from the prior year, a review of prior year variance to budget should be undertaken to ensure a realistic yet challenging budget is developed.	31/10/2015	Stuart Diggles (Interim)	Steve Bolam	October F&P sign off of 1617 business planning process, timetable and draft budget	Granular cost build up basis used in TRP continues to be used e.g. budgeting for pay costs is built up based on cost of current establish, cost of vacancies anticipated to be filled and estimated bank/agency required for safe establishment.	Yes	COMPLETE	COMPLETE
6	CIPs should only be reflected in budgets where there is a clearly defined plan for implementation and the proposed savings can be associated with a specific GL code.		Iain Johnson (KPMG)	Andrew Burn	CIPs now linked backed to GL codes as part of Green RAG rating	A QIA process is now in place. Savings are not taken out of budget unless a SSF has been completed. The DIPs will not get to cost centre level for FY16/17.	Yes	COMPLETE	COMPLETE
7	CIPs should concentrate on the development and delivery of large scale, transformational projects to deliver growth and / or significant efficiencies. CIPs and SIPs should be better connected to ensure that interdependencies are identified and monitored regularly. 'Business as usual' savings or ideas should not be reflected as CIPs and should be acted upon as part of day to day operations.	31/12/2015	KPMG support	Andrew Burn	KPMG support increased Trust focus on themes	This has been evidenced through the implementation and outcomes of the turnaround programme.	Yes	COMPLETE	COMPLETE
8	The timescales for all CIPs, SIPs and capital programmes should be reviewed to ensure feasibility and that associated costs are reflected in budgets in the appropriate time period.	Complete	Nina Schmidt-Marino	Steve Bolam	Reviewed as part of budget sign off (month M4). Will be re-reviewed in turnaround reforecast and a budget principle in 16/17 forecast	This has been done where possible. For the DIPs, due to the varying stages of maturity, it has not been possible to reflect costs against specific cost centre codes.	Yes	COMPLETE	COMPLETE
9	A scaled review, based on value, of contracts should be undertaken to ensure that the ongoing costs are reflected accurately within budgets. This should include a complete mapping of the timescales associated with the contracts and when contracts or elements thereof will cease and renewals are required.	31/03/2016	James Frain	Andrew Burn	Map database to GL	Basic contract database is now in place. Not currently being maintained and not fully populated. Contracts manager currently being recruited- aim to be in post by 30 June.	No - requires appointment of new contract manager. Once in post this will become BAU. Complete by July 2016	PROGRESSING	PROGRESSING
10	The process for developing and approving business cases needs to be more robust. These must reflect all associated costs (using the full cost rather than the marginal cost), and must reflect all risks and associated impact on the remainder of the Trust and other stakeholders. Changes to business cases that have been submitted to the Business Case Assurance Group ("BCAG") should be reassessed and, where significant, sent to the relevant committee or group for re-approval or reassessment.	Complete	Michael Armour	Rob Elek	Change the BC process, sign off and limits	New system introduced and being utilised.	N/A	COMPLETE	COMPLETE
11	Budgets including headcount and establishment should be allocated to divisions and corporate departments at the beginning of the year to aid performance management and ensure people understand what they are being held to account for.	31/01/2016	Stuart Diggles (Interim) supported by Wendy Brewer	Steve Bolam	September F&P sign off of 1617 business planning process and timetable	The TRP process has ensured that the budget holders are engaged fully in the content of their forecast (and therefore revised budgets). The TRP 16/17 has been completed and business planning is underway to ensure budgets are set and signed off by divisions on a timely basis. This has been implemented fully and is now BAU.	Yes	COMPLETE	COMPLETE
12	Approved budgets presented to the F&PC month on month should not be changed (even where the total remains the same) as this affects the ability of the Trust and Non-Executive Directors to challenge the underlying reasons for variances.	Complete	Anna Anderson (interim)	Steve Bolam	Reports will be against agreed budget to enable consistent reporting month on month	The F&PC budget is no longer changed unless there is an exceptional specific reason for this e.g. TRP.	Yes	COMPLETE	COMPLETE
13	The Trust should undertake a baseline review to ensure that it clearly understands its underlying deficit and run rate position.	30/11/2015	Stuart Diggles (Interim)	Steve Bolam	Budget refresh signed off by board oct 15	Completed via TRP and is reviewed as part of the monthly board report.	Yes	COMPLETE	COMPLETE

PwC ref	PwC action	DEADLINES AS AT END NOV 15	Owner for planned actions	Board Sponsor	End milestone	Review Comments - 17 March 2016	Complete by 31/3/16?	Status As at 7 March 2016	Status As at 21 March 2016
14	The Trust should review its recruitment strategy and process to ensure that both are fit for purpose and reflect the recent changes to the recruitment market, such as increased demand for certain staff groups.	Complete	KPMG support	Wendy Brewer	n/a	Trac in place and now fully functional. New head of recruitment in place, who is ensuring continued review of strategy and process as part of BAU.	Yes	COMPLETE	COMPLETE
15	The month-end close process should be reviewed; draft budget statements should not be provided to the directorates until they reflect central allocations and are considered to be reasonably accurate. There must be better communication between the Central Finance Teams and the divisions and directorates in relation to the allocation of central charges to allow better budgetary control. Where possible, there should be more time for analysis of variances and forecasting. This can only be achieved through better ledger discipline to shorten other parts of the month end close process.	31/12/2015	Julian Barrett	Steve Bolam	Revised closedown process documented and actioned	Improvements in closedown process have been reviewed. The new finance structure once implemented will also lead to greater levels of communication between central finance teams. Changes have been implemented and moved to business as usual. The Trust needs to be firmer at ensuring that people comply with the deadlines but this is BAU and not a reason to keep the action open.	Yes	COMPLETE	COMPLETE
16	The process for preparing forecasts should be systemised as far as possible, ensuring that the knowledge behind the process does not reside with a small group of individuals, and that schedules can be interpreted as standalone documents.	Complete	Anna Anderson (interim)	Steve Bolam	Standardised templates and documented process for forecasting in place	Model, manual and training delivered by Simon Miligan is now being used.	Yes	COMPLETE	COMPLETE
17	Forecasting of expenditure should be split into Pay and Non-Pay to provide three forecasted columns (Income, Pay and Non-Pay) as opposed to just the current two (Income and Expenditure). A more scientific and data driven approach should be applied to forecasting, such as looking at expected events or underlying activity trends.	Complete	Anna Anderson (interim)	Steve Bolam	Standardised templates and documented process for forecasting in place	The recommended splits have been made and included in Simon Miligan's model that is being used.	Yes	COMPLETE	COMPLETE
18	The forecast schedules should be produced using a consistent format. This should include consistent naming conventions and layout, use of actuals as well as variances and should allow the user to understand the assumptions used to prepare the forecast and track month on month changes. Any changes which mean that underlying schedules do not tie through to summaries should be clearly explained.	Complete	Anna Anderson (interim)	Steve Bolam	Standardised templates and documented process for forecasting in place	This has been included in the model being used.	Yes	COMPLETE	COMPLETE
19	Directorate forecasts should reflect confidence levels or a sensitivity analysis relating to additional income streams or cost savings, and should more closely consider downside risks. Greater scrutiny and challenge from the divisional leadership teams should be factored into the forecasting process. This should be complemented by scrutiny and challenge at a Trust-wide level to ensure a realistic Trust level forecast.	Complete	Anna Anderson (interim)	Steve Bolam	Upside/downside cases to be reviewed by TAB	This has been included in the model being used.	Yes	COMPLETE	COMPLETE
20	All increases to funding made during the year should be either funded from a clearly identified source (for example, reserves), or where there is no confirmed source, should represent a reduction to the forecast outturn against which mitigations should be planned.	Complete	Anna Anderson (interim)	Steve Bolam		Clear protocols are in place and being utilised.	Yes	COMPLETE	COMPLETE
21	There must be greater oversight and monitoring by appropriately senior members of the Finance Team of income and costs which are common to divisions and directorates, for example, Consultancy Services. Whilst these values may appear as small overspends within divisions, the bigger picture may show a trend which should be identified and investigated on a timely basis; currently this information is not available.	Complete	Anna Anderson (interim)	Steve Bolam	n/a	Monthly financial performance reviews are used to provide scrutiny. Improved classifications, account coding and scrutiny mean the spend will be appropriately reviewed at divisional level and material variances are unlikely to be unchallenged. Overspends are looked at on a global level especially in areas such as bank and agency. Has now been embedded into BAU	Yes	COMPLETE	COMPLETE
22	Where significant risks to financial performance are identified, and mitigations proposed, the Board should ensure that these are implemented in sufficient time to impact the financial position before risks crystallise. These mitigations should also be regularly reassessed to ensure that they are feasible, and monitored for effectiveness by the Board or a delegated sub-committee. Divisions should be required to develop plans to underpin proposed mitigations, highlighting the critical path for delivery.	31.1.16	Anna Anderson (interim)	Steve Bolam	F&P review end October	Processes are in place for the identification of risk and mitigations. There is some professional scepticism as to whether the operational mitigations implemented are actual robust and effective. This will continue to be monitored as part of BAU.	Yes	COMPLETE	COMPLETE
23	Robust plans and forecasting will need to be in place in 2015/16 to ensure cash is available to fund the committed capital expenditure for which funding was received but used to shore up the Trust's cash position in 2014/15. This should factor in the status of external funding, such as the London Energy Efficiency Fund ("LEEF")).	Complete	Dominic Sharp	Steve Bolam	New cash flow process to provide more accurate visibility over available cash	All process have been put in place and the trust has a clearer understanding of funds available. Monthly monitoring occurs. Need to ensure that budget holders report to agreed timelines but this is being picked up as BAU.	Yes	COMPLETE	COMPLETE
24	In order to achieve robust cash flow forecasting and cash management, it is key that the Trust puts in place a robust process for preparing and reviewing both a 13-week and rolling 12-month forecast to enable appropriate cash management to be put in place. This will enable the Trust to manage more effectively its cash requirements and identify any cash flow "pinch points" earlier which may require action (especially given the significant capital expenditure programme of the Trust over the short to medium term).	31/12/2015	Dominic Sharp/KPMG support	Andrew Burn	New cash flow process to provide more accurate visibility over available cash	A cash flow is now in place. Cash is now managed through a weekly cash crisis meeting and a monthly cash committee. In addition, Julian Barrett is monitoring the 13 week cash flow to ensure grip.	YES	COMPLETE	COMPLETE
25	Cash flow and capital expenditure plans should take into consideration the impact of any delay in sale of surplus assets and the receipt of any external loan funding and this should be factored into any downside scenario planning.	Complete	Dominic Sharp	Steve Bolam	New cash flow process to provide more accurate visibility over available cash	Papers submitted to FP each month showing full forecast outturn. Variance analysis is included within this. These process are being rolled out into next year as part of BAU.	Yes	COMPLETE	COMPLETE
26	There should be a clearly defined escalation and decision making process relating to overspends to allow for rapid and agile decision making.	31/12/2015	Julian Barrett	Steve Bolam	n/a	Process have been put in place for this. Documented protocol, div per rev, streamline budg holders and managing objectives will provide assurance of this.Budget holders are still to streamlined but this is being picked up elsewhere in the recommendations.	Yes	COMPLETE	COMPLETE
27	There should be a clearly defined escalation and decision making process relating to one off expenditure, to allow for rapid and agile decision making.	31/01/2016	Dominic Sharp, Julian Barrett	Steve Bolam	n/a	Procurement policy approved by EMT and implemented. Processes will ensure only executive approved retrospective POs are processed. Procurement since November, via Monthly Procurement Report, are highlighting offending divisions in order to improve organisational behaviours re waivers and SFI breaches. Internal comms have been issued..	Yes	COMPLETE	COMPLETE
28	There should be more robust controls around the use of temporary staff at a divisional level; the estimated financial implications of using temporary staff should be clearly communicated at the time the decision is made. The Trust should review how it uses E-rostering to ensure it is deriving the full benefits.	01/03/2016	Jemma Ball	Wendy Brewer	n/a	Costing has been added to E-rostering to allow users to understand cost. Procedures in place to ensure compliance with new agency cap guidelines. Revised use of E-Rostering including lock down of data on a six week basis to allow for ongoing reporting.	Yes	COMPLETE	COMPLETE

PwC ref	PwC action	DEADLINES AS AT END NOV 15	Owner for planned actions	Board Sponsor	End milestone	Review Comments - 17 March 2016	Complete by 31/3/16?	Status As at 7 March 2016	Status As at 21 March 2016
29	Any plans (for example, capacity schemes or recruitment plans) that could lead to additional costs should be closely monitored. A full consideration of potential costs (for example, a requirement for temporary staff whilst recruitment takes place) must be factored into any plans.	Complete	Kevin Harbottle	Steve Bolam	All plans for recurrent increased expenditure to be reviewed	Process in place for looking at business cases, which has increased the degree of scrutiny. IDDG in place and chaired by Rob Elek. Now BAU.	Yes	complete	COMPLETE
30	Challenges should be tracked and the information shared between the Contracts Team and Financial Management Team. Regular communication between the teams should take place to ensure that provisions are updated regularly to reflect the latest known and anticipated position.	Complete	Deirdre Baker	Steve Bolam	Kirk to review and provide recommendations to SB for implementation by end of September	This is achieved via monthly divisional performance management reviews.	Yes	complete	COMPLETE
31	Monthly challenges should be addressed and closed down promptly by the Contracts team and the commissioners to enable swift resolution of quarterly reconciliations. Q1, Q2 and Q3 quarterly reconciliations should be closed according to the annual timetable.	Complete	Deirdre Baker	Steve Bolam		A clear process is in place for dealing with challenges and the Trust complies with the national timetable. In addition, a new deputy contracts manager is due to start in April 2016 who will take on responsibility for challenges.	Yes	complete	COMPLETE
32	An external review of the use of the GL should be undertaken, to ensure that this is being used effectively and in line with good practice. This review should include a consideration of: - the posting of budgets and actuals to the same GL codes to allow tracking of variances; - appropriate classification of costs (for example, between pay and non-pay); - matching of income and expenditure to allow the tracking of underlying variances (for example, in respect of drugs, clinical consumables and offsite activity); and - the use of bucket codes. In particular, the use of the Consultancy Services code should be restricted.	Complete	Julian Barrett	Steve Bolam	FD review prior to completion of business planning process to ensure changes made	External review has not been carried out but the GL hs been cleansed of codes. Additional governance procedures in place to comply with recommendations.	Yes	COMPLETE	COMPLETE
33	Where individuals have made errors in the GL, training or support should be provided to ensure that these are not repeated.	Complete	Anna Anderson (interim)	Steve Bolam	Implementation of finance training	A training programme is in place and is used on a reactive basis when errors are encountered.	Yes	COMPLETE	COMPLETE
34	A business case should be developed to address the inadequate financial reporting as part of a modernisation programme of the systems, processes and reporting used by the Trust. The Trust should investigate whether (a) existing systems licensed by the Trust can support this modernisation programme, for example Tableau, as utilised by the information team, or (b) whether the use of additional external systems would help to provide greater clarity, effectiveness and efficiency in the management and reporting of its financial performance.	31/12/2015	Imran	Steve Bolam		Whilst no business case has been produced the Trust has taken several steps to address this, including simplified board reporting, improved use of tableau, reviewing and updating the information included in performance review papers, and application of consistent formatting across reports e.g. all negative numbers displayed in the same format.	Yes	COMPLETE	COMPLETE
35	The month end accounts process should be reviewed and updated to ensure timely accurate information to support decision making. (In FY14/15 the DDOs noted that the month end process changed and that, whilst they still got an initial draft of their numbers five days after month end, reports received changed significantly with two or three iterations before finalisation one to two weeks later).	15/11/2015	Anna Anderson (interim)	Steve Bolam	Recommendation implemented	One iteration of the numbers is now issued and this is being produced in a timely manner (usually within on week). Draft iterations are only issued is there a particular issue that requires clarity.	Yes	COMPLETE	COMPLETE
36	The Trust should avoid forecasting in respect of central income and expenditure when income and expenditure should be forecast at a divisional level (reflecting also the allocation of income and reserves to divisions wherever possible).	Complete	Anna Anderson (interim)	Steve Bolam	Standardised templates and documented process for forecasting in place	Forecasting is now done on a divisional basis. This is then used to build a bottom up trust-wide forecast.	Yes	COMPLETE	COMPLETE
37	The Trust should ensure month end accruals are posted appropriately, can be tracked and are subject to sufficient senior scrutiny to ensure the correct financial position is being recorded and reported. Accruals should be regularly monitored to ensure that past performance is taken into account and current accruals accurately reflect known and anticipated expenditure.	Complete	Anna Anderson (interim)	Steve Bolam	n/a	Procedures have been put in place, which have successfully highlighted issues prior to month end reports being issued. With regards agency/ bank expenditure, significant work has been undertaken with HR to ensure that as far as possible staff come through bank rather than agency. In addition, the trust is enforcing the rule that a bank requisition number is required prior to payment being made.	Yes	COMPLETE	COMPLETE
38	Regular monitoring should take place to ensure that the appropriate decision about whether expenditure is capital expenditure or revenue expenditure is taken on a timely basis.	Complete	Dominic Sharp	Steve Bolam	Issue by end of September	Monthly enquiry on system is carried out to ensure that every item over £5k is reviewed. Monthly review being undertaken and is on the monthly close checklist.	Yes	COMPLETE	COMPLETE
39	Management information should consistently present surpluses as positive and deficits as negative, to enable users without a financial background to interpret it. Information should consistently reflect actual values as well as variance to budget.	31/12/2015	Anna Anderson (interim)	Steve Bolam	Issue by end of September	This is significantly complete - any additional reports that are identified as not being in this format are being converted. As part of BAU all new reports will follow this process.	Yes	COMPLETE	COMPLETE
40	The quality, timeliness and usability of reports and information provided to divisions and directorates needs to improve and must be delivered consistently across all areas of the Trust. Directorates and divisions need direct access to detailed robust financial information to enable them to manage their financial position and understand the implications of operational decisions. General Managers must be able to analyse and drill down into information to allow rapid analysis and interpretation. The Trust should consider using Tableau for this purpose.	Complete	Anna Anderson (interim)	Steve Bolam	n/a	Divisional review packs are in place and used at meetings. Tableau upgrade is required for greater automation but this is in addition to the requirements of the recommendation.	Yes	COMPLETE	COMPLETE
41	Divisions and directorates should be able to readily access accurate headcount figures and associated costs, including the variance to budget and the breakdown between temporary and permanent staff.	31/12/2015	Anna Anderson (interim)	Steve Bolam	n/a	Trac system in - allows the Trust to monitor substantive headcount figures. WTE and costs for agency staff not booked via the bank are currently estimated. However, as the number of non-bank staff has reduced the accuracy has improved. Now BAU.	Yes	COMPLETE	COMPLETE
42	An effective workforce tracking mechanism should be put in place to ensure a complete overview is available, in 'real time', of current and known future headcount, vacancies and the associated costs to ensure greater oversight at a Trust-wide level.	31/03/2016	KPMG support	Wendy Brewer	n/a	Trac in place and operational. Issue with the weekly reporting onto Tableau. This is being addressed. Future workforce tracking is reliant on business planning process that is currently underway.	No - tableau issues to be addressed by IT and business planning needs completing. Anticipate that this will be dealt with and recommendation can be signed off by 30/04/2016.	PROGRESSING	PROGRESSING

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43	The Trust should ensure more robust version control and comparability in spreadsheets used by Financial Management Team. There are a number of similar schedules prepared each month to reflect, for example, forecasts and thoughts on what the numbers will be in the future. However, it is difficult to compare these forecasts month on month to see what has changed at a glance (for example, because the individual lines do not align). As such, more time is spent compiling data rather than analysing and interpreting it.	Complete	Anna Anderson (interim)	Steve Bolam	Standardised templates and documented process for forecasting in place	The forecast model has been implemented post TRP and continues to be used.	Yes	complete	COMPLETE
44	The Trust should also consider the analysis it requires in respect of movements in income and expenditure, the purpose for which such analysis is required and regularly assess if the analysis remains fit for purpose. Currently, a lot of analysis is performed on an ad hoc basis in Excel, with little written explanation and limited visibility to others in the Finance Team. Where analysis is or should be regularly undertaken, such as capacity or matched income and expenditure, standard reporting should be run to enable users to spend time determining the reasons for change rather than whether a change has occurred. For example, divisions should be able to see the income and expenditure associated with drugs, clinical consumables and offsite activity and easily identify areas of overspend to promptly determine the reason for the overspend and what action to take, if required, to manage the overspend.	Complete	Anna Anderson (interim)	Steve Bolam	Recommendation implemented	Performance review packs in place. Tableau has been improved to provide better information. Amount of ad hoc analysis now significantly reduced.	Yes	complete	COMPLETE
45	There should be an overall review of Board and sub-Committee papers to provide greater insight and intelligence. These should drive action focused conversations, setting out the reasons for performance variances, the actions being taken, how these actions will be monitored, when they are expected to be delivered and who is responsible for it. In the longer term, the Trust should consider more integrated reporting to incorporate, performance, quality and finance. This would enable the Board to identify Trust-wide performance against key metrics, with clear actions to address adverse performance. The Trust needs to ensure reports are succinct and contain the headline points.	31/03/2016	Gill Hall	Gill Hall	n/a	Integrated performance report is in place but needs refinement - lacks detail on actions required to address issues. Requires details of controls and assurances for risks on the risk register. QIA of intergrated report summary to be completed by responsible ED pre circulation. New cover sheet template being produced for all papers, which will provide an audit trail regarding which committees papers have been to prior to Board as well as a high level outcomes and actions section. This will require approval by the new chair and rolling out. Anticipated that this will be in place by May 2016.	No - new front sheet to be agreed and refinements to performance report to be implemented.	PROGRESSING	PROGRESSING
46	The Trust should review its finance reports for the F&PC and the Board and consider the use of exception based reporting through to the Trust Board as appropriate, to streamline reporting. Clear explanations for variances should be available on a timely basis, and there should be a greater focus on forward looking information.	Complete	Anna Anderson (interim)	Steve Bolam	Issue by end of September	Board papers have been amended based on requirements of users.	Yes	COMPLETE	COMPLETE
47	There are a number of metrics missing from Board reports that we would expect to see. These include: - routine working capital KPIs such as debtor days, creditor days and stock days; - length of stay metrics; and - financial implications of workforce issues (for example, temporary staff spend when compared to plan). Further, the Trust should consider improving the clarity of its reporting of drugs expenditure and SLA Exclusions income in the Finance Reports.	Complete	Anna Anderson (interim)	Steve Bolam	Issue by end of September	The metrics on the board report have been improved. Additional metrics are continually being added as required. This is now BAU.	Yes	COMPLETE	COMPLETE
48	The RAG rating scheme applied to CIPs in reporting must be clearly defined and communicated, as this has previously been applied differently, requiring the reversal of a number of schemes rated as green.	Complete	Nina Schmidt-Marino	Andrew Burn	n/a	Communications have been made. To simplify systems further, there will only be a red/ green system in place for FY16/17	YES	COMPLETE	COMPLETE
49	The Trust must develop a clear benefits tracker that clearly sets out the delivered benefits from SIPs and CIPs, as part of PMO reporting and reporting to the F&PC and the Board.	28/02/2016	Nina Schmidt-Marino	Andrew Burn	n/a	A tracker is now in place. This is highlighting that there is no benefit being derived from service improvement. This action can now be closed. Going forward monitoring of the tracker will be BAU.	Yes	COMPLETE	COMPLETE
50	The Trust should ensure that there is an effective process for tracking and monitoring the status of commissioner challenges and that the appropriate parties are all involved and aware of the current status.	Complete	Deirdre Baker	Steve Bolam		Challenges are recorded by the contracts team and are responded to in accordance to the national timeline. Where provisions are required in respect of the challenges they are reported to both F&P and the Board on a monthly basis.	Yes	COMPLETE	COMPLETE
51	Finance Managers should be offered additional training where they are not qualified accountants, to ensure they are able to provide the level of financial support and insight to the divisions that is required.	Complete	Anna Anderson (interim)	Steve Bolam	Implementation of finance training	All finance staff at band 8a are to be financially qualified. If they are not they will have a three year period in which to complete their training. This has been implemented as BAU.	Yes	COMPLETE	COMPLETE
52	Strategic Finance Managers ("SFMs") should have a role in up skilling and raising financial awareness amongst management in their division and within directorates. The Trust should consider developing a programme of finance training for budget holders covering how to set, manage and monitor financial performance.	30/06/2016	Anna Anderson (interim)	Iain Lynam	n/a	A training programme has been developed. This has been delayed due to the revised list of budget holders being agreed by EMT. Once this has been done the mandatory training process will be rolled out. Coaching elements have been added to job descriptions.	No - this will remain open until June 2016 when the reduction in budget holders has been transacted and the training programme has commenced..	PROGRESSING	PROGRESSING
53	The Trust should consider providing support to Divisional Chairs in how to run effective governance meetings, for example through coaching or holding workshops on what an effectively chaired meeting should be seeking to achieve. Specific areas to focus on include: - How discussions should be actions focussed rather than simply discursive; and - Importance of challenging report presenters to ensure that risks and issues highlighted are being addressed. Meetings should be focussed on holding directorates to account for all aspects of performance, including financial performance and agreeing actions to address adverse performance.	31/01/2016	Wendy Brewer	Miles Scott	n/a	Mid year appraisals carried out in November and December with a second round of appraisals cried out in February. Revised objectives completed for Simon McKenzie, Jenni Hall, Rob Elek, Eric Munro, Wendy Brewer. MS has attended Divisional Management Boards an can confirm that are action focused and challenge is brought. Good Governance guide, as produced by Peter Jenkinson, covers the points on effective governance being recirculated.	Yes	PROGRESSING	COMPLETE

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54	The Trust should review its approach to developing leadership capability and capacity within the divisions at all levels, and its succession planning approach for the Divisional Chair roles.	Complete	Wendy Brewer	Miles Scott	Established succession plan for the Divisional Chair roles	Leadership programme in place and being followed. Succession planning covered twice yearly at Remuneration Boards and can be evidenced in the meeting minutes.	Yes	COMPLETE	COMPLETE
55	The Trust should consider which fora could be used to share good practice and lessons learnt between the divisions and directorates and how to reduce silo working. For example, SFMs should share good practice in relation to the financial reporting between the divisions.	Complete	tbc	Martin Wilson	n/a	There are now regular meetings in place to share good practice and lessons learnt e.g. DDO meetings with the COO, SFM meetings. Additionally there have been a number of one off events, including divisional challenge sessions for transformation schemes, System Leadership Events for the Top 100. There will be subsequent events and learning incorporated in the Trust OD programmes as part of BAU.	Yes	COMPLETE	COMPLETE
56	The finance function operates in silos and is not seen as a supportive function to the business. Divisions find it difficult to access the information and support that is required. The Trust should undertake a skills assessment and consider whether additional resource or capability is required in the Finance Team to improve team working and links to the divisions.	31/12/2015	Anna Anderson (interim)	Steve Bolam	n/a	Skills assessment has been undertaken. There is ongoing OD work being done but this will progress as part of BAU.	Yes	COMPLETE	COMPLETE
57	The Board should revisit its previous Board development programmes and evaluate the impact these had. The findings should inform the development of a new programme. In addition, the Board should incorporate cultural and team assessment tools into its development sessions to build effective team working and resilience.	31/01/2016	Joy Warrington	Wendy Brewer	n/a	Exec Team have undergone Hay Leadership Assessment. Joy Warrington has implemented new board development programme. This commenced in January and quarterly sessions are scheduled going forward. The programme will continual be revised going forward as BAU.	Yes	PROGRESSING	COMPLETE
58	The role of the Strategic Finance Manager should be clarified; this should be to provide challenge and oversight to the divisions, rather than be purely focused on the preparation of business cases. The Strategic Finance Manager should report to the Director of Finance.	31/01/2016	Anna Anderson (interim)	Steve Bolam	Dev plans etc. in place by end of Sept	Work has been undertaken with both SFMs and DFMs to clarify their roles. The SFMs have been charged with challenge and oversight.	Yes	complete	COMPLETE
59	The Trust should consider the level of operational and financial support available to Divisional Chairs to enable them to leverage support in the management of their divisions. The Trust should also consider introducing a COO to support the divisions as they build their capability and capacity and to ensure there is a co-ordinated approach across all divisions as it looks to improve financial and operational performance over the coming year	31/12/2015	Wendy Brewer	Miles Scott	Recruitment of a COO	Interim in situ. Permanent appointment by March/ April. Leadership training programme in place.	Yes	COMPLETE	COMPLETE
60	The Trust should review the level of financial support available to divisions and directorates and the structures and processes in place to ensure the appropriate level of financial challenge provided to divisions and Directorates. In considering this, the Trust should be mindful of good practice in relation to high performing finance functions, including: □ the need for appropriately qualified and experienced finance staff to provide day to day challenge and support to divisions and Directorates; - the capacity required to conduct these roles, in the context of the financial requirements of each Division; and - the need for the Strategic Finance Managers to be ring fenced to ensure they are supporting the divisions in forward looking strategic financial support and provision of insight into financial performance	Complete	Anna Anderson (interim)	Steve Bolam	n/a	SFM roles have been changed and clearly defined. Going forward all staff at 8a or above will be financially qualified and if not they will have a three year period in which to complete training.	Yes	COMPLETE	COMPLETE
61	A review of the PMO and CIP management needs to be undertaken, with a particular focus on ensuring that the PMO is sufficiently resourced for an organisation of this size, and that PMO skills are embedded within the divisions as well as centrally.	Complete	KPMG support	Andrew Burn	n/a	A review has been undertaken by Internal Audit and was discussed at the January Audit Committee. PMO skills in divisions will replace embeds and SFMs will have increasing responsibility for financials in FY16/17	Yes	COMPLETE	COMPLETE
62	The Trust should undertake a review of Executive portfolios to ensure that these are balanced and that appropriate capacity and capability is in place (in particular, we note that the remit of the Director of Finance is particularly broad).	31/01/2016	n/a	Miles Scott	Board sign off and implementation of the new executive structure	New Exec structure in place. DoF role has been narrowed e.g. IMT and commercial have been assigned to new owners.	Yes	COMPLETE	COMPLETE
63	The Trust should review the Chairmanship of the F&PC. The Trust may benefit from appointing a Non-Executive Director other than the Chairman as the chair of this committee to ensure independence and avoid overreliance on one individual.	31/01/2016	Gill Hall	Sarah Wilton (acting chair)	n/a	New chair needs to be in place. Planned that Sarah will then continue as Audit Committee chair.	Yes	PROGRESSING	COMPLETE
64	Challenge at the Board and sub-committees should focus more on seeking assurance over actions taken to address adverse performance and in relation to risk. The provision of more concise and focused financial reports that highlight clearly the key issues, risks and proposed actions should enable more effective challenge.	31/03/2016	Gill Hall / Steve Bolam	Sarah Wilton (acting chair)	Issue by end of September	Improved financial reporting is in place. Additional actions still required to ensure sufficient challenge and assurance at Board meetings. Work is being undertaken as to how to measure that this has been achieved. It wil be approached through coaching and training - Board Development Programme is ongoing. Need to ensure that training covers the correct level and appropriateness of challenge that should be applied. Conclusions of the work flow review will help to get the correct core documents and better agendas so as to shape the conversation. New interim chair now in place to help shape the board and provide leadership. This action will be complete by the end of June 2016.	No - Specific governance workstream being developed to address all the governance actions. This acton will be complete by the end of June 2016.	PROGRESSING	PROGRESSING
65	The Board should ensure that it considers all the relevant matters pertaining to a single issue. For example, when considering overall activity, we would expect to see the triangulation of capacity, workforce and commissioner/ other funding to ensure that appropriate decisions are made. When facing recruitment issues, we would expect the Quality and Risk Committee ("QRC") to look at risk to patient safety, the Workforce Committee to look at recruitment processes and the F&PC to look at financial impact of temporary staff.	31/03/2016	Gill Hall	Sarah Wilton (acting chair)		F&P and QRC happen on the same day so not possible for outcomes of one to be shared with the other unless common attendees. This is interdependent with recommendation 66 and the map of information flow. Testing on the minutes of the three committees to ensure that the outcomes of each are impacting on it. New front sheet for board reports will allow more transparnecy to ensure that triangulation has occured.	No - Specific governance workstream being developed to address all the governance actions. This acton will be complete by the end of June 2016.	PROGRESSING	PROGRESSING

PwC ref	PwC action	DEADLINES AS AT END NOV 15	Owner for planned actions	Board Sponsor	End milestone	Review Comments - 17 March 2016	Complete by 31/3/16?	Status As at 7 March 2016	Status As at 21 March 2016
66	The Trust should review the meetings cycle for the Trust and map out the flow of information between committees and the Board. The Trust should also consider the various sub-groups and working groups that report into the committee structure and identify whether there is any duplication in theses in terms of attendees and reports being discussed. This review should consider exception reporting where appropriate through to the Board.	Complete	tbc	Gill Hall	n/a	Lack of evidence to confirm that this work has been undertaken. Map of information flow not completed - this is still ongoing. Requirement to check the Terms of Reference for meetings to review how minutes flow. Need to complete map to review whether there is duplication.	No - Anticipate first draft of information map and terms of reference to be prepared by May 2016. This will then need to be rolled out and will be complete and fully implemented. Specific governance workstream being developed to address all the governance actions. This acton will be complete by the end of June 2016.	COMPLETE	PROGRESSING
67	The content included in the Financial Risk Assessment should continue to be prepared and presented for the whole financial year (we note that from M5 (August) the paper was amended to a Forecast Outturn paper. This will ensure that the delivery of mitigations is more effectively tracked. A single, consistently prepared paper should be designed, which incorporates the key content from both the Financial Risk Assessment and the Forecast Outturn paper.	11/04/2016	Anna Anderson (interim)	Iain Lynam	Financial risk assessment presented to Board (private) and part of the ongoing monthly budget packs	The FRA is not currently being produced. A new process for producing a single consistently prepared paper is being designed for implication in 16/17. Anna Anderson is preparing this new process and it is anticipated to be in place for the start of the new financial year.	Yes - Anna Anderson is preparing this new process and it is anticipated to be in place for the start of the new financial year.	PROGRESSING	PROGRESSING
68	Divisional chairs and DDOs should attend the F&PC on a regular basis, for example bi-monthly to present and to be held account for financial performance and actions being taken to address adverse performance. Non-Executive Directors should explore with Divisional Chairs and DDOs any barriers to achieving their financial targets.	Complete	tbc	Gill Hall	n/a	Divisional chairs and DDOs now attending F&PC and can be evidenced via minutes.	Yes	COMPLETE	COMPLETE
69	The Audit Committee should obtain independent assurance over the CIP programme. This has been highlighted as a high risk area with no independent assurance to the Audit Committee since prior to 2013/14.	30/11/2015	Gill Hall	Mike Rappolt	Completion of the report,recommendations considered and where appropriate actions implemented	Internal Audit Revoew of CIPs carried out and shared with Audit Committee on 10.11.15. Majority of the planned CIP programme has been delivered. An Internal Audit Review has also been carried out on the Service Improvement Programme. A second audit is scheduled for the Service Improvement Programme in 16/17.	Yes	COMPLETE	COMPLETE
70	The Audit Committee should ensure that the scope of audit work is sufficient to enable them to receive assurance over key risks and controls. For example, effective Divisional and directorate financial reporting is fundamental to the overall financial control of the Trust. Therefore an audit of financial reporting should address this control.	Complete	Gill Hall	Mike Rappolt	Completion of the report, recommendations considered and where appropriate actions implemented	An Extraordinary Audit Committee meeting was held on 26/10/15, where the PwC report was reviewed in depth with both the internal and external auditors. Learning points were agreed and are being implemented for the 16/17 audit. Financial reporting is now being taken to directorate level and in some instances is being taken to care group level.	Yes	COMPLETE	COMPLETE
71	The Audit Committee should consider commissioning an independent internal audit effectiveness review, to assess how the Trust can more effectively use the internal audit function, and how this function can be developed and strengthened, particularly in relation to providing assurance over key risks and controls. This should include consideration of where the scope or scale of a task is outside or beyond the capabilities of the internal audit team, and the use of an external contractor may be of more benefit.	Complete	Gill Hall	Mike Rappolt	n/a	A new internal auditor has been appointed further to a tender process. As part of the panel to appoint the new IA a govenor was the panel. TIAA has been appointed as the new IA and attended both the january and March Audit Committees.	Yes	COMPLETE	COMPLETE
72	The role and remit of the CIP Board should be revisited to ensure that it takes an oversight of the delivery of the current year's CIPs, as well as planning for the subsequent year. The CIP Board should also take oversight of the interaction between SIPs and CIPs, to consider any risk to delivery of CIPs as a result of delays in delivering SIPs.	Complete	KPMG support	Andrew Burn	n/a	All risks on CIP and SIP are reported into Martin Wilson, the Director of Transformation. This provides a direct interaction between SIP and CIP.	YES	COMPLETE	COMPLETE
73	The Divisional Management Board agendas should be revised to include the reporting of divisional risk registers, with clear recording and tracking of any new risks, and the monitoring and challenge of CIP and SIP delivery.	Complete		Gill Hall	Divisional risk registers considered by the divisional governance boards, a subgroup of the Divisional Management Boards	Unclear as to why the recommendation was not accepted. Processes to be brought in place to address this. Need to ensure that divisional governance boards are reporting to the DMB and that there is not a governance gap.	No - process to be defined to ensure that divisional governance boards are reporting to DMB. Specific governance workstream being developed to address all the governance actions. This acton will be complete by the end of June 2016.	NOT ACCEPTED	PROGRESSING
74	An accountability framework should be established which clearly sets out the responsibilities of the care groups, directorates, divisions and the Board. This framework should define the performance management processes and the consequences for failure to deliver. The current performance management process should be reviewed and refreshed to ensure that (a) there is clear accountability and responsibility and (b) responsibility sits with those with relevant experience. For example, the PMO function should not have responsibility for finance functions and vice versa.	31/03/2016	tbc	Martin Wilson	Implement by end of Sept	The Trust has taken several steps to address this: 1. Introduction of the COO, with DDOs being accountable to her 2. Performance management has been moved from the Finance to the COO 3. Developed and implemented a new performance framework in August 2015. 4. The PMO has been moved to the Director of Transformation, who does not have financial responsibilities 5. A consistent set of objectives have been introduced for the 100 top leaders via their PDP 6 Accountability for transformation programmes has been set in to the Executive SROs objectives and appraisals. This action needs to remain open as the framework needs to be refreshed, to include consequences of failure to deliver.	No - it is anticipated that the refreshed framework will be in place by May 2016. The COO has taken over responsibility for this action.	PROGRESSING	PROGRESSING
75	Where escalation processes are put in place, for example to monitor control totals or a deterioration in performance, consideration should be given to the effectiveness of these, particularly reflecting on whether regular involvement of Executive Directors dilutes their impact.	Complete	Anna Anderson (interim)	Steve Bolam	Divisional management meetings now refreshed and established on a monthly basis (Finance and Ops). TOR agreed and robust challenge now being effected.	Divisional meetings occur monthly. TOR agreed. Continues as BAU.	Yes	COMPLETE	COMPLETE

St George's University Hospitals NHS
NHS Foundation Trust

DRAFT AUDIT COMMITTEE ANNUAL REPORT 2015/16

1. PURPOSE OF THE AUDIT COMMITTEE

The aim of the Audit Committee is to review and independently scrutinise St George's University Hospitals NHS Foundation Trust's systems of clinical/corporate governance, financial reporting, internal control and risk management thereby ensuring, through proper process and challenge, that integrated governance principles are embedded and practised across all St George's activities and that they support the achievement of the Trust's objectives.

It also reviews key internal and external financial, clinical, fraud and corruption and other policies, reports and assurance functions thereby providing independent assurance on them to the Board of St George's.

In addition, the Committee provides a form of independent check upon the executive arm of the Board.

Preparation of an annual report to the Board setting out how they have met their terms of reference during the financial year is recommended as best practice in the NHS Audit Committee Handbook. The annual report is also submitted to the Council of Governors of St George's University Hospitals NHS Foundation Trust setting out how the Audit Committee of the Trust has met its terms of reference.

2. TERMS OF REFERENCE AND MEMBERSHIP

The Audit Committee is a sub Committee of the Board.

2.1 Terms of Reference

The Committee reviewed its Terms of Reference in January 2015 and agreed no changes were required. It also reviewed them against the Monitor code of governance in September 2015. Members were also asked to feedback comments in January 2016.

The current Terms of Reference are shown at Appendix 1.

2.2 Frequency of Meetings

Under the terms of reference, the Committee is required to meet not less than four times a year. During 2015/16 the Committee met on six occasions (see Appendix 2 for meeting dates and attendees).

A special Audit Committee was convened in October 2015 to review the process and control issues arising relevant to the Audit Committee and its auditors arising from the Price Waterhouse Coopers report.

2.3 Membership

The Committee members, including the Chair, are appointed by the Board and comprise three Non-Executive Directors. Meetings require the attendance of two members in order to be quorate. The members of the Committee throughout the year, together with their other committee memberships, were:

- Michael Rappolt (Chair) - Nominations and Remuneration Committee, Finance and Performance Committee, FT Stakeholders Steering Group, Commercial Committee and Deputy Chair;
- Sarah Wilton - Finance and Performance Committee, FT Programme Board, Quality and Risk Committee (Chair), Nominations and Remunerations Committee (retired end January 2016 upon being appointed Acting Chair of the Trust);
- Judith Hulf – Quality and Risk Committee, Nominations and Remunerations Committee, Research Committee (retired end January 2016);
- Brian Dillon and Felicity Merz, Governors who were co-opted onto the Committee for its March meeting.

2.4 Agenda and Timetable

A risk based integrated work plan was published covering the Committee's business for 2015/16 and was approved by the Board on 30th April 2015.

The work plan is underpinned by the work of and reports from the Trust's internal and external auditors and the work plan is timetabled to ensure reports are received at the most appropriate times and that key reporting deadlines are met. There were some variations to the plan and additional requirements made of Internal Audit during the year.

Updates to the plan were periodically approved by the Board throughout the year.

2.5 Appointment of External Auditors

The current external auditors are Grant Thornton as approved by the Board of Governors at their meeting in February 2015.

The Audit Committee actively assessed the effectiveness of Grant Thornton by reviewing key performance indicators highlighting their performance.

2.6 Appointment of Internal Auditors

The internal auditors for 2015/16 were London Audit Consortium. Following a formal tendering process TIAA were appointed as the Trust's new Internal Auditors for 2016/17.

The Audit Committee actively assessed London Audit Consortium's effectiveness by reviewing key performance indicators highlighting their performance.

3. WORK DONE

3.1 General

The Committee performed its work by establishing risk based areas, in the form of its Audit Committee Work Plan, that it wished to receive assurance upon; commissioning internal audit and external audit to report on those areas; requiring those executives responsible to attend meetings to explain matters more thoroughly; and seeking further information from them as required.

A systematic 'Matters Arising' arrangement is used, to ensure outstanding issues and actions are brought back to the next appropriate meeting and followed up. In addition, the internal auditors follow an audit programme set out at the beginning of the year, which is discussed and agreed with Trust Management and the Audit Committee, approved by the Audit Committee and incorporated with the External Auditor's plan into the integrated plan.

The Trust uses an Audit Tracking System to monitor the implementation of agreed internal and external audit recommendations. The operation and maintenance of this tracking system is the responsibility of the Corporate Office, under the management of the Director of Corporate Affairs and is reviewed at each meeting. Towards the end of the year the updating process for the Audit Tracker was not as effective as it should have been due probably to other major pressures on Trust managers. A bottom up review of outstanding actions and the Audit Tracking Process is currently underway with a view to improving the process. Further improvements to the Audit Tracker are being sought for the upcoming 2016/17 year, as noted in Section 3.10.

The Committee is satisfied that the auditors have received the necessary assistance from Trust managers and staff when carrying out their work programmes and no limitations have been place by management on the scope of the work carried out by the auditors.

3.2 Briefings

The Committee was provided with regular briefings on the work of the Quality and Risk Committee, providing additional assurances on matters of quality and risk management.

The Chief Finance Officer, on behalf of the Finance and Performance Committee, provided briefings on the work of that committee and matters arising, providing additional assurances on matters of financial and performance control.

Other briefings received by the Audit Committee included:

- Whistleblowing – 6 Monthly Report;
- Briefing paper on Cybersecurity;
- CQC divisional governance arrangements;
- Clinical Audit briefing;
- Updates on the tendering process for internal audit;
- The Annual Fire Safety Report;
- Preventing Violent Extremism.

3.3 External Audit

The Audit Committee reviewed and where necessary approved, reports including:

- The Audit Plan 2015/16;
- Progress Reports;

- KPI Benchmark Report

3.4 Internal Audit

The Audit Committee reviewed and where necessary approved:

- The draft Internal Audit Plan 2016/17 TBC;
- The Head of Internal Audit Opinions for the Trust and the Foundation Trust on the effectiveness of the systems of internal control;
- Progress Reports at each meeting;
- Annual Report, including key performance indicators;
- Individual Internal Audit reports across the main areas of the Trust as follows:

    - **Governance:** Strategic Partnership, Complaints, Infection Control, MAST, Bank and Agency – Nursing, Risk Management, CQC and the Information Governance Toolkit

    - **Finance:** Medical Locums, Payroll, Accounts Payable, Accounts Receivable, Financial Ledger, Capital and Cashiers

    - **Safety, Clinical and Cost Effectiveness:** Diagnostic Test Follow Up (and also a follow-up report), Consultant Attribution and Discharge Summaries

    - **Care, Environment & Amenities:** ICT Strategy, Cybersecurity, SWL Pathology Service, Estates Review – Procurement Practice, Data Quality Governance – Follow-up, Central Stores, Fire Safety Follow Up, PFI Contract Management, Community Properties Compliance, Capacity, Service Improvements, and Estates Compliance Follow-up.

    - **Investigations:** Fetal Medicine

3.5 Local Counter Fraud Specialist (LCFS)

The Audit Committee received, reviewed and where necessary approved

- The LCFS Annual Report
- Progress reports;
- The LCFS plan 2016/17.

The Committee is satisfied with the efforts being made by the Trust to address fraud within the Trust and that the LCFS feels free to report any concerns to the Committee.

It was reported in May 2015 that the Trust was RAG rated green on all expected items using the NHS Protect Self Assessment Tool for counter fraud.

3.6 Annual report and financial reporting

The Audit Committee reviewed:

- Compliance with accounting standards and practices and any changes being proposed;
- Changes to Standard Financial Instructions;

- The financial accounts for the Trust for the 10 month to 31st January 2015 and the Foundation Trust for the 2 months to 31st March 2015,
- The Head of Internal Audit's Opinions on the effectiveness of the system of internal control for the Trust and the Foundation Trust covering the year ended 31 March 2015;
- Issues arising from the Audit of the accounts;
- The External Auditors' Annual Letter

and made recommendations to the Board.

3.7 Disclosure Statements

The Audit Committee reviewed:

- The 2 Annual Governance Statements for 2014/15 ;
- The Trust's Annual Report for 2014/15.

and made recommendations for adoption to the Board

3.8 Quality Accounts

The Audit Committee reviewed the Trust's Quality accounts from the perspective of assurance of the quality of the underlying data upon which the Quality Accounts were based, relying on assurances from External Audit. 2 quality indicators were tested and found to be satisfactory. The 3rd was unable to be tested as there was no data trail or agreed outcomes. Subject to this the committee recommended the content of the Quality Account to the Board.

3.9 Financial Governance

The Audit Committee regularly considered:

- Debt Write Offs;
- Losses and Ex Gratia Payments;
- Waivers of Standing Financial Instructions, mainly in respect of non-tendering of various procurement contracts.

The Committee also reviewed the revised SFI in September 2015.

3.10 Reporting to the Board

Minutes of the Audit Committee are provided by the Director of Corporate Affairs (this year sporadically) to the Trust Board. In addition, after each meeting, the Audit Committee Chair provides a written report to the next meeting of the Trust Board on significant conclusions, concerns and recommendations arising from the Committee's work. The issues highlighted to the Board this year included the following:

- **Audit Tracker -** The Audit Committee was disappointed and concerned by the numbers of outstanding overdue actions recorded on the recommendations Tracker, and the lack of updates being provided by management. Recommendations had been removed from the Tracker with no evidence of completion, and contrary to commitments made at the Board, the tracker was not always going to EMT before going to the Audit Committee.

It was agreed that the new incoming Internal Auditors, TIAA, would review the entire Tracker List, removing actions no longer relevant and confirm the status, dates, priorities and Executive responsibility for those remaining. This should be complete by the May meeting.

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.

- **Central stores -** Internal Audit undertook a review of recommendations made in January 2014 for better control of Central Stores. 9 of the 9 original recommendations reported as complete on the audit tracker were only partially complete. This brings into question the integrity of Trust reporting and we have requested that all reporting on actions in the Audit Tracker are signed off by the responsible Executive. We were reassured by the new Interim Head of Procurement that these actions would now be tackled and that Central Stores was rapidly being brought under control. We requested assurances that controls either are in place or would be put in place to pick up fraud, past and present.

- **Diagnostic Test Follow Up -** An Internal Audit of Diagnostic Test follow up gave Limited Assurance. This was worrying from a Patient Safety perspective as failures to follow up diagnostic tests SIs continue to be raised. The audit identified some progress but highlighted the lack of robust SOPs for all Care Groups linked to an IT solution and the fact that a Trustwide action plan although drawn up is not being specifically tracked. A new action plan was being developed. We were informed that the findings would not be a surprise to the Medical Director and urged him to tackle this area with the utmost priority and speed. A follow-up audit was commissioned for the March Committee, which showed that only 3 of the original 7 recommendations had been fully implemented. Technical and cultural issues were highlighted and the committee requested regular updates to QRC.

- **Consultant Attribution –** A limited assurance report was provided. Audit testing did not identify any one overriding issue for incorrect consultant attribution, but the committee recommended that the Medical Director is tasked with undertaking a root cause analysis of reasons for incorrect attribution and develops actions to address the underlying causes. Again, there are technical and cultural issues.

- **Discharge Summaries –** This follow-up review identified that only 2 of the 6 original recommendations had been fully implemented, and a significant number of discharge summaries were not being completed as per the Tableau data. The committee recommended that the Medical Director is tasked with producing regular performance figures and an action plan, and report progress to the F&P regularly.

- **Network Security / Penetration Testing** - Limited Assurance was given in this Follow Up review primarily because a number of recommendations from the original test had not been implemented yet. The Chief Financial Officer and ITC Director agreed a programme either to implement the remaining recommendations or not implement them but explicitly document the risk in so doing. A follow up discussion identified that with the recent broadening of Trust systems into partner organisations and the Community there was a need to fundamentally review security and the need for encryption of sensitive data.

- **Information Governance** – Although the audit of the IG toolkit provided reasonable assurance, it was noted that mandatory IG training, which was outside the scope of the review, was only at 65% against a mandatory target of 95% by the year-end.

- **Financial Management and Budgetary Control and CIP Process** – Audit Reports on Financial Management and Budgetary Control and the CIP process both cited improvements and gave Reasonable assurance for the basic framework, Limited Assurance was given overall reflecting the late commencement of these processes, the increased deficit, the shortfall in CIPs so far and the incomplete current action plan to improve them. The Audit Committee asked for a follow up audit early in 2016/17.

- **Complaints –** Although an overall reasonable assurance was provided, the control objective relating to action tracking received limited assurance. We were concerned as the Board has been receiving assurances that poor performance on complaints was being actioned. We recommended that the Director of Nursing updates the Complaints policy to state clearly the Divisional tracking required, how lessons learned will be disseminated across the Trust, and how assurance on this will be reported back to the Board.

- **Estates and Facilities Procurement Practice -** We received a long and in part forensic draft Internal Audit report on Estates and Facilities procurement practice and compliance with SFIs within Estates. It is a complex report but in summary concludes that SFIs and that in some cases procurement rules had been breached and mistakes 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, but there has been a combination of poor support from Procurement and Estates and Facilities taking short cuts (sometimes for reasons of urgency/patient safety). The Chief Executive and Director of Workforce and OD considered the report and determined that disciplinary action is not appropriate.

- **Medical Locums –** Whilst reasonable assurance was given to an Internal Audit report on Locums there were still some system weaknesses that 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.

- **Capacity Planning –** the audit report provided reasonable assurance on the direction of travel and improvement since the last audit in 2014/15 although a fully integrated capacity planning system is not yet operational within the Trust and is needed urgently. We were not given a date by which one would be operational. The committee recognised the complexity of this area but was disappointed to learn that despite significant expenditure with KPMG on the development of a capacity planning model in August of last year and significant resource input from the Trust integrated capacity planning was not yet fully operational within the Trust seemingly due to lack of Trust data availability. The committee requested a further Capacity Planning audit in 16/17, to include whether the Trust specified their requirements from KPMG adequately and whether the Trust received value for money from the KPMG expenditure on the Capacity Model.

- **Service Improvements** - Next year's cost improvement programme currently labelled Transformation is critical to the Trust achieving its financial objectives. Internal Audit undertook an audit to assess whether the Service Improvement programme was aligned with the Trust's objectives, whether there is sufficient capacity and capability to undertake the individual projects and whether there is appropriate project management. Reasonable assurance was given on the basis that this is a work in progress and that the application and effectiveness of the controls could not be tested as plans were still in development. There will be a further audit of the Transformation programme in 16/17.

- **Risk Management -** We received an Internal Audit on Risk Management within the Trust which provided reasonable assurance. The Board Assurance Framework is currently being revised to align it with Monitor's Well Lead Framework. One weakness highlighted was the delayed implementation of the risk management strategy at Directorate and Care Group level reflecting continuing weakness in obtaining assurance governance processes at Directorate and Care Group level. Weakness in governance processes at the Directorate and Care Group level is an underlying theme in many of our Internal Audit reports this year and needs to be urgently addressed by the Executive team

- **Financial Reports** - The Audit Committee receives a series of regular annual financial Internal Audit reports, including Accounts Payable, Accounts Receivable, Financial Ledger, Capital and Cashiers. The committee noted that in a number of instances assurance levels had dropped from Significant last year to Reasonable this year. The reasons are varied but include longer payment terms, regular supplier reconciliations not being carried out, retrospective order values increasing, debt levels rising, Fixed Asset Register (FAR) not being updated, no monthly reconciliations between FAR and the Ledger, as in previous years no disposal of assets recorded and key cash controls requiring tightening. Certainly some of these shortfalls can be ascribed to staff shortages. The annual salary overpayment report also showed that the % of salary overpayments had doubled from last year. The main reason was the failure of Care Groups and other departments to notify HR and finance in a timely manner. The committee endorsed the recommendations proposed by the Finance Department and will continue to monitor them.

3.11 Action Tracking

The Committee continued to monitor the implementation of agreed recommendations through the action tracking reports produced by the Director of Corporate Affairs. Discussions were held as to how the effectiveness of the system could be improved See 3.10 above.

4. SUPPORT TO THE AUDIT COMMITTEE

Support to the Committee was provided, as follows:

4.1 Internal Audit

The Trust's internal audit service during 2015/16 continued to be provided by London Audit Consortium (LAC), an NHS non-profit organisation providing a range of services to the NHS and other public sector bodies. The internal audit team has been based at the Trust throughout the year. Internal Audit report directly to the Audit Committee.

4.2 External Audit

The Trust's External Audit Service continued to be provided by Grant Thornton. The Annual Audit Letter for 2014/15 was presented to the Committee in September 2015.

4.3 Local Counter Fraud Specialist (LCFS)

The Trust has 2 employees acting as the Trust's LCFS. The LCFSs have a direct line of reporting to the Chief Finance Officer consistent with the Secretary of State's Directions.

4.4 Trust Executive and Senior Managers

The Director of Finance, Informatics and Performance or their deputy attend each meeting of the Committee. In addition, as and when required, other Trust executives and senior managers prepare reports, action follow up items and attend the Audit Committee meetings to discuss and comment upon internal audit reports relevant to their specific areas. A schedule of Trust managers attending is included in Appendix 2.

The Director of Corporate Affairs (Trust Secretary) has provided support to the Audit Committee throughout the year by acting as secretary to the Committee. There has been a change in personnel in this role during the year.

5. COMMITTEE DEVELOPMENTS

5.1 Audit Committee Self Assessment

The Audit Committee undertook its annual self-assessment survey in January 2016. Overall the results were broadly positive, but a number of actions were agreed :

- Audit Committee Induction training for new NEDs
- Trust Secretary to attend all meetings
- Regulatory issues to be linked into training
- Performance integration statement , to include process– March meeting
- Quality standards work
- Improved Action tracker
- Minutes available in 10 working days
- Reporting to be improved

6 CONCLUSION

The Audit Committee believes that it has, to the best of its ability, met its terms of reference. It gratefully acknowledges the excellent support it has received without which it could not have fulfilled its remit.

Mike Rappolt
Chair of the Audit Committee 2015/16

TERMS OF REFERENCE

AUDIT COMMITTEE

Policy No:	Audit Committee Terms of Reference
Version No:	1.5
Authorisation:	Trust Board
Date this version issued:	September 2015
Date this version authorised:	
Next review date:	January 2017
Pages:	7
Produced by: author(s) and/or SDU or Department	Peter Jenkinson, Director of Corporate Affairs

Document History		
Version	**Date**	**Comments**
V. 1.0	August 2009	Review of existing terms of reference
1.1	01.09.2009	Review comments from Chair of Audit Committee
1.2	19.01.2011	Annual review following annual committee effectiveness review
1.3	18.01.2012	Annual review following annual committee effectiveness review and changes to the trust management structure
1.4	21.01.2014	Annual review following annual committee effectiveness review
1.5	31.01.2015	Annual review following annual committee effectiveness review
1.6	09.10.2015	Review against the principles and provisions within Monitor's Code of Governance for foundation trusts

Terms of Reference

AUDIT COMMITTEE

The Trust Board hereby resolves to establish a sub-committee to be known as the **Audit Committee ('the Committee').**

AIMS

1.0 Aims

1.1 The Committee has been established to:

- review and independently scrutinise the St George's Healthcare NHS Trust systems of clinical governance, internal control and risk management thereby ensuring, through proper process and challenge, that integrated governance principles are embedded and practised across all St George's activities and that they support the achievement of the Trust's objectives.

- review key internal and external financial, clinical, fraud and corruption and other policies, reports and assurance functions thereby providing independent assurance on them to the Board of St George's.

- to review the integrity of financial statements prepared on the Trust's behalf.

- undertake all other statutory duties of an NHS Audit Committee.

Constitution

2.0 Membership

2.1 Members of the Committee shall be appointed by the Trust Board. The Committee shall consist of not less than three non-executive directors of the Board, at least one of whom will have recent and relevant financial experience. The Board shall appoint the Chair of the Committee from amongst the non-executive directors appointed to the Committee. The chair of the Quality & Risk Committee will, ex officio, be a member of the Committee.

2.2 The Chair of the Trust shall not be a member of the Committee, but shall have the right to attend committee meetings.

2.3 Committee meetings shall normally be attended by the Director of Finance, Chief Nurse/Director of Operations and Trust Secretary; other executive directors may be asked to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director.

2.4 The Corporate Office will provide secretarial support to the Committee, assisted by Internal Audit, providing appropriate support to the Chairman and committee members, and shall attend meetings.

2.5 The Heads of Internal and External Audit shall also normally attend. The Committee will meet privately with each of the External and Internal Auditors at least once a year.

3.0 Quorum

3.1 The quorum for meetings of the Committee shall be two members.

4.0 Frequency of meetings

4.1 The Committee will meet at least four times per year. Additional meetings may be called by the Chair of the Committee.

5.0 Declaration of interests

5.1 All Committee members must declare any conflict of interests, should they arise, and exclude themselves from the meeting for the duration of that specific item.

Duties and responsibilities

6.0 Duties and responsibilities

6.1 In fulfilling this purpose, the Committee will seek the assurances it considers necessary from management and other, independent sources and will assess the reliability of those assurances prior to advising the Board of its findings.

Without limitation, the Committee will carry out its duties as follows:

Integrated Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of ***integrated governance, risk management and internal control***, across the whole of the organisation's activities (both clinical and non-clinical and operational, corporate and support systems), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Standards for Better Health), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service
- the application of the Policy for Standards of Business Conduct thus offering assurance to the Board of probity.

Financial reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas
- significant adjustments resulting from the audit
- reviewing schedules of losses and special payments including the approval for case write offs, and making recommendations to the Board.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Corporate Governance

The Trust's Standing Orders and Standing Financial Instructions also place certain obligations upon the Committee. In particular, the Committee will provide assurance to the Board of probity in the conduct of Trust business, by:

- reviewing annually the continuing appropriateness of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation;
- monitoring the implementation of policy on standards of business conduct for staff
- receiving and considering information on any waivers to Standing Orders;
- reviewing schedules of losses and special payments including the case for write-offs.

Whistleblowing

The committee shall review the effectiveness of the Trust's Whistleblowing Policy and arrangements by which staff may raise concerns about possible improprieties in financial or other matters.

7.0 Approaches to obtaining relevant assurances

7.1 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness as set out below:

Internal Audit

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- annual review of the effectiveness of internal audit

External Audit

The Committee will review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Authority/Trust/PCT and associated impact on the audit fee
- review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses

Counter Fraud

The Committee will ensure that there is an effective local counter fraud function established by management that meets mandatory NHS Counter Fraud Standards and provides adequate arrangements to counter fraud. This will be achieved by:

- consideration of the provision of the Local Counter Fraud Service (LCFS), the cost of the service and any questions of resignation and dismissal
- review and approval of the LCFS strategy and annual plan, ensuring that this is consistent with the needs of the organisation and gives adequate assurances on all areas of the NHS Counter Fraud Strategy
- consideration of LCFS reports
- ensuring that the LCFS function is adequately resourced and has appropriate standing within the organisation
- annual review of the effectiveness of Counter Fraud via the LCFS annual report

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These may include, but not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Healthcare Commission,

NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Audit Committee will review the work of other relevant Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work, in particular, those Committees with a remit for clinical governance and risk. The Audit Committee will wish to satisfy themselves on the assurances that can be gained from those functions which audit clinical outcome and performance.

Management

The committee may request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

The committee will establish a formal system of following up recommendations arising from reports by:

- establishing and recording the resultant actions, the date by which they should be completed and which Executive Director is responsible for them
- reviewing and updating this list at each meeting

AUTHORITY and ACCOUNTABILITY

8.0 Accountability

8.1 The Committee is established as a permanent sub-committee of the Trust Board and is accountable to the Trust Board.

9.0 Authority

9.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

9.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

9.3 The Committee has no executive responsibilities except insofar as explicitly stated in these Terms of Reference.

10.0 Reporting

10.1 The minutes of the Committee will be formally recorded and submitted to the Board. In addition the chair of the Committee shall present a report to the Board after each meeting, drawing to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

10.2 The Committee will also submit a written report to the Board annually on its activities in support of the Statement on Internal Control.

MONITORING EFFECTIVENESS

11.1 In order to support the continual improvement of governance standards, sub-committees of the Trust Board and executive committees are required to annually:

- complete a self-assessment of the effectiveness of the committee;
- present an annual written report to the Board or committee from which the committee derives its delegated authority;
- review the terms of reference for the Committee, reaffirming the purpose and objectives;
- prepare a work plan, for approval by the Board on an annual basis.

11.2 This Committee will report the results of the assessment of its effectiveness and its annual report to the Trust Board.

Appendix 2

AUDIT COMMITTEE ATTENDANCE 2015/16

	26th May 2015	9th Sept 2015	26th Oct 2015 (Special)	11th Nov 2015	20th Jan 2016	17th Mch 2016
AUDIT COMMITTEE MEMBERS						
Mike Rappolt – Chair	✓	✓	✓	✓	✓	✓
Sarah Wilton	✓		✓	✓	✓	
Judith Hulf	✓	✓	✓		✓	
Brian Dillon – Council of Governors, co-opted member						✓
Felicity Merz – Council of Governors, co-opted member						✓
TRUST EXECUTIVE						
Steve Bolam- Chief Finance Officer	✓	✓		✓	✓	
Ian Lynam – Director of Finance						✓
Jennie Hall – Chief Nurse	✓	✓		✓		✓
Peter Jenkinson – Director of Corporate Affairs	✓	✓	✓	✓		
Jill Hall – Interim Trust Secretary					✓	
Martin Wilson – Director of Improvement & Delivery				✓		✓
Eric Munro – Joint Director of Estates & Facilities	✓	✓		✓	✓	✓
TRUST MANAGEMENT						
Luke Edwards – Head of Corporate Governance						✓
Dominic Sharp – Deputy Director of Finance	✓	✓		✓	✓	✓
Julian Barratt – Interim Director of Financial Operations						✓
Jacqueline McCullough - Deputy Director of HR		✓				
Sarah James – Head of Education and Training		✓				
Andrew Polley – Interim Head of Procurement		✓				
James Frain – Interim Head of Procurement						✓
John-Jo Campbell – Head of IT				✓		
Nigel Kennea – Associate Medical Director				✓		✓
Kate Hutt – Clinical Audit Manager				✓		
John-Jo Campbell – Head of IT				✓		
EXTERNAL AUDIT						
Paul Dossett - Grant Thornton	✓	✓	✓	✓	✓	
Elizabeth Olive – Audit Manager, Grant Thornton	✓	✓	✓		✓	✓

	26th May 2015	9th Sept 2015	26th Oct 2015 (Special)	11th Nov 2015	20th Jan 2016	17th Mch 2016
Tom Slaughter - Grant Thornton					✓	✓
INTERNAL AUDIT (LAC)						
Derek Corbett – Director, London Audit Consortium	✓		✓			
Lindsay Thatcher – Asst Director of Audit, London Audit Consortium	✓	✓	✓	✓	✓	✓
Mark Hughes – Asst Director of Audit, London Audit Consortium				✓		
Tim Williamson – Principal Internal Auditor, London Audit Consortium	✓	✓				
Silvan Koterba – Senior Internal Auditor					✓	✓
Peter Crabb – Interim Auditor, London Audit Consortium						✓
INTERNAL AUDIT (TIAA)						
Kevin Limn					✓	✓
Ashley Norman					✓	✓
LCFS						
Pauline Lewis – LCFS				✓		✓
Agnese Verrilli		✓			✓	
OBSERVERS						
Sir David Henshaw – Chairman (elect)						✓
Mia Bayles – Council of Governors						✓

INTERNAL AUDIT

tiaa

St George's University Hospitals NHS Foundation Trust

Internal Audit Annual Plan

2016/17

February 2016

Internal Audit Annual Plan

INTRODUCTION

This Annual Plan is drawn up in accordance with the Terms of Reference of TIAA and the Internal Audit Strategic Plan.

AUDIT STRATEGY METHODOLOGY

We adopt a risk based approach to determining your audit needs each year which includes reviewing your risk register and risk management framework, previous internal audit work for the organisations within the Trust, the Regulatory Framework and assessment of St George's University Hospitals NHS Foundation Trust, external audit recommendations together with key corporate documentation such as your business and corporate plan. , standing orders, and financial regulations. The Strategy will be based predominantly on our understanding of the inherent risks facing St George's University Hospitals NHS Foundation Trust and those within the sector and has been developed with senior management and Committee.

AUDIT COMMITTEE RESPONSIBILITY

It is the responsibility of the Audit Committee to determine that the number of audit days to be provided, the planned audit coverage is sufficient to meet the Committee's requirements and the areas selected for review are adequate provide assurance against the key risks within the organisation.

INTERNAL AUDIT ANNUAL PLAN

The Annual Plan (Annex A) sets out the reviews that will be carried out, the planned times and the scopes for each of these reviews. The rolling strategic plan is set out in Annex B. The rolling strategic plan will be subject to ongoing review and could change as the risks change for the organisation and will be formally reviewed with senior management and the Committee mid-way through the financial year or should a significant issue arise.

The planned time set out in the Annual Plan for the individual reviews includes: research, preparation and issue of terms of reference, production and review of working papers and reports and site work. The timings shown in the Annual Plan assume that the expected controls will be in place.

Substantive testing will only be carried out where a review assesses the internal controls to be providing 'limited' or 'no' assurance with the prior approval of St George's University Hospitals NHS Foundation Trust and additional time will be required to carry out such testing. St George's University Hospitals NHS Foundation Trust is responsible for taking appropriate action to establish whether any loss or impropriety has arisen as a result of the control weaknesses.

REPORTING

Assignment Reports: A separate report will be prepared for each review carried out. Each report will be prepared in accordance with the arrangements contained in the Terms of Reference agreed with TIAA and which accord with the requirements of the Public Sector Internal Audit Standards (PSIAS).

Progress Reports: Progress reports will be prepared for each Audit Committee meeting. Each report will detail progress achieved to date against the agreed annual plan.

Annual Report: An Annual Report will be prepared for each year in accordance with the requirements set out in the Public Sector Internal Audit Standards (PSIAS). The Annual Report will include our opinion of the overall adequacy and effectiveness of St George's University Hospitals NHS Foundation Trust's governance, risk management and operational control processes.

LIAISON WITH THE EXTERNAL AUDITOR

We will liaise with St George's University Hospitals NHS Foundation Trust's External Auditor. Any matters in the areas included in the Annual Plan that are identified by the external auditor in their audit management letters will be included in the scope of the appropriate review.

We will also liaise with the local counter fraud and security management teams throughout the year to ensure there is no duplication of work.

BACKGROUND

St George's University Hospitals NHS Foundation Trust serves a population of 1.3 million across southwest London. A large number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totaling around 3.5 million people.

Challenges facing St George's University Hospitals NHS Foundation Trust in the coming year:

- Achieve financial stability.
- Deliver the transformation plan.
- Reduce length of stay.
- Recruit to vacant Executive and Non-Executive Board roles.
- Embed a culture of compliance.

ASSESSMENT OF THE KEY RISK CONTROL OBJECTIVES

For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks will be provided. The assurance mapping process is set out in Annex C.

AUDIT REMIT

The Audit Remit (Annex D) formally defines internal audit's purpose, authority and responsibility. It establishes internal audit's position within St George's University Hospitals NHS Foundation Trust and defines the scope of internal audit activities and ensures compliance with the PSIAS.

CONFLICT OF INTEREST

We are not aware of any conflicts of interest and should any arise we will manage them in line with PSIAS requirements, the St George's University Hospitals NHS Foundation Trust's requirements and TIAA's internal policies.

LIMITATIONS AND RESPONSIBILITY

Internal controls can only provide reasonable and not absolute assurance against misstatement or loss. The limitations on assurance include the possibility of one or more of the following situations, control activities being circumvented by the collusion of two or more persons, human error, or the overriding of controls by management. Additionally, no assurance can be provided that the internal controls will continue to operate effectively in future periods or that the controls will be adequate to mitigate all significant risks that may arise in future.

The responsibility for a sound system of internal controls rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses that may exist. Neither should internal audit work be relied upon to identify all circumstances of fraud or irregularity, should there be any, although the audit procedures have been designed so that any material irregularity has a reasonable probability of discovery. Even sound systems of internal control may not be proof against collusive fraud.

Reliance will be placed on management to provide internal audit with full access to staff and to accounting records and transactions and to ensure the authenticity of these documents.

The matters raised in the audit reports will be only those that come to the attention of the auditor during the course of the internal audit reviews and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. The audit reports are prepared solely for management's use and are not prepared for any other purpose.

PERFORMANCE

The following Performance Targets will be used to measure the performance of internal audit in delivering the Annual Plan (Figure 1 below):

Figure 1 - Performance Targets

Area	Performance Measure	Target
Achievement of the plan	Completion of Planned Audits	100%
	Audits Completed in Time Allocation	100%
Reports Issued	Draft report issued within 10 working days of exit meeting	95%
	Final report issued within 10 working days of receipt of responses	95%
Professional Standards	Compliance with Public Sector Internal Audit Standards	100%

KEY CONTACT INFORMATION

Name	Contact Details
Kevin Lim Director	Kevin.Limn@tiaa.co.uk 07881 845472
Ashley Norman Director of Audit	Ashley.Norman@tiaa.co.uk 07870 681512
Nicola Meeks Senior Audit Manager	Nicola.Meeks@tiaa.co.uk 07789 650980

RELEASE OF REPORT

The table below sets out the history of this plan.

Date plan issued:	19/2/2016

Annex A

Annual Plan – 2016/17

Quarter	Audit	Type	Days	Scope
1-2	Delivery Arrangements Transformation Programme	Compliance		The review will consider the Trust's approach to Cost Improvement Planning, the types of savings made and the reporting of the cost Improvements. One specific Cost Savings Programme will be selected and reviewed in detail to determine how the savings are being delivered.
1	Follow Up Reviews (from previous recommendations)	Compliance		Topics identified from outstanding and overdue previous IA recommendations such as Medical Devices / iClip / Central Stores
1	Agency Cap	Compliance		Monitor and the NHS Trust Development Authority (TDA) have implemented a cap on the amount of money that trusts can pay per hour for agency staff working for the NHS. The cap came into force on 23 November 2015. The review will consider how the CAP has been introduced at the Trust and the compliance with the CAP
1	Risk Management – Corporate Risks	Assurance		The review will consider the operational and directorate risk registers and how risks are identified, added to the register and monitored. The review will also consider how the risks are reported and linkage to the Board Assurance Framework. The scope of the review does not include consideration of all potential mitigating arrangements or their effectiveness in minimising the opportunities for the identified risks to occur.
1	Overseas Patients – Pre-admission	Compliance		The review will consider the pre-admission procedures within the Trust for identifying and capturing overseas patients for recharge. The review will assist the Trust in identifying any additional gaps in the process. A follow up review will be completed in Quarter 3
1	Departmental Review – Out Patients	Assurance		The review will consider the systems and processes to manage patients systems and flows through the named department and make observations and good practice
1	Data Quality – Key Performance Targets	Compliance		The review will consider the arrangements for providing assurances to the Board, the sub committees of the Board and Senior Management Groups, through the use of Key Performance Indicators, such as 18 RTT, 4 hr A&E etc. and the systems that are used

Quarter	Audit	Type	Days	Scope
				to capture and calculate the attainment of these targets/ performance measures The scope of the review does not include consideration of the accuracy or completeness of all reports presented to the committees/groups or the appropriateness of all decisions taken.
	Quarter 1 Total		**110**	
2	Integrated Board Reporting (PWC)	Appraisal		Moving forward from the recommendations made within the PWC report, this review will consider the progress made by the Trust in implementing an integrated reporting model for the Trust Board and operation performance metrics that clearly align to financial data.
2	Cash Management (Divisional)	Assurance		A review of the divisional approach to the management of cash. This review has been trigged by adverse cash management issues having been identified in 2015/16.
2	IT – Projects (E-prescribing)	Assurance		The review will consider the roll out and implementation of the Electronic prescription IT project to ensure that adequate project management controls are in place and operating effectively and consistently and that adequate steps have been taken to ensure that implementation has successful outcomes for the Trust.
2	Budgetary Maturity Assessment Survey	Assurance		The review will consider the extent to which budget holders were involved in the budget setting process, the timeliness of budget availability and how well budget holders understand their budgets.
2	Cyber Security Maturity Assessment	Assurance		The review considers the extent to which the organisation has the appropriate controls in place to mitigate vulnerability to computer based threats to information security. The scope of the review does not extend to testing the robustness of the individual controls.
3	Use of Bank	Compliance		The review will consider the use of the bank staffing system for non-traditional resource including for example Administration / Clinical / Technicians.
	Quarter 2 Total		**105**	
3	Risk Management – Board Assurance Framework	Assurance		One of the roles of Internal Audit is to provide an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance arrangements support the achievement of the organisation's agreed objectives. Within the NHS, the Board Assurance

Quarter	Audit	Type	Days	Scope
				Framework (BAF) is used as a mechanism, which enables this task to be done. With this in mind, we are proposing to undertake a review of the BAF and associated control and governance arrangements with a view to identifying areas, which may require strengthening.
3	Overseas Patients – Pre-admission	FU		The review will follow up on any recommendations made to improve the identification and capture of overseas patients.
3	Core Financial Systems	Assurance		The review will consider the arrangements in place for the Trust's Core Financial Systems. This will include Accounts Payable, Accounts Receivable, Treasury Management and General Ledger.
3	Payroll	Assurance		The review considers the arrangements for: the creation, amendment and deletion of payroll records; payment of allowances and pay awards; and payment of salaries. The scope of the review does not include determination of salary scales, appointment and removal of staff, severance payments or reimbursement of travel and subsistence expenses, or pension arrangements.
3	ICT Telecoms and Security	Appraisal		The review will consider the IT Telecoms systems within the Trust and include system security, backup testing and BCP / DR planning.
3	Procurement Department Review	Operational		The review considers the arrangements operating within the Procurement Department for: the identification of need, sourcing, approving and receipt of the goods and services. The scope of the review does not include tendering arrangements, payment, and security of assets or the building maintenance systems.
	Quarter 3 Total		**90**	
1-4	Follow up	FUP		On-going follow-up of recommendations, working with the Trust to validate evidence of disposal of actions.
4	IG Toolkit	ICT		It is a mandated requirement of every NHS Trust to have an annual review of its Information Governance Toolkit self-assessment prior to its submission to Connecting for Health.
4	Facilities Management	Assurance		The review will consider the reactive maintenance arrangements within the Trust and include how contractors are identified and contracted to complete works, targets for completion and the use of Breach notices.

Quarter	Audit	Type	Days	Scope
	Quarter 4 Total		**45**	
1	2016/17 Annual Plan	-		Complimentary offering as part of tender proposal.
1	Strategic Plan	-		
4	2016/17 Annual Report	-		Production of the 2016/17 HoIAO and Annual Report.
1-4	Audit Management	-		This time includes attendance at Audit Committee meetings and overall contract management.
	Management Total		**40**	
		Total days	**390**	

Annex B

Rolling Strategic Plan

Review Area	Risk Ref	Type	Days Required		
			2016/17	2017/18	2018/19
Governance					
Clinical Governance		Assurance	-	-	Y
Integrated Board Reporting (PWC)		Appraisal	Y	-	-
Corporate Governance		Assurance	-	Y	-
Board Effectiveness Review		Appraisal	-	-	Y
Risk Management					
Risk Management Corporate		Assurance	Y	-	-
BAF		Assurance	Y	Y	Y
Risk Management Clinical		Assurance	-	Y	-
ICT					
Cyber Security		Appraisal	Y	-	-
E-Prescribing Project Review		Assurance	Y	-	-
ICT Telecoms Security		Appraisal	Y	-	-
IG Toolkit		Compliance	Y	Y	Y
ICT Project Review		Assurance	-	Y	Y
ICT Audits (TBC)		Assurance	-	Y	Y
Finance					
Core Financial Systems		Assurance	Y	Y	Y
Payroll (Process)		Assurance	Y	Y	Y
Payroll Data Analytics		Compliance	-	Y	-
Budgetary Maturity Assessment		Appraisal	Y	Y	Y
Financial Systems Analytics		Compliance	-	-	Y
Procurement		Assurance	-	Y	-
Asset Management		Assurance	-	Y	-

Review Area	Risk Ref	Type	Days Required		
			2016/17	2017/18	2018/19
Core Services					
Environment and Estate		Operational	-	-	Y
Infection and Control		Assurance	-	-	Y
CQC Compliance		Appraisal	-	Y	-
Complaints		Compliance	-	Y	-
Quality (Diagnostic Tests)		Assurance	-	Y	-
Delivery Arrangements Transformation Programme		Assurance	Y	Y	Y
Agency Cap		Compliance	Y	-	-
Follow-up Reviews		Follow-up	Y	Y	Y
Departmental Reviews (Outpatients Yr1, Procurement & Cancer Pathways Yr2)		Operational	Y	Y	-
Data Quality – Key Performance Targets		Compliance	-	Y	Y
Data Quality – Safety Thermometer		Compliance	Y	-	-
HR Reviews		Assurance	Y	Y	-
Medical Director Reviews		Assurance	Y	Y	-
Facilities Management		Assurance	Y	-	-
Medical Devices		Compliance	-	Y	-
Ionising Radiation		Compliance	-	-	Y
Theatres Management		Operational	-	Y	-
Capacity Planning		Assurance	-	-	Y
Safeguarding Adults		Assurance	-	-	Y
Safeguarding Children		Assurance	-	-	Y
Incidents		Assurance	-	-	Y
Serious Incidents		Assurance	-	-	Y
Hospital at night		Appraisal	-	-	Y
Workforce Utilisation		Assurance	-	-	Y
Consultant Job Planning		Assurance	-	-	Y
Other					
Follow up		N/A	Y	Y	Y
Strategic Plan		N/A	Y	-	Y

Review Area	Risk Ref	Type	Days Required		
			2016/17	2017/18	2018/19
Annual Plan		N/A	Y	Y	-
Annual Report		N/A	Y	Y	Y
Audit Management		N/A	Y	Y	Y
		Totals	**390**	**390**	**390**

Annex C

Assurance Mapping

Corporate assurance risks

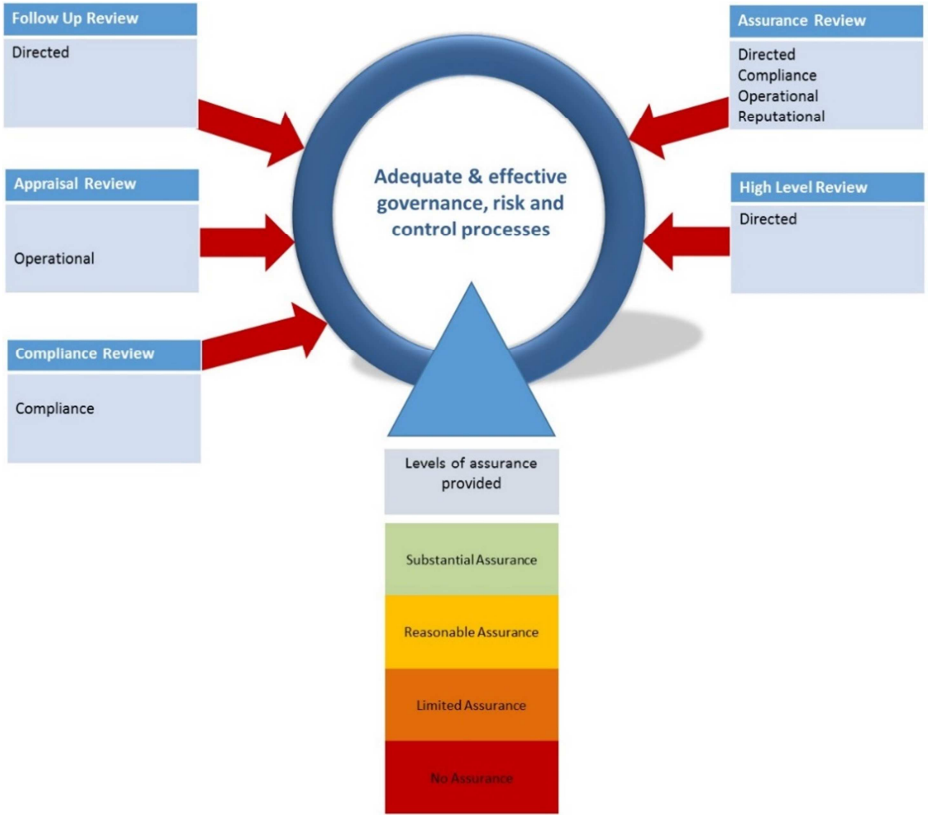
We consider four corporate assurance risks; directed; compliance; operational and reputational. The outcomes of our work on these corporate assurance risks informs both the individual assignment assurance assessment and also the annual assurance opinion statement. Detailed explanations of these assurance assessments are set out in full in each audit report.

Assurance assessment gradings

We use four levels of assurance assessment: substantial; reasonable, limited and no. Detailed explanations of these assurance assessments are set out in full in each audit report.

Types of audit review

The Annual Plan includes a range of types of audit review. The different types of review focus on one or more of the corporate assurance risks. This approach enables more in-depth work to be carried out in the individual assignments than would be possible if all four assurance risks were considered in every review. The suite of audit reviews and how they individually and collectively enable us to inform our overall opinion on the adequacy and effectiveness of the governance, risk and control arrangements is set out in the assurance mapping diagram.



Annex D

Audit Remit

Role

The main objective of the internal audit activity carried out by TIAA is to provide, in an economical, efficient and timely manner, an objective evaluation of, and opinion on, the overall adequacy and effectiveness of the St George's University Hospitals NHS Foundation Trust's framework of governance, risk management and control. TIAA is responsible for giving assurance to St George's University Hospitals NHS Foundation Trust's "Governing Body" (being the body with overall responsibility for the organisation) on the adequacy and effectiveness of St George's University Hospitals NHS Foundation Trust's risk management, control and governance processes.

Scope

All St George's University Hospitals NHS Foundation Trust's activities fall within the remit of TIAA. TIAA may consider the adequacy of controls necessary to secure propriety, economy, efficiency and effectiveness in all areas. It will seek to confirm that St George's University Hospitals NHS Foundation Trust's management has taken the necessary steps to achieve these objectives and manage the associated risks. It is not within the remit of TIAA to question the appropriateness of policy decisions. However, TIAA is required to examine the arrangements by which such decisions are made, monitored and reviewed.

TIAA may also conduct any special reviews requested by the board, audit committee or the nominated officer (being the post responsible for the day to day liaison with the TIAA), provided such reviews do not compromise the audit service's objectivity or independence, or the achievement of the approved audit plan.

Standards and Approach

TIAA's work will be performed with due professional care, in accordance with the requirements of the PSIAS.

Access

TIAA has unrestricted access to all documents, records, assets, personnel and premises of St George's University Hospitals NHS Foundation Trust and is authorised to obtain such information and explanations as they consider necessary to form their opinion.

Independence

TIAA has no executive role, nor does it have any responsibility for the development, implementation or operation of systems. However, it may provide independent and objective advice on risk management, control, governance processes and related matters, subject to resource constraints. For day to day administrative purposes only, TIAA reports to a nominated officer within St George's University Hospitals NHS Foundation Trust and the reporting arrangements must take account of the nature of audit work undertaken. TIAA has a right of direct access to the chair of the board, the chair of the audit committee and the responsible accounting officer (being the post charged with financial responsibility).

To preserve the objectivity and impartiality of TIAA's professional judgement, responsibility for implementing audit recommendations rests with St George's University Hospitals NHS Foundation Trust's management.

Consultancy activities are only undertaken with distinct regard for potential conflict of interest. In this role we will act in an advisory capacity and the nature and scope of the work will be agreed in advance and strictly adhered to. The objective of any consultancy work is to add value and improve governance, risk management and control processes. Internal audit will never take or assume management responsibility.

Irregularities, Including Fraud and Corruption

TIAA will without delay report to the appropriate regulator, serious weaknesses, significant fraud, major accounting and other breakdowns subject to the requirements of the Proceeds of Crime Act 2003.

TIAA will be informed when evidence of potential irregularity, including fraud,

corruption or any impropriety, is discovered so that TIAA can consider the adequacy of the relevant controls, evaluate the implication of the fraud on the risk management, control and governance processes and consider making recommendations as appropriate. The role of TIAA is not to investigate the irregularity unless commissioned to do so.

KEY MESSAGES TO THE BOARD FROM THE AUDIT COMMITTEE HELD ON 17th March 2016.

This report is somewhat longer than usual for two reasons:

- **The agenda for the meeting on 17th March was much longer than usual reflecting deferral/slippage of internal audits during the year and additional requests resulting in an accumulation of reports for this meeting**
- **There are also more issues we need to bring to the Board's attention from this meeting possibly reflecting the pressure the Trust has been under.**

The Audit Committee has two new members, both Governors, replacing two NEDs one who has retired and one who is conflicted having become Acting Chair of the Trust. I would like to thank those Governors for volunteering to become members of the Audit Committee. I feel it worth repeating verbatim in this report the comments of one of those Governors post the meeting:

"Firstly I would say the officers present at the Committee provided little evidence of commitment to setting an effective control environment, ensuring compliance through effective monitoring and hence providing assurance. There were too many examples of poor standards of compliance to give me confidence that the operational culture in the Trust provides a strong platform for delivering effective services. The officers have failed to provide auditors with the information needed to provide on time many scheduled reports to Audit Committee and generally seek to defer required actions to remedy poor control performance. As a result we were presented with a huge volume of paper at this Committee, with a large batch of late reports which probably merited more time for us to consider findings and agree actions. Whilst the auditors' presentations were in general OK the responses of some of the officers to Committee's questions were below the standard I would expect.

It appears to me that the Trust's senior management have sacrificed systems control and compliance by focusing staff resources on finding expenditure savings to meet Monitor and NHS targets. Unfortunately without compliance with underlying controls and procedures no-one can be confident that the monitoring information is accurate or that budget forecasts (clinical or finance) are credible or will be achievable. I agree with Committee that there appears to be a cultural problem with consultants failing to comply with clinical and patient control systems although I guess this is common to all NHS trusts. Clearly many of the management (IT) systems need upgrading or renewing with better functionality with staff properly trained in their use."

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

1. **The Audit Tracker which tracks actions arising from Internal Audits is slowly being revised by our new Internal Auditors TIAA. They are doing this in discussion with the Trust; using an IT based system; and by streamlining the process, removing actions no longer relevant, confirming status dates and priorities of the remaining actions, agreeing a single point Executive responsibility for their completion and ensuring completion is appropriately evidenced. We are promised that these revisions will be complete by our next meeting in May. In the meantime we were unable to undertake a review of the actions outstanding at this meeting**

2. **We received an Internal Audit on Risk Management within the Trust which gave Reasonable Assurance - the same as last year. This was largely because the Board Assurance Framework is currently being revised to align it with Monitor's Well Lead Framework. One weakness highlighted was the delayed implementation of the risk management strategy at Directorate and Care Group level reflecting continuing weakness in obtaining assurance governance processes at Directorate and Care Group level – for example there are no dedicated risk registers below the Divisional level due to limitations in the software (HealthAssure) the Trust uses. Weakness in governance processes at the Directorate and Care Group level is an underlying theme in many of our Internal Audit reports this year and needs to be urgently addressed by the Executive team**

3. **We received an Internal Audit report on the governance structure that gives assurance that the Trust complies with Care Quality Commission (CQC) standards. This was assessed as Reasonable on the basis that the Trust is transitioning from the CQC Essential Standards to the Fundamental Standards. However it was noted that Divisional and Care Group self-assessments have not always been completed in line with the Compliance Framework requirements.**

4. **An Internal Audit of IG Toolkit requirements was assessed at Reasonable but the audit highlighted the need for additional evidence to be assembled prior to the external assessment at the end of March. Although outside the scope of the audit it was noted that mandatory IG training was running at circa 65% against a mandatory target of 95% by year end. This needs to be corrected. Weak IG can lead to reputational damage, financial penalties and sanctions from the CQC.**

5. **The Board will remember that in our last report we highlighted a draft forensic Internal Audit of Estates, Facilities and Procurement Practice. This has now been finalised and all actions agreed by the Chief Executive and responsibilities allocated. The Chief Executive and the Director of Workforce and OD have determined that disciplinary action is not appropriate. This area will be re-audited in 16/17.**

6. **An Internal Audit of Capacity Planning, a high risk area, was presented to the Audit Committee and gave reasonable assurance on the direction of travel and improvement since the last audit in 2014/15 although a fully integrated capacity planning system is not yet operational within the Trust and is needed urgently. We were not given a date by which one would be operational. While recognising the complexity of this area the Audit Committee was disappointed to learn that despite significant expenditure with KPMG on the development of a capacity planning model in August of last year and significant resource input from the Trust integrated capacity planning was not yet fully operational within the Trust seemingly due to lack of Trust data availability. We have requested a further Capacity Planning audit in 16/17 and requested that in addition**

it address whether the Trust specified their requirements from KPMG adequately and whether the Trust received value for money from the KPMG expenditure on the Capacity Model.

7. **Next year's cost improvement programme currently labelled Transformation is critical to the Trust achieving its financial objectives. Internal Audit undertook an audit to assess whether this cost improvement programme, currently labelled Service Improvement Programme, is aligned with the Trust's objectives, whether there is sufficient capacity and capability to undertake the individual projects and whether there is appropriate project management. Reasonable assurance was given on the basis that this is a work in progress and that the application and effectiveness of the controls could not be tested as plans were still in development. There will be a further audit of the Transformation Programme in 16/17.**

8. **The Audit Committee received an oral report on how the Trust was going to address its legislative responsibilities for Preventing Violent Extremism. A further report will be presented in 6 month's time.**

9. **The Audit Committee received a very helpful report on action being taken to prevent fraud within the Trust and the progress on one potentially very serious case. We also approved the Counter Fraud plan for next year.**

10. **The Audit Committee routinely reviews Tender Waivers and approves Debt Write off. While we were satisfied that debt recovery procedures were robust we were very concerned at the sum of £312,044 that we were asked to write off relating to overseas visitors as much of this related not just to A&E admissions but to extended episodes of treatment ranging from 2 to 7 months. We heard that overseas patient debt write offs were running at over £2m per annum and were very concerned that overseas patient procedures were not working effectively post A&E admission. We have asked for an audit of this area in 16/17.**

11. **The Audit Committee approved the Cash Incident report already presented to the Board.**

12. **We received an annual report from the Finance Department on salary overpayments. We were disappointed that the level as a percentage of total salary payments as at month 10 had doubled from last year from 0.06% to 0.12% against a target of 0.05%. These percentages may not seem significant but they represent over £600,000 per annum which *is* significant in these cash constrained times. The overriding reason for these overpayments was failure of Care Groups and other departments to notify HR and Finance of changes to staffing in a timely manner as set out in the procedures. We therefore fully endorse the recommendations proposed by the Finance Department to address the situation and urge the Executive to approve them. We will continue to monitor salary overpayments.**

13. **The Audit Committee receives a series of regular annual financial Internal Audit reports designed to give assurance to our External Auditors when they conduct their audit of the financial accounts. The 2015/16 reports presented at this meeting were:**
    a. **Accounts Payable**
    b. **Accounts Receivable**
    c. **Financial Ledger**
    d. **Capital**
    e. **Cashiers**
    f. **Commissioners Challenges (although completed was not included on the agenda for the meeting and therefore not considered by the Audit Committee).**

    We need to advise the Board that it was noticeable that in a number of instances assurance levels had dropped from Significant last year to Reasonable this year and it is something we wish both the Board and the Finance department to note. The reasons are varied but include longer payment terms; regular supplier reconciliations not being carried out; retrospective order values increasing; debt levels rising; Fixed Asset Register (FAR) not being updated; no monthly reconciliations between FAR and the Ledger; as in previous years no disposal of assets recorded; key cash controls requiring tightening. Certainly some of these shortfalls can be ascribed to staff shortages. But the lowering in levels of assurance is of concern.

14. **The last two years has seen a significant rise in Serious Incidents related to failure to follow up diagnostic tests. The Audit Committee commissioned an Internal Audit into this area last year. At this meeting we were presented with a follow up Internal Audit to verify the progress on recommendations and agreed actions arising from the initial report. Out of seven recommendations made in summer of 2015 only 3 have been implemented, 3 have been partially implemented and 1 has not been implemented. Sadly despite concerted efforts by the Medical Director there are still significant compliance issues. Feedback indicates one of the main issues is incorrect or no Consultant attribution to patients (see 15 below). IT systems limitations were also cited. However based on a survey of Consultants the Audit Committee believes that there are underlying cultural issues in the lack of compliance. We cannot emphasise enough that failure to follow up can put patients' lives at risk. We ask that the Board require the Executive to address these issues urgently and report back to the Board what they have done and give subsequent regular progress reports to the QRC.**

15. **Part of the audit plan for 15/16 was an Internal Audit of Consultant Attribution. Only Limited Assurance could be given for the system of governance and control for consultant attribution for both In-Patients and Out-Patients. Correct consultant attribution is of critical importance to the Trust. The Board will be aware that incorrect consultant attribution to patients can result in an increased risk of adverse clinical**

outcomes and poor management information leading to incorrect activity and income allocations and incorrect consultant level activity data. Audit testing did not identify any one overriding issue for incorrect consultant allocation but it is recommended that as a matter of urgency the Medical Director be tasked to undertake a root cause analysis of the reasons for incorrect consultant allocation and develop actions to address the underlying causes. Again we believe from the consultant survey that part of the problem is cultural although there are also technical issues to be addressed

16. **We received an Internal Audit report on Discharge Summaries which followed up on an Internal Audit in 2013/14. The audit found that only 2 out of the 6 recommendations had been implemented, one had been superseded, 1 had been partially implemented and 2 had not been implemented. In the month of January the audit showed that 58.7% of discharge summaries were not completed and could not be evidenced as having been sent to GPs. Internal Audit was unable to conduct an audit of the quality of the Discharge Summaries due to difficulties in sourcing an independent and suitably qualified consultant. Information supplied post meeting by an Associate Medical Director deputising for the Medical Director indicated that for 43% of Discharge Summaries in January there was no evidence that they had been sent to GPs. Whichever figure is correct there is clearly a pressing need to improve. The timely communication of accurate information is very important in supporting the continued medical care once a patient has been discharged from hospital. It is also a CQUIN and so failure also has financial implications. The audit shows clearly that while the information is available the Divisions' and Care Groups' governance procedures and processes for Discharge Summaries in some instances are ineffective. We do not believe the Board will be prepared to accept the situation on Discharge Summaries as it exists. We therefore recommend that the Medical Director be tasked with producing regular performance figures and an action plan, based on the Audit Report recommendations, and be tasked with reporting back on progress to the F&P Committee on a regular basis.**

17. **We were due an Internal Audit report on Outpatients. We understand that the draft report is ready but could not be brought to the Audit Committee because it had not been reviewed and signed off by the COO.**

18. **We received reports from the External Auditors on the underlying considerations for setting materiality levels for the audit of the financial accounts and an update on the audit plan alerting us of delays to the audit due to lack of response from the Finance team. The External Auditors have signalled concerns over the capacity of the finance team to prepare a high quality set of accounts and working papers to the required timescales. Failure would result in increased auditor's fees and possibly missed deadlines for submission to the NHSI. The CFO has assured us that the timescales and quality standards will be met.**

19. The Audit Committee considered a draft of its annual report to the Board. It also reviewed a draft of the audit plan for 16/17. Both documents will be updated and brought to the May meeting of the Board for approval.

20. For 2016/17 we welcome our new Internal Auditors TIAA. On behalf of the Audit Committee would like to thank our current Internal Auditors London Audit Consortium and particularly their lead Auditor, Lindsay Thatcher, for their service to the Trust over a significant number of years.

MSJR
25th March 2016.